The Commonwealth of Massachusetts
HEALTH POLICY COMMISSION
2 BOYLSTON STREET, 6TH FLOOR
BOSTON, MASSACHUSETTS 02116
(617) 979-1400

STUART H. ALTMAN
CHAIR

DAVID M. SELTZ
EXECUTIVE DIRECTOR

July 17, 2014

The Honorable Janet L. Sanders
c/o Antitrust Division
Office of the Attorney General
One Ashburton Place
Boston, MA 02108

Re: *Commonwealth of Massachusetts v. Partners HealthCare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp.*, Superior Court Civil Action No. 14-2033-BLS

Dear Judge Sanders:

Pursuant to the process established by the court on June 30, 2014, the Health Policy Commission (HPC) submits the attached comment regarding the proposed consent judgment in the above-referenced matter for the court and parties' consideration.

The HPC is an independent state agency established in the Commonwealth's landmark health care cost containment law, "*An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation*," Chapter 224 of the Acts of 2012 (Chapter 224). Recognizing that excessive health care costs are crowding out other economic needs for government, households, and businesses, Chapter 224 set a statewide target for a sustainable rate of growth of total health care expenditures. This cost growth benchmark is set at 3.6% for 2014. Governed by an 11-member board with diverse experience in health care, the HPC is charged with monitoring the health care delivery and payment systems in the Commonwealth, including performance against the health care cost growth benchmark,[1] and developing policies to reduce overall cost growth while improving quality. Among its many statutory responsibilities, the HPC has two distinct duties relevant to this matter as described further below: 1) producing an annual report on health care spending and market trends; and 2) providing objective, data driven analyses of the impacts of specific provider transactions.

First, the law requires the HPC to report annually on health care spending and market trends in the Commonwealth and on the health care industry's efforts to meet the cost growth benchmark, while identifying opportunities to improve health care costs, quality, and access.[2] The HPC's *2013 Cost Trends Report* and the *July 2014 Supplement* to that report analyze the best available data, including Massachusetts's All Payer Claims Database, to examine the drivers

[1] Beginning next year, the HPC may require health care entities exceeding the benchmark to file and implement performance improvement plans. MASS. GEN. LAWS ch. 6D, § 10.
[2] MASS. GEN. LAWS ch. 6D, § 8(g).

of cost growth and developments affecting both short and long-term health care spending, quality, and access to care. These reports describe significant trends in the payer and provider markets, including the use of higher priced providers (provider mix), delivery system consolidation, hospital operating expenses, wasteful spending, and treatment of behavioral health conditions.

Second, because health care costs may be influenced by changes in the delivery system, Chapter 224 directs the HPC to track the frequency, type, and nature of changes in our health care market. This is done by analyzing notices of material change that are submitted to the Commission by provider organizations.[3] The HPC may also engage in a more comprehensive review of particular transactions anticipated to have a significant impact on health care costs or market functioning. The result of such "cost and market impact reviews" (CMIRs) is a public report detailing the HPC's findings. In order to allow for public assessment of the findings, the transactions may not be finalized until the HPC issues its Final Report. Where appropriate, such reports may identify areas for further review or monitoring, or be referred to the Attorney General or other state agencies in support of their work on behalf of health care consumers.[4]

The HPC has produced two CMIR reports regarding three transactions encompassed by the consent judgment in this matter:

1) *Review of Partners HealthCare System's Proposed Acquisitions of South Shore Hospital and Harbor Medical Associates: Final Report* (Feb. 19, 2014); and
2) *Review of Partners HealthCare System's Proposed Acquisition of Hallmark Health Corporation: Preliminary Report* (July 2, 2014).[5]

Consistent with the HPC's role to provide objective, data driven analyses of factors and transactions that affect the Commonwealth's ability to meet its cost growth benchmark, the HPC seeks to provide important factual context for the court and parties' ongoing consideration of the parties' agreement. For example, the proposed consent judgment requires the parties to confer on mitigating any material price impacts identified by the HPC in its review of the proposed Hallmark acquisition. Accordingly, the attached comment includes findings from our reports that bear on the need for mitigation of transaction-specific impacts. We submit the above-referenced cost trends and CMIR reports for review along with the attached synthesis of key findings, organized as follows: (1) a brief overview of HPC findings relevant to this civil action;

---

[3] *See* MASS. GEN. LAWS ch. 6D, § 13 (requiring health care providers to notify the HPC before making material changes to their operations or governance). *See also* MASS. HEALTH POLICY COMM'N, BULLETIN 2013-01: INTERIM GUIDANCE FOR PROVIDERS AND PROVIDER ORGANIZATIONS RELATIVE TO NOTICE OF MATERIAL CHANGE (Mar. 12, 2013), *available at* http://www.mass.gov/anf/docs/hpc/material-change-notices/20130312-interim-guidance-on-material-change-and-notice-form.pdf.

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

[5] The parties to this review may submit a written response by August 1, 2014 (within 30 days of issuance of the Preliminary Report), after which the HPC will issue a Final Report. MASS. GEN. LAWS ch. 6D, §13(f).

(2) a detailed outline of key findings from each report, including citations; and (3) copies of the four reports.

This matter is of public interest, and we hope you find these materials useful in this process and your review.

Sincerely,

Dr. Stuart Altman
Chair

Public Comment by the Massachusetts Health Policy Commission
In Re Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Shore Health and Educational Corporation, and Hallmark Health Corporation, Superior Court Civil Action No. 14-2033-BLS

The Massachusetts Health Policy Commission (HPC) hereby submits the following comment as authorized by the Suffolk Superior Court concerning Civil Action No. 14-2033-BLS, *In Re Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Shore Health and Educational Corporation, and Hallmark Health Corporation*. This comment is grounded in four reports completed by the HPC in the past year containing data driven analyses of the Massachusetts health care market and proposed health care transactions encompassed in this civil action:

1. MASS. HEALTH POLICY COMM'N, 2013 COST TRENDS REPORT PURSUANT TO G.L. C. 6D § 8(G): ANNUAL REPORT (Jan. 8, 2014) [hereinafter *2013 CT Report*];

2. MASS. HEALTH POLICY COMM'N, 2013 COST TRENDS REPORT PURSUANT TO G.L. C. 6D § 8(G): JULY 2014 SUPPLEMENT (July 2, 2014) [hereinafter *2014 CT Supplement*];

3. MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL AND HARBOR MEDICAL ASSOCIATES PURSUANT TO M.G.L. C. 6D, § 13: FINAL REPORT (Feb. 19, 2014) [hereinafter *PHS-SSH-Harbor Final Report*]; and

4. MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITION OF HALLMARK HEALTH CORPORATION PURSUANT TO M.G.L. C. 6D, § 13: PRELIMINARY REPORT (July 2, 2014) [hereinafter *PHS-HHC Preliminary Report*].[1]

Consistent with the HPC's role to provide objective analyses of factors and transactions that affect the Commonwealth's ability to meet its health care cost growth benchmark, the HPC seeks to provide important factual context for the court and the parties' ongoing consideration of the parties' agreement. For example, the proposed consent judgment requires the parties to confer on mitigating any material price impacts identified by the HPC in its review of the proposed Hallmark acquisition. Accordingly, this comment includes findings from our reports that bear on the need for mitigation of transaction-specific impacts. This comment is organized into three parts: (1) a brief overview of HPC findings relevant to this civil action, (2) a detailed outline of key findings from each report, including citations, and (3) copies of the four reports. This matter is of public interest, and we hope you find this comment useful in this process and your review.

