MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Hospitals and Provider Organizations

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

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

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization, and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

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

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

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email mailto:at HPC-Info@mass.gov a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

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

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, and/or 2017 pre-filed testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the templates, did not receive the email, or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC staff at HPC-Testimony@mass.gov or (617) 979-1400.

HPC Contact Information

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

AGO Contact Information

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

HPC Pre-Filed Testimony Questions

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

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

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

i. ***Nursing staff ratios***: Baystate Health's most significant area of concern regarding the state's ability to meet the 3.1% benchmark for growth in healthcare spending is the current nursing staff ratio ballot question which, if passed, would impose government-mandated registered nurse staffing ratios on every hospital in Massachusetts. These rigid ratios would be the same on every shift at all times, in every hospital – large and small, rural and urban, teaching and community. This mandate would override the judgment of nursing professionals who care for every patient. Hospitals in violation of the ratios at any time would be subject to a fine up to $25,000 per incident, per day. The impact on hospitals of the ballot question, if passed, would be devastating. It would cost the Massachusetts healthcare system more than $1.3 billion a year, threaten access to patient care, and increase the cost of healthcare in Massachusetts.

No existing scientific study has determined a "correct" nurse-to-patient ratio. In fact, the only state to adopt government-imposed ratios in 15 years, California, still performs lower than Massachusetts on nearly all quality and safety measures. Setting arbitrary, rigid ratios ignores the many variations in patient care, including differences in nurses' education and experience, ever-changing patient conditions, the composition of the whole patient care team, and the varying technologies and physical attributes of different facilities. At Baystate Health, we value nurses as a vital part of our caregiving teams and have worked closely with them in establishing how our hospitals operate. Our trained nurses and nurse leaders, some of whom have been with us for decades, have the power to arrange nurses according to the unique circumstances they are facing at the time. These are professionals we trust to make split-second staffing decisions. Flexibility is crucial to the way hospitals operate and the rigidity of this mandate would eliminate those who know best from the decision-making process.

Baystate Health, and the communities we serve, simply cannot afford this law. The mandate would cost Baystate Health alone approximately $40 million per year, without any promise of improved care. This represents a significant portion of our operating budget and would force the closing of some units, the elimination of other roles on the patient care teams, and the crippling our community hospitals. It may also require cutting community programming on which our neighbors have come to rely. We have worked

hard to offer world-class care to our patients and to operate as more than just health care providers. We have become members of the larger community and this proposed law threatens our ability to continue to meet the needs of residents throughout western Massachusetts.

With an astronomical and unfunded price tag, no promise of improved care, lack of scientific data to support the proposed law's arbitrary staffing levels, loss of bedside control for nursing staff, and a downstream of other unintended negative consequences, government-mandated nursing staff ratios would not only prevent the state from meeting the 3.1% benchmark for growth in healthcare spending, it would spell disaster for our state's healthcare delivery system.

ii. ***Prevalence of fee-for-service (FFS) payment methodologies***: Through our Accountable Care Organization (ACO) participation, we have made tremendous strides and believe we are on the right path to realizing the Triple Aim of healthier people, better quality care, and smarter spend. Nevertheless, we find it challenging for both hospitals and physicians to reconcile the dilemma of being "reimbursed for volume" (the underlying architecture of our payment system) and being asked to deliver "value-based" care. Today's health care reimbursement system remains largely FFS, which rewards hospitals on the volume of their admissions and emergency room visits and rewards physicians based on the number of office visits, tests or procedures they perform. All of the value-based contracts in which we participate continue to rely on an underlying FFS chassis, which when combined with continued downward pressure on reimbursement, perpetuates incentives to fill beds and generate RVUs to maximize cash flow. While this "foot in two canoes" analogy may be clichéd, this dichotomy presents a material hurdle to achieving the level of utilization management and the reduction of intended care variation that is necessary for the state to meet its 3.1% spending benchmark.

Our ACOs wrap infrastructure around their participating providers, share best practices in regular performance meetings, promote and participate in performance improvement processes, assist with medical practice redesign, develop inpatient and ambulatory care models, and try to change provider behavior through incentives in its funds flow model, but the ACOs often remain one step removed from the frontline providers who regularly receive conflicting messages about volume versus value. This leads to inertia, which is a barrier to moving our collective performance to the next level. For value-based care to be realized, the payment and care models must support each other and evolve in parallel.

iii. ***Financial barriers to supporting infrastructure needed for population health team based care***: Simultaneously, multi-faceted financial barriers impede the transition to value-based care, which is critical to containing the rate of growth of total medical expenses. Continuing disproportionate cost pressures on Baystate Health, a recognized early adopter of value-based care, continue to challenge the organization's ability to allocate appropriate resources to value-based care models. As we have indicated in prior written testimony, the infrastructure (including human capital, enabling technology, or other resources) to support population health management is and will continue to be costly. At the same time, providers continue to face the material, unfunded mandate of compliance with numerous regulations such as those required for Risk Bearing Provider Organizations under Chapter 224 and with achieving the HPC's ACO certification as a prerequisite for participating in the MassHealth Accountable Care Partnership Plan.

Further, the need (and likely government mandate) to build reserves over time is a significant barrier. All of the above are exacerbated by federal mandates, such as Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which require significant investments in infrastructure to comply with the plethora of reporting requirements. It remains unclear whether it will be possible to generate a positive return on, or even recover the costs of, these investments. Shared savings/shared loss models are not sustainable in the long term because participants are measured against themselves, face diminishing budgets over time as generated savings are removed from budgets, and likely do not have a sustainable or adequate upside potential.

Also, the current system of MassHealth supplemental payments favors providers in Eastern Massachusetts over those in the West. It enables ongoing efforts to divert care from lower cost venues in Western Massachusetts to higher cost providers in Eastern Massachusetts, as discussed in Section 1. c). iii. Some elements of supplemental funding, such as the Governor's recent assessment on hospitals, are disbursed in a fair and proportionate way, based on the relative MassHealth services rendered by the recipients. Others, such as the formula governing Delivery System Transformation Initiative funds from the 1115 Medicaid waiver, follow a complex formula that results in a significant disparity in funding per Medicaid beneficiary when one compares Greater Boston to Western Massachusetts. Adopting a funding methodology for all Medicaid supplemental payments that closed the gap (approximately 20%) between Medicaid and Medicare hospital reimbursement would create a level playing field and enable those providers with a large Medicaid burden to sustain key services in local, lower cost sites.

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

i. ***Nursing staff ratios***: With respect to our concerns about government mandated nursing staff ratios, our recommendation, for the reasons set forth above, is that there should not be government mandated nursing staff ratios imposed upon hospitals in Massachusetts.

ii. ***Transition to value-based care***: We strongly encourage payers, both public and private, to provide adequate infrastructure payments and support to their contracted providers to assist in broader implementation of value-based payment models and to accelerate their adoption. We previously noted the inherent challenges in further adopting value-based payment models when providers still have one foot firmly planted in the FFS world and the other in the value-based world. Until value-based agreements cover a critical mass of patients, it will not make financial or operational sense for providers to change their workflows fully to align with a value-based delivery system. Therefore, payers should be encouraged to offer value-based contracts of similar design to ease the administrative burden of implementation on the providers who are being asked to assume considerably more risk under these models.

We also suggest that payers should recognize the value of paying for non-provider based visits, e.g., diabetes education, in the transition to value-based payment models. We also suggest broadening the scope of practice of Advance Practitioners, who play a greater and greater role in our delivery system, particularly in primary care. Given the shortages of primary care physicians, having more liberal scope of practice laws would enable us to innovate around the model of care and ensure broader coverage by primary care for the communities of Western Massachusetts. We also believe that better reimbursement for

telehealth would also help lower total medical expense for our at risk lives and improve access to specialty care.

Telemedicine reimbursement that enables appropriate care to stay local or in the home would facilitate population health team-based care, while also lowering total medical expense for our at-risk lives, and improving access to specialty and other needed care. Patients who are frail, who have multiple chronic conditions that require multiple health visits, who need access to scarce specialty services, and/or who have multiple social determinants of health issues (including transportation) are among those who would benefit from covered telemedicine access if available. As demonstrated by the HPC CHART 2 grant, the ability to keep patients in their local community through telehealth access to a needed Baystate Health specialist addressed patient needs in a timely high-quality, high-value manner that often avoided transfer. Caveat, however, is that the telemedicine consult was provided by an available internal system provider, versus an external (potentially higher cost) provider with little knowledge of the system, providers, and processes. Similarly, the ability to provide needed care for patients in their home in an effective and timely manner supports convenient, high-value care access that prevents unnecessary and avoidable admissions.

We also continue to encourage removal of the significant financial barriers that are impeding adoption of value-based models. Consideration should be given to the unfunded mandates providers face in complying with regulations such as the Risk Bearing Provider Organization (RBPO) and Registration of Provider Organizations (RPO) regulations. The Massachusetts Hospital Association and others have clearly documented where these regulations require duplication of effort—both with requirements of other state agencies and health plans. Further, if an organization or one of its subsidiaries participates in the MSSP or NGACO Model, we feel strongly that applying for ACO certification at the state level should be optional. CMS has a robust application process and ongoing compliance and monitoring program for its ACOs, and having to duplicate these efforts at the state level creates additional administrative expense and burden without adding commensurate value. Amending the regulations to reduce these and similar administrative burdens would free up resources that could be directed to broader adoption of value-based payment models. Earlier, we noted the need for provider organizations and health systems to build reserves as they expand their value-based contract portfolios. As more risk shifts from insurance companies to providers, we continue to believe that careful thought should be given to how to avoid having insurance companies and providers maintain duplicate reserves. In addition, many risk-bearing entities, such as Baycare Health Partners, Inc., our Physician Hospital Organization (PHO), are structured as taxable entities, and existing tax laws make it considerably more difficult for them to build reserves to the same extent and as rapidly as their not-for-profit counterparts. Regulations governing provider reserves should reflect this hurdle, perhaps allowing for lower reserve thresholds or longer time periods for reserve accumulation for taxable RBPOs.

iii. ***Capitation***: As noted earlier, shared savings/shared loss models are not sustainable in the long term because participants are measured against themselves, face diminishing budgets over time as generated savings are removed from budgets, and likely do not have a sustainable or adequate upside potential. Therefore, we encourage and support continued experimentation with capitated payment models - not only by CMS but by the Commonwealth of Massachusetts and other payers – and investment in the claims

processing and other systems necessary to implement such models. We believe capitation, namely primary care capitation with a wraparound risk contract, could better align incentives and facilitate value-based care. Clearly, capitation is not a new concept, and the majority of the revenue of many high-performing medical practices is capitated. For capitation to be effective, however, the majority of a practice's volume needs to be capitated. Last fall, a Health Affairs article found that capitated payment might create an incentive for practices to increase their delivery of team- and non-visit-based primary care—if capitated payment levels were sufficiently high. Specifically, capitation produced gains if more than 63% of annual payments were capitated. The study also found that shifting time and resources from in-person visits with physicians to more team-based services freed up enough time to increase the number of unique patients seen annually per physician by about 20%. That is particularly appealing given that access to primary care and many specialties remains a challenge in our region and in other parts of the Commonwealth.

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

i. ***Acute and post-acute care management:***

Acute care management: In our acute care strategy, largely through our Medicare and Medicaid ACO activities, we are concentrating on decreasing unnecessary emergency room (ER) visits, inpatient admissions, and readmissions. Our Medicare ACO's most mature and longest standing tactic is its care management program. Since 2012, we have embedded care management teams in the primary care practices who participate in our value-based contracts. Registered nurse care managers and medical assistant level outreach workers/care coordinators support patients with understanding their medical conditions and how to have the best quality of life, education of disease, self-management, assessment of needs, elimination of barriers to care, and coordination of care across delivery sites while enhancing the value the practices provide to the population for which they are accountable. As part of our effort to improve transitions of care and minimize redundancy, we are working on cross silo care management integration to ensure shared clinical and communication processes and a governance structure that will facilitate shared decision making across care management entities and standardization wherever possible.

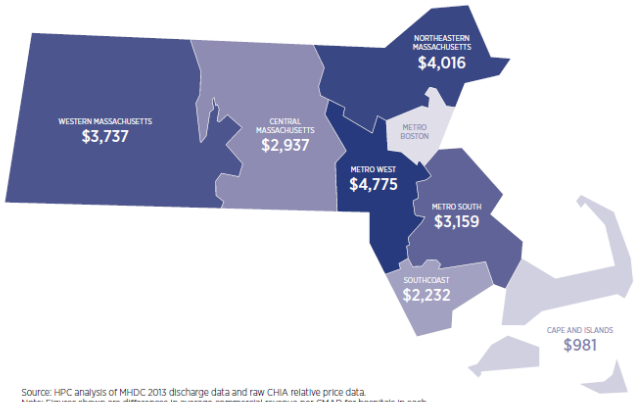
Post-acute care management: Our Medicare ACO has been working diligently since 2015 to decrease our post-acute spending by reducing inappropriate skilled nursing facility (SNF) lengths of stay, emergency room transfers, re-hospitalizations, and SNF admissions/1,000. Our tactics include close partnerships with a preferred network of SNFs, although we conduct performance improvement activities with all the SNFs in our service area, both preferred and non-preferred, to share best practices and emphasize data transparency. One of our most effective tactics has been to hire a post-acute care manager; this RN rounds at all the SNFs reviewing the care plans for our high-risk patients and ensuring warm handoffs across the continuum. There has been much emphasis on redesigning the inpatient care model to enable provision of high quality, evidenced based, cost conscious, patient-centered care and to maximize the coordination of inter-professional patient care teams across the entire care continuum. One example is the Acute Care for Elders or ACE unit. Research has shown that ACE interventions—i.e.,

involvement of geriatricians, safe hygiene, medication review, and ambulation—in similar ACE units around the country made a significant difference in outcomes. We have implemented a pilot with the ACO providing ambulators whose goal is to walk every patient at least two to three times per day with a goal of maintaining baseline functional status so more patients can safely go home after hospitalization rather than to a SNF. The care team focuses on the appropriate next site of care, asking "why not home?" and on the barriers to going home.

ii. ***ER Utilization***: Nationally, billions of dollars are wasted annually in the US in unnecessary care with 30% to 70% of ER visits considered non-urgent and 22.2 million 911 transports unnecessary or inappropriate. We have begun implementation of a major initiative to control unnecessary ER utilization by contracting with DispatchHealth, an in-home delivery platform designed to address the healthcare needs of the on-demand consumer and the access challenges of the at-risk patient. DispatchHealth's platform extends the reach of the traditional ER, providing high acuity and higher value care in the home. An extension of primary care, its model is a combination of emergency medicine diagnostic and treatment capability. DispatchHealth has multidisciplinary teams of physicians, nurse practitioners, physician assistants, registered nurses, clinical social workers, pharmacists and other licensed professionals who will provide non-emergent, mobile health care response services to patients residing in our service area.

iii. ***Keeping Care Local:*** As the Health Policy Commission outlined in its March 2016 Community Hospitals at a Crossroads report (see graphic below), quality care that can be provided locally in a particular region is unequivocally of lower cost than if that same care was provided in a Boston hospital.

