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:
   Worcester Surgical Center, provider of multi-specialty surgical services to our Medical
   Staff of 40 surgeons serving the greater Wrocester area, achieved an average annual operating expense growth of 4.8% from CY 2012 compared to CY 2013.
   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.

      Response - For the 3 year period ending CY2013, we experienced an average annual increase of 1.0% in case volume, 3.4% increase in cash received, and a 3.0% increase in Operating Expenses. Comparing YTD 6-30-14 to YTD 6-30-13,
      we have seen an increase of 2.8% in case volume, 3.1% in cash received, and an
      8.2 % increase in Operating Expenses. A 9% increase in Medical Supplies cost has
      been a significant factor for our increase in Operating Expenses. Some of this supply cost increase is due to case mix changes - performing more complex cases
      that have higher supply costs, as a percentage of our total cases.

   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?

      Response - We have implemented an annual wage increase of 2% for CY 2014, improved worked hours per patient to 9.75 (versus budget of 10.4 for YTD 6-30-14), and also added several new surgeons to our staff who's cases will increase our case volume and decrease our costs per case.

   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?

      Response -We are currently in a transition involving the sale of Symbion

Healthcare's majority Ownership Interest (as WSC's current General Partner) to

Tenet Health. The closing date will be determined after Tenet is notified of

approval by the State Dept. of Public Health of its request for an ASC license.

We are not aware of any changes the new Gerneral Partner will be considering

after the change in General Partner Owneship Interest.

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

Response - As a healthcare provider offering high quality outpatient surgery with 95% or greater satisfaction rates from our patients and their families, at a cost significantly lower than an outpatient department in an acute care hospital, we would encourage any systematic or policy changes that accomplish the following:

1. Maintain access for any surgeon to schedule his cases at an ASC and not be restricted by direct employment/affiliation agreements with area hospitals.

2. Payment rates to ASC's that are equivalent to HOPD rates since our costs for clinical staff and medical supplies for the same procedures are equivalent, while only receiving 57% of HOPD rates.

3. Remove/decrease the restrictions and barriers for growth of ASC's in MA, which ultimately decreases an individual's choice for a cost effective, high quality surgical provider.

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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:
As a licensed, Medicare certified ASC, we are reimbursed according to a mandated CPT system and are not reimbursed on a "fee-for-service" basis for any procedures performed at our facility, by any governmental or commercial contracted or non-contracted payer.

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?

Response - Our Surgical Center is already financially "incentivized" by our current "bundled" CPT code payment system to provide high quality clinical staff, supplies, and processes to the surgeon and his patient based on the acknowledged "Standard of Care" within the medical community. Such practices maximizes quality of care to the patient, reduce inefficiency, minimize errors, and help to control costs.

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).

Response - Since our inception in 1986, we have been on a "risk" based reimbursement system (through mandated, i.e., CMS, and/or negotiated fixed price "bundled" payments), based on CPT codes as determined by federal and private insurers. Alternative payment systems are not an option for ASC's 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.

Response - We do not have any results to share as no analyses have been performed.

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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 measures are not applicable to ambulatory surgery centers.

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?

Response - As a freestanding ambulatory surgery center, we have not had any experience with health status risk adjustment measures as they relate to changes in the patient population we serve, as they are not applicable to our industry.

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

   Response - We have no contracted payers who incorporate health status risk adjustment measures in our contractual payment agreements.

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?

   Response - Currently, we have no payers who have risk adjustment measures included in our contractual payment agreements.

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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: The information referenced in the question is not applicable to an ASC.

   ANSWER:
   As a freestanding ambulatory surgery center, our purpose is to provide surgical resources in support of the surgeon's need to surgically treat his patient, in the most cost-effective manner, with the highest quality of care possible. All necessary information to provide high quality surgical support of the physician and his patient is currently available through the surgeon's office and also our direct interaction with the patient prior to the surgery.

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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:
   Our Center is not a primary care provider, and therefore, we do not relate to the health plans in their need to attribute members to a primary care provider.
   a. Which attribution methodologies most accurately account for patients you care for?

      Response - Not applicable to our Center.

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

Response - We have no suggestions regarding implementing attribution methodologies.

