Reports on

Steward Health Care System

Pursuant to 2010 and 2011 Assessment & Monitoring Agreements

DECEMBER 30, 2015

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Naming Conventions, Abbreviations, and Acronyms

Steward Entities and Related Organizations

Caritas Christi Health Care	Caritas
Carney Hospital	Carney
Cerberus Capital Management	Cerberus
Good Samaritan Medical Center	Good Samaritan or Good Sam
Holy Family Hospital	Holy Family
Merrimack Valley Hospital	Merrimack Hospital or Merrimack
Morton Hospital	Morton
Nashoba Valley Medical Center	Nashoba
New England Sinai Hospital	New England Sinai or NE Sinai
Norwood Hospital	Norwood
Quincy Medical Center	Quincy Medical or Quincy
Roman Catholic Archdiocese of Boston	RCAB
Steward Health Care Network	SHCN
Steward Medical Group	SMG
Saint Anne's Hospital	St. Anne's
St. Elizabeth's Medical Center	St. Elizabeth's
Steward Health Care System	Steward

Massachusetts State Agencies

Center for Health Information and Analysis	CHIA
Department of Public Health	DPH
Division of Insurance	DOI
Health Policy Commission	HPC
Office of the Attorney General	AGO

Payers

Blue Shield and Blue Cross	BCBS
Fallon Community Health Plan	FCHP
Harvard Pilgrim Health Care	HPHC
Tufts Health Plan	THP

Other Terms and Acronyms

Accountable Care Organization	ACO
Asset Purchase Agreement	APA
Audited Consolidated Financial Statements	AFS
Employee Retirement Income Security Act	ERISA
Fiscal Year	FY
Full Time Equivalents	FTE
Gross Patient Service Revenue	GPSR
Health Maintenance Organization	HMO
Inpatient	IP
Limited Network Product	LNP
Managed Care Organization	MCO
Net Patient Service Revenue	NPSR
Outpatient	OP
Per Member Per Month	PMPM
Point of Service	POS
Primary Care Provider	PCP
Primary Service Area	PSA
Total Medical Expenses	TME
Year-End	YE

INTRODUCTION

Origins of the AGO's Monitoring Commitment

In May 2010, Caritas, a non-profit, charitable health care system, provided notice to the AGO under G.L. c. 180, § 8A(d)[1] of its intent to sell substantially all of its assets to Steward, a for-profit entity affiliated with private equity firm Cerberus.[2] At the time, Caritas was experiencing financial difficulties, including significantly underfunded pension plans, outstanding debt, outdated facilities, and need for capital.[3]

The AGO engaged in a comprehensive review of the proposed acquisition and issued a statement on October 6, 2010 (the "AGO Statement") finding that the transaction complied with the charities law and public interest requirements of G.L. c. 180, § 8A(d).[4] The AGO concluded that "[w]hile there are risks to the public inherent in any transfer of ownership of a hospital, under any tax or ownership structure, those risks are outweighed in this case by the known and quantifiable risks of not proceeding with the [t]ransaction."[5] The AGO also found certain provisions of the transaction supportive of the public interest, including Steward's commitment to assume Caritas' full pension liability, its commitment not to close or limit the purposes of the Caritas hospitals for a five year period, and its commitment to make necessary investments in the infrastructure of the system.[6]

At the time of the Caritas transaction, concerns were expressed that increased financial distress, or a potential Cerberus exit, would have a significant impact on the eastern Massachusetts market.[7] These scenarios would raise questions regarding clinical quality, patient safety, access for working class communities, employment considerations for thousands of health care employees, and possibly increased costs for the state. In addition, concern over the for-profit, investor-owned status of Steward as the acquirer and operator of Caritas' assets was a central thread of discussion at the time of the proposed transaction. As articulated in the AGO Statement on the Caritas transaction:[8]

1 *See* Off. of Att'y Gen., Hospital Conversions, *available at* http://www.mass.gov/ago/doing-business-in-massachusetts/public-charities-or-not-for-profits/findings-and-publications/findings-and-recommendations/hospital-conversions/. (Under G.L. c. 180, § 8A(d) transferring a Massachusetts non-profit acute care hospital to a for-profit entity is subject to review by the AGO).

2 Letter from Counsel for Caritas Christi to the Off. of the Att'y Gen., 9-11 (May 5, 2010) [hereinafter Letter from Caritas Counsel], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-l.pdf.

3 Off. of Att'y Gen., Statement of the Attorney General as to the Caritas Christi Transaction, 1 (Oct. 6, 2010) [hereinafter AGO Statement], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/statement-of-the-attorney-general-caritas-christi-transaction.pdf.

4 *Id.* at 14. In reaching this determination, the AGO found: (1) that Caritas was in a precarious and unstable financial situation and would likely be unable to meet its capital needs in light of its aging facilities, its underfunded pension liability, and it's debt obligations; (2) that it was impractical, if not impossible, for Caritas to continue to operate the system as a public charity; (3) that doing so would leave the pensions of some 13,000 current and former employees substantially underfunded, uninsured, and at risk; and (4) that at least one of the Caritas hospitals would likely have to close.

5 AGO Statement app., *supra* note 3, at 26.

6 Caritas Christi & Steward Health Care Sys. LLC, Asset Purchase Agreement (Mar. 19, 2010) [hereinafter Caritas APA], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-b.pdf; Quincy Med. Ctr. & Steward Health Care Sys. LLC, Asset Purchase Agreement (June 30, 2011) [hereinafter Quincy APA], *available a*t http://www.mass.gov/ago/docs/nonprofit/quincy/exhibit-a.pdf; Morton Hosp. & Steward Health Care Sys. LLC, Asset Purchase Agreement (Mar. 29, 2011) [hereinafter Morton APA], *available at* http://www.mass.gov/ago/docs/nonprofit/morton/complaint-exhibit-a.pdf.

7 *See* AGO Statement app., *supra* note 3, at A-1 – A-9.

8 *Id.* at A-2.

> Nevertheless, the size and complexity of this Transaction, the overnight presence of available capital and a clean balance sheet, the size of the system, the presence of disproportionate share hospitals in several of the Caritas markets, and the significant increase in the presence of the for-profit sector in our hospital marketplace, does merit close and on-going focus, attention, and monitoring.

In connection with the AGO's review, and in response to public concerns over the for-profit acquisition of Caritas' assets, the AGO and Steward executed an Assessment and Monitoring Agreement.[9] Under this agreement, for a five-year period following Steward's acquisition of Caritas' assets, the AGO would monitor (1) Steward's compliance with certain provisions of the Asset Purchase Agreement between Caritas and Steward relating to the public interest, and (2) the "impact of the Transaction on the provision of health care services to the Communities" served by Steward.[10] Similar public interest findings, commitments, and monitoring agreements were made with respect to the subsequent Morton and Quincy transactions.[11]

In committing to monitor Steward's impact, the AGO recognized that the Caritas acquisition represented a significant increase in for-profit health systems in Massachusetts, and that Steward's stated business strategy of developing a lower-cost option that keeps more care in the community would have broader implications for the health care market, including competitor providers, insurers, consumers, and other stakeholders. As explained in the October 2010 Statement of the Attorney General:[12]

> In the event that a community-hospital based health care system can provide effective care in a local setting without raising costs to the public, reducing services, or limiting access or choice, the public would be well served, and the Attorney General wants to document and understand the basis of that success. In the event the effort is not successful, the Attorney General wants to document and understand the basis of that failure . . . [T]he Attorney General strongly supports transparency, believes solutions must be system-wide, and views her role as working, with others, to better inform the executive branch, the legislature, policy makers and the public. The evaluations undertaken as part of the Assessment and Monitoring Agreement will further that objective.

Those reasons have continued to motivate the AGO's monitoring in the five years since the transaction. Notably, these monitoring commitments were made prior to the creation of the comprehensive health care monitoring system reflected in Ch. 224 of the Acts of 2012.

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9 Off. of the Att'y Gen., Caritas Christi & Steward Health Care Sys. LLC, Assessment & Monitoring Agreement, at ¶¶ 1-2 (Oct. 20, 2010) [hereinafter Caritas AMA], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-p.pdf.

10 *Id.* In September 2011, the AGO executed two substantively identical Assessment and Monitoring Agreements in connection with its review of Steward's proposed acquisition of Morton and Quincy, thereby bringing those transactions within the scope of its monitoring responsibilities. Off. of the Att'y Gen., Morton Hosp. and Med. Ctr. Inc. et al. & Steward Health Care Sys. LLC, Assessment & Monitoring Agreement, at ¶¶ 1-2 (Sept. 6, 2011) [hereinafter Morton AMA], *available at* http://www.mass.gov/ago/docs/nonprofit/morton/complaint-exhibit-l.pdf; Off. of the Att'y Gen., Quincy Med. Ctr. & Steward Health Care Sys. LLC, Assessment & Monitoring Agreement, Exhibit 5.2 at ¶¶ 1-2 (Sept. 7, 2011) [hereinafter Quincy AMA], *available at* http://www.mass.gov/ago/docs/nonprofit/quincy/quincy-ag-statement.pdf.

11 *See* Morton Hosp. and Med. Ctr. Transaction, Off. of the Att'y. Gen. [hereinafter Morton Hospital Transaction], *available at* www.mass.gov/ago/morton; Quincy Med. Ctr. Transaction, Off. of the Att'y. Gen. [hereinafter Quincy Medical Transaction], *available at* www.mass.gov/ago/quincy.

12 AGO Statement app., *supra* note 3, at A-9.

Overview of the AGO's Monitoring Commitment

Before turning to the details of the AGO's 2015 reports, it is worthwhile to consider five years of Steward ownership through the lens of the concerns raised by the public and regulators at the time of the 2010 Caritas transaction. As reflected in the AGO statement and the public comments that preceded it, the principal concerns raised with respect to the Caritas-Steward transaction were:

- Uncertainty over the fate of six Caritas community hospitals and the additional community hospitals later acquired by Steward, including concern that those hospitals would close, which would raise issues with respect to access to health care, employment, and other concerns of the hospital communities;
- Generalized concern over the expansion of a for-profit health care system in Massachusetts, including whether a for-profit system would lead to:
  - Increased prices;
  - Diverting revenue out of the system to satisfy investors;
  - A short-term sale of system assets to generate profits, causing instability in several health care markets;
- Fear that a for-profit system would end or decrease certain low-margin services, such as behavioral health services, in favor of more profitable services; and
- Concern over the fate of the underfunded Caritas pension system, with obvious implications for Caritas employees and retirees.

Five years later, the most dire of these concerns have not come to pass. Steward has kept the former Caritas system intact and operated the system as it had proposed, albeit in a health care market that remains challenging and dynamic. For instance:

- With the important exception of Quincy Medical Center, Steward has continued to operate each of its community hospitals;
- Steward has remained a low to moderately priced provider, with no significant spike in prices;
- Steward has continued to provide roughly the same mix of inpatient services in the communities it serves, and has maintained a strong commitment to providing much-needed behavioral health services in the markets it serves;
- Though the Caritas pension remains a serious financial obligation for Steward, it remains intact and is now federally insured.

The story of the 2010 Steward transaction continues to unfold. Steward acquired hospitals that were experiencing financial difficulties, and Steward has continued to experience challenges in its financial performance. Its ability to meet the requirements of its lenders and investors may be an important challenge for Steward. The AGO is pleased to issue these reports to carry out the AGO's commitment made in 2010 to monitor Steward's compliance with its agreements as well as the impact of the transaction on Massachusetts health care.

Report on Steward Health Care System Compliance with Asset Purchase Agreements

Pursuant to 2010 & 2011 Assessment & Monitoring Agreements

In connection with its review of the Caritas, Morton, and Quincy acquisitions, the AGO deemed certain aspects of the transactions to be in the public interest. The AGO and Steward entered into substantively identical enforcement agreements in each of those transactions confirming that the AGO would have the right to enforce those so-called public interest provisions (hereinafter "AGO Enforceable Provisions"). The Assessment and Monitoring Agreements that Steward and the AGO executed in connection with the transactions provided that the AGO would monitor Steward's compliance with the AGO Enforceable Provisions. The following section reports the result of that compliance monitoring effort.

The AGO issued its first report on Steward (the "2013 Monitoring Report") on January 30, 2013.[13] The 2013 Monitoring Report addressed compliance with the AGO Enforceable Provisions through Steward's first year of operations, or approximately calendar year 2011. Because the Morton and Quincy transactions closed in late 2011, the 2013 Monitoring Report focused primarily on the Caritas commitments. This report addresses Steward's compliance with the AGO Enforceable Provisions in all three transactions between 2012 and 2014. The report is based on information and documents the Non-Profit Organizations/Public Charities Division of the AGO obtained from Steward between 2012 and 2015.[14]

Maintenance of Services/No Closure Obligations

Each transaction included a slightly different commitment with respect to maintenance of services at the acquired hospitals. In the 2013 Monitoring Report, the AGO reported that Steward was in compliance with these commitments. This report includes Steward's noncompliance with certain of these commitments with respect to the closure of Quincy Medical Center, discussed below.

Caritas: In the Caritas transaction, Steward agreed that "[f]rom the Closing Date until the fifth anniversary of the Closing Date," it would not "close any of the Acute Care Hospitals, limit their general purpose, or close or decrease any Inpatient Behavioral Health Services at any of the Acute Care Hospitals . . . ."[15] Steward has not closed any of the Caritas hospitals, has not limited their general purpose, and has not decreased any of the inpatient behavioral health services.[16] Accordingly, Steward is currently in compliance with this commitment.

13 Off. of the Att'y Gen., Interim Reports on Steward Health Care Sys. Pursuant to 2010 and 2011 Assessment & Monitoring Agreements (Jan. 30, 2013) [hereinafter 2013 Monitoring Report], *available at* http://www.mass.gov/ago/docs/nonprofit/interim-steward-report.pdf. Note that specific citations to the 2013 Monitoring Report may refer to the *Report on Steward Health Care System Compliance with Asset Purchase Agreements or the Report on Steward Health Care System Performance & Impact* due to different pagination.

14 Steward operates on a fiscal year calendar. References to "FY20XX" are to the fiscal year that ended on December 31, 20XX.

15 Off. of the Att'y Gen., Caritas Christi & Steward Health Care Sys. LLC, Amendment No. 1, Asset Purchase Agreement, § 5 (Oct. 5, 2010), *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/amendment-1-to-apa.pdf.

16 Steward has made changes in the clinical services offered at several of the Caritas hospitals.

Morton: In the Morton transaction, Steward agreed that "[f]rom the Closing Date until the tenth anniversary of the Closing Date, [Steward] shall maintain an acute care hospital in Taunton, Massachusetts, or the immediately surrounding area, providing at least substantially the same scope of services as [Morton] currently provides (including at a minimum 14 inpatient, geriatric psychiatry beds)."[17] Although Steward closed Morton's inpatient pediatric unit and its home care service, it continues to operate Morton as an acute care hospital, including a 14-bed inpatient geriatric psychiatry unit. Accordingly, Steward is currently in compliance with this commitment.

Quincy: In the Quincy transaction, Steward agreed that "from the Closing Date[18] until the tenth anniversary of the Closing Date [Steward] shall maintain an acute care hospital in Quincy, Massachusetts, providing at least the same scope of services as [Quincy] currently provides (including a 22-bed inpatient, geriatric psychiatry unit) . . . ."[19]

On November 6, 2014, Steward notified the AGO that it intended to close Quincy by December 31, 2014. It provided similar notice to the DPH, although Massachusetts law requires a hospital to provide DPH at least 90 days' notice prior to closure.[20] On December 23, 2014, DPH approved Steward's plan to close Quincy and provide specified alternative services in the Quincy area, effective December 27, 2014. Steward failed to abide by the commitment it had made to maintain an acute care hospital in Quincy.

On January 14, 2015, after lengthy discussions about declining patient volume and increasing financial distress at Quincy, and after completion of the DPH review and approval process, the AGO entered into a settlement agreement with Steward waiving enforcement of the "no closure" commitment with respect to Quincy. The settlement agreement requires Steward to undertake other service commitments to the Quincy community, including:

- Operating a Satellite Emergency Facility ("SEF") in Quincy until at least December 31, 2016;
- Offering urgent care, specialty physician services and primary care services in Quincy until at least October 1, 2018;
- Offering transportation linking the SEF, Manet Community Health Center, the VA Community Based Outpatient Clinic, Carney, and other Steward provider locations until at least October 1, 2018;
- Funding the relocation of the VA Community Base Outpatient Clinic;
- Conducting an assessment of behavioral health service needs in Quincy and surrounding areas;

17 Off. of the Att'y Gen., Morton Hosp. and Med. Ctr. Inc. et al. & Steward Health Care Sys. LLC, Amendment No. 1, Asset Purchase Agreement, at § 4(c) (Sept. 6, 2011) [hereinafter First Amendment to the Morton APA], *available at* http://www.mass.gov/ago/docs/nonprofit/morton/amendment-1-to-apa.pdf.

18 The Quincy Medical Center transaction closed on October 1, 2011.

19 Quincy APA, *supra* note 6, at § 8.20(a), as amended by, Off. of the Att'y Gen., Quincy Med. Ctr. & Steward Health Care Sys. LLC, Second Amendment to Asset Purchase Agreement, at ¶ 4, § 8.20(a) (Sept. 7, 2011) [hereinafter Second Amendment to the Quincy APA], *available at* http://www.mass.gov/ago/docs/nonprofit/quincy/amendment-2-to-apa.pdf. The APA provided that Steward could close or limit services at Quincy after the fifth anniversary of the transaction under certain conditions, including negative operating margins in two consecutive years following the first three fiscal years of Steward's operation of Quincy, and provision of at least 18 months' notice to DPH. Quincy APA, § 8.20(d), as amended by the Second Amendment to the APA, ¶ 7. In essence, the APA would have permitted Steward to close Quincy, under sustained financial losses, on or around October 1, 2018.

20 G.L. c. 111, § 51G.

- Maintaining charity care and community benefits in Quincy until at least October 1, 2018; and
- Transitioning Quincy employees through re-employment, early retirement, severances or other means.

