

2017 Pre-Filed Testimony Providers



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 2, 2017, 9:00 AM
Tuesday, October 3, 2017, 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 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, 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 6, 2017, 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 Andrew Carleen at (617) 757-1621 or by email Andrew.Carleen@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

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

Exhibits B and C: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, 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, 2015, and/or 2016 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 inquiries related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030.

Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony 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.

If a question is not applicable to your organization, please indicate so in your response.

1. Strategies to Address Health Care Spending 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. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC [presented](#) at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between \$279 to \$794 million annually.

1. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
 - i. **Priority 1:** Shift care from high-cost settings (e.g., academic medical centers) to lower-cost settings (e.g., community hospitals)
 - ii. **Priority 2:** Reduce provider price variation
 - iii. If you selected "other," please specify: [Click here to enter text.](#)
2. Please complete the following questions for **Priority 1** (listed above).
 - i. What is your organization doing to advance this priority and how have you been successful?

Shift Care from High-Cost Settings (e.g., Academic Medical Centers) to Lower Cost Settings (e.g., Community Hospitals):

Steward's model of care continues to focus on achieving the highest quality care in the most cost-efficient manner and setting, this effort includes transitioning care to lower-cost community-based settings as clinically appropriate. 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 more than doubled its urgent care capacity, as well as increased the number of primary care providers participating in our model in order to maximize the use of primary and preventive care. Moreover, Steward continues to adopt value-based, alternative payment models to leverage our population health platforms and patient engagement tools to drive the use of community-appropriate care. In addition, the Medicaid ACO program will enable Steward to right-site patient care through the alignment of financial and clinical incentives for both participating providers and MassHealth members.

We have achieved tremendous success as demonstrated by our performance on quality metrics and lowering costs. For example, in the Medicare Pioneer ACO program we generated \$20M in savings at the end of 2013 and in the Medicare Bundled Payment Care Improvement initiative we reduced per beneficiary spending by 3%. In the commercial insurance space, we also achieved similar successes and maintained total medical expense (TME) and price at or below the state median. These outcomes have been accompanied by high scores in our patient care quality metrics.

- ii. What barriers does your organization face in advancing this priority?

Impact of Care Migration to Boston on Provider Price Variation:

Two thirds of all Massachusetts residents live in Eastern Massachusetts and approximately 60% of those residents continue to seek routine care at high-cost, academic medical centers in Boston, which increases costs for employers and the system. Each hospital stay that takes place at a Boston teaching hospital adds an average additional cost of \$3,400 per patient, without necessarily yielding an improvement in quality. Highly profitable, high-cost, non-profit Boston hospitals continue to draw higher numbers of commercially insured patients away from lower priced, high quality community-based hospitals for routine services, resulting in higher premiums and costs for everyone. This is an ongoing challenge that merits policy and regulatory action.

Over the past several years, Steward has publicly expressed concern regarding the impact of patient migration to Boston for routine services. 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 high-cost, Boston-based providers. While Steward can continue to improve its care management processes and tools, we alone cannot impact the shift of patient care from community-based settings to high-cost Boston-based settings. Specifically, systemic barriers to our work in this arena include:

- 1. Statewide cost containment goals – like the state's cost growth benchmark – do not address the effect of "patient migration" to Boston and in fact, advantage high-cost, highly profitable providers.*

In particular, the state's cost growth benchmark is set at an absolute level meaning every provider – regardless of market share – grows at the same percentage rate, regardless of their total revenue. Furthermore, under the current cost growth benchmark, payers extract reimbursement rate reductions from cost efficient providers with lower revenue and high government payer mix, yet negotiate higher rates with providers that have higher prices and higher commercial revenue.

- 2. Existing health insurance products do not adequately incentivize patients to utilize high-quality, cost efficient community based providers. While some progress has been made in this area, most insurance products do not include an adequate differential in premium cost to incentivize patients to use care where they live instead of going to a Boston-based provider for routine services.*
- 3. Arbitrary health insurance policies can shift care away from community based providers without first determining the most appropriate, cost-efficient setting for that care from a total population health perspective. For example, some commercial health insurance plans have implemented policies whereby services that are provided at a hospital are denied if there is a free-standing facility in the area that can perform those services. In particular, Anthem has announced that it will no longer pay for hospital outpatient-based MRI and CT scans in select markets and states. We are concerned that these type of siloed, arbitrary policies are being applied broadly without a comprehensive assessment of whether the outpatient settings are actually the most cost-efficient setting for the care from a population health perspective, especially when such patients are managed by a provider under a risk-based payment contract which holds the provider accountable for the total cost of care of the patient.*

- iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?*

We recommend the following changes to shift care from high-cost settings (e.g., academic medical centers) to lower-cost settings (e.g., community hospitals):

- 1. Statewide cost containment goals do not address the effect of "patient migration" to Boston:*

State agencies, including CHIA, should conduct an in-depth analysis of patient migration to Boston, using existing data sources such as the Registered Provider Organization physician roster data, to better understand physician referral practices to high cost facilities and their financial impact on health care costs and premiums as well as how such referrals affect community based providers' ability to deliver care.

2. *Existing health insurance products do not adequately incentivize patients to utilize care resources in the community:*

Current efforts to encourage consumers to choose high value (high quality, cost-efficient) providers through products like tiered, or limited network plans are not accompanied by meaningful financial incentives for consumers to make the shift to high-value providers. We recommend requiring carriers to offer narrow network health insurance products with premiums that are at least 30% lower than existing HMO premiums. This cost differential provides consumers with the appropriate financial motivation to choose products that promote the use of high value providers, as well as an immediate financial incentive (premium savings) to modify their perception of quality among providers. Narrow network products that are priced significantly lower in premium than HMO or PPO products have proven to drive lower costs for individuals and families with no discernible impact on quality or access.

3. *Arbitrary health insurance policies can shift care without first determining the most appropriate, cost-efficient setting for a patient's care:*

We recommend that state agencies, including CHIA the HPC and the DoI, carefully examine the impact of siloed, arbitrary insurance policies on the shift of care from inpatient to outpatient settings and the resulting impact on health care costs for the Commonwealth's premium payers, including the impact of shifting imaging services out of hospital outpatient-based settings to free-standing facilities. While it is commonly believed that a general shift from inpatient to outpatient settings will reduce the overall cost of care, this is not true in all circumstances, especially when providers are at full clinical and financial risk for a patient's care. Our preliminary assessment of available data in Massachusetts indicates that there is wide variation for the cost of a MRI or CT scan between a free-standing facility and a hospital. In fact, in some instances, the hospital outpatient-based setting is the less expensive setting for the service.

4. *Improve Reimbursements for Behavioral Health and Integrate Physical and Behavioral Health Across Care Settings*

In addition to the strategies we discuss above, the State must also consider changes in policy and reimbursement to address the challenges in treating patients with behavioral health or substance use issues, especially as providers attempt to shift behavioral health care to community-appropriate care settings.

While the federal Mental Health Parity and Addiction Equity Act (MHPAEA) prevents group health plans and health insurance plans that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits, the legislation did not address parity in reimbursement.

Chronically low levels of reimbursement by Medicaid and its contractors lead to a lack of service availability for this vulnerable population and worse, result in significant gaps in care and inappropriate use of certain services such as emergency department use. The chronically low levels of reimbursement for these services result in a model that fails patients needing intensive services or patients who are unable to receive care in primary, intermediate, or outpatient settings in their community.

We strongly recommend that all payers implement a reimbursement parity strategy for behavioral health and substance use services. We also urge the State to consider proposals that address the lack of infrastructure, resources and coordination of care across inpatient and outpatient settings for behavioral health services. A lack of infrastructure for intermediate and outpatient settings, as well as the lack of connectivity between and among those settings result in decreased resources to patients to help them better manage their medical conditions or physical needs.

For example, as part of a population health plan, the state can develop a program that that financially incentivizes primary care providers to collaborate with community-based organizations to develop placement strategies that encourage appropriate use of outpatient resources instead of inpatient based care. Such partnerships promote the appropriate use of outpatient settings and can also lead to investments in connectivity between inpatient and outpatient providers as they seek to better integrate patient care strategies across both physical and mental/behavioral health.

3. Please complete the following questions for **Priority 2** (listed above).

- i. What is your organization doing to advance this priority and how have you been successful?

