MASSACHUSETTS
HEALTH POLICY COMMISSION

2017 Pre-Filed Testimony

Hospitals

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

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The Hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled Hearing dates and location:

Monday, October 2, 2017, 9:00 AM
Tuesday, October 3, 2017, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 6, 2017, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube channel following the Hearing.

If you require disability-related accommodations for this Hearing, please contact Andrew Carleen at (617) 757-1621 or by email Andrew.Carleen@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibits B and C: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, and/or 2016 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030.

Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.
If a question is not applicable to your organization, please indicate so in your response.

1. Strategies to Address Health Care Spending Growth

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC presented at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between $279 to $794 million annually.

a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
   i. **Priority 1**: Increase the use of alternative payment methods (APMs)
   ii. **Priority 2**: Reduce unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions)
   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?

Berkshire Medical Center (BMC) has worked with its medical staff to develop a physician hospital organization called Partnership for Health in the Berkshires (PHB). PHB has partnered with the local federally qualified health center, Community Health Programs (CHP) and Fallon to create a Model A Partnership ACO in the Massachusetts Medicaid program. This program will begin March 1, 2018 and will be the PHB's first exposure to alternative payment models. The partnership will focus on reducing non-medically necessary utilization with a focus on emergency services that could be offered in a less intense setting, admissions and readmissions, and high tech imaging services. Berkshire Medical Center has some experience reducing post discharge emergency services and readmissions through the HPC's CHART program. BMC developed a neighborhood for health on the North Adams campus of BMC and focused on preventing follow up emergency and readmissions for patients who had been admitted at BMC. The program leveraged community health workers, social workers, behavioral health specialists, and advanced practice providers. BMC was able to reduce utilization for this population with the exception of those community members suffering from substance use disorders. BMC plans to use this experience, the clinical integration work of the PHB, existing partnerships with the behavioral health providers like the Brien Center and Fallon's long standing experience in managed care to optimize the care delivery system in Berkshire county.

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

With the nearest alternative providers located about 50 miles to the east and 40 miles to the west, BHS providers and facilities serve all of Berkshire County, a region of the Commonwealth that has experienced a steady decline in population for forty years. From a high of 149,402 in 1970, the population of Berkshire County was, as of the 2010 census, 131,219—averaging a 3.2% decline each decade. The projected population estimate as of July 1, 2016 from the census bureau is 126,903, a 3.3% decline in this five year time period.
The Berkshire County population is comparatively older and poorer than the rest of the Commonwealth. The region has proportionately fewer children and younger adults and more older

adults and elderly than in the Commonwealth as a whole. The population is split by age cohorts as follows:

	2010	2016
Persons under 18 years	19.5%	17.3%
Persons 65 Years and Over	18.6%	22.2%
Persons 18 to 65 Years (calculated)	61.9%	60.5%

The county has faced daunting challenges in employment opportunities for years and the median household income and average per capita income are substantially below the statewide numbers. Despite having county health rankings for quality of healthcare services of 5, (near the top of the 14 counties in Massachusetts), Berkshire County ranks 12th in overall health outcomes largely due to health behaviors and social and economic factors.

The county is large in area at 927 square miles (about the land mass of Rhode Island) with low population density of 142 residents per square mile. Public transit services are limited and not available at all to many residents who reside in the more sparsely populated parts of the county, making access to healthcare difficult for many residents. Broadband access is similarly limited with many parts of the county unable to achieve dependable internet or cellular telephone connections.

Although BHS directly provides many of the critical health services in the county, the entire healthcare delivery system in the region relies on BHS to provide support, stability and sustainability.

BHS has had a collaborative partnership with the Brien Center (the main outpatient behavioral health and substance use disorder provider in the Berkshires) for nearly 30 years. BHS provides clinical leadership to the Brien Center that helps to manage patients during their transitions between inpatient and outpatient services. For many years, BHS has recruited and employed the physician and advanced practice provider staff working at the Brien Center. Without this relationship, the Brien Center would not be able to recruit and retain these professionals. The Brien Center struggles with a consistent cash flow and BHS has established long-term funding and repayment programs with the Brien Center to help support their day to day operations.

BHS also has a long and positive relationship with the local federally qualified health center, Community Health Programs ("CHP"). CHP was created with the grant support of BHS and continues to be supported with ongoing IT support, recruitment assistance and grants to help renovate and otherwise improve the facilities of the CHP clinic locations. BHS works with CHP to transition struggling private primary care groups into CHP. The most recent example of this is with Berkshire Pediatrics in Pittsfield. It is the largest pediatric group in Pittsfield and will be transitioning to CHP on August 1, 2017.