With the settlement agreement, the AGO Enforceable Provisions no longer apply with regard to Quincy following its closure; below this report includes information about Steward's compliance with those Enforceable Provisions prior to the closure.

Offers of Employment

Each of the three transactions included a commitment that Steward would offer employment to most of the sellers' workforces.[21] There was no guarantee regarding the duration of that employment.

With respect to the Caritas and Morton transactions, Steward has confirmed its compliance with these commitments, and the AGO has not received any information of noncompliance.

With regard to the Quincy APA, in connection with Quincy's 2011 bankruptcy, two senior Quincy executives, Victor Munger and Dr. Apurv Gupta, alleged that Quincy and Steward breached the employment commitment provision of the Quincy APA. While the Bankruptcy Court denied Mr. Munger and Dr. Gupta's request for relief against Quincy, it granted them relief against Steward. Steward appealed to the U.S. District Court for the District of Massachusetts, which vacated that portion of the Bankruptcy Court's decision that granted Mr. Munger and Dr. Gupta relief. Mr. Munger and Dr. Gupta have appealed to the U.S. Court of Appeals for the First Circuit, and their appeal is currently pending.

Aside from the employment claims of Mr. Munger and Dr. Gupta, Steward has confirmed that it complied with the employment commitment in the Quincy APA, and the AGO has not received any information (aside from the allegations of Mr. Munger and Dr. Gupta) of noncompliance.

Capital Commitment and Related Expenditures

Each transaction included a commitment that Steward would spend or commit to spend a specified minimum amount in capital improvements or related expenditures to address significant deferred capital investment needs that had accumulated prior to the acquisition. The specific terms of each commitment, including the time horizons for meeting each commitment, vary among the three APAs.

Caritas: In the Caritas APA, Steward committed to spend at least $400 million in the first four years following the closing date "to promote the financial health, well-being and/or growth of the Health Care System, including amounts that would qualify as capital expenditures by the Health Care System under GAAP."[22] Information Steward submitted to the AGO shows that as of November 5, 2014, Steward had spent, or committed to spend, $423,008,631 on capital expenditures at the former Caritas hospitals. Based on this reported information, Steward has complied with its capital expenditure commitment under the Caritas APA.

21 Caritas APA, *supra* note 6, at § 8.6(a); Morton APA, *supra* note 6, at § 10.1(a); Quincy APA, *supra* note 6, at § 9.1.

22 Caritas APA, *supra* note 6, at § 8.8(a).

Morton: In the Morton APA, Steward agreed to the following capital expenditure commitments:[23]

- From the Closing Date until the fifth anniversary of the Closing Date (the "First Period"), Steward shall expend or commit to expend no less than $85,000,000 in the aggregate for capital expenditures and investments to improve, furnish, equip and expand the services of the acute care hospital, including amounts that would qualify as capital expenditures under GAAP. Of this $85,000,000, Steward must spend
  - No less $25,500,000 in the aggregate within the first twelve (12) months post-Closing (the "First Period"), including $10,000,000 in investment in information technology; and
  - No less than $59,500,000 in the aggregate in the forty-eight (48) months thereafter (the "Second Period") for investment in information technology and other capital improvements and investments.
- From the fifth anniversary of the Closing Date until the tenth anniversary of the Closing Date (the "Third Period"), Steward shall expend or commit to expend an average of 100% to 125% of the annual depreciation expense of the hospital for capital expenditures and investments to improve, furnish, equip and expand services; provided that Steward's expenditures shall be no lower than Twenty-five Million Dollars ($25,000,000) and shall not exceed Thirty-Five Million Dollars ($35,000,000) in the aggregate.

For the First Period, Steward reported $42,854,000 in capital expenditures, including $13,707,000 on "EMR and Networking investment." These figures exceed Steward's capital expenditure commitment for the First Period. For the Second Period, Steward reported $47,616,000 in capital expenditures. While this figure does not meet Steward's capital expenditure commitment for the Second Period ($59,500,000), the shortfall ($11,884,000) is offset by Steward's additional expenditures in the First Period ($17,354,000). In the aggregate, Steward reported that, as of August 7, 2015, it had spent, or committed to spend, $90,470,000 on capital expenditures at Morton Hospital, which exceeds its total capital expenditure commitment for the First and Second Periods (that is, through the fifth anniversary of the transaction). Based on that information, Steward is on track to meet its capital expenditure commitment under the Morton APA for the First and Second Periods. Steward's obligations with respect to the Third Period have not yet been triggered.

Quincy: In the Quincy APA, Steward agreed to the following capital commitments:[24]

- From the Closing Date until the fifth anniversary of the Closing Date, no less than $34,000,000 in the aggregate for capital expenditures and investments to improve, furnish, equip and expand the services of the Successor Hospital, provided that all such amounts shall qualify as capital expenditures under GAAP. Of this $34,000,000, Steward must expend or commit to expend no less than $15,000,000 in the aggregate within the first twelve (12) months post-Closing (the "First Period") and another Ten Million Dollars ($10,000,000) in the subsequent twelve (12) month period following the Closing (the "Second Period") (which amounts for both of said twelve (12)-month periods shall include Five Million Dollars ($5,000,000) in investment in information technology).

23 Morton APA, *supra* note 6, at §§ 11.6(a) and (b); First Amendment to the Morton APA, *supra* note 17, at §§ 4(a) and (b).
24 Quincy APA, *supra* notes 6, at §§ 8.20(b) and (c); Second Amendment to the Quincy APA, *supra* note 19, at ¶6, §8.20(c).

- Beginning on the fifth (5th) anniversary of the Closing Date and until the tenth (10th) anniversary of the Closing Date (the "Third Period"), Steward shall, in addition to capital investment for program expansions and service line developments, expend or commit to expend an average of between 110% and 125% of the annual depreciation expense of the Successor Hospital for the routine needs of such Hospital, such amount currently estimated to be no less than approximately $4,000,000 annually and approximately $20,000,000 over said five (5)-year period.

For the First Period, Steward reported $54,770,000 in capital expenditures, including $6,517,000 in "EMR and Networking Investment." The $54,770,000 included a $38,000,000 "payment to make creditors whole." Even if that "payment to make creditors whole" would not qualify as a capital expenditure under GAAP or the APA, the remaining $16,770,000 in capital expenditures in the First Period exceeded its commitment of $15,000,000.

For the Second Period, Steward reported $14,852,000 in capital expenditures, of which $2,172,000 was identified as "EMR and Networking Investment." The total expenditure amount Steward reported exceeds the capital expenditure commitment for the Second Period. Together, the amounts reported for "EMR and Networking Investment" in the First and Second Periods total over $8.6 million, exceeding the $5 million information technology commitment.

In the aggregate, Steward reported capital expenditures or expenditure commitments of $81,145,000 for the first five years after the closing of the Quincy transaction. Even excluding the $38,000,000 "payment to make creditors whole," the reported $43,145,000 in capital expenditures or commitments exceeded the $34,000,000 commitment.

Because Steward closed Quincy in 2014, there will be no further monitoring of Steward's capital expenditures in connection with that transaction.

Charity Care and Community Benefits

Each transaction included a commitment by Steward to maintain the charity and indigent care policies in effect at each hospital immediately prior to Steward's acquisition. Steward has since standardized charity and indigent care policies across its hospitals in a manner not inconsistent with the prior hospital administration's policies.

Steward agreed in each transaction to comply with the AGO's Community Benefits Guidelines and to report on community benefits and charity care under those Guidelines.[25] Steward has submitted those reports, and information on the community benefits and charity care levels at each Steward hospital is available on the AGO's Community Benefits website.[26]

25 The AGO's Community Benefits Guidelines for Non-Profit Hospitals are applicable to non-profit, tax-exempt acute care hospitals and outline principles for developing, implementing, and reporting on this component of charitable activity in the communities those hospitals serve. Steward agreed to maintain and report on community benefit activities at the acquired hospitals under the Guidelines, even though it is not entitled to tax exemption and accordingly pays real estate and other taxes in those communities. Steward reported that in 2012 it paid more than $26 million in taxes. Health Bus. Group, The Economic Impact of the Steward Health Care System on the Massachusetts Economy: 2010-2012, at 22 (2013), available at http://www.steward.org/EconomicImpact.

26 Off. of the Att'y Gen., Community Benefits Provided by Nonprofit Hospitals & HMOs, *available at* http://www.mass.gov/ago/doing-business-in-massachusetts/health-care/community-benefits.html

Caritas: In the Caritas transaction, Steward agreed to maintain for at least three years following the closing community benefits and community service programs at a level substantially similar to those provided by each such hospital as reflected in its FY2009 community benefits report.[27] In the 2013 Monitoring Report, the AGO reported that Steward's filings indicated that FY2011 community benefits and charity care expenditures at the six former Caritas hospitals equaled or exceeded pre-acquisition levels. In FY2012, all of the former Caritas hospitals except for St. Anne's reported total community benefits expenditures exceeding those in 2009. In the aggregate, total community benefit expenditures at the Caritas hospitals (including St. Anne's) in FY2012 were higher than those in FY2009. The three-year commitment concluded at the end of FY2012.

Morton: In the Morton transaction, Steward agreed to maintain "community benefits and charity care at the current levels."[28] Because the Morton agreements were executed in 2011, the AGO has used Morton's community benefit expenditures in FY2011 as the point of reference for determining "the current levels." Morton's reported total community benefit expenditures in each of FY2012 and FY2013 were higher than those in FY2011. In FY2014, Morton reported total community benefit expenditures of $3.50 million, slightly below Morton's $3.79 million in community benefit expenditures in FY2011. Notwithstanding the small dip in expenditures for FY2014, the average of annual community benefit expenditures at Morton over the three years since the transaction closed is still higher than the FY2011 level.

Steward also agreed to "maintain community benefit programs consistent with those currently provided . . . including the currently operated adult uninsured clinic and school based health centers" and to "provide culturally and linguistically appropriate services consistent with those currently provided."[29] Steward produced to the AGO a summary of community benefit programs that are consistent with those requirements.

Quincy: In the Quincy transaction, Steward agreed to maintain community benefit programs consistent with those "currently" provided by Quincy.[30] Because the parties executed the Quincy APA in 2011, the AGO has used Quincy's community benefit expenditures in FY2011 as the point of reference for determining the "current levels." Quincy's reported total community benefit expenditures in each of FY2012 and FY2013 were largely consistent with the expenditures in FY2011 (Quincy's expenditures in FY2012 slightly exceeded its expenditures in FY2011, and its expenditures in FY2013 were slightly below its expenditures in FY2011). Quincy's reported total community benefit expenditures for that portion of FY2014 in which Quincy was open were significantly below its expenditures in FY2011. Because Quincy closed during FY2014, however, there will be no further monitoring of its community benefit expenditures against the FY2011 benchmark as an AGO Enforceable Provision under the Monitoring Agreement.

27 Caritas APA, *supra* note 6, at § 8.9 and Schedule 8.9.
28 First Amendment to the Morton APA, *supra* note 17, at § 4(c).
29 First Amendment to the Morton APA, *supra* note 17, at § 4(d)(f).
30 Quincy APA, *supra* note 6, at § 8.20(a).

Use of Names

In each of the transactions, Steward committed to maintaining the use of names –including names of the hospitals and certain named portions of the hospitals– following the transactions.[31] As of the end of FY2014, Steward reported that it remains in compliance with these commitments, and the AGO has not received any information that indicates otherwise.

Regulatory Cooperation

In each of the transactions, Steward agreed that it "shall, notwithstanding its for-profit status, fully cooperate with any investigation, inquiry, study, report or evaluation conducted by the [Massachusetts Attorney General's Office] under her office's oversight authority of the non-profit charitable hospital industry to the same extent and subject to the same protections and privileges as if" Steward were a public charity.[32] As in the 2013 Monitoring Report, Steward is currently in compliance with this commitment.

Local Governing Boards

In each of the transactions, Steward agreed to establish a local governing board at each acquired hospital that would be responsible for certain decisions in accordance with Massachusetts Department of Public Health ("DPH") Determination of Need Regulations. See 105 CMR 100.602.

The relevant obligations in each transaction are similar, requiring decisions on the following matters to be made by each local board: (i) approval of borrowings in excess of Five hundred thousand ($500,000) dollars; (ii) additions or conversions which constitute substantial changes in service; (iii) approval of capital and operating budgets, including prioritization of capital investments; (iv) approval of the filing of any application for Determination of Need; (v) development of strategic plans for the community served by the Successor Hospital; (vi) medical staff credentialing; and (vii) community benefit planning.[33]

In its responses to the AGO's information requests, Steward provided the names, residential addresses, occupations and dates of appointment for each member of the local governing boards as well as the dates of meetings and the votes of the local governing boards. As of the end of FY2014, Steward has represented that it remains in compliance with these commitments, and the AGO has not received any information that indicates otherwise.

31 Caritas APA, *supra* note 6, at § 8.15; First Amendment to the Morton APA, *supra* note 17, at § 4(d)(i); Second Amendment to the Quincy APA, *supra* note 19, at ¶ 8, §8.20(l).

32 Off. of the Att'y Gen., Caritas Christi & Steward Health Care Sys. LLC, Amendment No.1 to Asset Purchase Agreement, ¶ 6, § 8.16 (Oct. 5, 2010) [hereinafter First Amendment to the Caritas APA], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/amendment-1-to-apa.pdf, First Amendment to the Morton APA, *supra* note 17, at § 4(d)(g); Second Amendment to the Quincy APA, *supra* note 19, at ¶ 8, §8.20(j).

33 Caritas APA, *supra* note 6, at § 8.7; Morton APA, *supra* note 6, at §11.8; Quincy APA, *supra* note 6, at § 8.20(e).

Change in Control Transaction

Steward agreed in each transaction, in slightly varying terms,[34] not to sell all or a substantial portion of its system or control over the system for at least several years following each acquisition (a "change in control" transaction). As in the 2013 Monitoring Report, Steward is currently in compliance with this commitment.

Obligations of Successors

In each of the transactions, Steward agreed that, in the event of a change in control transaction, Steward would ensure that a successor-in-interest assumed any commitments in the AGO Enforceable Provisions that had not expired at the time of the change in control.[35] Because Steward has not engaged in any "change in control" transaction, this commitment has not been triggered.

34 Caritas APA, *supra* note 6, at § 8.11, First Amendment to the Caritas APA, *supra* note 32, at ¶ 3, First Amendment to the Morton APA, *supra* note 17, at § 4(c), Second Amendment to the Quincy APA, *supra* note 19, at ¶ 4, at §8.20(a).

35 First Amendment to the Caritas APA, *supra* note 32, at ¶ 6, § 8.17; First Amendment to the Morton APA, *supra* note 17, at § 4(h); Second Amendment to the Quincy APA, *supra* note 19, at ¶ 8, § 8.20(k).

Report on Steward Health Care System Performance & Impact

Pursuant to 2010 & 2011 Assessment & Monitoring Agreements

Executive Summary

This is the AGO's second report monitoring the Steward system's impact on the provision of health care services to the Communities served by Steward. The AGO and Steward publicly committed for the AGO to monitor Steward's impact on health care access and affordability for a five-year period as part of Steward's acquisition of Caritas, and later Morton and Quincy.[36]

The relevance of monitoring today is consistent with the principal purposes highlighted in the 2013 Monitoring Report, in particular:

- Examining Steward's performance in fulfilling its business vision of keeping more care in the community, including implications for consumers, regional hospitals, and the Commonwealth's health care cost containment goals.
- Monitoring the financial condition of private assets that deliver critical public services throughout eastern Massachusetts, including to elderly and lower-income populations. Increased financial distress, reduction or cessation of services, or a potential sale of the Steward system would have significant implications for Massachusetts consumers.
- Monitoring Steward's compliance with its commitments in connection with its acquisition of significant charitable assets, including commitments to thousands of Caritas pensioners.

In line with these principles, this report analyzes the performance and impact of the Steward system in three major chapters: organizational profile, market analysis, and financial condition.[37] The organizational chapter focuses on major changes within the Steward organization, including major acquisitions, restructuring, and affiliations. The market analysis chapter assesses Steward's market profile in the Commonwealth and the impact it has had on health care markets. The final analytical chapter reviews Steward's financial condition and reports on the system's second, third, and fourth years of operations. Where relevant, these chapters compare Steward's performance to peer hospitals, physician groups, and health care systems. In addition to the AGO's efforts, DPH is monitoring Steward's clinical performance with respect to quality, safety, and access.[38]

36 Caritas AMA, *supra* note 9; Morton AMA, *supra* note 10; and Quincy AMA, *supra* note 10.

37 In assessing Steward's impact, the AGO focuses on these financial and market metrics because they are most relevant to the central purposes of monitoring described above. This report does not purport to be an exhaustive analysis of all aspects of Steward's performance (for example, it explicitly does not address Steward's clinical performance).

38 Caritas AMA, *supra* note 9, at § 4 (noting that DPH is to evaluate the impact of the transaction on "the availability of, and access to, health care services" within the communities served by Steward).

The 2013 Monitoring Report found that in its first year as a system, Steward sought to improve the financially weak hospitals it had recently acquired.[39] In this report, after reviewing four years of post-transaction data, we found Steward to be a low to moderately priced health care system that continues to serve a sizeable share of elderly and lower-income patients. Steward has experienced challenges in its financial performance over time, which may be due in part to underlying market dynamics that favor more expensive providers. To support communities Steward serves, the AGO recommends that Steward fully embrace the transparency principles established by Massachusetts health care statutes and that health care stakeholders take steps to improve upon documented market dysfunction.[40]

Our key findings are summarized below:

Organizational Profile

After acquiring the Caritas system, Steward continued to expand its organization by acquiring several hospitals and provider groups. By the end of 2012, Steward had created a health care system with ten acute care hospitals and one of the largest physician networks in the Commonwealth. Following this period of growth, the rate of acquisitions slowed as Steward made several changes to its hospital system and clinical affiliations. In 2014 and 2015, Steward merged Merrimack Hospital into Holy Family, closed Quincy Medical Center, and adjusted its clinical affiliations for oncology and pediatric services.

