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?

Signature Healthcare's top strategy to reduce health care expenditures is the improvement of safety and quality, knowing these efforts will reduce avoidable morbidity, complications, and mortality, in addition to improving patients' ability to manage their disease. As a consequence, we reduce admissions, readmissions and cost. In addition, Signature accepted population risk as a method of aligning the organization's mission with generating value for the community.

For more than eight years, Signature has managed operations using an operational excellence/lean management system; three to four years ago we added a safety management system, integrated the two and stabilized them system-wide through a standardized leadership method. The sustained effort to remove waste, standardize operations, and continuously improve processes, combined with safety management's focus on improving human compliance, reducing cognitive biases and improved communication have led to dramatic decreases in hospital acquired conditions, reduced sepsis mortality, improved cancer screening rates, improved ambulatory management of hypertension and diabetes, reduced readmissions, and reduced admission rates. All of these advancements have improved care, decreased utilization and reduced cost.

Signature has also accepted a significant portion of population risk with up and downside agreements for a Medicare Advantage plan, Medicare 90-day bundles, a commercial HMO plan and the Medicaid ACO. Until this year, the strategy was successful in providing resources needed to invest in improving care. The success in reducing TME generated additional income for reinvestment in access to care for the community. However, in 2019 dramatic reductions in the Medicare bundle target price, combined with the slow and continuous six-year reduction in the Medicare Advantage target budget has made it impossible for Signature to continue these programs, which provided significant benefit to the community. Population health success requires investment and when the target price continues to decline, at some point it is impossible to meet the new targets and sustain the investment in additional staff. Therefore, Signature is in the process of exiting both of these important population health programs. Additionally, the Medicaid ACO target price was set assuming Signature could continue to provide TME that was well under the state average, and somehow further improve on that performance. Signature has developed an exceptional team of care managers, community workers, social workers and pharmacists who have focused on 3% of the population that was predicted to expend the greatest resources. This care management program has been successful in returning $2 for every dollar invested. However, these savings have not been enough to overcome the target price, causing Signature to lose money in the Masshealth ACO and return to the state payments from a program that already pays less than cost.

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

Signature's experience has shown total medical expense can be reduced for government payers through focusing on ambulatory care and transitions from inpatient care. However, the program's interest in obtaining savings through reductions in the ongoing budget, allow no ability for a safety net hospital to absorb normal increases in cost. With 75% of Signature's payments coming from the government, through payments purposely established to pay less than cost, Signature must support programs of improving health and reducing TME through either population health savings or commercial insurance. As one of the lowest paid hospitals from commercial rates, the excess revenue from fee for service payments to support helping payers reduce total medical expense no longer exists.

Signature Healthcare is a relatively average sized community hospital with approximately 13,000 discharges and limited cash reserves, due to historically underfunded government reimbursement and lower than average commercial rates. As the organization transitions back to fee-for- service to be able to survive to care for the community, Signature expects total medical expense for Signature's panel of patients to increase. If payers want the organization to continue focusing on population health, while receiving fee–for-service payments, the payments for managing chronic illness in the ambulatory setting must change to allow more time per visit and more resources for chronically ill patients. In the past, these additional resources were added through the savings from population health. Since Signature suffers from payments dramatically lower than local competitors, the organization must reduce these resources when exiting population health agreements.

Signature has also worked with local employers to reduce *their* total medical expense, acknowledging the local employer insurance rates are artificially high to pay for care of wealthier patients at Boston hospitals. The Signature employer wellness team has an array of services from an onsite nurse practitioner to biometric screenings, with wellness programs aimed at the employer's individualized needs. These programs have shown success and Signature supported them for the community at a significant loss. With the recent dramatic reductions in Medicaid outpatient rates, combined with losses from population health contracts, it is questionable whether these programs can be sustained.

