Health Care for all

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September 11, 2014

The Honorable Martha Coakley
Attorney General
Attn: Anti-Trust Division
One Ashburton Place, 18th Floor
Boston, Massachusetts 02108

Re: Comments on the Proposed Final Judgment in Massachusetts v. Partners Healthcare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp., Civ. No. 14-2033 (BLS).

Dear Attorney General Coakley:

Health Care For All (HCFA) is the principal Massachusetts non-profit consumer health care organization. Since 1985, HCFA has been leading advocacy for Massachusetts health care policy on behalf of patients and consumers seeking high-quality, accessible, affordable health care. We were intimately involved in the policy process leading up to the passage of Chapter 224 of the Acts of 2012, and many provisions of the law reflect our input.

In addition to our advocacy work on health policy, HCFA also operates a free consumer HelpLine. Our HelpLine receives several thousand calls a month from Massachusetts consumers with health care concerns. Over 40% of our calls are in languages other than English. We also have an active cadre of hundreds of activists throughout the Commonwealth who participate in our work. Our policy advocacy is grounded in the input we receive from consumers who call our HelpLine or participate as activists in our work.

This submission draws on our long-standing policy expertise concerning health care in Massachusetts, and reflects our best view of the interests reflected in the consumers who are our members and participants in our activities.[1]

[1] We note for the purposes of full disclosure that HCFA receives financial support from Partners HealthCare System and South Shore Hospital, as well as from numerous other hospitals and providers that are competitors of Partners and from many Massachusetts insurance carriers. The majority of HCFA's funding comes from foundation grants, government contracts, and individual donations. HCFA's major sources of funding are listed in our 2013 annual report, available at https://www.hcfama.org/sites/default/files/annual_report_2013_final.pdf .

1. The Agreement ought to be reviewed by the Health Policy Commission before being considered by the Court.

Chapter 224 is among the most recent of a stream of state laws regulating hospitals and health care in Massachusetts. These reflect the vital public interest in our health care system. The provision of health care services is not treated as an ordinary, private commodity by the public or the Commonwealth. Health care is an intensely public good.

Thus, we urge the Court to treat the issues raised by the proposed settlement as part of the public policy process of Massachusetts. This demands that the issues covered by the agreement be subject to widespread and transparent public scrutiny. Accountable public officials must have an opportunity to investigate and make judgments about the impact of various consequences of the transactions and restrictions the Court is being asked to judge.

In effect, the proposed settlement would transform the initially proposed acquisitions into substantially new transactions. The original acquisition proposals were closely vetted by the Health Policy Commission (HPC), with detailed expert analysis, extensive public input, and a transparent, democratic decision-making process by individuals responsible to elected officials. The settlement before the Court, however, has undergone no such process.

Therefore, at a minimum, we urge the Court to refer the new, pending agreement to the HPC for further analysis and review. This will allow the state's political process to have an analytical basis for reaching conclusions, and will inform a robust public discussion of the options and expectations. The Court should have both the factual findings of the HPC and the judgment of its members to inform its decision on this proposed settlement.

2. Consumers are concerned most about the impact on their costs, on their access to care, and on the quality of their care.

As patient and consumer advocates, we know that average residents of the Commonwealth are generally not concerned with issues like "total medical expenses" or "market leverage." While these concepts are important tools for analyzing the proposed consent agreement before the Court, patients are more interested in the impact on their care and their costs. In addition to the general concerns of antitrust law, we urge that the agreement be looked at through three important consumer lenses:

1. The impact of the agreement on the cost of care, particularly costs directly paid by consumers through premiums or out-of-pocket cost sharing;
2. The impact of the agreement on access to care, particularly access for vulnerable populations, such as people receiving care through government programs such as

MassHealth (our Medicaid and CHIP program), Medicare, subsidized coverage through the Health Connector (our exchange under the Affordable Care Act), and the uninsured; and

3. The impact of the agreement on the quality of care and the overall health of the population served by the institutions involved.

Other parties may have more sophisticated analyses of the likely impact of the settlement on costs. Health Care For All knows that increased premiums and out-of-pocket costs directly impact and limit access to care. We would like to focus our comments on the role the Court should adopt in evaluating the impact of the proposed settlement on access to care and on the quality of care provided.

