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**: Required Answer: Choose an item.
   Increase the use of alternative payment methods (APMs)

   ii. **Priority 2**: Required Answer: Choose an item.
   Reduce unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions)

   iii. If you selected "other," please specify: N/A

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?

   Boston Medical Center (BMC) and Boston Medical Center Healthnet Plan (BMCHP) have long been committed to reducing health care costs and improving health outcomes by embracing alternative payment models and the evolution to publicly financed accountable care has given us more opportunity to flourish as a health system. BMC is the leading force in the Boston Accountable Care Organization (BACO) which participates in risk-based contracts with the major private payers, is a successful participant in the Medicare Shared Savings program and is participating in the MassHealth ACO pilot. BACO –which has evolved to include a slightly different composition of health centers as well as adding hospitals and health centers outside of Boston - and Boston Medical Center Health Plan (BMCHP) were also recently selected as a participant in the full MassHealth ACO initiative launching early next year. BMC and BMCHP are also in joint ventures with 3 other hospital systems: Mercy, Signature Brockton and SouthCoast for their ACOs. In total, we will be responsible for the health care and outcomes of 180,000 MassHealth members.

   Our approach under the new MassHealth model will incorporate collaborative planning and implementation of medical management programs, enhanced integration of behavioral health, installation of new case management and analytics systems, leveraging community partnerships and sharing financial risk and reward for quality and utilization performance. We have formed workgroups with all of our JV partners, successfully submitted planning year budgets to the Executive Office of Health and Human Services, begun implementation of our new IT systems and will be ready to go live on March 1. We have successfully met all our internal and external milestones for ACO readiness.

The BMC health system (BMCHS) is well positioned to succeed in the MassHealth ACO because of our deep understanding of both the health and social needs of our MassHealth patients and the many programs we have to address those. For example, BMCHS has many innovative programs to treat addiction which do not generate any margin in a traditional fee-for-service system, but which help create the best health outcomes for our patients. BMCHS has also designed an innovative program for babies born with neonatal abstinence syndrome (NAS). BMCHS replaced the traditional treatment that separated mother and child and relied on significant medication for the infant, with a model that keeps the mother and child together and nearly eliminates the need for medications. This approach reduced the average length of stay from 19 days to 9, nearly eliminated the need for medications, promoted breastfeeding and reduced the likelihood of readmissions.

BMCHS solidified its leading role in addiction treatment this year with a $25 million donation to create the Grayken Center for Addiction Medicine, which is dedicated to combatting the disease of addiction by furthering and disseminating its innovative research and treatment programs, training and research.

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

BMCHS has experienced barriers in its work to succeed under risk-based contracts as it has tried to address social determinants of health and substance use disorder. Having an impact on, and trying to reduce, the total cost of care for our patients/members involves addressing both medical and social determinants of health. Social determinants of health and substance use disorder represent unique challenges in reducing cost and improving quality for our patients and require greater financial investments and time before we can see improved outcomes.

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

In order to succeed under the ACO Model, the BMC health system requires sufficient funding for infrastructure and staffing investments in the complex needs of our patients/members. The total costs of care budgets through the various forms of payment need to recognize the unique challenges of care improvement in underserved populations to successfully address all the factors adversely affecting health outcomes for underserved patients.

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 order to reduce unnecessary hospital utilization, BMCHS has focused aggressively on high-risk patient case management and, related to this, reducing unnecessary readmissions.

For example, BMCHS and BACO have established a high-risk case management program. We have focused on the top 3% of patients who account for 40% of cost and a significant percentage of hospitalizations and Emergency Department (ED) visits. This effort is requiring enhanced support for hospital discharges and transitions of care to outpatient settings for patients at risk of readmissions, and improved case management support in the ED to safely return people to home or other outpatient settings when clinically appropriate.

BMCHS has integrated and consolidated its varied departmental readmissions initiatives into one centralized program to ensure consistency and to take full advantage of all resources for data analysis and timely provider feedback. At the core of the new program is a Readmissions Risk Assessment (RRA) Tool BMC developed and embedded into its electronic health record (EHR) to

allow for a real-time, customized readmission risk assessment. The tool links a static data warehouse with a live, dynamically-calculating EHR tool. The RRA tool is now used for the majority of BMC patients and categorizes patients according to their risk for readmissions. After identifying these high-risk patients, BMC deploys high-value interventions during their inpatient admissions and after discharge. This may include pharmacist admission and discharge medication reconciliation, negotiated follow-up appointment scheduling, enhanced needs assessments and case management involvement, and post-discharge outreach calls. As a result of these efforts, BMC has reduced unnecessary readmissions to any hospital (not only to BMC).

ii. What barriers is your organization facing in advancing this priority?
Required Answer: Click here to enter text.

In order to succeed in high-risk case management and readmissions reductions, we face specific barriers. For example:

- *Engaging patients: The majority of our patients' lives are complicated by the burdens of poverty. Our patients - who are often not native English speakers, have lower than average education levels- have low health literacy, experience housing instability and have lives that are challenged by other social factors. This requires us to be more vigilant in our case management and innovative and diligent in our approaches to medication adherence and patient outreach.*

- *Identifying the real cause of readmissions: For the at-risk population BMC serves, the seeming causes of readmissions may not reflect the actual factors (like lack of a support system and behavioral health issues that influence patient compliance) that bring patients unnecessarily back to the hospital.*

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

Here again, in order to succeed in effective high risk patient management, BMCHS and BACO require sufficient funding to address the total cost of care for our socially complex patients. BMC wants to commend and thank MassHealth for including homelessness and behavioral health factors in their risk adjustment methodology for the new ACO framework. Recognizing those factors in health in the ACO rates will be crucial to our ability to succeed with all our patients.

