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**: 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?

Our internal incentive program (the Internal Performance Framework) for physician compensation includes a site of care incentive in the overall TME calculation. This incentive has encouraged our sites to create access/transfer plans from high cost to low cost settings.

We proposed a merger and reorganization of our relationship with the Hallmark Health System in order to more fully utilize Lawrence Memorial Hospital in Medford as a low cost site of care for MGH patients, similar to the way the BWH and Faulkner Hospital are configured. Since this transaction was not approved, and it

appears that Lawrence Memorial will close as an acute care facility, it is likely that more patients from that community will seek care at MGH rather than fewer.

In addition, over the last year we have created programs at both the MGH and BWH to transfer willing ED patients to Newton Wellesley when they present with a secondary diagnosis that requires hospital admission. This program has successfully transferred 103 patients since December 2016 to date.

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

Please Note: The numbers below reflect compensation for community primary care physicians employed by Partners Community Physicians Organization, Newton-Wellesley, and North Shore Physicians Group. Physician compensation varies considerably across the system. Please see the responses of the Massachusetts General Hospital, Brigham and Women's Hospital, and McLean Hospital to see our other compensation models.

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

	%
Productivity (e.g., RVUs)	*84%*
Salary	
Panel size	*8%*
Performance metrics (e.g., quality, efficiency)	*7%*
Administrative/citizenship	
Other	*1%*

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

	%
Productivity (e.g., RVUs)	*97%*
Salary	
Panel size	
Performance metrics (e.g., quality, efficiency)	*3%*
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.

Partners Community Physicians Organization is currently undergoing a formal review of our physician compensation models, with the goal of implementing new models in the coming year. At the core all of the models (for both primary care physicians and specialty care physicians) is a plan to transition major portions of the basis of physician's compensation from productivity to various value based performance metrics (e.g. panel size, quality, patient engagement, administrative/citizenship). These transitions occur over a multi-year period to reflect the evolution of changes in the regulatory and reimbursement environments, while providing for elements of stability and predictability of compensation for our physicians.

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.

   See attached.

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?

   Primary care providers within our organization have established referral patterns and those generally do not change. If such change occurred, then patients would be notified at the point of service when discussing referral options with their primary care provider(s).

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)?

   ☒ Yes ☐ No

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

   ☐ Yes ☐ No

   In general, we do not notify the insurer. However, we have one arrangement where the insurer is aware of the arrangement.