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?

A. Length of Stay Reduction:

- To successfully address extended lengths of stay with the goal of improved transitions of care, clinical outcomes and decreased health care spending, several initiatives have been implemented. The following approaches resulted in a LOS reduction of .37 days in FY '19 (10/01/18 – 7/31/19) as compared to prior year same period, translating into an annual health care spending reduction of approximately$650,000 for the hospital.
    - Three times weekly Case Management led LOS meetings reviewing all patients with a LOS $\geq$ 3 days to identify potential barriers to and plan for safe discharge. Key participants include Case Management, Nursing, Senior Administration, Respiratory Therapy, Chief Medical Officer and Chief Hospitalist.
    - Daily focused interdisciplinary rounds on respective units, with participation by Nursing, Case Management, Hospitalists, Nutrition, and Physical Therapy to briefly review LOS, plan of care and anticipated discharge plan and timing.
    - Weekly conference call with Wrentham Development Center Director of Nursing to discuss plan of care and anticipated discharge for any patients currently at the hospital. These complex patients have notably longer lengths of stay. The goal is to improve communication, share relevant clinical information, and provide confirmation on often newly established patient baselines to facilitate safe, timely discharge. As a result of this collaboration, LOS for this patient population has been reduced by one day for the period October 2018 – July 2019, as compared to the prior year same period.

B. **Reduce Unnecessary Hospital, Admissions, Readmissions, Emergency Room visits:**

- The Sturdy Memorial Hospital readmission rate for CPOD for the 3 years ended 09/30/2018 was approximately 25.2%, well above the national average last year of 19.6%. The SMH readmission rate for CHF for the 3 years ended 09/30/2018 was 23.6, which also exceeded the national average of 21.7%. Readmissions for COPD and CHF are each running at approximately 21% in FY 2019, down significantly from prior years and in the case of CHF, below the national average.

- Prior to October 1, 2017 there was no formal Palliative Care program at Sturdy Memorial Hospital. The absence of this program contributed to unnecessary hospital admissions and readmissions for patients struggling with chronic, progressive and terminal illness. Since implementing the comprehensive program in November 2017, readmissions for patients

enrolled in palliative care decreased by a notable 30-35% as compared to hospitalizations prior to their active palliative care status.

The following initiatives were or are being put into place to facilitate improvements in these areas:

I. Focused Education for COPD/Pulmonary Patients

Goal: To improve understanding and appropriate utilization of home therapies while patients are in the hospital, resulting in improved post discharge clinical outcomes and associated reduced readmissions.

Timeline: Ongoing

Process: Respiratory therapists currently provide focused education on the proper use of inhalers and spacers. We utilize an interactive educational software module designed for use by COPD patients. This interactive software facilitates patient learning and comprehension in both the inpatient and home setting. Additionally, the health care team utilizes a common source of established educational protocol to ensure each patient is ready for discharge with detailed post discharge action plan tailored to their specific needs.

II. Established an Outpatient Pulmonary Clinic

Goal: To reduce 30-day readmissions for COPD and CHF patients

Timeline: On-going

Process:

- Establish a discharge follow-up plan that includes post-discharge phone call within 48 hours, along with a scheduled Pulmonary Clinic visit within 7 days
- Assure that community and home care services are in place and are being appropriately utilized
- Provide education on smoking cessation, inhaler use and recommended disease management approaches
- Provide timely referrals to PFT Testing and/or the Pulmonary Rehabilitation program
- Provide clinical care for basic symptom management during clinic hours
  Facilitate Palliative/Hospice discussions and referrals as appropriate
- Effectively communicate any changes in the care management plan with respective primary care physicians and/or pulmonologists

III. Dedicated Case Management clinical staff (RN) assigned to cover the Emergency Department, a key entry point for hospital admissions

Goal: Reduce hospital admissions/readmissions

Timeline: Ongoing

Process: A dedicated RN Case Manager is assigned to cover the Emergency Department to: a) facilitate earlier interventions, b) determine actual need for admission versus discharge back to skilled nursing facilities or home with supportive services, as a means of preventing unnecessary admissions/readmissions.

