Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine 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.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us 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 panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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 that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and 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 other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

[Remainder of page intentionally left blank]

Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY: DFCI has undertaken significant efforts to reduce costs and continue to improve quality, safety and value in the delivery of cancer care. Amidst reductions in reimbursement, DFCI has launched a number of initiatives to better coordinate care; reduce utilization of high-cost services; integrate comprehensive psychosocial, behavioral, and palliative care in our care delivery model; reduce variability in the treatment of cancer; enable clinicians to practice at the top of their license; and deliver cancer care in lower-cost community settings. We are proud of our efforts to deliver high-quality, cost-effective, comprehensive cancer care and believe the initiatives described below highlight our commitment to serving our patients and their families.
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

      Revenue

      •Payment rate adjustments from DFCI's top-3 Massachusetts commercial payors have ranged from -2% - +3% from CY2010-2014.
      •Medicare continues to reimburse DFCI at a rate that is below operating costs, the rate improved from 83% to 91% of cost in CY2012. Overall reimbursement from Medicare recently declined by 2% due to sequestration.
      •DFCI's charge increases approximated 4% in CY2010, 3% in both CY2011 and CY2012, and 2% in CY2013; charges did not increase in CY2014.
      •DFCI reduced imaging charges by 20% in CY2013 and 10% in CY2014.

      Utilization

      •Volume from clinic visits has grown steadily by approximately 5% to 6% per year from CY2010-2013.

      Operating Expenses

      •On a per unit basis, operating expenses increased by approximately 4% in CY2011(opened new OP clinical building), remained flat in CY2012 and increased slightly by 1% in CY2013 and YTD in CY2014

b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

•Established a physician practice model through Dana-Farber Cancer Care Network (d/b/a Dana-Farber Community Cancer Care) to provide lower-cost care in a community setting.

•Leveraged the expertise of our clinicians through Care Model Redesign to ensure that clinical staff and faculty operate at the top of their license.

•Established an inpatient palliative care unit to expand access to integrated palliative care services and reduce the use of high-cost interventions for hospitalized patients.

•Implemented a program to enhance advanced care planning and reduce resource use by aligning care delivery with patient preferences.

•Implemented interventions to reduce the use of high-cost drugs in accordance with clinical evidence.

•Consolidated and reorganized programs to decrease expenses.

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

•Implementing a "shared-care" model for patients undergoing stem-cell transplantation to coordinate patient care between the DFCI care team and the patient's community oncologist. The model will allow patients to receive appropriate post-transplant care in lower-cost community settings.

•Implementing Clinical Pathways to standardize cancer care and remove unnecessary variability and cost in care delivery.

•Establishing a diagnostic service to assist non-oncologists with the rational, cost-effective diagnostic workup of patients with a suspected malignancy to avoid unnecessary utilization.
•Enhancing the discharge planning process for hospitalized cancer patients and implementing an Urgent Care Model to improve care transitions to the outpatient setting and reduce unnecessary ED utilization and hospital readmissions.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

Prior Authorization (PA): PAs for radiology and drugs, which are almost always approved, require significant resources that add cost to the system and offer little to no benefit. Best practice would allow hospitals to obtain approval for an episode of care or treatment plan instead of requiring a PA for each drug administration.

Specialty Pharmacy: Health plans have implemented policies limiting the ability of hospitals to administer specific drugs in a clinic setting and requiring that patients procure their prescribed medications through specialty pharmacies. We are deeply concerned that this practice puts our patients at risk, compromises continuity of care, and adds an undue resource burden on providers trying to manage these policies for cancer patients.

Telemedicine: Reimbursement for telemedicine should be encouraged, particularly for teaching hospitals

---

2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.

   SUMMARY:

   DFCI has been a continuous source of innovation in high-quality, cost-effective cancer care and has developed a number of payment redesign projects that further our progress towards alternative payment methodologies (APM) and reward value-driven cancer care. Our efforts in this area reflect DFCI's distinctive role as the state's only freestanding comprehensive cancer center and highlight our leadership in developing unique arrangements that align with our single disease focus.

   We are unable to meaningfully participate in the APMs launched by our health plan partners, including global budgets and risk arrangements given our unique structure. However, as an industry leader in oncology-based payment redesign, DFCI has pioneered a bundled payment arrangement for our hematopoietic stem cell transplant program and piloted a number of projects focused on delivering high-value cancer care.

   a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?
      DFCI was one of the first cancer centers to implement a bundled payment arrangement for hematopoietic stem cell transplants (HCST). Under this arrangement, stem cell transplants are reimbursed based on case rate bundles:
      •A single global payment is made for a case rate period, which starts on the day of admission for transplant infusion and typically ends at discharge. The case rate bundle applies to all hospital and physician services provided during the case rate period.
      •Operationally, billing is completed through the industry standard approach.
      •Many agreements include stop loss provisions to share risk between the provider

and payer in outlier cases.
The model has also resulted in growing referral patterns, as the case rate bundle makes the costs associated with a HCST predictable and therefore, attractive to health plans. The volume of HCSTs DFCI provides helps us to deliver care more efficiently and ultimately contributes to superior patient outcomes.
In addition, we are exploring other services that may be appropriate for bundling, such as comprehensive second opinion services.

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).

Substantial effort and resources are required to develop, implement, and manage the pilots and projects described in Section 2. Without appropriate compensation for the coordination and management associated with the resulting changes in pre-authorizations, billing, and patient support, the implementation of such projects can increase administrative expenses.

Many key services that are critical for our ability to provide comprehensive, patient-centered care are not reimbursed or are poorly reimbursed by health plans (e.g., nurse coordinators, social workers, patient navigators etc.).

Furthermore, as health plans implement strategies for cost reduction and delivery reform, we have experienced a need for increased administrative staff to handle the burden of additional prior authorizations and bill processing. Administrative policies are routinely based on the operations and functions of a general hospital, not a specialty cancer center. As a result, the application of one size fits all policies to DFCI requires both DFCI and the health plans to expend time and effort to develop necessary exceptions, appeal decisions, and alternative payments.

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.

As discussed in the summary, we are unable to meaningfully participate in any APMs given our structure as a comprehensive cancer center, so we are unable to share relevant results or analyses.

However, in place of APMs, we have launched a number of initiatives in partnership with health plans that put a portion of our reimbursement at risk by tying it to reductions in system-wide costs. To date, our work has focused primarily on reducing unnecessary use of biologic compounds e.g., Bevacixumab (Avastin) and Cetuximab (Erbitux), in addition to other high-cost drugs such as granulocyte colony stimulation factors (Filgrastim/ Pegfilgrastim) and intensity-modulated radiation therapy. By leveraging evidence-based strategies to eliminate utilization of such services when not clinically indicated, we have demonstrated cost savings and improved patient care. In addition, the best-practice guidelines derived from these projects have helped to shape health plan policies for relevant

services and have contributed to reductions in system-wide costs as the guidelines are applied across payers and providers.

---

3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.
SUMMARY: A number of risk adjustment models have been created to account for factors that drive healthcare utilization and patient outcomes (e.g., patient demographics, severity of illness, comorbidities). However, the existing models are not oncology-specific and were not developed to address many primary drivers of cancer risk and outcomes, such as cancer type/stage, tumor markers, and functional status. In addition, risk adjustment methodologies are lacking for care delivered in the ambulatory setting, which has a disproportionate impact on DFCI.
While the utility of existing oncology models are limited by availability, quality, and applicability, DFCI continues to work with a variety of partners to design and test meaningful ambulatory risk adjustment methodologies for cancer care.
    a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

        Existing risk adjustment methodologies do not sufficiently account for the unique characteristics of DFCI's adult or pediatric populations.

        Tested risk adjustment strategies are lacking in oncology care measures, and especially for cancer care delivered in the ambulatory setting, where we deliver 94% of our care. As a result, we are unable to calculate meaningful population-level data that is risk adjusted.

        Traditional adjustment methodologies fail to capture characteristics that influence cancer therapeutic decision making and survival, such as stage, functional status, education level, and socioeconomic status. Risk adjustment methodologies are also lacking or inadequate for our pediatric, mental health, and palliative care patient populations. In addition, the majority of existing methods have been developed for the inpatient setting, rather than ambulatory services. The available tools do not reflect the complexity, acuity, and health status of cancer patients treated in a hospital-based outpatient facility like DFCI.

    b. How do the health status risk adjustment measures used by different payers compare?

        Risk adjustment methodologies for oncology and for care delivered in an outpatient setting are insufficient to allow for comparison across payers; however, we suggest that risk adjustments for ambulatory services be made at the episode level in order to group several ambulatory encounters/visits during a given time period.

Unfortunately, oncology episode groupers are still in their early stages of development and need to be tested before being used for risk adjustment purposes.

c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

Not applicable. The lack of adequate risk adjustment methodologies available for our unique structure and single disease focus prevent us from developing a variety of alternative payment methodologies and risk contracts with payers, as current tools/methodologies would shift a disproportionate share of the risk to the provider.

---

4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.

