MASSACHUSETTS
HEALTH POLICY COMMISSION

2017 Pre-Filed Testimony

Hospitals

Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

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 inquires 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**: Reduce unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions)
   ii. **Priority 2**: Reduce over-utilization of institutional post-acute care
   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?

Chronically ill patients with multiple medical conditions often need the most help coordinating their care. Partners' Integrated Care Management Program (iCMP) makes caring for these vulnerable patients its top priority. The goal of the program is to help patients stay healthier longer by providing the specialized care and services they need to prevent complications and avoid hospitalizations. Our Integrated Care Management Program ("iCMP") matches high-risk patients with a nurse care manager who works closely with them and their family to develop a customized health care plan to address their specific health care needs. The care managers closely monitor the patients during office appointments and after the visit when the patient is at home using phone calls and home visits. They serve as liaisons between the patient and other members of the care team. The care managers also help coordinate services such as diagnostic tests, transportation, social services, and specialist services. The program also ensures that iCMP patients who are in the emergency room continue to receive care that is tailored to their high-risk needs. Over the past decade, about 23,580 total patients have been enrolled in iCMP. On average there are about 11,000 active patients enrolled in iCMP on a monthly basis. Currently, the program has 87 registered nurse care managers, 29 social workers, 7 community health workers, 6 pharmacists, and 11 community resource specialists.

In addition to improving health outcomes for patients, iCMP is a best practice for controlling costs. Since 10% of Medicare patients represent nearly 70% of Medicare spending, this is an important contribution to overall costs of care. By coordinating all of the care that some of our sickest patients require and monitoring their health we are able to avoid unnecessary, costly hospitalizations and keep patients at home, where they are happiest.

Partners' Mobile Observation Unit (PMOU) is a nurse-practitioner led initiative designed to address urgent, patient-care needs and prevent admission or re-admission from the Emergency Department (ED), the ED/Observation setting and also from community-based primary care practices. In CY2016, 721 patients were "admitted" to the PMOU service, primarily with cardiac and respiratory-related diagnoses.

Home Hospital is an acute care, home-based disease specific (ex. heart failure) program. Patients have a choice to receive acute level care in the home rather than inpatient with equivalent quality and safety, improved cost, and improved patient experience. Currently, one program operates at Brigham and Women's Hospital, and one at Massachusetts General Hospital.

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

Evaluating the impact of the iCMP program has been challenging for us as we do not have a control population. However, there is strong evidence to suggest that iCMP program has been successful. A recent evaluation by the Congressional Budget Office found that the Massachusetts General Hospital's Care Management for High-Cost Beneficiaries Demonstration program, which the iCMP program is based upon, reduced hospital admissions by 19 percent to 24 percent.

Other barriers include:

- *Our Care Managers have somewhat limited capacity, which limits enrollment into the program.*
- *For our pediatric iCMP program, mobilization of resources across different geographic areas presents challenges.*
- *The system-wide implementation of Partners eCare (Epic) has provided opportunities and challenges as our care managers continue to learn new systems and workflows.*
- *For our PMOU program, challenges include data collection, measuring program effectiveness and ensuring appropriate referrals.*

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

The most important policy change is the movement away from fee for service toward a system that pays for value. But once providers are at risk we must then remove the regulatory and payment requirements that were set up by the fee-for-service system. These requirements can get in the way of care coordination and can also increase administrative costs. Examples include the 3-day rule, the 2 midnight rule, prior authorization programs, and limitations on reimbursement for telehealth and other innovative, efficient care delivery methods. These payment requirements/barriers can lead to administrative burden and costs and physician burn out.

Another problem facing is the duplication of risk-based capital. Providers taking on financial risk are required to backstop that risk with capital, and yet there has been no change in the requirements on insurance companies to meet their own risk requirements. So as insurers' risk has decreased, there has been no decrease in their own risk-based capital. This duplication of risk-based capital is wasteful.

Finally, pharmaceutical costs and prices continue to be an issue that is largely out of the control of providers and yet hospitals and physicians are held accountable for them as part of their overall TME calculation. It would be helpful as part of the TME calculation for pharmaceuticals to broken out separately when TME is reported at the state level, by payer, and by physician group. Pharmaceutical costs were a major focus of last year's cost trend hearing and yet no meaningful action has been taken to date.