Signature provided significant access to specialists in the Brockton area, knowing local patients with poor transportation choices to Boston would not access specialty care if it were not provided close to home. Lack of that specialty care is currently one of the causes for the higher rates of diabetes, hypertension, increased complication rates, and delayed diagnosis of cancer in the local area. As a not-for-profit, Signature does not place artificial and hidden limits on the volume or percentage of Medicaid patients cared for by the Signature Medical Group. Although some local providers accept Medicaid patients, the percentage penetration of volume of Medicaid, Medicare and dual eligible patients can be managed through selective admission of patients into a practice by offering new patient appointments so far out in the future that patients are discouraged. As a direct result of caring for a larger percentage of Medicaid and Medicare ambulatory patients, the Signature Medical Group loses over $13 million dollars a year which must be supported from the already underfunded hospital. There are no regulations requiring for-profit private primary care groups to provide unlimited care to Medicaid patients. There are also no policies or regulations saying a private group's panel must approximate the mix of Medicaid patients found in the surrounding area. As a result, large private groups are able to orient their care toward better

paying patients, increasing their ability to negotiate improved rates from insurance carriers. With a much richer base of patients they are able to generate much higher incomes per patient, creating upward pressure on the salaries Signature must provide physicians to pay them fairly for the volume of care delivered. This becomes an annual and vicious cycle of underfunding, cuts to programs and delayed maintenance to buildings and programs, creating further gaps to the wealthier systems that reinvest and continue to grow market share.

Massachusetts has wisely acknowledged many of these problems for years and attempted to address them through increased price transparency and support for care transitions in the new Medicaid ACO. The state could find the political will to narrow the unsupported price variation between the hospitals caring for the government's patients and the wealthier systems.

Signature acknowledges the state is aware of the situation, so we would like to offer an additional unique focus on safety and quality to reduce TME. The Betsy Lehman Center recently published a report that indicated Massachusetts spends more than $600 million dollars a year on care to treat patients suffering from avoidable harm. While the state has focused on TME, little concerted effort is made to reduce the expense due to medical error, and hold providers accountable for quality. There are no public hearings related to poor quality, or higher than expected rates of harm. Half of the hospitals in the State have a Leapfrog safety grade below an A and their patients have been suffering from poor care for years. A recent report from the Armstrong Institute for Patient Safety and Quality indicated that on average hospitals with a safety score of B have a 35% higher avoidable mortality rate, and Hospitals with a safety grade of C have an 88% higher mortality rate. These unacceptable low safety scores cost the state millions and untold anguish for families. The fact that safety has not improved in the State is an indicator the system is producing the care it was designed to produce. If history is a judge of the future; safety and quality, and subsequently, the unnecessary cost from harm will not improve until the system of delivery improves.

The state must decide if safe delivery of care is a priority for all state agencies that relate to and influence providers. This delivery system should include payment and reimbursement policies with incentives to move inpatients to an outpatient status to save Medicaid money rather than focusing on the appropriate care setting. The state currently outsources the review of Medicaid care to organizations that hire physicians to review cases they are not trained to treat; frequently denying the inpatient claims, which are already being paid at rates below cost. Appeal systems do not seem to work as the appeals process is designed to focus on unpublished and unshared rules and documentation gaps rather than whether care was safely delivered. These programs are creating subtle and continued pressure to not admit patients to avoid eventual denial of payments, even when the clinicians are worried about the safety of patients. This practice will not change until the State believes safety comes first, rather than reduced payments to already underpaid hospitals.

The State also needs to completely overhaul oversight standards for providers related to quality and include current information on safety management systems. The oversight organizations should review the longitudinal outcomes of facilities and spend the time and resources to fully investigate and understand the management and operating systems of an organization when they are failing the public from a history of higher than warranted safety problems. This will require a significant investment by the state in understanding safety science, safety management, and increasing the oversight of providers. The current performance would indicate the need for significant investigation and mitigation for half of the hospitals in the state.

