MASSACHUSETTS
HEALTH POLICY COMMISSION

DANA-FARBER CANCER INSTITUTE
FINAL SUBMISSION
9.8.17

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 provider practice pattern 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?

Many oncology patients periodically experience acute medical issues related to their disease or treatment that require same-day medical attention. Due to a lack of capacity for unscheduled visits in traditional care settings, cancer patients often visit Emergency Departments (ED) to address acute side effects of toxic therapies and/or complications of their disease. Tackling this issue is crucial to improve the quality of care for our patients and to reduce unnecessary health care expenditures.

Over the past few years, Dana-Farber Cancer Institute (DFCI) has partnered with several of the largest Massachusetts health plans to analyze ED utilization by our patient population across all providers/emergency facilities within the state. Preliminary data suggest that when cancer patients are seen in an ED, they are more likely to be admitted for further evaluation and treatment than if they are seen by medical personnel familiar with cancer, cancer treatments, and typical cancer co-morbidities. Further, symptoms that are related (or potentially related) to cancer and its treatment, including non-specific symptoms (e.g., fever, rash, lethargy, confusion) require special attention in a patient with cancer. Frequently, emergency providers may not feel confident in their ability to treat oncology patients, may not have critical condition- or drug-specific knowledge, and/or may not have the training for complex symptom management of oncology patients. In addition, many cancer patients are immunocompromised (have limited or otherwise compromised immune functionality) and risk exposure to pathogens in an ED setting that can further increase the risks of illness and potentially unnecessary hospitalization. Accordingly, the ED is often not the most clinically efficient or cost-effective treatment location for patients who are under the active care of a medical oncologist and who need to be seen by medical professionals, but who do not need emergency-level services. These findings suggest that a substantial

percentage of oncology-related ED visits and admissions could be avoided – and better care could be provided to patients – through an intervention designed to offer oncology expertise on a rapid, same-day basis when emergency-level care is not required.

In response to these findings, DFCI will be piloting a new program to provide a same-day, oncology-specific service option embedded in our existing Longwood Campus facility for established DFCI patients who develop acute clinical needs. Patients will have immediate access to oncology specialists, who are familiar with their medical histories, have access to their medical records, and can triage and treat patients appropriately while providing continuity of care.

The service initially will involve extended hours on weekdays and will be staffed by a multidisciplinary team including oncology-trained nurse practitioners, physician assistants, and program nurses, with involvement from the patients' primary oncologist or care team. We expect common interventions in this setting to include intravenous fluids/electrolytes, antibiotics/antivirals, transfusions, imaging, labs, supportive care medications, pain or nausea medication, and/or patient education, among other services, to manage acute complications and symptoms. The initial pilot will include four specific oncologic disease areas (Gastrointestinal, Thoracic, Breast, and Head/Neck), which account for a large percentage of oncology-related ED visits among our patient population. We expect to expand the program to all oncologic disease areas over time. Similar models have been launched in other states and have shown positive results in decreasing hospitalizations and generating cost-savings. Accordingly, we expect this intervention not only to help ensure best clinical practice, but also to reduce overall ED utilization and unnecessary ED-triggered admissions.

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

One challenge in developing stand-by outpatient capacity is creating oncology-specific triage guidelines and processes. These guidelines are currently under construction and will help to ensure standardization in triaging cancer patients with urgent needs on a diagnosis-specific basis and to safely and efficiently manage care transitions where required.

Another barrier is managing prior authorization requirements for unscheduled services, such as imaging or administration of supportive care medications. In cases where authorization cannot be secured immediately for time-sensitive services, there is reimbursement risk for providers and the potential for unnecessary delays in delivering patient care. This barrier is addressed in part (iii) of this section.

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

DFCI is developing clinical capacity for cancer patients with acute, time-sensitive, medical needs that will offer a higher-quality, expert, and lower-cost alternative to interventions available in an ED setting. As a result, we recommend that health plans waive any prior authorization or referral requirements for established patients to utilize these services during an unplanned, urgent visit at DFCI.

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?

