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Steward

September 16, 2016

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

Via Electronic Mail to HPC-Testimony@state.ma.us

Dear Executive Director Seltz:

Pursuant to your letter dated July 15, 2016 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. I acknowledge that it is signed under the pains and penalties of perjury.

Please contact Joseph C. Maher, Esq. at (617) 419-4708 should you have any questions.

Sincerely,

Ralph de la Torre, MD
Chairman and Chief Executive Officer
Steward Health Care System LLC

cc:
Stuart Altman, Ph.D.
Chair, Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02108

Ray Campbell
Executive Director
Center for Health Information & Analysis
501 Boylston Street, 5th 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

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, 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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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.

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 Suffolk, 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 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 Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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, 2014, and/or 2015 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

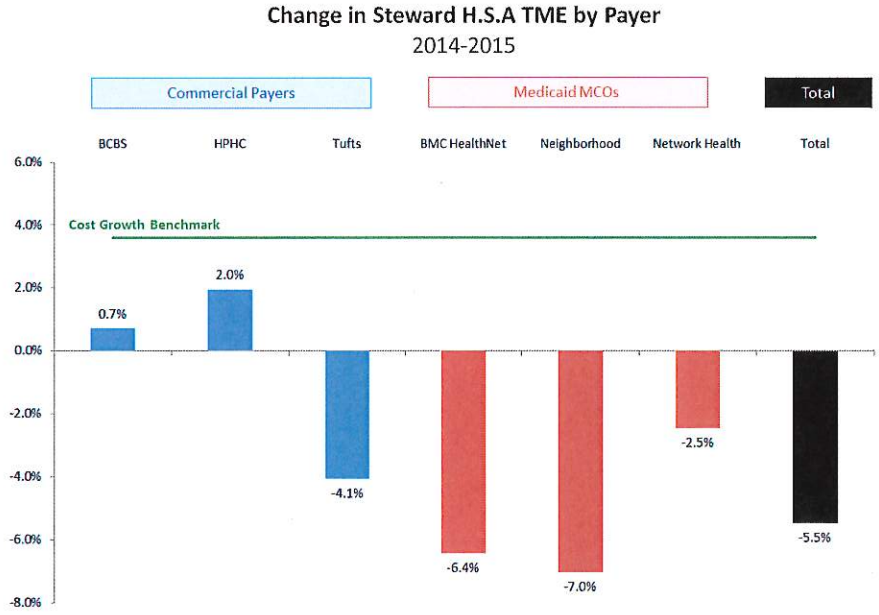
On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

1. Strategies to Address Health Care Cost Growth.

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 has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

Steward has consistently remained under the health care cost growth benchmark since its inception (as shown in the chart below). We continue to proactively focus on delivering the highest quality care in the most cost-efficient manner under non fee-for-service reimbursement models of care. However, we remain concerned about the following three issues and their effect on cost-efficient providers' ability to both compete and succeed under an environment that advantages highly profitable, Boston-based academic medical centers.



Source: Performance of the Massachusetts Health Care System – Annual Report, CHIA, September 2016

1) ***The 3.6% Benchmark Harms Cost-Efficient, Community Providers*** *– While Steward supports the state's cost containment benchmark, as currently configured, the 3.6% cap serves as an arbitrary benchmark that advantages high price providers whose prices continue to grow well above the cost containment benchmark. Despite the state's monitoring processes, certain providers' prices and costs have grown above the state's benchmark as evidenced by CHIA's 2016 Annual Report on the Performance of the Massachusetts Health Care System. Because the benchmark is set as an absolute*

target, health plans extract reimbursement rate reductions from cost efficient providers, yet negotiate higher rates from providers with already higher prices and higher commercial revenues. In other words, providers with high commercial payer mix and overall higher revenue fare better than providers with high government payer mix and lower revenues as evidenced in the chart in our response to Question 1B below.

This unintended outcome and continued variation in reimbursements leaves community hospitals – mostly disproportionate share hospitals – with lower levels of reimbursements and revenues as compared to their Boston-based competitors. As a result, community providers who are unable to compete with highly profitable, Boston-based academic centers, struggle to retain commercially insured patients who are attracted away from their local communities into Boston-based providers. Such patients help disproportionate share providers compensate for the chronically low reimbursement received for patients covered under government programs like MassHealth.

Coincidentally, CHIA's FY 2015 Acute Hospital Financial Performance Report indicated that community hospitals experienced an increase in median operating margin between FY2014 and FY 2015 and displayed data that showed the state's community hospitals as profitable. However, these data must be understood and reviewed in the appropriate context. A one year result in profitability must be placed in the context of total revenue and scale by provider which the report fails to do. In addition, many Massachusetts' community and disproportionate share hospitals continue to lose patient volume to their Boston academic counterparts, are implementing cuts to remain viable and achieve positive margins, and continue to struggle to make investments to enhance quality and patient care coordination. More to the point, an uptick in profitability does not erase years of low reimbursement, decaying infrastructure, and an anti-competitive environment that favors Boston-based academic medical centers. The discrepancy in reimbursement and the continued use of a cost-containment benchmark that advantages highly profitable, Boston-based providers and disadvantages providers who care for government subsidized residents will ultimately decrease consumer and employer access to affordable, high-quality local community providers.

