MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of July 18, 2018

MASSACHUSETTS HEALTH POLICY COMMISSION

Date of Meeting: Wednesday, July 18, 2018

Start Time: 12:05 PM

End Time: 4:28 PM

	Present?	ITEM 1: Approval of Minutes	ITEM 2: SHIFT-Care Investment Opportunity	ITEM 3: RBPO/ACO Appeals Regulation	ITEM 4: FY19 Budget Approval	ITEM 5: Preliminary CMIR Report
Stuart Altman*	X	X	M	X	M	X
Don Berwick	X	X	X	X	X	X
Martin Cohen	X	X	X	M	X	X
David Cutler	X	X	2nd	X	X	X
Wendy Everett	X	2nd	X	2nd	2nd	M
Timothy Foley	A	A	A	A	A	A
Chris Kryder	X	X	X	X	X	X
Rick Lord	X	A	A	A	A	X
Ron Mastrogiovanni	X	X	X	X	X	X
Sec. Marylou Sudders	X	M	X	X	ab	2nd
Sec. Michael Heffernan	X	X	X	X	X	X
Summary	**10 Members Attended**	**Approved with 9 votes in the affirmative**	**Approved with 9 votes in the affirmative**	**Approved with 9 votes in the affirmative**	**Approved with 8 votes in the affirmative**	**Approved with 10 votes in the affirmative**

Presented below is a summary of the meeting, including time-keeping, attendance, and votes.

*Chairman

(M): Made motion; (2nd): Seconded motion; (ab): Abstained from Vote; (A): Absent from Meeting

Proceedings

A regular meeting of the Health Policy Commission (HPC) was held on July 18, 2018 at 12:00 PM. A recording of the first portion of the meeting is available here. A recording of the second portion of the meeting is available here.

Commissioners present included Dr. Stuart Altman (Chair); Dr. Wendy Everett (Vice Chair); Dr. Donald Berwick; Mr. Martin Cohen; Dr. David Cutler; Dr. Chris Kryder; Mr. Ron Mastrogiovanni; Secretary Marylou Sudders, Executive Office of Health and Human Services; and Ms. Elizabeth Denniston, designee for Secretary Michael Heffernan, Executive Office of Administration and Finance.

Mr. Rick Lord joined the meeting at 1:15 PM.

Dr. Stuart Altman called the meeting to order at 12:05 PM and welcomed those present.

ITEM 1: Approval of Minutes from April 25, 2018

Dr. Altman provided a brief overview of the day's meeting. Dr. Altman called for a motion to approve the minutes from April 25, 2018. Sec. Sudders made a motion to approve the minutes. Dr. Everett seconded. The motion was unanimously approved.

ITEM 2: Care Delivery Transformation

Dr. Altman introduced Mr. Martin Cohen, Committee Chair for Care Delivery Transformation (CDT), who provided a brief overview of the CDT portion of the meeting.

ITEM 2a: SHIFT-Care Investment Opportunity Recommendation

Mr. Cohen introduced Mr. David Seltz, Executive Director, and Ms. Kathleen Connolly, Director, Strategic Investment. Mr. Seltz gave an overview of the SHIFT-Care investment opportunity. For more information, see slides 8-11.

Ms. Connolly provided details on each proposal recommended for funding. For more information, see slides 12-15.

Ms. Connolly requested that the board vote to approve the Executive Director's recommendations that the applicants for the SHIFT-Care investment opportunity receive reward funding.

Sec. Sudders asked if any Delivery System Reform Incentive Payment (DSRIP) Program funds would be used in the hospitals' in-kind contribution. Ms. Connolly said that the HPC would track the funding with use of a MassHealth template regarding DSRIP funds.

Dr. Altman motioned to approve the SHIFT-Care investment opportunity recommendation. Dr. Cutler seconded. The motion was unanimously approved.

Dr. Berwick said that he hoped there would be shared learning among the organizations selected. Ms. Connolly confirmed that there would be. She added that the HPC was particularly excited

for the initiation of the pharmacologic treatment in the emergency department (ED) and would ensure shared learning across those models.

Mr. Seltz recognized representatives of the SHIFT-Care awardees who were in attendance.

ITEM 2b: Regulation on Risk Bearing Provider Organization (RBPO) and Accountable Care Organization (ACO) Appeals

Mr. Cohen introduced Ms. Lois Johnson, General Counsel, and Mr. Steve Belec, Director, Office of Patient Protection (OPP). Ms. Johnson reviewed the statutory requirements for the HPC to develop requirements for internal appeals and an external review process for patients of certain provider organizations. For more information, see slide 19.

