MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 Pre-Filed Testimony

HOSPITALS AND PROVIDER ORGANIZATIONS

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

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

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), holds an annual public hearing on health care cost trends. The hearing examines 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.

The 2019 hearing dates and location:

Tuesday, October 22, 2019, 9:00 AM
Wednesday, October 23, 2019, 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 22. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 22.

The HPC also accepts written testimony. Written comments will be accepted until October 25, 2019, 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 25, 2019, 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 the Suffolk University website. 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 available via livestream and video will be 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 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 page on 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 2019 Annual Cost Trends Hearing.

You are receiving two sets of questions – one from the HPC, and one from the AGO. We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, 2017, and/or 2018 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.**

On or before the close of business on **September 20, 2019**, 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.

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 or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC Contact Information

For any inquiries regarding HPC questions, please contact General Counsel Lois H. Johnson at HPC-Testimony@mass.gov or (617) 979-1405.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Amara Azubuike at Amara.Azubuike@mass.gov or (617) 963-2021.

Pre-Filed Testimony Questions: Health Policy Commission

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:

Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced 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 strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

CHA is currently advancing several strategies to deliver efficient care and coordinate cost effective total medical expenditures, particularly under APMs as described below. Approximately, 40% of CHA's primary care patient population in APMs as of June 2019:

- *Medicare: Medicare Shared Savings, Medicare Advantage, Senior Care Options and Elder Service Plans;*
- *Medicaid: launched MassHealth ACO; and*
- *Commercial: Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan.*

CHA is closely watching the state's contemplated demonstration process for OneCare and Senior Care Options to further enhance APM expansion.

- **Community-Appropriate Care:** *In these initiatives, CHA is focused on greater use of community-appropriate care in the least restrictive setting in the community. This includes a greater share of care for the patient panel within CHA's community hospital and health center system and with high value in-network providers.*

- **Mental Health and Substance Use:** *We are also expanding our ability to address Serious Mental Illness (SMI), Substance use Disorder (SUD), Serious Emotional Disturbances (SED) and social determinants of health (SDoH), faced by a large segment of our patient population, in collaboration with community and social service organizations. CHA has deployed specialist intensive care managers dedicated to behavioral health diseases.*

- **Social Determinants of Health:** *CHA is screening for social factors in health across the organization in primary care, specialty care, and psychiatry settings and has successfully implemented the use of electronic tablets for patient self-completion of the tool in addition to other modalities. Social needs are highly prevalent in our patient population, especially food and housing insecurity. CHA has invested in an electronic platform directory, called Aunt Bertha, to assist with referrals to social service agencies to address unmet social service needs. In addition, CHA has developed a partnership with Medicolegal to conduct housing case reviews for patients facing housing instability. One of CHA's initiatives is the identification and analysis of its homeless population. One finding from this effort is that at least 3.5% of our Medicaid population is documented as homeless.*
- *CHA has developed community program partnerships to leverage community resources for maintaining health.*

- **Care Management:** *CHA recently became accredited by NCQA for care management and was delegated to conduct this service by one its major insurers with a corresponding allocation of per member per month funds to support these efforts proximate to patient care. CHA has expanded care management reach to cover admissions at other inpatient facilities and post-acute follow-up. Our electronic medical record's population health analytics platform (Epic's Healthy Planet) and the Johns Hopkins risk adjustment models are utilized to help effectively risk stratify and segment our population for the most appropriate care management and programmatic follow-up.*

b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?

Below are recommended areas of policy change that would support efforts to reduce health care expenditures and create a more sustainable health care system.

- **Addressing Commercial Price Variation and Other Payers:** *Near-term policy action to address the unwarranted acute hospital payment rate variation is an urgent priority, particularly as it relates to low-relative price community and safety net hospitals that are being left behind by commercial insurers, under-resourcing diverse communities in the state. A permanent legislative solution is needed to improve unsustainably low commercial rates for community and safety net hospitals to a minimum of 90% of the statewide average relative price in order to support their essential capacity and local access, and avoid the increased costs if care that can be delivered in the community is concentrated at higher priced medical centers. Additional incentives and monitoring are needed to promote community-hospital appropriate care, particularly in light of the development of large health systems.*
- *In addition, APM methodologies must create greater incentives for more efficient ACOs through greater weighting of the average market rate in developing their global budgets. Adequate public payer APM rates are necessary to sustain promising reform. ACOs that demonstrate value should not be subject to unrealistic short-term savings expectations versus payment more aligned with the average market rate.*

