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?

South Shore Health (SSH and/or System) is committed to providing high-quality, cost-effective care to individuals and families throughout our region. SSH continues to prioritize its comprehensive, multi-faceted approach to treating patients in the most appropriate and cost-efficient settings. Recent and ongoing initiatives to achieve this goal include:

- **In late 2018, SSH acquired a series of urgent care centers to provide patients with increased timely and cost-effective access to care outside of the Emergency Department (ED) setting. It is our intent to fully integrate urgent care into the System, including ensuring that coordinated, appropriate follow-up is conducted. By adding urgent care to the System, it will also allow SSH to develop a care delivery structure that will achieve health care savings for our patients and our organization in the future. It is important to note that SSH does not charge facility fees at our urgent care sites, which benefits our patients and reduces overall costs.**

- **SSH is interested in developing a Mobile Integrated Health (MIH) program, which could be used to address gaps in service delivery and prevent unnecessary emergency room visits or hospitalizations by utilizing cost-effective mobile resources to improve access to critical patient-centered health care in non-acute care settings. SSH has submitted an application to establish a MIH program to the Department of Public Health.**

- **Another key initiative is SSH's participation in Connected Care of Southeastern Massachusetts (Connected Care), an accountable care organization (ACO) established by SSH, South Shore Physician Hospital Organization and Brigham and Women's Harbor Medical Associates. As of July 1, 2019, Connected Care started participating in CMS' Medicare Shared Savings Program (MSSP). The goal of Connected Care is to ensure that patients get the right high-quality care at the right time at the right location, without duplicating services, at an appropriate cost.**

  One key strategy used by Connected Care is one-on-one, robust care coordination by an extended care team of RN Care Coordinators, Social Workers and Care Coaches for high-risk patients. This approach reduces

unnecessary office visits through improved patient self-management skills and improves collaboration between primary care providers, specialists, the Care Coordination Team (Team) and the patient. This allows patients greater understanding of their medical condition, treatment programs and importance of preventative services.

The Team is also focused on ensuring that acute care patients are discharged with coordinated and immediate care already in place to promote continued healing and reduce the risk of having a readmission. This includes patients that are discharged to a Skilled Nursing Facility (SNF). Connected Care includes a SNF Care Coach Program designed to facilitate smooth, safe transitions from the SNF setting to the next level of care.

SSH recently piloted a new initiative called, Reduce Admissions Convert ED (RACE). The goal of RACE is to provide rapid-access primary care and outpatient services follow up as an alternative to hospital admission for some patient populations. As part of the RACE pilot, SSH embedded a primary care clinician in the South Shore Hospital ED to identify South Shore Medical Center patients and work collaboratively with primary care physicians to do a warm-handoff and schedule any outstanding rapid-access follow-up. The initial pilot was successful in getting patients connected to the right care in the right setting in a timely manner.

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

As SSH continues to explore innovative, cost-effective ways to improve health outcomes for individuals and families across the South Shore, it is apparent that federal and state statutory and regulatory changes are needed to support these efforts.

Coverage parity for innovative services, such as telemedicine and MIH, across all public and private payers is needed. SSH has begun to explore ways in which telemedicine can be used to improve access to care for those that may have barriers to going into a primary care office or other care setting. Within SSH's home health program, we were successful in reducing the ED utilization and the readmission rate of patients with chronic conditions such as COPD and CHF through the use of telemonitoring. When SSH identifies a change in a patient's blood pressure, heart rate, weight or oxygen saturation, the situation is evaluated and if needed, a nurse is sent to the patient's home to do a further review of the patient's condition and develop a treatment plan. Although SSH does not receive payment for these services, it intends to increase the number of patients using this resource in the community due to its success providing timely intervention and in diverting patients from likely visits to the ED.

A streamlined, coordinated pathway to providing these services is also needed; proxy credentialing for telemedicine providers should be established in a manner that is consistent with federal regulations. By supporting payment and credentialing reform, health systems would be able to expand access to key services

that are challenging to access and in high demand, such as behavioral health services.

It is also critical that the Commonwealth take action to address the ongoing, skyrocketing costs of pharmaceutical drugs. For health systems, there is limited control over this area of spending. To address these rapidly increasing costs, increased transparency of actual pharmaceutical costs should be considered, along with statutory changes requiring pharmaceutical companies to be held to similar cost benchmarks as health systems.

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.

SSH believes that investing in direct primary care services and our primary care workforce is critical and ultimately allows the health system to become more efficient, while continuing to provide high-quality, cost-effective care. Over the past year, SSH has prioritized opening a new primary care practice in Braintree that is planned to move to Quincy. There is a significant need for primary care in our communities and we want to ensure that there are access points throughout our service area.