SUMMARY:
Our structure and single disease focus in oncology prevent us from having access to meaningful metrics to capture and reflect value; risk adjustment models to compare populations; and complete administrative data across the continuum of care. These data and metric constraints preclude us from participation in most APMs and pose challenges to obtaining timely, reliable, and actionable data needed to inform our population health management approach. However, DFCI has made significant progress in developing partnerships to leverage the data-sharing capabilities needed to implement timely interventions and improve patient care.

ANSWER: In order to provide high-value care and performance under APMs, access is needed to the following: meaningful metrics to capture and reflect value; risk adjustment models to compare populations; and complete and timely administrative data.

Metrics: As discussed in Section 6, oncology care lacks standardized measures to evaluate quality or value. There are few validated process measures available for oncology, and outcome metrics specific to oncology services are lacking. The 2013 Institute of Medicine report, Delivering High-Quality Cancer Care, concludes that more robust cancer-specific quality metrics are required, and in particular patient reported outcome measures.

Risk adjustment methods: As discussed in Section 3, the lack of meaningful risk adjustment methodologies for cancer care undermines our ability to compare quality across providers and settings, and to create oncology specific APMs across different cancer types.

Administrative data supplied in a timely manner: As a specialty hospital providing only oncology care, we lack population-level data for health care services our patients receive outside of our institution unless we partner with private payers and/or referring ACOs. In the absence of these partnerships, the data necessary to leverage a comprehensive population health management approach is extremely limited. This is of particular concern in our efforts to manage post-acute care transitions, as DFCI does not reliably have the information needed to initiate timely interventions. For example, our patients can be enrolled in hospice care from outside our institution without our knowledge.

Moreover, as oncology care treatments become increasingly complex, there is a significant need for appropriate care management throughout the acute/therapeutic, post-acute, and end-of-life stages to improve outcomes and avoid unnecessary utilization of services. We are committed to taking a more active role in managing patients across the continuum of care and achieving the gains associated with sharing care among specialists, community oncologists, and PCPs. To do so, we are actively pursuing partnerships with payers and ACOs to increase our access to this level of information and leverage it to improve patient care.

DFCI has developed data-sharing pilots in partnership with several health plans to improve care management and coordination. Areas of study include end-of-life care, oral chemotherapy adherence, and potentially avoidable hospitalizations and emergency department visits. For example, DFCI sends real-time chemotherapy treatment plans to our patients' health plans so that nurse care coordinators can use the information to flag individuals beginning a treatment regimen who may be at risk for side-effects or complications, and proactively coordinate services/interventions the patient may require as a result of the prescribed treatment. In addition, we are actively sharing data with one of our referring ACOs to track patients up to 2 years post-active therapy in order to monitor outcomes and early signs of relapse or disease progression. These pilot programs reflect our commitment and need to leverage data-sharing partnerships in order to improve patient care and reduce the need for high-cost interventions.

---

5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY:

   This question is not applicable to DFCI. As a specialty cancer center, we do not provide primary care services.

   a. Which attribution methodologies most accurately account for patients you care for?

      Not applicable.

   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

Not applicable.

6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.
SUMMARY: DFCI devotes significant resources to reporting quality measures to payers. As a result of our status as one of only eleven PPS-exempt NCI-designated comprehensive cancer centers, there are many reporting requirements which are not relevant to our patient population and are extremely limited in their ability to demonstrate quality and value in cancer care. The expertise and resources that DFCI provides to support our commitment to clinical innovation, such as the dedicated time of clinical, research, quality, financial, analytic and information technology professionals; information systems/database development; and evidence-driven improvements, are increasingly devoted to the growing number of uncoordinated payer reporting programs.

   ANSWER: DFCI reports data to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. We currently report five quality measures related to infection rates and the adjuvant treatment of breast and colon cancer. Data for these measures are submitted throughout the year using different reporting systems and deadlines. CMS has finalized seven additional measures to be added to the PCHQR program over the next two years. In rulemaking related to these measures, CMS estimated that reporting the expanded PCHQR measure set will require approximately nine FTEs at each cancer center, at a cost of more than $450,000 per year.

   The CMS EHR Inventive Program ('Meaningful Use') requires reporting of nine clinical quality measures. None of these measures are aligned with our PCHQR reporting and require additional resources. Further, DFCI reports core measures for each MassHealth patient. Although the majority of these measures are not relevant to our patient population, we must maintain a vendor contract for reporting and conduct quarterly record reviews.

   Quality data reported to local private payers is completely distinct. Due to the aforementioned limitations of the public payer measures to demonstrate quality and value, we have worked with private payers individually on reporting to better suit our specialized services and oncology population. Last FY we devoted approximately three FTEs on three unique performance improvement and reporting programs.

   While DFCI's payer reporting programs can reveal quality gaps, we have found that the most meaningful improvements in quality and efficiency have resulted from analyses that were internally initiated or the product of improvement collaborations. The expertise and resources that DFCI provides to support our commitment to clinical innovation (e.g., the dedicated time of clinical, research, quality, financial, analytic and information technology professionals; information systems/database development; evidence-driven improvements) are increasingly devoted to a growing number of uncoordinated payer reporting programs.

7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.

   SUMMARY:

   As a result of advances in the delivery of cancer care and in response to growing cost concerns, oncology care has largely shifted in recent decades from inpatient to outpatient settings. DFCI provides 94% of the care we deliver in the outpatient setting, which gives patients convenient access to our state-of-the-art facilities and multidisciplinary approach to care, while reducing overall cost to the healthcare system. In addition, DFCI has launched initiatives to study and reduce unnecessary hospital admissions through enhanced data-sharing and care management strategies, as described in Section 4.

   DFCI has developed partnerships with community hospitals to operate satellite facilities, and most recently, acquired a physician practice to provide cancer care in lower-cost community settings.

   a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.

      Not applicable.

   b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.

      DFCI understands the value of providing care to cancer patients in locations that will reduce the total cost of care and improve convenient access to care for our patients. Through partnerships and affiliations with a select number of local hospitals, DFCI operates four hospital satellite facilities located in Milford, Weymouth, Brighton, and Londonderry, NH. Our community cancer care model allows DFCI clinicians to be available in the communities where our patients live and to utilize the diagnostic, surgical, and inpatient services of lower-cost community providers.

      In addition, in July 2014, DFCI acquired the assets of a community physician oncology practice, formerly Commonwealth Hematology Oncology, which is now operating under the name Dana-Farber Cancer Care Network (d/b/a Dana-Farber Community Cancer Care). Through our physician practice model, we are now able to offer oncology care in lower-cost community settings.

8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.

   SUMMARY:

DFCI maintains a variety of partnerships with post-acute providers across the continuum of care to ensure that our patients have timely access to services needed post-discharge. Our palliative care service leverages the unique expertise of its clinicians and support staff to coordinate care for our sickest patients and has demonstrated success in reducing hospital readmissions through effective discharge planning and care transition management.

a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

   DFCI's palliative care service (PCS), which provides 13,000 adult visits and 1,933 pediatric visits per year, plays a major role in caring for our sickest patients and coordinating care to ensure the appropriate post-acute services are available upon discharge. Patients with unplanned oncology admissions have an average survival of approximately 4 months; the PCS plays a major role in helping this vulnerable population receive appropriate care in hospice and in avoiding subsequent hospitalizations. The service works closely with our palliative care (PC) Care Coordinator, social workers, and oncologists to identify discharge needs from the day of admission, and to assure appropriate outpatient PC follow-up. The readmission rate of the Palliative Care Unit is 18% -- about 30% below that of the general oncology service. Thirty-three percent of PCS patients are discharged to hospice. Discharged PC oncology patients are 15% less likely than non PC patients to be rehospitalized.

b. How does your organization ensure optimal use of post-acute care?

   DFCI partners with a variety of post-acute providers across the continuum of care, including skilled nursing facilities, long-term acute care hospitals, and home health services to ensure that the optimal post-acute care services are available and accessible to our patients. DFCI also maintains a robust partnership with our preferred hospice provider, Care Dimensions, who works closely with our staff and patients to manage care transitions for patients entering hospice.

   The care coordinators who work with our inpatients receive regular training about community-based care options for post-acute care. In addition, DF/BWCC has a specially-designated liaison nurse from Care Dimensions Hospice who provides patient support and discharge planning coordination services to patients entering hospice. Care Dimensions has also recently started an "Open Access" program, which has the potential to allow DFCI patients to receive both ongoing cancer-directed care and hospice services simultaneously. We believe this program has the potential to make a significant impact in reducing the barriers our patients and clinicians face in determining appropriate care options for patients with late-stage disease, especially as treatment options for advanced disease continue to expand.

In addition, our palliative care leadership team is working with Care Dimensions and other partners to enhance home-based palliative care services in order to better meet the needs of our patients.

---

9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

SUMMARY:

Pursuant to Chapter 224, Dana-Farber has developed a structured approach to coordinate incoming charge estimate requests, follow-up in a timely manner, and provide patients or potential patients with the best information available. To date, we have received charge-related requests from current patients, potential patients, physician practices, and health plans, and have been able to provide an estimate of the charges associated with a service or procedure as requested. A key part of our process includes assisting patients and other individuals in understanding the information provided in the estimate.