The provider community lacks uniform knowledge of safety science and insight into best practices in safety management. Many trustees lack training in safety, and the tools necessary to hold an organization's leadership accountable. The state should establish standards for executive training in safety, ongoing training requirements, as well as training and certification in safety for trustees.

While the state has appropriately focused on transparency for cost, little has been done to focus on unnecessary harm to patients. For example, if a hospital wanted to know if they were providing the best care for patients with sepsis, benchmark state owned is unavailable to the provider community. We do not currently measure enough safety data, and for the few things we do measure, they are not transparently displayed over time and not used to hold providers accountable.

Payers should hold hospitals accountable for quality, paying much higher rates for hospitals with a higher safety record. Signature's history of below average reimbursement rates with higher than average safety and quality, compared to hospitals with historically low safety grades and higher payments would indicate quality and payments are not matched.

The state's focus on safety would make it much easier for providers to continue to transform organizations toward zero harm. Newly hired staff would already be oriented to higher standards, increasing the pace of change.

In addition to safety, the state should place a priority on reducing the burden of chronic illness in areas where public policy can make a difference. For instance, public policies aimed at reducing smoking have made a difference. A good place to start would be to decrease the percentage of adults suffering from metabolic syndrome. More than 34% of adults over the age 18 have had metabolic syndrome and more than 40% of adults in their 60's and 70's. Metabolic syndrome is a collection of risk factors that increase risk for heart disease, stroke, and diabetes. Many of the causes for the syndrome relate to insulin resistance, which is heavily influenced by dietary habits, exercise and sleep habits. Clinicians have a minor influence on this problem, as many patients do not have symptoms until they are already suffering from the chronic diseases. However, government policies and education can have a significant impact. The state should aggressively pursue a coordinated agenda to impact this significantly increasing problem. After adopting this as an overarching state priority, the state should pass legislation creating tax incentives to reduce the purchase of the wrong foods and encourage the purchase of the right foods. The state should also incent employers to support reducing metabolic syndrome through their employer sponsored health plans, and ensure that schools adequately teach nutrition, mandate exercise and influence families through their children.

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care; even though evidence suggests 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.

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.

Signature Healthcare remains committed to increasing our investment in primary care. Over the past 2 years we have specifically grown both our employed pediatric and adult providers. This allowed greater access to primary care in our catchment area. In particular, our partnership with BMC to launch our Medicaid ACO is allowing us to improve the quality of care we provide to our patients. At the same time, the ACO focuses our efforts on reducing total cost of care for our population by reducing hospitalizations, ED visits, and by managing the top 3% of our population with complex care management.

However, Signature Healthcare is a safety net provider in a socio-economically depressed area with a high percentage of government insured and below average commercial rates. As a result of historically poor payments, Signature has operated with minimal cash reserves necessitating delayed maintenance of the hospital buildings. Over the past 8-9 years, Signature has invested a significant portion of limited funds in building and leasing additional office space, capital investment in finishing out the space and operating investments in employing and supporting new primary care and specialty physicians to provide access to care. Many of the area's patients do not have the ability to travel into Boston for care delaying or foregoing specialty care until they seek care in the emergency department. The investment in physician access has been accomplished at the expense of repairing and investing in a decaying hospital plant.

Signature has learned over the years that employing a physician is just the tip of the iceberg in terms of creating access, improving cancer screening rates, and reducing the burden of chronic illness. After successfully recruiting physicians, Signature needed to retain them and support their daily work. The first few years of establishing a new primary care panel are very expensive and require steep investment from the corporation in the practice. In an effort to meet the community's needs, SHC places no artificial barriers (such as restricted or delayed appointments for Medicaid patients) on physician scheduling practices. Since the mix of patients in Signature's clinics mimics the demographics of the service area, the average reimbursement for a Signature Medical Group (SMG) primary care physician is much lower than experienced by the competing local for-profit physician groups. Those groups directly recruit SMG physicians explaining they can see fewer patients and make significantly more money, and care for a significantly fewer number of Medicaid patients who are known to have much higher no-show rates. When Signature has lost a physician to a local competitor, Signature loses the panel of patients and any hope of a return on the very high upfront cost of recruiting and building the practice. In an effort to retain physicians, Signature increased pay to the physicians, further draining hospital resources in an effort to improve access for Medicaid and Medicare patients in the area. In addition to direct financial support through salary, Signature has developed and supported a management system for the practices that has helped the doctors to focus on patient care. Over a number of years Signature invested in a centralized call center for appointment management, a centralized

