MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Hospitals and Provider Organizations

As part of the *Annual Health Care Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), 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:

Tuesday, October 16, 2018, 9:00 AM
Wednesday, October 17, 2018, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, 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. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov 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 witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. 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, 2015, 2016, and/or 2017 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 templates, 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@mass.gov or (617) 979-1400.

HPC Contact Information

For any inquiries regarding HPC questions, please contact HPC-Testimony@mass.gov or (617) 979-1400.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@mass.gov or (617) 963-2030.

HPC Pre-Filed Testimony Questions

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.

1. ***As currently constructed, the 3.1% benchmark disadvantages cost-efficient, community providers.***

   Steward is a strong supporter of the state's cost containment benchmark and advocated for the state to lower the benchmark rate from 3.6% to 3.1% last March. However, the 3.1% growth benchmark disadvantages high quality, cost-efficient community providers because the benchmark is set as an absolute target. A 3.1% growth rate for a provider whose revenue is $7 billion results in a much larger dollar increase than a 3.1% growth rate for a provider whose revenue is $2 billion – this gap worsens each year and advantages high priced, highly profitable providers.

   In addition, the current structure of the 3.1% benchmark exacerbates reimbursement / price variation because the benchmark is not weighted by payer mix and revenue. Providers with high commercial payer mix and overall higher revenue fare better than providers with high government payer mix and lower revenue. 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. This continued reimbursement variation leaves community hospitals – mostly disproportionate share hospitals – with lower levels of reimbursements and revenues as compared to their Boston-based competitors, while also leaving them struggling to retain commercially insured patients. Commercially insured patients help disproportionate share providers compensate for the chronically low reimbursement received for patients covered under government programs like MassHealth.

2. ***Increased provider consolidation drives referrals away from high-value, community hospitals toward large academic medical centers and their affiliates.***

   Although often presented as an opportunity to aggregate strategies and resources in order to offer higher quality healthcare at a lower cost, research shows that provider consolidation often reduces competition among providers, draws volume away from cost-efficient community providers, and leads to an increase in total health care costs. A February 2018 study found that less competitive health-care markets correlate to both higher costs and higher insurance premiums for patients.[1] Another study finds extensive evidence that these

[1] https://www.ajmc.com/journals/issue/2018/2018-vol24-n2/aca-marketplace-premiums-and-competition-among-hospitals-and-physician-practices

price increases for hospitals, insurers, and physicians are not substantially offset in gains from improved quality or enhanced efficiency.[2] In particular, we are concerned that provider consolidation in Massachusetts will result in increased market power and leverage to draw volume away from community hospitals. In addition to pulling volume from cost-efficient community providers, large mergers give newly formed systems the leverage to demand higher prices from insurers, exclude certain hospitals from payer networks, and hurt the state's health care cost containment efforts.

3. ***If passed into law, the increased costs associated with the mandated nurse-staffing ratio (MNSR) would threaten the viability of community hospitals.***

   Community hospitals are crucial components to the health care delivery system in Massachusetts, providing essential services to patients in their communities. However, community hospitals are currently struggling to achieve financial and operational security due to changes in payer mix, low volume due to patient preference and changing demographics. If passed into law, the MNSR would further threaten the viability of Massachusetts' community hospitals. By requiring every hospital in the state – regardless of size, location, or patient need – to adopt rigid Registered Nurse-to-patient staffing ratios, several community hospitals would be at risk of closure. Furthermore, approval of this initiative could cost the Massachusetts health care system roughly $1.31 billion in the first year and $900 million annually thereafter due to nurse salaries, wage inflation, and technology, wiping out the gains achieved through the cost containment benchmark.[3] These costs would be passed along to consumers through higher insurance premiums, copays, deductibles and taxes.

b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?

1. ***Require commercial health plans and MCOs to "index" the health care cost growth benchmark.***

   The HPC, in conjunction with the Division of Insurance (DOI), MassHealth, and the Group Insurance Commission (GIC), should require commercial payers, as well as Medicaid Managed Care Organizations (MCOs) and GIC contracted payers, to index the 3.1% benchmark to the carrier specific median so that during rate negotiations, providers who are at or below the benchmark are not disadvantaged or penalized versus providers who have high revenue, high commercial payer mix, and are above the cost containment growth benchmark.

   Because the benchmark is set at an absolute level, larger, high-priced, highly profitable providers are allowed to grow at much larger rate than smaller providers, further perpetuating reimbursement disparities. 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.