[1] The parties to this review may submit a written response by August 1, 2014 (within 30 days of issuance of the Preliminary Report), after which the HPC will issue a Final Report. MASS. GEN. LAWS ch. 6D, §13(f).

I. OVERVIEW OF KEY RELEVANT FINDINGS

A. Spending and Delivery System Trends

Massachusetts is a national leader in innovative, quality health care, but high and rising costs pose an increasing burden for households, businesses, and the economy. Per capita health care spending in Massachusetts is the highest of any state, with Massachusetts devoting 16.6% of its economy to personal health care expenditures in 2012, compared with 15.1% for the nation. There are large opportunities to reduce costs as an estimated 21% to 39% of total health care spending in the state is wasteful and could be reduced over time without decreasing the quality of care people receive.

Over the past decade, growth in spending has been driven primarily by faster growth in commercial prices paid to providers for health care services – both growth in unit prices (the price paid per service or set of services), and a shift toward use of higher-priced providers ("provider mix" or "site of care" effects). Care has grown increasingly concentrated in several large, organized health care systems, with a greater proportion of discharges occurring in higher-priced major teaching hospital systems. In 2009, the top five systems accounted for 48% of commercial patient discharges, while in 2014, we estimate the top five systems will account for 56% of commercial discharges (estimated to increase to 61% if Partners HealthCare System (Partners) completes its proposed acquisitions of South Shore Hospital (SSH) and Hallmark Health System (Hallmark), with Partners' share of discharges greater than the next four systems combined). Many patients leave their home towns and cities and travel to receive inpatient care in Metro Boston: 81% of these patients go to major teaching hospitals and 47% of them go to Partners' hospitals.

Many providers are seeking to promote more patient-centered, accountable care through a variety of organizational models, and payers are increasingly implementing alternative payment arrangements in efforts to incentivize and support these care delivery reforms. These developments, including increasing provider alignments and consolidations, impact health care system performance and levels of medical spending. Shifting physician contracting affiliations, increases in market concentration, and changing sites of care and referral patterns (provider mix) can all increase the prices we pay for health care services. While provider alignments may improve an organization's ability to promote more efficient, coordinated care, thereby reducing wasteful utilization, evidence to date indicates these efficiencies have generally not outweighed the spending increases described above.

B. Impact of the Proposed Transactions

The HPC's reviews of Partners' proposed acquisitions of SSH, Harbor Medical Associates, and Hallmark found impacts across all of the above factors, with increases in spending anticipated to exceed potential savings from decreased utilization through care delivery reforms and population health management. From our review of the data and evidence, we found:

- For the three major commercial payers, the combined transactions are anticipated to increase total medical spending by more than $38.5 million to $49 million per year[2] as a result of *unit price* increases and shifts in care to higher-priced Partners facilities (*provider mix*).
- The resulting consolidated system is anticipated to have increased ability and incentives to leverage higher prices and other favorable contract terms in negotiations with payers (*bargaining leverage*), the costs of which are not included in the above projection.
- The parties to these transactions have not provided adequate evidence of how corporate ownership is instrumental to achieving the desired care delivery reforms, and their own experience and that of other providers offer compelling alternative approaches to effectively improving coordinated care delivery.[3]

The consent judgment before the Court would allow Partners to acquire SSH, Hallmark, and their related physicians, but includes provisions to constrain Partners' contracting practices, network growth, and prices for the next five to ten years. This agreement is designed to alter Partners' negotiating power and constrain costs and growth across its entire network, including mitigating some of the total medical spending increases anticipated from the proposed transactions. The constraint on average unit price growth across all Partners providers, and the individual application of that price constraint to South Shore providers, are examples of provisions that should mitigate some of the cost impacts of the proposed transactions. While the HPC did not conduct a separate analysis of the proposed consent judgment, we present below findings from our analytic reports relevant to this civil action for the consideration of the court, the parties, and the public.

Unit Price

In light of the proposed settlement's constraints on unit price growth, price increases from these transactions will not necessarily result in a net increase in Partners' average price growth for the life of the settlement. However, Partners appears to retain certain flexibility to allocate price increases across providers to maximize revenue and market position. For example, without an individual price cap, Hallmark providers may experience unit price growth faster than the rate of general inflation. Such price increases would set a permanently increased baseline upon which future price increases would be negotiated and permanently increase baseline total medical spending, and premiums, in an area of the state that has thus far not experienced the market impact of a local, high-priced Partners facility, including by impacting providers who refer their patients to Hallmark. Moreover, without lasting change to the market structures and

[2] Since our cost impact analyses are based on data from the three major commercial payers, who represent about 80% of the commercial market, they tend to underestimate the total dollar impact to commercial spending. Due to the nature of contract negotiations and bargaining leverage, we expect that these impacts could be proportionately greater for the other 20% of the market, which is comprised of smaller payers with less clout. *PHS-SSH-Harbor Final Report* at 30 n. 94; *PHS-HHC Preliminary Report* at 6, 49, 49 n. 179.

[3] For brevity, additional findings of the HPC's reviews – particularly the anticipated impact of the proposed acquisitions on health care access – are not summarized fully here, but are available at *PHS-SSH-Harbor Final Report* at 57 and *PHS-HHC Preliminary Report* at 66-72.

incentives that underlie the operation of bargaining leverage, price caps on their own may not be effective in keeping costs down.[4]

Provider Mix

The material price impact of shifts in patient care to higher-priced Partners providers is not fully encompassed by the current agreement.[5] Specifically, increased spending due to shifts in patient flow to higher-priced providers is not included in the agreement's unit price constraint, but rather would be measured as increases in total medical expenses (TME). Since the agreement only monitors the TME for Partners' commercial risk business, anticipated increases in TME as Partners grows its non-risk books of business, currently including Preferred Provider Organization (PPO) and non-risk Health Maintenance Organization (HMO)/Point of Service (POS) patients,[6] are not monitored. The latest publicly filed data by Partners (for 2012) indicates that the commercial risk business monitored by the TME provision of the agreement is about 11% of Partners' total commercial business.[7] The agreement also does not monitor the TME of patients associated with other provider systems who receive some of their care from Partners, SSH, and Hallmark facilities and specialists.

