



Steward Health Care System LLC 500 Boylston Street Boston, Massachusetts 02116  
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September 16, 2015

David Seltz  
Executive Director  
Health Policy Commission  
50 Milk Street, 8<sup>th</sup> floor  
Boston, MA 02108

*Via Electronic Mail to [HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us)*

Dear Executive Director Seltz:

Pursuant to your letter dated August 6, 2015 and in accordance with Massachusetts General Laws chapter 6D, § 8, please find included herein Steward Health Care System LLC's (Steward) responses to the questions outlined in Exhibits B and C. I am legally authorized and empowered to represent Steward Health Care System LLC and provide the enclosed testimony.

Please contact David Morales, Chief Strategy Officer, at (617) 419-4743 should you have any questions or need to discuss any part of this response.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Ralph de la Torre'.

Ralph de la Torre, MD  
Chairman and Chief Executive Officer

CC: Stuart Altman, Ph.D.  
Chair, Health Policy Commission  
50 Milk Street, 8<sup>th</sup> floor  
Boston, MA 02108

Áron Boros  
Executive Director  
Center for Health Information & Analysis  
501 Boylston Street, 5<sup>th</sup> floor  
Boston, MA 02116

Karen Tseng  
Chief, Health Care Division  
Office of the Attorney General  
One Ashburton Place  
Boston, MA 02108

## **Exhibit A: Notice of Public Hearing**

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Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

**Monday, October 5, 2015, 9:00 AM**  
**Tuesday, October 6, 2015, 9:00 AM**  
**Suffolk University Law School**  
**First Floor Function Room**  
**120 Tremont Street, Boston, MA 02108**

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to [HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us), or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: [www.mass.gov/hpc](http://www.mass.gov/hpc).

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: <http://www.suffolk.edu/law/explore/6629.php>. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at [Kelly.A.Mercer@state.ma.us](mailto:Kelly.A.Mercer@state.ma.us) a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, [www.mass.gov/hpc](http://www.mass.gov/hpc). Materials will be posted regularly as the hearing dates approach.

## **Exhibit B: Instructions and HPC Questions for Written Testimony**

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On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: [HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us). **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at [Kelly.A.Mercer@state.ma.us](mailto:Kelly.A.Mercer@state.ma.us) or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact Lois Johnson at [Lois.Johnson@state.ma.us](mailto:Lois.Johnson@state.ma.us) or (617) 979-1405.

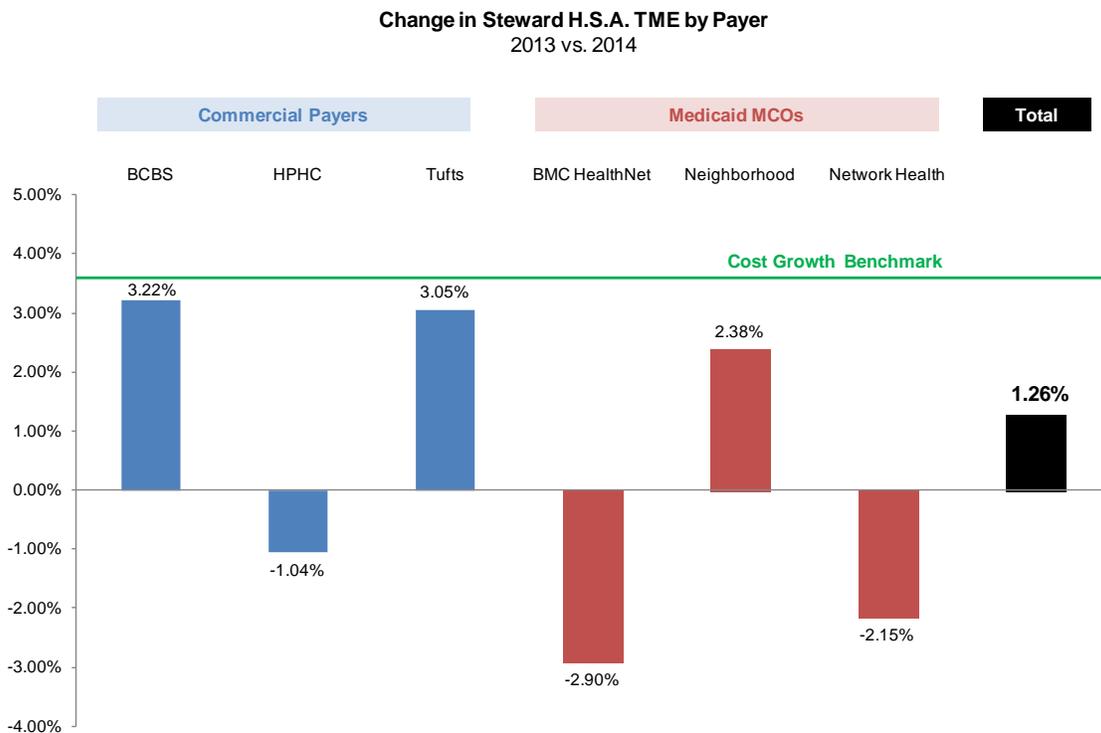
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## Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state’s economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.
  - a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

Between 2013 and 2014, Steward’s total medical expense grew below the health care cost growth benchmark of 3.6% for its three major commercial plans, Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan. Steward remained below this cost growth benchmark thanks in large part to our integrated care model and global risk-based payments under which Steward assumes full clinical and financial risk for almost 150,000 patients within these three commercial carriers.

Even though Steward is not under full risk with Medicaid Managed Care Organizations (MCO’s), Steward also remained below the cost growth benchmark with MCOs, as shown in the figure below. Steward continues to advocate for MCOs to enter into full-risk, global payment arrangements with Steward with minimal success. Steward recently entered into a “percent of premium” contract with Network Health and is confident that this arrangement will result in improved health care and lower costs for our Network Health patients.



Since its inception, Steward has aggressively focused on delivering the highest quality care in the most cost efficient manner at lower cost settings. In fact, the Steward’s community-based, integrated care model was founded on the premise that high-quality care can be administered

without compromising quality by “right siting patient care” to the most appropriate setting: in the community where patients reside.

While Steward has successfully remained cost efficient, we have observed at least three seminal challenges under health care reform. First, as the per-unit price reimbursements from payers decline, the per-unit cost of labor and medical supplies continues to grow annually at rates well above the state’s cost containment benchmark. In an environment of flat to declining reimbursements, labor and supply costs continue to outpace reimbursements from commercial payers, Medicare and Medicaid. Further, these costs are not subject or factored into, the same cost containment mandates as providers and payers. This incongruity harms providers as they seek to deliver services patients require, while remaining as cost-efficient as possible. This pressure is greater for community-based and disproportionate share providers like Steward who provide health care services to patients that are predominantly covered by Medicaid and Medicare and whose reimbursements are at least 30% to 50% below the actual cost of providing such services, according to our data. In fact, if the HPC analyzes hospital reimbursements and prices using a weighted average payer rate (WAPR), it would find that in most instances, community-based DSH hospitals are significantly under-reimbursed and are disadvantaged as compared to hospitals with high concentration of commercially insured patients.

