

2017 Pre-Filed Testimony Hospitals



Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts 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 2, 2017, 9:00 AM
Tuesday, October 3, 2017, 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 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, 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 6, 2017, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: <http://www.suffolk.edu/law/explore/6629.php>. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the [HPC's homepage](#) and available on the [HPC's YouTube channel](#) following the Hearing.

If you require disability-related accommodations for this Hearing, please contact Andrew Carleen at (617) 757-1621 or by email Andrew.Carleen@state.ma.us a minimum of two (2) 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, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibits B and C: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, and/or 2016 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquiries related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030.

Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

If a question is not applicable to your organization, please indicate so in your response.

1. Strategies to Address Health Care Spending Growth

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC [presented](#) at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between \$279 to \$794 million annually.

- a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
 - i. **Priority 1:** Shift care from high-cost settings (e.g., academic medical centers) to lower-cost settings (e.g., community hospitals)
 - ii. **Priority 2:** Reduce provider price variation
 - iii. If you selected "other," please specify: [Click here to enter text.](#)
- b. Please complete the following questions for **Priority 1** (listed above).
 - i. What is your organization doing to advance this priority and how have you been successful?
See Attached Priority 1.
 - ii. What barriers does your organization face in advancing this priority?
See Attached Priority 1.
 - iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
See Attached Priority 1.
- c. Please complete the following questions for **Priority 2** (listed above).
 - i. What is your organization doing to advance this priority and how have you been successful?
See Attached Priority 2.
 - ii. What barriers is your organization facing in advancing this priority?
See Attached Priority 2.
 - iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
See Attached Priority 2.

2. STRATEGIES TO REDIRECT CARE TO COMMUNITY SETTINGS

The HPC has identified significant opportunities for savings if more patients were treated in the community for community-appropriate conditions, rather than higher-priced academic medical centers.

- a. What are the top barriers that you face in directing your patients to efficient settings for community-appropriate care rather than to more-expensive settings, such as academic medical centers? (select all that apply)
 - ☐ Patient perception of quality
 - ☐ Physician perception of quality
 - ☒ Patient preference
 - ☐ Physician preference

- ☒ Insufficient cost-sharing incentives
- ☐ Limitations of EMR system
- ☐ Geographic proximity of more-expensive setting
- ☐ Capacity constraints of efficient setting(s)
- ☒ Referral policies or other policies to limit “leakage” of risk patients
- ☐ Other (please specify): [Click here to enter text.](#)

b. How has your organization addressed these barriers during the last year?

Patient perception

The false perception that only the “best” care is available at academic medical centers in Boston has been perpetuated for decades. Convincing patients that a small community hospital like Anna Jaques offers comparable care to Boston hospitals often named as top hospitals in the country in US News and World Report is quite challenging. Thus, the most expensive providers continue to attract more patients, increasing overall medical spending in a state which has among the highest health care costs in the nation. This places a burden on both families and businesses as their health care costs continue to rise – often by double digits -- every year. As a clinical affiliate of Beth Israel Deaconess Medical Center, a Boston academic medical center and a Harvard Medical School teaching hospital, Anna Jaques has seen a notable improvement in our reputation in recent years. A market study conducted by a third party on behalf of both institutions in 2016 found that affiliation is mutually beneficial and influencing patients to use both institutions. The study also found our scores related to patient loyalty and likelihood to recommend AJH are well above the national averages for a community hospital.

Insufficient cost-sharing incentives

Anna Jaques appreciates that the high deductible plans offered today are intended to foster more accountability and informed decision-making by the patient. Anna Jaques has attempted to communicate the benefits of selecting us as a high-value, lower-cost provider. Yet because society often equates low cost with low quality, touting the benefits of offering a lower-cost service can backfire, as consumers prioritize quality over cost when it comes to their health. High deductible plans have additional implications for patients and providers. First, patients who are high utilizers of health care will find they reach their annual deductible relatively quickly, and thus are indifferent to the costs that follow since the care is perceived as “free” once their deductible is met. Secondly, high deductible plans may increase financial barriers to accessing care (particularly as it relates to preventive and routine care), leaving health issues untreated in the short-term and thus driving up the cost of care long-term. Third, some patients are unable to afford or unwilling to pay for the high deductible plans they select. This leaves the hospital at risk for the unpaid balance, rather than the insurer. Finally, patients brought to the emergency room have little to no choice when it comes to selecting a provider, regardless of network affiliation or cost. Massachusetts should encourage the development of new insurance products with commercial payers that provide meaningful incentives to use lower-cost, high-value providers and contribute to the reduction of premiums.

