MASSACHUSETTS
HEALTH POLICY COMMISSION

2017 Pre-Filed Testimony

Providers

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

Exhibit A: Notice of Public Hearing

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

Scheduled Hearing dates and location:

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

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

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

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

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

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

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

Exhibits B and C: Instructions for Written Testimony

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

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

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

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

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

Exhibit B: HPC Questions

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

1. Strategies to Address Health Care Spending Growth

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

a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
   i. **Priority 1**: Shift care from high-cost settings (e.g., academic medical centers) to lower-cost settings (e.g., community hospitals)
   ii. **Priority 2**: 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?
   UMass Memorial Health Care has been actively working for several years to provide the highest quality care in the lowest cost setting.

   UMass Memorial Health Care includes three community hospitals (Clinton Hospital, Health Alliance Hospitals and Marlborough Hospital) in addition to UMass Memorial Medical Center which is comprised of three campuses (University, Memorial and Hahnemann). We have been actively encouraging optimal use of our community hospitals to provide lower cost options for patients whose clinical needs can be met at these lower acuity hospitals. We have recently hired an experienced clinical administrator who is leading our patient flow improvement program. She has demonstrated experience in developing and creating the systems needed to identify and efficiently move patients who would otherwise have been admitted to our University campus to our Memorial campus or to one of our community hospitals. We are already seeing much progress since June 2017. Patients are more effectively triaged in the emergency department and once a decision is made to admit, beds are identified and offered at the other campuses where the care can be closer to the patients' homes and/or where the clinical expertise is best for the patients' illness and acuity. Beds are then freed up at the University campus to accommodate incoming med flight patients and higher acuity transfer and surgical needs. This effort will be greatly enhanced when our entire system goes live on Epic on October 1, 2017. Everyone will then have the ability to get real-time information on bed capacity across our entire system (see below).

   For patients that present in the emergency department who do not need to be admitted we have begun new triage and care coordination efforts. As appropriate, we now connect patients with either skilled nursing facilities or home care agencies who can provide the right level of care while avoiding unnecessary and costly admissions. To facilitate coordination of care, we have established a preferred provider arrangement with a home care agency network and a preferred network of skilled nursing facilities based on objective quality measures to which we can, in many cases, directly admit subject to patient and provider choice.

On October 1, 2017, we will formally merge our Clinton and Health Alliance Hospitals. This merger will allow us to better utilize capacity at these two hospitals with improved access thereby allowing patients who would otherwise have been treated at the higher cost tertiary medical center in Worcester to receive care in the lower cost community setting closer to the patient's homes and caregivers.

We also have a large network of community based services including primary care, specialty care and an extensive behavioral health and substance abuse network which provide cost effective services outside the inpatient setting

In addition, as we have expanded our population health infrastructure and are moving into alternative payment arrangements when upon review and evaluation the arrangement provides reasonable and responsible risk levels. The Medical Director of our ACO has regular meetings with our providers through various venues to continue to educate them on the concept of value based care – the right care at the right time at the right place. We place significant value, time and expense on working with our providers on their quality measure reporting, documentation and adherence. Not only is it important to provide high quality care, it is important to document appropriately so that these measures can demonstrate that quality to our patients and payers.

Some initiatives that have been, or are in the process of being implemented that further this goal of providing care in the appropriate lower cost setting are –