Second, we have noticed that in certain markets inpatient admissions have declined while the utilization of outpatient services has increased dramatically. The trend toward higher utilization of outpatient services will continue to force providers to shift investments to outpatient services while potentially downsizing inpatient resources. Redirecting investments toward outpatient services allows providers to keep up with demands to lower health care costs and meet patients needs in the most clinically appropriate setting.

In an effort to address this evolving public policy and meet our patients’ needs, Steward continues to restructure operations, renegotiate labor contracts, renegotiate payer terms, and reconfigure medical services. For example, Steward continues to implement a primary care growth strategy across our entire network to expand access, remain cost-efficient, and meet ever-evolving government and payer policies that shift care to lower cost settings. We continue to increase primary care office hours to meet our patient’s needs, engage with community health centers and expand urgent care centers that offer more primary care-focused services for our patients. In fact, Steward’s primary care network includes 30 urgent care centers across Eastern Massachusetts. At the same time, we routinely evaluate our labor costs and supply costs in order to remain as cost efficient as necessary.

Third, government payers continue to cut fee for service reimbursements yet are slow to shift to alternative payments. This conflicting policy results in dramatically lower reimbursements for providers, and little if any, opportunity to move toward value based reimbursements, while at the same time attempting to meet consumer demands and government mandates that exceed the actual levels of reimbursements for such services.

This is the case with Medicaid in particular, which may be the most significant challenge facing providers today. While commercial payers and Medicare have implemented alternative, risk-based payment models – like ACOs and global, risk-based payments– Medicaid and Medicaid MCOs continue to reimburse primarily under fee-for-service arrangements. CHIA recently

reported that for Medicaid members covered by managed care, only 22% of members' care was covered under alternative payment models – a decline from 2013. Even worse, Medicaid managed care organizations are much less likely than the commercial market to engage in two-sided risk contracts with providers – only 54% of global budget membership accepted downside risk. This public policy merits immediate attention if the state truly intends to both meet the statewide cost containment benchmark and drive better value for patients.

Steward has continued to advocate for the implementation of a Medicaid accountable care model to ensure value and quality care for all Medicaid patients. While we are encouraged with the progress we have seen to date, we urge state leadership at all levels to push for swift implementation of a Medicaid accountable care model as soon as possible and to require Medicaid to implement the same payment and quality reforms that the commercial market and Medicare are implementing across the health care system.

- b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

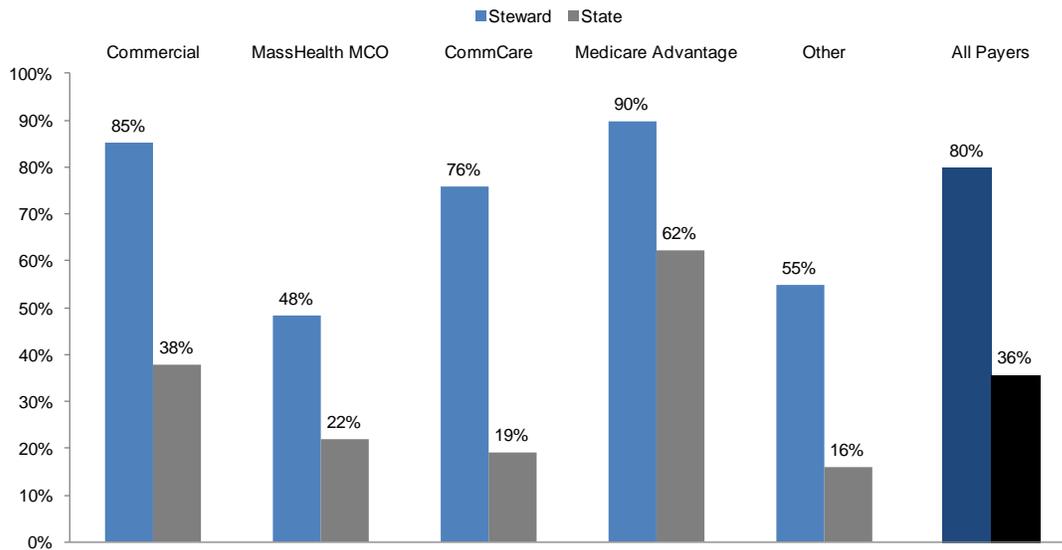
Since January 2014, Steward focused on five specific areas to reduce total cost of care:

- 1) Aggressive risk-based contracting with payers;
- 2) Expanded access to primary care services;
- 3) Support for narrow network insurance products; and
- 4) Investments in population health management resources;
- 5) Planning for a Medicaid accountable care model;

***Aggressive Risk-Based Contracting with Payers***

Steward has continued to engage commercial payers Medicare and Medicaid to shift our reimbursement and payment incentives to global, risk-based arrangements. Such contractual arrangements and incentives have led to better patient care coordination, lower medical spending over time, aligned incentives across our provider network, and better integration of our ACO resources. In fact, Steward's adoption of alternative payment methods exceeds the state average on every line of business, as shown in the figure below.

**Portion of Member Months in Alternative Payment Methods (APM) by Payer Type  
2014**



Steward Promise, our Medicare Pioneer ACO, is one of the top performing ACOs nationally in terms of delivering better care, while at the same time lowering total medical expense in Medicare. In its first year (2012), Steward’s ACO successfully reported all 33 quality measures and was one of only 13 original 32 Pioneer ACOs to achieve shared savings. Upon conclusion of Year 2 (2013), an independent evaluation of the program found that Steward was the best performing Pioneer ACO nationwide, having generated over \$20 million in total savings (24% of the nationwide total)—ahead of other Massachusetts ACOs. And by Year 3 (2014), Steward’s ACO reduced annual per beneficiary spending by 3% while continuing to achieve high quality performance.

Importantly, Steward remains one of only a few ACOs in the Pioneer program to embrace Population Based Payments, introduced for the first time in the PY4 (2015) performance year. Steward now has direct experience operationalizing this essential reimbursement and alignment tool, leveraging it as a foundation for increased provider and patient engagement across the continuum of care to advance care integration and quality outcomes.

In addition, Steward has been successful in our efforts to improve quality and manage cost in our commercial risk contracts. Steward’s Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (BCBSMA AQC) includes quality metrics similar to the Medicare Pioneer ACO program (e.g, management of members with chronic conditions such as diabetes and cardiovascular conditions, patient experience, preventative screenings). Steward’s performance under the AQC contract – among other risk-based contracts – demonstrates the system’s ability to improve quality over time and to engage patients successfully under alternative payment methodologies. Steward has also increased its composite AQC Quality Score, comprised of ambulatory and hospital quality measures, each year since entering the BCBSMA AQC contract and between 2008 and 2014 Steward increased our overall quality score by greater than 100%.

