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 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?

One strategic priority involves engagement with third party payors in shared savings efforts such as global contracts (BCBS AQC, MSSP, etc.) through accountable care organizations (BIDCO, C3). Through this engagement we are able to conduct several activities aimed at reducing health care costs, including…

- Identification and subsequent/ongoing care management of high risk and transitional patients aimed at reducing unnecessary/avoidable ER and inpatient utilization
- Standardized specialist and diagnostic testing referral pathways aimed at reducing provider practice variation that can lead to unnecessary specialist care, unnecessary diagnostic testing, and care that while necessary could have been provided less expensively within network.
- Clinical documentation improvement processes aimed at improving documentation and coding within the organization which leads to more accurate budgeting for patient care and better assessment of patient acuity at the health plan level
- Pharmacy programs aimed at increasing the use of generic medications over brand name ones, and preferred brand name medications over non-preferred brand name drugs.

As an FQHC, we have the ability to help patients deftly navigate the health insurance landscape and enroll them in coverage that meets their needs and provides them with access to preventive care before expensive medical problems arise.

Through our partnerships with government agencies (such as Massachusetts DPH) we can implement health navigation, screening, linkage to care, and engagement programs that serve the dual purpose of (a) providing health services to people who would not access them in more traditional settings and don't have existing coverage to pay for these services, and (b) leveraging navigation capabilities to introduce or re-enter patients into lifesaving and cost effective care.

The most important way we can help control costs is by ensuring that patients always have access to excellent primary care providers in a timely manner. We do this in a variety of ways: utilizing clinical teams across the organization that consist of various provider types (not just doctors), implementing same day and open access models of care at our ambulatory sites, and exploring ways to embed clinicians in less traditional settings (such as our needle exchange sites, etc.).

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

- Maintain without significant restrictions state (Health Safety Net) and federal (Ryan White, Title X) "payor of last resort" programs aimed at ensuring care for people who are either chronically or transiently uninsured/underinsured; health care reform in Massachusetts has not eliminated the need for these programs.
- Continue to increase provider reimbursement for—and insurance coverage of—primary care oriented medical and behavioral health outpatient, home-based, and telehealth services. The less patients have to pay for relatively low-cost primary care, the more likely they are to seek it in a timely and effective manner, and the lower downstream health care costs will be. At the same time, move away from the fee-for-service paradigms that have made American health care the most expensive in the world.
- Increase transparency across the state of both health care pricing and health care performance among physician and hospital networks.
- Empower the Massachusetts Health Policy Commission to regularly collect and publish unblinded quality and cost data across the Commonwealth, and to use that data to inform and enable legislative, executive, and judicial efforts aimed at eliminating anticompetitive and other unfair practices that hinder the HPC's goal of better health and better care at a lower cost.
- Allow the HPC or other agencies to assess the degree to which administrative burdens (prior authorization and other forms) from stakeholders (insurance companies, pharmacy benefit managers, specialty pharmacies) impede the provision of quality and affordable health care to patients and by health care providers within the Commonwealth.

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.
Our newest strategic plan for the health center was approved by our board of directors in September 10, 2019, and includes four domains: 1) clinical & quality, 2) financial, 3) general administration, and 4) board of directors.

The clinical & quality domain includes goals focused on prioritizing the following changes to our primary care practices:

- Working towards greater racial and ethnic health equity within our communities
- Increasing access to care for existing and patients
- Enhancing team-based models of care
- Redesigning services and programs to become more patient-centered
- Improving our ability to thrive in a population health and value-based health care environment

The financial domain includes the following goals focused on improving fiscal oversight:

- Improve the financial performance of Fenway Health by adopting best-in-class processes, technology, and workforce development
- Prepare Fenway Health for long-term financial viability in response to potential changes and disruption in healthcare

The overarching theme of these goals is to improve clinical quality and access while ensuring strict fiscal oversight. For example, there are action plan activities related to value-based contracting to improve our performance, i.e. improve care at a reduced cost. Each of these goals in the plan include detailed objectives and time-bound action plans, with accountability through reporting to the board.

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 year-plus, the BH department has continued to build-out and build-up our "low threshold" BH services, while also making purposeful efforts to open-up access to care by innovating systems of delivery and models of care in the following ways:

- Addition of Behavioral Health Walk-in service. Added January, 2018. This service provides same day, walk-in (no appt. needed) access to a master's level clinician for assessment, counseling, crisis intervention. This service means that more people who struggle with keeping scheduled appointments have continued access to "low barrier / threshold" BH care. Prior to the addition of this service, many of these people "fell out of care" or were "lost to follow-up". In terms of reducing costs of care, this service has been effective in "diverting" some individuals from use of the ED or inpatient treatment. As part of our strategic plan, this service, as well as other existing BH resources, will be deployed over the next 2 years to target individuals who frequently use EDs or inpatient treatment. The hope is that the walk-in and other low threshold BH access will replace the use of more costly care, such as ED visits and inpatient treatment. This service has demonstrated success based on volume of utilization, and demonstrated positive responsiveness from those who use the service. We are piloting an expansion of this service to FSE now.
- 4 FTEs for High-acuity, community based case managers for HIV positive individuals
- 2 FTEs High-acuity community based case managers for individuals with opioid use disorder and other SUDs
- 1 FTE Recovery Coach
- 1 Public Health Social Worker – HIV
    - All of the above positions also provide low barrier / threshold access to psychosocial supports, linkage to care (both medical, BH, MAT), supportive counseling care. These roles are intended to outreach and provide access to care to those that are not well connected to, or not established in any care at all. All these roles have a direct connection to the AAC locations and the public health programs run out of AAC. These roles have built-out and strengthened the continuity of care that we provide between our Fenway based clinical services and out PH services. As a result, we have a broader continuum of care today compared to the past.
- Newly created Behavioral Health Clinician for the Borum – HRSA expansion grant. To increase access to MH and SUD treatment, especially for the Borum age range. Master's

level clinician who will provide BH assessments, treatment, crisis intervention, as well as case management services. Will do outreach to Youth on Fire.

- Actively developing Same Day Access to our Addiction Recovery and Wellness Program (SUD treatment) – we are creating the foundation for piloting same day, no appointment needed access for SUD treatment. We are making use of technology to aid this project – data collection via iPads that will be imported into clinical documentation and enrollment paperwork. Clients will meet with an engagement specialist and a clinician for orientation, enrollment, assessment and the start of treatment.
- Actively developing Same Day Psychiatry Access – especially for post-hospitalization f/u care, and for clients who struggle with keeping scheduled appointments. As part of this project, we will be hiring a psych NP who will be spending 50% of time embedded in primary care, and 50% of time for follow up care. They will also be connected to our MAT program.
- Also, in January 2018, we hired a BH Quality Assurance / Utilization Review Coordinator – new role for the department. To support purposeful transformation of our "traditional" outpatient psychotherapy services, moving the model from a bias towards longer-term, open-ended psychotherapy to a model that is more goal / solution focus, and with an "episodic" frame.
- Some UDS stats:
    - In calendar year 2018 there was a 6% increase in patients seen for BH (MH TX), and a 12% increase in visit volume, compared to 2017
    - In calendar year 2018 there was a 16% increase in patients seen for SU treatment , and a 27% increase in visit volume, compared to 2017
    - In the first half of 2019, there is a 27% increase in patients seen for BH / SU (combined), and a 24% increase in visit volume, compared to first half of 2018

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?

- The provision of delivery system reform and incentive payments (i.e. DSRIP) directly to primary care practices—including substantial payments early and up front and ongoing payments thereafter—is instrumental in ensuring their transformation into high-functioning, high-quality, and efficient enterprises. Payors can and should partner with health care providers in this vital redesign of the health care system.
- Pairing DSRIP programs with timely and evidence-based technical support (through the Massachusetts League of Community Health Centers, the Massachusetts Medical Society, and other entities) ensures that practices will have the resources they need to make this redesign effective and sustainable.

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?

- Behavioral Health Integration efforts have made the modernization of patient privacy and confidentiality a paramount issue that has very passionate and well-reasoned patient-centered advocates on both sides. Co-located and integrated primary care / behavioral health / substance use treatment services are vital to improving the state of health care in the Commonwealth, as is the use of health information exchanges to securely share patients' medical records care networks. Policies and legislation that provide greater clarity around confidentiality and information sharing, while at the same time continuing to safeguard patient privacy, can result in higher quality and safer care.

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	Major Contributing Factor
Aging of your patients	Minor Contributing Factor
New or improved EHRs that have increased your ability to document diagnostic information	Minor Contributing Factor
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	Major Contributing Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe: Click here to enter text.	Level of Contribution

☐ 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	Low
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
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	High
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Low
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	Medium
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**		
	Q2		
	Q3		
	Q4		
CY2018	**Q1**		
	Q2		
	Q3		
	Q4		
CY2019	**Q1**		
	Q2		
	TOTAL:	Not available, see below	Not available, see below

    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.
    As a federally qualified health center, Fenway maintains a commitment to providing care to patients regardless of insurance status or ability to pay, including offering a sliding fee discount program. During the patient registration process all patients who are uninsured, as well as insured patients whose low income may present challenges with meeting deductible or copayment costs, are informed of the availability of the sliding fee discount program and advised how to meet with a Financial Assistance Specialist. Fenway

periodically reminds patients of the sliding fee discount program through lobby signs and printed messages on billing statements.

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?
Our primary barrier is in creating a system to track such inquiries. Staff add a note to the finance section of the registration record if a patient asks about pricing, including when such inquiries come from the billing department. However, our system does not have a mechanism to run a report to capture how many inquiries we have received over a given period covering all patients. In addition, the registration record is only for existing patients, and would not capture an inquiry if it were from a prospective patient. This has been discussed with the vendor of our electronic health record, but to date there is no resolution.

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.

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.