Average Additional Cost for Each Commercial Discharge at a Boston Hospital rather than a Local Hospital, by Region of Patient Origin



Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data.
Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.

In addition, the HPC analysis found that share of care provided by hospitals in the Metro Boston region from other regions of the state grew between 2009 and 2013, and that commercially-insured patients and patients from higher-income communities were more likely to travel outside of their home regions for care.

However, as encroachments are increasingly made into the Western MA market targeting the largely commercial suburban pediatric and adult populations, there is little state oversight and knowledge of how these encroachments are undermining and eroding the long-term stability and financial viability of providing expensive specialty tertiary care

and Level I trauma center services to a shrinking regional population. Five years ago, the four counties of Western MA had a projected population of roughly 830,000 individuals (adult and pediatric). Currently the population is estimated to be approximately 819,000 people, composed of increasingly poorer and older individuals. As the only Level I trauma center in Western MA, Baystate is able to provide these resource-intensive and expensive 24 hour call and coverage services to the children and adults of the region by also providing high-quality tertiary and specialty services to commercial patients. Therefore, to the extent that quality care exists in Western MA and can be provided by specialists in Western MA, efforts should be made to keep care local, versus being referred, tele-consulted, and transferred to Eastern MA (or Connecticut) unnecessarily. Otherwise, care needlessly leaves the region to be provided in higher cost (but not necessarily higher quality) settings, which undermines the State's and Baystate Health's value initiatives. See graphic below from HPC's 2017 Cost Trends Report (Note: the report does not outline data on the Boston Children's network specifically, but the organization would likely also fall on the far left side of the graphic, which the HPC should verify):

EXHIBIT 4.3 Average risk-adjusted commercial spending per member per year, by provider organization, 2015

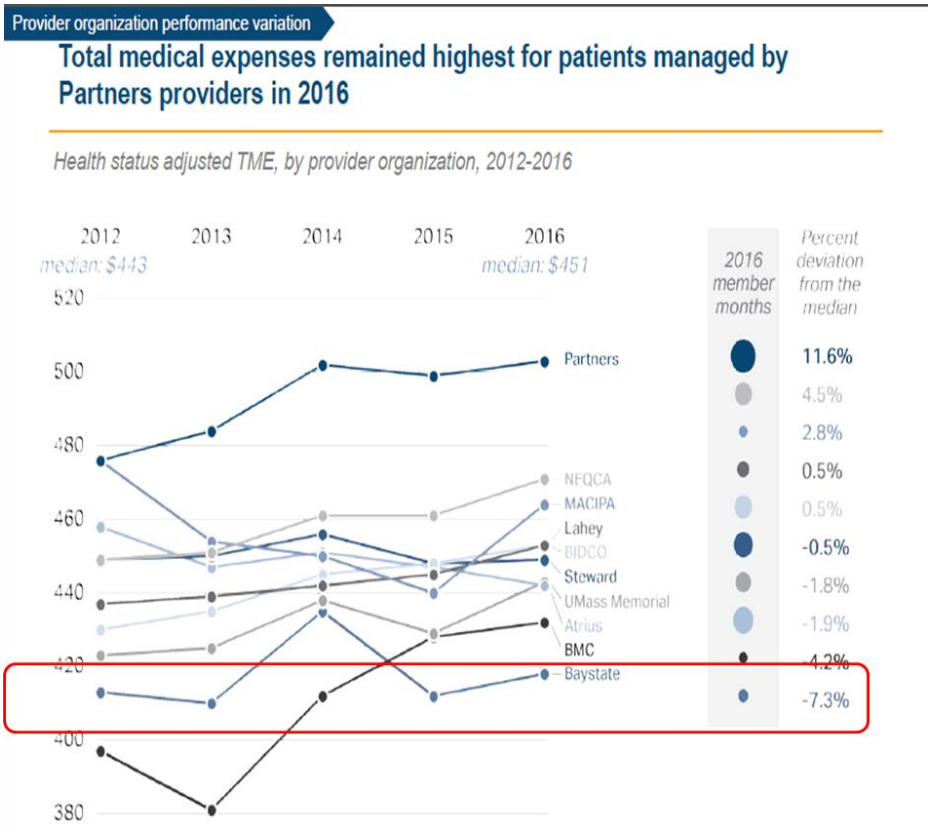
Notes: AMC = academic medical center. Spending adjusted using the Johns Hopkins Adjusted Clinical Groups (ACG®) grouper applied to claims data. Data includes only adults age 18 and older. Commercial payers include Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan.