medication refill department, ambulatory pharmacists, social workers, community workers, case managers, quality improvement staff, a referral management team, a physician mentor for new PCPs, leadership development for physician leaders and an operational excellence lean management system to support employee engagement in continuous improvement.

The investment in these resources has improved care and reduced TME. For example, Signature's initial rates in the Medicaid ACO were artificially reduced by the state because the state found that the TME from prior year was 4% less than the state average. Signature also had success in the Blue Cross ACO. Prior to the past two years, Signature was successful in reducing TME within a Medicare Advantage plan and Medicare inpatient bundles.

Signature has continued to invest and aim toward reducing TME, in spite of extremely low volume based reimbursement. The investments in physician access and infrastructure to support the physician enterprise have come from the hospital. Signature's hospital operated successfully at low cost by reducing errors, improving quality, removing waste, being very efficient and under-investing in capital.

Signature Healthcare Brockton Hospital has been able to invest in an upgraded and unified EMR, a new Cancer Center, and a replacement building for the 120 year-old School of Nursing. These investments required the organization to continue delaying needed building repairs such as leaking roofs, walls, windows, and aging clinical systems and equipment.

During 2019, Medicare changed the target price for the bundle program, well below Signature's previous target, and the target budget for Medicare advantage which was approximately $2 million dollars below the rate from 2013. Both of these changes placed Signature in a position of no longer being able to generate the income from population health in Medicare to fund unpaid population health initiatives. Unfortunately, the state reduced Medicaid payments for outpatient testing, further placing economic stress on the organization. As a result of these changes in government reimbursement (in programs designed to pay less than cost) Signature is re-examining investments in access to care and population health. Signature does not have the capital reserves to weather years where performance is lower than expected due to variation within a small pool of patients, or government programs that have unrealistic target prices.

In summary, investing in primary and specialty care has required capital investment and operating investment. Governmental rates for physicians are so uncompetitive, that all of these investments have come from the hospital, and the hospital's reimbursement has reached a new and critical low point.

a. 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.

Signature Healthcare hired a Chief of Psychiatry in order to help us strategize Signature's behavioral health plans moving forward. Signature opened an OBAT program based on BMC's "spoke and hub" model whereby an x-waivered provider initiates suboxone for our patients and once stabilized, transitions these patients back to their primary care. This allowed better access for some of our patients struggling with addiction. Furthermore, our new Chief of Psychiatry is working with our leadership team to build a model outpatient psychiatry program for our population struggling with severe depression and other serious mental illness.

b. 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?

The most effective strategy for improving quality and efficiency would be to establish government payment rates for ambulatory care that are market rates; if over 50% of an organization's patients are Medicaid and Medicare recipients. Significant improvements in quality and cost are possible, but require investment, that historically has come from the hospital taking resources and providing them to physicians. The top contract features should start with Medicaid and Medicare paying enough for a physician to spend adequate time with chronically ill patients to help them understand and manage their disease. Next, would be for contracts to adequately reimburse ambulatory pharmacists to help educate patients, find affordable medications, improve compliance and reduce over- medication.

c. 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?

Signature has been chronically underfunded by all payers. Medicaid and Medicare pay less than cost and the insurers reimburse significantly below average. The difference in just commercial rates between Signature and the closest three competitors range conservatively between $11 million and $30 million dollars per year. It is impossible for Signature to invest significant reserves in programs that are not funded by fee-for-service. Increasing access to primary care, behavioral care and specialty care require investment in facilities and financial support for physicians. Physician pay rates for Medicare and Medicaid are so far below market that access is provided only from the good will of non-profit systems or FQHCs. Investment funds for capital to build or lease buildings followed by sustainable payments are necessary for any meaningful increase in access for the socio-economically challenged areas.