For well over a decade, BHS has provided support to the remaining private physician practice groups in the form of recruitment loans (in accordance with Stark regulations) to assist the groups during provider transitions and to ensure improved or at least continued access for the community. More recently, physicians in Berkshire County (the average age of whom is above 50) have found that the payer mix available to them is inadequate to compete in the national recruitment market for the next generation of physicians. The problem became BHS' to solve, which could only lawfully be done by hiring those physicians directly. Unlike other health systems around the nation that may have taken on physician practices and other services in order to expand their market reach, BHS has, for years, done so only to

preserve the existence in the county of those practices and services. In Berkshire county, there are no more admissions or ancillary testing to be gained. From the physicians' and community's point of view, the access crises seem to be averted when BHS assumes responsibility for a practice or service, however, the financial challenges of the absorbed practice or service continue and have simply been transferred to BHS.

Three years ago, when North Adams Regional Hospital ("NARH") abruptly closed its doors BHS stepped in to reopen emergency services. Together with the support of then Governor Patrick, Secretary Polanowicz and others, BHS reestablished a walk in clinic at the Massachusetts College of Liberal Arts campus until it could open a satellite emergency facility ("SEF") on the former NARH campus seven weeks later. Instead of simply inviting north county residents to come to BHS' central county locations for care, BHS systemically began the process of reestablishing services on the former NARH campus. Today the community enjoys access to emergency services, imaging and surgical services, multi-specialty clinics, retail pharmacy, renal dialysis, wound and cardiac rehabilitation. The challenges of providing services to this sparse population across such a geographic expanse is best illustrated in renal dialysis services. With all renal dialysis patients in the county concentrated at a single, central location, the service was financially challenged enough to be unattractive to any potential commercial providers. However, because of the geographic and transportation challenges in the county, many patients who needed this vital service were going without it. After considerable deliberation, BHS followed its mission and divided the service into three locations, exacerbating the financial challenges but making the care accessible.

All of these issues create an environment where our healthcare delivery system acts less like a service market and more like a public utility. The community cannot afford to lose any of the services provided by BHS or the remaining providers in the community.

The lack of concentration of population in the county makes some of the proposals outlined in the Medicaid ACO rate development more challenging in Berkshire county than in other parts of the Commonwealth. The most obvious proposal is the LANE adjustment (low acuity, non-emergent). As mentioned earlier BHS reestablished a SEF on the North Adams campus. The SEF sees an average of 45 patients on a daily basis. BHS conducted a study with a consultant to identify where and how many urgent care clinics could operate effectively throughout the county. That work demonstrated that it was not feasible to open up urgent care clinics in the north or south portions of the county. It only made sense to have an urgent care clinic in the Pittsfield area, because it is the only part of the county with sufficient population concentration. Because a free-standing urgent care clinic was not sustainable in north county, BHS decided to open a walk-in clinic attached to its primary care practice in Williamstown. The walk-in clinic has been open for over a year and only sees on average 6 patients per day. This volume does not justify the walk-in clinic or the consideration of after hour office hours in primary care practices. Given this backdrop, the LANE adjustment seems to disproportionately harm the Berkshire provider community relative to more urban areas across the state.

It is the small population size and statewide adjustments such as this that don't recognize some of the disparities in Berkshire county that can create unintentional barriers to the success of APM's in Berkshire county. We will continue to pursue telehealth and other services to help improve access to the community and provide care at the right time, in the right place to our patients.

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

We would recommend the continued development of the recognition of social determinants of heatlh that impact the cost of providing care to the members of the community. Homelessness is certainly one of those determinants but other considerations like household income, education levels and heatlh habits should be considered as well when developing payment rates or overall budgets.

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?

Berkshire Medical Center continues to look at reducing healthcare expenditure with a focus on unnecessary hospital utilization of emergency department visits, admissions and readmissions. Current efforts are scoped under a COO-lead Continuum of Care Committee. Amongst the working subcommittees, the Familiar Faces Committee has been tasked with this initiative. This multidisciplinary team has constructed practice-based, high utilization data bases that further subdivide patient utilizations as ED visits, admissions and readmissions. Identified high resource utilizing patients are considered for individual Advanced Illness Management (AIM) plans. This template plan is constructed to provide precise and pertinent summaries with structured recommendations based on emergency department presentation, known effective inpatient course strategies and medico-psychosocial community-based longitudinal plans. On ED arrival, AIMs are flagged to the patient tracker to facilitate an organized cost-effective plan of care. Pertinent strategies, barriers to care, and key stakeholders and contacts are identified and contained within each plan. AIMs, while office-practice generated, are inputted with pertinent medical-surgical subspecialty, clinic activity, behavioral health resources, case management, and the emergency department insights. Familiar Faces maintains the registry, tracks utilization, templates new entries, and facilitates plan addendums and edits to integrate system wide care delivery.