2. ***Utilize an all-payer weighted average payer rate (WAPR) as a tool to measure and control health care.***

---

[2] https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html
[3] https://www.bwresearch.com/reports/bwresearch_mha-nlr-report_2018Apr.pdf

Today, CHIA and the HPC review a provider or a hospital's commercial prices or TME, without regard to the total revenue or reimbursement activity, including Medicare or Medicaid. We suggest utilizing an all-payer WAPR to better understand the impact that specific hospitals have toward cost growth. By weighting the average payment to a hospital for each payer by the corresponding volume a hospital experiences by payer and severity, the WAPR considers a hospital's overall payer mix and total reimbursements by payer. This analysis leads to a better understanding of a provider's value proposition and 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 to providing more context on the drivers of statewide spending growth, the WAPR could be used to help achieve the state's cost containment goals:

- *CHIA could report the WAPR for each hospital/provider as part of their public reporting requirements.*
- *The HPC could use the WAPR as an alternative way to address growth in hospital spending.*
- *Growth in spending could be tiered such that providers who are below the WAPR median would be allowed to grow at a faster rate than providers who are above the WAPR median.*

3. Improve efforts to publicly scrutinize large provider mergers.

Since its inception in 2012, the HPC has analyzed critical healthcare policy issues in the state, including the issue of provider consolidation. Currently, the HPC's efforts to obtain stakeholder comments end with the preliminary Cost and Market Impact Review (CMIR). Stakeholders, such as community organizations, other provider organizations, and health insurers, should be afforded a formal opportunity to react to the preliminary findings in the CMIR before the HPC issues the final report.

The HPC should amend their CMIR process to include more formal public discussion about the cost and market impact of large provider mergers, including a formal public comment period after the release of the preliminary CMIR and before the release of the final CMIR.

4. Conduct an impartial analysis on the impact of the mandated nurse staffing ratio.

One of the HPC's most important responsibilities, as outlined in Chapter 224, is to address substantive health policy issues in the state connected to healthcare spending, including reports on provider price variation, out-of-network pricing, and pharmaceutical spending. The mandated nurse staffing ratio ballot initiative is a pressing issue that will have a substantive impact on health care spending in the state. The HPC, in its role as an independent agency, should study the impacts of the ballot initiative on care quality, nurse burnout and depression, hospital operating expenses, insurance premiums, and total health care spending.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

1. ***Shift care from high-cost settings (e.g., academic medical centers) to lower-cost settings (e.g., community hospitals).***

For 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. In recent years, this migration has been exacerbated by the increased rate of hospital consolidation by some of the state's largest providers.

Steward has always aggressively focused on delivering the highest quality care in the most cost efficient manner. 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. As part of this commitment, Steward continues to fine tune its model to drive this shift through highly coordinated population health strategies, as well as provider network development initiatives that encourage patients to seek primary care and urgent care services as a means to managing their care in the most appropriate community-based setting. For example, Steward has partnered with other community organizations to create an integrated network of urgent care providers in Massachusetts.

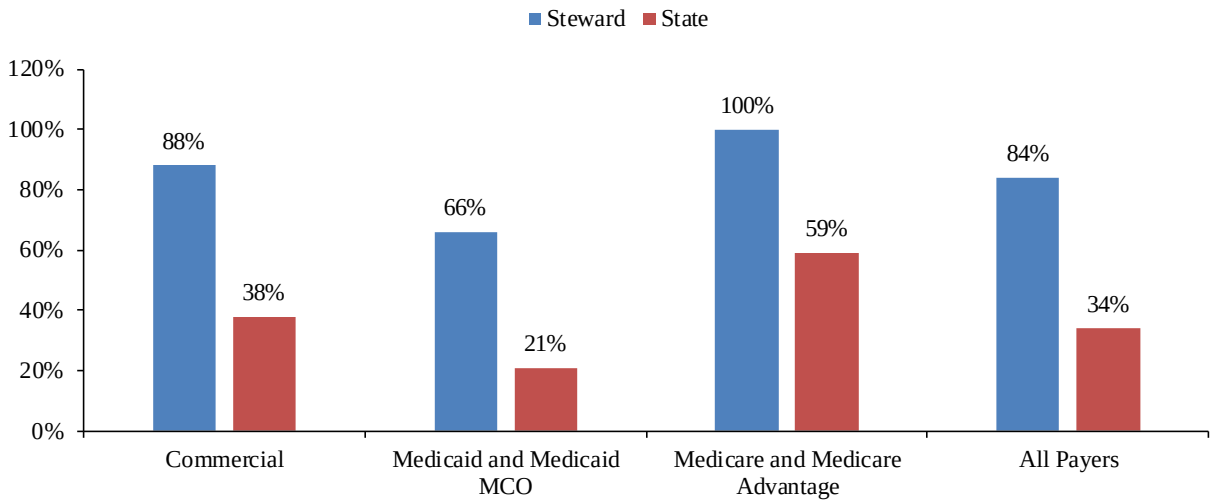
2. ***Continue aggressively pursuing the utilization of alternative payment models.***

Steward continues to adopt value-based, alternative payment models to leverage their population health platforms and patient engagement tools to drive the use of community-appropriate care. Being selected to participate in the Medicaid ACO program has further enabled Steward to right site patient care through the alignment of financial and clinical incentives for both participating providers and MassHealth members.