Health Care Service Price Inquiries				
Year		**Number of Inquiries via Website**	**Number of Inquiries via Telephone/In Person**	**Average (approximate) Response Time to Inquiries***
CY2014	**Q1**	0	14	24h
	Q2	0	12	24h
	Q3	0	5	24h
	TOTAL:	0	31	

** Please indicate the unit of time reported.*

ANSWER:

We have developed tools and trained staff to aide our efforts in managing incoming requests, conducting charge estimates, and tracking the request through completion. This process complements an existing process of providing estimates to self-pay patients or other financially responsible parties who have requested this information.

We consider any initial request – made by phone or in-person – for an estimate of the charge for an admission, procedure, or service to fall within our obligation under Chapter 224. To date, DFCI has received charge-related inquiries from prospective patients, existing patients, physician practices, and health plans.

Upon receipt and processing of a request, DFCI provides an estimate of the charges associated with any service, with the caveats described below that apply to individuals who are prospective patients. Estimates requested for a specific identified service are based on current charges. Estimates requested for a full treatment plan also reflect current charges, but are assembled based on the historical utilization and course of treatment prescribed for comparable patients.

Our ability to provide estimates for individuals with a cancer diagnosis who have not received a treatment plan from a DFCI physician is limited because our physicians may approach treating a specific type of cancer in ways that differ from other physicians and institutions. To receive an accurate and meaningful estimate based on the treatment the patient would receive at DFCI, we require that potential patients with a cancer diagnosis arrange a consult with a DFCI physician prior to receiving an estimate.

In some cases, we believe individuals use this information to assist in evaluating their out-of-pocket responsibilities. In other cases, patients are more interested in whether DFCI is participating as a network provider with their health plan. Frequently, the patient or potential patient is considering a second opinion.

In all cases, as part of our standard process, we help to educate patients about the information we provide in the written estimate. In particular, we assist patients in understanding that our estimates reflect the charges associated with the relevant service, and that this does not reflect their out-of-pocket responsibility.

While our charge estimate process does not reflect out-of-pocket responsibility, we have a number of policies in place to help patients understand their individual financial responsibility and any financial assistance that may be available to them. Specifically, we support patients in managing coverage gaps; provide discounts to self-pay patients; and assist patients who qualify for financial assistance or alternative coverage in accessing those options. In each case, our financial counselors work closely with patients to help them understand the information we have provided and to answer their questions as completely as possible.

---

10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
    SUMMARY:
    The evolution of tiered and limited network products has had a significant impact on DFCI and our patients. While we share the goal of providing high-quality care in cost-effective settings, we maintain concerns that tiered and limited network products may present undue access and financial barriers for cancer patients who require specialized treatment.

    ANSWER:

Ensuring that patients have timely and affordable access to the multi-disciplinary care we provide is critical when the treatment/services required are complex, time sensitive, and/or not otherwise offered within the network – and specifically in the case of rare and complex cancers, such as pediatric cancer, leukemia, sarcomas, and bone marrow transplants.

TIERED PRODUCTS: In some cases, DFCI has been placed in the highest cost sharing tier, which poses special hardships to our patients, many of whom are receiving a course of treatment that requires multiple visits. We maintain significant concerns about the financial impact that tiering has on our patients who suffer from the burden of rare and complex cancers and are further penalized by disproportionately higher out-of-pocket payments.

TIERING & QUALITY METRICS: M.G.L. c. 176J, s. 11(b), provides that carriers tier providers based on quality measures and on the basis of either health status adjusted total medical expenses or relative prices. Quality measures typically used for tiering purposes are not applicable to a specialty cancer hospital, and there are limited nationally recognized oncology metrics that have been adopted for this purpose. In the absence of meaningful and applicable quality metrics, several health plans have placed DFCI in the highest tier based on cost alone, which we believe is inappropriate and conflicts with the intent of the legislation.

We have appealed our assignment to the highest tier in several cases. While successful in overturning our placement in the highest tier in one case, other major health plans have upheld their placement of DFCI in the highest tier, unreasonably so in our view. We believe it is in the best interest of our patients and the health plans' members for us to remain in the middle or lower tier.

LIMITED NETWORKS: Patients in limited networks who require specialized cancer treatment services may also experience undue financial burden, delays in treatment, and difficulty obtaining medically necessary services out-of-network.

When patients are referred out-of-network to receive care, the out-of-pocket caps created under §1301(c) of the Affordable Care Act do not apply, posing a disproportionately significant financial barrier for these patients. We believe that patients with rare or complex cancers, regardless of whether they participate in a health plan that includes DFCI, should have access to our Center if they could benefit from our sub-specialized, multidisciplinary care and/or our more than 750 clinical trials.

PRICING CHANGES: In an effort to address the issues and disparities that emerge when tiered products require cancer patients to pay more for care, DFCI has made deliberate efforts to reduce the cost-sharing burden on our patients, such as decreasing charges for high-tech radiology.

---

11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with

a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

SUMMARY:

DFCI maintains a staff of 8 psychiatrists, 8 psychologists and 25 social workers who provide holistic, patient-centered care, with a particular focus on high-needs patients, including those who may have co-morbid behavioral health conditions. We provide 6,900 pediatric mental health visits and 4,642 adult mental health visits per year. In our cost-conscious model, social workers provide the majority of mental health care because they are highly competent and less costly. Mental health treatment is provided to patients through an integrated psychosocial approach, which includes individualized assessments and access to an array of support services. However, mental and behavioral health services are poorly reimbursed, which is a barrier to integration.

a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.

   In collaboration with the pediatric and adult oncology teams, mental health clinicians provide a comprehensive assessment to identify the needs of the patient and to connect him or her to the appropriate services. Patients at DFCI have access to a broad range of treatments including psychotherapy, psychopharmacology, and group therapy, in addition to specialized support services for sexual health, menopausal symptoms, bereavement, survivorship, and cognitive dysfunction, among others.

   Patients who have completed active cancer treatment but are in need of ongoing mental health treatment or services are referred to community providers. Mental health clinicians work closely with our palliative care clinicians through an integrated approach to address the needs of our sickest patients and their families.

b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

   Mental health treatment is integrated into our care model. Patients access mental health services by referral from oncology clinicians and/or by self-referral. We provide timely access to behavioral or mental health services if needed to prevent escalation of symptoms. Social workers evaluate high-risk patients receiving complex treatments such as bone marrow transplant; pediatric patients are evaluated by mental health clinicians based on need; and psychiatrists, psychologists and social workers are located on the disease center floors.

   We are currently piloting an electronic distress screen that will be administered universally to outpatients throughout the cancer experience. The goal is to

promptly identify at-risk patients and provide interventions to address patient needs and reduce utilization of high-cost services.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

Mental health, behavioral health, and palliative care services are not adequately reimbursed, which poses a significant barrier.

Overall, our behavioral and palliative care clinicians are co-located on the disease center floors and function as an interdisciplinary team, positioning us well to integrate care for high-risk patients. However, the challenge associated with this model is the time required for coordination, team meetings, and collaboration in the midst of high-demand clinical practices. We address this challenge in the following ways:

•Developing trusting clinical relationships among disease-focused teams of clinicians;
•Initiating a universal screening program to identify the high-risk patients; and
•Implementing regularly scheduled Patient Care Team meetings
•Initiating ad hoc meetings in-the-moment to address crises

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

We maintain clinic volume and billing data that we would be pleased to share with the Health Policy Commission or Commonwealth.

---

12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY:

While DFCI does not provide primary care services, we have been exploring and piloting oncology-based PCMH models that focus on referral management and care coordination between oncologists, PCPs, and other specialists on the care team.
In 2013, Commonwealth Hematology Oncology (CHO), now operating under DFCI as Dana-Farber Community Cancer Care (DFCCC), submitted an application to the National Committee for Quality Assurance (NCQA) as an early adopter of the Patient Centered Specialty Practice recognition program (PCSP), which recognizes practices that demonstrate patient-centered care and clinical quality. CHO was one of only two Massachusetts practices and the only oncology practice to seek this designation. CHO received approval on its initial NCQA corporate submission in April 2014 and DFCCC will apply for a final NCQA recognition designation for the program in April 2015.

a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?

While DFCI does not employ primary care providers, all of our 13 DFCCC physicians participate in our oncology patient centered medical home model, which is referenced above and described in greater detail in Appendix B.

b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

Not applicable. DFCI does not provide primary care services.

c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

We are currently in the early stages of collecting data from our oncology PCMH. We believe that our model's emphasis on clinical management throughout the cancer experience provides the greatest opportunity to improve patient outcomes and enhance the quality and value of care.

In regards to patient satisfaction, CHO conducted and DFCCC will continue to conduct a yearly survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The capture rate in 2012 and 2013 was 74% and 68%, respectively. The survey measures patient experience, satisfaction with the practice, physician communication, clinical and administrative staff, waiting time, timely access to care, and health care services provided.