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	Major Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Minor Contributing Factor

Factors	Level of Contribution
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Minor Contributing Factor
New, relatively less healthy patients entering your patient pool	Major Contributing Factor
Relatively healthier patients leaving your patient pool	Minor Contributing Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Not a Significant Factor
Other, please describe: More social determinants of health playing a critical role in not allowing our population to engage fully in the healthcare system	Major Contributing Factor

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

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	Low
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	High
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Low
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	High
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

Area of Administrative Complexity	Priority Level
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Low
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	Medium
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Medium
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	High
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	Medium
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: Establish incentives for employers to participate in managing the risk and wellness of their employees. APM's have been designed on the theory that moving risk to the primary care physician will help reduce cost by aligning the incentive to keep patients healthy, reduce the burden of chronic illness and teach patients to provide enhanced self-care. Primary care has been focusing on the top 2-3% of high utilizers where return on investment resides to pay for improvement. Long-term we need to find methods of engaging patients who have one or two chronic conditions; as well as those who are trending toward having a chronic condition that will require support from the employers. Employers can also be helpful in supporting their employees with chronic illness, through plan design, and supportive business practices. Signature's experience with small employers has shown reticence of many small employers to actively engage in wellness and employee health support.

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.

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**	8	8
	Q2	17	17
	Q3	10	10
	Q4	8	8
CY2018	**Q1**	13	13
	Q2	13	13
	Q3	6	6
	Q4	22	22
CY2019	**Q1**	34	34
	Q2	24	24
	TOTAL:	**155**	**155**

    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.

We use a tool called Patient Estimates which gathers information from our charge description master (CDM), payor contracts, claims data and eligibility response data to give an "estimate" of the service. Currently, we can't determine accuracy of the estimate. Since it's an online tool, if we have all the information entered in the system, the turnaround time is within minutes. We are still working out the reporting capabilities of this system.

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 common barrier we encounter in timely response to the consumer inquiry and not knowing the CPT code or diagnosis code of the service the consumer needs an estimate for. In that case we use Price Transparency Request Form (see attached policy and procedure).

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.

Signature Healthcare Brockton Hospital is not able to provide the requested information with complete confidence in the data's accuracy at this time. We recently conducted a review of the Hospital and Medical Group's data reporting and recording systems. It was at this time, we discovered a delay in the accessibility of data, as well as discrepancies in the data. Both accessibility and discrepancies in data underscored the Hospital's need for a decision support system. We chose to purchase and implement a new decision support system, and this system is being implemented in three phases, with each phase building on the previous; so that users can easily acclimate to the system, understand the power of information, and give sufficient time to ensure its accuracy. Therefore, we have provided the margin data at the total provider level. We have attached the Center for Health Information and Analysis Acute Hospital Financial Performance Trends for CHA for FYs 2013-2017, which can also be accessed at http://www.chiamass.gov/assets/Uploads/mass-hospital-financials/2017-annual-report/five-year-trend/brocktn.pdf**.**

   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.

As indicated above in question 3(a), Signature Healthcare Brockton Hospital is not able to provide the requested information with complete confidence in the data's accuracy at this time. We recently conducted a review of the Hospital and Medical Group's data reporting and recording systems. It was at this time, we discovered a delay in the accessibility of data, as well as discrepancies in the data. Both accessibility and discrepancies in data underscored the Hospital's need for a decision support system. We chose to purchase and implement a new

decision support system, and this system is being implemented in three phases, with each phase building on the previous; so that users can easily acclimate to the system, understand the power of information, and give sufficient time to ensure its accuracy.

