

2017 Pre-Filed Testimony Providers



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:** Increase the use of alternative payment methods (APMs)
 - 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?

Beth Israel Deaconess Care Organization ("BIDCO") is a value-based physician and hospital network and an Accountable Care Organization ("ACO"). To deliver value to patients, commercial payers, and government, BIDCO leverages the shared skills of more than 2,500 primary care physicians ("PCPs") and specialists and numerous community hospitals, including Anna Jaques Hospital, Beth Israel Deaconess Hospital-Milton ("BID-Milton"), Beth Israel Deaconess Hospital-Needham ("BID-Needham"), Beth Israel Deaconess Hospital-Plymouth ("BID-Plymouth"), Cambridge Health Alliance, and Lawrence General Hospital. There is one specialty hospital in BIDCO's network, New England Baptist Hospital, and BIDCO has a tertiary affiliation with Beth Israel Deaconess Medical Center ("BIDMC").

BIDCO is engaging in several key initiatives to encourage care delivery in the most clinically-appropriate setting, which includes increasing the delivery of health care services in community hospitals. For example, one of BIDCO's critical functions as an ACO is to provide hospitals and providers with pertinent analytics on their ability to retain care within the BIDCO network since BIDCO is already a high-quality, lower-cost network. BIDCO recognizes that the ability to retain and redirect care to clinically appropriate community settings has the potential to further reduce expenditures and help the state in meeting the health care cost growth benchmark. To achieve this, BIDCO creates data-driven reports based on real-time EMR and claims data, which are reviewed at various BIDCO settings, including: (1) quarterly BIDCO Quality and TME Committee meetings that ultimately report to the BIDCO Board of Managers; (2) monthly PCP Advisory meetings, which are gatherings of BIDCO PCP leaders in the network; and (3) bi-monthly risk unit meetings, which are gatherings of geographically aligned PCPs and their risk sharing hospital. It is through this process whereby BIDCO's staff, including its Performance Improvement Facilitators, engage providers and help them better understand how to turn the data into actionable practice changes to address any gaps or deficiencies, including identifying gaps revealing that patients are being treated in less-than-optimal settings from a clinical and cost effectiveness perspective.

Additionally, BIDCO is also building into its newly launched data repository with Arcadia Healthcare Solutions the ability to provide real-time referral information to physicians and practices. This will include the ability to collect admit, discharge and transfer information from member hospitals along with data from hospital inpatient systems, including

scheduling, lab, radiology and ambulatory data. With this added capability, a patient's physician is notified when a patient is admitted to a skilled nursing home or is discharged from the hospital. This functionality will significantly help bridge the current IT divide between hospitals and physicians and better equip practitioners in the BIDCO network to timely intervene when a patient is seeking care outside of the community setting when it is not clinically necessary. And finally, BIDCO, Harvard Medical Faculty Physicians and Affiliated Physicians Group recently established a care retention committee to evaluate quality and access reports, which include elements that support care coordination and care retention in the appropriate setting.

BIDCO recognizes the positive impact such efforts may have on community hospital patient volume when compared to volume at the academic medical center. For example, BIDMC has experienced an increase in capacity of higher acuity cases, as growth of high acuity admissions outpaced growth of community appropriate discharges from 2011-2015 at the academic medical center. (Center for Health Information and Analysis Discharge Data). Community hospitals BID-Milton, BID-Needham, and BID-Plymouth increased fiscal year ("FY") total hospitalized patient volume by 18.1%, 21.8% and 13.9%, respectively from FY14-FY16, while BIDMC itself grew a more modest 5% over the same timeframe. (Massachusetts Hospital Association 2016). Additionally, some of these positive trends plausibly correlate to BIDMC taking ownership of its affiliates supporting the broader objective to deliver health care in the right place at the right time. For example, BID-Plymouth was acquired in 2014, which corresponds to the time period where decreasing community appropriate discharges ceased.

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

The biggest barriers BIDCO faces in advancing this priority are: (1) consumer attitudes towards care in the community setting; (2) limitations in electronic medical records; and (3) competing incentives for insurers or employers.

Though BIDCO may avail itself and its network with the data necessary to understand patient care patterns, BIDCO desires greater advancements in influencing patients' perceived notions about receiving care in community hospitals. Anecdotally, branding and hospital system rankings tend to play a large role in consumer choice, and there is a perception that quality health care may only be found in higher-priced Boston facilities or from other higher-priced providers and hospitals. The body of growing qualitative and quantitative evidence, thanks in part to the measurements found in value-based contracts, shows that this is not true. For example, BID-Plymouth's percent of patients highly satisfied increased from 61% in 2012 and 2013 to 69% in 2015 and 2016; BID-Plymouth also improved on percent of patients who would definitely recommend this hospital to friends and family, from 68% to 75%. (*The Commonwealth Fund*, "Why Not the Best", accessed September 2017). BIDCO also understands that patients approach their primary care physician with specific referral requests and physicians often times feel pressure to satisfy patient choice. Responding to the patient's desire continues to challenge the ability to truly change the way BIDCO redirects care to the community.

