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September 11, 2014

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street, 6th floor
Boston, MA 02111

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

Dear Executive Director Seltz:

Pursuant to your letter dated August 1, 2014 and in accordance with Massachusetts General Laws chapter 6D, § 8, please find included herein Steward Health Care System's responses to the questions outlined in Exhibits B and C. I am legally authorized and empowered to represent Steward Health Care System and provide the enclosed testimony.

Please feel free to call Joseph Maher, General Counsel, at (617) 419-4708 should you have any questions.

Sincerely,

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

cc:
Stuart Altman, Ph.D.
Chair, Health Policy Commission
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Áron Boros
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Steward Health Care Responses to Exhibit B: Health Policy Commission Questions

Question 1 - Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.

Summary: Steward Health Care System LLC (Steward) is New England's largest integrated community-care, provider network encompassing eleven hospital campuses, nearly 3,000 physicians, specialists, nurses as well as home health, behavioral health, and outpatient services. Steward is also the third largest private employer in the Commonwealth, with over 17,000 employees. Steward's mission is straightforward: to provide world-class health care in the communities where our patients live.

Steward continues to strongly advocate that the Commonwealth's cost growth benchmark be adjusted – or indexed – to account for hospitals' wide variation in relative payment differentials. The Health Policy Commission's (HPC) current approach to establishing a uniform cost growth benchmark for all providers assumes that the relative payment across providers represents an appropriate baseline, when in fact it does not, but actually perpetuates existing price and payment disparities among providers. Since some provider's prices are exceedingly high and others—especially those serving low-to-moderate income communities with high government payer mix—are much lower, a uniform benchmark will widen the current reimbursement disparities among providers. For example, the cost growth benchmark must be adjusted to account for hospitals' relative payment differentials, requiring providers with high prices to hold their cost growth below the benchmark and simultaneously begin to address the wide variation in reimbursements among hospitals and providers, especially those providers whose prices are at or below the state median.

a) What trends has your organization experienced in revenue, utilization, and operating expenses from CY2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

Response: Steward has aggressively focused on cost efficiency since its inception. In fact, the Steward Community Care Model was founded on the premise that high-quality care can be administered in a more cost-efficient manner without compromising quality by "right siting of patient care" to the most appropriate setting. One of the challenges we have observed in the era of healthcare reform is that as unit price reimbursements from payers decline, the unit cost of labor and medical supplies has grown. In other words, in an environment of declining revenue, our labor and supply costs are out of pace with payments from commercial payers, Medicare and Medicaid. This imbalance places a strain on providers as they seek to deliver as many services as patients require, while remaining as cost-efficient as possible. This gap is actually worse for providers with high Medicaid payer mix.

We have also noticed that in certain markets, our inpatient admissions have declined while utilization of outpatient services has increased. This growing trend toward outpatient services will continue to force providers to shift infrastructure and resources toward outpatient services while potentially downsizing inpatient services in order to keep up with public policy and payer demands to lower health care costs. We are unsure what is driving this lower trend; it is difficult to assess whether it is due to aggressive care management, national health care trend or a combination of many factors.

In an effort to address these trends Steward continues to restructure operations, renegotiate labor contracts, renegotiate payer terms, and reconfigure services to meet patient demand and community needs. For example, Steward continues to implement a primary care growth strategy across our network with the goal of remaining cost-efficient, while addressing ever-evolving government and payer policies to shift care to lower cost settings. We continue to increase office hours to meet our patient's needs and expand urgent care centers that offer more primary care-focused services for our patients.

One area where providers continue to face serious challenges is in the Medicaid space. While commercial payers and Medicare have implemented payment reforms – like ACOs and global, risk-based payments– that reward good, cost-efficient care in an integrated manner, Medicaid continues to pay under traditional fee–for-service arrangements. <u>The lack of reform in how Medicaid reimburses providers makes it difficult for providers to care for Medicaid patients efficiently, worsens the existing price and reimbursement disparities among providers and perpetuates the practice of cost shifting to make up for Medicaid's dramatically low payments.</u>

b) What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

Response: Steward was created to meet the objectives of health care reform – to provide and achieve the highest quality care in the most cost-efficient manner. Steward has invested significant resources over the past three years to create an Integrated Community Care Model that improves access to high quality, cost-efficient, community-based health care to the more than 1 million residents we serve annually.

Steward's Integrated Community Care Model uses publicly available total medical expense (TME) and relative price data as a guide to reduce unnecessary health care spending and ultimately premiums. The TME data demonstrate that reductions in health care spending can be achieved by providing care among high quality, lower cost community settings and through local primary care providers where most Massachusetts residents live, instead of higher priced and highly paid Academic Medical Centers.

To that end, Steward continues to grow the number of primary care providers in our network to provide real-time access to health care services across our communities. We

continue to enhance our infrastructure to proactively coordinate health care services across our ACO under global, risk-based payment arrangements as a way to manage our patient's care. Steward is also partnering with community-based post-acute care providers to improve patient care transitions and to better integrate care. These enhancements have improved quality outcomes and have mitigated excessive medical spending, which are often the result of minimal patient service coordination and transitions of care.

In addition, Steward continues to leverage several health insurance product offerings to drive additional value to our patients and employers through significantly lower premiums. For individuals and small businesses, Steward offers a limited network product that features significant premium savings relative to the cost of comparable health insurance products. Steward also offers all of its employees a health insurance plan that features significantly discounted premiums. With over 75% employee participation, this lower premium product has been very popular among employees. In fact, our health insurance product's premiums are designed to be even more affordable for employees with lower wages. We also leverage robust care coordination programs to ensure that care is delivered in high quality, cost-efficient community-based settings rather than higher cost providers outside of the communities we serve.

We are also attempting to evolve our contractual relationships with commercial health plans toward "percent of premium" contracts. At Steward, we believe that the ultimate goal of health care reform should not be to lower "costs", but rather to lower health insurance premiums, particularly in the commercial market. One way in which we are working to achieve this goal is by attempting to move our commercial contracts with payers under percent of premium arrangements.

Under a percent of premium model, an integrated provider organization is placed at risk for a budgeted amount equal to the percent of premium dollar needed to provide medical services and programs for a defined population, while the health plan agrees to the percent of premium dollar needed to provide the administrative services under such contract. Part of the goal of this model is to reduce, or eliminate duplicative administrative costs (e.g. IT, care coordination, member engagement programs, analytics, etc.) and to enhance population health management programs in the delivery system where they are most cost-effective and appropriate. The health plan manages the administrative functions needed to supply the services and to facilitate the provider's health care services. State differently, a percent of premium model neutralizes the difference in what is considered TME and leverages both provider and insurance organizations to do what is most appropriate and efficient for patients and cost. If some providers are capable of offering insurance functions, than a higher percent of premium is retained. This innovative payment model enables Steward and its partner health plans to directly pass significant premium reductions onto employers and employees alike, while providing the same level of quality health care and broad access to the Steward provider network.

We believe that a percent of premium model is one of the most efficient means of focusing premium dollars - intended for medical spending - on direct patient medical care, as well as an effective means of reducing costs through integrated care management. The percent of premium model also refocuses the role of health plans toward administrative functions (e.g. sales and claims processing) since health plans continue to shift more risk onto providers.

Moreover, Steward has invested in population health management programs, which allow us to care for high-risk patients and manage their medical care more efficiently and effectively. Another significant part of our approach has been our investment of over $130 million in information systems that integrate community-based providers across the continuum of care. Steward's IT system enables our physicians and hospitals to provide real-time coordinated care, while simultaneously mitigating duplication of services and tests. This investment also includes an upgrade to our integrated image archiving system that unites all facilities under a common archive and patient index, ensuring that all comparison studies are available at the point of care and reducing potential duplication of imaging. Steward's highly integrated and interoperable information technology system has also helped to prevent readmissions and significantly improve our quality scores across our hospitals and physician offices.

Areas of opportunity to improve quality and efficiency of care include management of high-risk populations and chronic diseases. Steward's patient-focused Population Health Management program includes several initiatives designed to target quality of care, improve the overall health of our members, and lower the annual rate of health care cost growth. Some of these programs include the following.

- Clinical Integration Program: Improving quality and prevention through standardization of evidence-based, cost effective clinical protocols across the continuum for all Steward Health Care Network (SHCN) members regardless of funding source
- Emergency Room Re-direction: Avoids costly Emergency Department services that are more appropriately delivered by primary care providers (PCPs) or urgent care centers
- Complex and Chronic Patient Management: Risk stratification of patient populations to identify and manage high risk, high cost members to prevent avoidable admissions and ED visits
- Readmission Prevention: Acute discharge planning, medication reconciliation, and follow-up visits
- Skilled Nursing Facility (SNF) Patient Management: Focused on reducing the length of stay (LOS) of patients in SNFs while improving outcomes
- Congestive Heart Failure Program: Care Management teams develop care plans for patients with multiple co-morbidities to avoid unnecessary utilization and permit the patient to remain at home, rather than in higher cost settings
- Community Health Advocates (CHAs): CHAs currently operate at six Steward hospitals as trusted members of the community that help patients gain access to

available health programs and navigate the health care system. Steward's CHAs provide patients with information and assistance to access public insurance programs and aid newly-insured patients in finding a primary care provider, scheduling appointments, and overcoming other barriers to accessing health care, such as transportation or language differences. The CHAs also engage in health promotion with patients, encouraging healthy behaviors, such as good diet and exercise habits

- Telehealth: Critical care patients receive physician and nursing coverage through remote monitoring, which supplements on-site monitoring resulting in measurable decrease in morbidity, mortality and length of stay. Tele-stroke in five Steward hospital Emergency Departments supports timely evaluation and treatment of stroke patients

Steward's community-based teams further expand access and create linkages to primary care across our many ethnically and linguistically diverse communities, an essential strategy for reducing medical costs and unnecessary use of services in lower-income communities with high concentrations of Medicaid and Medicare populations.

Statewide, one of the largest opportunities to immediately reduce health care costs is to address the significant number of individuals that leave the community and travel into Boston to seek routine care at higher cost, highly paid Academic Medical Centers and their affiliates. Data provided by the Center for Health Information and Analysis (CHIA) at the 2011 Cost Trends hearings revealed that care in Boston is at least 50% more expensive than care provided in the community, resulting in higher priced hospitals and doctors taking in $80 of every $100 of all the money health insurers spend on hospitals and doctors. The disparity in commercial rates harms community hospitals and providers and threatens their ability to invest in population health and care coordination initiatives; the migration of patient volume from the community into Boston forces community providers to make service and operational cuts to an inflexible cost structure, eliminating jobs and reducing access to essential health care services in local communities over time. Unfortunately, recent data from the Health Policy Commission suggests that the migration toward expensive Boston teaching hospitals has persisted and even grown in the three years since this trend was first publicly reported, especially among patients with commercial insurance.

c) What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

Response: In the next year, Steward will focus on further strengthening and expanding our ACO model. In order for Steward and all providers to succeed in meeting the statewide cost containment benchmark we will need the Commonwealth's leadership in shifting away from fee for service, especially from the Medicaid program.