- **Risk Adjustment Refinement to Better Reflect Behavioral Health and Social Factors:** *Risk adjustment models need further refinement to address both behavioral health (SMI, SED, SUD) and SDoH. Currently, models do not appropriately allocate medical budgets to these population segments. This contributes to challenges with adequate APMs and further stresses to the healthcare delivery system, particularly safety net systems with disproportionate demands associated with such population needs.*

- **Behavioral Health:** *While the state has made significant investments in behavioral health services capacity for the MassHealth population, there are remaining gaps in the continuum of care and for sustaining payment rates across all payers. Please see additional detail in question 2.c. and d.*

- **Support for Innovative Care Delivery Approaches, Care Management and Coordination:** *Many important facets of better and more cost-effective care such as tele-health, e-consults, care coordination and management must be funded in the payment system. Current, fragmented payment policies create gaps in care across patient populations and slow the progression of low-cost interventional services in the market. Supportive policies are recommended to foster a variety of quality innovations and cost-effective care. For example, actions to require data sharing across the care continuum (such as admission, discharge, and transfer reports) will help coordinate care and prevent avoidable care. Another area of policy guidance is unifying the variation and scope of*

quality measures across multiple payers. Payers should be guided to accept data from electronic health records (including data during the measurement period when the patient was part of another insurer's panel). These arbitrary rules have the potential to result in duplication of testing and costs. Quality performance thresholds must reflect reasonable levels that account for patient circumstances such as patient rights, cultural/religious beliefs, and social factors.

- **Greater Patient Education and Engagement Around Care Seeking***: Given the important role of patients in their own health and care seeking patterns for services and appropriate levels of care, there may be a benefit of statewide public awareness campaigns.*

2. STRATEGIES AND POLICIES TO SUPPORT INVESTMENT IN PRIMARY CARE AND BEHAVIORAL HEALTH CARE:

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care, even though evidence suggests that a greater orientation toward primary care and behavioral health may increase health system efficiency and provide superior patient access and quality of care. Provider organizations, payers, employers, and government alike have important roles in prioritizing primary care and behavioral health *while still restraining the growth in overall health care spending.*

a. Please describe your organization's strategy for supporting and increasing investment in primary care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

CHA continues to make investments in primary care access and supportive services that include:

- *Primary care access expansion;*
- *Team-based primary care to best serve patients, including patient resource coordinators to assist patients who face social factors in health with resources; and*
- *Incremental information technology and quality advisor staff to address the increasing demands of quality improvement and reporting.*

In addition, CHA has implemented systems and process improvement initiatives focused on providing evidence-based patient care and tracking outcomes-based measures. There are increased resources devoted to outreaching to patients who have gaps in evidence-based care. These have resulted in a standardized approach and improved outcomes across many metrics. The organization has also implemented updated automated tools to remind patients to attend their scheduled visits and to allow patients to self-schedule appointments.

CHA has enhanced primary care access with an increase of the patient panel size by 5% and an increase in visits by 4% over the year.

At the end of FY 2018, CHA opened a new primary care practice location at Assembly Square, Somerville and in mid-FY 2019 significantly increased the size of the primary care practice in North Cambridge. Consistent with other CHA primary care initiatives, practices were designed to accommodate the patient support resources outlined above as well as team-based care. CHA is in the process of making physical plant modifications to

its East Cambridge primary care site to support the same principles. These investments have allowed for increased patient access and more standardized approaches to providing necessary care and support to patients.

b. Please describe your organization's top strategy for supporting and increasing investment in behavioral health care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

- **Population health focus:**

CHA's top strategy for supporting and increasing investment in behavioral health care is shifting from a traditional fee-for-service model to a population health model designed to improve the overall health of patients. CHA is pursuing numerous initiatives to enhance care for mental health and substance use conditions including those described below.

- **Expanding mental health and substance use access and services (geography and levels of care):**

CHA has undertaken efforts to expand access to mental health and substance use services within our delivery system and with community partners. This includes: expanding outpatient services in geographic areas in Everett and Revere in our service area that previously had limited behavioral health capacity, a partial hospital program in Cambridge, and a transitions service to improve access to timely post-discharge or post-emergency department visit follow-up appointments.

