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?

(1) Shift care from high-cost settings (e.g. academic medical centers) to lower-cost settings (e.g. community hospitals)

Steward has continually expressed concern regarding patient migration, specifically by commercially insured patients, away from high quality, low cost settings in the community to Boston's high cost academic teaching hospitals and their affiliate hospitals. Patient migrations has continued to worsen, driven by consolidation by some of the state's largest providers as well as aggressive outpatient expansion that is explicitly designed to pull commercial volume out of the community and into Boston

Steward focuses on delivering high-quality care in the most efficient setting. Steward's community based, integrated model is centered on the idea that high-quality care can be delivered at the most appropriate setting, which is most often in the communities in which our patients reside. We continue to build a robust provider network of primary care providers, specialists, and community organizations aimed at providing care to the totality of the patients with a particular focus on Behavioral Health and Social Determinants of Health.

(2) Continue aggressively pursuing alternative payment models

Steward continues to adopt value-based payment models to leverage our community-based integrated providers, our population health platforms, and our robust patient engagements tools to drive the utilization of high-quality, lower-cost sites of care. Steward has historically been one of the best performing Medicare ACOs, originally in Pioneer ACO, and continuing in the Next Gen ACO program. Steward also has performed well in the new Medicaid ACO program, generating significant savings for the Commonwealth.

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

Steward has continually advocated for policy interventions that reduce unwarranted price variation in the Commonwealth. The historic inequities among providers has created a cycle that promotes historically high-priced providers to continue to grow rapidly, while smaller community hospitals continue to be underpaid without the possibility of closing the gap. Steward believes the Commonwealth should take 3 concrete steps to put the current health care marketplace in proper context, and address provider price variation

Publish a Weighted Average Payer Rate (WAPR)
The WAPR is a metric that aggregates payment rates among the three payer types (Commercial, Medicare, and Medicaid) and weights those payments based on a provider's payer mix. The WAPR represents the totality of reimbursements a provider receives and allows policymakers to fully understand that entirety of the gap in reimbursement among providers.
Index the Cost Growth Benchmark
Annually, the Health Policy Commission reviews providers whose TME exceeds the cost growth benchmark. However, the benchmark is set in a regressive manner. Historically large, expensive providers are allowed to grow at the same percent rate as smaller, lower cost providers. As such, these large expensive providers are allowed to grow spending by a significantly larger gross amount, compounding annually. This leaves smaller, lower cost providers unable to compete in the marketplace
Reduce Unwarranted Commercial Price Variation
It is well documented that certain large brand name systems in Massachusetts leverage their brand and market power to extract unwarrantedly high reimbursement from payers. This has the effect of dampening the ability for smaller providers to compete while simultaneously increasing premiums and cost sharing for consumers. The Commonwealth should take direct action to reduce unwarranted price variation.

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.

Increasing access to behavioral health care within the primary care setting
SHCN has Embedded Care Coordinators (ECC) at high volume Medicaid Practices to support unmet SDOH needs and BH needs of the population. The ECC of the respective practice are referred patients by PCPs in order to conduct a Health Related Screening Tool to comprehensively and holistically assess the needs of the population. When BH needs are presented, the ECC can place referrals to BH providers and ensure there is communication with the PCP around these referrals in order to provide wraparound care. When more intensive BH needs are present, the ECC can place referrals to our internal BH Care Management team which provides 3 months of intensive case management. The BH Care Manager will work with patient in coordination with the ECC and PCP in order to integrate care and ensure care plan goals have been identified by those helping to assist the patients' health care goals.

There are also PCP practices which have BH providers/therapists embedded within the practice. The ECC and other internal SHCN CM programs work collaboratively with these providers to place referrals in order to have patients receive all services under one

umbrella. In 2020, we will be looking to further enhance in capability in practices that do not have this level of care.

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.