IV. Hospice and Palliative Care Services

Goal: Improve care transitions while preventing unnecessary readmissions.

Timeline: Ongoing

Process: As part of the standard nursing assessment, a palliative care screen is done for inpatients meeting criteria. Case Management, working in collaboration with the attending physician, facilitates a consult with the Palliative Care program's Nurse Practitioner who meets with the patient and family to establish goals of care. This may include inpatient palliative care, hospice GIP or post discharge palliative care in the home setting.

V. Schedule post discharge physician appointments for patients as soon as possible but ideally within 7 days of discharge to ensure appropriate and timely follow up care.

Goal: Ensure adherence to care plan through timely follow-up with primary care physicians, thereby improving clinical outcomes while simultaneously reducing unnecessary readmissions.

Timeline: Ongoing

Process: Prior to patient discharge, unit secretaries contact PCP offices to set up follow-up patient appointments with respective physicians. When transportation is identified as a barrier, it is provided for the patient as part of a community collaborative utilizing UBER
Follow up calls are made by the physician offices or the hospitalist group to all patients discharged home

VI. Urgent Care

Goal: Decrease unnecessary ER utilization (and to connect individuals in the community who have no PCP with a PCP to better manage their health care and contribute to reduced hospital admissions).

Timeline: Two sites have been opened in the past 2 years. Operations began at one site August 1, 2017. The second site opening in October, 2017.

Process: Urgent care services are provided out in the community where it is more accessible, at a lower copay, so patients with non-emergent care needs will not have to go to the emergency room.

Results: The combined volume at the two urgent care sites is approximately 22,000 visits per year. Below is a table of ER actual visits for the past two years and a projection for FY 2019 based on May 2019 actual visits. We anticipate a decrease in lower lever visits over the three year period ended FY 2019 (projected) and an increase in the two higher level codes. The drop in

the lower level ER visits would indicate that those visits would likely have been impacted by the urgent care service.

			Annualized	3 Year
CPT	**FY2017**	**FY2018**	**FY 2019**	**Change**
99281	358	349	266	(93)
99282	2,633	2,477	2,220	(413)
99283	16,980	16,408	15,227	(1,754)
99284	10,586	10,863	10,626	40
99285	14,199	15,696	15,759	1,560
99291	2,480	2,650	2,508	28

VII. Call patients discharged from the hospital emergency room

Goal: Decrease admissions/readmissions and emergency room visits.

Timeline: Ongoing

Process: Automated phone calls are made to all patients discharged from the emergency room to ensure discharge instructions (care plan) and pharmacy prescriptions are understood. Patients who answer "no" to one of five questions are called back within 24 hours by an emergency room practitioner.

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

A. Improve of commercial rates for independent community hospitals and physicians affiliated with those hospitals. According to CHIA, independent community hospitals and the physicians affiliated with those hospitals are routinely paid significantly less than the larger hospital systems, specifically Partners. Partners physicians are paid 70% more than Sturdy Memorial Associate physicians by Massachusetts Blue Cross according to the most recently published CHIA data. Partners ratio of commercial payments to government payments is far higher and should justify lower rates for Partners compared to independent hospital physicians. This change would help enable the few remaining independent hospitals to survive, which will contribute to lower long term costs.

B. The commonwealth has historically been served by a network of community hospitals supported by tertiary and specialty hospitals. Community hospitals can generally provide 85% of acute care, and at a lower cost, than the tertiary and specialty hospitals. Today, these tertiary and specialty hospitals are coming out to the "suburbs" in many cases providing the same healthcare services as the community hospital but at a higher cost. Most recently, Dana Farber is in the process of completing construction of a satellite clinic in Foxboro, Sturdy's service area. Sturdy physicians have referred and will continue to refer to Dana Farber in Boston

for the15% of cases that require specialized care. Dana Farber Boston participates in 800 research studies, a valuable resource for our patients. Dana Farber Foxboro will participate in 25 or less research studies. Dana Farber Foxboro will shift care from community hospitals and the result will be higher costs without any added healthcare benefit. The DoN process should be modified to preserve low cost community hospitals by requiring review of these type projects, without regard to their construction cost (it is the ongoing operational costs that should be considered).