Market Analysis

Steward primarily serves eastern Massachusetts and continues to provide a sizeable share of services to elderly and lower-income patients at nearly all its hospitals. Steward's hospitals continued to provide a larger share of medical and psychiatric inpatient services than the overall mix in their respective markets. The system's hospitals and physicians remain low to moderately priced compared to other area providers. There is evidence from one major insurer that patients with Steward PCPs have increasingly obtained outpatient care at Steward hospitals, while the system's share of inpatient discharges in a number of the markets it serves has decreased.

Financial Condition

Overall, the financial condition of the Steward system has declined since 2012. Although the operating performance of some of its hospitals appears to have improved over time, the system's operating losses increased as hospital expenses shifted to the parent company. The system has increasingly relied on bank term loans to fund operating losses and capital expenditures, leading to a capital structure in which debt exceeded equity by several multiples by December 2013. The pension plans, significantly underfunded when Steward acquired the Caritas system, remain one of the system's largest liabilities.

39 2013 Monitoring Report - Report on Steward Health Care System Performance & Impact, *supra* note 13, at 7-10.

40 *See* Off. of the Att'y Gen., Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12, § 11N: Report for Annual Public Hearing Under G.L. c. 6D, § 8 (September 18, 2015) [hereinafter AGO's Fifth Cost Trends Report], *available at* http://www.mass.gov/ago/docs/healthcare/cctcd5.pdf.

Data Reliance and Limitations

In developing this report, the AGO relied on information provided by Steward and a number of other sources, including state agencies, health insurers, and private organizations focused on the collection of health care business and financial data. The information examined was from as recent as 2014, where available. We appreciate the cooperation of Steward and other producing entities in support of our review. With the assistance of experts, the AGO collected information from these sources, assessed its consistency, and developed a reliable analysis of Steward's organization, market performance, and financial condition. Nonetheless, there are certain limitations to these public and private data sources.

The AGO gathered information from public sources such as CHIA, DOI, DPH, HPC, and the AGO's Non-Profit Organizations/Public Charities Division. Some of this information is hospital-specific as opposed to system-wide. There is also limited information available on outpatient services. As a result, the market analysis chapter does not provide a comprehensive view of Steward's market impact as it relies primarily on inpatient data.

Additionally, information held by private entities can be subject to unique parameters that can make comparisons over time or across organizations challenging, particularly when such information is held for internal management purposes and not for uniform public reporting. Even within an organization, changes in systems, data parameters, and analytic approaches over time can make meaningful trend analysis subject to error. We note in this Report where comparison of data from Caritas to Steward may be subject to such recordkeeping and analytic differences. Additionally, for-profit and nonprofit systems may be subject to different incentives and financial requirements as a result of their different ownership and organizational models. For example, a comparison of Caritas and Steward should take into account differing tax obligations as well as differences in incentives to hold large cash balances.[41] Subject to the data limitations outlined, this Report presents a reliable comparison of Steward's operations to Caritas baseline information and to the performance of other area providers.

41 According to AGO experts, nonprofit hospitals borrowing in tax-exempt markets tend to be rewarded with lower interest rates when they have large cash balances, while investors in for-profit systems tend to view large balances as a suboptimal use of company resources. Similarly, nonprofits and for-profits differ in their tax obligations; for-profits are required to pay real estate and other taxes that benefit the community. Steward reported that in 2012 it paid more than $26 million in taxes. Health Bus. Group, The Economic Impact of the Steward Health Care System on the Massachusetts Economy: 2010-2012, at 22 (2013), available at http://www.steward.org/EconomicImpact.

I. Organizational Profile

We begin with a brief overview of the organization and governance of the Steward system, focusing on major changes since 2012, including:

1. Significant hospital changes in 2014, such as Merrimack Hospital merging with Holy Family and the closure of Quincy Medical Center;
2. Expansion of Steward's physician contracting network (SHCN) to become the second largest provider network in the Commonwealth; and
3. New clinical affiliations with other provider organizations for cancer and pediatric care.

Steward was formed in 2010 to acquire Caritas and is now one of the largest provider systems in Massachusetts. It is owned by Cerberus, a for-profit private equity group, and primarily serves the eastern Massachusetts region. It is led by an eleven-person Senior Leadership Team and is governed by an eight-person Board of Directors, chaired since its inception by Steward Chief Executive Officer Dr. Ralph de la Torre.

Steward's stated business strategy is to develop a broad, low-cost, and high-quality health care system in Massachusetts that reduces overall costs to purchasers by keeping care within the community.[42] Since 2012, Steward has taken steps to acquire additional providers and develop strategic affiliations to broaden its referral base and keep more care in-system. Major changes are highlighted below.

42 *See*, e.g., AGO Statement, *supra* note 3, app. at A-8 ("Steward's stated objective is to improve and further develop a community-based health care system capable of (i) managing risk, (ii) providing high quality, local, and accessible care, and (iii) reducing out-migration of patients who now obtain services, otherwise *available at* a Caritas hospital, at higher cost, less accessible settings."); Letter from Caritas Counsel, *supra* note 2 (describing Steward's intention to "provide high-quality, lower-cost care in a community setting, as a complement to the highly-specialized care offered by Boston's academic medical centers").

HOSPITALS

Following the acquisition of the six Caritas hospitals in 2010,[43] Steward added five more hospitals. In May 2011, Steward finalized an agreement to purchase Merrimack and Nashoba from the for-profit corporation Essent Healthcare.[44] In separate transactions, Steward also acquired Morton and Quincy effective October 1, 2011.[45] On September 1, 2012 Steward acquired New England Sinai, a long-term care hospital.[46] Table 1 provides an overview of the hospital system as of year-end 2012.[47]

TABLE 1 – STEWARD HOSPITAL PROFILES (YE2012)

Hospital	Location	Med. Staff	Beds[45]	Teaching Affiliation
Carney	Dorchester	225	159	Tufts University
Good Samaritan	Brockton	352	198	--
Holy Family	Methuen	469	223	--
Merrimack	Haverhill	151	122	--
Morton	Taunton	104	133	--
Nashoba	Ayer	105	57	--
New England Sinai	Stoughton	22	157	--
Norwood	Norwood	322	263	--
Quincy	Quincy	155	196	--
St. Anne's	Fall River	312	160	--
St. Elizabeth's	Brighton	422	252	Tufts University

43 Steward finalized the acquisition of the Caritas system on November 6, 2010, including its six acute care hospitals: Carney, Good Samaritan, Holy Family, Norwood, St. Anne's, and St. Elizabeth's. *See* Caritas Christi Health Care Sys. Transaction, Off. of the Att'y. Gen., *available at* http://www.mass.gov/ago/caritas.

44 The transfer of a Massachusetts non-profit acute care hospital to a for-profit entity is subject to review by the Attorney General's Office under G.L. c. 180, § 8A(d). No review of the Merrimack and Nashoba transactions was conducted by the AGO because the acquisitions were for-profit to for-profit acquisitions and thus not subject to G.L. c. 180, § 8A(d). Similarly, no review was conducted for the New England Sinai transaction, as it is a long-term care hospital, and not an acute care hospital. *See also supra* note 1.

45 *See* Morton Hospital Transaction, *supra* note 11; Quincy Medical Transaction, *supra* note 11.

46 *See* New England Sinai Hosp. Transaction, Off. of the Att'y. Gen., *available at* http://www.mass.gov/ago/doing-business-in-massachusetts/public-charities-or-not-for-profits/findings-and-publications/findings-and-recommendations/long-term-care-hospital-conversions/new-england-sinai-hospital-transaction.html.

47 Steward pursued a third acquisition in 2012, for Landmark Health System, which operates two hospitals in Rhode Island. However, the parties ended these negotiations without reaching agreement. Steward Health Care terminates its agreement to buy Landmark Medical Center in Woonsocket, Boston Globe (Sept. 27, 2012), *available at* http://www.bostonglobe.com/business/2012/09/27/steward-health-care-terminates-its-agreement-buy-landmark-medical-center-woonsocket/lHV6FU2cO1Fc9yKmLP7jrM/story.html.

48 DPH bed counts as of Nov 8, 2012; on file with DPH and AGO.

Following this period of growth, Steward consolidated its hospital holdings. First, on August 1, 2014, Steward merged Merrimack Valley into Holy Family. In support of the merger, Steward stated the transaction would result in savings and improve the financial standing of Merrimack through the sharing of administrative costs.[49] Effective August 1, 2014, following Public Health Council approval, Merrimack began to operate under Holy Family's license.[50] On November 6, 2014, Steward provided notice to the AGO and other state agencies that it would close Quincy in December 2014, citing financial distress and decreased utilization of the facility. Such notice was less than the notice required to DPH under G.L. c. 111, § 51G, and the Quincy APA for the proposed closure of a hospital or discontinuance of an essential health service.[51] Information regarding Steward's compliance with maintenance of services obligations at Quincy is available in the Compliance Report. Following DPH review and approval of the Quincy transition plan, Steward closed Quincy on December 26, 2014.[52]

Physicians and Employees

Steward has also acquired a number of physician practices since 2011. The largest of these were Compass Medical and Physician's Healthcare in 2012, and Hawthorn Medical Associates in 2013.[53] These acquisitions include primary care practices, which Steward has described as central to its strategy to improve care coordination and retention and lower overall health care costs. Figure 1 tracks the growth in: 1) Steward's physician contracting network (SHCN), both physicians directly employed by Steward Medical Group (SMG) and independent/non-employed physicians who contract through the Steward network; and 2) individual employees[54] of Steward hospitals, home care, and SMG tracked by full time equivalents (FTEs).

The number of physicians within SHCN grew 47% from 1,617 in 2010, to 2,384 physicians in 2012, creating one of the largest physician networks in Massachusetts. The number of SMG physicians grew by 36%, contributing to the number of individual patient claims billed by SMG growing by about 70% from 2010 to 2012.

Similarly, the number of Steward physician and non-physician employees (measured by FTEs) grew to 10,095 in 2012, a gain of 38% over 2010. In 2012, the acquisitions of Morton, Quincy, and New England Sinai accounted for 1,662 of the additional FTEs (or 92% of total FTE growth from 2011 to 2012). There was also a substantial increase in the number of physician and non-physician employees at SMG, growing by 59% from 2010 to 2012.

49 DPH, Minutes of the Public Health Council, 5 (June 18, 2014), *available at* http://www.mass.gov/eohhs/docs/dph/public-health-council/2014/20140618-minutes.pdf; *see also* HPC, Steward Material Change Notice Comments ("In a preliminary review, the HPC found that there was limited scope for increases to health care spending since both Merrimack and Holy Family had relatively low commercial payer mix and commercial prices, with Holy Family's prices only slightly higher than Merrimack. The HPC did not find evidence that the transaction was likely to negatively impact clinical quality or patient access to services.").

50 Minutes of the Public Health Council, *supra* note 49 at 2-3, 5.

51 Second Amendment to the Quincy APA, *supra* note 19, at ¶ 7, § 8.20(d).

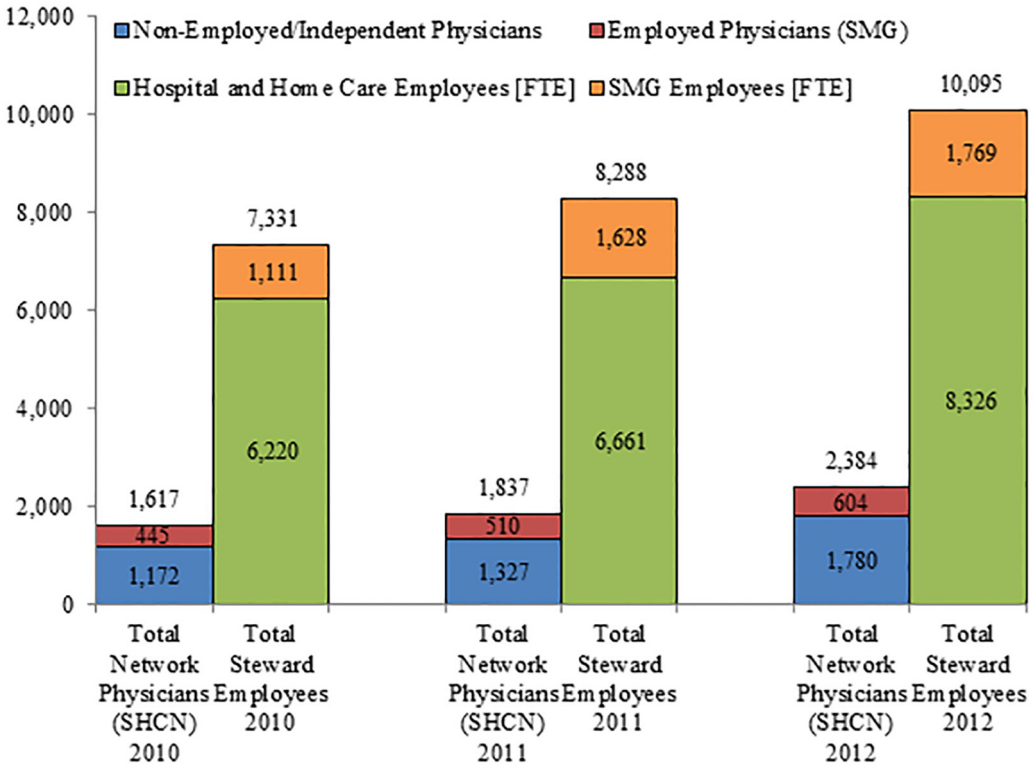
52 Since 2014, Steward has sought to transfer its cardiac catheterization license from Quincy to St. Anne's. Steward and Southcoast are engaged in litigation regarding Southcoast's efforts to stop transfer of the license and prevent Steward from opening a cardiac catheterization lab at St. Anne's. On December 17, 2015 the Suffolk Superior Court denied Southcoast's request for an injunction.

53 Steward acquired Physician's Healthcare for $8.6 million in cash, Compass Medical for $16.6 million cash, Hawthorn Medical Associates and affiliates for $31.3 million in cash, and various other physician practices for, in aggregate, cash consideration of $6.8 million.

54 Individual employees include physicians, mid-level practitioners, and non-licensed/administrative staff.

At the same time, Steward reduced FTEs at several of its hospitals. In terms of total employees, including full and part-time, Steward reported employing over 15,000 individuals in 2012, making it one of the largest private employers in the Commonwealth.[55]

Figure 1 – Total Steward Network Physicians (SHCN) and Employees (2010-2012)



NOTE: This figure provides two sets of data: 1) Steward's physician contracting network (blue/red); and 2) individuals employed by Steward (green/orange). While there are some correlations between the two groupings, they are not directly comparable as they are based on different types of employment and/or affiliation data.

55 Health Bus. Group, The Economic Impact of the Steward Health Care System on the Massachusetts Economy: 2010-2012, at 21 (2013), *available at* http://www.steward.org/EconomicImpact.

Payer and Provider Agreements

Steward entered into several agreements with payers and providers in Massachusetts to improve clinical and market performance and retain referrals within the Steward system. In 2011, Steward became a Medicare Pioneer ACO and entered or continued global payment contracts with major commercial insurers in Massachusetts. Steward also engaged THP and FCHP to create HMO limited network products (LNPs) primarily composed of Steward's hospitals and physicians. The 2013 Monitoring Report further details the administration and characteristics of each LNP.[56] The goal of the LNPs is to provide a more cost-effective health insurance option for residents of eastern Massachusetts by developing an insurance network based primarily around the lower-priced Steward system. As of 2014, these LNPs had a limited impact on Steward's market performance due to their low membership.[57]

In 2014, Steward entered into an agreement with Dana-Farber Cancer Institute to provide oncology services at St. Elizabeth's.[58] In 2015, Steward expanded this agreement to include Holy Family. In filings with the state, Steward stated the change would "increase access to cost-effective, high-quality oncology care in a community setting that currently lacks coordinated, integrated oncology services."[59] The HPC's preliminary review of the proposed affiliation found that it would be unlikely to increase health care spending or negatively impact clinical quality or patient access to services.[60]

On April 10, 2015, Steward notified the state that it would replace an existing Boston Children's Hospital clinical pediatrics affiliation at St. Elizabeth's, Good Samaritan, Holy Family, Norwood, and Morton with a Partners HealthCare System affiliation for the same services at those Steward hospitals.[61] Following an initial review of the filings, the HPC found it likely that the affiliation with Partners HealthCare System would provide lower-priced pediatric services than currently provided by Children's at those Steward hospitals and would be unlikely to have a negative impact on quality or access.[62]

56 2013 Monitoring Report - Report on Steward Health Care System Performance & Impact, *supra* note 13, at 47-49.

57 As one factor affecting the performance of LNPs, Steward has reported to the AGO that insurance brokers have not been incented to sell products that are less expensive than other insurance products on the market.

58 HPC, Notice of Material Change Form, (March 18, 2014), *available at* http://www.mass.gov/anf/docs/hpc/material-change-notices/hpc-notice-of-material-change-clinical-affiliation-steward-3-18-14.pdf.

59 HPC, Notice of Material Change Form, 5 (March 10, 2015), *available at* http://www.mass.gov/anf/docs/hpc/material-change-notices/20150310-steward-dfci-mcn.pdf.

60 HPC, Steward Material Change Notice Comments (The HPC made preliminary findings that the shift in medical oncology services from Holy Family's hospital outpatient setting to Dana-Farber's physician practice setting would likely result in similar or decreased prices for those services. For St. Elizabeth's, the HPC preliminarily found that the transaction could enable more patients to receive care at lower-priced St. Elizabeth's instead of at higher-priced academic medical centers and Dana-Farber Cancer Institute in Boston).

61 HPC, Notice of Material Change Form, (April 10, 2015), *available at* http://www.mass.gov/anf/docs/hpc/material-change-notices/20150410-steward-partners-mcn.pdf

62 HPC, Board Meeting, 33 (June 10, 2015), *available at* http://www.mass.gov/anf/docs/hpc/20150610-commission-document-june-10-presentation-vfinal.pdf.

