



MASSACHUSETTS HEALTH POLICY COMMISSION REVIEW OF

**Partners HealthCare System's Proposed
Acquisition of Massachusetts Eye and
Ear Infirmary, Massachusetts Eye and Ear
Associates, and Affiliates
(HPC-CMIR-2017-1)**

About the Health Policy Commission

The Health Policy Commission (HPC) is an independent state agency that develops policy to reduce health care cost growth and improve the quality of patient care. The HPC's mission is to advance a more transparent, accountable, and innovative health care system through its independent policy leadership and investment programs. The HPC's goal is better health and better care—at a lower cost—across the Commonwealth.

INTRODUCTION

Health care provider market changes, including consolidation and alignments between providers under new care delivery and payment models, can impact health care market functioning and the performance of the health care system in delivering high quality, cost effective care. Yet, due to confidential payer-provider contracts and limited information about provider organizations, the mechanisms by which market changes impact the cost, quality, and availability of health care services have not historically been apparent to government, consumers, and businesses which ultimately bear the costs of the health care system. Recognizing the importance and lack of transparency surrounding health care provider market changes, one of the Health Policy Commission's (HPC) core responsibilities is to monitor and publicly report on the evolving structure and composition of the provider market using the best available evidence.

Through the filing of notices of material change by provider organizations, the HPC tracks the frequency, type, and nature of changes in our health care market.¹ The HPC may also engage in a more comprehensive review of particular transactions anticipated to have a significant impact on health care costs or market functioning. The result of such "cost and market impact reviews" (CMIRs) is a public report detailing the HPC's findings. In order to allow for public assessment of the findings, the transactions may not be finalized until the HPC issues its Final Report. Where appropriate, such reports may identify areas for further review or monitoring, or be referred to other state agencies in support of their work on behalf of health care consumers.² This first-in-the-nation public reporting process is a unique opportunity to enhance the transparency of significant changes to our health care system and can inform and complement the many important efforts of other agencies, such as the Attorney General's Office, the Center for Health Information and Analysis, the Department of Public Health, and the Division of Insurance, in monitoring and overseeing our health care market.

The HPC conducts its work during continued dynamic change among provider organizations, including ongoing consolidation, new contractual and clinical alignments, and the increased presence of alternative payment models focused on promoting accountable care. The CMIR process allows us to improve our understanding and increase the transparency of these trends, the opportunities and challenges they may pose, and their impact on short and long term health care spending, quality, and consumer access. In addition, our reviews enable us to identify particular factors for market participants to consider in proposing and responding

¹ See MASS. GEN. LAWS ch. 6D, § 13 (requiring health care providers to notify the HPC before making material changes to their operations or governance). See also 958 CODE MASS. REGS. §§ 7.00. (2015), Notices of Material Change and Cost and Market Impact Reviews, available at <http://www.mass.gov/courts/docs/lawlib/900-999cmr/958cmr7.pdf>.

² For example, MASS. GEN. LAWS ch. 6D, §13(f) requires referral of the CMIR report to the state Attorney General's Office if the HPC finds that a provider under review (1) has a dominant market share in its service area, (2) charges prices that are materially higher than the median prices in its service area for the same services, and (3) has a health status adjusted total medical expense that is materially higher than the median in its service area.

to potential future organizational changes. Through this process, we seek to encourage providers and payers alike to evaluate and take steps to minimize negative impacts and enhance positive outcomes of any given material change.

This document is the HPC's fifth CMIR report, examining Partners HealthCare System's proposed acquisition of the Foundation of the Massachusetts Eye and Ear Infirmary, including its specialty hospital, the Massachusetts Eye and Ear Infirmary, and its physician organization, Massachusetts Eye and Ear Associates. Based on criteria articulated in Massachusetts' health care cost containment legislation, Chapter 224 of the Acts of 2012, and informed by the facts of the transaction, we analyzed the likely impact of this transaction, relying on the best available data and information. Our work included review of the parties' stated goals for the transaction and the information they provided in support of how and when it would result in efficiencies and care delivery improvements.

We now release this report to contribute important and evidence-based information to the public dialogue as providers, payers, government, consumers, and other stakeholders strive to develop a more affordable, effective, and accountable health care system.

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ACRONYMS AND ABBREVIATIONS

ACO	Accountable Care Organization
AGO	Massachusetts Attorney General's Office
AMC	Academic Medical Center
APCD	All-Payer Claims Database
Chapter 224	Chapter 224 of the Acts of 2012
CHIA	Massachusetts Center for Health Information and Analysis
CMIR	Cost and Market Impact Review
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DPH	Massachusetts Department of Public Health
EHR	Electronic Health Records
GPSR	Gross Patient Service Revenue
HIPAA	Health Insurance Portability and Accountability Act of 1996
HPC	Health Policy Commission
IQI	Inpatient Quality Indicator
MMCO	Medicaid Managed Care Organization
NPSR	Net Patient Service Revenue
PCP	Primary Care Physician
PSA	Primary Service Area
PSI	Patient Safety Indicator
RPO	Registration of Provider Organizations
TME	Health Status Adjusted Total Medical Expenses

NAMING CONVENTIONS

Parties and Related Organizations

BWH	Brigham and Women's Hospital
Faulkner	Brigham and Women's Faulkner Hospital
Cooley Dickinson	Cooley Dickinson Hospital
MEE	Foundation of the Massachusetts Eye and Ear Infirmary
MEEA	Massachusetts Eye and Ear Associates
MEEI	Massachusetts Eye and Ear Infirmary
MGH	Massachusetts General Hospital
MGPO	Massachusetts General Physicians Organization
Newton-Wellesley	Newton-Wellesley Hospital
NHP	Neighborhood Health Plan
NSMC	North Shore Medical Center
Partners	Partners HealthCare System
PCPO	Partners Community Physicians Organization

Payers

BCBS	Blue Cross Blue Shield of Massachusetts
HPHC	Harvard Pilgrim Health Care
THP	Tufts Health Plan

Other Providers

Atrius	Atrius Health
BIDCO	Beth Israel Deaconess Care Organization
Lahey	Lahey Health System
Steward	Steward Health Care System

EXECUTIVE SUMMARY

On May 30, 2017, Partners HealthCare System (Partners) and the Foundation of the Massachusetts Eye and Ear Infirmary (MEE) executed an Affiliation Agreement for Partners to acquire MEE, including its specialty hospital, the Massachusetts Eye and Ear Infirmary (MEEI), and its physician organization, Massachusetts Eye and Ear Associates (MEEA).³ MEEI and MEEA have longstanding clinical affiliations with Massachusetts General Hospital (MGH) and Brigham and Women's Hospital (BWH), and MEEA also has a contracting affiliation with Partners.⁴ Under the proposed transaction, MEEI and MEEA would become corporate subsidiaries of Partners and would contract through Partners for all contracts with payers. MEE and Partners would also explore options for expanding MEE's services across the Partners provider system. The parties have stated that the transaction will support MEE through integration of financial, managerial, and administrative supports, including the achievement of "market competitive rates" for MEEI, and that greater clinical and information technology integration between Partners and MEE will result in improved patient care.⁵

Following a 30-day initial review, the Health Policy Commission (HPC) determined that the proposed transaction was likely to have a significant impact on costs and market functioning in Massachusetts and warranted further review.⁶ This transaction is concurrently under review by the Massachusetts Department of Health's (DPH) Determination of Need (DoN) program. This Preliminary Report presents our analysis and the key findings from our review, some of which may be relevant to factors for DoN review.⁷ Following an opportunity for the parties to respond to these findings, the HPC will issue a Final Report.

This report is organized into five parts. Part I outlines our analytic approach and the data we utilized. Part II describes the parties to this cost and market impact review and their goals and plans for undertaking the transaction. Parts III and IV then present our findings. Part III reports on the parties' baseline performance leading up to the transaction, and Part IV reports on the projected impact of the proposed transaction on that baseline. We conclude in Part V. Below is a summary of the findings presented in Parts III and IV:

³ On April 3, 2017, Partners and MEE filed Notices of Material Change with the HPC pursuant to MASS. GEN. LAWS ch. 6D, § 13. See MEE NOTICE OF MATERIAL CHANGE, *infra* note 32. The executed Affiliation Agreement was provided confidentially by the parties.

⁴ MEEI and MGH are physically connected and provide clinical services for one another. MEE provides staffing and department chiefs for MGH's departments of otolaryngology and ophthalmology. MEEA physicians also staff the ophthalmology department at BWH, and provide clinical services at Brigham and Women's Faulkner Hospital. MEEA physicians currently participate in Partners' commercial payer contracts with the three largest commercial payers in Massachusetts, Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan, as part of the Massachusetts General Physicians Organization. See Section II.C for further details on the current relationship between Partners and MEE.

⁵ See MEE NOTICE OF MATERIAL CHANGE, *infra* note 32.

⁶ See MASS. HEALTH POLICY COMM'N, MINUTES OF THE HEALTH POLICY COMM'N (Sept. 13, 2017) (approving continuation of the cost and market impact review of the Partners-MEE transaction), available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/board-meetings/20170726-board-meeting-minutes.pdf> (last visited Oct. 28, 2017).

⁷ See 105 CMR 100.210.

1. **Cost and Market Baseline Performance:** Partners is the largest health care system in the state, with high inpatient, outpatient, and physician market shares. MEEI provides more outpatient otolaryngology and ophthalmology services than any other provider in its service area, and Partners provides some services that overlap with those provided by MEE. Partners patients have high total medical spending and the Partners system has high hospital and physician prices, including for outpatient otolaryngology and ophthalmology services.⁸ MEE's prices are substantially lower than Partners' prices.
2. **Quality Baseline Performance:** Given that MEE provides only a specialized set of services, there are relatively few relevant, standardized, publicly reported quality measures available to assess its performance. However, MEEI generally performs at or above the statewide average for relevant measures, and it performs particularly well on patient experience measures. Partners hospitals and physicians also generally perform at or above the statewide average on most of the measures we reviewed.
3. **Access Baseline Performance:** MEEI is the principal provider of a number of specialty otolaryngology and ophthalmology services, although there are few services for which MEEI is the sole provider. MEEI participates more frequently than Partners hospitals in Medicaid managed care organization (MMCO) networks and commercial limited network products, and is generally placed in more favorable cost sharing tiers of tiered network products than Partners hospitals. MEEI and most Partners hospitals have higher commercial payer mix and lower Medicaid payer mix relative to comparator hospitals.
4. **Cost and Market Impact:** After the transaction, Partners could likely obtain Partners physician rates for MEEA physicians across all commercial payers and would likely seek significant hospital rate increases for MEEI. Over time, we estimate that total commercial health care spending would increase by \$20.8 million to \$61.2 million annually if Partners achieves parity between MEEI's rates and the rates of Partners' other hospitals, depending on price levels obtained, and if MEEA physicians begin receiving Partners physician rates for all commercial payers. These spending increases would ultimately be borne by consumers and businesses through higher commercial premiums and may also impact other providers' spending against risk budgets to the extent that their patients use MEE. While the parties expect to achieve internal efficiencies that would reduce their own expenses, they have not committed to using the resulting savings to reduce prices or otherwise provided evidence that these savings would be passed on to payers or consumers.
5. **Quality Impact:** The parties have stated that the proposed transaction will facilitate improved quality, primarily by better integrating MEE into Partners' technical infrastructure, including its data warehouse, quality reporting platform, and electronic medical record system. However, it is unclear to what extent these technical improvements would result in improved patient care, given that MEE's quality

⁸ To analyze prices for otolaryngology and ophthalmology services, the HPC used data from the All-Payer Claims Database. See *infra* note 86 for details on methodology.

performance is already strong and comparable to that of Partners and recognizing the parties' existing collaborations. The parties have identified only a few metrics for quality improvement, and propose to collect baseline data and set improvement targets only after the transaction is completed. Given existing quality performance and unspecified targets, it is unclear that the proposed transaction is necessary or sufficient to achieve improvements in clinical quality.

6. **Access Impact:** While the parties have suggested that patient need for MEE's services is increasing, they have not described specific plans for when or where MEE might expand its services to meet those needs, or why corporate integration would be necessary to do so. In addition, if MEE adopts Partners' contracting patterns as a result of the transaction, patients in tiered and limited network products and Medicaid MMCOs may face barriers to accessing MEE's specialty services.

In summary, we find that the proposed transaction between Partners and MEE is likely to increase health care spending due to expected increases in hospital and physician prices that are consistent with the parties' stated goals of the transaction. While the parties have claimed that the transaction will result in operational efficiencies and improvements in the quality of patient care and access to services, they have not committed to using the resulting savings to reduce prices or otherwise reduce spending for payers or consumers, nor have they provided evidence that a corporate merger is either necessary or sufficient to achieve quality or access improvements. The parties also have not offered commitments regarding MEE's payer network participation that would protect against any impaired access to MEE's specialty services subsequent to the transaction. We invite the parties to address these concerns in their written response.

Based on these findings, this transaction may warrant further review and referral to the Massachusetts Attorney General's Office pursuant to MASS. GEN. LAWS ch. 6D, § 13.⁹ In addition, given that the proposed transaction is under concurrent review by DPH's DoN program, we may submit our findings to DoN program staff for consideration in the context of the factors for DoN approval.¹⁰ Following the period for written response, the HPC will publish a Final Report, including any referrals or recommendations to other agencies.

⁹ See MASS. HEALTH POLICY COMM'N, TECHNICAL BULLETIN FOR 958 CMR 7.00: NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS (Aug. 6, 2014) [hereinafter TECHNICAL BULLETIN], available at <http://www.mass.gov/anf/docs/hpc/regs-and-notices/technical-bulletin-circ.pdf> (last visited Oct. 28, 2017). The HPC is required to refer a final cost and market impact review report to the Massachusetts Attorney General's Office if one or more parties to the transaction have materially higher prices, materially higher total medical expense, and a dominant market share for inpatient services. Based on the most recent available data, Partners exceeds the threshold for each of these three metrics.

¹⁰ See 105 CMR 100.735(D)(1)(c).

I. ANALYTIC APPROACH AND DATA SOURCES

A. ANALYTIC APPROACH

The Health Policy Commission (HPC) is tasked with examining impact in three interrelated areas in a cost and market impact review (CMIR):¹¹

1. **Costs and market functioning.** The HPC may examine factors such as prices, total medical expenses, provider costs, and other measures of health care spending as well as market share, the provider's methods for attracting patient volume and health care professionals, and the provider's impact on competing options for care delivery.
2. **Quality.** The HPC may examine factors related to the quality of services provided, including patient experience.
3. **Access.** The HPC may also examine the availability and accessibility of services provided, such as the provider's role in serving at-risk, underserved, and government payer patient populations.

Additionally, the HPC may consider any other factors it deems to be in the public interest, including consumer concerns.¹²

Within this statutory and regulatory framework, the HPC determines those factors most relevant to a given transaction and then gathers detailed information relevant to those factors from the sources discussed below. The HPC examines recent data to establish the parties' *baseline performance and current trends* in each of these areas prior to the transaction. The HPC then combines the parties' baseline performance with known details of the transaction, as well as the parties' goals and plans, to project the *impact of the transaction on baseline performance*. The analytic sections of this report are divided into two parts that mirror this framework: Part III addresses baseline performance and Part IV addresses impact analyses.

B. DATA SOURCES

To conduct this review, we relied on the documents and data the parties produced to us in response to HPC information requests and the parties' own description of the transaction as presented in their material change notices and application for Determination of Need (DoN) filed with the Massachusetts Department of Public Health (DPH). The HPC also utilized extensive information from the Registration of Provider Organizations program (RPO)¹³ and obtained data and documents from a number of other sources. These include other state

¹¹ MASS. GEN. LAWS ch. 6D, § 13(d) and 958 CMR 7.06.

¹² *Id.*

¹³ MASS. GEN. LAWS ch. 6D, § 11 (requiring provider organizations to register biennially with the HPC and provide information on organizational structure and affiliations, and other requested information); *see also* 958 CODE MASS. REGS. §§ 6.00 (2014); *2015 Initial Registration*, MASS. HEALTH POLICY COMM'N, <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/material-change-notices-cost-and-market-impact-reviews/registration-of-provider-organizations/2015-initial-registration-data/> (last visited Oct. 31, 2017).

agencies such as the Massachusetts Attorney General’s Office (AGO) Non-Profit Organizations/Public Charities Division, from which we received audited financial statements for non-profit institutions relevant to our review, and the Center for Health Information and Analysis (CHIA), from which we received provider and payer-level data, hospital discharge data, and claims-level data from the All-Payer Claims Database (APCD);¹⁴ federal agencies such as the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS); and payers such as Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP). The HPC appreciates the cooperation of all entities that provided information in support of this review.

To assist in our review and analysis of information, the HPC engaged consultants with extensive experience evaluating provider organizations and their impact on health care costs and the health care market. Working with these experts, the HPC comprehensively analyzed the data and other materials detailed above.

Where our analyses rely on nonpublic information produced by the parties or other market participants, MASS. GEN. LAWS ch. 6D, § 13 and 958 CODE MASS. REGS. 7.09 prohibit the HPC from disclosing such information without the consent of the producing entity, except in a preliminary or final CMIR report where “the commission believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations.”¹⁵ Consistent with this requirement, this Preliminary Report contains only limited disclosures of such confidential information where the HPC has determined that the public interest in disclosure outweighs privacy, trade secret, and anti-competitive considerations.

For each analysis, the HPC utilized the most recent and reliable data available. Because data—whether publicly reported or privately held—is usually generated on a variable schedule from entity to entity, the most recent and reliable data primarily reflects 2014 to 2017 data.¹⁶ We have noted the applicable year for the underlying data throughout this report and, wherever possible, we examined multiple years of data to analyze trends and to report on the consistency of findings over time. For data and materials produced by the parties and other market participants, the HPC tested the accuracy and consistency of the data collected to the extent possible, but also relied in large part on the producing party for the quality of the information provided.

The availability of accurate data, time constraints, and a focus on those analyses that complement—rather than duplicate—the work of other agencies may affect the analyses included in this and other reviews of material changes. Future reviews may encompass new

¹⁴ The APCD includes medical, pharmacy, and dental claims, as well as information about member eligibility, benefit design, and providers for all payers covering Massachusetts residents. *See All-Payer Claims Database*, CTR. FOR HEALTH INFO. & ANALYSIS, <http://www.chiamass.gov/ma-apcd/> (last visited Oct. 20, 2017).

¹⁵ MASS. GEN. LAWS ch. 6D, § 13(c), *amended by* 2013 Mass. Acts 38, § 20.

¹⁶ Some data sources use fiscal year rather than calendar year data, notably CHIA’s hospital discharge data. Therefore, hospital discharge data presented here is fiscal year data.

and evolving analyses, depending on the facts of a transaction, recent market developments, areas of public interest, and the availability of improved data resources.

Finally, most of our analyses focus on the anticipated impact in the commercially insured market. In the commercially insured market, prices for health care services—whether fee-for-service, global budgets, or other forms of alternative payments—are established through private negotiations between payers and providers. The terms of these payer-provider contracts vary widely, both with regard to price and other material terms that impact health care costs and market functioning.¹⁷

¹⁷ See, e.g., OFFICE OF ATT’Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6 ½(b): REPORT FOR ANNUAL PUBLIC HEARING at 40-43 (Mar. 16, 2010), available at <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf> (last visited Oct. 28, 2017); MASS. HEALTH POLICY COMM’N, 2015 COST TRENDS REPORT: 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> (last visited Oct. 28, 2017).

II. OVERVIEW OF THE PARTIES AND THE TRANSACTION

On May 30, 2017, Partners HealthCare System (Partners) and the Foundation of the Massachusetts Eye and Ear Infirmary (MEE) executed an Affiliation Agreement for Partners to acquire MEE, including its specialty hospital, the Massachusetts Eye and Ear Infirmary (MEEI), and its physician organization, Massachusetts Eye and Ear Associates (MEEA).¹⁸ MEEI and MEEA have longstanding clinical affiliations with Massachusetts General Hospital (MGH) and Brigham and Women's Hospital (BWH), and MEEA and Partners have a contracting affiliation. Under the proposed transaction, MEEI and MEEA would become corporate subsidiaries of Partners and would contract through Partners for all contracts with payers. MEE and Partners would also explore options for expanding MEE's services across the Partners provider system. In addition to review by the HPC under the MCN and CMIR process, the parties submitted an application for a DoN by the DPH on July 17, 2017.¹⁹ This section describes the parties, their current relationship, and the proposed transaction.

A. PARTNERS HEALTHCARE SYSTEM

Partners was founded in 1994 by an affiliation between two of Boston's preeminent academic medical centers (AMCs), BWH and MGH.²⁰ Partners is the largest provider system in Massachusetts and remains one of the strongest financially, with operating revenue of more than \$11.5 billion dollars in 2016.²¹

¹⁸ See *supra* note 3 (reporting filing dates for the parties' notices of material change).