The DFCI Clinical Pathways program is an integrated, clinical decision-support tool, which is a key element of our quality strategy that allows us to extend expert, value-based cancer care throughout our owned and operated health care facilities by promoting adherence to standardized care pathways. Use of clinical pathways has demonstrated improved value by reducing unnecessary variation in clinical decision-making based on cancer diagnosis, stage, tumor biology, line of therapy, and patient characteristics. Since 2012, DFCI has been at the forefront of developing clinical pathways for many high volume and commonly diagnosed cancers, offering 31 distinct medical oncology pathways, with an additional 30 radiation oncology pathways currently under construction. Each pathway includes access to real-time, evidentiary-based, decision support created by nationally-recognized experts in their individual sub-specialized cancer fields, many of whom practice at DFCI. This decision support model is especially beneficial for general oncologists in the community who may not treat a large volume of any individual type of cancer, but can leverage the pathways to ensure their clinical practice is consistent with the most up-to-date guidelines.

As oncology care continues to become increasingly complex, with new drugs and therapies being approved for patients on a frequent and ongoing basis, DFCI believes that providing evidence-based and consensus-driven electronic, clinical decision support is the key to managing unwarranted variation in care with the goal to improve quality and manage cost. Pathways are constructed based on careful consideration and balancing of each potential treatment's efficacy, toxicity, and costs. When efficacy and toxicity are equal, the more cost-effective treatment is the preferred option. Early results have indicated that adherence to DFCI's Clinical Pathways reduces cost without compromising survival.

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

The primary barriers to advancing DFCI's Clinical Pathways program have been technical in nature. First, DFCI's Pathways are housed within a web-based platform which is external to DFCI's electronic health record. This requires additional time and commitment from clinicians who must navigate between the pathways platform and the electronic health record, and enter clinical data in two separate applications. This continues to be an obstacle to provider adoption, which we are working to address.

Another barrier is the rapid pace in which oncology care is changing. New, potentially practice-changing publications, therapies, and technologies appear regularly, which creates an almost constant need to update the pathways through a structured process between semi-annual updates.

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

DFCI is significantly affected by the growing burden of administrative costs associated with health plan utilization control requirements. Given the cost and complexity of services required to treat cancer, and the volume of new/innovative therapies and services we provide on a regular basis, extensive resources are expended at DFCI to ensure patients have appropriate health plan approvals in place to confirm coverage.

We recommend that the Health Policy Commission, in partnership with the Division of Insurance, convene a workgroup of stakeholders to evaluate prior authorization programs with the goal of increasing transparency and reducing unnecessary administrative burden. Specifically, the workgroup should consider and develop guidelines to address the following key issues:

- **Developing streamlined approval for treatment plans that follow established clinical pathways:**
  - Clinical pathways designed by an NCI-designated comprehensive cancer center are an evidence-based, consensus-driven approach to treating cancer. Instead of creating additional steps to authorize care for a patient's treatment on a defined pathway, adherence to the pathway should warrant approval in lieu of prior authorization.

- **Increasing transparency of health plan prior authorization programs:**

  - The criteria by which prior authorization requests are evaluated should be clear and transparent, with up-to-date metrics available to all parties. Increasingly, utilization management vendors develop and manage these programs on behalf of health plans. The evaluation criteria are not necessarily available to providers and are frequently out-of-date for specialized services such as molecular pathology laboratory testing.

  - The performance/results of health plan prior authorization programs should be made available to providers and to the Health Policy Commission. These metrics could help identify which types of radiology, drug, and lab authorization programs add value, and which programs add administrative cost to the system without demonstrable benefit.

- **Ensuring appropriate expertise for review of specialty service authorizations:**
  - Many reviewers of authorization requests have general medical expertise but lack the necessary background to evaluate care for oncology cases that include highly complicated medical histories and treatment plans. As an example, specialized molecular and genetic pathology laboratory testing is rapidly evolving and authorization programs and reviewers are not updated regularly enough to result in an efficient or appropriate exchange between the vendor and provider seeking approval. This increases the administrative burden on specialty providers to provide the relevant evidence base, which may not yet be reflected in health plan guidelines and algorithms.

- **Understanding the impact on patients and consumers:**
  - Denials and appeals can lead to significant stress and anxiety for patients with cancer. Payers and provider organizations must partner in an ongoing way to be certain that utilization management protocols do not interfere with the core mission of providing timely, medically necessary care to our patients.

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?