II. Market Analysis

The purpose of this chapter is to examine Steward's market impact in light of its stated business plan of developing a lower-cost provider system that keeps more care in the community.[63] That business plan aligns with a broader health care dialogue in Massachusetts about the importance of keeping care more accessible in communities, and at lower-priced, high value providers. We begin by examining Steward's market profile, which includes an overview of Steward's service areas, payer mix, inpatient service mix, and price. We then turn to assessing market impact, particularly referral patterns and inpatient utilization and market share. To provide greater context to the market analysis chapter, information on community, tertiary, and other area hospitals is included to illustrate regional and/or market-wide trends. Full charts, tables, and accompanying data are contained in the appendix to this report.

Market Profile

In reviewing Steward's market profile since 2012, the AGO found that:

1. Steward's share of elderly and lower-income patients increased, similar to many hospitals across the state;
2. In their respective service areas, most Steward hospitals continued to provide a larger share of medical and psychiatric inpatient services than the overall mix in each service area; and
3. Steward continued to be a low to moderately priced health care system compared to other area providers.

Service Areas

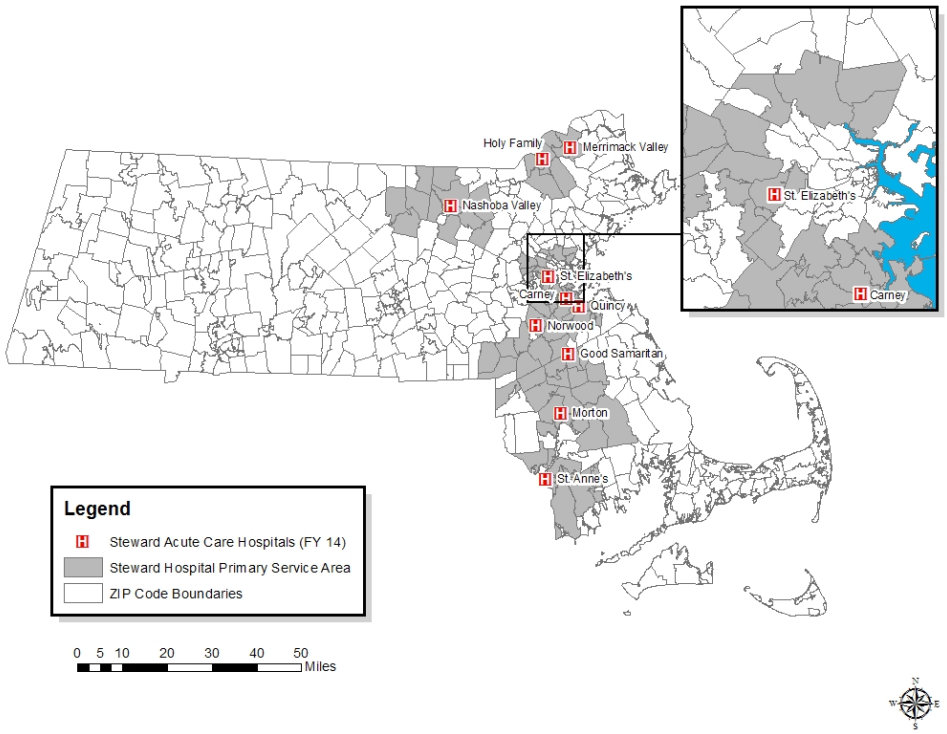
In 2014, Steward continued to serve patients in many communities throughout eastern Massachusetts, from Merrimack Valley in the north, to Fall River in the south. The primary service area (PSA) map in Figure 2 shows the main geographic areas that Steward hospitals drew patients from in 2014. The PSAs reflect several local areas, each with its own local and tertiary hospitals,[64] dominant health plans, and patient characteristics. We determined PSAs according to a methodology consistent with that documented in the 2013 Monitoring Report.[65]

63 The market analysis contained in this Report is designed to monitor the impact of Steward's business activity and does not constitute a market analysis for antitrust purposes.

64 In this report, tertiary hospitals are defined as either major hospitals that have a full complement of services or a specialty hospital dedicated to specific sub-specialty care to which referrals are made from primary care and secondary care providers. For purposes of this report, tertiary hospitals were defined as the following hospitals: Beth Israel Deaconess Medical Center, Boston Medical Center, Brigham and Women's Hospital, Children's Hospital Boston, Dana-Farber Cancer Institute, Lahey Clinic, Massachusetts Eye & Ear Infirmary, Massachusetts General Hospital, New England Baptist Hospital, Tufts Medical Center, and UMass Memorial Medical Center.

65 For purposes of this report, the PSA for all Steward hospitals (excluding St. Elizabeth's) was defined by including any Massachusetts zip code that contributed at least 2% of the hospital's total discharges in that year. As the system's main teaching hospital, St. Elizabeth's draws patients from zip codes across eastern Massachusetts. Thus, to define a coherent PSA for St. Elizabeth's, in addition to any zip code that contributed at least 2% of St. Elizabeth's total discharges for FY2014, the AGO included select zip codes from the counties surrounding St. Elizabeth's: (1) any Suffolk county zip code that contributed at least 2% of St. Elizabeth's total discharges for Suffolk county and (2) any Middlesex county zip code that contributed at least 2% of St. Elizabeth's total discharges for Middlesex county. *See also* 2013 Monitoring Report - Report on Steward Health Care System Performance & Impact, *supra* note 13, at 13-14.

FIGURE 2 – PRIMARY SERVICE AREAS OF STEWARD ACUTE CARE HOSPITALS (2014)



PAYER MIX

From 2010 to 2014, the proportion of Steward's payer mix attributable to government payers increased, with a corresponding decrease in its commercial payer mix. [66] Over the same period, a similar trend of increasing government payer mix was observed across the state. In 2014, nine Steward hospitals were classified by CHIA as "disproportionate share hospitals" because at least 63% of their payer mix was attributable to government payers.[67]

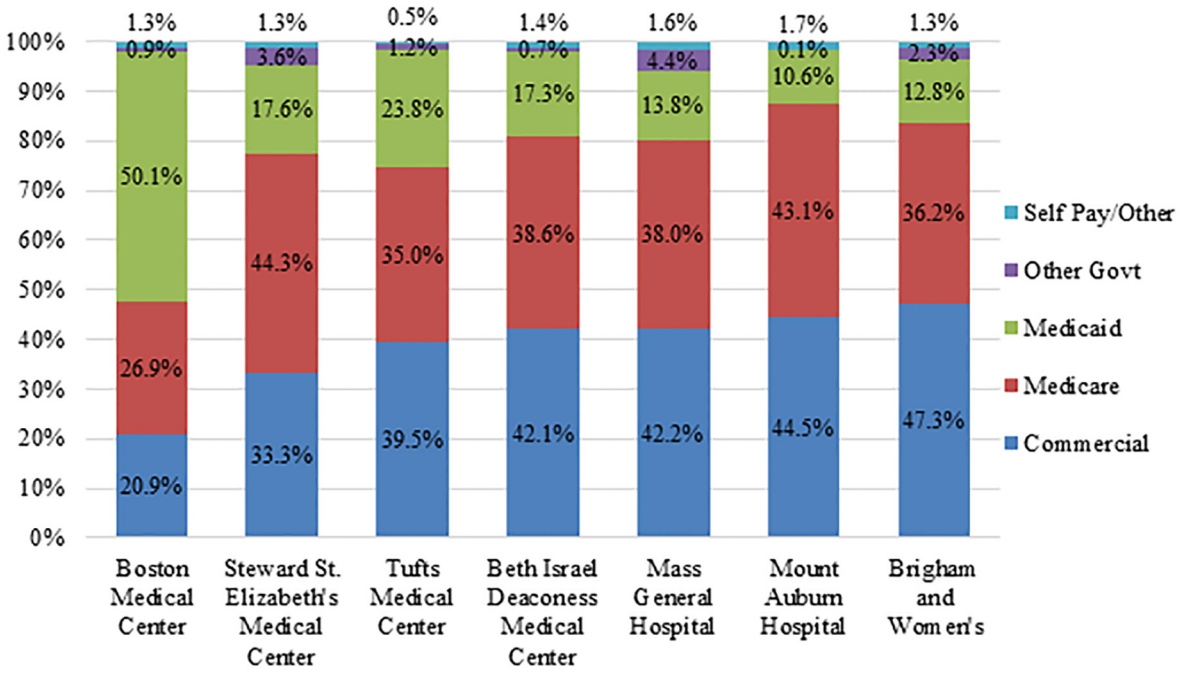
Figure 3 illustrates 2014 payer mix at St. Elizabeth's Medical Center, a Steward teaching hospital, compared to other academic medical centers and teaching hospitals in Metro Boston.[68] St. Elizabeth's had higher government payer mix (61.9%) and lower commercial mix (33.3%) than all but one area hospital. Only Boston Medical Center, the largest safety net hospital in the Commonwealth, had a higher government payer mix.

66 Payer mix describes the proportion of care delivered to patients covered by different insurance types.

67 Ctr. for Health Info. and Analysis [hereinafter CHIA], Disproportionate Share Hospitals, *available at* ; Massachusetts Disproportionate Share Hospital excel spreadsheet, available at http://www.chiamass.gov/assets/DSH-FY10-FY14.xls.

68 Metro Boston and other areas defined as: Metro Boston (Beth Israel Deaconess Medical Center, Boston Medical Center, Brigham and Women's Hospital, Massachusetts General Hospital, Tufts Medical Center, Mount Auburn Hospital); Metro South (South Shore Hospital, Beth Israel Deaconess Hospital-Milton, Brigham and Women's Faulkner Hospital); South East Massachusetts (Signature Healthcare Brockton Hospital, Beth Israel Deaconess Hospital-Plymouth) Fall River (Southcoast Hospitals); Merrimack Valley – (Lawrence General Hospital, Anna Jaques Hospital); Norwood (Newton-Wellesley Hospital, Sturdy Memorial Hospital, Milford Regional Medical Center); Greater Middlesex (Emerson Hospital, Lowell General Hospital, Health Alliance Leominster).

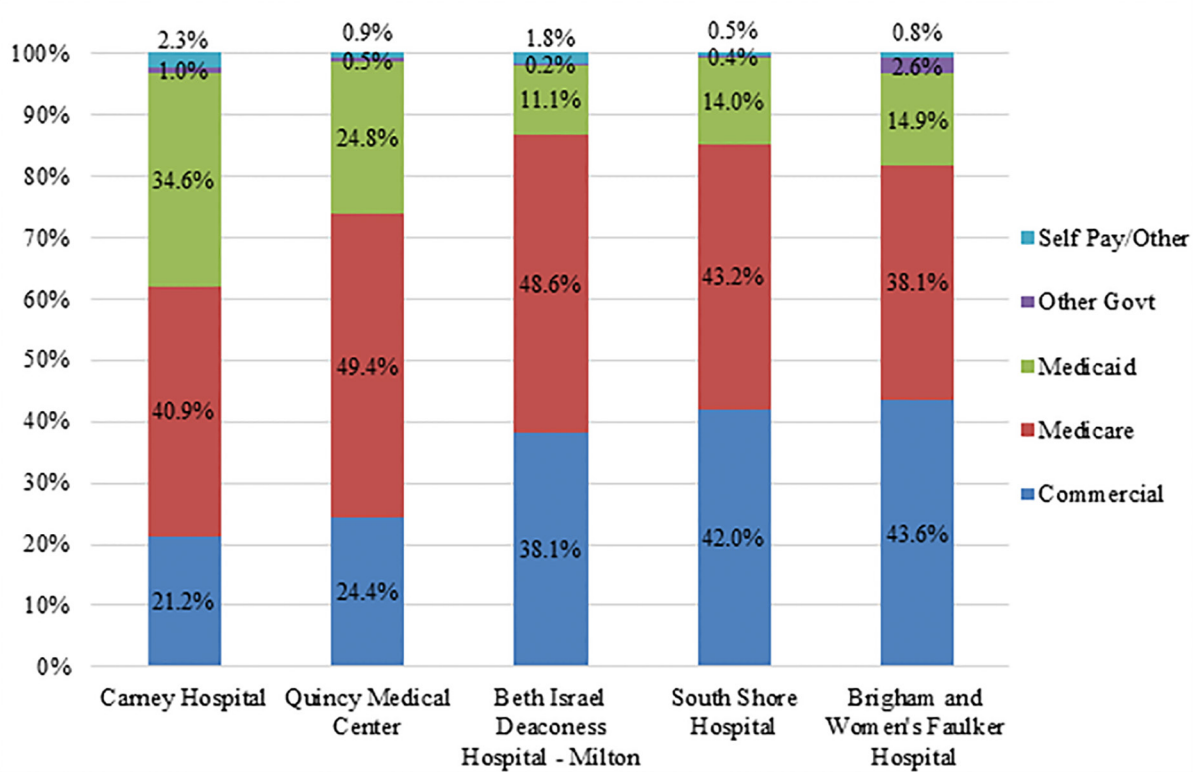
FIGURE 3 – METRO BOSTON GPSR PAYER MIX (INPATIENT & OUTPATIENT 2014)[69]



Most of Steward's other hospitals also had comparatively high public payer mix and low commercial payer mix in 2014. Figure 4 illustrates how the payer mix of two Steward hospitals compared to that of other community hospitals in Metro South. Carney and Quincy had the highest public payer mix and lowest commercial payer mix of all hospitals in the region.

69 For payer mix information on Steward's other hospitals, please refer to Table 7, in the appendix.

Figure 4 – Metro South GPSR Payer Mix (Inpatient & Outpatient 2014)



Service Mix

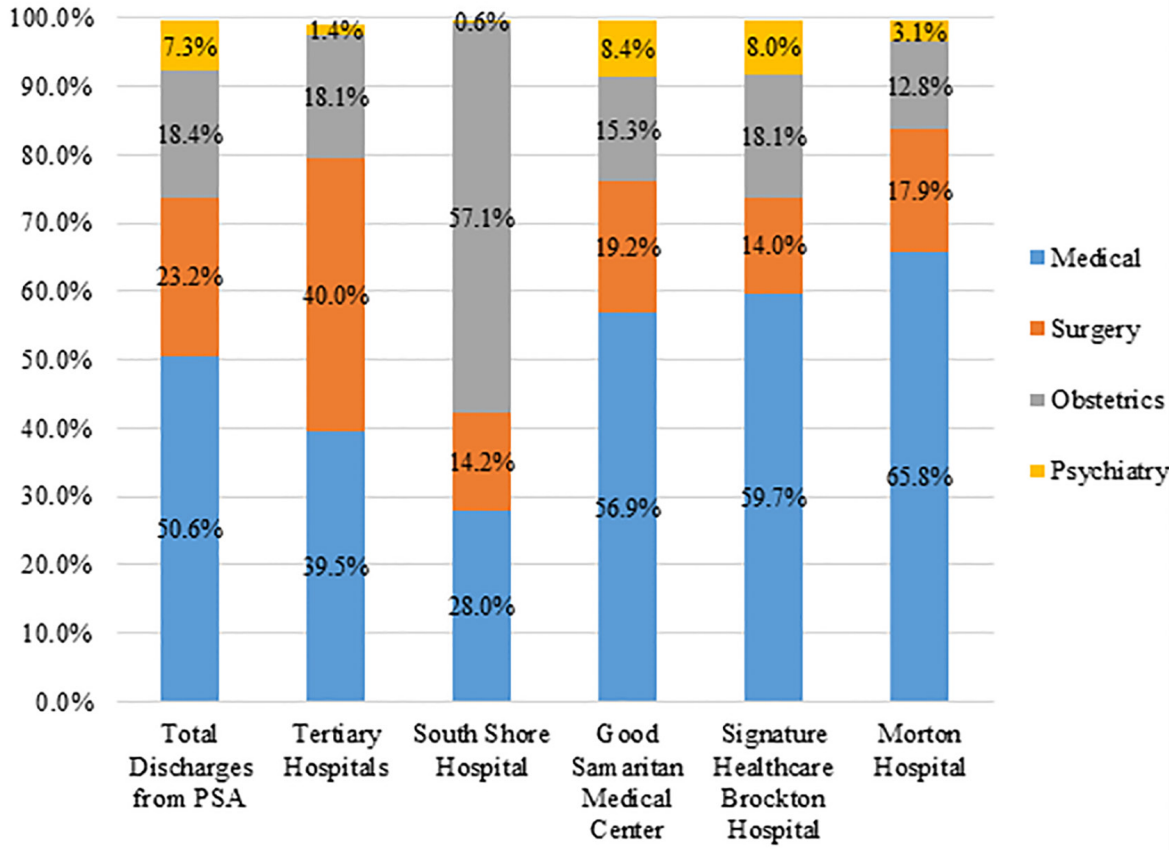
Like payer mix, service mix can be indicative of a hospital's financial strength because some services are better reimbursed than others. For example, the margins on certain service lines, such as surgical services, are usually better than the margins on medical and psychiatric services.[70] In addition, obstetrics services can be desirable as families may continue to obtain care at locations associated with their hospital post-delivery. In general, Steward's hospitals continued to provide a higher share of services that are lower-margin compared to other area hospitals.

In 2014, most Steward hospitals provided a larger share of medical and psychiatry discharges in their respective PSAs than the overall mix in the PSA. Conversely, in each of their respective PSAs, Steward hospitals provided a smaller share of surgery and obstetrics discharges (where inpatient obstetrics services were available at Steward hospitals) than the overall mix in their PSAs. Tertiary hospitals provided a higher mix of surgery discharges than the overall mix in each Steward PSA.

70 Specific hospital specialties included within the service mix categories are: Medical; (Cardiology, General Medicine, Medical Oncology/Hematology, Neurology, Transitional Care Unit); Surgery (Cardiac Catheterization, Cardiac Electrophysiology, Cardiac Surgery, Ear Nose Throat, General Surgery, Gynecology, Neurosurgery, Ophthalmology, Orthopedics, Spine, Thoracic Surgery, Transplant, Trauma, Urology, Vascular Services); Obstetrics (Obstetrics, Neonates); Psychiatry (Psychiatry, Substance Abuse).

