Corporate Office

Crown Colony Park
700 Congress Street
Quincy, MA 02169
Tel: 617-376-7400
Fax: 617-376-7419
www.shields.com

1) Chapter 224 of the Acts of 2012 (c.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 between CY2012-CY2013 and CY2013-CY2014 is 3.6%.

a) What are the actions your organization has undertaken to reduce the total cost of care for your patients?

Shields has been a leading advocate of consumer price transparency for its medical services. Our efforts to reign in health care expenses include, but are not limited to, the following:

i) Any annual increase in Shields' contractual reimbursement with health insurance carriers has always been below inflation across all payers. In certain contracts Shields experienced no increase in rates. Thus, patients served by Shields have experienced no increase in billable studies despite rising operational expenses bore by the service provider (Shields).
ii) For patients experiencing financial hardship Shields provides free care.
iii) In certain instances Shields' services are provided on a hospital campus and contrary to other providers, Shields services are billed at out-patient free standing rates, not billed according to a hospital-based fee schedule
iv) Shields is a leading provider in offering price transparency to consumers – please see our website and price calculator at www.shields.com.
v) Shields employed radiologists review all physician orders to ensure the physician-ordered imaging study is medically appropriate. In addition, Shields' radiologists regularly consult with referring physicians and offer educational forums to physicians on medically appropriate use of MRI and other imaging modalities.
vi) At freestanding facilities, patients and their family members have access to free parking and free transportation to and from the facility as needed.
vii) Shields works diligently to streamline services, automate where possible and eliminate redundant processes to ensure the patient experience is of the highest quality and respectful of the patient's time. Shields has incorporated evaluation / efficiency tools and processes such as 'six sigma' to reduce operational expenses. In addition, Shields employees, numbering 460 individuals (plus dependents), have seen no increase in their own health care premiums.

b) What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?

One of the greatest hurdles is the disparate treatment by carriers in the implementation of the pre-approval process. As a freestanding independent provider Shields must secure pre-approval for the majority of studies. Other, larger providers are exempt. No carrier or provider has shared with Shields data that supports or validates why some are exempt, others are not, or that the pre-approval process saves health care dollars. To Shields, as a provider, the cost of the pre-approval process equates to carrying salary and benefits for fifteen (15) full time employees annually. At present, this appears a burden to the health care system and subscribers without validation of its financial and medical efficacy.

i) Greater standardization among payers would improve efficiency & patient experience:

(1) payers operate unique collection and payment processes and systems;

(2) payers offer multiple and unique plans within their structure and the nuances result in varied financial burdens to the consumer;

(3) Streamlining patient collections – co pays, co insurance, high deductibles vary significantly . Likewise the administrative costs associated with patient collections are significant. Shields added 12 FTE's to address patient collections. Despite this effort approximately 25% appears uncollectable.

(4) Consumer Education on Price of Medical Services - price transparency for patients and referring physicians must be a priority. While we cannot quantify its impact we presume an informed and educated consumer / patient will be proactive and aid in reducing system costs.

(5) Shields devotes resources to a payer denial process that appears arbitrary and penalizes the provider despite providing bona fide services to patients:

- Denials due to change in location or approval of scan out of date range when such terms have been modified at patient request not changed by the provider;
- Out-of-state affiliated plans deny payment of scan that has been approved by the in-state affiliate;
- Manual Appeal process exceeds 90 days.

ii) Employee Choice based on Education of Quality and Price - As employers, hospital systems & ACO's, are limiting employee / dependent / subscriber choice. In some instances, subscribers are directed to the higher cost option while quality among providers is arguably equal. In effect, the hospital or ACO unilaterally dictates employee health care options when lower cost options are available. This drives up employee health coverage expense / experience levels, and artificially inflates the hospital's or ACO's utilization and market dominance.

c) What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?

Posting of charges (both professional and technical) at point of entry and point of service for patients by their carrier or responsible party. This information would be the first step toward full education of and awareness to the consumer / patient.

i) Elimination of disparate application of the pre-approval process. That is, operate similar to Medicare. The current system 'appears' to discriminate in

favor of the larger, more leveraged, system provider that is exempted from the pre-approval process. For providers like Shields, the current system adds overhead and costs without achieving demonstrative validation it saves the system costs or prevents unwarranted utilization *[perhaps utilization management tools such as Consumer Driven Health Plans are a valid tool for controlling unnecessary medical expenses.]*

ii) Standardization of plan design across and within health plans would reduce administrative costs for providers & physicians and price confusion for patients.

iii) As employers, hospital systems & ACO's are implementing barriers for their own employees and patients who seek high quality, cost effective services. That is, patients and consumers trapped in captive networks or care circles cannot be proactive in managing or electing high quality/ low cost providers. This artificially inflates the health care costs for a hospital's own employees/ subscribers and the hospital / ACO's market dominance.

iv) Disparate fee schedules - Presuming quality is equal it is unclear why a Hospital based service is reimbursed more than a freestanding service for similar quality, patient experience and patient satisfaction.

d) What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?

Shields has been a pioneer in educating employers, health care benefit management companies, and beneficiaries / subscribers/ employees on quality, price and benefit. As educated consumers of health care, the individual can make more informed choices in a free market. However, these efforts can be thwarted by a hospital-employer limiting employee / subscriber choice while artificially inflating utilization and market dominance.

i) When Shields has received contractual increases these increases have been below inflation. Shields continues to implement cost reduction programs to ensure Shields patients are not only informed consumers but are able to access the highest quality care at the lowest cost possible.

2) The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of the growth in prices on medical trend and what have been the results of these actions?