¹⁹ APPLICATION BY PARTNERS HEALTHCARE SYSTEM FOR DETERMINATION OF NEED FOR TRANSFER OF OWNERSHIP OF MASSACHUSETTS EYE AND EAR INFIRMARY (July 17, 2017), [hereinafter PARTNERS-MEE DON APPLICATION], available at <http://www.mass.gov/eohhs/docs/dph/quality/don/partners-health-system-application-form.pdf>. The DPH's DoN program evaluates applications based on a set of factors including the applicant's patient panel needs, the public health value of the project, and operational objectives including community engagement and the promotion of competition on measures of health spending. See 105 CMR 100.210.

²⁰ *About Partners HealthCare*, PARTNERS HEALTHCARE, <http://www.partners.org/About/Default.aspx> (last visited Oct. 28, 2017).

²¹ The HPC reviewed the 2015 audited financial statements for Partners and five of the six other largest provider systems in Massachusetts, Atrius Health, UMass Memorial Health Care, Beth Israel Deaconess Medical Center, Lahey Health System, and Tufts Medical Center Parent (now part of Wellforce) and found that Partners had net patient service revenue of over \$7.3 billion, more than three times that of the next largest provider system, and total net assets slightly lower than the next five largest systems combined. Compared to these other large Massachusetts provider systems, Partners had a substantially above average cash position, a better than average current ratio, a higher than average capitalization ratio, and a much lower average age of plant, although large increases in operating expenses have driven down Partners' margins in recent years. Like most providers in Massachusetts, Partners operates as a non-profit public charity. Financial statements for these entities are available from the Charities Division of the Massachusetts AGO at *Non-Profits & Charities Document Search*, OFFICE OF ATT'Y. GEN. MAURA HEALEY, <http://www.charities.ago.state.ma.us/> (last visited Aug. 3, 2017). Data for Steward Health Care System for 2015 was unavailable at the time of publication and was not included in HPC's review. For detailed comparisons of Partners' financial performance in 2011 and 2012 to that of other large provider systems in Massachusetts, see also MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL (HPC-CMIR-2013-1) AND HARBOR MEDICAL ASSOCIATES (HPC-CMIR-2013-2), PURSUANT TO M.G.L. C. 6D, § 13, FINAL REPORT at 12 (Feb. 19, 2014) [hereinafter PHS-SSH-HARBOR FINAL CMIR REPORT], available at <http://www.mass.gov/anf/docs/hpc/20140219-final-cmir-report-phs-ssh-hmc.pdf> (last visited Oct. 28, 2017);

Including its two flagship AMCs, Partners currently owns eight general acute care hospitals in Massachusetts with a total of 2,928 staffed beds:

Partners General Acute Care Hospitals in Massachusetts

Hospital	Hospital Type ²²	City/Town	Staffed Beds
Massachusetts General Hospital (MGH)	AMC	Boston	1,043
Brigham and Women's Hospital (BWH)	AMC	Boston	859
North Shore Medical Center (NSMC)	Community, High Public Payer	Salem & Lynn ²³	431
Newton-Wellesley Hospital (NWH)	Community	Newton	316
Brigham and Women's Faulkner Hospital (Faulkner)	Community	Boston	138
Cooley Dickinson Hospital (Cooley Dickinson)	Community	Northampton	87
Martha's Vineyard Hospital	Community	Oak Bluffs	31
Nantucket Cottage Hospital	Community	Nantucket	23

Source: HOSPITAL PROFILES ACUTE DATABOOK, *infra* note 35

Partners also owns McLean Hospital, a psychiatric specialty hospital in Belmont, Massachusetts; the Spaulding Rehabilitation Network, which includes rehabilitation hospitals in Cambridge, Charlestown, and East Sandwich; and Wentworth-Douglas Hospital, a general acute care hospital located in Dover, New Hampshire, which serves the Seacoast Region of New Hampshire and abutting communities in southern Maine.²⁴ Partners also contracts with major payers on behalf of a non-owned affiliate hospital in Massachusetts, Emerson Hospital.

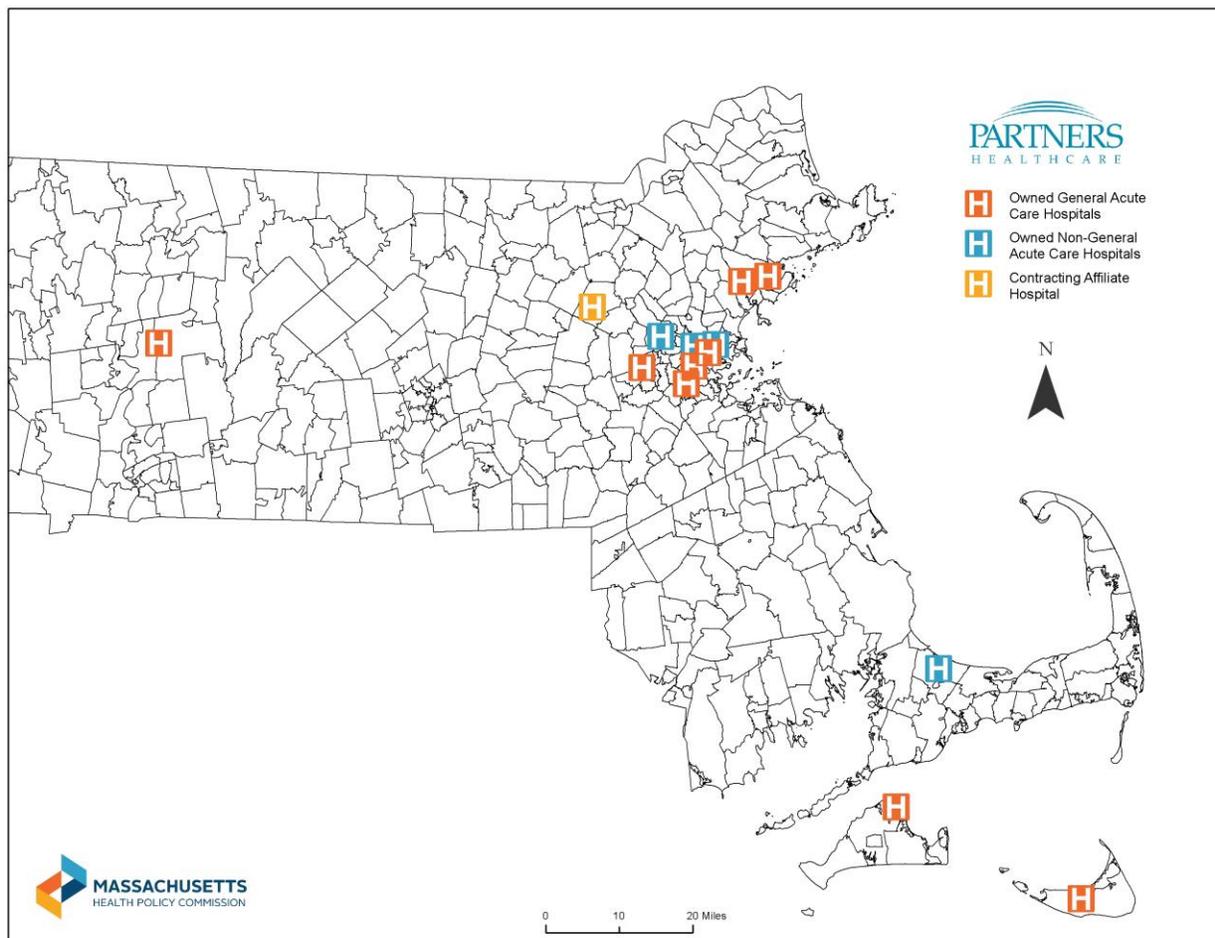
MASS. HEALTH POLICY COMM’N, REVIEW OF PARTNERS HEALTHCARE SYSTEM’S PROPOSED ACQUISITION OF HALLMARK HEALTH CORPORATION (HPC-CMIR-2013-4), PURSUANT TO M.G.L. C. 6D, § 13, FINAL REPORT at 18-19 (Sept. 3, 2014) [hereinafter HALLMARK FINAL CMIR REPORT], *available at* <http://www.mass.gov/anf/docs/hpc/material-change-notices/phs-hallmark-final-report-final.pdf> (last visited Oct. 28, 2017).

²² Hospital type is based on CHIA’s hospital cohort classifications; *see Massachusetts Acute Hospital Cohorts*, CTR. FOR HEALTH INFO & ANALYSIS, <http://www.chiamass.gov/massachusetts-acute-hospital-cohort-profiles/> (last visited Oct. 28, 2017).

²³ Partners is currently in the process of consolidating NSMC’s inpatient services at NSMC’s Salem campus; Partners currently plans for the campus in Lynn, also known as NSMC-Union, to continue to provide outpatient services. *See* Application by North Shore Medical Center for Determination of Need for New Construction and Renovation to Salem Hospital Campus, (Oct. 7, 2015); Letter from Andrew Levine to Nora Mann, Request for Approval of Significant Amendment to Determination of Need Project #6-3C46 (Jan. 20, 2017), *available at* <http://www.mass.gov/eohhs/docs/dph/quality/don/application-north-shore-med-center.pdf> (last visited Oct. 28, 2017).

²⁴ *See* WENTWORTH-DOUGLASS HEALTH SYSTEM, NOTICE OF MATERIAL CHANGE TO THE HEALTH POLICY COMM’N. (Sept. 2, 2017), AS REQUIRED UNDER MASS. GEN. LAWS CH. 6D, § 13, *available at*

Partners Hospitals in Massachusetts



Source: PARTNERS RPO FILING, *infra* note 26

Note: NSMC is represented by two symbols, representing each of the campuses at which Partners currently provides inpatient care. See *supra* note 23. Partners hospital satellite and clinic locations are not shown.

BWH and MGH, Partners' anchor AMCs and largest hospitals, serve as principal teaching hospitals of Harvard Medical School and are among the largest private hospital recipients of the National Institutes of Health funding in the nation.²⁵ As the Commonwealth's two largest AMCs, BWH and MGH have extensive clinical affiliations. These include MGH's affiliation with MEE, described in more detail in Section II.C below, as well as affiliations with Lowell General Hospital and several hospitals in New Hampshire and southern Maine, and BWH's affiliations with South Shore Hospital, Milford Regional Medical Center, and the

<http://www.mass.gov/anf/docs/hpc/material-change-notices/20160909-wentworth-douglass-partners-mcn.pdf> (last visited Oct. 28, 2017).

²⁵ See U.S. DEP'T. OF HEALTH AND HUMAN SERVS., NATIONAL INSTITUTES OF HEALTH, *NIH Awards by Location and Organization*, <https://www.report.nih.gov/award/index.cfm> (last visited Oct. 30, 2017).

Care New England system in Rhode Island.²⁶ Both BWH and MGH also have clinical affiliations with Dana Farber Cancer Institute and Boston Children's Hospital (Children's), and provide staffing and pediatric clinical leadership at Steward Health Care System's (Steward) hospitals.²⁷

Partners also has the largest physician network in Massachusetts, Partners Community Physicians Organization (PCPO). PCPO currently negotiates contracts with payers on behalf of more than 6,700 primary care physicians (PCPs) and specialist physicians, including physicians directly employed by Partners as well as physicians who are affiliated with Partners for contracting and clinical purposes, such as the MEEA physicians.²⁸

In addition to being the largest hospital and physician network in Massachusetts, Partners also owns Neighborhood Health Plan (NHP), a Massachusetts payer with more than 430,000 commercial and MassHealth members,²⁹ as well as Partners HealthCare at Home, a home care agency.

B. FOUNDATION OF THE MASSACHUSETTS EYE AND EAR INFIRMARY

The Foundation of the Massachusetts Eye and Ear Infirmary (MEE) is a Massachusetts non-profit corporation and the parent organization of the Massachusetts Eye and Ear Infirmary (MEEI), an acute care specialty hospital;³⁰ Massachusetts Eye and Ear Associates (MEEA), its affiliated physician group; and the Schepens Eye Research Institute.³¹

²⁶ MASS. HEALTH POLICY COMM'N, REGISTRATION OF PROVIDER ORGANIZATIONS 2015 INITIAL REGISTRATION: PARTNERS HEALTHCARE SYSTEM (Nov. 10, 2016) [hereinafter PARTNERS RPO FILING], available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/material-change-notices-cost-and-market-impact-reviews/registration-of-provider-organizations/2015-initial-registration-data/partners-healthcare-system-inc-final-2015.xlsx> (last visited Oct. 28, 2017).

²⁷ *Id.*

²⁸ HPC analysis of Registration of Provider Organizations data for 2015; see also MASS HEALTH POLICY COMM'N, ANNUAL HEALTH CARE COST TRENDS REPORT 2016, at 24 (Feb. 2017), available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2016-cost-trends-report.pdf> (last visited Oct. 28, 2017).

²⁹ *Id.*; *Who We Are*, NEIGHBORHOOD HEALTH PLAN, <https://www.nhp.org/whoweare/Pages/Who-We-Are.aspx> (last visited Oct. 30, 2017).

³⁰ MEEI is designated by CHIA both as an acute care hospital and as a specialty hospital. An acute hospital is a hospital that is licensed by the Massachusetts Department of Public Health and, like MEEI, contains a majority of medical-surgical, pediatric, obstetric, and/or maternity beds. However, for comparisons to other hospitals, MEEI is designated as a specialty hospital, indicating that it is not grouped into one of the other CHIA hospital cohorts due to the unique set of services it provides. See CTR. FOR HEALTH INFO. & ANALYSIS, MASSACHUSETTS ACUTE HOSPITAL PROFILES TECHNICAL APPENDIX 3, 7-8 (Mar. 2017), available at <http://www.chiamass.gov/assets/docs/r/hospital-profiles/2015/FY15-Profiles-Tech-Appendix.pdf> (last visited Oct. 28, 2017).

³¹ See MASS. HEALTH POLICY COMM'N, REGISTRATION OF PROVIDER ORGANIZATIONS 2015 INITIAL REGISTRATION: FOUNDATION OF THE MASS. EYE AND EAR INFIRMARY (Nov. 10, 2016) [hereinafter MEE RPO FILING], available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/material-change-notices-cost-and-market-impact-reviews/registration-of-provider-organizations/2015-initial-registration-data/massachusetts-eye-and-ear-infirmary-final-2015.xlsx> (last visited Oct. 28, 2017). MEE also includes associated property management subsidiaries.

MEEI was incorporated in 1827 and focuses on disorders relating to the eye, ear, nose, throat and adjacent regions of the head and neck;³² it has been a teaching affiliate of the Harvard School of Medicine since 1900.³³ Its main downtown Boston campus is next to MGH, and its main buildings are physically connected to MGH, helping to facilitate the close clinical relationship between the institutions, discussed in more detail below. MEEI has 41 staffed beds, 21 adult and 20 pediatric.³⁴ Most of MEEI's services are provided on an outpatient basis. In 2015, 90% of MEEI's \$163.5 million in net patient service revenue was received for outpatient services.³⁵ MEEI contracts independently with payers, and, as a specialty care provider, it has clinical affiliations with a number of different provider networks, including Partners as well as Atrius Health (Atrius),³⁶ Beth Israel Deaconess Care Organization (BIDCO), Steward, Highland Health Care Associates,³⁷ Children's, and the Joslin Diabetes Center.³⁸

MEEA is composed of approximately 200 specialist physicians, nearly all of whom are employed by MEEI.³⁹ MEEA physicians have dual appointments at MEEI and at MGH, and MEEA physicians staff MGH's otolaryngology and ophthalmology departments.⁴⁰ MEEA establishes some payer contracts on its own, but participates in Partners' contracts for the three largest commercial payers in Massachusetts as part of the Massachusetts General Physicians Organization (MGPO) local practice group.⁴¹

³² FOUNDATION OF THE MASS. EYE AND EAR INFIRMARY, NOTICE OF MATERIAL CHANGE TO THE HEALTH POLICY COMM'N. (Apr. 5, 2017), AS REQUIRED UNDER MASS. GEN. LAWS CH. 6D, § 13 [hereinafter MEEI NOTICE OF MATERIAL CHANGE], available at <http://www.mass.gov/anf/docs/hpc/material-change-notices/20170403-meei-phs-mcn.pdf> (last visited Oct. 28, 2017). Throughout this report we refer to otolaryngology and ophthalmology, the medical specialties relating to ear, nose, and throat and to the eyes, respectively.

³³ *History of Mass. Eye and Ear*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/about-us/meei-history-timeline> (last visited Oct. 28, 2017).

³⁴ *Quick Facts about Mass. Eye and Ear*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/news/facts> (last visited Oct. 28, 2017).

³⁵ CTR. FOR HEALTH INFO. & ANALYSIS, HOSPITAL PROFILE: MASSACHUSETTS EYE AND EAR INFIRMARY (Mar. 2017), available at <http://www.chiamass.gov/assets/docs/r/hospital-profiles/2015/mass-eye.pdf> (last visited Oct. 28, 2017); CTR. FOR HEALTH INFO. & ANALYSIS, MASSACHUSETTS HOSPITAL PROFILES ACUTE DATABOOK (DATA THROUGH FISCAL YEAR 2015) (Mar. 2017) [hereinafter HOSPITAL PROFILES ACUTE DATABOOK], available at <http://www.chiamass.gov/assets/docs/r/hospital-profiles/2015/FY15-Acute-Databook.xlsx> (last visited Oct. 28, 2017) (showing MEEI's inpatient and outpatient net patient service revenue).

³⁶ ATRIUS HEALTH, NOTICE OF MATERIAL CHANGE TO THE HEALTH POLICY COMM'N. (Nov. 16, 2015), AS REQUIRED UNDER MASS. GEN. LAWS CH. 6D, § 13, available at <http://www.mass.gov/anf/docs/hpc/material-change-notices/20151116-atruius-meei-mcn.pdf> (last visited Oct. 28, 2017).

³⁷ PARTNERS HEALTHCARE, Response to Determination of Need Program Questions at 5 (Sept. 1, 2017) [hereinafter Partners Sept. 1 DoN Response].

³⁸ See MEEI RPO FILING, *supra* note 31. To determine how frequently the patients of these clinical affiliates use MEEI, the HPC conducted an analysis of the APCD. Of the 123,000 claims from the three largest commercial payers in Massachusetts at MEEI for which we could identify a PCP in 2014 (representing 83% of the MEEI claims for these payers), 37.3% of claims were for the patients of Partners PCPs, 12.4% Atrius, 9.6% BIDCO, 8.0% Steward, 6.2% Wellforce, 5.9% Children's, 3.7% Lahey Health System, and 16.9% all other.

³⁹ HPC analysis of Registration of Provider Organizations data for 2015.

⁴⁰ See MEEI RPO FILING, *supra* note 31.

