MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 Pre-Filed Testimony

HOSPITALS AND PROVIDER ORGANIZATIONS

As part of the *Annual Health Care Cost Trends Hearing*

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

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), holds an annual public hearing on health care cost trends. The hearing examines 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.

The 2019 hearing dates and location:

Tuesday, October 22, 2019, 9:00 AM
Wednesday, October 23, 2019, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 22. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 22.

The HPC also accepts written testimony. Written comments will be accepted until October 25, 2019, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 25, 2019, 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 the Suffolk University website. 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 available via livestream and video will be available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email mailto:at HPC-Info@mass.gov a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing page on the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2019 Annual Cost Trends Hearing.

You are receiving two sets of questions – one from the HPC, and one from the AGO. We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, 2017, and/or 2018 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.**

On or before the close of business on **September 20, 2019**, please electronically submit written testimony to: HPC-Testimony@mass.gov. 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.

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 templates or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC Contact Information

For any inquiries regarding HPC questions, please contact General Counsel Lois H. Johnson at HPC-Testimony@mass.gov or (617) 979-1405.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Amara Azubuike at Amara.Azubuike@mass.gov or (617) 963-2021.

Pre-Filed Testimony Questions: Health Policy Commission

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:
   Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

   a. What are your organization's top strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

   i. ***Acute and post-acute care management:***

   Optimizing acute and post-acute care utilization remain among our highest priorities, due to the magnitude of the spend in these settings. Efforts in these areas are described below.

   ***Acute care management*: In our acute care strategy, largely through our Medicare and Medicaid ACO activities, we are concentrating on decreasing unnecessary emergency room (ER) visits, inpatient admissions, and readmissions. Our Medicare ACO's most mature and longest standing tactic is its care management program. Since 2012, we have embedded care management teams in the primary care practices who participate in our value-based contracts. Registered nurse care managers and medical assistant level outreach workers/care coordinators support patients with understanding their medical conditions and how to have the best quality of life, education of disease, self-management, assessment of needs, elimination of barriers to care, and coordination of care across delivery sites while enhancing the value the practices provide to the population for which they are accountable. As part of our effort to improve transitions of care and minimize redundancy, we continue to work on cross silo care management integration to ensure shared clinical and communication processes and a governance structure that will facilitate shared decision making across care management entities and standardization wherever possible.**

   In 2019, Baycare Health Partners (Baycare), the Baystate Health PHO, engaged Cyft (www.cyft.com) to use their experience with machine learning and natural language processing technology to help us measure the Return on Investment (ROI) of our care management interventions, to help us do a better job of identifying patients appropriate for care management, and to refine our interventions over time based on the continual learning inherent in the machine learning platform. Preliminary findings revealed that Baycare's care management program is successful and has reduced costs by approximately $4 million annually in 2017 and 2018. We are encouraged that continual process improvement efforts in collaboration with Cyft will help us identify patients most likely to benefit from our care management efforts sooner, which will result in avoiding unnecessary

utilization while ensuring quality and a positive patient experience. We anticipate the initial priority of this work will be in the acute care environment.

Additionally, there has been much emphasis on redesigning the inpatient care model to enable provision of high quality, evidenced-based, cost conscious, patient-centered care and to maximize the coordination of inter-professional patient care teams across the entire care continuum. One example is a new position, our Transitional Care Medical Director, who oversees efforts at the Baystate Health hospitals to decrease the number of patients unnecessarily sent to SNFs or acute rehab facilities and to decrease the number of readmissions due to poor transitions. He also leads the "why not home?" initiative, encouraging the inpatient care team to focus on the appropriate next site of care and on the barriers to going home.

