



MASSACHUSETTS HEALTH POLICY COMMISSION REVIEW OF

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

About the Health Policy Commission

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

INTRODUCTION

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

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

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

¹ See MASS. GEN. LAWS ch. 6D, § 13 (requiring health care providers to notify the HPC before making material changes to their operations or governance). See also MASS. HEALTH POLICY COMM'N, 958 CMR 7.00: NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS (Jan. 2, 2015) [hereinafter MCN AND CMIR REGULATIONS], available at <http://www.mass.gov/anf/docs/hpc/regs-and-notices/consolidated-regulations-circ.pdf>.

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

us to identify particular factors for market participants to consider in proposing and responding to potential future organizational changes. Through this process, we seek to encourage providers and payers alike to evaluate and take steps to minimize negative impacts and enhance positive outcomes of any given material change.

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

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

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ACRONYMS AND ABBREVIATIONS

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

NAMING CONVENTIONS

Parties and Related Organizations

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

Payers

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

Other Providers

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

EXECUTIVE SUMMARY

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

Following a 30-day initial review, the Health Policy Commission (HPC) determined that the proposed transaction was likely to have a significant impact on costs and market functioning in Massachusetts and warranted further review.⁶ This transaction is concurrently under review by the Massachusetts Department of Health's (DPH) Determination of Need (DoN) program. On November 1, 2017, the HPC issued a Preliminary Report presenting the analysis and key findings from its review.⁷ The parties provided a written response to these findings on November 30, 2017 (Parties' Response).⁸ The HPC now issues this Final Report,

³ On April 3, 2017, Partners and MEE filed Notices of Material Change with the HPC pursuant to MASS. GEN. LAWS ch. 6D, § 13. See MEE NOTICE OF MATERIAL CHANGE, *infra* note 33. The executed Affiliation Agreement was provided confidentially by the parties.

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

⁵ See MEE NOTICE OF MATERIAL CHANGE, *infra* note 33.

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

⁷ MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITION OF MASSACHUSETTS EYE AND EAR INFIRMARY, MASSACHUSETTS EYE AND EAR ASSOCIATES, AND AFFILIATES (HPC-CMIR-2017-1), PURSUANT TO M.G.L. C. 6D, § 13 PRELIMINARY REPORT (Nov. 1, 2017), available at <http://www.mass.gov/anf/docs/hpc/material-change-notices/20171101-preliminary-phs-mee-report-final.pdf> [hereinafter Preliminary Report].

⁸ PARTNERS HEALTHCARE SYSTEM AND FOUNDATION FOR THE MASS. EYE AND EAR INFIRMARY, RESPONSE TO HEALTH POLICY COMMISSION PRELIMINARY REPORT DATED NOVEMBER 1, 2017 HPC-CMIR 2017-1 CONCERNING PROPOSED ACQUISITION OF MASSACHUSETTS EYE AND EAR INFIRMARY, ET AL. (Nov. 30, 2017), Exh. A [hereinafter Parties' Response].

including the Parties' Response (attached as Exhibit A) and the HPC's analysis of the Parties' Response (attached as Exhibit B).

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

1. **Cost and Market Baseline Performance:** Partners is the largest health care system in the state, with high inpatient, outpatient, and physician market shares. MEEI provides more outpatient otolaryngology and ophthalmology services than any other provider in its service area, and Partners provides some services that overlap with those provided by MEE. Partners patients have high total medical spending and the Partners system has high hospital and physician prices, including for outpatient otolaryngology and ophthalmology services.⁹ MEE's prices are substantially lower than Partners' prices.
2. **Quality Baseline Performance:** Given that MEE provides only a specialized set of services, there are relatively few relevant, standardized, publicly reported quality measures available to assess its performance. However, MEEI generally performs at or above the statewide average for relevant measures, and it performs particularly well on patient experience measures. Partners hospitals and physicians also generally perform at or above the statewide average on most of the measures we reviewed.
3. **Access Baseline Performance:** MEEI is the principal provider of a number of specialty otolaryngology and ophthalmology services, although there are few services for which MEEI is the sole provider. MEEI participates more frequently than Partners general acute care hospitals in Medicaid managed care organization (MMCO) networks and commercial limited network products, and is generally placed in more favorable cost sharing tiers of tiered network products. MEEI and most Partners hospitals have higher commercial payer mix and lower Medicaid payer mix relative to comparator hospitals.
4. **Cost and Market Impact:** After the transaction, Partners could likely obtain Partners physician rates for MEEA physicians across all commercial payers and would likely seek significant hospital rate increases for MEEI. Over time, we estimate that total commercial health care spending would increase by \$20.8 million to \$61.2 million annually if Partners achieves parity between MEEI's rates and the rates of Partners' other acute care hospitals, depending on price levels obtained, and if MEEA physicians begin receiving Partners physician rates for all commercial payers. The parties concede that they expect MEEI and MEEA to receive higher prices and have declined to offer an unequivocal and measurable commitment to limit such increases. These rate

⁹ To analyze prices for otolaryngology and ophthalmology services, the HPC used data from the All-Payer Claims Database. See *infra* note 91 for details on methodology.

increases would ultimately be borne by consumers and businesses through higher commercial premiums, including for tiered and limited network products that include MEE, and may also impact other providers' spending against risk budgets to the extent that their patients use MEE. Simultaneously, the parties expect to achieve internal efficiencies that would reduce their own expenses.

5. **Quality Impact:** The parties have stated that the proposed transaction will facilitate improved quality, primarily by better integrating MEE into Partners' technical infrastructure, including its data warehouse, quality reporting platform, and electronic medical record system. However, it is unclear to what extent these technical improvements would result in improved patient care, given that MEE's quality performance is already strong and comparable to that of Partners and recognizing the parties' existing collaborations. The parties have identified only a few metrics for quality improvement, and propose to collect baseline data and set improvement targets only after the transaction is completed. Given existing quality performance and unspecified targets, it is unclear that the proposed transaction is necessary or sufficient to achieve improvements in clinical quality.
6. **Access Impact:** While the parties have suggested that patient need for MEE's services is increasing, they have not described specific plans for when or where MEE might expand its services to meet those needs, or why corporate integration would be necessary to do so. In addition, if MEE adopts Partners' contracting patterns as a result of the transaction, patients in tiered and limited network products may face barriers to accessing MEE's specialty services, although the parties have stated a commitment to continue MEE's participation in MMCO networks.

In summary, we find that the proposed transaction between Partners and MEE is likely to increase health care spending due to expected increases in hospital and physician prices that are consistent with the parties' stated goals of the transaction. While the parties have claimed that the transaction will result in operational efficiencies and improvements in the quality of patient care and access to services, they have declined to offer an unequivocal and measurable commitment to limit the price increases that would increase spending for payers and consumers, and have not provided evidence that a corporate merger is either necessary or sufficient to achieve quality or access improvements. The parties also have not offered commitments regarding MEE's commercial payer network participation that would protect against any impaired access to MEE's specialty services subsequent to the transaction.

Given that the proposed transaction is under concurrent review by DPH's DoN program, the HPC will provide a copy of this Final Report to DoN program staff for consideration in the context of the factors for DoN approval.¹⁰ In addition, the HPC finds that Partners meets the criteria for mandatory referral to the Massachusetts Attorney General's

¹⁰ See 105 CMR 100.735(D)(1)(c). The HPC expresses no opinion on whether the parties' DoN application ought to be approved or rejected, but rather provides its findings to assist DoN staff in evaluating whether the application, subject to conditions set by DPH pursuant to 105 CMR 100.210(B), meets all applicable DoN review factors.

Office pursuant to MASS. GEN. LAWS ch. 6D, § 13(f) as Partners has “dominant market share,” “materially higher prices” than other providers, and “materially higher TME” than other providers.¹¹

¹¹ See MASS. HEALTH POLICY COMM’N, TECHNICAL BULLETIN FOR 958 CMR 7.00: NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS (Aug. 6, 2014) [hereinafter TECHNICAL BULLETIN], *available at* <http://www.mass.gov/anf/docs/hpc/regs-and-notices/technical-bulletin-circ.pdf>. The HPC is required to refer a final cost and market impact review report to the Massachusetts Attorney General’s Office if one or more parties to the transaction has or is expected to have materially higher prices, materially higher total medical expense, and a dominant market share for inpatient services. Based on the most recent available data, Partners exceeds the threshold for each of these three metrics.

I. ANALYTIC APPROACH AND DATA SOURCES

A. ANALYTIC APPROACH

The Health Policy Commission (HPC) is tasked with examining impact in three interrelated areas in a cost and market impact review (CMIR):¹²

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

Additionally, the HPC may consider any other factors it deems to be in the public interest, including consumer concerns.¹³

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

B. DATA SOURCES

To conduct this review, we relied on the documents and data the parties produced to us in response to HPC information requests and the parties' own description of the transaction as presented in their material change notices and application for Determination of Need (DoN) and supporting materials filed with the Massachusetts Department of Public Health (DPH). The HPC also utilized extensive information from the Registration of Provider Organizations program (RPO)¹⁴ and obtained data and documents from a number of other sources. These

¹² MASS. GEN. LAWS ch. 6D, § 13(d) and 958 CMR 7.06.

¹³ *Id.*

¹⁴ MASS. GEN. LAWS ch. 6D, § 11 (requiring provider organizations to register biennially with the HPC and provide information on organizational structure and affiliations, and other requested information); *see also* 958 CODE MASS. REGS. §§ 6.00 (2014); *2015 Initial Registration*, MASS. HEALTH POLICY COMM'N, <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/material-change-notices-cost-and-market-impact-reviews/registration-of-provider-organizations/2015-initial-registration-data/>.

include other state agencies such as the Massachusetts Attorney General’s Office (AGO) Non-Profit Organizations/Public Charities Division, from which we received audited financial statements for non-profit institutions relevant to our review, and the Center for Health Information and Analysis (CHIA), from which we received provider and payer-level data, hospital discharge data, and claims-level data from the All-Payer Claims Database (APCD);¹⁵ federal agencies such as the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS); and payers such as Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP). The HPC appreciates the cooperation of all entities that provided information in support of this review.

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

Where our analyses rely on nonpublic information produced by the parties or other market participants, MASS. GEN. LAWS ch. 6D, § 13 and 958 CODE MASS. REGS. 7.09 prohibit the HPC from disclosing such information without the consent of the producing entity, except in a preliminary or final CMIR report where “the commission believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations.”¹⁶ Consistent with this requirement, this Final Report contains only limited disclosures of such confidential information where the HPC has determined that the public interest in disclosure outweighs privacy, trade secret, and anti-competitive considerations.

For each analysis, the HPC utilized the most recent and reliable data available. Because data—whether publicly reported or privately held—is usually generated on a variable schedule from entity to entity, the most recent and reliable data primarily reflects 2014 to 2017 data.¹⁷ We have noted the applicable year for the underlying data throughout this report and, wherever possible, we examined multiple years of data to analyze trends and to report on the consistency of findings over time. For data and materials produced by the parties and other market participants, the HPC tested the accuracy and consistency of the data collected to the extent possible, but also relied in large part on the producing party for the quality of the information provided.

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

¹⁵ The APCD includes medical, pharmacy, and dental claims, as well as information about member eligibility, benefit design, and providers for all payers covering Massachusetts residents. *See All-Payer Claims Database*, CTR. FOR HEALTH INFO. & ANALYSIS, <http://www.chiamass.gov/ma-apcd/> (last visited Oct. 20, 2017).

¹⁶ MASS. GEN. LAWS ch. 6D, § 13(c), *amended by* 2013 Mass. Acts 38, § 20.

¹⁷ Some data sources use fiscal year rather than calendar year data, notably CHIA’s hospital discharge data. Therefore, hospital discharge data presented here is fiscal year data.

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

Finally, most of our analyses focus on the anticipated impact in the commercially insured market. In the commercially insured market, prices for health care services—whether fee-for-service, global budgets, or other forms of alternative payments—are established through private negotiations between payers and providers. The terms of these payer-provider contracts vary widely, both with regard to price and other material terms that impact health care costs and market functioning.¹⁸

¹⁸ See, e.g., OFFICE OF ATT’Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6 ½(b): REPORT FOR ANNUAL PUBLIC HEARING at 40-43 (Mar. 16, 2010), available at <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf>; MASS. HEALTH POLICY COMM’N, 2015 COST TRENDS REPORT: PROVIDER PRICE VARIATION (Jan. 2016), available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf>.

II. OVERVIEW OF THE PARTIES AND THE TRANSACTION

On May 30, 2017, Partners HealthCare System (Partners) and the Foundation of the Massachusetts Eye and Ear Infirmary (MEE) executed an Affiliation Agreement for Partners to acquire MEE, including its specialty hospital, the Massachusetts Eye and Ear Infirmary (MEEI), and its physician organization, Massachusetts Eye and Ear Associates (MEEA).¹⁹ MEEI and MEEA have longstanding clinical affiliations with Massachusetts General Hospital (MGH) and Brigham and Women's Hospital (BWH), and MEEA and Partners have a contracting affiliation. Under the proposed transaction, MEEI and MEEA would become corporate subsidiaries of Partners and would contract through Partners for all contracts with payers. MEE and Partners would also explore options for expanding MEE's services across the Partners provider system. In addition to review by the HPC under the MCN and CMIR process, the parties submitted an application for a DoN by the DPH on July 17, 2017.²⁰ This section describes the parties, their current relationship, and the proposed transaction.

A. PARTNERS HEALTHCARE SYSTEM

Partners was founded in 1994 by an affiliation between two of Boston's preeminent academic medical centers (AMCs), BWH and MGH.²¹ Partners is the largest provider system in Massachusetts and remains one of the strongest financially, with operating revenue of more than \$11.5 billion dollars in 2016.²²

¹⁹ See *supra* note 3 (reporting filing dates for the parties' notices of material change).

²⁰ APPLICATION BY PARTNERS HEALTHCARE SYSTEM FOR DETERMINATION OF NEED FOR TRANSFER OF OWNERSHIP OF MASSACHUSETTS EYE AND EAR INFIRMARY (July 17, 2017), [hereinafter PARTNERS-MEE DON APPLICATION], available at <http://www.mass.gov/eohhs/docs/dph/quality/don/partners-health-system-application-form.pdf>. The DPH's DoN program evaluates applications based on a set of factors including the applicant's patient panel needs, the public health value of the project, and operational objectives including community engagement and the promotion of competition on measures of health spending. See 105 CMR 100.210.

²¹ *About Partners HealthCare*, PARTNERS HEALTHCARE, <http://www.partners.org/About/Default.aspx> (last visited Oct. 28, 2017).

²² The HPC reviewed the 2015 audited financial statements for Partners and five of the six other largest provider systems in Massachusetts, Atrius Health, UMass Memorial Health Care, Beth Israel Deaconess Medical Center, Lahey Health System, and Tufts Medical Center Parent (now part of Wellforce) and found that Partners had net patient service revenue of over \$7.3 billion, more than three times that of the next largest provider system, and total net assets slightly lower than the next five largest systems combined. Compared to these other large Massachusetts provider systems, Partners had a substantially above average cash position, a better than average current ratio, a higher than average capitalization ratio, and a much lower average age of plant, although large increases in operating expenses have driven down Partners' margins in recent years. Like most providers in Massachusetts, Partners operates as a non-profit public charity. Financial statements for these entities are available from the Charities Division of the Massachusetts AGO at *Non-Profits & Charities Document Search*, OFFICE OF ATT'Y. GEN. MAURA HEALEY, <http://www.charities.ago.state.ma.us/> (last visited Aug. 3, 2017). Data for Steward Health Care System for 2015 was unavailable at the time of publication and was not included in HPC's review. For detailed comparisons of Partners' financial performance in 2011 and 2012 to that of other large provider systems in Massachusetts, see also MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL (HPC-CMIR-2013-1) AND HARBOR MEDICAL ASSOCIATES (HPC-CMIR-2013-2), PURSUANT TO M.G.L. C. 6D, § 13, FINAL REPORT at 12 (Feb. 19, 2014) [hereinafter PHS-SSH-HARBOR FINAL CMIR REPORT], available at <http://www.mass.gov/anf/docs/hpc/20140219-final-cmir-report-phis-ssh-hmc.pdf>; MASS. HEALTH POLICY

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

Partners General Acute Care Hospitals in Massachusetts

Hospital	Hospital Type ²³	City/Town	Staffed Beds
Massachusetts General Hospital (MGH)	AMC	Boston	1,043
Brigham and Women's Hospital (BWH)	AMC	Boston	859
North Shore Medical Center (NSMC)	Community, High Public Payer	Salem & Lynn ²⁴	431
Newton-Wellesley Hospital (NWH)	Community	Newton	316
Brigham and Women's Faulkner Hospital (Faulkner)	Community	Boston	138
Cooley Dickinson Hospital (Cooley Dickinson)	Community	Northampton	87
Martha's Vineyard Hospital	Community	Oak Bluffs	31
Nantucket Cottage Hospital	Community	Nantucket	23

Source: HOSPITAL PROFILES ACUTE DATABOOK, *infra* note 36

Partners also owns McLean Hospital, a psychiatric specialty hospital in Belmont, Massachusetts; the Spaulding Rehabilitation Network, which includes rehabilitation hospitals in Cambridge, Charlestown, and East Sandwich; and Wentworth-Douglas Hospital, a general acute care hospital located in Dover, New Hampshire, which serves the Seacoast Region of New Hampshire and abutting communities in southern Maine.²⁵ Partners also contracts with major payers on behalf of a non-owned affiliate hospital in Massachusetts, Emerson Hospital.

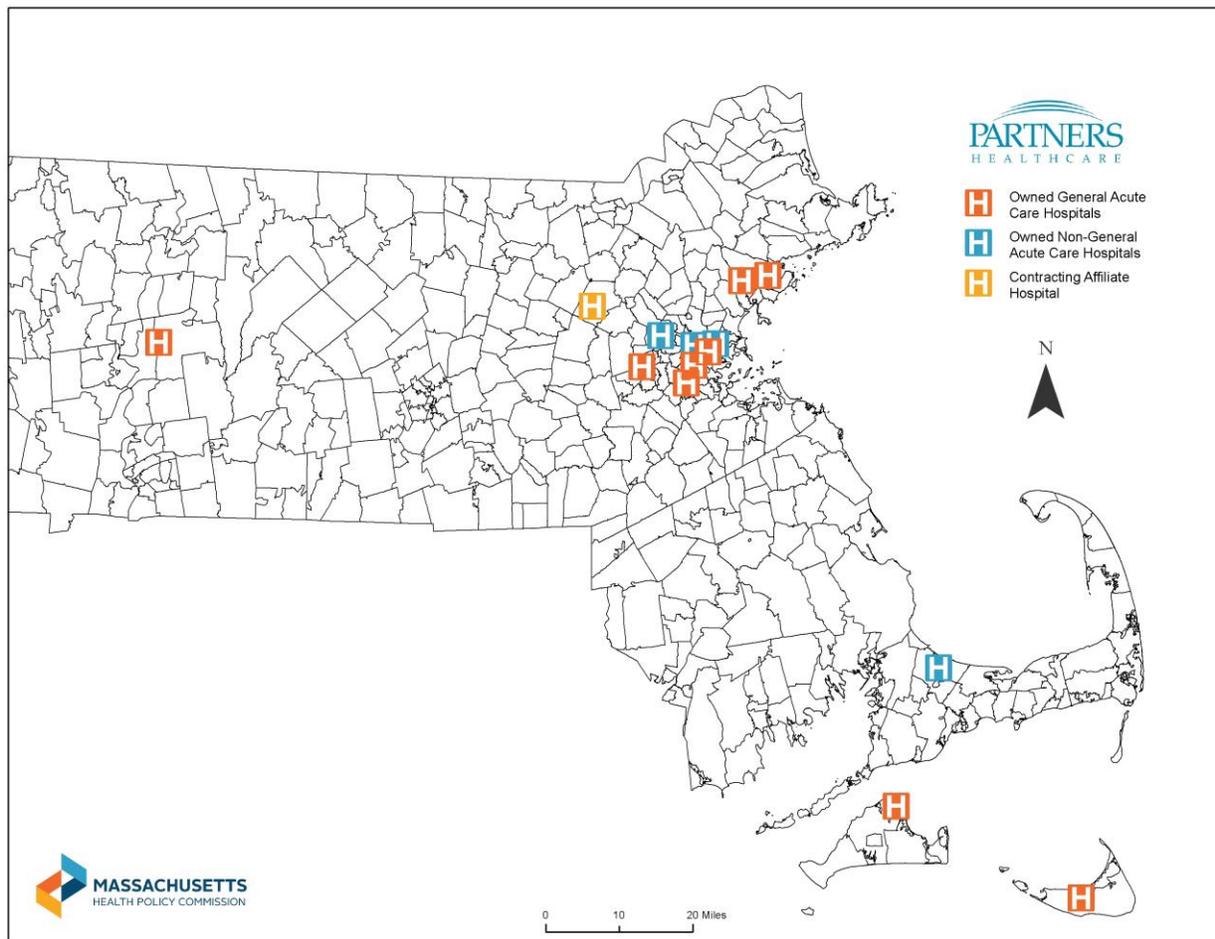
COMM’N, REVIEW OF PARTNERS HEALTHCARE SYSTEM’S PROPOSED ACQUISITION OF HALLMARK HEALTH CORPORATION (HPC-CMIR-2013-4), PURSUANT TO M.G.L. c. 6D, § 13, FINAL REPORT at 18-19 (Sept. 3, 2014) [hereinafter HALLMARK FINAL CMIR REPORT], available at <http://www.mass.gov/anf/docs/hpc/material-change-notices/phs-hallmark-final-report-final.pdf>.

²³ Hospital type is based on CHIA’s hospital cohort classifications; see *Massachusetts Acute Hospital Cohorts*, CTR. FOR HEALTH INFO & ANALYSIS, <http://www.chiamass.gov/massachusetts-acute-hospital-cohort-profiles/> (last visited Oct. 28, 2017).

²⁴ Partners is currently in the process of consolidating NSMC’s inpatient services at NSMC’s Salem campus; Partners currently plans for the campus in Lynn, also known as NSMC-Union, to continue to provide outpatient services. See PARTNERS HEALTHCARE, Application by North Shore Medical Center for Determination of Need for New Construction and Renovation to Salem Hospital Campus, (Oct. 7, 2015); MASS. DEPT. OF PUBLIC HEALTH, NOTICE OF FINAL ACTION: PROJECT NUMBER 6-3C46.1 NORTH SHORE MEDICAL CENTER (Aug. 9, 2017), available at <https://www.mass.gov/files/documents/2017/10/11/north-shore-med-center-decision-letter.pdf>.

²⁵ See WENTWORTH-DOUGLASS HEALTH SYSTEM, NOTICE OF MATERIAL CHANGE TO THE HEALTH POLICY COMM’N (Sept. 2, 2017), AS REQUIRED UNDER MASS. GEN. LAWS CH. 6D, § 13, available at <http://www.mass.gov/anf/docs/hpc/material-change-notices/20160909-wentworth-douglass-partners-mcn.pdf>.

Partners Hospitals in Massachusetts



Source: PARTNERS RPO FILING, *infra* note 27

Note: NSMC is represented by two symbols, representing each of the campuses at which Partners currently provides inpatient care. *See supra* note 24. Partners hospital satellite and clinic locations are not shown.

BWH and MGH, Partners' anchor AMCs and largest hospitals, serve as principal teaching hospitals of Harvard Medical School and are among the largest private hospital recipients of the National Institutes of Health funding in the nation.²⁶ As the Commonwealth's two largest AMCs, BWH and MGH have extensive clinical affiliations. These include MGH's affiliation with MEE, described in more detail in Section II.C below, as well as affiliations with Lowell General Hospital and several hospitals in New Hampshire and southern Maine, and BWH's affiliations with South Shore Hospital, Milford Regional Medical Center, and the Care New England system in Rhode Island.²⁷ Both BWH and MGH also have clinical

²⁶ See U.S. DEP'T. OF HEALTH AND HUMAN SERVS., NATIONAL INSTITUTES OF HEALTH, *NIH Awards by Location and Organization*, <https://www.report.nih.gov/award/index.cfm> (last visited Oct. 30, 2017).