C. Pass legislation to permit proxy credentialing. The Massachusetts Board of Registration in Medicine should be required allow proxy credentialing of providers as is the case for almost every other state. This would save a significant amount of unnecessary administrative time in hospitals and possibly allow the Board to process applications faster. The lead time on credentialing providers with the Board and payers can often take six months. The payer credentialing process often takes six weeks for most payers.

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.

According to the American Academy of Primary Care Physicians the utilization of primary care physicians changes the dynamic and puts an emphasis on the physician-patient relationship by shifting the focus from physician-centered care to patient-centered care. Studies show that an increase of one primary care doctor per 10,000 people has been shown to result in a 5% decrease in outpatient visits, a 5.5% decrease in inpatient admissions, a 10.9% decrease in ER visits and a 7.2% decrease in surgeries, lowering the cost of healthcare across the board.

The Community Health Needs Assessment preformed in 2019 by Sturdy Memorial Hospital, identified *Access to Care* as a key finding, reinforcing our commitment to expand Primary Care in our community. The 2019 report highlighted that the majority of Sturdy's service area, which is in Bristol County of Massachusetts, has a provider-to-population ratio of 1,830:1, compared to a national benchmark of 1,030:1 and a state benchmark of 950:1. Data pulled from January 1, 2018 through December 31, 2018 showed 40,735 visits to Sturdy Emergency Department who were not admitted as inpatients. Of those visits, 7,320 or 17.97% of the patients did not list a primary care physician. These patients were 57.60% male and 42.40% female. The majority of patients with no primary care physician were between the ages of 28 to 48 totaling 46.08%. Patients between 18 and 27 years old were the second highest group

not having a PCP at 30.37%. The lowest percent of patients with no primary care physician were patients 65 years or older with 3.77% and adolescents under the age 17 at 5.56%.

Sturdy invests time and money to recruit and higher primary care physicians. Sturdy offers a competitive sign-on bonus and generous fringe benefit package to attract both new and seasoned physicians. We have increased the starting salary for both Family Medicine physicians and Internal Medicine physicians several times over the past 3 years.

We engage our employees and medical staff in helping to recruit primary care physicians including offering a financial incentive when we are successful in hiring a recruit that they identify. We utilize third party recruitment firms and currently have contracts with 30 firms for permanent placement and locum positions. Sturdy offers a generous permanent placement fee for successful IM or FP hires.

We recently engaged a consultant to source physician candidates to fill key vacant positions in primary care specifically for us. In the past we relied only on search firms. The sourcing strategy development includes implementation and management of sourcing plan, utilizing physician job boards and databases utilized or to be purchased by the organization (i.e. Practice Link, Practice Match and Profiles Residents database), updating and refining physician opportunity descriptions and promotional messages, and identification and solicitation of approved target physician population via direct contact.

Recruiting physicians to our community hospital setting has a series of challenges including location, urban versus rural geography and attracting talent to a non-teaching hospital. Investments have been made in establishing a relationships with Brown Medical School. We recently entered into an agreement with Brown Medical School to create a Longitudinal Integrated Clerkship for 3rd year Brown Medical Students at Sturdy. Students spend one half-day with physician mentors in family medicine, internal medicine, obstetrics and gynecology, pediatrics and surgery over the course of 31 weeks. During this time dtudents also complete inpatient time in other rotations at outside institutions. Students develop a patient panel of approximately 3-5 patients per mentor site and follow these patients in various health care settings that include the operating room, labor and delivery, diagnostic imaging, specialist visits as well as primary care visits. Sturdy is an ideal system in which to participate as we have a relatively closed system with primary care practitioners referring to specialists within the practice therefore allowing students the ability to follow patients through the continuum of the health care process. Sturdy began participation in 2019 with two medical students. The students will be rotating through the different specialties as noted above. Ten established Sturdy physicians have volunteered to be mentors willing to participate in the program. It is our hope that by doing this we can raise awareness about the advantages of working at Sturdy with those students and their peers so that when they are ready to join the workforce that they will have some interest in working at our hospital.