This has expanded the number of patients we care for within our existing services array, supported through a Lean performance improvement process. This has enabled CHA to offer 110% more intake appointments for new adult patients than in the prior year. Significantly increasing access during FY 2019, CHA's outpatient psychiatry services had an annual visit growth of over 7% to over 113,000 annual visits.

- **Integrating paraprofessional service providers and peer specialists/recovery coaches into clinical teams:**

CHA is utilizing paraprofessionals or partnerships with community-based provider in patient outreach.

In addition, CHA is deploying recovery coaches in the emergency department setting. During the first year of the recovery coach program at the CHA Everett Hospital Emergency Department, 507 unique patients were referred to the program with a 65% engagement rate. Ninety-two patients navigated to inpatient detox or CSS, 24 patients navigated to outpatient treatment, and 176 patients navigated to other treatment services. For FY 2020, the program expanded to CHA's Cambridge Hospital Emergency Department. Despite its effectiveness, this program's long-term sustainability is in question given the lack of alignment between patient needs during an acute emergency department visit and needed reimbursement for the encounter with the recovery coach.

- ***Use of Technology for Specialty Behavioral Health Care:***

CHA is increasing the use of technology for specialty mental health and addiction care in order to provide ready access to psychiatric consultation for medical service providers, other community-based providers, and/or direct consultation with patients. This optimizes CHA's primary care-behavioral health integration step model and supports community partners along the continuum. A team of seasoned clinicians provide

psychiatric e-consultation and work with providers to improve care of behavioral patients.

- ***Substance Use Integration and Continuum of Care Needs:***

CHA is integrating substance use services across the continuum of care, including screening and referral to treatment in primary care and medication assisted treatment offered in primary care and behavioral health settings. Approximately, 37% of CHA's patient with opioid use disorder received medication-assisted treatment in the past year, a 14% improvement over the prior year.

To address gaps in the continuum of substance use treatment, CHA is exploring ways to expand the continuum of care for substance use, such as adding new capacity for inpatient detoxification and residential services through partnerships.

- ***Intensive Behavioral Health Needs:***

CHA is providing access to intensive case management for individuals identified with SMI or those who are high utilizers of acute care and emergency services. In addition, CHA has referred 775 MassHealth patients with serious mental illness and/or substance use disorder to a behavioral health community partners with which it has contracted. CHA actively works with the community partner to engage patients and coordinate treatment plans.

- **Risk stratification to identify high-risk cases and/or frequent service users:**

CHA's risk stratification approach utilizes our electronic health record and Johns Hopkins predictive risk scores. Interventions are tailored to meet the specific needs of each segment of our patient population. Patients with common behavioral health conditions, such as depression, anxiety, and addiction, receive screening and brief treatment through our primary care behavioral health integration intervention. Patients with more intensive behavioral health needs are referred to specialized treatment in our outpatient psychiatry department or higher levels of care and to care management resources such as primary care-based complex care management, specialty psychiatry case workers, or behavioral health community partners. Patients with SMI may use CHA's Behavioral Health Medical Home for integrated medical and psychiatric care.

c. Payers may also provide incentives or other supports to provider organizations to deliver high-functioning, high-quality, and efficient primary care and to improve behavioral health access and quality. What are the top contract features or payer strategies that are or would be most beneficial to or most effective for your organization in order to strengthen and support primary and behavioral health care?

Improving reimbursement for primary care and behavioral health services is essential to allocate resources to these areas that have the potential to promote wellness, overall health, and cost-effectiveness.

Improving behavioral health acuity systems is needed not only in risk adjustment methods (related to global budgets) but also for ambulatory behavioral health treatment. For instance, the resources required to treat serious and persistent mental illness or serious emotional disturbance in children are of greater intensity than other behavioral health conditions.

Across all payers, it is recommended that coverage be expanded for innovative services such as new tele-health, inter-professional consultations, e-consults/visits, care coordination and management, remote monitoring and mobile integrated health.

Presently, providers are often penalized in terms of quality incentives when they care for the most complex patients. For example, inpatient quality incentives related to length of stay may be diminished for a provider organization if they accept hard to place patients that require a longer inpatient stay or face barriers in transitioning to the next level or appropriate level of care.