²⁷ MASS. HEALTH POLICY COMM'N, REGISTRATION OF PROVIDER ORGANIZATIONS 2015 INITIAL REGISTRATION: PARTNERS HEALTHCARE SYSTEM (Nov. 10, 2016) [hereinafter PARTNERS RPO FILING], available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/material->

affiliations with Dana Farber Cancer Institute and Boston Children's Hospital (Children's), and provide staffing and pediatric clinical leadership at Steward Health Care System's (Steward) hospitals.²⁸

Partners also has the largest physician network in Massachusetts, Partners Community Physicians Organization (PCPO). PCPO currently negotiates contracts with payers on behalf of more than 6,700 primary care physicians (PCPs) and specialist physicians, including physicians directly employed by Partners as well as physicians who are affiliated with Partners for contracting and clinical purposes, such as the MEEA physicians.²⁹

In addition to being the largest hospital and physician network in Massachusetts, Partners also owns Neighborhood Health Plan (NHP), a Massachusetts payer with more than 430,000 commercial and MassHealth members,³⁰ as well as Partners HealthCare at Home, a home care agency.

B. FOUNDATION OF THE MASSACHUSETTS EYE AND EAR INFIRMARY

The Foundation of the Massachusetts Eye and Ear Infirmary (MEE) is a Massachusetts non-profit corporation and the parent organization of the Massachusetts Eye and Ear Infirmary (MEEI), an acute care specialty hospital;³¹ Massachusetts Eye and Ear Associates (MEEA), its affiliated physician group; and the Schepens Eye Research Institute.³²

MEEI was incorporated in 1827 and focuses on disorders relating to the eye, ear, nose, throat and adjacent regions of the head and neck;³³ it has been a teaching affiliate of the

[change-notices-cost-and-market-impact-reviews/registration-of-provider-organizations/2015-initial-registration-data/partners-healthcare-system-inc-final-2015.xlsx](http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2016-cost-trends-report.pdf).

²⁸ *Id.*

²⁹ HPC analysis of Registration of Provider Organizations data for 2015; *see also* MASS HEALTH POLICY COMM'N, ANNUAL HEALTH CARE COST TRENDS REPORT 2016, at 24 (Feb. 2017), *available at* <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2016-cost-trends-report.pdf>.

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

³¹ MEEI is designated by CHIA both as an acute care hospital and as a specialty hospital. An acute hospital is a hospital that is licensed by the Massachusetts Department of Public Health and, like MEEI, contains a majority of medical-surgical, pediatric, obstetric, and/or maternity beds. However, for comparisons to other hospitals, MEEI is designated as a specialty hospital, indicating that it is not grouped into one of the other CHIA hospital cohorts due to the unique set of services it provides. *See* CTR. FOR HEALTH INFO. & ANALYSIS, MASSACHUSETTS ACUTE HOSPITAL PROFILES TECHNICAL APPENDIX 3, 7-8 (Mar. 2017), *available at* <http://www.chiamass.gov/assets/docs/r/hospital-profiles/2015/FY15-Profiles-Tech-Appendix.pdf>.

³² *See* MASS. HEALTH POLICY COMM'N, REGISTRATION OF PROVIDER ORGANIZATIONS 2015 INITIAL REGISTRATION: FOUNDATION OF THE MASS. EYE AND EAR INFIRMARY (Nov. 10, 2016) [hereinafter MEE RPO FILING], *available at* <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/material-change-notices-cost-and-market-impact-reviews/registration-of-provider-organizations/2015-initial-registration-data/massachusetts-eye-and-ear-infirmary-final-2015.xlsx>. MEE also includes associated property management subsidiaries.

³³ FOUNDATION OF THE MASS. EYE AND EAR INFIRMARY, NOTICE OF MATERIAL CHANGE TO THE HEALTH POLICY COMM'N. (Apr. 5, 2017), AS REQUIRED UNDER MASS. GEN. LAWS CH. 6D, § 13 [hereinafter MEE NOTICE OF MATERIAL CHANGE], *available at* <http://www.mass.gov/anf/docs/hpc/material-change-notices/20170403-meei->

Harvard School of Medicine since 1900.³⁴ Its main downtown Boston campus is next to MGH, and its main buildings are physically connected to MGH, helping to facilitate the close clinical relationship between the institutions, discussed in more detail below. MEEI has 41 staffed beds, 21 adult and 20 pediatric.³⁵ Most of MEEI's services are provided on an outpatient basis. In 2015, 90% of MEEI's \$163.5 million in net patient service revenue was received for outpatient services.³⁶ MEEI contracts independently with payers, and, as a specialty care provider, it has clinical affiliations with a number of different provider networks, including Partners as well as Atrius Health (Atrius),³⁷ Beth Israel Deaconess Care Organization (BIDCO), Steward, Highland Health Care Associates,³⁸ Children's, and the Joslin Diabetes Center.³⁹

MEEA is composed of approximately 200 specialist physicians, nearly all of whom are employed by MEEI.⁴⁰ MEEA physicians have dual appointments at MEEI and at MGH, and MEEA physicians staff MGH's otolaryngology and ophthalmology departments.⁴¹ MEEA establishes some payer contracts on its own, but participates in Partners' contracts for the three largest commercial payers in Massachusetts as part of the Massachusetts General Physicians Organization (MGPO) local practice group.⁴²

[phs-mcn.pdf](#). Throughout this report we refer to otolaryngology and ophthalmology, the medical specialties relating to ear, nose, and throat and to the eyes, respectively.

³⁴ *History of Mass. Eye and Ear*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/about-us/meei-history-timeline> (last visited Oct. 28, 2017).

³⁵ *Quick Facts about Mass. Eye and Ear*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/news/facts> (last visited Oct. 28, 2017).

³⁶ CTR. FOR HEALTH INFO. & ANALYSIS, HOSPITAL PROFILE: MASSACHUSETTS EYE AND EAR INFIRMARY (Mar. 2017), available at <http://www.chiamass.gov/assets/docs/r/hospital-profiles/2015/mass-eye.pdf>; CTR. FOR HEALTH INFO. & ANALYSIS, MASSACHUSETTS HOSPITAL PROFILES ACUTE DATABOOK (DATA THROUGH FISCAL YEAR 2015) (Mar. 2017) [hereinafter HOSPITAL PROFILES ACUTE DATABOOK], available at <http://www.chiamass.gov/assets/docs/r/hospital-profiles/2015/FY15-Acute-Databook.xlsx> (showing MEEI's inpatient and outpatient net patient service revenue).

³⁷ ATRIUS HEALTH, NOTICE OF MATERIAL CHANGE TO THE HEALTH POLICY COMM'N. (Nov. 16, 2015), AS REQUIRED UNDER MASS. GEN. LAWS CH. 6D, § 13, available at <http://www.mass.gov/anf/docs/hpc/material-change-notices/20151116-atrui-meei-mcn.pdf>.

³⁸ PARTNERS HEALTHCARE, Response to Determination of Need Program Questions at 5 (Sept. 1, 2017) [hereinafter Partners Sept. 1 DoN Response], available at <https://www.mass.gov/files/documents/2017/10/11/partners-health-system-responses.pdf>.

³⁹ See MEE RPO FILING, *supra* note 32. To determine how frequently the patients of these clinical affiliates use MEEI, the HPC conducted an analysis of the APCD. Of the 123,000 claims from the three largest commercial payers in Massachusetts at MEEI for which we could identify a PCP in 2014 (representing 83% of the MEEI claims for these payers), 37.3% of claims were for the patients of Partners PCPs, 12.4% Atrius, 9.6% BIDCO, 8.0% Steward, 6.2% Wellforce, 5.9% Children's, 3.7% Lahey Health System, and 16.9% all other.

⁴⁰ HPC analysis of Registration of Provider Organizations data for 2015.

⁴¹ See MEE RPO FILING, *supra* note 32.

⁴² MEE NOTICE OF MATERIAL CHANGE, *supra* note 33. As discussed in greater detail in Section IV.A., Partners physicians receive varying rates from payers based on the nature of their affiliation with Partners; physicians in the local practice groups affiliated with Partners' AMCs, MGPO and the Brigham and Women's Physician Organization, receive the highest commercial payer rates. PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 22, at 32, note 98.

In addition to its main campus, MEEI currently provides outpatient services at eight hospital satellite locations.⁴³ MEEA operates 10 physician practice sites, including one in Rhode Island. Notably, 14 of these clinic and hospital satellite sites have been newly established since 2007, including MEEI’s Longwood surgical site in 2013.⁴⁴

MEE Hospital Satellite and Clinic Locations

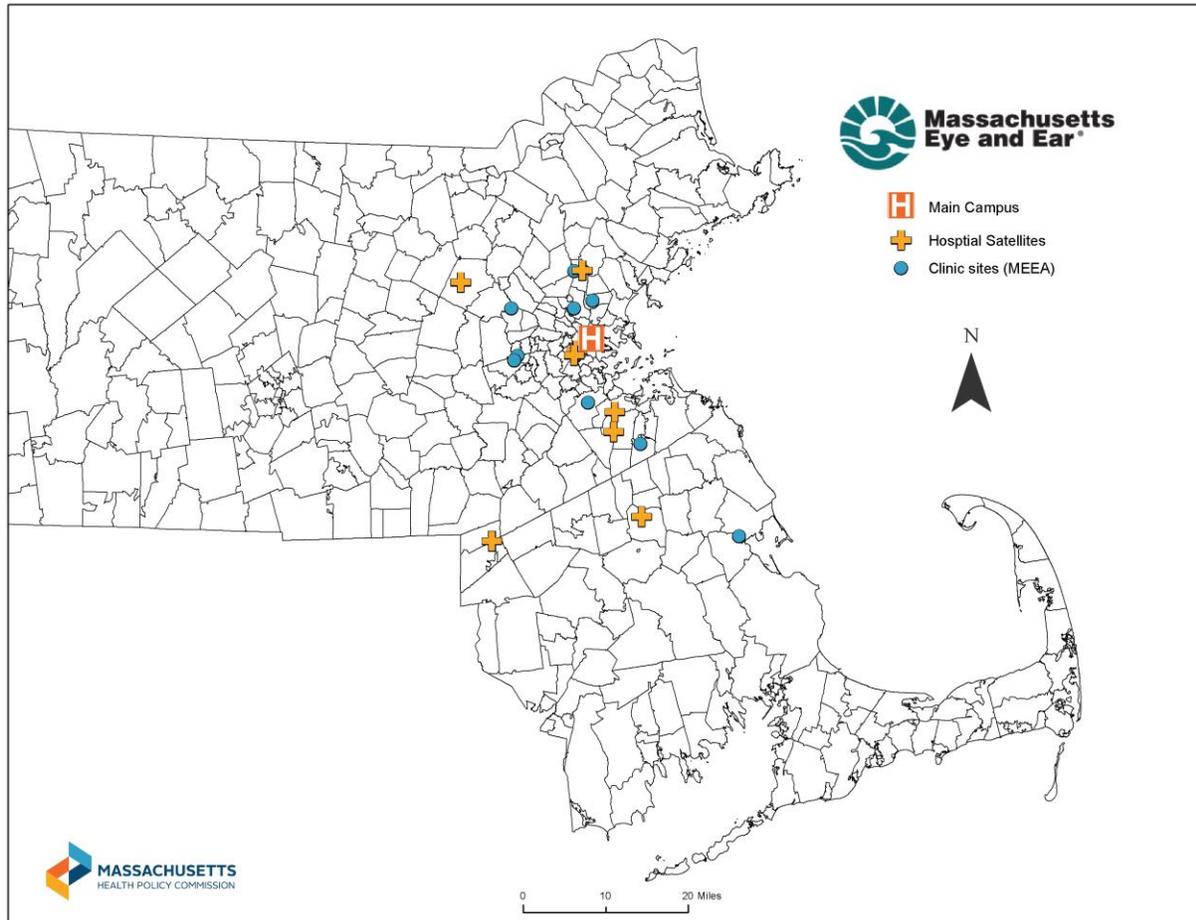
MEEI Hospital Satellites	MEEA Physician Practice Sites
Braintree	Duxbury
Concord	Malden
East Bridgewater	Medford
Longwood (two sites, including a joint site with the Joslin Diabetes Center)	Milton
Plainville	Newton
Quincy	Stoneham
Stoneham	Waltham
	Wellesley
	Weymouth
	Providence, RI

Source: *Massachusetts Eye and Ear Locations*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/locations> (last visited Oct. 29, 2017); MEE RPO FILING, *supra* note 32

⁴³ Hospital satellites are facilities owned by a hospital and operated under that hospital’s license, usually primarily for the purpose of providing outpatient services. As described in the HPC’s 2015 Cost Trends Report, hospital satellites often provide some services similar to services provided in non-hospital facilities like clinics; however, because they are considered part of a hospital, satellites may bill patients or payers separately for professional and facility costs, resulting in a higher total bill than if the same service were performed in a non-hospital setting. *See* MASS. HEALTH POLICY COMM’N, 2015 COST TRENDS REPORT 39-44 (Jan. 2016), *available at* <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-cost-trends-report.pdf>.

⁴⁴ MASS. EYE AND EAR INFIRMARY, Annual Report 2016 at 1 [hereinafter MEEI ANNUAL REPORT], *available at* <http://www.masseyeandear.org/about-us/annual-report> (last visited Oct. 28, 2017); MASS. EYE AND EAR INFIRMARY, *History of Mass. Eye and Ear*, *supra* note 34 (including the opening of the Longwood surgical center).

MEE Locations in Massachusetts



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

MEE's recent expansions have helped to increase its outpatient volume by nearly 80% and more than double its net patient service revenue over the past decade, and the parties expect continued otolaryngology and ophthalmology volume growth due to the needs of the Commonwealth's aging population for these services.⁴⁵ Despite this revenue growth, MEE had negative operating margins in fiscal years 2013 and 2014 and sold off non-clinical real estate assets in fiscal years 2015 and 2016 to augment its revenue. Without the revenue from asset sales MEE would have incurred losses in 2015 and 2016 as well.⁴⁶ In February 2017, Standard

⁴⁵ See MEEI ANNUAL REPORT *supra* note 44; PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section F1.a.ii (describing otolaryngology and ophthalmology utilization rates among older populations and Massachusetts' aging demographic trends, as well as MEEI's recent growth in these services, as indicative of expected future volume).

⁴⁶ The HPC reviewed audited financial statements for MEE for fiscal years 2013 through 2016, as well as documents provided confidentially by the parties. MEE's operating expenses have grown faster than revenues in recent years, and MEE's current ratio has decreased. MEE's financial statements are available from the Charities Division of the AGO; *see supra* note 22. *See also* Parties' Response, Exh. A, at 2.

and Poors affirmed MEE's bond rating of BBB but revised the outlook on the bond to "negative."⁴⁷ Although MEE's financial position has weakened in recent years, there is no indication that MEE is in imminent danger of closure. Some of MEE's financial metrics are favorable,⁴⁸ MEE has continued to invest in its clinical operations and begun efforts to improve its financial position independent of the proposed transaction, and some recent information suggests that MEE's financial performance may be starting to improve.⁴⁹ Nonetheless, the parties have stated that MEE "will soon find it difficult to maintain all aspects of its clinical, research and teaching missions" due to a variety of financial pressures, including rising labor and pharmaceutical costs and reductions in federal funding for research and medical education.⁵⁰ They have stated that they hope the transaction will improve MEE's long-term viability, as discussed in Section II.D, although they have indicated that they expect this can be accomplished without significant rate increases.⁵¹

C. CURRENT RELATIONSHIP BETWEEN PARTNERS AND MEE

Partners and MEE have a long history of close clinical collaboration.⁵² The main campus hospital buildings of MGH and MEEI are physically connected, MEEA physicians have dual appointments at both institutions, and patients and physicians move regularly between institutions.⁵³ MGH's departments of otolaryngology and ophthalmology are staffed by MEEA physicians and led by MEEI's department chiefs.⁵⁴ MEE also provides eye care to MGH emergency department patients, and MGH provides pathology services and surgical

⁴⁷ See S&P GLOBAL RATINGS, MASSACHUSETTS DEVELOPMENT FINANCE AGENCY: MASSACHUSETTS EYE & EAR INFIRMARY; HOSPITAL (Feb. 13, 2017) [hereinafter S&P Report], attached to Parties' Response, Exh. A.

⁴⁸ MEE has an adequate reserve of cash and other readily available assets, its patient service revenue has been growing steadily, and its investments in capital improvements and equipment are reflected in improvements in its average age of plant from 2014 to 2016. See *supra* note 46.

⁴⁹ As discussed in the HPC's Analysis of the Parties' Response, Exh. B, at 5, note 19, MEE provided documents from 2016 confidentially to the HPC describing all of MEE's financial metrics as either "positive" or "neutral," and discussing cost-saving and revenue-enhancing measures designed to improve MEE's financial position independent of the proposed transaction. MEE's financial projections for fiscal year 2017 and budgeted fiscal year 2018 show that MEE expects continued operating losses in these years, but expects those losses to substantially decline. This assessment aligns with MEE's statement in the S&P Report that it expected its operating performance to gradually improve through the year 2020. See S&P Report, *supra* note 47, at 5.

⁵⁰ PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section 2.1. The parties have also stated that "MEE in partnership with Schepens Eye Research Institute, comprises the world's largest vision and hearing research centers" with \$30.1 million for ophthalmology research and \$13.5 million for otolaryngology research in fiscal year 2016. Partners Sept. 1 DoN Response, *supra* note 38, at 9.

⁵¹ Parties' Response, Exh. A, at 3.

⁵² *Massachusetts Eye and Ear announces plans to join Partners HealthCare*, MASS. EYE & EAR INSTITUTE, <http://www.masseyeandear.org/news/press-releases/2017/01/mass-eye-and-ear-announces-plans-to-join-partners-healthcare> (Jan. 27, 2017) (last visited Oct. 28, 2017) ("Throughout nearly two centuries, MEE clinicians and scientists have enjoyed a close collaboration with colleagues at Massachusetts General Hospital").

⁵³ *MGH and MEEI formalize relationship*, MASS. GENERAL HOSPITAL, <http://www.massgeneral.org/News/newsarticle.aspx?id=1837> (Aug. 7, 2009) (last visited Oct. 28, 2017).

⁵⁴ *Mass. Eye and Ear and Mass General Enter Formal Relationship to Provide Top Eye and ENT Care*, MASS. EYE & EAR INSTITUTE, <https://www.masseyeandear.org/news/press-releases/2009/10/mghcollaboration> (Oct. 19, 2009) (last visited Oct. 28, 2017).

support to MEEI.⁵⁵ In addition to MEE's relationship with MGH, MEEA physicians staff the ophthalmology department at BWH, and provide clinic services at Faulkner.⁵⁶

In addition to these clinical relationships, MEEA has a contracting affiliation with Partners as noted above. MEEA physicians currently participate in Partners' commercial payer contracts with the three largest commercial payers in Massachusetts, BCBS, HPHC, and THP.⁵⁷ For the purpose of these contracts, MEEA physicians are considered part of MGH's affiliated physician group within Partners, the MGPO.⁵⁸ MEEA currently contracts separately from Partners for smaller payer contracts, while MEEI contracts independently for all payer contracts.

To allow for management of their joint patients and to facilitate transitions between MEE and Partners institutions, MEEI has also developed health information technology linkages with Partners, including by participating in the Partners electronic health record system, "Partners eCare," and the Partners Patient Gateway.⁵⁹ This system provides patient-facing tools and allows all providers in the Partners HealthCare network, including MEEI, access to a single medical record.⁶⁰ However, the Partners and MEE record systems are not fully integrated and include restrictions on how and when non-physician staff can access patient records for shared patients.⁶¹

D. THE PROPOSED TRANSACTION

The parties have indicated that the proposed transaction would serve both financial and clinical goals. The parties have stated that the acquisition will allow MEE to achieve "market competitive rates,"⁶² and have indicated that they expect rate increases for MEE as Partners begins contracting for MEEI and as MEEA physicians join Partners contracts with all commercial payers.⁶³ The parties also state that they expect that MEE would achieve operating

⁵⁵ *Emergency and Trauma Eye Care*, MASS. EYE & EAR INSTITUTE, <https://www.masseyeandear.org/specialties/ophthalmology/emergency-and-trauma-eye-care> (last visited Oct. 28, 2017); MEE RPO Filing, *supra* note 32.

⁵⁶ *Ophthalmology*, PARTNERS HEALTHCARE, http://www.brighamandwomens.org/Departments_and_Services/surgery/Ophthalmology/default.aspx (last visited Oct. 28, 2017); MEE RPO FILING, *supra* note 32.

⁵⁷ MEE NOTICE OF MATERIAL CHANGE, *supra* note 33.

⁵⁸ PARTNERS RPO FILING, *supra* note 27.

⁵⁹ MEE RPO FILING, *supra* note 32; *Partners Patient Gateway*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/for-patients/adult-surgical-services/partners-patient-gateway> (last visited Oct. 28, 2017).

⁶⁰ *Upgrading our Electronic Health Record System*, MASS. EYE & EAR INFIRMARY, <https://www.masseyeandear.org/partnersecare> (last visited Oct. 28, 2017).

⁶¹ Partners and MEEI have stated that the federal Health Insurance Portability and Accountability Act requires Partners and MEE to maintain technical separations in their medical record systems for security reasons and that this prevents efficient data sharing and requires duplicative administrative work by each organization because they are not under common corporate ownership. *See* Partners Sept. 1 DoN Response, *supra* note 38, at 12.

⁶² MEE NOTICE OF MATERIAL CHANGE, *supra* note 33.

⁶³ Confidential documents provided by the parties include projections of substantial increases in MEE revenue based on rate increases for MEE, notwithstanding statements that Partners has provided "no guaranty that it will achieve any *specific* rate increases" for MEE. PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section

efficiencies as a result of joining the Partners system. In particular, the parties state that MEE would avoid certain capital expenditures, including by using operating room capacity at existing or planned Partners sites as demand increases, rather than building or expanding its own clinical sites.⁶⁴ The parties also state that MEE would purchase goods and services at lower cost through Partners' vendors, share in Partners system-wide research and administrative supports, and be able to borrow capital more cheaply through use of Partners' borrowing arrangements.⁶⁵

Regarding clinical goals, the parties have stated that they intend for MEE to become the "system-wide ophthalmology ... and otolaryngology ... resource for Partners."⁶⁶ The parties have indicated that this means that, in addition to maintaining the current clinical relationships between MEE and certain Partners providers detailed above, they would develop arrangements for MEE to become the provider of otolaryngology and ophthalmology for at least some of Partners' community hospitals and outpatient sites, potentially including new outpatient sites that Partners may establish.⁶⁷ The parties have not identified where, when, or to what extent such integration or expansion might occur, and have indicated that this planning would occur after the transaction. The parties have also stated that MGH would explore options for providing additional clinical and administrative support to MEEI.⁶⁸ Finally, the parties have indicated that MEE would be fully integrated into Partners' information technology systems, which the parties say would remove technical barriers (discussed in Section II.C above) that currently limit effective patient management and quality improvement.⁶⁹

F1.a.iii (emphasis added). The Parties' Response concedes that the transaction would result in rate increases for MEE, although the parties dispute the HPC's estimates of the size of the potential increases. *See* Parties' Response, Exh. A, at 3-4. We address this point in Exhibit B, Section I.

⁶⁴ PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section 2.1 and Section F1.a.ii; *see also supra* note 45.

⁶⁵ PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section 2.1. Section IV.A.4 details some of the areas in which they expect to achieve operational savings. The parties have projected that they expect such efficiencies to reduce the rate of growth of MEE's operating expenses from 5% per year to 4% per year for the three years following the closing of the transaction, and that additional savings may accrue thereafter. Partners Sept. 1 DoN Response, *supra* note 38, at 3. The parties have indicated that any such savings would be retained and redirected to MEE's clinical and research activities. PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section F1.a.iii.

⁶⁶ MEE NOTICE OF MATERIAL CHANGE, *supra* note 33.

⁶⁷ Partners Sept. 1 DoN Response, *supra* note 38, at 3, 5.

⁶⁸ Partners Sept. 1 DoN Response, *supra* note 38, at 3.

⁶⁹ PARTNERS-MEE DON APPLICATION, *supra* note 20, at Sections F1.b.i - F1.b.ii.

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

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

A. COST AND MARKET BASELINE PERFORMANCE

The law governing cost and market impact reviews directs the HPC to examine different measures of the parties' respective cost and market position, including their size, prices, health status adjusted total medical expenses (TME), and market shares.⁷⁰ The HPC examined these measures over time and compared to other providers to establish the parties' baseline performance leading up to the proposed transaction. In Section IV, we will combine the parties' current performance with details of the transaction and the parties' goals and plans to project the likely impacts of the transaction.