Ms. Johnson reviewed the timeline of the regulatory development process. For more information, see slide 20.

Ms. Johnson reviewed the key considerations in regulatory development. For more information, see slide 21.

Ms. Johnson reviewed the comments and testimony provided during the public hearing on May 25, 2018, and the HPC recommendations to the the regulation. For more information, see slides 22-25.

Ms. Denniston asked Ms. Johnson for clarification on the definition of "clear factual error" in regulation. Ms. Johnson responded that this is an error with the facts of the case, such as an incorrect patient name, provider name, or diagnosis and would necessitate the case being sent back to the internal review agency to ensure the correct information was reviewed. Ms. Denniston asked Ms. Johnson for clarification on the definition of "material procedural error." Ms. Johnson responded that a material procedural error involved the appeal process.

Dr. Berwick asked Ms. Johnson if there was a way to retrospectively examine the process laid out by the regulation in a year and ensure that it was functioning properly. He said that he also had concerns regarding the expedited medical review, and asked if using calendar days versus business days could cause harm in the hypthetical case that a patient requires emergency care on a weekend. Dr. Berwick also stated that he had concerns in regards to accessing medical records only after the appeals process has been initiated, and that having access to medical records prior to the appeals process could potentially avoid an appeal. He asked, given the other statutory requirements on providers, how quickly the records could be obtained by someone trying to decide whether to make an appeal.

Regarding Dr. Berwick's first question, Ms. Johnson said yes. The HPC would require reporting and would gain an understanding of the number and nature of the reviews. She explained that carrier reviews involve the patient's physician having access to the medical records and the carrier does its own clinical review of those records. In the context of internal appeals, the provider organization does the reviewing so it would have access to the medical records, as opposed to the patient.

Dr. Berwick clarified his question and asked how fast would the patient be able to access their own medical records. Ms. Johnson responded that the statute does not address this issue and so the ability of the HPC to alter existing statutory access to medical records is not contemplated in this statute. She added that she did not recommend changing timelines in this context without legislative direction.

Regarding Dr. Berwick's question on the use of calendar days versus business days Ms. Johnson said that the regulation addresses gathering information to send to the internal review agency and does not impact the time for the external review agency to render its decision. She noted that this truncates the time on the external review agency's end, but not in terms of the decision affecting the patient.

Dr. Kryder asked what would be the expected volume of appeals during a 12-month period. Ms. Johnson said that in the year and a half that the HPC has been tracking internal reviews there were less than 200 internal appeals across 20 different provider organizations and that staff expect a significantly smaller portion of those going through external review. She added that providers have expressed that most of the appeals would be resolved internally before being referred to the HPC. She said that like the carrier side, staff expect a small proportion likewise, out of the larger scope on the internal appeals. Dr. Kryder asked for a range of the amount of the carrier review appeals. Mr. Belec said that the expectation would be less than 5 percent of the carrier review appeals.

Sec. Sudders asked for clarification on whether the regulation would affect MassHealth. Ms. Johnson responded that the regulation applies only to commercial patients, and that MassHealth and Medicare patients have other appeal avenues.

Dr. Altman highlighted that Massachusetts is the first state to have this type of process, but asked if other states are pursuing a similar type of process. Ms. Johnson responded that Massachusetts is the first state to do this on the commercial side. She further explained that other states with Medicaid ACOs have different processes.

Dr. Altman asked for confirmation on whether staff would be providing more information on the outcomes of the regulation to the commissioners. Ms. Johnson confirmed that staff would.

Mr. Cohen motioned to approve the RBPO/ACO Appeals Regulation and acknowledged the work of the staff in the development of the regulation. Dr. Everett seconded. The motion was approved unanimously.

ITEM 3: Executive Director's Report

Dr. Altman introduced Mr. Seltz and Ms. Coleen Elstermeyer, Deputy Executive Director, to provide the Executive Director's report.

Mr. Seltz reviewed the Summer Fellowship Program and highlighted the competitive application process. For more information, see slide 34.

ITEM 3a: Fiscal Year 2019 (FY19) Budget Approval

Mr. Seltz reviewed the FY19 budget proposal. For more information, see slides 36-40.

Dr. Altman asked if commissioners had questions or comments regarding the proposed HPC FY19 operating budget. Dr. Altman added that the subcommittee had reviewed the proposal and approved the budget.