The figure below illustrates the service mix profiles of hospitals serving residents in Good Samaritan's market in 2014. In Figure 5, Good Samaritan provided a larger share of psychiatry discharges in its PSA than the overall mix in the PSA. With regard to obstetrics, Good Samaritan and Morton provided a lower share of discharges compared to other area hospitals and tertiary hospitals. By contrast, tertiary hospitals held a strong share of surgery discharges in Good Samaritan's PSA.

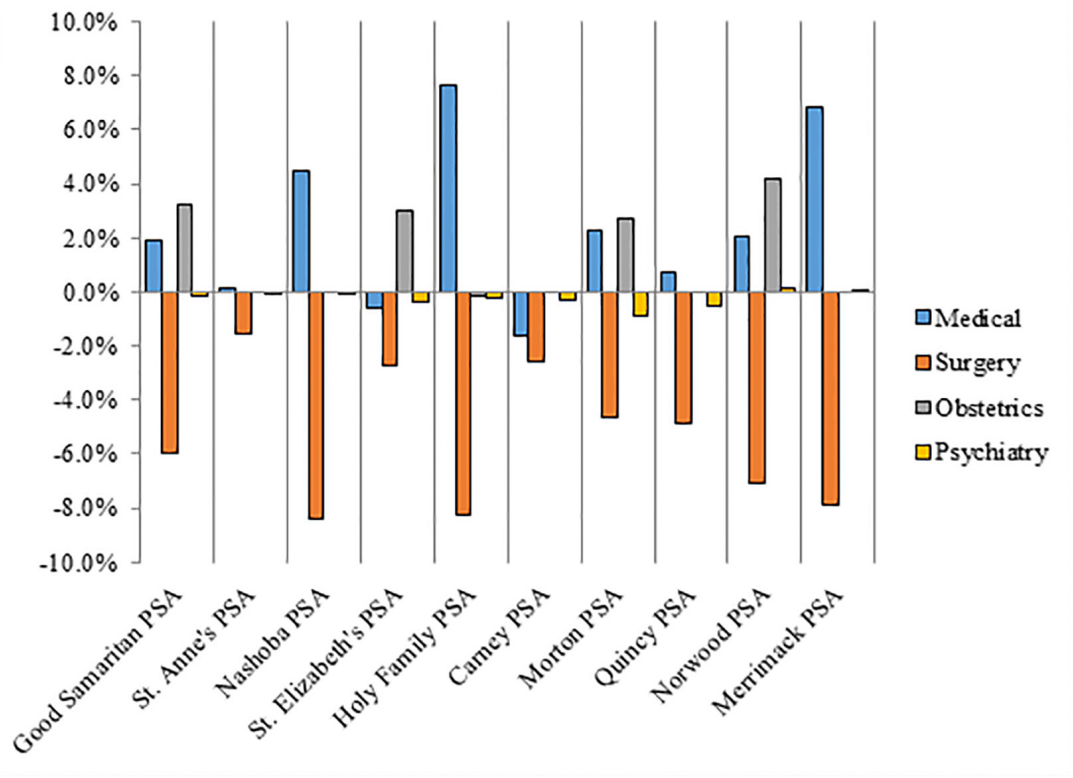
FIGURE 5 – INPATIENT SERVICE MIX IN GOOD SAMARITAN'S PSA (2014)[71]



From 2010 to 2014, Steward hospitals and tertiary hospitals experienced some changes in the mix of inpatient services provided to residents in the respective Steward PSAs. For example, as a group, tertiary hospitals experienced a decrease in their share of surgical discharges across all PSAs, while Steward hospitals experienced an increase in their respective share of surgical discharges in some PSAs, and a decrease in others. Across all Steward PSAs, the overall mix of surgical discharges in the PSA decreased slightly compared to other types of discharges, which may be explained in part by a shift in care to outpatient surgical sites. Figure 6 illustrates these and other changes in the inpatient service mix of tertiary hospitals in each Steward PSA from 2010 to 2014.

71 Service mix analysis for each Steward hospital is provided in the appendix at Table 15. Note that dental and other nominal service categories were not included in the service mix analysis for 2014; therefore percentages may not add to 100%.

Figure 6 – Change in Tertiary Inpatient Service Mix Share (2010/2014)



NOTES: Steward provides inpatient obstetrics services at five of its hospitals,[72] therefore tertiary service mix for obstetrics was excluded in markets where Steward does not provide obstetrics services.

Prices and Total Medical Expenses

Figure 7, Figure 8, and Figure 9 show how Steward's prices[73] and total medical expenses (TME) compare to those of area providers for each of the three major commercial insurers in Massachusetts. Steward has stated an important component of its strategy to improve care coordination and manage total medical expenses has been its adoption of alternative payment arrangements with both private and public payers. Steward has entered alternative payment contracts with each of the major commercial insurers as well as with Medicare and Medicaid MCOs, including participating as a Medicare Pioneer ACO.

72 Good Samaritan, St. Elizabeth, Holy Family, Morton, and Norwood.

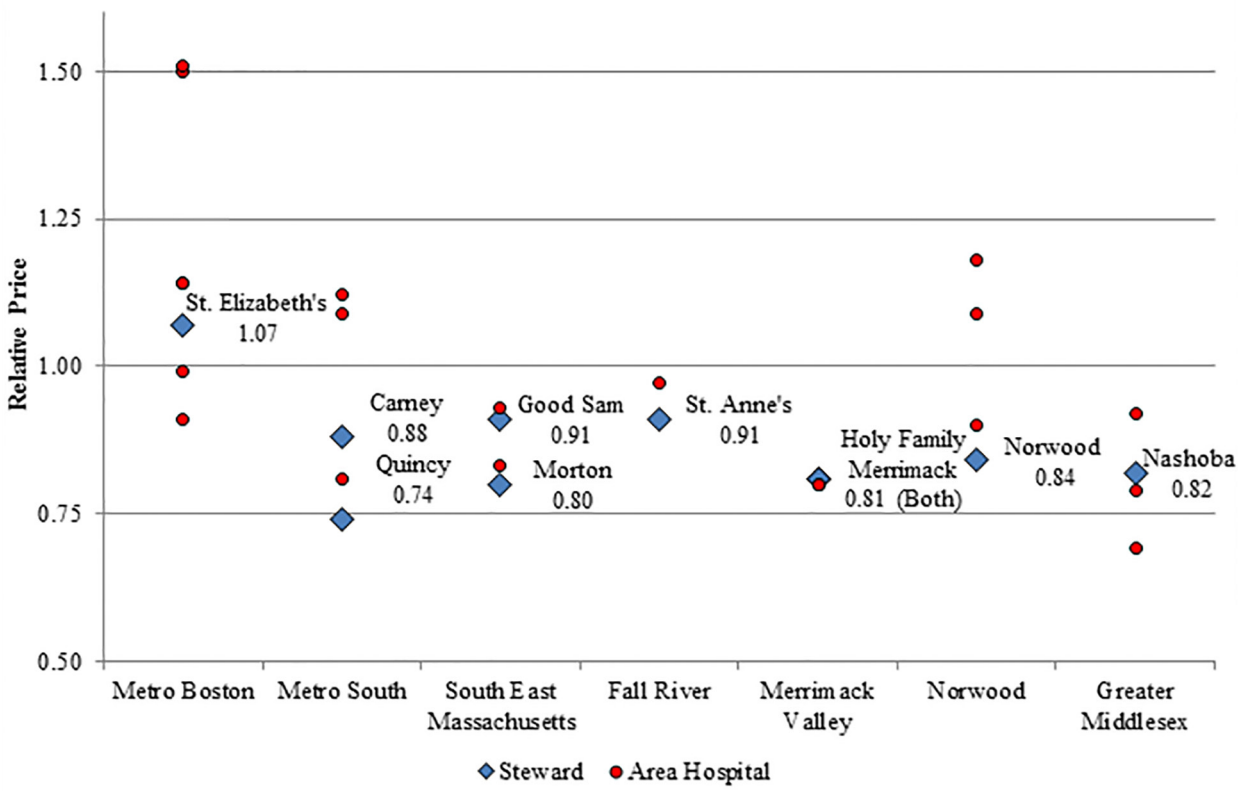
73 The price section compares Steward's relative price (1.00 reflects the network average for one year) and relative price *percentiles* (0.50 represents the network median across years) to that of other providers to see the relative amount each insurer pays Steward versus other competitors. These prices reflect an aggregate composite of the prices or payments for all hospital services (inpatient and outpatient) and all commercial insurance products (i.e., HMO, PPO). For more information on relative prices, *see* CHIA, Relative Price and Provider Price Variation, *available at* http://www.chiamass.gov/relative-price-and-provider-price-variation/.

Hospital Prices

In 2010, relative prices for Caritas hospitals varied by insurer and geography, with some Caritas hospitals on par with area hospitals, others less expensive, and others more expensive.

Over the next three years, Steward hospitals' relative price percentiles decreased or remained the same across the three major insurers. Accordingly, as of 2013, Steward hospitals continued to be low or moderately priced compared to other area hospitals.

Figure 7 - Relative Prices for Steward and Area Hospitals (BCBS 2013)[74]



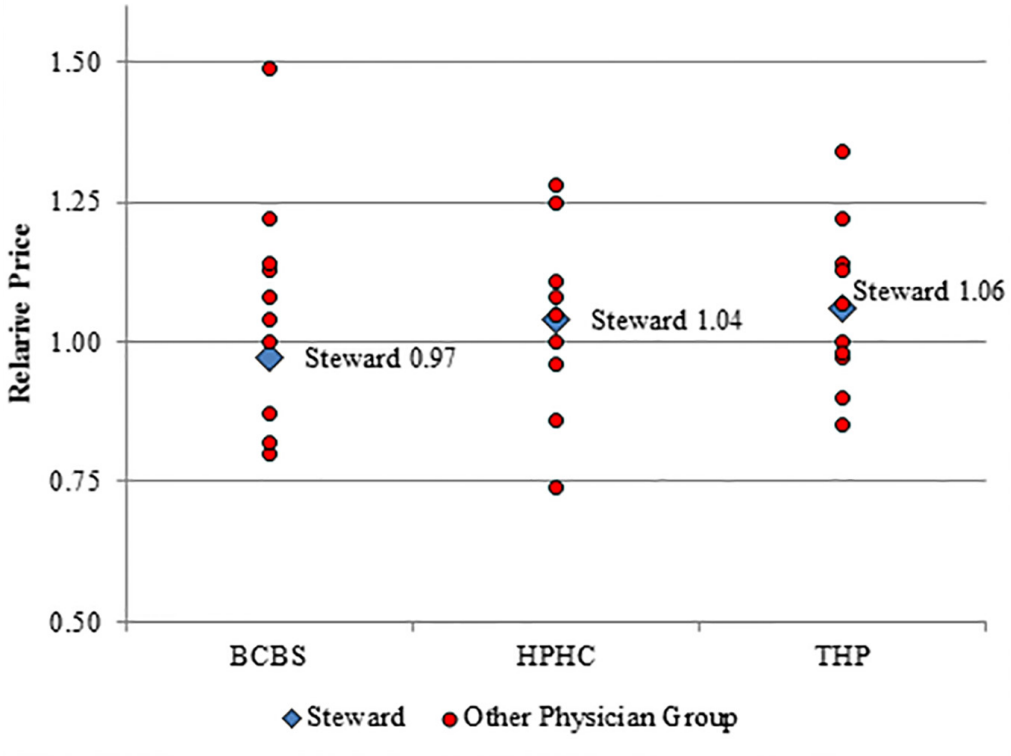
Physician Prices

In 2010, Caritas' physician prices were near the network average for BCBS, THP, and HPHC. From 2010 to 2012, Steward's physician relative price percentile increased slightly for BCBS and HPHC, decreased slightly for THP, but generally remained around the network median across all three insurers.[75] Overall, Steward physicians continued to be moderately priced in 2012 compared to other physician groups.

74 For a list of areas and hospitals, see *supra* note 68. Some hospitals' relative prices may be superimposed and not appear distinctly in this figure. For example, Holy Family and Merrimack are superimposed in the figure because they both have a relative price of 0.81.

75 Physician relative prices for 2013 were not yet available at the time of development of this report.

FIGURE 8 – RELATIVE PRICES FOR STEWARD AND OTHER PHYSICIAN GROUPS (2012)[76]



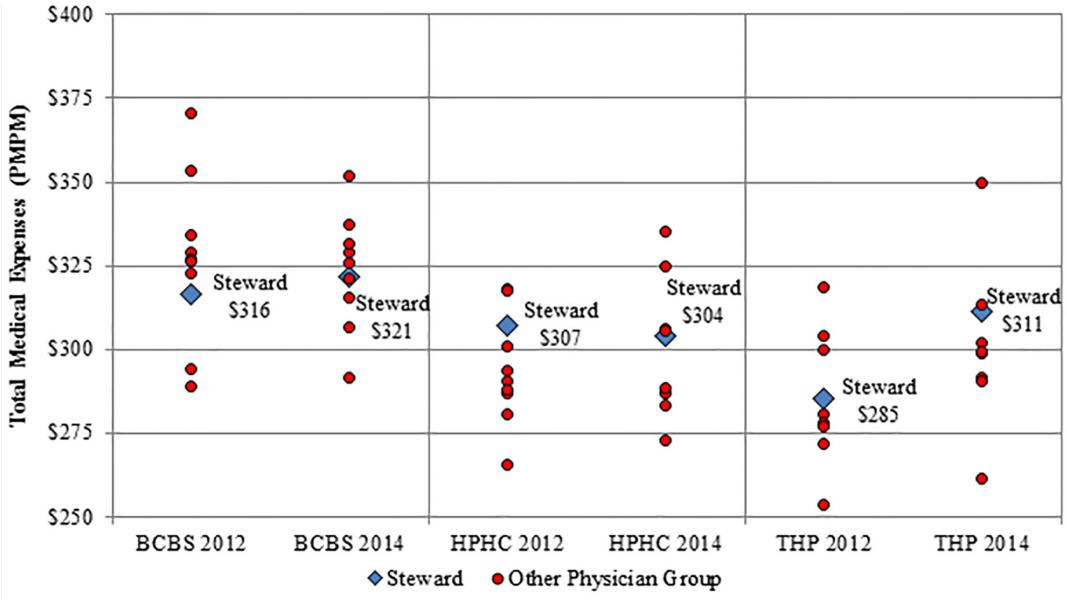
TOTAL MEDICAL EXPENSES

Figure 9 shows Steward's average health status adjusted per member per month TME compared to other provider groups for BCBS, HPHC, and THP.[77] In 2012, Steward's TME was generally mid-range across the three major commercial insurers. After several years of management, Steward has remained a moderate TME system in 2014, although an increase was observed for THP.

76 Other Physician Groups: Atrius Health; Beth Israel Deaconess PO; Boston Medical Center Management Service; Lawrence General IPA; Lowell General PHO; Mount Auburn Cambridge IPA; New England Quality Care Alliance (NEQCA); Partners Community HealthCare, Inc.; Signature Healthcare; South Shore Physician Hospital Organization; Southcoast Physicians Network. Note that some non-Steward physician groups' relative price may overlap together and may not be apparent in this figure.

77 TME measures the total cost of care for a patient. For analytic purposes, a patient's TME can be attributed to the provider system where the patient has his/her primary care provider (PCP). The TME data we present is adjusted using the health status scores provided by each insurer, to minimize bias in comparison due to differences in the sickness of the populations measured. Note that each insurer calculated health status scores for its network according to its own methodology, such that the reader should not necessarily compare TME *across* insurers.

FIGURE 9 – TME FOR STEWARD AND OTHER PHYSICIAN GROUPS (2012, 2014)[78]



MARKET IMPACT

In assessing the impact of Steward's stated strategy of retaining more care in the community, the AGO found:

1. For one major insurer, Steward appeared to increase retention of outpatient care within the Steward system;
2. Steward experienced slight declines in inpatient utilization and market share across a number of its hospitals, similar to tertiary hospitals' experience.

CARE RETENTION

Insurers provided referral pattern information to help understand where members are receiving their health care services.[79] Monitoring referral patterns over time and determining how often Steward patients are receiving care within the Steward network, as opposed to at tertiary or other community hospitals, is useful in measuring the effectiveness of Steward's "care-retention" strategy. The three largest commercial insurers each provided referral pattern data for patients with Steward PCPs from 2010 through 2013. One insurer was able to provide referral pattern data in a way that appropriately reflected any changes in physician network affiliation from one year to the next ("adjusted referral patterns"). That data is shown below.[80]

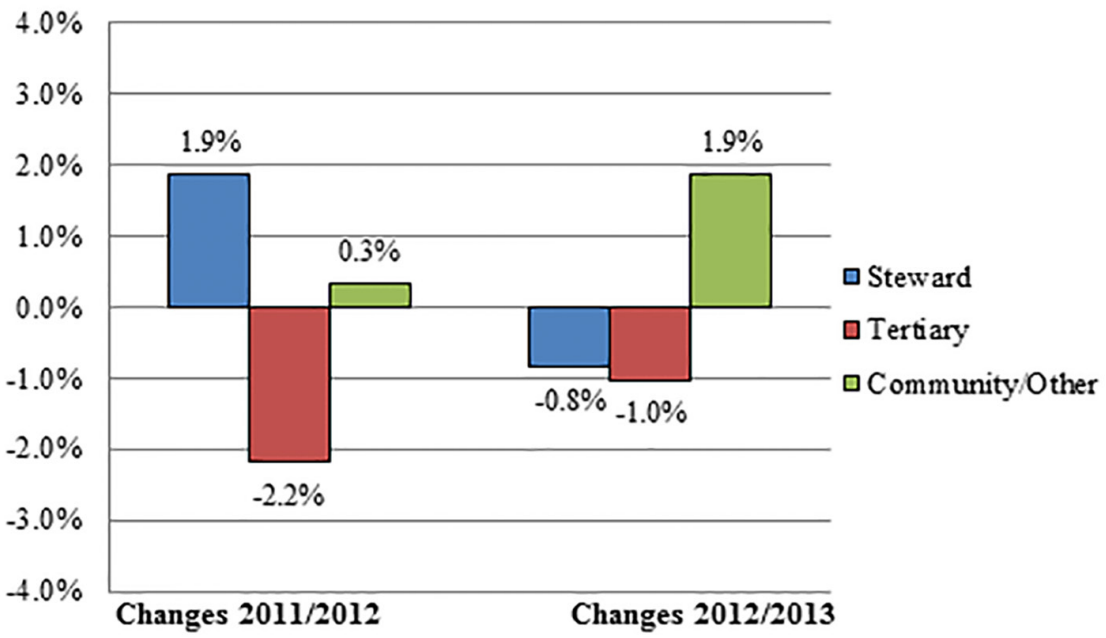
78 Other Physician Groups include: Atrius Health; Beth Israel Deaconess PO; Boston Medical Center Management Service, Lowell General PHO; Mount Auburn Cambridge IPA; New England Quality Care Alliance (NEQCA); Partners Community HealthCare, Inc.; Signature Healthcare; South Shore Physician Hospital Organization; and Southcoast Physicians Network. Note that some non-Steward physician groups' TME may overlap together and may not be apparent in this figure.