Steward has engaged both commercial payers and Medicare to shift our reimbursements and payment incentives to global, risk-based arrangements. These efforts have led to better patient care coordination, lower costs, aligned incentives across our provider network, and better integration of our ACO. One example is our Medicare Pioneer ACO, Steward Promise, which is one of the top five (5) performing ACOs nationally in terms of delivering better care, while at the same time lowering TME in Medicare. We believe that the growth in provider-led ACOs supported by global, risk-based payments are essential to helping the Commonwealth lower the rate of growth in health care costs and successfully meet the cost growth benchmark.

Unfortunately, Medicaid remains the only major payer in Massachusetts that has yet to implement an ACO model, or global, risk-based payment arrangements with providers. Medicaid is the second largest payer in Massachusetts serving over 1.6 million beneficiaries (approximately 25% of the state's population) at over $10 billion in annual spending – mostly under fee-for- service. In order for the entire state to succeed, Medicaid must immediately become a partner in payment reform, instead of perpetuating reimbursement disparities among providers and forcing providers with high government payer mix to cost shift further increasing health costs for everyone.

Since the passage of Chapter 224 in 2012, Steward has advocated that Medicaid implement an ACO program. The fact that Medicaid has yet to implement a legislatively mandated initiative, or a payment model that both the commercial market and Medicare have successfully implemented, merits intense scrutiny and a full understanding of the program's operational integrity and future plans for payment reform.

d) What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

Response: The primary systematic or policy change that would enable Steward to operate more efficiently without reducing quality is the development of a Medicaid ACO payment model. While this is mandated in Chapter 224, the state has yet to implement this payment reform.

Since the beginning of health care reform, the commercial market has implemented payment reforms that lower costs without compromising quality. Blue Cross Blue Shield (BCBS) implemented the Alternative Quality Contract (AQC), other health plans have implemented their versions of ACOs and global, risk-based payments, and providers continue to shift their reimbursement platforms toward risk-based arrangements. Once the Affordable Care Act (ACA) was passed, Medicare implemented the Medicare Pioneer ACO program, as well as the Medicare Shared Savings Programs. All of these ACO, risk-based reimbursement models have worked to shift providers away from fee for service and incent them to better integrate health care services in a cost-efficient manner.

Unfortunately, Medicaid has yet to adopt a provider-led ACO program to foster enhanced provider innovation, or shift providers away from fee-for-service. It is essential that Medicaid move quickly to implement a Medicaid ACO in order to keep pace with the innovation taking place in the commercial market and Medicare; one that has demonstrated success in lowering costs. In fact, CHIA's Annual Report on the Performance of the Massachusetts Health Care System shows that the state was successful in keeping the THCE below 3.6%, in large part due to the commercial market and Medicare's alternative payment models, including ACOs and risk-based payment models.

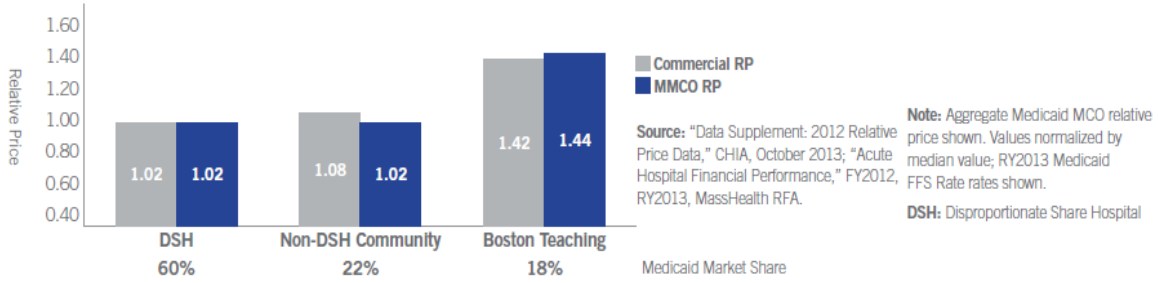
Medicaid however, continues to pay primarily under fee for service, even with legislative mandates to do otherwise under Chapter 224. Less than 3% of Medicaid's fee-for-service spending is dedicated to alternative payment methodologies. Even though it represents nearly 25% of the state's total health care expenditures, Medicaid continues to function as a claims payment entity for providers, rather than as a health insurance organization dedicated to promoting and rewarding providers for delivering integrated care and better outcomes to the Medicaid patients for whom it provides care.

The Commonwealth must also encourage Medicaid to reform its contracting practices and enable integrated providers with a Risk Certificate from the Division of Insurance to contract directly with Medicaid for the provision of health care services for Medicaid beneficiaries. Competition among providers and payers will lead to new innovations and cost effective models of providing better value to both patients and taxpayers without compromising the gains Massachusetts has made to expand access to coverage.

Another area for the Commonwealth to take a more proactive approach to lower costs and narrow provider price variation is within its own Medicaid Managed Care Organization (MCO) program and the Group Insurance Commission (GIC). In analyzing CHIA data, we have observed that provider price variation in the Medicaid MCO program and the state's GIC program is in many instances worse than the price variation found in the commercial market – please see the figure below from *Healthcare Inequality in Massachusetts: Breaking the Vicious Cycle*, a report released by the Healthcare Equality and Affordability League (H.E.A.L.) earlier this year. This wide variation in payments among taxpayer funded health care programs is a major opportunity for the Commonwealth to implement payment reforms and merits immediate attention from state policymakers.

Medicaid managed care health plans' reimbursement rates also disadvantage community hospitals

Figure 11. Commercial and Medicaid MCO RP by Cohort



Source: "Data Supplement: 2012 Relative Price Data," CHIA, October 2013; "Acute Hospital Financial Performance," FY2012, RY2013, MassHealth RFA.

Note: Aggregate Medicaid MCO relative price shown. Values normalized by median value; RY2013 Medicaid FFS Rate rates shown.

DSH: Disproportionate Share Hospital

Question 2 - C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.

Response: Steward supports the immediate transition away from fee-for-service payments toward global, risk-based payments for providers and ACOs. Currently, Steward provides care for over 300,000 commercial, Medicare, and GIC members in an ACO supported by risk-based contracts. Risk-based payment arrangements have enabled Steward to meet the needs of our patients, as well as invest in infrastructure and care coordination programs necessary to sustain high quality, lower cost care for the patients we serve.

Steward is currently engaged in risk-based contracts with Blue Cross Blue Shield (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP), as well as Medicare. Steward's TME trend has outperformed our target budget annually since 2009 for BCBS, HPHC, and THP. Additionally, quality and outcomes scores have improved every year since 2009 across our health plans and quality improvements have been clearly measurable in BCBS's AQC program.

Steward is also one of only 23 provider organizations nationally participating in Medicare's risk-based Pioneer ACO contract and was one of only 13 organizations to successfully lower its medical cost trend below a shared savings target in the initial year of the program. In the second year of Medicare's Pioneer ACO model, Steward was within the top five of highly selective, innovative ACO providers who delivered high quality care and lowered medical cost trends below a shared savings threshold, resulting in savings to the Medicare program.

Steward believes that ACOs supported by global, risk-based contracting models are the best opportunity to lower cost because, unlike fee-for-service, globally paid arrangements reward the provision of high quality, cost effective, integrated care, and allow providers to make the necessary investments in health care delivery infrastructure needed to care comprehensively for communities and patients. Global, risk-based payment arrangements

also enable providers to focus on clinical integration and care improvement initiatives that address both high-risk patients as well as routine care services for all patients. Moreover, such payment arrangements create financial and clinical incentives necessary for providers to appropriately meet the total population health needs of patients. For example, most health plans "carve out" their behavioral health patients, resulting in very fragmented care outcomes and incentives for such patients. Medicaid also carves out its behavioral health services, contributing to the dysfunctional delivery and reimbursement system that exists for patients with such medical conditions. In order for providers to better integrate care and implement integrated models of care, commercial health plans must transition their contracting strategy from a focus on budget-based risk contracts to percent of premium contracting across all of their "books of business"

On the government side, Medicaid must implement a provider-led ACO payment program where providers can be placed at financial and clinical risk for the care they provide to Medicaid beneficiaries. Medicaid's existing fee for service payment model perpetuates rising health care costs, as well as the wide disparities among provider reimbursements in the market.

An area for the HPC to review in the future is the fact that alternative payment arrangements in the commercial market have thus far been confined to managed care fully insured (HMO) products. Only one local plan currently includes self insured HMO services in their risk payment arrangement. PPO product information reveals that most large health plans have between half and two-thirds of their commercial lives in PPO products, virtually all paid under fee-for-service. The adoption of PPO risk arrangements is challenging given the lack of a benefit design requiring PCP selection and PCP management of care. These arrangements need greater alignment of member benefits that favorably recognize members receiving care from providers participating in alternative arrangements in order to be successful.

Of those PCPs who have been with Steward over the past four years, we have observed all-payer annual declines in HMO membership, with declines of 2 - 6% this year alone. This year-over-year decline in HMO membership negatively impacts the opportunities for both payers and providers to operate under risk-based arrangements as the universe of potential risk membership declines.

Finally, notably absent is the ability to engage Medicaid MCOs in alternative payment arrangements. The Medicaid MCOs have been focused on lowering providers' fee-for-service rates. This is another area of significant payment reform opportunity for the state to demonstrate leadership in lowering health care costs.

a) How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments)

affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?

Response: APMs are a central part of Steward's Integrated Community Care Model. We have embraced APMs across commercial and governmental (e.g., Medicare) payers, providing a common platform for our efforts in population health management and quality improvement.

Our overall quality performance has improved through the support of a common, system-wide approach to clinical integration and best clinical practice. Our system-wide quality programs incorporate clinical expertise drawn from all of our communities to develop standardized protocols that can be implemented at the practice level, including within the EHR, supplemented by support from our network staff.

Looking ahead, we will continue to advocate that Medicaid implement an ACO payment program and that they contract directly with providers who are certified by the Division of insurance as Risk-Bearing Provider Organizations. As we have stated previously, costs associated with ongoing provider-sponsored care management efforts, analytics, and infrastructure should be appropriately reimbursed and discounted from health plan premium costs in order to both avoid duplication of costs within premiums and inadvertently penalizing providers that have successfully become more efficient in managing the cost of care for their patients in the early stages of APMs. This will not only lower health care costs, but will also push both providers and payers to explore innovative ways to better deliver and administer health care and related administrative services.

b) Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).