Controlling unnecessary emergency room (ER) utilization is another key aspect of our acute-care management efforts. Nationally, billions of dollars are wasted annually in the US in unnecessary care with 30% to 70% of ER visits considered non-urgent and 22.2 million 911 transports unnecessary or inappropriate. We continue to implement a major initiative to control unnecessary ER utilization by contracting with DispatchHealth, an in-home delivery platform designed to address the healthcare needs of the on-demand consumer and the access challenges of the at-risk patient. DispatchHealth's platform extends the reach of the traditional ER, providing high acuity and higher value care in the home. An extension of primary care, its model is a combination of emergency medicine diagnostic and treatment capability. DispatchHealth has multidisciplinary teams of physicians, nurse practitioners, physician assistants, registered nurses, clinical social workers, pharmacists and other licensed professionals who provide non-emergent, mobile health care response services to patients residing in our service area. Results from the first three quarters of this successful intervention include nearly $2 million in avoided costs, or approximately $1,700 per DispatchHealth visit. Patients are highly satisfied with the program, which maintains a net promoter score well over 90.

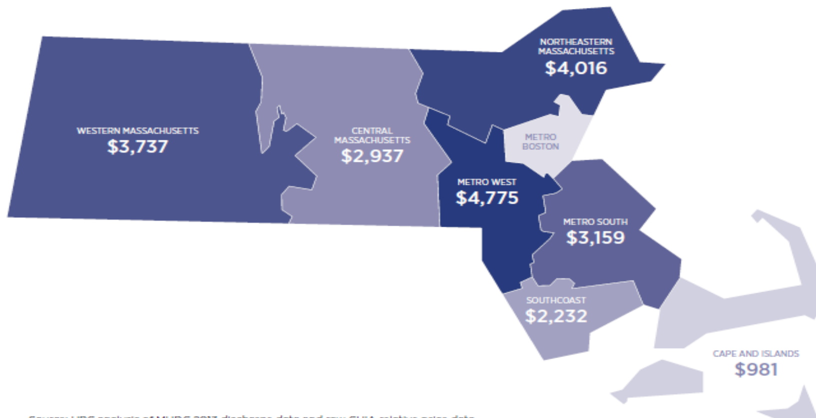
Post-acute care management: **Our Medicare ACO has been working diligently since 2015 to decrease our post-acute spending by reducing inappropriate skilled nursing facility (SNF) lengths of stay, emergency room transfers, re-hospitalizations, and SNF admissions/1,000. Our tactics continue to include close partnerships with a preferred network of SNFs, although we conduct performance improvement activities with all the SNFs in our service area, both preferred and non-preferred, to share best practices and emphasize data transparency. One of our most effective tactics has been to employ a post-acute care manager; this RN rounds at all the SNFs, reviewing the care plans for our high-risk patients and ensuring warm handoffs across the continuum. These efforts have been successful as evidenced by our Medicare ACO's SNF average length of stay of 17.4 days in 2018, a rate that rivals those of managed Medicare Advantage populations and is the lowest among comparable ACOs in a national learning collaborative to which we belong.**

ii. *Keeping Care Local:*

As was noted last year, the Health Policy Commission (HPC) has evaluated inpatient care delivery in the state, and found that care that is provided locally (to patients who live in a particular region) is unequivocally of lower cost than if that equivalent care is provided in a Boston area hospital (see graphic below). Additionally, HPC reported both an increasing trend of care

out migration to Metro Boston facilities as well as increased likelihood that commercially-insured patients and patients from higher-income communities contribute to that outmigration.

Average Additional Cost for Each Commercial Discharge at a Boston Hospital rather than a Local Hospital, by Region of Patient Origin

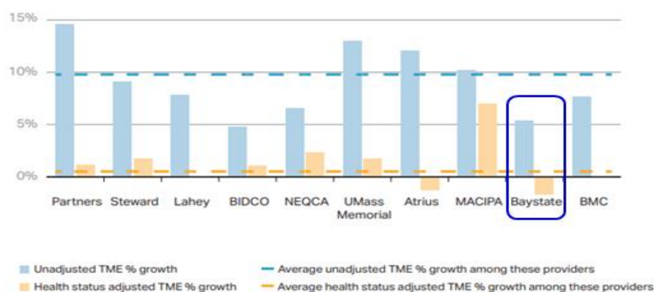


Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data.
Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.

