STAFF REPORT TO THE PUBLIC HEALTH COUNCIL
FOR THE DETERMINATION OF NEED

DoN Project Number	17082413
Applicant Name	1. **Lahey Health System, Inc. ("LHS")** The parent of Lahey Clinic Hospital, Inc. ("LHMC"), Northeast Hospital Corp. d/b/a Beverly Hospital, Addison Gilbert Hospital, and BayRidge Hospital[1], and Winchester Hospital. 2. **CareGroup, Inc.** The parent of Beth Israel Deaconess Medical Center, Inc. ("BIDMC"), which includes Beth Israel Deaconess Hospital-Milton, Inc.("BID-Milton"), Beth Israel Deaconess Hospital – Needham, Inc.("BID-Needham"), and Beth Israel Deaconess Hospital – Plymouth, Inc.("BID-Plymouth"), New England Baptist Hospital ("NEBH"), and Mount Auburn Hospital ("MAH"). 3. **Seacoast Regional Health Systems, Inc. ("SRHS")** The parent of Anna Jaques Hospital ("AJH").
Applicant Address	1. Lahey Health System, Inc. 41 Mall Road, Burlington, MA 01805 2. CareGroup, Inc., 109 Brookline Ave, Boston, MA 02215 3. Seacoast Regional Health Systems, Inc., 25 Highland Avenue, Newburyport, MA 01950
Date Received	September 7, 2017
Type of DoN Application	Transfer of Ownership
Total Value	$5,323,154,000.00
Ten Taxpayer Group (TTG)	4 Registered TTGs

[1] Bayridge Hospital is a behavioral health facility offering comprehensive substance abuse and mental health services

Public Hearing	1. December 5, 2017 Roxbury, MA 2. December 6, 2017 Gloucester, MA 3. January 3, 2018 Newburyport, MA
Community Health Initiative (CHI)	Exempt from DoN Factor 6 105 CMR 100.210(6)
Staff Recommendation	Approval with conditions
Public Health Council (PHC) Meeting Date	April 4, 2018

PROJECT SUMMARY AND REGULATORY REVIEW

CareGroup, Inc. ("CareGroup"); Lahey Health System, Inc. ("Lahey" or "LHS"); and Seacoast Regional Health Systems, Inc. ("SRHS"), intend to affiliate to create what they describe as a new comprehensive and distributed high-value healthcare delivery system in Eastern Massachusetts, currently named NewCo. NewCo will function as the sole corporate member of each hospital and effectively replace CareGroup, Lahey, and SRHS as the exclusive parent organization.[2]

The Applicant is NewCo. NewCo seeks a Determination of Need (DoN) for a proposed Transfer of Ownership. Transfers of Ownership are reviewed subject to M.G.L. c.111 §§ 51 and 53 and the DoN regulation, specifically, 105 CMR 100.735 which provides, in relevant part that "no Person shall be issued an Original License for a Hospital unless the Department has first issued a Notice of Determination of Need for such Proposed Project at the designated Location." Transfers of Ownership are subject to Factors 1, 3, and 4 of the DoN regulation and certain standard conditions which are set out in Attachment 1.

The Department received written comment and held public hearings on December 5th and 6th, 2017 and on January 3rd, 2018. A list of speakers can be found at Attachment 2 and a description of the comments received at Attachment 3. Four groups registered as Ten Taxpayer Groups.

The transaction which is the subject of this DoN is also subject to review by the Health Policy Commission (HPC). On December 12, 2017, the HPC voted to authorize a Cost and Market Impact Review (CMIR). The CMIR will not be completed until after the review of this DoN. Pursuant to 105 CMR 100.735(D), any Notice of DoN issued shall not go into effect until 30 days after HPC completes the CMIR.

[2] NewCo will become the sole corporate member of the following hospitals: Beth Israel Deaconess Medical Center, Inc. (BIDMC) and its subsidiary hospitals, Beth Israel Deaconess Hospital – Needham, Inc. (BID-Needham), Beth Israel Deaconess Hospital–Milton, Inc. (BID-Milton), and Beth Israel Deaconess Hospital –Plymouth, Inc. (BID-Plymouth); New England Baptist (NEBH); Mount Auburn Hospital (MAH); Lahey Health System ("LHS") and its subsidiary hospitals, which includes Lahey Clinic Hospital, Inc. (LHMC), Winchester Hospital, and Northeast Hospital Corp. d/b/a Beverly Hospital, Addison Gilbert Hospital, and BayRidge Hospital; and Seacoast Regional Health System(SRHS) and its subsidiary Anna Jaques Hospital (Anna Jaques).

Introduction and Background

The Parties to this transaction are CareGroup, Inc. and Lahey Health System, Inc., both multi-acute hospital systems; and Seacoast Regional Health Systems, Inc., the parent of Anna Jaques Hospital. The Parties propose to integrate clinically and financially to become what the Applicant describes as a high-value choice for healthcare in Massachusetts. To facilitate this integration, a new corporation, known for the time being as NewCo, will serve as the sole corporate member of 13 clinically and geographically complementary hospitals: one academic medical center (AMC), two teaching hospitals (TH), eight community hospitals (CHs), and two specialty hospitals, with 2,400 beds, 1,000 primary care physicians (PCP) and 3,600 specialists. NewCo will utilize a shared governance strategy with decision-making at the parent level. Local hospital management and local boards will incorporate input at the community level. NewCo will also become the sole corporate member of a clinically integrated network (NewCo CIN).[3] The entities that comprise the NewCo system will share fiduciary objectives and decision-making which, NewCo asserts, will promote mutual goals and objectives of the system.

NewCo asserts that it will be a lower cost, high-value alternative for healthcare consumers in Massachusetts and proposes to use its management of a broad population and its enhanced geographic distribution to shift care to its lower cost network and, ultimately, drive down spending. NewCo will create what it describes as a fully integrated clinical delivery system with broad capacity at a reasonable price in order to improve quality outcomes and cost performance. Integration will, NewCo asserts, foster the spread of best practices as well as the shared incentives and alignment necessary to reduce healthcare expenditures. NewCo maintains that its clinical delivery model is defined by its full continuum network encompassing the essential clinical services (acute, non-acute, rehabilitation, behavioral health, long-term care and post-acute care) to address the patient panel's health care needs, all within one lower cost network. NewCo states that its geographic coverage and comprehensive clinical services represent the kind of improved access to high-value care that will make it attractive to consumers, employers, and payers, and will increase NewCo's ability to attract patients to its network, strengthen its competiveness, and lower costs overall. NewCo asserts that it will drive innovation in the marketplace "to create a competitive marketplace in which the cost growth benchmark becomes more achievable." [4,5]

[3] NewCo CIN will be the sole parent of Beth Israel Deaconess Care Organization ("BIDCO"), which includes both a physician network, and a hospital network; Lahey Clinical Performance Network, LLC ("LCPN"); and Lahey Clinical Performance Accountable Care Organization, LLC ("LCP ACO"). Mount Auburn Cambridge Independent Practice Association, Inc. ("MACIPA"), which will remain an independent corporate entity, will participate in the design, management, and governance of, and become a participating provider in NewCo CIN and a contracting affiliate of CIN. BIDCO, LCPN, and MACIPA are not subject to the DoN regulations because they are not health care facilities. See, NEWCO-17082413-TO DoN Application, at page 2.

[4] Chapter 224 of the Acts of 2012 established the health care cost growth benchmark, a statewide target for the rate of growth of total health care expenditures (THCE). The Health Policy Commission (HPC) sets the benchmark

The Applicant points out that, even with high rates of health insurance coverage in Massachusetts (96.3% insured in 2017), and a robust health service system, cost is still a significant barrier to accessing healthcare.[6] Citing reports from the Massachusetts Attorney General (AGO) and the Health Policy Commission (HPC), NewCo states that healthcare costs in Massachusetts are rising at unsustainable levels. NewCo asserts that previous attempts to reduce healthcare expenditures have been unable to correct the inadequacies in the market.

Measures of consumer spending on healthcare reflect a significant burden on consumers. In 2015, the annual health insurance premium plus cost-sharing for a typical family in Massachusetts accounted for almost 30% of the median income.[7] Moreover, rising healthcare costs for Massachusetts families burden household budgets that include increasing expenditures on housing, food and transportation. The high cost of healthcare and the fear of incurring high medical bills may cause some people to delay seeking care and one in five insured adults in Massachusetts have an unmet health need due to costs.[8,9]

Massachusetts ranks second in the nation for per capita healthcare spending.[10] NewCo cites estimates of wasteful spending ($12.1 to $22.4 billion in 2015 in Massachusetts)[11,12] as an opportunity for improvement, pointing out that care coordination and payment and delivery reforms will help to reduce wasteful spending and benefit patients. Through the tighter clinical and economic affiliation proposed in this transaction, NewCo asserts it will transform care delivery and reduce healthcare expenditures. In a changing healthcare industry where financial performance is increasingly tied to clinical outcomes, NewCo argues that provider focus must

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for the following calendar year annually between January 15 (when the potential gross state product is established) and April 15. THCE is a per-capita measure of total state health care spending growth.

[5] NEWCO-17082413-TO DoN Application, at page 31.

[6] *Findings from the 2017 Massachusetts Health Insurance Survey* (Rep.). (2017, December). Retrieved December, 2017, from CHIA website: http://www.chiamass.gov/assets/docs/r/survey/mhis-2017/2017-MHIS-Report.pdf

[7] *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, § 17* (Rep.). (2016, October 3). Retrieved Sept. & oct., 2017, from Commonwealth of Massachusetts Office of the Attorney General website: http://www.mass.gov/ago/docs/healthcare/cc-market-101316.pdf

[8] Auerbach, D. (2017, October 2). Massachusetts health care cost trends in a national context. In *Annual Healthcare Cost Trends Hearing*. Retrieved October, 2017, from http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/annual-cost-trends-hearing/2017/2017-cth-master-deck-vfinal.pdf

[9] Long, S. K., Skopec, L., Shelton, A., Nordahl, K., & Walsh, K. K. (2016). Massachusetts Health Reform At Ten Years: Great Progress, But Coverage Gaps Remain. *Health Affairs,* 1633-1637. Retrieved Oct. & nov., 2017, from http://www.healthaffairs.org/doi/references/10.1377/hlthaff.2016.0354

[10] Auerbach, D. (2017, October 2). Massachusetts health care cost trends in a national context. In *Annual Healthcare Cost Trends Hearing*. Retrieved October, 2017, from http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/annual-cost-trends-hearing/2017/2017-cth-master-deck-vfinal.pdf

[11] *2013 Cost Trends Report* (Rep.). (2014, January). Retrieved Sept. & oct., 2017, from Health Policy Commission website: http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-full-report.pdf

[12] HPC defines wasteful spending as spending in the provision of health services that could be eliminated without harming consumers or reducing the quality of care people receive.

include the management of chronic illness, prevention, and an increased focus on the social determinants of health. NewCo asserts that it will be a proactive system that addresses its patient panel's needs through assuming greater responsibility for health outcomes.