2) ***Patient Migration from Local Communities to Boston Hospitals –*** *Today, neither the 3.6% benchmark, nor health insurance products address the effect of "patient migration" to Boston, whereby patients bypass local community providers to access routine health care services at Boston hospitals or their affiliates for services that can be safely and adequately provided at their local community providers. According to data from the HPC and CHIA[1], the majority of inpatient care – over ~60% – administered at Boston teaching hospitals could have been cared for at a local community hospital with the same quality outcomes. Each hospital stay that takes place at a Boston teaching hospital adds an additional cost of $3,400 per patient[2], without necessarily yielding an accompanying increase in quality. Patient migration from local community hospitals to Boston teaching hospitals has several deleterious effects that merit regulatory intervention, including:*

   a. *Erosion of affordable health care options: As Boston-based providers continue to attract commercially insured patients away from local communities, high-quality, affordable community providers close or limit services in an effort to compete or remain viable. This practice results in fewer access points for patients, especially vulnerable patients who often cannot travel to Boston for such services.*

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[1] *Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System*, Health Policy Commission, March 2016

[2] *Massachusetts Hospital Profiles: Data Through Fiscal Year 2014*, CHIA, November 2015

b. *Higher health care costs: The continued growth of Boston providers and their affiliates leads to higher costs for individuals and employers through both higher premiums and out of pocket expense. It is well documented that premiums are driven by high provider prices.*[3] *The more individuals frequent highly profitable, high priced providers – especially commercially insured patients – the higher premiums and out of pocket costs will grow annually.*

c. *Higher out of pocket costs: The 2016 CHIA report documents that out of pocket costs increased by 2.5% for the fully-insured market and 6.0% for the self-insured market. But the real concern we see is the dual measure of growing out of pocket costs and premiums in tandem. In addition to the growth in out of pocket costs, premium costs grew 1.6% between 2014 and 2015 for the fully-insured market and cost-of-claims increased by 2.1% for the self-insured market. This shift to consumers both in terms of premium growth and out of pocket costs continues to outpace the average growth in household income. This trend will continue as highly profitable, Boston-based providers continue their growth into community settings and attract commercially insured patients away from high-quality, affordable community providers.*

d. *Higher taxpayer costs: As commercially insured patients migrate away from local communities, providers who would otherwise care for a balanced mix of insured patients will struggle to keep services open, especially as their mix of patients shifts toward primarily government subsidized patients. Given the historically low rates of reimbursements, providers tend to cut costs or services to stay viable leading to higher levels of government subsidies and state budget expenses to support such providers. Examples include the DSTI program, add-on payments for DSH hospitals, supplemental payments to certain hospitals, etc.*

3) ***Anemic Shift toward APMs and Prospective Global Payments*** *– We are concerned that despite Chapter 224's requirement to have 80% of MassHealth members under APMs by July 1, 2015, MassHealth continues to lag in the adoption of such payment models, with overall APM adoption for MassHealth MCOs at 32%.*[4] *Additionally, the adoption of APMs in payer-provider contracts in the commercial market declined by 2% to 35.1% in 2015. APM adoption in the PPO market lags even further behind. While we support MassHealth's recent efforts to implement a Medicaid ACO model, we feel that more aggressive steps must be taken in order to contain costs and shift providers and payers to value based arrangements. We strongly encourage commercial health plans and MassHealth to embrace a model that reimburses providers under prospective population based payments where providers are accountable under down side risk for the total cost of care of their attributed patients.*

We also continue to be concerned about the rise in spending by Medicaid Managed Care Organizations (MMCOs) as noted in CHIA's 2016 Annual Report (6.1% in 2015). This large increase in spending raises questions about the current ability of MMCOs and the state's Behavioral Health managed care company to effectively manage care and to control costs under a predominantly fee for service reimbursement scheme they have administered for decades.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