Response: Steward has made a significant investment in its integrated Community Care Model, and we believe that this investment is most efficacious when applied across a broad patient population through APMs. Currently, we are able to leverage such scale and efficiency across some commercial payers and Medicare, but not in Medicaid. It is crucial that the state implement a Medicaid ACO payment program supported by global, risk-based payments. Steward plays a significant role in the Medicaid program, and we believe that the immediate implementation of a Medicaid ACO for Medicaid beneficiaries will deliver value to our Medicaid patients and the Commonwealth. While legislation and regulatory policies have pushed the commercial market to evolve toward risk-based payments and ACOs, Medicaid has maintained a status quo of fee-for-service payments and rate cuts to providers.

Medicaid must immediately leverage its enormous $13 billion in purchasing power to transform the way in which it reimburses Medicaid providers and at the same time motivate all payers to continue the shift away from the pervasive fee for service payment

model. Medicaid's continued policy of paying providers under fee-for-service models directly through the FFS/PCC program - and indirectly through its MCO health plans - has contributed to higher costs, continued cost shifting in the commercial market, and discouraged providers from accepting more Medicaid patients particularly as MCOs continue to press providers to lower their rates and implement administrative polices that often delay patient care.

Medicaid has the ability to immediately implement ACOs supported by global-risk-based, global payments directly with providers since a significant number of Massachusetts providers have already developed ACOs and accept global, risk-based payments. Moreover, these providers care for about 50% of Medicaid's covered lives. Given this advanced provider market environment, the Massachusetts Medicaid program is positioned to immediately establish a Medicaid ACO directly with a majority of providers and to align Medicaid payment policies with existing Medicare ACO programs, as well as commercial ACO arrangements supported by global, risk-based payments.

Finally, transitioning the Commonwealth's $13 billion spending across its health care programs – Medicaid, the Connector, the Group Insurance Commission – toward global, risk-based contracts with providers will eliminate the existing misaligned payment incentives and enable integrated provider organizations to not only focus on quality improvement and care management programs, but to lower the overall rate of growth of health care costs in the market.

c) Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.

Response: Please refer to our response to question 2b.

Question 3 **- Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.**

a) In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

Response: Health status risk adjustment factors are requisite components of APMs, for these adjustment factors help ensure that benchmarks are set appropriately for the population being cared for. <u>The purpose of health status adjustment is to risk stratify populations to better account for projected costs. This enables a level playing field for the provision of care. Our current structure negates the effect of socioeconomic factors on cost and undermines the use of health status risk adjustment.</u> It is crucial that implementation of these health status risk adjustment factors incorporate consideration of socioeconomic

factors. Traditionally, health status adjustment is based on use of demographic information and diagnoses obtained from prior claims, which is hindered in a population that may seek care on a more intermittent basis and from various providers. Basing health status adjustments solely on available claims information is therefore prone to omission of constantly changing risk factors among populations. Risk factors are changing constantly and should continuously be adjusted to account for better care management of a patient, socio-economic conditions, new prescription drugs, better health outcomes due to care interventions, etc.

Also, many of the existing risk adjustment methodology tools include cultural bias since they do not account for social determinants of health, such as housing, literacy, access to food, or transportation, which literature has shown can impact overall health status of patients. This is especially true in populations from ethnically diverse areas, non-English speakers, and populations with a behavioral health diagnosis where risk factors are often under-reported or not captured by existing tools. Failure to account for this potentially incomplete health status adjustment presents a significant obstacle to the success of any future Medicaid ACO and must be thoughtfully included under one standard risk adjustment methodological tool.

Steward is actively working to bring attention to the issue of socioeconomic health care disparities in medical spending across communities. Research conducted by the Attorney General and Division of Health Care Finance and Policy in 2011 revealed a regressive dynamic underlying commercial insurance in Massachusetts whereby lower income communities with low TME are effectively subsidizing the higher medical spending of individuals in higher income communities. As payers in Massachusetts transition to budget-based models of payment it will be critical to ensure socioeconomic neutrality so that individuals of both low and high income communities are assigned equal TME budgets based on health status.

b) How do the health status risk adjustment measures used by different payers compare?

Response: Steward is subject to many different health status risk adjustment measures employed by payers as specified in contractual terms. For example, currently, population DxCG Health Status views are provided monthly to Steward at the plan membership level by HPHC and THP, while BCBS sends individual member DxCG scores. For clinical integration and population health management, Steward has the capability of applying customized health status algorithms to all-payer member groupings at the provider, chapter, and network levels, stratified by specific products or clinical conditions and assessed/monitored for change over time.

In the case of the Medicare Pioneer ACO program, this methodology is currently in flux, with a final determination of the methodology to be implemented in 2015 still under active consideration.

In a clinically integrated organization, the challenge is to effectively use the various payer specific risk adjustment factors across our total population to consistently identify and engage with patients at risk. Given the differing methodologies and interpretations of risk scores, the clinical teams are often challenged with stratifying the populations in a payer agnostic and impactful way. A more universal approach to health risk adjustment that incorporates total member claims regardless of the plan providing coverage, clinical factors, and socio-economic determinants will help provider groups improve our ability to provide care consistent with nationally recognized evidence based protocols.

c) How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

Response: Steward continues to investigate the interplay between health status adjustment factors and other elements of APMs. We at Steward are very supportive of risk adjustment of performance measures such as Medicare's 30-day readmission rate. However, the risk adjustment methodology is not available to our analytic teams to internally monitor and manage comparable metrics. Ensuring transparency in all risk adjustment performance measures will help provider groups like Steward more effectively manage our populations at risk.

Question 4 - A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.

Response: Timely, reliable, and actionable data is absolutely crucial to enable providers to better manage care, develop real-time care management interventions for chronically ill patients and allow real time fulfillment of quality initiatives designed to deliver better patient outcomes. Such data would also enable providers to achieve successful performance under APMs. Steward has made a multimillion-dollar investment in its information technology infrastructure to support data integration, quality management, population health analytics, and care management. Crucial data elements include clinical, financial, referral, and authorization data. While our access to clinical and financial data has improved over time, more frequent and timely feeds would offer a more real-time view on our performance and patient utilization trends. Payers should be directed to offer real-time referral and authorization data under APMs that would allow more active patient management for purposes of utilization management, care coordination, transitions of care, readmission prevention, and redirection of care to low-cost facilities. These additional real-time data would help providers identify more robust methods of caring for patients (as claims data is often lagged by several months) and offer a leading indicator for impending financial performance under an APM. Historic data will be particularly important when

considering new or expanded populations for management under APMs, as such data would permit financial and risk modeling.

Additionally, as the Commonwealth continues toward community-focused, integrated models of care, it is essential to have a full sense of total medical spending, including spending by governmental payers. Steward strongly recommends CHIA report on all total medical expense data including Medicare and Medicaid in future publications. The analysis as currently reported does not give an adequate representation of the health care cost growth in Massachusetts. Specifically, the TME data does not provide any information regarding medical spending for Medicare, Medicaid, and other state-subsidized patient populations. If our goal is to truly lower the annual increases in health care spending, we must have a complete understanding of all the factors driving such expense, including the public payer experience, which accounts for a large portion of members in our market.

Question 5 - C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.

a) Which attribution methodologies most accurately account for patients you care for?

Response: Direct patient selection or attestation represents the most accurate method for selecting a primary care provider. The selection or attestation process ensures transparency for the patient, promotes patient engagement, and ensures a more complete understanding of the plan design elements including the care coordination role of the primary care provider. Steward believes that newly formed APM programs, including a future Medicaid ACO, should permit direct patient engagement by providers to enroll patients seeking care in our provider offices, hospitals, urgent care centers, and affiliated facilities.

As an industry, we know well that having a designated PCP results in more coordinated and better quality care for patients while lowering health care costs. Medicaid's fee-for-service program does not require its enrollees to select a PCP to coordinate their care. In this respect, Medicaid is similar to Medicare's fee-for-service program. With nearly 40% of enrollees in the fee-for-service program, Medicaid should move to PCP designation immediately in order to realize the potential savings and improved patient outcomes associated with this policy and observed in the commercial market.

b) What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

Response: Please also refer to our response to question 5a.

Steward recommends a direct patient selection or attestation that names a primary care provider, which is currently used in commercial and Medicare Advantage APMs. Medicaid and other state programs should adopt models centered on members' need to select a primary care provider. This model would strengthen the patient–physician relationship and

ensure “buy-in” from patients and consumers. Furthermore, even when selecting a PCP, Medicaid members have the ability to change monthly and seek care independent of the PCP’s referral. This makes member engagement difficult at best and results in lack of continuity of care for members. Stable PCP relationships will align individuals in a manner appropriate for risk contracting as well as ensure that individuals are receiving the most appropriate health care services in the most cost-efficient settings.

While health education and wellness program materials are provided to patients and employees in our hospitals, clinics, and offices, the most effective way to promote health and wellness is in partnership with patient’s primary care provider. At Steward, we believe having an established primary care provider is essential to ensuring consistent and effective health outcomes for the patients we serve across the continuum of care. Currently, we provide patients with information to access our “Doctor Finder” tool to help establish care with an accountable, primary care provider. Primary care providers should have meaningful input into managing the care of aligned members and should be reimbursed accordingly for accepting the risk and care coordination costs and responsibilities of this effort.

Indirect methods that assign an attribution to an individual patient are inherently flawed because they do not permit the same level of patient engagement that is crucial to proactively coordinate care. Particularly egregious is the indirect attribution method that relies on a retrospective attribution of patients to a provider group after a performance period. This methodology eliminates transparency and hampers the provider’s ability to deliver the care to patients who may not be aware they are attributed to a specific physician or provider.

Auto-assignment of patients to primary care providers could be considered only if direct patient selection efforts are exhausted. Such methodology would require careful consideration of the criteria used to auto-assign (e.g., proximity to provider, provider language, gender, specialties, etc.), and should factor in the patient’s historical patterns of care. Lastly, auto-assignment requires significant engagement with both the patient and provider to ensure that both parties are aware of the assignment and that the patient understands the provider’s model of care (including the provider’s network of specialists and facilities).

Question 6 - Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.

Response: Like most providers, Steward is subject to hundreds of disparate quality measures administered by commercial and governmental payers. The unrelated and extensive amount of quality measures incorporates multiple definitions, inclusions, exclusions, and reporting periods for each measure, adding significant administrative costs to the reporting process and hindering the ability of individual providers to succeed under a complex array of differing quality measures.

