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September 25, 2018

Stuart Altman, Ph.d., Chairman
David Seltz, Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Re: HPC's Potential Referral of the Beth Israel Lahey Health (BILH) Transaction

Dear Dr. Altman and David:

On September 13th, Lawrence General Hospital, a Level 3 Trauma Center accredited by the American College of Surgeons, activated its trauma call, and treated thirteen people injured by the devastating gas leak explosions. One of those injured would not have survived a med flight outside of the community. This tragedy highlights the importance of having a vibrant hospital with capabilities that meet community needs.

We have had a mutually beneficial relationship with Beth Israel Deaconess for some time. We write today, not to object to the merger, but to ask policy makers and the health policy commission to specifically make clear their interest that Lawrence General Hospital be held harmless from impacts that could result from your referral to the Attorney General or the DPH. Any limitation on price or total medical expense of the merged entity will harm Lawrence General because we are a contracting affiliate of BIDCO and the HPC currently includes us in the analysis of the merger.

Although we are not a proposed member of the merged BILH system, we are a member of BIDCO, the Beth Israel Medical Center's contracting organization. Lawrence General Hospital and 127 local physicians, including primary care physicians and specialists in Greater Lawrence who are members of the Choice Plus PHO and/or the Lawrence General IPA, are also contracting members of BIDCO. The hospital and these physicians participate in risk contracts with BIDCO through the IPA with a number of commercial insurance carriers, including BCBS, HPHC and Tufts, in addition to Medicare. Membership in BIDCO allows the hospital and physicians to participate in a large accountable care organization and risk contracts.

Lawrence General has the third lowest commercial rates of payment[1] as most recently reported by CHIA, and is paid 73.6% of the statewide average relative price. This low rate is a direct result of our high Medicaid exposure that diminishes our market leverage with health plans. Taken together, our high Medicaid volume and our low commercial rates result in our having consistently slim operating margins. This ultimately makes us less attractive to health systems.

Therefore, **if the Health Policy Commission refers the BILH merger to Attorney General Maura Healey and/or the Department of Public Health, Lawrence General and the Lawrence General IPA ask to be held harmless from any potential limitation in price or total medical expense growth either the attorney general or the DPH would place on the new system.**

Further, we ask that you specifically reference your desire to protect Lawrence General Hospital and the Choice Plus PHO/Lawrence General IPA from conditions that would negatively impact their price or total medical expense if a referral is made to the Attorney General and DPH. The price and total medical expense data for Lawrence General and its physicians are readily available from the three health plans. Neither the hospital nor the IPA or its providers will be part of the financially consolidated new system, and will therefore remain exposed to the challenges of serving our community as independent providers. The hospital and IPA should not be a part of any limit the AG or DPH may seek to impose on price or total medical expense. To do so would limit the potential for Lawrence General's rates to rise from third lowest in the state which already threatens the hospital, and would penalize us unfairly for being an affiliate of BIDCO.

We cannot endure a further disadvantage imposed on us by policy makers as an independent, high Medicaid, low commercial insurance rate hospital. As the Health Policy Commission's 2016 Provider Price Variation report stated, "the HPC found that if lower-priced hospitals were to receive 3.6% annual rate increases, it would take approximately 19 years for some hospitals to reach the prices of the 75th percentile"[2].

I urge you to consider the impact on Lawrence and the surrounding communities we serve. If the health policy commission does not recommend that we be held harmless it will threaten the strong and vibrant hospital our region requires.

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[1] Massachusetts Hospital Payment Variation Chart based on the most recent 2016 CHIA state average relative price data published March, 2018