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						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$19.1	$1.6	$.6	$.0	$8.9		-	-	$.9	-	$.2	-			
Tufts Health Plan	-	-	-	-	$2.9	-	$.0	-	-	-	$2.8	$1.7			
Harvard Pilgrim Health Care	$11.2	-	$.2	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.7	-			
HPI	-	-	-	-	-	-	-	-	-	-	$6.1	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	$3.2	-			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.8	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$2.3	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.6	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$8.1			
Total Commercial	$30.3	$1.6	$.7	$.0	$11.8	-	$.0	-	$.9	-	$19.7	$9.8			
Network Health	-	-	-	-	-	-	-	-	-	-	$9.3				
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$10.6	-			
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	$16.6				
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$4.9	$.1			
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$41.3	$.1			
MassHealth	-	$27.0	-	$.8	-	-	-	-	-	-	-	-			
Tufts Medicare Preferred	-	-	-	-	$5.6	-	$1.1	-	-	-	$1.4	$.0			
Blue Cross Senior Options	-	-	-	-	-	-	-	-	-	-	$1.6	$2.1			
Senior Whole Health	-	-	-	-	-	-	-	-	-	-	$7.4	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$2.5	-			
Commercial Medicare Subtotal	-	-	-	-	$5.6	-	$1.1	-	-	-	$12.9	$2.1			
Medicare	-	-	-	-	-	-	-	-	-	-	-	$74.5			
Other	-	-	-	-	-	-	-	-	-	-	-	$8.1			
GRAND TOTAL	$30.3	$28.6	$.7	$.9	$17.5	-	$1.2	-	$.9	-	$73.9	$94.6			

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	$8.8	$8.5	$.3	$.3	$14.3	-	-	-	$.4	-	$.4	$.2			
Tufts Health Plan	-	-	-	-	$4.5	-	$.1	-	-	-	-	$3.3			
Harvard Pilgrim Health Care	$11.9	-	$.0	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.4	-			
HPI	-	-	-	-	-	-	-	-	-	-	$6.4	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	-	$3.6			
Unicare	-	-	-	-	-	-	-	-	-	-	$2.3	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$2.4	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.9	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$8.3			
Total Commercial	$20.7	$8.5	$.4	$.3	$18.8	$.0	$.1	$.0	$.4	$.0	$14.8	$15.4			
Tufts - Network Health	-	-	-	-	-	-	-	-	-	-	$10.0	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$12.7	-			
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	$16.2	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$4.4	$.4			
Total Managed Medicaid	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$43.2	$.4			
MassHealth	-	$25.7	-	$1.0	-	-	-	-	-	-	-	-			
Tufts Medicare Preferred	-	-	-	-	$7.4	-	$.3	-	-	-	$.0	-			
Blue Cross Senior Options	-	-	-	-	-	-	-	-	-	-	$3.8	-			
Senior Whole Health	-	-	-	-	$6.4	-	-	-	-	-	-	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$3.0	$.5			
Commercial Medicare Subtotal	$.0	$.0	$.0	$.0	$13.8	$.0	$.3	$.0	$.0	$.0	$6.8	$.5			
Medicare	-	-	-	-	-	$17.5	-	$3.0	-	-	-	$54.8			
Other	-	-	-	-	-	-	-	-	-	-	-	$7.5			
GRAND TOTAL	$20.7	$34.2	$.4	$1.3	$32.6	$17.5	$.4	$3.0	$.4	$.0	$64.9	$78.7			