Additionally, since BIDCO is a diverse network of independent physician practices and hospitals, it must manage, validate and normalize patient data coming from multiple EHRs. BIDCO presently does not have the functionality to view care retention data through embedded provider directories. Though this is a functionality BIDCO is pursuing, it currently presents a significant barrier to better understanding the extent to which BIDCO is able to keep care in a clinically appropriate setting while being able to address the issue in real-time.

Finally, health plans and employers have the ability to create incentives that also cater to consumer preference, but at the same time they may challenge an ACO's ability to cost-effectively manage care. For example, small employers providing more than one offering to their employees are less likely to offer products focused on tiered, high-value networks; and employers may also require the inclusion of higher value networks because employees request having access to those options. (*Examination of Health Care Cost Trends and Cost Drivers*, Office of the Attorney General, June 2015). The proliferation of such incentives will continue to impede BIDCO's ability to keep care in the setting where it is most appropriate.

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

BIDCO recommends that state leaders continue to encourage the promotion of high-value choices including those outlined in the *Special Commission on Provider Price Variation Report* (March 2017). For example, increasing price differentials among tiers may be a helpful tool that could drive consumers toward high-value and lower-cost plans and that, in turn, would encourage patients to receive care in the most clinically-appropriate settings. BIDCO also supports increasing the premiums between limited- and tiered network plans and broader commercial plans. Such innovative product designs are most impactful when paired with the ability to relieve insurance constraints on limited- and tiered-network plans, as this would help increase adoption and consumer selection of such products.

- 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?

BIDCO exists today expressly to provide physician groups and hospitals the infrastructure to contract, share risk, and build care management systems together, with the goal of providing the highest quality care in the most cost-efficient way. Presently, covering more than 195,000 member lives in such value-based arrangements, BIDCO will continue focusing its efforts on increasing the number of lives in APMs. For example, the number of risk-lives BIDCO providers manage has nearly doubled since 2014. Though much of this growth is attributed to the expansion of the BIDCO network, BIDCO estimates that approximately 56% of its overall growth during that time period is attributable to the adoption of new risk-products alone.

While BIDCO grew, the organization continued to perform and meet the objectives of such value-based arrangements. Of particular note, during its participation in the Center for Medicare and Medicaid Institute's Pioneer ACO Model, which covered more than 56,000 Medicare beneficiaries at its peak, BIDCO achieved more than \$54 million in savings. Approximately \$26 million of that \$54 million was the federal government's recognized share.

BIDCO will continue advancing this priority by focusing on several key projects in the coming year. For example, BIDCO will participate in the MassHealth ACO Program and will serve approximately 48,500 new lives in that product. This will be the first BIDCO-wide APM in a Medicaid product. BIDCO is also currently participating in its first performance year in Track 3 of the Medicare Shared Savings Program. In this Medicare program, the Centers for Medicare and Medicaid Services ("CMS") assigned 63,000 beneficiaries to BIDCO, and there is an opportunity to increase the number of covered lives for the 2018 performance year through "Voluntary Alignment." Voluntary Alignment is a feature of the program which will allow a Medicare beneficiary to designate a particular provider as their main doctor as long as certain criteria are met. BIDCO was successful in past Voluntary Alignment efforts in increasing the number of risk-lives in the ACO by several thousand beneficiaries.

- ii. What barriers is your organization facing in advancing this priority?

There are several barriers that BIDCO faces as it continues to increase APM adoption within its network. First, a strong partnership with payers is a necessity, particularly in the commercial market. Carriers must continue to improve their flexibility and be creative with ACOs when designing APMs. Lack of entrepreneurial partnership can hinder the pursuit of new or innovative models. Additionally, payers rely upon different quality measures or risk adjustment methodologies; however, reporting on payer-specific sets of metrics decreases providers' appetites for engaging in new products while also placing greater administrative burden on BIDCO to normalize and standardize the data. As BIDCO – as well as the general health care community – is aware, providers are payer agnostic when rendering health care services and any effort to encourage the focus of treatment of the patient and reduce reporting burden on the physician, the better.

Second, population health clinical expertise is required to manage beneficiaries participating in these value-based arrangements, and it requires resources and time to fully reap the benefits of such investments. BIDCO continues

to sharpen its current clinical delivery processes, and it is beginning to see progress in how doctors across its diverse network approach population health. But the struggle rests in attempting to innovate while being cost effective. Balancing these priorities will continue to be an area of focus for BIDCO, and BIDCO is optimistic that its clinical-facing initiatives will continue to develop.