NewCo states that this transaction will allow the NewCo providers to more effectively transition away from fee-for-service toward population health management (PHM) by making changes to delivery and costs of care. Because of financial and resource constraints and smaller geographic footprints, NewCo maintains that cost and quality aims would not be possible for each system individually. NewCo claims that it will create a new clinical delivery model that will ensure the sustainability of the participating facilities and preserve access to high-value care for its patient panel.

Contemporaneous Review of this Transaction

On December 12, 2017, the Massachusetts Health Policy Commission (HPC) authorized the initiation of a Cost and Market Impact Review (CMIR) which will analyze the impact of the proposed transaction on costs and market function, the size and market position of the proposed new entity, as well as NewCo's role in serving at-risk, underserved and government payer populations. The CMIR will also examine the potential impact of NewCo's plans on quality, costs, and market dynamics. The CMIR is in process at this time and its anticipated completion is late spring of 2018. Because this transaction is subject to a CMIR, any Determination of Need (DON) approved by the Department of Public Health will not go into effect until 30 days following the HPC's completion of the CMIR. 105 CMR 100.735(D)(1)(c).

The DoN Regulation further states that the HPC may provide a written recommendation to the Commissioner that the DoN should not go into effect based on the findings of the CMIR. If the information in the CMIR causes the Commissioner to conclude that the Holder would fail to meet one or more of the specified Factors, the Public Health Council can reconsider the matter and may rescind or amend an approved Notice of Determination of Need. Separately, HPC can make a referral of its report to the office of the Massachusetts Attorney General's Office (AGO) and must make such a referral if the HPC determines in its preliminary report that the Provider Organization has a dominant market share for the services it provides; charges materially higher prices than the median prices; and the provider organization has materially higher health status adjusted Total Medical Expenses (TME) as other proviers in the same market. See M.G.L. c. 6D, § 13.

Analysis

This analysis and the recommendations made herein reflect the purpose and objective of DoN which is "to encourage competition and the development of innovative health delivery methods and population health strategies within the health care delivery system to ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost advancing the Commonwealth's goals

for cost containment, improved public health outcomes, and delivery system transformation". 105 CMR 100.001

In its analysis of the proposed transaction DoN staff will review the goals of the project to ascertain that NewCo meets the applicable factors that guide the DoN review process. The staff report will analyze the patient panel need identified by NewCo to determine if the proposed transaction will support evidence-based and measurable outcomes that improve quality of life of the patient panel while competing on price and other measures of healthcare spending. The staff report will consider the project's impact on health equity, and the context of the Massachusetts healthcare market as it currently functions in order to examine the assertion that the creation of NewCo will add value to the market in the form of increased access to care at lower costs with improved health outcomes.

Transfers of Ownership are subject to Factors 1, 3, and 4 of the DoN regulation. This staff report addresses each of those factors in turn.

Factor 1

Factor 1 requires that the Applicant establish that the project:

- will meet a demonstrated need of the existing patient panel;
- will add measurable public health value in terms of improved health outcomes and quality of life of the Applicant's existing patient panel, while providing reasonable assurances of health equity;
- will result in efficient and effective operations that improve continuity and coordination of care for the Applicant's patient panel, including appropriate linkages to patients' primary care services;
- is characterized by sound community engagement throughout the development of the proposed transaction; and
- will be competitive on the basis of price, total medical expense (TME), provider costs, or other recognized measures of health care spending. 105 CMR 100.210(A)(1).

In addition, Factor 1 requires that the Applicant provide evidence of consultation with the relevant regulatory agencies. The Applicant has provided this evidence and, as a result this will not be addressed further in the Staff Report.

Patient Panel and Need

Demographics

The NewCo patient panel consists of 1,230,952 unique patients in FY 2017.[13] The majority (74.6%) of the patient panel self-reported as White. Women comprise 58.3% of the patient panel and men, 41.7%. Sixty-five percent of the patient panel is between the ages of 18 and 64. The payer mix in 2017 was:

Commercial Payers	Medicare	Medicaid	Multiple Payors[14]	Other	Unknown
52.9%	24.2%	12.8%	4.7%	4.3%	1.1%

NewCo frames the impact of this transaction as extending beyond its patient panel. They looked at the demographics of each constituent hospital's Primary Service Area to understand the needs of the population that could be served by the NewCo network.[15] To understand the broader population and its health needs, NewCo used data from the most recent Community Health Needs Assessment (CHNA) prepared by each of the several facilities who will be parties to the proposed transaction (the NewCo Party Hospitals) to describe health status, including risk factors for disease and effects on longevity and quality of life.[16] NewCo asserts that the proposed new system offers the potential to mitigate many of those health care needs.

Disease and Disparities

Chronic Disease

The Applicant reported 116,769 inpatient discharges in 2017 of which 31% were diagnosed with a chronic condition. That percentage has been relatively stable for the past three years. NewCo asserts that its patient panel reflects the chronic medical and behavioral conditions in the

[13] The Applicant defines patient panel as the number of unique patients that visited a facility on a NewCo hospital license for inpatient or outpatient services, including patients who were admitted through the emergency department. Unique patients are identified at the hospital level, with the exception of Addison Gilbert and Beverly Hospital, which are jointly identified, and LHMV-Burlington and LHMC-Peabody, which are jointly identified. Patients visiting multiple hospitals in a given year are not uniquely identified. DoN Application 17082413 Patient Panel Summary, at page 2.

[14] Patients whose primary payor is missing in the data are included in "Unknown." Patients whose primary payors within a given fiscal year fall into more than one payor category are included in "Multiple Payors." "Other" includes the following payor categories: self-pay, worker's compensation, other government payment, free care, health safety net, auto insurance, Commonwealth Care/ConnectorCare plans, and dental plans. DoN Application 17082413 Table NewCo Patient Panel Summary, at page 2.

[15] Based on analysis of fiscal year 2015 data provided by CHIA. Hospital service areas are defined as zip codes where 75% of patients reside.

[16] The Parties note that while the CHNAs encompass broad geographies, and may include individuals that have not historically been patients at a NewCo facility or of a NewCo physician, the parties believe the attributes identified in the CHNAs are consistent with those of the patients served by NewCo Party hospitals and provide relevant context for better understanding the needs of the patient panel. DoN Application 17082413, at page 10, fn6.

broader community. CHNA data correlates with national statistics which show that chronic disease is widespread, that the risk for chronic illness increases with age, and that minorities and individuals with low income are disproportionately affected.[17] Chronic disease leads to higher rates of hospitalizations, emergency department (ED) visits, and deaths, is costly to the healthcare system and can affect employment and quality of life.[18,19] Health systems can address these factors with chronic disease prevention and management strategies that reduce provider and health system cost.

Racial/ethnic and income disparities

Racial/ethnic health disparities among NewCo communities indicate a need for increased access to prevention, screening and treatment services. Rates of obesity for Black/African Americans (33%) and Hispanics (27%) in Boston are twice as high compared to Whites (16%).[20] Minority communities in Boston and surrounding areas are disproportionately affected by cancer, indicating a need for enhanced access to cancer screening to improve early diagnosis and treatment. Prevention measures are needed as well to reduce exposure to risk factors and disease burden, a cost effective strategy.[21,22] Physical inactivity and poor nutrition, leading risk factors for chronic disease and obesity, were recorded in the CHNAs from NewCo communities. These neighborhoods also lacked access to affordable healthy foods and safe environments, which create barriers to healthy eating, exercise and erode community cohesion. BIDMC's CHNA reports that communities with lower socioeconomic status, and increased disease burden, often do not have a regular source of care and utilize EDs for care instead of primary care offices, a resource for preventive services.[23]

Age Disparities

NewCo reported that 26.6% of its patient panel is age 65 and over (up from 24.9% in 2015). Consistent with national trends, Massachusetts' 65 and older population rose from 16% in 2017

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[17] *Chronic Conditions Among Older Americans* (Rep.). (n.d.). Retrieved November, 2017, from AARP website: https://assets.aarp.org/rgcenter/health/beyond_50_hcr_conditions.pdf

[18] Chronic Disease Prevention and Health Promotion. (n.d.). Retrieved October, 2017, from https://www.cdc.gov/chronicdisease/

[19] *Chronic Conditions Among Older Americans* (Rep.). (n.d.). Retrieved November, 2017, from AARP website: https://assets.aarp.org/rgcenter/health/beyond_50_hcr_conditions.pdf

[20] *Community Health Needs Assessment* (Rep.). (2016, September 20). Retrieved October, 2017, from Beth Israel Deaconess Medical Center website: http://www.bidmc.org/~/media/Files/Centers%20and%20Departments/Community%20Initiatives/FY16%20Community%20Health%20Needs%20Assessment.pdf

[21] *Community Health Needs Assessment* (Rep.). (2016, September 20). Retrieved October, 2017, from Beth Israel Deaconess Medical Center website: http://www.bidmc.org/~/media/Files/Centers%20and%20Departments/Community%20Initiatives/FY16%20Community%20Health%20Needs%20Assessment.pdf

[22] Cancer prevention. (2017). Retrieved November, 2017, from http://www.who.int/cancer/prevention/en/

[23] *Community Health Needs Assessment* (Rep.). (2016, September 20). Retrieved October, 2017, from Beth Israel Deaconess Medical Center website: http://www.bidmc.org/~/media/Files/Centers%20and%20Departments/Community%20Initiatives/FY16%20Community%20Health%20Needs%20Assessment.pdf

to 18.5% in 2022.[24] The Agency for Healthcare Research and Quality (AHRQ) reported that 80% of individuals age 65 and older have multiple chronic conditions.[25] Chronic disease and its associated disability can have a significant impact on daily living and quality of life for older patients. Healthcare needs of the older populations reported in the CHNAs include depression, anxiety, isolation and increased likelihood of chronic and physical conditions. Elderly patients often receive care in a variety of settings across the system, and half will make at least one visit to the emergency room in a year, further emphasizing the need for cost-effective, integrated care to manage complex conditions.[26]