In addition, DFCCC continues to partner with HPHC on a pilot program launched in July 2012, which focuses on value-based initiatives, such as measuring treatment adherence for specific cancers; education and compliance tracking for oral chemotherapy ; ongoing analysis of pharmacy costs and utilization; and establishment of a relationship with behavioral health providers to promote integration

---

13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
SUMMARY:
While the HPC's 2013 Cost Trends Report highlights a number of issues and areas of opportunity, our experience in the market reflects a number of other key issues related to trends in reimbursement reductions and health plan administrative policies that negatively impact DFCI.

ANSWER:

REIMBURSEMENT:
In addition to the revenue data summarized in Section 1a, which largely focuses on commercial payors and Medicare, below is further information relative to Medicaid reimbursement:

DFCI's outpatient Medicaid reimbursement (Payment Amount Per Episode) has declined by 30% since 2011, amounting to a loss of $9 million over 3 years, due to an unexplained 60% reduction in our case mix index. Our internal review reveals that our case mix has remained largely unchanged during this time, but because MassHealth's case mix calculation methodology is not publicly available, it is not possible for us to demonstrate that the reductions in reimbursement are unwarranted.

MANAGING COMPLEX SPECIALTY CARE:
In areas where our institution maintains a unique expertise and understanding of the different uses and clinical justifications for a test, procedure or service, we assert that decisions about the appropriate use of those services should be made by our specialty providers, and not representatives from health plans who may not hold the same level of expertise or understanding. This is especially true for oncology drugs and certain advanced lab tests, such as molecular pathology.

We use molecular pathology testing for a variety of clinically-indicated purposes including genetic screening and to inform the use of targeted therapies and personalized medicine in clinical decision-making. We regularly experience denials from health plans that place the onus on us to supply documentation and explanations to support each test, which is an unnecessary and costly administrative burden. As industry leaders in this rapidly growing field, DFCI maintains the expertise to determine and apply standards for appropriate clinical use. Health plans should not implement administrative policies to restrict use of cutting-edge services through onerous authorizations programs or denial of legitimate and medically necessary testing.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing for each year 2010 to 2013 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Hospital Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

   Completed in Attachment AGO Hospital Exhibit 1

   Responses provided in Attachment A (AGO Hospital Exhibit 1).

   DFCI does not participate in risk-contract arrangements. Our total revenue under pay-for-performance contracts and fee for service arrangements are reflected in the attached spreadsheet.

   Please note that we are unable to break out revenue at the HMO or PPO product-level as requested in the spreadsheet provided, and have therefore consolidated the revenue for each category in the HMO column, leaving the PPO column blank.

---

2. For each year 2010 to present, please submit a summary table showing for each line of business (commercial, government, other, total) your inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as AGO Hospital 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.

   Completed in Attachment AGO Hospital Exhibit 2

   Responses provided in Attachment B (Payor Mix Analysis and Margin Analysis).

---

3. Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.

Not applicable. DFCI does not participate in risk contracts.

---

4. Please explain and submit supporting documents that show how you analyze and track the volume of inpatient and outpatient referrals to your hospital and the associated revenue from those referrals by particular physicians or provider groups. Please include a description and examples of how your organization uses this information.

DFCI collects information on the volume of outpatient referrals to DFCI through our internal registration system. These data are not tied to revenue data, and are primarily used for education and marketing purposes, such as sharing information with clinicians about Continuing Medical Education (CME) opportunities or available clinical trials based on their disease area focus.

2014 Cost Trends Hearing Pre-Filed Testimony

Dana-Farber Cancer Institute

September 8, 2014

DANA-FARBER CANCER INSTITUTE

Edward J. Benz, Jr. M.D.
President and CEO
Dana-Farber Cancer Institute

Director
Dana-Farber / Harvard Cancer Center

Richard and Susan Smith
Professor of Medicine
Harvard Medical School

Professor of Pediatrics
Harvard Medical School

Professor of Genetics
Harvard Medical School

450 Brookline Ave., DA1628
Boston, MA 02215-5450
617.632.4266 tel. 617.632.2161 fax
edward_benz@dfci.harvard.edu
www.dana-farber.org

Submitted Electronically via
HPC-Testimony@state.ma.us

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

September 8, 2014

Dear Mr. Seltz:

Dana-Farber Cancer Institute is committed to continue working alongside the Health Policy Commission, the Attorney General's Office, and the Center for Health Information and Analysis to further our shared goal of improving access to cost-effective health care services in the Commonwealth.

We are pleased to submit the enclosed information as a testament to our efforts to reduce costs and improve quality in the delivery of adult and pediatric cancer care and believe that our testimony reflects the unique role that Dana-Farber fulfills in the continuum of care as the state's only freestanding comprehensive cancer center.

Enclosed you will find written testimony for Dana-Farber as requested for the upcoming Annual Cost Trends Hearing in your letter dated August 1, 2014.

By my signature below, I certify that I am legally authorized and empowered to represent Dana-Farber Cancer Institute for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please direct any follow-up questions to Anne Levine, Vice President of External Affairs, at 617-632-4433 or Anne_Levine@dfci.harvard.edu.

Sincerely,

Edward J. Benz Jr., MD
President and Chief Executive Officer

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
SUMMARY:

SUMMARY:

DFCI has undertaken significant efforts to reduce costs and continue to improve quality, safety and value in the delivery of cancer care. Amidst reductions in reimbursement, DFCI has launched a number of initiatives to better coordinate care; reduce utilization of high-cost services; integrate comprehensive psychosocial, behavioral, and palliative care in our care delivery model; reduce variability in the treatment of cancer; enable clinicians to practice at the top of their license; and deliver cancer care in lower-cost community settings. We are proud of our efforts to deliver high-quality, cost-effective, comprehensive cancer care and believe the initiatives described below highlight our commitment to serving our patients and their families.

a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

Revenue:

- Payment rate adjustments from DFCI's top-3 Massachusetts commercial payors have ranged from -2% - +3% from CY2010-2014.
- Medicare continues to reimburse DFCI at a rate that is below operating costs, the rate improved from 83% to 91% of cost in CY2012. Overall reimbursement from Medicare recently declined by 2% due to sequestration.
- DFCI's charge increases approximated 4% in CY2010, 3% in both CY2011 and CY2012, and 2% in CY2013; charges were not increased in CY2014.
- DFCI reduced imaging charges by 20% in CY2013 and 10% in CY2014.

Utilization:

- Volume from clinic visits has grown steadily by approximately 5% to 6% per year from CY2010-2013.

Operating Expenses:

- On a per unit basis, operating expenses increased by approximately 4% in CY2011(opened new OP clinical building), remained flat in CY2012 and increased slightly by 1% in CY2013 and YTD in CY2014.

b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

- Established a physician practice model through Dana-Farber Cancer Care Network (d/b/a Dana-Farber Community Cancer Care) to provide lower-cost care in a community setting.
- Leveraged the expertise of our clinicians through Care Model Redesign to ensure that clinical staff and faculty operate at the top of their license.
- Established an inpatient palliative care unit to expand access to integrated palliative care services and reduce the use of high-cost interventions for hospitalized patients.
- Implemented a program to enhance advanced care planning and reduce resource use by aligning care delivery with patient preferences.
- Implemented interventions to reduce the use of high-cost drugs in accordance with clinical evidence.
- Consolidated and reorganized programs to decrease expenses.

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

- Implementing a "shared-care" model for patients undergoing stem-cell transplantation to coordinate patient care between the DFCI care team and the patient's community oncologist. The model will allow patients to receive appropriate post-transplant care in lower-cost community settings.
- Implementing Clinical Pathways to standardize cancer care and remove unnecessary variability and cost in care delivery.
- Establishing a diagnostic service to assist non-oncologists with the rational, cost-effective diagnostic workup of patients with a suspected malignancy to avoid unnecessary utilization.
- Enhancing the discharge planning process for hospitalized cancer patients and implementing an Urgent Care Model to improve care transitions to the outpatient setting and reduce unnecessary ED utilization and hospital readmissions.

a. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

Prior Authorization (PA): PAs for radiology and drugs, which are almost always approved, require significant resources that add cost to the system and offer little to no benefit. Best practice would allow hospitals to obtain approval for an episode of care or treatment plan instead of requiring a PA for each drug administration.

Specialty Pharmacy: Health plans have implemented policies limiting the ability of hospitals to administer specific drugs in a clinic setting and requiring that patients procure their prescribed medications through specialty pharmacies. We are deeply concerned that this practice puts our patients at risk, compromises continuity of care, and adds an undue resource burden on providers trying to manage these policies for cancer patients.

Telemedicine: Reimbursement for telemedicine should be encouraged, particularly for teaching hospitals.

2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. SUMMARY:

SUMMARY:

DFCI has been a continuous source of innovation in high-quality, cost-effective cancer care and has developed a number of payment redesign projects that further our progress towards alternative payment methodologies (APM) and reward value-driven cancer care. Our efforts in this area reflect DFCI's distinctive role as the state's only freestanding comprehensive cancer center and highlight our leadership in developing unique arrangements that align with our single disease focus.