Steward continues to focus on evolving our contractual relationships with commercial health

plans toward “percent of premium” arrangements. As described in Steward’s 2014 testimony, the “percent of premium” model aims to reduce or eliminate duplicative administrative costs (e.g. IT, care coordination, member engagement programs, analytics, etc.) and to enhance population health management programs in the delivery system where they are most cost-effective and appropriate. This innovative payment model enables Steward and its partner health plans to directly pass significant premium reductions onto employers and employees alike, while providing the same level of quality health care and broad access to Steward’s vast provider network.

### ***Expanded Access to Primary Care Services***

Publicly available total medical expense (TME) data demonstrate that tangible reductions in health care spending can be achieved by providing robust access to health care services at high quality, lower cost community settings and through local primary care providers. Policy makers must do more to align provider and payer incentives to encourage individuals to seek, access and consume health care locally instead of at higher priced and highly reimbursed Academic Medical Centers in Boston. Risk-based, global payments are an important tool in achieving this objective.

In an effort to support those objectives, Steward continues to expand the number of primary care providers in our network to provide real-time access to high quality, cost efficient providers across our local communities. Since 2011, Steward has expanded its network of primary care providers by approximately 225%, including primary care physicians, physician assistants, nurse practitioners, community health centers and outpatient urgent care centers. We continue to invest in primary care services and to proactively coordinate health care services across our ACO under global, risk-based payment arrangements. These enhancements include partnering with community health centers where exceptional health care services are delivered in a culturally sensitive manner that welcomes patients from any background, regardless of their insurance status.

Steward also partners with community-based post-acute care providers to improve patient care transitions and to better integrate care, especially for those patients who need intense interventions and preventive strategies to avoid unnecessary emergency room admissions. These enhancements have improved quality outcomes and have mitigated excessive medical spending, which often result from minimal patient care coordination or lack of transitions in care.

### ***Support for Narrow Network Insurance Products***

Steward continues to leverage health insurance product offerings to drive additional value to our patients and employees through low premium products. For individuals and small businesses, Steward offers a limited network product that features significant premium savings relative to the cost of comparable health insurance products. Steward also offers all of its employees a health insurance plan that features significantly discounted premiums. With over 80% employee participation, our narrow-network, low premium product has been very popular among employees. Our health insurance product’s premiums are also designed to be even more affordable for employees with lower wages. We also leverage robust care coordination programs to ensure that care is delivered at high quality, cost-efficient community-based

settings, rather than at higher cost providers.

### ***Investments in Population Health Management***

Steward's investments in population health management programs enable us to appropriately care for high-risk patients and manage their medical care more effectively, improving quality and lowering total cost of care. A significant part of our approach has been our investments in information systems that integrate community-based providers across the continuum of care – acute, post-acute, and ambulatory care. Steward's IT system enables our physicians, hospitals and health center partners to provide real-time coordinated care, while simultaneously mitigating duplication of services and tests. Steward's highly integrated and interoperable information technology system has also helped to prevent readmissions and significantly improve our quality scores across our hospitals and physician offices.

Steward's patient-focused population health management program includes several initiatives designed to target quality of care, improve the overall health of our members, and lower the annual rate of health care cost growth. Steward's community-based teams and care navigators further expand access and create linkages to primary care across our many ethnically and linguistically diverse communities, an essential strategy for reducing medical costs and unnecessary use of services in lower-income communities with high concentrations of Medicaid and Medicare patients.

### ***Planning for Medicaid Accountable Care***

Chapter 224 mandates implementation of alternative payment models, especially under Medicaid. To date, this requirement has not been met. Medicaid's budget has grown to over \$15 billion for the current state fiscal year, and with over 1.8 million enrollees<sup>1</sup>, Medicaid is now Massachusetts' largest insurer. The Center for Health Information and Analysis' Annual Report on the Performance of the Massachusetts Health Care System released recently found that Medicaid expenditures grew 19% from 2013 to 2014, which is more than five times the state's established cost growth benchmark and a clear indication of the program's current unsustainability. A program of this size and scale demands immediate transformation and should, at a minimum, implement the mandates of Chapter 224. Policymakers and state leaders should act swiftly to launch accountable care arrangements in Medicaid that seek to lower costs and improve health care delivery for our most vulnerable residents.

Steward has continued to advocate for implementation of a global, risk-based Medicaid ACO to deliver value to both our Medicaid patients and to the Commonwealth. The growth of provider-led ACOs supported by global, risk-based payments is essential to lower the rate of cost growth in Medicaid and successfully meet the Commonwealth's cost growth benchmark. The state cannot succeed in lowering overall health care costs if nearly one third of its health care dollars do not meet the same cost containment criteria as other segments of the market. As noted in response to question 1a, Steward is actively engaged in and very encouraged by recent

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<sup>1</sup> *MassHealth: The Basics - Facts, Trends and National Context*. The Blue Cross Blue Shield Foundation of Massachusetts. July 2015.

stakeholder engagement efforts to introduce an ACO-like reimbursement model in MassHealth that accounts for the total cost of care. We urge the HPC and the Baker Administration to move forward with the immediate implementation of an accountable care reimbursement model in Medicaid.

- c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

Steward continues to focus on transitioning all of its commercial contracts, as well as government programs (to the extent feasible) to full risk, global payment arrangements that account for the total cost of care of our aligned patients. These contracts have significantly helped Steward remain at or below the statewide median on price and TME, as well as assisted us to improve our overall quality scores. Increased adoption of alternative payment methods has been noticeably and largely absent in both Medicaid and the Group Insurance Commission.

As stated throughout this testimony, Steward is particularly focused on our Medicaid patient population. Steward appreciates the Baker Administration's commitment to reform Medicaid and we will continue to work with MassHealth leadership through its second public stakeholder engagement process to bring Medicaid accountable care to fruition.

Steward also encourages the Commonwealth to introduce payment reforms to the Connector and the Group Insurance Commission, respectively. These two programs – responsible for over \$2 billion dollars of state health care spending – should also introduce new models of reimbursement that either enable risk bearing providers to compete for such contracts or direct their contracted health plans to contract with providers under percent of premium arrangements that lower cost and improve quality. These reforms will serve as additional measures to ensure the state meets the statewide cost containment benchmark.

- d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

Two primary systematic or policy changes that would enable Steward to operate more efficiently without reducing quality are:

- (1) Immediate implementation of an accountable care model that reimburses providers under full risk, global payments in Medicaid, the Group Insurance Commission, and health care programs operated by the Health Connector; and,
- (2) Ending provider price disparities in the commercial and Medicaid managed care (MCO) markets, respectively.

While both policies are mandated in Chapter 224, the state has yet to implement these critical payment reforms that will improve access to care and lower costs over time.