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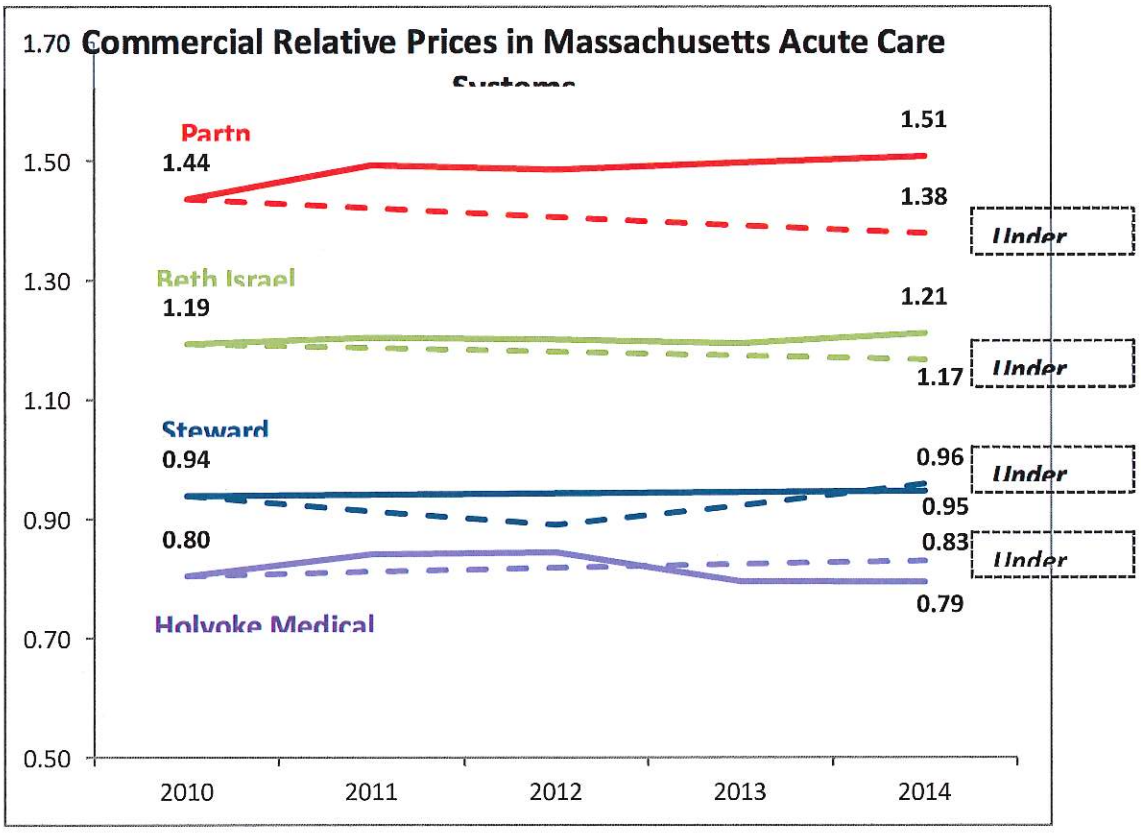
[3] *Examination of Health Care Cost Trends and Cost Drivers,* Office of the Attorney General, September 2015

[4] *Performance of the Massachusetts Health Care System – Annual Report*, Center for Health Information and Analysis, September 2016

Steward offers the following three suggestions to advance effective cost containment and expanded access to care, without compromising high-quality care:

1) ***Require Commercial Health Plans and MCOs to "Index" the Health Care Cost Growth Benchmark***– *The HPC, in conjunction with the Division of Insurance, MassHealth and the Group Insurance Commission, should require commercial payers, as well as MCOs and payers contracted by the GIC, to index the 3.6% benchmark to the carrier specific median so that during rate negotiations, providers who are at or below the cost containment benchmark are not disadvantaged or penalized versus providers who have high revenue, high commercial payer mix and are above the cost containment benchmark. The existing benchmark sets a uniform cost growth benchmark that all providers must adhere to at an absolute level, thereby assuming that all providers are similarly situated and the same in size and revenue when they are not. This absolute benchmark perpetuates existing reimbursement disparities among providers. Some providers have exceedingly high prices, high commercial payer mix and large revenue, while other providers —especially those serving low-to-moderate income communities—have much lower revenues, high government payer mix, and modest or low prices. This uniform cost containment benchmark locks-in and widens reimbursement disparities among providers and should be addressed with regulatory guidance from the State agencies referenced above. As exhibited below, indexing the commercial price growth would help to address the wide reimbursement disparity among providers over time.*



Note: Aggregate relative price shown, inclusive of all commercial payers.
Source: *Provider Price Variation in the Massachusetts Health Care Market (2014 data)*, CHIA, February 2016; CHIA Price Variation data 2010 to 2014.

2) ***Behavioral Health/Psychiatric Care Reimbursements That Meet The Actual Cost of Providing The Care*** – *The Commonwealth and the nation took a major step forward with the passage of the Mental Health parity law which requires payers who offer mental health benefits to cover the diagnosis and treatment of certain mental disorders to the same extent that they cover the diagnosis*

and treatment of physical disorders. Unfortunately, those landmark laws did not address the significant underpayment that exists for such services. In fact, reimbursements to providers that are well below the actual cost of providing such care negatively impact access to behavioral health and psychiatric services (BH/Psych). Moreover, low reimbursement for BH/Psych exacerbates the fragmentation of care (mental vs. physical) and discourages providers from offering such services or from building infrastructure to integrate behavioral health and physical care.

Together, the fragmentation between physical and mental health and alarmingly low reimbursements increase health care costs for the State and limit the availability of services for this vulnerable population. Reports by both the Attorney General's Office and HPC have documented this dilemma and note that increasing the low reimbursements for behavioral health services is one way to improve outcomes, while controlling overall long-term cost growth.

