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**: 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?

Priority 1: Reduce unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions)

1. Improve conditioning of COPD patients

A. Patient education

Goal: Improve utilization of home therapies while patients are in the hospital, resulting in improved clinical outcomes and reduced readmissions.
Timeline: Ongoing
Process: Respiratory therapists currently review the proper use of inhalers with each inpatient utilizing an inhaler. We have been collaborating with an outside vendor to introduce an interactive education program focusing on COPD patients. This interactive software which is currently in beta testing phase, will facilitate patients' self-education in the hospital and home settings

B. Establish an Outpatient Pulmonary Clinic

Goal: To reduce 30-day readmissions for COPD exacerbation as well as Emergency Care Center utilization
Timeline: Fall 2017
Process:

- Establish a discharge follow-up plan that includes post-discharge phone call within 48 hrs.and a Pulmonary Clinic visit within 7 days.
- Assure that community and home care services are in place and are being appropriately utilized.
- Provide education on smoking cessation, inhaler use and disease management plans.
- Provide timely referrals to PFT Testing and/or the Pulmonary Rehab program.
- Provide clinical care for basic symptom management during the clinic hours.
- Verify/honor advance directives. Facilitate Palliative/Hospice discussions and referrals when appropriate.
- Closely communicate any changes in care management with patients' PCPs.

2. Increased case management staff to the Emergency Care Center on weekends

   Goal: Reduce hospital admissions/readmissions
   Timeline: Ongoing
   Process: Additional case management staff in the Emergency Care Center on weekends will allow earlier interventions to determine actual need for admission versus discharge back to skilled nursing facilities or home with supportive services to prevent unnecessary admissions and readmissions from occurring.

3. Hospice and palliative care services

   Goal: Improve care transitions and prevent unnecessary readmissions.
   Timeline: In Process
   Process: Nursing currently screens inpatients who may be in need of hospice or palliative care services with case management and physicians notified for follow up. In addition, a community visiting nurses group had been taking outpatient palliative care referrals until the VNA lost that particular staff member. This service is currently suspended. The hospital has recently signed an agreement with a hospice and palliative care organization which will provide palliative care consults in the hospital prior to patient discharge. That service is scheduled to begin in October of 2017.

4. Implement a hospital based retail pharmacy

   Goal: Reduce readmissions by ensuring patients receive and understand their medications before they leave the hospital.
   Timeline: Construction of pharmacy is complete and operations are scheduled to commence on October1, 2017.
   Process: Patients will be able to fill prescriptions prior to leaving the hospital. Education will be provided to those who require it.

5. Schedule post discharge physician appointments for patients as soon as possible but ideally within 7 days of discharge to help ensure appropriate and timely follow up care. i

   Goal: Reduce readmissions
   Timeline: Ongoing
   Process: Prior to patient discharge as part of the discharge plan, unit secretaries call PCP offices to set up patient appointments with their physicians.
   Follow up calls are made to all patients discharged home. These calls are made by the physician offices or the hospitalist group.

6. Urgent Care

   Goal: Decrease unnecessary ER utilization (and to connect individuals in the community who have no PCP with a PCP to better manage their health care and contribute to reduced hospital admissions).
   Timeline: Operations began at one site August 1, 2017. Second site is under construction and will be opening October 24, 2017.
   Process: Urgent care services are provided out in the community where it is more accessible, at a lower copay, so patients with non-emergent care needs will not have to go to the emergency room.
   Results: Insufficient time to evaluate, however, it is likely that other urgent care providers in our service area have already diverted patients from our emergency room which has resulted in a decrease in low level emergency room visits. Below is a table of ER actual visits for three years and a projection for FY 2017 based on June actual visits There was a decrease in overall ER visits in FY 16 and a projected drop in FY 17. The decline predominates in the lower level visits.

CPT	FY 2014	FY 2015	FY 2016	FY 2017	FY 15 vs 14	FY 16 vs 15	FY 17 vs 16
99281	546	455	365	348	-91	-90	-17
99282	2,631	3,219	3,302	2,561	588	83	-741
99283	19,313	19,367	18,270	16,747	54	-1,097	-1,523
99284	12,801	12,320	11,454	10,440	-481	-866	-1,014
99285	12,172	12,645	13,464	13,928	473	819	464
99291	1,843	1,956	1,576	2,447	113	-380	871
Total	49,306	49,962	48,431	46,471	656	-1,531	-1,960

7. Call patients discharged from the hospital emergency room

   Goal: Decrease admissions/readmissions and emergency room visits.
   Timeline: Ongoing
   Process: Automated phone calls are made to all patients discharged from the emergency room to ensure discharge instructions (care plan) and pharmacy prescriptions are understood. Patients who answer "no" to one of five questions are called back within 24 hours by an emergency room practitioner.

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

- We have implemented several strategies to lower unnecessary readmissions and emergency room visits. These initiatives require funding and when successful, reduce hospital volume. The result is increased costs and reduced reimbursement. A portion of the loss will likely be reduced by lower VBP penalties for hospital readmissions, but the lag time between the measurement period and the payment period for the CMS readmission measure makes it financially more difficult to absorb the cost of the initiatives.
- Difficulty in successfully recruiting nurse case managers.

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

- MassHealth rates should be increased to more closely cover provider costs.
- The penalty period for CMS readmission penalties should closely align with the measurement period.

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?