Steward is encouraged by the Baker Administration's work and thought-leadership on alternative payment methods, and continues to believe immediate implementation of Medicaid accountable care is essential to lower costs in Medicaid and to keep pace with the innovation taking place in the commercial market and Medicare. The shift to alternative payment models like ACOs has demonstrated success in lowering costs for the Medicare program. The state should adopt a similar model in Medicaid. Using its multi-billion dollar purchasing power, Medicaid should implement ACOs supported by risk-based, global payments directly with providers. A significant number of Massachusetts providers have already developed ACOs and demonstrated sustainable and significant reductions in cost under ACOs.

Unfortunately, Medicaid has yet to adopt a provider-led ACO program to foster enhanced provider innovation. Medicaid also continues to pay primarily under fee-for-service, even with legislative mandates to do otherwise under Chapter 224. As shown in CHIA's 2015 Performance of the Massachusetts Health Care System annual report, none of Medicaid's direct spending from fee for service and the Primary Care Clinician program is dedicated to alternative payment methodologies. Even though Medicaid represents nearly one-third of the state's total health care expenses, Medicaid continues to function as a claims payment entity for providers, rather than as a health insurance organization dedicated to promoting and rewarding providers for delivering integrated care and better outcomes to the Medicaid patients for whom it provides care.

The Commonwealth's health care programs overseen by the Health Connector and the Group Insurance Commission should also move to implement global, risk-based contracts with providers. Immediate action to do so will align payment incentives and enable integrated provider organizations to lower the annual rate of growth of health care costs and improve the overall quality of care.

In addition to Medicaid reforms, the Commonwealth must immediately address growing disparities in commercial prices among providers. These price disparities have worsened since the passage of Chapter 224 and will not be alleviated through market forces alone. As described in response to question #4, commercial price disparities harm providers caring for the greatest amount of patients with public coverage, especially Medicaid. In addition, price disparities pervade Medicaid managed care contracting with providers, and in some instances are even worse than the price disparities observed in the commercial market.

One policy proposal to address commercial price disparities has surfaced as a ballot initiative led by the 1199SEIU. Given the severity and pervasiveness of price disparities among providers throughout the commercial market and Medicaid managed care, immediate attention by policy makers is warranted. We urge policy makers to actively consider and develop additional approaches that address price disparities for the legislature's consideration as soon as possible.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

The most formidable challenge remains Medicaid's inability to implement payment reforms that align clinical and financial incentives, as described in question 1c and 1d. Unlike the commercial market, Medicaid - the largest payer in the Commonwealth - has yet to implement reforms that lower costs and improve quality. In fact, CHIA's 2015 health system report found that Medicaid's spending far exceeded the state's cost containment benchmark. While public policies have pushed the commercial market to implement payment reforms and lower costs, Medicaid continues to use fee-for-service as its predominant form of payment, as described throughout our response to question 1. Medicaid must expeditiously move to full-risk global payments, which hold providers accountable for clinical and financial outcomes of their Medicaid patient care.

We acknowledge that existing regulatory and reimbursement environment forces providers to do more with less. To do so, providers must accept clinical and financial risk to improve their health care delivery and to lower costs. Unfortunately, Medicaid is slowing this transformation and has not updated decades-old policies with the evolving and innovative efforts taking place in the market. In order for Steward and other community-based and DSH providers to thrive in the future, all payers, especially Medicaid, must support global, risk-based payments that foster better care coordination for patients and lower the rate of growth in the total cost of health care.

Finally, the prevalence of behavioral health "carve out" organizations, particularly within the Medicaid program, is also a major barrier to both lowering costs and integrating behavioral and medical care. First, carve outs frustrate care coordination between behavioral health and medical care because they handle behavioral health care services separately. Patients who are covered by behavioral health carve outs experience fragmented care, dealing with both medical and behavioral health managers separately and vastly different prior authorization or reimbursement policies altogether. In addition, the payment stream for medical care and behavioral health has created a 'two-tier' structure where providers are not reimbursed adequately for the behavioral health care they provide. In fact, behavioral health services for Medicaid patients are reimbursed at approximately 60% to 70% below Medicare, according to our data. Publicly available data regarding carved out care does not exist, inhibiting policymakers from understanding the full scope of integrated physical and behavioral health care needs in Massachusetts. Lastly, carve-outs for behavioral health care lead to additional duplicative administrative costs within the MassHealth program that inhibit investments in fully coordinated behavioral health and medical services (see Steward's response to HPC Question #5). We urge MassHealth to integrate behavioral health and medical services under one contract, or one reimbursement model that accounts for the total cost of health care of Medicaid patients.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
  - a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

### *Post-acute Care*

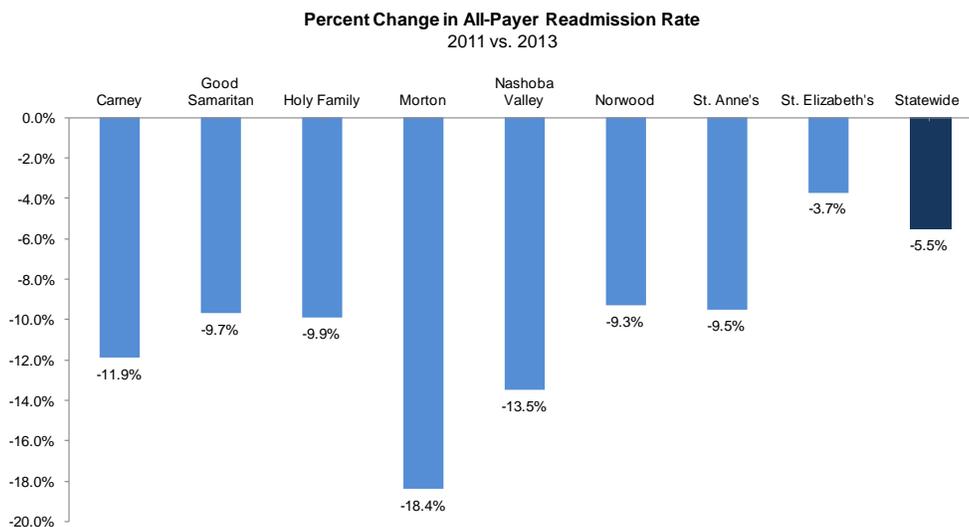
Thanks in part to our participation in the Medicare Pioneer ACO program, Steward has observed significant variation in both the quality and length of stay among outpatient providers. This variation is not attributable to case mix or diagnosis. Our integrated care ACO model ensures patient care is administered by high-quality post-acute care providers that coordinate patient care in real-time. Operating under an ACO model supported by risk-based payment incentives ensures that all providers are appropriately aligned to drive better care and better value for both the patient and the system.