Behavioral Health and Disparities

NewCo reported that 5.4% of the 116,769 inpatient discharges in 2017 had a behavioral health (BH) diagnosis. Data from the CHNAs show rising rates of substance use and mental health issues.[27] NewCo argues that, in terms of disease prevalence and incidence, "there are meaningful differences among individual communities and demographic cohorts," NewCo states that "the ability to understand the unique needs is crucial in ensuring optimal care is available to each community and [that] statistics provide a framework for developing system-wide plans, but also provide evidence that local community-specific care plans, like each hospital's Community Health Improvement Plan, remain a priority to best address unique needs of local populations."[28] Qualitative data from the CHNAs point to what they describe as the lack of adequate substance use disorder (SUD) and mental health services to respond to the increasing need for BH services brought on by the opioid epidemic. NewCo communities have been significantly affected: 10 out of the 15 cities/towns in LHMC's primary service area had statistically higher rates of opioid-related Emergency Department (ED) visits per 100,000 population than the Commonwealth. The highest rate was reported in Wakefield, two times higher than the state average, with 518 opioid-related ED visits per 100,000.[29]

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[24] Pop-Facts Premier. (2017). Retrieved November, 2017, from https://www.claritas.com/Default.jsp?ID=transactional-reports&menuOption=qmi

[25] Gerteis, J., Izrael, D., Deitz, D., LeRoy, L., Ricciardi, R., Miller, T., & Basu, J. (2014, April). *Multiple Chronic Conditions Chartbook 2010* (Rep.). Retrieved Oct. & nov., 2017, from AHRQ website: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf

[26] Ko, K., Lesser, A., Biese, K., Hwang, U., & Carpenter, C. (2017, September 12). The Journey Of Geriatric Emergency Medicine: Acceleration, Diffusion, And Collaboration As Keys To Continued Growth. Retrieved October, 2017, from http://www.healthaffairs.org/do/10.1377/hblog20170912.061810/full/

[27] Pop-Facts Premier. (2017). Retrieved November, 2017, from https://www.claritas.com/Default.jsp?ID=transactional-reports&menuOption=qmi

[28] NEWCO-17082413-TO DoN Application, at page 11

[29] *Community Health Needs Assessment* (Rep.). (2016). Retrieved October, 2017, from Lahey Hospital & Medical Center website:https://www.lahey.org/uploadedFiles/Content/About_Lahey/In_the_Community/2016%20Community%20Health%20Needs%20Assessment.pdf

Public Health Value (Outcomes, quality of life, and equity)

Public Health Value, for the purposes of DoN, requires that the project have an evidence base, be outcome oriented and address health inequities. Staff examined the impact of the transaction on improved coordination of care and patient access to care as well as the impact upon outcomes and quality of life as a result of the transaction.105 CMR 100.210(A)(1)(b)

NewCo asserts that existing clinical and operational successes experienced by the NewCo Party Hospitals provide the foundation from which NewCo will leverage clinical expertise across the system to support the public health value of the transaction. This section of the report will look at existing initiatives at the NewCo Party Hospitals which NewCo offers as examples of programs with measurable public health value that can be scaled up and implemented throughout the new system.

Enhanced Chronic Disease Management
NewCo Party Hospitals have implemented risk stratification programming to identify patients in need of chronic disease management and prevention services. This program generated measurable improvement in health outcomes.

- Beth Israel Deaconess Care Organization (BIDCO) is a value-based Accountable Care Organization (ACO) that recently launched the Rising Risk program to a subset of its network. Rising Risk supports the patient practitioner relationship and combines the skills of a health coach and a pharmacist, using Population Health Management (PHM) and data analytics to identify patients with 'rising risk' of five chronic diseases toimprove care quality, overall health, and quality of life.
- Mount Auburn Hospital (MAH) developed a program to establish inpatient guidelines for congestive heart failure management which reduced readmission rates 3.28% (18.05% to 14.77%) over the course of one-year (2015-2016) leading to the expansion of the model to chronic obstructive pulmonary disease (COPD).
- Lahey's participation in the Oncology Care Model, developed by the Center for Medicare & Medicaid Innovation Center (CMS Innovation) with a focus on providing high quality oncology care at lower costs, led to the development of a risk stratification program that calculates a risk score which generates a response that includes care navigation and risk stratification (embedded in the Lahey Electronic Health Records (EHR) system) and which they assert prevents readmission through aggressive care management.

Pointing to these examples, NewCo asserts that it has the capacity to provide tailored chronic disease care that in more fragmented delivery systems could be compromised. NewCo asserts that it will improve quality and health outcomes for the patient panel through expanding existing initiatives that focus on improving care delivery to more effectively support patient management of chronic disease. NewCo says it will expand its use of risk stratification and care management tools to match patients with appropriate care, streamline care transitions, and improve outcomes and that the transaction will result in enhanced data analytic capabilities

and increased understanding of the causes and factors associated with chronic disease. Information technology (IT) will support team-oriented treatment models and chronic disease programming, such as the Lahey risk assessment for breast cancer, will be expanded and integrated across the NewCo system. NewCo asserts that prevention and screening services will be delivered with a more expansive and thorough approach to improve chronic disease management and prevention.

Increased Access to Behavioral Healthcare Services

The Applicant states NewCo Party Hospitals will use their collective experience implementing innovative methods of expanding access to Behavioral Health (BH) services to address the unmet need for these services among the NewCo patient panel. NewCo offers the following examples:

- BIDMC was one of the first providers to embed mental health practice within primary care and BIDMC and BIDCO launched telephonic services to enhance behavioral health capacity in primary care practices.
- BIDMC conducts universal screening for substance use in its EDs; BIDMC trains residents, attending physicians, resource social workers and nurses to administer Screening Brief Intervention, Referral and Treatment (SBIRT)[30]; and BIDMC's Department of Psychiatry offers an urgent care program with rapid psychiatric consultation. BID-Milton coordinates and integrates behavioral healthcare provided in the ED which has led to a 20% reduction in behavioral health boarding hours.
- BID-Plymouth, is an important provider of behavioral healthcare for seniors and inpatient geriatric psychiatry.
- NEBH, a specialty hospital for orthopedic and musculoskeletal conditions, is working to improve outcomes for musculoskeletal patients who present with behavioral health conditions. Their approach includes preadmission screening, arranging home-based services prior to surgery, arranging for detox prior to surgery, and post-operative high-risk screening and evaluation to eliminate post-operative delirium and readmission.
- Lahey has embedded behavioral health resources in 11 of its primary care practices spanning the system's entire service area.
- Lahey Health Behavioral Services (LHBS), a private, nonprofit agency of Lahey Health, is the largest provider of outpatient behavioral health services to MassHealth patients, serving over 50,000 patients annually including 12,000 children.
- LHBS created new access points for care in over 45 communities, in Emergency Departments, homes, schools and residential settings. Innovations in behavioral health

[30] According to the Substance Abuse and Mental Health Services Administration (SAMSAH), "SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur." About Screening, Brief Intervention, and Referral to Treatment (SBIRT). (2017, September 20). Retrieved January, 2018, from https://www.samhsa.gov/sbirt/about

aimed at cost reduction adopted by LHBS, include a behavioral health electronic health record (EHR), and embedding behavioral health clinicians in primary care practices.

- Anna Jaques hospital, is a critical provider of inpatient pediatric psychiatry services to the region and has expanded access to behavioral health services through integrating behavioral health and primary care and emergency care.

NewCo commits to integrate the behavioral healthcare expertise of its Party Hospitals to enhance prevention, screening, and treatment services and to address the social determinants of health, funding instability, and workforce development difficulties that NewCo states pose a barrier to enhancing these services. NewCo reports that MassHealth ACO participation will enhance the NewCo CIN's ability to provide care to MassHealth members with behavioral health needs. MassHealth ACO participation will be prioritized in NewCo's system; BIDCO is requiring all member physicians participate and the Lahey plans for care coordination will ensure that MassHealth ACO members receive the right level of care and expertise.[31] BIDCO will create an Accountable Care Partnership Plan (ACPP) which will identify and address social needs through assessments provided to new members and through which they will expand access to behavioral services for MassHealth patients. LHBS will become a Behavioral Health Community Partner (BHCP) as part of the MassHealth delivery redesign effort, and will support patients with high, sometimes complex, behavioral healthcare needs.

According to a recently released report by the Health Policy Commission, patients needing behavioral health services seek care in EDs due to long wait times for appointments and patients presenting to the ED with behavioral conditions have significantly longer boarding times than those without a behavioral health diagnosis, indicating a need for improved access and management of care.[32] NewCo asserts that becoming part of the NewCo system will increase each Party Hospital's capacity to identify underlying behavioral health care needs and improve access to behavioral health services in the multiple settings where patients present for care. The NewCo system will bring together the clinical expertise and care coordination of existing initiatives that NewCo asserts have already improved the experience of care and outcomes for patients with behavioral health conditions.

[31] LCPN ran two separate ACOs after Lahey's affiliation with Winchester, ultimately combining the two ACOs into LCP ACO beginning in performance year 2016. NEWCO-17082413-TO DoN Application, at page 31

[32] *Behavioral Health-Related Emergency Department Boarding in Massachusetts* (Rep.). (2017, November). Retrieved November, 2017, from Health Policy Commission (HPC) website: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/20171113-hpc-ed-boarding-chart-pack.pdf

Population Health Management / Care Coordination

Effective population health management (PHM) requires that systems attract and retain new primary care patients, provide high and measurable value, and deliver high satisfaction to patients and providers.[33] NewCo points to the expertise of its affiliated networks' ACOs in PHM:

- BIDCO, was selected as one of 32 Pioneer ACOs[34] and in 2015 earned the highest quality score (98%) of the group;
- Lahey Clinical Performance Network (LCPN) Medicare Shared Savings Program (MSSP) ACOs ranked second in Massachusetts for savings while maintaining high quality scores (above 90% or above) in 2014 and 2015;
- Winchester ACO leads in savings per beneficiary with high quality scoring; and
- Mount Auburn Cambridge Independent Practice Association, Inc. (MACIPA) participates in the Pioneer ACO Program, caring for 10,000 patients and generated 14 million in savings to Medicare.

NewCo commits to continue to develop system level Population Health Management (PHM) through NewCo CIN. They assert that this will facilitate patient transfers across providers and settings and after discharge, and will promote team collaboration and risk-based contracting. NewCo asserts that standardized care and managed protocols will incentivize provider participation. LCPN will expand its current PHM methods, and incorporate Medicare ACO initiatives that target health inequities.

NewCo states that designating a provider to lead the coordination of care for patients who often access care from several providers in multiple settings will decrease fragmentation.[35] NewCo says it will expand access to primary and specialty care as well as post-acute and home care to incentivize appropriate care utilization patterns. NewCo asserts that its structure will facilitate relationship building between physicians which, in turn will support achieving the shared goals and effecting the decision making that influences referral patterns and affects the delivery of care. NewCo will recruit new physicians into its network, putting primary care at the center of care coordination thereby enhancing access to care across the continuum.