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:
   Currently, we report 10 quality measures as required by CMS's Ambulatory Surgical Center Quality Reporting (ASCQR) Program on an on-going basis, with a reimbursement penalty if this reporting is not performed. The level of effort, i.e., staff time, involved in reporting these quality measures to third party requestors is fairly minimal. However, we are concerned that the cost-benefit of this effort will become too high if required informaton to third parties is not contributing sufficient value to our organization, e.g., through better quality care for the patients we serve.

   ANSWER:
   We spend about 5 man hours per week identifying quality measures (as determined by a third party) that need reporting. Our concern is the high probability that the number of quality measures (as defined by whoever wants to define a measure) will become almost endless in scope and numbers, will involve measures that have no direct benefit to our services offered, and become an all-too-consuming burden on the resources of provider organizations to maintain. We have relatively few payers requiring the reporting of quality measures, but have seen some fairly specific quality measures being requested for reporting. We are concerned that the level of detail and seemingly infinite number of measures that could be required to be reported, depending on the payer, will quickly become a major cost to providers with little benefits to their organization.

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 an ambulatory "day surgery" center and not involved in providing inpatient services.

   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 to our Center

   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.

Not applicable to our Center.

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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:

   As a provider of ambulatory surgical services, we are not an acute care facility. Our patients are scheduled for elective surgeries and discharged directly to home with minimal need for post-op care that cannot be provided by the patient's family or support person.

   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.

      Not applicable to our organization. We are not an acute care facility.

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

      Not applicable to our facility.

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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 received only one inquiry from a patient in the past two years requesting a quote for a procedure, which we provided for the procedure to be performed.

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	0	0
	Q2	0	0	0
	Q3	0	0	0
	TOTAL:	0	0	

** Please indicate the unit of time reported.*

ANSWER:

Periodically, after a procedure has been scheduled by the patient's surgeon, the patient will call our billing staff to obtain an idea of what the patient will owe, based on an estimated charge, amount projected to be paid by the insurance company, and the patient's deductible and co-insurance. The patient is not "price shopping", but trying to determine the out-of-pocket expense to be incurred. For procedures that are not covered by the patient's insurance (almost 100% are cosmetic cases performed by a plastic surgeon), we have provided a fee schedule to their offices for the non-covered procedures that the surgeon could schedule at our Center.

We have received only one call in the past two years for a quote for a procedure fee - from a patient who inquired what the self-pay fee would be for a cataract removal procedure.

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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:
As a free-standing ASC, we are contracted with most commercial and government plans, and have not experienced any effect to date from a plan's tiered or limited provider network.

ANSWER:
We are a very cost effective, high quality provider of ambulatory surgery services and, thus, included as a outpatient surgery provider option in almost any plan that an insurer would market in our area. To date, we have not conducted any analyses on this issue.

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 issue 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.

Not applicable to our organization as a freestanding ambulatory surgery center.

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.

Not applicable to our organization as a freestanding ambulatory surgery center.

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.

As an ambulatory surgery center, we are not a provider of behavioral care services

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.

As an ambulatory surgery center, our state license and accreditation certifications do not include the provision of services and/or treatment to individuals in need of behavioral services.

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

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?

Response - Unknown. We do not have any PCP's on our Medical Staff. We are not aware of whether or not any of our Medical Staff providers are recognized or accredited as PCMHs by one or more organizations.

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

N/A. We do not have any Primary Care Providers on our staff.

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.

N/A. We have not conducted any analyses concerning PCMH recognition as it is not applicable to our Center.

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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:

I reviewed both the 2013 Cost Trends Report and the July 2014 Supplement. This well prepared and documented report confirms that costs incurred in ambulatory surgery centers have a minimal impact on overall Massachusetts healthcare costs. I believe that free standing ambulatory surgical centers are a vastly underutilized lower cost option for patient's whose personal out-of-pocket expenditures will continue to increase. While not a big factor in the overall MA healthcare cost "picture", the high quality, lower cost, and "ease of use" experienced in using an ambulatory surgery center would be a great benefit to a huge number of the State's residents.

ANSWER: No additional comments.

As signator to this document, I am legally authorized and empowered to represent the named organization for the purposes of this testimony, and that this tesitimony is electronically signed under the pains and penalties of perjury, as of September 5, 2014.

Respectfully submitted on behalf of Worcester Surgical Center,

Larry Fischer

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Lawrence A. Fischer, Administrator
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