High-cost trends in post-acute care result from pervasive fee-for-service reimbursements used by both Medicaid and Medicare to reimburse for such post-acute services. For example, SNF’s existing volume and per diem-based financial incentives are misaligned with the goals of improving efficiency and quality among providers. Reliance on fee-for-service/per diem payments rewards SNFs and other providers who often extend stays, rather than rewarding providers that invest in proactive care management, monitoring, and rehabilitation required to provide high-quality, cost-efficient care.

While Steward has extensively collaborated with our post acute partners, we continue to face many challenges. To help align incentives across the continuum, ACOs and providers operating under significant risk contracts need the ability to use risk-contracting levers with post acute providers to “right size and right site” care among accountable care populations. Payers must work with providers to incentivize providers to work together in order to better coordinate care and deliver services in the most appropriate settings.

### *Reducing Avoidable 30-day Readmissions*

CHIA’s July 2015 publication regarding readmissions in Massachusetts demonstrates Steward’s success reducing all payer readmissions. From 2011 to 2013, Steward improved its all-payer readmission rate at eight hospitals, seven of which outperformed the statewide average, as shown in the figure below.



Note: Analyses exclude obstetric and primary psychiatric discharges.

Steward has actively participated in the Institute for Healthcare Improvement's multi-state initiative to reduce avoidable readmissions, partnering with skilled nursing facilities, home health agencies, ambulatory practices, patients, and caregivers.

Through our robust population health tools, we have been able to demonstrate that follow-up within 3-5 days with a patient's PCP or medical subspecialist significantly reduces readmissions. Steward's performance teams, through process improvement efforts, work to optimize timely access and open scheduling. Steward's PCP and specialists incentive models encourage open access to patients to ensure timely follow-up post discharge from both acute and skilled nursing home admissions.

Steward's highly integrated and interoperable information technology system has also helped to prevent readmissions and significantly improve our quality scores across our hospitals and physician offices.

### ***Reducing Avoidable Emergency Department Use***

Steward utilizes multi-disciplinary patient care navigator teams in settings within and beyond hospitals that include multi-lingual staff who assist patients to enroll in appropriate health insurance programs and that connect patients with primary and preventative care.

Steward has developed a network of alternatives to Emergency Departments for patients requiring care for urgent conditions. These alternatives include free-standing urgent care facilities, practice-based urgent care clinics, and extended hours in primary care. In fact, Steward's primary care and outpatient care network includes 30 urgent care centers across Eastern Massachusetts. Moreover, our high risk/high cost risk stratification targets high utilizers of emergency services for intervention through ambulatory care management. Our robust care management team follows up with patients discharged from the emergency room to engage and educate patients about their disease conditions, ensure a prompt follow-up appointment in a primary care setting, and help patients understand how to access an appropriate site for additional care, as needed.

While we have made significant advances in this area with commercial and Medicare patients, we continue to struggle with high incidence of long stays for Medicaid patients who have behavioral health conditions. These long stays are exacerbated by mandatory provider participation in the Emergency Service Provider (ESP) program. Exempting providers who assume clinical and financial risk from this program would allow providers to efficiently care for Medicaid behavioral health patients who present in our emergency departments and to better care for them across the continuum.

### ***Real-Time Care Management Strategy***

Steward's Community Care Model aims to achieve better health, better care, and lower costs by providing comprehensive care and services in the communities where our patients live and work. Steward accomplishes this using multi-disciplinary care teams with providers across the continuum of care that have contributed to our success in our Pioneer ACO program and other commercial risk contracts.

Steward's multi-disciplinary care team is provider led and supported by teams focused on three priorities: (1) process improvement and multidisciplinary care; (2) information technology and electronic medical record optimization; and (3) promoting evidence-based protocols and care plans to integrate the system of care.

- b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

#### ***Post-acute Care***

Steward will continue efforts described in 3(a) in the coming 12 months, including ongoing extended care facility care management efforts, which we recently rebuilt to incorporate improved workflow standardization, and our Preferred SNF Network. In addition, Steward plans to deploy Acute Care Nurse Navigators at select Steward facilities to coordinate acute care stays and transitions of care for BPCI (Bundled Payment for Care Improvement) and ACO patients. The Nurse Navigator assists in the identification and case management process for BPCI and ACO patients during acute care medical and surgical stays and prior to an acute care stay to confirm and set expectations for BPCI patients with elective surgical admissions. The Nurse Navigator directs the discharge plan to ensure a timely and safe transition to the next level of care.

Steward will also engage local Aging Services Access Points (ASAPs) to leverage the community resources available to our patients. The goal of the ASAP system is to provide frail elders with services that enable them to live independently, preventing or extending the need for institutional care. In addition, they are uniquely positioned to assist patients with the psychosocial and economic deterrents to full engagement and participation in their medical plan of care.

#### ***Reducing Avoidable 30-day Readmissions***

System-wide initiatives at Steward focused on reducing avoidable 30-day readmissions include the many programs described in 3(a), which will continue in the next 12 months.

In addition, as a Section 1115 Demonstration Waiver Delivery System & Transformation Initiative (DSTI) recipient, Steward Carney Hospital has committed to partnering with MassHealth to reduce avoidable 30-day readmissions of Medicaid patients over state fiscal years 2016 and 2017. Under DSTI, Carney will encourage meaningful communication with patients during the discharge process to increase patient-provider engagement, improve overall patient health, and reduce preventable readmissions. Through implementation of a re-engineered discharge process, we will improve patient communication, satisfaction, and continue to maintain low rates of readmission.

We recommend that policymakers review readmissions policies to ensure that socioeconomic disparities are incorporated into any state-wide readmissions policies. Many social determinants of health are beyond the control of a hospital, yet contribute to readmissions, such as homelessness. As the Medicare PAC notes in its report to Congress in October 2012, research has shown a correlation between socioeconomic status and readmission rates. The Commission recommends factoring in these disparities by computing targets for readmission rates for peer

groups of hospitals with similar shares of low-income patients. All payers – especially Medicaid – should adjust their readmissions policies to account for socio-economic differences in the populations that providers serve.

This project requires assessing unnecessary utilization of the ED as gauged by the New York University criteria and to targeting efforts to subpopulations most in need of direct engagement and education. Targeted populations are defined by prior behavior, geography, or preferred practice location. We are also seeking innovative partnerships to help us address avoidable emergency department use, particularly for Medicaid patients. Last, Steward continuously works to improve timely access to providers, especially primary care providers and imaging services within our network.

### ***Focused Care for High-Risk High-Cost Patients***

Steward plans to continue its efforts described in 3(a), supported by continued investments in a robust analytic environment capable of incorporating clinical, claims, and lab data. We are restructuring our care management department to further standardize internal processes and performance management. As described in response to question 3(a), we will standardize evidence-based, cost effective clinical protocols across the continuum for all patients regardless of funding source, leveraging learning from our clinical integration efforts.