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	$.5	$11.5	$.0	$.4	$11.0	-	-	-	$.8	-	$5.0	$.3			
Tufts Health Plan	-	-	-	-	$6.0	-	$.1	-	-	-	-	$1.1			
Harvard Pilgrim Health Care	$9.4	-	$.0	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$1.0	-			
HPI	-	-	-	-	-	-	-	-	-	-	$6.3	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	-	$3.2			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.9	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$1.1	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$1.7	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$6.0			
Total Commercial	$9.9	$11.5	$.1	$.4	$17.1	$.0	$.1	$.0	$.8	$.0	$17.0	$10.8			
Tufts - Network Health	-	-	-	-	-	-	-	-	-	-	$12.9	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$13.6	-			
BMC HealthNet, Inc.	-	-	-	-	-	-	-	-	-	-	$19.5	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$5.8	$.3			
Total Managed Medicaid	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$.0	$51.8	$.3			
MassHealth	-	$28.3	-	$.8	-	-	-	-	-	-	-	-			
Tufts Medicare Preferred	-	-	-	-	$9.4	-	-$.7	-	-	-	$.0	-			
Blue Cross Senior Options	-	-	-	-	-	-	-	-	-	-	$3.3	-			
Senior Whole Health	-	-	-	-	$6.4	-	-	-	-	-	-	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$4.5	$.1			
Commercial Medicare Subtotal	$.0	$.0	$.0	$.0	$15.7	$.0	-$.7	$.0	$.0	$.0	$7.8	$.1			
Medicare	-	-	-	-	-	$18.5	-	$3.6	-	-	-	$58.5			
Other	-	-	-	-	-	-	-	-	-	-	-	$7.6			
GRAND TOTAL	$9.9	$39.8	$.1	$1.2	$32.8	$18.5	-$.7	$3.6	$.8	$.0	$76.6	$77.3			

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						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$.8	$10.9	$.0	$.4	$11.9	-	-	-	$.5	-	$4.7	$.4			
Tufts Health Plan	-	-	-	-	$5.5	-	$.1	-	-	-	-	$.7			
Harvard Pilgrim Health Care	$8.8	-	$.0	-	-	-	-	-	-	-	-	-			
Fallon Community Health Plan	-	-	-	-	-	-	-	-	-	-	$.9	-			
HPI	-	-	-	-	-	-	-	-	-	-	$6.4	-			
United Healthcare	-	-	-	-	-	-	-	-	-	-	-	$2.9			
Unicare	-	-	-	-	-	-	-	-	-	-	$1.6	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$.9	-			
Aetna	-	-	-	-	-	-	-	-	-	-	$2.1	-			
Other Commercial	-	-	-	-	-	-	-	-	-	-	-	$7.1			
Total Commercial	$9.6	$10.9	$.1	$.4	$17.4	$.0	$.1	$.0	$.5	$.0	$16.6	$11.1			
Tufts - Network Health	-	-	-	-	-	-	-	-	-	-	$9.4	-			
Neighborhood Health Plan	-	-	-	-	-	-	-	-	-	-	$4.9	-			
BMC HealthNet, Inc.	-	-	-	-	-	$31.4	-	-	-	-	$4.1	-			
Other Managed Medicaid	-	-	-	-	-	-	-	-	-	-	$5.1	$.4			
Total Managed Medicaid	$.0	$.0	$.0	$.0	$.0	$31.4	$.0	$.0	$.0	$.0	$23.5	$.4			
MassHealth	-	$24.0	-	$.3	-	-	-	-	-	-	-	-			
Tufts Medicare Preferred	-	-	-	-	$9.7	-	$.4	-	-	-	$.0	-			
Blue Cross Senior Options	-	-	-	-	-	-	-	-	-	-	$3.0	-			
Senior Whole Health	-	-	-	-	$6.8	-	-	-	-	-	-	-			
Other Comm Medicare	-	-	-	-	-	-	-	-	-	-	$7.4	$.0			
Commercial Medicare Subtotal	$.0	$.0	$.0	$.0	$16.5	$.0	$.4	$.0	$.0	$.0	$10.4	$.0			
Medicare	-	-	-	-	-	$20.1	-	$2.6	-	-	-	$53.6			
Other	-	-	-	-	-	-	-	-	-	-	-	$8.6			
GRAND TOTAL	$9.6	$34.9	$.1	$.7	$34.0	$51.5	$.5	$2.6	$.5	$.0	$50.5	$73.7			