We are unable to meaningfully participate in the APMs launched by our health plan partners, including global budgets and risk arrangements given our unique structure. However, as an industry leader in oncology-based payment redesign, DFCI has pioneered a bundled payment arrangement for our hematopoietic stem cell transplant program and piloted a number of projects focused on delivering high-value cancer care.

a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?

DFCI was one of the first cancer centers to implement a bundled payment arrangement for hematopoietic stem cell transplants (HCST). Under this arrangement, stem cell transplants are reimbursed based on case rate bundles:

- A single global payment is made for a case rate period, which starts on the day of admission for transplant infusion and typically ends at discharge. The case rate bundle applies to all hospital and physician services provided during the case rate period.
- Operationally, billing is completed through the industry standard approach.
- Many agreements include stop loss provisions to share risk between the provider and payer in outlier cases.

The model has also resulted in growing referral patterns, as the case rate bundle makes the costs associated with a HCST predictable and therefore, attractive to health plans. The volume of HCSTs DFCI provides helps us to deliver care more efficiently and ultimately contributes to superior patient outcomes.

In addition, we are exploring other services that may be appropriate for bundling, such as comprehensive second opinion services.

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).

Substantial effort and resources are required to develop, implement, and manage the pilots and projects described in Section 2. Without appropriate compensation for the coordination and management associated with the resulting changes in pre-authorizations, billing, and patient support, the implementation of such projects can increase administrative expenses.

Many key services that are critical for our ability to provide comprehensive, patient-centered care are not reimbursed or are poorly reimbursed by health plans (e.g., nurse coordinators, social workers, patient navigators etc.).

Furthermore, as health plans implement strategies for cost reduction and delivery reform, we have experienced a need for increased administrative staff to handle the burden of additional prior authorizations and bill processing. Administrative policies are routinely based on the operations and functions of a general hospital, not a specialty cancer center. As a result, the application of one size fits all policies to DFCI requires both DFCI and the health plans to expend time and effort to develop necessary exceptions, appeal decisions, and alternative payments.

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.

As discussed in the summary, we are unable to meaningfully participate in any APMs given our structure as a comprehensive cancer center, so we are unable to share relevant results or analyses.

However, in place of APMs, we have launched a number of initiatives in partnership with health plans that put a portion of our reimbursement at risk by tying it to reductions in system-wide costs. To date, our work has focused primarily on reducing unnecessary use of biologic compounds e.g., Bevacixumab (Avastin) and Cetuximab (Erbitux), in addition to other high-cost drugs such as granulocyte colony stimulation factors (Filgrastim/ Pegfilgrastim) and intensity-modulated radiation therapy. By leveraging evidence-based strategies to eliminate utilization of such services when not clinically indicated, we have demonstrated cost savings and improved patient care. In addition, the best-practice guidelines derived from these projects have helped to shape health plan policies for relevant services and have contributed to reductions in system-wide costs as the guidelines are applied across payers and providers.

3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers. SUMMARY:

SUMMARY:

A number of risk adjustment models have been created to account for factors that drive healthcare utilization and patient outcomes (e.g., patient demographics, severity of illness, comorbidities). However, the existing models are not oncology-specific and were not developed to address many primary drivers of cancer risk and outcomes, such as cancer type/stage, tumor markers, and functional status. In addition, risk adjustment methodologies are lacking for care delivered in the ambulatory setting, which has a disproportionate impact on DFCI.

While the utility of existing oncology models are limited by availability, quality, and applicability, DFCI continues to work with a variety of partners to design and test meaningful ambulatory risk adjustment methodologies for cancer care.

a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

Existing risk adjustment methodologies do not sufficiently account for the unique characteristics of DFCI's adult or pediatric populations.

Tested risk adjustment strategies are lacking in oncology care measures, and especially for cancer care delivered in the ambulatory setting, where we deliver 94% of our care. As a result, we are unable to calculate meaningful population-level data that is risk adjusted.

Traditional adjustment methodologies fail to capture characteristics that influence cancer therapeutic decision making and survival, such as stage, functional status, education level, and socioeconomic status. Risk adjustment methodologies are also lacking or inadequate for our pediatric, mental health, and palliative care patient populations. In addition, the majority of existing methods have been developed for the inpatient setting, rather than ambulatory services. The available tools do not reflect the complexity, acuity, and health status of cancer patients treated in a hospital-based outpatient facility like DFCI.

b. How do the health status risk adjustment measures used by different payers compare?

Risk adjustment methodologies for oncology and for care delivered in an outpatient setting are insufficient to allow for comparison across payers; however, we suggest that risk adjustments for ambulatory services be made at the episode level in order to group several ambulatory encounters/visits during a given time period.

Unfortunately, oncology episode groupers are still in their early stages of development and need to be tested before being used for risk adjustment purposes.

c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

Not applicable. The lack of adequate risk adjustment methodologies available for our unique structure and single disease focus prevent us from developing a variety of alternative payment methodologies and risk contracts with payers, as current tools/methodologies would shift a disproportionate share of the risk to the provider.

4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.
SUMMARY:

ANSWER:

SUMMARY:

Our structure and single disease focus in oncology prevent us from having access to meaningful metrics to capture and reflect value; risk adjustment models to compare populations; and complete administrative data across the continuum of care. These data and metric constraints preclude us from participation in most APMs and pose challenges to obtaining timely, reliable, and actionable data needed to inform our population health management approach. However, DFCI has made significant progress in developing partnerships to leverage the data-sharing capabilities needed to implement timely interventions and improve patient care.

ANSWER:

In order to provide high-value care and performance under APMs, access is needed to the following: meaningful metrics to capture and reflect value; risk adjustment models to compare populations; and complete and timely administrative data.

Metrics: As discussed in Section 6, oncology care lacks standardized measures to evaluate quality or value. There are few validated process measures available for oncology, and outcome metrics specific to oncology services are lacking. The 2013 Institute of Medicine report, *Delivering High-Quality Cancer Care*, concludes that more robust cancer-specific quality metrics are required, and in particular patient reported outcome measures.

Risk adjustment methods: As discussed in Section 3, the lack of meaningful risk adjustment methodologies for cancer care undermines our ability to compare quality across providers and settings, and to create oncology specific APMs across different cancer types.

Administrative data supplied in a timely manner: As a specialty hospital providing only oncology care, we lack population-level data for health care services our patients receive outside of our institution unless we partner with private payers and/or referring ACOs. In the absence of these partnerships, the data necessary to leverage a comprehensive population health management approach is extremely limited. This is of particular concern in our efforts to manage post-acute care transitions, as DFCI does not reliably have the information needed to initiate timely interventions. For example, our patients can be enrolled in hospice care from outside our institution without our knowledge.

Moreover, as oncology care treatments become increasingly complex, there is a significant need for appropriate care management throughout the acute/therapeutic, post-acute, and end-of-life stages to improve outcomes and avoid unnecessary utilization of services. We are committed to taking a more active role in managing patients across the continuum of care and achieving the gains associated with sharing care among specialists, community oncologists, and PCPs. To do so, we are actively pursuing partnerships with payers and ACOs to increase our access to this level of information and leverage it to improve patient care.

DFCI has developed data-sharing pilots in partnership with several health plans to improve care management and coordination. Areas of study include end-of-life care, oral chemotherapy adherence, and potentially avoidable hospitalizations and emergency department visits. For example, DFCI sends real-time chemotherapy treatment plans to our patients' health plans so that nurse care coordinators can use the information to flag individuals beginning a treatment regimen who may be at risk for side-effects or complications, and proactively coordinate services/interventions the patient may require as a result of the prescribed treatment. In addition, we are actively sharing data with one of our referring ACOs to track patients up to 2 years post-active therapy in order to monitor outcomes and early signs of relapse or disease progression. These pilot programs reflect our commitment and need to leverage data-sharing partnerships in order to improve patient care and reduce the need for high-cost interventions.

5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY:

SUMMARY:

This question is not applicable to DFCI. As a specialty cancer center, we do not provide primary care services.

a. Which attribution methodologies most accurately account for patients you care for?

Not applicable.

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

Not applicable.

6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.
SUMMARY:

ANSWER:

SUMMARY:

DFCI devotes significant resources to reporting quality measures to payers. As a result of our status as one of only eleven PPS-exempt NCI-designated comprehensive cancer centers, there are many reporting requirements which are not relevant to our patient population and are extremely limited in their ability to demonstrate quality and value in cancer care. The expertise and resources that DFCI provides to support our commitment to clinical innovation, such as the dedicated time of clinical, research, quality, financial, analytic and information technology professionals; information systems/database development; and evidence-driven improvements, are increasingly devoted to the growing number of uncoordinated payer reporting programs.