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
  - a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

Price variation – price disparities among similarly situated providers – is unacceptable and has no place in our market, especially when there is no difference in quality of care among those providers. When insurers have set premium dollars with which to reimburse all providers for care and higher priced teaching hospitals and academic medical centers claim a growing majority of those dollars, community and disproportionate share hospitals are left with low reimbursement and declining revenues to care for vulnerable residents. Price disparities have stunted smaller, community hospitals and have prohibited infrastructure investments required to maintain commercial patients within their communities to compensate for the chronically low reimbursement received for patients covered under government programs. Community DSH hospitals cannot compete in this environment. While individuals and families can choose to travel to expensive Boston-based teaching hospitals, many low-income individuals and families stay local for their care. This phenomenon bleeds into the Medicaid Managed Care market, where the average difference between the highest and lowest paid provider in an MCO network is 275%. These disparities are harmful to an already unstable provider environment that faces continued lower levels of reimbursements from all payers and must be addressed.

- b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

The biggest impact of Massachusetts' price variation on the cost of care is what some have termed the "wealth transfer" effect, where low-income individuals subsidize wealthier patients' health care consumption. When patients from wealthy suburbs receive routine care at higher priced, Boston-based academic medical centers, costs rise for everyone, and lower-income individuals essentially subsidize health care consumption of the wealthy. In 2013, 60% of commercial patients that received low acuity, routine inpatient care at Boston hospitals came from wealthy communities outside Boston where the median annual household income was greater than \$70,000.

Policy solutions to consider include: 1) index the state's cost containment benchmark to the median price and 2) implement health insurance product incentives that encourage patients to use local, community based providers for their routine health care needs. Indexing the state's cost containment benchmark to the median price provides a concrete lever to close the gap between the highest and lowest priced providers. And examples of health insurance product incentives include premium reductions for limited network products and cost-sharing reductions for routine services sought at local, community based providers.

The Commonwealth must also take a more proactive approach to end provider price disparities within the Medicaid program, especially the Medicaid Managed Care Organization (MCO). As described in 4a, Steward has observed via CHIA data that provider price variation in the Medicaid MCO program is in many instances worse than price variation observed in the commercial market. This wide variation in prices among taxpayer funded health care programs is a major opportunity for the Commonwealth to implement payment reforms that lower total health care expenditures and encourages robust re-investments in community-based care. This disturbing finding merits immediate attention from state policymakers.

In addition, the Administration and the HPC must reconsider the objective of the health care cost growth benchmark and ensure tangible consequences exist when the benchmark is not met. Currently, there are no consequences for a payer or provider who exceeds the cost growth benchmark. As the HPC develops its Performance Improvement Plan (PIP) approach, Steward strongly advocates for policymakers to add "teeth" to any corrective activities for payers or providers who exceed the benchmark. For commercial payers, the consequences could involve disapproval of any premium increase requests. Medicaid Managed Care Organizations that exceed the benchmark could have fewer MassHealth enrollees assigned to their programs until such time they can demonstrate consistently keeping costs below the benchmark. For providers, consequences could include a freeze to any and all expansion, including a freeze for any Determination of Need requests or revocation of their tax-exempt status. Moreover, providers primarily reimbursed under fee-for-service who cannot keep their costs below the benchmark should not be able to build or expand their footprint.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
  - a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

As the largest community-based provider of acute inpatient behavioral health services in Eastern Massachusetts, Steward recognizes the importance of managing care for the whole patient, both medical and behavioral conditions. Health care costs for behavioral health patients with comorbid medical conditions may be two to three times higher than patients with the same medical conditions who do not have a behavioral health diagnosis. Steward has addressed this in several ways. First, we have closely integrated hospitalists and behavioral health staff. Hospitalists (including Nurse Practitioners) in many geropsychiatric programs spend much of their day on the BH unit participating in team rounds, as well as managing medications and medical issues both acute and chronic. Clinical pharmacists also assist in medication evaluation on various units, and Family Medicine residents oversee care for adolescents in our behavioral health unit at Carney Hospital.

In acute care hospitals, behavioral health units are often segregated from the rest of the hospital, or even avoided by other specialties. In recognition of the need for strong clinical integration and coordination in the care of this vulnerable population, Steward adopted a new centralized model to oversee Behavioral Health, as described in Steward's 2014 cost trends testimony. Steward's Chief Medical Officer, a national expert in Quality and Safety, assembled an experienced and passionate team of leaders who meet weekly to address all aspects of behavioral health care for the system. The team includes the Vice President of Behavioral Health, a psychologist with a strong track record providing culturally competent care and wellness, is also a key team member. He developed and now oversees the Steward Behavioral Health Access Center, ensuring timely bed access for patients presenting at any Steward hospital. He also oversees the Behavioral Health Navigators, who are licensed mental health professionals who evaluate Emergency Department (ED) patients with behavioral health conditions. Steward's Senior Director of Behavioral Health Quality and Regulatory Affairs, a nurse practitioner with 18 years of behavioral health management experience in various care settings, leads performance improvement projects and related strategic planning efforts.

Through weekly meetings with hospital behavioral health program directors and monthly meetings with physician directors, the Behavioral Health Leadership Team implements shared goals and best practices, with resultant policy standardization, regulatory compliance, and patient experience improvement. Safety has been a particular focus at Steward. Good Samaritan Medical Center, a Steward hospital, was one of ten hospitals chosen nationally to receive a grant from the Agency for Healthcare Research and Quality's (AHRQ) Fall Prevention Training and Technical Assistance Program. The grant will allow the Steward

Healthcare system to collaborate, generate and disseminate best practices, tools and educational materials for preventing falls across the system. Each hospital has developed a falls collaborative to focus efforts on fall reductions across the system. Restraint reduction continues to be a top safety focus. Ten of Steward's fourteen units have restraint rates well below the state mean. We share best practices used for restraint reduction across sites within our system.

In addition, the National Alliance on Mental Illness reported that 70% of primary care visits are related to psychosocial issues. Research shows that depression occurs in up to 20% of patients with diabetes and coronary artery disease. If depression results in low adherence to medications, medical complications may ensue. Steward is focused on this behavioral health care challenge through the Family Medicine program at Carney Hospital. Mental health professionals are an integral part of the program and all patients with diabetes are screened for depression to ensure early intervention. Patients who would not otherwise go to a mental health specialist get their needs met with the primary care physician that they trust. The family physician or resident gets more training to be able to provide certain behavioral counseling or medication prescribing. The caregiver then provides a warm handoff to connect the patient to the psychologist or psychiatrist, increasing the chances that the patient will access care from a BH provider.