We strongly recommend that commercial payers, GIC, and MassHealth and its behavioral health contractors be required to reimburse providers at no less than the actual cost of providing such care. In addition, the Commonwealth should require payers to establish an incentive payment for providers with a high proportion of behavioral health or psychiatric inpatient volume and hospital beds. This dual approach will incentivize providers to expand their practices to service MassHealth patients with behavioral health needs and will offer providers with an already high behavioral health patient mix the appropriate financial incentives to make investments required to meet federal and state mandates at their facilities, but also to appropriately service the high demand that exists for physical and behavioral health.

As a financing strategy, the Commonwealth could consider redistributing resources from providers with high commercial payer mix and low behavioral health volume to providers with high behavioral health volume and low commercial payer mix. A similar redistribution approach was signed into law by Governor Baker for the $257M Hospital Assessment. This recommendation could also lead to much needed investments by providers for outpatient services which are in high demand and are a major factor in the alarmingly high rates of Emergency Department "boarding" experienced in Massachusetts today.

For example, Steward, as one of the largest providers for inpatient behavioral health patients in Eastern Massachusetts, faces a lack of outpatient facilities or providers in which patients should be appropriately cared for. The lack of community-based outpatient behavioral health providers can cause patients to end up "boarding" at the ED while hospital staff seek to find appropriate outpatient care settings for the patient with very low reimbursements for such boarding. The process to find appropriate outpatient care can take days and forces patients to spend days in hospital settings unnecessarily. A concerted effort by the Commonwealth to build behavioral health infrastructure and improve reimbursements will catalyze providers who already treat a high number of behavioral health patients to better integrate care and reduce overall healthcare costs, and will attract new providers to treat MassHealth patients with BH needs.

3) ***Supply Side Incentives for Individuals with Commercial Insurance*** *– Any effort to contain costs should be accompanied by a corresponding effort to incentivize individuals to utilize high quality, affordable providers. The State through the Division of Insurance, the GIC and the Connector can require health plans to issue affordable health insurance products with premiums that are no less than 30% below existing HMO premiums. Current efforts to encourage consumers to choose high value (lower cost, high quality) providers through mechanisms such as tiered, or limited network plans are not accompanied by meaningful financial incentives for consumers to make the shift. As cited in the HPC Provider Price Variation: Stakeholder Discussion Series Summary Report, even a*

reduction of 20% in premiums to members who chose a Primary Care Physician (PCP) in a hypothetical non-limited network model will not guarantee that members will choose the lower cost providers.

In Steward's experience, health insurance products and plan design options need to include aggressive premium reductions of at least 30% below existing HMO premiums in order to incentivize consumers to change their behavior toward frequent high value providers. Requiring plan options that are 30% lower than existing HMO premiums will provide the consumers with the right financial motivation to choose products that offer high value providers. This policy should also incentivize health insurance brokers, agents and distribution channels to sell health insurance products that promote and offer lower premiums. This shift to high value care through the use of supply side incentives should apply to all carriers offering products in Massachusetts for fully insured groups under the Division of Insurance, as well as carriers participating in the Group Insurance Commission, and the Commonwealth Connector.

2. Strategies to Address Pharmaceutical Spending.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

The answers below reflect Steward's responses as a self insured employer that offers health insurance benefits, inclusive of pharmaceutical options to its 17,000+ employees.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Does NOT Plan to Implement in the Next 12 Months

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Currently Implementing

iv. Establishing internal formularies for prescribing of high-cost drugs

Does NOT Plan to Implement in the Next 12 Months

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Currently Implementing

vii. Other: *With regards to Question (iv) on establishing internal formularies for prescribing of high-cost drugs, Steward currently uses formularies which have been established by the payers. In addition, Steward's Employee Sponsored Insurance (ESI) plan has a national formulary in place.*

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

As the largest provider of inpatient acute behavioral health care, Steward is strongly committed to the integration of behavioral and physical health. Our patients with behavioral health conditions often have serious and chronic co-morbid conditions that are the major drivers of healthcare utilization and cost. Therefore, fully integrating treatment protocols across inpatient, outpatient and community based settings are essential to improving their health outcomes, while simultaneously mitigating unnecessary costs. Below are three of the many strategies that Steward is pursuing to integrate behavioral health care:

1. ***Hospital-Based Integrated Care Teams*** *- At most hospital locations, Steward brings together multiple disciplines from across the healthcare spectrum into the treatment teams at our inpatient behavioral health units. Physical health providers work side by side with the behavioral health teams enabling them to address both the physical and behavioral health needs of our patients at the facility. Our behavioral health units are located within the acute care hospital, which allows us to provide specialty medical and surgical care to our patients in real time, if necessary.*