Sec. Sudders asked for clarification regarding slide 38 and said the numbers represented a 4.9 percent increase in general operating expenses.

Mr. Seltz responded that there are two things to look at including the line item itself, which increased by $290,000. Mr.Seltz responded that the line item increased by 3.3 percent in terms of total spending, and the employee fringe assessment is not included in the line item. Mr. Seltz said that Secretary Sudders' calculation of 4.9 percent may be correct.

Sec. Sudders asked what percentage of the 3 percent is attributed to the Community Hospital Acceleration, Revitalization, & Tranformation (CHART) investment program winding down. Mr. Seltz responded that staff were recommending a 29 percent reduction from the Distressed Hospital Trust Fund (DHTF). Sec. Sudders added that she appreciated the reduction, but added that these numbers represented $500,000 more in payroll and operating costs. Mr. Seltz said that that was correct.

Dr. Altman asked if there were any further questions. Seeing none, he motioned to approve the FY19 Operating Budget. Dr. Everett seconded. The motion passed with nine votes in the affirmative and one abstention.

Dr. Altman announced that there would be a 10-minute break and and the meeting would reconvene at 1:10 PM.

ITEM 4: Market Oversight and Transparency

Dr. Altman reviewed the Cost and Market Impact Review (CMIR) process and purpose.

Sec. Sudders asked Dr. Altman to clarify whether the motion involved authorizing the report be released to the public. Dr. Altman confirmed that the motion would be to release the preliminary CMIR report to the public.

ITEM 4a: Notices of Material Change

In the interest of time, Mr. Seltz opted to skip the update on notices of material change portion of the presentation.

ITEM 4b: Preliminary Report on the Cost and Market Impact Review on the proposed Beth Israel Lahey Health (BILH) Transaction

Mr. Seltz introduced Ms. Kate Mills, Director, Market Performance, Ms. Megan Wulff, Deputy Director, Market Performance, and Mr. Sasha Hayes-Rusnov, Senior Manager, Market Performance. Mr. Seltz also commended the parties' cooperation in developing this report.

The slides for the presentation on the preliminary CMIR report can be viewed here.

Ms. Mills summarized the proposed transaction to create "Beth Israel Lahey Health" System, the parties of the transaction, and the goals of the transaction. For more information, see slides 2-15.

Ms. Mills summarized the baseline review and impact analysis in relation to cost and market. For more information, see slides 15-27.

Dr. Everett asked which comparators were examined in the system-wide prices. Ms. Mills responded that the comparators were those listed in the slides, including for the analysis of relative price over time.

Dr. Altman asked for clarification on whether the hospitals would be getting the same rates. Ms. Mills responded that different contracting networks have different patterns. Neither the Beth Israel Deaconness Care Organization (BIDCO) network nor the Lahey network have tended to have level prices for all of the hospitals within their respective networks. She added that these networks do tend to have uniform prices across their physicians.

Dr. Altman asked whether hospital expenses are included in the spending numbers as some of the organizations are physician-only. Ms. Mills said that health-status-adjusted total medical expenses (TME) is a metric that includes all of the spending (physician, hospital, and pharmaceutical) for the patients who are attributed to the primary care physicians (PCPs) of each provider network, regardless of where they receive care.

Dr. Kryder asked for further clarification on attribution to a provider network. Ms. Mills responded that the Center for Health Information and Analysis (CHIA) defines the health-status-adjusted (HSA) TME as measuring spending for those patients who are participating in a product that requires them to designate a PCP, which are largely health maintainence organization (HMO) and point of service (POS) patients and do not usually include preferred provider organization (PPO) POS patients.

Dr. Berwick asked whether a comparator was a similarly situated hospital. Ms. Mills responded in the affirmative. She further clarified that the way comparator was defined was by looking at the patients living in the primary service areas of the hospitals that were focal hospitals and other hospitals that were providing services in that geographic area that also had a similar level of acuity.

Mr. Lord asked what the comparators would be for specialty hospitals like New England Baptist Hospital. Ms. Mills responded that New England Baptist comparators were defined two different ways: to academic medical centers (AMCs) and to community hospitals that serve a large number of orthopedic patients.