Despite increasing encroachments into Western Massachusetts targeting commercial suburban pediatric and adult populations, as well as specialty providers, Baystate Health continues to advance its value-based population health work as a strategic priority as well as provide the critical tertiary and trauma services the regional community needs despite the resource-intensity required to deliver them. Doing so further reduces state healthcare expenditures by preventing unnecessary outmigration (both to the east and south).

At the same time, despite the resource commitment required to provide these services, as can be seen by the latest HPC Cost Trends graphic below, Baystate Health continues to be among the highest value tertiary health systems in the state, if not the highest:

TME by Provider Group, 2015-2017



Between 2015 and 2017, unadjusted TME grew 10%, on average, for these top ten provider groups but health status adjusted (HSA) TME grew only 0.5% on average.

The difference between the unadjusted and adjusted growth rates is due to growth in the risk scores for these providers' patients. During this 2015 to 2017 period, risk scores increased by an average of 9.5%.

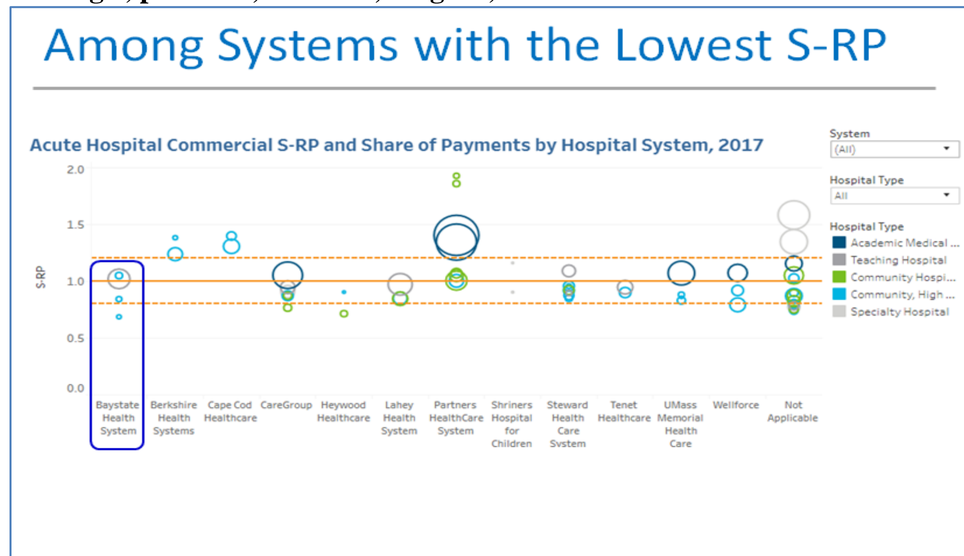
Risk scores are intended to quantify the expected difference in spending for a given set of patients, relative to a benchmark population, given the diagnoses and demographic characteristics of that set of patients. However, both providers and payers face incentives to increase risk scores.* The extent to which this increase in risk scores reflects changes in coding practices (e.g., documentation of a more extensive set of diagnoses, or coding diagnoses as more complex) or a sicker or older population is not yet clear.

* For example, the Affordable Care Act's risk adjustment methodology redistributes funds from health plans with lower-risk enrollees to plans with higher-risk enrollees in the individual and small group markets. Provider budgets under risk contracts are typically adjusted based on patient risk scores. Provider groups in Massachusetts may be subject to Performance Improvement Plans under Chapter 224 based on their HSA TME.

NOTES: Analysis includes 10 largest PCP groups and three largest commercial payers as identified by the Center for Health Information and Analysis in terms of member months. Because risk adjustment methodology may vary across payers, this graph only includes data from the top three payers which use similar methods (BCBSMA, THP, HPHC) as in the previous exhibit.

TME BY PROVIDER GROUP

As the only Level I trauma center in Western Massachusetts, Baystate Health continues to provide in a high-value manner (see CHIA graphic below) the resource-intensive and expensive 24 hour call and coverage services needed by the children and adults of the region, including required tertiary cardiac, neuroscience, oncologic, pediatric, neonatal, surgical, and trauma care.