2. ***Behavioral Health Navigators*** *- Given our commitment to BH, Steward hires independently licensed behavioral health clinicians called Behavioral Health Navigators (BHN) as part of the integrated care teams at each hospital facility. BHNs are fully integrated into the Emergency Department's care team. BHNs provide emergency mental health crisis evaluations and connect patients with physical health services, such as appointments with primary care physicians. BHNs also perform smoking cessation counseling and help patients navigate the healthcare system in order to access the appropriate resources to reduce gaps in their care and improve their health outcomes. BHNs have helped Steward provide expeditious service to patients with BH needs, while lowering the wait times of our clients and lowering costs borne by patients who would otherwise board unnecessarily.*

3. ***Integration with Community-Based Providers*** *- Steward continues to leverage relationships with community-based providers to further integrate the services provided to our patients. We've worked with our community partners on initiatives to reduce ED utilization and hospital readmissions. In fact, Steward maximized the use of the Infrastructure and Capacity Building (ICB) grants to establish a robust provider network comprised of several community-based partners who specialize in BH/Psych services. Under the ICB grant, Steward is also actively analyzing data and tactics to identify patterns of care for patients we may be servicing today but due to a fragmented reimbursement environment, may not be servicing in a coordinated manner. Ultimately, we hope to develop automated systems and dashboards that display ED visits and admits/readmits to our provider partners to alert them when their clients visit one of Steward's acute care facilities or urgent care centers.*

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

Please see our response to Question 1B.

In addition, the lack of publicly available data for behavioral health spending, costs, and service line utilization in Massachusetts makes it very difficult to assess how we fare as a Commonwealth regarding patient access, prices, utilization, and medical expense in the behavioral health space. The lack of publicly available claims and utilization data adds to the fragmentation of the behavioral health care system and further exacerbates the lack of coordination between the behavioral health and medical care delivery provider paradigms. The Commonwealth can begin to address this problem immediately by requiring MassHealth and its BH vendor – who comprise ~50% of the expenditures in the BH market – to make their data publicly available.[5] This is an issue that merits immediate attention by the HPC and the AG.

4. Strategies to Recognize and Address Social Determinants of Health.

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

Steward's model of care is focused on "right siting patient care" to the most appropriate setting: in the community where patients reside. This approach requires us to both understand and help address the social determinants of health that affect our patients' overall physical, social, and mental health. As part of the Infrastructure and Capacity Building grant process, Steward undertook an 8 month effort to incorporate the social determinants of health into its care management and population health management processes. Steward is currently using the work from the ICB grant in its contracting process, including the Medicaid ACO. While this work is not yet complete, Steward strongly recommends that the relevant State agencies work together with the industry to develop a standardized set of measurable metrics for social determinants of health. Such a set of metrics could ultimately be used to reimburse providers under risk-based payments for both administering medical care, while also coordinating strategies to address social determinants of health for the patients they serve.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

There are two main barriers to addressing the social determinants of health for our patients –a lack of accurate patient-specific data and a lack of incentives for providers to address the social determinants.

1) ***Current Medical Data Systems Do Not Capture Data on the Social Determinants of Health***
Historically, most medical claims data (e.g. DRGs and RVUs) have not captured information regarding social determinants of health and their effects on patient well-being. Providers can use claims data to make assumptions about patient needs but the lack of available data regarding factors such as socioeconomic status, housing, domestic violence, and food insecurity make it difficult for providers to understand and address these determinants with their patients. Without a

[5] Examination of Health Care Cost Trends and Cost Drivers, Office of the Attorney General, June 2015

system that both reimburses providers for this work and that accurately captures patient-specific data on the social determinants of health, providers are unable to fully address the impact that these factors have on whole patient health.

2) ***Neither State Policy Nor Payers Offer Incentives to Providers to Address Social Determinants of Health***

Existing reimbursement methods (fee-for-service or APMs) do not address overall social determinants of health. In addition, existing reimbursement methods do not include clinical or financial incentives for providers to address such social determinants of health. Addressing these determinants requires a considerable commitment by regulators and the industry to establish the appropriate metrics of measuring social determinants of health and benchmarks of success.

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

For well over two years, Steward has publicly expressed concern regarding the migration of commercially insured patients from community-based, affordable care settings to Boston's higher cost, academic teaching hospitals and their affiliates. This migration is exacerbated by the increasing growth of Boston's academic providers and their affiliates in communities outside of Boston, i.e. what we refer to as "colonial outposts" or wealth transfer (see last year's Cost Trends submission).

Despite our status as a disproportionate share provider, Steward continues to implement tools and tactics that advance coordinated care for all of our patients regardless of their insurance status, or ability to pay. We have documented many of these tactics in prior Cost Trends submissions. One of the key tools Steward leverages to drive enhanced care coordination and performance from our providers is risk-based contracts that encourage our providers to maximize the use of the Steward health care provider network for patient care and services.