Referral policies or other policies to limit “leakage” of risk patients

Referral patterns are engrained in both providers’ and patients’ minds and take time and tremendous effort to change. Anna Jaques acknowledges we do not have direct control over the referral process nor can we. In Massachusetts, we have seen a correlation of direct-to-consumer marketing/branding of the highest paid Boston academic medical centers that impacts decision making, while there are very few counter balancing forces (i.e. health plan design) to motivate patients to select to high-value providers. Stronger transparency and alignment of goals and incentives must be created among patients, physicians and hospitals if reducing leakage is a priority. Health plan product design for patients should better align incentives to select high-value, lower cost providers. On the hospital side, payors might consider dis-incentives for tertiary hospitals to perform community-based care. This would serve to encourage the appropriate use of resources throughout the health system and reduce overall TME in the Commonwealth.

3. INFORMATION ON PHYSICIAN COMPENSATION MODELS

Please answer the following questions regarding the current compensation models for your *employed* physicians. Indicate N/A if your organization does not employ physicians. ☐ N/A

- a. For **primary care physicians**, list the approximate percentage of total compensation that is based on the following:

	%
Productivity (e.g., RVUs)	33%
Salary	67%
Panel size	
Performance metrics (e.g., quality, efficiency)	
Administrative/citizenship	
Other	

- b. For **specialty care physicians**, list the approximate percentage of total compensation that is based on the following:

	%
Productivity (e.g., RVUs)	3%
Salary	97%
Panel size	
Performance metrics (e.g., quality, efficiency)	
Administrative/citizenship	
Other	

- c. Describe any plans to change your organization's compensation models for primary care and/or specialty care physicians that you employ.

Anna Jaques has no plans to change our compensation models at this time.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030. **If a question is not applicable to your organization, please indicate so in your response.**

1. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.
 - a. Please use the following table to provide available information on the number of individuals that seek this information. **Required Question.**

Health Care Service Price Inquiries CY2015-2017			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In Person
CY2015	Q1		
	Q2		13
	Q3		5
	Q4	4	6
CY2016	Q1		15
	Q2		5
	Q3	9	6
	Q4	4	8
CY2017	Q1		12
	Q2	3	7
TOTAL:		20	77

- b. **Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analysis.**
AJH monitors inquiries for price information as depicted in the chart above. Overall, patients have shown relatively little interest in obtaining information about the price of specific services.
 - c. **What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?**
It is difficult to provide pricing information at times because patients do not always have the full picture of what a procedure or service may involve. We strive to be as accurate as possible based on the information shared with us by the patient and with our historical care patterns of those services.
2. For each year 2014 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.
See Attached Exhibit 3, Q2.

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

i. What is your organization doing to advance this priority and how have you been successful?

As a high-value, community-based hospital, Anna Jaques is known for offering high quality care at a lower cost with a superior patient experience. Our focus in shifting more care to our institution has been to expand our services and providers locally, improve care coordination with the Whittier Independent Practice Association (IPA), and to leverage our clinical affiliation with Beth Israel Deaconess Medical Center (BIDMC) to ensure care is delivered in the most appropriate setting. These efforts have contributed to our ability to consistently grow annual patient volume and revenue, despite a host of other market challenges.

Physicians in the Whittier IPA are encouraged to refer to in-network specialists, and quarterly reports of quality measures, referral patterns, and TME leakage out of our network are distributed and discussed.

Anna Jaques' clinical affiliation with BIDMC has brought a greater number of tertiary affiliated providers to practice within the greater Newburyport community, reducing the need of patients to go to Boston for care. This fosters greater patient satisfaction, keeps care local and in a more appropriate, cost-effective setting, and reduces overall cost to the Commonwealth. Together with BIDMC, we have expanded specialty services available in the region, including cancer care, thoracic, and maternal-fetal medicine services. The hospital has also expanded its primary care base and covered lives, adding seven new PCPs over the past 18 months. We have opened and co-branded two primary care practices with Beth Israel Deaconess Healthcare, adding five affiliated physicians in Amesbury and Haverhill.

Our clinical affiliation has also enabled Anna Jaques to more seamlessly transfer patients to BIDMC when tertiary or quaternary care is needed. BIDMC is a high-value alternative to other significantly more expensive academic medical centers in Boston, thus reducing the overall cost of care for those patients who do leave the community.

ii. What barriers does your organization face in advancing this priority?