In terms of costs, Steward spends over $10 million annually to comply with hospital and physician group quality reporting requirements. While a portion of this spending is allocated for quality monitoring initiatives, much of it is used to customize reporting for various payers' quality requirements as well as regulatory initiatives. This lack of standardization across various payers, APMs and regulatory quality reporting requirements should be better aligned, so that patients have comparable data, cost savings can be achieved and providers can use a payer agnostic approach that lets them focus on patient care. Standardization would significantly facilitate quality improvement, reducing the administrative burden of monitoring, outreach, analytics, and reporting. For an example of the quality measures Steward is required to report, see attached list.

Question 7 – An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.

Summary: Data from the Office of the Attorney General, the former Division of Health Care Finance and Policy, the Center for Health Information and Analysis, and H.E.A.L. show that patient migration to Boston-based academic medical centers is very high, and an obstacle to achieving the Commonwealth's cost containment goals. Since we know that two-thirds of all health care costs are driven by price, the more that residents frequent academic medical centers for routine care, the more that overall prices - and therefore health care costs - will continue to increase.

The state should consider reviewing the Division of Insurance's (DoI) narrow network regulations, as well as the financial incentives between health plans, brokers and agents. As we understand it, arrangements between and among those parties offer little incentives to encourage the sale of narrow networks. In fact, since most of the incentives among those parties are based on premiums, the state may need to assess whether action is need to reform narrow network regulations, as well as the financial arrangements among those parties.

a) Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.

Response: Please refer to the figures below from the H.E.A.L. report for trends in patient migration to AMCs.

Driving births out of the community

Figure 2. Percent of Births in Teaching and Community Hospitals, 1992–2012

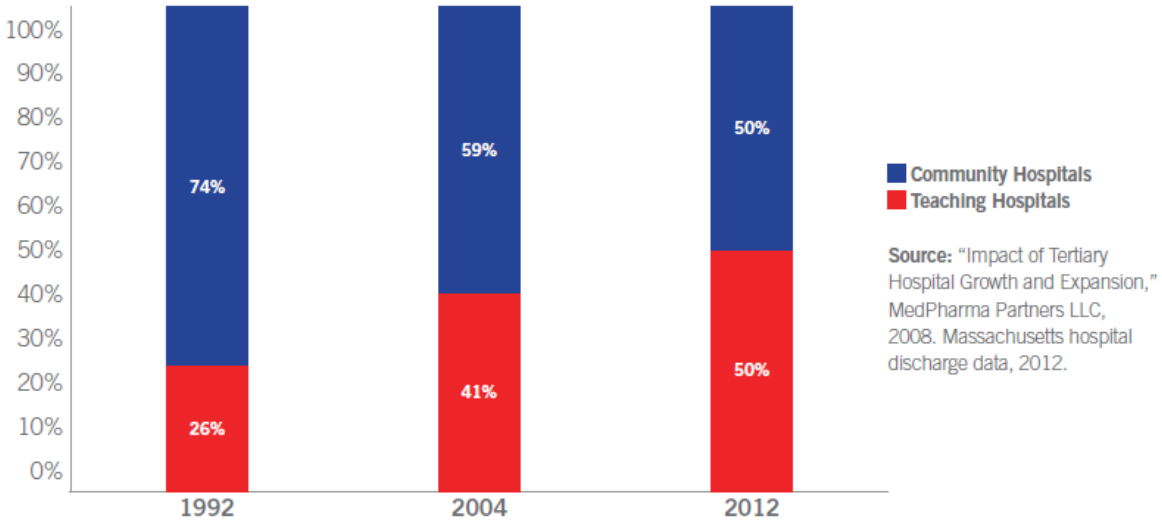
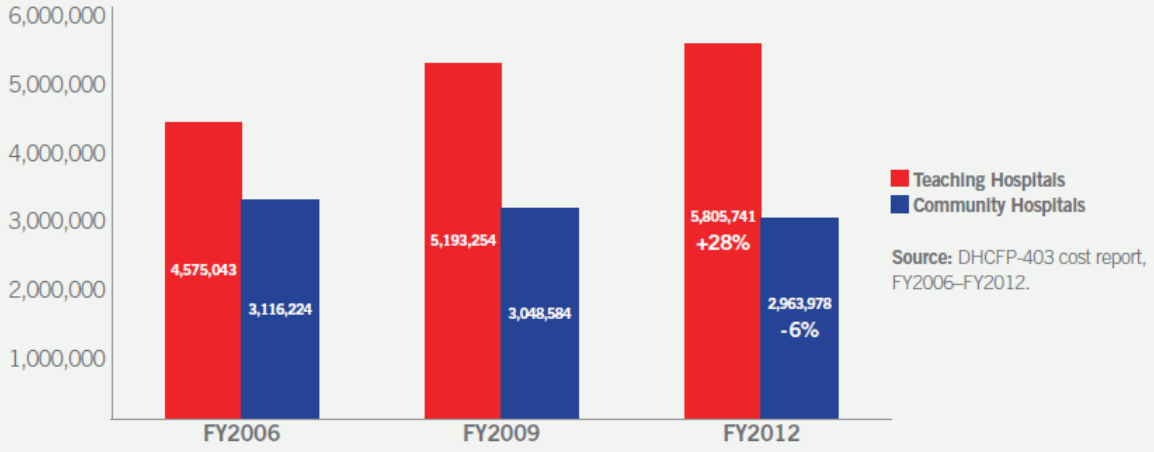


Figure 4. Teaching and Community Hospital Clinic Visits, FY2006–FY2012



b) Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.

Response: Steward's Integrated Community Care model promotes highly integrated care within a limited network of physicians and providers designed to either proactively care for

patient needs within a community or respond to the ever-changing health needs of communities. This community-based network relies on primary care physicians, specialists and hospitals to provide real-time care management and coordination of patients. We are also focusing on health and wellness activities and education in every part of our provider network and employee base. Among our community based providers we provide education and services that promote healthy lifestyles as well as preventive care including cancer screening and vaccinations. We also reinforce the importance of healthy lifestyle to aid in the management of patient's ongoing health. This is achieved in the form of patient education materials, newsletters distributed to patients in our facilities and physician clinics.

Additionally, our Employee Health Departments reinforce healthy behaviors, sponsor educational activities and provide direct care to Steward employees. Programs such as health coaching and chronic condition management are also provided to our employees in support of their ongoing health care needs. As mentioned in our response to question five, the most effective way to promote health and wellness is in partnership with a patient's primary care provider and the coordination of the appropriate care management tools to help our patients establish closer communication with an accountable, primary care provider.

Additionally, wellness programs are an important aspect of improving quality and long-term outcomes for patients. These programs are supported under risk-based payment models, as traditional fee-for-service models do not reimburse for medical expenses incurred outside of specific DRGs, nor do they incent providers or health plans to pass on any measurable savings to employers or individuals through lower premiums.

Please also see our response to question 1(b) for discussion of Steward's efforts concerning physician engagement and patient care follow-up.

Question 8 - The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.

a) Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

Response: Thanks in part to our participation in the Medicare Pioneer ACO program we have observed significant variation in both the quality and length of stay among outpatient providers, especially among skilled nursing facilities (SNFs), which are not attributable to case mix, or diagnosis. Our integrated care ACO model is focused on ensuring that patient care is administered by high-quality post-acute care providers that coordinate patient care in real-time. Operating under an ACO model supported by risk-based payment incentives

ensures that all providers are appropriately aligned to drive better care and better value for both the patient and the system.

We believe that the high-cost trends in post-acute care, especially among SNFs is a result of the pervasive fee for service structure used by both Medicaid and Medicare to reimburse for such services. For example, SNFs existing volume/per diem based financial incentives are misaligned with the goals of improving efficiency and quality among providers. The reliance on fee for service/per diem payments rewards SNFs who extend stays, rather than rewarding SNFs who invest in pro-active management, monitoring, and rehabilitation required to provide high-quality, cost-efficient care.

b) How does your organization ensure optimal use of post-acute care?

Response: Steward's SNF Patient Management Program optimizes the use of post-acute care in our risk populations, including a group of care managers focused on optimizing use of Skilled Nursing Facilities. These care managers assist with the transition from the acute care facility, actively monitor patients in preferred post-acute facilities through participation in multi-disciplinary rounding teams, coordinate transitions to home, and help reduce length of stay when appropriate to help reduce costs. Steward was granted a SNF waiver under the Medicare Pioneer ACO program that waives a traditional three-day inpatient stay requirement prior to a SNF admission when using a select group of approved, high-quality post-acute facilities.

While Steward has done extensive work to collaborate clinically with our post acute partners, there are still many challenges we face. In Massachusetts, the number of Skilled Nursing Facilities is higher than the national average and therefore use of SNF facilities tends to be higher than national benchmarks. To help align incentives across the continuum, provider groups like Steward need the ability to use risk contracting levers with SNFs to have "right size and right site" care in our accountable populations. Steward Home Health and Hospice offers a range of home-based services to further optimize post-acute care. This service benefits from coordination with the population health team to facilitate appropriate handoffs between care teams to ensure a smooth transition of care.

Question 9 - C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

Summary: Steward has been strong supporter of transparency in the health care market since inception. Steward strongly supports transparency of cost and quality information for providers. As such, Steward is one of the only providers in Massachusetts to maintain a

publicly accessible website that publishes its inpatient quality scores – and its competitors – using publicly reported data (quality.steward.org). Steward is also a member of the H.E.A.L., a coalition dedicated to transparency of cost and quality information and the reduction of health care payment disparities. In this particular area of price and costs transparency, while we are a supporter of transparency, we strongly believe that health plans, which represent the payment of health care for all residents, are the most appropriate party with whom to have this conversation.

Question 10 - Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.

Response: Tiering methodologies deployed by the payers lack consistency and transparency. Moreover, provider tiering strategies are by design structured to be used by consumers when they are sick. Unlike limited networks, tiered provider plans discourage proactive use of health care services as part of a "total health care plan" to keep people healthy. In other words, consumers who buy limited network plans tend to be proactive about their health care needs and are thoughtful about the providers they will want to frequent on a regular basis.

Under tiered methods, preferential consideration is often given to high priced providers with significant commercial volume and therefore market leverage. These arbitrary methodologies result in significant harm to cost efficient, community-based providers, as patients are incentivized to break longstanding relationships due to tier assignments. Providers seeking to challenge tier assignments are not given adequate opportunity to review or challenge the underlying methodology. This lack of transparency represents a threat to the underlying foundation of APMs and should be addressed at the regulatory level.

Limited network products that focus care on high value providers represent an opportunity for addressing cost concerns within the Commonwealth, but adoption of such limited network products will require that health plans, brokers, agents, and insurance intermediaries are appropriately incentivized to both sell and promote such products in the market.

Question 11 – The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

a) Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.