Sources: HPC analysis of Massachusetts All Payer Claims Database, 2015; Registration of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015

Therefore, Baystate Health seeks to create awareness of this ongoing and increasing trend of non-value-add care (inpatient, outpatient, and virtual) that is moving eastward or southward under the guise of better quality and/or patient choice, versus being Eastern MA or national network-driven. As care becomes increasingly outpatient and alternative channel driven, the non-value element will also become increasingly apparent. The negative ramifications are significant for maintaining a robust Level I trauma center in Western MA that is equipped to serve the critical healthcare needs of the adults and children in this region.

In the Next Steps section of HPC's Community Hospitals at a Crossroad report, HPC concludes that in order to encourage consumers to use high-value providers for their care, the Commonwealth must work with the healthcare stakeholders to identify opportunities to provide better information and incentives to consumers about high-value care options. Some of the steps listed in HPC's report included the following, which Baystate Health strongly encourages the State to pursue:

- The Commonwealth should continue to closely monitor market dynamics that impact patient referral patterns (Baystate Health would ask that this also include oversight of the pediatric market, specifically PPOC and the Boston Children's Hospital network in relation to outpatient, telemedicine, and inpatient care)
- Payers must seek to effectively incentivize members to choose providers and sites of care based on value (see HPC Cost Trends Report graphic below).
- Payers should continue to improve price and quality information available to members



2) INFORMATION ABOUT ALTERNATIVE CARE SITES

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

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

a) Using the most recent information, please list the names and locations of any alternative care sites your organization owns or operates in Massachusetts. Indicate whether the site is corporately

owned and operated, owned and operating through a joint venture, or a non-owned affiliate clinical affiliate.

Corporately owned and operated:
Baystate Urgent Care - Springfield
Baystate Rapid Care – Belchertown
Baystate Urgent Care – Northampton
Noble Express Care – Westfield
Noble Express Care - Feeding Hills

Owned and operating through a joint venture with Shields Health Care Group:
Baystate Urgent Care - Longmeadow

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

Number of unique patient visits	49,209

Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	Commercial 47% Medicare 19% MassHealth 26% Self-Pay 7% Other 1%
Percentage of patient visits where the patient is referred to a more intensive setting of care	Information not readily available

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

The clinical staffing model at our urgent care sites is multidisciplinary. There is a mixture of Advanced Practice Providers and physicians. We support our clinicians with other professionals including medical assistants and some nursing presence.

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

We have a variety of ways that we ensure that primary care physicians receive information about the clinical care of their patient. We have interoperable EHRs and a secure information exchange, Pioneer Valley Information Exchange (PVIX), which allows both Baystate and certain community providers to immediately see urgent care notes. We also back up electronic access and notification of that note with traditional faxing in a timely manner of visit summary and notes to sites based on the provider's preference. While connectivity issues have been a barrier we have faced in sharing real-time information about patient visits to our alternative care sites, we have worked to overcome those barriers by addressing the connectivity issues, and by using other communication methods while the connectivity issues are being addressed.

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

At our patient-centered primary care sites we have many sites with expanded hours as well as schedules that have slots designated for same day/next day urgent visits. Additionally, we are piloting alternative visits including phone, electronic portal, and telemedicine visits for our primary care patients to decrease unnecessary ER and hospital utilization.

Our MassHealth ACO, The BeHealthy Partnership, is implementing a clinical transformation strategy predicated on "Team-based" care as opposed to "Physician-based" care. Tactics to drive this change include establishing Care Teams (nurse, care coordinator and community health workers at each site to provide care management for high risk patients); and incorporating Community Health Workers to implement a Care Needs Screening tool to enable the teams to better address social needs and link patients to community resources.
We are also exploring expanding the use of telehealth visits as way to expand timely access to care with the goal of reducing unnecessary hospital utilization. Also, as mentioned above, we have also begun implementation of a major initiative to control unnecessary ER utilization by

contracting with DispatchHealth, an in-home delivery platform designed to address the healthcare needs of the on-demand consumer and the access challenges of the at-risk patient.

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

In caring for populations of patients, we are focused on providing high quality, accessible care at affordable cost —connected by care teams and an EMR. Alternative visits via telemedicine, group visits for chronic diseases, and nurse- driven protocols are ways to support increased access to care given the national shortage of primary care providers. Urgent care sites provide additional access points for our patients afterhours and on weekends and are part of our population health strategy to keep patients well and avoid unnecessary ER or hospital care for ambulatory sensitive conditions.