⁴¹ MEEI NOTICE OF MATERIAL CHANGE, *supra* note 32. As discussed in greater detail in Section IV.A., Partners physicians receive varying rates from payers based on the nature of their affiliation with Partners; physicians in the local practice groups affiliated with Partners' AMCs, MGPO and the Brigham and Women's Physician

In addition to its main campus, MEEI currently provides outpatient services at eight hospital satellite locations.⁴² MEEA operates 10 physician practice sites, including one in Rhode Island. Notably, 14 of these clinic and hospital satellite sites have been newly established since 2007, including MEEI’s Longwood surgical site in 2013.⁴³

MEE Hospital Satellite and Clinic Locations

MEEI Hospital Satellites	MEEA Physician Practice Sites
Braintree	Duxbury
Concord	Malden
East Bridgewater	Medford
Longwood (two sites, including a joint site with the Joslin Diabetes Center)	Milton
Plainville	Newton
Quincy	Stoneham
Stoneham	Waltham
	Wellesley
	Weymouth
	Providence, RI

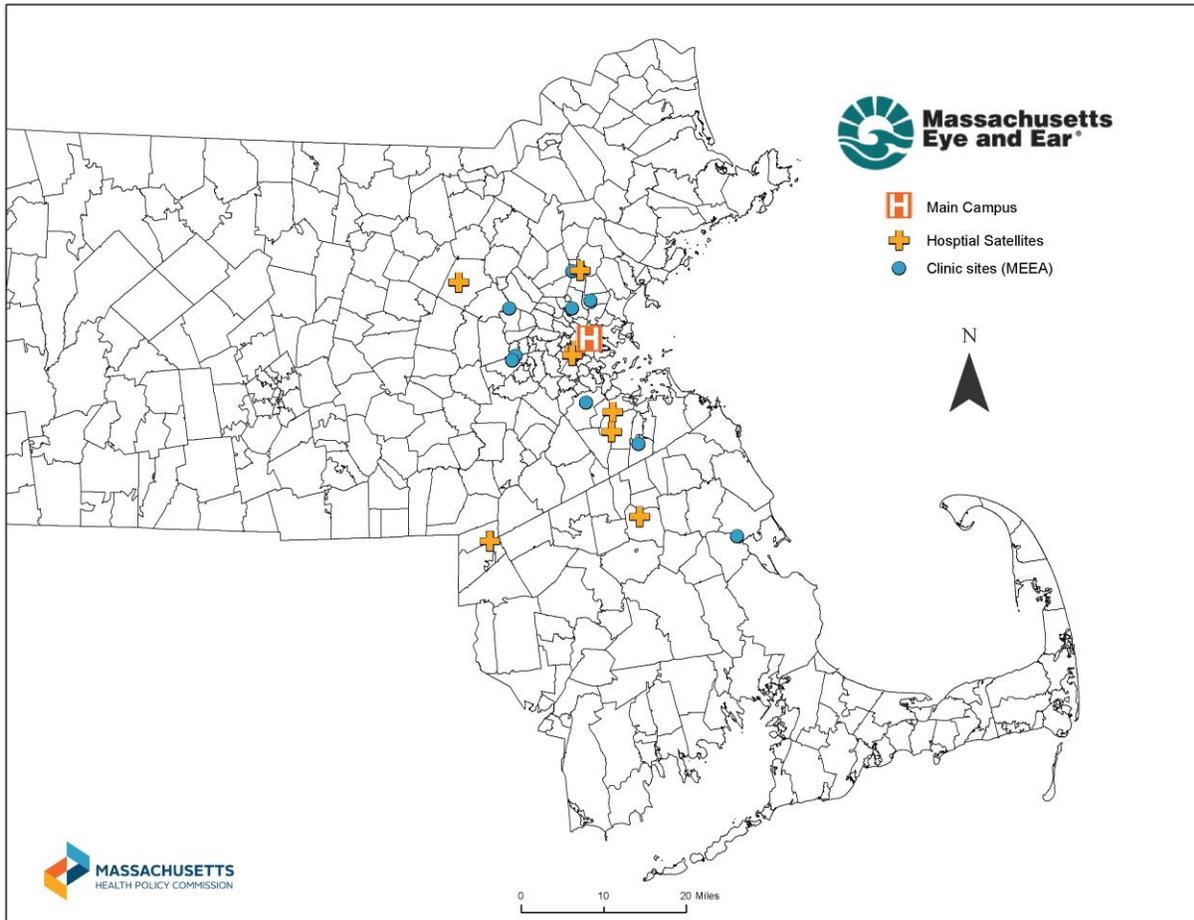
Source: *Massachusetts Eye and Ear Locations*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/locations> (last visited Oct. 29, 2017); MEE RPO FILING, *supra* note 31

Organization, receive the highest commercial payer rates. PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 21, at note 98.

⁴² Hospital satellites are facilities owned by a hospital and operated under that hospital’s license, usually primarily for the purpose of providing outpatient services. As described in the HPC’s 2015 Cost Trends Report, hospital satellites often provide some services similar to services provided in non-hospital facilities like clinics; however, because they are considered part of a hospital, satellites may bill patients or payers separately for professional and facility costs, resulting in a higher total bill than if the same service were performed in a non-hospital setting. See MASS. HEALTH POLICY COMM’N, 2015 COST TRENDS REPORT 39-44 (Jan. 2016), *available at* <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-cost-trends-report.pdf> (last visited Oct. 28, 2017).

⁴³ MASS. EYE AND EAR INFIRMARY, Annual Report 2016 at 1 [hereinafter MEEI ANNUAL REPORT], *available at* <http://www.masseyeandear.org/about-us/annual-report> (last visited Oct. 28, 2017); MASS. EYE AND EAR INFIRMARY, *History of Mass. Eye and Ear*, *supra* note 33 (including the opening of the Longwood surgical center).

MEE Locations in Massachusetts



Source: MASS. EYE AND EAR INFIRMARY, *Massachusetts Eye and Ear Locations*, <http://www.masseyeandear.org/locations> (last visited Oct. 29, 2017)

MEE’s recent expansions have helped to increase its outpatient volume by nearly 80% over the past decade and more than doubled its net patient service revenue, and the parties expect continued otolaryngology and ophthalmology volume growth due to the needs of the Commonwealth’s aging population for these services.⁴⁴ Overall, MEE is a financially stable organization.⁴⁵ However, increases in MEE’s operating expenses resulted in negative operating margins in fiscal years 2013 and 2014, and expenses continued to grow in 2015 and 2016.

⁴⁴ See MEEI ANNUAL REPORT *supra* note 43; PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section F1.a.ii (describing otolaryngology and ophthalmology utilization rates among older populations and Massachusetts’ aging demographic trends, as well as MEEI’s recent growth in these services, as indicative of expected future volume).

⁴⁵ The HPC reviewed audited financial statements for MEE for fiscal years 2013 through 2016. MEE has a healthy reserve of cash and other readily available assets, its patient service revenue has been growing steadily, and its investments in capital improvements and equipment are reflected in improvements in its average age of plant from 2014 to 2016; however, its operating expenses have also grown. Although MEE’s current ratio has decreased in recent years, the decline is not suggestive of dire financial condition. MEE’s financial statements are available from the Charities Division of the AGO; see *supra* note 21.

MEE achieved positive operating margins in 2015 and 2016 primarily as a result of significant gains on sales of non-clinical assets in each year. The parties have stated that MEE “will soon find it difficult to maintain all aspects of its clinical, research and teaching missions” due to a variety of financial pressures, including rising labor and pharmaceutical costs and reductions in federal funding for research and medical education.⁴⁶ They have stated that they hope the transaction will improve MEE’s long-term viability through operational efficiencies, rate increases, and access to Partners capital resources, as discussed in Section II.D.

C. CURRENT RELATIONSHIP BETWEEN PARTNERS AND MEEI

Partners and MEE have a long history of close clinical collaboration.⁴⁷ The main campus hospital buildings of MGH and MEEI are physically connected, MEEA physicians have dual appointments at both institutions, and patients and physicians move regularly between institutions.⁴⁸ MGH’s departments of otolaryngology and ophthalmology are staffed by MEEA physicians and led by MEEI’s department chiefs.⁴⁹ MEE also provides eye care to MGH emergency department patients, and MGH provides pathology services and surgical support to MEEI.⁵⁰ In addition to MEE’s relationship with MGH, MEEA physicians staff the ophthalmology department at BWH, and provide clinic services at Faulkner.⁵¹

In addition to these clinical relationships, MEEA has a contracting affiliation with Partners as noted above. MEEA physicians currently participate in Partners’ commercial payer contracts with the three largest commercial payers in Massachusetts, BCBS, HPHC, and THP.⁵² For the purpose of these contracts, MEEA physicians are considered part of MGH’s affiliated physician group within Partners, the MGPO.⁵³ MEEA currently contracts separately from Partners for smaller payer contracts, while MEEI contracts independently for all payer contracts.

⁴⁶ PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section 2.1. The parties have also stated that “MEE in partnership with Schepens Eye Research Institute, comprises the world’s largest vision and hearing research centers” with \$30.1 million for ophthalmology research and \$13.5 million for otolaryngology research in fiscal year 2016. Partners Sept. 1 DoN Response, *supra* note 37, at 9.

⁴⁷ *Massachusetts Eye and Ear announces plans to join Partners HealthCare*, MASS. EYE & EAR INSTITUTE, <http://www.masseyeandear.org/news/press-releases/2017/01/mass-eye-and-ear-announces-plans-to-join-partners-healthcare> (Jan. 27, 2017) (last visited Oct. 28, 2017) (“Throughout nearly two centuries, MEE clinicians and scientists have enjoyed a close collaboration with colleagues at Massachusetts General Hospital”).

⁴⁸ *MGH and MEEI formalize relationship*, MASS. GENERAL HOSPITAL, <http://www.massgeneral.org/News/newsarticle.aspx?id=1837> (Aug. 7, 2009) (last visited Oct. 28, 2017).

⁴⁹ *Mass. Eye and Ear and Mass General Enter Formal Relationship to Provide Top Eye and ENT Care*, MASS. EYE & EAR INSTITUTE, <https://www.masseyeandear.org/news/press-releases/2009/10/mghcollaboration> (Oct. 19, 2009) (last visited Oct. 28, 2017).

⁵⁰ *Emergency and Trauma Eye Care*, MASS. EYE & EAR INSTITUTE, <https://www.masseyeandear.org/specialties/ophthalmology/emergency-and-trauma-eye-care> (last visited Oct. 28, 2017); MEE RPO Filing, *supra* note 31.

⁵¹ *Ophthalmology*, PARTNERS HEALTHCARE, http://www.brighamandwomens.org/Departments_and_Services/surgery/Ophthalmology/default.aspx (last visited Oct. 28, 2017); MEE RPO FILING, *supra* note 31.

⁵² MEE NOTICE OF MATERIAL CHANGE, *supra* note 32.

⁵³ PARTNERS RPO FILING, *supra* note 26.

To allow for management of their joint patients and to facilitate transitions between MEE and Partners institutions, MEEI has also developed health information technology linkages with Partners, including by participating in the Partners electronic health record system, “Partners eCare,” and the Partners Patient Gateway.⁵⁴ This system provides patient-facing tools and allows all providers in the Partners HealthCare network, including MEEI, access to a single medical record.⁵⁵ However, the Partners and MEE record systems are not fully integrated and include restrictions on how and when non-physician staff can access patient records for shared patients.⁵⁶

D. THE PROPOSED TRANSACTION

The parties have indicated that the proposed transaction would serve both financial and clinical goals. The parties have stated that the acquisition will allow MEE to achieve “market competitive rates,”⁵⁷ and have indicated that they expect significant rate increases for MEE as Partners begins contracting for MEEI and as MEEA physicians join Partners contracts with all commercial payers.⁵⁸ The parties also state that they expect that MEE would achieve operating efficiencies as a result of joining the Partners system. In particular, the parties state that MEE would avoid certain capital expenditures, including by using operating room capacity at existing or planned Partners sites as demand increases, rather than building or expanding its own clinical sites.⁵⁹ The parties also state that MEE would purchase goods and services at lower cost through Partners’ vendors, share in Partners system-wide research and administrative supports, and be able to borrow capital more cheaply through use of Partners’ borrowing arrangements.⁶⁰

Regarding clinical goals, the parties have stated that they intend for MEE to become the “system-wide ophthalmology ... and otolaryngology ... resource for Partners.”⁶¹ The parties

⁵⁴ MEE RPO FILING, *supra* note 31; *Partners Patient Gateway*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/for-patients/adult-surgical-services/partners-patient-gateway> (last visited Oct. 28, 2017).

⁵⁵ *Upgrading our Electronic Health Record System*, MASS. EYE & EAR INFIRMARY, <https://www.masseyeandear.org/partnersecare> (last visited Oct. 28, 2017).

⁵⁶ Partners and MEEI have stated that the federal Health Insurance Portability and Accountability Act requires Partners and MEE to maintain technical separations in their medical record systems for security reasons and that this prevents efficient data sharing and requires duplicative administrative work by each organization because they are not under common corporate ownership. *See* Partners Sept. 1 DoN Response, *supra* note 37, at 12.

⁵⁷ MEE NOTICE OF MATERIAL CHANGE, *supra* note 32.

⁵⁸ Confidential documents provided by the parties include projections of substantial increases in MEE revenue based on rate increases for MEE, notwithstanding statements that Partners has provided “no guarantee that it will achieve any *specific* rate increases” for MEE. PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section F1.a.iii (emphasis added).

⁵⁹ PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section 2.1 and Section F1.a.ii; *see also supra* note 44.

⁶⁰ PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section 2.1. The parties have projected that they expect these steps to reduce the rate of growth of MEE’s operating expenses from 5% per year to 4% per year for the three years following the closing of the transaction, and that additional savings may accrue thereafter. Partners Sept. 1 DoN Response, *supra* note 37, at 3. The parties have indicated that any such savings would be retained and redirected to MEE’s clinical and research activities. PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section F1.a.iii.

⁶¹ MEE NOTICE OF MATERIAL CHANGE, *supra* note 32.

have indicated that this means that, in addition to maintaining the current clinical relationships between MEE and certain Partners providers detailed above, they would develop arrangements for MEE to become the provider of otolaryngology and ophthalmology for at least some of Partners' community hospitals and outpatient sites, potentially including new outpatient sites that Partners may establish.⁶² The parties have not identified where, when, or to what extent such integration or expansion might occur, and have indicated that this planning would occur after the transaction. The parties have also stated that MGH would explore options for providing additional clinical and administrative support to MEEI.⁶³ Finally, the parties have indicated that MEE would be fully integrated into Partners' information technology systems, which the parties say would remove technical barriers (discussed in Section II.C above) that currently limit effective patient management and quality improvement.⁶⁴

⁶² Partners Sept. 1 DoN Response, *supra* note 37, at 3, 5.

⁶³ Partners Sept. 1 DoN Response, *supra* note 37, at 3.

⁶⁴ PARTNERS-MEE DON APPLICATION, *supra* note 19, at Sections F1.b.i - F1.b.ii.

III. ANALYSIS OF PARTIES' BASELINE PERFORMANCE (2014-2017)

Our analysis of the impact of a proposed transaction begins with the parties' baseline performance, prior to the transaction. This Part III examines the parties' recent performance and trends with respect to costs and market functioning, care delivery and quality, and access. The analyses detailed in this section are based on the most recent available data, which primarily span 2014 to 2017.

A. COST AND MARKET BASELINE PERFORMANCE

The law governing cost and market impact reviews directs the HPC to examine different measures of the parties' respective cost and market position, including their size, prices, health status adjusted total medical expenses (TME), and market shares.⁶⁵ The HPC examined these measures over time and compared to other providers to establish the parties' baseline performance leading up to the proposed transaction. In Section IV, we will combine the parties' current performance with details of the transaction and the parties' goals and plans to project the likely impacts of the transaction.

Comparisons of providers' market shares in their service areas show their relative importance to patients in those areas and the payers that cover those patients. Comparisons of providers' hospital and physician prices and medical spending show differences in provider efficiency and costs that can impact total health care spending. In examining these elements of the parties' cost and market profile, the HPC found:

- Partners is the largest health care system in the state, with high inpatient, outpatient, and physician market shares.
- MEEI provides more outpatient otolaryngology and ophthalmology services than any other provider in its service area, but a relatively small share of inpatient services and outpatient services overall. Partners provides some services that overlap with those provided by MEE, particularly outpatient otolaryngology services.
- Partners hospitals and physicians garner some of the highest prices in the state, and its primary care patients have among the highest health status adjusted medical spending. MEE's prices are substantially lower than Partners' prices, and MEE is frequently treated by payers as a more efficient provider than Partners providers in tiered and limited network products.

⁶⁵ See Section I.A. Because provider organizations primarily negotiate with commercial, not government, payers for prices, commercial market share is more relevant for assessing the competitive impact of a transaction. Our assessments of market shares for provider organizations or contracting networks are based on the share of services of hospitals or physicians for which the organization establishes commercial contracts, as well as any providers from which a provider organization receives patient service revenue.

1. Partners is the largest health care system in the state, with high inpatient, outpatient and physician market shares.

As the HPC has documented in past reports, Partners is the largest system in the state by a substantial margin, with high commercial market share across inpatient, outpatient, and primary care services, both statewide and in its service areas.⁶⁶ In 2016, Partners hospitals accounted for 27.0% of inpatient discharges for commercially insured patients in the state, whereas the next largest provider network, BIDCO, accounted for 14.0%.⁶⁷ Similarly, in the most recent year for which data were available, Partners providers accounted for 26.7% of outpatient visits for patients insured by the three largest commercial payers in Massachusetts, more than twice that of BIDCO, at 13.0%.^{68,69}

Statewide Commercial Market Share

	Share of Inpatient Discharges (All commercial payers, 2016)	Share of Outpatient Facility Visits (Three largest comm. payers, 2014)
Partners	27.0%	26.7%
BIDCO	14.0%	13.0%
Lahey	8.1%	10.6%
UMass	7.0%	5.4%
Wellforce	6.2%	6.5%
Steward	5.9%	5.6%
All Other Combined	31.9%	32.2%

Source: HPC analysis of 2016 CHIA hospital discharge data for all commercial payers (for inpatient discharges) and of 2014 APCD data for the three largest commercial payers (for outpatient visits)

Note: “Lahey” refers to Lahey Health System and “UMass” refers to UMass Memorial Health Care.

⁶⁶ PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 21, at 7-8, 17-18; HALLMARK FINAL CMIR REPORT, *supra* note 21, at 8-9, 21-23.

⁶⁷ We used 2016 CHIA hospital discharge data to identify each provider’s share of commercial hospital discharges provided in Massachusetts for general acute care services (i.e., services provided in non-specialty inpatient hospitals), excluding normal newborns (including normal newborns would effectively double-count a single delivery as two discharges), non-acute discharges (e.g., discharges with a length of stay of greater than 180 days, rehabilitation discharges), and out-of-state patients.

⁶⁸ We used claims-level data from the 2014 APCD for BCBS, HPHC, and THP to identify services provided by all facilities, including acute and non-acute hospital outpatient departments and satellite facilities, and freestanding ambulatory surgery centers. We then determined the share of patient visits at each provider, counting all claims on the same day at the same provider for the same patient as a single visit.

⁶⁹ Partners also had the highest statewide share of primary care physician visits for patients insured by one of the three largest commercial payers (15.8%, followed by Steward at 10.7%, Children’s at 9.8%, and Wellforce at 9%) in the 2014 APCD. For more information on our methodology for defining shares of primary care physician visits, see MASS. HEALTH POLICY COMM’N, REVIEW OF BETH ISRAEL DEACONESS CARE ORGANIZATION’S PROPOSED CONTRACTING AFFILIATION WITH NEW ENGLAND BAPTIST HOSPITAL AND NEW ENGLAND CLINICAL INTEGRATION ORGANIZATION (HPC-CMIR-2015-1) AND BETH ISRAEL DEACONESS CARE ORGANIZATION’S PROPOSED CONTRACTING AFFILIATION AND BETH ISRAEL DEACONESS MEDICAL CENTER’S AND HARVARD MEDICAL FACULTY PHYSICIANS’ PROPOSED CLINICAL AFFILIATION WITH METROWEST MEDICAL CENTER (HPC-CMIR-2016-1), PURSUANT TO M.G.L. C. 6D, § 13, FINAL REPORT (Sept. 7, 2016) at 28, note 111, *available at* <http://www.mass.gov/anf/docs/hpc/material-change-notices/bidco-nebh-metrowest-bidmc-final-cmir.pdf> (last visited Oct. 29, 2017).

Within the primary service areas⁷⁰ (PSAs) for its hospitals, Partners' shares of inpatient services were higher and often substantially higher than those of other systems.⁷¹

2. MEEI provides more outpatient otolaryngology and ophthalmology services than any other provider in its service area, but a relatively small share of inpatient and outpatient services overall. Partners provides some services that overlap with those provided by MEEI.

- a. *Inpatient services*

As described in Section II.B, MEEI provides relatively few inpatient services. In total, MEEI had only 831 discharges in 2016, and had only 0.2% of all discharges in its own PSA. However, MEEI does not provide a full range of inpatient general acute care services. In order to assess MEEI's share of the services for which it competes, the HPC examined its market share for the inpatient services it provides most frequently, largely otolaryngology and ophthalmology services, which we refer to as MEEI's inpatient "core services."⁷² We then defined MEEI's PSA for these services⁷³ and calculated the parties' shares of those services in MEEI's PSA. Even focusing on these inpatient services that MEEI provides most frequently, we found that MEEI accounted for only 3.5% of discharges in its PSA in 2016. However, Partners hospitals provided 34.0% of these discharges within MEEI's PSA.⁷⁴ Given that Partners hospitals do not specialize in otolaryngology and ophthalmology services, Partners'

⁷⁰ We use the term "primary service area" or "PSA" to refer to the area from which a hospital draws 75% of its commercial patients. For methodology details, see TECHNICAL BULLETIN, *supra* note 9.

⁷¹ In each Partners hospital PSA in 2016, Partners hospitals accounted for 31.3% (Cooley Dickinson) to 82.9% (Nantucket Cottage Hospital) of general acute care inpatient discharges. In the PSAs of NSMC, Martha's Vineyard Hospital, and Nantucket Cottage Hospital, Partners' share of inpatient services exceeded 40%, the HPC's threshold for "dominant market share" for inpatient services pursuant to MASS. HEALTH POLICY COMM'N, 958 CMR 7.00: NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS (Jan. 2, 2015) at 958 CMR 7.02 [hereinafter NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS], *available at* <http://www.mass.gov/anf/docs/hpc/regs-and-notices/consolidated-regulations-circ.pdf> (last visited Oct. 28, 2017) (defining a provider or provider organization as having dominant market share for inpatient general acute care services when it has 40% of the commercial discharges in one or more of its hospital PSAs). Partners' share in Faulkner's PSA was 39.8%, just 0.2% below the threshold for dominant market share.