[2] July 2016 HPC Provider Price Variation Report, page 13

Sincerely,

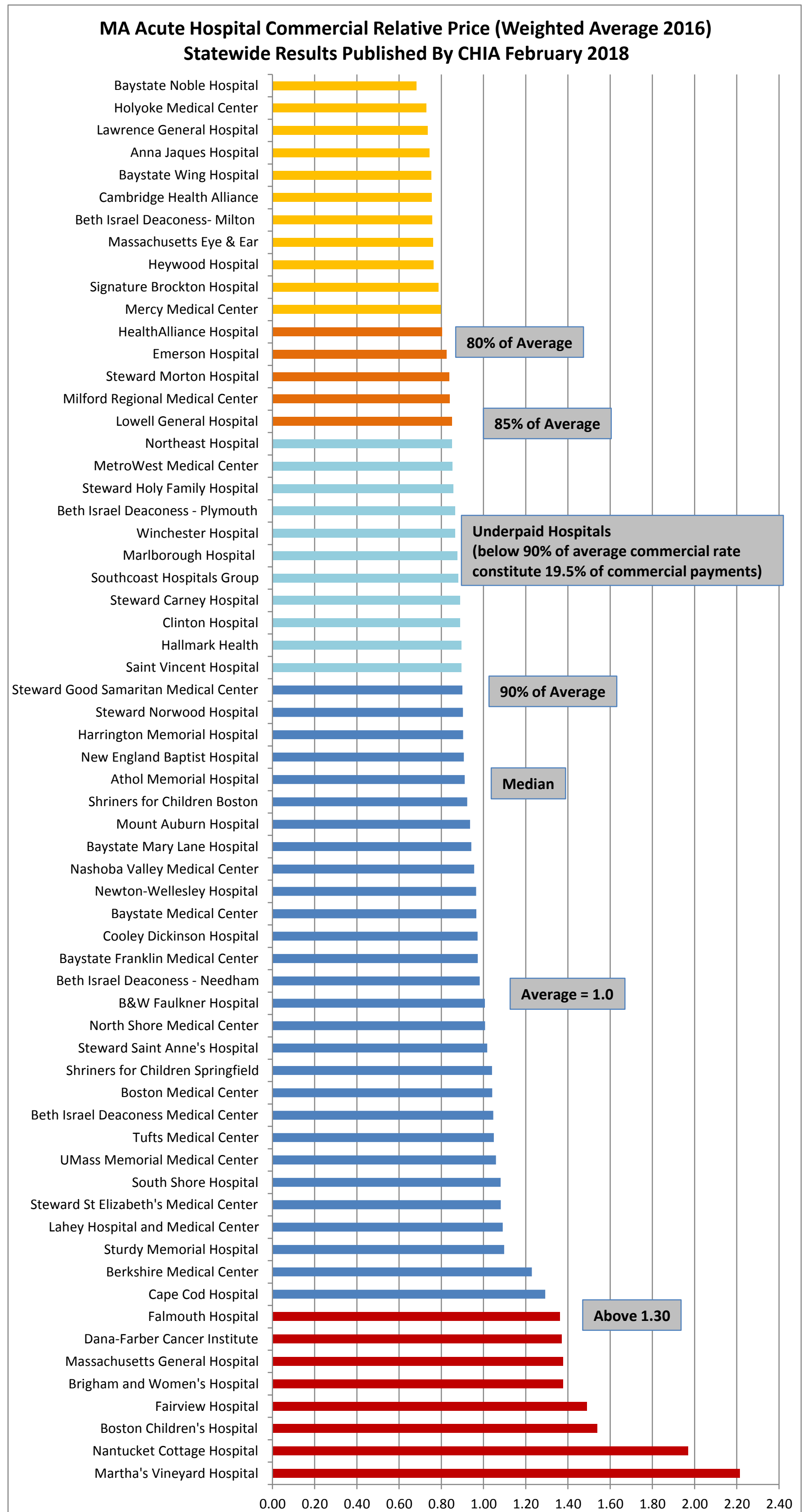
Dianne J. Anderson
President & Chief Executive Officer

Copy to:
Attorney General Maura Healey
Secretary Marylou Sudders
Health Policy Commission Board Members
Assistant AG, Chief, Health Care & Fair Competition Bureau Mary Beckman
Assistant AG and Chief Health Care Bureau Chief Eric Gold

Attachments:
1. Massachusetts Hospital Payment Variation Chart based on the most recent 2016 CHIA state average relative price data published March, 2018
2. July 2016 HPC Provider Price Variation Report, page 13