3. Access issues

In its review, the Health Policy Commission examined the likely effect of the proposed transactions on health care access. We are concerned that the settlement does not adequately address the access issues in the HPC's preliminary and final reports, and that the proposed transactions raise further access concerns related specifically to access to behavioral health and safety net services, network adequacy and continuity of care/provider choice.

a) Access to behavioral health services

The Health Policy Commission's Preliminary and Final Cost and Market Impact Review (CMIR) of Partners' proposed acquisition of Hallmark Health raises significant concerns regarding potential impacts to the accessibility of inpatient and outpatient behavioral health services in the northeastern Massachusetts region which have not yet been addressed by the parties. Specifically, the potential impacts of the proposed settlement include both a direct impact on access to behavioral health services and an indirect but real danger that the overall financial impacts on the system will lead to a loss of inpatient psychiatric beds, as they are the most under-reimbursed beds in the system.

Under the proposed *Programs and Facilities Rationalization Initiative*, all behavioral health services from Hallmark-Lawrence Memorial Hospital (LMH), Hallmark-Melrose Wakefield Hospital (MWH), and North Shore Medical Center (NSMC)-Salem would be consolidated and relocated to NSMC-Union in Lynn.[2] We are concerned about the centralization of all inpatient behavioral health services without related plans to address the increased transportation barriers to patients and their support systems. As pointed out by the HPC's final CMIR, hospitals in the northeast region serve a relatively high mix of government payer patients who tend to be low-

[2] Health Policy Commission, Review of Partners Healthcare System's Proposed Acquisition of Hallmark Health Corporation (HPC-CMIR-2013-4), Final Report (September 3, 2014) at 12-13, available at: http://www.mass.gov/anf/docs/hpc/material-change-notices/phs-hallmark-final-report-final.pdf.

income, elderly, and/or disabled.[3] This fact, combined with the unique vulnerabilities of behavioral health patients, raises the concern that the increased transportation barriers that this service restructuring would introduce are likely to cause considerable difficulty for patients seeking necessary and important behavioral health care.[4]

The HPC analysis found that for patients currently seeking behavioral health services at Hallmark-LMH, Hallmark-MWH, and NSMC-Salem, drive times to care would generally increase by 50 percent or more under the proposed *Rationalization Initiative*.[5] For patients who rely on public transportation, this impact would be even more pronounced as service lines between these areas are limited.[6] Public transportation times for patients seeking care at NSMC-Union post-transaction are estimated to be up to 90-minutes in transit,[7] or could be more for those who must take multiple transit lines.

The HPC's final CMIR further documents existing concerns regarding insufficient access to behavioral health services in the region.

> To further examine area service capacity and need, the HPC studied boarding of patients in emergency departments (EDs) in the region. Specifically, the HPC examined the number of patients who visited regional emergency departments with a behavioral health need and had to wait over 12 hours for an inpatient admission. This showed that although only about 5.9% of emergency department patients have diagnosed behavioral health-related conditions, these patients are disproportionately represented among ED boarders; over half of patients who boarded at area hospitals had a behavioral health diagnosis. This data suggests that additional inpatient and outpatient behavioral health capacity is likely necessary in the region. . . . (pp. 36-37)
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> We evaluated the parties' plans to improve access to certain services as well as their potential impact on the vulnerable patient populations that Hallmark and NSMC serve, and found: . . . Relocating inpatient behavioral health services may have an adverse impact on access to those services for vulnerable populations. (p. 70)
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> (Footnotes omitted)

The final CMIR further points out that the parties' responses to the preliminary CMIR still do not provide adequate information and commitments on how the proposed transaction will impact inpatient behavioral health capacity and achieve improvements in the quality of and access to behavioral health services.[8] Given the existing problems with access to behavioral health

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[3] Id. at 75.
[4] Id. at 76.
[5] Id. at 75, see footnote 274.
[6] Id. at 75.
[7] Id. at 75, see footnote 275.
[8] Id. at 72-73 and Exhibit B at 20-21.

services, we are concerned that the proposed settlement does not offer any assurance that relocation of inpatient behavioral health services will have no adverse impact on the availability of these services on those geographic areas currently served by Hallmark.