As the only freestanding, NCI-designated comprehensive cancer center in New England, DFCI maintains a unique role in the continuum of care in Massachusetts by providing high-quality, expert medical care to children and adults with cancer. DFCI treats many of the Commonwealth's sickest and most acute cancer patients at our Longwood Campus, including a high volume of patients with rare and orphan cancers who require tertiary and quaternary level care.

Over the last 10 years, we have developed community-based facilities, including our four hospital satellites located in Milford, Weymouth, and Brighton, MA and Londonderry, NH, as well as three DFCI-owned physician practices located in Weymouth, Lawrence, and Methuen, MA. Approximately one-third of DFCI's care is delivered in these community locations, which has increased from about fifteen percent (15%) four years ago. The purpose of building these facilities is to increase patient access to high-quality oncology care in integrated community settings. Our community cancer care model also allows our patients to utilize the diagnostic, surgical, ancillary, consultative, and inpatient services of local community providers, which helps to reduce the overall cost of care and increase convenience for our patients. Through this model, we provide high-quality cancer care in the community for less complex cases and/or ongoing treatment where appropriate, while also offering access to the novel therapies and tertiary/quaternary services centralized at our Longwood Campus, including genomic testing, complex clinical trials, and other forms of subspecialty care when required.

It is important to note that from a health planning perspective, there are certain services and resources needed for the treatment of cancer that require such specialized, complex, and costly resources that they cannot safely be replicated in the community; rather they should be available only at specialty centers. For example, engineered cell therapies, a form of targeted therapy in which a patient's own immune cells are genetically engineered to target and destroy cancer cells, are a highly-specialized form of treatment that demonstrates

extraordinarily promising outcomes in previously incurable cancers, but carries potential for significant patient risk and requires intensely complex and costly resources. Other examples include bone marrow transplantation and pediatric oncology services. For these services, there are not specific barriers to directing patients to the community, but rather, it is more efficient and safer for patients to receive such resource-intensive and highly complex care at our Longwood Campus.

Despite our efforts to develop and offer appropriate cancer care services in the community, patient and provider preferences and perceptions of quality remain barriers that can discourage patients from receiving care in local settings. To combat these barriers, we continue to educate patients and providers about our hospital facilities and physician practices, with the goal of conveying that our system is designed to ensure that patients are treated in the most appropriate location for their specific medical needs. For example, our community providers are trained to refer the most complex cases to our Longwood Campus, while our subspecialist providers in Longwood aim to direct more routine patient cases to community locations, when appropriate and consistent with patient preference. Further, the implementation of DFCI Pathways at our community sites has been a key step to demonstrate that patients being cared for at any of our hospital facilities are receiving high-quality care consistent with the recommendations developed by subspecialty experts at our Longwood Campus.

There is an important bill pending before the state legislature that would help to expand services offered in community settings through telemedicine. Providing remote access to certain subspecialized services centralized at our Longwood Campus would enhance the level of cancer care provided in the community and reduce the need for patients to travel to Boston to receive these services. Accordingly, we strongly support House Bill 578 and Senate Bill 549, *An Act Advancing and Expanding Access to Telemedicine Services*, sponsored by Representative Scibak and Senator Lewis, which would require insurers to provide coverage for telemedicine services at a reimbursement level consistent with an in-person visit. Our testimony submitted to the Joint Committee on Financial Services in July 2017 in support of this bill is attached as **Attachment A**.

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	

Part (a) is not applicable to DFCI. As a specialty cancer hospital, we do not employ primary care physicians.

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

	%
Productivity (e.g., RVUs)	**4%**
Salary	**85%**
Panel size	0%
Performance metrics (e.g., quality, efficiency)	**1%**
Administrative/citizenship	**5%**
Other	**5%**

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

Prior to the start of each new academic year (July through June), DFCI evaluates and updates the compensation model for the majority of our employed physicians based on an assessment of institutional priorities and initiatives related to key areas such as quality, patient safety, compliance, patient access, and/or efficiency. We identify appropriate metrics in these areas that become part of our physician compensation structure and bonus plan for the upcoming year. The bonus includes payments that relate to productivity (e.g., RVUs), performance metrics, and administrative leadership roles. For example, one metric this year links bonus compensation with physician use of our Clinical Pathways system described in Question #1(c). The priority initiatives for next fiscal year have not yet been identified but will be completed in the spring of 2018.