Bargaining Leverage

We understand that the proposed consent judgment aims to mitigate Partners' bargaining leverage by allowing payers to negotiate for all or only certain components of the Partners network. While we recognize the potential for this change in current contracting practices to promote a more competitive market, we note that the impact of this change will depend, among other considerations, on whether and to what extent payers vigorously pursue this option and on how the market responds.[8]

---

[4] In other circumstances where merging providers have been subject to a price cap, prices have risen after the cap's expiration. *PHS-HHC Preliminary Report* at 42 n. 152.

[5] These transactions are anticipated to result in net shifts in patient volume from other providers to the Partners system. *See PHS-SSH-Harbor Final Report* at 35 and Exh. B-1 at 11; *PHS-HHC Preliminary Report* at 45, 53-54, and 56. This shift in volume and revenue to the Partners system is not only anticipated to increase spending, but may also affect the financial viability of lower-priced provider options. *See PHS-HHC Preliminary Report* at 15, n. 61 (describing how "providers often rely on a balanced mix of services and payers to maintain financial viability and adequate access to all services" and cautioning that if the proposed transaction "drive[s] changes in the service mix or payer mix of the parties or other area providers, these changes could have significant implications for how our health care system finances adequate access to all needed services, including low-margin services, for all populations"). *See also PHS-HHC Preliminary Report* at 14-15, n. 58; *2013 CT Report* at 34.

[6] Patients in PPO products, which do not require patients to designate a primary care provider (PCP) or obtain referrals to other providers through that PCP, are currently excluded from commercial risk contracts. The extent to which HMO/POS patients are covered by risk contracts differs by payer and provider; for example, for some major payers, self-insured HMO/POS patients are currently not included in risk contracts.

[7] *See* MASS. HEALTH POLICY COMM'N, Annual Cost Trends Hearing (2013), Pre-Filed Written Testimony of Partners HealthCare System, Response to Exh. C, Q.5, *available at* http://www.mass.gov/anf/docs/hpc/attachment-b-for-phs.xlsx.

[8] For example, relevant considerations may include whether purchasers and consumers find more limited networks that include only components of provider systems appealing; how component contracting will operate in the context of a shift to global payment arrangements, which generally seek to reimburse providers for coordinating care across their entire networks; and, in light of the time delimited nature of the settlement, to what extent component

Monitoring of Settlement Terms

Finally, in light of the HPC's extensive work monitoring the metrics of health care cost growth, we note that the full impact of the proposed settlement will depend on effective measurement and monitoring of key terms underlying the agreement, such as prices and TME. There appear to be some aspects of the current definition of those terms that could allow for price and TME increases in excess of general inflation and the health care cost growth benchmark, respectively, and other aspects that are not yet determined and may be refined through the monitoring process.[9]

C. Conclusion

Massachusetts law establishes a statewide benchmark for a sustainable rate of growth of total health care expenditures, set at 3.6% for 2014. This target is not a short-term goal, but one that is envisioned to be maintained as outlined in the law for the next decade and beyond. While recent spending growth in Massachusetts has slowed in line with slower national growth, sustaining lower growth rates over the long term will require a concerted effort to advance a more competitive, value-based health care market and efficient health care delivery system.

This comment reflects the HPC's view that all factors that impact total medical spending growth should be closely monitored and moderated in order to achieve the benchmark. Consistent with the HPC's role to provide data driven analyses of factors and transactions that affect the Commonwealth's ability to meet its benchmark, this comment includes findings from our reports of market and TME impacts from the proposed transactions that are not addressed by the current agreement, such as shifts in patient care to higher-priced providers and the impact of unit price increases over time. Increased spending as Partners providers grow their non-risk books of business is not monitored by the current agreement. Growth in unit prices from these transactions will set a permanently increased baseline upon which future price increases will be negotiated and will permanently increase baseline total medical spending in areas of the state that have thus far not experienced the market impact of a local Partners facility. Moreover, without lasting change to the market structures and incentives that underlie the operation of bargaining leverage, price caps on their own may not be effective in keeping costs down.

Finally, we note that Partners, Hallmark, and SSH have consistently advocated for these transactions on the basis that they will lower total medical spending, and have publicly stated their purpose in consolidating is not to raise prices. As such, increases in total medical spending and growth in unit prices would be inconsistent with those claims.

We hope you find these materials useful in this process and your review.

---

contracting can effect lasting changes to the market structures and incentives that underlie the operation of bargaining leverage. *Cf. supra* note 4.

[9] For example, we understand that the price growth restriction will be monitored based on Partners' revenue from the previous year, including the previous year's mix of patient membership and services. It would be helpful to obtain more detail on this provision, as it may be possible for price growth in excess of general inflation to be realized based on a shift in Partners' mix of patient membership or services from one year to the next.

II. DETAILED OUTLINE OF FINDINGS

Below is a more detailed outline of key findings from each report, including relevant citations. It is organized into four subparts: (a) spending levels and trends in the Massachusetts health care market, (b) Massachusetts delivery system trends, (c) profile of Partners, SSH, and Hallmark, and (d) impacts of the proposed transactions.

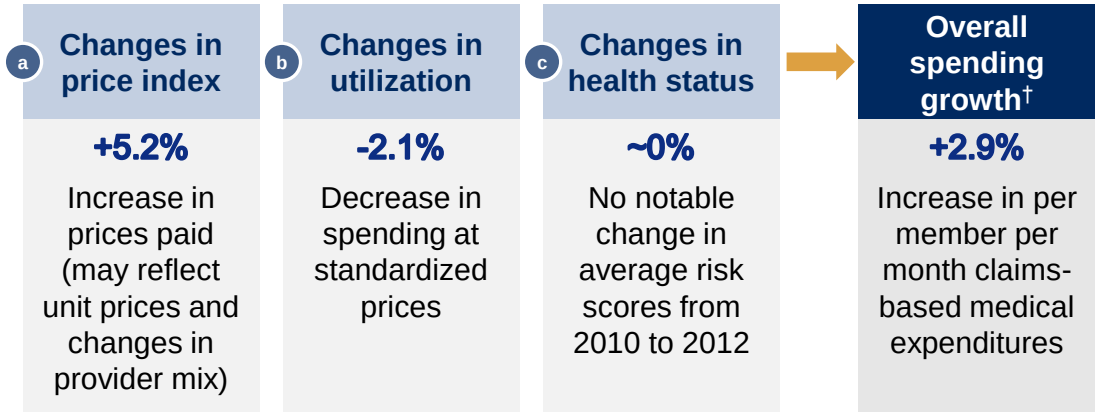
A. Spending Levels and Trends

- Per capita health care spending in Massachusetts is the highest of any state in the United States, with higher spending than the national average across commercial insurers and public payers. Massachusetts devoted 16.6% of its economy to personal health care expenditures in 2012, compared with 15.1% for the nation. *2013 CT Report* at 8-12.
- Massachusetts has better overall health care quality performance and offers better access to care than many other states, but there are large opportunities to reduce costs without harming the quality of care, as an estimated 21% to 39% of total health care spending in Massachusetts could be considered wasteful (representing $14.7 to $26.9 billion in 2012). *2013 CT Report* at 36.
- Higher spending levels in Massachusetts reflect both higher prices and higher utilization of services.
    - Over the past decade, Massachusetts health care spending has grown much faster than the national average, driven primarily by faster growth in commercial prices. *2013 CT Report* at 12-15; *2014 CT Supplement* at 8.
    - Price increases include changes in unit price (the price paid per unit of service by particular payers to particular providers) and changes in provider mix (whether services are obtained in higher-priced or lower-priced care settings). *2013 CT Report* at 11.
    - Massachusetts has 10% more inpatient hospitalizations (adjusted for age) and 72% more hospital outpatient visits per capita than the U.S. average. *2013 CT Report* at 10.