- the opening of several Urgent Care Centers through a joint venture with CareWell to move visits from our Emergency Departments that can be taken care of in a lower cost setting
- the construction of a new Ambulatory Surgery Center through a joint venture with Shields to provide a lower cost option for surgeries that don't need to be performed in the inpatient setting
- building a new psychiatric hospital in Worcester through a joint venture with HealthVest so we can transfer fewer patients out of the region for inpatient psychiatric care and create additional space for medical surgical beds at the Medical Center to reduce boarding in our emergency department
- the expansion of our telemedicine capabilities, such as
    - eICU and Telestroke services which enables clinical oversight of critical care patients in our community hospitals and other local community hospitals as an alternative to these patients being transferred and treated in a higher cost, tertiary setting
    - Teledermatology platform, which allows remote diagnosis and reduces wait times for dermatology appointments
    - Behavioral Medicine telemedicine initiative, partially funded by a Health Policy Commission grant, which allows behavioral health clinicians to deliver early intervention, referral to treatment and medication assisted treatments in primary care settings
    - We now have over 25 discrete virtual medicine programs and have created a Virtual Medicine Steering Committee. We have appointed an Associate Vice President for Virtual Medicine who is tasked with creating a single access point for our tele-mentoring services and develop standardized workflows that can be applied across all our programs.

- On October 1, 2017, we will go live with our new system wide integrated EMR (Epic). By adding a fully integrated EMR, we expect to improve patient care and reduce cost by eliminating redundancies, and improving efficiency, not only in the clinical areas, but in the back office and support areas as well.

Based on 2015 data, 41% of the commercially insured patients for our primary service area go to Boston for inpatient cancer services. This out-migration of care from central Massachusetts to Boston

(especially to Partners whose hospitals' costs are approximately 30% higher than UMass Memorial's) increases the overall cost of care for patients in central Massachusetts. Reducing the out-migration of patients to Boston by becoming the healthcare provider of choice for patients, caregivers and referring physicians in the region is one of our three strategic goals in 2017.
Part of this strategy centers around creating a value proposition for our affiliate hospitals and private providers by helping them with outpatient quality measurement and improvement through our office of clinical integration, joint contracting services through our managed care network, as well as malpractice insurance through our captive insurance company and an integrated electronic health record through EPIC. Partnering with private physicians and hospitals in the region will allow us to better integrate care across the full continuum and improve the quality of care delivered to the patients we serve. Creating a stronger partnership with private physicians and hospitals in the region and improving our access to services should also reduce the need for patients to travel to more expensive Boston hospitals, thereby reducing the overall cost of care for patients in the region.

ii. What barriers does your organization face in advancing this priority?
Patient behavior and preference is sometimes a barrier in trying to refer them to an appropriate lower cost setting. Besides the patients' preferences to seek care in Boston hospitals, we also face patient reluctance to be cared for at one of the community hospitals in our system. Often, we seek to care for patients at our lower cost Marlborough, Clinton or Health Alliance hospitals however the patient prefers and insists on care at the higher cost teaching Medical Center.

Our historic IT and EHR systems also did not facilitate the highest levels of coordination of care across the System. UMass Memorial's new EHR system, Epic, which is going live on October 1, 2017, will provide interfaces to other provider systems who utilize the Epic EHR as well as with those that are using non-Epic EHRs, significantly enhancing coordination of care across different settings.

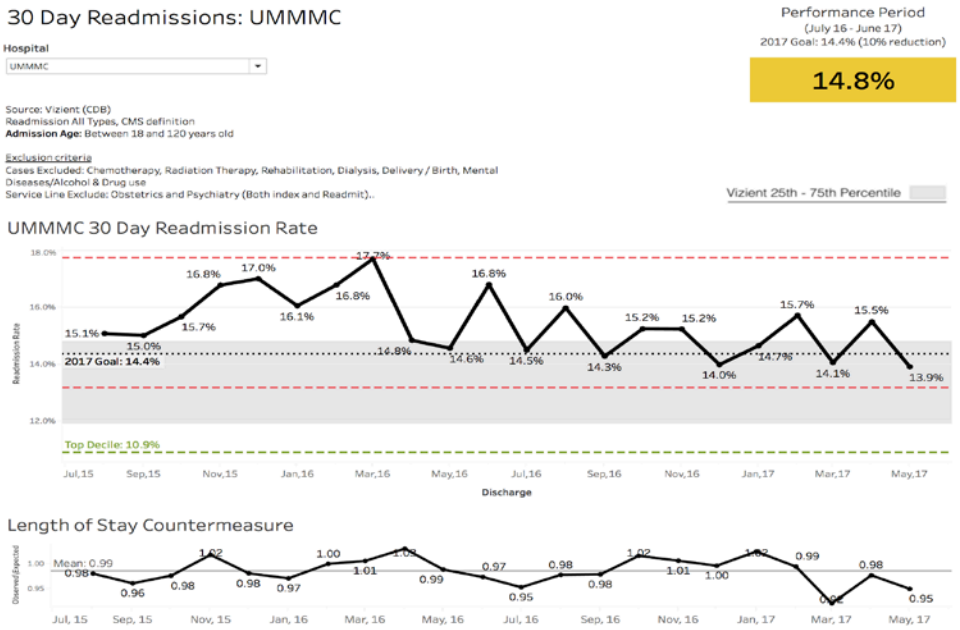
iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
Telemedicine could be further expanded if there were appropriate payments to cover the cost of developing and providing the service and less restrictive professional licensing requirements.