ANSWER:

DFCI reports data to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. We currently report five quality measures related to infection rates and the adjuvant treatment of breast and colon cancer. Data for these measures are submitted throughout the year using different reporting systems and deadlines. CMS has finalized seven additional measures to be added to the PCHQR program over the next two years. In rulemaking related to these measures, CMS estimated that reporting the expanded PCHQR measure set will require approximately nine FTEs at each cancer center, at a cost of more than $450,000 per year.

The CMS EHR Inventive Program ('Meaningful Use') requires reporting of nine clinical quality measures. None of these measures are aligned with our PCHQR reporting and require additional resources. Further, DFCI reports core measures for each MassHealth patient. Although the majority of these measures are not relevant to our patient population, we must maintain a vendor contract for reporting and conduct quarterly record reviews.

Quality data reported to local private payers is completely distinct. Due to the aforementioned limitations of the public payer measures to demonstrate quality and value, we have worked with private payers individually on reporting to better suit our specialized services and oncology population. Last FY we devoted approximately three FTEs on three unique performance improvement and reporting programs.

While DFCI's payer reporting programs can reveal quality gaps, we have found that the most meaningful improvements in quality and efficiency have resulted from analyses that were internally initiated or the product of improvement collaborations. The expertise and resources

that DFCI provides to support our commitment to clinical innovation (e.g., the dedicated time of clinical, research, quality, financial, analytic and information technology professionals; information systems/database development; evidence-driven improvements) are increasingly devoted to a growing number of uncoordinated payer reporting programs.

7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers. SUMMARY:

SUMMARY:

As a result of advances in the delivery of cancer care and in response to growing cost concerns, oncology care has largely shifted in recent decades from inpatient to outpatient settings. DFCI provides 94% of the care we deliver in the outpatient setting, which gives patients convenient access to our state-of-the-art facilities and multidisciplinary approach to care, while reducing overall cost to the healthcare system. In addition, DFCI has launched initiatives to study and reduce unnecessary hospital admissions through enhanced data-sharing and care management strategies, as described in Section 4.

DFCI has developed partnerships with community hospitals to operate satellite facilities, and most recently, acquired a physician practice to provide cancer care in lower-cost community settings.

a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.

Not applicable.

b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.

DFCI understands the value of providing care to cancer patients in locations that will reduce the total cost of care and improve convenient access to care for our patients. Through partnerships and affiliations with a select number of local hospitals, DFCI operates four hospital satellite facilities located in Milford, Weymouth, Brighton, and Londonderry, NH. Our community cancer care model allows DFCI clinicians to be available in the communities where our patients

live and to utilize the diagnostic, surgical, and inpatient services of lower-cost community providers.

In addition, in July 2014, DFCI acquired the assets of a community physician oncology practice, formerly Commonwealth Hematology Oncology, which is now operating under the name Dana-Farber Cancer Care Network (d/b/a Dana-Farber Community Cancer Care). Through our physician practice model, we are now able to offer oncology care in lower-cost community settings.

8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
SUMMARY:

SUMMARY:

DFCI maintains a variety of partnerships with post-acute providers across the continuum of care to ensure that our patients have timely access to services needed post-discharge. Our palliative care service leverages the unique expertise of its clinicians and support staff to coordinate care for our sickest patients and has demonstrated success in reducing hospital readmissions through effective discharge planning and care transition management.

a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

DFCI's palliative care service (PCS), which provides 13,000 adult visits and 1,933 pediatric visits per year, plays a major role in caring for our sickest patients and coordinating care to ensure the appropriate post-acute services are available upon discharge. Patients with unplanned oncology admissions have an average survival of approximately 4 months; the PCS plays a major role in helping this vulnerable population receive appropriate care in hospice and in avoiding subsequent hospitalizations. The service works closely with our palliative care (PC) Care Coordinator, social workers, and oncologists to identify discharge needs from the day of admission, and to assure appropriate outpatient PC follow-up. The readmission rate of the Palliative Care Unit is 18% -- about 30% below that of the general oncology service. Thirty-three percent of PCS patients are discharged to hospice. Discharged PC oncology patients are 15% less likely than non PC patients to be rehospitalized.

b. How does your organization ensure optimal use of post-acute care?

DFCI partners with a variety of post-acute providers across the continuum of care, including skilled nursing facilities, long-term acute care hospitals, and home health services to ensure that the optimal post-acute care services are available and accessible to our patients. DFCI also maintains a robust partnership with our preferred hospice provider, Care Dimensions, who works closely with our staff and patients to manage care transitions for patients entering hospice.

The care coordinators who work with our inpatients receive regular training about community-based care options for post-acute care. In addition, DF/BWCC has a specially-designated liaison nurse from Care Dimensions Hospice who provides patient support and discharge planning coordination services to patients entering hospice. Care Dimensions has also recently started an "Open Access" program, which has the potential to allow DFCI patients to receive both ongoing cancer-directed care and hospice services simultaneously. We believe this program has the potential to make a significant impact in reducing the barriers our patients and clinicians face in determining appropriate care options for patients with late-stage disease, especially as treatment options for advanced disease continue to expand.

In addition, our palliative care leadership team is working with Care Dimensions and other partners to enhance home-based palliative care services in order to better meet the needs of our patients.

9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY:

SUMMARY:

Pursuant to Chapter 224, Dana-Farber has developed a structured approach to coordinate incoming charge estimate requests, follow-up in a timely manner, and provide patients or potential patients with the best information available. To date, we have received charge-related requests from current patients, potential patients, physician practices, and health plans, and have been able to provide an estimate of the charges associated with a service or procedure as requested. A key part of our process includes assisting patients and other individuals in understanding the information provided in the estimate.

ANSWER:

We have developed tools and trained staff to aide our efforts in managing incoming requests, conducting charge estimates, and tracking the request through completion. This process complements an existing process of providing estimates to self-pay patients or other financially responsible parties who have requested this information.

We consider any initial request – made by phone or in-person – for an estimate of the charge for an admission, procedure, or service to fall within our obligation under Chapter 224. To date, DFCI has received charge-related inquiries from prospective patients, existing patients, physician practices, and health plans.

Upon receipt and processing of a request, DFCI provides an estimate of the charges associated with any service, with the caveats described below that apply to individuals who are prospective patients. Estimates requested for a specific identified service are based on current charges. Estimates requested for a full treatment plan also reflect current charges, but are assembled based on the historical utilization and course of treatment prescribed for comparable patients.

Our ability to provide estimates for individuals with a cancer diagnosis who have not received a treatment plan from a DFCI physician is limited because our physicians may approach treating a specific type of cancer in ways that differ from other physicians and institutions. To receive an accurate and meaningful estimate based on the treatment the patient would receive at DFCI, we require that potential patients with a cancer diagnosis arrange a consult with a DFCI physician prior to receiving an estimate.

In some cases, we believe individuals use this information to assist in evaluating their out-of-pocket responsibilities. In other cases, patients are more interested in whether DFCI is participating as a network provider with their health plan. Frequently, the patient or potential patient is considering a second opinion.

In all cases, as part of our standard process, we help to educate patients about the information we provide in the written estimate. In particular, we assist patients in understanding that our estimates reflect the charges associated with the relevant service, and that this does not reflect their out-of-pocket responsibility.

While our charge estimate process does not reflect out-of-pocket responsibility, we have a number of policies in place to help patients understand their individual financial responsibility and any financial assistance that may be available to them. Specifically, we support patients in managing coverage gaps; provide discounts to self-pay patients; and assist patients who qualify for financial assistance or alternative coverage in accessing those options. In each case, our financial counselors work closely with patients to help them understand the information we have provided and to answer their questions as completely as possible.

Health Care Service Price Inquiries

Year		Number of Inquires via Web	Number of Inquires via Telephone/In person	Average response time
CY2014	Qtr 1	0	14	24hrs
	Qtr 2	0	12	24hrs
	Qtr 3	0	5	24hrs

The Following Supporting Testimony for Question 9 is included in Appendix A:

Summary of Request Types

Service	Volume
MD visit	10
MD visit along with other services (labs, pathology, imaging)	7
Radiation treatment	4
Treatment	3
Drug	2
Bone marrow biopsy	2
MRI	1
CT scan	1
Mammography	1
Total	31

10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
SUMMARY:

ANSWER:

SUMMARY:

The evolution of tiered and limited network products has had a significant impact on DFCI and our patients. While we share the goal of providing high-quality care in cost-effective settings, we maintain concerns that tiered and limited network products may present undue access and financial barriers for cancer patients who require specialized treatment.

ANSWER:

Ensuring that patients have timely and affordable access to the multi-disciplinary care we provide is critical when the treatment/services required are complex, time sensitive, and/or not otherwise offered within the network – and specifically in the case of rare and complex cancers, such as pediatric cancer, leukemia, sarcomas, and bone marrow transplants.

TIERED PRODUCTS: In some cases, DFCI has been placed in the highest cost sharing tier, which poses special hardships to our patients, many of whom are receiving a course of treatment that requires multiple visits. We maintain significant concerns about the financial impact that tiering has on our patients who suffer from the burden of rare and complex cancers and are further penalized by disproportionately higher out-of-pocket payments.