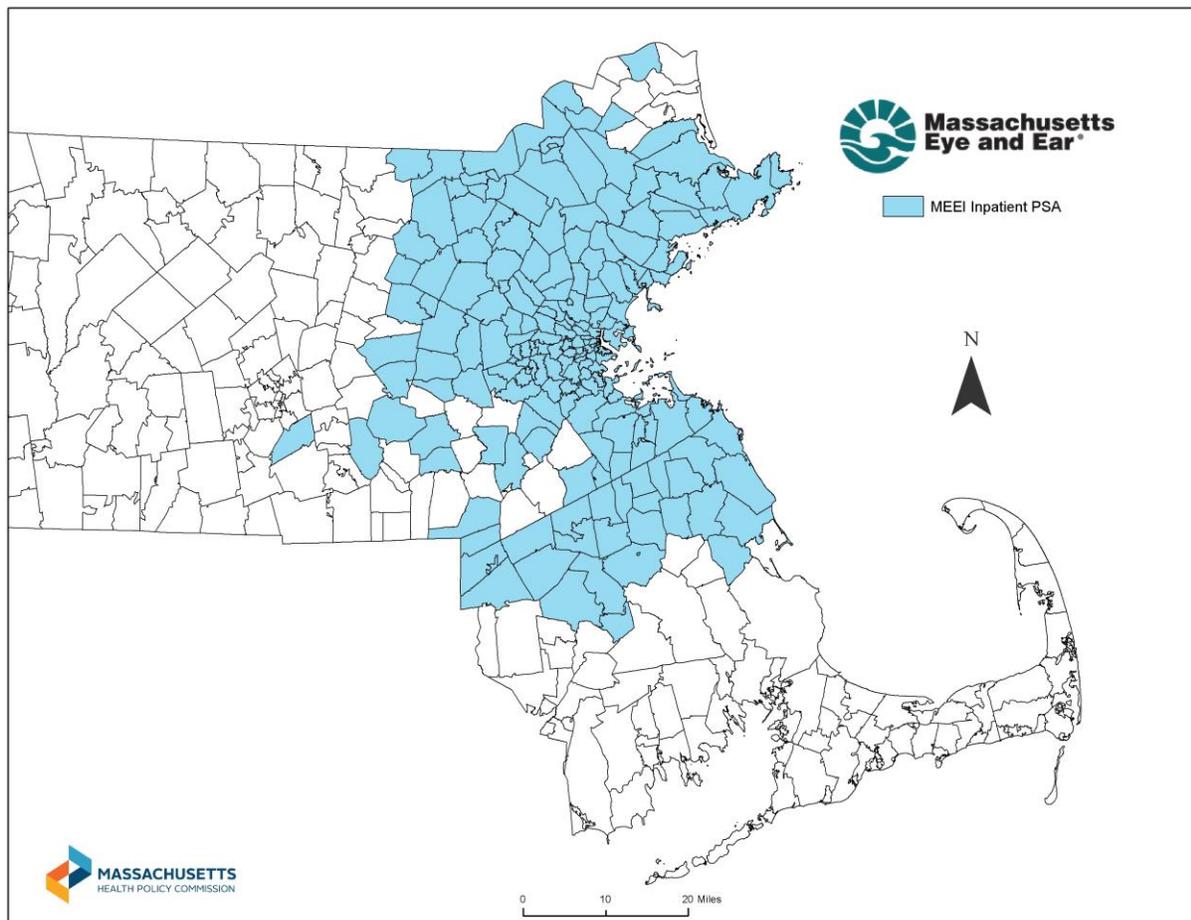
⁷² We used 2016 CHIA Hospital Discharge Data to identify the inpatient services MEEI most commonly provides, based on the most common Medicare Severity-Diagnosis Related Groups (MS-DRG) for MEEI patients and including all levels of acuity. Our core services definition also includes relatively uncommon services for which MEEI provides at least 10% of all commercial discharges among hospitals in its PSA. In total, our method of defining MEEI's inpatient core services accounted for approximately 83% of MEEI's commercial discharges in 2016. The 67 MS-DRGs in our definition of MEEI's core services include, but are not limited to, inpatient otolaryngology and ophthalmology services. They are: 11-13, 25-27, 113-117, 121-122, 124-125, 129-136, 146-148, 152-156, 204-206, 576-581, 602-603, 606-607, 625-627, 643-645, 820-825, 840-842, 856-858, 862-863, and 919-921.

⁷³ The HPC defined MEEI's inpatient PSA as the contiguous zip codes closest to the hospital from which the hospital draws 75% of its commercial discharges for its core services.

⁷⁴ In its own PSAs, Partners provided an even greater share of MEEI's inpatient core services, ranging from 34.0% to 77.8%.

share of these inpatient services likely reflects its substantial share of the overall inpatient market, as described above.

MEEI Inpatient Core Services Primary Service Area



Source: HPC analysis of hospital discharge data

b. Outpatient services

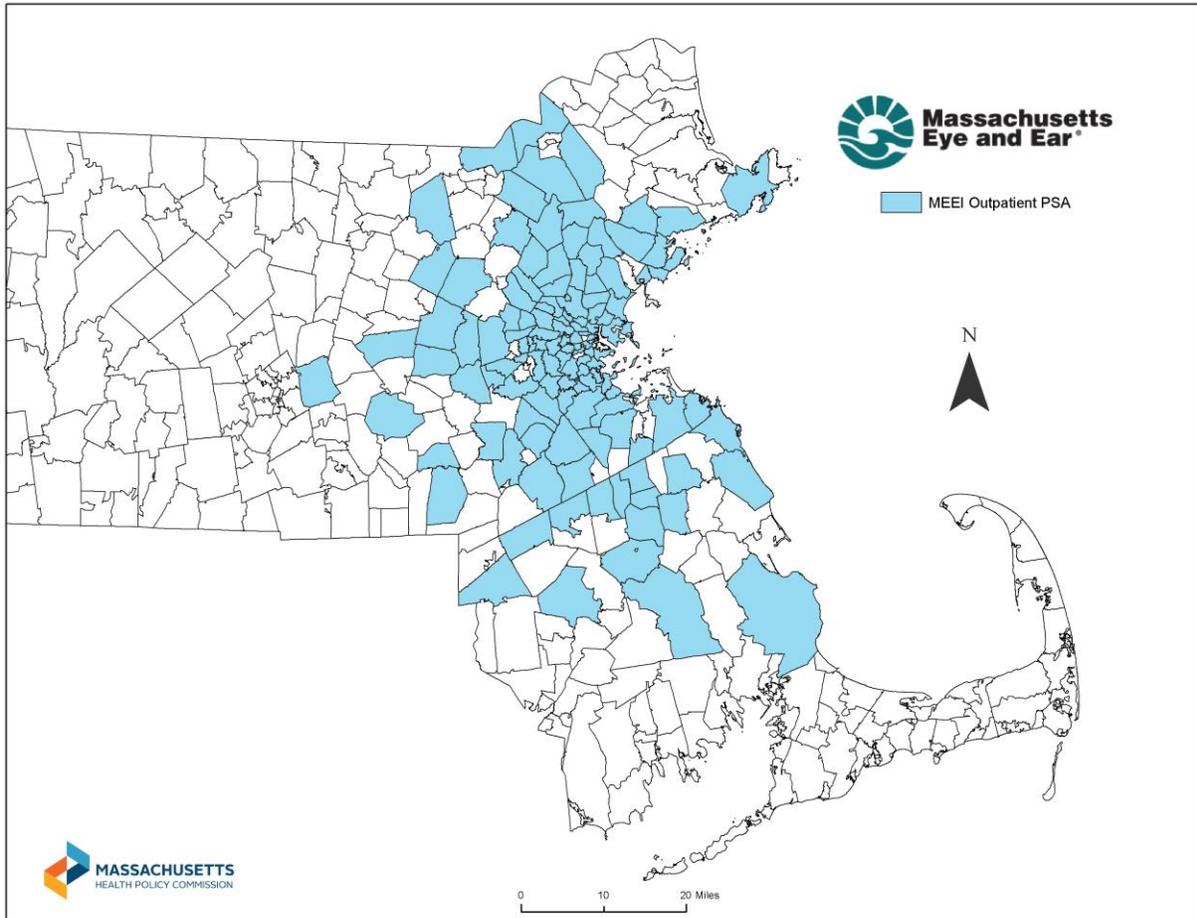
As described in Section II.B, MEEI predominantly provides *outpatient* otolaryngology and ophthalmology services. To analyze the parties' market position for the services for which MEEI competes, we identified outpatient otolaryngology and ophthalmology facility visits⁷⁵ based on a clinical classification of outpatient procedure codes billed during those visits.⁷⁶ We

⁷⁵ As described in *supra* note 68, facility visits include services provided at acute care hospitals and their satellite locations, non-acute care hospitals (e.g., rehabilitation hospitals) and their satellite locations, and freestanding ambulatory surgery centers.

⁷⁶ Current Procedural Terminology (CPT) code clusters are based on clinical categories in the CPT Codebook published by the American Medical Association. AMERICAN MEDICAL ASS'N, *CPT® 2014 Professional Edition* (2014). The Codebook includes approximately 300 clinical categories, which the HPC aggregated into 42 categories that parallel major specialties and subspecialties in clinical care. Otolaryngology and ophthalmology are two such aggregated categories.

then defined MEEI's PSA for these services. As shown below, the PSA includes most of eastern Massachusetts.⁷⁷

MEEI Outpatient Otolaryngology and Ophthalmology Primary Service Area



Source: HPC analysis of hospital discharge data

⁷⁷ Using claims-level data in the 2014 APCD for BCBS, HPHC, and THP, we defined MEEI's outpatient PSA as the zip codes from which it draws 75% of its outpatient visits for these services, and then calculated shares of outpatient otolaryngology and ophthalmology visits, respectively, for MEEI, Partners, and other major health care systems in the Commonwealth. As with all outpatient services, we counted all claims on the same day at the same provider for the same patient as a single visit.

In its PSA, we found that MEEI had the highest shares of both otolaryngology and ophthalmology facility visits, at 26.5% and 34.6%, respectively. Partners also had a significant share of outpatient facility otolaryngology visits in MEEI’s PSA, at 18.7%. By contrast, Partners’ share of outpatient facility ophthalmology visits in this service area was only 1%.^{78,79}

Shares of Commercial Outpatient Otolaryngology Facility Visits in MEEI’s PSA

Hospital System/Network	Share of Commercial Outpatient Otolaryngology Facility Visits
MEEI	26.5%
Partners	18.7%
Children’s	16.0%
Lahey	7.1%
HealthSouth	6.2%
All Other Combined	25.5%

Source: HPC analysis 2014 APCD data for the three largest commercial payers

Notes: Outpatient shares refer to the parties’ shares within MEEI’s outpatient PSA. These findings include data from the three largest commercial payers.

“HealthSouth” is a network of rehabilitation hospitals.

⁷⁸ Most claims in an outpatient setting include both a facility component and a professional component. We focus on the facility component of outpatient services because the MEEA physicians already contract through Partners for BCBS, THP and HPHC, which are the three payers for which we have APCD data. We do not anticipate a change to the parties’ share of outpatient professional services, or share of professional services in other settings (e.g., physician offices or clinics) for these payers, and do not currently have access to the data for other payers for which there would be a change in share. For these three largest commercial payers, the parties’ combined share of outpatient professional revenue from facility settings in MEEI’s outpatient PSA was 44.6% for otolaryngology and 44.0% for ophthalmology as of 2014, the most recent year for which data were available. In non-hospital settings (e.g., physician offices or clinics), the parties’ combined share of professional revenue in MEEI’s outpatient PSA was 29.5% for otolaryngology and 30.6% for ophthalmology.

⁷⁹ In our examination of the APCD claims data for otolaryngology and ophthalmology services, we also found that a number of services are provided in both facility and non-facility settings (e.g., physician offices or clinics), suggesting that for some services, patients could choose to receive the service in either a facility or non-facility setting. We therefore also examined the parties’ shares of revenue for the same CPT codes across outpatient facility and non-facility settings, including both the facility and professional components of revenue. We found that for otolaryngology services, MEE facilities and physicians received 22.9% of revenue from visits in MEEI’s outpatient PSA, while Partners facilities and physicians (excluding MEEA) received 15.3%. For ophthalmology services, MEE facilities and physicians received 14.9% of the revenue from visits in MEEI’s outpatient PSA, while Partners facilities and physicians (excluding MEEA) received 20.3%. As described above, Partners facilities only received 1% of outpatient facility visits for ophthalmology; the higher share of ophthalmology for Partners facilities and physicians combined reflects the fact that some non-MEEA Partners physicians provide ophthalmology services at non-Partners facilities including independent eye surgery centers, MEEI, and other non-Partners hospitals, as well as in non-facility settings.

Shares of Commercial Outpatient Ophthalmology Facility Visits in MEEI's PSA

Hospital System/Network	Share of Commercial Outpatient Ophthalmology Facility Visits
MEEI	34.6%
Wellforce	16.1%
Lahey	11.5%
Boston Medical Center	8.9%
...	...
Partners	1.0%
All Other Combined	27.9%

Source: HPC analysis 2014 APCD data for the three largest commercial payers

Notes: Outpatient shares refer to the parties' shares within MEEI's outpatient PSA.

These findings reflect data from the three largest commercial payers. Although other providers have higher ophthalmology shares, Partners' share is shown for reference.

We also examined the parties' shares of *all* outpatient services in MEEI's outpatient PSA. We found that Partners hospitals provided 32.3% of commercial outpatient facility visits across all categories of outpatient services in MEEI's outpatient PSA, whereas MEEI provided 1.5% of such visits. Partners' very high share of outpatient services in this service area is consistent with its high statewide shares, described above. MEEI's smaller share of all outpatient services is consistent with its role as a provider of specialty services.

3. Partners hospitals and physicians garner some of the highest prices in the state, and its primary care patients have among the highest health status adjusted medical spending. MEE's prices are substantially lower than Partners' prices.

As the HPC has also documented in past reports, along with Partners' strong market position, its hospitals and physicians also have some of the highest prices in the Commonwealth.⁸⁰ For the three largest commercial payers in 2015, Partners' AMCs had the highest commercial relative prices among the six AMCs in the Commonwealth, and Partners' community hospitals had some of the highest commercial relative prices among the state's community hospitals. Partners' community hospitals were also frequently the highest priced hospital among local comparators.⁸¹ Partners hospitals also had prices that were similar to each

⁸⁰ PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 21, at 14-16; HALLMARK FINAL CMIR REPORT, *supra* note 21, at 23-25.

⁸¹ Relative price is a standardized pricing measure that accounts for differences among provider service volume, service mix, patient acuity, and insurance product types in order to allow comparison of negotiated price levels. In 2015, BWH and MGH had the highest inpatient and outpatient blended relative prices among all AMCs for the three largest payers, ranging from 1.26 to 1.46. With the exception of Cooley Dickinson, which does not yet contract through Partners (see *infra* note 84), Partners community hospitals were among the top 12 most-expensive community hospitals in the Commonwealth for the three largest commercial payers (out of 44 community hospitals total). Only the community hospitals located on Cape Cod or in Berkshire County are consistently more expensive. CTR. FOR HEALTH INFO. & ANALYSIS, PROVIDER PRICE VARIATION IN THE MASSACHUSETTS HEALTH CARE MARKET (CALENDAR YEAR 2015 DATA) (May 2017) [hereinafter CHIA RELATIVE PRICE DATABOOK], available at <http://www.chiamass.gov/assets/docs/r/pubs/17/Relative-Price-Databook-2017.xlsx> (last visited Oct. 29, 2017) These prices constitute "materially higher price" for all Partners hospitals, as

other. MEEI's 2015 commercial prices were substantially lower than those of MGH and BWH, as well as lower than those of the Partners community hospitals in greater Boston.⁸²

The following chart shows 2015 blended inpatient and outpatient relative prices for one major payer for Partners hospitals, comparators providing similar services to patients residing in the same areas, and MEEI. Pricing for these hospitals is similar in other payer networks. As shown below, the Partners hospitals were generally higher-priced, and sometimes considerably higher-priced, than local comparators.⁸³ The Partners AMCs had the same relative price, and the three community hospitals in greater Boston had nearly identical relative price levels.⁸⁴ MEEI's relative price was lower than the relative prices of both of Partners' AMCs and its Boston-area community hospitals.

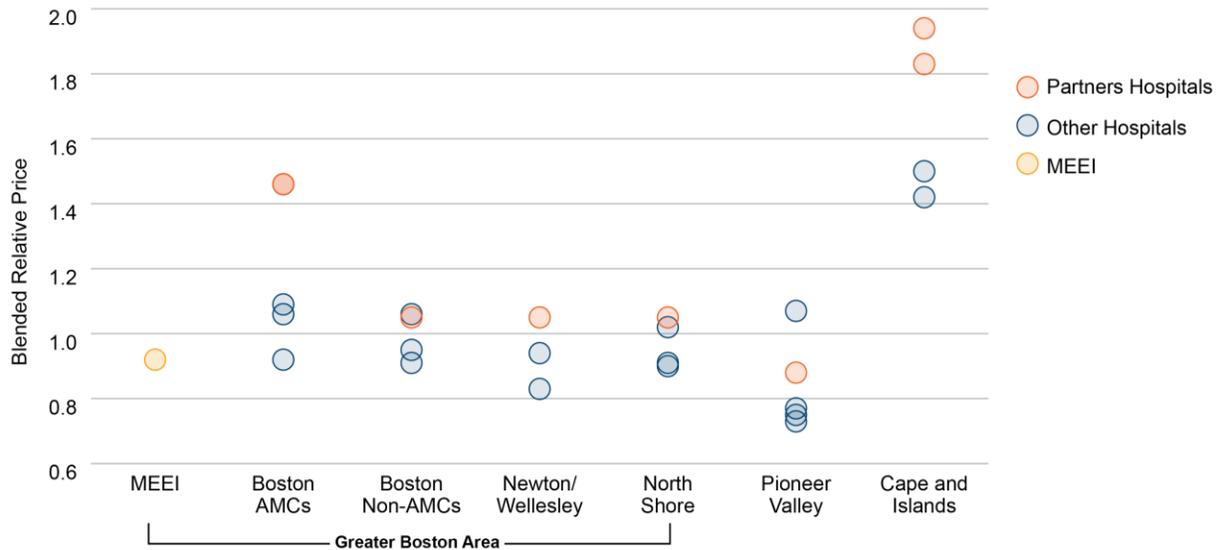
defined in NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS, *supra* note 71, and further described in TECHNICAL BULLETIN, *supra* note 9.

⁸² For example, MEEI's 2015 inpatient and outpatient blended relative prices ranged from 0.79 to 0.92 for the three largest commercial payers, compared with a range of 1.02 to 1.09 for Partners' three Boston-area community hospitals and, as noted above, a range of 1.26 to 1.46 for Partners' AMCs. CHIA RELATIVE PRICE DATABOOK, *supra* note 81.

⁸³ The HPC identified comparators for each Partners hospital that reflect a set of local hospitals that a local patient could choose as a substitute for each Partners hospital. The comparators are based on geographic proximity, patient flow patterns, and hospital type (AMC and non-AMC), and therefore may not align with municipal boundaries or other fixed regions. *See* PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 21, at 5-6.

⁸⁴ Cooley Dickinson and its physicians do not yet contract through Partners due to an agreement with the AGO that precludes joint contracting until June 1, 2018. This agreement may change pricing dynamics in Cooley Dickinson's market. However, in 2015, Cooley Dickinson was already the most expensive hospital in the Pioneer Valley for the other two of the three largest payers.

Inpatient and Outpatient Blended Relative Price for Partners Community Hospitals and AMCs, MEEI, and Local Comparators (BCBS 2015)



Local Comparators: **Boston AMCs:** BWH, MGH, Beth Israel Deaconess MC, Boston MC, Tufts MC; **Boston Non-AMCs:** BWH-Faulkner, Carney Hospital, Norwood Hospital, St. Elizabeth's MC; **Newton/Wellesley:** Newton-Wellesley Hospital, BID-Needham, Mt. Auburn Hospital; **North Shore:** NSMC, Hallmark Health, Lahey Hospital and Medical Center, Northeast Hospital; **Pioneer Valley:** Cooley Dickinson, Baystate MC, Holyoke MC, Mercy Hospital, Noble Hospital; **Cape and Islands:** Martha's Vineyard, Nantucket, Cape Cod Hospital, Falmouth Hospital

Source: HPC analysis of CHIA RELATIVE PRICE DATABOOK, *supra* note 82.

The parties' prices across inpatient, outpatient and physician services are compared in more detail below.

a. 2017 Hospital Prices

Analyzing both publicly available data and more recent confidential data on inpatient prices, we found that Partners' greater Boston area community hospitals are currently approximately 11.5% higher-priced and MGH is approximately 34.6% higher-priced than MEEI in the three largest commercial payer networks.⁸⁵

Similarly, when we analyzed current data for the three largest commercial payers in 2017, we found that Partners community hospitals in the greater Boston area have outpatient prices approximately 5.9% to 52.2% higher and MGH has outpatient prices that are 57.8% to

⁸⁵ To model the potential impact of this transaction on inpatient spending, the HPC first calculated 2015 inpatient price differentials for all payers for which 2015 relative price data were available. The parties provided information about each hospital's 2016 and 2017 rate increases, which we applied to the 2015 price differentials in order to calculate 2017 price differentials. These differentials are only slightly decreased from those reported in 2015 inpatient relative price, which show Partners' greater Boston area community hospitals as approximately 12.3% higher priced than MEEI, and MGH as approximately 34.6% higher priced than MEEI. CHIA RELATIVE PRICE DATABOOK, *supra* note 81.