79 Referral patterns are measured for patients in HMO/POS health insurance plans, which require PCP selection, and the patterns identified determine how often patients use services within their PCP's network (Steward) versus services outside their PCP's network (Tertiary, other Community).

80 For this insurer, the AGO received this information for 2011/2012 and separately for 2012/2013. These two data sets were then adjusted for any groups of PCPs with over 500 members that joined or departed.

In 2011, for patients with Steward PCPs, 30.6% of inpatient admissions were at Steward hospitals. In 2012, this proportion increased by 1.9%. However, from 2012 to 2013, the adjusted referral pattern data we received indicates a decrease in the share of admissions that went to Steward hospitals.

Figure 10 – Changes in Inpatient Referral Patterns for One Major Insurer[81]

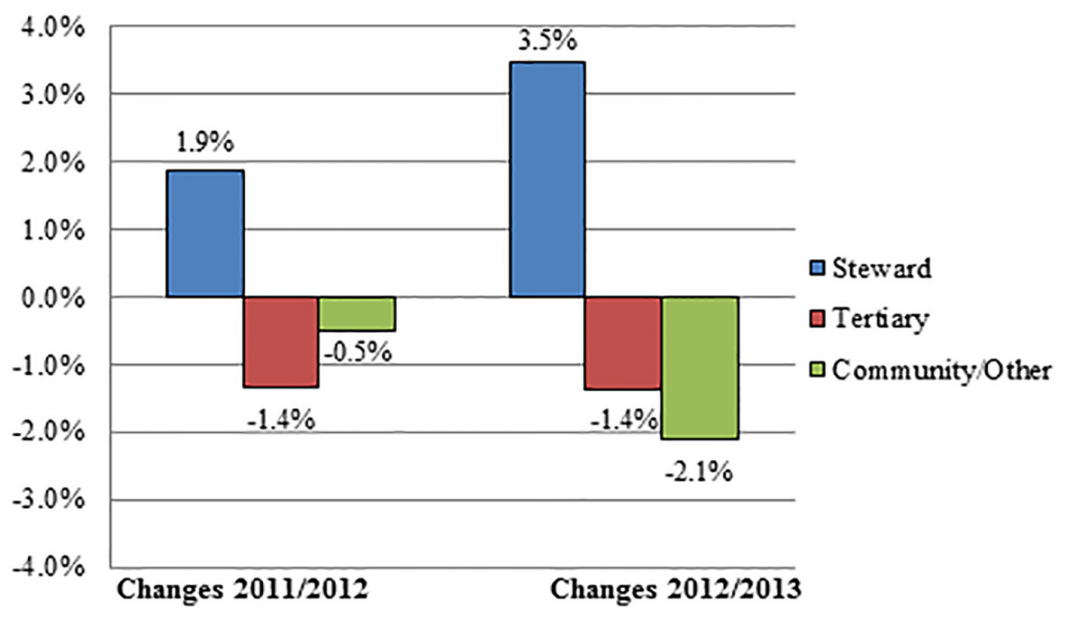


The AGO also examined hospital outpatient referral patterns in a similar manner.[82] For the same major insurer, the proportion of hospital outpatient services that patients with Steward PCPs received at Steward hospitals increased by 1.9% from 2011 to 2012. Similarly, the proportion of hospital outpatient services that patients with Steward PCPs received at Steward hospitals also increased by 3.5% from 2012 to 2013.

81 Referral analysis data is available in the appendix at Table 11 (inpatient).

82 One insurer was not able to provide outpatient utilization data by hospital, rather they provided outpatient total allowed claims by hospital. The allowed claims data were adjusted for differences in relative price by hospital to normalize for differences in unit cost by hospital. This methodology does not adjust for differences in the mix of the types of services provided by one hospital versus another.

Figure 11 – Changes in Outpatient Referral Patterns for One Major Insurer[83]



Inpatient Utilization and Market Share

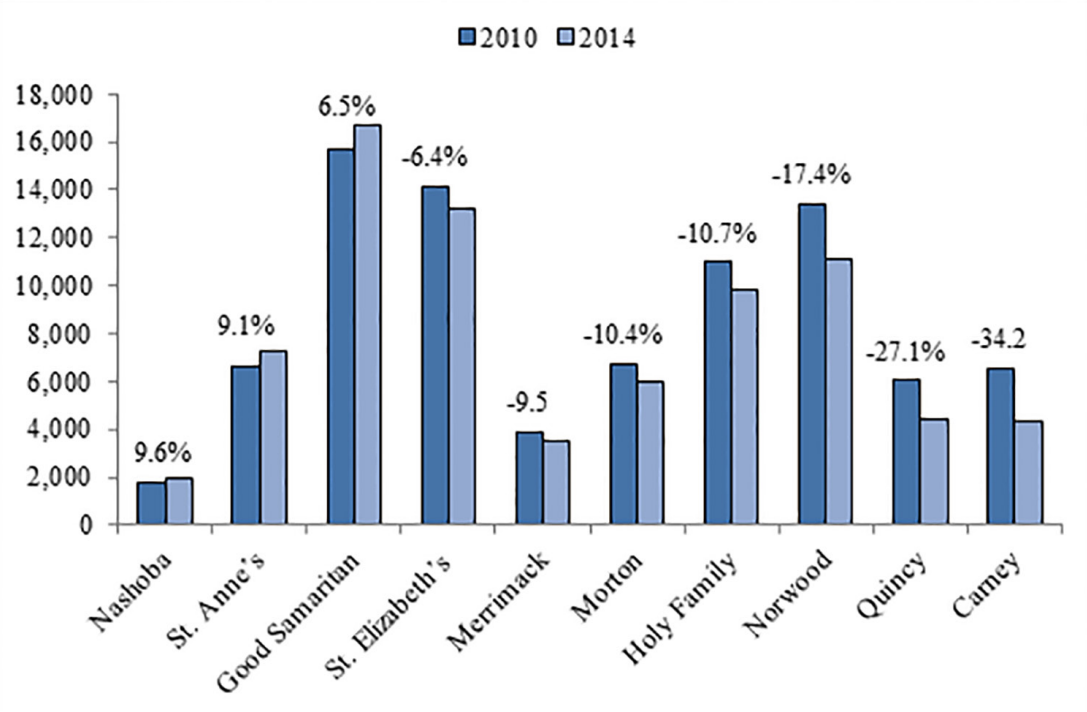
This section reviews Steward's inpatient volume and market share across its ten acute care hospitals from 2010 to 2014. Outpatient data was not available.

Utilization

From 2010 to 2014, overall discharges across all hospitals in the Commonwealth decreased 7.7%. Total discharges for tertiary hospitals decreased by 8.5%. Over the same period, inpatient volume declined for seven Steward hospitals, while Nashoba, St. Anne's, and Good Samaritan experienced an increase in inpatient discharges. Possibilities for the consistent loss in inpatient volume experienced by hospitals across the state include a drop in patient demand due to a weak economy, better care management, and/or a shift in sites of care from hospital inpatient settings to hospital outpatient settings, physician offices, and/or free-standing facilities. Steward's total overall decline of 8.8% is slightly more than the statewide decline, but similar to the decline experienced by tertiary hospitals during the same period.

83 Referral analysis data is available in the appendix at Table 12 (outpatient).

FIGURE 12 – INPATIENT DISCHARGES FOR STEWARD HOSPITALS (2010, 2014)[84]



NOTE: Hospital inpatient discharge data arranged from greatest proportional increase (left) to greatest proportional decrease (right) at Steward hospitals from 2010 and 2014.

MARKET SHARE

This section examines inpatient dynamics within the respective PSAs of Steward's ten acute hospitals.[85] Our analysis of PSA dynamics examines (1) Steward's inpatient market share in each PSA compared to other area hospitals; and (2) the share of patients residing in a PSA community who are going to Boston-area tertiary hospitals for their inpatient care.

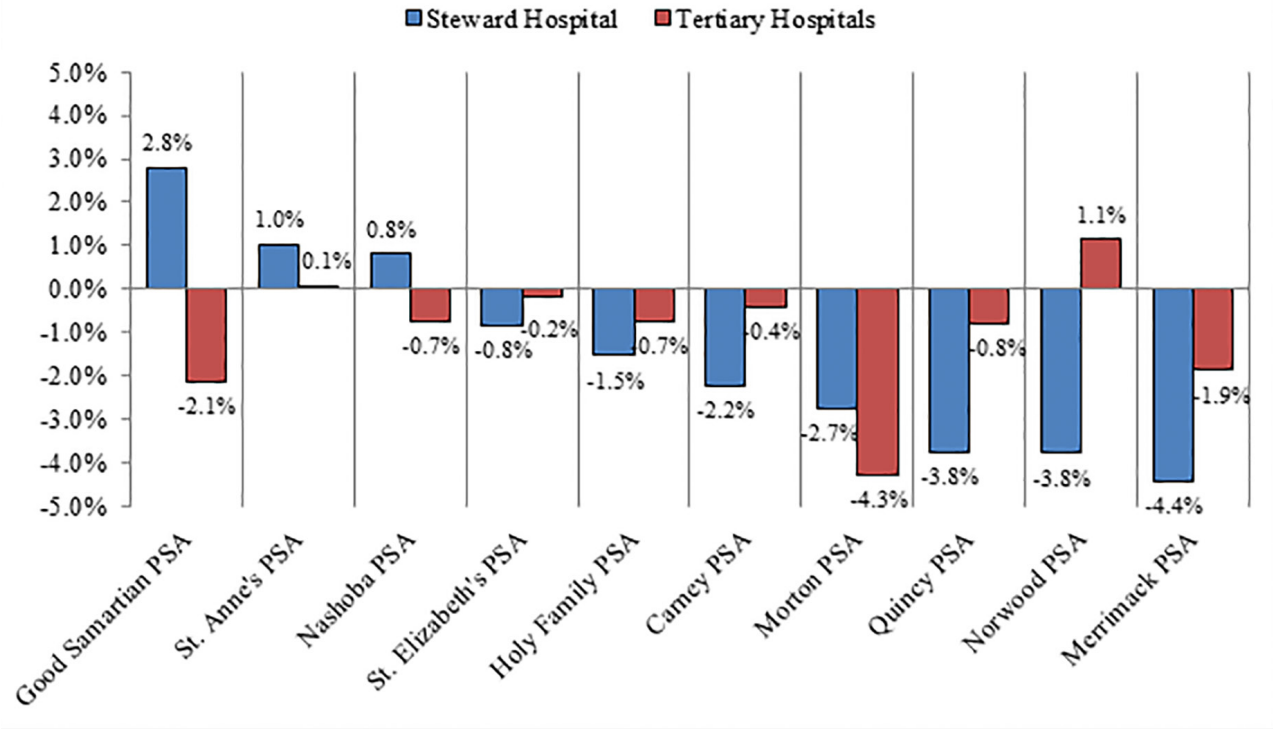
Figure 13 shows a slight decrease in inpatient market share from 2010 to 2014 for the principal Steward hospital in seven of Steward's ten acute hospital PSAs. As set forth in Table 14 in the Appendix, for three of these seven PSAs (Merrimack, Morton, and Norwood), the decrease in inpatient share experienced by Steward's principal hospital serving the PSA was partially, but not completely, offset by an increase in inpatient share experienced by another Steward hospital serving the same PSA (specifically, Holy Family also serves the Merrimack PSA, and Good Samaritan also serves the Morton and Norwood PSAs).

84 Utilization data for each Steward hospital is provided in the appendix at Table 13.

85 Market share is defined as the hospital's share of the total discharges for the PSA. Table 14 in the Appendix shows 2010-2014 inpatient market share data using a consistent cohort of zip codes from 2010 to 2014, so that any changes are not confounded by the addition or deletion of zip codes.

For three of Steward's acute hospital PSAs (Good Samaritan, St. Anne's, and Nashoba) the principal Steward hospital serving the PSA increased its inpatient market shares, and two of those three did so while tertiary hospitals' share of discharges in the PSA decreased. In eight of the ten PSAs, tertiary hospitals' share of discharges decreased (though generally decreased less than the associated Steward hospital).

Figure 13 – Changes in Inpatient Market Share (2010/2014)



NOTES: (1) Market share data arranged from largest increase in market share (left) to largest decrease in market share (right) at the principal Steward hospital in the PSA (blue) from 2010 to 2014; (2) PSAs show the market share of the principal Steward hospital serving the PSA (blue) and the market share of the tertiary hospital cohort (red) (e.g., Good Samaritan PSA column shows market share data for Good Samaritan Hospital and the performance of tertiary hospitals[86] in that particular market). Please see Table 13 in the Appendix for the inpatient shares of other hospitals that serve these PSAs, including Steward hospitals that serve PSAs other than their own.

86 *See supra* note 64 for hospitals included in the tertiary hospital cohort.

III. Financial Condition

This section analyzes Steward's financial performance, relying on the system's AFS and supplemental consolidating statements through 2014.[87] In reviewing Steward's AFS[88] from FY2012 to FY2014, the AGO found:

1. The profitability, liquidity, and solvency position of the system declined as debt increased, while operating losses and pension fund charges eroded equity;
2. Steward increased its reliance on long term debt financing; and
3. Steward's obligations related to its pension plans, significantly underfunded when Steward acquired Caritas, continued to be one of the system's largest liabilities, increasing to $368 million by December 2014.

Operating Performance

Steward System

Steward's AFS from FY2012 to FY2014 show consecutive years of substantial losses. In the fourth fiscal year of operations (FY2014), operating expenses continued to increase faster than revenues, resulting in a decline of the operating margin as net losses increased. The total net loss reported by Steward for FY2014 was $78.4 million, and was primarily due to operating losses at Quincy ($63.2 million) and the parent company ($85.8 million).[89] The operating losses at the parent company, where revenues were stable, was driven by a $34 million increase in depreciation expenses (corresponding to a $31 million decrease in depreciation expenses at the Steward hospitals), indicating that certain depreciable assets had been transferred from the hospitals to the parent. The system's liquidity also exhibited a declining trend over this period as current ratio, days cash on hand, and cash balances declined, each reaching a low point in 2014.

87 Management has discretion to allocate revenues and expenses among the system's multiple units, thus shifting profitability or losses across operating units based on internal criteria that may vary from year to year.

88 Steward is also required to file its AFS annually with the state pursuant to G.L. c. 12C § 8 and 114.1 Mass. Code Regs. 42.00, which it has not yet done for its 2014 consolidated AFS, due to CHIA in April 2015. Massachusetts requires the timely and complete filing of hospital organizations' AFS to enable adequate monitoring of the financial condition of the Commonwealth's hospitals and health care system.

89 The losses at Quincy included a loss of $39 million from operations during the year prior to closure, and a $24 million closing charge to write down Quincy's assets to fair market value.

Table 2 – System Financials (FY2012-FY2014)

(Amounts in Thousands)	FY2012	FY2013	FY2014
NPSR (Less Bad Debt)	$1,678,068	$1,756,248	$1,845,908
Operating Income (Loss)	($22,198)	($54,991)	($75,002)
Net Loss	($33,053)	($51,958)	($78,357)
Operating Margin	-1.1%	-2.6%	-3.5%
Current Ratio	0.99	0.93	0.79
Days Cash on Hand	9.95	6.49	2.25
Cash Balances	$52,182	$36,514	$13,046

Steward hospitals and SMG are the dominant drivers of the system's financial performance and condition. Taken together, the NPSR of these subsidiaries accounted for over 95% of the system's consolidated NPSR before eliminations in each year.

Steward Hospitals

The hospitals' operating profitability improved as the number of hospitals reporting operating profits increased and the number reporting operating losses decreased. In FY2014, the hospitals had a combined operating profit of $14.4 million, compared with a loss of $18.4 million in the prior year. However, the overall profitability of the hospitals as a group is due, in part, to the redistribution of expenses from hospitals to the parent company. A higher percentage of expenses was allocated to the parent in FY2014, which, by itself, served to improve the reported operating income at the Steward hospitals.

Table 3 - Operating Income (Loss) by Hospitals (FY2012-FY2014)

(Amounts in Thousands)	FY2012	FY2013	FY2014
St. Elizabeth's	$3,631	$9,735	$16,682
St. Anne's	$25,262	$12,874	$24,413
Holy Family	($2,902)	$7,714	$10,825
Carney	($10,029)	($9,005)	($9,311)
Norwood	($8,570)	($1,361)	$9,092
Good Sam	($3,943)	$4,045	$19,688
Merrimack	($5,801)	($10,705)	($3,674)
Nashoba	($1,613)	$130	$3,157
Morton	($3,724)	($9,691)	$8,926
Quincy	($5,389)	($20,522)	($63,264)
NE Sinai	(1,673)	($1,583)	($2,178)
Combined	($14,751)	($18,369)	$14,356

Steward Medical Group

SMG revenues increased steadily through the acquisition of physician group practices. However, SMG incurred operating losses in each year of analysis. In 2014, approximately one-third of SMG's total revenues ($130 million) represented payments from several Steward hospitals based on physician services provided at the hospitals.