However, emerging alternative care sites operated by non-traditional health care disruptors that largely focus on commercial patients in siloes and seek to isolate or remove hospitals from the care continuum pose patient care challenges. Although seemingly "lower cost" in the immediate-term, by cutting out hospitals/systems, these disruptors potentially increase patient care safety issues by creating holes in the care continuum and raise overall healthcare costs in the longer term. Unlike other industries, not-for-profit healthcare has a mission that includes providing care to all who need it, but who may not be able to afford it. As the latter disproportionately becomes larger for not-for-profit hospitals, they will become increasingly distressed, increasingly highlighting the need for resources to care for all of the Commonwealth's population—particularly the individuals that the disruptors seek to avoid.

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

Earlier this year, the HPC held a special event entitled, *Partnering to Address Social Determinants of Health: What Works?*, where many policymakers, experts, and market participants all highlighted the need for health care systems to partner with community-based organizations to address patients' and families' health-related social needs (e.g., housing stability, nutrition, transportation) in order to improve health outcomes and slow the growth in health care costs.

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

☒ Legal barriers related to data-sharing
☒ Structural/technological barriers to data-sharing
☒ Lack of resources or capacity of your organization or community organizations
☒ Organizational/cultural barriers
☒ Other: There need to be incentives put in place for provider teams to address patient social determinant of health needs through partnerships with community based social service entities.

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

Promoting health and preventing disease, which will improve health outcomes and decrease health care costs, requires other stakeholders such as social service agencies to have more

resources to support people's social needs and connect effectively and efficiently to health care providers and systems. We suggest:

i. State funding should be allocated directly to community based social service agencies to provide basic services in order to support residents/patients having appropriate amounts of food, sleep, housing, reliable and living wage employment, etc. All of these basic human needs are important to promote health and curb disease. Funding should be linked to health outcomes.

ii. State policies need to address prevention and easier mechanisms for healthcare and social services to work together. The ACO models are helping to address some patients' social determinants of health, but it's at a time in an individual's situation when disease has already set in.

iii. State policy and funding mechanisms are needed to promote community based solutions to promote health. For example, supporting efforts like the MA Food Trust that are in place to seed funding for health food retail in food deserts.

iv. The state should provide technical assistance to both healthcare and social service agencies to ensure referral mechanisms between healthcare and social service agencies are easy, confidential and in real time.

v. Funding for healthcare staff should support better linkage to community based solutions such as the Prevention and Wellness Trust Fund activities that funded community/clinical linkages as well as the CHART activities that also fostered healthcare positions to liaison with community based social services and support patients.

Also, we would like to add that the MassHealth ACO model holds promise of getting providers to partner outside of their clinic walls to address the social determinants of health. Baystate Health has been an enthusiastic adopter of the focus on the social determinants of health, including through our participation in a MassHealth ACO (the BeHealthy Partnership Plan).

AGO Pre-Filed Testimony Questions

1. For provider organizations: please submit a summary table showing for each year 2014 to 2017 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

See AGO Provider Exhibit 1 attachment.

2. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.

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

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**	5	48
	Q2	6	57
	Q3	10	96
	Q4	9	89
CY2017	**Q1**	12	110
	Q2	10	99
	Q3	15	139
	Q4	27	246
CY2018	**Q1**	16	151
	Q2	8	89
	TOTAL:	118	1,124

b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analysis.

Although we assess generally the accuracy and timeliness of our responses to consumer requests for price information, we currently do not perform subsequent direct monitoring or analysis. We engage in a robust effort to be accurate and timely in our responses. All estimates for facility services are processed by software purchased by Baystate Health. The software uses past experience for same services, contract terms, eligibility responses, and current pricing to provide an estimate for all scheduled services including total charges and patients out of pocket amount based upon all available data. We have received very few complaints about the timeliness and accuracy of our responses.

c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

While certain procedures are straight forward and easily estimable, such as x-rays and colonoscopies, other services are much more difficult to estimate based on the complexity of treatment. We believe that the barrier has been addressed by purchasing the software and establishing a work flow or process that attempts to obtain the required information to calculate the estimate as accurately as possible.

3. For hospitals and provider organizations corporately affiliated with hospitals:

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

   See 3.a. summary table attachment for operating margin by payer for Baystate Medical Center and Baystate Franklin Medical Center, Baystate Health's two largest hospitals, and a list of carriers included in those margins. Further detail of revenue and margin differences for HMO business, PPO business and business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled is not readily available at this time.

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

   See AGO Provider Exhibit 2 attachment.

