Steward Health Care System LLC 111 Huntington Ave, Suite 1800 Boston, Massachusetts 02199
T: 617-419-4700 F: 617-419-4800 www.steward.org

March 10, 2017

Via Electronic Submission

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

Dear Executive Director Seltz:

Steward Health Care System LLC (Steward) is New England's largest community-based accountable care organization, encompassing ten hospital campuses and over 3,000 physicians and specialists, as well as nurses, home health, behavioral health and allied services professionals. All of Steward's acute care hospitals are classified as disproportionate share hospitals (DSH). Steward plays a critical role in providing care to low-income and vulnerable populations in the communities where our patients live and work.

Steward strongly supports innovative health care solutions that enhance quality, promote total population health and lower the cost of health care. Steward was among the first in the nation to spearhead and shape Medicare's ACO programs and subsequently was a top performer in the Medicare Pioneer ACO nationally. Steward was also selected to participate in Medicare's Next Generation ACO program as part of an elite group of ACOs. In Massachusetts, we are one of a handful of providers participating in the Medicaid ACO pilot.

Health Care Reform: The Shift to Value

Since inception in 2011, Steward has publicly advocated for health care reform via various public policy initiatives focused on shifting away from fee-for-service arrangements to a value based model. We fundamentally believe that access to high quality health care is a right, which we as a society must continue to protect. At the same time – as one of Massachusetts' largest employers and taxpayers – we recognize that lowering the annual rate of growth of health care costs is essential. As an active participant in the ongoing conversation pertaining to cost containment, Steward has continued to advocate for measures that encourage providers and payers to devise products and solutions that support patients to seek high quality care in their local community and at the most cost efficient locations. We have put this advocacy into action

by operating efficiently, while maintaining exceptional quality across all of our locations. In fact, Steward has consistently remained under the health care cost growth benchmark and our hospital prices are generally at or below the statewide median.

Despite some of our gains, Steward remains deeply concerned about the future of cost-efficient community based providers and their ability to both compete and succeed in an environment that advantages highly priced, Boston based providers with predominantly commercial payer mix.

For well over five years, we have highlighted these issues in numerous forums and have offered suggestions to address these concerns which continue to negatively affect our health care system today. The following are examples of some of those issues:

1. *Patient migration from local communities to Boston for routine services*

Highly profitable, high-priced Boston hospitals continue to draw higher numbers of commercially insured patients away from lower priced, low-cost, high quality community-based hospitals for routine services. It has been well documented that routine medical services can be adequately provided in the community with exceptional outcomes and at much lower cost. The Weighted Average Payer Rate for a low-price, high value community hospital is $13,265, while a visit to a high-priced hospital in Boston will, on a Weighted Average Payer Rate basis, cost $22,491 without an accompanying increase in quality. We have noted the impact of this patient migration over several years in our testimony to the HPC. This problem continues to impede the Commonwealth's cost containment efforts as health care costs continue to increase for individuals and employers through higher premiums and out of pocket expenses driven by higher utilization of highly profitable Boston-based providers.

2. *Anemic shift toward high value care and value-based payment models*

Steward has consistently advocated that the Commonwealth adopt risk-based global payment contracts as an effective tool for driving value in the health care system, i.e. high quality care in the most cost effective manner. In our 2013 Cost Trends Testimony, we noted that incentives for providers to adopt such payment models were negligible and that even fewer incentives exist for under-resourced providers to invest in the infrastructure needed to move away from fee-for-service. Four years later, not much has changed – providers still work in an environment where fee-for-service is the primary means of reimbursement. To make matters worse, the ongoing cuts to fee-for-service rates with the concomitant mandates for providers to implement unfunded regulatory mandates and invest in patient care resources advantages highly profitable providers with high commercial payer mix and perpetuates a vicious cycle of anti-competitiveness and care migration to Boston.

Furthermore, despite Chapter 224's requirements to shift to alternative payment arrangements (APMs), Massachusetts continues to lag in the adoption of APMs and global payments which

have demonstrated tangible results in reducing total cost of care. For example, Chapter 224 required 80% of MassHealth members be under APMs by July 1, 2015, yet overall APM adoption for MassHealth MCOs is at 32%. Moreover, the adoption of APMs in payer-provider contracts for the commercial market actually declined to 35.1% in 2015. According to the 2016 HPC Cost Trends Report, the commercial PPO market's APM coverage rate was 1% in 2015.

3. Uneven playing field among providers

For over six years we have known that unwarranted price variation among providers leaves community hospitals – mainly disproportionate share community hospitals – with lower levels of revenue and volume as compared to their Boston-based competitors. As a result, many community providers struggle to compete with highly profitable, Boston-based providers to retain commercially insured patients who are attracted away from their local communities. These high quality, cost efficient community hospitals are left with fewer resources to invest in patient care services, or the capital improvements needed to remain viable, all while caring for a disproportionate number of Medicaid patients, many with significant behavioral health and substance use issues.

4. Behavioral health reimbursements that are well below the cost of providing care

It has been well documented that reimbursements for psychiatric and behavioral health services are well below the actual cost of providing such care. This underpayment negatively impacts access to these services, exacerbates the fragmentation of care (mental vs. physical) and discourages providers from offering or investing in such services.