Dr. Berwick asked for confirmation that Cambridge Health Alliance (CHA), Lawrence General, and MetroWest had the lowest prices among the organizations. Ms. Mills confirmed that the BIDCO network community hospitals, both the owned hospitals and the affiliated hospitals, tend to be relatively low-priced in comparison to other community hospitals.Dr. Everett asked if data

presented regarding changes in shares of community-approppriate dishcarges at the parties' newly-owned community hospitals could possibly be due to the newness of the incorporation and affiliation, and what it might mean for predicting the future. Ms. Mills responded that it is hard to draw firm conclusions as the analysis is preliminary, recognizing that for many of these affiliations we don't have many years of data.

Dr. Everett asked what years the data was from. Ms. Mills said that the data was from one year prior to the affiliation with the earliest pre-transaction year of 2011 to the most recent data which is 2016.

Ms. Denniston stated that she wanted to reconcile the data on BID-Plymouth's increased share of local community appropriate discharges with the finding that volume shifts in this service area would result in higher commercial payments. Ms. Mills noted that the all-payer trends are shown in the graphic whereas the HPC used commercial-only trends to calculate price differentials. She said that the trends for shifts in volume are also somewhat different for commercial discharges. Ms. Mills further explained that it is important to know both where the patient went to and where the patient came from. She added that hospitals that were losing share were significantly lower–priced, which could lead to price increases even where a community hospital (rather than a teaching hospital) was seeing an increased share.

Dr. Berwick asked if there was data on the volume of admissions. Ms. Mills responded that she would follow up with Dr. Berwick after the meeting to provide that data but noted that, by and large, the volume shifts are relatively small.

Sec. Sudders asked for clarification on which hospitals are the anchor teaching hospitals for each of the community hospitals on slide 21. Ms. Mills responded that for Anna Jacques, Cambridge Health Alliance, Lawrence General, BID-Milton, and BID-Plymouth, the anchor was BIDMC; for Winchester and Northeast, the anchor was Lahey. Sec. Sudders responded that it is confusing to say "anchor teaching" because in the case of CHA, CHA is itself a teaching hospital. Ms. Mills agreed that the labeling of the graph was not ideal.

Ms. Mills turned the presentation over to Ms. Wulff who reviewed the willingness-to-pay analysis for the proposed transaction. For more information, see slides 28-36.

Mr. Lord asked if it was correct that the percentage increases are above the cost growth benchmark of 3.1 percent, and how would this affect the negotiations between the payers and the providers. Ms. Mills responded that the percentage increases would not necessarily happen over one year and could potentially happen over a contract term, which might be less likely to run up against the benchmark while still ultimately yielding the same price impact. Ms. Mills also noted that the TME measure currently only includes HMO spending, so providers could build greater price increases onto the PPO side to be less likely to run afoul of the benchmark.

Dr. Berwick said that this analysis was for the effect of consolidation on the parties' price leverage. He noted that the parties' claim that the current dominant player, Partners, would be affected by increased competition. He asked how the merger would affect the market as a whole, and in particular whether Partners' prices would potentially go down to compensate for the new

competitor. Ms. Mills responded that the merger alone does not change the bargaining leverage of anyone else. Only if the parties make themselves more attractive to patients such that they increase their volume and decrease some of Partners' volume would they be able to chip away at some of Partners' negotiating leverage. She then explained that the HPC modeled this scenario and found that the effects on Partners' prices would be fairly small and, as BILH's volume increased, its leverage to negotiate higher prices would increase beyond the increases modeled in the willingness-to-pay. She added that these two spending effects (from lower prices at Partners and other providers and higher prices for BILH) would tend to cancel each other out negating the potential to achieve substantial savings in this way.

Dr. Berwick asked if the willingness-to-pay model included any possibility that the parties would keep their prices down in order to increase their ability to attract more patients and compete with Partners. Mr. Seltz noted that the projected price increases are not certainties but that the parties have indicated an interest in closing the price gap with Partners and have not identified a specific price target. Dr. Cory Capps, Bates White Economic Consulting, observed that the parties are already in payer networks and the prices patients face are largely defined by plan benefit structure rather than the contracted prices, so lower prices will not increase their volume.

Dr. Everett observed that both the willingness-to-pay increase (the increase caused by the merger) and the regular annual rate increases that would happen absent the merger would be part of the negotiation with payers. She asked if there might be a compromise between the two, instead of being additive. Dr. Capps explained that in any negotiation, the payer and provider each start with their objectives and the end result would be somewhere in between these two positions. Willingness-to-pay measures how much additional power the provider has in the negotiation.