Massachusetts Hospital Payment Variation

#	Hospital	2015 Relative Price	2016 Relative Price	Share of Commercial Payments
1	Baystate Noble	0.681	0.682	0.2%
2	Holyoke Medical Center	0.722	0.728	0.2%
3	Lawrence General	0.754	0.736	0.4%
4	Anna Jaques	0.756	0.743	0.5%
5	Baystate Wing	0.749	0.752	0.2%
6	Cambridge Health Alliance	0.797	0.754	0.6%
7	BIDH - Milton	0.760	0.757	0.4%
8	Massachusetts Eye & Ear	0.833	0.760	
9	Heywood Hospital	0.752	0.763	0.4%
10	Signature Brockton	0.785	0.787	0.7%
11	Mercy Medical Center	0.806	0.796	0.6%
12	HealthAlliance	0.781	0.804	0.4%
13	Emerson	0.846	0.824	1.1%
14	Steward Morton	0.855	0.837	0.4%
15	Milford Regional	0.840	0.840	1.1%
16	Lowell General	0.822	0.850	1.6%
17	Northeast Beverly	0.867	0.851	1.3%
18	MetroWest	0.856	0.853	1.0%
19	Steward Holy Family	0.859	0.857	0.7%
20	Winchester Hospital	0.892	0.865	1.6%
21	BIDH - Plymouth	0.861	0.865	0.8%
22	Marlborough	0.849	0.875	0.2%
23	Southcoast Health	0.908	0.880	2.1%
24	Steward Carney	0.895	0.888	0.2%
25	Clinton	0.942	0.889	0.1%
26	Hallmark Health	0.91	0.895	1.0%
27	Saint Vincent	0.836	0.896	1.7%
28	Steward Good Samaritan	0.907	0.900	0.8%
29	Steward Norwood	0.897	0.902	0.7%
30	Harrington Memorial	0.905	0.903	0.5%
31	New England Baptist	0.935	0.907	
32	Athol Memorial	0.950	0.911	0.1%
33	Shriners for Children	0.925	0.923	
34	Mount Auburn	0.938	0.936	1.5%
35	Baystate Mary Lane	1.001	0.942	0.1%
36	Nashoba Valley	0.991	0.956	0.2%
37	Newton-Wellesley	1.014	0.965	3.2%
38	Baystate Medical	1.010	0.966	3.3%
39	North Shore Medical Center	1.005	0.972	1.6%
40	Baystate Franklin	0.985	0.973	0.3%
41	BIDH - Needham	0.983	0.982	0.4%
42	Brigham and Women's Faulkner	1.046	1.006	1.2%
43	Cooley Dickinson	1.005	1.007	0.8%
44	Steward Saint Anne's	0.934	1.017	0.8%
45	Shriners Children Springfield	0.909	1.040	
46	Lahey Clinic	1.011	1.041	3.9%
47	BIDMC	1.064	1.046	6.3%
48	Tufts Medical	1.050	1.049	2.5%
49	UMass Memorial Medical	1.066	1.059	5.0%
50	South Shore	1.108	1.081	2.7%
51	Steward St Elizabeth's Medical	1.079	1.082	1.2%
52	Boston Medical	1.011	1.091	1.3%
53	Sturdy Memorial	1.051	1.098	0.7%
54	Berkshire Medical	1.130	1.229	1.5%
55	Cape Cod	1.311	1.292	1.7%
56	Falmouth	1.519	1.362	0.7%
57	Dana-Farber Cancer	1.503	1.371	
58	Brigham &Women's	1.409	1.376	10.5%
59	MGH	1.405	1.376	13.9%
60	Fairview	1.324	1.490	0.1%
61	Boston Children's	1.514	1.539	
62	Nantucket Cottage	1.960	1.970	0.2%
63	Martha's Vineyard	1.932	2.215	0.3%



COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

PROVIDER PRICE VARIATION

STAKEHOLDER DISCUSSION SERIES SUMMARY REPORT

July 2016

- Payer representatives discussed the importance of placing increasingly stringent efficiency and quality requirements on providers participating in HMO/POS-based APMs, so as to improve performance over time in a context where providers have been able to build necessary capacities.
- The group discussed the role of APMs in incentivizing quality improvement. Chairman Altman suggested that while APMs must never lead to decreased quality, if an APM can control spending without negatively impacting quality, it is producing a valuable outcome. He further noted that improved quality might increase healthcare spending, at least for some period of time, and questioned whether that outcome would increase the financial burden on low-income patients. Another stakeholder advocated for a more sophisticated definition of quality that captures proper utilization.
- Representatives of both payers and purchasers emphasized the importance of expanding the use of APMs in PPO products alongside efforts to improve APMs in place for HMO/POS populations.
- Representatives of both payers and providers recognized the importance of being able to make adjustments to the structure of a global budget arrangement during the contract cycle. Mid-cycle changes can help providers continue to participate in the APM and can control for unanticipated contextual changes, such as natural disasters or epidemics.
- The group generally agreed that accurate risk adjustment is critical for APMs. Representatives of providers and consumer groups stated that risk adjustment methodologies should better account for socioeconomic status risk factors. The group also expressed concerns over the Next Generation ACO model's capping the increase of a population's risk score at 3%, as this might discourage providers from making inroads with underserved communities.

Overall, stakeholders – including representatives of providers, payers, and consumer groups – supported ongoing work to expand and enhance APMs. This included agreement by many stakeholders that the market should transition from using historic performance as the primary basis for financial benchmarks in global budgets.

DIRECT LIMITS ON PRICE VARIATION

The HPC held its third and final stakeholder discussion of provider price variation on May 19, 2016, focusing on potential direct limits on price variation. In addition to a presentation by HPC staff, Dr. Joshua Sharfstein, former Secretary of the Maryland Department of Health and Mental Hygiene and current professor and Associate Dean of the Johns Hopkins University Bloomberg School of Public Health, presented on Maryland's all-payer rate-setting system and new hospital global budgeting model.

HPC Staff Presentation

Direct limits on price variation, unlike policies to address price variation by changing demand-side or supply-side market incentives, involve some degree of government intervention to prohibit or limit unwarranted price variation. Direct limits have the potential to address price variation more directly and quickly than demand or supply-side approaches and they may be more specifically targeted to reducing variation.