In recent years, the increase in prices paid has been the biggest contributor to commercial spending growth

DRIVERS OF GROWTH IN CLAIMS-BASED MEDICAL EXPENDITURES* IN MASSACHUSETTS

Percent annual growth in claims-based medical expenditures, 2010-2012



* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

† (1 + overall spending growth) = (1 + changes in price index) x (1 + changes in utilization) / (1+ changes in health status)

SOURCE: HPC analysis of the All-Payer Claims Database

B. Delivery System Trends

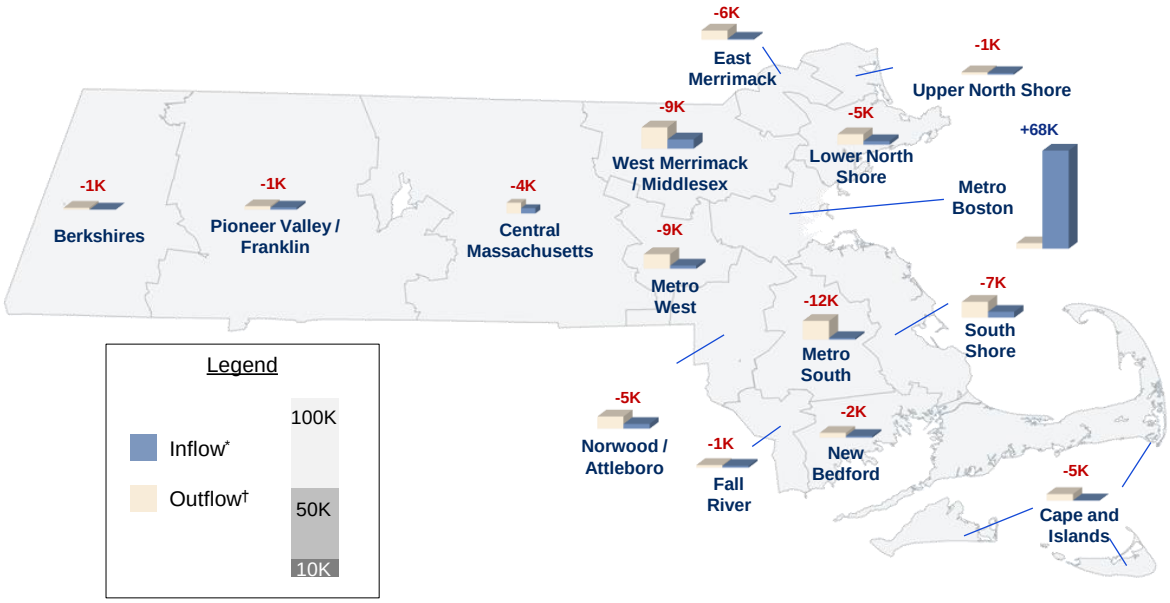
1. Providers and Site of Care

- The Massachusetts delivery system provides care in more expensive settings, on average, than the nation as a whole:
  - The Massachusetts delivery system is characterized by greater capacity and greater use of major teaching hospitals than the national average, with 40% of Medicare discharges in these types of hospitals for Massachusetts residents compared to 16% nationwide. *2013 CT Report* at 17.
  - Hospitals in Massachusetts that receive higher rates of reimbursement and incur greater operating expenses do not consistently achieve higher levels of quality performance, even after adjustments for case mix and regional wage levels. *2013 CT Report* at 30-32.
- Many patients leave their home regions for inpatient care and seek care in Metro Boston; the Metro Boston region has a net inflow of nearly 70,000 non-emergency, non-transfer hospital discharges per year, while every other region in the state has a net outflow of patients. *2014 CT Supplement* at 25.
  - Of patients who leave their home region to seek care in Metro Boston, 81% go to major teaching hospitals and 47% go to Partners hospitals. *2014 CT Supplement, Technical Appendix*.

Most Massachusetts residents who leave their home region for inpatient care seek their care in Metro Boston

DISCHARGES FLOWS IN AND OUT OF MASSACHUSETTS REGIONS

Number of inpatient discharges for non-emergency, non-transfer volume, 2012



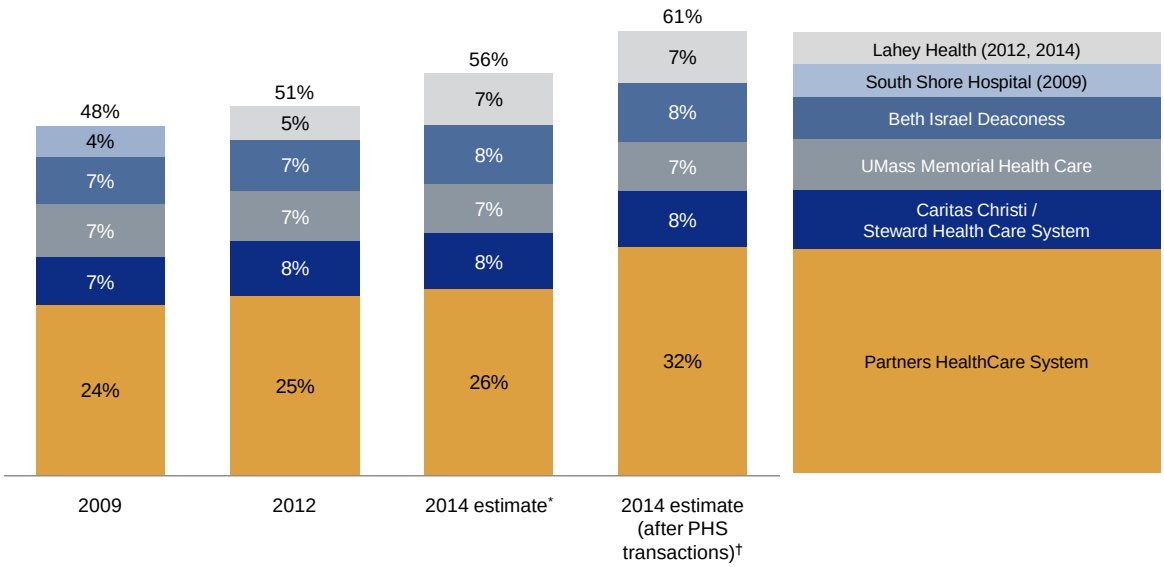
* Discharges at hospitals in region for patients who reside outside of region
† Discharges at hospitals outside of region for patients who reside in region
SOURCE: Center for Health Information and Analysis; HPC analysis

- Inpatient care is growing increasingly concentrated in several large systems. In 2009, the top five systems accounted for 43% of all discharges and 48% of commercial discharges. In 2014, we estimate the top five systems will account for 50% of all discharges and 56% of commercial discharges (55% and 61% if Partners completes its proposed acquisitions of SSH and Hallmark, with Partners' share of discharges growing from 24% to 32% in five years and becoming greater than the combined shares of the next four highest-volume systems). *2014 CT Supplement* at 27.