Steward currently operates 335 Behavioral Health beds as well as 53 SUD beds across Massachusetts, along with 3 licensed outpatient clinics. In addition our Medicaid ACO and our employed professional practice (Steward Medical Group) care for a number of co-morbid BH/SUD patients in a primary care practice continuum. We have been active in OAT/MAT programming within our EDs and have been a champion for BH placements from our EDs under EOHHS Expedited Psychiatric Inpatient Admission (EPIA) guidelines. Also, we have spoken with DPH BSAS regarding the establishment of 4.0 level services in southeastern Mass., and filed an FYI as part of the Section 35 Commission for beds in central Mass. We have worked with Mass Health to establish an integrated service line for ESP's at 6 of our ED's and also with Mass Health payers (notably Beacon and MBHP) to achieve efficiencies along quality and outcome metrics at our 10 campuses that provide BH/SUD services. Our access is to capacity, serving some 90% occupancy across our 388 beds every day and maintaining 40% placement within 12 hours and 80% placement within 24 hours of BH presentment in our EDs. Capacity and clinical programming expansion in line with DMH Bulletins has also enhanced our BH offerings. Cost reductions are thwarted by recruitment and retention increases for physicians, mid-level practitioners, and patient care related staff.

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?

Steward's health care model is predicated on a strong primary care foundation. Our provider performance model, which is built into many of our payer contracts, heavily incentivizes primary care provider to meet and exceed target and thresholds in order to drive population health improvements. Performance model components include:

i. *Quality: a set of quality measures across all payers that align with Steward Health Care Network performance improvement team priorities*
ii. *Patient Experience: Completed surveys across all payers, including questions on provider communication and access to timely care*
iii. *Total Medical Expense (TME): Performance based on risk-adjusted TME trend*

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?

Currently, there is a fundamental lack of investment in Behavioral Health in Massachusetts, specifically for Medicaid beneficiaries, due to a lack of meaningful investment by the Commonwealth in behavioral health services. Without adequate reimbursement for behavioral health services it is very difficult to maintain the level of behavioral health care currently provided within Massachusetts, and additional investment is nearly impossible.

Additionally, structural challenges create patient boarding issues within acute hospitals that provide behavioral health services. Steward proudly places 40% of patients within 12 hours and 80% placement within 24 hours of presentment in our Emergency Departments. However, often these patients are placed within the hospital at which the patients present due to a lack of open beds within state and community based providers. There needs to be robust investment in non-acute behavioral health in order to reduce the logjam and wrong site treatment of too many behavioral health patients.

Finally, similar to the HPC grant for support for behavioral health within the emergency room, there needs to be an increase in commercial payer support for behavioral health providers in primary care offices and emergency departments.

3. CHANGES IN RISK SCORE AND PATIENT ACUITY:

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

Factors	Level of Contribution
Increased prevalence of chronic disease among your patients	Major Contributing Factor
Aging of your patients	Minor Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Minor Contributing Factor
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	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Major Contributing Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe: Click here to enter text.	Level of Contribution

☐ 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	Medium
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Medium
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	Medium
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Medium
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Medium
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Medium
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	High
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Medium
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Medium
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

Area of Administrative Complexity	Priority Level
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: 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.

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**		288
	Q2		288
	Q3		288
	Q4		288
CY2018	**Q1**		288
	Q2		288
	Q3		288
	Q4		288
CY2019	**Q1**		350
	Q2		350
	TOTAL:		3,154

    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.
    Steward's price estimates are provided to consumers in real time. We work with a vendor to extract necessary and relevant information and ensure that it is provided to the patient in a timely manner and at the point of service when requested. Starting January 1, 2019 Steward created a patient estimation line. This is published on each facilities website. The addition of the direct patient line has increased inquiries pertaining to price estimation.

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?
We have processes in place to ensure that consumers receive accurate and timely information regarding the price of the services they desire and work with our vendor to resolve any problems that may arise.

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.

Steward is unable to provide data for this request in a standardized format that will accurately capture the information

    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.

Steward is unable to provide data for this request in a standardized format that will accurately capture the information