In the Emergency Department, on-site Behavioral Health Navigators (BHNs) work closely with the Emergency Medicine clinicians, both evaluating emerging behavioral health issues and connecting behavioral health patients to both behavioral and medical resources in the community. BHNs primarily provide emergency mental health crisis evaluations and integrate behavioral and physical health within the ED. The BHNs also provide substance abuse screening, referral services, and smoking cessation counseling; make referrals to primary care physicians; contact PCPs when appropriate to discuss the care of patients who are presenting in the ED; make referrals to outpatient behavioral health services; and connected uninsured patients to the Community Health Advocates (CHA) to enroll in Commonwealth subsidized health programs. The BHNs have been an invaluable asset to the Emergency Departments of eight Steward hospitals to place patients from the ED to the right care at the right time, especially those patients who have typically been frequent users of the ED or who have previously experienced long lengths of stay due to the complexity of their mental and physical clinical presentation. In addition to their training in behavioral health, all Steward BHNs receive a three (3) day Screening, Brief Intervention and Referral to Treatment training for drug and alcohol abuse from the Boston University School of Public Health BNI ART Institute. The BHNs also receive training in performing culturally competent care from the Disparities Solutions Center at Massachusetts General Hospital.

- b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

Over the next 12 months Steward plans to improve integration of physical health and behavioral health services across the continuum of care by continuing to leverage and build upon the numerous partnerships with service providers in the community that we have cultivated over the years. This integration will continuously improve our delivery of high quality care to our patients.

By coordinating with community-based partners, we provide care to our patients to keep them healthy and functioning in the community while avoiding unnecessary Emergency Department visits and unnecessary inpatient stays. To this end, we are focused on reducing readmissions to our inpatient psychiatric units this year. Our comprehensive behavioral health patient registry has allowed us to identify those patients who are high utilizers of both the ED and inpatient psychiatric services. We use this data to develop a multidisciplinary approach to reduce unnecessary use of services and alleviate gaps in care, which may contribute to the high utilization of services by these patients. Each inpatient psychiatric unit within our system is developing a multidisciplinary treatment plan for patients who frequently use our inpatient services to ensure that they receive the best care possible, while aiming to reduce their need to utilize emergency and acute services.

We are undertaking similar approaches for high utilizers of our emergency department services. As described in response to question 5(a) Steward has several licensed behavioral health clinicians embedded within the Emergency department at our hospitals. These BHNs will continue to play an integral role on our team to reduce ED utilization among our highest utilizers.

Steward has also partnered with the Boston Public Health Commission to create a Substance Abuse Patient Navigator position. This role provides substance abuse referrals and resources to patients in the ED and inpatient psychiatric units. This Patient Navigator also reaches out to our patients who are high utilizers of emergency services (as they often are patients with substance abuse problems) to offer them treatment resources in order to decrease their high utilization of emergency services. Steward utilizes Peer Support groups on some of our inpatient psychiatric units to help increase our patient's chances of success as they transition to the community. Peer Support groups have been proven a valuable asset to help patients navigate the healthcare system in addition to providing them with resources and structure in their communities, which decreases the unnecessary use of ED and inpatient care services.

Steward has also integrated wellness education into group therapy, as chronic disease is prevalent within the behavioral health population. Steward has taken several steps to integrate care of our behavioral health patients across the continuum of care and we eagerly anticipate a Medicaid ACO, which will allow us to better leverage our relationships with our community partners to provide fully integrated care to our patients. As described in response to question 2, until payers integrate behavioral health and medical services – especially in Medicaid – providers cannot fully, effectively, and efficiently manage care for patients with behavioral health needs.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

As an Accountable Care Organization, Steward believes timely, reliable, and actionable data is absolutely crucial to enable providers to better manage care, develop real-time care management interventions for chronically ill patients, and allow real time fulfillment of quality initiatives designed to deliver better patient outcomes. Such data enables providers to achieve successful performance under APMs. Steward has made a multimillion-dollar investment in its information technology infrastructure to support data integration, quality management, population health analytics, and care management. Crucial data elements include clinical, financial, referral, and authorization data. While our access to clinical and financial data has improved over time, more frequent and timely data feeds would offer a real-time view on our patient care management performance and patient utilization experience and trends.

Payers should be directed to offer real-time referral and authorization data to providers that operate under APMs to enable providers to develop proactive patient management tools for purposes of utilization management, care coordination, transitions of care, readmission prevention, and redirection of care to low-cost facilities. Additional real-time data would help providers leverage robust methods of caring for patients (as claims data is often lagged by several months) and offer a leading indicator for impending performance under APMs. Historic data will be particularly important when considering new or expanded populations for management under APMs, as such data would facilitate risk predictive modeling.

Moreover, Steward has invested in population health management programs, which allow us to care for high-risk patients and manage their medical care more efficiently and effectively, as described throughout our responses to questions 1(b), 3(a), 3(b), 5(a) and 5(b). Our robust population health management programs attempt to identify high risk/high cost patients through predictive analytics, surveillance, and referrals. These patients are managed through a cross-continuum team utilizing onsite and telephonic interactions to coordinate care between the home, office, hospital, and post-acute facility. Our complex and chronic disease care management program engages each patient with an individually designed care program, including defined goals intended to provide an achievable pathway for improved health outcomes. Navigators assist patients with transitions in care. Extended care facility physicians and nurses ensure communication with the primary care physician and close management of rehabilitation services that align with patient expectations and goals. Our performance teams work closely with individual providers and practices to address gaps in care, documentation, and patient experience. These resources are backed by a team of social workers, pharmacists, and wellness coaches, as well as our highly engaged network of physicians and office staff.

Steward does not believe that a new, siloed model of care like the PCMH model is needed to drive better value for patients. Minimal evidence exists to support the idea that care provided by PCMH practices is superior to care provided at non-PCMH practices. From a national health

care perspective, the National Committee for Quality Assurance's PCMH Certification program has demonstrated negligible evidence that support certification's value for PCMHs. In fact, a study published by *Health Affairs* found that PCMH certification does not improve quality or reduce cost, particularly for vulnerable populations.<sup>2</sup> In the absence of firm evidence that PCMH certification improves health outcomes, Steward believes PCMH should be promoted only in a way that creates value for patients or in a form that encourages PCMH's to thrive within an ACO. Specifically, the PCMH model could serve as one of many incentives for smaller primary care provider practices to move towards accepting full risk for patient outcomes or to align with an ACO in a particular region.

7. Since 2013, Steward Health Care System (Steward) has completed a number of material changes, including acquiring a provider group—Hawthorn Medical Associates (Hawthorn), establishing several clinical affiliations, and merging two of its hospitals. Please provide information, as described in more detail below, about these recent material changes and attach analytic support for your responses where available.
  - a. How have costs (e.g. prices and total medical expenses), referral patterns, quality, and access to care changed after these material changes?

Changes in specific costs, referral patterns, quality and access to care related to these specific material changes are difficult to assess because of the relatively short time that each of these arrangements have been in place. We continue to strongly support the rationale behind these agreements and have anecdotally seen many instances in which these arrangements have led to improved coordination of care between different sites, reduced duplication of services, and improved quality. Most importantly, each of these arrangements carries with it a collaboration mechanism that ensures open dialogue between parties in optimizing the delivery of care, both in general and at the level of individual patient case reviews.

