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.

Statement that signatory is legally authorized to represent MACIPA, signed under pain of perjury
I, Barbara Spivak, MD, the President and Chairman of the Board of the Mount Auburn Cambridge Independent Practice Association, Inc. am legally authorized to represent MACIPA, signed under pains and penalties of perjury.

Date: 9/7/17

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 over-utilization of institutional post-acute care
   ii. **Priority 2**: Reduce growth in prescription drug spending
   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?

-MACIPA works closely with our five preferred skilled nursing facilities (SNFs) which treat the highest volume of our patients. A MACIPA Case Manager partners with the SNFs and attending physician to facilitate and assist in coordinating care for our patients. The Case Manager meets onsite weekly with our preferred SNFs to review and track patient goals, progress and barriers to discharge, as well as the services that are available to patients returning to the community. This collaboration with the SNFs improves the quality of patient transitions back to the community, and decreases the overall average length of stay in the SNF.
Successes include:

- The average length of stay for our ACO has decreased from 25 in 2011 to 14.1 in the first quarter of 2017.
- For our 5 preferred SNFs, (which represents 58% of our admissions) our average length of stay has decreased from 26 in 2011 to 11.8 for the first quarter of 2017.
- For our Medicare Advantage population, MACIPA's average length of stay for 2016 was 12.66 compared to 13.55 for the rest of the network.

-Beginning in June of 2017 MACIPA entered into an arrangement with Patient Ping, which provides notification of ACO aligned beneficiary admissions and discharges at hospitals and SNFs. Prior to this implementation we knew of facility admissions only when a patient was discharged from Mount Auburn Hospital. Now we receive real-time notification when admissions occur at a large number of facilities which allows us to communicate with the facility, share information, and facilitate safe and timely transitions back to the community.

-In 2017, as a Track 3 Medicare Shared Savings Program participant, MACIPA began utilizing the SNF 3 Day Rule Waiver when appropriate. Forty patients have been admitted to SNFs via the 3 day waiver. The earlier admission to the SNF enables the more intensive physical therapy and recovery process to begin. This shortens the SNF length of stay and is a benefit to the patient. As an example, 15 patients who otherwise would have been admitted to the hospital for 3 days prior to a SNF, were admitted directly from the ED under the 3 Day Waiver rule, and benefited in their recovery process from starting their physical therapy treatment sooner.

-Beginning in 2016, MACIPA partnered with TMP to develop a SNF rounding and post discharge program. A Nurse Case Manager from TMP is onsite at 3 of our most highly utilized SNFs. She rounds on our TMP patients and discusses the care plan and post discharge plan with the patient's PCP. In 2017 she began providing post SNF discharge home patients who were identified as a high risk for SNF bounce back or readmission.

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

One challenge is the lack of incentives that hospitals with which MACIPA is not sharing risk or is not otherwise clinically integrated (i.e. other than our community hospital partner Mount Auburn) have to collaborate with us on discharge planning. Greater collaboration could result in more patients going home with appropriate supports rather than being transitioned to a SNF.

A second challenge is the way that Medicare reimburses SNF care. The current system does not reward them for efficient lengths of stay.

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

Adjustments to the Medicare payment policy for SNFs that would align payment more closely with measured quality, efficiency, and outcomes would be helpful in improving overall post-acute care utilization. The current payment model does not incorporate metrics or incentives for facilities to improve the quality of care for their patients and/or reduce costs. If a quality incentive payment model was established for SNFs similar to a value based model for physicians, payments would be linked to performance and one could argue better outcomes for the patient, a reduction in length of stay and perhaps bounce back rates.

Clarification on existing vague SNF admission criteria that Medicare and other insurers utilize for transfers to post-acute facilities would be beneficial. The current criteria recognizes the degree of professional judgment that must be exercised in making each admission determination, but that also leads to unnecessary admissions that could be managed in the community. Well-defined, objective criteria with room for clinical judgment would be beneficial.

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?

MACIPA has established several programs that will reduce the growth and/or prevent more complex and expensive pharmaceutical treatments. Preventing diseases is key to improving the health of patients and keeping rising health costs under control. Chronic diseases, such as heart disease, cancer, and diabetes account for majority of the nation's health spending. By promoting preventive services, we hope to eliminate or reduce the need for pharmaceutical treatments that would occur if diseases/conditions progressed. Examples are below.

- *MACIPA has a full time Pharmacy Director*. As a member of the MACIPA senior management team, he works with our physicians and their support staff to optimize the effectiveness, safety and cost of medication therapy for all patients. He also works with MACIPA's Medical Directors, Quality Staff and Care Management Department to develop new strategies to improve patient care. For patients with uncontrolled chronic conditions and gaps in care, the pharmacist works with physicians and other providers to recommend medications and dosing regimens tailored to each patient's unique needs.

-*MACIPA's Pharmacy and Therapeutic Committee* manages an internal drug formulary. This committee meets quarterly and consists of the Pharmacy Director, physicians and members of our quality team. The mission of the committee is to utilize current medical literature, free of drug manufacturer bias, to promote the appropriate use of medications that are safe, efficacious and cost-effective. This process guides prescribing toward the most clinically appropriate, cost effective and evidence-based choices, with a focus on generics. These efforts results in lower net cost of medications for MACIPA patients, their employers and health plans. In addition, the MACIPA's pharmacist is also a member of the Mount Auburn Hospital Pharmacy and Therapeutics Committee

-*Metabolic Team.* This consists of the Quality Improvement Director, Pharmacy Director, PCP/Endocrinologist, Health Coaches, and Practice Facilitators. This initiative is focused on systematically tracking diabetic and hypertension patient outcomes and providing support for practices to manage their diabetic and hypertensive populations. This includes recommendations made by the team to minimize the patient's financial impact/ out-of-pocket costs for prescription drugs.

-*Systematic Case Review Team.* This consists of Health Coaches, Social Worker, Pharmacy Director, PCP/Endocrinologist, Cardiologist, Pulmonologist, and Psychiatrist. This team reviews high-risk patients and communicates recommendations to the PCPs, taking into account a holistic approach for each individual in addition to incorporating behavioral and psychosocial care with the medical recommendations. Health Coaches, who have direct contact with patients, create, deliver, and support a strong and well-rounded patient-centered plan. The Pharmacist and Specialists work together to optimize the pharmaceutical treatment plan with more appropriate and lower cost treatment options for patients reviewed by this team.

- *MACIPA's Quality Improvement department* focuses on promoting preventive health services such as Cancer Screening, Vaccinations, and Well Child Visits. Detecting issues early through screenings and preventive care help our patients stay healthier, and avoid or delay the onset of diseases requiring expensive drug therapy or other costly treatment modalities. The QI Bonus Program provides an incentive for providers/practices to focus on these preventive health services.

Implementation of a new integrated EMR across the MACIPA network has occurred for most of the MACIPA physicians and the hospital during 2017. This enhances information sharing across primary care and specialty providers who make up the patient's overall care team. In the EMR we have implemented an alternate messaging system that diverts providers to generics as alternatives to high cost medications. This being done at the point of care, provides a more effective method of redirecting providers to lower cost alternatives while not compromising the care of the patients. Further optimization including automated medication alerts to alternative lower cost drugs will help advance the priority of reducing growth in prescription drug spending.

Examples of success

There is an increase in the overall patients who are in goal at the time of discharge (vs. time of enrollment) for the HbA1c, BP and PHQ9 NCQA metrics.

- For the patients enrolled and discharged in the SCR program in 2016 and early 2017, 83% were in control for A1c (A1c<9) at discharge. This was up from 56% at goal at time of enrollment.
- Almost 97% of members were in control for their blood pressure reading at discharge from the program. This was up from 89% when enrolled.
- The PHQ9 survey showed that 70% of patients were in goal (<9) at enrollment, and by discharge 90% of the members had reached target.

Health Plan Performance

- BCBSMA: For 2016, our RX PMPM is trending 2.5% better than network averages. (MACIPA (-2.8%); Network (– 0.3%)). *(BCBSMA- MACIPA-INS HMO Ins medical expense by service category report 04/30/2017)*

- HPHC: For 2016, our RX PMPM is trending 12.7% better than network averages. (MACIPA (-6 %); Network (6.7%)). *(HPHC-PMPM (HPHC Liability) medical cost by year -by expense type)*

- THP: "MACIPA's pharmacy costs in aggregate are 9% below the Tufts adult HMO Network" – (*Data Review and Performance Discussion Q4 2016 Data TMP presented on June 22, 2017)*

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

We are continuing to improve our communication to all practitioners, including mid-levels, about low cost/effective prescription options. We are working with our EMR vendor to improve information dissemination for our physicians at the time the prescription is ordered. Alerts to certain generics or lower cost drugs have been added but this will continue to be more robust during the optimization phase of the EMR implementation.

Patients are seeing more advertisements for medications on television and on the internet, and develop an expectation of need without having all the facts about cost, efficacy, and side effects.

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

MACIPA supports a reexamination of Chapter 258 of the Acts of 2014 (MA drug formulary commission - abuse deterrent formulations of Opioids). It was an important first step but more work is needed. We support the mission to prevent the abuse of narcotics. The approach is costly with no proven benefit; as outlined by an independent non-profit research organization (ICER).

The ubiquitous advertisement of prescription drugs, especially through televised ads are a barrier to this priority. Benefits are exaggerated, risk are minimized or not understood, and there are no references to cost. A ban on these advertisements is needed.

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): Physician Recruitment, Patient perception of needing to go to a well-known Boston hospital

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

-There are continuing efforts to promote more use of our local community hospital, Mount Auburn Hospital. Mount Auburn Hospital offers more than the typical community hospital services since it is also a teaching hospital and is more cost effective than using a quaternary medical center.

Our PCPs are, in addition to the many other tasks they need to handle, continually working on improving referral management and encourage the use of a MACIPA specialist. MACIPA and Mount Auburn Hospital recently implemented a fully integrated EMR for most of our physicians and the hospital, which helps provide integrated care within the MACIPA network. The goal is to keep promoting this to physicians and patients along with the advantages of staying within our system.

-MACIPA physicians are expected to refer to specialty providers within the MACIPA network to facilitate better care management and cost-effectiveness. New providers have a formal orientation where the expectation and information about the network, as well as the specialist expertise within the system, is provided. New specialists meet with our physician leaders to discuss the services they provide and to develop relationships. We monitor leakage on a quarterly basis with our PCPs. We have also monitored access to specialists and have worked with our specialists to improve access. Integration of nurse and social work case management have also helped to decrease leakage and has had the effect of directing more patients to Mount Auburn Hospital verses other hospitals.

Example of success: For our largest commercial payer we were able to reduce our inpatient admissions to non-Mount Auburn Hospitals by over 5% from 2014 to 2016

-In the summer of 2017 MACIPA launched a new website. One feature is a user friendly physician directory so that PCPs can easily look up specialists in the network.

-MACIPA employs a full time PCMH facilitator who has worked with MACIPA practices on PCMH transformation. Sixteen primary care practices (comprising 66% of our PCPs) are recognized by NCQA as Patient Centered Medical Homes. MACIPA works diligently with practices to provide timely access to services. The trust cultivated by our providers has a strong influence on the retention of patients within our system. As part of PCMH, we work with the practices to promote our specialists and other services available at our community hospital with patients and families. MACIPA providers have strong collaborative relationships that are evidenced by the continuity of care and the information sharing in our EMR. Our team approach to care creates an environment of respect and collaboration with patients and families regardless of their medical conditions. A goal for 2018 is to achieve PCSP recognition in our specialty practices and these efforts will help retain our patients within our community hospitals/specialists.

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.
Required Answer: Click here to enter text.

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.**

Exhibit C: AGO Questions for Written Testimony

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?

New physicians are expected to refer within the MACIPA network. Referrals to specialists are discussed at the patient's visit with their PCP.

We do not believe the information necessary for PCPs to make informed decisions around cost is available to them and thus to their patients at this time and would encourage better and more user friendly access to this information when a PCP needs to refer out of network.

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