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

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

⁷⁰ See Section I.A. Because provider organizations primarily negotiate with commercial, not government, payers for prices, commercial market share is more relevant for assessing the competitive impact of a transaction. Our assessments of market shares for provider organizations or contracting networks are based on the share of services of hospitals or physicians for which the organization establishes commercial contracts, as well as any providers from which a provider organization receives patient service revenue.

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

As the HPC has documented in past reports, Partners is the largest system in the state by a substantial margin, with high commercial market share across inpatient, outpatient, and primary care services, both statewide and in its service areas.⁷¹ In 2016, Partners hospitals accounted for 27.0% of inpatient discharges for commercially insured patients in the state, whereas the next largest provider network, BIDCO, accounted for 14.0%.⁷² Similarly, in the most recent year for which data were available, Partners providers accounted for 26.7% of outpatient visits for patients insured by the three largest commercial payers in Massachusetts, more than twice that of BIDCO, at 13.0%.^{73,74}

Statewide Commercial Market Share

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

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

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

⁷¹ PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 22, at 7-8, 17-18; HALLMARK FINAL CMIR REPORT, *supra* note 22, at 8-9, 21-23.

⁷² We used 2016 CHIA hospital discharge data to identify each provider’s share of commercial hospital discharges provided in Massachusetts for general acute care services (i.e., services provided in non-specialty inpatient hospitals), excluding normal newborns (including normal newborns would effectively double-count a single delivery as two discharges), non-acute discharges (e.g., discharges with a length of stay of greater than 180 days, rehabilitation discharges), and out-of-state patients.

⁷³ We used claims-level data from the 2014 APCD for BCBS, HPHC, and THP to identify services provided by all facilities, including acute and non-acute care hospital outpatient departments and satellite facilities, and freestanding ambulatory surgery centers. We then determined the share of patient visits at each provider, counting all claims on the same day at the same provider for the same patient as a single visit.

⁷⁴ Partners also had the highest statewide share of primary care physician visits for patients insured by one of the three largest commercial payers (15.8%, followed by Steward at 10.7%, Children’s at 9.8%, and Wellforce at 9%) in the 2014 APCD. For more information on our methodology for defining shares of primary care physician visits, see MASS. HEALTH POLICY COMM’N, REVIEW OF BETH ISRAEL DEACONESS CARE ORGANIZATION’S PROPOSED CONTRACTING AFFILIATION WITH NEW ENGLAND BAPTIST HOSPITAL AND NEW ENGLAND CLINICAL INTEGRATION ORGANIZATION (HPC-CMIR-2015-1) AND BETH ISRAEL DEACONESS CARE ORGANIZATION’S PROPOSED CONTRACTING AFFILIATION AND BETH ISRAEL DEACONESS MEDICAL CENTER’S AND HARVARD MEDICAL FACULTY PHYSICIANS’ PROPOSED CLINICAL AFFILIATION WITH METROWEST MEDICAL CENTER (HPC-CMIR-2016-1), PURSUANT TO M.G.L. C. 6D, § 13, FINAL REPORT (Sept. 7, 2016) at 28, note 111, *available at* <http://www.mass.gov/anf/docs/hpc/material-change-notice/bidco-nebh-metrowest-bidmc-final-cmir.pdf>.

Within the primary service areas⁷⁵ (PSAs) for its hospitals, Partners' shares of inpatient services were higher and often substantially higher than those of other systems.⁷⁶

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

- a. *Inpatient services*

As described in Section II.B, MEEI provides relatively few inpatient services. In total, MEEI had only 831 discharges in 2016, and had only 0.2% of all discharges in its own PSA. However, MEEI does not provide a full range of inpatient general acute care services. In order to assess MEEI's share of the services for which it competes, the HPC examined its market share for the inpatient services it provides most frequently, largely otolaryngology and ophthalmology services, which we refer to as MEEI's inpatient "core services."⁷⁷ We then defined MEEI's PSA for these services⁷⁸ and calculated the parties' shares of those services in MEEI's PSA. Even focusing on these inpatient services that MEEI provides most frequently, we found that MEEI accounted for only 3.5% of discharges in its PSA in 2016. However,

⁷⁵ The CMIR statute directs the HPC to "examine factors relating to the provider or provider organization's business and its relative market position," including "the provider or provider organization's size and market share within its *primary service areas*" and "the provider or provider organization's impact on competing options for the delivery of health care services within its *primary service areas*." MASS. GEN. LAWS ch. 6D, § 13(d) (emphasis added). The HPC defines a hospital's primary service area or PSA as the area from which a hospital draws 75% of its commercial patients. For details regarding the HPC's methodology for defining an inpatient PSA, see TECHNICAL BULLETIN, *supra* note 11. As articulated by the Federal Trade Commission and Department of Justice, "[a]lthough a PSA does not necessarily constitute a relevant geographic market, it nonetheless serves as a useful screen for evaluating potential competitive effects." Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (ACO), 76 FED. REG. 67026, 67028 (Oct. 28, 2011), [available at http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf](http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf).

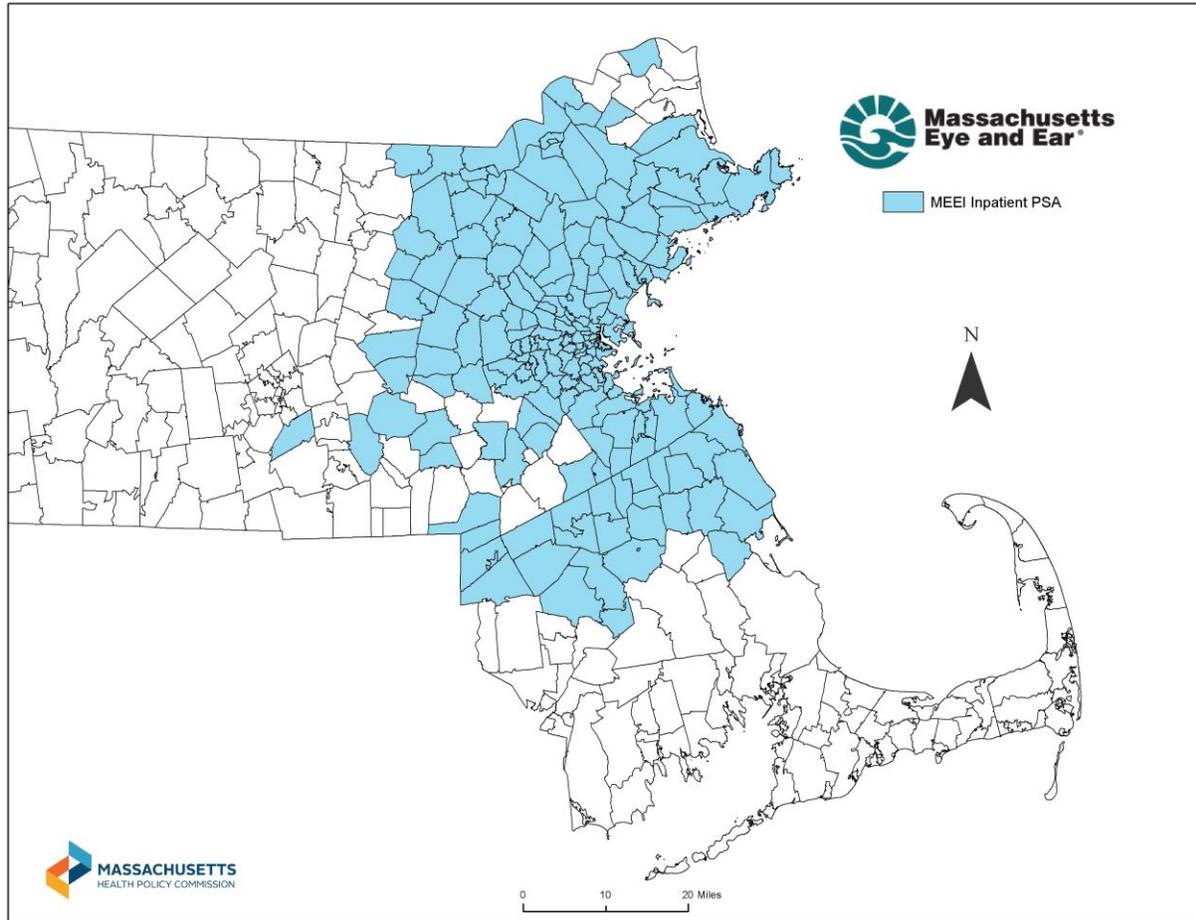
⁷⁶ In each Partners hospital PSA in 2016, Partners hospitals accounted for 31.3% (Cooley Dickinson) to 82.9% (Nantucket Cottage Hospital) of general acute care inpatient discharges. In the PSAs of NSMC, Martha's Vineyard Hospital, and Nantucket Cottage Hospital, Partners' share of inpatient services exceeded 40%, the HPC's threshold for "dominant market share" for inpatient services pursuant to MCN AND CMIR REGULATIONS, *supra* note 1, at 958 CMR 7.02 (defining a provider or provider organization as having dominant market share for inpatient general acute care services when it has 40% of the commercial discharges in one or more of its hospital PSAs). Partners' share in Faulkner's PSA was 39.8%, just 0.2% below the threshold for dominant market share.

⁷⁷ We used 2016 CHIA Hospital Discharge Data to identify the inpatient services MEEI most commonly provides, based on the most common Medicare Severity-Diagnosis Related Groups (MS-DRG) for MEEI patients and including all levels of acuity. Our core services definition also includes relatively uncommon services for which MEEI provides at least 10% of all commercial discharges among hospitals in its PSA. In total, our method of defining MEEI's inpatient core services accounted for approximately 83% of MEEI's commercial discharges in 2016. The 67 MS-DRGs in our definition of MEEI's core services include, but are not limited to, inpatient otolaryngology and ophthalmology services. They are: 11-13, 25-27, 113-117, 121-122, 124-125, 129-136, 146-148, 152-156, 204-206, 576-581, 602-603, 606-607, 625-627, 643-645, 820-825, 840-842, 856-858, 862-863, and 919-921.

⁷⁸ The HPC defined MEEI's inpatient PSA as the contiguous zip codes closest to the hospital from which the hospital draws 75% of its commercial discharges for its core services.

Partners hospitals provided 34.0% of these discharges within MEEI's PSA.⁷⁹ Given that Partners hospitals do not specialize in otolaryngology and ophthalmology services, Partners' share of these inpatient services likely reflects its substantial share of the overall inpatient market, as described above.

MEEI Inpatient Core Services Primary Service Area



Source: HPC analysis of hospital discharge data

b. Outpatient services

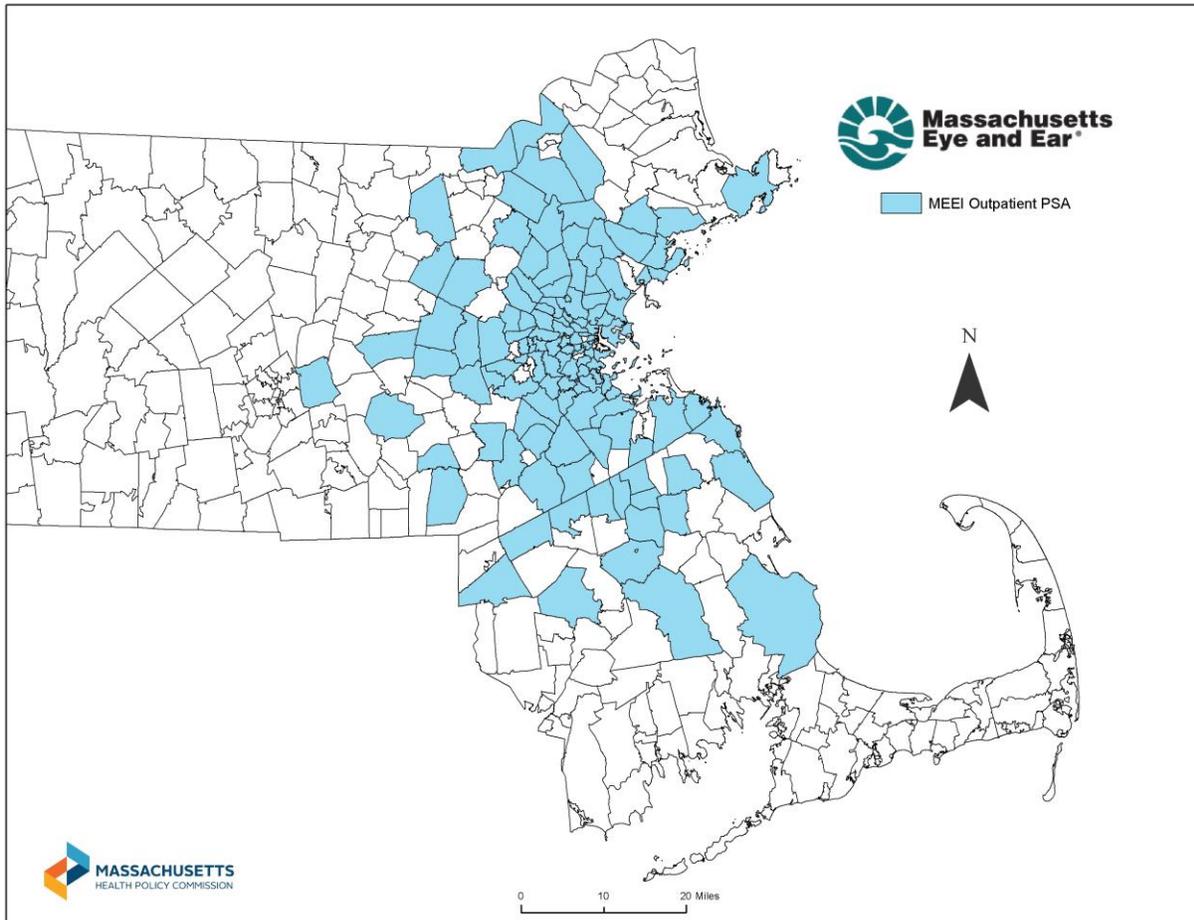
As described in Section II.B, MEEI predominantly provides *outpatient* otolaryngology and ophthalmology services. To analyze the parties' market position for the services for which MEEI competes, we identified outpatient otolaryngology and ophthalmology facility visits⁸⁰

⁷⁹ In its own PSAs, Partners provided an even greater share of MEEI's inpatient core services, ranging from 34.0% to 77.8%.

⁸⁰ As described in *supra* note 73, facility visits include services provided at acute care hospitals and their satellite locations, non-acute care hospitals (e.g., rehabilitation hospitals) and their satellite locations, and freestanding ambulatory surgery centers.

based on a clinical classification of outpatient procedure codes billed during those visits.⁸¹ We then defined MEEI's outpatient PSA for these services.⁸² As shown below, MEEI's outpatient otolaryngology and ophthalmology PSA includes most of eastern Massachusetts.

MEEI Outpatient Otolaryngology and Ophthalmology Primary Service Area



Source: HPC analysis of 2014 All-Payer Claims Database

In this outpatient PSA, we found that MEEI had the highest shares of both otolaryngology and ophthalmology facility visits, at 26.5% and 34.6%, respectively. Partners

⁸¹ Current Procedural Terminology (CPT) code clusters are based on clinical categories in the CPT Codebook published by the American Medical Association. AMERICAN MEDICAL ASS'N, *CPT® 2014 Professional Edition* (2014). The Codebook includes approximately 300 clinical categories, which the HPC aggregated into 42 categories that parallel major specialties and subspecialties in clinical care. Otolaryngology and ophthalmology are two such aggregated categories.

⁸² Using claims-level data in the 2014 APCD for BCBS, HPHC, and THP, we defined MEEI's outpatient PSA as the zip codes from which it draws 75% of its outpatient visits for these services, and then calculated shares of outpatient otolaryngology and ophthalmology visits, respectively, for MEEI, Partners, and other major health care systems in the Commonwealth. As we did with all outpatient services, we counted all claims from the same provider for the same patient on the same day as a single visit.

also had a significant share of outpatient facility otolaryngology visits in MEEI’s PSA, at 18.7%. By contrast, Partners’ share of outpatient facility ophthalmology visits in this service area was only 1%.^{83,84}

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

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

Source: HPC analysis 2014 APCD data for the three largest commercial payers
Notes: Outpatient shares refer to the parties’ shares within MEEI’s outpatient PSA. These findings include data from the three largest commercial payers.
“HealthSouth” is a network of rehabilitation hospitals.

⁸³ Most claims in an outpatient setting include both a facility component and a professional component. We focus on the facility component of outpatient services because the MEEA physicians already contract through Partners for BCBS, THP and HPHC, which are the three payers for which we have APCD data. We do not anticipate a change to the parties’ share of outpatient professional services, or share of professional services in other settings (e.g., physician offices or clinics) for these payers, and do not currently have access to the data for other payers for which there would be a change in share. For these three largest commercial payers, the parties’ combined share of outpatient professional revenue from facility settings in MEEI’s outpatient PSA was 44.6% for otolaryngology and 44.0% for ophthalmology as of 2014, the most recent year for which data were available. In non-hospital settings (e.g., physician offices or clinics), the parties’ combined share of professional revenue in MEEI’s outpatient PSA was 29.5% for otolaryngology and 30.6% for ophthalmology.

⁸⁴ In our examination of the APCD claims data for otolaryngology and ophthalmology services, we also found that a number of services are provided in both facility and non-facility settings (e.g., physician offices or clinics), suggesting that for some services, patients could choose to receive the service in either a facility or non-facility setting. We therefore also examined the parties’ shares of revenue for the same CPT codes across outpatient facility and non-facility settings, including both the facility and professional components of revenue. We found that for otolaryngology services, MEE facilities and physicians received 22.9% of revenue from visits in MEEI’s outpatient PSA, while Partners facilities and physicians (excluding MEEA) received 15.3%. For ophthalmology services, MEE facilities and physicians received 14.9% of the revenue from visits in MEEI’s outpatient PSA, while Partners facilities and physicians (excluding MEEA) received 20.3%. As described above, Partners facilities only received 1% of outpatient facility visits for ophthalmology; the higher share of ophthalmology for Partners facilities and physicians combined reflects the fact that some non-MEEA Partners physicians provide ophthalmology services at non-Partners facilities including independent eye surgery centers, MEEI, and other non-Partners hospitals, as well as in non-facility settings.

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

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

Source: HPC analysis 2014 APCD data for the three largest commercial payers
 Notes: Outpatient shares refer to the parties’ shares within MEEI’s outpatient PSA.
 These findings reflect data from the three largest commercial payers. Although other providers have higher ophthalmology shares, Partners’ share is shown for reference.

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

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

As the HPC has also documented in past reports, along with Partners’ strong market position, its hospitals and physicians also have some of the highest prices in the Commonwealth.⁸⁵ For the three largest commercial payers in 2015, Partners’ AMCs had the highest commercial relative prices among the six AMCs in the Commonwealth, and Partners’ community hospitals had some of the highest commercial relative prices among the state’s community hospitals. Partners’ community hospitals were also frequently the highest priced hospital among local comparators.⁸⁶ Partners hospitals also had prices that were similar to each

⁸⁵ PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 22, at 14-16; HALLMARK FINAL CMIR REPORT, *supra* note 22, at 23-25.

⁸⁶ Relative price is a standardized pricing measure that accounts for differences among provider service volume, service mix, patient acuity, and insurance product types in order to allow comparison of negotiated price levels. In 2015, BWH and MGH had the highest inpatient and outpatient blended relative prices among all AMCs for the three largest payers, ranging from 1.26 to 1.46. With the exception of Cooley Dickinson, which does not yet contract through Partners (*see infra* note 89), Partners community hospitals were among the top 12 most-expensive community hospitals in the Commonwealth for the three largest commercial payers (out of 44 community hospitals total). Only the community hospitals located on Cape Cod or in Berkshire County are consistently more expensive. CTR. FOR HEALTH INFO. & ANALYSIS, PROVIDER PRICE VARIATION IN THE MASSACHUSETTS HEALTH CARE MARKET (CALENDAR YEAR 2015 DATA) (May 2017) [hereinafter CHIA RELATIVE PRICE DATABOOK], available at <http://www.chiamass.gov/assets/docs/r/pubs/17/Relative-Price-Databook->

other. MEEI's 2015 commercial prices were substantially lower than those of MGH and BWH, as well as lower than those of the Partners community hospitals in greater Boston.⁸⁷

The following chart shows 2015 blended inpatient and outpatient relative prices for one major payer for Partners acute care hospitals, comparators providing similar services to patients residing in the same areas, and MEEI. Pricing for these hospitals is similar in other payer networks. As shown below, the Partners hospitals were generally higher-priced, and sometimes considerably higher-priced, than local comparators.⁸⁸ The Partners AMCs had the same relative price, and the three community hospitals in greater Boston had nearly identical relative price levels.⁸⁹ MEEI's relative price was lower than the relative prices of both of Partners' AMCs and its Boston-area community hospitals.

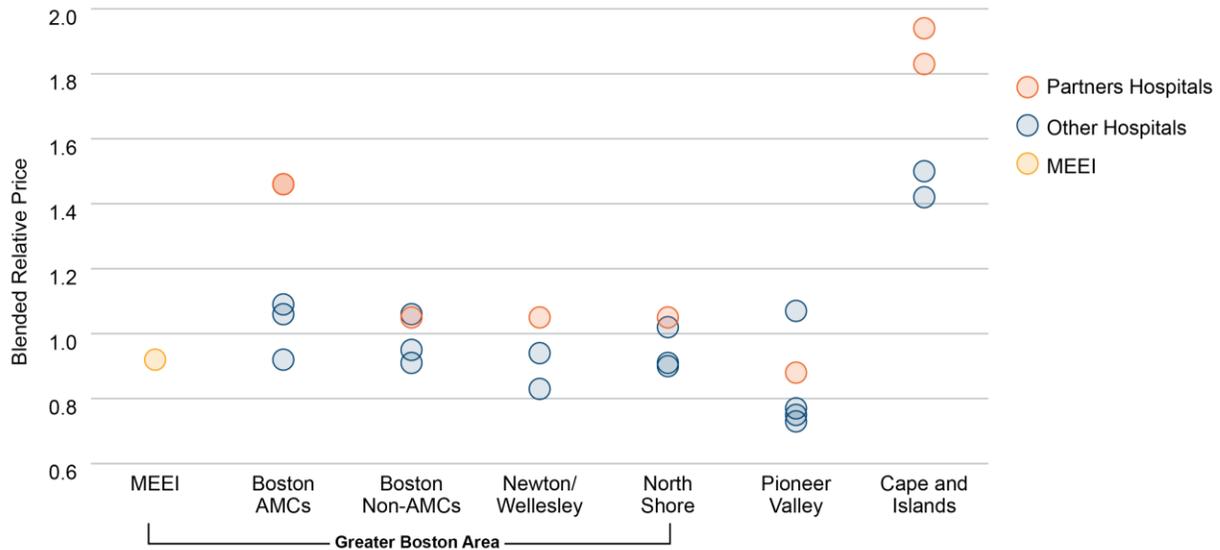
[2017.xlsx](#). These prices constitute “materially higher price” for all Partners acute care hospitals, as defined in MCN AND CMIR REGULATIONS, *supra* note 1, and further described in TECHNICAL BULLETIN, *supra* note 11.

⁸⁷ For example, MEEI's 2015 inpatient and outpatient blended relative prices ranged from 0.79 to 0.92 for the three largest commercial payers, compared with a range of 1.02 to 1.09 for Partners' three Boston-area community hospitals and, as noted above, a range of 1.26 to 1.46 for Partners' AMCs. CHIA RELATIVE PRICE DATABOOK, *supra* note 86.

⁸⁸ The HPC identified comparators for each Partners hospital that reflect a set of local hospitals that a local patient could choose as a substitute for each Partners hospital. The comparators are based on geographic proximity, patient flow patterns, and hospital type (AMC and non-AMC), and therefore may not align with municipal boundaries or other fixed regions. *See* PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 22, at 5-6.

⁸⁹ Cooley Dickinson and its physicians do not yet contract through Partners due to an agreement with the AGO that precludes joint contracting until June 1, 2018. This agreement may change pricing dynamics in Cooley Dickinson's market. However, in 2015, Cooley Dickinson was already the most expensive hospital in the Pioneer Valley for the other two of the three largest payers.

