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

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.

Statement that signatory is legally authorized to represent Hilltown Community Health Centers, Inc. (HCHC), signed under pain of perjury:

I, Eliza B. Lake, the Chief Executive Officer of the Hilltown Community Health Centers, Inc., am legally authorized to represent HCHC, signed under pains and penalties of perjury.

Signature

9/13/18

Date

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.
Hilltown Community Health Center's primary areas of concern for the state's ability to meet the benchmark are primarily related to the role of primary care in the control of health care costs.

First, primary care, such as is provided by federally-qualified health centers like HCHC is the least expensive segment of the health care system, and yet is often asked to control a disproportionate share of the costs of the entire system without substantial (re)investment in our system. Primary care providers are very good at controlling their own costs, often to the detriment of our own bottom lines. We cannot control the overutilization of diagnostic imaging, pharmaceuticals, and other expensive resources when patients can access these resources through specialists and hospitalizations. While the new Medicaid ACO program and its focus on supporting primary care to reduce hospitalizations and specialty care use is a start, a greater focus on the sustainability of our primary care system will ultimately yield better results in achieving the benchmark.

Second, providers are graduating with so much educational debt that recruiting them into less lucrative careers in primary care is increasingly difficult. The economic pressures on these new providers inhibits their ability to choose to make less money and treat patients in the least expensive setting. Instead, medical and nurse practitioner students are choosing to work where they can make the most money, which is often not primary care. We do not think that this is due to a lack of interest in primary care, but we cannot expect people to impoverish themselves for the sake of the system. Particularly when there are more opportunities to make more money as specialists or hospitalists.

Finally, individuals who only have access to care through the Health Safety Net must receive some services through hospital Emergency Departments. Primary care providers cannot write orders for imaging and other services for these individuals, and are forced to send them to the most expensive option for care, as it is the only way for the services to be paid. This creates both a greater expense for the Commonwealth, and disrupts the continuity of care that federally-qualified health centers can provide for these patients.

b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?
Allowing health centers to expand the scope of services for its providers would increase our ability to provide integrated, and therefore cost-effective care. Policy changes such as those

considered in the 2018 Legislative session, such as the Nurse Practitioner and Optometry bills, would expand health centers' ability to provide primary care in the most cost effective setting.

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.
Through our participation in the Community Care Cooperative ACO, HCHC is working to control and reduce the total cost of care for our MassHealth patients, and will adopt the best practices from this process in the care of all of our patients. We are focused on transitions of care from hospitals to the community setting, practice transformation to ensure efficient and effective workflows, complex care management for individuals identified as being at risk of future hospitalizations, and care coordination for patients with chronic conditions. We are working to ensure that all identified patients are receiving needed primary care screenings and services, and have robust follow-up systems to reduce the risk of re-hospitalizations. Finally, as an FQHC, we are able to provide a wide range of services to our patients on-site, including behavioral health, dental services, optometry, and community services such as health insurance navigation, community health workers, domestic violence victim advocacy, family supports and education, and assistance with public benefits such as housing, fuel assistance, SNAP, and other programs that address social determinants of health. By having all of these services available within one organization, we are able to reduce expenditures on patients with numerous needs.

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.
Not Applicable

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	Not applicable

Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	Not applicable
Percentage of patient visits where the patient is referred to a more intensive setting of care	Not applicable

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.
Not applicable

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?
Not applicable

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).
As a community health center, we prioritize providing access to everyone regardless of their ability to pay. First, we do so through our ability to serve patients enrolled in Health Safety Net, who do not have access to primary care services in non-FQHC settings. We have recently opened a new site in Amherst, a community that came to us concerned about the growing population of individuals without access to primary care. Second, we ensure that at all of our sites that patients have access to same day visits, which reduces the need for our patients to access urgent care and Emergency Department services. This is in addition to having regular evening hours and weekend hours at our sites on a rotating basis. And third, the health center model of having a wide range of services onsite enables our providers to do warm hand-offs to our behavioral health, dental, and optometry providers, as well as calling in community health workers and other community staff to help meet patients' diverse needs. In so doing, we are able to reduce unnecessary hospitalizations and control costs.

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.
As mentioned in Question 1B, our concern with urgent/alternative care sites is the wasted time and effort that could be avoided should primary care be able to be more accessible. These sites skim off the high volume/low intensity patients from patient-centered medical sites that would provide integrated, comprehensive care. As also mentioned above, this is negatively affecting our financial stability, threatening the safety net for low-income and vulnerable patients.

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: 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?
As a rural FQHC, HCHC is the only major provider of services that address social determinants of health – see question 1C above – so internal communication and legal barriers are dramatically lessened. What we lack are reimbursement for many of these services, and instead have to rely upon grants and other unreliable sources of funding. This is particularly true for our Community Health Workers, who we consider to be part of our medical team, but for whom we are subject to the whims of our grant funders.