Mitigate Provider Price Variation:

Steward has advocated for policy interventions that end or mitigate provider price variation for quite some time. 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. Governor Baker's proposal to establish tiered provider rate caps;*
- 2. Reporting by CHIA on health care prices for the top 50 most utilized procedures and services;*
- 3. Indexing the state's cost containment benchmark to a provider Weighted Average Payer Rate (WAPR) median; and,*
- 4. Use of 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. By weighting the average payment to a hospital or physician group for all payers (commercial, Medicare and Medicaid) by the corresponding volume a hospital or physician group experiences by payer and severity, the WAPR takes into account a provider's overall payer mix and total reimbursements by payer. This measure will demonstrate the health care cost impact that a provider has on Massachusetts health care spending, including premium growth, because it captures their total reimbursements, not just commercial reimbursements.*

We believe that these proposals will empower individuals and employers – as well as regulators – to understand the effects of both price and market share on their premiums and rising health care costs. 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 community-based 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.

ii. What barriers is your organization facing in advancing this priority?

As we noted in our cost growth benchmark testimony earlier this year, we remain 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 barriers that consumers, employers and stakeholders face in advancing this priority:

1. *Commercial 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, 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-priced, 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. This problem impedes 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. *Provider price variation and an uneven playing field among providers*

For over six years it has been well documented 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.

3. *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.

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. The underpayment particularly impacts community hospitals who care for behavioral health patients and who, as a result of unwarranted price variation, have lower levels of revenue and volume in comparison to their competitors.

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.

- iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

We recommend the following changes in order to mitigate the negative effects of provider price variation:

1. *Require the Health Policy Commission (HPC) to index the cost growth benchmark to an "all-payer" Weighted Average Payer Rate (WAPR) median in order to narrow reimbursement disparities among providers.*

As currently constructed, the cost growth benchmark advantages high-priced, highly profitable providers whose prices continue to increase, imposing higher costs on employers and individuals. The state's cost growth benchmark is set at an absolute level meaning every provider – regardless of size and market share – grows at the same percentage rate, regardless of their total revenue. Consider the following example comparing provider A with \$1B in revenues and provider B with \$8B in revenues.

If the total revenues for provider A are \$1B and its rate increase (4%) is twice provider B's, provider A's increase in revenue is \$40M. If provider B's total revenues are \$8B and provider B's annual rate increase is 2%, then provider B's revenue increase is \$160M; much larger than provider A's increase. If both providers are capped at 3.1%, provider A's "capped" growth is \$31M, but provider B's growth is "capped" at \$248M, resulting in a much larger revenue opportunity than provider A's. Provider B therefore has a lot more resources to expend and therefore more of an impact on health care cost growth than provider A.

Under the current cost growth benchmark, this disparity among providers widens each year and advantages high-priced, highly-profitable providers, especially those with larger market share.

Requiring the HPC to index the cost growth benchmark to an all-payer, weighted average payer rate median will help to begin to mitigate reimbursement disparities among providers and enable the HPC to review providers whose cost growth and market share are driving higher costs and impeding the state's ability to lower the rate of growth in health care costs. In addition, providers and payers who exceed the cost growth benchmark should be required to submit a remediation plan within 90 days to both the HPC and the Attorney General's Office.

2. *Require the Center for Health Information and Analysis (CHIA) to annually report an "all-payer" Weighted Average Payer Rate for the top 50 most utilized services.*

Steward strongly supports CHIA's efforts to create a consumer-friendly site where consumers and employers can access provider price information for the most common procedures in health care. As such, Steward urges CHIA to publish health care prices by provider, for use by both

consumers and employers. We recommend the use of an all-payer WAPR in CHIA's reporting of health care prices for the top 50 most utilized procedures and services. This measure will demonstrate the health care cost impact that a provider has on Massachusetts health care spending, including premium growth, because it captures their total reimbursements, not just commercial reimbursements.

In addition, an all-payer WAPR should be included as an explicit review factor in the referral process for a Performance Improvement Plan and the HPC should be required to examine the WAPR for all providers as part of its annual Cost Trends Hearing.

3. Require the Division of Insurance (DOI) and the Group Insurance Commission (GIC) to tier provider growth by a provider's "all-payer" WAPR.

Similar to Governor Baker's original proposal for tiered provider growth caps, we suggest that the State consider implementing tiered provider growth caps based on a provider's WAPR for both the commercial market and the GIC in order to contain health care costs while simultaneously incentivizing the adoption of value-based care models, such as ACOs.

The following suggested tiers are based on a comparison between a provider's all-payer WAPR to the WAPR median:

Tier 1	Providers who are at or below 0.99 of the all-payer WAPR median	No growth limit
Tier 2	Providers who are at or between 1.00 and 1.14 of the all-payer WAPR median	Growth limited to 1%
Tier 3	Providers who are at or above 1.15 of the all-payer WAPR median	No growth allowed

In addition, providers and ACOs that take on clinical and financial risk – especially those who participate in a MassHealth ACO program – should be allowed to grow an additional 1% in order to incentivize providers to move toward high value-based care models that assume clinical and financial risk for the patient care they provide. This tiered cap proposal could sunset after 3 years in order to evaluate its effectiveness and its impact on reducing health care costs.