Finally, HPC's anticipated shift of inpatient volume to Hallmark from non-Partners hospitals raises concerns about the impact on psychiatric beds in community hospitals:

> Our analysis shows that Hallmark is likely to increase its inpatient volume as a Partners hospital, but that this new volume is more likely to come from net volume reductions at non-Partners hospitals than from any net change in volume at the Partners AMCs. Specifically we estimate that of the net volume increase at Hallmark, about 60% will likely derive from net volume reductions at non-Partners community hospitals and about 40% from net volume reductions at non-Partners AMCs, with no statistically significant change in net volume of patients using Partners AMC and community hospitals.[9]

If the proposed acquisition results in a drain of beds from community hospitals, as predicted by the HPC, they will most likely be non-psychiatric beds, which account for substantially higher per bed revenues than psychiatric beds. The majority of psychiatric inpatients rely on lower-paying public insurance, while non-psychiatric inpatients are disproportionately insured by higher-paying commercial insurers. If unsubsidized by non-behavioral bed revenues, psychiatric beds are more likely to close. If beds close in this region, behavioral health patients will have to seek out beds elsewhere in the state, where inadequacy of current beds is well-documented, and which could lead to the worsening of emergency department boarding for people in need of treatment.

b) Impact on safety net providers

The final judgment also could harm the safety net health systems serving the most vulnerable populations of Massachusetts. While the Unit Price Cap provisions of the agreement may curb the rate of increase in Partners' prices, these provisions lock in and widen the already substantial health care reimbursement rate disparities between Partners-owned facilities and safety net facilities. For example, according to public comment from Dr. Laura Sullivan of Cambridge Health Alliance given at the Health Policy Commission meeting on July 2, Massachusetts General Hospital is paid 2 to 2.2 times the rates paid to Cambridge Health Alliance (CHA) for the same services and quality. The HPC also notes in its final CMIR that Partners' hospitals consistently receive higher reimbursement rates than other area hospitals.[10] If, under the agreement, Partners is allowed continued growth in its prices consonant with general inflation, safety net systems will not be similarly able to command equal price increases and the disparities in reimbursement rates will widen. Such a financial situation will affect the ability of our safety

[9] Id. at 56.
[10] Id. at 23-24.

net health systems to continue to provide necessary care and services to our most vulnerable populations.

The proposed final agreement further allows Partners to expand its physician base by nearly 500 physicians over the next five years. Though restricted from affirmatively soliciting existing practice groups at competitor academic medical centers (AMCs) in Eastern Massachusetts, the agreement does not similarly prohibit affirmative solicitation of non-AMC physicians such as those at safety net health systems like Cambridge Health Alliance. In light of the disparities in resources and reimbursement rates commanded, it is likely that these safety net systems will be unable to effectively compete with Partners to retain and recruit physicians, further calling into question the long-term viability of our safety net health system. The agreement also does not prohibit Partners from capitalizing on overtures from competitor AMC physicians interested in joining Partners as employees or contracting affiliates which, given the wide publicity of Partners' significantly higher reimbursement rates, may prove to be a serious loophole to the agreement's efforts to protect the physician base of other AMCs.

c) Preservation of existing services

Unlike the proposed specific remedies applicable to South Shore Hospital, the final agreement does not require Partners to preserve the level of services provided at any of the Hallmark medical facilities or in the Hallmark system at large. Further, while Partners and Hallmark have expressed an intention to shift volume from the more expensive, urban academic medical centers to the less expensive community medical centers and thereby keep patients in their community for the purposes of receiving care when appropriate, there are no guarantees in the current agreements that this will be measured or come to fruition.[11] The lack of safeguards in the final agreement as to these issues could negatively impact patient access to hospital services in their own communities.

d) Network adequacy and limited provider choice for subsidized patients

We are concerned that the proposed transactions may further limit access to provider networks for vulnerable populations, including enrollees in MassHealth, ConnectorCare and state programs for the dually eligible covered by both Medicaid and Medicare. MassHealth is the state's combined Medicaid and CHIP programs. It serves over 1.4 million low-income residents of Massachusetts, including seniors, parents and children, people with disabilities, pregnant women and some childless adults. MassHealth members generally get their care either through the managed fee-for-service program, or through an insurer, known as a managed care organization (MCO). Among those with full MassHealth coverage (excluding people with

[11] Id. at 55-59.