Another consideration is a requirement to designate a primary care provider (PCP) for insurance coverage regardless of type of insurance plan. Having a PCP is integral to management of care and APMs. In order for ACOs to make progress for APMS with additional insurance types including PPOs, an integral payer policy is for the patient to declare a PCP.

d. What other changes in policy, market behavior, payment, regulation, or statute would best accelerate efforts to reorient a greater proportion of overall health care resources towards investments in primary care and behavioral health care? Specifically, what are the barriers that your organization perceives in supporting investment in primary care and behavioral health and how would these suggested changes in policy, market behavior, payment, regulation, or statute mitigate these barriers?

Many core functions of patient-centered medical homes in primary care are not reimbursed in today's payment system. These include care management, patient resource coordinators to assist patients address social needs that impact health, and integrated behavioral health consultations.

There is a challenge in billing for integrated behavioral health visits within the primary care setting.

The payment system and acuity/risk adjustment systems for primary care and behavioral health must be redesigned and improved. This can be done in ways that support better care management for patients.

Barriers include: workforce shortages especially for behavioral health psychopharmacology and multi-lingual, diverse behavioral health providers; gaps in available levels of behavioral health care needed by patients and families; bottlenecks and delays in insurance credentialing and provider enrollment especially for behavioral health providers; and current delays in Massachusetts psychology licensing board.

There is an opportunity for payers to recognize and reimburse for additional levels of professionals such as peer recovery coaches and community health workers, etc.

3. CHANGES IN RISK SCORE AND PATIENT ACUITY:

In recent years, the risk scores of many provider groups' patient populations, as determined by payer risk adjustment tools, have been steadily increasing and a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications. Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your patient population.

Factors	Level of Contribution
Increased prevalence of chronic disease among your patients	Major Contributing Factor
Aging of your patients	Minor Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Major Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Not a Significant Factor
New, relatively less healthy patients entering your patient pool	Minor Contributing Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe: **Social factors impacting health, recognized by some payers** **Churn particularly in the Medicaid population**	Major Contributing Factors

☐ Not applicable; neither risk scores nor acuity have increased for my patients in recent years.

As noted in the set of factors above, there are many influences that drive patient acuity and risk score. Behavioral health and substance use disorder needs, including those related to the opioid crisis, have given rise to an expanded group of patients with very serious treatment needs and consequent expenses, which often do not receive adequate weighting in traditional risk adjustment approaches. Some insurers, including MassHealth, have adopted "risk normalization," in which insurers rebase or "normalize" risk scores to "1.0" on a periodic basis, potentially negating real overall risk change over time. Social determinants of health factors have more recently been recognized as important contributors to costs, but formal recognition of social determinants by payers is mixed. MassHealth has included some social determinant adjustment, which could be critical to align with patient social complexity and the required resource intensity.

4. REDUCING ADMINISTRATIVE COMPLEXITY:

Administrative complexity is endemic in the U.S. health care system. It is associated with negative impacts, both financial and non-financial, and is one of the principal reasons that U.S. health care spending exceeds that of other high-income countries. For each of the areas listed below, please indicate whether achieving greater alignment and simplification is a **high priority**, a **medium priority**, or a **low priority** for your organization. Please indicate **no more than three high priority areas**. If you have already submitted these responses to the HPC via the June 2019 *HPC Advisory Council Survey on Reducing Administrative Complexity*, do not resubmit unless your responses have changed.

Area of Administrative Complexity	Priority Level
Billing and Claims Processing – processing of provider requests for payment and insurer adjudication of claims, including claims submission, status inquiry, and payment	Medium
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Medium
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Medium
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	Medium
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Medium
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	High
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Low
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	High
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	High
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Low
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	Low
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level

5. STRATEGIES TO SUPPORT ADOPTION AND EXPANSION OF ALTERNATIVE PAYMENT METHODS:

For over a decade, Massachusetts has been a leader in promoting and adopting alternative payment methods (APMs) for health care services. However, as noted in HPC's 2018 Cost Trends Report, recently there has been slower than expected growth in the adoption of APMs in commercial insurance products in the state, particularly driven by low rates of global payment usage by national insurers operating in the Commonwealth, low global payment usage in preferred provider organization (PPO) products, and low adoption of APMs other than global payment. Please identify which of the following strategies you believe would most help your organization continue to adopt and expand participation in APMs. **Please select no more than three.**