Commercial inpatient care in Massachusetts has grown more concentrated among large hospital systems over the past 5 years

CONCENTRATION OF COMMERCIAL INPATIENT CARE IN MASSACHUSETTS

Share of commercial inpatient discharges held by five highest-volume systems, 2009-2012



* 2014 data not yet available. Based on applying systems established by 2014 (including 2013 Partners HealthCare acquisition of Cooley Dickinson and 2014 Lahey Health acquisition of Winchester hospital) to 2012 inpatient discharge data

† Includes South Shore Hospital and Hallmark Health hospitals within Partners HealthCare System

SOURCE: Center for Health Information and Analysis; HPC analysis

2. Payment and Insurance Trends

- Chapter 224 encouraged a shift from the fee-for-service payment system to alternative payment methods (APMs). In 2012, 29% of insured Massachusetts residents were covered by APMs. *2014 CT Supplement* at 31.
- Continued expansion of APMs has faced countervailing trends. While payers have enrolled new provider organizations in these contracts, these contracts currently only extend to patients on HMO/POS plans, which require patients to designate a primary care provider. In the last few years, the proportion of patients on HMO plans has declined as PPO plans have grown in popularity. *2013 CT Report* at 20-21.

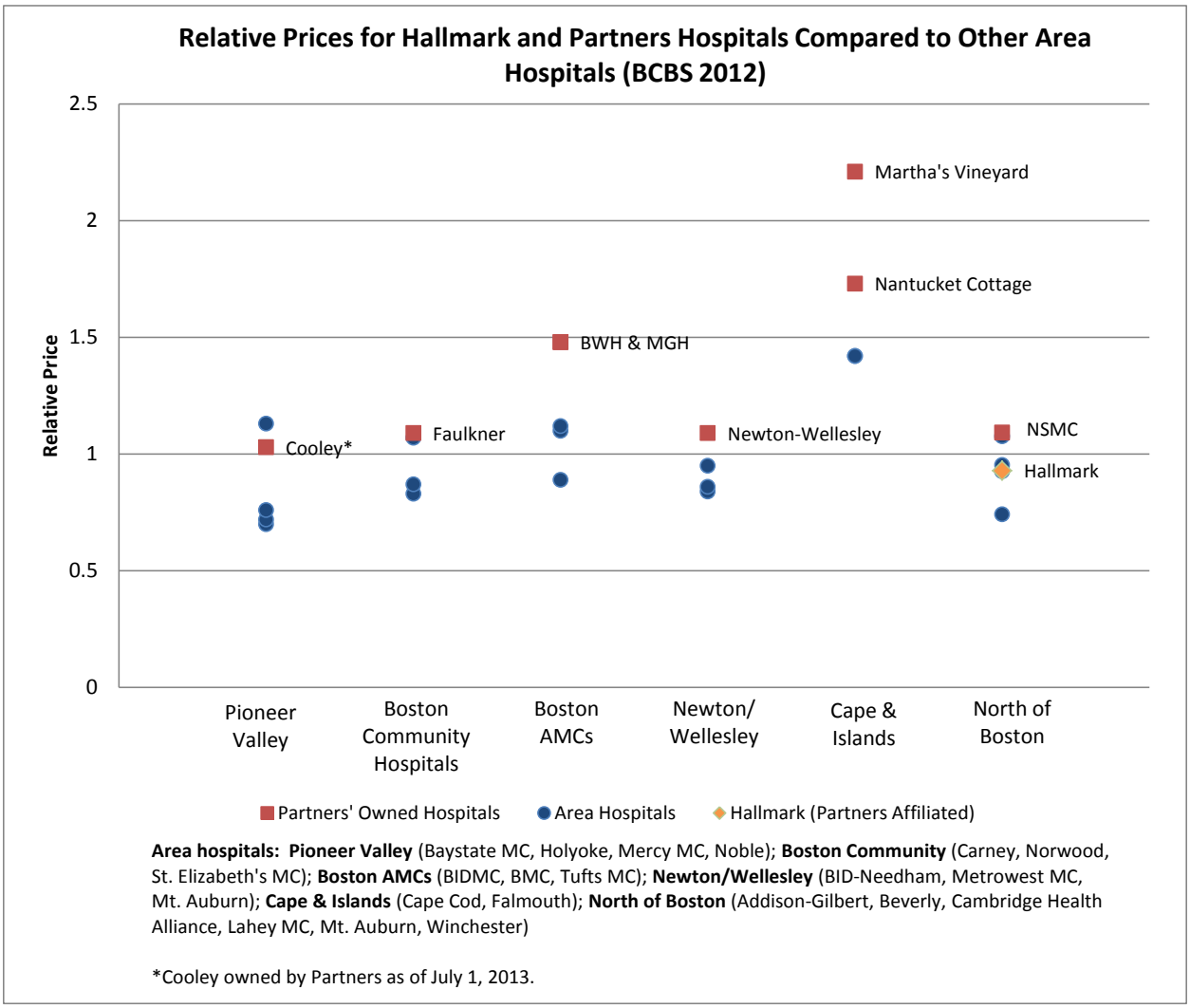
C. Overview of the Parties

1. Partners HealthCare System

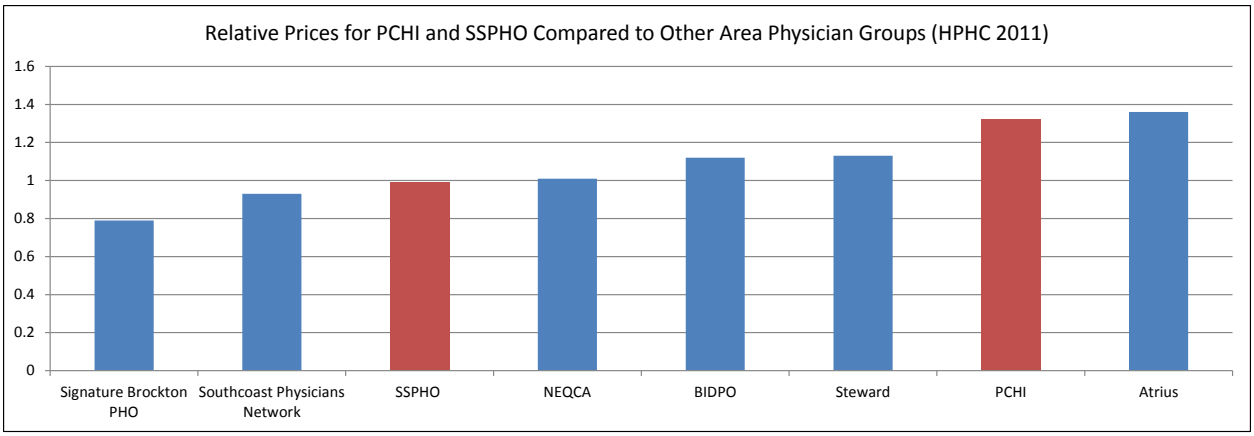
- Partners owns eight general acute care hospitals in five regions of the state (the addition of SSH and Hallmark would make it eleven) and negotiates contracts on behalf of approximately 6,200 physicians. Partners also owns a network of psychiatric hospitals, rehabilitation facilities, and home care facilities. *PHS-HHC Preliminary Report* at 7; *PHS-SSH-Harbor Final Report* at 7-8. It is the largest

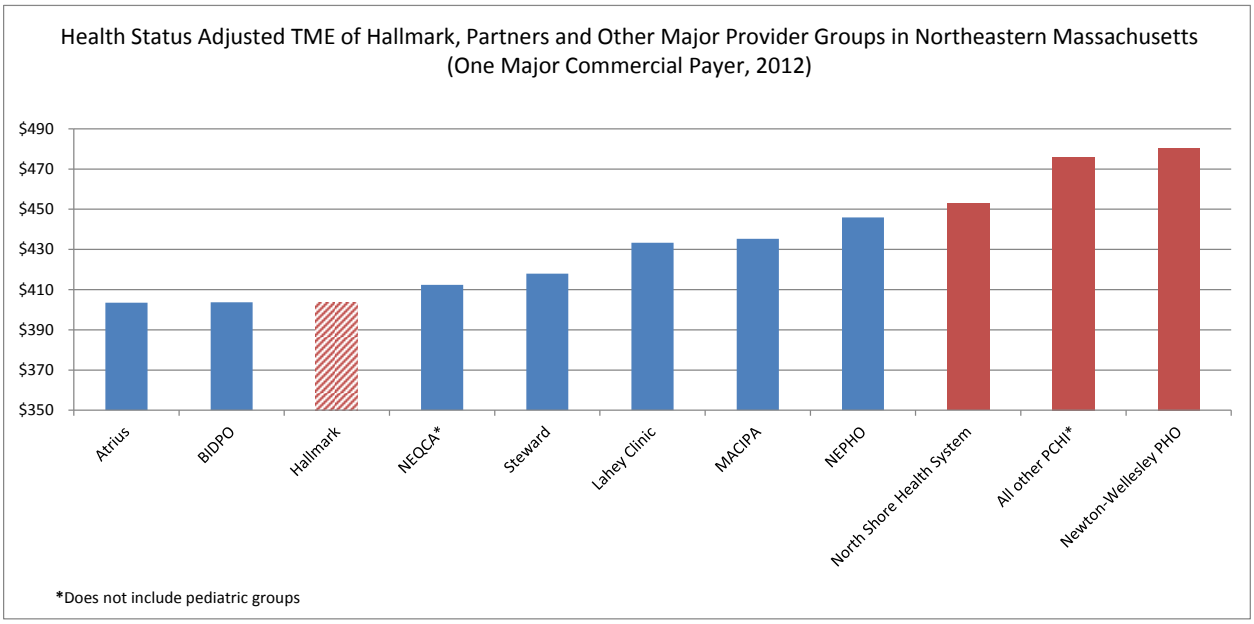
hospital system and physician group in Massachusetts, receiving nearly one-third of statewide payments to acute hospitals and approximately one-quarter of statewide payments to physician groups in 2011. *PHS-HHC Preliminary Report* at 21-22.

- Partners' total net assets are more than double the combined assets of the next five largest systems in Massachusetts. Its total operating revenue increased by approximately 20% in the last four years, from $7.5 billion to nearly $9 billion, and its total net assets grew by 6.2% (over $300 million). *PHS-HHC Preliminary Report* at 16-17.