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[33] Matthews, M. R., Stroebel, R. J., Wallace, M. R., Bryan, M. J., Swanson, J. A., Allen, S. V., & Bunkers, K. S. (2017). Implementation of a Comprehensive Population Health Management Model. *Population Health Management, 20*(5), 337-339. Retrieved November, 2017, from http://online.liebertpub.com/doi/pdf/10.1089/pop.2016.0130

[34] The Pioneer Accountable Care Organization (ACO) Model was designed for health care organizations and providers that were already experienced in coordinating care for patients across care settings. It allowed these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program. And it was designed to work in coordination with private payers by aligning provider incentives, which improved quality and health outcomes for patients across the ACO, and achieved cost savings for Medicare, employers and patients. https://innovation.cms.gov/initiatives/Pioneer-aco-model/

[35] Bresnik, J. (2015, May). Poor Care Coordination Raises Chronic Disease Costs by $4500. *Health IT Analytics*. Retrieved December, 2017, from https://healthitanalytics.com/news/poor-care-coordination-raises-chronic-disease-costs-by-4500

The Massachusetts Center for Health Information and Analysis (CHIA) describes high-quality care as "safe, effective, efficient, patient-centered, equitable, and timely."[36] NewCo states that it will continue to support patient-centered care models, driven by the primary care physician (PCP), pointing to examples including:

- the Lahey Emergency Department's PCP assignment and scheduling for post-discharge follow-up;
- Mount Auborn Hospital's (MAH) process of scheduling PCP visits within seven to 14 days of discharge;
- Medical home principles embedded in the LCPN primary care practices to improve outcomes and reduce inequities;
- The use by BIDCO providers of member registries of primary care providers and care managers to coordinate care; and
- Lahey and MAH's hospice and home care programs which support the integration of home-based care, senior care, skilled nursing, inpatient rehabilitation, and assisted living with primary care.

NewCo points to the use of PHM tools and software to further support care coordination in its system. Enhanced data management systems will be expanded across the NewCo system to support access to data in real-time and reduce the duplication of services and ensure that patients can address all of their care needs in NewCo's system.[37] NewCo cites effective use of technology employed by NewCo Party Hospitals that will be models for the NewCo system.

- Lahey achieved HealthCare Information and Management Systems Society (HIMSS) stage seven recognition which NewCo asserts demonstrates their efforts to share patient information to improve care delivery, coordination, and outcomes;
- BIDCO and the LCPN, invested in interoperable IT systems that aggregate information from electronic health records to allow for the sharing of information; and
- MAH made an investment in technology to improve system coordination through a multi-year electronic health record conversion.

Measurement

NewCo asserts that data collection, data sharing, and data analytics will be integrated through electronic health records and other information exchanges which tie the data to the new collaborative nature of care delivery and cost containment.[38] NewCo commits to using

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[36] Quality & Patient Safety. (n.d.). Retrieved Oct. & nov., 2017, from http://www.chiamass.gov/quality/

[37] Brown, B. (2013). *Surviving Value-Based Purchasing in Healthcare: Connecting Your Clinical and Financial Data for the Best ROI* (Rep.). Retrieved November, 2017, from Health Catalyst website: http://www.healthcatalyst.com/wp-content/uploads/2013/08/WhitePaper_HFMA.pdf

[38] Brown, B. (n.d.). How Analytics Will Lower Waste and Reduce Costs for the Healthcare Industry. Retrieved November, 2017, from https://www.healthcatalyst.com/healthcare-analytics-reduce-costs

measures including quality, readmissions, mortality rates, patient satisfaction, and cost per episode of care to assess value-based care, relying on the data and metrics published by CHIA and the Health Policy Commission to measure and report on its impact on the system overall.

Clinical and programmatic efforts will be measured to address variances in care that undermine quality of care and health outcomes. Data management systems will support advanced data analytics to evaluate and improve care. Implementation of tracking and reporting tools across the NewCo system will ensure efforts to measure impact of NewCo on the Massachusetts healthcare system are integrated and coordinated. NewCo proposes system wide implementation of measures tracked in the MassHealth ACO Program, as well as existing LCPN metrics, both of which are provided in Attachment 4 and which address social determinants of health, behavioral health access, and utilization.

Community Engagement

Community Engagement for this proposed transaction was based upon the work done in the context of each system's Community Health Needs Assessment (CHNA). The several CHNAs used a quantitative and qualitative methodology in the context of assessing the health needs of the patient population with attention paid to vulnerable populations. NewCo embarked on a targeted engagement strategy that included Community Health Centers (CHCs) and discussions with employers.[39] The Applicant held town halls and other local forums to discuss the transaction with employees at all levels, had discussions with local health departments and local nonprofit representatives which helped define the impact of the proposed transaction, and extended invitations to meetings about the transaction to organizations representing local businesses, first responders, and local elected officials.[40]

Competition

Research has shown that hospital mergers have historically resulted in more consolidated markets with reduced competition and higher prices.[41,42] However, NewCo asserts that this transaction will introduce competition into the healthcare market in a way that will make care more affordable. NewCo believes that this transaction will result in an attractive and high-value option which will compete with the market's largest systems to shift utilization and decrease healthcare expenditures. According to the HPC's initial review of the parties' service areas and

[39] Community Care Alliance (CCA) is a partnership of six community health centers, affiliated with BIDMC, five of which are federally qualified health centers (FQHC) mandated to serve low income and underserved populations.
[40] NewCo provided a list of meeting dates which included participating health systems, member hospital locations where the meetings took place, and the number of community attendees and commits to continue community engagement efforts during the DoN Application process.
[41] Gaynor, M., Mostashari, F., & Ginsburg, P. B. (2017, April). *Making Health Care Markets Work: Competition Policy for Healthcare* (Rep.). Retrieved January, 2018, from https://www.brookings.edu/wp-content/uploads/2017/04/gaynor-et-al-final-report-v11.pdf
[42] Dafny, L. S., & Lee, T. H. (2016, December). Health Care Needs Real Competition. *Harvard Business Review*. Retrieved January, 2018, from https://hbr.org/2016/12/health-care-needs-real-competition

market share, after the transaction NewCo will "have the second largest inpatient, outpatient, and primary care market shares in the Commonwealth.[43,44] (see, HPC charts, below)

Statewide Inpatient Market Share

Commercial inpatient market share for all discharges
2016 CHIA hospital discharge data, all commercial payers

Hospital System/Network	Statewide Share 2016
Partners	27.0%
BIDCO, Lahey, Mt. Auburn combined	**24.7% (14.0% + 8.1% + 2.7%)**
UMass	7.0%
Wellforce	6.2%
Steward	5.9%

Statewide Outpatient Facility Market Share

Commercial outpatient facility visit market share
2014 APCD data for the three largest commercial payers

Hospital System/ Network	Statewide Share (2014)
Partners	26.7%
BIDCO, Lahey, Mt. Auburn combined	**26.0% (13.0% + 10.6% + 2.4%)**
Wellforce	6.7%
Steward	5.6%
UMass	5.4%

[43] Health Policy Commission Board Meeting. (2017, December 12). Retrieved December, 2017, from http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/board-meetings/20171212-commission-document-presentation.pdf

[44] Health Policy Commission Board Meeting. (2018, January 31). Retrieved January, 2018, from https://www.mass.gov/files/documents/2018/01/31/20180131%20-%20Commission%20Document%20-%20Presentation.pdf

Commercial primary care visit market share
2014 APCD data for the three largest commercial payers

Physician Network	Share of Statewide Primary Care Visits
Partners	15.8%
BIDCO, Lahey, MACIPA combined	**14.1% (7.2% + 5.0% + 2.0%)**
Steward	10.7%
Children's	9.8%
Wellforce	9.0%
Atrius	6.8%

Health Policy Commission Board Meeting. (2018, January 31). Retrieved January, 2018, from https://www.mass.gov/files/documents/2018/01/31/20180131%20-%20Commission%20Document%20-%20Presentation.pdf

NewCo states that, "[it] will compete more effectively and bring truly market-based competition for value, thereby accomplishing transformative shifts in care delivery and healthcare expenditures."[45] NewCo argues that it will create an alternative system with the size, geographic distribution and breadth of services to attract consumers from higher-priced systems into its lower-cost network and that in doing so it will achieve savings for consumers and the Commonwealth without compromising quality or access to care. NewCo aims to foster competition in the healthcare market by addressing price and utilization.[46,47]

Price

Reports focusing on the Massachusetts healthcare system indicate that price is the most significant contributor to the growth in healthcare spending.[48,49] NewCo asserts that the proposed transaction will bolster its low-cost position in the market and will support its ability to compete on price, total medical expenses (TME), provider costs and other measures of healthcare spending. CHIA provides two metrics on healthcare sector performance in

[45] NEWCO-17082413-TO DoN Application, at page 6.
[46] *Special Commission on Provider Price Variation Report* (Rep.). (2017, March 15). Retrieved Oct. & nov., 2017, from CHIA website: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/ppv-report-final.pdf
[47] *2016 Health Care Cost and Utilization Report* (Rep.). (2018, January). Retrieved January, 2018, from Health Care Cost Institute website: https://drive.google.com/file/d/1vi3S2pjThLFVwB7OtYwFmOiLVPTFl_wk/view
[48] *Special Commission on Provider Price Variation Report* (Rep.). (2017, March 15). Retrieved Oct. & nov., 2017, from CHIA website: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/ppv-report-final.pdf
[49] *The Evaluation of the 2012 Health Care Cost Containment Law in Massachusetts* (Rep.). (2017, June). Retrieved January, 2018, from Office of the Massachusetts State Auditor website: http://www.mass.gov/auditor/docs/chapter-224/osa-chapter-224-report-june-2017.pdf

Massachusetts, relative price (RP) and TME.[50] NewCo uses these metrics to support its assertion that it has a low-cost position in the market.