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



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

Source: HPC analysis of CHIA RELATIVE PRICE DATABOOK, *supra* note 86.

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

a. 2017 Hospital Prices

Analyzing both publicly available data and more recent confidential data on inpatient prices, we found that Partners' lowest-priced greater Boston area community hospital is currently approximately 11.5% higher-priced and MGH is approximately 34.6% higher-priced than MEEI in the three largest commercial payer networks.⁹⁰

Similarly, when we analyzed current data for each of the three largest commercial payers in 2017, we found that Partners community hospitals in the greater Boston area have outpatient prices approximately 5.9% to 52.2% higher and MGH has outpatient prices that are 57.8% to 104.7% higher than those of MEEI for the mix of outpatient services that MEEI

⁹⁰ To model the potential impact of this transaction on inpatient spending, the HPC first calculated 2015 inpatient price differentials for all payers for which 2015 relative price data were available. The parties provided information about each hospital's 2016 and 2017 rate increases, which we applied to the 2015 price differentials in order to calculate 2017 price differentials. These differentials are only slightly decreased from those reported in 2015 inpatient relative price, which show Partners' lowest-priced greater Boston area community hospital as approximately 12.3% higher priced than MEEI, and MGH as approximately 34.6% higher priced than MEEI. CHIA RELATIVE PRICE DATABOOK, *supra* note 86.

provides.⁹¹ The likely explanation for Partners’ comparatively higher prices—even where MEEI currently provides more outpatient otolaryngology and ophthalmology services than Partners’ facilities as described above—is that outpatient prices are not negotiated at the specialty level, but rather at broader service categories, such as ambulatory surgery or radiology.⁹² As a result, Partners’ strong market position across these broader outpatient service categories, and for outpatient services generally, would have a greater effect on its prices for otolaryngology and ophthalmology than its shares of these particular services.

b. Professional Prices

Partners’ physician network, PCPO, also has high relative prices compared to other providers.⁹³ PCPO physicians receive different commercial rates depending on the nature of their affiliation with Partners, with the highest rates for physicians affiliated with Partners’ AMCs, including MGPO.⁹⁴ For the three largest commercial payers, for which the MEEA physicians contract through Partners, the MEEA physicians already receive these highest rates as part of MGPO.⁹⁵ For all other commercial payers, MEEA physicians negotiate

⁹¹ The most recent relative price data showed that Partners’ greater Boston area community hospitals had outpatient prices approximately 28.0% to 41.5% higher and MGH had outpatient prices approximately 58.0% to 99.3% higher than MEEI’s in 2015 in the three largest commercial payer networks. CHIA RELATIVE PRICE DATABOOK, *supra* note 86. We updated these data to adjust for the fact that MEEI has a different mix of outpatient service categories than most general acute care hospitals; specifically, MEEI provides a relatively larger proportion of outpatient ambulatory surgery services. To calculate outpatient relative price, however, CHIA utilizes hospital revenue data and service category-specific fee schedule multipliers submitted by payers for each provider, and then adjusts such data to reflect a standard *network average* mix of outpatient services. See CTR. FOR HEALTH INFO. & ANALYSIS, RELATIVE PRICE METHODOLOGY PAPER (September 2016), available at <http://www.chiamass.gov/assets/docs/r/pubs/16/RP-Methodology-Paper-9-15-16.pdf>. The HPC utilized the underlying raw data submitted by payers to calculate a relative price for the parties’ hospitals in the three largest payer networks based on MEEI’s service mix instead of the network average service mix. This adjustment was not necessary for inpatient services, because inpatient relative price is calculated based on net patient service revenue per case-mix-adjusted discharge, and the case mix adjustment already effectively captures differences in service mix. We then used confidential data from the parties to update these outpatient differentials for 2017. The scale of these price differentials was also confirmed by analysis of the APCD. Specifically, we examined all hospital outpatient claims in the 2014 APCD for BCBS, HPHC, and THP for the CPT codes that comprise MEEI’s outpatient otolaryngology and ophthalmology services. We found that for the three largest payers combined in 2014, Partners community hospital prices were 33% above MEEI’s prices for otolaryngology services, and 37% above MEEI’s prices for ophthalmology services. Partners AMC prices were 61% above MEEI’s prices for otolaryngology services, and 53% above MEEI’s prices for ophthalmology services.

⁹² This understanding was conveyed by several payers and confirmed by the HPC’s examination of outpatient relative price data and information provided by the parties, both of which identify the service categories that are subject to separate price negotiations. Individual services within a specialty are often dispersed across several of these service categories. The prices a provider receives for a particular specialty service will depend on the prices negotiated for the service categories into which the specialty falls.

⁹³ Across all commercial payers, in the most recent year for which data were available, PCPO’s physician prices were second only to physicians affiliated with Children’s. CHIA RELATIVE PRICE DATABOOK, *supra* note 86.

⁹⁴ See PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 22, at 32, notes 97-98 (describing how Partners’ physicians are paid one of three rates, “affiliated,” “integrated, or “academic”).

⁹⁵ Some payers have “physician growth caps,” which are limits on the number of physicians for whom Partners is permitted to contract at a given time, or for whom Partners may obtain its highest (academic) rates. While all MEEA physicians contract through MGPO for the three largest payers, it is possible that some of these physicians do not receive academic rates due to these caps.

independently. When we examined relative prices for four of the commercial payers with whom the MEEA physicians negotiate independently, we found that PCPO's prices ranged from 23% to 60% higher than MEEA's in 2014, the most recent published data.⁹⁶

c. Total Medical Expenses

In addition to having higher prices than other providers, Partners' primary care patients also have higher overall medical spending than patients of other provider networks, which is not explained by differences in health status.⁹⁷ These higher health status adjusted total medical expenses (TME) for Partners' primary care patients could reflect higher utilization of services and/or the use of Partners' higher-priced physicians and facilities.⁹⁸ Because TME is based on health care spending for patients attributed to a provider organization's primary care providers, and MEEA does not include any primary care providers, there is no TME calculation for MEEA.

d. Network participation

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

⁹⁶ These commercial payers are UniCare Life and Health Insurance Company, Neighborhood Health Plan, United Healthcare Insurance Company, and Aetna Health. MEEA relative prices were not reported for any other commercial payers in 2014. CHIA RELATIVE PRICE DATABOOK, *supra* note 86. The HPC also estimated a 2017 service mix adjusted physician price differential by approximating MEEA's service mix utilizing the 2014 APCD and applying that mix to MEEA's and MGPO's 2017 fee schedules for Cigna Health and Life Insurance Company, Neighborhood Health Plan, UniCare Life and Health Insurance Company, and United Healthcare Insurance Company. This analysis showed that PCPO's 2017 prices for the services that MEEA provides range from approximately 38% to 92% higher than MEEA's prices for these four payers.

⁹⁷ We compared Partners' 2015 health status adjusted total medical expenses (TME) for the three largest payers to the TME of Baycare Health Partners, UMass Memorial Health Care, Lahey Health System, BIDCO, Steward Network, New England Quality Care Alliance, and Atrius. CTR. FOR HEALTH INFO. & ANALYSIS, PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM: TOTAL MEDICAL EXPENSES DATABOOK 2016 (CY 2013 - CY 2015 Data) (Updated October 5, 2016), available at <http://www.chiamass.gov/assets/2016-annual-report/2016-Annual-Report-TME-Databook.xlsx>. TME is expressed as a per member per month dollar figure that reflects the average monthly covered medical expenses paid by the payer and the member for all of the health care services the payer's members receive in a year, adjusted for the members' health status.

⁹⁸ Partners' 2015 TME constitutes "materially higher health status adjusted total medical expenses" as defined in MCN AND CMIR REGULATIONS, *supra* note 1, and further described in TECHNICAL BULLETIN, *supra* note 11. For the largest commercial payer, which accounts for more than one third of Partners' commercial revenue, Partners' TME was 8.6% above the average for all other provider organizations.

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

B. QUALITY BASELINE PERFORMANCE

To understand the parties’ baseline performance in delivering high-quality patient care, the HPC assessed recent quality metrics for each party in the areas of health care system structures, clinical outcomes, and patient experience. Because MEEI provides only a specialized set of services, there are fewer relevant, standardized, publicly reported quality measures available to assess its performance.⁹⁹ We examined over 50 validated and nationally endorsed measures,¹⁰⁰ focusing on those applicable to MEEI,¹⁰¹ and found that Partners hospitals and MEEI perform well compared to state and national averages.

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

⁹⁹ For example, few clinical process measures were applicable to MEEI as a specialty provider and we therefore did not assess MEEI in this domain. However, we assessed clinical process measures for the Partners hospitals and found that, as in years past, Partners hospitals generally perform at or above the statewide average. *See* HALLMARK FINAL CMIR REPORT, *supra* note 22, at 28-29. Similarly, MEEI is composed entirely of specialists therefore cannot be assessed on most measures of ambulatory care processes. However, we assessed the performance of the PCPO primary care physicians on 16 ambulatory care process measures and found that PCPO met or exceeded the average statewide performance on all but four of these measures. *See* NAT’L COMM. FOR QUALITY ASSURANCE, *HEDIS*® and *Quality Compass*®, <http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx> (last visited Oct. 29, 2017). The HPC obtained 2014 HEDIS data from CTR. FOR HEALTH INFO & ANALYSIS, PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM: A FOCUS ON PROVIDER QUALITY DATABOOK 2016 (Sept. 2016), *available at* <http://www.chiamass.gov/assets/docs/r/pubs/16/Quality-Report-Databook-2016.xlsx> (last visited Oct 29, 2017).

¹⁰⁰ We assessed a broad spectrum of measures, with a focus on certain measures most relevant to the proposed transaction. Applicable measures were drawn in part from the 2017 Massachusetts Standard Quality Measure Set. *See* CTR. FOR HEALTH INFO & ANALYSIS, STANDARD QUALITY MEASURE SET (SQMS), <http://www.chiamass.gov/sqms/> (last visited Oct. 29, 2017).

¹⁰¹ For additional assessments of Partners performance on a range of hospital and physician metrics beyond those most relevant to MEEI, *see* PARTNERS-HALLMARK FINAL REPORT, *supra* note 22, at Section III.B.

entry system.¹⁰² Partners hospitals also generally performed well on these and similar measures where data were available.¹⁰³ Both Partners and MEE also have robust internal systems for tracking quality metrics and regularly reporting results to employees to facilitate quality improvement.¹⁰⁴

On outcome measures, such as readmission rates, hospital-related complications rates, and mortality rates, we found that the parties' hospitals generally performed comparably to statewide averages. Thirty-day, all-cause readmission rates for the parties' hospitals were comparable to the statewide average except for BWH, which performed slightly below average.¹⁰⁵ Based on the Agency for Healthcare Research and Quality composite Patient Safety Indicator (PSI) 90, we also found that the rate at which patients experienced hospital-related complications at MEEI and Partners hospitals was comparable to the statewide average.¹⁰⁶ Finally, MEEI and most Partners hospitals performed comparably to statewide averages on risk-adjusted mortality rates for certain procedures and conditions, utilizing the Inpatient Quality Indicator (IQI) 90 and IQI 91 composite measures.^{107, 108}

¹⁰² MEEI has not fully implemented certain other policies, including some recommended by the National Quality Forum for avoiding patient harm, and did not score as well on a standard of safe medication administration practices. For more detail on these measures, see THE LEAPFROG GROUP®, THE LEAPFROG HOSPITAL SURVEY SCORING ALGORITHMS: SCORING DETAILS FOR SECTIONS 2-9 OF THE 2017 LEAPFROG HOSPITAL SURVEY, available at http://www.leapfroggroup.org/sites/default/files/Files/2017ScoringAlgorithms_FINAL_v3.pdf (last visited Oct. 28, 2017). *Compare Hospitals*, THE LEAPFROG GROUP, <http://www.leapfroggroup.org/compare-hospitals> (last visited Oct. 29, 2017).

¹⁰³ MGH, Nantucket Cottage Hospital, Martha's Vineyard Hospital, and NSMC did not respond to the most recent Leapfrog survey, and thus no data are available for these hospitals. NWH and Cooley Dickinson received notably low ratings on their implementation of policies related to medication administration and appropriate use of antibiotics, but otherwise performed well. Healthcare workers' influenza vaccination rates at MEEI and several Partners hospitals were below the statewide average in 2016.

¹⁰⁴ MEE's published quality reports on its ophthalmology (2010-2015) and otolaryngology (2010-2014) practices are examples of voluntary transparency, seem to show positive results, and may be an indication of an organization with a culture of clinical quality, although these reports have not been updated in recent years. See *Quality and Outcomes Book*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/about-us/quality-measures/quality-and-outcomes-book> (last visited Oct. 29, 2017)

¹⁰⁵ The HPC obtained data on 2016-2017 readmission rates at *Hospital Compare datasets*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://data.medicare.gov/data/hospital-compare> (last visited Oct. 29, 2017).

¹⁰⁶ The PSI 90 is a composite of observed-to-expected ratios for 11 measures of patient safety and adverse events and was calculated based on CHIA 2016 hospital discharge data. For more detail on PSI measures, see *Patient Safety Indicators Overview*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, http://www.qualityindicators.ahrq.gov/modules/psi_resources.aspx (last visited Oct. 29, 2017); (For full measure specifications, see AGENCY FOR HEALTH CARE RESEARCH & QUALITY, PATIENT SAFETY AND ADVERSE EVENTS COMPOSITE TECHNICAL SPECIFICATIONS, PATIENT SAFETY INDICATORS 90 (PSI 90), AHRQ QUALITY INDICATORS™, VERSION V6.0, (2016), available at https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V60-ICD09/TechSpecs/PSI_90_Patient_Safety_and_Adverse_Events_Composite.pdf (last visited Oct. 29, 2017).

¹⁰⁷ IQI 90 and IQI 91 are composite measures that examine risk-adjusted inpatient mortality for certain procedures and conditions, respectively, and were calculated based on 2016 discharges. These composites include certain procedures and conditions not applicable to MEEI's specialty services. For more detail on IQI measures, see *Inpatient Quality Indicators Overview*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, http://www.qualityindicators.ahrq.gov/modules/psi_resources.aspx (last visited Oct. 29 2017); For full measure specifications, see AGENCY FOR HEALTH CARE RESEARCH & QUALITY, MORTALITY FOR SELECTED PROCEDURES, INPATIENT QUALITY INDICATORS #90 (IQI #90), March 2017 (2017), available at https://www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V60/TechSpecs/IQI_90_Mortality_for_Selected_Procedures.pdf (last visited Oct. 29, 2017) and AGENCY FOR HEALTH CARE RESEARCH & QUALITY, MORTALITY

In the domain of patient experience¹⁰⁹ we found that both MEEI and the Partners hospitals consistently perform above the statewide average on measures of overall patient satisfaction and patient willingness to recommend the hospital.¹¹⁰ MEEI performed comparably to the top Partners hospitals on patient willingness to recommend, and received a higher score on overall patient rating than any Partners hospital.

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

C. ACCESS BASELINE PERFORMANCE

The HPC monitors a variety of factors relating to health care access in its review of provider material changes in order to assess, for example, whether the parties' plans could reduce or improve access to needed care, particularly for underserved patient populations.¹¹¹ We evaluated the following measures of access in our review of this transaction:

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

Our findings are detailed below.

FOR SELECTED CONDITIONS, INPATIENT QUALITY INDICATOR #91 (IQI #91), March 2017, (2017), available at https://www.qualityindicators.ahrq.gov/Downloads/Modules/IQI/V60/TechSpecs/IQI_91_Mortality_for_Selected_Conditions.pdf (last visited Oct. 29, 2017).

¹⁰⁸ MGH and Martha's Vineyard Hospital performed slightly below average on IQI 91.

¹⁰⁹ *Hospital Quality Initiative: HCAHPS – Patients' Perspectives of Care Survey*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/HospitalQualityInits/HospitalHCAHPS.html> (last visited Oct. 27, 2017). The HPC obtained 2016-2017 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data at *Hospital Compare* datasets, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://data.medicare.gov/data/hospital-compare> (last visited Oct. 27, 2017).

¹¹⁰ HCAHPS questions "What number would you use to rate this hospital during your stay?" and "Would you recommend this hospital to your friends and family?" CMS rates hospitals based on percentages of patients who chose the most positive response option, like "always," to the survey questions. *Survey of patients' experiences (HCAHPS)*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicare.gov/hospitalcompare/about/survey-patients-experience.html> (last visited Oct. 29, 2017).

¹¹¹ MASS. GEN. LAWS ch. 6D, § 13(d)(vi, ix-xii).

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

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

To assess the extent to which MEEI provides specialty services that are not generally provided by other area hospitals, we examined inpatient discharges and outpatient procedure codes to identify those for which MEEI was the principal or sole provider in its PSA. We found that, for most of the inpatient services that MEEI provides, other hospitals provide at least half of the discharges in MEEI's inpatient PSA. MEEI was not the sole provider of any type of inpatient services, although it is the principal provider of inpatient uncomplicated intraocular procedures in its PSA, with over two-thirds of discharges for this service.¹¹²

For outpatient care, we identified approximately 30 procedure codes for which MEEI was the only facility provider in its outpatient PSA for commercial members of the three largest payers in 2012, 2013, and 2014.¹¹³ In total, MEEI performed approximately 100 of these procedures over the three-year period we examined. This analysis suggests that, while MEEI's role as the sole provider of these relatively rare services makes it an important access point in these cases, these cases represent a small share of outpatient volume, both for MEEI and the Commonwealth. However, in addition to this low number of services for which MEEI is the *sole* facility provider, MEEI is also the *principal* facility provider for several other outpatient otolaryngology and ophthalmology codes,¹¹⁴ consistent with its high outpatient market share across otolaryngology and ophthalmology services as a whole. Payers have noted to the HPC that MEEI is thus an important component of their provider networks, even if most of MEEI's services are available, at least to some degree, at other area providers.

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

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

¹¹² Based on HPC analysis of 2015 and 2016 CHIA hospital discharge data.

¹¹³ Based on HPC analysis of 2012, 2013, and 2014 APCD claims to identify outpatient procedures for which MEEI was the only facility with any facility claims. As discussed in *supra* note 73, our analyses of outpatient facility claims include hospital outpatient departments, hospital satellites, and freestanding ambulatory surgery centers.

¹¹⁴ For example, for each year from 2012 to 2014, more than two-thirds of facility claims for certain specialized ophthalmology diagnostic procedures in MEEI's outpatient PSA were done at MEEI; the annual volume for many of these procedures was notably higher than for procedures for which MEEI was the sole provider. As discussed in *supra* note 84, some of these outpatient services are also performed in non-facility settings such as clinics, which may represent alternative points of access in some cases.

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

The table below summarizes the participation of MEEI and Partners' greater Boston area acute care hospitals in tiered and limited plans offered by the three largest payers.¹¹⁵ MEEI participates in commercial limited network plans offered by BCBS and HPHC, as well as limited network products offered by smaller commercial networks. Most of these products exclude at least some Partners hospitals, particularly MGH and BWH, and some exclude Partners physicians. MEEI also participates in tiered network products, and is often placed in the most efficient tier. For the tiered network products in which they participate, Partners AMCs are often placed in the least efficient tier, while the tier placement of Partners community hospitals varies.¹¹⁶

¹¹⁵ We excluded Martha's Vineyard Hospital and Nantucket Cottage Hospital from our analysis due to their unique geographic isolation. We also excluded Cooley Dickinson from this analysis because it does not yet contract through Partners.

¹¹⁶ While Partners tends to make uniform decisions regarding its hospitals' participation in a limited network, individual hospitals may be placed in different tiers in a tiered network.

Tiered and Limited Networks for the Three Largest Commercial Payers

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

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

Notes: In one of THP's tiered network products, Navigator PPO, MEEI is in the middle tier rather than the most efficient tier, and Faulkner, NWH, and NSMC are in the middle tier rather than the least efficient tier. We also reviewed the limited network participation status of Partners' specialty hospitals, McLean Hospital Corporation and Spaulding Rehabilitation Hospital. We found that these non-acute care specialty hospitals were more frequently, though not universally, included in these products.

We also assessed the parties' participation in MMCO networks. Like limited network plans, MMCO networks typically exclude certain providers based on cost and quality, but specialty provider non-participation may result in barriers to access. MEEI is a more common participant in MMCO networks than most Partners hospitals and physicians. Despite having a relatively low share of public payer patients, as further discussed below, MEEI is available as a participating provider for members of most MMCOs, whereas Partners acute care hospitals are not included in most MMCO networks.¹¹⁷ Only Partners' owned insurance company, NHP,¹¹⁸ includes both MEEI and all of the Partners hospitals in the greater Boston area in its MMCO network.

¹¹⁷ Health New England and Fallon Health offer MMCO plans that are only available in certain regions of Massachusetts. We did not evaluate the parties' participation in these regional plans. See *Plans Available for Members in MassHealth Standard, CommonHealth, and Family Assistance*, EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES, <http://www.mass.gov/eohhs/consumer/insurance/enroll-in-a-health-plan/plans-available-for-members-in-mh-standard-commonhealth-family-assistance.html> (last visited Oct. 24, 2017).

¹¹⁸ See PARTNERS RPO FILING, *supra* note 27 (showing the NHP is a wholly owned corporate affiliate of Partners).

MMCO Network Participation for MEEI and Partners Hospitals

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

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

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

Examining a provider’s payer mix can indicate whether it attracts a larger or smaller share of one type of patient compared to other nearby providers and compared to the population living in its service area. Providers serving high proportions of patients on government insurance, in particular Medicaid, provide important points of access for patients who often face barriers obtaining care. In addition, a provider’s payer mix may impact its financial and quality performance due to lower payments by government payers relative to commercial payers and socioeconomic factors that disproportionately impact the complexity and health outcomes of government payer patients. These factors can in turn incentivize providers to try to attract more commercial patients rather than Medicaid patients.¹¹⁹

Given MEEI’s low inpatient volume, we assessed the parties’ payer mix using gross patient service revenue (GPSR) data, which reflects both inpatient and outpatient charges.¹²⁰

¹¹⁹ See, e.g., INSTITUTE OF MEDICINE, ACCESS TO HEALTH CARE IN AMERICA at 40 (Michael Millman ed., 1993) (“[M]ost structural barriers to access have their roots in the way health care is financed. Despite a greatly enlarged physician force and the existence of some 600 community health centers, many of today’s poor still find it difficult to identify physicians who will accept Medicaid. A major reason for this dilemma is Medicaid’s low reimbursement rates”).