To support this strategic priority of keeping needed tertiary and trauma care local, Baystate Health is undertaking a number of initiatives, which in turn require support and resources. Among them are initiatives to build, strengthen, and retain the specialized workforce necessary (e.g., clinician pipeline programs including advanced practitioner training, RN and MD residency programs, UMass-Baystate, investment in career development, investment in international nurses, and building team member resiliency), which are in various stages of progress.

Efforts are also underway to enhance access to primary and specialty care to minimize access-related outmigration. As the only regional Level I trauma center, Baystate Health is able to provide these resource-intensive and expensive 24 hour call and coverage services to the children and adults of the region by also providing high-quality tertiary and specialty services to commercial patients. Unnecessary outmigration of these patients erodes the long-term capabilities of providing resource-intense trauma and tertiary services. Therefore, to the extent that high-quality, high-value care exists in the region, can be provided by providers and specialists in the region, and serves as the foundation of a Level I trauma center, all efforts should be made to keep care local, rather than allow referral, tele-consultation, and/or transfer out of the region unnecessarily, which ultimately results in higher-cost care that is not necessarily of higher quality.

In addition, work is underway related to palliative care and increasing palliative care capacity (including training, EHR enhancements to improve ease of access to advance care planning documents, multidisciplinary strategic planning, development of a palliative care dashboard, etc.). Although the work is in progress, palliative care has been shown in numerous studies to lower overall costs of care.

As an example, research published in JAMA demonstrated that across 6 studies and over 130,000 patients, adults who received palliative care had a lower cost of care than those who did not. Hospitals can deliver best care at $3,237 less cost per patient on average when a patient had palliative care added. For cancer patients, the savings were even higher—$4,251 per hospital stay.

Therefore, Baystate Health continues to work to strengthen its abilities to provide high-quality, high-value care (including primary, specialty, and trauma care), as well as build and bolster the tertiary and Level I trauma center foundation of Baystate Health to serve the population for the long-term in the most fiscally responsible manner.

b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?

***Ongoing infrastructure payments*: Preliminary evidence strongly suggests that value-based care models lower health care costs while maintaining quality. As one compelling example, according to CMS, MSSP ACOs saved $1.1 billion in 2017. Therefore, we continue strongly to encourage payers, both public and private, to provide ongoing and adequate infrastructure payments and support to their contracted providers to assist in broader implementation of value-based payment models and to accelerate their adoption. It is a common contention among payers that once they provide seed funding for a few years to assist their contracted providers in deploying various population health infrastructure and programs (e.g., care management programs, data analytics platforms), the value-based programs will become self-sustaining over time and support the continued provision of this population health infrastructure. We believe this contention is unproven at best and misguided at worst given that shared savings/shared loss models are not sustainable in the long term because participants are measured against themselves, face diminishing budgets over time as generated savings are removed from budgets, and likely do not have a sustainable or adequate upside potential.**

***Transition to value-based care*: We face inherent challenges in further adopting value-based payment models when providers still have one foot firmly planted in the fee-for-service (FFS) world and the other in the value-based world. Until value-based agreements cover a critical mass of patients, it will not be financially or operationally feasible for providers to change their workflows fully to align with a value-based delivery system. Therefore, payers should be encouraged to offer value-based contracts of similar design to ease the administrative burden of implementation on the providers who are being asked to assume considerably more risk under these models. Payers also should be encouraged to extend these value-based arrangements to PPO populations—while including and offering actuarially sound mechanisms for retaining the insurance risk for these populations at the payer given that providers have significantly fewer opportunities to manage the utilization of PPO populations given their very nature of not being gatekeeper models. Such mechanisms could include risk corridors, risk mitigation/carveout of high-cost cases, and shared loss caps. At the same time, we encourage and support continued experimentation with capitated payment models—by public and private payers—and investment in the claims processing and other systems necessary to**

implement such models. We believe capitation, namely primary care capitation with a wraparound risk contract, could better align incentives and facilitate the delivery of more team- and non-visit-based primary care, and expand access.