For physicians who desire teaching opportunities, we have created the Sturdy Memorial and Alpert Medical School at Brown University Teaching Affiliation. This strategy was developed to attract young physicians interested in academics. Sturdy offers two options that are available to Sturdy PCP's looking for teaching opportunities: a four-hour (one ½ day session) per week precepting residents at a clinic at Rhode Island Hospital or hosting a Medical Student in his/her clinic at Sturdy Memorial Associates. Sturdy employs the physician and pays the salary for the physician when they are on teaching assignment.

The goal of hiring five new Primary Care Physician's in FY 2020 is expected to take an investment of $500,000, excluding the costs of developing a new practice.

In the past 12 months we have hired 3 primary care physicians. Prior to that we had hired zero in 18 months. We believe a renewed focus on PCP recruitment has contributed to that success but it is too early to conclude on the relationships we have formed with Brown.

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. Initiatives in behavioral health care include the following:

- In April 2019 a joint venture was created between Column Health and Sturdy Memorial Hospital to provide increased access to treatment for patients with substance use disorder. Treatment at the clinic includes medication assisted treatment (suboxone therapy), psychotherapy, psychopharmacology, group therapy and psychiatric therapy. Since opening the clinic on April 24th, 2019 there have been a total of 314 patient registrations. Initial data shows that patients who began receiving care in the clinic in May have had a 75% reduction in ED visits as compared to 5 months prior to May.
- Through Column Health a patient navigator has been hired to connect with patients in the ED, ICU and inpatient units and facilitate successful transition to the Column Health Clinic. Since May, the navigator has connected with 83 patients with 78% of these patients successfully registering for appointments at Column Health.
- All ED physicians have obtained DEA-X waiver to prescribe bridging suboxone therapy to patients who present to the ED with opioid use disorder. A bridge suboxone program has been created in the ED with ability to dispense 48 hours of suboxone to patients upon discharge from the ED
- All patients presenting to the ED after opioid overdose are discharged home with Naloxone in hand and referral to Column Health. Patients who are agreeable are given an appointment to Column Health direct from the ED or within 24 hours.
- Staffing in the ED was significantly increased with an approximately $500, 000 investment to improve the monitoring of behavioral health patients so as to ensure their safety while in the ED
- Investments have been made to convert ED rooms into ligature free rooms to ensure safety of our high risk behavioral health patients. Renovations have included removal of furniture from rooms, conversion of ceilings to hard ceilings, and addition of ligature free sinks and door hardware.
- Access to psychiatry consultation both in the ED and inpatient units was also added in FY19 to improve medication management of behavioral health patients and assist with expediting disposition of appropriate patients.

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?

Sturdy participates in the MassHealth ACO program with BMC. The ACO provides financial incentives for funding social worker costs at five of our affiliated physician practices. This has been beneficial in scratching the surface to address the behavioral healthcare shortage in our community. The agreement with BMC also provides incentives for coding certain diagnosis's which will help in identifying potential problems in the community, such as homelessness. Our current commercial contracts do not incentivize strengthening and supporting primary and behavioral healthcare. Our affiliated physician group has recently agreed to contract through the South Shore PHO which will help us to shift to a model that encourages such behavior.

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?

A common barrier to timely, effective transition of patients is scarcity of inpatient psych beds, resulting in unnecessary long lengths of stay for patients who have been medically cleared and do not meet hospital level of care. Additionally, outpatient behavioral health services are in short supply, with excessive waiting times for appointments, and those in crisis repeatedly ending up in Emergency Rooms with nowhere else to turn. Efforts should be accelerated to better address and direct needed resource to meeting the critical needs of this vulnerable, at risk patient population who frequently languish in alternative settings such as emergency rooms and inpatient medical beds, further driving up the cost of healthcare.

Additionally, poor reimbursement from payors for services provided by psychiatrists, pyschotherapists and clinical social workers has led to a significant decrease in availability of these needed resources which directly contributes to increased waiting times for outpatient appointments. Poor reimbursement also prevents creation of outpatient behavioral health programs as it is not possible to sustain these programs/clinics when expense significantly exceeds reimbursement.