While Steward continues to aggressively move more of our providers and contracts to downside risk platforms or APMs, it is clear from CHIA's most recent report that the adoption of APMs has significantly slowed. Regulators should do more to push payers to implement contracts with down side risk that reimburse providers for delivering better care and lowering total cost of care. Payers should also be directed to offer plan designs and insurance products that encourage and financially reward individuals for using community-based providers who have lower prices and lower medical expense in community settings. Ultimately, health plans have the statutory responsibility of offering individuals and employers the best choice and options of insurance and provider networks that drive better value, i.e. high quality health care and cost efficient products. Finally, regulators should require commercial health plans, carriers contracted by GIC, and MassHealth's MCOs to help health care providers use robust claims data and other real time data capabilities to enable providers to manage care proactively and in a coordinated manner.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If yes, please describe what information is included.
Click here to enter text.

ii. If no, why not?

We suggest that payers are best positioned to offer such information to consumers.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If yes, please describe what information is included.
Click here to enter text.

ii. If no, why not?

We suggest that payers are best positioned to offer such information to consumers.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?

Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.

Steward's electronic health care record system can interface with contracted or corporately affiliated provider systems. For provider organizations' systems which are not corporately affiliated or jointly contracted with Steward, there are some circumstances where we can align in terms of patient services and share relevant patient data as appropriate.

ii. If no, why not?
Click here to enter text.

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

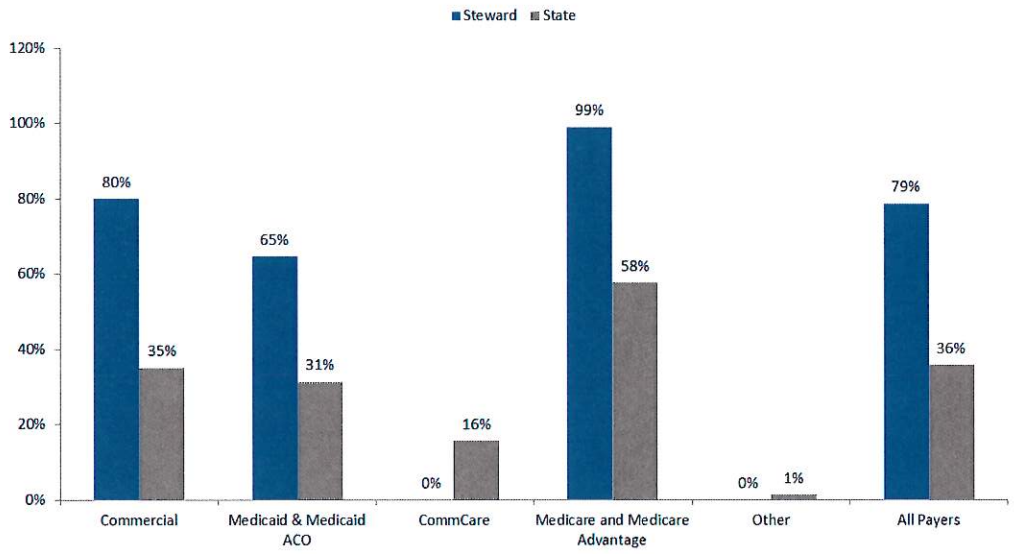
In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

Steward continues to lead in the adoption of alternative payment methods and continues to engage commercial payers, Medicare, and Medicaid in shifting from fee-for-service based reimbursement systems to global, risk-based arrangement. Currently, Steward is pursuing the following strategies:

1. ***Risk-Based Contracts/Population Based Payments:*** *Steward's adoption of alternative payment methods continues to exceed the state average on just about most lines of coverage as evidenced below. Steward continues to push for contracts with downside risk and believes that prospective population-based payments are the most effective tool of increasing both provider performance, but also of enabling providers to reduce cost, maximize care coordination, and improve quality outcomes.*

Portion of Member Months in Alternative Payment Methods (APM) by Payer Type
2015



Source: Performance of the Massachusetts Health Care System – Annual Report, CHIA, September 2016

2. ***Percent of Premium Arrangements Between Health Plans and Providers****: In the absence of prospective, population based payments, Steward continues to pursue "percent of premium" arrangements with commercial health plans. This contracting model aims to reduce or eliminate duplicative administrative costs and enhance population health management. This model ideally should also allow Steward and its partner health plans to pass on premium reductions and savings back to employers and their insured employees.*

b. *What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)*

1. ***APMs with Down Side Risk in the PPO Market****: Alternative payment arrangements in the commercial market have thus far been mainly confined to HMO products. As of 2015, three of the six largest Massachusetts-based commercial payers reached the 60% HMO target originally set in the HPC's 2014 Cost Trends Report. However, APM adoption in the PPO market*

continues to lag far behind the 33% target.[6] *We understand that the adoption of risk arrangements in the PPO market is challenging given that PPO benefit designs typically do not require primary care selection, and therefore PCP management of care.*