There is a wide range of different policy options that can be categorized as direct limits on price variation, including everything from an all-payer prospective rate-setting system (under which a government agency would set allowed prices for all services and all payers) to policies that would set forth certain rules or guardrails governing the extent of and/or reasons for variation, within which market participants would negotiate prices.

To set the stage for the discussion, HPC staff focused its presentation on a handful of potential policy options to directly limit price variation in Massachusetts:

- Rate banding, or prohibiting prices from varying by more than a given amount;
- Creating differential rate growth rates where lower-priced or more efficient providers are allowed greater increases in prices or global budgets than higher-priced or less efficient providers;
- Limiting variation (in either FFS rates or global budgets) to value-based factors that provide benefit to the Commonwealth; and
- Approaches adopted in other payment systems, including by other states, federally, and internationally.

Rate Banding

"Rate banding" refers to policies that prohibit prices from varying from mean or median prices by more than a fixed amount (e.g., no more than 20% greater or 10% less than the average in a payer's network). Within the defined "bands," providers and payers would continue to negotiate specific prices. A number of such policies have been proposed in the Commonwealth, including a recent, proposed ballot initiative. While most proposed policies related to rate banding have focused on hospital price variation, HPC staff noted that rate banding could be applied to physician groups and other provider types as well. Similarly, while most proposed policies have applied to all hospitals, HPC staff also noted that the rate bands could be calculated separately for different cohorts of providers; in other words, the thresholds could be defined differently for academic medical centers (AMCs) versus community hospitals.

Policies of this type generally result in immediate reductions in total spending because the price reductions would be concentrated at institutions with high patient volume while price increases would generally be concentrated at institutions with lower volume. However, this also means that higher-priced providers would face significant and potentially immediate revenue reductions, which could have significant market implications. The long-term impact of such a policy might also be difficult to quantify because providers and patients may change utilization patterns in response to significant price changes. HPC staff also described how the impact of rate banding policies would depend on key design factors including where the upper and lower bands on prices are set, whether the policy applied to all providers or whether some providers (e.g., specialty hospitals) were excluded, and the time over which the policy was implemented (i.e., full implementation in the first year or a more gradual trajectory).

Differential Growth Rates

Differential rates of price growth policies allow different levels of annual price increases for providers based on their initial price levels. Such a policy could be implemented in a number of different ways, but would be designed to lead to price convergence over time. As with rate banding, such a policy could be applied to hospitals, physician groups, or other provider types. It could also apply to FFS prices, global budgets, or both. Depending on the permitted growth levels for different providers, convergence could be achieved over different timeframes, but HPC staff noted that such convergence could still take a considerable amount of time. For example, due to the current extent of price variation in the Massachusetts healthcare market, the HPC found that if lower-priced hospitals were to receive 3.6% annual rate increases, it would take approximately 19 years for some hospitals to reach the prices of the 75th percentile in some major payer networks.[xxi] Of course, a higher rate of increase would allow a faster rate of convergence.

Limiting Variation to Acceptable Factors

One of the drawbacks of both rate banding policies and differential growth rate policies is that these policies limit all price variation, regardless of whether some price variation may be warranted to support activities that are beneficial to the Commonwealth. Policies to limit variation to acceptable factors—ranging from full rate-setting systems to systems that create certain guardrails within which payer-provider rate negotiations occur—could provide an alternative, more nuanced approach that would allow prices to vary where that variation is tied to value while reducing *unwarranted* price variation.

The HPC has found that across a range of healthcare systems, there tends to be a common nexus of factors identified as acceptable reasons for prices to vary. For hospitals, these factors include clinical complexity, geography (variation in local labor costs), a hospital's teaching mission,[xxii]

xxi MA Health Policy Comm'n, 2015 Cost Trends Report Pursuant to M.G.L. 6D, §8(g): Special Report on Provider Price Variation (Jan. 2016), *available at* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf.

xxii It is not clear empirically whether training and employing medical residents is a net financial cost or benefit to teaching hospitals. *See* Amy Nordrum, *The High Cost of Healthcare: America's $15B Program to Pay Hospitals for Medical Resident Training is Deeply Flawed,* INT'L BUS. TIMES (Aug. 13, 2015), *available at* http://www.ibtimes.com/high-cost-healthcare-americas-15b-program-pay-hospitals-medical-resident-training-2040623 (last visited Jan. 11, 2016); Barbara O. Wynn et al., Does it Cost More to Train Residents or to Replace Them? RAND CORPORATION (2013), *available at* http://www.rand.org/content/dam/rand/pubs/research_reports/RR300/RR324/RAND_RR324.pdf (last visited Jan. 11, 2016).