Response: In acute care hospitals, behavioral health units are often segregated from the rest of the hospital or even avoided by other specialties. In recognition of the need for strong clinical integration and coordination in the care of this vulnerable population, Steward adopted a new centralized model to oversee Behavioral Health in 2013. Steward's Chief Medical Officer, a national expert in Quality and Safety, assembled an experienced and passionate team of leaders who meet weekly to address all aspects of behavioral health care for the system. The team includes the Chair of Psychiatry for St. Elizabeth's Medical Center, who advises on clinical protocols, as well as physician staffing, EHR optimization, medication management and leads a monthly Morbidity and Mortality Conference for the system. Our Vice President of Behavioral Health, a psychologist with a strong track record in addressing health disparities and wellness within the Behavioral Health population, is also a key team member. He developed and now oversees the Steward Behavioral Health Access Center, ensuring timely bed access for patients presenting at any Steward hospital. He also oversees the Behavioral Health Navigators, who are licensed mental health professionals who evaluate Emergency Department (ED) patients with behavioral health conditions. Lastly, Steward's Senior Director of Behavioral Health Quality and Regulatory Affairs, a nurse practitioner with 18 years of behavioral health management experience in various care settings, leads performance improvement projects and related strategic planning efforts.

Through *weekly* meetings with hospital behavioral health program directors and *monthly* meetings with physician directors, the Behavioral Health Leadership Team works toward shared goals and best practices, with resultant policy standardization, regulatory compliance, and patient experience improvement. Safety has been a particular focus this year. Through shared learning and strategic interventions there has been a 29% reduction in falls with injury over last year. A second focus has been restraint reduction. Across 14 units, 12 (86%) have reduced restraints or were already top quartile performers. Nine units (64%) are recognized by DMH for top quartile performance through June 2014 (one hospitals data pending). In addition, the Leadership Team works closely with the Emergency Department and with the hospitalists to break down traditional silos between disciplines and ensure clinically integrated care for our patients. Through the Steward Behavioral Health Access Center, and the Behavioral Health Navigators, patient access has been maintained despite a 40% increase in ED behavioral health visits Q1- 14 vs Q1 13.

As the second largest private provider of acute inpatient behavioral health services in the Commonwealth, Steward recognizes the importance of managing the total patient, both medical and behavioral conditions. It is well documented that the health care costs for behavioral health patients with comorbid medical conditions may be two to three times higher than patients with the same medical conditions who do not have a behavioral health

diagnosis. Steward has addressed this in several ways. First, we have created a close integration between the hospitalists and the behavioral health staff. Hospitalists (including Nurse Practitioners) in many programs spend much of their day on the BH unit, participating in team rounds, as well as managing medications and medical issues both acute and chronic. Clinical pharmacists also assist in medication evaluation on these units.

In the Emergency Department on-site Behavioral Health Navigators (BHNs) work closely with the Emergency Medicine clinicians, both evaluating emerging behavioral health issues and also connecting behavioral health patient to both behavioral and medical resources in the community. In addition to their training in behavioral health, all Steward BHNs receive a three (3) day SBIRT training (Screening, Brief Intervention and Referral to Treatment) for drug and alcohol abuse from the Boston University School of Public Health BNI ART Institute. The BHNs also receive training in performing culturally competent care from the Disparities Solutions Center at Massachusetts General Hospital. The BHNs have become integral members of the Emergency Departments of eight (8) Steward hospitals, where they play a crucial role in assessment and placement of the behavioral health and substance abuse patients. In addition to performing crisis evaluations, the Navigators have made referrals to primary care physicians, contacted PCPs when appropriate to discuss the care of patients who are presenting in the ED, made referrals to outpatient behavioral health services, provided information and or counseling on smoking cessation, and connected uninsured patients to the Community Health Advocates (CHA) for enrollment in Commonwealth subsidized health programs. Steward also works closely with the ESPs (External Service Providers) and outpatient providers to ensure that patients are receiving care in manner that is collaborative across the continuum of care.

In addition, it has been reported by the National Alliance on Mental Illness that 70% of primary care visits are related to psychosocial issues. It is known that depression occurs in up to 20% of patients with diabetes and coronary artery disease. If depression results in low adherence to medications, medical complications may ensue. One way that Steward is addressing this is through the Family Medicine program at Carney Hospital. Mental health professionals are an integral part of the program and all patients with diabetes are screened for depression to ensure early intervention. The patients who would not otherwise go to a mental health specialist actually get their needs met with the primary care physician that they trust. The family physician or resident gets more training to be able to do certain behavioral counseling or prescribing of medications with education on why this medication and what to look for. At times there will also be a warm handoff that will connect the patient to the psychologist or psychiatrist for further care making them much more like to show up for further care.

b) Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

Response: Steward is working to ensure that patients who do not need acute ED or hospital level of care become aware of behavioral health resources within their own communities. BHN professionals, who are independently licensed or doctoral level mental health clinicians, are developing relationships with community behavioral health resources. The BHNs not only perform crisis mental health evaluations in the ED, but also complete drug and alcohol screenings and make referrals for patients to relevant resources in the community. BHNs are educating clients and families about other options such as partial hospitalization programs, intensive outpatient programs and community support programs that can be utilized in the community to provide support and treatment for psychiatric illnesses. BHNs are making appointments to outpatient providers, such as therapists and/or psychiatrists, or following up with current providers, when patients do not need hospital level of care. This ensures treatment is being provided in the community as a more appropriate and sustainable care model than the Emergency Department.

In addition when patients are discharged after an inpatient stay, the patient is given a follow up appointment with a behavioral health provider and a primary care physician. Relevant discharge information and continuing care plan is sent to the community behavioral health provider. We also take advantage of an emerging "transitional visit" benefit provided by a growing number of payers. Immediately after discharge and before leaving the hospital the patient has a transitional visit wherein a healthcare provider reviews with the patient their medications, upcoming doctor's appointments, etc. with the goal of clarifying any questions that the patient may have about their treatment and what will be required to reduce their chances of relapse or unnecessary utilization of the ED or inpatient psychiatric services.

Finally, Steward has created a registry of patients receiving behavioral health care in the hospital and/or the ED. Patterns of utilization can be evaluated. BHNs then work with these patients to identify where the gaps in care occurred and work collaboratively with the patient to fill the gaps, identifying appropriate resources and thereby reducing unnecessary utilization of emergency services and potentially preventing the need for inpatient care by early intervention.

c) Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

Response:

<u>Successes that Steward has experienced in providing care for these patients</u>

1. Steward has added 94 BH beds since 2010 for a total of 381 beds

2. Steward is reducing time spent waiting in EDs for evaluation
   - Steward crisis intervention teams (BH Navigators) are present on site in the ED and evaluate patients immediately, offloading the ESPs who are still

required to travel to the various hospitals and see Medicaid patients. BHNs also assist in bed finding for patients needing admission.

3. Steward has created and staffed a centralized bed access center for timely bed finding
   - Enables bed tracking through an electronic dashboard;
   - If a bed is not available at the hospital where patient is first seen, another bed will be found either inside or outside the Steward system (based on patient preference and needs)

4. Steward has invested in a system Behavioral Health Oversight Team including the following: Chief Medical Officer, Psychologist, Psychiatrist, and Nurse Practitioner.
   - Collaborative learning and performance improvement and standardization initiatives across behavioral health programs
     - Weekly system conference calls with the leadership of the inpatient psychiatric and detox treatment units.
     - Daily morning huddle calls with the BH units to plan appropriately for admissions and discharge of patients in the ED and on the inpatient units.

<u>Challenges that Steward has experienced in providing care for these patients</u>

1. Dramatic underpayment for Behavioral Health / Psych services by Medicaid and the commercial market

2. Care delivery is challenged by time spent waiting in EDs for evaluation when provider is from External Service Providers (ESPs)

3. MBHP has ESPs who evaluate ED patients
   - Medicaid patients ***must*** be evaluated by ESP (by regulation)
   - Commercial and Medicare patients ***may*** be evaluated by ESP (for a fee) although Steward has nearly eliminated the need in this population by hiring our own BHNs
   - In the interest of timely evaluation and patient care, Steward BHNs will also evaluate the Medicaid patients while awaiting arrival of ESPs

4. ESPs are consultants who are not credentialed or known to the hospital Medical Staff

5. ESPs performance varies
   - Wait times: ESPs cover multiple sites at once and delays are introduced by the demand for their services at multiple sites as well as time to travel to each site
   - Communication and Handoffs: Note content and note availability (not in Electronic Health Record)

This inefficient system creates a separate and unequal system of care for patients with Medicaid vs. those who can afford commercial insurance. Furthermore, since these providers are often not credentialed or familiar with the standards of care and procedures in the hospital, integration of care for the patient is very difficult.

6. Reimbursement for behavioral health patient services in the ED is inadequate. These patients often require additional resources (e.g. continuous 1:1 bedside safety sitter) while they are being cared for in the ED for which we are not reflected in the reimbursement.

7. Open payer networks make it difficult to coordinate plan design for patients as their care is often received across multiple networks.

d) There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

Response: It is critical that the Commonwealth decide on a single set of data definitions for identifying patients with behavioral health conditions. In addition there needs to be a very specific set of measures to capture throughput, ED wait times, recidivism for this population. Finally, there is a need to also track the medical needs of behavioral health patients and the behavioral health needs of patients being treated for medical conditions. Data needs to be equally robust on the prevention side as on the treatment side.

There is much attention to ED throughput measurement, which is often simply a mean length of stay. This number is of no operational utility as it does not stratify for critical variables. Steward has developed a HIPAA compliant registry of patients seen for a primary behavioral health diagnosis either in the ED or on the inpatient unit. The structure of this database allows real-time analysis and trending of utilization and challenges and interventions. We would be happy to share our methodology and also discharge data.

Regarding inpatient and ED patient evaluation the following issues apply:

- Standardize definition: e.g. patients with a *principle* diagnosis in any of these ICD-9 code categories.

Psych*		Substance
290.**	306.**	291.**
293.**	307.**	292.**
294.**	308.**	303.**
295.**	309.**	304.**
296.**	310.**	305.**
297.**	311.**	
298.**	312.**	
299.**	313.**	
300.**	314.**	
301.**	780.1	
	V62.84	

- Stratify by substance abuse or mental health
- Stratify by destination
  - Admitted to same site hospital
  - Transferred to another hospital
- Define times by "door-to-depart" not "decision to admit to depart"
  - "Decision to admit to depart" is not captured in standardized way and fails to identify significant cause of delay which is wait time for evaluation (e.g. ESPs must evaluate patients and multiple sites and travel times may vary.)
- Measure by percentage of patients out by 6, 12, 18, 24, 48 or >48 hours as mean or median time for all BH patients is misleading.