- Partners' hospitals generally receive the highest prices in their region, an example of which is shown in the chart below. *PHS-HHC Preliminary Report* at 22-23; *PHS-SSH-Harbor Final Report* at 14-15.



- Partners' physician groups also receive higher prices and have higher health status adjusted total medical expenses than nearly all other physician groups in Massachusetts. *PHS-HHC Preliminary Report* at 23-25; *PHS-SSH-Harbor Final Report* at 15-17.





- Partners has continued to grow in recent years, acquiring Neighborhood Health Plan, a Massachusetts payer with over 260,000 members, and Cooley Dickinson Hospital in Northampton, in 2012 and 2013, respectively. *PHS-HHC Preliminary Report* at 8; *PHS-SSH-Harbor Final Report* at 8.

2. South Shore Hospital

- SSH is the largest hospital in its region, with net patient service revenue that is nearly double that of the next largest hospital in the region. *PHS-SSH-Harbor Final Report* at 13. Its managed care network, South Shore Physician Hospital Organization (SSPHO), includes about 400 physicians. *PHS-SSH-Harbor Final Report* at 9.
- SSH is in strong financial condition, with total operating revenue and total net assets substantially greater than those of area hospitals. Between 2009 and 2012, its total net assets grew by 32.9% (over $44 million). *PHS-SSH-Harbor Final Report* at 13. SSPHO is the seventh largest physician group in the state as measured by 2011

payments from nine of the largest commercial payers in Massachusetts. *PHS-SSH-Harbor Final Report* at 18.

- SSH is the highest priced hospital among area hospitals. While SSPHO physicians have not had high prices compared to area physician groups, they have among the highest TME of area groups. *PHS-SSH-Harbor Final Report* at 14-17.

3. Hallmark Health

- Hallmark includes two general acute care hospitals, Melrose-Wakefield in Melrose and Lawrence Memorial in Medford, a number of outpatient facilities, and a managed care network of approximately 400 physicians. *PHS-HHC Preliminary Report* at 9.
- Hallmark's financial position is positive and improving. Its operating margin and total margin are consistently high compared to area community hospitals and its cash reserves and current ratio are strong. *PHS-HHC Preliminary Report* at 18-19.
- Hallmark contracts through Partners with most of the major payers, but its hospital and physician prices and health status adjusted TME are consistently lower than those of Partners' owned hospitals and physician groups. *PHS-HHC Preliminary Report* at 22-25.