2014

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	62,145,318	89,054,217	2,148,733	2,859,922	-	-	196,659	-	-	-	719,670	470,820	-	-	-
Tufts Health Plan	21,188,128	2,628,490	44,382	-	-	-	-	-	-	-	111,365	14,584	-	-	-
Harvard Pilgrim Health Care	5,728,175	5,239,449	11,625	-	-	-	-	-	-	-	19,778	3,682	-	-	-
Fallon Community Health Plan	15,982,864	-	35,463	-	-	-	-	-	-	-	38,895	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	21,765,265	8,219,232	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	14,747,375	679,553	-	-	-
Aetna	-	-	-	-	-	-	-	-	-	-	14,290,599	2,549,947	-	-	-
Other Commercial	-	-	-	-	61,772,018	45,636,505	2,615,488	-	-	-	76,094,285	13,030,161	-	-	-
Total Commercial	105,044,485	96,922,156	2,240,204	2,859,922	61,772,018	45,636,505	2,812,147	-	-	-	127,787,232	24,967,978			
Network Health	-	-	-	-	-	-	-	-	-	-	5,761,763	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	10,001,318	-	-	-	-
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	122,297,479	-	-	-	-
Health New England	-	-	-	-	22,147,332	-	221,629	-	-	-	647,785	-	-	-	-
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	813,536	850,921	-	-	-
Other Managed Medicaid	49,572	80,713	-	-	-	-	-	-	-	-	9,573,762	2,785,880	-	-	-
Total Managed Medicaid	49,572	80,713	-	-	22,147,332	-	221,629	-	-	-	149,095,643	3,636,801	-	-	-
MassHealth	80,420,397	-	1,940,490	-	-	-	-	-	-	-	1,396,000	-	-	-	-
Tufts Medicare Preferred	-	-	-	-	-	-	-	-	-	-	5,693,374	29,016	-	-	-
Blue Cross Senior Options	-	-	-	-	11,662,209	11,284,121	472,022	-	-	-	320,913	-	-	-	-
Other Comm Medicare	-	-	-	-	20,365,680	-	386,569	-	-	-	62,760,306	202,695	63,357	-	-
Commercial Medicare Subtotal	-	-	-	-	32,027,889	11,284,121	858,591	-	-	-	68,774,593	231,711	63,357	-	-
Medicare	-	-	-	-	-	-	-	-	-	-	388,709,236	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	33,251,145	-	-	-	-
GRAND TOTAL	185,514,454	97,002,869	4,180,694	2,859,922	115,947,240	56,920,625	3,892,367	-	-	-	769,013,848	28,836,490	63,357	-	-

2015

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	62,262,698	95,614,817	2,295,643	3,291,355	-	-	-	-	-	-	636,440	177,809	-	-	-
Tufts Health Plan	22,002,607	1,889,850	-	-	-	-	-	-	-	-	113,468	45,991	-	-	-
Harvard Pilgrim Health Care	9,466,036	5,163,458	13,459	-	-	-	-	-	-	-	56,689	14,705	-	-	-
Fallon Community Health Plan	14,460,669	-	24,787	-	-	-	-	-	-	-	68,121	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	22,920,303	9,997,444	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	13,704,288	650,128	-	-	-
Aetna	-	-	-	-	-	-	-	-	-	-	14,381,966	4,555,703	-	-	-
Other Commercial	-	-	-	-	60,000,321	60,095,866	1,250,489	-	-	-	88,146,822	13,154,542	-	-	-
Total Commercial	108,192,010	102,668,125	2,333,889	3,291,355	60,000,321	60,095,866	1,250,489	-	-	-	140,028,096	28,596,323	-	-	-
Network Health	-	-	-	-	-	-	-	-	-	-	10,916,696	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	11,477,277	-	-	-	-
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	34,756,296	-	-	-	-
Health New England	-	-	-	-	97,351,700	-	461,402	-	-	-	13,430,951	-	-	-	-
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	3,474,715	436,350	-	-	-
Other Managed Medicaid	911,303	1,108,192	-	-	-	-	-	-	-	-	9,454,373	1,507,611	-	-	-
Total Managed Medicaid	911,303	1,108,192	-	-	97,351,700	-	461,402	-	-	-	83,510,307	1,943,960	-	-	-
MassHealth	102,035,980	-	1,638,911	-	-	-	-	-	-	-	506,784	-	-	-	-
Tufts Medicare Preferred	-	-	-	-	-	-	-	-	-	-	6,833,057	702,404	-	-	-
Blue Cross Senior Options	-	-	-	-	13,302,979	15,244,281	560,000	-	-	-	319,593	-	-	-	-
Other Comm Medicare	-	-	-	-	27,389,815	-	367,640	-	-	-	90,513,582	506,966	-	-	-
Commercial Medicare Subtotal	-	-	-	-	40,692,793	15,244,281	927,640	-	-	-	97,666,232	1,209,370	-	-	-
Medicare	-	-	-	-	-	-	-	-	-	-	440,133,111	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	32,745,807	-	-	-	-
GRAND TOTAL	211,139,293	103,776,317	3,972,800	3,291,355	198,044,815	75,340,147	2,639,531	-	-	-	794,590,337	31,749,653	-	-	-