***Point of care interventions*: Other enabling policies at the point of care include requiring payers to recognize the value of paying for non-provider-based visits (e.g., diabetes education) and waiving copayments for certain chronic conditions (e.g., diabetes, hypertension, and congestive heart failure) to facilitate patient compliance and adherence to treatment protocols. We also suggest broadening the scope of practice of Advance Practitioners, who play a greater and greater role in our delivery system, particularly in primary care. Given the shortages of primary care physicians, having more liberal scope of practice laws would enable us to innovate around the model of care and ensure broader coverage by primary care for the communities of Western Massachusetts. We also believe that better and comprehensive reimbursement for telehealth would also help lower total medical expense for our at-risk lives and improve access to specialty care.**

***Removal of financial barriers*: We also continue to encourage removal of the significant financial barriers that are impeding adoption of value-based models. Consideration should be given to the unfunded mandates providers face in complying with regulations such as the Risk Bearing Provider Organization (RBPO) and Registration of Provider Organizations (RPO) regulations. The Massachusetts Hospital Association and others have clearly documented where these regulations require duplication of effort—both with requirements of other state agencies and health plans. Further, if an organization or one of its subsidiaries participates in the MSSP or NGACO Model, we feel strongly that applying for ACO certification at the state level should be optional. CMS has a robust application process and ongoing compliance and monitoring program for its ACOs and requiring providers to duplicate these efforts at the state level creates additional administrative expense and burden without adding commensurate value. Amending the regulations to reduce these and similar administrative burdens would free up resources that could be directed to broader adoption of value-based payment models. Provider organizations and health systems are expected to build reserves as they expand their value-based contract portfolios. As more risk shifts from insurance companies to providers, we continue to believe that careful thought should be given to how to avoid having insurance companies and providers maintain duplicate reserves. In addition, many risk-bearing entities such as Baycare are structured as taxable entities, and existing tax laws make it considerably more difficult for them to build reserves to the same extent and as rapidly as their not-for-profit counterparts. Regulations governing provider reserves should reflect this hurdle, perhaps allowing for lower reserve thresholds or longer time periods for reserve accumulation for taxable RBPOs.**

***Support to keep care local:* In order to best serve Western Massachusetts and reduce health care expenditures in the state, unnecessary patient and provider leakage must be prevented from Western Massachusetts. To that end, attention, support, and resources are needed to bolster proven high-value systems such as Baystate Health that serve as essential population health hubs, and prevent their needless erosion. As an example, HPC's recommendations from its 2016 *Community Hospitals at a Crossroads* report include: (1) efforts to inform, encourage, and**

incentivize consumers to use high-value systems and providers for their care (see also the 2018 HPC Cost Trends Report graphic and CHIA graphic above), and (2) efforts to monitor market dynamics that negatively impact (both adult and pediatric) patient referral patterns from regions such as Western Massachusetts to other area providers (this should include pediatric specialty care referral patterns and market activity—whether inpatient, outpatient, or virtual).

Concrete support in terms of more equitable allocation of state Medicaid reimbursement (proportionate to the actual care provided to Medicaid patients, which takes into account a region's economic demography when calculating support) is also needed. In summary, concerted efforts and incentives to keep regional care local; to maintain a strong and vibrant tertiary care, trauma and population health hub in Western Massachusetts; to strengthen the regional healthcare workforce through pipeline, development and retention efforts; and to support leading population health work (including a strong palliative care program) would contribute to the critical bolstering of Baystate Health as it continues to meaningfully advance on its value journey while helping to keep state healthcare expenditures down.