¹²⁰ Because GPSR is based on charges rather than negotiated payment amounts, it can be used as a proxy for volume since charge amounts do not vary by payer. We also examined the parties’ payer mix based on discharges using 2016 CHIA hospital discharge data. We assessed hospital inpatient payer mix by first determining the payer

We found that, notwithstanding MEEI's participation in most MMCO networks as described above, MEEI has a higher commercial payer mix and lower Medicaid than any of the Boston-area AMCs, including MGH and BWH.¹²¹ While MEEI's commercial payer mix is high, it has been decreasing over time, from 54.0% in 2010 to 49.3% in 2016. This change was largely driven by an increase in MEEI's Medicare payer mix, which is consistent with data supplied by the parties that suggest the aging population in Massachusetts is driving increased volume at MEEI.¹²² As shown below, MGH and BWH also have a higher proportion of commercial volume and a lower proportion of Medicaid volume than other Boston-area AMCs. We found the same pattern of higher commercial payer mix and lower Medicaid payer mix relative to comparator hospitals for Faulkner and NWH; NSMC is the notable exception to this trend, with both lower commercial payer mix and higher Medicaid payer mix than its comparators.¹²³

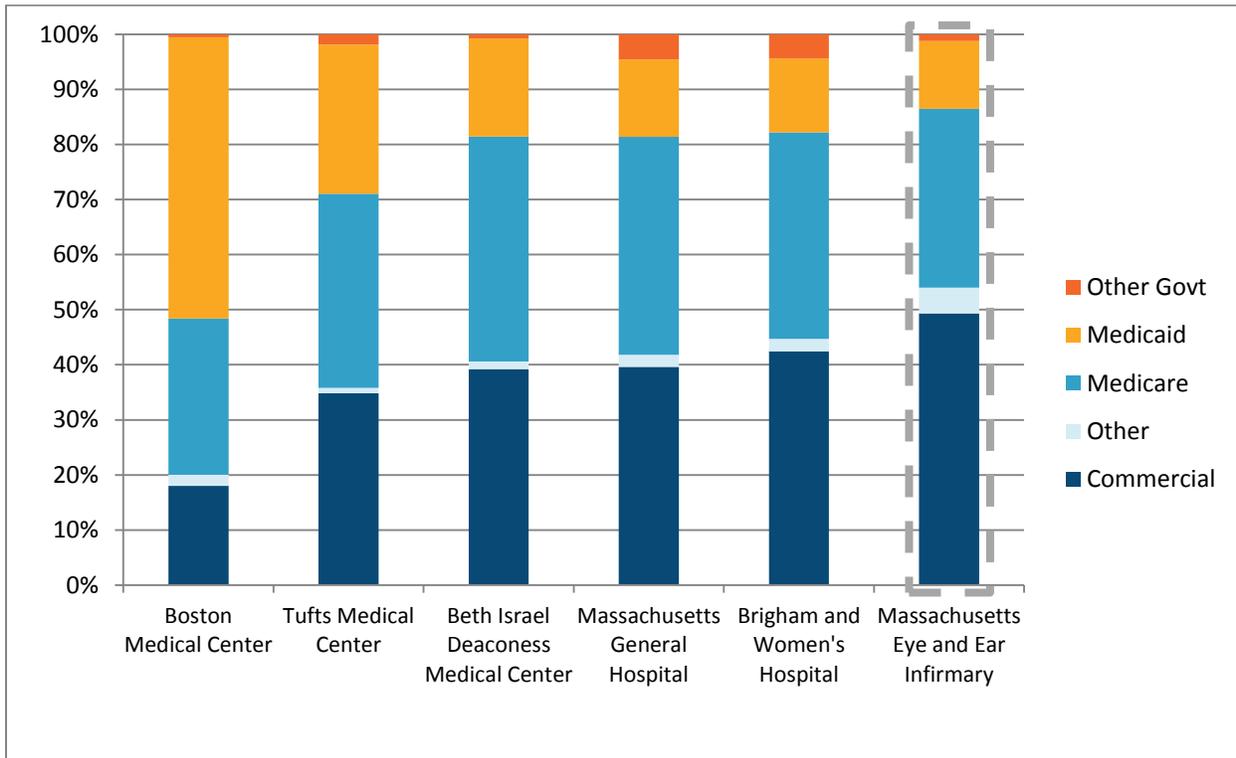
mix of the hospital's PSA, which represents all discharges for residents of the hospital's PSA. We then compared the overall payer mix of the PSA to the mix of patients from the PSA that went to the focal hospital. We limited our analysis to discharges reflecting MEEI's core inpatient otolaryngology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

¹²¹ Because GPSR includes all patient service revenue, it does not account for differences in service mix. We compared MEEI's payer mix for its core inpatient services to the payer mix of its PSA and other hospitals as discussed in *supra* note 120. We did not have sufficient data available to analyze the payer mix of MEEI and comparator hospitals for only outpatient otolaryngology and ophthalmology services.

¹²² See PARTNERS-MEEI DON APPLICATION, *supra* note 20, at Section F1.a.ii (describing otolaryngology and ophthalmology utilization rates among older populations and Massachusetts' aging demographic trends, as well as MEEI's recent growth in these services).

¹²³ Comparator hospitals are chosen based on geography, patient population, and teaching status. Comparator hospitals for Faulkner included Beth Israel Deaconess Hospital-Milton, Norwood Hospital, Saint Elizabeth's Medical Center, and South Shore Hospital. Comparators for NWH included Beth Israel Deaconess Hospital - Needham, MetroWest Medical Center, Mount Auburn Hospital, South Shore Hospital, and Winchester Hospital. Comparators for NSMC included Hallmark Health, Northeast Hospital, and Winchester Hospital. We did not evaluate payer mix for Martha's Vineyard Hospital or Nantucket Cottage Hospital given the lack of potential comparator hospitals in their geographic areas.

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



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

Note: Graph is in ascending order of commercial payer services.

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

IV. IMPACT PROJECTIONS (2018 ONWARD)

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

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

A. COST AND MARKET IMPACT

One of the HPC's central responsibilities is to monitor health care spending to ensure that the Commonwealth can successfully meet the health care cost growth benchmark set forth in Chapter 224 of the Acts of 2012 (Chapter 224).¹²⁴ Health care spending consists of two broad factors: price (each provider's individual rates as well as the distribution of patients at higher- or lower-priced providers) and utilization (total number of services as well as the specific services that patients receive). Provider consolidations and alignments can affect both of these mechanisms, resulting in:

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

We examined each of these mechanisms and found:

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

¹²⁴ MASS. GEN. LAWS ch. 6D, § 9 (requiring the HPC to establish annually "a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth," pegged to the growth rate of the gross state product).

- Partners would likely seek significant hospital rate increases for MEEI's main campus and hospital-licensed outpatient sites after an acquisition. Over time, we estimate that health care spending would increase by \$14.9 million to \$55.3 million annually if Partners achieves parity between MEEI's rates and those of Partners' other acute care hospitals, consistent with Partners' past practice.
- As the MEEA physicians join Partners contracts for all commercial payers, changes in MEEA's physician rates would additionally increase total medical spending in Massachusetts by approximately \$5.9 million annually.
- Significant shifts in referral patterns are unlikely given the existing clinical affiliations between the parties. However, additional volume at MEEI or its hospital-licensed facilities could have further spending impacts if prices increase as expected.
- The parties claim that the transaction would yield operational efficiencies and allow MEEI to avoid capital expenditures, which would likely improve MEE's financial performance even absent additional rate increases.

In total, the HPC thus estimates that the proposed transaction would, over time, increase commercial spending by approximately \$20.8 million to \$61.2 million annually.¹²⁵ These spending increases would ultimately be borne by consumers and businesses through higher commercial premiums and may also impact other providers' spending against risk budgets to the extent that their patients use MEE providers.

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

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

Recognizing that providers with significant market share may be able to negotiate for higher prices and other favorable contractual terms with commercial payers,¹²⁶ Chapter 224 directs the HPC to examine the impact of proposed transactions on providers' market position and market shares. For Partners' proposed acquisition of MEE, we examined the impact on the parties' inpatient and outpatient market shares overall, as well as shares in the applicable specialty service lines,¹²⁷ utilizing publicly available data as well as information from several large Massachusetts payers.

¹²⁵ Internal documents related to the proposed transaction developed by the parties and provided to the HPC contemplate revenue increases due to rate lifts for MEE generally consistent with our lower estimate.

¹²⁶ Commercial prices for health care services are established through contract negotiations between payers and providers. The results of these negotiations – both the prices that payers will pay for services and other contractual terms – are influenced by the bargaining leverage of the negotiating parties. Bargaining leverage impacts negotiations because a payer network that excludes important providers will be less marketable to purchasers (employers and consumers). If there are few or no effective substitutes for that provider in a market, the potential cost to a payer of excluding the provider from that payer's network will be high, and that provider will have increased ability to command a higher price (or other favorable contract terms) from the payer.

¹²⁷ We did not analyze the impact on physician market shares because data on physician market shares is currently only available for the three largest commercial payers. Because Partners already contracts for MEEA physicians for these payers, we do not anticipate a significant market impact for these payers.

a. Inpatient market

As described in Section III.A.2, MEEI’s 2016 market share for inpatient services overall was very small, at only 0.2% of discharges in its PSA,¹²⁸ while Partners’ market share in MEEI’s PSA was much higher, at 33.1%.¹²⁹ Even among the core inpatient services that MEEI provides, MEEI provided only 3.5% of discharges in its service area in 2016. By contrast, Partners hospitals accounted for 34.0% of these discharges within MEEI’s PSA.^{130,131} Following the transaction, the combined shares of Partners and MEE would be substantial and, as shown below, well above the shares of the next-largest systems. However, that sizeable market share would be primarily attributable to Partners’ large preexisting inpatient market share, not the addition of MEEI’s market share.

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

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

Source: HPC analysis of 2016 CHIA hospital discharge data

b. Outpatient market

We also examined the potential impact of this transaction on the outpatient market, which incorporates both outpatient services provided on the MEEI and Partners hospitals’ main campuses, as well as their hospital-licensed outpatient sites.¹³² As described in Section III.A.2 and presented in the table below, for the most recent year for which data were available, Partners had the highest share of outpatient facility visits across all general acute care service lines in MEEI’s outpatient PSA,¹³³ while MEEI had a 1.5% share. Following the transaction, Partners would continue to have the highest share of all outpatient services in this area, predominantly due to its current high share of these services.

¹²⁸ For a description of how we defined MEEI’s inpatient PSA, see *supra* note 78.

¹²⁹ In the PSAs of Partners hospitals, MEEI provided 1% or less of all discharges in 2016, and Partners provided between 31.3% and 82.9% of all discharges.

¹³⁰ For a description of the methodology for defining MEEI’s inpatient core services, see *supra* note 77.

¹³¹ In Partners hospitals’ PSAs, MEEI provided a similarly modest share of discharges for its core services in 2016, and Partners provided between 34.0% and 77.8% of these discharges.

¹³² As discussed in *supra* note 43, services provided at hospital-licensed outpatient sites can include the same facility fees as services provided at the main hospital campus.

¹³³ For details on the definition of MEEI’s outpatient PSA, see *supra* note 82.

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

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

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

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

Focusing specifically on the outpatient services that MEEI provides, however, the pattern is different. For otolaryngology services, MEEI and Partners had the two highest shares of outpatient facility visits, at 26.5% and 18.7%, respectively, in MEEI's outpatient PSA in 2014, as described in Section III.A.2 and shown in the table below. Following the proposed transaction, the combined system would have nearly three times the outpatient facility share of the next-largest system.¹³⁴

¹³⁴ As described in *supra* note 83, we also examined the parties' shares of revenue for otolaryngology services in both facility and non-facility settings. While we do not estimate market impacts from those findings because our physician data are limited to commercial payers for which MEEA already contracts with MGPO, we note that the parties' combined share of otolaryngology revenue across both settings, 38.2%, remains well above the share of the next closest system.

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

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

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

For ophthalmology services, MEEI was the top provider of outpatient facility visits in its PSA in 2014 (including services that were provided at its main campus and at its hospital-licensed outpatient facilities), while Partners hospitals had only a 1.0% share of these services. Following the transaction, the combined system would continue to have over twice the share of the next-highest system, based almost entirely on the strength of MEEI's current share.¹³⁵

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

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

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

These increases would strengthen Partners' already-substantial outpatient market shares, particularly for outpatient otolaryngology services.¹³⁶ While contracted rates are not

¹³⁵ We conducted the same analysis for the parties' shares of revenue for ophthalmology services in both facility and non-facility settings as described for otolaryngology services in *supra* note 134. The parties' combined share of ophthalmology revenue, 35.3%, is comparable to their combined share of ophthalmology facility visits.

¹³⁶ The shares shown do not include potential increases in the parties' market shares as a result of their stated plans of expanding MEEI's services at additional Partners locations, and the parties have not provided sufficient information about their plans to model these potential increases. However, any such expansions at current or future Partners hospitals or hospital satellites would be in addition to the projected increases in Partners' already-

typically negotiated at the specialty level, this transaction would give Partners two additional specialty services for which it would be the largest provider in most of eastern Massachusetts, adding incrementally to Partners' negotiating leverage for many commercial insurance products. Having joined with its largest competitor for otolaryngology services, MEEI would also be able to benefit from Partners' negotiating leverage, allowing Partners to seek significant rate increases for MEEI. Specifically, once MEEI is part of Partners, the ability of commercial payers to credibly threaten to exclude MEEI from their networks in order to obtain lower rates will be reduced because, as discussed above, Partners' dominant shares of general acute inpatient services and very high shares of all outpatient services make it difficult to market "broad network" products that exclude Partners hospitals. As a result, payers' ability to negotiate lower rates for MEEI's services in these "broad network" products would be diminished. At the same time, after the merger, limited networks that do not include Partners and tiered networks that place Partners in a less favorable tier may have reduced access to MEEI providers. This would reduce the value of such tiered and limited network products, meaning that payers may seek to include MEEI in these networks, even at a higher price. Partners likely also has the ability to add MEEI physicians to many of its existing payer contracts, and we would expect these physicians to be added at the highest, academic physician rates since these physicians are members of MGPO.¹³⁷ Both these changes to hospital and physician prices would have a significant impact on health care spending in the Commonwealth as detailed below.

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

As the largest provider of inpatient and outpatient services in MEEI's service area, Partners already demands high prices for inclusion in many commercial insurance products, and its ability to do so would likely be strengthened by becoming the largest provider of two additional specialty fields in MEEI's outpatient PSA, which includes most of eastern Massachusetts. If MEEI's participation in networks is connected to that of Partners, Partners would likely be able to obtain significant price increases for MEEI, both for its main campus and its hospital-licensed outpatient sites.¹³⁸ Indeed, it is the parties' stated intent to seek "market competitive rates" for MEEI in connection with the transaction.¹³⁹

substantial outpatient market shares. As discussed in *supra* note 43, services provided at any additional hospitals or hospital-licensed outpatient sites could also include facility fees.

¹³⁷ Note that we do not analyze the impact on physician market shares for these payers because our data on claims for physician services is only from the three largest payers, for which Partners already contracts for MEEI. See *supra* note 127. There may be limitations on MGPO's ability to bill additional physicians at academic rates; see *supra* note 95; *infra* note 150.

¹³⁸ Changes in hospital prices will require contract renegotiation, and Partners stated in its DoN filing with DPH that the parties do not intend to renegotiate contracts until their current contracts expire. PARTNERS-MEEI DoN APPLICATION, *supra* note 20, at Section F1.a.iii. Therefore, we would expect MEEI price changes to take effect over time (likely in the next contract term or potentially over two contract terms), not immediately.

¹³⁹ MEEI NOTICE OF MATERIAL CHANGE, *supra* note 33.

Partners' past practices and interviews with payers indicate that Partners is likely to seek parity between the rates of MEEI and those of its existing hospitals over time.¹⁴⁰ Therefore, we modeled a range of scenarios estimating the impact of Partners achieving parity for MEEI (both for its main campus and its hospital-licensed outpatient sites) with rates of other Partners acute care hospitals over time, assuming that MEEI maintains its current mix of services. These estimates are based on the *current* prices of MEEI and Partners hospitals, and do not assume or reflect any additional increases in Partners' current rates as a result of the transaction.^{141,142}

Specifically, we found that if Partners were to achieve comparable prices between MEEI and Partners' greater Boston community hospitals, MEEI's inpatient rates would increase by an estimated 12.2%, with an annual spending impact of over \$865,000 across all commercial payers for which data were available.¹⁴³ If Partners were to achieve comparable prices between MEEI and Partners' greater Boston community hospitals for MEEI's outpatient services,¹⁴⁴ both at its main campus and at its seven hospital-licensed outpatient facilities, we estimate that outpatient rates would increase by 16.9% to 18.8%, with an annual spending impact of \$14.0 million to \$15.6 million across all commercial payers for which data were available.^{145,146} If, however, MEEI were to receive MGH rates,¹⁴⁷ its inpatient rates would

¹⁴⁰ As described in Section III.A.3 and shown in the graph on page 26, Partners' two AMCs have nearly identical relative prices, as do Partners' community hospitals in the greater Boston area, suggesting a practice of seeking parity for similar institutions within Partners. These rates are all higher than those of MEEI. *See also*, HALLMARK FINAL CMIR REPORT, *supra* note 22, at 53 (stating that "[t]he three largest payers confirmed that Partners seeks consistent rates for its owned community hospitals in the greater Boston area").

¹⁴¹ Partners has noted that it has not made any commitment to MEE that Partners will negotiate any particular rate level for MEEI, and the parties expect that "rate relief" for MEEI can be "achieved by [Partners] allocating to MEE part of the overall rate increases that [Partners] negotiations with commercial payers." PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section F1.a.iii. The parties do expect that Partners will secure higher rates for MEE than MEE would be able to obtain in the absence of the transaction. Absent a specific, enforceable commitment to limit price increases, there is no reason to believe that Partners would negotiate a rate increase across its provider network of less than the maximum amount it is able to obtain from payers and, as discussed above, this transaction will likely only enhance Partners' current negotiating leverage and enable MEEI to benefit from that leverage. Thus it is our expectation that the addition of MEE to its network would allow Partners to negotiate a higher rate increase than it otherwise could.

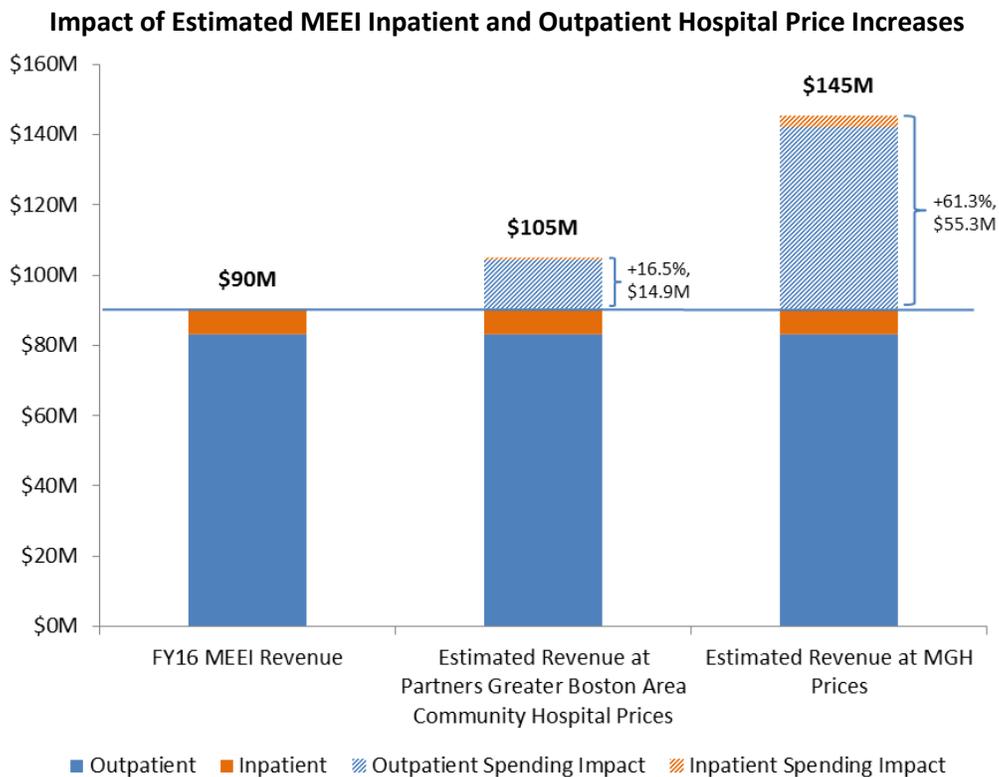
¹⁴² While we understand that MEE would likely seek inflationary rate increases absent the transaction, our spending impacts are based on *differentials* between the parties' current price levels. Absent the transaction, we would not expect these differentials to materially change over time, given that both parties would be seeking inflationary rate increases.

¹⁴³ *See supra* note 90 for details on our methodology for updating 2015 relative prices to calculate 2017 price differentials. We applied the resulting 2017 price differentials to fiscal year 2016 MEEI inpatient revenue confidentially provided by the parties in order to estimate an annual spending impact.

¹⁴⁴ As discussed in Section III.A.3, while inpatient price differentials are based on prices across all inpatient services adjusted for acuity, outpatient price differentials are based on the different rates negotiated for different service lines. When we adjusted for differences in service mix in the 2015 relative price data, we found that the price differential across the three largest payers between MEEI and Partners hospitals was somewhat smaller than the price differential suggested by the unadjusted data. *See supra* note 91.

¹⁴⁵ To model the potential impact of this transaction on outpatient spending, we first calculated outpatient price differentials based on MEEI's outpatient service mix for the three largest commercial payers (BCBS, HPHC, and THP) using 2015 relative price data. As discussed in *supra* note 144, adjusting for service mix results in a smaller price differential, and thus represents a conservative approach. Due to data limitations, we were unable to calculate service mix-adjusted price differentials for other commercial payers. Therefore, we calculated price

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



In total, we estimate that commercial spending would increase by between \$14.9 million and \$55.3 million annually if Partners were to seek prices comparable to other Partners

differentials for these payers using standard relative price data. We applied information provided by the parties about each hospital’s 2016 and 2017 rate increases to the 2015 price differentials to yield estimated 2017 price differentials. We applied the resulting 2017 price differentials to fiscal year 2016 MEEI outpatient revenue confidentially provided by the parties in order to estimate an annual spending impact. Given that the parties expect that MEEI’s volume will continue to increase over time, as described in *supra* note 45, it is likely that any rate increases would be applied to an even higher revenue base. Therefore, we expect that this is a conservative approach.

¹⁴⁶ As a sensitivity analysis, we also calculated price differentials between MEEI and Partners hospitals’ current-year rates by outpatient service category for each payer using information provided by the parties about the service line multipliers established under each payer contract for the current year, broken out by product type (health maintenance organization (HMO), preferred provider organization (PPO), indemnity) where applicable. We then applied the multiplier-based differentials for each service line to the revenue MEEI received from each payer under each service line. This method resulted in a similar, though slightly higher, overall spending impact estimate.

¹⁴⁷ Similar to MGH, MEE is a teaching and research institution whose physicians are part of MGPO. Therefore, we consider MGH rates to be a reasonable upper bound for MEEI’s future rates. Indeed, given MEEI’s close relationship with MGH, and MEEA physicians’ membership in MGPO, it is reasonable to expect Partners would more likely seek rates for MEEI similar to MGH rather than to Partners’ community hospitals.

acute care hospitals for the services that MEEI provides. In addition to their effects on overall health care spending, these price increases could have other important effects, such as directly affecting risk contract performance for provider organizations whose patients use MEEI and impacting tiered and limited network products.^{148, 149}

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

As described above in Section III.A.3, MEEA physicians are members of MGPO. Because they contract through Partners and receive Partners' academic physician rates with the three largest commercial payers already, we would not expect much, if any physician price increase or spending impact for the three largest commercial payers after the acquisition of MEEA.¹⁵⁰ However, MEEA physicians currently establish contracts with other commercial payers separately from Partners. As corporately integrated members of Partners, MEEA physicians would join all other Partners commercial contracts. Subject to specific terms in each payer contract, we expect that MEEA could begin receiving Partners rates for many of these contracts without the need for contract renegotiation, meaning that the price impacts could occur almost immediately.¹⁵¹ For those Partners contracts that have higher rates for academic physicians, we also expect that MEEA would likely receive these higher rates as members of MGPO.

If MEEA physicians were to receive Partners rates for the non-top-three commercial payers in the state, we estimate that MEEA's prices for these payers would increase by approximately 50%, yielding an annual commercial spending increase of \$5.9 million.¹⁵²

¹⁴⁸ For example, several provider organizations have identified MEEI as a preferred provider for their patients. To the extent that these providers continue to direct care to MEEI, increased MEEI prices would be expected to adversely affect their TME and performance on its risk contracts and year-to-year budget increases. See *supra* note 39, detailing our analysis of the provider groups that frequently refer to MEEI.

¹⁴⁹ As discussed in Section IV.C, if MEEI is excluded from tiered and limited network products due to its higher prices, patients could face barriers to accessing MEEI's services. However, excluding an important specialty provider like MEEI may also diminish the value of tiered and limited network products. This dynamic could encourage payers to seek to include MEEI their networks, notwithstanding its higher prices, which could have implications for the design and implementation of such insurance products.

¹⁵⁰ It is possible that some MEEA physicians could receive higher prices from these payers. See *supra* note 95. It is not clear whether Partners currently has room under its physician growth caps for these payers to add MEEA physicians to the group receiving academic rates. To the extent there is room to do so, we anticipate that Partners would be more likely to do so following this transaction, since it would own MEEA and thus have an incentive to obtain the resulting revenue increase.

¹⁵¹ To the extent that physician growth caps apply to any of the payers with whom MEEA currently contracts independently, the annual spending impacts estimated in this section could take time to be fully realized. For more information on this topic, see PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 22, at 31-32.