The addition of patient navigators and care coordinators would enhance our care teams enabling them to work much more effectively to coordinate the patients' care, to guide the care to the lower cost settings when appropriate, to reduce unnecessary use of the emergency departments, etc. The reimbursement for patient navigators is practically non-existent. This service needs to be valued as much as the clinical providers are valued in the care team. The opportunities for improving the patient and caregiver experience while creating economic value via cost reduction are significant and therefore should be added in a stable and sustainable manner to the healthcare education, employment and reimbursement mechanisms.

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?
   UMass Memorial Health Care has many initiatives under way to reduce unnecessary hospital utilization. Some of these initiatives are:
      - Readmission reduction work is occurring in numerous areas –
        - We have a significant effort going on across our hospitals to reduce readmissions this year. There are several teams and multiple initiatives happening each day with the goal to reduce readmissions by 10% overall this year. Some of the many teams that are working on this effort:
          - UMMMC Readmissions Team
          - ACO High Risk/TME

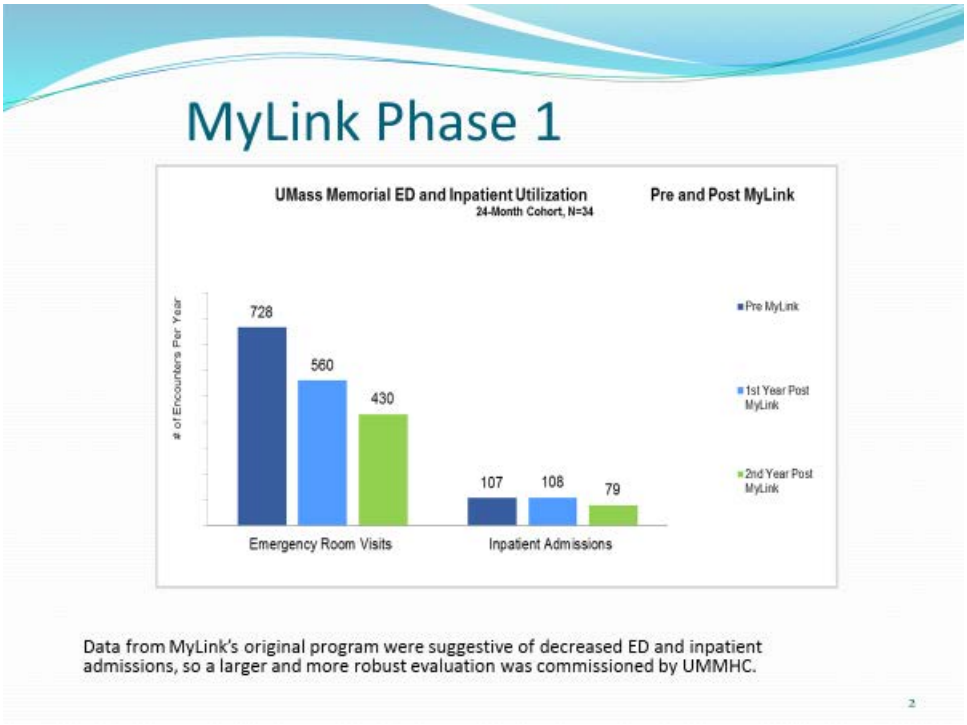
- Utilization/Care Management Committee
- A3 Team – Longitudinal Care Management
- UMMMG Group Practice Quality Committee
- ED, Discharge, Re-Admission
- Ambulatory Follow-Up Visits
- OCI Optum one Complex/Readmissions
- EPIC: Healthy Planet - Readmission Risk Scores
- LACE index, LACE +
- Re-Admissions – SNF
- Curaspan High Cost Members
- Navicare