Table 4 - Steward Medical Group Financial Performance (FY2012-FY2014)

(Amounts in Thousands)	FY2012	FY2013	FY2014
Total Revenues	$312,820	$418,601	$459,639
NPSR (Less Bad Debt)	$209,152	$275,109	$329,523
Operating Income (Loss)	($1,845)	($13,675)	($6,955)

Capital Structure

Since initially investing $245.9 million in the system, Cerberus has not contributed additional equity to Steward. Similarly, Steward did not distribute significant amounts of cash or other assets to Cerberus. For its cash requirements, Steward principally relied on two forms of bank financing: a revolving credit agreement and a term loan.

Major Sources of Financing

Until early 2013, Steward primarily relied on a secured bank revolving credit agreement provided by three banks. The revolving credit, set up in 2011, was set to mature in June 2016. Following successive amendments of the revolving credit that increased the maximum borrowing limit from $150 million to $275 million, Steward refinanced in April 2013. A $285 million, seven-year term loan due in 2020 was set up to repay the outstanding balance of the revolving credit, which was then amended to provide a reduced borrowing limit of $100 million. Steward hospitals and other real estate were pledged to secure the term loan, and collateral for the revolving credit included the system's remaining assets (primarily consisting of accounts receivable).

Both the term loan and the revolving credit agreement require Steward to meet certain financial covenants. The most restrictive financial covenants put maximum limits on the ratio of total debt relative to operating cash flow. In a credit opinion published in April 2015, Moody's Investors Service estimated that Steward would remain in compliance with its financial covenants, but noted that "slower than anticipated [cash flow] improvement has resulted in relatively modest cushion under the maximum leverage and minimum interest coverage covenants."[90] Table 5 shows the development of Steward's long term debt, equity, and assets from FY2012-FY2014.

90 Credit Opinion: Steward Health Care System LLC, Moody's Investors Services, 3 (April 2, 2015), *available at* https://www.moodys.com/credit-ratings/Steward-Health-Care-System-LLC-credit-rating-823355719.

Table 5 - Financial Condition (FY2012-FY2014)

(Amounts in Millions)	FY2012	FY2013	FY2014
Long Term Debt	$326.4	$407.8	$413.3
Equity[90]	$21.3	$64.1	($185.4)
Assets	$1,246.2	$1,276.6	$1,219.6

The solvency position of the system declined as debt increased, while operating losses and pension fund charges eroded equity. Outstanding debt (excluding pension liabilities) went from $326 million at the end of FY2011, to $413 million at the end of FY2014. By FY2014, equity was a negative $185 million, while total liabilities exceeded $1.4 billion. Steward was in compliance, according to its AFS, with all applicable debt covenants as of December 31, 2014.

Other Sources of Financing

In 2012, Steward borrowed $100 million pursuant to a real estate financing with Healthcare Trust of America (HCA). In this transaction, Steward leased certain medical office properties to HCA for 99 years, and leased back from HCA parts of such properties. The lease and leaseback with HCA was restructured in 2013 as a sale and leaseback, which had minimal cash flow effect. In 2013, Steward granted IPC Healthcare exclusive hospitalist provider status for the Steward hospitals for five years in exchange for a cash payment to Steward of $44.5 million. In 2014, Steward entered into an agreement with Quest Diagnostics to sell Steward's laboratory testing and cytology services businesses for approximately $35 million in cash and a ten-year non-compete agreement. That same year, Steward also agreed to a sale leaseback of the New England Sinai campus, land, buildings, and equipment for $23.4 million, leased back to Steward for fifteen years with renewal options of ten years.

91 Equity declined in 2011 and 2012 as most of the original Cerberus equity investment in Steward ($246 million) was consumed by net losses. Equity increased in 2013, notwithstanding Steward's large loss, primarily due to a non-cash reduction in pension liability arising from changes in certain actuarial assumptions, consistent with applicable federal standards. Further changes in those assumptions contributed significantly to the reduction in equity reflected in 2014.

Material Noncurrent Liabilities and Obligations Affecting Financial Performance

This section addresses other Steward obligations and activities affecting system financial performance.[92]

Pensions

Steward continues to have increasing financial obligations with respect to the defined benefit pension plans that it assumed in the acquisitions of Caritas Christi,[93] Morton Hospital, and New England Sinai. The federal Employee Retirement Income Security Act (ERISA) requires Steward to amortize the underfunded amount of each plan with cash contributions over seven years. These contributions are included in an annual minimum contribution that ERISA requires. Unlike Steward's bank debt, its pension obligations are unsecured, though the pensions are insured through the Pension Benefit Guaranty Corporation.[94] Steward reported on its financial statements the total underfunded amount. The underfunded amount of a pension plan is subject to fluctuation from year to year as market forces may change the value of plan assets and actuarial assumptions may change the benefit obligation. The federal Pension Benefit Guarantee Corporation, Department of Labor, and Internal Revenue Service oversee ERISA benefit plan funding and payment requirements, including Steward's obligations under the three defined-benefit plans it assumed from Caritas, Morton, and New England Sinai.

Table 6 - Steward's Pension Liability[95]

(Amounts in Thousands)	FY2012	FY2013	FY2014
Benefit Obligation	$822,488	$737,774	$905,976
Fair Value Plan Assets	$458,301	$518,622	$537,361
Underfunded Amount[95]	$364,187	$219,152	$368,615

92 For example, in 2013, Steward disbursed $30.9 million to a number of executives in the form of five-year loans. The amounts were secured by certain equity interests awarded to executives as incentive compensation beginning in 2011. The program provided that once an executive's interests vested, each executive had the option to surrender the equity interests to Steward in satisfaction of the loan disbursement. By the end of 2014, most of the executive loans had vested.

93 As part of its 2010 acquisition of Caritas, Steward agreed to accept financial responsibility for three defined benefit pension plans covering approximately 13,000 employees and retirees of Caritas. Two of the three plans were specific to Norwood and Good Samaritan. A third and much larger plan covered employees and retirees of Caritas and was maintained by the RCAB.

94 When the RCAB maintained the Caritas pension plan, it was not entitled to that insurance.

95 Although still large relative to Steward's financial condition, the underfunded amount of the Steward plans declined in 2013 by almost $150 million, driven by investment gains in plan assets ($62.0 million) and "actuarial gain" ($87.2 million) from assumed higher discount rates used to calculate the projected benefit obligation. Further changes in actuarial assumptions, relating to discount rates and mortality tables, caused the underfunded amount to increase in 2014 by approximately $150 million.

96 Each of the three Caritas defined benefit plans was substantially underfunded at the time Steward acquired the Caritas system. Steward's subsequent acquisitions of Morton and New England Sinai, added their underfunded pension plans to Steward's total pension liabilities.

Steward has reported the assets and liabilities of the Caritas Plan on its financial statements since it assumed the obligations under that plan as part of the Caritas transaction, but during a transition period the RCAB continued to administer the plan. That transition period ended on May 1, 2014. As of that date, Steward assumed full responsibility for the Caritas Plan and the plan became subject to ERISA requirements including seven year amortization of its underfunded amount. The first payments for this plan will be due from Steward in 2016, and would mean a significant increase in Steward's cash outlays for the pension plans.

Capital Commitments

The physical plants of the Caritas, Morton, and Quincy hospitals that Steward acquired had been neglected over an extended period, and required substantial investment in order to support operations in the relevant markets.[97] Information regarding Steward's compliance with its capital commitments is available in the Compliance Report.[98]

97 *See* AGO Statement, *supra* note 3, at 13-14

98 Compliance Report on Steward Health Care System, *supra* text, at 6-8.

Conclusion

Steward is an important health system in the Commonwealth that continues to serve a sizeable share of elderly and lower-income patients. After several years of operation, evidence of Steward's progress on meeting its goal of keeping more care within the community shows mixed results. Steward has experienced challenges in its financial performance over time, which may be due in part to underlying market dynamics that favor more expensive providers.

Our principal findings are summarized as follows:

Organizational Profile

After acquiring the Caritas system, Steward continued to expand its organization by acquiring several hospitals and provider groups. By the end of 2012, Steward had created a health care system with ten acute care hospitals and one of the largest physician networks in the Commonwealth. Following this period of growth, the rate of acquisitions slowed as Steward made several changes to its hospital system and clinical affiliations. In 2014 and 2015, Steward merged Merrimack Hospital into Holy Family, closed Quincy Medical Center, and adjusted its clinical affiliations for oncology and pediatric services.

Market Analysis

Steward primarily serves eastern Massachusetts and continues to provide a sizeable share of services to elderly and lower-income patients at nearly all its hospitals. Steward's hospitals continued to provide a larger share of medical and psychiatric inpatient services than the overall mix in their respective markets. The system's hospitals and physicians remain low to moderately priced compared to other area providers. There is evidence from one major insurer that patients with Steward PCPs have increasingly obtained outpatient care at Steward hospitals, while the system's share of inpatient discharges in a number of the markets it serves has decreased.

Financial Condition

Overall, the financial condition of the Steward system has declined since 2012. Although the operating performance of some of its hospitals appears to have improved over time, the system's operating losses increased as hospital expenses shifted to the parent company. The system has increasingly relied on bank term loans to fund operating losses and capital expenditures, leading to a capital structure in which debt exceeded equity by several multiples by December 2013. In addition, the pension plans, significantly underfunded when Steward acquired the Caritas system, remain one of the system's largest liabilities. As a result, the ability to meet requirements of its lenders and investors may be an important challenge for Steward.

The market trends Steward has experienced are similar to those experienced by other lower cost community providers across the state. As documented by this office, health care market dysfunction persists, with negative consequences for many lower cost providers. Without improvement to market functioning, community-based care in the Commonwealth will likely continue to experience challenges. The AGO's September 18, 2015 Cost Trends Report documents these market findings in greater detail and provides specific recommendations.[99]

99 *See* AGO's Fifth Cost Trends Report, *supra* note 40.

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The Attorney General's Office thanks the agencies, market participants, and other stakeholders who provided information for this Report for their courtesy and cooperation.

Table 7 – GPSR Payer Mix (Inpatient & Outpatient: FY2010, FY2014)[100]

Metro Boston	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014
	Commercial		Medicare		Medicaid		Other Govt.		Self-Pay/Other	
St. Elizabeth's*	33.95%	33.29%	41.16%	44.26%	12.98%	17.57%	10.77%	3.57%	1.15%	1.32%
Boston Medical Center	25.11%	20.86%	27.98%	26.88%	44.73%	50.07%	0.53%	0.87%	1.65%	1.32%
BIDMC	48.09%	42.10%	35.35%	38.61%	14.62%	17.27%	0.64%	0.66%	1.30%	1.35%
Partners - BWH	49.59%	47.29%	33.24%	36.23%	12.38%	12.81%	3.54%	2.32%	1.26%	1.35%
Partners - MGH	45.09%	42.18%	35.70%	38.03%	13.68%	13.75%	4.11%	4.42%	1.43%	1.62%
Mount Auburn	45.50%	44.47%	42.64%	43.05%	9.31%	10.64%	0.14%	0.15%	2.41%	1.69%
Tufts Medical Center	42.31%	39.52%	33.08%	35.00%	23.83%	23.85%	0.24%	1.18%	0.55%	0.45%
Metro South	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014
	Commercial		Medicare		Medicaid		Other Govt.		Self-Pay/Other	
Carney*	27.77%	21.23%	43.63%	40.86%	26.60%	34.61%	1.15%	1.02%	0.84%	2.28%
Quincy*	32.72%	24.38%	49.00%	49.38%	17.18%	24.84%	0.28%	0.49%	0.83%	0.91%
BID - Milton	40.68%	38.15%	49.05%	48.64%	8.05%	11.13%	0.18%	0.25%	2.04%	1.83%
Partners - Faulker	49.23%	43.55%	35.78%	38.11%	11.55%	14.94%	1.33%	2.62%	2.11%	0.78%
South Shore	47.59%	41.97%	39.54%	43.15%	11.69%	13.96%	0.35%	0.40%	0.83%	0.52%
Southeastern MA	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014
	Commercial		Medicare		Medicaid		Other Govt.		Self-Pay/Other	
Good Samaritan*	32.95%	31.42%	45.31%	44.37%	18.78%	22.55%	1.88%	1.26%	1.07%	0.39%
Morton*	35.26%	30.93%	43.02%	43.88%	19.89%	23.65%	1.08%	0.88%	0.75%	0.67%
BID - Plymouth	43.03%	36.20%	43.82%	49.39%	12.09%	13.12%	0.52%	0.60%	0.54%	0.69%
Signature Brockton	31.43%	27.41%	36.46%	38.41%	29.86%	32.72%	1.00%	0.87%	1.25%	0.59%

100 GPSR payer mix analysis based on CHIA 403 hospital cost reports. *See* CHIA, Information for Data Submitters: Hospital Cost Reports, *available at* http://www.chiamass.gov/information-for-data-submitters-hospital-cost-reports/. Commercial includes: managed commercial (HMO), non-managed commercial (PPO), and workers compensation; Medicare (Federal and Private) includes: tradition Medicare and managed Medicare (private); Medicaid (State and Private) includes: traditional Medicaid (MassHealth), managed Medicaid (private), Children's Health Insurance Program, Commonwealth Care/Connector Care, and the Health Safety Net; Other Govt. includes: CHAMPUS, DMH, DPH, DSS, Other Mass. State and Local Agencies, Out-of-State Government Agencies, and Out-of-State Medicaid; Self-Pay and Other includes: self-payers, free care for patients not eligible for the Health Safety Net, foundations, and research grants for patient care. *See* CHIA, Hospital Statement of Costs, Revenues, and Statistics, 15-19, *available at* http://www.chiamass.gov/assets/docs/p/hospital-reports/403-instructions.pdf.

Fall River	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014
	Commercial		Medicare		Medicaid		Other Govt.		Self-Pay/Other	
St. Anne's*	27.72%	30.43%	49.22%	49.14%	21.80%	19.61%	0.78%	0.65%	0.48%	0.17%
Southcoast	29.37%	26.35%	47.14%	47.34%	21.20%	24.47%	0.68%	0.83%	1.61%	1.00%
Merrimack Valley	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014
	Commercial		Medicare		Medicaid		Other Govt.		Self-Pay/Other	
Merrimack Valley*	28.71%	24.42%	52.93%	54.73%	16.56%	19.60%	0.59%	0.38%	1.21%	0.86%
Holy Family*	37.22%	32.16%	41.53%	42.57%	18.80%	23.75%	0.85%	0.87%	1.60%	0.65%
Anna Jaques	41.14%	39.68%	43.20%	44.20%	13.85%	14.06%	0.44%	0.87%	1.37%	1.19%
Lawrence General	28.71%	22.66%	37.09%	39.26%	29.87%	33.44%	0.55%	0.76%	3.79%	3.87%
Norwood	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014
	Commercial		Medicare		Medicaid		Other Govt.		Self-Pay/Other	
Norwood*	41.93%	35.71%	45.65%	48.93%	10.68%	14.05%	1.04%	0.95%	0.70%	0.37%
Milford Regional	49.98%	47.11%	38.13%	38.51%	10.36%	13.13%	0.48%	0.29%	1.05%	0.96%
Newton-Wellesley	64.14%	58.54%	28.31%	30.85%	5.37%	7.10%	1.00%	2.39%	1.18%	1.12%
Sturdy Memorial	40.49%	34.07%	41.51%	44.45%	16.41%	19.94%	0.41%	0.57%	1.18%	0.97%
Greater Middlesex	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014
	Commercial		Medicare		Medicaid		Other Govt.		Self-Pay/Other	
Nashoba*	44.96%	35.83%	39.86%	47.52%	11.60%	13.67%	2.49%	2.12%	1.09%	0.86%
Emerson Hospital	56.30%	53.47%	35.22%	36.02%	5.04%	7.05%	1.88%	1.85%	1.55%	1.62%
HealthAlliance	35.79%	31.18%	39.74%	40.60%	20.30%	23.70%	2.52%	3.58%	1.64%	0.95%
Lowell General	43.56%	33.86%	35.25%	40.10%	19.30%	23.69%	0.46%	0.49%	1.43%	1.86%
Totals	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014	FY 2010	FY 2014
	Commercial		Medicare		Medicaid		Other Govt.		Self-Pay/Other	
Total Steward*	34.26%	31.31%	44.59%	46.03%	17.13%	20.50%	3.04%	1.42%	0.98%	0.72%
Total Massachusetts	42.33%	38.87%	36.73%	38.60%	17.74%	19.34%	1.93%	2.05%	1.27%	1.15%

*Denotes Steward Hospital

Table 8 – Hospital Relative Price Percentiles by Commercial Insurer (2010, 2013)[101]

	BCBS		HPHC		THP	
Metro Boston	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile
St. Elizabeth's*	0.66	0.70	0.70	0.70	0.63	0.62
Boston Medical Center	0.39	0.41	0.43	0.49	0.25	0.19
Mount Auburn	0.48	0.64	0.55	0.53	0.77	0.77
Tufts Medical Center	0.59	0.81	0.62	0.66	0.40	0.58
BIDMC	0.78	0.81	0.74	0.68	0.87	0.83
Partners – BWH	0.94	0.94	0.83	0.85	0.94	1.00
Partners – MGH	0.95	0.95	0.83	0.89	0.98	0.96
Cohort Average	0.68	0.75	0.67	0.69	0.69	0.71
Metro South	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile
Carney*	0.36	0.36	0.32	0.28	0.58	0.50
Quincy*	0.06	0.06	0.02	0.00	0.06	0.1
BID - Milton	0.20	0.20	0.06	0.11	0.00	0.00
South Shore	0.72	0.80	0.87	0.98	0.81	0.69
Partners - Faulkner	0.72	0.72	0.66	0.79	0.60	0.67
Cohort Average	0.41	0.43	0.39	0.43	0.41	0.39
Southeastern MA	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile
Good Samaritan*	0.41	0.41	0.49	0.43	0.46	0.37
Morton*	0.33	0.16	0.15	0.36	0.12	0.10
Signature Brockton	0.20	0.27	0.23	0.21	0.33	0.27
BID - Plymouth	0.48	0.47	0.53	0.49	0.33	0.25
Cohort Average	0.36	0.32	0.35	0.37	0.31	0.25
Fall River	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile
St. Anne's*	0.69	0.41	0.89	0.87	0.52	0.33
Southcoast	0.56	0.56	0.57	0.47	0.63	0.81
Cohort Average	0.62	0.48	0.73	0.67	0.58	0.57

101 Relative price percentiles analysis based on relative price information provided by CHIA. *See* CHIA, *supra* note 73.

