

2018 Pre-Filed Testimony Hospitals and Provider Organizations



**As part of the
*Annual Health Care
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.

Pharmaceuticals

The increase in the cost of Pharmaceuticals is a major concern. Harrington Hospital has made major improvements in its supply chain management. However, the increases in Pharmaceuticals have offset any gains achieved.

Pharmaceutical costs have increased due to the introduction of new cancer therapies, new special pharmaceuticals and increased utilization of new and enhanced (latest and greatest) pharmaceuticals.

Cost of Physicians and skilled clinical positions

The next cost concern is the supply of Physicians, especially Primary Care. The competition for PCP's is fierce. Many times a PCP has multiple offers. Healthcare Systems are stealing from one another which drive up the salaries in the surrounding communities.

In addition to the increasing costs of Physicians, there is intense pressure on wages for skilled clinical employees. Hospital data suggests that Harrington Hospital is a training ground for new graduates, especially RN's. After five years, RN's tend to leave for higher paying positions at Academic Medical Centers. The real question lies before us, what will happen to nursing costs if Question #1 is approved by the vote in November?

Many hospital have spent heavily on first generation, interoperate IT system that do not easily communicate with other IT systems. Today, we find ourselves looking a costly second generation systems to make the seamless EMR a reality.

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

There needs to be more rationalization in Hospital Payment System. As published by CHIA, Hospital payment rates have wide variations and those Hospitals with market clout are the winners. If this continues, I predict the loss of the low cost community hospitals, - these Hospitals will be absorbed by the larger, more costly institutions. Any system savings hospitals with relative values below 1 will be more than offset by future increases resulting from provider consolidation.

- 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.

Harrington Memorial Hospital contracted with a consulting firm to identify opportunities for improvement. Approximately \$11M of operational improvements have been documented. Much of the improvements have been offset with Pharmaceutical costs and skill labor costs.

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.

<u>Name</u>	<u>Address</u>	<u>Ownership</u>
Charlton Urgent Care	10 N. Main St., Charlton	wholly owned
Oxford Urgent Care	78 Sutton Ave, Oxford	wholly owned

- 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	24,802
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<u>Payor Category</u> Commercial (Private commercial, Medicare & Medicaid managed care plans, Tricare, Veterans)	Proportion: 86%
<u>Medicare (only)</u>	8%
<u>MassHealth (only)</u>	4%
<u>Self Pay</u>	1%
<u>Other (No fault & Worker's Comp)</u>	1%
Percentage of patient visits where the patient is Referred to a more intensive setting of care	3%

- 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 provides coverage for 11 hours of service Mon- Fri, and 8 hours Sat and Sun. The model consists of 1 RN or LPN – responsible for triaging (face to face or by telephone), administering medication, IV insertion, test resulting, and intake; 2 Medical Assistants, who room patients, perform the initial work up, enter labs, and begin the HPI; and 1 to 2 clinical providers, either PA, NP, and/or MD, who examine, diagnose, and treat patients. The MD also provides clinical supervision and oversight to the mid-level providers (PA and NP).

- 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?

Upon completion of a patient visit, a summary of care/transition of care document is produced from our Electronic Health Record. That document is transmitted via secure fax for providers outside of our healthcare system. If the patient's primary care provider is within our system, the document generates directly in a task view for the primary care to review. The visit documentation for patients within our healthcare system is available in real time to the primary

care provider. The challenge faced most commonly is the lack of interoperability between Electronic Medical Record Systems.

- 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).

Not Applicable

- 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.

Opening the Urgent Care Centers did create more access capacity. Not only did volume increase in the Urgent Care Centers, but volume also increased in PCP offices. While growth was experienced in non-hospital settings, Harrington Memorial Hospital did not experience corresponding decline in its two emergency room locations. One needs to study the expansion of non-hospital sites to see if lower unit costs are being offset by an increase in utilization.

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: Transportation legal challenge

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

Maybe every Provider/Organization that receives state funds have the technology to electronically communicate with HealthCare Providers.

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.