¹⁵² To estimate a physician price impact, we first calculated a current price differential using the methodology described in *supra* note 96. We then applied this differential to MEEA's fiscal year 2016 revenue from each of these payers, as produced by MEEA. This yielded an annual commercial spending increase of \$3.7 million. For Aetna Health and Fallon Health, fee schedule data was not available. Therefore, the HPC applied the average price differential for the four payers above to the fiscal year 2016 revenue reported for Aetna Health and Fallon Health. This yielded an estimated annual commercial spending increase of \$1.9 million for Aetna Health and approximately \$240,000 for Fallon Health. As a sensitivity analysis, we also used 2014 relative price data to

4. The parties claim that the transaction would yield operational efficiencies and allow MEEI to avoid capital expenditures, which would likely improve MEE's financial performance even in the absence of additional rate increases.

As described in Section II.B above, MEEI anticipates a growing need for otolaryngology and ophthalmology services in the Commonwealth, primarily due to the aging of the population. Given current and projected growth, MEEI anticipates a need to invest in additional operating capacity.¹⁵³ By utilizing available operating room capacity at Partners sites, MEEI expects to avoid the substantial capital expenditure of building new operating rooms itself.¹⁵⁴ To the extent that demand for otolaryngology and ophthalmology surgeries increases, it is not clear that corporate ownership by Partners is the only alternative to MEE building new capacity independently. For example, MEE could utilize clinical affiliations or leasing arrangements to allow MEE to make use of any unused operating room capacity at Partners facilities or those of other provider systems.¹⁵⁵

In addition to avoided capital expenditures, the parties have identified several areas where they expect to achieve operational efficiencies. They note that the transaction would allow MEE to purchase goods and services and access capital at lower cost through Partners' vendor and borrowing arrangements, to engage in joint long-term real estate planning to determine the most efficient and integrative use of Partners' and MEE's physical space, to achieve material cost savings in MEE's research efforts by enabling it to access a larger pool of scientists and utilize Partners' more efficient research and large scale data management infrastructure, and to achieve reduced costs for its teaching program through participation in Partners' medical education infrastructure.¹⁵⁶ The parties expect that extending these and other Partners corporate and administrative services (such as revenue cycle, treasury, employee benefit, payer contracting, asset management, and information services) to MEE would benefit MEE as well as Partners' existing providers by spreading the aggregate costs of these services over a larger base, reducing the cost of these services to each Partners provider, including MEE, individually.¹⁵⁷ The parties also state that the proximity of the MEE and MGH campuses provide future opportunities to integrate certain services such as laboratory and other ancillary services, and for MGH to provide or support long-term clinical operational services for MEE, such as management of its nursing and physical therapy staffs, and operational services such as on-site security and parking.¹⁵⁸

estimate the relative price differential between MEEA and PCPO, and applied this differential to MEEA's fiscal year 2016 revenue from Aetna Health. The resulting estimated spending increase was nearly identical to that found by the other method described.

¹⁵³ See Partners Sept. 1 DoN Response, *supra* note 38, at 2-3.

¹⁵⁴ *Id.*

¹⁵⁵ We expect that Partners would likely seek to ensure that its operating room capacity is used, rather than sitting idle, to the maximum extent possible. If Partners' spare operating room capacity is used for MEE surgeries, it is possible that new capacity would need to be built for whatever other services Partners would have located at these sites in the absence of this transaction.

¹⁵⁶ PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section 2.1.

¹⁵⁷ See Partners Sept. 1 DoN Response, *supra* note 38, at 3.

¹⁵⁸ *Id.*

The parties estimate that as a result of these and other efficiencies, MEEI's cost growth would be reduced from 5% to 4% per year, and that additional savings not yet quantifiable would be realized over time after MEE fully migrates to Partners' clinical, research, financial, and administrative systems.¹⁵⁹ While we are not able to specifically evaluate these claims, it is likely that savings would accrue to MEEI through the use of Partners resources. Based on HPC analysis of confidential financial projections provided by the parties, the scale of operating savings, if realized, could amount to more than \$20 million per year in a few years' time. The parties have stated that they plan to use these efficiencies to support MEE's clinical and research activities, improving its operating margins and long-term financial viability.¹⁶⁰ The scope of the operating efficiencies and volume growth the parties expect to achieve as a result of the proposed transaction, if realized, would substantially improve MEE's financial performance over time even if MEE did not achieve additional rate increases as a result of the transaction.

In summary, we find that the proposed transaction would increase Partners' already-substantial outpatient market shares, particularly for outpatient otolaryngology services. Having joined with its largest competitor for otolaryngology services, MEEI would likely be able to benefit from Partners' negotiating leverage once acquired, allowing Partners to seek significant rate increases for MEEI, and Partners would likely be able to add MEEA physicians to many of its existing payer contracts at higher rates than MEEA receives currently. Over time, this transaction has the potential to increase total health care expenditures in the Commonwealth by an estimated \$20.8 and \$61.2 million annually, as shown below in the table below. Internal documents related to the proposed transaction developed by the parties and provided to the HPC contemplate revenue increases due to rate lifts for MEE generally consistent with our lower estimate. While the parties have identified certain potential efficiencies from the transaction, they have declined to offer an unequivocal and measurable commitment to limit the price increases that would result in increased spending for payers and consumers.

Impact of Estimated MEE Hospital and Physician Price Increases

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

¹⁵⁹ *Id.*

¹⁶⁰ See PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section F1.a.iii ("the parties expect that the Transaction will generate operating efficiencies and overhead savings for MEE that will help it to sustain its clinical and research activities").

B. QUALITY IMPACT

As discussed in the baseline section, MEE is a well-regarded institution that performs well on relevant quality measures. Partners hospitals and physicians also perform well on most measures compared to statewide averages. However, the parties claim that the merger will facilitate improved quality by better integrating MEE into Partners' technical infrastructure, including its data warehouse, quality reporting platform, and electronic medical record system.¹⁶¹ The parties have also identified a handful of measures they expect to monitor in order to assess the quality and access impacts of the transaction.

Specifically, Partners has stated that it intends to fully integrate MEE into its technology systems and reporting initiatives, including the Partners Patient Reported Outcomes Measures program, which would improve MEE's data analysis and patient management capabilities. The parties claim that this and other aspects of corporate integration will allow MEE to improve its quality data collection and measurement programs, thereby improving the quality of patient care and increasing the likelihood of shared savings under alternative payment methodology (APM) contracts.¹⁶² A robust health information technology infrastructure can support quality data analysis and improvement programs, and further integration between the parties may result in more efficient sharing of data and innovations in quality measurement for MEE. However, as noted in Section III.B, MEE has a strong history of measuring, evaluating, and reporting on its quality performance already. Moreover, in confidential documents provided by the parties, Partners has recognized MEE's track record for exceeding quality goals focused on clinical processes and patient experience. Finally, as discussed in Section III.A, MEEA physicians already participate in Partners' payer contracts with the three largest commercial payers, are considered part of MGPO, and are thus already subject to the same quality incentives as other Partners physicians.¹⁶³ Given MEE's already-strong quality performance and the fact that the MEEA physicians are already subject to MGPO quality incentives, it is unclear whether corporate ownership of MEE would significantly improve quality, and the public must weigh the likelihood and scope of any such improvements against the other impacts of the proposed merger on costs, quality and access.

The parties have also indicated that the proposed transaction would remove current restrictions on sharing protected health information imposed by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prevent clinicians at different provider organizations from having "complete" access to a patient's medical record. HIPAA's Security Rule requires health care providers that do not share corporate ownership or control to maintain administrative, physical and technical safeguards for their electronic protected health information systems.¹⁶⁴ Therefore, although MEE and Partners currently share an electronic

¹⁶¹ PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section F1.b.ii.

¹⁶² PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section F1.b.i.

¹⁶³ As described in previous publications, Partners-affiliated providers participate in an internal performance framework that establishes a standard set of financial and quality performance benchmarks on which providers are measured and incentivized. See HALLMARK FINAL CMIR REPORT, *supra* note 22, at 69; PHS-SSH-HARBOR FINAL CMIR REPORT, *supra* note 22, at 48.

¹⁶⁴ See 45 CFR 164.302 *et seq.*, available at <https://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-part164-subpartC.pdf> (last visited Oct. 29, 2017).

medical record system, their systems are managed in separate technical environments.¹⁶⁵ While, corporate integration may circumvent certain technical barriers created by the HIPAA Security Rule, HIPAA's Privacy Rule already allows unaffiliated providers to disclose patient information to other providers for treatment, payment, and health care operations,¹⁶⁶ and both MEE and Partners state that they use and disclose patient protected health information for these purposes.¹⁶⁷ Furthermore, Partners has been expanding access to its unified electronic health record system to other entities with which it is clinically, but not corporately, affiliated¹⁶⁸ and has indicated that this expansion is resulting in "safer, coordinated care, and a better overall experience" for their patients.¹⁶⁹ Here, too, it is unclear to what extent corporate integration would drive improvement in the quality of patient care beyond what is currently achievable, or that the marginal benefits only achievable by corporate integration counterbalance the concerning aspects of a corporate merger.

Finally, Partners proposed eight measures in its DoN application to track the quality and access results of the proposed transaction.¹⁷⁰ However, only three such measures align with nationally validated quality metrics (regarding patient experience).¹⁷¹ The parties have

¹⁶⁵ Partners Sept. 1 DoN Response, *supra* note 38, at 12.

¹⁶⁶ See 45 CFR 164.506 *et seq.*, available at <https://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-part164-subpartE.pdf> (last visited Oct. 29, 2017); *Uses and Disclosures for Treatment, Payment, and Health Care Operations*, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html> (last visited Oct. 29, 2017). Payment and health care operations include utilization review, quality assessment and improvement, and population health activities. While a provider must limit disclosures to the "minimum necessary" for payment and operations purposes, disclosures for treatment purposes are not similarly restricted.

¹⁶⁷ See *Notice of Privacy Practices*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/for-patients/patient-guide/privacy-practices> (last visited Oct. 30, 2017); PARTNERS HEALTHCARE SYSTEM, PARTNERS HEALTHCARE NOTICE FOR USE AND SHARING OF PROTECTED HEALTH INFORMATION, available at http://www.partners.org/Assets/Documents/Notices/Partners_Privacy_Policy_English.pdf (last visited Oct. 29, 2017).

¹⁶⁸ See *Upgrading our Electronic Health Record System*, MASS. EYE AND EAR INFIRMARY, <http://www.masseyeandear.org/partnersecure> (last visited Oct. 19, 2017).

¹⁶⁹ See *How Partners eCare is Changing the Way you Receive Care*, PARTNERS HEALTHCARE, <http://www.partners.org/for-patients/Partners-eCare.aspx> (last visited Oct. 19, 2017).

¹⁷⁰ See PARTNERS-MEE DON APPLICATION, *supra* note 20, at F1.b.ii. The parties have also stated that they plan to work together to identify and possibly develop new measures in the future. *Id.* (stating that "the Transaction will lead to a fully integrated health information technology system allowing Partners HealthCare to identify a core set of OPH and ORL measures... [and allow] for the development of internal benchmarks for physicians within the system that can help lead to best practices").

¹⁷¹ Two of the proposed measures (number of Partners patients receiving otolaryngology and ophthalmology services from MEE physicians, and the percentage of Partners diabetic patients receiving an annual eye exam from an MEE physician) would track the frequency with which Partners patients use MEE physicians for care, rather than quality. Two are structural measures (the average time between a referral for Partners patients and the date of their appointment at MEE, and the participation of MEE staff on Partners pharmacy quality committees). Finally, Partners proposes to track "The percentage of time protocols are followed for eliminating unnecessary [preoperative] testing." Partners provided no specifications related to this measure in response to HPC inquiries, and we therefore cannot verify its validity. See PARTNERS-MEE DON APPLICATION, *supra* note 20, at F1.b.ii.

provided no baseline data or measure specifications¹⁷² for the measures they propose to study, and have not identified performance improvement goals by which they and the state may measure success, claiming that this would be impossible prior to the proposed transaction.¹⁷³ The parties have also not indicated how they identified these measures as priorities for improvement.¹⁷⁴ Based on the information currently available, it is not possible for the HPC to assess the scope or likelihood of improvement on these measures or whether these measures would assess areas in need of improvement.

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

C. ACCESS IMPACT

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

- Making MEEI the Partners system-wide resource for otolaryngology and ophthalmology services and enabling MEE to provide ambulatory surgical services in the community at Partners facilities that currently have surgical capacity,
- Meeting a growing need for otolaryngology and ophthalmology services in the population at large and specifically for Partners patients, and
- Ensuring that MEE can remain viable as a provider of specialty services in a market shifting to accountable care organization (ACO) structures.

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

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

The parties state that despite MEE's current clinical integration with MGH and BWH, "there is little integration of MEE's specialty services with community-based provider members of the Partners ACO."¹⁷⁵ They have also stated that the proposed transaction will enable MEE to provide services at additional Partners community facilities.¹⁷⁶ Yet, it is unclear

¹⁷² Measure specifications include definitions of terms, study populations, and other information needed to assess the validity of the proposed measures. For example, it is unclear what pre-operative protocols the parties propose to use to assess whether a patient has received unnecessary testing. *See id.*

¹⁷³ The parties state that they cannot calculate baseline performance data due to HIPAA-imposed restrictions on sharing protected health information, and have described their intention to implement a plan that will enable this type of reporting within six months of the transaction. *See Parties' Response*, Exh. A, at 5-6.

¹⁷⁴ Partners proposes three measures related to surveys of patient satisfaction in MEEA clinics. *Id.* As MEEI's performance on similar measures in hospital settings is already better than most Partners hospitals, as discussed in Section III.B, it is unclear why the parties have identified this as a priority area for improvement.

¹⁷⁵ PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section 2.1.

¹⁷⁶ MEE NOTICE OF MATERIAL CHANGE, *supra* note 33.

why such integration of MEE as a Partners system-wide resource requires corporate ownership of MEE. As members of the MGPO, utilizers of the Epic electronic medical record system, and participants in Partners contracts with the three largest commercial payers, MEEA physicians already have shared tools and incentives for alignment with other members of the Partners ACO.

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

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

The parties have also stated that MEEI must expand its ambulatory surgical capacity to meet the expected growth in demand for otolaryngology and ophthalmology services that will accompany the Commonwealth's aging population. The parties have provided some data on statewide population trends and utilization among older patients to support this expectation.¹⁷⁷ However, MEE has been steadily increasing its outpatient presence in recent years as an independent entity: MEE has added 14 clinic and outpatient locations in the last ten years, including outpatient surgery sites, thereby increasing its total outpatient sites to 18.¹⁷⁸ While the provision of otolaryngology and ophthalmology services at additional Partners sites could potentially increase community access to these services, without details on the specific Partners facilities in which MEE may offer new services, the HPC cannot evaluate the extent to which utilization of Partners facilities would increase MEE's already broad geographic presence.

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

The parties suggest that MEE's clinical and research mission may be threatened in the absence of the transaction due to changes in the health care payment and delivery system.¹⁷⁹ They suggest that new payment incentives will cause Massachusetts ACOs to reduce referrals to MEE in an effort to keep more care in-system. However, as discussed in Section II.B, MEE's patient volume has been growing substantially in recent years, despite a general

¹⁷⁷ See PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section F1.a.ii.

¹⁷⁸ See MEEI ANNUAL REPORT, *supra* note 44.

¹⁷⁹ PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section 2.1 ("the Applicant and MEE believe that the Transaction is necessary to enable the Applicant to meet this patient need and to ensure the ongoing viability of MEE's clinical and research mission").

increase in the share of commercial health maintenance organization (HMO) members covered by alternative payment methods during this time.¹⁸⁰ As discussed above, the parties have cited MEE's volume growth, and the expectation of additional volume due to an aging population, as the impetus for MEE's further expansion into new community sites. In addition to its current relationship with Partners, MEE has affiliations with several other major Massachusetts providers, which the parties have stated they expect to continue after the affiliation.¹⁸¹ Here, too, it is unclear to what extent a continued shift toward a more coordinated delivery and payment system would reduce patient volume for MEE or threaten its viability.¹⁸²

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

As discussed in Section III.C.1, MEEI is the principal facility provider of a small set of specialty services, making it an important access point for patients. Access to these rare services might be impacted if MEEI were to adopt the contracting patterns of Partners' acute care hospitals regarding participation in MMCO networks and commercial limited and tiered network products.¹⁸³

If MEEI's rates increase over time as a result of joining Partners, as discussed in Section IV.A.2, payers creating limited network products may exclude MEEI as being too expensive, and payers creating tiered products may put MEEI in less favorable tiers. MEEI may also simply participate in fewer tiered and limited networks over time, similar to Partners acute care hospitals.¹⁸⁴ Any change in MEEI's network participation or tiering would

¹⁸⁰ We looked at the percentage of commercial HMO members covered by an APM for Massachusetts' largest physician groups according to share of total commercial HMO member months in 2014 and found that all but one of these groups had over two thirds of their commercial HMO members covered by alternative payment method contracts. Half of these groups saw an increase of at least 10 percentage points in this percentage from 2013 to 2014. See CTR. FOR HEALTH INFO. & ANALYSIS, CHIA ANNUAL REPORT SERIES: ADOPTION OF ALTERNATIVE PAYMENT METHODS IN MASSACHUSETTS 2012 - 2014 (March 2016), available at <http://www.chiamass.gov/assets/docs/r/pubs/16/apm-chartbook-2016.pdf>.

¹⁸¹ See Section II.

¹⁸² As discussed at pages 14 to 15, MEE has experienced substantial increases in operating expenses in recent years, and has recently used proceeds from the sale of non-clinical assets to achieve positive financial margins. The parties have also stated that federal funding supporting MEE's research activities has declined in recent years, and have suggested that the transaction will support MEE's research mission. See, e.g., PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section F1.b.iv. While the transaction would likely result in additional resources for MEE's clinical and research activities, it is unclear to what extent these resources would come from efficiencies as MEE joins Partners research infrastructures, as opposed to resulting from rate increases for commercial payers and increases in health care spending.

¹⁸³ While Partners has asserted in its DoN application that the proposed transaction would not impact MEE's participation in limited network plans, it has only committed to maintain MEE's existing agreements with non-Partners *provider* networks. While this commitment is welcome, it does not ensure access to MEE for members of tiered and limited *payer* networks. PARTNERS-MEE DON APPLICATION, *supra* note 20, at Section F1.a.iii.

¹⁸⁴ As stated in the Parties' Response, and acknowledged in Section III.C.2, Partners' non-acute care specialty hospitals, McLean and Spaulding Rehabilitation Hospital, participate more regularly in commercial limited network products than Partners' general acute care hospitals. See Parties' Response, Exh. A, at 5. The parties suggest that these specialty hospitals' contracting patterns and participation decisions may better reflect MEEI's future contracting patterns, given its status as a specialty hospital. However, unlike McLean and Spaulding, MEEI

negatively impact access for plan members, particularly for those services for which MEEI is the primary or exclusive provider, and might drive up costs for patients and payers. Specifically, patients in a limited network product that does not include MEEI would generally not be able to receive services at MEEI unless they paid the full cost, and patients in a tiered network product for which MEEI is placed in a high cost-sharing tier would only be able to access MEEI services by paying higher co-pays or co-insurance.¹⁸⁵ While most MEEI services can be provided by other providers in eastern Massachusetts as described in Section III.C, its absence from a greater number of limited networks and placement in less-efficient tiers would reduce choice for consumers enrolled in these products. Moreover, it is not clear that other providers would have capacity to serve all or most patients who could no longer access MEEI.

As with commercial limited and tiered network products, changes in MEEI's participation in MMCO networks would negatively impact access for MassHealth members. The Parties' Response states that they are "fully committed to having MEE continue to participate after the Transaction in MEE's existing MMCO contracts."¹⁸⁶ This commitment helps to alleviate our concerns about potential impacts on access to MEEI's services by MassHealth patients in MEEI's current contracts, and we expect that this commitment would also apply to MEE's participation in new MassHealth ACO contracts.

In summary, while the parties have suggested that there may be a growing need for MEE's services over time, they have not provided sufficient information to allow the HPC to judge whether the proposed transaction is necessary or sufficient to meet such needs, or that corporate integration is the most efficient means of doing so. In addition, the differences between the current participation of MEE and Partners providers in tiered and limited network

is licensed as an acute care hospital and the services it provides are a subset of those provided by general acute care hospitals. Partners could seek to represent MEEI in negotiations more similarly to its other acute care hospitals, rather than its non-acute care specialty hospitals. Absent a commitment from the parties to seek to continue MEEI's participation in commercial limited networks, we cannot discount a potential impact on access for patients in these products.

¹⁸⁵ If patients of a limited network product use an out-of-network provider, the patient may pay the extremely high "full charge" rate of the provider, or the payer may cover this higher charge if the needed care was not otherwise available from an in-network provider, and may pass on these additional costs in the form of later premium increases. The HPC analyzed 2014 APCD claims for outpatient hospital services for which MEEI had at least a 50% market share and Partners and MEEI combined had at least an 80% market share in MEEI's PSA (i.e., MEEI services that are not likely to be easily accessible outside of the Partners system after the transaction). "Full charge" rates were approximately 74% higher than the reimbursement rates currently MEEI receives from the top three commercial payers for these services. Furthermore, payers have indicated to the HPC that increased MEEI prices and changes in MEE participation in tiered and limited network products would make these products less marketable to consumers, which could result in a shift of members to plans without these cost-saving incentives and undermine payer efforts to limit total health care spending.

¹⁸⁶ See Parties' Response, Exh. A, at 5. The parties also note that MassHealth has recently taken steps to institute greater pricing uniformity among its providers, thereby reducing the likelihood that MMCOs would exclude MEEI on the basis of price. While we acknowledge this change to the MassHealth program, we also note that MMCOs can apply for a waiver from this pricing requirement.

products raise concerns that members in these products could face barriers to accessing MEE's specialty services, or make such networks harder to establish and market to consumers.

V. CONCLUSION

As described in Section IV, the HPC found:

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

In summary, we find that the proposed transaction between Partners and MEE is likely to increase health care spending due to expected increases in hospital and physician prices that are consistent with the parties' stated goals of the transaction. While the parties have claimed that the transaction will result in operational efficiencies and improvements in the quality of patient care and access to services, they have declined to offer an unequivocal and measurable commitment to limit the price increases that would increase spending for payers and consumers, and have not provided evidence that a corporate merger is either necessary or

sufficient to achieve quality or access improvements. The parties also have not offered commitments regarding MEE's commercial payer network participation that would protect against any impaired access to MEE's specialty services subsequent to the transaction.

Given that the proposed transaction is under concurrent review by DPH's DoN program, the HPC will provide a copy of this Final Report to DoN program staff for consideration in the context of the factors for DoN approval. In addition, the HPC finds that Partners meets the criteria for mandatory referral to the Massachusetts Attorney General's Office pursuant to MASS. GEN. LAWS ch. 6D, § 13(f) as Partners has "dominant market share," "materially higher prices" than other providers, and "materially higher TME" than other providers.

Acknowledgements

Commissioners

Dr. Stuart Altman, Chair

Dr. Wendy Everett, Vice Chair

Dr. Donald Berwick

Mr. Martin Cohen

Dr. David Cutler

Mr. Timothy Foley

Secretary Michael J. Heffernan
Executive Office of Administration and Finance

Mr. Richard C. Lord

Mr. Renato (Ron) Mastrogiovanni

Secretary Marylou Sudders
Executive Office of Health and Human Services

Executive Director

Mr. David Seltz

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

Exhibit A:
**Foundation of the Massachusetts Eye and Ear
Infirmary and Partners HealthCare System's
Response to Preliminary Report**



November 30, 2017

By email: david.seltz@state.ma.us

And by U.S. Mail

David Seltz
Executive Director
Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

RE: Response to Health Policy Commission Preliminary Report
dated November 1, 2017
HPC-CMIR 2017-1 Concerning Proposed Acquisition of
Massachusetts Eye and Ear Infirmary, et al.

Dear Executive Director Seltz:

The Foundation of the Massachusetts Eye and Ear Infirmary ("MEE") and Partners HealthCare System, Inc. ("Partners") value the efforts of the Massachusetts Health Policy Commission ("HPC") to review and understand the impact of the proposed acquisition of corporate control of MEE by Partners (the "Transaction") as reflected in HPC's November 1, 2017 Preliminary Report of CMIR (the "Preliminary Report"), and we appreciate the opportunity to respond to certain aspects of the Preliminary Report.

Our principal concern with the Preliminary Report is that HPC mischaracterized the current financial condition of MEE and, as a result, did not give sufficient weight to the parties' principal rationale for the Transaction, which is ensuring the long-term financial sustainability of MEE. In addition, the parties want to comment on certain assumptions and methodologies and related conclusions in the Preliminary Report with which they disagree.