104.7% higher than those of MEEI for the mix of outpatient services that MEEI provides.⁸⁶ The likely explanation for Partners’ comparatively higher prices—even where MEEI currently provides more outpatient otolaryngology and ophthalmology services than Partners’ facilities as described above—is that outpatient prices are not negotiated at the specialty level, but rather at broader service categories, such as ambulatory surgery or radiology.⁸⁷ As a result, Partners’ strong market position across these broader outpatient service categories, and for outpatient services generally, would have a greater effect on its prices for otolaryngology and ophthalmology than its shares of these particular services.

b. Professional Prices

Partners’ physician network, PCPO, also has high relative prices compared to other providers.⁸⁸ PCPO physicians receive different commercial rates depending on the nature of their affiliation with Partners, with the highest rates for physicians affiliated with Partners’ AMCs, including MGPO.⁸⁹ For the three largest commercial payers, for which the MEEA physicians contract through Partners, the MEEA physicians already receive these highest rates

⁸⁶ The most recent relative price data showed that Partners’ greater Boston area community hospitals had outpatient prices approximately 28.0% to 41.5% higher and MGH had outpatient prices approximately 58.0% to 99.3% higher than MEEI’s in 2015 in the three largest commercial payer networks. CHIA RELATIVE PRICE DATABOOK, *supra* note 81. We updated these data to adjust for the fact that MEEI has a different mix of outpatient service categories than most general acute care hospitals; specifically, MEEI provides a relatively larger proportion of outpatient ambulatory surgery services. To calculate outpatient relative price, however, CHIA utilizes hospital revenue data and service category-specific fee schedule multipliers submitted by payers for each provider, and then adjusts such data to reflect a standard *network average* mix of outpatient services. See CTR. FOR HEALTH INFO. & ANALYSIS, RELATIVE PRICE METHODOLOGY PAPER (September 2016), *available at* <http://www.chiamass.gov/assets/docs/r/pubs/16/RP-Methodology-Paper-9-15-16.pdf> (last visited Oct. 29, 2017). The HPC utilized the underlying raw data submitted by payers to calculate a relative price for the parties’ hospitals in the three largest payer networks based on MEEI’s service mix instead of the network average service mix. This adjustment was not necessary for inpatient services, because inpatient relative price is calculated based on net patient service revenue per case-mix-adjusted discharge, and the case mix adjustment already effectively captures differences in service mix. We then used confidential data from the parties to update these outpatient differentials for 2017. The scale of these price differentials was also confirmed by analysis of the APCD. Specifically, we examined all hospital outpatient claims in the 2014 APCD for BCBS, HPHC, and THP for the CPT codes that comprise MEEI’s outpatient otolaryngology and ophthalmology services. We found that for the three largest payers combined in 2014, Partners community hospital prices were 33% above MEEI’s prices for otolaryngology services, and 37% above MEEI’s prices for ophthalmology services. Partners AMC prices were 61% above MEEI’s prices for otolaryngology services, and 53% above MEEI’s prices for ophthalmology services.

⁸⁷ This understanding was conveyed by several payers and confirmed by the HPC’s examination of outpatient relative price data and information provided by the parties, both of which identify the service categories that are subject to separate price negotiations. Individual services within a specialty are often dispersed across several of these service categories. The prices a provider receives for a particular specialty service will depend on the prices negotiated for the service categories into which the specialty falls.

⁸⁸ Across all commercial payers, in the most recent year for which data were available, PCPO’s physician prices were second only to physicians affiliated with Children’s. CHIA RELATIVE PRICE DATABOOK, *supra* note 81.

⁸⁹ See PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 21, at notes 97-98 (describing how Partners’ physicians are paid one of three rates, “affiliated,” “integrated, or “academic”).

as part of MGPO.⁹⁰ For all other commercial payers, MEEA physicians negotiate independently. When we examined relative prices for four of the commercial payers with whom the MEEA physicians negotiate independently, we found that PCPO's prices ranged from 23% to 60% higher than MEEA's.⁹¹

c. Total Medical Expenses

In addition to having higher prices than other providers, Partners' primary care patients also have higher overall medical spending than patients of other provider networks, which is not explained by differences in health status.⁹² These higher health status adjusted total medical expenses (TME) for Partners' primary care patients could reflect higher utilization of services and/or the use of Partners' higher-priced physicians and facilities.⁹³ Because TME is based on health care spending for patients attributed to a provider organization's primary care providers, and MEEA does not include any primary care providers, there is no TME calculation for MEEA.

d. Network participation

The HPC examined the status of MEEI and several Partners hospitals for commercial limited and tiered network insurance products offered in the Commonwealth. As detailed in Section III.C.2 below, we found that MEEI participates more frequently than Partners hospitals in limited networks, and is generally in the most efficient tier of the tiered networks we examined. Partners AMCs are generally in the least efficient tier and the tier placement of Partners' greater Boston community hospitals varies. This is consistent with MEEI's position as a lower-cost provider and Partners' position as a higher-cost provider, particularly for its AMCs.

⁹⁰ Some payers have "physician growth caps," which are limits on the number of physicians for whom Partners is permitted to contract at a given time, or for whom Partners may obtain its highest (academic) rates. While all MEEA physicians contract through MGPO for the three largest payers, it is possible that some of these physicians do not receive academic rates due to these caps.

⁹¹ These commercial payers are UniCare Life and Health Insurance Company, Neighborhood Health Plan, United Healthcare Insurance Company, and Aetna Health. In 2014, MEEA relative prices were not reported for any other commercial payers. CHIA RELATIVE PRICE DATABOOK, *supra* note 81.

⁹² We compared Partners' 2015 health status adjusted total medical expenses (TME) for the three largest payers to the TME of Baycare Health Partners, UMass Memorial Health Care, Lahey Health System, BIDCO, Steward Network, New England Quality Care Alliance, and Atrius. CTR. FOR HEALTH INFO. & ANALYSIS, PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM: TOTAL MEDICAL EXPENSES DATABOOK 2016 (CY 2013 - CY 2015 Data) (Updated October 5, 2016), available at <http://www.chiamass.gov/assets/2016-annual-report/2016-Annual-Report-TME-Databook.xlsx> (last visited Oct. 29, 2017). TME is expressed as a per member per month dollar figure that reflects the average monthly covered medical expenses paid by the payer and the member for all of the health care services the payer's members receive in a year, adjusted for the members' health status.

⁹³ Partners' 2015 TME constitutes "materially higher health status adjusted total medical expenses" as defined in NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS, *supra* note 70 and further described in TECHNICAL BULLETIN, *supra* note 9. For the largest commercial payer, which accounts for more than one third of Partners' commercial revenue, Partners' TME was 8.6% above the average for all other provider organizations.

In summary, Partners is the largest health care system in the state, with high inpatient, outpatient, and physician market shares. MEEI provides more outpatient otolaryngology and ophthalmology services than any other provider in its service area, but only a small share of all inpatient and outpatient services. Partners hospitals and physicians have some of the highest prices in the state—across inpatient, outpatient and physician services—and are generally higher priced than local comparators. MEEI’s prices are substantially lower than Partners’ prices, and MEEI is frequently treated by payers as a more efficient provider than Partners providers in tiered and limited network products. These measures of the parties’ market share and cost performance to date will form the basis for our projections of the impacts of the proposed transaction on total health care spending and market functioning in Section IV.A.

B. QUALITY BASELINE PERFORMANCE

To understand the parties’ baseline performance in delivering high-quality patient care, the HPC assessed recent quality metrics for each party in the areas of health care system structures, clinical outcomes, and patient experience. Because MEEI provides only a specialized set of services, there are fewer relevant, standardized, publicly reported quality measures available to assess its performance.⁹⁴ We examined over 50 validated and nationally endorsed measures,⁹⁵ focusing on those applicable to MEEI,⁹⁶ and found that Partners hospitals and MEEI perform well compared to state and national averages.

We found that the parties generally perform well on structural factors related to quality and patient safety including, for example, internal policies, accreditation, and quality measurement initiatives. Based on publicly reported data, MEEI has fully implemented some commonly accepted standards to support patient safety, including fully adopting the core elements of the Centers for Disease Control and Prevention’s Antibiotic Stewardship Program and ordering the majority of inpatient medications through a computerized physician order entry system.⁹⁷ Partners hospitals also generally performed well on these and similar measures

⁹⁴ For example, few clinical process measures were applicable to MEEI as a specialty provider and we therefore did not assess MEEI in this domain. However, we assessed clinical process measures for the Partners hospitals and found that, as in years past, Partners hospitals generally perform at or above the statewide average. See HALLMARK FINAL CMIR REPORT, *supra* note 21, at 28-29. Similarly, MEEI is composed entirely of specialists therefore cannot be assessed on most measures of ambulatory care processes. However, we assessed the performance of the PCPO primary care physicians on 16 ambulatory care process measures and found that PCPO met or exceeded the average statewide performance on all but four of these measures. See NAT’L COMM. FOR QUALITY ASSURANCE, *HEDIS*® and *Quality Compass*®, <http://www.ncqa.org/HEDISQualityMeasurement/WhatIsHEDIS.aspx> (last visited Oct. 29, 2017). The HPC obtained 2014 HEDIS data from CTR. FOR HEALTH INFO & ANALYSIS, PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM: A FOCUS ON PROVIDER QUALITY DATABOOK 2016 (Sept. 2016), available at <http://www.chiamass.gov/assets/docs/r/pubs/16/Quality-Report-Databook-2016.xlsx> (last visited Oct 29, 2017).

⁹⁵ We assessed a broad spectrum of measures, with a focus on certain measures most relevant to the proposed transaction. Applicable measures were drawn in part from the 2017 Massachusetts Standard Quality Measure Set. See CTR. FOR HEALTH INFO & ANALYSIS, STANDARD QUALITY MEASURE SET (SQMS), <http://www.chiamass.gov/sqms/> (last visited Oct. 29, 2017).

⁹⁶ For additional assessments of Partners performance on a range of hospital and physician metrics beyond those most relevant to MEEI, see PARTNERS-HALLMARK FINAL REPORT, *supra* note 21, at Section III.B.

⁹⁷ MEEI has not fully implemented certain other policies, including some recommended by the National Quality Forum for avoiding patient harm, and did not score as well on a standard of safe medication administration

where data were available.⁹⁸ Both Partners and MEE also have robust internal systems for tracking quality metrics and regularly reporting results to employees to facilitate quality improvement.⁹⁹

On outcome measures, such as readmission rates, hospital-related complications rates, and mortality rates, we found that the parties' hospitals generally performed comparably to statewide averages. Thirty-day, all-cause readmission rates for the parties' hospitals were comparable to the statewide average except for BWH, which performed slightly below average.¹⁰⁰ Based on the Agency for Healthcare Research and Quality composite Patient Safety Indicator (PSI) 90, we also found that the rate at which patients experienced hospital-related complications at MEEI and Partners hospitals was comparable to the statewide average.¹⁰¹ Finally, MEEI and most Partners hospitals performed comparably to statewide averages on risk-adjusted mortality rates for certain procedures and conditions, utilizing the Inpatient Quality Indicator (IQI) 90 and IQI 91 composite measures.^{102, 103}

practices. For more detail on these measures, see THE LEAPFROG GROUP®, THE LEAPFROG HOSPITAL SURVEY SCORING ALGORITHMS: SCORING DETAILS FOR SECTIONS 2-9 OF THE 2017 LEAPFROG HOSPITAL SURVEY, available at http://www.leapfroggroup.org/sites/default/files/Files/2017ScoringAlgorithms_FINAL_v3.pdf (last visited Oct. 28, 2017). *Compare Hospitals*, THE LEAPFROG GROUP, <http://www.leapfroggroup.org/compare-hospitals> (last visited Oct. 29, 2017).

⁹⁸ MGH, Nantucket Cottage Hospital, Martha's Vineyard Hospital, and NSMC did not respond to the most recent Leapfrog survey, and thus no data are available for these hospitals. NWH and Cooley Dickinson received notably low ratings on their implementation of policies related to medication administration and appropriate use of antibiotics, but otherwise performed well. Healthcare workers' influenza vaccination rates at MEEI and several Partners hospitals were below the statewide average in 2016.

⁹⁹ MEE's published quality reports on its ophthalmology (2010-2015) and otolaryngology (2010-2014) practices are examples of voluntary transparency, seem to show positive results, and may be an indication of an organization with a culture of clinical quality, although these reports have not been updated in recent years. See *Quality and Outcomes Book*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/about-us/quality-measures/quality-and-outcomes-book> (last visited Oct. 29, 2017)

¹⁰⁰ The HPC obtained data on 2016-2017 readmission rates at *Hospital Compare datasets*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://data.medicare.gov/data/hospital-compare> (last visited Oct. 29, 2017).

¹⁰¹ The PSI 90 is a composite of observed-to-expected ratios for 11 measures of patient safety and adverse events and was calculated based on CHIA 2016 hospital discharge data. For more detail on PSI measures, see *Patient Safety Indicators Overview*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, http://www.qualityindicators.ahrq.gov/modules/psi_resources.aspx (last visited Oct. 29, 2017); (For full measure specifications, see AGENCY FOR HEALTH CARE RESEARCH & QUALITY, PATIENT SAFETY AND ADVERSE EVENTS COMPOSITE TECHNICAL SPECIFICATIONS, PATIENT SAFETY INDICATORS 90 (PSI 90), AHRQ QUALITY INDICATORS™, VERSION V6.0, (2016), available at https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD09/TechSpecs/PSI_90_Patient_Safety_and_Adverse_Events_Composite.pdf (last visited Oct. 29, 2017).

¹⁰² IQI 90 and IQI 91 are composite measures that examine risk-adjusted inpatient mortality for certain procedures and conditions, respectively, and were calculated based on 2016 discharges. These composites include certain procedures and conditions not applicable to MEEI's specialty services. For more detail on IQI measures, see *Inpatient Quality Indicators Overview*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, http://www.qualityindicators.ahrq.gov/modules/psi_resources.aspx (last visited Oct. 29 2017); For full measure specifications, see AGENCY FOR HEALTH CARE RESEARCH & QUALITY, MORTALITY FOR SELECTED PROCEDURES, INPATIENT QUALITY INDICATORS #90 (IQI #90), March 2017 (2017), available at https://www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V60/TechSpecs/IQI_90_Mortality_for_Selected_Procedures.pdf (last visited Oct. 29, 2017) and AGENCY FOR HEALTH CARE RESEARCH & QUALITY, MORTALITY FOR SELECTED CONDITIONS, INPATIENT QUALITY INDICATOR #91 (IQI #91), March 2017, (2017), available at https://www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V60/TechSpecs/IQI_91_Mortality_for_Selected_Conditions.pdf (last visited Oct. 29, 2017).

In the domain of patient experience¹⁰⁴ we found that both MEEI and the Partners hospitals consistently perform above the statewide average on measures of overall patient satisfaction and patient willingness to recommend the hospital.¹⁰⁵ MEEI performed comparably to the top Partners hospitals on patient willingness to recommend, and received a higher score on overall patient rating than any Partners hospital.

In summary, based on our review of applicable quality measures, both parties appear to generally deliver high-quality care, with performance equal to or above the state average on most of the measures we examined.

C. ACCESS BASELINE PERFORMANCE

The HPC monitors a variety of factors relating to health care access in its review of provider material changes in order to assess, for example, whether the parties' plans could reduce or improve access to needed care, particularly for underserved patient populations.¹⁰⁶ We evaluated the following measures of access in our review of this transaction:

1. **Provision of Uncommon Specialty Services:** We studied MEEI's volume of specialty services that are less frequently provided by other Massachusetts hospitals.
2. **Payer Network Participation:** We evaluated whether and how MEEI's participation rate in commercial tiered and limited networks and Medicaid Managed Care Organization (MMCO) plans differs from that of Partners.
3. **Payer mix:** We examined the proportion of care delivered to patients covered by different forms of insurance, including government payer patients.

Our findings are detailed below.

¹⁰³ MGH and Martha's Vineyard Hospital performed slightly below average on IQI 91.

¹⁰⁴ *Hospital Quality Initiative: HCAHPS – Patients' Perspectives of Care Survey*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/HospitalQualityInits/HospitalHCAHPS.html> (last visited Oct. 27, 2017). The HPC obtained 2016-2017 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data at *Hospital Compare* datasets, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://data.medicare.gov/data/hospital-compare> (last visited Oct. 27, 2017).

¹⁰⁵ HCAHPS questions "What number would you use to rate this hospital during your stay?" and "Would you recommend this hospital to your friends and family?" CMS rates hospitals based on percentages of patients who chose the most positive response option, like "always," to the survey questions. *Survey of patients' experiences (HCAHPS)*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicare.gov/hospitalcompare/about/survey-patients-experience.html> (last visited Oct. 29, 2017).

¹⁰⁶ MASS. GEN. LAWS ch. 6D, § 13(d)(vi, ix-xii).

1. MEEI is the principal provider of a small number of uncommon specialty services in its service area.

We analyzed the extent to which MEEI provides inpatient and outpatient services that are not generally available at other area hospitals. Hospitals that offer specialized services provide an important access point for patients with rare conditions or who need complex procedures by allowing them to seek care in or near their community.

To assess the extent to which MEEI provides specialty services that are not generally provided by other area hospitals, we examined inpatient discharges and outpatient procedure codes to identify those for which MEEI was the principal or sole provider in its PSA. We found that, for most of the inpatient services that MEEI provides, other hospitals provide at least half of the discharges in MEEI's inpatient PSA. MEEI was not the sole provider of any type of inpatient services, although it is the principal provider of inpatient uncomplicated intraocular procedures in its PSA, with over two-thirds of discharges for this service.¹⁰⁷

For outpatient care, we identified approximately 30 procedure codes for which MEEI was the only facility provider in its outpatient PSA for commercial members of the three largest payers in 2012, 2013, and 2014.¹⁰⁸ In total, MEEI performed approximately 100 of these procedures over the three-year period we examined. This analysis suggests that, while MEEI's role as the sole provider of these relatively rare services makes it an important access point in these cases, these cases represent a small share of outpatient volume, both for MEEI and the Commonwealth. However, in addition to this low number of services for which MEEI is the *sole* facility provider, MEEI is also the *principal* facility provider for several other outpatient otolaryngology and ophthalmology codes,¹⁰⁹ consistent with its high outpatient market share across otolaryngology and ophthalmology services as a whole. Payers have noted to the HPC that MEEI is thus an important component of their provider networks, even if most of MEEI's services are available, at least to some degree, at other area providers.

2. MEEI participates in more limited network insurance products and MMCO networks than Partners, and is generally in more favorable cost sharing tiers than Partners hospitals.

We reviewed the participation of both Partners hospitals and physicians and MEEI in limited and tiered commercial payer networks. Payers create limited network plans to provide members access to certain providers while excluding others, based on payer assessments of

¹⁰⁷ Based on HPC analysis of 2015 and 2016 CHIA hospital discharge data.

¹⁰⁸ Based on HPC analysis of 2012, 2013, and 2014 APCD claims to identify outpatient procedures for which MEEI was the only facility with any facility claims. As discussed in *supra* note 68, our analyses of outpatient facility claims include hospital outpatient departments, hospital satellites, and freestanding ambulatory surgery centers.

¹⁰⁹ For example, for each year from 2012 to 2014, more than two-thirds of facility claims for certain specialized ophthalmology diagnostic procedures in MEEI's outpatient PSA were done at MEEI; the annual volume for many of these procedures was notably higher than for procedures for which MEEI was the sole provider. As discussed in *supra* note 79, some of these outpatient services are also performed in non-facility settings such as clinics, which may represent alternative points of access in some cases.

provider cost and quality. In tiered network plans, payers stratify providers into two or more tiers based on a combination of cost and quality, and incentivize members to use higher-value providers through differentiated cost-sharing. The goal of both tiered and limited networks is to encourage the use of more efficient providers, resulting in lower per-member spending and thus lower premiums. However, patients enrolled in tiered or limited network insurance products may face access barriers when providers elect not to participate in these types of insurance plans or are placed in a plan tier with higher cost-sharing. MEEI participation in tiered and limited networks is particularly important given its status as the principal provider of some services and the sole provider of a select number of outpatient procedures, as described above.

