Lawrence General Hospital

From the office of Dianne J. Anderson
President &CEO

September 20, 2019

Lois J. Johnson
General Counsel
Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Via email: HPC-Testimony@mass.gov

Dear Ms. Johnson;

On behalf of Lawrence General Hospital, please find enclosed our written pre-filed testimony for the 2019 Annual Cost Trends Hearing.

This testimony is signed under the pains and penalties of perjury.

Sincerely,

Dianne J. Anderson RN, MS
President & CEO

DJA/jg

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

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?
   We have accepted value based contracting opportunities for commercial contracts, and Medicare, and partnered to create a local Medicaid ACO with the community health center. We have established programs to reduce emergency department utilization and skilled nursing facility days and to refer care to local providers. We have made critical investments in care planning and established a pharmacy management program to ensure that the medications and care patients require is better coordinated. Many of our patients have low health literacy due to language or educational access and they need enhanced bedside education and training in their native language to understand their disease, medication regimen and the beneficial impact of their adherence to care plans. Investing in a pharmacy management system to ensure we have access to medications patients are taking, and ensuring that patients follow medication protocols and also can afford to fill their prescriptions has been an important component of reducing unnecessary expenditures like readmissions. In the Medicaid ACO we have also focused resources on coordinating local access to specialty care since the care delivered to Medicaid patients is largely delivered either at the health center or the ancillary services of the hospital.

   Local access to care is the single most important strategic priority. It is the most effective way to save health care expenditure. Our care is efficient, accessible and very high value. Every tool we can afford to build to retain care locally reduces health care expenditures, and ensures the future viability and access of our regional medical center.

   b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?
   To sustain vital and high quality acute care access and services that serves the Greater Lawrence region, commercial health plans must pay more equitable rates to Lawrence General Hospital. Persistently low commercial rates which have been evident since the passage of Chapter 288 have intensified an efficiency imperative, but also threatens our critical lifesaving programs like Trauma, Stroke and Cardiac Care. With nearly 70,000 Emergency visits and 12,000 discharges delivered at a high value, the greatest contribution we could make to reduce health expenditures is to deliver more care to the local population that leaks to higher cost providers.

90% statewide average relative price equity is urgently needed to make up for years of unsustainably low commercial insurance rates paid to Lawrence General Hospital.

If commercial health plans were required to pay us adequately we could ensure access to a larger volume of patients and save costs. The savings commercial health plans could achieve by providing the necessary resources to sustain access in our region alone, are measurable and significant.

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.
We have a local practice we have recruited a handful of primary care physicians to in the past few years. We do not have resources to recruit, employ and subsidize a significant amount of primary care physicians without partnering with the large health systems to do so. We have a joint family practice residency with the local community health center that attracts residents and faculty to serve the population in Greater Lawrence that relies on Medicaid.

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.
We have an ambitious plan whose funding is not secured yet to build space adjacent to the emergency department to care for patients awaiting behavioral health inpatient care. Given our current negligible operating margin for critical lifesaving acute care, trauma, cardiac, and medical care, our payor mix and low commercial relative price of 73%, 3rd lowest in the Commonwealth, it is not feasible to provide behavioral health inpatient services and we lack the infrastructure to maintain robust access. Behavioral health care has largely been the domain of for-profit providers in our region for more than a decade. We have done some unsuccessful joint recruitment with the community health center of behavioral health professionals and staff but without an established program with the full complement of services it is not enduring. We rely on 24-hour emergency bed placement under contract with Lahey Health and we frequently fail to secure needed inpatient placement for patients who require it because there are no beds. Our highest priority is maintaining high quality acute care access, for which we receive the lowest commercial health plan rates, and serving low income patients who rely on Medicaid which does not cover the cost of care, and for whom we are working to

serve under the Medicaid ACO which like most around the Commonwealth, are operating at a deficit because it is underfunded.

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?
Payment from Medicaid for behavioral health within the E&M codes or an enhanced code for E&M of behavioral health, and greater reimbursement for behavioral health care that is delivered in the emergency department over an episode of care due to limited access within the broader behavioral health capacity would allow us to provide services we do not otherwise have available.
Hospitals like Lawrence General do not have inpatient psych units because we use all of our beds for acute care. Providers who are paid the lowest rates of payment by the health plans and low commercial reimbursement in general have limited capacity to maintain behavioral health services and rely on a growing network of for profit health care providers to try to meet community need.
Adequate rates for acute care would permit investments in primary care and behavioral health access.