D. Impact of the Proposed Transactions

- Provider alignments and consolidations impact health care system performance and levels of medical spending. Shifting physician alignments, changes in market concentration, and changing site of care (provider mix) can all impact the prices we pay for health care services. *PHS-HHC Preliminary Report* at 40-41; *PHS-SSH-Harbor Final Report* at 28-29.
- Changes in total medical spending are driven by four principal factors: unit price, utilization, provider mix, and service mix. Provider consolidations or alignments can affect all of these factors, resulting in:
  - Changes in bargaining leverage, or shifts in incentives to use existing bargaining leverage, which impact providers' negotiation of commercial prices and other contract terms;
  - Changes in physician, hospital, or other facility prices as consolidations or alignments change the affiliations of provider groups;
  - Changes in site of care, or use of differently priced providers, as physicians shift where they send their patients for care in response to consolidations or alignments; and
  - Changes in the nature or amount of services patient populations utilize as a result of proposed care delivery changes. *PHS-HHC Preliminary Report* at 41; *PHS-SSH-Harbor Final Report* at 29.

1. Partners-South Shore Hospital-Harbor Medical Associates

Over time, for the three major commercial payers studied, Partners' acquisition of SSH and its related physicians is anticipated to increase total medical spending by $23 million to $26 million each year as a result of increases in physician prices and shifts in care to

higher-priced Partners and SSH facilities. The resulting system is anticipated to have increased ability to leverage higher prices and other favorable contract terms in negotiations with commercial payers, the costs of which are not included in the above projection. Overall, increases in spending are anticipated to far exceed potential cost savings from expanding Partners' existing population health management initiatives into the South Shore region. *PHS-SSH-Harbor Final Report* at 2.

Bargaining Leverage/Market Dynamics

- SSH and Partners are direct competitors, with respectively the first and second largest shares of commercial inpatient services in SSH's primary service area (PSA). *PHS-SSH-Harbor Final Report* at 39-40. This proposed merger will substantially reduce competition in SSH's PSA and increase the ability of the resulting system to leverage higher prices and other favorable contract terms. *PHS-SSH-Harbor Final Report* at 36-44.
- The resulting system will account for 50% of commercial discharges in SSH's PSA, with a corresponding increase in market concentration of 1,254 (as measured through the Herfindahl-Hirschman Index (HHI)). This increase in market concentration is well over the Department of Justice/Federal Trade Commission threshold above which mergers are presumed likely to enhance market power (an increase in HHI of 200 in similarly concentrated markets). *PHS-SSH-Harbor Final Report* at 41.

Unit Price

Physicians

- As a subset of SSPHO physicians (including Harbor Medical Associates) join Partners' contracts pursuant to existing contract provisions, increases in physician prices will increase spending for the three major commercial payers by an anticipated $15.8 million per year. *PHS-SSH-Harbor Final Report* at 33. If additional SSPHO physicians are permitted to join Partners' network under more expansive contract provisions, annual spending by the three major commercial payers would increase by up to $50.9 million. *PHS-SSH-Harbor Final Report* at 34.

Hospitals

- Significant increases in market concentration, particularly in concentrated markets like the SSH PSA, increase providers' ability to leverage higher prices and other favorable contract terms. *PHS-SSH-Harbor Final Report* at 41. An extensive review of published papers found that an HHI increase of 800 points within a metropolitan statistical area (a generally larger geographic area than a PSA) led to an average price increase of 5%. *PHS-SSH-Harbor Final Report* at 41, n. 132.

Facilities

- Potential increases in facility fees as a result of these transactions, particularly for ancillary and ambulatory surgery services, would further increase total medical spending. *PHS-SSH-Harbor Final Report* at 44-45 and Exh. B-1 at 11.

Shift to Higher-Priced Providers (Provider Mix)

- These transactions are anticipated to shift care to higher-priced Partners and SSH facilities, thereby increasing total medical spending. *PHS-SSH-Harbor Final Report* at 34-36. If SSPHO physicians refer to higher-priced sites of care in line with the referral practices of Partners physicians, spending for the three major payers is anticipated to increase by about $1.6 million per year. *PHS-SSH-Harbor Final Report* at 35.
- If the parties' 27 to 42 newly recruited primary care physicians (PCPs) draw their patients from area physician groups, spending for the three major payers is anticipated to increase by an additional $5.8 to $9.0 million per year as these patients are referred to a higher-priced mix of hospitals. *PHS-SSH-Harbor Final Report* at 35.

Utilization/Service Mix

- While Partners' experience in accountable care initiatives demonstrates potential for reducing utilization, known cost increases far exceed the potential savings from expanding these initiatives into the South Shore region. *PHS-SSH-Harbor Final Report* at 47-53.
- The parties did not provide adequate evidence of how corporate ownership is instrumental to achieving the desired care delivery reforms, and their own experience and that of other providers offer alternative approaches to effectively coordinating care delivery. *PHS-SSH-Harbor Final Report* at 53-56.

2. Partners-Hallmark Health

Over time, this transaction is anticipated to increase spending in northeastern Massachusetts by an estimated $15.5 million to $23 million per year for the three major commercial payers due to material price effects, which are not expected to be offset by commensurate savings from decreased utilization through population health management. The transaction will also reinforce Partners' position as the provider with the highest share of inpatient and primary care services in its northeastern Massachusetts service areas. *PHS-HHC Preliminary Report* at 3.

Bargaining Leverage/Market Dynamics

- Ownership of Hallmark will reinforce Partners' position as the provider with the highest share of inpatient and PCP services in its northeastern Massachusetts service areas and will strengthen Partners' ability and incentives to negotiate price increases and other favorable contract terms for Hallmark. Specifically, while Hallmark already contracts with most major payers through Partners, Partners faces different incentives in negotiating rates for Hallmark compared to providers that Partners owns. Because Partners does not currently own Hallmark's revenue, it does not directly profit if Hallmark's margins or volume increase. Ownership of Hallmark's revenue is thus anticipated to increase the alignment of Partners' ability and

incentives to command higher rates for Hallmark. *PHS-HHC Preliminary Report* at 43-48.