Question 12 - Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

a) What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?

Response: While Steward does not have an official designation of the PCMH model within our network, our Integrated Community Care ACO Model acts as a medical home across our many communities since it is designed to meet local patient needs, which are unique to each community we serve. Our ACO contains the key tools and principles of care coordination and interdisciplinary teams featured in the PCMH model. We believe that our integrated ACO model and a combination of regionalized and centralized network support are better suited to the very heterogeneous physician groups and populations represented within our network, including solo practitioners and large primary care provider groups. A centralized network staff promotes quality performance in all provider settings, and regionalized clinical staff such as registered nurses (RNs) and pharmacists (PHarmD) are available in the communities of providers and patients we serve. We also encourage the use of mid-level (PA and NP) providers within primary care offices. The PCMH model is accompanied by a complex and burdensome array of regulatory, accreditation, and reporting requirements that is not justified by incremental success relative to our more flexible approach that accommodates a variety of practice types.

b) What percentage of your organization's primary care patients receives care from those PCPs or other providers?

Response: Steward does not have data available to respond to this question.

c) Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

Response: Steward does not have data available to respond to this question.

Question 13 - After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

Response: In order for the Commonwealth to successfully meet its cost containment goals we recommend at a minimum the following solutions:

1. Implement a provider-led Medicaid ACO payment program
   The state must take a proactive role to implement payment reforms in Medicaid and to operate Medicaid as a health insurance program for the most vulnerable. Implementing a Medicaid ACO program supported by global, risk-based, global payments is a first step in reforming Medicaid. Given that Medicaid provides government subsidized coverage to over 1.6 million residents at a cost of over $13 billion annually, the agency should lead efforts to reduce overall health care costs in the Commonwealth. Unlike the commercial market, Medicaid - the second largest payer in the Commonwealth - has done little to implement payment reforms that lower costs and improve quality. While legislation and regulatory policies have forced the commercial market to implement payment reforms and lower costs, Medicaid continues to use fee-for-service as its predominant form of payment.

2. Index the Statewide 3.6% Cost Containment Benchmark
   Adjust – or index – the Commonwealth's cost growth to account for hospitals' wide variation in relative payment differentials. The Commonwealth's current approach to establishing a uniform cost growth benchmark for all providers assumes that the relative payment across providers represents an appropriate baseline, when in fact it will perpetuate existing price and payment disparities among providers. Since some provider's prices are exceedingly high and others—especially those serving low-to-moderate income communities—are much lower, a uniform benchmark will lock-in, and possibly even widen, the current reimbursement disparities among providers.

3. Require Transparency in Medicaid
   According to CHIA, Medicaid represents 25% of the state's total health care spending; yet little if any data is publicly available regarding Medicaid. Publicly release Medicaid payment data for all providers, as well as Medicaid Managed Care Organization reimbursement data. It is common knowledge that Medicaid dramatically underpays providers. Transparency is crucial to understanding the true disparity and would help to identify tangible solutions to address this long-standing problem that continues to shift costs to taxpayers and small businesses.

4. Mandate Transparency of Health Care Utilization Data
   The HPC should make publicly available any and all data relative to patterns of patient migration. Specifically, analysis regarding patient migration patterns (i.e., where patients seek care, where they travel to access medical services, referral trends, etc.) would be invaluable as providers and payers move forward to lower costs while providing the services that patients across all communities seek outside of their community. This data would help to address care gaps, better coordinate care, properly integrate services, and enhance the care experience for individuals, among other outcomes.

Steward Health Care Responses to Exhibit C: Office of the Attorney General Questions

Question 1 - Please submit a summary table showing for each year 2010 to 2013 your total revenue under pay for performance arrangements, risk contracts, and other fee-for-service arrangements according to the format and parameters provided and attached as AGO Provider Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

Response: Reporting on total Steward revenue is limited to the data extracts provided by health plans within the context of a risk arrangement. If data extracts are provided to Steward by the plans, Steward aggregates the information by payer and assesses the total Steward in-network and Steward out-of-network costs. In addition, Steward analyzes the potential for additional retention of care within the community setting calculates the corresponding savings.

Further, historical responses to this request have resulted in disparate data from other providers. We believe such variation in responses is misleading and creates confusion for the consumer. In particular, it raises concerns that any aggregated or summarized view of the submitted data will lead to confusing and inaccurate conclusions. Therefore, we believe that the data requested can be provided more accurately and comprehensively by the health plans.

Question 2 - Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.

Response: Steward analyzes and manages the risk levels of each risk contract with following approach:

1. Prior to entering a risk-based agreement, the SHCN Analytics and Negotiation team analyzes historical claims extracts to determine critical factors in managing the specific risk population such as TME levels and trend, membership levels and trends, risk scores, severity trends, retention percentages, service mix, and product benefit specifications. Based on these factors, SHCN projects a level of risk for the given population and negotiates protections to mitigate downside exposure such as percentage share of the deficits, per member per month maximums on deficits, and/or carve-outs of high cost members.

2. In addition to the contract terms, SHCN further addresses financial risk with reinsurance and maintenance of projected reserves needed to cover potential downside risk.

   Steward manages performance under APMs through the use of physician-led network governance, population health analytics, financial analysis, care management and regular performance reports. Based on our promotion of our high-value, high-quality network of providers and hospitals, we have successfully managed populations under APMs in both commercial and governmental programs. We regularly monitor performance on a monthly (or more frequent) basis and share the results of these internal projections with the executive team and physician leadership. These reviews are supported by actuarial and analytic staff and ensure that appropriate resources are being applied to the management of these programs. The probability of deficit scenarios is assessed regularly in the context of contractual terms and available resources.

   As health plans continue to shift financial risk to providers, it will be imperative that health plans transfer the commensurate level of premium dollars to providers in order to appropriately address the health care needs of the population that providers serve. To date, health plans have shown little flexibility to reduce their contribution to build reserves or contribute any portion of their reserves toward such provider contracting arrangements even though they are transferring a significant amount of risk (and thus need for reserves) to providers.

Question 3 - Please explain and submit supporting documents that show the process by which (a) your physicians refer patients to providers within your provider organization and outside of your provider organization; and (b) your physicians receive referrals from within your provider organization and outside of your provider organization. Please include a description of how you use your electronic health record and care management systems to make or receive referrals, any technical barriers to making or receiving referrals, and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization.

Response: The referral process is dictated by the payers, based on the plan type and contractual terms of each individual patient's policy. Although providers are increasingly taking on risk under commericial APMs, the plan designs and technology offered by the payers do not fully support comprehensive care management. Steward believes that the success of our integrated Community Care Model depends on coordinating care between network providers, which ensures the promotion of high-value, low-cost health care and success under APMs. Ideal plan design would empower the provider groups taking risk under APMs with a more comprehensive ability to coordinate care of patients, to help limit use of high-cost settings. When available in individual provider offices, electronic health records are used to make and receive referrals. Real time connectivity between the plans

and providers is needed to ensure member care is managed when scheduling services rather than at the time care is to be delivered or, worse, after the fact.

Question 4 – Please explain and submit supporting documents that describe how, if at all, information on cost and quality is made available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care. Include in your response any type of information on costs or quality made available to your physicians through electronic health management, care management, disease management, large case-management or other clinical management programs.

Response: Steward has no information to submit for this request.

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Acute Myocardial Infarction (AMI)/Chest Pain																		
AMI-1 Aspirin at Arrival		AR																
AMI-2 Aspirin Prescribed at Discharge		AR			AE			PQ					PQ					
AMI-3 ACEI or ARB for LVSD		AR																
AMI-5 Beta-Blocker Prescribed at Discharge		AR																
AMI-7 Median Time to Fibrinolysis		AR																
AMI-7a Fibrinolytic Therapy w/in 30 Minutes of Arrival	AR	AR			AE	PQ				PQ			PQ					
AMI-8 Median Time to Primary PCI		AR																
AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival	AR	AR			AE	PQ		PQ		PQ			PQ					
AMI-10 Statin Prescribed at Discharge		AR			AE			PQ					PQ					
OP-1 Median Time to Fibrinlysis (Outpt)	AR																	
OP-2 Fibrinolytic Therapy w/in 30 minutes of arrival (Outpt)	AR									PQ								
OP 3 - Median Time to Transfer to Another Facility for Acute Coronary Intervention (Outpt)	AR							PQ										
OP 4 - Aspirin at Arrival (Outpt)	AR							PQ		PQ								
OP 5 - Median Time to ECG (Outpt)	AR							PQ										
Heart Failure																		
HF-1 Discharge Instructions	AR	AR				PQ		PQ		PQ			PQ					
HF-2 Evaluation of LVSD	AR	AR						PQ					PQ					
HF-3 ACEI/ARB for LVSD		AR						PQ					PQ					
Pneumonia																		
PN-3a BC in 24 hrs Prior to or 24 hrs after Arrival for Pt's adm. to ICU w/in 24 hrs. of Arrival	AR	AR																
PN-3b Blood Cultures in ED Prior to Initial Received Antibiotic	AR	AR				PQ	AR	PQ		PQ			PQ					
PN-6 Initial Abx Selection for Immunocompetent Patient	AR				AE	PQ	AR	PQ		PQ			PQ					
PN-6a Initial Abx Selection for Immunocompetent Patient - ICU		AR																
PN-6b Initial Abx Selection for Immunocompetent Patient - Non ICU		AR																
Surgical Care Improvement Project (SCIP)																		
SCIP-Inf-1 Prophylactic Abx w/in 1 Hr prior to incision	AR	AR			AE	PQ	AR	PQ		PQ			PQ					
SCIP-Inf-2 Prophylactic Abx Selection	AR	AR			AE	PQ	AR	PQ		PQ			PQ					
SCIP-Inf-3 Prophylactic Abx D/C w/in 24 Hrs after Surgery	AR	AR				PQ	AR	PQ		PQ			PQ					
SCIP-Inf-4 Cardiac Surgery Patients with Controlled Post-op Blood Glucose	AR	AR				PQ		PQ		PQ			PQ					
SCIP-Inf-6 Appropriated Hair Removal		AR																