While still early in the rollout process, there has been notable success to date. A subset of three patients with significant behavioral health/substance use disorders had AIM plans developed and communicated across psychiatry, addictions services, case management and primary care. These three patients had combined for 29 admissions over the past 12 months. Since their AIM plan introduction (6 months running), combined, only one admission has been incurred (noting one patient has been incarcerated for a couple months). There would appear to be ample opportunity to further impact such healthcare expenditure as we further populate the registry, construct and educate plans, and operationalize the program across the county.

Instrumental to success will be the integrated and organizational aspects facilitated by Familiar Faces but created and maintained within community based practices. It will be imperative that primary care practices have enabled practice managers, care coordinators/navigators, community health care workers, and social workers to create these plans, monitor utilization, and update frequently to keep process current, effective, and manageable. This needs to be front door embedded throughout the community.

Soon to follow will be supplementing this effort with pertinent telehealth services. Whether to open access, “check-in”, triage, and follow-up on post-acute care needs, or navigate subspecialty care, telehealth can offer a wide variety of support services. Incorporation of telehealth covered services within Massachusetts is a necessity. We are very much behind the national effort here. Operationalizing such plans with telehealth supports services will undoubtable assist in efforts to control healthcare expenditures. Facilitating a network care team inclusive of community health/social workers and supporting telemedicine payment reform are major challenges ahead.

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

As noted above, the integrated care team is instrumental to reducing hospital utilization. These services are typically not reimbursable causing practices to hesitate to adopt these models of care.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
Telemedicine services are critical to the most efficient deployment of critical clinical and support services to this population. It is imperative that these services are reimbursable so that telemedicine can become part of the care delivery tool kit.

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?
Berkshire Medical Center shares its quality outcomes with the community as well as the medical staff.

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)	7.3%
Salary	87.4%
Panel size	
Performance metrics (e.g., quality, efficiency)	
Administrative/citizenship	5.3%
Other	

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

	%
Productivity (e.g., RVUs)	10.0%
Salary	88.4%
Panel size	
Performance metrics (e.g., quality, efficiency)	
Administrative/citizenship	1.6%
Other	

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

The organization has the right in most of the compensation agreements to introduce performance metrics for a portion of the physician compensation. This is under discussion but no plans have been put into place to initiate this process.

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. Required Question.

Health Care Service Price Inquiries CY2015-2017			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In Person
CY2015	**Q1**		
	Q2		
	Q3		
	Q4		23
CY2016	**Q1**		19
	Q2		11
	Q3		18
	Q4		15
CY2017	**Q1**		35
	Q2	2	15
	TOTAL:	2	136

   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.

- Management periodically samples the completed spreadsheets to review the accuracy of the cost estimate determination. Any discrepancies are reviewed with the appropriate staff and reinforced in periodic educational sessions.

   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?

- One barrier encountered is the ability to manage the price estimates for same day services. To overcome this barrier we have gathered together a list of most commonly performed same day services and corresponding codes (CPT). Another barrier is that patients are often not aware of exact procedure code (CPT) so it takes time to research, which involves contacting the office for exact CPT code. To minimize this a list of the various services with the corresponding CPT codes has been developed for easy retrieval. A third barrier is one medical service may often have multiple codes and costs, which can vary by provider, making the estimate time consuming and causing delayed responses to the inquiries.

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.

BERKSHIRE MEDICAL CENTER

Payor Mix (% of gross revenue)	2014	2015	2016	2017 (YTD June)
Commercial	27.97%	27.07%	28.43%	27.64%
Government	68.64%	70.47%	70.08%	71.09%
Other	3.39%	2.45%	1.49%	1.27%
	100.00%	**100.00%**	**100.00%**	**100.00%**

Operating Margin by Payor					
Payors		**Commercial**	**Government**	**All Other**	**Total**
	Fiscal Year	**Operating Margin ($)**	**Operating Margin ($)**	**Operating Margin ($)**	**Operating Margin ($)**
Grand Total	**2016**	**73,055,645**	**-36,071,996**	**-14,587**	**36,969,062**
Grand Total	**2015**	**66,444,159**	**-34,778,208**	**-49,372**	**31,616,579**
Grand Total	**2014**	**56,547,506**	**-30,704,970**	**-516,189**	**25,326,347**

Among the commercial payers are Aetna, Blue Cross, Cigna, Harvard, Health New England, Tufts, United Healthcare. Government payers include Medicare, Medicaid and Managed Medicaid products. Free Care and self pay make up most of the all other payer group. Berkshire does not calculate the operating margins between product types. The amounts presented above do not include the losses incurred by Berkshire Health Systems for its physician practices which have grown over the past three years.