Steward's adoption of alternative payment methods continues to exceed the state average on every major line of coverage as evidenced below. By continuing to push for contracts with downside risk and relying on provider performance to earn prospective population-based payments, Steward is able to reduce costs, maximize care coordination, and improve quality outcomes. For example, in the first year of the Medicare Next Generation ACO Program, Steward was successful in reducing readmissions among Medicare beneficiaries as well as increasing annual wellness visits among beneficiaries by 13.9%.[4]

[4] https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf

Portion of Member Months in Alternative Payment Models (APM) by Payer Type
2017



3. Publically advocate for policy interventions that reduce provider price variation.

A key tenet of Steward's stated strategy is to offer "a high-quality, lower-cost, community-based health care system that can serve as a viable alternative to more expensive models of care, such as those often centered at urban academic medical centers". To this end, Steward has continually advocated for policy interventions that end or mitigate provider price variation. Such variation must be addressed as the Commonwealth shifts from a fee-for-service model to one that emphasizes population health and prioritizes equal access for all. Without addressing provider price variation, value-based models of care will continue to perpetuate historical inequities in provider payments, negatively impacting community hospitals and the patients for whom they care. To address provider price variation, Steward has publicly advocated for and supported the following proposals:

1. Promoting the adoption and use of narrow networks;
2. Reporting by CHIA on health care prices for the top 50 most utilized procedures and services;
3. Instituting provider tiering for the Group Insurance Commission;
4. Indexing the state's cost containment benchmark to the median price; and
5. Using an all-payer Weighted Average Payer Rate (WAPR) as a metric to examine the impact that providers have on the health care cost growth benchmark.

2) INFORMATION ABOUT ALTERNATIVE CARE SITES

The HPC recently released a new policy brief examining the significant growth in hospital and non-hospital based urgent care centers as well as retail clinic sites in Massachusetts from 2010 to 2018. Such alternative, convenient points of access to health care have the potential to reduce avoidable and costlier emergency department (ED) visits.

Question Instructions: *If your organization does not own or operate any alternative care sites such as urgent care centers, please only answer questions (e) and (f) below. For purposes of this question, an urgent care center serves all adult patients (i.e., not just patients with a pre-existing clinical relationship with the center or its providers) on a walk-in (non-appointment) basis and has hours of service beyond*

normal weekday business hours. Information requested in question (a) below may be provided in the form of a link to an online directory or as an appended directory.

a) Using the most recent information, please list the names and locations of any alternative care sites your organization owns or operates in Massachusetts. Indicate whether the site is corporately owned and operated, owned and operating through a joint venture, or a non-owned affiliate clinical affiliate.

Facility Name	**Address**	**Ownership/Affiliation Status**
Compass Medical Urgent Care Center – East Bridgewater	1 Compass Way, East Bridgewater, MA 02333	Non-owned affiliate clinical affiliate
Compass Medical Urgent Care Center – Easton	21 Bristol Drive, Easton, MA 02375	Non-owned affiliate clinical affiliate
Compass Medical Urgent Care Center – Middleborough	8 Commerce Blvd, Middleborough, MA 02346	Non-owned affiliate clinical affiliate
Compass Medical Urgent Care Center – Quincy	54 Miller Street, Quincy, MA 02169	Non-owned affiliate clinical affiliate
Hawthorn Medical Urgent Care Center	531 Faunce Corner Road, Dartmouth, MA 02747	Non-owned affiliate clinical affiliate

In addition to these non-owned clinical affiliates, Steward partners with a number of community organizations, including American Family Care (formerly Doctors Express), to provide urgent care to our patients.

b) Please provide the following aggregate information for calendar year 2017 about the alternative care sites your organization owns or operates in Massachusetts, including those operated through a joint venture with another organization (information from non-owned affiliates should not be included):

Steward does not own any of the above urgent care centers.

Number of unique patient visits	
Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	
Percentage of patient visits where the patient is referred to a more intensive setting of care	

c) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the clinical staffing model, including the type of clinicians (e.g., physicians, nurse practitioners, physician assistants, paramedics, nurses). If different models are used, describe the predominant model.

Hawthorn Medical Urgent Care Center in Dartmouth utilizes a staffing model that includes 5 MDs and 2 mid-level providers. The Compass Medical Urgent Care sites utilize staffing models that include both MDs as well as Advanced Practice Providers.

d) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the method and timeliness of how the medical record of a patient's visit to an alternative care site is shared with that patient's primary care provider (e.g., interoperable electronic health record, secure email transfer, fax). What barriers has your organization faced in sharing real-time information about patient visits to your alternative care sites with primary care providers or other health care providers?