- ☐ Expanding APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payments
- ☒ Identifying strategies and/or creating tools to better manage the total cost of care for PPO populations
- ☐ Encouraging non-Massachusetts based payers to expand APMs in Massachusetts
- ☐ Identifying strategies and/or creating tools for overcoming problems related to small patient volume

  Enhancing data sharing to support APMs (e.g., improving access to timely claims data to support population health management, including data for carve-out vendors)

  Aligning payment models across payers and products

  Enhancing provider technological infrastructure
- ☒ Other, please describe: **(1) Improving global budgets and payments for hospitals/providers historically underpaid by commercial insurers,** which presently deprive populations and communities resources for health services and population health. **(2) Global payments that recognize the impact of behavioral health and social determinants** on the cost of care, and that adequately compensate providers for the infrastructure needed to manage population health, including quality. Additionally, APMs must recognize and reward high performance delivery systems so that progress can be sustained, and avoid a "race to the bottom" approach where high performance systems receive unsustainable budgets due to their success at removing costs from the system.

Pre-Filed Testimony Questions: Attorney General's Office

1. For provider organizations: please submit a summary table showing for each year 2015 to 2018 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.

AGO Provider Exhibit 1 incorporates total revenue for CHA's Hospital and Physician network. In some circumstances, risk arrangements may not incorporate both our hospital and physicians, and data represents an aggregated result of these contracts. The data is supplied in total (not apportioned by HMO and PPO), as systems are not presently in place to track to this level. The data exhibits the level of reporting in place during a particular fiscal year. Therefore, conclusions should not be drawn about the relative changes in reimbursement or shifts in payer-related activity year-over-year.

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 Calendar Years (CY) 2017-2019			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	**Q1**	43	All Phone
	Q2	82	All Phone
	Q3	102	All Phone
	Q4	76	All Phone
CY2018	**Q1**	95	All Phone
	Q2	86	All Phone
	Q3	122	All Phone
	Q4	107	All Phone
CY2019	**Q1**	131	All Phone
	Q2	121	All Phone
	TOTAL:	965	All Phone

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.

CHA has created a price quote line within its Financial Assistance Department which is promoted both externally, via the CHA website, and internally, as a resource for patients to request a price quote for all services at CHA. CHA Customer Service staff manage the request internally, utilizing a standardized price quote request form to expedite the process in a timely fashion. Coding staff perform the necessary research and evaluation, following CHA and regulatory policies and procedures, and then send the information back to Customer Service staff to complete and communicate back to the patient. The patient is called with the information and sent a confirmation letter, or the letter is e-mailed based on patient preference, once the request is completed. The standard letter format includes both the pricing for the requested services and a link to the website of the payer for the patient to access information related to the required allowed amount by their insurance company.

A tracking system was established in February of 2016 to maintain a record of requests received and to monitor the turnaround time for such requests. Copies of confirmation letters are also scanned and kept on file for future reference. The average rate of turnaround within 48 hours is 97.25% of total requests.

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?

Obstacles to providing price quotes usually relate to a lack of accuracy as to the particular request. The implementation of a standardized price quote request form and staff training has helped to improve service to patients in this area.

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

a. For each year **2016 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.

CHA is unable to complete this table because it does not have a validated cost accounting system in place at this time. While it may be possible to make estimates of the contribution margin by payer utilizing ratios from sources such as the Medicare cost report, these estimates would not be an accurate assessment of costs at the individual patient, and therefore aggregated payer, level. Given the level of assumptions necessary to develop this type of analysis, CHA has concerns that, even if it were able to submit information, the results would not be comparable across providers. We have provided the margin data at the total provider level. Please find linked the Center for Health Information and Analysis Acute Hospital Financial Performance Trends for CHA, which

can be accessed at http://www.chiamass.gov/assets/Uploads/mass-hospital-financials/2017-annual-report/five-year-trend/cambr-ha.pdf.

CHA's high government payer mix and lower commercial insurance payer mix makes adequate commercial insurer reimbursement of critical importance to carrying out its patient care mission to care for all.

