MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Hospitals and Provider Organizations

As part of the
Annual Health Care

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

Cost Trends Hearing

Notice of Public Hearing

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

Scheduled hearing dates and location:

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

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

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

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

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

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

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

Instructions for Written Testimony

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

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

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

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

HPC Contact Information

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

AGO Contact Information

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

HPC Pre-Filed Testimony Questions

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

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

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

The Brookline Community Mental Health Center (BCMHC) is encouraged by the steady progress toward a sustainable level of total health care spending. We believe that the Masshealth payment reform initiative will accelerate this process in the coming years as value-base payment decreases total health care spending and improves patient care. At the same time, we know that untreated and under-treated behavioral health needs continue to be significant drivers of higher total costs of care.

We believe that these costs can be reduced if there is a concerted effort to improve access to good quality mental health care. But at present, there are significant barriers:

1. A lack of behavioral health providers accepting all insurance payers. A dearth of available providers, especially those accepting Medicare and Medicaid, has led to long waiting times for clients with acute needs. The lack of providers has been exacerbated by low reimbursement rates that have led to an increase in providers opting to not accept insurance and demand out-of-pocket payment.
2. A lack of behavioral health providers willing and able to care for clients with complex needs. Providers are often unable to provide the collateral care that is necessary to provide quality care and service to clients with complex needs, that often involves coordination of services across different systems. This work is time consuming and is most often not reimbursable.
3. Hospital and primary care based services have revenue sources that are not available to community mental health agencies, and therefore offer significantly higher salaries. This results in a "brain drain" of staff away from community mental health centers. At the same time, these medical settings are not able to offer the set of services needed by the seriously mentally ill such as clinical groups, in-home therapy, therapeutic mentoring, family therapy, and case management.

Required Answer: Click here to enter text.

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

We believe that, in an effort to both contain costs and to improve behavioral health care, community-based behavioral health providers must be able to participate in value-based payment models. The ability to participate in such contracts requires significant infrastructure investments:

1. Community mental health providers need to have the ability to demonstrate value and cost savings. A lack of interoperability between electronic health records and inaccessible cost data has left behavioral health providers with an inability to drive decision making, programmatic offerings, and clinical services based on outcome data. Investment and

policy should focus on partnerships, integration, and technological upgrades to allow community based behavioral health providers to engage in data sharing collaboratives. In addition, significant improvements need to be made in the field of data sharing at large. There must be a move towards definition and enforcement of standardized record keeping to allow for sharing across systems.

2. Secondly, the State must address the barriers to quality care that are imposed by 42 CFR Part 2. The stigmatization of substance use related data reinforces the challenges of integrated care and exacerbates the stigma of substance use disorders and treatment. Although the privacy of a patient's records must be upheld, a standardized interpretation of the law, and the ability of a patient to easily and universally allow for the sharing of substance use related information would greatly improve the quality of care and consequently have a positive effect on the total cost of care.
3. Lastly, we must address the increasing administrative demands on healthcare providers. In particular, behavioral health providers in smaller organizations are at an increased risk of the significant financial burden associated with increasing administrative demands. These organizations were largely excluded from the incentive payments for improving electronic health records. The State must put efforts towards strategies that will support smaller organizations that are already losing money per unit of service due to low reimbursement rates. Regulations addressing uniformity of administrative requirements across payers has the potential to alleviate this burden.

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.

BCMHC has identified the following strategic priorities to reduce health care expenditures:

1. Investment in the development and dissemination of its Healthy Lives complex care model, which has been shown to significantly decrease the total cost of care for complex, high cost patients. By developing a successful, community based model, BCMHC has been able to implement the model in several care settings, including hospital-based primary care, community health care, and within an ACO. With foundation and public support, BCMHC has created a curriculum to promulgate the principles of its model to other health care systems looking to have significant impact on costs and patient outcomes for this historically difficult to engage patient population.
2. Investment in robust EHR technology. Although technological improvements are often too costly for independent outpatient behavioral health providers, BCMHC has recognized the need for EHR technology that will allow for robust data analysis that includes predictive analytics and the potential for data sharing through the MassHIway. This will pave the way for future integration with healthcare systems and ACOs that have the potential to greatly improve care integration and access to behavioral health services.
3. Partnerships with community agencies. In an effort to meet patients in the community, and to provide more integrated, collaborative care, BCMHC has already entered into contracted partnerships with local schools, housing authorities, and elder service agencies to provide, not only direct service to patients, but also educational services, vocational training, and program development. These partnerships facilitate sharing of information and data across systems – leading to improved efficiency of service, strengthened care teams, and rapid identification of high-risk patients in order to prevent avoidable emergency and inpatient utilization.

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.

   The Brookline Center for Community Mental Health does not currently operate any alternative care sites.

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	n/a

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

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.
n/a

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?
n/a

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).
n/a

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.
n/a

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

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

Please see Question 1b regarding challenges related to systems interoperability, data sharing, and administrative capacity.

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.

Please see Exhibit 1 submitted in conjunction with this document

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**	0	38
	Q2	0	42
	Q3	0	31
	Q4	0	29
CY2017	**Q1**	0	43
	Q2	0	31
	Q3	0	53
	Q4	0	27
CY2018	**Q1**	0	48
	Q2	0	53
	TOTAL:	0	395

   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.