Despite our best efforts, we have seen only a modest shift in care to Anna Jaques as a high-value community provider. Referral patterns and patient choice are difficult to change without patient-centered motivation to drive decision-making. As a small, independent hospital, we also face unique challenges in offering certain specialty services (i.e. vascular surgery or rheumatology) where the volume levels are insufficient for even one full-time physician, and do not justify the cost to provide the service. Hospitals that are a part of a system with full integration between academic medical centers and community hospitals have seen more success in substantial shifts in care to lower cost, community settings.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

As stated in prior years, we believe health plans have the ability, and in our opinion responsibility, to design benefit plans that incentivize patients to use high quality, low cost (high value) facilities. They must be redesigned with meaningful disincentives for patients currently seeking community-level care at the most expensive hospitals in the state. Despite their best intentions, tiered and high-deductible plans have not resulted in a shift away from consumers seeking care at the highest paid providers. If a patient's perspective is limited to their own cost of care, which is often a \$100 co-pay regardless of the provider they choose, rather than the thousands of dollars in inequitable rate differential between providers, they won't translate their decisions as significantly impacting healthcare cost trends.

Priority #2 – Reduce Provider Price Variation

i. What is your organization doing to advance this priority and how have you been successful?

In September 2016, Governor Charlie Baker's Administration formed a 23-member Special Commission to Review Variation in Prices among Providers which was charged with reviewing the various factors contributing to price variation in physician, hospital, diagnostic testing and ancillary services, and ultimately making recommendations to the legislature to address this complex issue.

Anna Jaques Hospital President & CEO Mark Goldstein was appointed as one of three hospital representatives on the Commission. Participation in this Special Commission gave Anna Jaques a unique opportunity to have our voice heard on this critical issue which for two decades has been harmful to the hospital and the patients we serve, as well as a major contributor to the growth of health care costs in the Commonwealth. Considerable time and effort was put forth by the members of the Commission to develop thoughtful recommendations and potential draft legislation that will guide the future financing and delivery of healthcare in Massachusetts.

After months of discussion and deliberation, the Special Commission on Provider Price Variation and its three subcommittees reached a consensus and made formal recommendations which were filed with its report with the legislature in March 2017. The recommendations were based on the principles that all stakeholders must work together to ensure the sustainability of providers across the Commonwealth, and that proposed actions should not increase the total healthcare spending in the state nor cause a financial burden to patients or employers.

ii. What barriers does your organization face in advancing this priority?

Unjustified and dramatic variation in prices paid to providers for comparable care continues to disrupt the healthy functioning of the health care market in Massachusetts. We remain hopeful that the state will address this issue with a legislative solution based on the recommendations of the Special Commission that will be designed to provide both immediate and long-term financial relief to high-value, low-cost providers.

Payment disparities threaten the very viability of the hospitals on the lowest end of the payment spectrum, whose payments are 15-60% less for surgeries, MRIs, X-rays, and other medical services. Anna Jaques Hospital has consistently been one of the lowest cost providers in the Commonwealth. According to statewide relative price data, Anna Jaques rates are in the lowest quartile of all providers in the state and 30 to 50 percent less than even the median provider of the upper quartile. Payment disparity exists not only between community hospitals and academic medical centers but even among community hospitals. The impact of this disparity continues to compound year after year, as even modest rate increases of 1-2% bring the highest paid providers to ever-higher levels of reimbursement. For Anna Jaques, a 1% operating margin annually leaves scarce financial resources to reinvest into facilities to offer up-to-date equipment and technology in our local communities, further disadvantaging Anna Jaques from a competitive perspective.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

The key to the state managing healthcare costs must be the continued existence of the low-cost provider community. Anna Jaques continues to pursue a variety of market-based solutions to operate efficiently and ensure our viability into the next century. However, the sustainability of the entire community hospital system is at stake if corrective action is not taken to address this unwarranted payment disparity. Anna Jaques is hopeful that in light of the inability of market forces to self-correct this disparity, the legislature will enact policies designed to help balance the playing field and stabilize the low-cost community hospital network across the Commonwealth.

Exhibit 3, Q2:

Health Policy Commission					
2017 Pre Filed Testimony					
Exhibit C					
Item 2					
Payor		FY 2014	FY 2015	FY 2016	FY 2017
Grouping					YTD June
Commercial		-7.1%	10.5%	11.4%	13.4%
Government		-1.1%	-4.3%	-5.7%	-9.1%
Other		<u>-113.6%</u>	<u>107.8%</u>	<u>-62.8%</u>	<u>-104.1%</u>
Total		1.0%	0.9%	1.1%	0.3%

The major carriers for each section based on revenue are:

Government

- Medicare
- Medicaid
- Neighborhood Health Plan – Managed Medicaid
- Tufts Medicare Preferred
- United Healthcare Medicare

Commercial

- Blue Cross Blue Care
- HMO Blue
- Harvard Pilgrim HMO
- Tufts Associated Health Plan
- United Passport

Other

- Health Safety Net
- Self Pay
- Worker's Compensation

Although the data is summarized by the categories specified above, the underlying costs structures are consistent across the payor categories other than for utilization and resource consumption variation. The differential in rates paid by the groupings is the reason for the variation in margins.