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?

In April 2015, Partners launched a pilot implementation of the algorithm-based naviHealth LiveSafe tool. Using patient function as a key variable, this tool predicts the optimal, first post-acute care setting, Skilled

Nursing Facility (SNF) length of stay, therapy intensity, functional improvement and burden of care following discharge from the post-acute care setting. The tool has now been effectively deployed across all of Partners. "Transition Coordinators" embedded in SNF and follows patients to collaborate with care team to manage length of stay and maximize time at home.

Additionally, Partners has been working to create, grow, and sustain a quality-based network of SNFs to provide the highest quality of care to a wide variety of patients discharged from Partners HealthCare facilities. Specific goals including length of stay, readmissions and episode costs. We are working to unite local teaching hospitals and community hospitals efforts into a uniform, integrated approach to SNF care.

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

The underlying mis-alignment of financial incentives for SNFs present challenges to collaboration around length of stay reduction.

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

The three-day rule requires patients to spend three days in the hospital before Medicare will pay for a stay in a skilled nursing facility. This forces many elderly adults to be hospitalized much longer than necessary. Under the Pioneer ACO waiver of this rule, Partners has avoided over 200 hospitalizations of Medicare beneficiaries, resulting in better care and lower costs. Providers in Massachusetts are well along the path of adopting accountability for costs of care, but there has been very little movement to reduce the payment requirements that constrain providers' options for delivering care that meet patient needs, nor has there been a reduction in the highly inefficient administrative processes required by payers, processes that add many millions of dollars of unproductive expenses to the costs of delivering care. We would recommend that the state continue to seek federal waivers to the 3-day rule and other payment rules designed for a fee for service system that hinder care coordination in a ACO model.

2. STRATEGIES TO REDIRECT CARE TO COMMUNITY SETTINGS

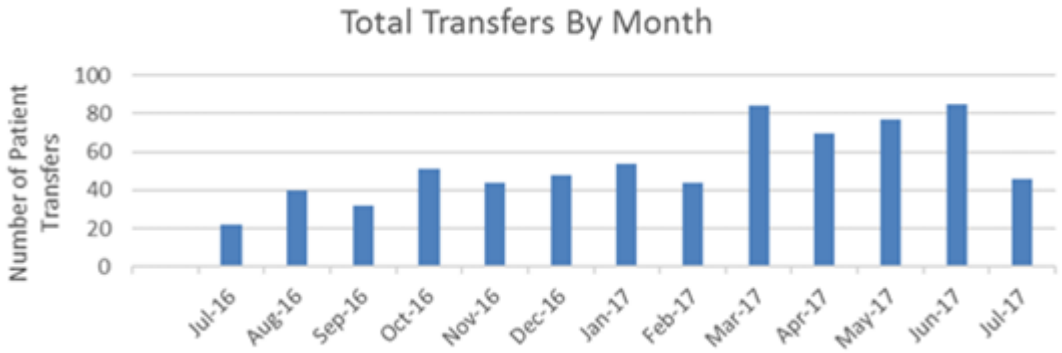
The HPC has identified significant opportunities for savings if more patients were treated in the community for community-appropriate conditions, rather than higher-priced academic medical centers.

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?

At Brigham and Women's Hospital (BWH), we have deepened the clinical integration with Brigham and Women's Faulkner Hospital (BWFH) in Jamaica Plain, as part of our Brigham Health family strategy. We have worked tirelessly to ensure identical levels of quality, patient safety, and service experience on the two campuses. The implementation of a common electronic health record system has expedited care integration. Many primary and secondary Brigham services are now based on the BWFH campus, which has helped with moving patient activity from the main campus. Finally, we have made significant strides in the BWH-to-BWFH transfer program called "Faulkner 21" where appropriate patients needing an inpatient general medicine hospitalization can be directly admitted from the BWH emergency department to an inpatient unit at BWFH. The goal of the Faulkner21 program is to transfer 21 patients each week, or 3 patients per day, from BWH to BWFH where patients can be cared for at the same level of excellence, but for a lower cost. The program is made possible because BWFH has the same quality and safety standards as BWH and because we have integrated physicians, training programs and diagnostic services, as well as an integrated medical records system to allow for seamless patient care across both campuses. The chart below outlines the increased success we've had with the program in recent months.