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?
Market behavior and payment together have led to a dearth of behavioral health access, and primary care access that is divided between organized medical groups and health centers. The barriers to investment in behavioral health and primary care by our hospital is a matter of scarce resources. We have limited resources to invest, and additional recruitment of providers, whether they were staff with enhanced practice capabilities or supported by reimbursement would need to be financially viable. In Massachusetts primary care for low income populations is largely delivered by community health centers that provide primary care access for a predominantly Medicaid population. In suburban communities, particular affluent ones, primary care is provided by medical groups that are oftentimes members of a local Physician Health Organization but who often contract with or are owned by Boston based physician groups affiliated with academic medical centers.

Lack of access to resources to recruit primary care physicians to the community is the single largest driving factor for access to primary care. Behavioral health resources are predominantly delivered by for profit entrants to the market who are limited in capacity.

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	Major 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	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)	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	High
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	High
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Medium

Area of Administrative Complexity	Priority Level
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	High
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	Medium
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	High
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	Low
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: Substantial infrastructure payments would enhance adoption for providers

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		23
	Q4		9
CY2018	**Q1**		
	Q2		
	Q3		18
	Q4	1	27
CY2019	**Q1**		17
	Q2		8
	TOTAL:	1	102

    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.
    We had engaged and relied on an external vendor to respond to price inquiries (Sutherland). They were not able to provide a log describing the nature of the call and resolution. The Hospital has terminated the relationship effective 9/30/2018 as a result. We undertook the task internally in the last two quarters of 2017 which we reported here and we are resuming that work internally now.

Respondents to inquiries must document patient name, date of request, nature of request and action taken to address inquiry. Patient financial services (PFS) monitors log with this documentation.

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?
The following situations are common:

- **Translating a patient's request into searchable form (e.g., "a lab test for XXXXX" needs have a CPT/HCPCS assigned to it). In these situations, PFS staff will work with the patient narrow the possibilities to a most likely option or will request the patient to contact their physician.**
- **In situations where a patient's out of pocket costs are defined as a percentage of benefit versus a percentage of charges, patients are advised to contact their insurance carrier.**

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.

At this time the Hospital's systems are not capable of providing this information at a level of accuracy which we believe to be appropriate for distribution to external parties.

2018	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$10M	$13M	$.32M	$.45M			<$.01M>	<$.01M>							
Tufts Health Plan					$5M		<$.01M>								
Harvard Pilgrim Health Care						$11.M		<$.01M>							
Fallon Community Health Plan															
CIGNA												$1M			
United Healthcare												$4M			
Aetna												$.8M			
Other Commercial												$4M			
Total Commercial	**$10M**	**$13M**	**$.32M**	**$.45M**	**$5M**	**$11.M**	**<$.02M>**	**<$.02M>**				**$50M**			
Network Health											$4M				
Neighborhood Health Plan					$16M		$.029M				$2M				
BMC HealthNet, Inc.											$2M				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$1M				
Total Managed Medicaid					**$16M**		**$.029M**				**$25M**				
MassHealth		$36M		$.5M											
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal												**$13M**			
Medicare												**$74M**			
Other															
GRAND TOTAL	**$10M**	**$49M**	**$.32M**	**$.95M**	**$21M**	**$11M**	**$.01M**	**<$.02M>**		**$25M**		**$137M**			

The Hospital contracts with non - government payors through a third party which provides reporting at a summary level. Because not all of the Hospital's private sector business involves risk sharing settlements, the Hospitals total NPSR is reflected under the columns "P4P Contracts" while only the risk sharing surplus/<deficit> is reported under the columns "Risk Sharing".

Because the Hospital accrues for MassHealth P4P reveneu in the fiscal year subsequent to the RFA rate year to which the P4P bonus applies, there will be a one year difference between the amounts in EOHHS's records the the amounts reported on this schedule. And, as such the FY 2018 MassHealth P4P amount is an estimate.