The data below from the Center for Health Information and Analysis's databook (May 2019 Provider Price Variation in the Massachusetts Commercial Market report) highlights this observation. The commercial health plans pay CHA unsustainably far below the payer-specific average hospital relative prices and a minimum payment level of 90% of the statewide average relative price, which we seek to support thriving local health care access, which will enable a greater share of care provided locally in more cost-effective community settings.

CHA Calendar Year 2017 Payer-Specific Relative Price – Acute Hospitals
Source: CHIA Relative Price Databook (May 2019)

Payer Name	Hospital Name	Hospital Type	Insurance Category	Data Year	Product Type	Blended RP	Blended RP Percentile
Aetna	Cambridge Health Alliance	Acute	Commercial (self and fully insured)	2017	All-product	0.640	3.2
Blue Cross Blue Shield of MA	Cambridge Health Alliance	Acute	Commercial (self and fully insured)	2017	All-product	0.830	18.2
CIGNA	Cambridge Health Alliance	Acute	Commercial (self and fully insured)	2017	All-product	1.110	61.4
Fallon Community Health Plan	Cambridge Health Alliance	Acute	Commercial (self and fully insured)	2017	All-product	0.750	23.1
Harvard Pilgrim Health Care	Cambridge Health Alliance	Acute	Commercial (self and fully insured)	2017	All-product	0.780	24.3
Neighborhood Health Plan	Cambridge Health Alliance	Acute	Commercial (self and fully insured)	2017	All-product	0.670	22.5
Network Health	Cambridge Health Alliance	Acute	Commercial (self and fully insured)	2017	All-product	0.790	27.4
Tufts	Cambridge Health Alliance	Acute	Commercial (self and fully insured)	2017	All-product	0.750	12.1
UniCare	Cambridge Health Alliance	Acute	Commercial (self and fully insured)	2017	All-product	0.790	28.5

b. For **2018 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.

Please see the response to question 3.a) above.

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.

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						
		Both		Both		Both		Both		Both		Both			Both
Blue Cross Blue Shield**						30.4		0.3		0.2					
Tufts Health Plan**						11.5		0.1							
Harvard Pilgrim Health Care**						11.8		0.1							
Fallon Community Health Plan												0.2			
CIGNA												2.4			
United Healthcare												4.5			
Aetna												3.6			
Other Commercial								0.0				12.0			
Total Commercial	0.0	0.0	0.0	0.0	0.0	53.7	0.0	0.5	0.0	0.2	0.0	22.8	0.0	0.0	0.0
Network Health						36.2		0.3							
Neighborhood Health Plan												23.1			
BMC HealthNet, Inc.												2.4			
Health New England															
Fallon Community Health Plan												0.5			
Other Managed Medicaid												2.4			
Total Managed Medicaid	0.0	0.0	0.0	0.0	0.0	36.2	0.0	0.3	0.0	0.0	0.0	28.4	0.0	0.0	0.0
MassHealth		36.6		1.3		25.0		1.9							
Tufts Medicare Preferred						2.3		0.1							
Blue Cross Senior Options												0.9			
Other Comm Medicare						13.4		1.3				7.4			
Commercial Medicare Subtotal	0.0	0.0	0.0	0.0	0.0	15.7	0.0	1.4	0.0	0.0	0.0	8.3	0.0	0.0	0.0
Medicare								0.2				66.0			
Other												3.7			
GRAND TOTAL	0.0	36.6	0.0	1.3	0.0	130.6	0.0	4.4	0.0	0.2	0.0	129.1	0.0	0.0	0.0

*Numbers in millions

** The risk for these contracts are settled in the aggregate, results were prorated across these payors for purposes of estimating impact