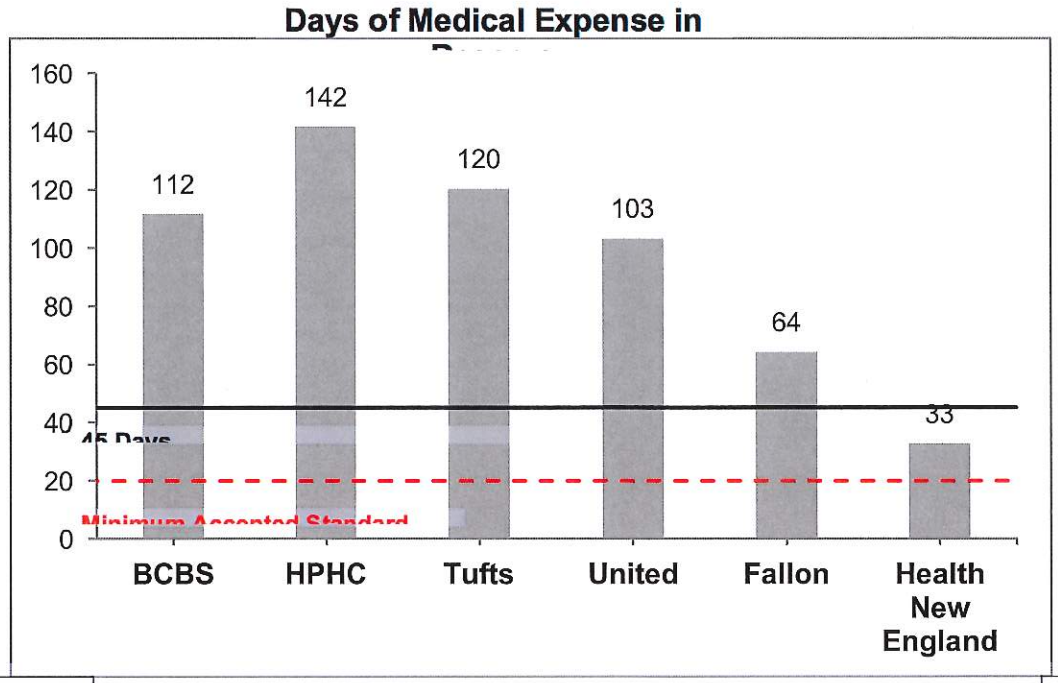
Steward recommends that the Division of Insurance require payers to move their PPO products to percent of premium contracts with providers under down side risk.

2. ***Downside Risk Contract Targets Between Providers and Health Plans*** *– Steward has encountered some resistance from carriers in pushing for prospective population-based contracts. A carrier's business model is predicated on the management of members/covered lives and premium dollars. As a result, many carriers have been reluctant to shift control of lives and premiums, making it difficult for provider organizations to adopt alternative payment models. In fact, according to CHIA's 2016 Performance of the Massachusetts Health Care System Annual Report, the proportion of two-sided risk contracts among MassHealth MCO payers actually declined by 3.9% during 2015.*

   Steward recommends that the State set binding targets and guidelines around the increased adoption of APMs with down side risk for commercial, GIC and MassHealth, respectively, and hold all parties accountable to these targets. For example, the Division of Insurance and the HPC could work together to establish a five-year transition period where payers and providers have to shift away from fee for service and operate over 75% of their reimbursements under downside risk contracts.

3. ***Health Plan Reserves*** *– Even though payers have shifted significant levels of financial risk to providers, health plans have not demonstrated how that shift in risk has resulted in lower premiums for employers or in a commensurate decrease in reserves. According to data from the June 2015 Health Plan Performance Report from the Massachusetts Hospital Association, commercial health plans may be "over reserved" in excess of $2B in premiums per year. Employers and their employees could see a substantial decrease in premiums if the Division of Insurance changed the risk based capital requirements to a maximum of 45 days in reserves.*

[6] *Performance of the Massachusetts Health Care System – Annual Report*, Center for Health Information and Analysis, September 2016