SSH has also focused on investing in our primary care workforce, especially in family medicine. While SSH has been actively recruiting more providers across all of our primary care sites, there is a shortage of primary care providers nationwide, including within Massachusetts. To address this evolving workforce crisis, we have prioritized identifying ways to more effectively and efficiently use our current providers, including:

- **Expanding the role of Advance Practice Clinicians (APC) across our sites to collaboratively work in teams with physicians.**
- **In some instances, APCs function as primary care physicians and have their own patient panel. This has improved access and our ability to see patients in a timely manner.**
- **SSH developed a two-track work schedule to accommodate adult medicine providers and improve quality of life for physicians. Some physicians choose to work Monday through Friday during traditional work hours and some choose to work weeknights and weekends. The ability to choose the schedule that best fits his/her needs has been a recruitment tool for SSH.**

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.

SSH's key goal is to create a "community door" for individuals and families to access critical behavioral health services across the entire continuum of care, while advancing our belief and guiding principal that mental health is a key component of overall health. With the assistance of the generous $10 million gift which SSH received from John and Eilene Grayken in February 2019, SSH recently established the Grayken Center for Treatment at South Shore Health. This Center will help us develop and implement a coordinated and integrated approach to behavioral health. Key strategic priority initiatives include:

- **In an effort to provide Medication Assisted Treatment (MAT) to individuals with Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD) that want to start treatment immediately, SSH intends to develop and operate a "Bridge Clinic." This program will be available to new and existing SSH adult patients (18+) along with patients served by other health entities.**

  The focus will be on treatment for opioid dependence and alcohol dependence. The program will offer initial diagnosis and treatment, care plans for patient stabilization and maintenance, individual therapy, and referrals for other community-based services. The goal of the Bridge Clinic is to be a temporary resource for patients and to be transitioned to other community supports within 6 weeks.

- **The Bridge Clinic is also composed of the "Perinatal Behavioral Health Program" (PBHP). Led by a Certified Nurse Midwife who is also a Psychiatric Nurse Practitioner, the goal of the PBHP is to ensure that pregnant and parenting women with addiction and mental health conditions receive the critical services that they need. The PBHP will offer initial diagnosis and treatment, care plans for patient stabilization and maintenance, individual and group therapy, and referrals for other community-based services. The PBHP is designed to serve pregnant and parenting mothers for up to 2 years.**

- **SSH is focused on establishing a new Addiction Consult service within South Shore Hospital and continuing to enhance relationships with key community partners.**

- **Efforts are underway across all of SSH's home health and primary care practices to integrate behavioral health care into our existing services. Within home health, SSH is developing a psychiatric care team to work with its home health population to complement the medical care that is provided today. This will enhance our ability to serve patients with psychiatric and medical diagnoses in a coordinated, comprehensive manner.**

Within primary care, it is our fundamental goal that all primary care locations should have embedded behavioral health providers with expertise designed to the populations and cultures they serve. To work toward this goal, South Shore Medical Center (SSMC) has clinicians from Integrated Behavioral Associates (IBA), a private behavioral health care provider of services to adults and children, embedded within each of SSH's primary care practice locations. The IBA clinicians work in close collaboration with physicians, nurses, advance practice clinicians and other staff to break down barriers to care and ensure that there is a comprehensive and coordinated approach to treating patients with behavioral health needs and are able to immediately see a patient in an acute situation.

Despite having some success and experience in offering on-site behavioral health care in the primary care setting, there are fundamental and logistical limits to expanding this to larger populations. For example, most provider offices do not have the option of using an exam room for the length of time typically allotted for a behavioral health visit. Many primary care practices rely on exam room turn over to meet patient demand for primary care visits. Further, most primary care office or medical office exam rooms are designed to meet the needs of providers who will use the exam rooms most frequently. It's difficult to have exam rooms that are multi-purpose and allow for the type of décor or aesthetic found in typical behavioral health settings. This requires medical practices to have dedicated spaces for behavioral health and may limit the practice from using the space to rotate through other specialties. Insurance coverage can also be a limiting factor.

- **Within each primary care practice, SSH has instituted mandatory depression screenings using a standardized screening tool for all patients over 12 years of age. The goal of the screenings is to get patients connected to behavioral health care at an earlier point. By using a standardized tool, it also allows SSH to identify opportunities to standardize treatment plans and measure over time to determine if such plans result in patients having better outcomes. We want to ensure that we are providing our patients with the right mix of treatment options to feel better over time. Primary care remains the focus of the patient's care plan with appropriate referrals made to specialty care.**

- **SSMC is adding dedicated infrastructure to better serve their existing patients with SUD. Starting this October, initial MAT at SSMC will be directed at patients suffering from alcohol use disorder with the goal of implementing a comprehensive Office Based Addiction Treatment (OBAT) program.**

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?