Relative Price (RP) is used to compare provider prices within a payer's network and Statewide Relative Price (S-RP) allows for the comparison of provider price across payers within an insurance category.[51] The Center for Health Information and Analysis reporting on community hospitals showed that the lowest commercial S-RPs were at Anna Jaques Hospital (0.76) and BID-Milton (0.76), which is 24% below the statewide average (1.0) across all hospitals.[52] The average S-RPs average for CareGroup (0.92) and Lahey Health (0.92) fell below 1.0 and were 8% below the statewide average when compared to other large health systems. BIDCO, LCPN, and New England Baptist Clinical Integration Organization (NEBCIO), three of the four physician groups associated with NewCo, all have a relative price index below average (1.0).[53]

TME measures healthcare spending by public and private payers.[54] TME is a component of Total Healthcare expenditures (THCE), which measures total state healthcare spending growth.[55] CHIA data on TME shows that "the health status adjusted TME of the constituent physician groups who will become part of NewCo is lower or comparable to the TME of most market competitors, and significantly lower than that of other physician groups for the markets three largest commercial payers, Blue Cross Blue Shield (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health plan."[56] NewCo asserts that it will have lower than average hospital prices.[57,58]

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[50] *Special Commission on Provider Price Variation Report* (Rep.). (2017, March 15). Retrieved Oct. & nov., 2017, from CHIA website: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/ppv-report-final.pdf

[51] *Provider Price Variation in the Massachusetts Commercial Market* (Rep.). (2017, May). Retrieved January, 2017, from CHIA website: http://www.chiamass.gov/assets/docs/r/pubs/17/Relative-Price-Report-2017.pdf

[52] *Id.*

[53] *Id.*

[54] Total Medical Expenses. (n.d.). Retrieved January, 2018, from http://www.chiamass.gov/total-medical-expenses-2/

[55] Health Care Cost Growth Benchmark. (2018). Retrieved January, 2018, from http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/health-care-cost-growth-benchmark.html

[56] NEWCO-17082413-TO DoN Application Exhibits, at page 7

[57] FY 2016 Individual Multi Acute Health System Profiles. (2016). Retrieved Nov. & dec., 2017, from http://www.chiamass.gov/hospital-systems-and-parent-organizations/

[58] NewCo reports that the case-mix adjusted average cost per discharge in all the constituent hospitals for CMI 1, CMI 2, and CMI 3, is lower than the Massachusetts state average ($11,483);that BID–Milton's case mix adjusted cost per discharge ($6,366, CMI Group 2) is the lowest among comparable hospitals including Saint Anne's (Steward, $6,418, CMI Group 2), and North Shore Medical Center (Partners, $11,705, CMI Group 2). CMI is often considered in relation to average costs to adjust for the complexity and acuity of cases at a particular hospital. CMI group 1 reflects hospitals with a high CMI, greater than 1.15. CMI group 2 reflects hospitals with a CMI between 0.90 and 1.15. CMI group 3 reflects hospitals with a low CMI, less than 0.90." NEWCO-17082413-TO DoN Application Exhibits, at page 10

Utilization - Community Hospital Outmigration

NewCo points to data (see chart below) showing that for certain services, a substantial percentage of community-appropriate cases leave the region to high-cost academic medical centers (AMCs) and that the average additional cost of receiving care in a Boston hospital versus locally is estimated at $4,016 for patients in Northeastern Massachusetts.[59,60]

Service	Percent of community-appropriate cases leaving the region for patient residing in Northeastern Massachusetts
Mental Health	80%
Maternity Discharges	75%
Surgical Procedures	60%
Medical Discharges	30%

The Health Policy Commission reported average spending per commercial discharge from a Boston hospital is $981 to $4,775 higher compared to other regions of the state and, estimates cost savings of $43 million for shifting 5% of community appropriate care from teaching hospitals (TH) to community settings.[61,62] The Special Commission on Provider Price Variation states that market power and brand may lead patients to associate brand and higher cost with higher quality and cause them to seek out higher-priced services.[63] NewCo points to out-migration and provider price variation, i.e., price variances which do not reflect differences in case mix, quality or health outcomes as significant and recognized drivers of healthcare costs. Community outmigration poses a challenge to the financial viability of community hospitals and increases the threat of their closure, which could lead patients who would otherwise have sought care at a community hospital to seek higher priced care if the community hospital is no longer available.[64]

NewCo asserts that BIDMC and Lahey's affiliation with and subsequent financial and clinical investments in their community hospitals expanded access to primary and specialty care locally, and reduced outmigration. NewCo asserts that the NewCo Party Hospitals have provided evidence of their capacity to improve the standing of community hospitals, increase access to

[59] County Health Rankings, 2017. (n.d.). Retrieved from http://www.countyhealthrankings.org/

[60] Hayes-Rusnov, S., Gerard, C., & Scarborough Mills, K. (2016, March). *Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System* (Rep.). Retrieved Sept. & oct., 2017, from Health Policy Commission (HPC) website: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf

[61] *Id.*

[62] *Consumer Preferences, Hospital Choices, and Demand-Side Interventions.* (2017, April 10). Retrieved November, 2017, from http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/20170410-hpc-special-event-hpc-presentation.pdf

[63] *Special Commission on Provider Price Variation Report* (Rep.). (2017, March 15). Retrieved Oct. & nov., 2017, from CHIA website: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/ppv-report-final.pdf

[64] *Id*

care locally, and shift consumer preference for care locally. As examples, NewCo points to the following:

- In 2014, after Winchester Hospital became a fully integrated community-based member of Lahey, outmigration from Winchester hospital and community appropriate discharges at LHMC decreased. This increased LHMC's capacity to treat higher acuity patients.
- Lahey provided infectious disease back-up coverage at Winchester hospital and recruited thoracic surgeons to allow for this care to be made accessible locally. The Applicant reports that heart failure metrics at Winchester hospital improved from 92% to 100% over a 2-year period following affiliation.
- A 2012 merger between Lahey Clinic and Northeast Hospital Corp. created Lahey Health System.
    - Lahey invested $8 million in Addison Gilbert Hospital, and committed to enhancing access to care locally.
    - Hospitalists and critical care physicians from LHMC provide services at Northeast and Winchester hospitals enhancing care for local residents.
    - Lahey assisted in the recruitment of a pulmonologist and addition of a neurosurgeon at Beverly hospital enhancing physician coverage that served to elevate critical care capabilities and reduce outmigration.
- Lahey implemented policies that allowed ICU patients to be transferred from Peabody to Beverly and LHMC to Winchester to allow patients to receive care closer to home.
- NewCo asserts that the inclusion of percutaneous coronary intervention (PCI) services at Beverly Hospital, thoracic services at Beverly and Winchester Hospitals, and a breast program at Danvers, and the addition of an outpatient facility at Beverly are evidence of Lahey's investment in community hospitals which will provide care locally and retain care in the system.
- Lahey's hospital transfer policy of delivering lower acuity care in the community setting and higher acuity care at the teaching hospital resulted in 1,000 transfers from LHMC (Burlington and Peabody locations) to Beverly Hospital, Addision Gilbert Hospital, and Winchester Hospital, since Lahey's creation in 2012.
- Volume and Case-mix index (CMI) have increased at Lahey's community hospitals since their affiliations with the Lahey Health system.
- The affiliations creating BID-Milton in 2005, and BID-Plymouth in 2011 provided the financial stability and clinical service advancement to improve access to primary and specialty care locally.
    - BIDMC helped to establish robotic surgery at BID-Milton following affiliation. The BID-Milton hospital reports the measurable benefits of the use of the technique including reduced patient hospital stay, less pain, and quicker return to normal functioning.[65]

[65] Robot-Assisted Surgery. (2014). Retrieved January, 2018, from https://www.miltonhospital.org/services/surgical-services/robot-assisted-surgery/

  - Enhancements to care at BID-Milton include the addition of a Hospitalist program and bariatrics which is part of the Beth Israel Deaconess Bariatric Network, co-location of BIDMC spine center, a new perioperative suite and a comprehensive cancer center.
  - Collaboration between BIDMC and BID-Plymouth on the development of a comprehensive cardiac interventional program allows complex cases to be cared for locally.
- Investments at BID-Needham, include a new Emergency Department and inpatient unit, new perioperative suite and comprehensive cancer center.
- Total hospitalizations at the affiliate community hospitals increased following affiliation with BIDMC and enhanced clinical capacility and improved care delivery led to increases in Case Mix Index (CMI) at all facilities:
  - Total hospitalizations increased at BID-Plymouth by 9%, at BID-Milton by 18%, and at BID-Needham by 26% between 2014 and 2016.
- BIDMC expansion in clinical services and investments its community hospitals contributed to improvements in surgical care scores at BID-Needham from 97.4% to 100% in a three-year period, and patient reports of high satisfaction increased from 61% in 2012 to 69% over a four-year period at BID-Plymouth.

NewCo asserts the proposed transaction will improve care delivery in the most clinically-appropriate and cost-effective settings and will, at the same time, relieve the steadily increasing and high occupancy rates experienced by NewCo party tertiary and quaternary facilities through shifting appropriate care to community hospitals, where NewCo asserts, they operate at below 85%.[66]

NewCo asserts that reducing outmigration from community hospitals will improve their sustainability and enhance the economic vitality of the communities they serve. The Health Policy Commission reports that low (less than 1%) or negative operating margins impact the decision-making at community hospitals and limits their ability to invest in infrastructure.[67,68,69] NewCo asserts that through this transaction, shifting care will benefit NewCo community hospitals and their communities. The Applicant states that Anna Jacques in particular, will be

[66] BIDMC's inpatient occupancy increased 7% (85% to 92%) from 2014 to 2017 and LHMC's inpatient occupancy increased 7% (82%to 89%) from 2014 to 2017.

[67] Hayes-Rusnov, S., Gerard, C., & Scarborough Mills, K. (2016, March). *Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System* (Rep.). Retrieved Sept. & oct., 2017, from Health Policy Commission (HPC) website: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf

[68] Individual Hospital Financial Trend Analysis. (n.d.). Retrieved January, 2018, from http://www.chiamass.gov/hospital-financial-trend-analysis/

[69] NewCo asserts that declining margins at Anna Jaques pose a challenge its ability to make strategic capital and operating investments that would allow it to improve care delivery that better meets the needs of the community.

able to improve care options for the community and make capital and operating investments through the shifts in care proposed by the Applicant.

Utilization - Attracting More Consumers

NewCo aims to increase utilization of its lower priced network to achieve cost savings for the consumer and the Commonwealth. NewCo states that as it becomes more efficient and competitive, its enhanced market position will allow it to work with payers to establish new tiered network commercial insurance products to match employer needs and provide lower cost sharing for consumers. NewCo contemplates participating in an insurance product which offers a geographically broad provider network, with extensive service offerings which will, NewCo claims, serve employer needs, bolster its attractiveness to payers and employers, and incentivize patients to make choices based on value. NewCo says that this will, in turn, increase utilization of the NewCo system and, by providing competition to high-priced providers, reduce overall healthcare costs.[70] In this way, NewCo asserts, its presence in the market will reduce disparities in spending and resource allocation between low-income and high-income communities and, in the long run, that by maintaining its status as a high-value provider, NewCo will offer real competition in the healthcare market.