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SCIP-Inf-9 Urinary Catheter Removed on POD 1/ POD 2	AR	AR			AE	PQ		PQ		PQ			PQ					
SCIP-Inf-10 Perioperative Temperature Management	AR	AR											PQ					
SCIP-Card-2 On Beta-Blocker Therapy Prior to Arrival	AR	AR				PQ		PQ		PQ			PQ					
SCIP-VTE-2 Received Appropriate Venous Thromboembolism Prophylaxis w/in 24 Hrs	AR	AR				PQ		PQ		PQ			PQ					
OP 6 - Timing of Antibiotic Received (Outpt)	AR							PQ		PQ								
OP 7 - Antibiotic Selection (Outpt)	AR							PQ		PQ								
Emergency Department Measures																		
ED-1 Median from Arrival to ED Departure (Inpt)	AR	AR			AR		AR											
ED - 2 Admit Decision Time to DE Departure Time (Inpt)	AR	AR			AR		AR											
OP-18 Median time from arrival to ED departure (Outpt)	AR				AE													
OP-20 Door to Diagnostic Evaluation by a Qualified Medical Professional	AR																	
OP-22 Patient Left without Being Seen	AR																	
Immunization Measures																		
IMM-1 Pneumococcal Immunization	AR	AR																
IMM-2 Influenza Immunization	AR	AR				PQ												
Psych (HBIPS)Publicly Reported CY2014																		
SUB-1 Alcohol Use Screening	AR																	
HBIPS-2 Hours of Restraint Use	AR																	
HBIPS-3 Hours of Seclusion Use	AR																	
HBIPS-4 Pts Discharged on Multiple Meds	AR																	
HBIPS-5 Pts Discharged on Multiple Meds w Justification	AR																	
HBIPS-6 Post Discharge Continuing of Care Plan Created	AR																	
HBIPS-7 Post Discharge Continuing of Care Plan Transmitted	AR																	
Stroke																		
STK-1 VTE Prophylaxis	AR																	
STK-2 Discharged on Antithrombotic Therapy	AR				AR													
STK-3 Anticoagulation Therapy for Atrial Fibrillation	AR				AR													
STK-4 Thrombolytic Therapy	AR				AR													
SKT-5 Antithrombotic Therapy by End of Day2	AR				AR													
STK-6 Discharged on Statin Medication	AR				AR													
STK-8 Stroke Education	AR				AR													
STK-10 Assessed for Rehab	AR				AR													
OP-23 Head CT/MRI scan interpretation for stroke pts w/in 45 minutes of arrival (Outpt)	AR																	
Venous Thromboembolism (VTE)																		

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VTE-1 VTE Prophylaxis	AR				AR													
VTE-2 ICU VTE Prophylaxis	AR				AR													
VTE-3VTE Pts w Anticoagulation Therapy	AR				AR													
VTE-4 VTE Pts Receive Heparin w/ Dosages/Platelet Monitoring	AR				AR													
VTE - 5 VTE Discharge Instructions	AR				AR													
VTE - 6 Hospital Acquired Potentially-preventable VTE	AR				AR													
Imaging																		
OP-8 MRI Lumbar Spine for Low Back Pain	AR																	
OP-9 Mammography Follow-up Rates	AR																	
OP-10 Abdomen CT - Use of Contrast Material	AR																	
OP-11 Thorax CT Use of Contrast Material	AR																	
OP-13 Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery	AR																	
OP-14 Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT	AR																	
OP-15 Use of Brain Computed Tomography (CT) in the ED for Atraumatic Headache	AR																	
Maternity & Neonate																		
PC-01 Elective Delivery ≥ 37 Weeks and ≤39 Weeks Gestation	AR				AR			PQ										
PC-02 C-Section																		
PC-03 Antenatal Steroids																		
PC-04 Health Care-Associated Bloodstream Infections in Newborns																		
PC-05 Exclusive Breast Milk Feeding					AE													
MAT-1 Intrapartum Antibiotics							AR											
MAT-2a Perioperative Antibiotics for C-Section (timing)							AR											
MAT-2b Perioperative Antibiotics for C-Section (Choice)							AR											
MAT-3 Elective Delivery > 37 Weeks and <39 Weeks Gestation							AR											
Care Coordination Measures																		
CCM-1 Inpt Medication List Received by Pt at Discharge							AR											
CCM-2 Transition Record Received at Discharge							AR											
CCM-3 Timely Transmission of Transition Record							AR											
Pediatric Asthma																		
CAC-1 Relievers for Inpatient Asthma		AR					AR											
CAC-2 Systemic Corticosteroids for Inpatient Asthma		AR					AR											
CAC-3 HMPC Document Given to Patient/Caregiver		AR			AE		AR											

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Patient Satisfaction - HCAHPS																		
Overall Rate	SR					PQ				PQ								
Recommend Hospital	SR																	
Communication w/Nurse	SR					PQ		PQ		PQ								
Communication w/ Doctors	SR					PQ		PQ		PQ								
Response of Hospital Staff	SR					PQ		PQ		PQ								
Quietness of Environment	SR					PQ				PQ								
Cleanliness of Room	SR					PQ				PQ								
Pain Management	SR					PQ		PQ		PQ								
Communication re: Meds	SR					PQ		PQ		PQ								
Discharge Instructions	SR					PQ		PQ		PQ								
Hospital Acquired Infections																		
Methicillin Resistant Staph Aureus	AR																	
C-Difficile	AR																	
Central Line Infections (LTAC, ICU)	AR			AR		PQ												
Catheter Associated Urinary Tract Infections (LTAC, ICU)	AR			AR		PQ												
SSI - hysterectomy	AR			AR		PQ												
SSI - Colon Surgery	AR			AR		PQ												
SSI-Hip				AR														
SSI-Knee				AR														
SSI-CABG				AR														
Healthcare Personnel Influenza Vaccination	AR			AR														
30-Day Risk Adjusted Mortality																		
AMI	PC					PQ							PQ					
Heart Failure	PC					PQ							PQ					
Pneumonia	PC					PQ							PQ					
COPD	PC																	
Stoke	PC																	
30-Day Readmissions																		
All Cause Unplanned Readmissions	PC						PC	PQ										
AMI	PC												PQ					
Heart Failure	PC												PQ					
Pneumonia	PC												PQ					
THA/TKA	PC																	
COPD	PC																	
Stoke	PC																	
Leapfrog																		
CPOE (computerized order entry)												AE						
Evidenced Based Hospital Referral												AE						
CABG Antiplatelet med prescribed												AE						
CABG IMA grafting												AE						
CABG Beta blocker 24hrs prior to surgery												AE						

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CABG Beta blocker prescribed at discharge												AE						
CABG Lipid lowering therapy at discharge												AE						
Isolated CABG 14 day readmits												AE						
CABG geometric mean LOS												AE						
CABG risk factors												AE						
PCI 14 day readmits												AE						
PCI geometric mean LOS												AE						
PCI risk factors												AE						
Aortic valve replacement volume												AE						
Aortic valve replacement mortality												AE						
AAA volume												AE						
Unruptured AAA volume												AE						
Unruptured AAA mortality												AE						
AAA periop beta blocker												AE						
Pancreatic resection volume												AE						
Pancreatic resection w/cancer dx volume												AE						
Pancreatic resection mortality												AE						
Esophagectomy volume												AE						
Esophagectomy w/cancer volume												AE						
Esophagectomy mortality												AE						
Bariatric surgery volume												AE						
Bariatric surgery mortality												AE						
VLBW infants admitted to NICU												AE						
VLBW infant volume												AE						
VLBW mothers received antenatal steroids												AE						
AMI 14 day readmits												AE						
AMI geometric mean LOS												AE						
AMI risk factors												AE						
Pneumonia 14 day readmits												AE						
Pneumonia geometric mean LOS												AE						
Pneumonia risk factors												AE						
Live births volume												AE						
Newborns electively delivered												AE						
Newborn bilirubin screening												AE						
DVT prophylaxis for c-sections												AE						
ICU Physician Staffing												AE						
Safe Practices												AE						
Smooth Patient Scheduling-not publicly reported												AE						
AHRQ																		
PSI 90 Complication/patient Safety for Selected Indicators (composite)	PC					PQ												
PSI 04 Death among Surgical Patients with Treatable Serious Complications	PC																	

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PSI 06 Iatrogenic Pneumothorax	PC							PC										
PSI 07 Central Venous CA-BSI								PC										
PSI 11 Post-op Respiratory Failure	PC							PC										
PSI 12 Post-op PE/DVT	PC							PC										
PSI 14 Post-op Wound Dehiscence	PC																	
PSI 15 Accidental Puncture/Laceration	PC							PC										
PSI 17 Birth Trauma Injury to Neonate								PC										
PSI 18 OB Trau - Vag w Instrument								PC										
PSI 19 OB Trau - Vag w/o Instrument								PC										
IQI 11 AAA Mortality Rate	PC																	
IQI 19 Hip Fracture Mortality Rate	PC																	
IQI 32 Mortality AMI w/o Transfers								PC										
IQI 91 Mortality for Selected Medical Conditions	PC																	
IQI 90 Mortality for Selected Surgical Procedures	PC																	
Hospital Acquired Conditions																		
HAC-1 Foreign Bodies Retained after Surgery	PC																	
HAC-2 Air Embolism	PC																	
HAC-3 Blood Incompatibility	PC																	
HAC-4 Pressure Ulcers (III/IV)	PC																	
HAC-5 Falls and Trauma	PC																	
HAC-6 Vascular Catheter Associated Infection	PC																	
HAC-7 Catheter Associated Urinary Tract Infections	PC																	
HAC-8 Manifestations of Poor Glycemic Control	PC																	
Serious Reportable Events																		
Surgery performed on wrong body part				AR														
Wrong body part, side or site surgery or procedure				AR														
Wrong patient surgery or procedure				AR														
Wrong surgery or procedure performed				AR														
Foreign object left in patient after procedure unknowingly				AR														
Death of ASA Class I patient during surgery or within 24 hours				AR														
Contaminated drugs, device or biologics				AR														
Device misuse or malfunction				AR														
Intravascular air embolism				AR														
Patient discharged to unauthorized person				AR														
Serious injury or death during patient disappearance				AR														
Suicide or self-harm				AR														
Serious injury or death from medication error				AR														
Unsafe blood transfusion				AR														
Maternal serious injury or death associated with labor or delivery				AR														
Newborn serious injury or death associated with delivery				AR														