Priority 2: Reduce over-utilization of institutional post-acute care

1. Orthopedics Total Joints.

   Goal: Reduce length of stay in the hospital and the post- acute setting as well as increasing the number of patients discharged home (not SNF) with home health services.
   Timeline: On going
   Process: The program began with the goal of improving the conditioning of total joint patients in the hospital. Pre-operative classes were made available to patients which included discharge expectations to home with services, and not a rehab hospital unless medically appropriate. Care plans for in hospital care were rewritten to ambulate patients sooner after surgery. Changes in anesthesia and pain control were also made to allow patients to be mobile sooner.
   Results: The percentage of patients discharged to SNFs has dropped from 68.8% in FY 13 to 37.5% in FY 16 as noted in the table below. In addition, patients are being discharged sooner from the hospital (see following page):

Hip/Knee				
Measure	FY13	FY14	FY15	FY16
Volume	263	269	268	299
LOS	3.5	3.2	3.1	2.8
CMI*	2.17	2.20	2.17	2.12
% disch to SNF	68.8%	63.9%	45.1%	37.5%

2. Develop and monitor a 10-day rehabilitation/PT protocol at local SNF's to reduce length of stay.
   Goal: Reduced post-acute costs
   Timeline: Begun in 2016, it is on going
   Process: The Sturdy Physical Therapy Department developed the PT protocol and provided in-service education for participating VNA and skilled nursing facility PT staff. The VNA and area rehabs met in 2016 to review expectations and protocols for patients.

3. Meet with Nursing Home Directors and Medical Directors quarterly.
   Goal: Reduce nursing home length of stay, post-acute care costs.
   Timeline: Ongoing
   Process: Hospital and nursing home representatives have been meeting for many years to work on a variety of issues many of which focus on transitions of care. We shared with this group the high post-acute care costs in our community, relative to Massachusetts and the U.S., which data we received from CMS as part of their value based purchasing efficiency measure. We were unsuccessful in getting the nursing homes toreduce their lengths of stay which is likely related to the per diem payment mechanism for SNF services.

4. Participated in Medicare Shared Savings ACO
   Goal: reduce post-acute care costs
   Timeline: Joined the ACO in January 2016, ending December 2017
   Process: When we agreed to participate in the Shared Savings ACO, we anticipated that we would be receiving data on our Medicare population that would allow us to learn how to better manage their care and costs. Unfortunately the ACO produced no actionable data in the 18 months in which we have been participating. We had also hoped to learn to strategies to specifically direct post-acute care, particularly in the skilled nursing setting; however, that did not happen. In January 2018 we will begin a Next Gen Medicare ACO with different partners, one of which has more experience with developing and managing ACOs.

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

   - CMS does not allow physicians to direct patients to low cost SNFs. Therefore, there is no incentive for SNFs to lower their length of stay (cost).

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

   - Change SNF reimbursement to discourage unnecessarily long lengths of stay. Front load payments or shift to a fixed payment per admission for certain diagnosis, such as hip and knee replacement.
   - Allow physicians to direct patients to a limited network of SNFs that we know deliver high quality care at a lower cost.

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): 1.) Inability to recruit primary care physicians and most specialty physicians. 2.) Financial incentives for care to go to tertiary care facilities rather than our own community hospital. 3.) Higher priced academic medical centers setting up outpost physician practice and outpatient facilities in communities to compete with lower priced community hospitals on non-tertiary services.

b. How has your organization addressed these barriers during the last year?
We are constantly recruiting new physicians. We are in the process of completing a new modern multi-specialty medical office building to bolster recruitment, improve efficiency and enhance the patient experience. Educating payers on tiering strategies to prevent incentives for patients to seek out a more expensive network.

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)	5
Salary	95
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)	5
Salary	95
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.
We are currently reviewing the existing compensation model but have no specific plans at this time to change it.

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**	0	34
	Q2	2	44
	Q3	2	42
	Q4	2	47
CY2016	**Q1**	1	41
	Q2	2	57
	Q3	2	47
	Q4	0	46
CY2017	**Q1**	1	52
	Q2	1	44
	TOTAL:	13	454

   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.
   Any calls received in the hospital are directed to the Patient Financial Assistance Supervisor who normally does the estimates in the same business day. A log of calls is kept including the day the estimate was prepared. We do not monitor the results (how close the estimate is to the actual charges) since the patient is not required to give their name and may or may not receive services.

   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?
   Services on payments linked to a fee schedule, such as lab and imaging are generally straight forward. Surgical procedures are the most challenging to price since the charges will vary from case to case.

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.

We are not aware of any differences in revenue or margins between the HMO and PPO business. The reimbursement methodology is not materially different and there is no separate tracking of expenses. Two of our commercial contracts include a pmpm budget target but the upside and downside risk is slight and not material to total payments. The programs were grouped as follows:

- Commercial: Managed Care; Non-Managed Care; QHP
- Government: Managed and Non-Managed Medicare; Managed and Non-Managed MassHealth; Other Government.
- Other: Self Pay; Worker's Compensation; HSN

Below is the table requested showing profit margins and percent of total business:

FY 2014	Operating Margin	Percent of Total Business
Commercial	31.7%	33.0%
Government	-11.5%	64.4%
All Other	-79.7%	2.7%
Total	6.9%	100.0%
FY 2015		
Commercial	31.7%	32.2%
Government	-14.3%	65.3%
All Other	-57.1%	2.5%
Total	5.5%	100.0%
FY 2016		
Commercial	32.4%	31.0%
Government	-12.4%	66.7%
All Other	-59.6%	2.3%
Total	6.2%	100.0%

Operating margin was calculated using data as submitted in the 403 cost report. As we do not utilize a cost accounting system, Expenses were simply allocated based on Gross Patient Service Revenue, also from the 403, without any adjustments for acuity or intensity of services.