The table below summarizes the participation of MEEI and Partners hospitals in tiered and limited plans offered by the three largest payers.¹¹⁰ MEEI participates in commercial limited network plans offered by BCBS and HPHC, as well as limited network products offered by smaller commercial networks. Most of these products exclude at least some Partners hospitals, particularly MGH and BWH, and some exclude Partners physicians. MEEI also participates in tiered network products, and is often placed in the most efficient tier. For the tiered network products in which they participate, Partners AMCs are often placed in the least efficient tier, while the tier placement of Partners community hospitals varies.¹¹¹

¹¹⁰ We excluded Martha's Vineyard Hospital and Nantucket Cottage Hospital from our analysis due to their unique geographic isolation. We also excluded Cooley Dickinson from this analysis because it does not yet contract through Partners.

¹¹¹ While Partners tends to make uniform decisions regarding its hospitals' participation in a limited network, individual hospitals may be placed in different tiers in a tiered network.

Tiered and Limited Networks for the Three Largest Commercial Payers

Hospital	BCBS		HPHC		THP	
	Limited Network	Tiered Networks	Limited Network	Tiered Networks	Limited Network	Tiered Networks*
MEEI	In Network	Most Efficient	In Network	Most Efficient	Out of Network	Most Efficient
BWH	Out of Network	Least Efficient	Out of Network	Least Efficient	Out of Network	Least Efficient
MGH	Out of Network	Least Efficient	Out of Network	Least Efficient	Out of Network	Least Efficient
Faulkner	Out of Network	Most Efficient	Out of Network	Middle	Out of Network	Least Efficient
NWH	Out of Network	Most Efficient	Out of Network	Middle	Out of Network	Least Efficient
NSMC	Out of Network	Most Efficient	Out of Network	Middle	Out of Network	Least Efficient

Sources: HPC analysis of tiered and limited plans for Massachusetts hospitals, excluding provider-specific networks; each of the three largest payers offered one applicable limited network product and four applicable tiered network products; See *Find a Doctor and Estimate Costs*, BLUE CROSS AND BLUE SHIELD OF MASS., <https://myfindadoctor.bluecrossma.com/> (last visited Oct. 29, 2017); *Find a Doctor or Care Provider*, HARVARD PILGRIM HEALTH CARE, <https://www.providerlookuponline.com/harvardpilgrim/po7/Search.aspx> (last visited Oct. 29, 2017); *Find a Doctor*, TUFTS HEALTH PLAN, <http://tuftshealthplan.prismisp.com/> (last visited Oct. 29, 2017).

Note: In one of THP's tiered network products, Navigator PPO, MEEI is in the middle tier rather than the most efficient tier, and Faulkner, NWH, and NSMC are in the middle tier rather than the least efficient tier.

We also assessed the parties' participation in MMCO networks. Like limited network plans, MMCO networks typically exclude certain providers based on cost and quality and specialty provider non-participation may result in barriers to access. MEEI is a more common participant in MMCO networks than most Partners hospitals and physicians. Despite having a relatively low share of public payer patients, as further discussed below, MEEI is available as a participating provider for members of most MMCOs, whereas Partners hospitals are not included in most MMCO networks.¹¹² Only Partners' owned insurance company, NHP,¹¹³ includes both MEEI and all of the Partners hospitals in the greater Boston area in its MMCO network.

¹¹² Health New England and Fallon Health offer MMCO plans that are only available in certain regions of Massachusetts. We did not evaluate the parties' participation in these regional plans. See *Plans Available for Members in MassHealth Standard, CommonHealth, and Family Assistance*, EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES, <http://www.mass.gov/eohhs/consumer/insurance/enroll-in-a-health-plan/plans-available-for-members-in-mh-standard-commonhealth-family-assistance.html> (last visited Oct. 24, 2017).

¹¹³ See PARTNERS RPO FILING, *supra* note 26 (showing the NHP is a wholly owned corporate affiliate of Partners).

MMCO Network Participation for MEEI and Partners Hospitals

Hospital	Medicaid Managed Care Organization Payer			
	BMC HealthNet Plan	CeltiCare Health Plan	Neighborhood Health Plan	Tufts Health Public Plans
MEEI	In Network	Out of Network	In Network	In Network
BWH	Out of Network	Out of Network	In Network	Out of Network
MGH	Out of Network	Out of Network	In Network	Out of Network
Faulkner	Out of Network	Out of Network	In Network	Out of Network
NWH	Out of Network	Out of Network	In Network	Out of Network
NSMC	In Network	Out of Network	In Network	Out of Network

Sources: HPC analysis of MMCO plans for Massachusetts hospitals; *See Find a Doctor, Hospital, or Pharmacy*, BOSTON MEDICAL CENTER HEALTHNET PLAN, <https://www.bmchp.org/utility-nav/find-a-provider/masshealth>, (last visited Oct. 29, 2017); *Find a HealthCare Provider*, CELTICARE HEALTH PLAN, <https://providersearch.celticarehealthplan.com/>, (last visited Oct. 29, 2017); *DoctorSmart online tools*, NEIGHBORHOOD HEALTH PLAN, https://nhp.vitalschoice.com/?ci=DFT&geo_location=02150,chelsea,ma,city&network_id=5, (last visited Oct. 29, 2017); *Find a Doctor, Hospital, or Pharmacy*, TUFTS HEALTH PLAN, <http://networkhealth.prismisp.com/?plan=together&str=together-en>, (last visited Oct. 29, 2017)

3. MEEI and most Partners hospitals have higher commercial payer mix and lower Medicaid payer mix relative to comparator hospitals.

Examining a provider’s payer mix can indicate whether it attracts a larger or smaller share of one type of patient compared to other nearby providers and compared to the population living in its service area. Providers serving high proportions of patients on government insurance, in particular Medicaid, provide important points of access for patients who often face barriers obtaining care. In addition, a provider’s payer mix may impact its financial and quality performance due to lower payments by government payers relative to commercial payers and socioeconomic factors that disproportionately impact the complexity and health outcomes of government payer patients. These factors can in turn incentivize providers to try to attract more commercial patients rather than Medicaid patients.¹¹⁴

Given MEEI’s low inpatient volume, we assessed the parties’ payer mix using gross patient service revenue (GPSR) data, which reflects both inpatient and outpatient charges.¹¹⁵

¹¹⁴ See, e.g., INSTITUTE OF MEDICINE, ACCESS TO HEALTH CARE IN AMERICA at 40 (Michael Millman ed., 1993) (“[M]ost structural barriers to access have their roots in the way health care is financed. Despite a greatly enlarged physician force and the existence of some 600 community health centers, many of today’s poor still find it difficult to identify physicians who will accept Medicaid. A major reason for this dilemma is Medicaid’s low reimbursement rates”).

¹¹⁵ Because GPSR is based on charges rather than negotiated payment amounts, it can be used as a proxy for volume since charge amounts do not vary by payer. We also examined the parties’ payer mix based on discharges using 2016 CHIA hospital discharge data. We assessed hospital inpatient payer mix by first determining the payer

We found that, notwithstanding MEEI's participation in most MMCO networks as described above, MEEI has a higher commercial payer mix and lower Medicaid than any of the Boston-area AMCs, including MGH and BWH.¹¹⁶ While MEEI's commercial payer mix is high, it has been decreasing over time, from 54.0% in 2010 to 49.3% in 2016. This change was largely driven by an increase in MEEI's Medicare payer mix, which is consistent with data supplied by the parties that suggest the aging population in Massachusetts is driving increased volume at MEEI.¹¹⁷ As shown below, MGH and BWH also have a higher proportion of commercial volume and a lower proportion of Medicaid volume than other Boston-area AMCs. We found the same pattern of higher commercial payer mix and lower Medicaid payer mix relative to comparator hospitals for Faulkner and NWH; NSMC is the notable exception to this trend, with both lower commercial payer mix and higher Medicaid payer mix than its comparators.¹¹⁸

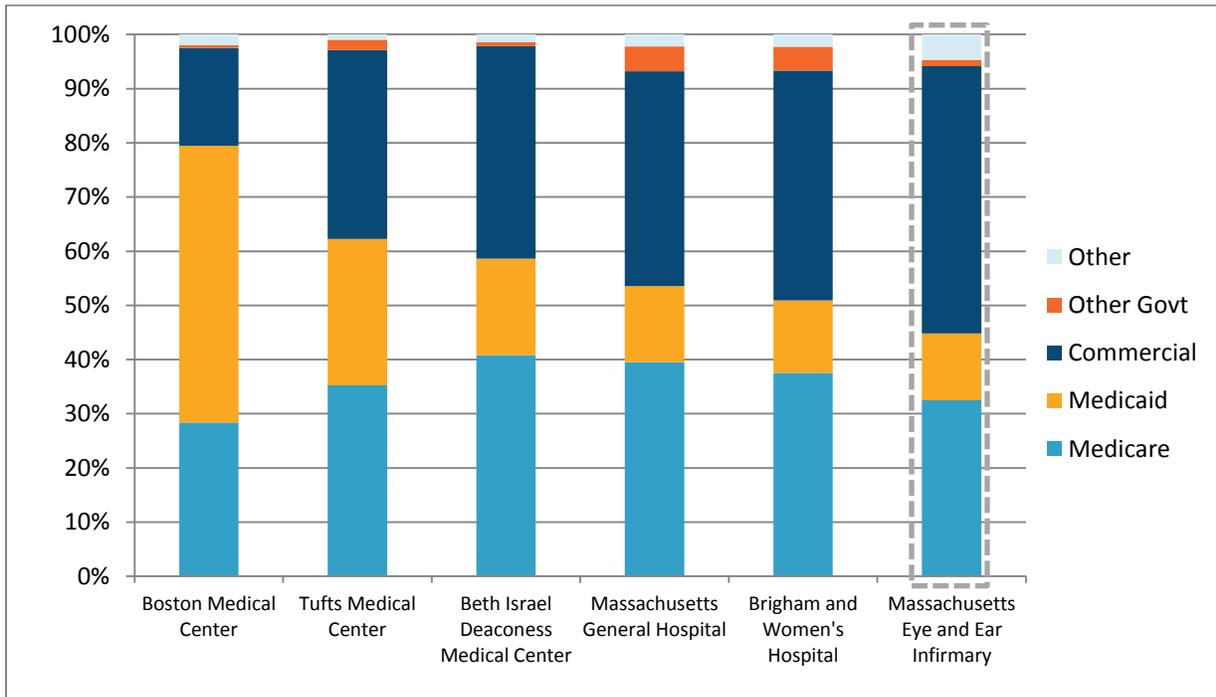
mix of the hospital's PSA, which represents all discharges for residents of the hospital's PSA. We then compared the overall payer mix of the PSA to the mix of patients from the PSA that went to the focal hospital. We limited our analysis to discharges reflecting MEEI's core inpatient otolaryngology and ophthalmology services, and found that MEEI's mix of discharges from its PSA for these services was 42.8% commercial patients, 34.7% Medicare patients, and 16.8% Medicaid patients, compared to the overall payer mix for these services in the PSA of 29.9%, 42.8%, and 24.9%, respectively. When compared to the top 10 hospitals by total number of discharges for these services for patients in MEEI's PSA, MEEI's commercial mix was higher than all but one of these hospitals and its Medicaid mix was lower than all but two. We used a similar method to assess Partners hospitals' baseline payer mix, but we did not limit the type of discharges that we included in the analysis. Consistent with our GPSR-based analysis, we found that most Partners hospitals had higher commercial payer mix and lower Medicaid payer mix compared to their PSAs.

¹¹⁶ Because GPSR includes all patient service revenue, it does not account for differences in service mix. We compared MEEI's payer mix for its core inpatient services to the payer mix of its PSA and other hospitals as discussed in *supra* note 115. We did not have sufficient data available to analyze the payer mix of MEEI and comparator hospitals for only outpatient otolaryngology and ophthalmology services.

¹¹⁷ See PARTNERS-MEEI DON APPLICATION, *supra* note 19, at Section F1.a.ii (describing otolaryngology and ophthalmology utilization rates among older populations and Massachusetts' aging demographic trends, as well as MEEI's recent growth in these services).

¹¹⁸ Comparator hospitals are chosen based on geography, patient population, and teaching status. Comparator hospitals for Faulkner included Beth Israel Deaconess Hospital-Milton, Norwood Hospital, Saint Elizabeth's Medical Center, and South Shore Hospital. Comparators for NWH included Beth Israel Deaconess Hospital - Needham, MetroWest Medical Center, Mount Auburn Hospital, South Shore Hospital, and Winchester Hospital. Comparators for NSMC included Hallmark Health, Northeast Hospital, and Winchester Hospital. We did not evaluate payer mix for Martha's Vineyard Hospital or Nantucket Cottage Hospital given the lack of potential comparator hospitals in their geographic areas.

Combined Inpatient and Outpatient Payer Mix for MEEI and Boston-Area AMCs (2016)



Source: *Hospital Cost Report Data Access Tool (FY 2016 data)*, CTR. FOR HEALTH INFORMATION & ANALYSIS, <http://www.chiamass.gov/hospital-cost-report-data-access-tool/> (last visited October 29, 2017)

Note: Graph is in descending order of government payer services, which is the sum of the Medicaid/CHIP, Medicare, and Other Government shares.

In summary, based on available data, MEEI appears to be an important access point for patients seeking specialty services, even though it is the *sole* provider of very few such services. MEEI is also recognized as an important component of payer networks and a relatively efficient provider—it is frequently placed in the most efficient tier of tiered network products and included in MMCOs as well as commercial limited network products. In contrast, Partners hospitals are excluded from many MMCOs and limited network products, and are placed in less efficient tiers in most tiered network products. Notwithstanding the fact that MEEI participates in most MMCOs, MEEI has a very high mix of commercial insured patients, with a commercial payer mix higher than that of MGH, BWH, and all other AMCs.

IV. IMPACT PROJECTIONS (2018 ONWARD)

Building on the baseline performance and trends described above, the HPC utilized the known details of the proposed transaction, the parties' goals and plans, and the data sources detailed in Section I.B to examine the ways in which the proposed transaction may impact the competitive market, total health care spending, the quality of care the parties provide, and patient access to needed services. Our impact findings are detailed throughout this Section IV.

As described above, the parties before us are high-quality providers who have stated that the proposed transaction will allow them to deliver care more efficiently and expand access to MEEI's services. At the same time, there is the prospect that the merger of a high-value specialty provider into the largest system in the state, with high prices and spending, would raise the cost of this important specialty provider, with potentially negative consequences for costs, market functioning, and access to MEEI's services. The remainder of the report addresses these issues, including whether any savings and expansion of services would accrue to payers and consumers and counterbalance any negative impacts to costs and market functioning.

A. COST AND MARKET IMPACT

One of the HPC's central responsibilities is to monitor health care spending to ensure that the Commonwealth can successfully meet the health care cost growth benchmark set forth in Chapter 224 of the Acts of 2012 (Chapter 224).¹¹⁹ Health care spending consists of two broad factors: price (each provider's individual rates as well as the distribution of patients at higher- or lower-priced providers) and utilization (total number of services as well as the specific services that patients receive). Provider consolidations and alignments can affect both of these mechanisms, resulting in:

- Changes to bargaining leverage, or shifts in incentives to use existing bargaining leverage, which may allow hospitals and physicians to negotiate higher commercial prices and other favorable contract terms with commercial payers;
- Changes in prices as consolidations or alignments change the affiliations of provider organizations; and
- Changes in utilization or referrals as physicians shift care patterns in response to consolidations or alignments.

We examined each of these mechanisms and found:

- The transaction is not anticipated to substantially increase Partners' overall hospital inpatient or outpatient market share. However, the transaction would substantially increase Partners' share of outpatient otolaryngology and ophthalmology services.

¹¹⁹ MASS. GEN. LAWS ch. 6D, § 9 (requiring the HPC to establish annually "a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth," pegged to the growth rate of the gross state product).

- Partners would likely seek significant hospital rate increases for MEEI's main campus and hospital-licensed outpatient sites after an acquisition. Over time, we estimate that health care spending would increase by \$14.9 million to \$55.3 million annually if Partners achieves parity between MEEI's rates and those of Partners' other hospitals, consistent with Partners' past practice.
- As the MEEA physicians join Partners contracts for all commercial payers, changes in MEEA's physician rates would additionally increase total medical spending in Massachusetts by approximately \$5.9 million annually.
- Significant shifts in referral patterns are unlikely given the existing clinical affiliations between the parties. However, additional volume at MEEI or its hospital-licensed facilities could have further spending impacts if prices increase as expected.
- The parties claim that the transaction would yield operational efficiencies and allow MEEI to avoid capital expenditures. However, the parties have not committed to using the resulting savings to reduce prices or otherwise provided evidence that these savings would be passed on to payers or consumers.

In total, the HPC thus estimates that the proposed transaction would, over time, increase commercial spending by approximately \$20.8 million to \$61.2 million annually.¹²⁰ These spending increases would ultimately be borne by consumers and businesses through higher commercial premiums and may also impact other providers' spending against risk budgets to the extent that their patients use MEE providers.

The remainder of this section discusses these findings in greater depth.

1. The transaction is not anticipated to substantially increase Partners' overall hospital inpatient or outpatient market share. However, the transaction would increase its share of outpatient otolaryngology and ophthalmology services.

Recognizing that providers with significant market share may be able to negotiate for higher prices and other favorable contractual terms with commercial payers,¹²¹ Chapter 224 directs the HPC to examine the impact of proposed transactions on providers' market position and market shares. For Partners' proposed acquisition of MEE, we examined the impact on the parties' inpatient and outpatient market shares overall, as well as shares in the applicable

¹²⁰ Internal documents related to the proposed transaction developed by the parties and provided to the HPC contemplate revenue increases due to rate lifts for MEE generally consistent with our lower estimate.

¹²¹ Commercial prices for health care services are established through contract negotiations between payers and providers. The results of these negotiations – both the prices that payers will pay for services and other contractual terms – are influenced by the bargaining leverage of the negotiating parties. Bargaining leverage impacts negotiations because a payer network that excludes important providers will be less marketable to purchasers (employers and consumers). If there are few or no effective substitutes for that provider in a market, the potential cost to a payer of excluding the provider from that payer's network will be high, and that provider will have increased ability to command a higher price (or other favorable contract terms) from the payer.

specialty service lines,¹²² utilizing publicly available data as well as information from several large Massachusetts payers.

a. Inpatient market

As described in Section III.A.2.a, MEEI’s 2016 market share for inpatient services overall was very small, at only 0.2% of discharges in its PSA,¹²³ while Partners’ market share in MEEI’s PSA was much higher, at 33.1%.¹²⁴ Even among the core inpatient services that MEEI provides, MEEI provided only 3.5% of discharges in its service area in 2016. By contrast, Partners hospitals accounted for 34.0% of these discharges within MEEI’s PSA.^{125,126} Following the transaction, the combined shares of Partners and MEE would be substantial and, as shown below, well above the shares of the next-largest systems. However, that sizeable market share would be primarily attributable to Partners’ large preexisting inpatient market share, not the addition of MEEI’s market share.

Post-Acquisition Shares of Commercial Discharges for MEEI’s Inpatient Core Services in MEEI’s PSA

Hospital System/Network	Share of Discharges for MEEI’s Core Services After Acquisition
Partners + MEE	37.6% (34.0% + 3.5%)
BIDCO	12.7%
Lahey	12.1%
Wellforce	8.0%
Children’s	7.9%
All Other Combined	21.7%

Source: HPC analysis of 2016 CHIA hospital discharge data

b. Outpatient market

We also examined the potential impact of this transaction on the outpatient market, which incorporates both outpatient services provided on the MEEI and Partners hospitals’ main campuses, as well as their hospital-licensed outpatient sites.¹²⁷ As described in Section III.A.2.b and presented in the table below, for the most recent year for which data were available, Partners had the highest share of outpatient facility visits across all general acute

¹²² We did not analyze the impact on physician market shares because data on physician market shares is currently only available for the three largest commercial payers. Because Partners already contracts for MEEA physicians for these payers, we do not anticipate a significant market impact for these payers.

¹²³ For a description of how we defined MEEI’s inpatient PSA, see *supra* note 73.

¹²⁴ In the PSAs of Partners hospitals, MEEI provided 1% or less of all discharges in 2016, and Partners provided between 31.3% and 82.9% of all discharges.

¹²⁵ For a description of the methodology for defining MEEI’s inpatient core services, see *supra* note 72.

¹²⁶ In Partners hospitals’ PSAs, MEEI provided a similarly modest share of discharges for its core services in 2016, and Partners provided between 34.0% and 77.8% of these discharges.

¹²⁷ As discussed in *supra* note 42, services provided at hospital-licensed outpatient sites can include the same facility fees as services provided at the main hospital campus.

care service lines in MEEI’s outpatient PSA,¹²⁸ while MEEI had a 1.5% share. Following the transaction, Partners would continue to have the highest share of all outpatient services in this area, predominantly due to its current high share of these services.

**Post-Acquisition Shares of Commercial Facility Visits for All Outpatient Services
in MEEI’s PSA**

Hospital System/Network	Share of All Outpatient Facility Visits After Acquisition
Partners + MEEI	33.8% (32.3% + 1.5%)
BIDCO	15.4%
Lahey	13.7%
Wellforce	7.8%
Steward	5.3%
All Other Combined	23.9%

Source: HPC analysis of 2014 APCD data for the three largest commercial payers

Notes: Outpatient shares refer to the parties’ shares within MEEI’s outpatient PSA. These findings reflect data from the three largest commercial payers.