2016

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	59,222,073	109,278,059	1,101,016	2,149,353	-	-	1,851,041	-	687,567	-	819,562	473,539	178,278	-	-
Tufts Health Plan	23,385,069	2,244,840	10,758	-	-	-	-	-	-	-	70,695	75,349	-	-	-
Harvard Pilgrim Health Care	15,210,623	5,178,319	6,836	-	-	-	-	-	-	-	75,024	8,038	-	-	-
Fallon Community Health Plan	11,264,825	-	39,325	27,110	-	-	27,110	-	-	-	20,473	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	25,741,714	11,553,330	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	16,021,684	732,351	-	-	-
Aetna	-	-	-	-	-	-	-	-	-	-	12,754,945	4,387,283	-	-	-
Other Commercial	-	-	47,467	-	62,951,446	74,389,948	(546,625)	-	456,648	-	90,838,081	13,897,633	668,855	-	-
Total Commercial	109,082,591	116,701,218	1,205,402	2,176,463	62,951,446	74,389,948	1,331,525	-	1,144,215	-	146,342,178	31,127,523	847,133	-	-
Network Health	-	-	-	-	-	-	-	-	-	-	13,569,607	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	9,631,156	-	-	-	-
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	20,493,239	-	-	-	-
Health New England	-	-	-	-	102,523,850	-	67,107	-	-	-	17,215,786	-	-	-	-
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	1,565,272	376,880	-	-	-
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	10,564,150	1,837,152	258,010	-	-
Total Managed Medicaid	-	-	-	-	102,523,850	-	67,107	-	-	-	73,039,210	2,214,032	258,010	-	-
MassHealth	120,249,070	-	1,686,201	-	-	-	-	-	-	-	671,711	-	-	-	-
Tufts Medicare Preferred	-	-	-	-	-	-	-	-	-	-	8,265,896	912,460	-	-	-
Blue Cross Senior Options	-	-	-	-	11,964,048	18,933,714	220,296	-	-	-	1,085,426	-	-	-	-
Other Comm Medicare	-	-	12,584	-	32,165,617	-	30,618	-	319,240	-	93,867,367	53,755	126,584	-	-
Commercial Medicare Subtotal	-	-	12,584	-	44,129,665	18,933,714	250,914	-	319,240	-	103,218,689	966,215	126,584	-	-
Medicare	-	-	-	-	-	-	-	-	-	-	494,265,002	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	27,104,236	-	-	-	-
GRAND TOTAL	229,331,661	116,701,218	2,904,187	2,176,463	209,604,961	93,323,662	1,649,546	-	1,463,455	-	844,641,026	34,307,769	1,231,727	-	-

2017	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	58,125,922	110,971,037	1,155,442	2,230,617	-	-	655,824	-	526,113	-	277,959	561,655	5,172	-	-
Tufts Health Plan	21,707,126	1,222,757	-	-	-	-	-	-	-	-	195,906	5,805	-	-	-
Harvard Pilgrim Health Care	12,965,521	5,121,916	21,794	-	-	-	-	-	-	-	52,325	36,344	-	-	-
Fallon Community Health Plan	11,111,159	-	23,025	-	-	-	-	-	-	-	167,050	-	-	-	-
CIGNA	-	-	-	-	-	-	-	-	-	-	28,080,253	13,898,257	-	-	-
United Healthcare	-	-	-	-	-	-	-	-	-	-	16,917,331	903,423	-	-	-
Aetna	-	-	-	-	-	-	-	-	-	-	14,338,182	3,017,448	-	-	-
Other Commercial	-	-	407,051	-	53,071,221	82,547,597	(632,063)	-	627,902	-	105,004,820	13,732,161	7,395	-	-
Total Commercial	103,909,727	117,315,709	1,607,312	2,230,617	53,071,221	82,547,597	23,761	-	1,154,015	-	165,033,826	32,155,093	12,567	-	-
Network Health	-	-	-	-	-	-	-	-	-	-	16,868,858	-	-	-	-
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	8,951,006	-	-	-	-
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	18,243,858	-	-	-	-
Health New England	-	-	-	-	92,417,264	-	40,037	-	-	-	20,469,825	-	17,503	-	-
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	1,655,342	360,485	-	-	-
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	11,194,470	1,421,938	-	-	-
Total Managed Medicaid	-	-	-	-	92,417,264	-	40,037	-	-	-	77,383,360	1,782,423	17,503	-	-
MassHealth	128,579,760	-	1,357,349	-	-	-	-	-	-	-	690,252	-	-	-	-
Tufts Medicare Preferred	-	-	-	-	-	-	-	-	-	-	9,692,620	412,857	-	-	-
Blue Cross Senior Options	-	-	-	-	11,598,485	17,893,139	41,996	-	-	-	2,479,310	1,626,769	-	-	-
Other Comm Medicare	-	-	18,209	-	28,732,129	-	748,092	-	288,321	-	105,310,353	32,145	-	-	-
Commercial Medicare Subtotal	-	-	18,209	-	40,330,614	17,893,139	790,088	-	288,321	-	117,482,284	2,071,771	-	-	-
Medicare	-	-	-	-	-	-	-	-	-	-	482,634,884	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	34,974,966	-	-	-	-
GRAND TOTAL	232,489,488	117,315,709	2,982,869	2,230,617	185,819,100	100,440,736	853,885	-	1,442,336	-	878,199,571	36,009,287	30,070	-	-