Mr. Mastrogiovanni discussed a scenario under which the parties achieve some rate increases but are still lower-priced than Partners, which would still provide a competitive edge for BILH. Dr. Capps agreed, noting that there is room for the parties to achieve the projected increases while remaining lower-priced than Partners.

Dr. Altman reviewed the degree to which the projected estimates would close the gap between the parties and Partners.

Sec. Sudders noted that this analysis is based on the willingness-to-pay projections. She asked if there is any way mergers can drive down prices and asked for confirmation that the willingness-to-pay model can only predict price increases. Ms. Mills responded that the HPC had closely examined whether growth of a second-largest system could improve competition and that there was not economic literature that squarely addressed this question. Ms. Mills explained that staff were able to find one practical example of growth of a second-largest system enhancing competition, in Peoria, Illinois, which is not a comparable market. Dr. Capps added that mergers of closely substitutable hospitals tend to increase prices. He said that willingness-to-pay is focused on the potential for reduced competition and increased prices and forms a hurdle that parties would need to overcome with efficiencies and other factors.

Dr. Cutler explained that he had asked many economists this question and that it is very difficult to say. On average, mergers lead to higher prices, but there is not evidence to suggest how they impact other competitors. He noted that there is not certainty about how prices will be affected. Dr. Capps noted that today, payers can and do form networks that exclude Partners and include the parties, so the merger does not make this newly feasible.

Ms. Denniston asked why staff had not conducted a willingness-to-pay analysis for specialty physician services. Ms. Mills responded that physician data is more difficult to work with and therefore the HPC had to decide which service lines to focus on. Mr. Seltz emphasized that in the report, the estimate that is not based on willingness-to-pay is kept separate and not added into the projected total. Ms. Mills noted that the fact that the price increase estimates for inpatient, outpatient, and adult primary care services are in such a tight range does speak to the robustness of the results and indicates that it is reasonable to expect there would be some price increases, likely in a similar range, for these other services.

Ms. Wulff noted that the parties could achieve these price increases – substantially increasing health care spending – while remaining lower-priced than Partners. Mr. Lord observed that the price increases would still probably cause the parties to exceed the benchmark, which would mean they could be subject to a performance improvement plan (PIP), which could temper the price increases. Mr. Seltz agreed and added that the benchmark is not a price cap and the HPC has been very clear that the benchmark should not be interpreted as a price cap in neogtiations. He stated that if the parties were successful in negotiating increases, it is still unclear how it would play out in terms of the HPC's ability to review them through the PIPs process.

Sec. Sudders noted that the benchmark has served an important public purpose and that while it is important to review the willingness-to-pay results, it is also necessary to keep in mind the levers that might constrain prices. Dr. Altman explained that the model predicts increases beyond what would happen without the merger and should not be compared to the benchmark, because health care spending increases are due to a combination of price and volume increases. He noted that this analysis was examining price increases beyond what would otherwise happen.

Ms. Mills explained that the HPC looked at the relationship between willingness-to-pay and price over time and this relationship did not degrade following implementation of the benchmark as might have been expected if the benchmark were constraining the exercise of negotiating leverage. Ms. Mills also noted that Chapter 224 envisioned that the PIP and CMIR processes would both be needed because there are market changes that might increase spending that would not be captured by the PIP process. In addition, she explained that there are several factors that would make it more difficult to use PIPs to regulate problems from some mergers.

Dr. Altman noted the time and reminded Commissioners that there was still a considerable portion of the presentation remaining. He suggested that Commissioners be cognizant of the time when asking their questions.

Dr. Berwick said that it appeared that the analysis suggested a one-time increase in costs following a merger. He asked whether the same logic of willingness-to-pay also applied to willingness to accept price increases year after year as the new entity would have leverage to

increase prices in subsequent years. Dr. Capps referenced the schemetic on slide 30 and noted that the price increase would happen once but its spending impact would endure over time.

Dr. Kryder asked whether staff were concerned with the static nature of the model regarding fee-for-service versus value-based care. He also asked how concerned staff, as representatives of the Commonwealth, were with overall spending versus just commercial. Dr. Capps said that, on the commercial side, non fee-for-service, capitated-rate, value-based treatment is still subject to negotiation so similar factors would be at play. He said that it was still an open question among economists whether the increased competition would foster innovation or retard it. Addressing Dr. Kryder's second question, Ms. Mills clarified that Group Insurance Commission (GIC) data was included in the analysis. She said that staff had focused on the commercial insurance market because that was where prices were negotiated and that the differentials in the Medicare and Medicaid realms tend to be far less than they are in the commercial realm.