2. STRATEGIES TO REDIRECT CARE TO COMMUNITY SETTINGS

The HPC has identified significant opportunities for savings if more patients were treated in the community for community-appropriate conditions, rather than higher-priced academic medical centers.

- a. What are the top barriers that you face in directing your patients to efficient settings for community-appropriate care rather than to more-expensive settings, such as academic medical centers? (select all that apply)
 - ☒ Patient perception of quality
 - ☐ Physician perception of quality
 - ☐ Patient preference
 - ☐ Physician preference
 - ☒ Insufficient cost-sharing incentives
 - ☐ Limitations of EMR system
 - ☒ Geographic proximity of more-expensive setting
 - ☐ Capacity constraints of efficient setting(s)
 - ☐ Referral policies or other policies to limit "leakage" of risk patients
 - ☐ Other (please specify): [Click here to enter text.](#)
- b. How has your organization addressed these barriers during the last year?

Steward has and will continue to work on addressing these barriers by advancing our model of care. However, shifting care to community-appropriate settings can only be accomplished through a coordinated strategy across all sectors and stakeholders of the health care system where the reimbursement and clinical incentives are aligned across all payers to achieve this outcome.

1. Patient Perception of Quality

Steward continues to select, track and improve upon quality performance targets across our entire organization as part of our mission to deliver high value (high quality, cost efficient) care. However, patient perception that high cost care equals better care is still pervasive and presents a significant barrier to our ability to drive patients to community-appropriate care. While the state collects and publishes a variety of quality metrics, it is unclear whether this information reaches the average health care consumer in a way that is easily understood and that can be used by consumers to make informed health care decisions that counter this perception. We support the work that CHIA is undertaking to develop a consumer transparency website and suggest that CHIA continue to solicit stakeholder feedback, especially from potential users (e.g. small business employees, individual health insurance purchasers) and that the state consider developing a broad education or stakeholder outreach initiative to inform patients on this consumer transparency effort.

2. Insufficient Cost-Sharing Incentives

As we discuss above, existing efforts to encourage consumers to choose high value (lower cost, high quality) providers through products like tiered, or limited network plans are not accompanied by meaningful financial incentives for consumers to make the shift to high-value providers. While cost-sharing incentives to use high value providers are a useful tool in driving care to the appropriate community settings, it is equally important to ensure that there is a sufficient premium differential between narrow network products and other HMO/PPO products. In Steward's experience, health insurance products and plan design options need to offer premiums that are at least 30% below existing HMO products in order to meaningfully incentivize consumers to frequent high value providers. While we have partnered with health insurance plans in the past to develop narrow network products with a significant premium differential, the success of these products was hampered by the incentive structure of health insurance brokers and agents. The state, in addition to requiring carriers to offer narrow network products with significant premium differentials, should develop policies that financially incentivize health insurance brokers, agents, and health plan distribution channels to sell insurance plans that promote and offer products with substantially lower premiums.

3. Geographic Proximity of More-Expensive Settings

Steward has several initiatives and processes in place to help retain care within our network. We support both our patients and our providers in disseminating information about in-network versus out-of-network services in order to help patients make decisions on their care. However, patient migration to more expensive settings that are close in proximity to community hospitals must be examined on a comprehensive basis and cannot be fully addressed by any one provider organization. The state should more carefully examine care migration patterns in order to understand factors that are driving patients to Boston-based providers instead of community-based settings. Based on the results of this examination, the state can implement policies both on the demand and supply side of health care to address care migration. These policies can include incentivizing commercially insured consumers to use more cost-efficient settings through the promotion of narrow network products with significant premium differentials, indexing the state's cost growth benchmark such that high priced providers are no longer unfairly advantaged, and increasing transparency on the cost of services by facility or physician group.