MassHealth as secondary coverage to other coverage, such as Medicare, or where MassHealth supplements employer coverage), some 49% of MassHealth members are enrolled in an MCO.[12]

Currently, Partners hospitals contract with very few MassHealth MCOs (see chart below). For example, the three hospitals in the Greater Boston region (Brigham & Women's Hospital, Faulkner Hospital, and Massachusetts General Hospital) contract only with Neighborhood Health Plan (NHP), which Partners acquired in 2012. We are concerned that if acquired by Partners, South Shore Hospital and Hallmark Health would similarly limit their contracting with MassHealth MCOs to only NHP or a more limited number of MassHealth MCOs. Such contracting exclusions could have serious consequences for MassHealth members, including limiting access to essential providers and disruptions in continuity of care.

Eastern and Northeastern MA Hospitals Participating in MassHealth MCO Networks[13]

Hospital	BMC HealthNet Plan	CeltiCare Health Plan	Fallon Community Health Plan	Neighborhood Health Plan	Network Health
Partners Hospitals					
North Shore Medical Center - Salem Hospital	✓			✓	
North Shore Medical Center - Union Hospital	✓			✓	
Brigham & Women's Hospital				✓	
Brigham & Women's/Faulkner Hospital				✓	
Mass. General Hospital				✓	
Martha's Vineyard Hospital	✓			✓	
Nantucket Cottage Hospital	✓			✓	
Newton Wellesley				✓	
Hallmark Health Systems					
Hallmark -Melrose Wakefield	✓	✓		✓	✓
Hallmark - Lawrence Memorial	✓	✓	✓	✓	✓
South Shore Hospital					
South Shore Hospital	✓			✓	✓

Effective January 1, 2014

Similar limitations also exist for insurers participating in other state-subsidized health programs. The ConnectorCare program is the state's supplemental benefits program for low-income people who do not qualify for MassHealth but are eligible for tax credits through the Affordable Care

[12] Blue Cross Blue Shield Foundation of Massachusetts, MassHealth: The Basics, at 14, available at http://bluecrossmafoundation.org/publication/updated-masshealth-basics-facts-trends-and-national-context (presentation, April 2014).

[13] See addendum, MassHealth MCOs Serving Standard, CommonHealth, Family Assistance, and CarePlus Hospital Network List. Effective January 1, 2014. The chart reproduced excludes Health New England, an insurer solely serving Western Massachusetts.

Act.[14] ConnectorCare is offered through seven managed care plans. Partners participates fully in only one ConnectorCare plan, its subsidiary Neighborhood Health Plan. Members of BMC Health Net can only access North Shore Medical Center and North Shore Physicans Group. They are excluded from all other Partners' facilities. Members of the CeltiCare Plan may only seek care at Spaulding Rehabilitation hospitals and Partners-affiliated nursing homes. The other four ConnectorCare plans have no contracts with Partners and their members are excluded from Partners hospitals and physicians.

We are additionally concerned with further limiting access to primary care providers for members of the One Care programs and Senior Care Options (SCO) programs. Both are federal-state programs that provide care to people who qualify for both Medicare and Medicaid. The SCO program is for seniors, and is offered through five managed care plans. The One Care program is for people with disabilities, and is offered through three managed care plans. Primary care doctors affiliated with Partners do not participate in the network of any of the insurers in either of these programs, despite multiple requests by the insurers to contract with the physician groups.

The consent agreement does not include any provisions requiring Partners to maintain or expand the participation of its acquired hospitals and physician practices in MassHealth and other safety net programs. We are concerned that as Partners expands, insurance plans that serve low-income Massachusetts residents will exclude increasing numbers of hospitals and other providers. This could result in further limiting these patients' choice of providers.

4. The Agreement should be reviewed and monitored based on its impact on the quality of health care provided to patients.

In its review, the Health Policy Commission looked at the likely effect of the proposed transactions on health care quality. In both transactions, the HPC did not find that the proposed transactions would likely improve the quality of care. With respect to the acquisition of South Shore Hospital, the HPC concluded,

> … [G]iven SSH and SSPHO's historically strong quality performance, and their own experience managing populations through risk-based payments, it is unclear how corporate integration of the parties is instrumental to raising quality performance in the South Shore region.[15]

[14] The ConnectorCare program will replace Commonwealth Care for 2015, and is for Massachusetts residents eligible for Advanced Premium Tax Credits under the ACA with incomes up to three times the federal poverty level.
[15] Health Policy Commission, Review of Partners Healthcare System's Proposed Acquisitions of South Shore Hospital (HPC-CMIR-2-13-1) and Harbor Medical Associates (HPC-CMIR-2013-2), Final Report (February 19, 2014) at 58, available at: http://www.mass.gov/anf/docs/hpc/20140219-final-cmir-report-phs-ssh-hmc.pdf.