SSH has been focused on working collaboratively with payers to implement strategies that focus on value-based and risk contracting that promotes high-quality, cost-effective care.

In late 2018, Blue Cross Blue Shield of Massachusetts (Blue Cross) and SSH launched a first-of-its-kind pilot program to improve patient care, slow the rise of health care costs, and change the way hospitals are paid. This innovative program moves private health plan reimbursement for hospitals away from the volume of care they provide patients to the value of care they provide. Under the new model, SSH is accountable for the health of its community and for reducing overall medical expenditures. If the hospital makes progress toward those goals, Blue Cross will pay SSH a higher reimbursement rate which will allow the Health system to expand and improve valuable community health services for its patients.

The program is designed to improve care coordination for SSH patients and ensure that those patients are treated in the setting that is most appropriate for their needs, whether at their doctor's office, an urgent care center, the hospital, or their own home. This more collaborative approach aims to improve care for patients, decrease wait times in the Emergency Department, and enable SSH to reserve the hospital setting for patients with the most complex or acute health needs.

SSH expects that the provisions in this pilot will be beneficial to the organization. SSH continues to look for opportunities to work with payers to identify meaningful incentives, especially for behavioral health. It may be effective to consider episode-based or performance based payments that incentivize providers to develop continuums of coordinated, effective care plans and to track the progress of patients to ensure that the services and supports are working.

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?

Information sharing across health care providers continues to be a point of confusion, ultimately resulting in barriers to care for patients. There needs to be more awareness and training of key laws, including HIPAA and 42 CFR Part 2, so that all providers are aware of what patient information can and cannot be shared.

Additionally, there needs to be coverage parity for behavioral health services, along with telemedicine and MIH, which will greatly improve access to primary and behavioral health care. A streamlined, coordinated pathway to providing these services is also needed; proxy credentialing for telemedicine providers should be established in a manner that is consistent with federal regulations. By supporting payment and credentialing reform, health systems would be able to expand access to key services that are challenging to access and in high demand- like behavioral health services.

Despite contract terms and philosophical agreement for a health system to be accountable and responsible for "whole person care," the health systems taking on the risk often have little, if any, influence on the number and type of behavioral health providers in a health plan network to effectively provide adequate access and care for the larger populations that fall under increased risk arrangements. With differences in behavioral health provider networks across different payers, it's challenging for a primary care system to have a payer-blind approach to assessment and referral to appropriate and timely behavioral health providers. It is not sufficient to create relationships and coordinate care with local behavioral health providers. Even if referrals to specialty behavioral services are refined and primary care absorbs more basic treatment, existing providers cannot support the volume of patients. Payers and state authorities should invest in behavioral health network development and increasingly focus on ensuring behavioral health provider networks meet existing access and availability standards as well adhere to care coordination requirements.

A combination of financial incentives and penalties could influence the development and management of the networks. Under the premise that reimbursement for behavioral health services is underfunded, there must be greater incentives for behavioral health providers to be responsive to the accountable care organization or the health system holding the risk (not just the health plan who manages the network). Shared-risk models with quality targets and a movement away from fee-for-services should be expanded to behavioral health networks. To improve primary and behavioral health care integration, health systems taking on risk to care for a population should be afforded the ability to create and provide its own financial incentives to coordinate access to care with key, existing behavioral health providers.

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	Minor Contributing Factor
Aging of your patients	Minor Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Not a Significant Factor
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Major Contributing Factor
New, relatively less healthy patients entering your patient pool	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor

Factors	Level of Contribution
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Not a Significant Factor
Other, please describe: **Programs that emphasize risk coding**	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	High
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	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	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

Area of Administrative Complexity	Priority Level
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: **Provider Insurance Credentialing—**timely enrollment of providers into insurance plans.	Medium
Other, please describe: **Variation in Insurance Plans Accepted by Providers**—the complexity associated with the variation in plans accepted by providers, which may result in "surprise billing" to patients.	Medium
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: Click here to enter text.

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.

   Please see attached.

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**		
	Q2		
	Q3		
	Q4	9	638
CY2018	**Q1**		
	Q2		
	Q3		
	Q4	6	236
CY2019	**Q1**		
	Q2	3	207
	TOTAL:	18	1,081

The information included in the above table is related to the hospital-based price inquiries. We have the ability produce this information on an annual basis, not quarterly.