Shields has been a pioneer in educating employers, health care benefit management companies and beneficiaries / subscribers/ employees on quality, price and benefit. As educated consumers of health care, consumers can make more informed choices in a free market. However, these efforts can be thwarted by a hospital-employer limiting employee subscriber choice while artificially inflating utilization and market dominance.

i) When and if Shields has received contractual increases such increases have been below inflation. Shields continues to implement cost reduction programs to ensure Shields patients are not only informed consumers but are able to access the highest quality care at the lowest cost possible.

3) C.224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration?

a) What potential opportunities have you identified for such integration?

i) As an employer Shields has been a strong advocate and educator of its employee and dependents as to the resources available through its employee benefit management firm and the fact this is a privileged communication between the individual and the resource sought.

b) What challenges have you identified in implementing such integration?

i) The greatest challenge has been educating employees of this benefit.

c) What systematic or policy changes would further promote such integration?

i) As an employer, we defer to the expertise of employee benefit management firms statewide and nationally.

4) C.224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative payment methods.

a) Describe your organization's efforts to promote these goals.

i) As a provider of high quality medical services at a competitive price, Shields advocates consumer / subscriber choice consistent with the federal ACA and the goals of the Commonwealth. Shields has been a pioneer in educating employers, accountable care organizations, health care benefit management companies, insurers, and beneficiaries / subscribers/ employees on quality, price and benefit. As educated consumers of health care, consumers can make more informed choices in a free market. However, these efforts can be thwarted by hospital-employer, ACO structures limiting employee / subscriber choice while artificially inflating utilization and market dominance.

b) What current factors limit your ability to promote these goals?

i) Shields does not control physician behavior via physician incentive or payment models and therefore cannot dictate referral patterns as may be the case in closed networks or care circles that offer financial incentives or salary.

ii) As an independent fee-for-service provider for whom patient choose based on quality and service, the current push to eliminate 'all' fee-for-service ignores the benefits price competition through a free-market and free-choice can provide. Specifically, an informed consumer with the ability to make educated choices will do so.

c) What systematic or policy changes would support your ability to promote more efficient and accountable care?

Disparate fee schedules - Presuming quality is equal, it is unclear why a particular hospital-based service is reimbursed more than a free–standing service for similar quality, patient experience and patient satisfaction.

One of the greatest hurdles is the disparate treatment by carriers in the implementation of the pre-approval process. As a freestanding independent provider Shields must secure pre-approval for the majority of studies. Other, larger providers are exempt. No carrier or provider has shared with Shields data that supports or validates why some are exempt, other are not, or that the pre-approval process saves the health care system dollars. To Shields, as a provider, the cost of the pre-approval process equates to our carrying salary and benefits for fifteen (15) full time employees annually. At present, this appears a burden to the health care system, subscribers and employers without validation of its financial and medical efficacy.

Patients and physicians chose Shields based on quality and service. Shields cannot control or dictate physician referral patterns as may be the case in a closed network or care circle using financial incentives or salary.

As an independent fee-for-service provider for whom success has been based on quality and service, the current push to eliminate 'all' fee-for-service ignores the benefits of competition based on quality, price and choice. Specifically, an informed consumer with the ability to make an educated choice will do so.

5) What metrics does your organization use to track trends in your organization's operational costs?

We would be privileged to invite you and your representatives to view our systems as it is difficult to adequately express and assure the reader of the depth and breadth of resources implemented. In the interim, please accept the following as a brief outline and attempt to address the questions asked.

a) What unit(s) of analysis do you use to track cost structure (e.g., at organization, practice, and/or provider level)?

The metrics employed gauge quality, patient satisfaction, utilization and cost efficiency daily, weekly, monthly, quarterly, and annually (to name a few) from system-wide to a specific patient encounter.

b) How does your organization benchmark its performance on operational cost structure against peer organizations?

Shields benchmarks performance based on inputs available from local and national imaging providers, and metrics provided by national consulting firms such as The Advisory Board.

c) How does your organization manage performance on these metrics?

Shields measures performance at the technologist, manager, entity, and system level. Personal and system goals and objectives at each level are reviewed quarterly. Patient satisfaction / patient response are reviewed and evaluated routinely.

6) Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee, as required by c.224.

It is important to note, Shields has been posting patient cost information on our website and has offered a toll-free telephone number for patient dialogue on cost since 2012. We are a, if not 'the', pioneer in advocating consumer price transparency. Education and access to patient out-of-pocket expense tools and on-line calculators have been available since 2011.

7) After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the finding presented in light of your organization's experiences.

Great strides have been made in both access and cost containment yet work remains to achieve systemic change and goals. Patient / subscriber access and choice operate in tandem. Without choice one cannot access the highest quality - lowest cost provider as previously stated with regard to exemption of the pre-approval process for certain providers which often directs patients and subscribers to higher cost, perhaps the highest cost, providers in the Commonwealth.

Shields provides imaging of the highest quality at a price substantially below most competitors; however, the pre-approval process applies disproportionately to Shields facilities versus certain larger hospital networks. Shields is conveniently located throughout the Commonwealth, offers IT connectivity for all physicians to be able to view patient imaging results *(despite efforts by competing hospitals and ACOs to prevent the secure movement of authorized and necessary personal medical record / health care information*). Shields also employs radiologist, trained at Harvard Medical School and other Ivy Medical Schools, whose specialty is high-end imaging interpretation, research and analysis. These are significant and strategic factors that aid a patient electing in access high quality medical care at a reasonable price; however, patient choice is limited by artificial barriers and these barriers must be negated to secure and ensure patient access, choice and price competition.