- b. Steward indicated that it expected its acquisition of Hawthorn to enhance the coordination of care as “[p]hysicians and other health care providers who see patients at [Hawthorn] locations will have access to Steward’s global payment contracts with commercial insurers, which include quality, safety, access, and cost-related incentives.” Have physicians at Hawthorn locations joined Steward global payment contracts, and have the identified incentives of these contracts brought about measurable changes in the cost or quality of care for Hawthorn's patients?

The physicians of Hawthorn Medical Associates (HMA) joined commercial global payment contracts under Steward and also participate in the Pioneer Medicare ACO and the Medicare Bundled Payments for Care Improvement Initiative. All of the performance improvement and care management initiatives in place at Steward are also deployed at HMA, and the physicians at HMA are active members of the physician-led network governance structure. Changes in specific costs, referral patterns, quality and access to care related to these specific material changes are difficult to assess because of the relatively short time that each of these

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<sup>2</sup> Cole, Evan S., Claudia Campbell, Mark L. Diana, Larry Webber and Richard Culbertson. Patient-Centered Medical Homes In Louisiana Had Minimal Impact On Medicaid Population's Use Of Acute Care And Costs. *Health Affairs*, 34, no.1 (2015):87-94.

arrangements have been in place. However, we anticipate that with some additional experience we will be able to report very positive results to the HPC.

- c. Steward anticipated that one impact of its two affiliations with Dana-Farber Cancer Institute would be to “increase the coordination of oncology care between community providers and specialists, and enable patients to access such care in their local community.” To what extent have these affiliations resulted in more patients receiving such care in their local community?

Steward’s two affiliations with the Dana-Farber Cancer Institute are in their early stages, making a reliable, data-driven assessment of its impact difficult, particularly in isolation from the many other performance and quality improvement efforts in place across the system. One key benefit of the affiliations is a mutual desire to collaborate on initiatives to improve the quality and coordination of care for oncology patients at community settings. Oversight of the affiliation incorporates frequent dialogue to ensure alignment around the principle of delivering appropriate care within the community to better serve the interests of patients and their families. While it remains too early to demonstrate the overall impact of this relationship, preliminary data suggests that more patients have been able to stay in their community to receive treatments such as chemotherapy and imaging instead of traveling to receive those services at higher priced and higher cost facilities in Boston.

## Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for providers. To the extent that a provider system submitting pre-filed testimony responses is affiliated with a hospital also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
<b>CY2014</b>	Q1	40	0	40	Radiology, Ultrasound, Colonoscopy, Mammogram, Lab, Surgical, CT, MRI
	Q2	31	0	31	Radiology, Ultrasound, Colonoscopy, Mammogram, CT, surgical
	Q3	49	0	48	Radiology, Ultrasound, Colonoscopy, Mammogram, CT, surgical, cardiac, Labor & Delivery, Revere Vasectomy, Holter Monitor, Bone Density, Mammography, Oncology Drug, Cataract Surgery, Pain Clinic, MRI, Breast Ultrasound, Abdominal Plasty
	Q4	50	0	50	Radiology, Ultrasound, Colonoscopy, Mammogram, Lab, surgical, MRI, Labor & Delivery, Revere Vasectomy, Holter Monitor, Bone Density, Mammography, Breast Ultrasound, Abdominal Plasty, Bone Density, Lastation Consultation, home sleep study
<b>CY2015</b>	Q1	94	0	94	Radiology, Ultrasound, Colonoscopy, Mammogram, CT, surgical, Chest X-Ray, Shoulder X-Ray, CT Scan Abd/Pelvis, EKG, DOT Physical, Lab work (CBC, CMP, Liver Function, TSH, FSH), Physician Office Visit, Labor & Delivery, Revere Vasectomy, Holter Monitor, Bone Density, Mammography, Breast Ultrasound, Abdominal Plasty, Retina case, Colonoscopy, EEG
	Q2	179	0	179	Radiology, Ultrasound,

					Colonoscopy, Mammogram, Lab, Physical Therapy, Observation, Radiology, Surgery, OB, surgical, MRI, Cardiac, MRI Brain w/ & w/o contrast, MRI Lumbar Spine w/o contrast, Chest X-Ray, Travel clinic vaccines (typhoid, yellow fever, malaria, Japanese encephalitis), Lab, ECG, Labor & Delivery, Revere Vasectomy, Holter Monitor, Bone Density, Mammography, Breast Ultrasound, Abdominal Plasty, Diagnostic Mammogram, Breast Ultrasound, MRI LS Spine
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Please note the one (1) unresolved inquiry in Q3 2014 occurred because Steward was unable to reach the inquirer after several attempts to make contact.

2. Please submit a summary table showing for each year 2011 to 2014 your total revenue under pay for performance arrangements, risk contracts, and other fee-for-service arrangements according to the format and parameters provided and attached as **AGO Provider Exhibit 1** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

Reporting total Steward revenue is limited to data extracts provided by health plans within the context of a risk arrangement. If data extracts are provided to Steward by the plans, Steward aggregates the information by payer and assesses the total Steward in-network and Steward out-of-network costs. In addition, Steward analyzes the potential for additional retention of care within the community setting and calculates the corresponding savings.

Further, historical responses to this request have resulted in disparate data from other providers. We believe such variation in responses is misleading and creates confusion for the consumer and the broader health care community. In particular, it raises concerns that any aggregated or summarized view of the submitted data will lead to confusing and inaccurate conclusions. Therefore, consistent with our previous responses to this inquiry, Steward believes the data requested can be provided more accurately and comprehensively by health plans.

3. Please explain and submit supporting documents that describe (a) the process by which your physicians make and receive patient referrals to/from providers within your provider organization and outside of your provider organization; (b) how you use your electronic health record and care management systems to make or receive referrals, including a description of any technical barriers to making or receiving referrals and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization; (c) how, if at all, you make cost and quality information available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care; and (d) whether your organization, in referring patients for services, ascertains the status in the patient's insurance network of the provider

to whom you are referring the patient, and informs the patient if that provider is not in the patient's insurance network.

In the current fee-for-service driven system, the referral process is dictated by the payers and based on the plan type and contractual terms of each individual patient's policy. Although providers are increasingly contracting under risk under commercial APMs, the plan designs and technology offered by the payers do not fully support comprehensive care management (e.g. lack of real time data, incomplete data, etc.). Steward believes that the success of our integrated Community Care Model depends on coordinating care between network providers, which ensures the promotion of high-value, low-cost health care and success under APMs. Ideal plan design would empower the provider groups taking risk under APMs with a more comprehensive ability to coordinate care of patients to help limit use of high-cost settings. This requirement will become even more important as providers contemplate extending risk arrangements to new products, such as Preferred Provider Organization (PPO) plans. When available in individual provider offices, electronic health records are used to make and receive referrals. Real time connectivity between the plans and providers is needed to ensure member care is managed when scheduling services rather than at the time care is to be delivered or, worse, after the fact.