The increase in pediatric and geriatric psychiatric patients with either concominant decrease (in the case of pediatric inpatient beds) or lack of increase (in the case of geriatric psychiatric inpatient beds) has led to these 2 at risk populations have significant boarding times in ED's or inpatient beds while awaiting bed availability.

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.

This question was difficult to answer given we currently have just one risk agreement that we might get relevant feedback on those changes.

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)	Minor 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
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Not a Significant 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	Medium
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	High
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	High

Area of Administrative Complexity	Priority Level
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	High
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	High
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	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	Medium
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	High
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	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	Low
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level

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

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

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

☒ Identifying strategies and/or creating tools for overcoming problems related to small patient volume
Enhancing data sharing to support APMs (e.g., improving access to timely claims data to support population health management, including data for carve-out vendors)
Aligning payment models across payers and products
☒ Enhancing provider technological infrastructure
Other, please describe: 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**	0	53
	Q2	0	45
	Q3	0	38
	Q4	1	34
CY2018	**Q1**	0	42
	Q2	1	45
	Q3	1	51
	Q4	4	45
CY2019	**Q1**	1	55
	Q2	2	52
	TOTAL:	10	460

    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.
    Click here to enter text.Inquiries are logged into a spreadsheet as they arrive. They are handled by PFS Manager, with the pricing information provided to the caller on the same day, whenever possible. During absence, price request inquiries are sent to the Director of Patient Accounts to ensure the **consumer** receives a response within 24 hours. For additional accuracy, a review of actual charges is compared to the estimate.

Clinical and Registration departments have been educated to forward price inquires to the PFS Manager. This ensures appropriate response to the consumer and allows for accurate inquiry tracking. Consumers calling are provided with the PFS Manager's name and telephone number. Complaints would be arise, if the information supplied was not within a reasonable estimate range. There is no record of receiving negative calls from consumers with inquiry variations, since we began tracking inquires.

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?
Click here to enter text.We do not find barriers, with timely response. The inquiry is addressed as soon as possible to ensure timely response. The process can be challenging, when multiple testing (example: Lab work) pricing is required. The vast majority of inquiries are provided to the consumer, the same day as requested. Accuracy is always a concern, as most inquiries arrive by phone. Working with a contact in the Lab, when test names in our computer system (Meditech), differ from the test name supplied by the consumer. (example: A1C vs Glychohemoglobin) Surgical procedure estimates are identified by running reports by the CPT codes. A review of 10 current cases, is performed to obtain the procedure average. The consumer is provided with the average, in addition to the (high/low) range**.**

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. 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. Attached

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											$33,204,489				
Tufts Health Plan					$9,679,223		-$378,912								
Harvard Pilgrim Health Care	$9,972,303														
Fallon Community Health Plan											$1,451,583				
CIGNA											$1,317,230				
United Healthcare											$7,721,887				
Aetna											$2,714,804				
Other Commercial											$7,349,266				
Total Commercial											$53,759,260				
Network Health											$3,128,285				
Neighborhood Health Plan											$5,080,648				
BMC HealthNet, Inc.											$7,633,856				
Health New England											$6,189				
Fallon Community Health Plan											$0				
Other Managed Medicaid											$473,979				
Total Managed Medicaid											$16,322,957				
MassHealth											$7,151,943				
Tufts Medicare Preferred											$399,363				
Blue Cross Senior Options											$1,203,944				
Other Comm Medicare											$3,678,381				
Commercial Medicare Subtotal											$5,281,687				
Medicare											$54,745,044				
											$0				
Other											$3,920,536				
GRAND TOTAL	$9,972,303				$9,679,223						$141,181,427				