   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.

South Shore Health (SSH) has several mechanisms for providing consumers with health care pricing information. For all hospital based care, estimates are aggregated, using a payment estimation tool through Passport/Experian. Estimates are derived by comparing the consumer's health insurance product against the hospitals charge master and contracted rates for a specific episode of care description or CPT code.

Using the payment estimation tool allows multiple hospital areas to supply real time price inquires to consumers. The results of the inquiries are stored and archived within the estimation tool, allowing for tracking and referencing of given estimations. The estimation tool also supports SSH's ability to print and supply the consumer with a written estimation of out of pocket expenses after insurance.

At times, complex surgical procedures with multiple CPT codes need additional support using a contract management tool called Harvest, to calculate the expected charges for a given procedure. These types of estimation are not frequent and can take up to the two working days allowed under Chapter 224.

The hospital supports a direct phone line for patient pricing inquiries. The pricing line information and hours of operation are available on the SSHS website. The quality and accuracy of price inquiries is supported by the updating of contracted rates and hospital charge master within the third party systems.

SSH has one primary physician practice which uses a fee schedule spreadsheet to support consumer price inquires for physician based care. They report minimal price inquiries annually. The registration and billing areas support consumer inquiries using the practices fee schedule. Inquiries can be responded to real time using the fee schedule spreadsheet. Any pricing inquiries for hospital based care would be secured through the hospital's payment estimation tools.

SSH's Home Health Care and Hospice division also reviews insurance coverage and out of pocket amounts with consumers. Generally, consumers do not contact the division for pricing inquiries and are referred to these services via a medical provider

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?

South Shore Health is able to appropriately respond to all of the inquiries received from consumers. There may be barriers to supplying a real time estimation of cost depending on the information being supplied by the consumer. Consumers often call with minimal information, which affects the timeliness of an accurate response. In the event that the consumer does not have their insurance information, it can create delays in the provider's ability to provide an accurate and timely response to the consumer.

Another barrier to supplying timely pricing is a result of complex surgical procedure inquiries. These procedures may be done infrequently or are new to the organization. Securing an accurate response to an inquiry may involve multiple hospital areas and a manual calculation may be necessary.

To support consumer access, SSH provides a direct line for patient pricing inquiries. Leveraging electronic payment estimation tools that combine hospital pricing and consumer insurance benefits, also supports our ability to provide real time pricing information.

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.

    Please see attached.

    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.

    South Shore Hospital does not currently have cost accounting systems to respond in the level of detail requested. South Shore Health is currently evaluating a new enterprise resource planning system that will include the capability to provide the information requested, however, the functionality is estimated to be available in fiscal year 2021.

Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.

4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.

5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.

6. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.

7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).

8. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.

9. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.

10. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.

11. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2014	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	44M	56.7M	1.3M	1.7M	X	X	X	X	X	X	2.4M	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	34.9M	X	X	X	X
Harvard Pilgrim Health Care	73M	X	1.5M	X	X	X	X	X	X	X	1.6M	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	3.3M	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	3.7M	X	X	X	X
United Healthcare	7.5M	X	.060M	X	X	X	X	X	X	X	.6M	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	6.1M	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	30.3M	X	X	X	X
Total Commercial	124.5M	X	2.8M	X	X	X	X	X	X	X	82.9M	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	.1M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	.6M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	.2M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X		X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	.002M	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X		X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	1M	X	X	X	X
MassHealth	X	X	.5M	X	X	X	X	X	X	X	45.2M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	14.7M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.2M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	8.3M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	23.2M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	157.1M	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	6.2M	X	X	X	X
GRAND TOTAL	124.5M	56.7M	3.3M	1.7M	X	X	X	X	X	X	315.6M	X	X	X	X

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	41.6M	57M	1.2M	1.6M	14M	X	.045M	X	1.6M	X	2.6M	9.2M	X	X	X
Tufts Health Plan	X	X	X	X	X	X	.034M	X	X	X	38.1M	2.6M	X	X	X
Harvard Pilgrim Health Care	75.8M	X	3.8M	X	X	X	1.1M	X	X	X	6.7M	2.1M	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	4.2M	.066M	X	X	X
CIGNA	9M	X	X	X	X	X	X	X	X	X	4.6M	.064M	X	X	X
United Healthcare	X	X	.1M	X	X	X	X	X	X	X	3.8M	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	8.4M	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	31.9M	.007M	X	X	X
Total Commercial	126.4M	57M	5.1M	1.6M	14M	X	1.2M	X	1.6M	X	100.2M	14M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	6.1M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	17.5M	.0001M	.3M	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	5.3M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	.002M	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	5.7M	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	34.6M	.0001M	.3M	X	X
MassHealth	X	X	.7M	X	X	X	X	X	X	X	19.30	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	1.5M	X	(1.5M)	X	.005M	X	18.2M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.2M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	12.50	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	1.5M	X	(1.5M)	X	.005M	X	30.9M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	182.3M	5.2M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	11.2M	1.9M	X	X	X
GRAND TOTAL	126.4M	57M	5.8M	1.6M	15.5M	X	(.3M)	X	1.6M	X	378.5M	21.1M	.3M	X	X