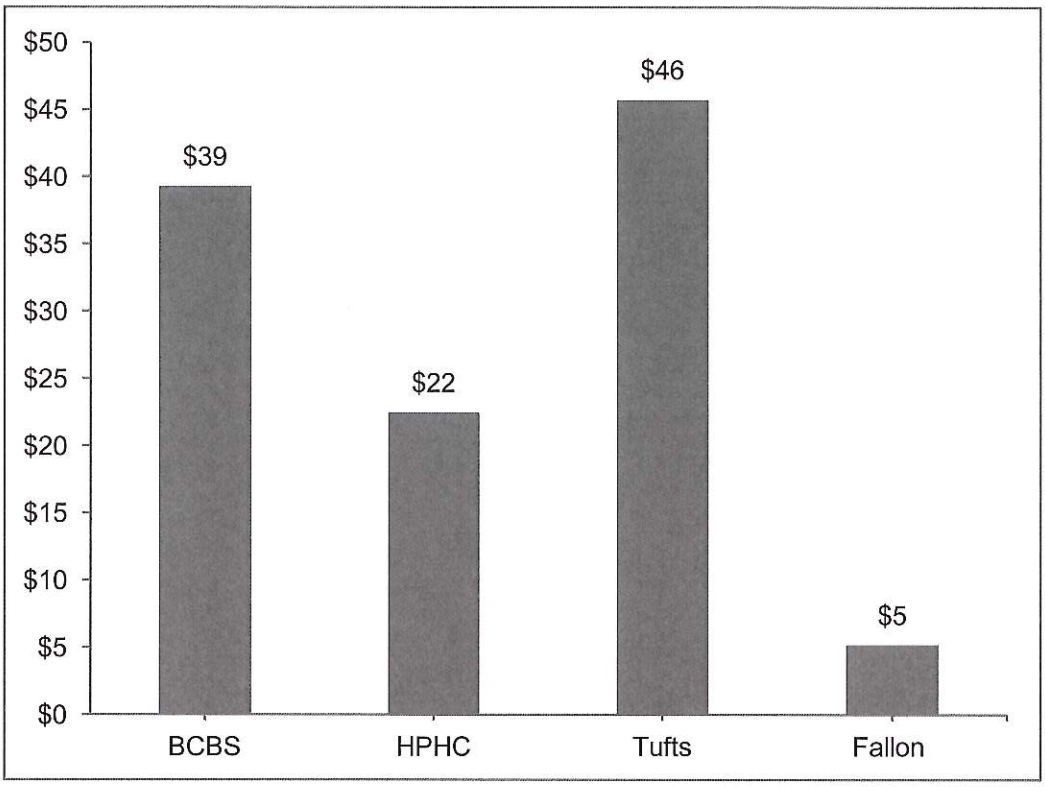


Amount in Excess							Total:
20 Days	$1,474M	$471M	$638M	$130M	$116M	$19M	$2,847M
45 Days	$1,072M	$375M	$479M	$91M	$50M	N/A	$2,066M

Note: Days of Medical Expense in Reserve is calculated by dividing Net Worth by Daily Medical Expense
Source: *Health Plan Performance*. Massachusetts Hospital Association.

PMPM Premium Discount Per Year

Maximum 45 Days in Medical Reserves Allowed



Current Premium PMPM	**$431**	**$438**	**$455**	**$414**

As such, Steward recommends that the Division of Insurance require each carrier to report their risk contracts by provider, including their amount of financial risk and require that a certain amount of such risk be redistributed back to employers in the form of either premium discounts or premium rebate checks. This requirement would force both providers and payers to drive value to employers and their insureds by adopting contracts that lower expense and drive better value. Alternatively, given the large amount of risk transferred to providers under alternative payments today, the Division of Insurance could require that Carriers transfer a specific amount of reserves to providers to enable providers with downside risk to invest in population health management programs that both improve care and lower total cost of care.

c. Are behavioral health services included in your APM contracts with payers?
Yes

i. If no, why not?
Some of our APM contracts include behavioral health services.

7. Strategies to Improve Quality Reporting.

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

Steward is subject to hundreds of disparate quality measures administered by both commercial and governmental payers. The extensive number of quality measures incorporates multiple definitions, inclusion and exclusion criteria, and reporting periods for each measure and unduly increases the reporting burden on our organization.

Although the lack of alignment in quality reporting has created additional work and expense, Steward's investments in population health management programs and effective IT enable us to manage the abundance of quality measures and appropriately care for high-risk patients and manage their medical care. Despite the plethora of measures and a lack of clear direction on statewide priorities for quality improvement efforts, Steward has been able to successfully perform on a variety of quality measures in both its public and private payer contracts through the substantial investment of resources into information and data collection systems. We have invested in information systems that integrate community-based providers across the continuum of care – acute, post-acute, and ambulatory care –and that enable our physicians, hospitals, and health center partners to provide real-time coordinated care, while simultaneously mitigating duplication of services and tests. This highly integrated and interoperable IT 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 programs 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.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

As was mentioned in the 2014 Cost Trends Report, Steward suggests that the State prioritize efforts to align quality measures through a comprehensive and transparent public stakeholder process. This work could include setting priority areas for quality measures, discussing the quantity of quality measures that providers and payers can use in contracting, specifying measure definitions, and addressing reporting frequency and format. Other states have effectively used this process to reduce the administrative reporting burden on providers and to set clear priorities on quality improvement initiatives for all involved entities. The creation of a standard, aligned measure set would greatly reduce the costly reporting burden on provider organizations.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.
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Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **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.

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

      Steward has a system in place to respond to consumer inquiries for prices of services both for patients who are "shopping" for prices with facilities and for patients who are scheduled for a service. In both cases, Steward has staff that is fully trained to help patients use these price estimator tools.

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.

      Steward's price estimates are provided to consumers in real-time. We work with a vendor to extract the necessary and relevant information and ensure that it is provided to the patient in a timely manner and at the point of service when requested.

   c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

We have processes in place to ensure that consumers receive accurate and timely information regarding the price of the service they desire and work with the vendor to resolve any problems that may arise.