TIERING & QUALITY METRICS: M.G.L. c. 176J, s. 11(b), provides that carriers tier providers based on quality measures and on the basis of either health status adjusted total medical expenses or relative prices. Quality measures typically used for tiering purposes are not applicable to a specialty cancer hospital, and there are limited nationally recognized oncology metrics that have been adopted for this purpose. In the absence of meaningful and applicable quality metrics, several health plans have placed DFCI in the highest tier based on cost alone, which we believe is inappropriate and conflicts with the intent of the legislation.

We have appealed our assignment to the highest tier in several cases. While successful in overturning our placement in the highest tier in one case, other major health plans have upheld their placement of DFCI in the highest tier, unreasonably so in our view. We believe it is in the best interest of our patients and the health plans' members for us to remain in the middle or lower tier.

LIMITED NETWORKS: Patients in limited networks who require specialized cancer treatment services may also experience undue financial burden, delays in treatment, and difficulty obtaining medically necessary services out-of-network.

When patients are referred out-of-network to receive care, the out-of-pocket caps created under §1301(c) of the Affordable Care Act do not apply, posing a disproportionately significant financial barrier for these patients. We believe that patients with rare or complex cancers, regardless of whether they participate in a health plan that includes DFCI, should have access to our Center if they could benefit from our sub-specialized, multidisciplinary care and/or our more than 750 clinical trials.

PRICING CHANGES: In an effort to address the issues and disparities that emerge when tiered products require cancer patients to pay more for care, DFCI has made deliberate efforts to reduce the cost-sharing burden on our patients, such as decreasing charges for high-tech radiology.

11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
SUMMARY:

SUMMARY:

DFCI maintains a staff of 8 psychiatrists, 8 psychologists and 25 social workers who provide holistic, patient-centered care, with a particular focus on high-needs patients, including those who may have co-morbid behavioral health conditions. We provide 6,900 pediatric mental health visits and 4,642 adult mental health visits per year. In our cost-conscious model, social workers provide the majority of mental health care because they are highly competent and less costly. Mental health treatment is provided to patients through an integrated psychosocial approach, which includes individualized assessments and access to an array of support services. However, mental and behavioral health services are poorly reimbursed, which is a barrier to integration.

a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.

In collaboration with the pediatric and adult oncology teams, mental health clinicians provide a comprehensive assessment to identify the needs of the patient and to connect him or her to the appropriate services. Patients at DFCI have access to a broad range of treatments including psychotherapy, psychopharmacology, and group therapy, in addition to specialized support services for sexual health, menopausal symptoms, bereavement, survivorship, and cognitive dysfunction, among others.

Patients who have completed active cancer treatment but are in need of ongoing mental health treatment or services are referred to community providers. Mental health clinicians work closely with our palliative care clinicians through an integrated approach to address the needs of our sickest patients and their families.

b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

Mental health treatment is integrated into our care model. Patients access mental health services by referral from oncology clinicians and/or by self-referral. We provide timely access to behavioral or mental health services if needed to prevent escalation of symptoms. Social workers evaluate high-risk patients receiving complex treatments such as bone marrow transplant; pediatric patients are evaluated by mental health clinicians based on need; and psychiatrists, psychologists and social workers are embedded on the disease center floors.

We are currently piloting an electronic distress screen that will be administered universally to outpatients throughout the cancer experience. The goal is to promptly identify at-risk patients and provide interventions to address patient needs and reduce utilization of high-cost services.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

Mental health, behavioral health, and palliative care services are not adequately reimbursed, which poses a significant barrier.

Overall, our behavioral and palliative care clinicians are co-located on the disease center floors and function as an interdisciplinary team, positioning us well to integrate care for high-risk patients. However, the challenge associated with this model is the time required for coordination, team meetings, and collaboration in the midst of high-demand clinical practices. We address this challenge in the following ways:

- Developing trusting clinical relationships among disease-focused teams of clinicians;
- Initiating a universal screening program to identify the high-risk patients; and
- Implementing regularly scheduled Patient Care Team meetings
- Initiating ad hoc meetings in-the-moment to address crises

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

We maintain clinic volume and billing data that we would be pleased to share with the Health Policy Commission or Commonwealth.

12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY:

SUMMARY:

While DFCI does not provide primary care services, we have been exploring and piloting oncology-based PCMH models that focus on referral management and care coordination between oncologists, PCPs, and other specialists on the care team.

In 2013, Commonwealth Hematology Oncology (CHO), now operating under DFCI as Dana-Farber Community Cancer Care (DFCCC), submitted an application to the National Committee for Quality Assurance (NCQA) as an early adopter of the Patient Centered Specialty Practice recognition program (PCSP), which recognizes practices that demonstrate patient-centered care and clinical quality. CHO was one of only two Massachusetts practices and the only oncology practice to seek this designation. CHO received approval on its initial NCQA corporate submission in April 2014 and DFCCC will apply for a final NCQA recognition designation for the program in April 2015.

e. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?

While DFCI does not employ primary care providers, all of our 13 DFCCC physicians participate in our oncology patient centered medical home model, which is referenced above and described in greater detail in the appendix.

f. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

Not applicable. DFCI does not provide primary care services.

g. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

We are currently in the early stages of collecting data from our oncology PCMH. We believe that our model's emphasis on clinical management throughout the cancer experience provides the greatest opportunity to improve patient outcomes and enhance the quality and value of care.

In regards to patient satisfaction, CHO conducted and DFCCC will continue to conduct a yearly survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The capture rate in 2012 and 2013 was 74% and 68%, respectively. The survey measures patient experience, satisfaction with the practice, physician communication, clinical and administrative staff, waiting time, timely access to care, and health care services provided.

In addition, DFCCC continues to partner with HPHC on a pilot program launched in July 2012, which focuses on value-based initiatives, such as measuring treatment adherence for specific cancers; education and compliance tracking for oral chemotherapy; ongoing analysis of pharmacy costs and utilization; and establishment of a relationship with behavioral health providers to promote integration.

The Following Supporting Testimony for Question 12 is included in Appendix B:

DFCCC Practice Model

The DFCCC practice model leverages a patient-centered, team-based approach to care that includes:

- **Coordination:** Referral management and care coordination among the oncologist, PCP and other specialists involved in the patient's care. This exchange of information expedites timeliness and appropriateness of the referrals and improves overall patient care.

- **Timely Access:** Providing patients with access to services, including urgent care, around the clock based on an evaluation of patient needs and preferences.

- **Leveraging HIT:** Using an electronic medical records system, including adoption and successful accomplishment of the Centers for Medicare and Medicaid Services Meaningful Use measures.

- **Culturally Competent Care:** Providing culturally and linguistically appropriate care by offering interpreter services, hearing relay services, and patient information materials in various languages.

- **Supporting Self-Care:** Providing tools, education, and assistance for patients to support self-care.

- **Clinical Management:** Providing medication management, test tracking, coordination of follow-up care, and management of care transitions.

- **Patient Satisfaction:** Measuring patient satisfaction through survey tools.

- **Quality Improvement & Performance:** Implementing a clear and ongoing quality improvement strategy and process that includes a routine review of performance data, an evaluation of the data against goals and benchmarks, and implementation of improvements based upon the data review.

13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
SUMMARY:

ANSWER:

SUMMARY:

While the HPC's 2013 Cost Trends Report highlights a number of issues and areas of opportunity, our experience in the market reflects a number of other key issues related to trends in reimbursement reductions and health plan administrative policies that negatively impact DFCI.

ANSWER:

REIMBURSEMENT:
In addition to the revenue data summarized in Section 1a, which largely focuses on commercial payors and Medicare, below is further information relative to Medicaid reimbursement:

DFCI's outpatient Medicaid reimbursement (Payment Amount Per Episode) has declined by 30% since 2011, amounting to a loss of $9 million over 3 years, due to an unexplained 60% reduction in our case mix index. Our internal review reveals that our case mix has remained largely unchanged during this time, but because MassHealth's case mix calculation methodology

is not publicly available, it is not possible for us to demonstrate that the reductions in reimbursement are unwarranted.

MANAGING COMPLEX SPECIALTY CARE:
In areas where our institution maintains a unique expertise and understanding of the different uses and clinical justifications for a test, procedure or service, we assert that decisions about the appropriate use of those services should be made by our specialty providers, and not representatives from health plans who may not hold the same level of expertise or understanding. This is especially true for oncology drugs and certain advanced lab tests, such as molecular pathology.

We use molecular pathology testing for a variety of clinically-indicated purposes including genetic screening and to inform the use of targeted therapies and personalized medicine in clinical decision-making. We regularly experience denials from health plans that place the onus on us to supply documentation and explanations to support each test, which is an unnecessary and costly administrative burden. As industry leaders in this rapidly growing field, DFCI maintains the expertise to determine and apply standards for appropriate clinical use. Health plans should not implement administrative policies to restrict use of cutting-edge services through onerous authorizations programs or denial of legitimate and medically necessary testing.