2. STRATEGIES AND POLICIES TO SUPPORT INVESTMENT IN PRIMARY CARE AND BEHAVIORAL HEALTH CARE:

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care; even though evidence suggests that a greater orientation toward primary care and behavioral health may increase health system efficiency and provide superior patient access and quality of care. Provider organizations, payers, employers, and government alike have important roles in prioritizing primary care and behavioral health *while still restraining the growth in overall health care spending.*

a. Please describe your organization's strategy for supporting and increasing investment in primary care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

   Baystate is committed to the growth of the primary care team. We have invested in Integrated Behavioral Health for our practices. We have expanded our care teams and panel sizes to serve more of our community. We increased access to same day and next day appointments to decrease unnecessary ER visits. We created over 50,000 visits at our health centers and 15 primary care sites in Western Massachusetts to better serve our patients. Our patients asked for same day availability and in some sites we were able to create walk-in appointments as well. This helps decrease emergency room visits especially for our BeHealthy ACO patients. The BeHealthy ACO is an Accountable Care Partnership Plan under the MassHealth managed care program developed by Baystate affiliated entities and in which Baystate affiliated entities participate. Our patient satisfaction around the question of ability to access timely care improved as families took advantage of the new offerings. Additionally, we have invested in alternative visits to include portal, phone, and televisits as other ways to expand access to care and reduce total cost of care.

We have developed a partnership with Dispatch Health so we can bring emergent care to patients in their home. Dispatch has two vehicles which provide services to patients in the region who can be treated at home rather than in the more expensive emergency department setting. We have also formed a joint venture with Shields Healthcare to provide urgent care capabilities across our primary service area. We are currently in three sites and are planning on opening an additional four to five sites over time. These sites provide a more convenient, lower cost site of care compared to the emergency department and provide greater access to patients who are unable to be seen by their primary care physician.

UMASS Medical School-Baystate (UMMS-Baystate), the recently launched first and sole regional campus of the Commonwealth's only public medical school, is currently selecting its fourth cohort (the class of 2024) of students and is 18 months away from graduating its inaugural class of medical students. UMMS-Baystate represents a major investment by Baystate Health to create an investment in a pipeline for a future primary care- and specialty physician workforce in Western Massachusetts and the Commonwealth. The foundational principle of the regional campus is to educate the next generation of health care providers in population health and the social factors that impact the health of our communities; hence, the program is named the "Population Health-based Urban and Rural Community Health (i.e. PURCH) track. As part of the new medical school and its unique PURCH curriculum, we have created and launched the inaugural Department of Family Medicine at Baystate Health/UMMS-Baystate. This is the first department that is anchored in our northern, underserved region (Franklin County) and is envisioned to galvanize that community and seed the next generation of primary care providers for that region. We have successfully recruited the founding chair, who is charged with growing a faculty of family medicine providers and developing an accredited residency program that will launch in 2022.

b. Please describe your organization's top strategy for supporting and increasing investment in behavioral health care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

Over the past six years Baystate Health has made a significant investment in integrating behavioral care into general health care settings. Specific initiatives include:

1. <u>Integrated Behavioral Health (IBH) in Primary Care</u>. Baystate has IBH Psychiatrists consulting in over 20 primary care sites, including its three full service urban Health Centers and a Federally Qualified Health Center affiliated with the BeHealthy ACO. Baystate IBH social workers and psychologists are placed in nine of the sites, and we partner with a local community mental health center to provide IBH clinicians, peer counselors and case worker in the five health center sites associated with the BeHealthy ACO. In addition, the BeHealthy ACO provides primary care to its members in a manner that directly addresses integration of behavioral health and consideration of social determinants of health.

2. <u>Behavioral Resource Team (BRT)</u>. Baystate Medical Center's BRT includes the hospital's constant companion team (known as "Behavioral Resource Technicians"), who all report to a licensed mental health clinician. In addition, the BRT includes a team of specialized Behavioral Resource Nurses (BRNs). BRNs round on all the med/surg floors to provide nursing consultation on patients who are struggling with co-occurring psychiatric disorders or who are behaviorally dysregulated, including those whose behaviors or risk to self may require a 1:1 Constant Companion. BRNs provide education to nursing staff, assist with development of behavioral plans of care, intervene directly with patients, consult with attending providers and collaborate with the Psychiatry Consultation Team as needed.