Financial Sustainability of MEE

MEE, the last independent eye and ear hospital in the country, has experienced operating losses in each of the last several fiscal years¹; and in view of the market developments that we described in our discussions and submissions to HPC (including provider consolidation and the growing prevalence of risk bearing arrangements and accountable care organizations), these losses are likely to worsen in the coming years. As a result of these historical and projected operating losses, the MEE Board of Directors, exercising its fiduciary obligation to MEE, determined that MEE must join a financially strong and mature health system, and finding Partners to be the best fit for MEE in view of their common patient care, teaching and research missions and the geographic proximity of MEE and MGH, the MEE Board initiated the discussions with Partners that resulted in the Transaction agreement.

MEE and Partners have determined that joining MEE with Partners will enable them to sustain MEE's financial health into the future through a combination of (i) cost savings realized through the consolidation of corporate and administrative services and utilization by MEE of existing Partners clinical facilities, (ii) revenue increases achieved through modest rate increases (see the Rate Increases section below) and (iii) volume growth resulting from the increasing demand for ophthalmology and otolaryngology services. A financially healthy MEE will be able to continue to provide the residents of the Commonwealth and beyond with access to the high-quality specialty services that have been provided by MEE for over 200 years and cutting-edge research seeking cures for deafness and blindness.

However, citing certain limited financial measures, HPC concludes in the Preliminary Report that "[o]verall, MEE is a financially stable organization."²

¹ Please note that the positive trend in MEE's financial performance in FY2015 and FY2016 that HPC identified in the Preliminary Report (see p. 14) was due to one-time sales of real estate assets.

² See Preliminary Report, p. 13 and footnote 45 that lists revenue growth, "a healthy reserve of cash and other readily available assets" and "improvements in its average age of plant" as the basis for HPC's conclusion of financial stability.

Standard and Poor's Global Ratings ("S&P"), an internationally recognized financial rating agency, drew a materially different conclusion about MEE's financial health. In February, 2017, S&P reported that MEE's "financial profile is vulnerable, demonstrated by negative operating margins and overall financial metrics that are light compared to S&P's expectations for the BBB- rating level." After removing the positive effects of the one-time real estate sales, S&P found that MEE generated a negative 11.8% operating margin (\$41.0 million operating loss) in FY15 and a negative 6.9% operating margin (\$25.5 million operating loss) in FY16. Comparing these operating results to its 2015 median operating margin of 1.50% for BBB- rated stand-alone hospitals, S&P concludes that MEE lacks financial stability. The rating agency affirmed MEE's 'BBB-' long-term credit rating but revised its credit outlook to negative from stable, an indication of greater than 50% likelihood that the rating will be downgraded within a two-year period.³ MEE's own projections that were submitted to HPC indicate that these operating losses will continue in FY17 and FY18 if MEE continues to operate on a stand-alone basis.

These financial challenges, if left unchecked, will ultimately erode access for patients within the Commonwealth to MEE's high-quality ophthalmology and otolaryngology services and will weaken MEE's world-class research program. Accordingly, it is the parties' belief that the Transaction is necessary to restore and sustain MEE's financial health and thus assure long-term access to its outstanding clinical services and the viability of its world-class research program. Furthermore, as we outline below, these goals will be accomplished without the significant rate increases that HPC predicts will result from the Transaction.

Comments on Specific Elements of the Preliminary Report

1. Rate Increases

CHIA data shows that MEE's current commercial hospital rates are below the average rates paid to Massachusetts acute care hospitals. In the Preliminary Report, HPC assumes that Partners will successfully close that gap through negotiating "significant" rate increases for MEE that bring MEE's hospital rates at least to parity with Partners community

³ See Attachment 1 – S&P's February 13, 2017 rating report on MEEI.

acute care hospitals.⁴ The documents that the parties provided to HPC clearly indicate, however, that their goal is only to seek market competitive hospital rates for MEE. Using CHIA data, the parties estimate that achieving such rates would result in an annual increase in the cost of MEE's hospital services that is 33% below HPC's lower end estimate.⁵ The parties also question HPC's assumption that Partners would separately negotiate parity rates for a specialty hospital like MEE since (i) Partners negotiates with commercial payers on a comprehensive, system-wide basis, not at an individual provider level; and (ii) Partners has not negotiated parity rates for its specialty hospitals such as McLean and the Spaulding Network hospitals.

It is also important to note that any future rate increases for Partners providers, including MEE, will continue to be constrained by established state limits on total medical expenditures and payer contract negotiations which, in recent years, have yielded increases for Partners of inflation or less.⁶ Therefore, after the Transaction, MEE will remain competitive from a rate perspective and fully accessible from a cost perspective to all Massachusetts patients.

2. Access

The Preliminary Report assumes that, following the Transaction, commercial payers will exclude MEE from their limited networks or place it in more expensive tiers because of the higher rates that HPC assumes will be negotiated for MEE. We have shown in the prior discussion on rate increases that HPC has overestimated the potential hospital rate increase effect of the Transaction. The Preliminary Report also projects reduced access to MEE services "**if MEE adopts** Partners' contracting patterns related to participation in MMCO networks and commercial limited and tiered network products."⁷ It is unclear why MEE would adopt such restricted network participation which would clearly run contrary to MEE's financial interest in

⁴ See Preliminary Report, pp. 15 and 38.

⁵ Since MEE accounts for only 0.3% of total Massachusetts total medical expense ("TME"), it is highly unlikely that any rate increases achieved by MEE will result in any increase in Massachusetts health insurance premiums.

⁶ Partners has not guaranteed that MEE will achieve any rates increases, and since MEE would represent just 3% of Partners' overall system revenue, there is no basis for assuming that the addition of MEE to Partners payer contracting would enable Partners to achieve any rate increases for MEE.

⁷ *Emphasis added.* See Preliminary Report, page 52.

maximizing its patient service revenue. Moreover, HPC has missed the fact that Partners' other specialty hospitals, McLean Hospital and all of the Spaulding Network hospitals, participate broadly in limited networks, including those limited networks that have excluded the Partners acute care hospitals.

With respect to access to MEE by MassHealth members specifically, as we stated in our discussions with HPC staff, MEE and Partners are fully committed to having MEE continue to participate after the Transaction in MEE's existing MMCO contracts. Further, HPC's suggestion that "MMCO networks may exclude MEEI as being too expensive"⁸ fails to recognize that in 2017 MassHealth instituted a program that is intended to move all MassHealth providers to more uniform pricing that will eliminate or reduce any cost-based reasons to exclude MEE from MMCO networks.

3. Quality Improvement

We understand HPC's frustration that "based on the information currently available, it is not possible for HPC to assess the scope or likelihood of improvement" on available measures.⁹ However, as we indicated in our discussions with HPC staff and in our written submissions to HPC, because of the limitations on the sharing of protected health information imposed by HIPAA, Partners and MEE cannot currently share the clinical information necessary to establish baseline performance for a core set of measures. As a solution, the parties have committed to implement within the first six months following the Transaction a joint plan for the development of integrated care models using a fully integrated electronic medical record and a framework for sharing data that will enable the establishment of quality metrics and the baseline data against which the parties can measure future quality improvement. The parties are committed to tracking the quality and access results of the proposed Transaction.

⁸ See Preliminary Report, p. 52.

⁹ See Preliminary Report, p. 49.

The Transaction will also enable MEE to gain access to quality measurement tools and quality improvement programs that have been implemented by Partners. These tools and programs would be unattainable by MEE as a stand-alone organization because of their significant costs. One specific example is MEE's ability after the consummation of the Transaction to participate in the Partners Patient Reported Outcomes Measures (PROMS) program.¹⁰ PROMS is an important, nationally recognized measurement tool that enables clinicians to understand what patients value, which may differ from physician goals, and therefore develop better therapeutic options with their patients.

4. Market Share Methodology

The Preliminary Report continues HPC's standing practice of calculating market shares using so-called "primary services areas,"¹¹ a methodology that has been criticized for its tendency to exaggerate actual market shares and for being an improper method for defining relevant geographic markets for antitrust purposes. *See, e.g., Gordon v. Lewistown Hospital*, 272 F. Supp 2d 393 (M.D. Pa. 2003), *aff'd*, 423 F.3d 184 (3d Cir. 2005); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999). When faced with this point previously, HPC has indicated that its approach is merely being used as a screening tool to determine whether a transaction warrants further review, but this limitation in the proper use of the PSA methodology is not acknowledged in the Preliminary Report. Nor does HPC acknowledge in the Preliminary Report that in response to a Hart-Scott-Rodino notice filed by the parties the Federal Trade Commission declined to undertake an in-depth antitrust review of the proposed Transaction.

In addition, in the Preliminary Report HPC expands its use of the PSA methodology to calculate outpatient market shares. In contrast, the broadly accepted approach for antitrust analysis of outpatient markets focuses on identifying the geographic area in which a

¹⁰ This participation will only be possible when, as a result of the Transaction, MEE will be able to be in the same Partners eCare (Epic) "service area" as all of the other Partners providers.

¹¹ See Preliminary Report, page 19, footnote 70.

hypothetical monopolist for the services at issue could profitably raise prices by a small but significant amount.¹² HPC neither acknowledges this expansion in the use of its PSA methodology nor provides any explanation as to how a methodology that is based on inpatient discharge data can be used to determine outpatient market shares.

In conclusion, we hope that after giving due consideration to this response, including in particular the parties' description of MEE's actual financial condition, and after further evaluating the benefits of the Transaction as a whole, the HPC staff and the Commission itself will support the Transaction at its December 12, 2017 meeting, thereby ensuring the financial sustainability of MEE so it can continue providing great patient care, teaching and research for many years to come.

Please note that this Response is subject to the statutory protections provided by M.G.L. c. 6D, § 13(c). Accordingly, the HPC must keep information contained herein confidential and non-public, except where disclosure in the HPC's final report is in the public interest. MEE and Partners would expect advance notice of HPC's intent to make any such disclosure in order to fully discuss a balancing of such public interest and MEE's and Partners' legitimate privacy, trade secret and competitive interests.

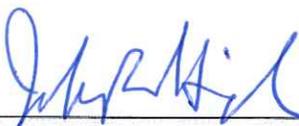
Respectfully submitted,

The Foundation of the Massachusetts
Eye and Ear Infirmary

By: 

Martha Pyle Farrell, Vice President
Human Resources, General Counsel
and Compliance

Partners HealthCare System, Inc.

By: 

John R. Higham
Counsel

¹² See, e.g., *St. Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys.*, 778 F.3d 775, 784 (9th Cir. 2015) (affirming the district court's focus on the "likely response of insurers to a hypothetical demand by all the PCPs in particular market for a [small but significant price increase or SSNIP]" when defining the relevant geographic market for adult PCP services).

RatingsDirect®

Massachusetts Development Finance Agency Massachusetts Eye & Ear Infirmary; Hospital

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Massachusetts Development Finance Agency, Massachusetts

Massachusetts Eye & Ear Infirmary, Massachusetts

US\$65. mil hosp rev bnds (Massachusetts Eye & Ear Infirmary) ser 2010 dtd 09/29/2010 due 07/01/2014-2020 2035

Long Term Rating

BBB-/Negative

Affirmed

Rationale

S&P Global Ratings revised its outlook to negative from stable and affirmed its 'BBB-' long-term rating on the Massachusetts Development Finance Agency's series 2010 hospital revenue bonds, issued for Massachusetts Eye & Ear Infirmary (MEE).

The negative outlook reflects our view of MEE's continued operating losses, by our calculation, and weak coverage of pro forma maximum annual debt service (MADS; based on the full draw on bank debt).

MEE's enterprise profile is very strong, in our view, characterized by its leading market share for ophthalmic and otolaryngology services across a broad primary service area, and its financial profile is vulnerable, demonstrated by negative operating margins (according to our calculation) and overall financial metrics that are light compared to our expectations for the rating level. MEE remains in a transition period, where it has invested significantly in its physician complement and space reconfiguration. This investment and financial regulatory demands have put strain on its financial performance and a slow draw on its cash resources. The sale of noncore assets in fiscal years 2015 and 2016 helped MEE maintain its cash metrics in line with our expectations for the rating level. Also contributing to our assessment of the rating is credit risk associated with the organization's specialty hospital status. Combined, we think these credit factors lead to an indicative assessment of 'bbb-' and a final assessment of 'BBB-'.

A lower rating is currently precluded by MEE's modest improvement in financial performance through interim fiscal 2017 (first quarter ended Dec. 31, 2016), which we expect will continue to strengthen over time, and its balance-sheet metrics that we think will remain intact as the organization executes on its strategic capital plans through the next few years. MEE's capacity to maintain the current rating depends on its ability to limit future operating losses, generate sufficient cash flow to maintain adequate unrestricted cash reserves, and successfully fund its strategic plan without putting significant strain on its balance-sheet metrics.

MEE recently announced that it intends to formally join as a full-member hospital of Partners HealthCare, the largest health system in the competitive Boston market (rated 'AA-'). If approved, MEE would continue as its own organization, retaining its hospital license, name, medical staff, and mission. While patients are unlikely to see major changes in the care and caregivers, as a member of Partners, MEE would be able to leverage the size and strength of a

larger system to build on its successful expansion efforts throughout the region. MEE already has a strong relationship with many Partners hospitals; the MEE chiefs of ophthalmology and otolaryngology are also both chiefs of these departments at the Massachusetts General Hospital (MGH) and similarly, the MEE physicians are the staff of the MGH's departments of ophthalmology and otolaryngology. At BWH, MEE ophthalmologists lead and staff the division of ophthalmology, and at Newton Wellesley, a MEE otolaryngologist is the chief of otolaryngology. With MEE already using Partners eCare electronic medical record (EMR) and revenue cycle system and MEE patients accessing their information on Partners Patient Gateway, we expect even greater collaborations and efficiencies. The letter of intent has been signed and we view this transaction favorably, although we need to learn more of the specifics as they unfold and the agreement still requires approval of state regulators.

The 'BBB-' rating for MEE reflects our assessment of the following strengths:

- Healthy volume and slightly improved financial performance through the first quarter of fiscal 2017;
- Better-than-budgeted financial performance at MEE's Longwood campus, and management expects its investments will lead to profitability by the close of fiscal 2017 (one year ahead of plan); and
- Net patient revenue growth in recent years.

Partly offsetting factors include our view of the following:

- Continued operating losses, based on our adjusted results for fiscal years 2016 and 2015; and
- An additional \$34 million in debt expected within the next 12 to 18 months, as we anticipated, as the organization fully draws down its 2015 direct-purchase bank loan.

The rating is based on our view of MEE's group credit profile (GCP) and the obligated group's core status. Accordingly, the long-term rating is commensurate with the GCP. A lien on gross receipts from the obligated group as well as various mortgages secure the bonds. The obligated group consists of MEE, a foundation, and Massachusetts Eye & Ear Associates (the faculty practice plan). The obligated group does not include Schepens Eye Research Institute (SERI), an affiliate that joined MEE in 2011. SERI is a small institute that conducts basic and clinical vision research and training. The parent also controls two other small corporations and we have included their results in this analysis. MEE currently does not have any swap agreements in place.

MEE operates a 41-bed hospital (22 adult and 19 pediatric beds) specializing in the treatment of, and teaching and research related to, disorders of the eye, ear, nose, throat, and neck. MEE, in downtown Boston and adjacent to MGH, is Harvard Medical School's principal teaching hospital in otolaryngology and ophthalmology specialties.

Outlook

The negative outlook reflects our view of MEE's continued operating losses, by our calculation, and weak coverage of pro forma maximum annual debt service (MADS; based on the full draw on bank debt).

Downside scenario

We could consider a lower rating through the two-year outlook period if MEE's financial performance doesn't improve in fiscal years 2017 and 2018, according to our calculation. Any deterioration in balance-sheet metrics beyond the final draw on bank debt could also be given negative consideration, especially if the size of the issuance grows to a higher

level, if operating performance does not continue to recover, and if unrestricted reserves deteriorate.

Upside scenario

We could return to a stable outlook if MEE can reduce its operating losses through the outlook period and maintain its balance-sheet metrics and enterprise strengths. We could also consider a higher rating, based on our Group Rating Methodology, if MEE signs a definitive agreement with MGH and Partners HealthCare.

Enterprise Profile

Industry risk

Industry risk addresses the health care sector's overall cyclical and competitive risk and growth by applying various stress scenarios and evaluating barriers to entry, the level and trend of industry profit margins, risk from secular change and substitution of products, services, and technologies, and risk in growth trends. We believe the health care services industry represents an intermediate credit risk when compared with other industries and sectors.

Economic fundamentals

MEE's service area is very broad, covering the majority of Massachusetts across the three counties of Middlesex, Suffolk, and Worcester. Middlesex and Suffolk counties stretch across most of the Boston proper area and have favorable wealth and income levels compared to U.S. growth figures. We also expect continued demographic growth in these service areas in the coming years.

Market position

MEE remains the region's leading eye and ear hospital and has a strong national reputation. It does not have regional competition for its complex eye and ear procedures. It is also the primary teaching hospital for Harvard Medical School's ophthalmology and otolaryngology students. MEE is Massachusetts' only 24-hour emergency room dedicated to otolaryngology and ophthalmology and the only designated eye-trauma center. Both service area chiefs are also the department chairs at Harvard Medical School. Management has hired several new physicians across various specialties during the past several years.

MEE implemented a plan to provide its services in collaboration with other Harvard teaching hospitals in 2009. As noted previously, MEE has a solid relationship with MGH. It also has a clinical affiliation with Brigham and Women's Hospital (BWH), and has provided eye and otology care for BWH through a professional services agreement since July 2009. This relationship, along with a stronger collaboration with the Joslin Diabetes Center, has allowed MEE to build its presence in the Longwood medical and academic area, the epicenter for a large percentage of the tertiary services offered in Boston. In addition, Children's Hospital Ophthalmology Foundation physicians provide services at MEE, including some surgical procedures. MEE has also extended its services outside of Boston (a strategy used by most of the tertiary providers) to 18 locations surrounding the city to broaden geographic access to its services.

QLT Inc. judgment

In January 2009, a federal appeals court ruled in favor of MEE on liability and damages for the organization's claims of unjust enrichment and unfair trade practices against QLT Inc. According to management, MEE believed it was entitled to royalties associated with a QLT drug used in patented clinical trials at the MEII; the court agreed and awarded MEE

approximately \$127.1 million in damages. The organization has approximately \$13 million remaining in deferred revenue, which management indicates it will likely recognize during the next few years. MEE funds research and academic efforts directly with this awarded revenue and is uncertain how it will cover these costs once it depletes the funds. If MEE continues to fund research without a funding replacement, we believe it could create an added credit risk, with the potential for greater operating losses in future years.

Patient volume increased (primarily outpatient) in fiscal 2016 and management notes further growth through the first quarter of fiscal 2017, improved by the successful recruiting across its specialties.

Management and governance

MEE's senior executive team has remained largely unchanged, with routine turnover at the board level. It continues to focus on patient volume growth related to changing demographic trends (primarily the aging of the local population), enhancing its alliances with Boston's major academic medical centers, growing its market share through collaboration with other providers, and execution on its strategic plan.

Financial Profile

Financial policies

The financial policies assessment is neutral, reflecting our opinion that, while there may be some areas of risk, the organization's overall financial policies are not likely to impair its future ability to pay debt service. Our analysis of financial policies includes a review of the organization's financial reporting and disclosure, investment allocation and liquidity, debt profile, contingent liabilities, legal structure, and a comparison of these policies to similar providers.

Financial performance

MEE typically reports annual revenue growth and an operating loss from operations, according to our calculation. We calculate operating margins by excluding investment income and contributions, although MEE includes these figures in its reporting of operating revenue. It reported continued operating losses through fiscal years 2015 and 2016, although management highlights that its operating margin and overall income statement metrics are stable when adjusted for expense and revenue items it would not have otherwise incurred if it hadn't benefited from \$64 million in proceeds from the recent sale of noncore assets (\$40 million in fiscal 2015 and \$24 million in fiscal 2016). Management notes that its overall financial plan is on target, following its master strategy through fiscal 2020 and that operations are expected to gradually improve through that timeframe. MEE expects to be on-budget in fiscal 2017, generating, according to our calculation, an operating loss of approximately \$9.5 million by the close of the fiscal year.

Through fiscal 2016, MEE's excess margin resulted in a thin level of debt service coverage (DSC), using pro forma MADS of approximately \$15.7 million, which includes debt from its SERI affiliate. When including MEE's and SERI's operating leases in our DSC calculation, the ratio decreases slightly. Our calculation of DSC excludes the gains MEE recently recorded as part of its asset sales, but its master trust indenture does not require the removal of those items, resulting in a much stronger level of DSC. For fiscal 2016, MEE reported master trust indenture DSC of 2.5x, which was well excess of its 1.1x covenant, which it calculates using only the financial performance and debt service of the obligated group and does not include operating leases.

Liquidity and financial flexibility

As of Sept. 30, 2016, MEE's unrestricted reserves were adequate but light for the rating, in our opinion, with a balance of approximately \$122 million, or 119 days' cash on hand and 98% compared to long-term debt. With the full draw on its direct-purchase bank loan (Series D), we expect cash-to-long-term debt will decline to a weaker 77%.

Debt and contingent liabilities

MEE's pro forma debt as a percentage of capitalization becomes elevated for the rating at 56% once the organization fully draws on its bank loan. MEE does not expect to take on further debt to support its future master facility plan. Its most recent capital spending has been on the renovation of the main hospital ORs and clinical space, the Longwood campus, and continued community expansion. Terms for MEE's series 2015 bank debt include loans from three banks, including Citizens Bank, Middlesex Savings Bank, and Eastern Bank. Terms of the loan require at least 1.2x DSC, to be calculated semi-annually and a minimum requirement of 75 days' cash on hand. The terms of its traditional fixed-rate bonds require slightly more aggressive 1.1 x coverage. MEE was in compliance with these covenants as of Sept. 30, 2016. On a pro forma basis, approximately 50% of MEE's debt will have pure variable interest rate exposure, although we understand its series D loan is offset by a fixed interest rate swap which minimizes some of this exposure. As of Sept. 30, 2016, MEE reported a negative \$4.2 million mark-to-market on a swap notional amount of approximately \$29 million. No collateral posting was required.

MEE's defined-benefit pension plan was under-funded at 61% as of its Sept. 30, 2016, measurement period, although, in our view, it was adequately funded for the rating level. The plan migrated to a defined-benefit, cash balance plan in 2004.

Massachusetts Eye & Ear Infirmiry -- Selected Financial Statistics

	Fiscal year ended Sept. 30				Medians: Stand-alone hospitals 2015	
	2016	2015	2014	2013	'BBB-'	Speculative grade
Enterprise Profile						
Inpatient admissions	1,129	1,286	1,325	1,512	MNR	MNR
Equivalent inpatient admissions	11,841	13,302	13,250	12,600	MNR	MNR
Emergency visits	21,973	19,896	18,902	18,506	MNR	MNR
Inpatient surgeries	971	1,044	1,079	1,219	MNR	MNR
Outpatient surgeries	22,495	21,042	19,003	17,571	MNR	MNR
Medicare case mix index	1.7800	1.8000	1.7700	1.6500	MNR	MNR
FTE employees	1,965	1,919	1,809	1,802	MNR	MNR
Active physicians	523	519	524	519	MNR	MNR
Top 10 physicians admissions %	66.0	66.0	64.0	62.0	MNR	MNR
Based on net/gross revenues	Net	Net	Net	Net	MNR	MNR
Medicare %	32.0	33.0	33.0	32.0	MNR	MNR
Medicaid %	9.0	9.0	10.0	9.0	MNR	MNR
Commercial/blues %	51.0	51.0	52.0	54.0	MNR	MNR
Financial Profile						
Financial performance						
Net patient revenue (\$000s)	282,889	261,320	239,244	227,896	123,203	101,765

Massachusetts Eye & Ear Infirmary -- Selected Financial Statistics (cont.)

