

# 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](mailto: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, 8<sup>th</sup> 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](http://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](mailto: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](mailto: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](mailto:HPC-Testimony@mass.gov) or (617) 979-1400.

### **HPC Contact Information**

For any inquiries regarding HPC questions, please contact [HPC-Testimony@mass.gov](mailto: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](mailto: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.
- **Healthcare spending is the function of a wide range of variables, many of which the state has little-to-no control over through healthcare mechanisms (e.g. labor market trends, societal trends, SDH, broader market forces). Despite this, as it is commonly known, healthcare spending is spent disproportionately on specialty care and pharmaceuticals, as opposed to the primary care providers with the greatest capacity to maximize population health.**
  - **In addition, the timeline for influencing change in the realm of social service supports is almost certainly beyond a single year, and therefore the lack of immediate ROI may obfuscate proper recourse over time.**
- b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?
- As a community based organization, we advocate for drawing attention to the areas where the state could exert influence, primarily on SDH through an increase in social service supports that provide preventive care to the disproportionate share of the population responsible for the majority of healthcare costs. Organizations tied to the community such as FQHCs are uniquely positioned to provide these supports compared to MCOs (with shifting, geographically dispersed populations) and hospital systems (that have vastly different financial margins and priorities).**
- 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.
- Due to our organization's PACE division, and its multiple APM risk contracts, much of our finances are tied into the total health care expenditures of our populations. While we employ multiple strategies around this, our core values have been:**
- **Provide comprehensive physical, behavioral, and social services to our population**
  - **Limit referrals through excellent primary care delivery**

### 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.

**Upham's Corner Health Center operates an Urgent Care for its Primary Care population that is corporately 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	n/a
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- 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.
- 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?
- 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).  
**We are exploring telemedicine, looking to improve our after-hours call line, and providing case management support that emphasizes patient education around treatment recourse.**
- 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.  
**We advocate for alternative care sites (ACS) that are closely linked to patient's primary care providers (PCPs). Barring this, strong communication channels between ACS's and PCPs is essential to promoting PCMH principles of care coordination and continuity.**

### 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?  
**Our organization would recommend an increase in resources available to address socio-economic issues that are not tied to an ROI on total cost of healthcare dollars within**

unreasonable time frames, though still based in a broader evidence base. Community based organizations are in the best position to provide on-the-ground insight on social change, and in conjunction with the knowledge base and monetary resources of the state, present a significant opportunity for change.

## 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		
	Q2		
	Q3		
	Q4		
CY2017	Q1		
	Q2		
	Q3		
	Q4		
CY2018	Q1		
	Q2		
	TOTAL:		

- 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.  
**As an FQHC, we are required to have a sliding scale fee schedule established for our in-scope services, and provide this information immediately to individuals paying out-of-pocket costs.**

- 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?

**Keeping staff up-to-date on the process is a challenge, which we address through on-going trainings.**

- 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.

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.

n/a

## Exhibit 1 AGO Questions to Providers

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### 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	X	X	X	X	X	X	X	X	X	X	251,812	X	X	X	X
Tufts Health Plan											416,259				
Harvard Pilgrim Health Care											655				
Fallon Community Health Plan															
CIGNA															
United Healthcare															
Aetna															
Other Commercial											679,496				
<b>Total Commercial</b>	-	-	-	-	-	-	-	-	-	-	1,348,222	-	-	-	-
Network Health															
Neighborhood Health Plan											762,727				
BMC HealthNet, Inc.											623,262				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid					712,601						295,500				
<b>Total Managed Medicaid</b>	-	-	-	-	712,601	-	-	-	-	-	1,681,489	-	-	-	-
<b>MassHealth</b>									1,573,111		1,597,541				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare					305,400						102,928				
<b>Commercial Medicare Subtotal</b>	-	-	-	-	305,400	-	-	-	-	-	102,928	-	-	-	-
<b>Medicare</b>												526,414			
<b>Other</b>												944,251			
<b>GRAND TOTAL</b>	-	-	-	-	1,018,001	-	-	-	1,573,111	-	4,730,180	1,470,665	-	-	-

