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.

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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: Expenses and costs have increased, reimbursement has not changed or decreased and utilization has also remained flat or decreased. We have attempted to counter these losses by increased use of technologies and increasing efficiencies within the Center.
   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.
      Expenses per procedure have increased more than revenue per procedure from 2010 to YTD 2014. Meanwhile our utilization has remained flat or decreased over the same time period. We have attributed the lack of growth to several factors: 1) Hospital employed referring physicians changing their referral patterns to send patients to the hospital outpatient department where the cost for care is significantly higher. 2) The increase in high deductible healthplans requiring more out-of-pocket expense for the patient. 3) General economic slow-down (or slow to recover) affecting some demographic areas.
   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?
      We consistently evaluate our buying contracts to ensure best pricing in order to keep our supply cost in control. We also more closely scrutinize implants to determine the best value at the highest quality. We have analyzed our many processess and made changes to improve patient flow and/or reduce required manpower. We have matched responsibilities with resources for the most efficient use of the available skill sets. Through these actions we have been able to maintain a positive growth, in the face of decreased utilization and reimbursement.
   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?
      Technology plays a large part in our efforts to lower our costs and improve access to low-cost healthcare. We have a comprehensive web site that provides access to patients to pre-register, read about their provider, and get directions, in addition to providing general information. Our patients use an online pre-registration system which reduces the amount of phone calls, improves communication and patient safety, and creates an overall efficient registration process, thus improving

quality and patient satisfaction. The development of new a new service line in pain management will provide the community with a valuable, quality of life, resource that offers efficient and cost-effective patient care outside of the hospital based outpatient department.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
There are many regulatory agencies involved in the assessment and accountability of our ability to provide safe, high quality care in MA. There is significant overlap in what is reported on different forms for different agencies which creates unneccessary repetitive work. We feel a coordinated effort to regulate health care providers could save time and money and improve efficiency without reducing quality.

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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: We have not entered into any APM's
    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?
    We have not entered into any alternative payment methods (APMs) at this time. However, we have had discussions with some payors regarding the potential for this change. A few barriers we have come across are the agreement on appropriate measurments for a pay for performance incentive and the payor's current software / program ability to accommodate an APM.
    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).
    We have not implemented any APMs at this time.
    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.
    NA

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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: These types of measures have not been applicable to the contracts at our facility.
    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?

NA

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

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?
NA

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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: As stated previously we have not entered into any APMs.
ANSWER: However, we do feel there is potential for certain procedures to have a set of quality metrics that are measurable and meaningful. The first step is to have agreeement on what those metrics are and how they are measured. This information, coupled with price transparency would facilitate the patient's ability to find high-value care. For preventive type procedures the cost of treating a preventable disease is data that should be made available for population health management. For example, modeling the cost of a colonoscopy compared to the average cost of treating colon cancer could change the access and potentially remove access to these preventive services AND save the healthcare system money.

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY: This question is non-applicable to our ASC.

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

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

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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: The center reports data to CMS per the requirements of the ASC Quality Reporting program. CMS is the only payer to whom quality data is reported. Therefore, it is undetermined to what extent quality measures vary across payers.
ANSWER: With regards to the level of effort required, the center is assisted by a corporate partner in collecting data needed for reporting to CMS. Tools are developed by

corporate staff and utilized by the center to capture quality data codes related to CMS measures. The effort expended is nursing time to track the reportable events through the patient stay, record the data, and transmit it to the billing staff for transmission to CMS. Other measures are reported to CMS by the corporate staff on behalf of the center, such as volume data and use of safe surgical checklist. Tools have also been developed to assist in the collection of GI-specific measures ASC-9 and ASC-10. However, medical record reviews must be completed by the center and recorded after determining the starting population for review. The impact on the center is measured in staff time spent collecting the measures, which is offset by obtaining the full Medicare payment update.

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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: We are proponants of the most appropriate care at the lower-cost setting.
   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.
      Our patients are typically discharged home from our ASC so this is 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.
      Our facility is currently not actively marketing itself to the public. We rely soley on physician referrals and word of mouth advertising. Efforts are underway to begin community marketing emphasing our high patient satisfaction rate and degree of quality care. The competition from local hospitals, and the impetus to refer patients to hospital based facilities for identical services that are available at a lower cost in the community, has directly influenced this response. We strive to educate patients on the cost differential, and continue to meet with our referral sources and educate them on the cost differential.

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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: This question is not-applicable to our ASC.
   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.
      NA
   b. How does your organization ensure optimal use of post-acute care?
      NA

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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: We have not collected data on the number of individuals that seek pricing information.

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			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER: Our center has access to a proprietary pre-procedure patient payment estimator tool that estimates the procedure cost of treatment at the surgery center/endoscopy center based on the actual reimbursement for specific procedures that are scheduled to be performed. The tool also estimates the patient financial liability based on deductible, co-insurance, and/or co-payment. All patients that we see at our facility can get estimates directly from the facility. Patients appreciate knowing their financial liability and having greater transparency. We believe that more needs to be done to educate referring physicians on the cost of procedures at entities that they routinely refer to. We also spend a fair amount of time educating patients on the other charges they may encounter with this medical treatment episode such as professional reimbursement, anesthesia or pathology.

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: Our facility has had limited interaction with tiered and limited networks, resulting in negligable loss. However, despite being a low cost provider of outpatient surgical services, we may see fewer patients in the future if our affiliated physicians are

excluded from select networks or are not included in the top network tier. Narrow and tiered networks often do not take into account cost and quality.

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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: This question is not-applicable to our ASC.
    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.
       NA
    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.
       NA
    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.
       NA
    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.
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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
    SUMMARY: This question is not-applicable to our ASC.
    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?
       NA
    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
       NA
    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.
       NA

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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: All comments are incorporated in the previous questions.

ANSWER: