MASSACHUSETTS
HEALTH POLICY COMMISSION

2017 Pre-Filed Testimony

Providers

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**: 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?

Lahey Health System's ("Lahey") model is predicated on delivering care in the most cost-efficient and clinically appropriate setting across the system. Lahey has advanced this priority through the establishment of a patient transfer policy whereby lower-acuity services are delivered in the community hospital setting (e.g. Beverly Hospital, Addison Gilbert Hospital, and Winchester Hospital) and higher-acuity services requiring tertiary and quaternary care are delivered at Lahey Hospital and Medical Center ("LHMC").

Lahey's hospital transfer policy has achieved significant success as more than 1,000 transfers from LHMC (Burlington and Peabody locations) to Beverly Hospital, Addison Gilbert Hospital, and Winchester Hospital have occurred since Lahey's inception in 2012. As a result of this policy, and in combination with other clinical integration activities, Lahey's community hospital volumes have increased (versus a trended decline pre-affiliation), CMI has increased, and patients are treated closer to their home and families. At the same time, LHMC's census has remained at near full capacity and its CMI has increased. These results, in combination, have presented significant cost savings opportunities as a greater share of care is delivered in a community setting (versus an AMC or teaching hospital) and sicker and more complex patients are treated in a lower-cost tertiary setting without having to out-migrate to certain downtown Boston hospitals that are significantly more expensive and without any difference in quality.

Lahey has also invested in reducing unnecessary ED utilization by creating and expanding urgent care capacity in its service area. Lahey currently delivers urgent care services in Burlington, Woburn, and Wilmington and has a co-branding relationship with Carewell at urgent care centers located in Billerica, Lexington, Peabody, and Tewksbury. Lahey recognizes that urgent care services can help reduce unnecessary readmissions by offering more convenient access for certain conditions at a significantly lower cost (cost difference ratio of approximately 10/1 between the same services in the ED setting versus urgent care). Furthermore, urgent care facilities located in Lahey's primary service improve access by not requiring advanced appointments as can be the case with primary care, can

decrease wait times in the ED, and increases acuity level in the ED setting. Due to these factors, Lahey plans to open facilities in Danvers, Gloucester, and Lynnfield in order to meet patient need and to help the state decrease rates of unnecessary ED utilization.

Lahey has also attempted to reduce unnecessary institutional post-acute care through the establishment of its extensive home health network, Lahey Health at Home (LHH). LHH is actively participating in system-wide initiatives to coordinate care across the continuum. LHH works closely with Lahey ACOs, hospital care managers, physicians groups, skilled nursing facilities, and community organizations in an effort to create initiatives around hospital avoidance. LHH uses best practices to provide the highest quality care in the lowest cost setting, which is in the home.

LHH is currently integrating and standardizing care from three legacy home health agencies into one organization. LHH currently functions as two branches, located north and south of the service area, and its goal is to completely cover the Lahey service area.

LHH's leadership team is working with Lahey's human resource department on a recruitment campaign to increase our workforce capacity, so that we can expand our presence in the Lahey service area and develop programs to best meet the needs of home health patients. With strong satisfaction scores, LHH strives to be the employer of choice for home health clinicians.

LHH is actively promoting and growing palliative and hospice programs. LHH educates and collaborates with system providers in those practice areas to develop programs to increase access and enhance quality in those much needed specialties.

LHH is promoting a "Call Us First" program in an effort to have patients contact their home health provider instead of presenting to the ED for a condition that can be safely and effectively treated in the home setting. Educating Lahey physicians about the benefits of this program is critical in developing and building-out this high-quality and cost-effective service. LHH continues to offer educational programming in order to teach Lahey providers about LHH programs and maximize awareness across the system.

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

Lahey's successes in shifting care to lower-cost settings are a result of many different factors (e.g. the patient transfer policy described above); however, the key driver is through fulfillment of mission. Lahey was formed and organized around the principle of shared governance, where each legacy organization has an equal voice at the system level. Through this governance structure, Lahey established clinical integration guiding principles and formal physician leadership councils in order to form a culture of care centered around providing the highest quality of care as close to the patient's home as possible. These structures encourage physicians to admit and refer patients to lower-cost community settings and serve as a vehicle of endorsement for Lahey practices and policies that further its mission of providing care in the most clinically appropriate and cost-effective setting. The cultural and physician alignment barriers that existed pre-affiliation (and otherwise exist in the market) can be overcome by strong leadership and endorsement of practices that maximize the use of high-quality, lower-cost, care settings.

Shifting care to lower-cost settings is generally not in the best interest of a provider from a purely financial perspective. Consumers of health care should be rewarded for making value-based decisions, or electing to receive care in lower-cost settings. The state and industry could make more progress in shifting care to these settings if provider, payer, and consumer incentives were aligned, and tangible and significant benefits accrued to those who made care decisions based on value.

Progress in this space will be limited until that type of alignment occurs, and high value purchasers will continue to subsidize, without their knowledge, low value providers.

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

Consumers, patients, employers, and other purchasers of health care must be financially rewarded or accrue a meaningful benefit for making informed and educated care delivery decisions based on cost and quality. The state has made meaningful progress in implementing value-based arrangements between payers and providers, where providers can earn a surplus or avoid a deficit for directing care to lower-cost settings. This type of cost-sensitive framework should be applied more aggressively in the purchaser-insurer relationship. The Attorney General's concept of an insurance product based on a primary care providers' total medical expense efficiency is a strong example of this. It proposes the type of cost differential (in the form of premiums at the point of PCP and plan selection) necessary to meaningfully motivate consumers to access care in lower-cost settings and at lower-cost providers, which is inherently aligned with provider strategies to deliver care in lower-cost, community-based settings. Furthermore, to the extent feasible, health care insurance premiums should be evenly distributed to spread the risk of illness, and not the choice of provider.

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?

Lahey participates in APM contracts with major commercial payers, in the Medicare Shared Savings Program, and the MassHealth ACO Program. While Lahey has traditionally participated in APMs in the commercial HMO book of business, Lahey more recently entered into an APM with Blue Cross Blue Shield and Cigna for the PPO segment. Lahey also holds other smaller shared savings contracts with other payers. Shared savings arrangements are intended to be a precursor to full risk arrangements. Lahey's strategic goals include expanding participation in APMs with payers we don't currently contract with and increasing the net patient service revenue in existing APMs by certain benchmark dates.

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

Lahey's participation in APMs and general tolerance for accepting risk is predicated on its ability to perform successfully, achieve savings, and reduce exposure to downside risk. The capacity to perform successfully requires significant investment in population health capabilities, including care management, data analytics, and patient engagement tools. The resources to fund these types of investment are constrained by significant downward pressure on reimbursement across both government and commercial payers. Commercial payers are limited by the cost growth benchmark, Medicare and Medicaid reimbursement is flat or negative, and medical expense inflation is approximately double the rate of the revenue or reimbursement trend. These factors in combination significantly limit providers' ability to deploy the necessary resources to meet quality and financial performance targets and their tolerance for entering into higher-risk and broader risk sharing arrangements. If the state's policy goals are grounded in a shift towards population health, the state should encourage appropriate and sustainable resource allocation for providers to be successful in APM arrangements.

The state should also recognize that providers are more likely to achieve savings under APMs if the actuarial soundness of its covered population is stable and predictable. This requires covering a large enough population so that unforeseen claims experience and outlier costs do not materially change the claims experience of the covered population. In essence, the larger the population covered, the more

likely it is that providers can achieve savings, and in turn, the more likely it is that providers enter into more advanced APM arrangements with a greater share of revenue at risk.

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

The resource disadvantage of providers that are lower-cost and efficient has been well-documented in numerous state reports. Because the cost growth benchmark inherently reinforces this disadvantage, an adjustment could be made to the benchmark so that efficient providers can grow at a rate greater than the rate of less efficient providers. If this change were to occur, lower-cost, efficient providers would have greater resources to deploy the population health tools that are integral to expanding their presence in APM arrangements.

The cost growth benchmark could incorporate flexibility relative to provider infrastructure costs to ensure that providers have the resources necessary to be successful under APMs and risk contracting. MassHealth has acknowledged the importance of population health infrastructure funding through its Delivery System Reform Incentive Payment Program (DSRIP), and this same recognition should also be applied in the commercial space.

APMs alone will not solve our current market dysfunction. Many high value ACOs and provider organization will need greater regulator flexibility to grow highly integrated systems that will create demand in the market for value-based services.

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?
See 1.b.ii.

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)	~71
Salary	~17

Panel size	~3
Performance metrics (e.g., quality, efficiency)	~9
Administrative/citizenship	0
Other	0

* Salary refers to base salary. Lahey has various primary care employment models across the system. In some instances, the productivity component is not completely independent from the salary component.

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

	%
Productivity (e.g., RVUs)	~2
Salary	~92
Panel size	0
Performance metrics (e.g., quality, efficiency)	~3
Administrative/citizenship	~3
Other	0

* Salary refers to base salary. The salary component is loosely correlated to the productivity component because it is based on prior performance year productivity (RVUs).

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

Lahey has ongoing discussions relative to its compensation model for employed and specialty care physicians. To retain and recruit a high performing employed physician network, Lahey must adjust and adapt to a constantly evolving and competitive market. Lahey's overall approach to compensation is centered on motivating physicians to enhance access, improve quality, and reduce costs.

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?

   Patients are generally not notified if primary care providers (PCPs) change their preferred referral partners; however, patients who access care in the Lahey system generally understand that Lahey PCP are affiliated with Lahey hospitals and other Lahey care settings and providers (e.g. urgent care centers, skilled nursing facilities, and behavioral health locations).

   If a new practice is acquired, Lahey sends a patient notification letter announcing the change in practice name and subsequent affiliation. If the practice is remaining in network, the letter notifies the patient about a potential notification from the insurer, and to contact the insurer if the patient would like to remain with the provider. If the network is changing, the letter notifies the patient about a potential notification from the insurer, and that no action is required on the part of the patient. If the acquired practice has a contract with a payer that does not have a contract with Lahey, Lahey sends the patient a notification letter alerting the patient of the impending change. These letters are sent about 45 days prior to the acquisition date.

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