- This transaction is also anticipated to result in net shifts in patient volume from other providers to the Partners system. *See PHS-HHC Preliminary Report* at 45, 53-54, and 56. This shift in volume and revenue to the Partners system is not only anticipated to increase spending, but may also affect the financial viability of lower-priced provider options. *See PHS-HHC Preliminary Report* at 15, n. 61 (describing how "providers often rely on a balanced mix of services and payers to maintain financial viability and adequate access to all services" and cautioning that if the proposed transaction "drive[s] changes in the service mix or payer mix of the parties or other area providers, these changes could have significant implications for how our health care system finances adequate access to all needed services, including low-margin services, for all populations").
- Similarly, there are concerns that the investments proposed in connection with this transaction, which may be supported by historic payments not tied to value, will tend to perpetuate a non-value-based advantage of the parties to drive up the level of competitive spending in the region, such as in the recruitment and retention of physicians, with negative effects for the delivery of high-value health care. *PHS-HHC Preliminary Report* at 14-15, n. 58 (citing OFFICE OF ATT'Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6 ½(B): REPORT FOR ANNUAL PUBLIC HEARING 38-39 (Mar. 16, 2010), which contrasts "highly paid providers [who] are able to fund depreciation consistently at or above industry standard" with "hospitals with lower prices [who] are unable to put comparable resources toward building maintenance or equipment acquisition," resulting "in a loss of volume to better capitalized, more expensive hospitals"). *Cf. 2013 CT Report* at 34 (contrasting "hospitals with stronger market leverage [that] can earn higher revenues from commercial payers and therefore have less pressure to constrain their expenses" with "hospitals with limited market leverage [that] receive lower rates of commercial payer reimbursement and, under greater financial pressure, tend to be more aggressive at maintaining lower operating expenses").

Unit Price

Physicians

- Anticipated increases in Hallmark's physician prices are projected to increase total medical spending in northeastern Massachusetts by approximately $6.8 million annually for the three major payers. *PHS-HHC Preliminary Report* at 49-50. If Partners achieves its stated goal of more tightly integrating with all of Hallmark's physicians, this cost impact would be closer to $14.6 million per year. *PHS-HHC Preliminary Report* at 49-50.

Hospitals

- If Partners seeks parity between Hallmark's prices and those at its owned community hospitals, increases in Hallmark's prices would increase total medical spending in

northeastern Massachusetts by an estimated $9.3 million annually for the three major commercial payers. *PHS-HHC Preliminary Report* at 50-51.

Facilities

- Anticipated increases in facility prices and staffing by higher-priced Massachusetts General Hospital (MGH) physicians of the Hallmark facilities proposed to be licensed under MGH will further increase total medical spending in northeastern Massachusetts. *PHS-HHC Preliminary Report* at 51-52.

If price growth for Hallmark physicians, hospitals, and facilities were meaningfully capped at general inflation or a lower number, this would better constrain, for the life of the cap, how much prices would grow a result of this transaction, and contribute to a smaller permanent increase to baseline total medical spending in this region. *PHS-HHC Preliminary Report* at 50-51, n. 180 and 183. At the same time, we recognize that price caps may not be effective in keeping costs down long term without lasting change to the market structures and incentives that underlie the operation of bargaining leverage. *PHS-HHC Preliminary Report* at 42, n. 152.

Shift to Higher-Priced Providers (Provider Mix)

- Contrary to the parties' claims that this transaction will generate significant savings by facilitating a net shift in care away from higher-priced providers, we found that changes in site of care/referral patterns are unlikely to result in significant savings. To the contrary, if Partners seeks rate increases for Hallmark, anticipated changes in referral patterns to higher-priced providers will increase total medical spending. For example, if Hallmark's prices increase to those of Partners' owned community hospitals in greater Boston, anticipated changes in inpatient site of care are estimated to increase spending for the three major payers by $4 million per year. *PHS-HHC Preliminary Report* at 52-56.
- If the parties' 25 newly recruited PCPs draw their patients from area physician groups, spending for the three major payers is anticipated to increase by an additional $1.3 to $3.8 million per year as these patients are referred to a higher-priced mix of hospitals. *PHS-HHC Preliminary Report* at 56-57.

This material price effect of shifts in patient care to higher-priced providers – especially for patients in PPO and non-risk HMO/POS insurance products – is not fully encompassed by the current agreement. *PHS-HHC Preliminary Report* at 2, 40. Specifically, increased spending due to shifts in care to higher-priced providers is not encompassed by the unit price cap in the current agreement, but rather would be measured as increases in TME. Since only TME for Partners' commercial risk business is monitored pursuant to the current agreement, increases in TME for Partners' non-risk books of business, which include all of its PPO business, are not covered by the agreement. The latest publicly filed data by Partners, for 2012, shows that the commercial risk business monitored by the current agreement is about 11% of Partners' total commercial business. MASS. HEALTH POLICY COMM'N, Annual Cost Trends Hearing (2013), Pre-Filed Written Testimony of Partners HealthCare System, Response

to Exh. C, Q.5, *available at* http://www.mass.gov/anf/docs/hpc/attachment-b-for-phs.xlsx.

Utilization/Service Mix

- While the parties have outlined a set of care management strategies that have the potential to reduce wasteful utilization, the scope of potential savings from these initiatives is likely smaller than the parties project, and is not expected to offset anticipated increases in total medical spending. *PHS-HHC Preliminary Report* at 57-64.
- It is also unclear how corporate ownership is instrumental to improving care delivery in ways the parties' longstanding affiliation has not. *PHS-HHC Preliminary Report* at 66.

Access

- While the proposed transaction has the potential to expand access to a number of services in northeastern Massachusetts, current plans lack the detail necessary to evaluate the extent to which such potential will be realized. *PHS-HHC Preliminary Report* at 67-70.
- In light of Hallmark's high government payer mix, proposed relocations of services are anticipated to impact especially vulnerable populations as they seek to access services at new, more distant locations. *PHS-HHC Preliminary Report* at 66-72.
- The retention and expansion of primarily high-margin services raise questions about whether these service expansions reflect alignment with unmet community need. *PHS-HHC Preliminary Report* at 69.

Consistent with the HPC's role to provide data driven analyses of factors and transactions that affect the Commonwealth's ability to meet its benchmark, this comment includes findings from our reports of market and TME impacts from the proposed transactions that are not addressed by the current agreement, such as shifts in patient care to higher-priced providers and the impact of unit price increases over time. We hope you find these materials useful in this process and your review.

III. RELEVANT HPC REPORTS

Please see attached.

Relevant HPC Reports

1. MASS. HEALTH POLICY COMM'N, 2013 COST TRENDS REPORT PURSUANT TO G.L. C. 6D § 8(G): ANNUAL REPORT (Jan. 8, 2014) *available at* http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-full-report.pdf.

2. MASS. HEALTH POLICY COMM'N, 2013 COST TRENDS REPORT PURSUANT TO G.L. C. 6D § 8(G): JULY 2014 SUPPLEMENT (July 2, 2014) *available at* http://www.mass.gov/anf/docs/hpc/07012014-cost-trends-report.pdf.

3. MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL AND HARBOR MEDICAL ASSOCIATES PURSUANT TO M.G.L. C. 6D, § 13: FINAL REPORT (Feb. 19, 2014) *available at* http://www.mass.gov/anf/docs/hpc/20140219-final-cmir-report-phs-ssh-hmc.pdf.

4. MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITION OF HALLMARK HEALTH CORPORATION PURSUANT TO M.G.L. C. 6D, § 13: PRELIMINARY REPORT (July 2, 2014) *available at* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/20140702-phs-hallmark-preliminary-report.pdf.