- There are disease specific hospital teams working to reduce readmissions in our CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), CKD (chronic kidney disease) and Diabetic patients
- We are working with the skilled nursing facilities in our area to reduce readmissions that come to us from the SNF's, our Medicare ACO care management team is working with their patients to try to prevent readmissions
- Below are trends showing our improvements in both readmissions and Preferred SNF arrangements:



- There are also numerous efforts around reducing avoidable emergency department visits –
  - The MyLink program, which was started several years ago, on a small-scale grant funded pilot, is now being further operationalized and studied in our Medical Center emergency department. The MyLink program places community support workers in the emergency department to meet directly with high utilizers (5 or more visits over the past 12 months) while they are there to begin a relationship where they provide intense care management and address behavioral health needs or direct them to our community based crisis stabilization programs.
    The University ED's Behavioral Health Service (BHS) identifies ED super utilizers, provides information about the MyLink service and brief motivational counseling to increase patient receptivity, and, for those who consent, connection to MyLink during the ED visit
    MyLink community support workers provide intensive care management services:
    - Comprehensive needs assessment
    - Home visits
    - Care coordination
    - Identification, enrollment, and engagement of community services
    - Problem solving
    - Facilitation of treatment and service engagement

    This pilot program has shown reductions of 25% in emergency utilization as noted the results chart below:



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A key aspect of our MyLink program includes a research component which will ensure efficacy and design program expansion. In April 2017, we reached the minimum required study size of 200 patients enrolled; In October 2017, we will have completed the follow up assessments; By February 2018 we will have our Early Analysis completed to ascertain the efficacy of the current program and go forward path for continuation.

We will evaluate the intervention's impact on:

- Healthcare utilization patterns (ED visits, outpatient visits)
- Non-emergent ED visits
- Total healthcare expenditure
- Quality of life

  - Our Medicare ACO care managers are working with patients that are frequent visitors to the emergency department to reduce visits that could be handled in the primary care setting. Through relationships created with these patients they are often able to work with the patient to ensure their primary care visits are scheduled and that they can attend the appointment. Sometimes assistance is merely coordinating the scheduling of the primary care appointment or transportation for the patient which otherwise may have been too challenging for the patient themselves resulting in avoidable emergency department usage.
  - We have developed education materials for providers that have a listing of alternatives to the emergency department (urgent care centers, primary care clinics with extended hours, etc.)

- We have significantly expanded our population health capabilities, among them –
  - Care management expansion, including development of a longitudinal care management team and several programs and initiatives targeting high risk patients who would likely benefit from more intensive cross-setting care coordination and intervention
  - Our ACO care managers are calling Medicare ACO patients after discharge from the hospital to discuss their medication adherence and other post discharge issues and concerns to try to prevent their readmission