2016	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		QualitX Incentive Revenue						
		Both		Both		Both		Both		Both		Both			Both
Blue Cross Blue Shield**						30.8		1.0		0.5					
Tufts Health Plan**						10.6		0.2							
Harvard Pilgrim Health Care**						11.5		0.6							
Fallon Community Health Plan												0.2			
CIGNA												2.9			
United Healthcare												4.8			
Aetna												3.7			
Other Commercial								0.03				20.0			
Total Commercial	0.0	0.0	0.0	0.0	0.0	52.9	0.0	1.8	0.0	0.5	0.0	31.6	0.0	0.0	0.0
Network Health						30.2		1.0							
Neighborhood Health Plan												25.4			
BMC HealthNet, Inc.												5.0			
Health New England															
Fallon Community Health Plan												0.2			
Other Managed Medicaid												3.4			
Total Managed Medicaid	0.0	0.0	0.0	0.0	0.0	30.2	0.0	1.0	0.0	0.0	0.0	34.0	0.0	0.0	0.0
MassHealth		30.0		0.9		27.0		2.1							
Tufts Medicare Preferred								0.0				2.1			
Blue Cross Senior Options												1.3			
Other Comm Medicare						14.0		1.8				8.4			
Commercial Medicare Subtotal	0.0	0.0	0.0	0.0	0.0	14.0	0.0	1.8	0.0	0.0	0.0	11.9	0.0	0.0	0.0
Medicare												67.6			
Other												3.7			
GRAND TOTAL	0.0	30.0	0.0	0.9	0.0	124.1	0.0	6.7	0.0	0.5	0.0	148.8	0.0	0.0	0.0

*Numbers in millions

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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						
		Both		Both		Both		Both		Both		Both			Both
Blue Cross Blue Shield**						33.6		0.3		0.7					
Tufts Health Plan**						11.0		0.1							
Harvard Pilgrim Health Care**						10.7		0.2							
Fallon Community Health Plan												0.2			
CIGNA												3.1			
United Healthcare												5.0			
Aetna												3.7			
Other Commercial												24.5			
Total Commercial	0.0	0.0	0.0	0.0	0.0	55.4	0.0	0.6	0.0	0.7	0.0	36.4	0.0	0.0	0.0
Network Health						31.3									
Neighborhood Health Plan												23.0			
BMC HealthNet, Inc.												6.6			
Health New England															
Fallon Community Health Plan												0.2			
Other Managed Medicaid								0.0				2.8			
Total Managed Medicaid	0.0	0.0	0.0	0.0	0.0	31.3	0.0	0.0	0.0	0.0	0.0	32.6	0.0	0.0	0.0
MassHealth		36.9		0.5		28.0		-0.2							
Tufts Medicare Preferred						3.3									
Blue Cross Senior Options												1.1			
Other Comm Medicare						15.2		0.4				10.2			
Commercial Medicare Subtotal	0.0	0.0	0.0	0.0	0.0	18.5	0.0	0.4	0.0	0.0	0.0	11.2	0.0	0.0	0.0
Medicare												67.1			
Other												3.9			
GRAND TOTAL	0.0	36.9	0.0	0.5	0.0	133.1	0.0	0.8	0.0	0.7	0.0	151.3	0.0	0.0	0.0

*Numbers in millions

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2018	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
		Both		Both		Both		Both		Both		Both			Both
Blue Cross Blue Shield**						32.9		-0.2		0.3					
Tufts Health Plan**						10.2		0.0							
Harvard Pilgrim Health Care**						14.4		-0.1							
Fallon Community Health Plan												0.2			
CIGNA												3.1			
United Healthcare												4.8			
Aetna												3.6			
Other Commercial												24.7			
Total Commercial	0.0	0.0	0.0	0.0	0.0	57.5	0.0	-0.3	0.0	0.3	0.0	36.4	0.0	0.0	0.0
Network Health						40.7									
Neighborhood Health Plan												11.7			
BMC HealthNet, Inc.												7.2			
Health New England															
Fallon Community Health Plan												0.6			
Other Managed Medicaid								0.0				1.8			
Total Managed Medicaid	0.0	0.0	0.0	0.0	0.0	40.7	0.0	0.0	0.0	0.0	0.0	21.3	0.0	0.0	0.0
MassHealth		42.6		0.8		21.6		-3.3							
Tufts Medicare Preferred						2.8									
Blue Cross Senior Options												1.1			
Other Comm Medicare						17.5		0.2				11.7			
Commercial Medicare Subtotal	0.0	0.0	0.0	0.0	0.0	20.3	0.0	0.2	0.0	0.0	0.0	12.7	0.0	0.0	0.0
Medicare												65.5			
Other												3.9			
GRAND TOTAL	0.0	42.6	0.0	0.8	0.0	140.1	0.0	-3.5	0.0	0.3	0.0	139.8	0.0	0.0	0.0

*Numbers in millions

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