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)	*75%*
Salary	
Panel size	*10%*
Performance metrics (e.g., quality, efficiency)	*11%*
Administrative/citizenship	
Other *(Years since residency; BWH years)*	*4%*

Each Brigham and Women's Physicians Organization (BWPO) specialty department has its own compensation model/plan. The plan described below is for Department of Medicine, the largest specialty department in the BWPO with approximately 625 physicians. The breakdown below represents a composite for Department of Medicine; individual divisions within the department may have slight variation.

Examples of plans in other departments include revenue and expense models where physicians receive salary and incentive payments net of expenses and overhead.

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

	%
Productivity (e.g., RVUs)	*12%*

Salary	*81%*
Panel size	
Performance metrics (e.g., quality, efficiency)	*3%*
Administrative/citizenship	
Other	*4%*

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

<u>Primary Care</u>: we intend to move to a compensation model that puts a greater emphasis/incentive on panel size. In the proposed, new model panel size will represent ~ 75% of total compensation, quality will represent ~ 20%, and a citizenship-like component will represent ~ 5%. Embedded in the model will also be a minimum wRVU expectation/threshold which is in process of being determined.

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.

   Unfortunately, we are unable to provide a breakout of inquiries via different reporting methods

Health Care Service Price Inquiries CY2015-2017			
Year		Aggregate Number of Inquiries (Written, Phone, Online, and In-Person)	
CY2015	**Q1**	159	
	Q2	157	
	Q3	158	
	Q4	131	
CY2016	**Q1**	197	
	Q2	255	
	Q3	190	
	Q4	154	
CY2017	**Q1**	210	
	Q2	279	
	TOTAL:	1890	

   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.

   Timeliness and accuracy of estimates are monitored via three mechanisms. The first is a process to record start and completion times via an excel spreadsheet. The second is a verbal escalation process that allows financial counselors to notify management of any estimates that are not on track to be completed within the 48-hour timeframe required by state law. The third is a report via our EHR that can measure the accuracy of the price information provided vs. the services provided. The variance from price estimate vs. the reality of the actual cost of the service is due mainly to additional services completed during the date of service; incomplete information on the patient; and/or technical limitations of our EHR system. These limitations are being addressed at the enterprise level as well as with our EHR provider.

   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?

The largest barrier to processing timely estimates is obtaining the correct CPT/DRG codes. There are several parties within the organization that provide this information and deciphering the exact procedure a physician's office intends to perform can be a challenge. To address this issue, several of the hospitals store their historical estimates for future use on similar cases. Others also rely on their relationships with physicians' offices to obtain the correct codes. Having these codes are key to providing the most accurate price estimate. While physicians are not experts in coding, in some cases the CPT or DRG codes provided as part of the estimate are not the same once the services are provided due to complications or more accurate coding post visit.

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.

BWH Total Operating Margin (Millions) FY13 - FY16

Fiscal Year	Margin	Commercial	Government	Other	Total
FY13	Net Margin	$318.80	($151.22)	$4.86	$172.44
	Net Revenue	$1,119.05	$604.38	$64.92	$1,788.36
	Margin %	**28%**	**-25%**	**7%**	**10%**
FY14	Net Margin	$309.00	($159.98)	$5.39	$154.41
	Net Revenue	$1,112.57	$627.80	$63.63	$1,804.01
	Margin %	**28%**	**-25%**	**8%**	**9%**
FY15	Net Margin	$285.82	($187.04)	$9.16	$107.94
	Net Revenue	$1,090.58	$650.55	$73.00	$1,814.12
	Margin %	**26%**	**-29%**	**13%**	**6%**
FY16	Net Margin	$311.46	($224.47)	$4.25	$91.24
	Net Revenue	$1,143.43	$700.25	$89.18	$1,932.86
	Margin %	**27%**	**-32%**	**5%**	**5%**