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	44.6M	67.1M	1.2M	1.7M	10.4M	X	.4M	X	1.7M	X	3M	11.7M	X	X	X
Tufts Health Plan	X	X	X	.098M	X	X	.1M	X	X	X	38.2M	.7M	X	X	X
Harvard Pilgrim Health Care	78.2M	X	X	X	5.9M	X	(.8M)	X	.1M	X	1.8M	1.2M	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	3.1M	.037M	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	7.9M	1.1M	X	X	X
United Healthcare	10.2M	X	.1M	X	X	X	X	X	X	X	3.5M	.006M	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	9M	.031M	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	37M	.1M	X	X	X
Total Commercial	133M	67.1M	1.3M	1.8M	16.3M	X	(.3M)	X	1.8M	X	103.5M	14.9M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	7.1M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	23.3M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	5.7M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	3.9M	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	40M	X	X	X	X
MassHealth	X	X	.5M	X	X	X	X	X	X	X	18.9M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	1.6M	X	(2M)	X	.021M	X	19.2	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.3M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	14.9M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	1.6M	X	(2M)	X	.021M	X	34.4M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	188.4M	5.1M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	7.7M	.001M	X	X	X
GRAND TOTAL	133M	67.1M	1.8M	1.8M	17.9M	X	(2.3M)	X	1.8M	X	393M	20M	X	X	X

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	43.1M	67.5M	1.2M	1.8M	11.7M	X	(1.3M)	X	1.7M	X	4.7M	11.2M	X	X	X
Tufts Health Plan	X	X	X	X	X	X	.2M	X	X	X	37.4M	1M	X	X	X
Harvard Pilgrim Health Care	71.7M	X	5.4M	X	7.4M	X	X	X	X	X	2.2M	.8M	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	3.8M	.021M	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	8.1M	1.2M	X	X	X
United Healthcare	10M	X	.4M	X	X	X	X	X	X	X	3M	1.3M	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	8.6M	.1M	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	38.3	.062M	X	X	X
Total Commercial	124.8M	67.5M	7M	1.8M	19.1M	X	(1.1M)	X	1.7M	X	106M	15.7M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	4.2M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	23.1M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	4.7M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	7.5M	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	39.5M	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	17.8M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	1.6M	X	.4M	X	.042M	X	17.8	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	.2M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	20.1M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	1.6M	X	.4M	X	.042M	X	38.1M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	199.6M	5.3M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	6.2M	.003M	X	X	X
GRAND TOTAL	124.8M	67.5M	7M	1.8M	20.7M	X	(.7M)	X	1.7M	X	403.2M	21M	X	X	X

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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						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$44.8M	$60.4M	$1M	$1.4M	$13.3M	X	X	X	X	X	$9.1M	$17.1M	X	X	X
Tufts Health Plan	X	X	$.3M	X	X	X	X	X	X	X	$24.6M	$2.4M	X	X	X
Harvard Pilgrim Health Care	$65M	X	X	X	X	X	X	X	X	X	$11.7M	$.8M	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	$4.2M	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$11M	$1.8M	X	X	X
United Healthcare	$9.1M	X	$.2M	X	X	X	X	X	X	X	$.2M	$5.4M	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$10.1M	$.4M	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	$15.1M	X	X	X	X
Total Commercial	$118.9M	$60.4M	$1.5M	$1.4M	$13.3M	X	X	X	X	X	$86M	$27.9M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$7.8M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$10.4M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	$1.3M	X	X	X	X	X	$10.7M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X		X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	$.4M	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$7.8M	X	X	X	X
Total Managed Medicaid	X	X	X	X	$1.3M	X	X	X	X	X	$37.1M	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	$35.8M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	$1.6M	X	X	X	X	X	$16.4M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	$1.2M	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$34.5M	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$1.6M	X	X	X	X	X	$52.1M	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	$235.1M	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	$24.9M	X	X	X	X
GRAND TOTAL	$119M	$60M	$1.5M	$1.4M	$16.2M	X	X	X	X	X	$471M	$27.9M	X	X	X