    - Patient Ping – we have implemented this technology which provides real-time notifications when our patients are admitted to emergency departments or as inpatients in any hospital that uses Patient Ping. This allows us to provide transitional care coordination to our patients, even when they are seen in non-UMMHC hospitals.
    - Enhanced analytics – several new reports and tools have been developed to help identify patients at risk for readmission or avoidable ED utilization. These include the Patient Management Report, High Risk Lists and the Patient Quadrant Analysis for in depth review and intervention development at primary care practices. New tools and reports are continuously being developed as needed.
- We have many behavioral health programs which target high risk patients who are at risk for readmissions and unnecessary ED utilization -
    - An active consultation-liaison service
    - An active health psychology consultation service with special expertise in pain and opioid management
    - An outpatient consultation service for patients with co-morbid addictions and psychiatric illness
    - A parallel program to provide intensive psychiatric social work services to medically hospitalized patients post overdose
    - A research program in systems and psychosocial advances research (SPARC)
    - Addiction services provided by our behavioral health provider Community HealthLink (CHL)
    - An active continuous quality improvement program at the medical center
    - A medical home for our most complex intellectually and developmentally disabled patients
    - Integrated behavioral health and primary care services, capable of following up with complex patients
    - Medical emergency department behavioral health services triage program
    - A depression registry at primary care locations
    - An office based opioid treatment program.
- Several other programs that also target high risk patients which will lead to reduced readmissions and avoidable ED visits are –
    - Specialty Pharmacy Program for chronically ill patients – pharmacy liaisons work with the patient and their care team to help keep the patients with the highest needs adherent to their medications
    - Hot-Spotting – A program in partnership with UMass Medical School which expands our case capacity of our Care Management Team
    - UMass Memorial Health Care co-chairs the Pediatric Asthma Task Force and collaborates with clinical and community partners to create a multidisciplinary care team to provide assessment and management services in homes, schools, and clinics to high-risk children with asthma.
    - The Medical Legal Partnership in collaboration with Community Legal Aid provides on-site consultation and a network of pro bono attorneys to address health harming social needs, such as substandard, unsafe or insecure housing or benefits denials

ii. What barriers is your organization facing in advancing this priority?
Some of the barriers we face in terms of advancing this priority are –

- Many of these initiatives are not supported by sufficient, or any, payments. Care management is an expensive service without a direct source of payment
- Shortage of primary care providers, which restricts our ability to direct patients to the primary care setting
- Lack of adequate support for integrated behavioral health models of care, which has resulted in a shortage of behavioral health providers in the area

- Problems with claims data from payers – claims data received are not standardized, are incomplete and are not timely enough to enhance our decision making

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
We would recommend –
- Improved funding for care management and care coordination to allow for the expansion of these services which are critical in the effort to reduce unnecessary hospital utilization
- Adequate and flexible behavioral health access and reimbursement to allow for increased integration of behavioral health services into the primary care setting
- Regulated standardized, timely and complete claims data including risk factors

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): in depth and up to date provider knowledge of community based resources and services.

b. How has your organization addressed these barriers during the last year?
We have increased our capacity of more efficient settings by opening more urgent care centers throughout our service area. We are also in the process of building an Ambulatory Surgical Center, which will be a more efficient option for certain types of surgeries. We also continue to work on education and awareness of our providers and patients of these options for less expensive, more efficient care.

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)	11.4%
Salary	77.5%
Panel size	0%
Performance metrics (e.g., quality, efficiency)	8.2%
Administrative/citizenship	2.9%
Other	0%

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

	%
Productivity (e.g., RVUs)	8.4%
Salary	85.3%
Panel size	0%
Performance metrics (e.g., quality, efficiency)	1.8%
Administrative/citizenship	3.6%
Other	0.9%

This data represents approximately 60% of total physician compensation which we feel is representative of the total compensation.

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

There are no major changes planned to our physician compensation models for Fiscal Year 2018. Each year, all compensation plans are reviewed and minor adjustments made. All plans, in all departments follow the UMass Memorial Medical Group's compensation philosophy guidelines.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030. **If a question is not applicable to your organization, please indicate so in your response.**

1. Please submit a summary table showing for each year 2013 to 2016 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1**, with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue. Required Question. See Attached Excel File

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?

   Referrals are handled on a case by case basis and patients are notified of referral partners when the referral is being made.

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