Ms. Wulff presented on the savings that would be achievable if the parties achieved their care redirection goals, and Ms. Mills discussed the reasons why the HPC's estimates were likely to be conservative and why savings, including from reducing Partners bargaining leverage, were unlikely to offset projected price increases. For more information, see slides 32-41.

Ms. Mills turned the presentation over to Mr. Hayes-Rusnov who presented on the care delivery and quality portion of the findings. For information, see slides 43-53.

Ms. Mills presented on the access to care portion of the analysis. For more information, see slides 55-63.

Regarding slide 59, Mr. Cohen asked whether the figures had been cut for behavioral health as well. Ms. Mills responded that they had only been cut by the zip code income and average area deprivation index listed on the slide. Mr. Cohen suggested that if it were cut for behavioral health, it might show a higher rate of Medicaid patients.

Dr. Cutler noted that when the New England Baptist affiliation with BIDCO was approved, the parties in that transaction claimed that there would be an expansion of Medicaid patients. He asked whether the HPC had been able to determine whether that had happened. Ms. Mills said that staff had received the 2017 hospital discharge database relatively recently and had not been able to update all of the analyses in the preliminary report with that data. She said that staff had done some initial sensitivities with the data, however, to ensure that the findings in the preliminary report were not off-base and had found that New England Baptist's Medicaid mix in the 2017 data had risen but remained under one percent.

Ms. Mills asked if there were any further questions. Hearing none she provided an overview of next steps in the CMIR process. For more information, see slide 64.

Dr. Altman thanked the staff and asked Commissioners to offer final comments.

Dr. Everett noted that this was the first CMIR the HPC had had to conduct as the parties were putting the entity together and that because of this, the agency has a number of questions that the parties are not yet able to answer. She said that this presented difficulties for evaluating the

merger in the same way the Board had in the past. Regarding slide 21, Dr. Everett asked whether the parties were able to explain why the shift to community-appropriate discharges was so difficult.

Mr. Seltz raised the example of Winchester Hospital which had been able to retain more of its local community-appropriate discharges and said that staff had had conversations with the clinical leadership at Lahey who described specific programs they had put in place to promote this outcome. He noted that this was anecdotal but recognized that this had been a goal of these organizations that they had proactively worked towards in some cases.

Dr. Cutler noted that this was an opportunity for Board members to ask questions to which they would like answers from the parties. He said that the historical record of these organizations with regard to the issues raised in the report was mixed and sited specific examples from the presentation. He also said that the models shown in the report presented more difficulties in predicting future outcomes than any single case considered by the Board in the past and therefore the level of certainty regarding the predictions made would be less than in other cases. Dr. Cutler asked that the parties provide further information on how they hoped to achieve back-office savings. He also asked the parties to explain what they could do as a merged entity that they could not do independently to achieve greater savings through their increased market share.

Dr. Altman added that he would also like to see information on the likelihood that there could be savings that would generate lower prices. Dr. Cutler added that they could affect prices as the entities could either cut costs or raise prices to increase investment in their institutions. He said that it was preferable for the Commonwealth that the entities choose to cut costs and defer price increases.

Sec. Sudders noted that achieving additional efficiencies in behavioral health could be something that would bring these parties together. She said that the component parts of these parties represented a robust set of substance abuse patients with co-occuring mental health issues and that this population is both highly vulnerable and expensive to treat. Referencing slide 21, Sec. Sudders said that the question is how long does it take for systems to start to change referral patterns to more community-appropriate care. She said that the transaction presented an opportunity for the parties to convince the HPC that they could create a system centered around high-value, mid-priced care, and that it is going to rely on the good faith of parties coming to the table and making strong statements about constraining rates and the positives of bringing together these systems. She encouraged the proponents to use the comment period to demonstrate this. She thanked the staff for its work on the report.