NewCo plans to use these consumer-driven insurance products as demand-side incentives to encourage the use of more cost-effective settings.[71,72] NewCo maintains that its Plan design will include measurable benefits for the consumer in the form of cost sharing differentials. NewCo will reduce cost sharing by keeping prices low and passing on savings to consumers which, NewCo asserts, will also redirect consumer choice, and introduce price competition into the marketplace to incentivize utilization of NewCo's high-value care.

NewCo states that as a function of the fully integrated healthcare system structure, there will be provider incentives in which the affiliated organizations operate with a shared bottom line, accountability for quality outcomes and cost containment in value-based contracts, and an

[70] The Special Commission on Price Variation presents research showing some 'change in patient preferences' because of TNPs with the effect of reducing prices. That effect is limited once the consumer has reached their deductible and cost-sharing becomes less important and in emergent situations when patients are forced make healthcare choices during stressful situations. *Special Commission on Provider Price Variation Report* (Rep.). (2017, March 15). Retrieved Oct. & nov., 2017, from CHIA website: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/ppv-report-final.pdf

[71] Demand-side incentives, are "strategies or mechanisms to encourage consumers, employers, and employees to make high-value choices," and encourage individuals and employers to make high-value choices. In order to be effective, these strategies should reduce out-of-pocket costs and lower premiums for consumers. See, Demand-side incentives to address provider price variation. (2016, December 13). Retrieved January, 2018, from file:///C:/Users/LClarke/Downloads/Meeting%205%20-%20David%20Auerbach%20-%20Demand-Side%20Incentives.pdf

[72] *Id.*

underlying philosophy that it is in the best interests of patients and communities to "keep care local".[73]

Cost Savings
NewCo asserts that efficiencies and consolidation of administrative functions, such as supply chain and IT, will also generate cost savings and reduce the duplication of services that contribute to wasteful spending. The larger NewCo system will be able to secure lower interest rates, refinance existing investments, and pursue attractive future investments, and the additional funds will allow for increased investment in IT software and system enhancements that will share patient information across platforms and track transitions in care with the goal of streamlining the process to enhance the patient experience. Shared decision-making around capital expenditures and resources will result in system-wide priorities for spending and joint initiatives that will improve the standing of all NewCo hospitals. NewCo asserts that the reduction in unnecessary utilization of services will improve the quality of care and lower TME.

Finding - Factor 1

Analysis of the proposed project reflects a transaction that is likely to improve health outcomes and quality of life for the NewCo patient panel through increased access to high-value healthcare and decreased consumer cost-sharing. NewCo's description of the health concerns of the patient panel and the service area demonstrates sufficient need for the proposed transaction and supports the potential for addressing these concerns through an integrated system. The proposed transaction can be found to have a focus on health equity through bringing together the necessary components to address the healthcare needs of a broad, diverse and growing patient panel within one system. On approval, the transaction has the potential to transform care delivery through improving access to and coordination of primary and specialty care, in multiple settings.

NewCo describes the current healthcare market and unsustainable rising costs that will worsen without the transaction. In this context, staff looked at NewCo's ability to serve as an alternative health care delivery system that will challenge the current functioning of the healthcare market against NewCo's size and the potential risk that its size and market power might allow it to leverage higher rates for the system. NewCo has not identified rate increases as a necessary component of the transaction, and argues that maintaining its competitive position in the marketplace requires retaining its status as a high-value provider compared to system alternatives. Moreover, NewCo asserts that it will face competition from larger systems, and NewCo will need to differentiate itself by providing value within a broad and complementary system.

Staff concludes that this Application meets the requirements in Factor 1, but with conditions which are attached to this report. These conditions include measureable benchmarks to track

[73] NEWCO-17082413-TO DoN Application, at page 19

the impact of care coordination on patient outcomes and quality of life, payer mix, and NewCo's position as a high-value provider.

Factor 3

Factor 3 requires compliance with relevant licensure, certification, or other regulatory oversight for which Applicant provided sufficient information to determine compliance.

Factor 4

The DoN regulation at 105 CMR 100.210(A) (4) requires that an Applicant for a DoN provide "sufficient documentation of the availability of sufficient funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant's existing Patient Panel and that the Proposed Project is financially feasible and within the financial capability of the Applicant." Factor 4 requires that the documentation provided in support of the Department's finding shall include an analysis of the Applicant's finances, completed by an independent Certified Public Accountant (CPA Report).

The CPA review included an analysis of five-year financial projections for the individual Systems (CareGroup, Inc., LHS, and SRHS) and for NewCo for the years-ending September 30, 2018 through 2022. The report is based on historical and prospective financial information including NewCo Pro Forma Projections, NewCo financial orientation presentations, and financial statements for the individual Systems. Industry reports and hospital websites were included in the review process.

NewCo provided projections with four potential scenarios (baseline, low, medium, and high) to estimate the impact of the combination of the systems into NewCo. Financial ratios for profitability, liquidity and solvency for NewCo were calculated at baseline, low, medium, and high projections over a five-year time frame (for fiscal years 2017 through 2022). Projected revenues were estimated based on anticipated changes to commercial and governmental reimbursement rates, patient volume and facilities, and payer mix.

The CPA Report assumes a shift in payer mix from commercial to government reimbursement rates based on historical trends showing an aging of the population. Trends in patient volume show an increase in outpatient services, "in excess of what the system has recently experienced" and a more modest growth in inpatient services. The CPA Report examines capital expenditures and future cash flows of the system to determine whether sufficient funds would be reinvested to sustain operations of NewCo and whether the cash flow would be able to support reinvestment.

The CPA report found that the operating expenses, projected capital expenditures and cash flows were reasonable in nature and feasible. Value drivers and synergies would result in increased volume and decreased expenses for NewCo. Low revenue projections were 1.1 %

higher than the cumulative revenue in the baseline projections. An earnings before interest depreciation and amortization (EBIDA) of 6.1% was estimated which is 9.13% higher than baseline projections. A detailed analysis was not determined for medium and high projections.

CPA analysis concluded that the projections are reasonable, meaning supportable and proper, given the underlying information and feasible, meaning based on the assumptions used, the plan is not likely to result in a liquidation of the underlying assets or the need for reorganization. The projections are not likely to have a negative impact on the patient panel.

Finding - Factor 4

With these findings there is sufficient evidence that the project is within the financial capabilities of the Applicant and in that context, will not have a negative impact on the patient panel.

Factor 5 –does not apply

Factor 6 –does not apply

Public Hearing

The Department held public hearings on December 5th and 6th, 2017 and on January 3rd, 2018. The names of those testifying at the hearing or submitting written comments are listed in Attachment 2 and a summary of comments on Attachment 3.

Written Comment
The Department received written comments related to the project.

Ten Taxpayer Groups (TTGs)
Four ten taxpayer groups registered in connection with this project.

1. TTG registered on August 28, 2017
2. TTG registered on September 18, 2017.
3. TTG registered on October 2, 2017
4. TTG GOTEACH registered on October 12, 2017

Findings and Recommendation

Pursuant to 105 CMR 100.735, the staff recommends approval of the proposed project. Any approval is subject to 105 CMR 100.735(D)(1)(a) which provides that any DoN shall not go into effect until 30 days following HPC's completed Cost and Market Impact Review and to 105 CMR 100.735(D)(3) relative to noncompliance.

Approval shall be subject to the Standard Conditions relevant to Transfers of Ownership (see Attachment 1) and the following additional requirements which shall become conditions of the DoN:

Other Conditions

1. In its first report mandated by 105 CMR 100.310(L), the Holder will provide the following:
   a. A report that details, for each measure set out in the Assessment Tool (Attachment 4)
      i. the baseline measures
      ii. expected benchmarks;
      iii. measure specifications; and
      iv. the anticipated time to meet benchmark.
   b. A description of the current payer mix of NewCo, reported by each of the health insurance coverage categories reported on by CHIA.[74]
      i. Private Commercial – Overall
      ii. Private Commercial – MA Health Connector QHPs (Subsidized and Unsubsudized)
      iii. MassHealth – Overall
      iv. MassHealth – Temporary
      v. MassHealth – Managed Care Organizations (MCO)
      vi. Senior Care Options, One Care, PACE
      vii. Medicare Fee-for-Service (Parts A and B)
      viii. Medicare Advantage
   c. A description of the then-current Network Participation of NewCo, including but not limited to the number of:
      i. Limited network products;
      ii. Tiered products, including NewCo's tier level for each of these products;
      iii. Other commercial products;
      iv. MassHealth Fee for Service;
      v. MassHealth Managed Care Organizations
      vi. Medicare Fee for Service; and
      vii. Medicare Managed Care Organizations
   d. A description of the measures by which the Holder will define itself as a high-value network.

[74] *Enrollment Trends Technical Appendix* (Rep.). (2018, February). Retrieved February, 2018, from CHIA website: http://www.chiamass.gov/assets/Uploads/enrollment/2018-feb/Enrollment-Trends-Technical-Appendix-.pdf

2. For the duration of the reporting period mandated by 105 CMR 100.310 (L), the Holder will provide the following:
   a. A report on the measurable achievement toward the measures sets out in Attachment 4.
   b. Updates on the payer mix of NewCo as outlined in 1.b.
   c. Updates on Network Participation as outlined in 1.c.
   d. Updated information on the measures provided in 1.d.
   e. Updates on the integration of data management systems to support access to patient records and data across the NewCo system.
   f. A description of the operating efficiencies and savings associated with those operational efficiencies achieved in the past year and cumulatively.

3. For the duration of the reporting period, the Holder will engage in reasonable efforts to inform the public and relevant stakeholders on the status of the affiliation including any service or other changes with likely impact on the patient panel or local communities.

4. The Holder will ensure that the health status adjusted total medical expense of the NewCo system does not exceed in any calendar year the health care cost growth benchmark established under M.G.L. c. 6D, §9 for such year. The parties shall annually certify compliance with this section to the Department and provide any requested documentation necessary to assess compliance.

5. Other requirements in terms of the form, frequency and content of the reporting may be set out as contemplated in 105 CMR 100.310(L) and this information shall be updated annually in accordance with the Regulation. Pursuant to 100.310(Q), All Standard and Other Conditions attached to the Notice of Determination of Need shall remain in effect for a period of five years following completion of the project for which the Notice of Determination of Need was issued, unless otherwise expressly specified within one or more Condition. The Department reserves the right, based upon its reasonable discretion, to extend the reporting period for up to an additional five years provided notice thereof is provided to the Holder one year prior to the end of the first five year period.

Attachment 1

LIST OF FACTORS and STANDARD CONDITIONS RELEVANT TO TRANSFERS OF OWNERSHIP

Only Factors 1, 3, and 4 apply to transfers of ownership.