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	31
	Q2	0	53
	Q3	0	19
	Q4	0	12
CY2017	Q1	0	16
	Q2	0	25
	Q3	0	38
	Q4	0	45
CY2018	Q1	0	59
	Q2	0	170
TOTAL:		0	468

- 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.

Most estimates are requested via telephone, turnaround time depends on complexity of estimate but most are provided within 48 hours. Estimate copies are scanned in patient's account if one exists. PDF copies of estimates created in Change Healthcare are available on their site. New internal process includes running estimates for scheduled services to identify patient responsibility. This information is shared with the patient during the pre-registration process. We use an estimator tool which has charge master downloaded. No additional monitoring around accuracy at this time.

- 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?

Barriers encountered deal with drug pricing not available in charge master, looking up complex surgical/imaging procedures which are made up of multiple and estimates requested without CPT

information. Unavailability of drug pricing is a result of pricing changes during time of purchase. Estimates can be obtained by calling pharmacy, however, very few estimate requests received for drug pricing. Surgical/complex procedures require manual estimation as these are not maintained in estimator tool. We use several methods to look for appropriate CPT's to help us provide estimates. These include calling provider, using CPT books or looking up via internet.

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: [Click here to enter text.](#)
- 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.

The hospital does not have a cost accounting system, which is expensive to acquire and maintain. Any information provided would be estimates based upon relationships and would not be of any value.

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.

[illegible]

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	\$17,309,871	\$15,205,340									\$2,165,952				
Tufts Health Plan	\$8,031,560														
Harvard Pilgrim Health Care											\$8,705,413				
Fallon Community Health Plan											\$22,536,405				
CIGNA											\$3,771,632				
United Healthcare											\$4,550,015				
Aetna											\$2,457,066				
Health New England											\$553,364				
Other Commercial											\$5,632,011				
Total Commercial	\$25,341,431	\$15,205,340									\$50,371,858				
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid															
MassHealth MCO											\$23,439,796				
Other MassHealth											\$52,741,110				
Total MassHealth											\$76,180,906				
Commercial Medicare											\$34,475,565				
Traditional Medicare											\$68,936,882				
Total Medicare											\$103,412,447				
Other Government												\$5,063,837			
Other												\$3,750,856			
GRAND TOTAL		\$40,546,771										\$238,779,904			

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					\$18,592,337	\$18,157,860					\$1,433,351	\$826,211			
Tufts Health Plan					\$7,083,459										
Harvard Pilgrim Health Care					\$10,730,322										
Health New England											\$635,820				
Fallon Community Health Plan											\$21,532,709				
CIGNA											\$4,252,802				
United Healthcare											\$4,122,413				
Aetna											\$2,349,808				
Other Commercial											\$6,284,619				
Total Commercial					\$36,406,118	\$18,157,860					\$40,611,522	\$826,211			
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid															
MassHealth MCO											\$63,805,831				
Other Mass Health											\$23,487,013				
Total MassHealth											\$87,292,844				
Commercial Medicare											\$41,308,399				
Traditional Medicare											\$83,936,649				
Total Medicare											\$125,245,048				
Other Government												\$4,917,998			
Other												\$6,585,766			
GRAND TOTAL						\$54,563,978						\$265,479,389			

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					\$20,116,909	\$19,646,805					\$1,550,886	\$893,960			
Tufts Health Plan					\$7,664,303										
Harvard Pilgrim Health Care					\$11,610,208										
Health New England											\$687,957				
Fallon Community Health Plan											\$23,298,391				
CIGNA											\$4,601,532				
United Healthcare											\$4,460,451				
Aetna											\$2,542,492				
Other Commercial											\$6,799,958				
Total Commercial					\$39,391,420	\$19,646,805					\$43,941,667	\$893,960			
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid															
MassHealth MCO											\$69,037,909				
Other MassHealth											\$25,412,948				
Total MassHealth											\$94,450,857				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Commercial Medicare											\$44,695,688				
Traditional Medicare											\$90,819,454				
Total Medicare											\$125,245,048				
Other Government												\$5,321,274			
Other												\$7,125,799			
GRAND TOTAL						\$59,038,224						\$276,978,605			