Focusing specifically on the outpatient services that MEEI provides, however, the pattern is different. For otolaryngology services, MEEI and Partners had the two highest shares of outpatient facility visits, at 26.5% and 18.7%, respectively, in MEEI’s outpatient PSA in 2014, as described in Section III.A.2.b and shown in the table below. Following the proposed transaction, the combined system would have nearly three times the outpatient facility share of the next-largest system.¹²⁹

¹²⁸ For details on the definition of MEEI’s outpatient PSA, see *supra* note 77.

¹²⁹ As described in *supra* note 78, we also examined the parties’ shares of revenue for otolaryngology services in both facility and non-facility settings. While we do not estimate market impacts from those findings because our physician data are limited to commercial payers for which MEEA already contracts with MGPO, we note that the parties’ combined share of otolaryngology revenue across both settings, 38.2%, remains well above the share of the next closest system.

**Post-Acquisition Shares of Commercial Outpatient Otolaryngology Facility Visits
in MEEI's PSA**

Hospital System/Network	Share of Outpatient Otolaryngology Facility Visits After Acquisition
MEEI + Partners	45.2 % (26.5% + 18.7%)
Children's	16.0%
Lahey	7.1%
HealthSouth	6.2%
All Other Combined	25.5%

Source: HPC analysis 2014 APCD data for the three largest commercial payers
Notes: Outpatient shares refer to the parties' shares within MEEI's outpatient PSA. These findings reflect data from the three largest commercial payers.

For ophthalmology services, MEEI was the top provider of outpatient facility visits in its PSA in 2014 (including services that were provided at its main campus and at its hospital-licensed outpatient facilities), while Partners hospitals had only a 1.0% share of these services. Following the transaction, the combined system would continue to have over twice the share of the next-highest system, based almost entirely on the strength of MEEI's current share.¹³⁰

**Post-Acquisition Shares of Commercial Outpatient Ophthalmology Facility Visits
in MEEI's PSA**

Hospital System/Network	Share of Outpatient Ophthalmology Facility Visits After Acquisition
MEEI + Partners	35.6% (34.6% + 1.0%)
Wellforce	16.1%
Lahey	11.5%
Boston Medical Center	8.9%
All Other Combined	27.9%

Source: HPC analysis 2014 APCD data for the three largest commercial payers
Notes: Outpatient shares refer to the parties' shares within MEEI's outpatient PSA. These findings reflect data from the three largest commercial payers.

These increases would strengthen Partners' already-substantial outpatient market shares, particularly for outpatient otolaryngology services.¹³¹ While contracted rates are not

¹³⁰ We conducted the same analysis for the parties' shares of revenue for ophthalmology services in both facility and non-facility settings as described for otolaryngology services in *supra* note 129. The parties' combined share of ophthalmology revenue, 35.3%, is comparable to their combined share of ophthalmology facility visits.

¹³¹ The shares shown do not include potential increases in the parties' market shares as a result of their stated plans of expanding MEEI's services at additional Partners locations, and the parties have not provided sufficient information about their plans to model these potential increases. However, any such expansions at current or future Partners hospitals or hospital satellites would be in addition to the projected increases in Partners' already-

typically negotiated at the specialty level, this transaction would give Partners two additional specialty services for which it would be the largest provider in most of eastern Massachusetts, adding incrementally to Partners' negotiating leverage for many commercial insurance products.¹³² Having joined with its largest competitor for otolaryngology services, MEEI would also be able to benefit from Partners' negotiating leverage, allowing Partners to seek significant rate increases for MEEI, as discussed in the next section.¹³³ Partners likely also has the ability to add MEEA physicians to many of its existing payer contracts, and we would expect these physicians to be added at the highest, academic physician rates since these physicians are members of MGPO.¹³⁴ Both such changes would have a significant impact on health care spending in the Commonwealth.

2. Partners would likely seek significant hospital rate increases for MEEI's main campus and hospital-licensed outpatient sites after an acquisition.

As the largest provider of inpatient and outpatient services in MEEI's service area, Partners already demands high prices for inclusion in many commercial insurance products, and its ability to do so would likely be strengthened by becoming the largest provider of two additional specialty fields in MEEI's outpatient PSA, which includes most of eastern Massachusetts. If MEEI's participation in networks is connected to that of Partners, Partners would likely be able to obtain significant price increases for MEEI, both for its main campus and its hospital-licensed outpatient sites.¹³⁵ Indeed, it is the parties' stated intent to seek "market competitive rates" for MEEI in connection with the transaction.¹³⁶

Partners' past practices and interviews with payers indicate that Partners is likely to seek parity between the rates of MEEI and those of its existing hospitals over time.¹³⁷

substantial outpatient market shares. As discussed in *supra* note 42, services provided at any additional hospitals or hospital-licensed outpatient sites could also include facility fees.

¹³² At the same time, after the merger, networks that do not include Partners (or that place Partners in a less favorable tier) may no longer have access to MEEI providers. This would reduce the value of such tiered and limited network products.

¹³³ Once MEEI is part of Partners, the ability of commercial payers to credibly threaten to exclude MEEI from their networks in order to obtain lower rates will be reduced because, as discussed above, Partners' dominant shares of general acute inpatient services and very high shares of all outpatient services make it difficult to market "broad network" products that exclude Partners hospitals. As a result, payers' ability to negotiate lower rates for MEEI's services would be diminished.

¹³⁴ Note that we do not analyze the impact on physician market shares for these payers because our data on claims for physician services is only from the three largest payers, for which Partners already contracts for MEEA. See *supra* note 122. There may be limitations on MGPO's ability to bill additional physicians at academic rates; see *supra* note 90; *infra* note 146.

¹³⁵ Changes in hospital prices will require contract renegotiation, and Partners stated in its DoN filing with DPH that the parties do not intend to renegotiate contracts until their current contracts expire. PARTNERS-MEEI DoN APPLICATION, *supra* note 19, at Section F1.a.iii. Therefore, we would expect MEEI price changes to take effect over time (likely in the next contract term or potentially over two contract terms), not immediately.

¹³⁶ MEEI NOTICE OF MATERIAL CHANGE, *supra* note 32.

¹³⁷ As described in Section III.A.3 and shown in the graph on page 25, Partners' two AMCs have nearly identical relative prices, as do Partners' community hospitals in the greater Boston area, suggesting a practice of seeking parity for similar institutions within Partners. These rates are all higher than those of MEEI. See also, HALLMARK FINAL CMIR REPORT, *supra* note 21, at 53 (stating that "[t]he three largest payers confirmed that Partners seeks consistent rates for its owned community hospitals in the greater Boston area").

Therefore, we modeled a range of scenarios estimating the impact of Partners achieving parity for MEEI (both for its main campus and its hospital-licensed outpatient sites) with rates of other Partners hospitals over time, assuming that MEEI maintains its current mix of services. These estimates are based on the *current* prices of MEEI and Partners hospitals, and do not assume or reflect any additional increases in Partners' current rates as a result of the transaction.^{138,139}

Specifically, we found that if Partners were to achieve comparable prices between MEEI and Partners' greater Boston community hospitals, MEEI's inpatient rates would increase by an estimated 12.2%, with an annual spending impact of over \$865,000 across all commercial payers for which data were available.¹⁴⁰ If Partners were to achieve comparable prices between MEEI and Partners' greater Boston community hospitals for MEEI's outpatient services,¹⁴¹ both at its main campus and at its seven hospital-licensed outpatient facilities, we estimate that outpatient rates would increase by 16.9% to 18.8%, with an annual spending impact of \$14.0 million to \$15.6 million across all commercial payers for which data were available.^{142,143} If, however, MEEI were to receive MGH rates,¹⁴⁴ its inpatient rates would

¹³⁸ Partners has noted that it has not made any commitment to MEE that Partners will negotiate any particular rate level for MEEI, and the parties expect that "rate relief" for MEEI can be "achieved by [Partners] allocating to MEE part of the overall rate increases that [Partners] negotiations with commercial payers." PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section F1.a.iii. The parties do expect that Partners will secure higher rates for MEE than MEE would be able to obtain in the absence of the transaction. Absent a specific, enforceable commitment to limit price increases, there is no reason to believe that Partners would negotiate a rate increase across its provider network of less than the maximum amount it is able to obtain from payers and, as discussed above, this transaction will likely only enhance Partners' current negotiating leverage and enable MEEI to benefit from that leverage. Thus it is our expectation that the addition of MEE to its network would allow Partners to negotiate a higher rate increase than it otherwise could.

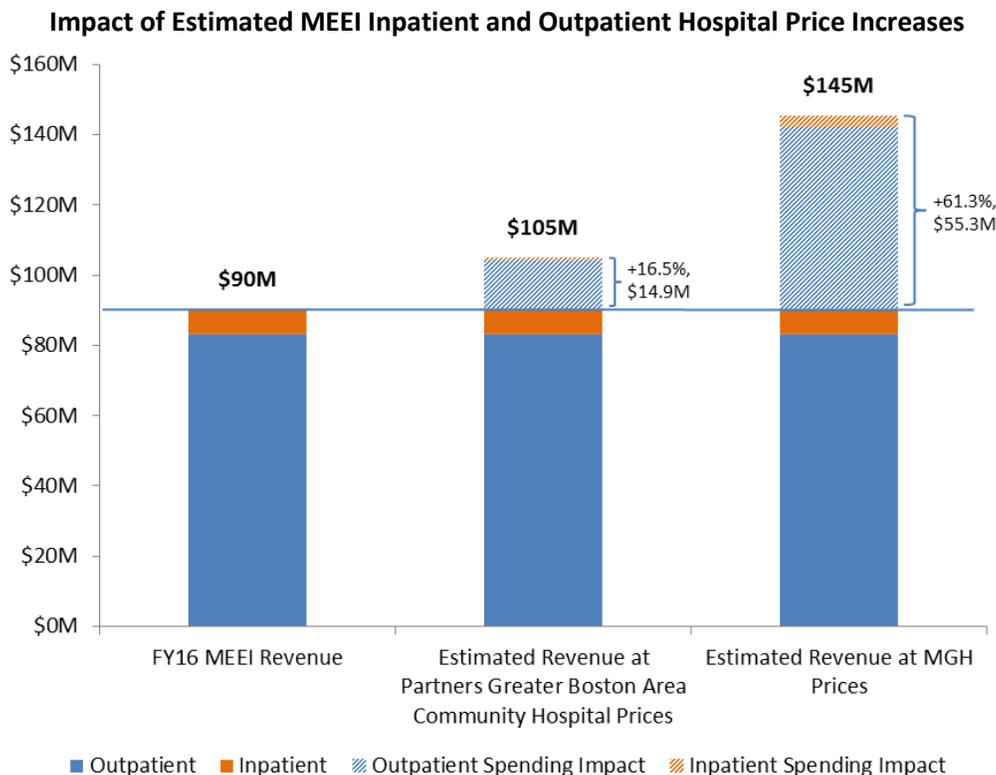
¹³⁹ While we understand that MEE would likely seek inflationary rate increases absent the transaction, our spending impacts are based on *differentials* between the parties' current price levels. Absent the transaction, we would not expect these differentials to materially change over time, given that both parties would be seeking inflationary rate increases.

¹⁴⁰ See *supra* note 85 for details on our methodology for updating 2015 relative prices to calculate 2017 price differentials. We applied the resulting 2017 price differentials to fiscal year 2016 MEEI inpatient revenue confidentially provided by the parties in order to estimate an annual spending impact.

¹⁴¹ As discussed in Section III.A.3.a, while inpatient price differentials are based on prices across all inpatient services adjusted for acuity, outpatient price differentials are based on the different rates negotiated for different service lines. When we adjusted for differences in service mix in the 2015 relative price data, we found that the price differential across the three largest payers between MEEI and Partners hospitals was somewhat smaller than the price differential suggested by the unadjusted data. See *infra* note 86.

¹⁴² To model the potential impact of this transaction on outpatient spending, we first calculated outpatient price differentials based on MEEI's outpatient service mix for the three largest commercial payers (BCBS, HPHC, and THP) using 2015 relative price data. As discussed in *supra* note 141, adjusting for service mix results in a smaller price differential, and thus represents a conservative approach. Due to data limitations, we were unable to calculate service mix-adjusted price differentials for other commercial payers. Therefore, we calculated price differentials for these payers using standard relative price data. We applied information provided by the parties about each hospital's 2016 and 2017 rate increases to the 2015 price differentials to yield estimated 2017 price differentials. We applied the resulting 2017 price differentials to fiscal year 2016 MEEI outpatient revenue confidentially provided by the parties in order to estimate an annual spending impact. Given that the parties expect that MEEI's volume will continue to increase over time, as described in *supra* note 44, it is likely that any rate increases would be applied to an even higher revenue base. Therefore, we expect that this is a conservative approach.

increase by an estimated 47.0%, with an annual spending impact of \$3.3 million, and its outpatient rates would increase by 62.6%, with an annual spending impact of \$51.9 million. The estimated impacts on MEEI’s inpatient and outpatient rates are illustrated in the graph below.



In total, we estimate that commercial spending would increase by between \$14.9 million and \$55.3 million annually if Partners were to seek prices comparable to other Partners hospitals for the services that MEEI provides. In addition to their effects on overall healthcare spending, these increases in MEEI inpatient and outpatient prices would also directly affect risk contract performance for provider organizations whose patients use MEEI.¹⁴⁵

¹⁴³ As a sensitivity analysis, we also calculated price differentials between MEEI and Partners hospitals’ current-year rates by outpatient service category for each payer using information provided by the parties about the service line multipliers established under each payer contract for the current year, broken out by product type (health maintenance organization (HMO), preferred provider organization (PPO), indemnity) where applicable. We then applied the multiplier-based differentials for each service line to the revenue MEEI received from each payer under each service line. This method resulted in a similar, though slightly higher, overall spending impact estimate.

¹⁴⁴ Similar to MGH, MEE is a teaching and research institution whose physicians are part of MGPO. Therefore, we consider MGH rates to be a reasonable upper bound for MEEI’s future rates. Indeed, given MEEI’s close relationship with MGH, and MEEA physicians’ membership in MGPO, it is reasonable to expect Partners would more likely seek rates for MEEI similar to MGH rather than to Partners’ community hospitals.

¹⁴⁵ For example, several provider organizations have identified MEEI as a preferred provider for their patients. To the extent that these providers continue to direct care to MEEI, increased MEEI prices would be expected to adversely affect their TME and performance on its risk contracts and year-to-year budget increases. *See supra* note 38, detailing our analysis of the provider groups that frequently refer to MEEI.

3. As MEEA physicians join Partners contracts for all commercial payers, changes in MEEA's physician rates would additionally increase total medical spending in Massachusetts by approximately \$5.9 million annually.

As described above in Section III.A.3.b, MEEA physicians are members of MGPO. Because they contract through Partners and receive Partners' academic physician rates with the three largest commercial payers already, we would not expect much, if any physician price increase or spending impact for the three largest commercial payers after the acquisition of MEEA.¹⁴⁶ However, MEEA physicians currently establish contracts with other commercial payers separately from Partners. As corporately integrated members of Partners, MEEA physicians would join all other Partners commercial contracts. Subject to specific terms in each payer contract, we expect that MEEA could begin receiving Partners rates for many of these contracts without the need for contract renegotiation, meaning that the price impacts could occur almost immediately.¹⁴⁷ For those Partners contracts that have higher rates for academic physicians, we also expect that MEEA would likely receive these higher rates as members of MGPO.

If MEEA physicians were to receive Partners rates for the non-top-three commercial payers in the state, we estimate that MEEA's prices for these payers would increase by approximately 50%, yielding an annual commercial spending increase of \$5.9 million.¹⁴⁸

¹⁴⁶ It is possible that some MEEA physicians could receive higher prices from these payers. *See supra* note 90. It is not clear whether Partners currently has room under its physician growth caps for these payers to add MEEA physicians to the group receiving academic rates. To the extent there is room to do so, we anticipate that Partners would be more likely to do so following this transaction, since it would own MEEA and thus have an incentive to obtain the resulting revenue increase.

¹⁴⁷ To the extent that physician growth caps apply to any of the payers with whom MEEA currently contracts independently, the annual spending impacts estimated in this section could take time to be fully realized. For more information on this topic, see PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 21, at 31-32.

¹⁴⁸ This estimate is based on analysis of several data sources and methods. For Cigna Health and Life Insurance Company, Neighborhood Health Plan, UniCare Life and Health Insurance Company, and United Healthcare Insurance Company, the parties provided 2017 fee schedules for MEEA and MGPO. The HPC calculated the price differentials for each code in these schedules. Then, we used claims data from the 2014 APCD to estimate MEEA's service mix for these codes. Note that this service mix is MEEA's mix for the three largest commercial payers, which we assumed would apply to other payers as well. We used this service mix to estimate a service-mix-adjusted price differential between MEEA and MGPO. Finally, we applied this differential to MEEA's fiscal year 2016 revenue from each of these payers, as produced by MEEA. This yielded an annual commercial spending increase of \$3.7 million. For Aetna Health and Fallon Health, fee schedule data was not available. Therefore, the HPC applied the average price differential for the four payers above to the fiscal year 2016 revenue reported for Aetna Health and Fallon Health. This yielded an estimated annual commercial spending increase of \$1.9 million for Aetna Health and approximately \$240,000 for Fallon Health. As a sensitivity analysis, we also used 2014 relative price data to estimate the relative price differential between MEEA and PCPO, and applied this differential to MEEA's fiscal year 2016 revenue from Aetna Health. The resulting estimated spending increase was nearly identical to that found by the other method described.

4. The parties claim that the transaction would yield operational efficiencies and allow MEEI to avoid capital expenditures. However, the parties have not committed to using the resulting savings to reduce prices or otherwise provided evidence that these savings would be passed on to payers or consumers.

As described in Section II.B above, MEEI anticipates a growing need for otolaryngology and ophthalmology services in the Commonwealth, primarily due to the aging of the population. Given current and projected growth, MEEI anticipates a need to invest in additional operating capacity.¹⁴⁹ By utilizing available operating room capacity at Partners sites, MEEI expects to avoid the substantial capital expenditure of building new operating rooms itself.¹⁵⁰ The HPC does not have data to substantiate MEEI's expectations regarding future demand for otolaryngology and ophthalmology surgeries. However, to the extent that this demand does materialize, it is not clear that corporate ownership by Partners is the only alternative to MEE building new capacity independently. For example, MEE could utilize clinical affiliations or leasing arrangements to allow MEE to make use of any unused operating room capacity at Partners facilities or those of other provider systems.¹⁵¹ Even if we assume that MEE would build new capacity absent this transaction, there is no indication that the capital expenses that it saves from not doing so would flow to payers or consumers.

In addition to avoided capital expenditures, the parties have identified several areas where they expect to achieve operational efficiencies. These include allowing MEE to purchase goods and services and access capital at lower cost through Partners' vendor and borrowing arrangements, to utilize Partners' research infrastructure, and to achieve reduced costs for its teaching program through participation in Partners' medical education infrastructure.¹⁵² The parties estimate that as a result of these and other efficiencies, MEEI's cost growth would be reduced from 5% to 4% per year.¹⁵³ While we are not able to specifically evaluate these claims, it is likely that some savings would accrue to MEEI through the use of Partners resources. Based on HPC analysis of confidential financial projections provided by the parties, the scale of these overhead savings, if realized, could amount to more than \$20 million per year in a few years' time. Despite the parties' expectation that these efficiencies would improve MEE's margins and support its clinical and research activities,¹⁵⁴ they have not committed to reducing prices or otherwise passing some of these savings on to consumers.

¹⁴⁹ See Partners Sept. 1 DoN Response, *supra* note 37, at 2-3.

¹⁵⁰ *Id.*

¹⁵¹ We expect that Partners would likely seek to ensure that its operating room capacity is used, rather than sitting idle, to the maximum extent possible. If Partners' spare operating room capacity is used for MEE surgeries, it is possible that new capacity would need to be built for whatever other services Partners would have located at these sites in the absence of this transaction.

¹⁵² PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section 2.1.

¹⁵³ See Partners Sept. 1 DoN Response, *supra* note 37, at 3.

¹⁵⁴ See PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section F1.a.iii ("the parties expect that the Transaction will generate operating efficiencies and overhead savings for MEE that will help it to sustain its clinical and research activities").

In summary, we find that the proposed transaction would increase Partners’ already-substantial outpatient market shares, particularly for outpatient otolaryngology services. Having joined with its largest competitor for otolaryngology services, MEEI would likely be able to benefit from Partners’ negotiating leverage once acquired, allowing Partners to seek significant rate increases for MEEI, and Partners would likely be able to add MEEA physicians to many of its existing payer contracts at higher rates than MEEA receives currently. Over time, this transaction has the potential to increase total health care expenditures in the Commonwealth by an estimated \$20.8 and \$61.2 million annually, as shown below in the table below. Internal documents related to the proposed transaction developed by the parties and provided to the HPC contemplate revenue increases due to rate lifts for MEE generally consistent with our lower estimate. While the parties have identified certain potential efficiencies from the transaction, the parties have not committed to using the resulting savings to reduce prices or otherwise provided evidence that these savings would be passed on to payers or consumers.