Finally, BIDCO aspires to participate in bundled payment APMs and in PPO products in the near future. Prioritizing the launch of the critical MassHealth ACO product required deferring implementation of these initiatives for the short-term. However, BIDCO anticipates furthering its collaboration with New England Baptist Hospital and other BIDCO hospital members that implement bundled payment models in the not too distant future. As for participation in PPO risk products, some BIDCO providers are reluctant to bear risk on a patient not attributed to them. Though a coalition of provider organizations and payers developed consensus attribution guidelines two years ago – a process in which BIDCO was a participant – the product is generally characterized as a consumer or employer benefit and that presumption tends to take precedence over operationalizing a value-based product that permits an ACO to effectively manage the patient population. BIDCO plans to continue educating its network and working with payers in the hope that it may launch a PPO product that will address any remaining concerns.

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

BIDCO commends state leaders for their efforts to influence and increase the uptake of APMs. As noted in the HPC's presentation at the *Health Care Cost Growth Benchmark Hearing* (March 2017) and in its *2016 Health Care Cost Trends Report* (February 2017), establishing statewide targets for HMO and PPO patients and MassHealth members may continue to encourage APM adoption. BIDCO recognizes that without an effective penalty in place, it will still remain challenging to meet the targets. Additionally, BIDCO supports public policies establishing greater alignment among APM models, particularly in regards to setting total medical expense ("TME") budgets, quality measurement and quality reporting.

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?

During the last year, BIDCO has undertaken several strategic efforts to improve the health of its providers' patients while managing TME and to obtain complete engagement from physicians and hospitals in its network to improve quality and reduce TME. Redirecting care from higher-cost settings to lower-cost settings is a key focus of that

work, and – as indicated in the previous response – it is one of BIDCO’s top priorities to reduce health care expenditures. More specifically, BIDCO has undertaken two major initiatives in the last year that directly and indirectly meet these objectives:

- (1) Implementing the Arcadia Healthcare Solutions population health software, including deployment to targeted provider sites, and
- (2) Entering into an agreement with Tufts Health Public Plans to participate in the MassHealth ACO Program as an Accountable Care Partnership Plan.

As discussed above, BIDCO relies upon actionable data in order to educate its physician and hospital network on the effects of care delivery routines. BIDCO has a well-formed deployment strategy to deliver relevant information to PCPs and hospitals, but implementation of the Arcadia Healthcare Solutions population health platform will enable BIDCO to merge and digest data in near-real time. Physicians will also have access to numerous quality improvement dashboards and cost and quality reports, as well as the ability to develop customized reports or analytics most relevant to their practice.

Second, by increasing participation in APMs, including participation in new products, such as the MassHealth ACO Program, BIDCO can more effectively engage its network with the strategies and principles associated with performance in risk arrangements. In other words, the more volume that BIDCO can shift away from fee-for-service and into value-based models, the better the opportunity to implement clinical delivery strategies on a broad scale that support population health outcomes, which includes the redirection of care to clinically-appropriate and community appropriate settings.

Engaging in these major initiatives while still conducting and improving existing activities in BIDCO’s population health management program collectively show BIDCO’s commitment to aligning its business operations with the Commonwealth’s objectives. BIDCO will move forward and continue to develop innovative, commercial solutions to the challenges that face the healthcare marketplace.

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)	
Salary	
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)	
Salary	
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.

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. Please submit a summary table showing for each year 2013 to 2016 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1**, with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue. **Required Question.**
2. When primary care providers within your organization (including, e.g., newly-acquired practices) change their preferred referral partners, are patients notified of such changes? If so, what information is shared with patients, and when?

BIDCO's unique operating structure permits its membership to maintain organizational and operational independence while benefiting from centralized clinical management activities for patients who are targeted for intervention and support. BIDCO always keeps the patient in the forefront when designing its initiatives and activities; however, BIDCO primarily provides direct support to physicians and hospitals as they engage in processes to manage a population of patients. While BIDCO continues to refine its operations and policies to support these objectives, BIDCO does not presently take an active role in notifying patients when a primary care provider's preferred referral partner changes. BIDCO's members have the ability to initiate policies regarding referral notifications that best suit their organization's needs, the needs of their physicians, and most importantly, the needs of the patients that each practice and hospital serves. BIDCO supports its network and encourages providers to focus care delivery in the most appropriate setting, and this includes notification when a provider referral pattern changes.

3. Do you participate in any provider-to-provider "discount arrangements" (e.g., a form of preferred provider relationship that includes a discount or rebate from one provider to another in connection with health care services furnished under the agreement)? **Required Question.**

☐ Yes ☒ No

If so, do you notify patients' insurers of such arrangements?

☐ Yes ☐ No