3. INFORMATION ON PHYSICIAN COMPENSATION MODELS

Please answer the following questions regarding the current compensation models for your *employed* physicians. Indicate N/A if your organization does not employ physicians. ☐ N/A

- a. For **primary care physicians**, list the approximate percentage of total compensation that is based on the following:

	%
Productivity (e.g., RVUs)	
Salary	
Panel size	
Performance metrics (e.g., quality, efficiency)	
Administrative/citizenship	
Other	

- b. For **specialty care physicians**, list the approximate percentage of total compensation that is based on the following:

	%
Productivity (e.g., RVUs)	
Salary	
Panel size	
Performance metrics (e.g., quality, efficiency)	
Administrative/citizenship	
Other	

- c. Describe any plans to change your organization's compensation models for primary care and/or specialty care physicians that you employ.

Steward's employed physicians are part of Steward Medical Group (SMG), a multispecialty practice with over 140 locations in Massachusetts. The SMG compensation models are founded on Steward's commitment to our Community Care model and leading position in promoting the tenets of value-based care. Our employed physicians are a key component of our accountable care organization, Steward Health Care Network (SHCN), and participate fully in the value-based contracts of the network across the full range of commercial and governmental products, including Medicare, Medicaid, and the Commonwealth Connector.

Primary Care Compensation Model

SMG maintains a primary care compensation model that incorporates elements of quality, management of total medical expense, productivity (as measured in wRVUs), panel size, citizenship, and tenure. This model is recalculated annually and providers are regularly given information that informs their ongoing performance, both to promote transparency and to serve as a foundation for continuous improvement. Our medical group operations are centered on creating processes that promote quality, patient experience, and appropriate utilization, through engagement of the practice staff, automation, analytics, and patient outreach. Overall quality and value-based contract performance account for approximately 25% of PCP compensation.

Specialty Compensation Models

SMG maintains a variety of specialty compensation models, as these models depend on specialty, practice type, and setting. Like our PCPs, all of our specialists are members of our accountable care organization, and all participate in a full array of value-based commercial and governmental contracts through the network. Distributions from the network incorporate various elements, with a focus on the management of total medical expense and care coordination. In addition, select specialists participate in management of episodic bundles and receive compensation through successful performance in these bundles. Typical specialist compensation includes a base salary and an incentive compensation model that incorporates productivity. Individuals with departmental or service line leadership responsibilities will often have elements of compensation that depend on group-level measures of inpatient and outpatient quality, efficiency, and patient experience.

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 Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030. If a question is not applicable to your organization, please indicate so in your response.

1. Please submit a summary table showing for each year 2013 to 2016 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. **Required Question.**

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. When primary care providers within your organization (including, e.g., newly-acquired practices) change their preferred referral partners, are patients notified of such changes? If so, what information is shared with patients, and when?

Communications to patients regarding primary care providers' preferred referral partners, if any, takes place in the practice setting by their providers, as Steward believes that the medical decision making process rests between the provider and the patient. In addition, we are in compliance with the Division of Insurance's RBPO regulation requiring practices that are part of risk-bearing provider organizations to post a notice to patients regarding referral requests and complaint/appeal rights.

3. Do you participate in any provider-to-provider "discount arrangements" (e.g., a form of preferred provider relationship that includes a discount or rebate from one provider to another in connection with health care services furnished under the agreement)? **Required Question.**

☒ Yes ☐ No

If so, do you notify patients' insurers of such arrangements?

☒ Yes ☐ No

Steward uses provider-to-provider "discount arrangements" as part of its Medicare Next Generation ACO model. Steward has partnered with skilled nursing facilities (SNFs) across its service area to create the Steward Preferred SNF Network in order to reduce unnecessary spending and improve quality for Medicare ACO patients.

Under this model, SNFs are eligible to receive an incremental bonus on the Medicare Fee-for-Service claims submitted by the SNF for ACO aligned beneficiaries if performance improves, or similarly, forgo the same amount of their reimbursed Medicare fees for aligned beneficiaries if performance is not optimal. As this is a Next Generation ACO model program, Steward submits a Fee Reduction Agreement to the Center of Medicare &

Medicaid Innovation (CMMI) that outlines the percent of fees for ACO beneficiaries which are considered at-risk as part of this program.

Because this program was operational in 2017, no final results are available at this time, but real-time data for 2017 are trending positively: both average SNF length of stay and SNF discharges to acute facilities (a proxy for acute readmissions) for aligned beneficiaries have declined. Between January to August 2017, average length-of-stay has decreased by 1.3 days while SNF discharges to acute facilities have decreased by seven percentage points.

The Steward ACO works closely with members of the Preferred SNF Network to ensure effective transitions and coordination between settings of care with the goal of improving the overall quality of care delivered to ACO beneficiaries.