Merrimack Valley	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile
Holy Family*	0.16	0.20	0.30	0.28	0.46	0.33
Merrimack Valley*	0.25	0.20	0.04	0.02	0.08	0.13
Anna Jaques	0.09	0.16	0.23	0.23	0.12	0.02
Lawrence General	0.17	0.16	0.09	0.15	0.17	0.13
Cohort Average	0.17	0.18	0.16	0.17	0.21	0.15
Norwood	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile
Norwood*	0.31	0.28	0.36	0.32	0.56	0.44
Milford Regional	0.41	0.39	0.45	0.32	0.42	0.44
Partners – Newton-Wellesley	0.66	0.72	0.68	0.74	0.71	0.75
Sturdy Memorial	0.83	0.86	0.81	0.64	0.92	0.88
Cohort Average	0.55	0.56	0.57	0.51	0.65	0.63
Greater Middlesex	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile	2010 Percentile	2013 Percentile
Nashoba*	0.28	0.25	0.11	0.15	0.15	0.44
Lowell General	0.17	0.02	0.45	0.43	0.27	0.23
HealthAlliance	0.20	0.14	0.17	0.11	0.17	0.27
Emerson	0.41	0.45	0.21	0.26	0.42	0.50
Cohort Average	0.27	0.21	0.23	0.23	0.25	0.36

*Denotes Steward Hospital

Table 9 – Physician Relative Price Percentiles by Commercial Insurer (2010, 2012)[102]

Physician Groups	BCBS		HPHC		THP	
	2010 Percentile	2012 Percentile	2010 Percentile	2012 Percentile	2010 Percentile	2012 Percentile
Caritas/Steward	0.47	0.53	0.50	0.59	0.68	0.64
Atrius Health	0.94	0.94	0.91	0.91	0.91	0.91
Beth Israel Deaconess PO	0.24	0.35	0.59	0.73	0.86	0.86
Boston Medical Center Management Service	n/a	n/a	0.09	0.23	0.18	0.36
Lawrence General IPA	n/a	n/a	n/a	n/a	0.27	0.27
Lowell General PHO	0.65	0.65	0.36	0.77	0.32	0.82
Mount Auburn Cambridge IPA	0.88	0.88	0.82	0.64	0.59	0.73
New England Quality Care Alliance (NEQCA)	0.76	0.71	0.41	0.45	0.59	0.45
Partners Community HealthCare, Inc.	0.82	0.76	0.95	0.95	0.95	0.95
Signature Healthcare	n/a	n/a	0.14	0.00	0.18	0.41
South Shore Physician Hospital Organization	0.18	0.18	0.55	0.41	0.36	0.14
Southcoast Physicians Network	n/a	n/a	0.27	0.27	0.14	0.18
Cohort Average	0.52	0.53	0.51	0.54	0.50	0.56

102 *See generally id.*

Table 10 – Health Status Adjusted TME by Commercial Insurer (2012, 2014)[103]

Provider Group	BCBS		HPHC		THP	
	2012	2014	2012	2014	2012	2014
Steward	$316.44	$321.43	$306.95	$303.81	$285.01	$311.07
Atrius Health	$353.47	$328.76	$293.35	$286.86	$280.43	$313.37
BIDPO/BIDCO	$294.04	$306.36	$300.68	$306.21	$278.14	$301.64
Boston Medical Center Management Service	$289.14	$291.34	$265.71	$283.03	$253.26	$261.11
Lowell General PHO	$328.81	$321.19	$286.64	$272.75	$277.07	$298.65
Mount Auburn Cambridge IPA	$370.58	$337.36	$290.32	$288.60	$299.63	$299.54
New England Quality Care Alliance (NEQCA)	$327.09	$331.66	$287.65	$305.28	$271.62	$291.43
Partners Community HealthCare, Inc.	$334.07	$351.87	$317.85	$335.11	$318.37	$349.84
Signature Healthcare	$322.68	$315.62	n/a	n/a	n/a	n/a
South Shore Physician Hospital Organization	$326.36	$325.99	$317.46	$324.57	$304.16	$290.47
Southcoast Physicians Network	n/a	n/a	$280.42	n/a	n/a	n/a

Table 11 – Inpatient Referral Patterns for One Major Insurer (2011-2012; 2012-2013)

	Adjusted for 2012		Adjusted for 2013	
	2011	2012	2012	2013
Steward	30.6%	32.4%	28.6%	27.7%
Tertiary[104]	26.8%	24.6%	23.0%	22.0%
Community/Other	42.6%	43.0%	48.4%	50.3%

Table 12 – Outpatient Referral Patterns for One Major Insurer (2011-2012; 2012-2013)

	Adjusted for 2012		Adjusted for 2013	
	2011	2012	2012	2013
Steward	40.6%	42.5%	38.5%	42.0%
Tertiary	26.2%	24.8%	26.1%	24.7%
Community/Other	33.2%	32.7%	35.4%	33.3%

103 Health status adjusted TME analysis based on information provided by CHIA. *See generally* CHIA, Total Medical Expenses, *available at* http://www.chiamass.gov/total-medical-expenses-2.

104 *See supra* note 64 for tertiary hospitals.

Table 13 – Inpatient Discharges for Steward and Tertiary Hospitals (2010–2014)[105]

Hospitals	2010	2011	2012	2013	2014	% Change 14/10
Carney	6,545	5,835	5,353	5,135	4,305	-34.2%
Good Sam	15,671	16,134	16,911	16,513	16,690	6.5%
Holy Family	10,977	11,359	12,099	10,760	9,804	-10.7%
Norwood	13,425	13,173	12,827	11,479	11,085	-17.4%
St. Anne's	6,638	6,992	7,174	6,938	7,242	9.1%
St. Elizabeth's	14,131	13,913	13,449	12,770	13,224	-6.4%
Merrimack	3,873	3,697	3,537	3,126	3,507	-9.5%
Nashoba	1,787	1,913	1,829	1,827	1,958	9.6%
Morton	6,702	6,274	6,720	6,447	6,004	-10.4%
Quincy	6,047	5,875	5,413	4,774	4,408	-27.1%
All Steward	85,796	85,165	85,312	79,769	78,227	-8.8%
Tertiary Group[106]	288,991	287,585	278,138	268,987	264,302	-8.5
MA Total	851,154	853,207	829,868	806,139	785,485	-7.7%

Table 14 – Steward Hospitals' Inpatient Market Share (2010, 2014)

Carney PSA	2010	2014	Change 10/14
Carney*	8.5%	6.3%	-2.2%
South Shore	7.7%	8.8%	1.1%
BID - Milton	6.9%	6.1%	-0.8%
Quincy*	5.8%	5.8%	0.0%
Tertiary Total	60.9%	60.5%	-0.4%
All Other	10.2%	12.4%	2.2%
Total Admissions in PSA	*54,668*	*46,742*	*-14.5%*
Good Samaritan PSA	2010	2014	Change 10/14
Good Samaritan*	24.1%	26.9%	2.8%
Brockton	23.2%	21.2%	-2.0%
Morton*	11.3%	10.6%	-0.7%
South Shore	5.3%	5.3%	0.0%
Tertiary Total	23.7%	21.6%	-2.1%
All Other	12.4%	14.5%	2.0%
Total Admissions in PSA	*45,856*	*42,792*	*-6.7%*

105 Inpatient discharge data based on information from the Massachusetts Health Data Consortium's Inpatient Discharge Data and CHIA's Case Mix - Hospital Inpatient Discharge Database. *See generally* Massachusetts Health Data Consortium, *available at* http://www.mahealthdata.org/; CHIA, Case Mix Data, *available at* http://www.chiamass.gov/case-mix-data [hereinafter Massachusetts Health Data Consortium and CHIA data].

106 *See supra* note 64 for hospitals included in the tertiary hospital cohort.

Holy Family PSA	2010	2014	Change 10/14
Holy Family*	25.4%	23.9%	-1.5%
Lawrence General	31.7%	34.6%	2.9%
Merrimack Valley*	7.4%	6.7%	-0.6%
Anna Jaques	3.0%	3.2%	0.2%
Tertiary Total	21.5%	20.7%	-0.7%
All Other	11.0%	10.8%	-0.2%
Total Admissions in PSA	*33,158*	*31,434*	*-5.2%*
Norwood PSA	2010	2014	Change 10/14
Norwood*	30.1%	26.3%	-3.8%
Good Samaritan*	7.2%	8.7%	1.5%
Newton-Wellesley	7.1%	7.7%	0.6%
Sturdy Memorial	6.4%	6.3%	-0.1%
Tertiary Total	29.4%	30.5%	1.1%
All Other	19.8%	20.4%	0.6%
Total Admissions in PSA	*32,568*	*29,927*	*-8.1%*
St. Anne's PSA	2010	2014	Change 10/14
St. Anne's*	26.9%	27.9%	1.0%
Southcoast	62.5%	59.6%	-2.9%
Good Samaritan*	0.3%	1.1%	0.8%
St. Elizabeth's*	0.4%	0.9%	0.5%
Tertiary Total	7.4%	7.5%	0.1%
All Other	2.5%	3.0%	0.5%
Total Admissions in PSA	*20,930*	*19,998*	*-4.5%*
St. Elizabeth's PSA	2010	2014	Change 10/14
St. Elizabeth's*	9.1%	8.3%	-0.8%
Mount Auburn	9.1%	8.8%	-0.3%
Newton-Wellesley	8.1%	8.5%	0.4%
Tertiary Total	53.7%	53.5%	-0.2%
All Other	20.0%	21.0%	1.0%
Total Admissions in PSA	*77,703*	*65,382*	*-15.9%*
Morton PSA	2010	2014	Change 10/14
Morton*	41.5%	38.7%	-2.7%
Good Samaritan*	9.1%	10.6%	1.5%
Brockton	6.8%	6.4%	-0.4%
BID – Plymouth	3.7%	3.9%	0.2%
Tertiary Total	22.5%	18.2%	-4.3%
All Other	16.4%	22.2%	5.7%

Total Admissions in PSA	*13,979*	*13,013*	*-6.9%*
Quincy PSA	2010	2014	Change 10/14
Quincy*	19.5%	15.7%	-3.8%
South Shore	29.0%	32.1%	3.1%
BID - Milton	4.5%	5.5%	1.0%
Tertiary Total	35.2%	34.5%	-0.8%
All Other	11.7%	12.1%	0.4%
Total Admissions in PSA	*24,588*	*22,083*	*-10.2%*
Merrimack PSA	2010	2014	Change 10/14
Merrimack*	24.2%	19.8%	-4.4%
Anna Jaques	20.0%	21.3%	1.3%
Lawrence General	12.9%	15.7%	2.8%
Holy Family*	9.9%	12.1%	2.1%
Tertiary Total	22.6%	20.8%	-1.9%
All Other	10.4%	10.4%	0.0%
Total Admissions in PSA	*12,487*	*12,216*	*-2.2%*
Nashoba PSA	2010	2014	Change 10/14
Nashoba*	17.7%	18.5%	0.8%
Emerson	25.2%	23.5%	-1.7%
Lowell General	8.8%	10.3%	1.5%
Tertiary Total	29.0%	28.3%	-0.7%
All Other	19.3%	19.5%	0.2%
Total Admissions in PSA	*8,220*	*7,851*	*-4.5%*

Table 15 – Steward and Tertiary Hospitals' Inpatient Service Mix (2010, 2014)[107]

Carney PSA	2010			2014		
	Total Discharges from PSA	Carney	Tertiary Hospitals	Total Discharges from PSA	Carney	Tertiary Hospitals
Medical	49.3%	63.6%	44.7%	47.4%	62.5%	43.0%
Surgery	25.1%	19.3%	27.9%	23.3%	18.5%	25.3%
Obstetrics	19.2%	0.3%[108]	24.6%	22.2%	0.3%	28.4%
Psychiatry	6.4%	16.7%	2.8%	6.5%	18.3%	2.5%
Good Samaritan PSA	**2010**			**2014**		
	Total Discharges from PSA	Good Samaritan	Tertiary Hospitals	Total Discharges from PSA	Good Samaritan	Tertiary Hospitals
Medical	51.2%	57.2%	37.6%	50.6%	56.9%	39.5%
Surgery	25.4%	20.1%	46.0%	23.2%	19.2%	40.0%
Obstetrics	16.9%	14.0%	14.8%	18.4%	15.3%	18.1%
Psychiatry	6.5%	8.7%	1.5%	7.3%	8.4%	1.4%
Holy Family PSA	**2010**			**2014**		
	Total Discharges from PSA	Holy Family	Tertiary Hospitals	Total Discharges from PSA	Holy Family	Tertiary Hospitals
Medical	45.4%	47.6%	37.7%	47.1%	47.2%	45.3%
Surgery	26.2%	17.7%	49.1%	23.7%	18.9%	40.8%
Obstetrics	21.0%	19.5%	11.9%	21.3%	20.7%	11.7%
Psychiatry	7.4%	15.2%	1.4%	7.4%	12.8%	1.2%
Norwood PSA	**2010**			**2014**		
	Total Discharges from PSA	Norwood	Tertiary Hospitals	Total Discharges from PSA	Norwood	Tertiary Hospitals
Medical	48.3%	62.1%	36.8%	46.7%	57.5%	38.9%
Surgery	28.8%	21.3%	45.9%	26.5%	22.1%	38.8%
Obstetrics	16.2%	7.6%	16.2%	18.2%	8.4%	20.4%
Psychiatry	6.8%	9.0%	1.1%	8.1%	11.4%	1.3%
St. Anne's PSA	**2010**			**2014**		
	Total Discharges from PSA	St. Anne's	Tertiary Hospitals	Total Discharges from PSA	St. Anne's	Tertiary Hospitals
Medical	56.5%	76.2%	38.4%	57.3%	73.3%	38.5%
Surgery	25.1%	18.6%	56.1%	23.0%	22.5%	54.6%
Obstetrics	13.9%	0.4%[109]	4.1%	14.3%	0.1%	4.9%
Psychiatry	4.4%	4.8%	1.5%	5.1%	3.6%	1.5%

107 See Massachusetts Health Data Consortium and CHIA data, *supra* note 105. Note that dental and other nominal service categories were not included in the service mix analysis for 2014; therefore proportions may not add to 100%.

108 Carney does not offer obstetrics services. The few recorded discharges for 2010 and 2014 reflect unusual circumstances.

109 St. Anne's does not offer obstetrics services. The few recorded discharges for 2010 and 2014 reflect unusual circumstances.

St. Elizabeth's PSA	2010			2014		
	Total Discharges from PSA	St. Elizabeth's	Tertiary Hospitals	Total Discharges from PSA	St. Elizabeth's	Tertiary Hospitals
Medical	45.3%	47.2%	42.3%	43.5%	44.2%	41.8%
Surgery	25.5%	24.7%	29.8%	23.5%	20.7%	27.1%
Obstetrics	21.6%	14.2%	25.0%	24.7%	16.9%	28.1%
Psychiatry	7.6%	13.9%	2.9%	7.8%	17.9%	2.5%
Morton PSA	2010			2014		
	Total Discharges from PSA	Morton	Tertiary Hospitals	Total Discharges from PSA	Morton	Tertiary Hospitals
Medical	51.2%	68.9%	37.2%	49.8%	65.6%	39.5%
Surgery	27.4%	16.5%	53.1%	26.0%	18.5%	48.4%
Obstetrics	15.9%	11.3%	7.7%	17.1%	12.8%	10.4%
Psychiatry	5.5%	3.4%	2.0%	6.7%	2.7%	1.1%
Quincy PSA	2010			2014		
	Total Discharges from PSA	Quincy	Tertiary Hospitals	Total Discharges from PSA	Quincy	Tertiary Hospitals
Medical	48.9%	69.0%	35.9%	48.5%	68.5%	36.6%
Surgery	26.9%	24.1%	37.5%	24.6%	24.0%	32.6%
Obstetrics	17.6%	0.1%[110]	24.2%	19.5%	0.1%	28.2%
Psychiatry	6.6%	6.8%	2.5%	6.9%	7.0%	2.0%
Merrimack PSA	2010			2014		
	Total Discharges from PSA	Merrimack	Tertiary Hospitals	Total Discharges from PSA	Merrimack	Tertiary Hospitals
Medical	45.7%	72.7%	36.8%	46.8%	65.9%	43.6%
Surgery	26.3%	18.3%	51.5%	22.7%	14.0%	43.6%
Obstetrics	19.2%	0.1%[111]	10.5%	19.4%	0.0%	10.9%
Psychiatry	8.8%	8.9%	1.2%	10.8%	19.7%	1.3%
Nashoba PSA	2010			2014		
	Total Discharges from PSA	Nashoba	Tertiary Hospitals	Total Discharges from PSA	Nashoba	Tertiary Hospitals
Medical	43.9%	78.4%	36.0%	45.4%	76.6%	40.5%
Surgery	30.7%	19.0%	53.8%	28.5%	18.9%	45.3%
Obstetrics	18.0%	0.1%[112]	8.7%	19.0%	0.0%	11.7%
Psychiatry	7.4%	2.5%	1.5%	6.6%	4.2%	1.5%

110 Quincy did not offer obstetrics services. The few recorded discharges for 2010 and 2014 reflect unusual circumstances.
111 Merrimack does not offer obstetrics services. The few recorded discharges for 2010 reflect unusual circumstances.
112 Nashoba does not offer obstetrics services. The few recorded discharges for 2010 reflect unusual circumstances.

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