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	3
	Q2	0	6
	Q3	0	2
	Q4	0	3
CY2017	**Q1**	0	4
	Q2	0	3
	Q3	0	1
	Q4	0	5
CY2018	**Q1**	0	2
	Q2	0	1
	TOTAL:	0	30

   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 inquiries have been telephonic, and are answered immediately by our billing department, so there are no timeliness concerns. Staff refer to the current fee schedule, to ensure accuracy.

   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 only challenge in addressing these inquiries is that often the patient contact us prior to their visit with a PCP, so staff are not able to give an exact price, as it is dependent upon the reason for the visit. Instead, they give the patient a price range, based on the type of visit.

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.
   Not applicable.

   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.
   Not applicable.

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	140,270		36,769								38,755	113,489			
Tufts Health Plan	170										35,222				
Harvard Pilgrim Health Care											17,671				
Fallon Community Health Plan											41,472				
CIGNA											36,248				
United Healthcare												28,622		362	
Aetna												15,683		214	
Other Commercial	216,355		3,282								158,231	78,239			
Total Commercial	356,795										327,599	236,033			
Network Health											27,638				
Neighborhood Health Plan											38,829				
BMC HealthNet, Inc.											286,897				
Health New England											9,012				
Fallon Community Health Plan															
Other Managed Medicaid											4,041				
Total Managed Medicaid											366,417				
MassHealth											158,865				
Tufts Medicare Preferred	31,724														
Blue Cross Senior Options															
Other Comm Medicare											259				
Commercial Medicare Subtotal	31,724										259	-			
Medicare												5,422		489,940	
Other														24,224	
GRAND TOTAL	388,519										853,140	241,455		514,164	

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	138,624		38,704								39,090	120,269			
Tufts Health Plan	4,761		633								49,665				
Harvard Pilgrim Health Care											28,650				
Fallon Community Health Plan											57,571				
CIGNA											41,299				
United Healthcare												26,151		341	
Aetna												19,874		296	
Other Commercial	219,803		3,455								150,205	72,344			
Total Commercial	363,188										366,480	238,638			
Network Health											5,354				
Neighborhood Health Plan											64,053				
BMC HealthNet, Inc.											264,116				
Health New England											109,926				
Fallon Community Health Plan															
Other Managed Medicaid											90,653				
Total Managed Medicaid	-										534,102				
MassHealth											203,509				
Tufts Medicare Preferred	49,476														
Blue Cross Senior Options															
Other Comm Medicare											603				
Commercial Medicare Subtotal	49,476										603				
Medicare												7,713		651,439	
Other														42,827	
GRAND TOTAL	412,664										1,104,694	246,351		694,266	

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	122,393		41,993								35,221	134,665			
Tufts Health Plan	7,024		1,305								79,527				
Harvard Pilgrim Health Care											35,158				
Fallon Community Health Plan											50,078				
CIGNA											34,405	183			
United Healthcare												25,127		142	
Aetna												18,284		439	
Other Commercial	199,851		7,032								120,760	59,455			
Total Commercial	329,268										355,149	237,714			
Network Health											(1,036)				
Neighborhood Health Plan											74,311				
BMC HealthNet, Inc.											213,126				
Health New England											82,699				
Fallon Community Health Plan															
Other Managed Medicaid											85,051				
Total Managed Medicaid											454,151				
MassHealth											210,440				
Tufts Medicare Preferred	59,715														
Blue Cross Senior Options															
Other Comm Medicare											1,433				
Commercial Medicare Subtotal	59,715										1,433				
Medicare												2,306		687,825	
Other														34,706	
GRAND TOTAL	388,983										1,021,173	240,020		722,531	

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	125,614		48,596								32,296	157,277			
Tufts Health Plan	10,008		1,633								79,483				
Harvard Pilgrim Health Care											21,041				
Fallon Community Health Plan											47,004				
CIGNA											38,450				
United Healthcare												34,934		256	
Aetna												20,499			
Other Commercial	216,905		1,508								168,254	72,192			
Total Commercial	352,527										386,528	284,902			
Network Health															
Neighborhood Health Plan											56,383				
BMC HealthNet, Inc.											186,453				
Health New England											90,680				
Fallon Community Health Plan															
Other Managed Medicaid											92,690				
Total Managed Medicaid											426,206				
MassHealth											219,485				
Tufts Medicare Preferred	57,016														
Blue Cross Senior Options															
Other Comm Medicare											4,654	20			
Commercial Medicare Subtotal	57,016										4,654	20			
Medicare												4,812		706,896	
Other														23,753	
GRAND TOTAL	409,543										1,036,873	289,734		730,649	