Impact of Estimated MEE Hospital and Physician Price Increases

	Lower estimate	Higher estimate
Hospital inpatient rates	\$865K	\$3.3M
Hospital outpatient rates	\$14.0M	\$51.9M
MEEA physician rates	\$5.9M	\$5.9M
Total spending impact of potential rate increases	\$20.8M	\$61.2M

B. QUALITY IMPACT

As discussed in the baseline section, MEE is a well-regarded institution that performs well on relevant quality measures. Partners hospitals and physicians also perform well on most measures compared to statewide averages. However, the parties claim that the merger will facilitate improved quality by better integrating MEE into Partners’ technical infrastructure, including its data warehouse, quality reporting platform, and electronic medical record system.¹⁵⁵ The parties have also identified a handful of measures they expect to monitor in order to assess the quality and access impacts of the transaction.

Specifically, Partners has stated that it intends to fully integrate MEE into its technology systems, which would improve MEE’s data analysis and patient management capabilities. The parties claim that this and other aspects of corporate integration will allow MEE to improve its quality data collection and measurement programs, thereby increasing the likelihood of shared savings under alternative payment methodology (APM) contracts.¹⁵⁶ A robust health information technology infrastructure can support quality data analysis and improvement programs, and further integration between the parties may result in more efficient sharing of data. However, as noted in Section III.B, MEE has a strong history of measuring,

¹⁵⁵ PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section F1.b.ii.

¹⁵⁶ PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section F1.b.i.

evaluating, and reporting on its quality performance already. Moreover, in confidential documents provided by the parties, Partners has recognized MEE's track record for exceeding quality goals focused on clinical processes and patient experience. Finally, as discussed in Section III.A, MEEA physicians already participate in Partners' payer contracts with the three largest commercial payers, are considered part of MGPO, and are thus already subject to the same quality incentives as other Partners physicians.¹⁵⁷ Given MEE's already-strong quality performance and the fact that the MEEA physicians are already subject to MGPO quality incentives, it is not clear how corporate ownership of MEE would significantly improve quality, and the public must weigh the likelihood and scope of any such improvements against the other impacts of the proposed merger on costs, quality and access.

The parties have also indicated that the proposed transaction would remove current restrictions on sharing protected health information imposed by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prevent clinicians at different provider organizations from having "complete" access to a patient's medical record. HIPAA's Security Rule requires health care providers that do not share corporate ownership or control to maintain administrative, physical and technical safeguards for their electronic protected health information systems.¹⁵⁸ Therefore, although MEE and Partners currently share an electronic medical record system, their systems are managed in separate technical environments.¹⁵⁹ While, corporate integration may circumvent certain technical barriers created by the HIPAA Security Rule, HIPAA's Privacy Rule already allows unaffiliated providers to disclose patient information to other providers for treatment, payment, and health care operations,¹⁶⁰ and both MEE and Partners state that they use and disclose patient protected health information for these purposes.¹⁶¹ Furthermore, Partners has been expanding access to its unified electronic health record system to other entities with which it is clinically, but not corporately, affiliated¹⁶² and has indicated that this expansion is resulting in "safer, coordinated care, and a better overall

¹⁵⁷ As described in previous publications, Partners-affiliated providers participate in an internal performance framework that establishes a standard set of financial and quality performance benchmarks on which providers are measured and incentivized. See HALLMARK FINAL CMIR REPORT, *supra* note 21, at 69; PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 21, at 48.

¹⁵⁸ See 45 CFR 164.302 *et seq.*, available at <https://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-part164-subpartC.pdf> (last visited Oct. 29, 2017)

¹⁵⁹ Partners Sept. 1 DoN Response, *supra* note 37, at 12.

¹⁶⁰ See 45 CFR 164.506 *et seq.*, available at <https://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-part164-subpartE.pdf> (last visited Oct. 29, 2017); *Uses and Disclosures for Treatment, Payment, and Health Care Operations*, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html> (last visited Oct. 29, 2017). Payment and health care operations include utilization review, quality assessment and improvement, and population health activities. While a provider must limit disclosures to the "minimum necessary" for payment and operations purposes, disclosures for treatment purposes are not similarly restricted.

¹⁶¹ See *Notice of Privacy Practices*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/for-patients/patient-guide/privacy-practices> (last visited Oct. 30, 2017); PARTNERS HEALTHCARE SYSTEM, PARTNERS HEALTHCARE NOTICE FOR USE AND SHARING OF PROTECTED HEALTH INFORMATION, available at http://www.partners.org/Assets/Documents/Notices/Partners_Privacy_Policy_English.pdf (last visited Oct. 29, 2017).

¹⁶² See *Upgrading our Electronic Health Record System*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/partnersecure> (last visited Oct. 19, 2017).

experience” for their patients.¹⁶³ It is therefore unclear to what extent corporate integration would drive improvement in the quality of patient care beyond what is currently achievable, or that the marginal benefits only achievable by corporate integration counterbalance the concerning aspects of a corporate merger.

Finally, Partners has proposed eight measures in its DoN application to track the quality and access results of the proposed transaction.¹⁶⁴ However, only three such measures align with nationally validated quality metrics (regarding patient experience).¹⁶⁵ The parties have provided no baseline data or measure specifications¹⁶⁶ for the measures they propose to study, and have not identified performance improvement goals by which they and the state may measure success. The parties have also not indicated how they identified these measures as priorities for improvement.¹⁶⁷ Based on the information currently available, it is not possible for the HPC to assess the scope or likelihood of improvement on these measures or whether these measures would assess areas in need of improvement.

The parties have not provided any other specific plans that suggest that the proposed transaction would facilitate quality improvement in ways not already achievable through existing or future clinical arrangements.

C. ACCESS IMPACT

The parties have outlined several objectives of the proposed transaction related to access, including:

- Making MEEI the Partners system-wide resource for otolaryngology and ophthalmology services and enabling MEE to provide ambulatory surgical services in the community at Partners facilities that currently have surgical capacity,

¹⁶³ See *How Partners eCare is Changing the Way you Receive Care*, PARTNERS HEALTHCARE, <http://www.partners.org/for-patients/Partners-eCare.aspx> (last visited Oct. 19, 2017).

¹⁶⁴ See PARTNERS-MEE DON APPLICATION, *supra* note 19, at F1.b.ii. The parties have also stated that they plan to work together to identify and possibly develop new measures in the future. *Id.* (stating that “the Transaction will lead to a fully integrated health information technology system allowing Partners HealthCare to identify a core set of OPH and ORL measures... [and allow] for the development of internal benchmarks for physicians within the system that can help lead to best practices”).

¹⁶⁵ Two of the proposed measures (number of Partners patients receiving otolaryngology and ophthalmology services from MEE physicians, and the percentage of Partners diabetic patients receiving an annual eye exam from an MEE physician) would track the frequency with which Partners patients use MEE physicians for care, rather than quality. Two are structural measures (the average time between a referral for Partners patients and the date of their appointment at MEE, and the participation of MEE staff on Partners pharmacy quality committees). Finally, Partners proposes to track “The percentage of time protocols are followed for eliminating unnecessary [preoperative] testing.” Partners provided no specifications related to this measure in response to HPC inquiries, and we therefore cannot verify its validity. See PARTNERS-MEE DON APPLICATION, *supra* note 19, at F1.b.ii.

¹⁶⁶ Measure specifications include definitions of terms, study populations, and other information needed to assess the validity of the proposed measures. For example, it is unclear what pre-operative protocols the parties propose to use to assess whether a patient has received unnecessary testing. See *id.*

¹⁶⁷ Partners proposes three measures related to surveys of patient satisfaction in MEEA clinics. *Id.* As MEEI’s performance on similar measures in hospital settings is already better than most Partners hospitals, as discussed in Section III.B, it is unclear why the parties have identified this as a priority area for improvement.

- Meeting a growing need for otolaryngology and ophthalmology services in the population at large and specifically for Partners patients, and
- Ensuring that MEE can remain viable as a provider of specialty services in a market shifting to accountable care organization (ACO) structures.

We address each of these claims in turn in this section, as well as other potential impacts of the proposed transaction on access to care.

1. It is unclear why the proposed transaction is necessary for MEE to be the Partners system-wide resource for otolaryngology and ophthalmology services.

The parties state that despite MEE’s current clinical integration with MGH and BWH, “there is little integration of MEE’s specialty services with community-based provider members of the Partners ACO.”¹⁶⁸ They have also stated that the proposed transaction will enable MEE to provide services at additional Partners community facilities.¹⁶⁹ Yet, it is unclear why such integration of MEE as a Partners system-wide resource requires corporate ownership of MEE. As members of the MGPO, utilizers of the Epic electronic medical record system, and participants in Partners contracts with the three largest commercial payers, MEEA physicians already have shared tools and incentives for alignment with other members of the Partners ACO.

The parties also have yet to identify specific ways in which MEE would expand its services within the Partners network or pinpoint the additional Partners facilities where MEE would provide services. Indeed, the parties have stated that the process of incorporating MEE’s services at Partners sites where MEE does not currently provide services will require bilateral negotiations between MEE and each of the other Partners subsidiaries, and that the nature of each clinical relationship will vary based on Partners hospitals’ needs. Again, it is not clear then how corporate ownership of MEE is necessary to expand services within the Partners network or at other Partners sites. As an independent provider with a close clinical and contracting relationship with Partners, MEE can enter into clinical affiliations, joint venture arrangements, or other affiliations with Partners’ subsidiaries without a change in ownership.

2. Without additional information, the HPC cannot evaluate the extent to which the parties’ expansion plans would meaningfully improve access to MEE’s services.

The parties have also stated that MEEI must expand its ambulatory surgical capacity to meet the expected growth in demand for otolaryngology and ophthalmology services that will accompany the Commonwealth’s aging population. The parties have provided some data on statewide population trends and utilization among older patients to support this expectation.¹⁷⁰ However, MEE has been steadily increasing its outpatient presence in recent years as an independent entity: MEE has added 14 clinic and outpatient locations in the last ten years,

¹⁶⁸ PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section 2.1.

¹⁶⁹ MEE NOTICE OF MATERIAL CHANGE, *supra* note 32.

¹⁷⁰ See PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section F1.a.ii.

including outpatient surgery sites, thereby increasing its total outpatient sites to 18.¹⁷¹ While the provision of otolaryngology and ophthalmology services at additional Partners sites could potentially increase community access to these services, without details on the specific Partners facilities in which MEE may offer new services, the HPC cannot evaluate the extent to which utilization of Partners facilities would increase MEE's already broad geographic presence.

3. Patient volume at MEE has increased substantially in recent years, despite its status as an independent provider.

The parties suggest that MEE's clinical and research mission may be threatened in the absence of the transaction due to changes in the health care payment and delivery system.¹⁷² They suggest that new payment incentives will cause Massachusetts ACOs to reduce referrals to MEE in an effort to keep more care in-system. However, as discussed in Section II.B, MEE's patient volume has been growing substantially in recent years, despite a general increase in the share of commercial health maintenance organization (HMO) members covered by alternative payment methods during this time.¹⁷³ As discussed above, the parties have cited MEE's volume growth, and the expectation of additional volume due to an aging population, as the impetus for MEE's further expansion into new community sites. In addition to its current relationship with Partners, MEE has affiliations with several other major Massachusetts providers, which the parties have stated they expect to continue after the affiliation.¹⁷⁴ It is therefore unclear that a continued shift toward a more coordinated delivery and payment system would reduce patient volume for MEE or threaten its viability, such that corporate affiliation with Partners is necessary.¹⁷⁵

4. If MEE were to adopt Partners' contracting patterns as a result of the transaction, patients in limited and tiered commercial products and MMCOs may face barriers to accessing MEE's services.

¹⁷¹ See MEEI ANNUAL REPORT, *supra* note 43.

¹⁷² PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section 2.1 ("the Applicant and MEE believe that the Transaction is necessary to enable the Applicant to meet this patient need and to ensure the ongoing viability of MEE's clinical and research mission").

¹⁷³ We looked at the percentage of commercial HMO members covered by an APM for Massachusetts' largest physician groups according to share of total commercial HMO member months in 2014 and found that all but one of these groups had over two thirds of their commercial HMO members covered by alternative payment method contracts. Half of these groups saw an increase of at least 10 percentage points in this percentage from 2013 to 2014. See CTR. FOR HEALTH INFO. & ANALYSIS, CHIA ANNUAL REPORT SERIES: ADOPTION OF ALTERNATIVE PAYMENT METHODS IN MASSACHUSETTS 2012 - 2014 (March 2016), *available at* <http://www.chiamass.gov/assets/docs/r/pubs/16/apm-chartbook-2016.pdf> (last visited Oct. 29, 2017)

¹⁷⁴ See Section II.

¹⁷⁵ As discussed at pages 13 to 14, MEE has experienced substantial increases in operating expenses in recent years, and has recently used proceeds from the sale of non-clinical assets to achieve positive financial margins. The parties have also stated that federal funding supporting MEE's research activities has declined in recent years, and have suggested that the transaction will support MEE's research mission. See, e.g., PARTNERS-MEE DON APPLICATION, *supra* note 19, at Section F1.b.iv. While the transaction would likely result in additional resources for MEE's clinical and research activities, it is unclear to what extent these resources would come from efficiencies as MEE joins Partners research infrastructures, as opposed to resulting from rate increases for commercial payers and increases in health care spending.

As discussed in Section III.C.1, MEEI is the principal facility provider of a small set of specialty services, making it an important access point for patients. Access to these rare services may be impacted if MEEI adopts Partners' contracting patterns related to participation in MMCO networks and commercial limited and tiered network products.¹⁷⁶ If MEEI's rates increase over time as a result of joining Partners, as discussed in Section IV.A.2, payers creating limited network products and MMCO networks may exclude MEEI as being too expensive, and payers creating tiered products may put MEEI in less favorable tiers. MEEI may also simply participate in fewer tiered and limited networks and MMCO products over time, similar to Partners providers. Any change in MEEI's network participation or tiering may negatively impact access for plan members, particularly for those services for which MEEI is the primary or exclusive provider, and might drive up costs for patients and payers. Specifically, patients in a limited network product that does not include MEEI would generally not be able to receive services at MEEI unless they paid the full cost, and patients in a tiered network product for which MEEI is placed in a high cost-sharing tier would only be able to access MEEI services by paying higher co-pays or co-insurance.¹⁷⁷ While most MEEI services can be provided by other providers in eastern Massachusetts as described in Section III.C, its absence from a greater number of limited networks and placement in less-efficient tiers would reduce choice for consumers enrolled in these products. Moreover, it is not clear that other providers would have capacity to serve all or most patients who could no longer access MEEI.

In summary, while the parties have suggested that there may be a growing need for MEEI's services over time, they have not provided sufficient information to allow the HPC to judge whether the proposed transaction is necessary or sufficient to meet such needs, or that corporate integration is the most efficient means of doing so. In addition, the differences between the current participation of MEEI and Partners providers in tiered and limited network products and MMCO plans raise concerns that members in these products could face barriers to accessing MEEI's specialty services, or make such networks harder to establish and market to consumers.

¹⁷⁶ While Partners has asserted in its DoN application that the proposed transaction would not impact MEEI's participation in limited network plans, it has only committed to maintain MEEI's existing agreements with non-Partners *provider* networks. While this commitment is welcome, it does not ensure access to MEEI for members of tiered and limited *payer* networks. PARTNERS-MEEI DON APPLICATION, *supra* note 19, at Section F1.a.iii.

¹⁷⁷ If patients of a limited network product use an out-of-network provider, the patient may pay the extremely high "full charge" rate of the provider, or the payer may cover this higher charge if the needed care was not otherwise available from an in-network provider, and may pass on these additional costs in the form of later premium increases. The HPC analyzed 2014 APCD claims for outpatient hospital services for which MEEI had at least a 50% market share and Partners and MEEI combined had at least an 80% market share in MEEI's PSA (i.e., MEEI services that are not likely to be easily accessible outside of the Partners system after the transaction). "Full charge" rates were approximately 74% higher than the reimbursement rates currently MEEI receives from the top three commercial payers for these services. Furthermore, payers have indicated to the HPC that increased MEEI prices and changes in MEEI participation in tiered and limited network products would make these products less marketable to consumers, which could result in a shift of members to plans without these cost-saving incentives and undermine payer efforts to limit total health care spending.

V. CONCLUSION

As described in Section IV, the HPC found:

1. **Cost and Market Impact:** After the transaction, Partners could likely obtain Partners physician rates for MEEA physicians across all commercial payers and would likely seek significant hospital rate increases for MEEI. Over time, we estimate that total commercial health care spending would increase by \$20.8 million to \$61.2 million annually if Partners achieves parity between MEEI's rates and the rates of Partners' other hospitals, depending on price levels obtained, and if MEEA physicians begin receiving Partners physician rates for all commercial payers. These spending increases would ultimately be borne by consumers and businesses through higher commercial premiums and may also impact other providers' spending against risk budgets to the extent that their patients use MEE. While the parties expect to achieve internal efficiencies that would reduce their own expenses, they have not committed to using the resulting savings to reduce prices or otherwise provided evidence that these savings would be passed on to payers or consumers.
2. **Quality Impact:** The parties have stated that the proposed transaction will facilitate improved quality, primarily by better integrating MEE into Partners' technical infrastructure, including its data warehouse, quality reporting platform, and electronic medical record system. However, it is unclear to what extent these technical improvements would result in improved patient care, given that MEE's quality performance is already strong and comparable to that of Partners and recognizing the parties' existing collaborations. The parties have identified only a few metrics for quality improvement, and propose to collect baseline data and set improvement targets only after the transaction is completed. Given existing quality performance and unspecified targets, it is unclear that the proposed transaction is necessary or sufficient to achieve improvements in clinical quality.
3. **Access Impact:** While the parties have suggested that patient need for MEE's services is increasing, they have not described specific plans for when or where MEE might expand its services to meet those needs, or why corporate integration would be necessary to do so. In addition, if MEE adopts Partners' contracting patterns as a result of the transaction, patients in tiered and limited network products and Medicaid MMCOs may face barriers to accessing MEE's specialty services.

In summary, we find that the proposed transaction between Partners and MEE is likely to increase health care spending due to expected increases in hospital and physician prices that are consistent with the parties' stated goals of the transaction. While the parties have claimed that the transaction will result in operational efficiencies and improvements in the quality of patient care and access to services, they have not committed to using the resulting savings to reduce prices or otherwise reduce spending for payers or consumers, nor have they provided evidence that a corporate merger is either necessary or sufficient to achieve quality or access improvements. The parties also have not offered commitments regarding MEE's payer network participation that would protect against any impaired access to MEE's specialty services

subsequent to the transaction. We invite the parties to address these concerns in their written response.

Based on these findings, this transaction may warrant further review and referral to the Massachusetts Attorney General's Office pursuant to MASS. GEN. LAWS ch. 6D, § 13. In addition, given that the proposed transaction is under concurrent review by DPH's DoN program, we may submit our findings to DoN program staff for consideration in the context of the factors for DoN approval. Following the period for written response, the HPC will publish a Final Report, including any referrals or recommendations to other agencies.

Acknowledgements

Commissioners

Dr. Stuart Altman, Chair

Dr. Wendy Everett, Vice Chair

Dr. Carole Allen

Dr. Donald Berwick

Mr. Martin Cohen

Dr. David Cutler

Mr. Timothy Foley

Secretary Michael J. Heffernan
Executive Office of Administration and Finance

Mr. Richard C. Lord

Mr. Renato (Ron) Mastrogiovanni

Secretary Marylou Sudders
Executive Office of Health and Human Services

Executive Director

Mr. David Seltz

Megan Wulff, Deputy Director for Market Performance, Sasha Hayes-Rusnov, Senior Manager for Market Performance, Rebecca Balder, Project Manager for Market Performance, Amy Katzen, Project Manager for Market Performance, and Kara Vidal, Senior Manager for Market Performance prepared this report under the direction of Katherine Scarborough Mills, Director of Policy for Market Performance, with significant contributions by Samuel Breen, Thomas Hajj, Ramsay Hogue, Ashley Johnston, Lyden Marcellot, Natasha Reese-McLaughlin, Elizabeth Reidy, and Lois Johnson. The HPC wishes to acknowledge the analytic support provided by Bates White, LLC, Freedman Healthcare, LLC, Gorman Actuarial, Inc., and Health Management Associates, Inc. The HPC would also like to thank the health insurers and providers who provided information for this report for their courtesy and cooperation.

Health Policy Commission

50 Milk Street, 8th Floor

Boston, MA 02109

www.mass.gov/HPC