With respect to the Hallmark acquisitions, the HPC concluded,

> The differences in Partners and Hallmark's historic quality performance indicate potential for the transaction to drive quality improvement. However, Partners and Hallmark have already been affiliated for nearly 20 years, including joint clinical and contracting efforts, and it is unclear how this merger is necessary to improve clinical quality in ways the parties' longstanding affiliation has not.[16]

Consumers in the Commonwealth see this proposed transaction as an opportunity to insure that the parties commit themselves to substantial improvements in the quality of health care provided to their patients. The third-party Compliance Monitor that is established by the agreement should be required to independently determine if the parties are using the transactions under the agreement to improve quality.

We believe that the Compliance Monitor should be directed to closely review and publicly report on the impact of the transactions in four critical areas:

a. Quality of care, particularly improved patient outcomes: Many of the quality measures used to measure health performance look at processes of care, such as the proportion of patients offered a particular treatment. While these are valuable in assessing narrow aspects of health care quality, a broader review would also focus on outcomes - how well the health care provider performs in improving a patient's health and well-being. Measuring outcomes such as preventable readmissions or complications would allow the Compliance Monitor to assess if the combined system is able to improve the totality of care received by patients. These measures would allow the Monitor, and the public, to judge the results of the transactions on its broad impact on improving patient health.

b. Enhanced patient-centeredness of care delivered: When care revolves around the interests of the patient, clinical outcomes and patient satisfaction are maximized. Too often, health care providers face financial incentives to increase patient volumes, leaving little time during rushed appointments to build a trusting relationship with patients. Institutional and financial needs trump other concerns. Patient-centered care resets the relationship with the provider to allow for empathy, communication, and a true partnership. Techniques like shared medical decision making bring patients and their clinicians together to jointly make treatment decisions.[17] Patient-centeredness can be measured by validated

[16] HPC-CMIR-2013-4, Final Report, supra note 2, at 78.

[17] Lee, O. E. & Emanuel, E. J. (2013). Shared Decision Making to Improve Care and Reduce Costs, *New England Journal of Medicine*, 368: 6-8.

techniques such as the patient confidence index or the patient activation measure.[18] Measuring progress among the acquired hospitals and physician practices on patient-centered care would be a critical indicator of the clinical benefit of the proposed transactions.

c. Care integration: One of the significant opportunities in each of these transactions is to increase access to team-based care.

d. Community and population health improvements: The parties all express support for the goal of improved overall health status for their communities as a key marker of the success of the transactions. Hospitals, physician practices, and other clinical providers are ultimately responsible for the health of the broader community in which they sit. Their attention must go beyond the walls of the clinic, and beyond the patients who happen to seek care at their sites at any time. Rather, health care providers in Massachusetts acknowledge a duty towards the health of the general public. The Department of Public Health uses sophisticated tools to measure population health, and the Court's Compliance Monitor should transparently report the impact of the parties on overall population health on behalf of the public.

Conclusion

Effective policy concerning complex health care issues, such as those implicated by the consent agreement, are never simple. Massachusetts has established a complex system of fact-finding, analysis and regulation of health care. Yet the consent agreement before the court has not had the benefit of any of these existing processes. In light of the issues raised above and other concerns, Health Care For All urges the court to defer any action on the agreement and submit it for review by the Health Policy Commission and the political arms of the Commonwealth.

[18] Hibbard, J. H. & Greene, J. (2013). What The Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs. *Health Affairs*, 32(2): 207–214; Hibbard, J. H., Greene, J, Sacks, R., et al. (2013). When Seeing the Same Physician, Highly Activated Patients Have Better Care Experiences Than Less Activated Patients. *Health Affairs*, 32(7): 1295–1305; Wasson, J.H., A Patient-Reported Spectrum of Adverse Health Care Experiences: Harms, Unnecessary Care, Medication Illness, and Low Health Confidence. 2013. *Journal of Ambulatory Care Management*, 36(3) 3: 245–250.