105 CMR 100.210(A) The Department shall determine that need exists for a Proposed Project, on the basis of material in the record, where the Applicant makes a clear and convincing demonstration that the Proposed Project meets each Determination of Need Factor set forth within 105 CMR 100.210, unless otherwise expressly specified within 105 CMR 100.000.

[Factor] 1 Applicant Patient Panel Need, Public Health Value, and Operational Objectives.

a. The Applicant has demonstrated sufficient need for the Proposed Project by the Applicant's existing Patient Panel;
b. The Applicant has demonstrated that the Proposed Project will add measurable public health value in terms of improved health outcomes and quality of life of the Applicant's existing Patient Panel, while providing reasonable assurances of health equity;
c. The Department has determined that the Applicant has provided sufficient evidence that the Proposed Project will operate efficiently and effectively by furthering and improving continuity and coordination of care for the Applicant's Patient Panel, including, sufficient evidence that the Proposed Project will create or ensure appropriate linkages to patients' primary care services;
d. The Applicant has provided evidence of consultation, both prior to and after the Filing Date, with all Government Agencies with relevant licensure, certification, or other regulatory oversight of the Applicant or the Proposed Project;
e. The Applicant has provided evidence of sound community engagement and consultation throughout the development of the Proposed Project, including documentation of the Applicant's efforts to ensure engagement of community coalitions statistically representative of the Applicant's existing Patient Panel. Representation should consider age, gender and sexual identity, race, ethnicity, disability status, as well as socioeconomic and health status; and
f. The Applicant has demonstrated that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending.

[Factor] 2 Intentionally Omitted

[Factor] 3 Compliance.

The Department has determined, in consultation with all Government Agencies with relevant licensure, certification, or other regulatory oversight of the Applicant or the Proposed Project, that the Applicant has provided sufficient evidence of compliance and good standing with federal, state, and local laws and regulations, including, but not limited to compliance with all previously issued Notices of Determination of Need and the terms and Conditions attached therein.

[Factor]4 Financial Feasibility and Reasonableness of Expenditures and Costs.

The Department, in consultation with CHIA, has determined that the Applicant has provided sufficient documentation of the availability of sufficient funds for capital and

ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant's existing Patient Panel. Said documentation shall be completed and certified under the pains and penalties of perjury by an independent certified public accountant (CPA). Said independent CPA's analysis shall include, but not be limited to: a review of the Applicant's past and present operating and capital budgets; balance sheets; projected cash flow statements; proposed levels of financing for the Proposed Project, including a five-year financial sustainability analysis; and any other relevant information required for the independent CPA to provide reasonable assurances to the Department that the Proposed Project is financially feasible and within the financial capability of the Applicant, and where appropriate, as a matter of standard accounting practice, its Affiliates; and

If the Department has determined that an independent cost-analysis is required pursuant to M.G.L. c. 111, § 25C(h), the analysis has demonstrated that the Proposed Project is consistent with the Commonwealth's efforts to meet the health care cost-containment goals.

[Factor 5 and 6] Intentionally Omitted

Standard Conditions that Apply to Transfers of Ownership

Only a subset of all the standard conditions set out in 105CME 100.310 apply to transfers of ownership.

105 CMR 100.310: Standard Conditions

Unless otherwise expressly specified within 105 CMR 100.000, each Notice of Determination of Need issued by the Department shall be subject to the following Conditions. The Commissioner may specify additional Standard Conditions within Guideline which shall be attached to all Notices of Determination of Need, unless otherwise specified, and which shall be determined by the Commissioner as advancing the objectives of 105 CMR 100.000. Prior to issuance, such Guideline shall be developed through a public process consistent with 105 CMR 100.440 and in consultation with applicable Government Agencies, community-based organizations, relevant stakeholders, and the Public Health Council.

(A) The Notice of Determination of Need shall be subject to administrative review by the Health Facilities Appeals Board and may be stayed by the Health Facilities Appeals Board. If the Health Facilities Appeals Board is not constituted on the date of issuance of the Notice of Determination of Need, the Notice shall be considered a Final Action subject to review under M.G.L. c. 30A.

(B) Intentionally Omitted

(C) Unless extended for Good Cause Related to Project Implementation, or as a result of an approved amendment to a previously issued Notice of Determination of Need, the Notice of Determination of Need shall constitute a valid authorization only for the Proposed Project for which the Notice of Determination of Need is made, and for only the total Capital Expenditure approved.

(D) The Notice of Determination of Need shall constitute a valid authorization only for the Person to whom it is issued and may be transferred only upon the expressed written permission of the Department pursuant to 105 CMR 100.635(A)(3), except that a Notice of Determination of Need issued for an Original License pursuant to 105 CMR 100.730 and a Notice of Determination of Need for a Transfer of Ownership pursuant to 105 CMR 100.735 shall not be transferable.

(E)-(G) Intentionally Omitted

(H) The Government Agency license of the Health Care Facility or Health Care Facilities for which, and on behalf of, the Holder possesses a valid Notice of Determination of Need, shall be conditioned with all Standard and Other Conditions attached to the Notice of Determination of Need.
(I)-(J) Intentionally Omitted
(K) If the Health Care Facility or Heath Care Facilities for which the Notice of Determination of Need has been issued is eligible, the Holder shall provide written attestation on behalf of the Health Care Facility or Heath Care Facilities, under the pains and penalties of perjury, of participation, or their intent to participate, in MassHealth pursuant to 130 CMR 400.000 through 499.000.
(L) The Holder shall report to the Department, at a minimum on an annual basis, and in a form, manner, and frequency as specified by the Commissioner. At a minimum, said reporting shall include, but not be limited to, the reporting of measures related to the project's achievement of the Determination of Need Factors, as directed by the Department pursuant to105 CMR 100.210.
(M) Intentionally Omitted
(N) The Holder shall provide to Department Staff a plan for approval by the Office of Health Equity for the development and improvement of language access and assistive services provided to individuals with disabilities, non-English speaking, Limited English Proficiency (LEP), and American Sign Language (ASL) patients.
(O) The Holder shall provide for interpreter services to the Holder's Patient Panel. The Holder shall ensure that all medical and non-medical interpreters, inclusive of staff, contractors, and volunteers providing interpreter services to the Holder's Patient Panel maintain current multilingual proficiency and have sufficient relevant training. Training for non-medical interpreters should include, at a minimum:

(1) the skills and ethics of interpretation; and
(2) cultural health beliefs systems and concepts relevant to non-clinical encounters.
(3) Training for medical interpreters should include, at a minimum:
(a) the skills and ethics of interpretation; and
(b) multilingual knowledge of specialized terms, including medical terminology, competency in specialized settings, continuing education, and concepts relevant to clinical and non-clinical encounters.

(P) The Holder shall require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically appropriate services (CLAS), including, but not limited to, patient cultural and health belief systems and effective utilization of available interpreter services.
(Q) All Standard and Other Conditions attached to the Notice of Determination of Need shall remain in effect for a period of five years following completion of the project for which the Notice of Determination of Need was issued, unless otherwise expressly specified within one or more Condition.

105 CMR 100.735(D) Other Conditions. A Notice of Determination of Need issued to a Holder resulting from an Application required pursuant to 105 CMR 100.735(A) shall include the following Other Condition(s):
(1) (a) Unless rescinded pursuant to 105 CMR 100.735(D)(1)(c), any Notice of Determination of Need issued to a Holder that is subject to a Cost and Market Impact Review pursuant to M.G.L. c. 6D § 13 and 958 CMR 7.00 shall not go into effect until: 30 days following HPC's completed Cost and Market Impact Review. Unless extended for Good Cause Related to Project Implementation, or as a result of an approved amendment to a previously issued Notice of Determination of Need, the Notice of Determination of Need shall constitute a valid authorization for a period of not more than three years following the approval of the Department, unless otherwise expressly noted as an Other Condition, and shall only be for the purposes of the approved project. No Notice of Determination of Need shall remain

in authorization unless the Holder complies with all prescribed terms and Conditions as set forth by the Department.
(b) The Department shall receive within 30 days of issuance of the written notification made pursuant to 105 CMR 100.625(A) a written acknowledgement of receipt of such written notification by the Holder, documented in the form of an attestation, signed by the Holder's chief executive officer and board chair, and returned to the Department and all Parties of Record.
(c) Notwithstanding 105 CMR 100.735(D)(1)(a), as part of a completed Cost and Market Impact Review, the HPC may provide a written recommendation to the Commissioner that the Notice of Determination of Need should not go into effect on the basis of findings contained within the completed and publicly released Cost and Market Impact Review. Upon receipt, the Commissioner shall determine if the Cost and Market Impact Review contains information sufficient for the Commissioner to conclude that the Holder would fail to meet one or more of the specified Factors. Should the Commissioner determine that the Holder would fail to meet one or more of the specified Factors, the Department may rescind or amend an approved Notice of Determination of Need. The Department shall consider the HPC's written recommendation pursuant to the Commissioner's determination prior to the Notice of Determination of Need going into effect, and within the context of all specified Determination of Need Factors. If a Notice of Determination of Need is rescinded by the Department, the Person for which the rescinded Notice of Determination of Need was issued must file a new Application for Determination of Need, if so desired. Such Application must satisfy 105 CMR 100.210 and shall account for the concerns expressed by the Department within their findings.
(2) Intentionally omitted
(3) If it is determined by the Department that the Holder has failed to sufficiently demonstrate compliance with the terms and Conditions of the issued Notice of Determination of Need, the Holder shall fund projects which address one or more of the Health Priorities set out in Department Guideline, as approved by the Department, which in total, shall equal up to 5% of the Total Value of the approved project. In making such determination, the Department shall provide written notification to the Holder at least 30 days prior to requiring such funding, and shall provide the Holder the opportunity to appear before the Department. The Department shall consider factors external to the Holder that may impact the Holder's ability to demonstrate compliance.
(4) Upon Notice of Determination of Need issued pursuant to 105 CMR 100.735(A), where the acquired Health Care Facility is a Holder of an approved, but not yet implemented Notice of Determination of Need, the acquired Health Care Facility's unimplemented Notice of Determination of Need shall be rendered null and void, unless the acquiring Holder receives the express written approval from the Department, pursuant to a Significant Change amendment, see 105 CMR 100.635(A)(3).