Hawthorn Medical Urgent Care Center in Dartmouth coordinates care with Hawthorn Primary Care Practice through their EMR system. This allows clinicians at each site to track data over time, easily identify which patients are due for screenings, and monitor and improve overall quality of care. Although the Compass sites operate a separate EMR system than Steward Medical Group, each Compass urgent care site and Compass Primary Care site coordinate using the same EMR system.

e) Besides establishing alternative care sites, what other strategies is your organization pursuing to expand timely access to care with the goal of reducing unnecessary hospital utilization (e.g., after-hours primary care, on-demand telemedicine/virtual visits).

Steward has effectively expanded timely access to care through the utilization of telehealth monitoring. Through our Telehealth Monitoring program, Steward provides daily home monitoring services for patients diagnosed with medical conditions, such as congestive heart failure and chronic obstructive pulmonary disease. The home monitoring system enables health care providers to monitor patients with the goal of increasing patient awareness and self-care while reducing unnecessary doctor's visits, emergency room visits, and hospitalizations. In addition, Steward pursues continuous quality initiatives and has the ability to directly book patients into practice schedules, both of which expand access to care.

Steward Healthcare Network is also working to expand timely access to care and reduce unnecessary hospital utilization by working with various community partners in our most disadvantaged communities to address social determinants of need for our most complex patients. In fact, in July, Steward was awarded $500,000 as a part of the HPC's SHIFT-Care Challenge Initiative grant in order to strengthen these community partnerships to more effectively address avoidable hospital admissions, readmissions, and emergency department utilization.

f) Please comment on the growth of alternative care sites in Massachusetts, including implications for your organization as well as impacts on health care costs, quality, and access in Massachusetts.

While alternative care sites have the potential to increase access to care and reduce avoidable ED visits, the state needs to holistically examine all outpatient growth (hospital or non-hospital, urgent care centers, other clinics) in order to carefully analyze shifts in volume and their impact on the quality and cost of care, including the health care cost growth benchmark.

3) STRATEGIES TO SUPPORT PROVIDERS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS

Earlier this year, the HPC held a special event entitled, *Partnering to Address Social Determinants of Health: What Works*?, where many policymakers, experts, and market participants all highlighted the need for health care systems to partner with community-based organizations to address patients' and

families' health-related social needs (e.g., housing stability, nutrition, transportation) in order to improve health outcomes and slow the growth in health care costs.

a) What are the primary barriers your organization faces in creating partnerships with community-based organizations and public health agencies in the community/communities in which you provide care? [check all that apply]

- ☐ Legal barriers related to data-sharing
- ☒ Structural/technological barriers to data-sharing
- ☒ Lack of resources or capacity of your organization or community organizations
- ☐ Organizational/cultural barriers
- ☐ Other: Click here to enter text.

b) What policies and resources, including technical assistance or investments, would your organization recommend to the state to address these challenges?

1. **Develop reliable standards with which hospitals can measure SDOH factors, as well as a medical data system to capture and report on SDOH data.**

   Before providers can effectively address SDOH, regulators and the industry must work together to establish appropriate metrics to measure determinants and create benchmarks of success. With such metrics in place, providers are better equipped to collect patient-specific SDOH data, such as socioeconomic status, employment, and housing. Knowing this type of information would allow providers to take a more holistic approach to treatment provision.

2. **Work with payers to create a program which offer incentives to providers to address SDOH**.

   Existing reimbursement methods do not address SDOH and consequently do not offer any type of incentive to providers who work to address patient's social and economic needs. Although addressing such determinants would reduce avoidable readmissions and significantly move the needle in containing health care costs, without financial incentive, health care providers in the most distressed communities (with the greatest need to address SDOH), do not possess adequate resources to address issues such as transportation and food insecurity.

AGO Pre-Filed Testimony Questions

1. For provider organizations: please submit a summary table showing for each year 2014 to 2017 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 price information on admissions, procedures, and services available to patients and prospective patients upon request.

   a) Please use the following table to provide available information on the number of individuals that seek this information.

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**		
	Q2		
	Q3		
	Q4		
CY2017	**Q1**		
	Q2		
	Q3		
	Q4		
CY2018	**Q1**		
	Q2		

	TOTAL:		

Based on interviews with our Patient Access Directors, we estimate an average of 3 requests weekly per facility, resulting in approximately 288 requests per quarter.

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 analysis.

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 services they desire and work with the vendor to resolve any problems that may arise.

3. For hospitals and provider organizations corporately affiliated with hospitals:
   a) For each year 2015 to present, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

   Steward is unable to provide data for this request in a standardized format that will accurately capture the information.

   b) For 2017 only, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

   Steward is unable to provide data for this request in a standardized format that will accurately capture the information.