3. <u>Addiction Consultation Team (ACT)</u>. This new team consists of a Medical Director, a full-time Social Worker and a full-time Psychiatric Nurse Practitioner. The team focuses especially on med/surg inpatients who have Opioid Use Disorders, offering induction on suboxone or other Medication Assisted Treatment (MAT) as needed. The ACT has partnered with local community mental health center Behavioral Health Network (BHN) on their SAMHSA-funded "MAT-TAT" grant which provides Transitional Addiction Treatment for patients induced on MAT in inpatient settings. TAT nurses and recovery coaches meet with patients in the hospital and facilitate their successful transition to outpatient MAT services in the community.

c. Payers may also provide incentives or other supports to provider organizations to deliver high-functioning, high-quality, and efficient primary care and to improve behavioral health access and quality. What are the top contract features or payer strategies that are or would be most beneficial to or most effective for your organization in order to strengthen and support primary and behavioral health care?

Much of the work that has been shown to make Integrated Behavioral Health effective is not reimbursable under traditional fee-for-service payment methodologies. This includes warm hand-off between PCPs and IBH clinicians, telephone consultation and EMR messaging consultation between psychiatry providers and PCPs, behavioral health care coordination and behavioral health participation in teams and huddles. Payment structures could be advanced to include payment for these strategies, or global payments can be structured to include behavioral health outcomes that will reward investment in IBH services as part of a comprehensive Primary Care model of care. Experimentation with capitated payment models for primary care with wrap around risk contracts could better align incentives and facilitate value-based care.

d. What other changes in policy, market behavior, payment, regulation, or statute would best accelerate efforts to reorient a greater proportion of overall health care resources towards investments in primary care and behavioral health care? Specifically, what are the barriers that your organization perceives in supporting investment in primary care and behavioral health and how would these suggested changes in policy, market behavior, payment, regulation, or statute mitigate these barriers?

A primary barrier to supporting investment in primary care and behavioral health is inadequate or absent reimbursement for elements of care integration that do not fit neatly into the traditional fee-for-service model. To facilitate the integration of behavioral health care in primary care, we would support regulatory and payment reforms to enforce and reward reasonable standards regarding access to care for behavioral health, requiring health systems to monitor access to care standards and providing performance-based incentive payments to systems that are able to ensure timely access for patients who screen positive for common and high impact behavioral health issues (e.g., depression, substance use disorders, trauma-related mental health problems for adults and children, etc.). This will encourage primary care screening, warm handoffs and good care coordination, all of which are necessary elements of integrated care. Similarly, we would advocate that more robust behavioral health quality measures be incorporated with associated value based payments in risk contracts. For instance, tracking the percentage of patients who have poorly controlled chronic diseases (such as diabetes, asthma, COPD, CAD) and patients who are high utilizers of healthcare services, who receive a robust annual mental health screening in the primary care setting, who are provided a full behavioral health assessment if they screen positively, and who receive appropriate behavioral health follow-up when it is indicated by the assessment.

We strongly encourage payers, both public and private, to provide adequate infrastructure payments and support to their contracted providers to assist in broader implementation of value-based models and to accelerate their adoption. There are inherent challenges in further adopting value-based payment models when providers have one foot in the fee-for-service world and the other in the value-based world. Experimentation with capitated payment models for primary care with wrap around risk contracts could better align incentives and facilitate value-based care. Until this sort of payment reform is possible, we suggest that payers recognize the value of paying for non-provider based visits such as diabetes education and care coordination. Alternative visits such as televisits, phone, and asynchronous portal/email visits should be reimbursed as they can lower the total cost of care and increase patient satisfaction.

3. CHANGES IN RISK SCORE AND PATIENT ACUITY:

In recent years, the risk scores of many provider groups' patient populations, as determined by payer risk adjustment tools, have been steadily increasing and a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications. Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your patient population.

Factors	Level of Contribution
Increased prevalence of chronic disease among your patients	Minor Contributing Factor
Aging of your patients	Major Contributing Factor
New or improved EHRs that have increased your ability to document	Not a Significant Factor

Factors	Level of Contribution
diagnostic information	
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Major Contributing Factor
New, relatively less healthy patients entering your patient pool	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Major Contributing Factor
Other, please describe: More reimbursement models using prospective risk budgeting	Minor Contributing Factor

☐ Not applicable; neither risk scores nor acuity have increased for my patients in recent years.