Exhibit C: Instructions and AGO Questions for Written Testimony

1. Please submit a summary table showing for each year 2010 to 2013 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Hospital Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

   Completed in Attachment AGO Hospital Exhibit 1

Responses provided in **Attachment A** (AGO Hospital Exhibit 1).

DFCI does not participate in risk-contract arrangements. Our total revenue under pay-for-performance contracts and fee for service arrangements are reflected in the attached spreadsheet.

Please note that we are unable to break out revenue at the HMO or PPO product-level as requested in the spreadsheet provided, and have therefore consolidated the revenue for each category in the HMO column, leaving the PPO column blank.

2. For each year 2010 to present, please submit a summary table showing for each line of business (commercial, government, other, total) your inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as AGO Hospital 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.

Completed in Attachment AGO Hospital Exhibit 2

Responses provided in **Attachment B** (Payor Mix Analysis and Margin Analysis).

3. Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.

Not applicable. DFCI does not participate in risk contracts.

4. Please explain and submit supporting documents that show how you analyze and track the volume of inpatient and outpatient referrals to your hospital and the associated revenue from those referrals by particular physicians or provider groups. Please include a description and examples of how your organization uses this information.

DFCI collects information on the volume of outpatient referrals to DFCI through our internal registration system. These data are not tied to revenue data, and are primarily used for education and marketing purposes, such as sharing information with clinicians about Continuing Medical Education (CME) opportunities or available clinical trials based on their disease area focus.

APPENDIX A

Supporting Testimony for **Exhibit B, Question 9**

Summary of Request Types

Service	Volume
MD Visit	10
MD Visit along with other services (labs, pathology, imaging)	7
Radiation Treatment	4
Treatment	3
Drug	2
Bone Marrow Biopsy	2
MRI	1
CT Scan	1
Mammography	1
Total	31

DANA-FARBER
CANCER INSTITUTE

APPENDIX B

Supporting Testimony for Exhibit B, Question 12

DFCCC Practice Model

The DFCCC practice model leverages a patient-centered, team-based approach to care that includes:

- **Coordination:** Referral management and care coordination among the oncologist, PCP and other specialists involved in the patient's care. This exchange of information expedites timeliness and appropriateness of the referrals and improves overall patient care.

- **Timely Access:** Providing patients with access to services, including urgent care, around the clock based on an evaluation of patient needs and preferences.

- **Leveraging HIT:** Using an electronic medical records system, including adoption and successful accomplishment of the Centers for Medicare and Medicaid Services Meaningful Use measures.

- **Culturally Competent Care:** Providing culturally and linguistically appropriate care by offering interpreter services, hearing relay services, and patient information materials in various languages.

- **Supporting Self-Care:** Providing tools, education, and assistance for patients to support self-care.

- **Clinical Management:** Providing medication management, test tracking, coordination of follow-up care, and management of care transitions.

- **Patient Satisfaction:** Measuring patient satisfaction through survey tools.

- **Quality Improvement & Performance:** Implementing a clear and ongoing quality improvement strategy and process that includes a routine review of performance data, an evaluation of the data against goals and benchmarks, and implementation of improvements based upon the data review.

ATTACHMENT A

Exhibit 1 AGO Questions to Hospitals

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. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **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.
6. **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.
7. **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.
8. **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).
9. **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.
10. **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.
11. **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.
12. **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.

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	146,757,105		2,584,155												
Tufts Health Plan	28,338,824		-												
Harvard Pilgrim Health Care	52,699,679		-												
Fallon Community Health Plan											12,955,584				
CIGNA											12,398,734				
United Healthcare											18,559,216				
Aetna											17,812,171				
Other Commercial											4,105,551				
Total Commercial	227,795,608		2,584,155								65,831,257		-		
Network Health											4,836,123				
Neighborhood Health Plan											8,385,879				
BMC HealthNet, Inc.											1,165,403				
Health New England											939,455				
Fallon Community Health Plan											-				
Other Managed Medicaid											1,223,870				
Total Managed Medicaid	-		-								16,550,730		-		
MassHealth											18,360,120				
Tufts Medicare Preferred											6,285,530				
Blue Cross Senior Options											1,043,688				
Other Comm Medicare											10,819,111				
Commercial Medicare Subtotal	-		-								18,148,329		-		
Medicare													91,845,316		
Other											55,898,064				
GRAND TOTAL	227,795,608		2,584,155								174,788,500		91,845,316		

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	144,658,487		2,350,765												
Tufts Health Plan	29,662,691		-												
Harvard Pilgrim Health Care	64,300,793		-												
Fallon Community Health Plan											12,097,524				
CIGNA											11,320,849				
United Healthcare											22,404,351				
Aetna											19,790,402				
Other Commercial											3,975,900				
Total Commercial	238,621,971		2,350,765								69,589,026		-		
Network Health											4,522,917				
Neighborhood Health Plan											13,254,886				
BMC HealthNet, Inc.											1,670,025				
Health New England											576,752				
Fallon Community Health Plan											205,726				
Other Managed Medicaid											2,206,932				
Total Managed Medicaid	-		-								22,437,237		-		
MassHealth											15,605,345				
Tufts Medicare Preferred											7,973,503				
Blue Cross Senior Options											1,669,424				
Other Comm Medicare											5,099,474				
Commercial Medicare Subtotal	-		-								14,742,401		-		
Medicare													110,723,707		
Other											58,161,105				
GRAND TOTAL	238,621,971		2,350,765								180,535,114		110,723,707		

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	139,435,089		2,698,746												
Tufts Health Plan	33,268,427		1,140,387												
Harvard Pilgrim Health Care	72,746,370		1,058,120												
Fallon Community Health Plan											11,564,867				
CIGNA											11,238,206				
United Healthcare											26,185,975				
Aetna											24,377,375				
Other Commercial											2,470,176				
Total Commercial	245,449,885		4,897,253								75,836,598		-		
Network Health											4,845,568				
Neighborhood Health Plan											15,420,383				
BMC HealthNet, Inc.											1,244,687				
Health New England											1,116,529				
Fallon Community Health Plan											108,178				
Other Managed Medicaid											2,504,900				
Total Managed Medicaid	-		-								25,240,245		-		
MassHealth											17,782,008				
Tufts Medicare Preferred											8,833,258				
Blue Cross Senior Options											2,196,319				
Other Comm Medicare											6,886,113				
Commercial Medicare Subtotal	-		-								17,915,689		-		
Medicare													132,720,478		
Other											66,595,457				
GRAND TOTAL	245,449,885		4,897,253								203,369,998		132,720,478		

2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget (Deficit)		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	135,979,546		2,620,297												
Tufts Health Plan	40,176,243		985,124												
Harvard Pilgrim Health Care	79,774,516		1,171,075												
Fallon Community Health Plan											14,063,729				
CIGNA											8,192,369				
United Healthcare											26,819,928				
Aetna											23,996,470				
Other Commercial											2,414,460				
Total Commercial	255,930,305		4,776,496								75,486,956		-		
Network Health											5,396,025				
Neighborhood Health Plan											19,198,149				
BMC HealthNet, Inc.											941,056				
Health New England											1,266,597				
Fallon Community Health Plan											306,508				
Other Managed Medicaid											1,282,214				
Total Managed Medicaid	-		-								28,390,549		-		
MassHealth											13,869,577				
Tufts Medicare Preferred											11,163,318				
Blue Cross Senior Options											4,037,070				
Other Comm Medicare											7,907,746				
Commercial Medicare Subtotal	-		-								23,108,134		-		
Medicare													144,875,875		
Other											63,055,524				
GRAND TOTAL	255,930,305		4,776,496								203,910,739		144,875,875		

Dana-Farber Cancer Institute
Operating Margin Analysis
CY10 - CY13

Payor Category	CY10	CY11	CY12	CY13
Commercial				
Total Margin	22.0%	19.1%	21.5%	21.1%
Government				
Total Margin	-11.8%	-21.6%	-16.0%	-15.0%
Other Payors				
Total Margin	31.4%	27.5%	27.8%	23.5%
All Other	-12.2%	-9.9%	-10.4%	-8.3%
Total Institute	**2.1%**	**-0.3%**	**1.5%**	**1.8%**

Dana-Farber Cancer Institute
Payor Mix Analysis
CY10 - CY13

Payor Category	CY10	CY11	CY12	CY13
Commercial *				
Inpatient Payor Mix	50.6%	49.2%	40.5%	39.1%
Outpatient Payor Mix	53.6%	52.0%	49.5%	49.2%
Government				
Inpatient Payor Mix	35.3%	40.3%	42.9%	48.3%
Outpatient Payor Mix	38.5%	40.2%	42.8%	43.0%
Other Payors				
Inpatient Payor Mix	14.1%	10.5%	16.6%	12.6%
Outpatient Payor Mix	7.9%	7.7%	7.7%	7.7%
Total Clinical				
Inpatient	100.0%	100.0%	100.0%	100.0%
Outpatient	100.0%	100.0%	100.0%	100.0%

* Commercial includes: Blue Cross, Tufts, HPHC, Fallon, Cigna, United, Aetna