Together, the fragmentation between physical and mental health and alarmingly low reimbursements increase health care costs 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. As the largest provider of inpatient acute behavioral health care, we have strongly advocated for our regulatory leaders to address this unjust disparity.

5. Health care costs continue to rise

For the second year in a row, Massachusetts exceeded its cost growth benchmark of 3.6% and continues to be a high cost state for health care in comparison to the rest of the nation. According to HPC's 2016 Cost Trends Report, commercial health care spending is 6%-9% higher than the national average and commercial premiums are among the highest in the nation. In addition to increasing premiums, cost-sharing continues to grow faster than inflation and wage growth, causing small businesses and consumers to bear a greater proportion of overall health care costs. This cost-shift to small businesses and consumers is unsustainable.

Five years after the passage of Chapter 224 these issues persist in Massachusetts, as data from the Attorney General, the HPC, and CHIA all demonstrate. As we discuss modifications to the cost growth benchmark, it is important to understand that all of these issues are inter-related and that the state's cost growth benchmark can serve as a catalyst to drive the market to address these issues, as cost containment efforts continue.

Modifying the Cost Growth Benchmark

We encourage the HPC and its Board to adopt the following three reforms:

i. Set the statewide cost growth benchmark at 3.1% for 2018-2022 and index the cost growth benchmark to the Weighted Average Payer Rate (WAPR) median

According to Chapter 224 of the Acts of 2012, the annual health care cost growth benchmark will be reduced to 3.1% in 2018 unless the HPC Board determines that the benchmark should be adjusted. **Steward urges the HPC to set the cost growth benchmark at 3.1%.**

The HPC can leverage the cost growth benchmark as a tool to encourage providers and payers to continue the shift to value. Setting the benchmark at 3.1% also sends a strong signal to the health care industry that the cost containment agenda remains a top priority for the Commonwealth.

In addition, we recommend that the HPC index the cost growth benchmark. As currently constructed, the benchmark advantages high priced, highly profitable providers whose prices continue to grow. Because the benchmark is set at an absolute level, providers with high commercial payer mix and overall higher revenue fare better than providers with high government payer mix and lower revenue, as payers extract reimbursement rate reductions from cost efficient providers with lower revenue, yet negotiate higher rates with providers that have higher prices and higher commercial revenue.

To address this problem, we suggest that the HPC index the cost growth benchmark to an all payer, weighted average payer rate (WAPR) median. Indexing growth to an all payer WAPR median will help address reimbursement disparities among providers over time. The all-payer WAPR takes into account a provider's total reimbursement footprint inclusive of Commercial, Medicare, and Medicaid. A lower benchmark that is indexed to an all-payer WAPR median will hold providers with more resources and high unwarranted prices to a greater degree of transparency and the operational rigor needed to demonstrate value, while simultaneously allowing high value providers to compete and demonstrate their value to employers and payers.

ii. Adopt the Weighted Average Payer Rate (WAPR) as a public metric to measure health care costs and provider value

Today, CHIA and the HPC review a hospital's commercial rates or Total Medical Expense (TME), without regard to their total revenue or reimbursement activity, including Medicare or Medicaid. This leads to an incomplete understanding of a provider's efficiency and the value of

the care they provide. We propose that the HPC adopt the Weighted Average Payer Rate (WAPR) as a metric to better understand a provider's impact on costs as well as their value.

By weighting the average payment to a hospital for each payer by the corresponding volume a hospital experiences by payer and severity, the WAPR takes into account a hospital's overall payer mix and total reimbursements by payer. This analysis leads to a better understanding of a provider's value proposition for employers and patients.

For example, if provider A has a commercial rate that is 20% higher than provider B, yet its payer mix is 20% commercial vs. provider B's 80% commercial, then provider A is likely to be a better overall value for consumers. It also acknowledges that the health care cost impact a provider has on Massachusetts health care spending and premiums is not limited to commercial insurance. In addition, it enables a discussion of value and efficiency among providers, as well as an understanding that through cost shifting all health care is interrelated.

iii. Allow high-value providers to grow above the 3.1% benchmark

As a way to reward high value providers who deliver high quality care in a cost-efficient manner, we suggest that the HPC allow "high-value" providers to grow at an additional 1% above the cost growth benchmark by excluding such providers from the HPC's annual review of CHIA-Identified Entities (entities whose increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the state to meet the cost growth benchmark). High value providers can be defined as a provider organization with an all payer WAPR that is at or below the all payer WAPR median and who participates in ACO programs under Medicare with downside risk.

<u>In conclusion, Steward recommends that the HPC set the cost growth benchmark at 3.1%.</u>

We believe that setting the cost growth benchmark at 3.1% and indexing the benchmark to the all payer WAPR median will encourage providers and payers to both continue the shift to high-value care and tangibly demonstrate their impact on health care costs.

Finally, we commend the HPC. The HPC's efforts are essential to advancing the Commonwealth's cost containment agenda and we encourage the HPC to advance its work. A more aggressive move to value will increase our delivery system's efficiency and also lower overall medical spending (not simply prices) so that all Massachusetts residents can have sustainable access to affordable care. We appreciate the opportunity to comment and thank you for your consideration of our comments.

Sincerely,

David Morales
Chief Strategy Officer