Attachment 2
Speakers at the Public Hearing

Hearing 1, Roxbury, MA, December 5, 2017

Kevin Tabb
Ann-Ellen Hornidge
Jeannette Clough
Trish Hannon
Bonny Gilbert
Peter Smialek
Guadaloupe Mota
David Welch
Linda Percy
Brian Miller
Deborah Felton
Myechia Minter-Jordan
Stephen Boswell
Rich Fernandez
Karen Peterson
Josh Zakim
Eva Millona
Catherine D'Amato
Carl Sciortino
Phillomin Laptiste
Swannie Jett
Rachel Rodrigues
Kira Khazatsky
Bill Henning
Kenneth Tangvik
Amy Schectman
Lisa Lachance
William Boyd
Richard Weiner
Patricia Fitzgerald
Sarika Aggarwal
Kathleen Diamond
Michael Cruza
Donna Doherty
Kevin Coughlin
Stephanie Jones
April Lamoureux
Shari Gold-Gomez
Laura Adams
Richard Rouse
Joseph Li
Ken Farbstein
Marie Sanchez
Michel Soltani
Nelson Lui
Bruce Keary
Mary Ann Nelson
Hanoi Reyes
Santa Rosado
Luz Corporan
Patricia Flaherty
Joanne Pokaski
Carmen Pola
Karen Gately
Chhorvi Voinn Sumsethi

Hearing 2, Gloucester, MA December 6, 2017

Theodore Speliotis
Sefatia Romeo Theken
James O'Hara
Tim Flaherty
Ann Margaret Ferrante
Howard Grant
Mark Goldstein
Cynthia Cafasso-Donaldson
Bruce Tarr
Ken Riehl
Julie LaFontaine
Richard Nesto
Joe Palizio
Shirley Conway
Scott Trenti
Leanora Swekla
June Boulter
Nancy Palmer
Ray Cryan
Margaret O'Malley
Barbara Collins
Peggy Hegarty-Steck
Jennifer Holmgren
Mary Crockett
Mary Aloisio
Grace Numerosi

Patti Page
Eileen Matz
John Maney
Linda Gipstein
Gin Wallace
Hilary Jacobs
Karen Pischke
Zina Zappala
Ann Rhinelander
Janine Burns
Sylvia Quesada
John Doverman
Al Johnson
Sue Gabriel
Ross Burton
Sandi Akers
Adrienne Naves
Frederick Tarr
Howard Maki
Austin O'Keeffe
Joseph Muzio
Steve Dexter
Val Gilman
Hanoi Reyes
Altagracia Mae
Bonnie Kaplan
Sue Hall

Hearing 3, Newburyport, MA January 3, 2018

Mark Goldstein
Stan Lewis
Donna Holaday
Kathleen O'Connor Ives
James Kelcourse
Rick Marggraf
Charles Tontar
David LaFlamme
Charlie Cullen
Ann Lagasse
George Ellison
Mary Ann Abbott
Donna Sylvester
Mary Ann Clancy
Chris Johnston
Grace Connelly
Alison Sekelsky
Frank G. Cousins Jr.
Ginny Eramo
Dixie Patterson
Saira Nasser-Ghiasuddin
Jeanette Isabella

Attachment 3

Hearing 1, Roxbury, MA, December 5, 2017

Representatives from NewCo Party hospitals spoke in support of the transaction. The Applicant stated that NewCo will be a single, integrated network that will provide high-quality affordable care closer to home. The Applicant asserted that NewCo will drive change in the healthcare system and will pursue new opportunities to improve care for patients and populations. Representatives from the various hospitals reported that NewCo will work with community organizations to address the needs of vulnerable populations, reduce disparities and address public health issues.

Current and former employees of NewCo Party Hospitals, members of the Patient Family Advisory Council (PFAC) of NewCo Party Hospitals, community organizations, patients, and concerned citizens spoke in support of the transaction, stating that:

- the transaction will create a sustainable, high-value healthcare network that is consistent with the Commonwealth's goals of improving health status and quality of life;
- NewCo will 'leverage' the shared values and successes of NewCo Party Hospitals and offered examples of Party Hospitals' impact.
- they appreciated the high quality of care they received at NewCo Party Hospitals and the ability to access emergency services and specialized care 'without delay';
- NewCo Party Hospitals provide culturally sensitive care, improve access through medical interpreters, and invest in community hospitals by equipping them with the ability to provide high quality care locally;
- NewCo Party Hospitals made improvements in their community facilities including supporting career advancement of employees, onsite internships, and working with community partners to identify job candidates;
- NewCo will continue to support linkages with community partners and integrated care at community health centers;
- additional benefits include more innovative ways to partner with communities, enhanced response to healthcare challenges like the opioid epidemic, and improvements in the system through technology and infrastructure upgrades.

Organizations and individuals expressing criticism of the transaction:

- cited a lack of information and reporting by the Applicant on the cost implications of the transaction, particularly the potential for increases in costs, and asserted that the transaction will reduce competition in the healthcare market;
- advocated for reasonably priced treatments and discussed the challenges consumers faced managing rising healthcare costs;
- expressed concern for the impact on minority and immigrant communities and asked that the Applicant focus on the social determinants of health as a way of improving health outcomes and reducing healthcare costs; and
- espressed concern that the expanded presence of NewCo will attract patients from outside of Massachusetts and decrease access for local residents.

Hearing 2, Gloucester, MA December 6, 2017

The Applicant, speaking in support of the transaction, stated that NewCo will add value to the healthcare system. The Applicant asserted that NewCo will contain the necessary elements in one network to care for its patients and NewCo's low-cost position in the market will make it an attractive alternative for consumers seeking high-quality care, in lower-cost settings, closer to home.

Elected officials, current and previous employees of Addison Gilbert Hospital (AGH), community organizations, business owners, and residents of Gloucester/Cape Ann, spoke in favor of the proposed transaction. Proponents of the merger:

- stated that Lahey's merger with Northeast Hospital corp. strengthened AGH and Beverly hospital;
- reported improvement in the quality and range of services provided at AGH and Beverly Hospital following affiliation;
- discussed the role NewCo Party Hospitals play in their communities including partnering with local organizations to support services that community members rely on and coordinating with community initiatives to better serve the needs of their patients;
- spoke to the important role the hospital plays in identifying and addressing individual and community concerns, particularly for vulnerable populations; and
- discussed NewCo's investment in community hospitals as indication of the potential to improve NewCo facilities and the communities they serve through the transaction.

Role of Addison Gilbert Hospital (AGH) Proponents spoke about the significant role of Addison Gilbert Hospital (AGH) to the community and the importance of the transaction to its viability and longevity, particularly for seniors, who experience challenges accessing care. Speakers stated that NewCo will improve health outcomes, reduce disparities, and allow Party hospitals to pursue innovations in care delivery.

Speakers in support of the transaction discussed the improvements that will result from the merger including:

- allowing community hospitals to increase access to providers and services of AMCs and THs to their local communities;
- helping to sustain current efforts to improve care and services for patients of AG and Beverly hospitals.

Speakers expressed concern about potential negative effects of the transaction on AGH addressing:

- what they considered an 'erosion' of services at AGH and the potential for a similar outcome with the NewCo transaction;
- a decrease in services and employment at AGH and called for the restoration of services, staff, and equipment upgrades at AGH to strengthen the hospital;
- the importance of receiving emergency services locally;
- lack of access to transportation for some residents and lack of social supports for seniors;
- the lack of information about the impact on the healthcare costs, the viability of all NewCo Party Hospitals, their staff and services, and the Applicant's plan for continued commitment to the community.

Speakers asked for more information about how input will be incorporated in decision-making and called on the Applicant to protect the needs and interests of low-income residents and small business.

Hearing 3, Newburyport, MA January 3, 2018

The Applicant spoke in support of the transaction and stated that the new high-quality, low-cost system will provide security to Anna Jaques Hospita (AJH) and foster change in the healthcare system. The applicant gave a brief history and overview of AJH and noted that AJH is the smallest independent community hospital in Massachusetts, and the largest employer in Newburyport. The Applicant asserted that the affiliation between BIDMC and AJH resulted in an expansion of primary care offices and specialized services and the new system will build upon these types of affiliations.

Current and former elected official, AJH employees, local organizations, former patients, and residents, spoke in favor of the transaction pointing out that:

- AJH has served as a source of high quality care for generations of Newburyport residents;
- the transaction was 'important and necessary' for Anna Jaques to survive and will strengthen AJH and provide the support necessary to continue investments in infrastructure and care delivery that have improved care and the patient experience;
- BIDMC has "played an integral role in strengthening and sustaining Anna Jaques," and the merger will provide better access to primary and specialty care close to home and bring about new partnerships that will improve the level of care at AJH. It was stated that the transaction will, "ensure that this community continues to receive the benefits of high-quality, affordable care."

It was noted that the older population relies on AJH for their care and concern was expressed that NewCo's size will result in residents traveling longer distances to receive care.

Attachment 4

Measurements Proposed by the Applicant (From the DoN Application Responses)

MassHealth ACO Metrics
Reduce Total Expenditures and Cost: 1. Establishment of at least one tiered, high-value network insurance product with a commercial payer 2. Increased utilization of community hospitals (instead of academic and teaching facilities) for community-appropriate care
Access to High-Value Care: 1. Number of active value-based payment contracts 2. Percentage of primary care patients who had at least one well-care visit during the past calendar year
Access to Behavioral Health Services: 1. Percentage of primary care patients screened for clinical depression 2. Number of primary care practices integrated with behavioral health resources
Chronic Disease Management and Prevention: 1. Control of high blood pressure: Percentage of adults who had a diagnosis of hypertension and whose blood pressure was adequately controlled based on age/condition-specific criteria 2. The rate of COPD or adult asthma admissions 3. The percentage of patients with diabetes whose HbA1c level is under control 4. The rate of admission with diabetes with short-term complications as the principal diagnosis, excluding obstetric admissions and transfers
Coordination of Care: 1. Percentage of primary care patients identified for care management/care coordination with documentation of a care plan 2. All cause, all payer readmission rates at each hospital location

LCPN Metrics
1. Network adequacy for all Members, including those with special healthcare needs, in Lahey communities 2. Success rate in connecting with Members for the approved initial care screening 3. Percent of Members with a primary care visit in the last year (population management) 4. Appropriate reductions in avoidable ED and inpatient hospitalizations and re-admissions 5. Customer service support and member experience, including culturally and linguistically appropriate services 6. Timely access to care including urgent care 7. Integrating medical and behavioral health services 8. Reducing unnecessary readmissions 9. Strengthening partnerships with community organizations 10. Developing the care team to meet member needs: LCPN plans to devote Delivery System Reform Incentive Payment Program investments to develop strong care teams that engage Members in their health, provide transitional support, and integrate behavioral and medical care management 11. Continuing to build strategic partnerships with providers and organizations in Lahey communities to enhance communication and integrated care for MassHealth Members