4. REDUCING ADMINISTRATIVE COMPLEXITY:

Administrative complexity is endemic in the U.S. health care system. It is associated with negative impacts, both financial and non-financial, and is one of the principal reasons that U.S. health care spending exceeds that of other high-income countries. For each of the areas listed below, please indicate whether achieving greater alignment and simplification is a **high priority**, a **medium priority**, or a **low priority** for your organization. Please indicate **no more than three high priority areas**. If you have already submitted these responses to the HPC via the June 2019 *HPC Advisory Council Survey on Reducing Administrative Complexity*, do not resubmit unless your responses have changed.

Area of Administrative Complexity	Priority Level
Billing and Claims Processing – processing of provider requests for payment and insurer adjudication of claims, including claims submission, status inquiry, and payment	Medium
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Medium
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	High
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	Medium
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	High

Area of Administrative Complexity	Priority Level
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Medium
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Medium
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	Medium
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Medium
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	High
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	Medium
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level

5. STRATEGIES TO SUPPORT ADOPTION AND EXPANSION OF ALTERNATIVE PAYMENT METHODS:

For over a decade, Massachusetts has been a leader in promoting and adopting alternative payment methods (APMs) for health care services. However, as noted in HPC's 2018 Cost Trends Report, recently there has been slower than expected growth in the adoption of APMs in commercial insurance products in the state, particularly driven by low rates of global payment usage by national insurers operating in the Commonwealth, low global payment usage in preferred provider organization (PPO) products, and low adoption of APMs other than global payment. Please identify which of the following strategies you believe would most help your organization continue to adopt and expand participation in APMs. **Please select no more than three.**

- ☐ Expanding APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payments
- ☒ Identifying strategies and/or creating tools to better manage the total cost of care for PPO populations
- ☐ Encouraging non-Massachusetts based payers to expand APMs in Massachusetts
- ☐ Identifying strategies and/or creating tools for overcoming problems related to small patient volume

☒ Enhancing data sharing to support APMs (e.g., improving access to timely claims data to support population health management, including data for carve-out vendors)
☒ Aligning payment models across payers and products
☐ Enhancing provider technological infrastructure
☐ Other, please describe: Click here to enter text.

Pre-Filed Testimony Questions: Attorney General's Office

1. For provider organizations: please submit a summary table showing for each year 2015 to 2018 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.

2. 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.

Health Care Service Price Inquiries Calendar Years (CY) 2017-2019			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	**Q1**	12	146
	Q2	10	123
	Q3	15	167
	Q4	27	261
CY2018	**Q1**	16	161
	Q2	8	94
	Q3	7	82
	Q4	9	98
CY2019	**Q1**	9	99
	Q2	8	89
	TOTAL:	151	1610

    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.

    Although we assess generally the accuracy and timeliness of our responses to consumer requests for price information, we currently do not perform subsequent direct monitoring or analysis. We engage in a robust effort to be accurate and timely in our responses. All estimates for facility services are processed by software purchased by Baystate Health. The software uses past experience for same services, contract terms, eligibility responses, and current pricing to provide an estimate for

all scheduled services including total charges and patients out of pocket amount based upon all available data. We have received very few complaints about the timeliness and accuracy of our responses.

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?

While certain procedures are straight forward and easily estimable, such as x-rays and colonoscopies, other services are much more difficult to estimate based on the complexity of treatment. We believe that the barrier has been addressed by purchasing the software and establishing a work flow or process that attempts to obtain the required information to calculate the estimate as accurately as possible.

3. *For hospitals and provider organizations corporately affiliated with hospitals:*

a. For each year **2016 to present**, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these 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.

See 3.a. summary table attachment for operating margin by payer for Baystate Medical Center and Baystate Franklin Medical Center, Baystate Health's two largest hospitals, and a list of carriers included in those margins. Further detail of revenue and margin differences for HMO business, PPO business and business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled is not readily available at this time.

b. For **2018 only**, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

See AGO Provider Exhibit 2 attachment.