Dr. Berwick said that to his mind the role of the HPC is three-part: to protect the Commonwealth from excessive health care costs, to improve care for those who need it, and to improve equity by protecting vulnerable people in the state. He noted that the HPC's power in this realm was limited to commentary and therefore the agency must focus on trying to get people to pay more attention to achieving these three goals. Dr. Berwick added that the market power of Partners had historically had the biggest influence in these three realms and that it was an open question as to what would happen to that entity should the transaction be approved or not appoved. He asked

whether there were conditions that would mitigate the risks of increased costs and suggested that the entities should be focused on new health care designs, adding that there is competition between the vision of innovating new care and taking advantage of the opportunity of increased price leverage. Dr. Berwick said that he would also like to see better predictions of how vulnerable populations, particularly in Cambridge and Lawrence, would fare if the transaction were to go through. He re-summarized his points in the form of five questions: 1. Will the entities take advantage of the increased leverage to increase prices? 2. What kind of conditions could be attached to the approval to convince the HPC that the intention to deliver better care at a lower cost was authentic? 3. Is there any information to suggest how Partners would respond to approval or disapproval of the transaction? 4. How would service to vulnerable populations be improved by the transaction? and 5. What kind of truly new care would this transaction facilitate were it to go forward?

Mr. Lord said he agreed with the prior comments from other Commissioners. He said that he was looking forward to the response from the parties particularly regarding the modeled price increases and how the parties intended to increase community-appropriate care. He added that, as a representative of the business community, the current system is not working for small employers in particular. He said that the rate increases faced by businesses with small margins threatens their viability.

Mr. Cohen said that he wanted to understand the long-term financial implications for the organizations involved should the transaction not go through. He added that he was concerned for the entities' behavioral health services given the low margins of these services. He asked what the viability of these services would be in the future should the merger not be approved and what they would look like should the merger be approved. He lauded the work of Lahey Behavioral Health and suggested there was opportunity to expand the footprint of that work, adding that he would like to see more detail from the parties on that.

Dr. Cutler said that situations in which economic studies find mergers to be valuable tend to be those in which one of the parties is in a very poor financial position, may be going to fail, and can be made by the merger into a viable competitor. He said that it would be important to know if that were the case in this transaction.

Mr. Mastrogiovanni noted that there was not enough data to affirmatively say that this merger would increase competition in Massachusetts. He stated that changing the name to Beth Israel Lahey Health was not going to convince people to stop going to Partners and that it was critical that the HPC get further information from the parties including the kinds of innovative programs they plan to develop, how many resources BILH would devote to marketing, and other ways they planned to make Massachusetts a more competitive environment for health care.

Ms. Denniston asked why the data was showing a decline in community-appropriate discharges at contracting affiliate hospitals. She said that she would also like to know more about the impact on the Commonwealth and the GIC in particular. She said she looked forward to the next steps.

Dr. Kryder echoed Dr. Cutler's point in wanting more information about back office savings and also said he was eager to learn more about opportunities for systems integration, suggesting that

there would likely be ample opportunity for consolidation in certain areas without affecting quality of care. He said that he would like to hear more about the proponents' proposals for innovative insurance products. Dr. Kryder said that the biggest question in his mind was how this transaction was going to be different from Partners in 1994. He also asked his fellow Commissioners whether 30 days was enough time for a response.

Mr. Seltz said that additional time could be allowed if requested but that the HPC hoped to move forwarded expeditiously to allow completion of the work before the end of the statutory timeline in September.

Dr. Altman acknowledged the hard work of the staff . He said that there were two key issues he would like to focus on. The first is the potential for price and spending increases. He said that the willingness-to-pay model used in this analysis is head and shoulders above other models,that it remains a probabilistic estimate, but that it does give us a direction. Dr. Altman said that he also objected to the notion subscribed to by economists that behavioral modificiations do not work in the sense that Massachusetts has a greater capacity to do monitoring and understand what is happening in the market than other states. To the extent that the parties could come forward and help reduce the likelihood of price increases, he said that everyone would be better served. The second issue is that of service mix. Dr. Altman noted that the likely losers in the market, were the transaction to go through, would be hospitals that treat a disproportionate number of low-income patients and that the HPC could not ignore this. He asked that the parties focus on ways to minimize the losers or even make the losers into winners. He said that he believed that behavioral modifications could be developed that could create a win-win situation but that the potential for increased spending and losers in the market could not be ignored. He said that both of these issues needed to be dealt with. Dr. Altman asked if there were any further questions from Commissioners. None were heard.

Dr. Altman called for a motion to authorize the release of the preliminary CMIR report on the proposed Beth Israel Lahey Health transaction. Dr. Everett made the motion. Sec. Sudders seconded it. The motion passed unanimously.

Dr. Altman opened the floor for testimony from the public. Members of the public offered testimony.

Dr. Altman adjourned the meeting at 4:28 PM.