	Fiscal year ended Sept. 30				Medians: Stand-alone hospitals 2015	
	2016	2015	2014	2013	'BBB-'	Speculative grade
Total operating revenue (\$000s)	369,692	348,341	337,950	328,069	MNR	MNR
Total operating expenses (\$000s)	395,191	389,365	349,142	339,483	MNR	MNR
Operating income (\$000s)	(25,499)	(41,024)	(11,192)	(11,414)	MNR	MNR
Operating margin (%)	(6.90)	(11.78)	(3.31)	(3.48)	1.50	-0.70
Net non-operating income (\$000s)	8,344	10,986	12,274	12,691	MNR	MNR
Excess income (\$000s)	(17,155)	(30,038)	1,082	1,277	MNR	MNR
Excess margin (%)	(4.54)	(8.36)	0.31	0.37	2.90	0.50
Operating EBIDA margin (%)	0.16	(4.16)	3.91	3.66	7.50	7.80
EBIDA margin (%)	2.36	(0.98)	7.28	7.25	8.50	8.40
Net available for debt service (\$000s)	8,918	(3,509)	25,504	24,690	15,524	10,499
Maximum annual debt service (\$000s)	15,675	15,675	15,675	15,675	MNR	MNR
Maximum annual debt service coverage (x)	0.57	(0.22)	1.63	1.58	3.20	1.70
Operating lease-adjusted coverage (x)	0.73	0.21	1.42	1.66	2.50	1.60
Liquidity and financial flexibility						
Unrestricted reserves (\$000s)	121,735	112,837	89,218	103,474	54,500	21,537
Unrestricted days' cash on hand	118.8	112.4	99.3	118.6	132.50	85.90
Unrestricted reserves/total long-term debt (%)	97.9	131.2	101.7	112.3	102.30	59.40
Average age of plant (years)	11.6	10.3	13.0	12.1	11.60	13.90
Capital expenditures/depreciation and amortization (%)	215.7	77.8	74.4	118.6	85.10	60.70
Debt and liabilities						
Total long-term debt (\$000s)	124,369	86,036	87,755	92,135	MNR	MNR
Long-term debt/capitalization (%)	50.3	42.6	41.9	41.8	40.90	48.10
Debt burden (%)	3.90	3.93	4.48	4.60	3.40	4.00
Defined benefit plan funded status (%)	60.83	58.43	65.75	67.69	60.20	63.60
Pro forma ratios (Remaining draw of \$34 million on Series D-1)						
Unrestricted reserves (\$000s)	121,735	N/A	N/A	N/A	MNR	MNR
Total long-term debt (\$000s)	158,369	N/A	N/A	N/A	MNR	MNR
Unrestricted days' cash on hand	118.8	N/A	N/A	N/A	MNR	MNR
Unrestricted cash/total long-term debt (%)	76.9	N/A	N/A	N/A	MNR	MNR
Long-term debt/capitalization (%)	56.3	N/A	N/A	N/A	MNR	MNR

Inpatient admissions exclude Newborns, Psychiatric, Rehabilitation admissions, MNR--Median not reported. N/A--Not applicable.

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Exhibit B:
**HPC Analysis of Parties' Response
to Preliminary Report**

Exhibit B

HPC Analysis of the Parties' Written Response to the HPC's Preliminary Report

This document analyzes and addresses the principal topics raised in the November 30, 2017 Response to Health Policy Commission Preliminary Report dated November 1, 2017 HPC-CMIR 2017-1 Concerning Proposed Acquisition of Massachusetts Eye and Ear Infirmary, et al. (Parties' Response).

The Parties' Response includes certain new information not previously provided to the HPC, though such information would have been responsive to HPC's information requests,¹ and the parties were required, pursuant to M.G.L. c. 6D, § 13 and 958 CMR 7.07, to timely provide such requested information. The parties were also required, pursuant to 958 CMR 7.11(2), to "certify that none of the information included in the written response [to the HPC's Preliminary Report], or any information referred to therein, is responsive to the Commission's requests for information in connection with the notice of Cost and Market Impact Review and was previously available but not provided."² The parties' failure to timely provide this information prevented the HPC from considering it when developing the Preliminary Report.³ We nevertheless address this new information in this document and in the Final Report.⁴

The principal topics and new information in the Parties' Response and addressed here include:

1. **Rate Increases:** The parties concede that they expect rate increases for MEE as a result of the proposed transaction, but assert that the scale of the rate increases would be somewhat smaller than the increases modeled by the HPC;
2. **MEE's Financial Condition:** The parties provided new information about MEE's financial position, and assert that the HPC did not adequately take into account the parties' position that the transaction is necessary to restore and sustain MEE's financial health;

¹ The HPC requested on July 7, 2017 all information relied upon by senior leadership of the parties when choosing to undertake the proposed transaction, as well as the parties' projections of the potential impacts of the transaction on prices, health care spending, quality, and access to care. However, the parties did not provide, until their November 30, 2017 response, their projection of the potential impact of the transaction on health care spending as a result of rate increases for MEEI, or the February 2017 bond rating report from Standard and Poors that they assert supports MEE's financial rationale for undertaking the transaction. *See* S&P GLOBAL RATINGS, MASSACHUSETTS DEVELOPMENT FINANCE AGENCY: MASSACHUSETTS EYE & EAR INFIRMARY; HOSPITAL (Feb. 13, 2017), attached to Parties' Response [hereinafter S&P Report].

² In particular, the S&P Report provided with the Parties' Response for the first time was available at the time of the HPC's information requests. *See supra* note 1.

³ MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITION OF MASSACHUSETTS EYE AND EAR INFIRMARY, MASSACHUSETTS EYE AND EAR ASSOCIATES, AND AFFILIATES (HPC-CMIR-2017-1), PURSUANT TO M.G.L. C. 6D, § 13 PRELIMINARY REPORT (Nov. 1, 2018) [hereinafter Preliminary Report], available at <http://www.mass.gov/anf/docs/hpc/material-change-notice/20171101-preliminary-phs-mee-report-final.pdf>.

⁴ MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITION OF MASSACHUSETTS EYE AND EAR INFIRMARY, MASSACHUSETTS EYE AND EAR ASSOCIATES, AND AFFILIATES (HPC-CMIR-2017-1), PURSUANT TO M.G.L. C. 6D, § 13 FINAL REPORT (Jan. 3, 2018) [hereinafter Final Report].

3. **Market Analysis:** The parties contest the HPC’s use of primary service areas (PSAs) to examine market dynamics; and
4. **Access and Quality:** The parties assert that access to care would not be impacted by contracting practices for MEE after the proposed transaction, and state that they cannot provide additional data to assess the potential quality impacts of the proposed transaction.

We identify, as applicable, where these points are addressed in the Final Report.

I. Rate Increases

In their response to the Preliminary Report, the parties do not dispute that spending will increase due to price increases for MEE, but they argue that the amount of these increases will be somewhat lower than the HPC’s estimates. Specifically, the parties state that their goal is “only to seek market competitive rates for MEE,” and for the first time offer a projection that this would result in an annual increase in the cost of MEEI’s services that is 33% below the HPC’s lower-bound estimate of \$14.9 million in new hospital spending, or approximately \$10 million annually.⁵ The parties do not dispute the HPC’s analysis that physician spending would increase by approximately \$5.9 million per year as MEEA joins all PCPO contracts. They thus concede that the proposed transaction would result in commercial spending increases of nearly \$16 million annually.⁶ However, they also make no commitments to limit price increases to these—or any other—amounts.

As described in the Preliminary and Final reports, in addition to the physician price increases, which the parties do not dispute, the HPC estimated that commercial health care spending would increase by \$14.9 million to \$55.3 million annually if MEEI received rate

⁵ When the HPC initiated this cost and market impact review, it requested the parties’ estimates of MEE price changes following the transaction, but the parties have provided this estimate for the first time in the Parties’ Response. They do not describe the basis for this estimate or provide any data to support this projection, thus preventing the HPC from fully evaluating it.

⁶ The parties also argue that this transaction is highly unlikely to result in any increase in commercial premiums given that MEE accounts for 0.3% of statewide total health care expenditures (THCE). Parties’ Response, Exh. A, at 4, note 5. The HPC disagrees. The projected spending increases of \$20.8 million to \$61.2 million annually that are detailed in the Final Report represent an estimated 16.5% to 61.3% increase in MEEI’s prices across commercial payers, in addition to an increase in MEEA’s prices for those payers with whom it currently contracts independently. Past transactions proposed by Partners and reviewed by the HPC have projected comparable spending increases—for the proposed acquisition of South Shore Hospital and Harbor Medical Associates we estimated an annual increase in commercial health care spending of \$23 million to \$26 million due to physician price increases and increased use of the parties’ facilities, and for the proposed acquisition of Hallmark Health System we estimated an annual increase in commercial health care spending of \$15.5 million to \$23 million due to likely hospital and physician price increases. The projected increases here also would not be distributed evenly across all statewide spending, but would disproportionately impact payers and consumers in Eastern Massachusetts, patients who use MEE, and providers who refer to MEE. Finally, even using the parties’ logic of comparing the projected price increases here to statewide spending, it is worth noting that the projected spending increases from this single transaction alone would account for approximately 3% to 9% of all allowable commercial spending growth statewide under the 2018 health care cost growth benchmark of 3.1%. Given that MEE accounts for only 0.3% of statewide THCE, as highlighted by the parties, this impact underscores the scale of the projected price increases.

increases to achieve parity with either Partners' community hospitals or MGH, consistent with Partners' past practices.⁷ The parties' own internal estimates generated for their respective Boards of Directors contemplate revenue increases due to rate increases that are generally consistent with the HPC's lower estimate.⁸ However, these rate increases could be significantly higher if Partners seeks to bring MEEI's rates in line with those of MGH given that — like MGH — MEEI is also a teaching and research institution whose physicians are part of the MGPO.

The parties argue that the external constraint of the health care cost growth benchmark will limit the scale of potential rate increases.⁹ However, it is within the parties' control to alleviate concerns about the spending impact of this transaction. They have declined to offer an unequivocal and measurable commitment not to increase MEE prices beyond MEE's historic rate of increase. This is an important fact for consideration by other state agencies and the public in evaluating the potential impact of the proposed transaction.

II. MEE's Financial Condition

The parties assert that the proposed transaction is necessary to “restore and sustain MEE's financial health” and maintain the long-term viability of MEE's clinical and research missions, that this is the principal rationale for the transaction, and that this can be accomplished without significant rate increases.¹⁰ The Parties' Response also includes a bond rating report from Standard and Poors (S&P) not previously provided to the HPC.¹¹

In analyzing the financial condition of MEE for the Preliminary Report, the HPC relied on MEE's publicly available audited financial statements and a broad range of standard metrics of financial health.¹² Although the S&P Report would have been responsive to the HPC's information requests as part of the rationale for undertaking the transaction, the parties did not

⁷ The parties state that Partners has not negotiated rates for McLean Hospital or Spaulding Network hospitals on parity with its other hospitals. However, unlike Partners' other hospitals or MEEI, McLean and Spaulding are not licensed by DPH as acute care hospitals. For this reason, they are categorized separately by CHIA for relative price calculations, and thus data are not available to directly compare the pricing for these hospitals with those of Partners' general acute care hospitals. However, when compared to other psychiatric and rehabilitation hospitals, respectively, McLean and Spaulding are among the highest-priced, similar to the high relative prices of Partners' general acute care hospitals compared to other general acute care hospitals in their areas. *See* CTR. FOR HEALTH INFO. & ANALYSIS, PROVIDER PRICE VARIATION IN THE MASSACHUSETTS HEALTH CARE MARKET (CALENDAR YEAR 2015 DATA) (May 2017), available at <http://www.chiamass.gov/assets/docs/r/pubs/17/Relative-Price-Databook-2017.xlsx>. Accordingly, the parties' assertions about Partners' non-acute care hospitals do not contradict the HPC's expectation that Partners would seek significant price increases for MEEI.

⁸ *See* Preliminary Report, *supra* note 3, at 38, note 120; Final Report, *supra* note 4, at 39, note 125.

⁹ Parties' Response, Exh. A, at 4.

¹⁰ Parties' Response, Exh. A, at 1, 3.

¹¹ *See supra* note 1.

¹² The parties incorrectly suggest that the HPC examined only a limited set of financial measures, specifically revenue growth, reserves of cash and equivalents, and average age of plant. Parties' Response, Exh. A, at 2, note 2. However, the HPC's Preliminary Report also explicitly discussed MEE's operating expenses, operating margin, and current ratio. *See* Preliminary Report at 13. In addition to the metrics explicitly discussed, the HPC examined a broad range of other standard financial metrics in assessing MEE, including, but not limited to, total margin, days cash on hand, debt to capitalization, total net assets, and equity to assets.

provide this report to the HPC prior to their response to the Preliminary Report.¹³ The HPC has revised its assessment of MEE's financial position in the Final Report to reflect the new information in the S&P Report.¹⁴

Specifically, the Final Report acknowledges that while S&P affirmed MEE's bond rating of BBB, it revised MEE's credit outlook to negative in February 2017.¹⁵ The Final Report also considers the S&P assessment in the context of other financial information, including MEE's audited financial statements,¹⁶ other third-party assessments,¹⁷ MEE's statements and projections in the S&P Report,¹⁸ and confidential documents provided to the HPC.¹⁹ Taking into account all of this available information, the HPC acknowledges that MEE's financial position has been weakened in recent years, but there is no indication that MEE is in imminent danger of closure. MEE has continued to invest in its clinical operations and begun efforts to improve its financial position independent of the proposed transaction, and some recent information suggests that MEE's financial performance may be starting to improve. Nonetheless, the parties have stated that MEE "will soon find it difficult to maintain all aspects of its clinical, research and teaching missions" due to a variety of financial pressures, including rising labor and pharmaceutical costs and reductions in federal funding for research and medical education.²⁰ Yet even while the parties claim that the transaction is necessary for MEE's long-term financial health, they concede that significant rate increases are not necessary.²¹ Indeed, the Final Report recognizes that achieving the parties' projected operating efficiencies²² would substantially improve MEE's financial performance absent any additional rate increases for MEE.

¹³ See *supra* note 1.

¹⁴ See Final Report, *supra* note 4, at 14-15.

¹⁵ See S&P Report, *supra* note 1, at 2.

¹⁶ See Final Report, *supra* note 4, at 14.

¹⁷ A Moody's Investors Service assessment in July 2016 affirmed a "stable outlook" for MEE based on "expectations of some continued one-time strategic expenses in FY 2016 accompanying the second building sale, but a return to near break-even operations in FY 2017 with improved cash flow and further growth of wealth and revenue to support increased debt service and capital plans." MOODY'S INVESTORS SERVICES, *Rating Action: Moody's Affirms Massachusetts Eye & Ear Infirmary's Baa3; Outlook Stable*, https://www.moodys.com/research/Moodys-Affirms-Massachusetts-Eye-Ear-Infirmarys-Baa3-Outlook-Stable--PR_903315066 (last visited Dec. 4, 2017).

¹⁸ MEE management indicated to S&P that it expects MEE's financial performance to improve over the next three years, independent of the proposed transaction. See S&P Report, *supra* note 1, at 5.

¹⁹ An internal MEE document from early 2016 described all of MEE's financial metrics as either "positive" or "neutral;" a document from late 2016 discusses the development of a plan to improve MEE's margins, separate and distinct from MEE's plans to merge with Partners; and MEE's financial projections for FY17 and budgeted FY18, referenced at page 3 of the Parties' Response, show that MEE expects substantial declines in its operating losses. As discussed in the Final Report, *supra* note 4, at Section II.B, MEE has seen steady growth in patient volume and revenue, has expanded its clinical operations substantially in recent years as a result, and expects continued growth in demand for its services as a result of demographic changes in the Commonwealth.

²⁰ APPLICATION BY PARTNERS HEALTHCARE SYSTEM FOR DETERMINATION OF NEED FOR TRANSFER OF OWNERSHIP OF MASSACHUSETTS EYE AND EAR INFIRMARY (July 17, 2017), at Section 2.1, *available at* <http://www.mass.gov/eohhs/docs/dph/quality/don/partners-health-system-application-form.pdf>.

²¹ Parties' Response, Exh. A, at 3.

²² See Final Report, *supra* note 4, at 48-49, discussing the parties' expectation that MEE will achieve overhead savings of more than \$20 million per year within a few years' time.

III. Market Analysis

The parties also contest the HPC's use of PSAs on the basis that the methodology may not yield relevant geographic areas for antitrust purposes, and they suggest that the HPC's use of PSAs may exaggerate the parties' market shares. They also object to the HPC's use of outpatient PSAs, on the basis that we have not explained "how a methodology that is based on inpatient discharge data can be used to determine outpatient market shares."²³ As the HPC has detailed in its past reports,²⁴ the HPC's methodology for analyzing market shares in PSAs is relevant to assessing competitive impact, and is consistent with the HPC's statutory mandate,²⁵ the recommendations of the Department of Justice and the Federal Trade Commission,²⁶ and the screening purpose of CMIR reports.²⁷ To avoid any confusion, we have added additional explanatory statements about our methodology in the Final Report.²⁸ Finally, contrary to the parties' claims and as described in the Preliminary and Final Reports, the outpatient PSA methodology is not based on inpatient discharge data, but rather on outpatient claims data.²⁹ This methodology has also been described and used in past HPC reports.³⁰

²³ Parties' Response, Exh. A, at 7.

²⁴ See, e.g., MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITIONS OF SOUTH SHORE HOSPITAL (HPC-CMIR-2013-1) AND HARBOR MEDICAL ASSOCIATES (HPC-CMIR-2013-2), PURSUANT TO M.G.L. C. 6D, § 13, FINAL REPORT at 37-39 (Feb. 19, 2014), *available at*: <http://www.mass.gov/anf/docs/hpc/20140219-final-cmir-report-phs-ssh-hmc.pdf>; MASS. HEALTH POLICY COMM'N, REVIEW OF PARTNERS HEALTHCARE SYSTEM'S PROPOSED ACQUISITION OF HALLMARK HEALTH CORPORATION (HPC-CMIR-2013-4), PURSUANT TO M.G.L. C. 6D, § 13, FINAL REPORT at Exhibit B, Section I.B (Sept. 3, 2014), *available at* <http://www.mass.gov/anf/docs/hpc/material-change-notice/phs-hallmark-final-report-final.pdf>.

²⁵ The CMIR statute directs the HPC to "examine factors relating to the provider or provider organization's business and its relative market position," including "the provider or provider organization's size and market share within its *primary service areas*," "the provider or provider organization's impact on competing options for the delivery of health care services within its *primary service areas*," and "any other factors that the commission determines to be in the public interest." MASS. GEN. LAWS ch. 6D, § 13(d) (emphasis added).

²⁶ The Department of Justice and Federal Trade Commission have described market shares within PSAs as "a useful screen for evaluating potential competitive effects." See U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM at 7 (2011), *available at* <https://www.justice.gov/sites/default/files/atr/legacy/2011/10/20/276458.pdf>. It is also worth noting that, contrary to the parties' implication, a small region *can* constitute an appropriate relevant geographic area, although, in this particular case, the inpatient and outpatient PSAs for MEEI are very large, and include most of eastern Massachusetts. It is not clear that other methods of examining market dynamics would lead to larger geographies or result in lower market shares for the parties. For examples of relevant geographic areas that are fairly small, see *St. Alphonsus Med. Ctr. v. St. Luke's Health Sys.*, 778 F.3d 775 (9th Cir. 2015); *FTC v. Penn. State Hershey Med. Ctr.*, 838 F.3d 327 (3d Cir. 2016); *FTC v. Advocate Health Care Network*, No. 16-2492 (7th Cir. 2016); Opinion of the Commission, *ProMedica Health Sys., Inc.*, F.T.C. Docket No. 9346 (June 25, 2012), *aff'd*, 749 F.3d 559 (6th Cir. 2014), *cert. denied*, 135 S.Ct. 2049 (2015).

²⁷ 76 FED. REG. 67026, 67028 (Oct. 28, 2011), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf>.

²⁸ See Final Report, *supra* note 4, at 20.

²⁹ See Preliminary Report, *supra* note 3, at 20-21; Final Report, *supra* note 4, at 21-22. We have adjusted the note to the map on page 22 of the Final Report to align with the description of our outpatient PSA methodology in the rest of the section.

³⁰ See MASS. HEALTH POLICY COMM'N, REVIEW OF BETH ISRAEL DEACONESS CARE ORGANIZATION'S PROPOSED CONTRACTING AFFILIATION WITH NEW ENGLAND BAPTIST HOSPITAL AND NEW ENGLAND CLINICAL INTEGRATION ORGANIZATION (HPC-CMIR-2015-1) AND BETH ISRAEL DEACONESS CARE ORGANIZATION'S PROPOSED

IV. Access and Quality

The parties suggest that the proposed transaction will not impede access to MEE for patients in commercial tiered and limited network products, observing that Partners' non-acute care specialty hospitals, McLean Hospital and the Spaulding Network hospitals, participate in more limited networks than Partners' general acute care hospitals.³¹ The Final Report reflects the fact that McLean and Spaulding do participate more frequently, although not universally, in the limited network products offered by the three largest commercial payers, and we would welcome any commitments by the parties to continue MEEI's participation in limited network products. However, unlike McLean and Spaulding, MEEI is licensed as an acute care hospital, and the services it provides are a subset of those provided by general acute care hospitals. Therefore, Partners could choose to represent MEEI in negotiations more similarly to how it represents its other acute care hospitals, rather than its non-acute care hospitals.

With regard to MEEI's participation in MMCO networks, the parties state that they are "fully committed to having MEE continue to participate after the Transaction in MEE's existing MMCO contracts."³² The HPC acknowledges this commitment in the Final Report, and expects that MEE is similarly committed to participating in future contracts with health plans covering MassHealth members.³³

With regard to quality improvement, the parties reiterate that the transaction would allow Partners to share innovative quality measurement tools and improvement programs.³⁴ The parties also claim that Partners and MEE cannot share clinical data with each other prior to the transaction, and thus cannot provide additional information for the HPC and other state agencies

CONTRACTING AFFILIATION AND BETH ISRAEL DEACONESS MEDICAL CENTER'S AND HARVARD MEDICAL FACULTY PHYSICIANS' PROPOSED CLINICAL AFFILIATION WITH METROWEST MEDICAL CENTER (HPC-CMIR-2016-1), PURSUANT TO M.G.L. C. 6D, § 13, FINAL REPORT (Sept. 7, 2016) at 32, note 125, available at <http://www.mass.gov/anf/docs/hpc/material-change-notice/bidco-nebh-metrowest-bidmc-final-cmir.pdf>.

³¹ Parties' Response, Exh. A, at 4-5. The parties imply that Payers would be unlikely to exclude MEEI from limited networks or place it in a more expensive cost-sharing tier in tiered networks because price increases would not be as high as modeled by the HPC. We address the parties' points concerning price increases in Section I of this Exhibit B. The parties also suggest that leaving limited networks would be contrary to MEEI's financial interests. Given that the same financial incentive should apply to all Partners general acute care hospitals, which nevertheless do not participate in the largest commercial limited network products, it is not clear that the patient volume and associated patient service revenue from participating in limited network products alone would be a sufficient incentive to ensure MEEI's continued participation.

³² Parties' Response, Exh. A, at 5.

³³ The parties also note that MassHealth has recently taken steps to institute greater pricing uniformity among its providers, thereby reducing or eliminating the likelihood that MMCOs would exclude MEEI on the basis of price. While we acknowledge this change to the MassHealth program, we also note that MMCOs can apply for a waiver from this pricing structure. Hospitals may also choose not to participate in an MMCO plan if they consider the rates to be too low.

³⁴ Parties' Response, Exh. A, at 6. As discussed in the Final Report, *supra* note 4, at 49, given MEE's current close relationship with Partners and already-strong quality performance, it is unclear to what extent access to these programs will translate into improvements in clinical quality and patient experience.

to assess the scope and likelihood of improvement on their set of proposed quality measures.³⁵ The HPC notes these statements in the Final Report.

V. Conclusion

The Final Report includes updates to our findings, as described in this Analysis of the Parties' Response, reflecting careful consideration of each of the points raised in the Parties' Response. We now provide our Final Report to assist the public and other state agencies as they assess whether the potential benefits of this transaction are sufficiently significant and concrete to outweigh the substantial spending impacts documented in the Final Report, particularly in the absence of any affirmative and measurable commitment by the parties to constrain price or spending increases to mitigate the impact on payers and consumers.

³⁵ Parties' Response, Exh. A, at 5. Although the parties reiterate that they plan to provide these data after the transaction, this commitment does not allow us to assess the scope or likelihood of improvement on the metrics they propose to measure or whether these metrics would assess areas in need of improvement.

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