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											$33,591,350				
Tufts Health Plan					$11,697,990		-$411,624								
Harvard Pilgrim Health Care	$8,049,510		$471,175												
Fallon Community Health Plan											$1,273,320				
CIGNA											$1,642,858				
United Healthcare											$7,582,740				
Aetna											$2,089,147				
Other Commercial											$6,676,463				
Total Commercial											$52,855,876				
Network Health											$4,280,919				
Neighborhood Health Plan											$6,586,952				
BMC HealthNet, Inc.											$7,938,792				
Health New England											$18,603				
Fallon Community Health Plan											$0				
Other Managed Medicaid											$697,442				
Total Managed Medicaid											$19,522,707				
MassHealth											$6,437,734				
Tufts Medicare Preferred											$621,599				
Blue Cross Senior Options											$1,704,603				
Other Comm Medicare											$4,398,742				
Commercial Medicare Subtotal											$6,724,944				
Medicare											$57,820,162				
Other											$3,618,411				
GRAND TOTAL	$8,049,510				$11,697,990						$146,979,834				

* We do not seperately track type of product within insurance carrier
Incentive and risk money would be related to HMO business.

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											$34,134,727				
Tufts Health Plan					$13,105,584		-$246,564								
Harvard Pilgrim Health Care	$6,658,539		$125,401												
Fallon Community Health Plan											$1,016,441				
CIGNA											$1,793,022				
United Healthcare											$8,512,962				
Aetna											$2,046,606				
Other Commercial											$6,908,459				
Total Commercial											$54,412,216				
Network Health											$5,235,946				
Neighborhood Health Plan											$6,602,744				
BMC HealthNet, Inc.											$7,863,762				
Health New England											$20,240				
Fallon Community Health Plan											$0				
Other Managed Medicaid											$742,638				
Total Managed Medicaid											$20,465,330				
MassHealth											$7,430,281				
Tufts Medicare Preferred											$565,153				
Blue Cross Senior Options											$1,701,052				
Other Comm Medicare											$6,317,441				
Commercial Medicare Subtotal											$8,583,647				
											$0				
Medicare											$58,565,867				
Other											$4,665,096				
GRAND TOTAL	$6,658,539				$13,105,584						$154,122,437				

AGO Provider Exhibit 1

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											39,136,689				
Tufts Health Plan					13,058,655		-$268,674								
Harvard Pilgrim Health Care	6,438,250		$63,210												
Fallon Community Health Plan											924,005				
CIGNA											2,524,813				
United Healthcare											8,540,076				
Aetna											2,121,340				
Other Commercial											6,175,434				
Total Commercial											$59,422,357				
Network Health											$4,210,824				
Neighborhood Health Plan											$3,240,487				
BMC HealthNet, Inc.											$13,548,133				
Health New England											$2,452				
Fallon Community Health Plan															
Other Managed Medicaid											$448,273				
Total Managed Medicaid											$21,450,169				
MassHealth											$7,062,266				
Tufts Medicare Preferred											$857,279				
Blue Cross Senior Options											$2,269,817				
Other Comm Medicare											$7,978,996				
Commercial Medicare Subtotal											$11,106,092				
Medicare											$63,809,291				
Other											$3,916,123				
GRAND TOTAL	$6,438,250	$0	$63,210	$0	$13,058,655	$0	-$268,674	$0	$0	$0	$166,766,298				

* We do not seperately track type of product within insurance carrier
Incentive and risk money would be related to HMO business.

AGO Provider Exhibit 2

Service Category	Commercial				Medicare				Medicaid				All Other				Total			
	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Pulmonary																				
Rehab																				
Rheumatology																				
Transplant Surgery																				
Trauma																				
Urology																				
Vascular Surgery																				
All Inpatient	20,003,086	4,771,919			38,964,735	-9,862,346			9,495,809	-1,998,990			2,418,169	-303,645			70,881,799	-7,393,062		
Imaging																				
Other Treatments																				
Laboratory																				
Ambulatory Surgery																				
Therapies																				
Office Visits																				
Observation																				
All Outpatient			58,538,483	24,224,337			34,912,174	-8,114,389			12,232,982	-3,180,127			9,697,765	1,650,674			115,381,405	14,580,494
GRAND TOTAL																				

* Sturdy does not have a cost accounting system. We do not track margin by product or inpatient / outpatient, much less by service category.
The above numbers are estimates based on cost to charge ratios from cost reports. Attempts to further break down the information have potential to become less and less representative of fact.