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	X	X	X	X	X	X	X	X	X	X	250,773	X	X	X	X
Tufts Health Plan											117,655				
Harvard Pilgrim Health Care											52,396				
Fallon Community Health Plan															
CIGNA															
United Healthcare											185				
Aetna															
Other Commercial											1,114,263				
<b>Total Commercial</b>	-	-	-	-	-	-	-	-	-	-	1,535,272	-	-	-	-
Network Health															
Neighborhood Health Plan											775,409				
BMC HealthNet, Inc.											592,586				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid					809,951						241,632				
<b>Total Managed Medicaid</b>	-	-	-	-	809,951	-	-	-	-	-	1,609,627	-	-	-	-
<b>MassHealth</b>									1,905,075		1,303,049				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare					347,122						84,238				
<b>Commercial Medicare Subtotal</b>	-	-	-	-	347,122	-	-	-	-	-	84,238	-	-	-	-
<b>Medicare</b>												442,788			
<b>Other</b>												1,129,410			
<b>GRAND TOTAL</b>	-	-	-	-	1,157,073	-	-	-	1,905,075	-	4,532,186	1,572,198	-	-	-

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	X	X	X	X	X	X	X	X	X	X	258,111	X	X	X	X
Tufts Health Plan											325,891				
Harvard Pilgrim Health Care											145,132				
Fallon Community Health Plan															
CIGNA															
United Healthcare											512				
Aetna															
Other Commercial											1,167,172				
<b>Total Commercial</b>	-	-	-	-	-	-	-	-	-	-	1,896,818	-	-	-	-
Network Health															
Neighborhood Health Plan											1,058,499				
BMC HealthNet, Inc.											625,730				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid					828,554						304,769				
<b>Total Managed Medicaid</b>	-	-	-	-	828,554	-	-	-	-	-	1,988,998	-	-	-	-
<b>MassHealth</b>									1,955,259		1,122,656				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare					355,094						113,659				
<b>Commercial Medicare Subtotal</b>	-	-	-	-	355,094	-	-	-	-	-	113,659	-	-	-	-
<b>Medicare</b>												474,366			
<b>Other</b>												1,364,911			
<b>GRAND TOTAL</b>	-	-	-	-	1,183,648	-	-	-	1,955,259	-	5,122,131	1,839,277	-	-	-

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	X	X	X	X	X	X	X	X	X	X	298,857	X	X	X	X
Tufts Health Plan											228,454				
Harvard Pilgrim Health Care															
Fallon Community Health Plan															
CIGNA															
United Healthcare											807				
Aetna															
Other Commercial											1,215,131				
<b>Total Commercial</b>	-	-	-	-	-	-	-	-	-	-	1,743,249	-	-	-	-
Network Health															
Neighborhood Health Plan											686,158				
BMC HealthNet, Inc.											529,084				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid					966,545				199,034		352,986				
<b>Total Managed Medicaid</b>	-	-	-	-	966,545	-	-	-	199,034	-	1,568,228	-	-	-	-
<b>MassHealth</b>											2,274,941				
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare					414,234				85,300		132,818				
<b>Commercial Medicare Subtotal</b>	-	-	-	-	414,234										
<b>Medicare</b>												429,857			
<b>Other</b>												960,739			
<b>GRAND TOTAL</b>	-	-	-	-	1,380,779	-	-	-	199,034	-	5,586,418	1,390,596	-	-	-

2017

Service Category	Commercial				Medicare				Medicaid				All Other				Total			
	Inpatient Revenue (\$)	Inpatient Margin (\$)	Outpatient Revenue (\$)	Outpatient Margin (\$)	Inpatient Revenue (\$)	Inpatient Margin (\$)	Outpatient Revenue (\$)	Outpatient Margin (\$)	Inpatient Revenue (\$)	Inpatient Margin (\$)	Outpatient Revenue (\$)	Outpatient Margin (\$)	Inpatient Revenue (\$)	Inpatient Margin (\$)	Outpatient Revenue (\$)	Outpatient Margin (\$)	Inpatient Revenue (\$)	Inpatient Margin (\$)	Outpatient Revenue (\$)	Outpatient Margin (\$)
Burns																				
Cardiology Total																				
Invasive																				
Medical																				
Cardiac Surgery																				
Dental																				
Dermatology																				
Endocrinology																				
Gastroenterology																				
General Medicine																				
General Surgery																				
Gynecology																				
Hematology																				
Infectious Disease																				
Neonatology																				
Nephrology																				
Neurology																				
Neurosurgery																				
Normal Newborns																				
Obstetrics																				
Oncology																				
Ophthalmology																				
Orthopedics																				
Otolaryngology																				
Psychiatry																				
Pulmonary																				
Rehab																				
Rheumatology																				
Transplant Surgery																				
Trauma																				
Urology																				
Vascular Surgery																				
Other Inpatient																				
Imaging																				
Other Treatments																				
Laboratory																				
Ambulatory Surgery																				
Therapies																				
Office Visits																				
Observation																				
Other Outpatient																				
GRAND TOTAL																				

Information is not  
maintained by these  
categories