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Serious injury or death after a fall				AR														
Stage 3, Stage 4 or unstageable pressure ulcer				AR														
Artificial insemination with wrong egg or sperm				AR														
Serious injury or death from loss of irreplaceable biological specimen				AR														
Serious injury or death from lack of follow up or communication of lab result				AR														
Serious injury or death from electric shock				AR														
Oxygen or gas delivery error				AR														
Serious injury or death from burn				AR														
Serious injury or death from physical restraints				AR														
Serious injury or death from metallic object in MRI				AR														
Impersonation of a health care provider				AR														
Abduction of patient				AR														
Sexual abuse or assault of patient or staff member				AR														
Serious injury or death after physical assault of patient or staff				AR														
Other																		
Participation in a Systematic Database for Cardiac Surgery	AR																	
Participation in a Systematic Database Registry for Stoke Care	AR																	
Participation in a Systematic Database Registry for Nursing Sensitive Care	AR																	
Participation in a Systematic Database Registry for General Surgery	AR																	
Safe Surgery Checklist Use (Inpt)	AR																	
Data Accuracy and Completeness Acknowledgement	AR																	
THA/TKA Surgical Complications	PC																	
Medicare Spending per Beneficiary	PC					PQ												
AMI Payment per Episode of Care	PC																	
Healthy Term Newborn					AE													
EHDI-1a Hearing Screening before Hospital Discharge					AE													
HD-2 Health Disparities Composite							AR											
OP-12 Receive Lab data Electronically Directly into ONC_Certified HER	AR																	
OP-17 Tracking Clinical Results between Visits	AR																	
OP-19 Transition Record with Specified Elements Received by Discharged Patients	AR																	
OP-21 Median Time to Pain Management for Long Bone Fracture	AR																	
OP-25 Safe Surgery Checklist Use	AR																	

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OP-26 Hospital Outpt volume data on Selected Procedures	AR																	
OP-27 Influenza Vaccination Coverage among Healthcare Personnel	AR																	
OP-29 Appropriate F/u Interval for Normal Colonoscopy	AR																	
OP-30 Colonoscopy Interval for Pts with Hx of Polyps	AR																	
Pressure Ulcer Prevalence													AR	AR				
Patient Falls													AR	AR				
Patient Falls w/ Injury													AR	AR				
Death or serious injury of a neonate associated with labor and delivery in a low-risk pregnancy							AR											
Unstageable pressure ulcer acquired after admission							AR											
Patient death or serious injury resulting fro failure to follow up or communicate lab, pathology or radiology test results							AR											
Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area							AR											
Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen							AR											
Staffing Plans													AR					
Nursing Care Hours														AR				
Census Report														AR				
Joint Commission Patient Safety Goals																		
Use at least two patient identifiers when providing care, treatment & services		C-NS																
Eliminate transfusion errors related to patient misidentification		C-NS																
Label all meds, med containers & other solutions on/ off sterile field in periop & other procedural settings		C-NS																
Reduce the likelihood of patient harm associated with the use of anticoagulant therapy		C-NS																
Maintain and communicate accurate patient medication information		C-NS																
Comply with either CDC/WHO hand hygiene guidelines		C-NS																
Implement evidence-based practices for preventing surgical site infections		C-NS																
Conduct a preprocedure verification process		C-NS																
Mark the procedure site		C-NS																
A time-out is performed before the procedure		C-NS																

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Angioplasty (PCI)																		
Mortality				PC								AE						
Number of patients				PC								AE						
Percentage of patients whose severity of illness was major or extreme				PC														
Bypass Surgery (CABG)																		
Mortality				PC								AE						
Number of patients				PC								AE						
Percentage of patients whose severity of illness was major or extreme				PC														
Cardiac Valve Surgery																		
Mortality				PC														
High risk treatment rating				PC														
Number of patients				PC														
Percentage of patients whose severity of illness was major or extreme				PC														
Weight-loss Surgery																		
High risk treatment rating				PC														
Number of patients				PC								AE						
Mortality				PC								AE						
Percentage of patients whose severity of illness was major or extreme				PC														
Gall Bladder																		
High risk treatment rating				PC														
Number of patients				PC														
Percentage of patients whose severity of illness was major or extreme				PC														
Intestinal Surgery																		
High risk treatment rating				PC														
Number of patients				PC														
Percentage of patients whose severity of illness was major or extreme				PC														
Hip Fracture																		
Mortality				PC														
High risk treatment rating				PC														
Number of patients				PC														
Percentage of patients whose severity of illness was major or extreme				PC														
Hip Replacement																		
Mortality				PC														
High risk treatment rating				PC														
Number of patients				PC														
Percentage of patients whose severity of illness was major or extreme				PC														

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	Regulators					Regulator and Payer		Other Payers				National/Regional Organizations						
Indicator	CMS[2]	TJC	BORM	DPH (EOHHS)[7]	Meaningful Use	VBP	Mass Health	BCBS[8]	Tufts	HPHC	CMMI Pioneer	Leapfrog[3]	Patient Care Link	NDNQI	MHQP	STS	ACC	NICU
Knee Replacement																		
Mortality				PC														
High risk treatment rating				PC														
Number of patients				PC														
Percentage of patients whose severity of illness was major or extreme				PC														
Back Procedures																		
High risk treatment rating				PC														
Number of patients				PC														
Percentage of patients whose severity of illness was major or extreme				PC														
Vaginal Delivery																		
Number of patients				PC														
Percentage of patients whose severity of illness was major or extreme				PC														
Cesarean Section																		
Number of patients				PC														
Percentage of patients whose severity of illness was major or extreme				PC														
Normal Newborn																		
Number of patients				PC														
Number of patients being treated in the Neonatal Intensive Care Unit on an average day				PC														
COPD																		
Number of patients				PC														
Percentage of patients whose severity of illness was major or extreme				PC														
HEDIS MEASURES OUTPATIENTS ONLY																		
High Blood Pressure Control *															Payer C			
Asthma Care															Payer C			
Medications for Children (Ages 5 to 17)															Payer C			
Medications for Adults (Ages 18 to 56)															Payer C			
Depression Care for Adults																		
Short-term Medication															Payer C			
Long-term Medication															Payer C			
Follow-up Appointments															Payer C			
Diabetes Care for Adults																		
HbA1c Test															Payer C			
HbA1c—Poor Blood Sugar Control (Lower score is better) *															Payer C			
HbA1c—Good Blood Sugar Control *															Payer C			
Blood Pressure Control *															Payer C			
Cholesterol (LDL-C) Screening Test															Payer C			
Cholesterol (LDL-C) Good Control *															Payer C			

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Tests to Monitor Kidney Disease															Payer C			
Diagnostic and Preventive Care																		
Correct Imaging Test Use for Lower Back Pain															Payer C			
Colorectal Cancer Screening Tests (Ages 50 to 80)															Payer C			
Heart Disease and Cholesterol Management															Payer C			
Cholesterol Screening Test after a Heart Attack or Heart Surgery															Payer C			
Cholesterol (LDL-C) Good Control *															Payer C			
Pediatric Care															Payer C			
Well-Visits for Children 0 to 15 Months of Age															Payer C			
Well-Visits for Children Ages 3 to 6															Payer C			
Well-Visits for Adolescents Ages 12 to 21															Payer C			
Correct Antibiotic Use for Upper Respiratory Infections															Payer C			
Women's Health																		
Breast Cancer Screening (Ages 40 to 69)															Payer C			
Cervical Cancer Screening (Ages 21 to 64)															Payer C			
Chlamydia Screening (Ages 16 to 20)															Payer C			
Chlamydia Screening (Ages 21 to 25)															Payer C			
CAHPS: Getting timely care, appointments, and information											SR							
CAHPS: How well your providers communicate											SR							
CAHPS: Patients' rating of provider											SR							
CAHPS: Access to specialists											SR							
CAHPS: Health promotion and education											SR							
CAHPS: Shared decision making											SR							
CAHPS: Health status/functional status											SR							
Risk standardized all condition readmission (new version to be released Spring 2014)											AR							
Ambulatory Sensitive conditions admissions: chronic obstructive pulmonary disease (COPD) or asthma in older adults											AR							
Ambulatory sensitive conditions admissions: heart failure (HF)											AR							
Percent of primary care physicians who successfully qualify for an EHR program incentive payment											AR							
Medication reconciliation											AR							
Falls: screening for future fall risk											AR							
Diabetes all-or-nothing composite:											AR							
▪High blood pressure control											AR							
▪Low density lipoprotein (LDL-C) control											AR							
▪Hemoglobin A1c control (<8%)											AR							
▪Daily aspirin or antiplatelet medication use forpatients with diabetes and ischemic vasculardisease											AR							

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▪Tobacco non-use											AR							
Controlling high blood pressure											AR							
Ischemic vascular disease: complete lipid panel and LDL control											AR							
Ischemic vascular disease: use of aspirin of another antithrombotic											AR							
Heart failure: beta-blocker therapy for left ventricular systolic dysfunction											AR							
Coronary artery disease all-or-nothing composite:											AR							
Lipid Control											AR							
Angiotensin-converting enzyme inhibitor or angiotensin receptor blocker therapy—diabetes of left ventricular systolic dysfunction											AR							
Meaningful Use																		
Use CPOE					AR													
Implement drug-drug, drug-allergy, drug-formulary checks					AR													
Maintain an up-to-date problem list and active diagnosis codes					AR													
Maintain active med list					AR													
Maintain active medication allergy list					AR													
Record demographics (language, gender, race, ethnicity, dob)					AR													
Record and chart changes in vital signs (height, weight, blood pressure, calculate BMI)					AR													
Record smoking status for pts >= 13					AR													
Report hospital CQM to CMS					AR													
Implement one clinical decision support rule related to high priority hospital condition					AR													
Provide patients with an electronic copy of their health information					AR													
Provide patients with an electronic copy of discharge instructions					AR													
Protect electronic health information created or maintained by certified HER					AR													
Implement drug formulary checks					AR													
Record advance directive for pts >=65					AR													
Incorporate clinical lab-test results into HER					AR													
Generate lists of patients by specific conditions to use for quality improvement					AR													
Use certified HER technology to identify patient-specific education resources					AR													
Perform medication reconciliation at relevant encounters					AR													

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Provide summary care record for each transition of care or referral					AR													
Capability to submit electronic data to immunization registries					AR													
Capability to provide electronic laboratory results to public health agencies					AR													
Capability to provide electronic syndromic surveillance data to public health agencies					AR													
Use clinical decision support to improve performance on high-priority health conditions					AR													
Provide patients with the ability to view online, download, and transmit information about admission					AR													
Automatically track medications using assistive technologies in conjunction with an eMAR					AR													
Record electronic notes in patient records					AR													
Imaging results consisting of image itself and explanation/other accompanying information accessible through CEHRT					AR													
Record patient family health history as structured data					AR													
Generate and transmit permissible discharge eRx					AR													
Provide structured electronic lab results to ambulatory providers					AR													

Organization

1. TJC Joint Commission
2. Centers for Medicare & Medicaid
4. Patient's First
3. Leapfrog
5. Hospital Quality Alliance
6. Division of Medical Assistance
7. Department of Public Health
8. Blue Cross Blue Shield of Ma
9. National Center for Nursing Quality

Press Ganey
Quality Net: Information web-site for Public Reporting data collection
Leapfrog
HCAHPS
National Quality Forum (NQF)
Outcome Science: Data Collection web-site for Inpatient Stroke cases.
Agency Healthcare Research & Quality