For patients outside of our ACO, the availability of data continues to be a challenge. Timely information is a barrier to measurement. While some hospitals have executed agreements which aggregate ADT feeds, not all facilities participate. We recommend that the Commonwealth continue its efforts to improve its data reporting capabilities.

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?

In order to succeed under an ACO structure, the BMC system must ensure that patients receive efficient care that is, where possible, community based. In order to address patient and physician preferences that may favor more expensive care settings, BACO and BMC have worked to assure adequate options for quality care in community settings. The BACO network, for example, includes 10 community health centers. BMC and BACO have also executed preferred provider arrangements with skilled nursing facilities and home healthcare organizations so that patients can receive care in affordable, community-based settings. With adequate patient choices in place, BMC and BACO will begin educating both patients and physicians about the benefits of navigating within the BACO network where care team members can easily communicate.

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.

BMC does not directly employ its physicians. However, all clinicians practicing at BMC are actively engaged in execution of the ACO. The hospital is collaborating closely with the Faculty Practice Foundations and Boston University School of Medicine to evolve physician compensation practices to align with the ACO paradigm.

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. 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**	0	3
	Q2	18	61
	Q3	33	125
	Q4	22	111
CY2016	**Q1**	25	84
	Q2	24	115
	Q3	33	90
	Q4	17	71
CY2017	**Q1**	21	114
	Q2	26	130
	TOTAL:	219	904

   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. Required Question: Click here to enter text.

   BMC continues, as described in our previous year's testimony, to monitor and analyze consumer requests for price information. Calls received by customer service or Financial Counseling are recorded on a price transparency log and we have established a specific email distribution group who is notified of inquiries. The inquiries are then added to a central tracking document, which is monitored daily, to ensure a timely response. The central document and emails to the distribution group record detailed information about the request and assigns responsibility for follow-up. We also document the CPT code and price equivalent to the code provided.

   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?

Required Question: Click here to enter text.

BMC continues to face some level of difficulty in obtaining the clinically appropriate CPT codes which are not always readily known or available. To solve this, we created a Self-Pay Inquiry form for clinics to complete and send to Patient Outreach to further document the process. Price inquiry emails and logs are saved in Outreach price inquiry folder for future reference. It is also difficult to understand the application of benefits from respective payers. Sometimes this is conditional based on specific diagnosis codes and as a provider, we don't always understand the contract exclusions which make is difficult to provide estimates. We will explain the situation to the patient and ask them to contact his or her insurance company as well, to ensure that they are getting a complete and accurate answer.

Required Question: Click here to enter text.

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.
Required Question: Click here to enter text.

	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
2014 GRAND TOTAL	57,892,366	(7,197,226)	71,335,306	(20,809,900)	300,837,042	(36,859,410)	281,412,467	(49,478,887)	5,828,389	(5,533,000)	4,603,932	(6,734,510)	364,557,797	(49,589,636)	357,351,705	(77,023,297)
2015 GRAND TOTAL	53,194,144	(8,474,657)	72,731,558	(19,363,479)	315,696,203	(41,776,889)	295,750,615	(54,614,965)	5,631,558	(6,250,578)	4,807,643	(8,727,174)	374,521,905	(56,502,124)	373,289,816	(82,705,618)
2016 GRAND TOTAL	68,205,698	(4,119,908)	94,878,023	(17,961,113)	329,019,051	(44,945,272)	301,834,466	(82,902,095)	3,937,387	(1,973,703)	4,245,982	6,611,323	401,162,136	(51,038,883)	400,958,471	(94,251,885)

2016 Margin by payer and program

Payor rollup	Payor Type	Payor	Net Revenue	Margin
Government	Indigent	Free Care	31,001,228	(1,660,802)
	Medicaid	Comm Care BMCHP	11,036,571	2,968,931
		Comm Care Other	9,660,093	(6,551,810)
		HMO Medicaid BMCHP	108,981,731	19,285,610
		HMO Medicaid NHP	34,393,604	(11,331,322)
		HMO Medicaid Other	24,260,417	(12,943,850)
		Medicaid	156,304,441	(60,740,133)
		Other	607,552	(817,418)
	Medicare	BCBS	2,475,284	(178,193)
		EverCare	727,700	(113,846)
		HMO HPHC	-	(537)
		HMO Medicare	41,596,145	(10,290)
		HMO Tufts	7,464,179	(2,824,961)
		Medicare	180,741,282	(20,991,019)
		Other	2,196,591	(482,214)
	Government Total		**611,446,818**	**(96,391,854)**
Commercial	Commercial	BCBS	45,171,398	(10,011,469)
		Comm	20,581,430	(2,969,567)
		HMO HPHC	29,546,435	(5,667,609)
		HMO NHP	7,366,556	(468,366)
		HMO Other	12,749,933	(3,238,274)
		HMO Tufts	7,116,635	(4,289,726)
		Other	3,392,297	(1,191,713)
	Medicare	BCBS	1,018	(1,412)
Commercial Total			**125,925,702**	**(27,838,136)**
All Other	Other	Comm	358,422	(314,994)
		Other	3,926,634	(6,184,291)
		Work Comp	4,219,798	(1,699,225)
	Self Pay	Other	187	(1,795)
		Self Pay	1,934,160	(6,777,447)
All Other Total			**10,439,201**	**(14,977,752)**
Grand Total			**747,811,721**	**(139,207,742)**

2016			
Payer Mix	Inpatient	Outpatient	Total
Commercial	17%	24%	20%
Government	82%	75%	79%
All Other	1%	1%	1%
Total	100%	100%	100%