All new clients entering care at BCMHC are provided with a written document stating pricing information, which includes insurance related costs, such as co-pays, and self-pay fees if applicable. This information is mailed to the client's home address after registration. We do not currently have systems in place to monitor accuracy, although clients are encouraged to contact our Registration Department with any questions or concerns on an ongoing basis.

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?

The following have been encountered as barriers to accuracy and timeliness in this process:

1. Long wait times – some private payers can have wait times that exceed 40 minutes when calling to inquire about pricing information. These extended calls are burdensome to administrative staff and lead to overall delays in the response to client inquiries and the registration process.
2. Inaccuracy of information – Although not routine, registration staff are sometimes provided with inaccurate information from payers when inquiring about covered benefits and client costs. Although registration staff document each phone call and reference number, historically, payers have not been able to access information from the original call to adjust the costs accordingly. This has put the burden of pricing discrepancies on the organization and the client.
3. Providing information to clients with emergent needs – Pricing information is gathered during the registration process and requires the client to provide accurate information about their insurer and policy number. For clients unable to provide this information, but who have a clinical need to be seen urgently, there is a need to provide care prior to this information being available. In this case, if clients are then unable to pay, the burden of non-payment again falls on the organization.
4. Changing insurance providers – Clients whose coverage changes during treatment are responsible to the provider for notification of this change. Clients who do not report such a change because they are unable or unaware, often are presented with changes to the cost of care unexpectedly. As an organization, we have migrated to a third party billing system with the capacity to bill more frequently and to therefore have the ability to alert clients to any issues in a more timely manner. However, services have been delivered prior to notification that may no longer be covered and, depending on the circumstance, and a client's ability to pay, the cost of this care may be non-reimbursable both by the payer and the client.
5.

BCMHC is currently screening EHR providers with a commitment to the implementation of a more technically robust EHR system that will allow for automation and electronic documentation of this process with the hopes of decreasing the time from request to provision of information.

Click here to enter text.

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.
Required Question: N/a

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.
Required Question: N/a

Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
6. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
8. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
9. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
10. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
11. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

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											$ 477,658.00				
Tufts Health Plan											$ 187,040.00				
Harvard Pilgrim Health Care											$ 201,574.00				
Fallon Community Health Plan															
CIGNA											$ 7,566.00				
United Healthcare															
Aetna											$ 29,928.00				
Other Commercial											$ 129,298.00				
Total Commercial											$ 1,033,064.00				
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$ 272,318.00				
Total Managed Medicaid											$ 272,318.00				
MassHealth											$ 145,347.00				
Tufts Medicare Preferred											$ 10,815.00				
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal											$ 28,771.00				
Medicare											$ 195,846.00				
Other															
GRAND TOTAL											**$ 1,675,346.00**				

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											$391,777				
Tufts Health Plan											$170,837				
Harvard Pilgrim Health Care											$209,185				
Fallon Community Health Plan															
CIGNA											$17,563				
United Healthcare															
Aetna											$32,999				
Other Commercial											$118,631				
Total Commercial											$940,992				
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$326,455				
Total Managed Medicaid											$326,455				
MassHealth											$309,612				
Tufts Medicare Preferred											$8,724				
Blue Cross Senior Options															
Other Comm Medicare											$41,141				
Commercial Medicare Subtotal											$49,865				
Medicare											$174,371				
Other															
GRAND TOTAL											**$ 1,842,436.00**				

2016	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											$ 417,323.00				
Tufts Health Plan											$ 186,662.00				
Harvard Pilgrim Health Care											$ 224,107.00				
Fallon Community Health Plan											$ 1,391.00				
CIGNA											$ 11,641.00				
United Healthcare															
Aetna											$ 37,468.00				
Other Commercial											$ 132,895.00				
Total Commercial											$ 1,011,487.00				
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$ 376,082.00				
Total Managed Medicaid											$ 376,082.00				
MassHealth											$ 172,442.00				
Tufts Medicare Preferred											$ 13,181.00				
Blue Cross Senior Options															
Other Comm Medicare											$ 36,358.00				
Commercial Medicare Subtotal											$ 49,539.00				
Medicare											$ 189,207.00				
Other															
GRAND TOTAL											**$ 1,835,115.00**				

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											$ 336,025.00				
Tufts Health Plan											$ 218,219.00				
Harvard Pilgrim Health Care											$ 215,386.00				
Fallon Community Health Plan															
CIGNA											$ 17,832.00				
United Healthcare															
Aetna											$ 34,331.00				
Other Commercial											$ 124,790.00				
Total Commercial											**$ 946,583.00**				
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$ 303,592.00				
Total Managed Medicaid											**$ 303,592.00**				
MassHealth											**$ 274,192.00**				
Tufts Medicare Preferred											$ 20,908.00				
Blue Cross Senior Options															
Other Comm Medicare											$ 47,645.00				
Commercial Medicare Subtotal											**$ 68,553.00**				
Medicare											**$ 200,453.00**				
Other															
GRAND TOTAL											**$ 1,841,018.00**				