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.

Health Care Service Price Inquiries CY2015-2017			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In Person
CY2015	**Q1**	0	19
	Q2	0	35
	Q3	0	32
	Q4	0	9
CY2016	**Q1**	0	6
	Q2	0	4
	Q3	0	24
	Q4	0	7
CY2017	**Q1**	0	17
	Q2	0	15
	TOTAL:	**0**	**168***

**Note: 14 of the 168 requests were cancelled by the requestor. Upon communicating with a Financial Counselor, the requestor was no longer interested in receiving an estimate. Reasons included that the requester was planning to obtain care at another facility or the requester was actually interested in other information related to their insurance coverage, which was addressed during the discussion with the Financial Counselor.*

   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.

DFCI periodically samples the accuracy of price estimates provided to patients by comparing the estimate to actual charges incurred based on the clinical services a patient received. Physician, staff, and patient feedback regarding DFCI's delivery of estimate information is also collected. Over the course of several years, improvements have been made based on the feedback we have received to increase the accuracy of estimates. Examples of such improvements include adjusting estimate charges for medications based on the patient's weight and height for dosing purposes, as well as adjusting the physician treatment request template to query if high-cost supportive agents, diagnostic radiology, and/or radiation therapy are likely to be needed.

DFCI tracks all patient-requested price estimates in its Price Estimate Request Tracker. The tracker includes the patient demographic and insurance information, the date of the request, a summary of the specific request, and the date a Financial Counselor provides a written estimate to the patient. A manager reviews the tracker regularly to ensure estimates are presented within the targeted timeframe of 2 working days from receipt of the request. Seventy-five percent (75%) of estimates from Q1 CY2015 through Q2 CY2017 were provided on the same day of the request. Eighty-five percent (85%) of estimates were completed within 1 working day. In rare instances, estimates were not able to be provided within the targeted 2 business day timeframe (6%). Typically, these infrequent delays are a result of staff not being able to reach the patient for additional information regarding the request or complicated estimates that require input from other resources (e.g., retail pharmacy).

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?

We often learn that patients contacting us for price estimates are actually looking for other types of information. While a patient initially may ask for a price estimate, further discussions often reveal that the patient is interested in other information such as his/her out of pocket expenses (e.g., outstanding balance based on the time of year or coverage for specific services). DFCI's Financial Counselors work directly with patients to ensure all of the patient's questions are fully addressed. DFCI's Financial Counselors also clearly explain verbally, and in the letter that accompanies the charge estimate, that the estimate does not represent the patient's actual personal financial responsibility, which often is the key information patients are seeking. Patients are encouraged to discuss any questions about their coverage or benefits with a Financial Counselor. As part of this process, we offer other financial resources to uninsured and underinsured patients consistent with our Financial Assistance Policy (FAP).

Additionally, consumer inquiries regarding individual services such as high-tech radiology (e.g., MRI, PET/CT) often can be easily and accurately addressed at the time of inquiry by referencing DFCI's charge schedule. However, there are barriers to producing an accurate and timely estimate for a comprehensive cancer treatment plan due to the complexity and duration of oncology services. To help mitigate this challenge, DFCI typically produces treatment estimates based on charges incurred by 3-5 comparable patients who previously received the proposed regimen. However, there is significant variation in the charges incurred among cancer patients based on the duration of treatment, the doses of medications prescribed, the patient's size and comorbidities, as well as side effects of treatment that require supportive care, which all impact the accuracy of an estimate. In addition, as cancer treatment becomes increasingly personalized, it is more difficult to provide an accurate price estimate based on comparable patients given the level of treatment variation between patients with similar diagnoses. In order to address these complexities, DFCI educates the patient about the estimate

process and the information provided, and explains verbally, and in writing, that the charges may vary based on the actual services received. DFCI's long-term goal is to pull significantly larger numbers of comparable patients from its database in order to provide a more statistically supported estimate.

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.

The data requested on margin and payor mix, and the list of carriers/programs are provided in Excel format as **Attachment B**.

DFCI does not have any payor contracts that incorporate a per member per month budget. We do not look at revenue or margin based on HMO business and PPO business. In general, there are very few payor contracts where there is a reimbursement impact based on HMO or PPO; in cases where there are, there is a very small difference between the two.