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?

- ***Partners 2.0*** *is a multi-year, system-wide initiative to take advantage of opportunities to optimize efficiency across Partners HealthCare and its member institutions. We are streamlining structures and processes to help sustain our enterprise and protect important priorities in a challenging new regulatory, legislative and consumer environment. Total savings to date is $324M, which includes FY17, F18, and FY19 Q2. Examples of projects include: centralized credentialing, emergency department productivity teams, imaging procurement practices, and optimizing lab work.*

- ***Partners ambulatory care strategy*** *is designed to offer care to patients closer to their homes at lower costs. A key component of the plan will involve working with each community to address their specific health care needs. The new investments in medical facilities and outpatient surgery will offer the community a range of ambulatory services-primary and urgent care, behavioral health services chronic disease management, and imaging and day surgery. This includes joint replacement surgery, which is increasingly able to be performed on an outpatient basis at a fraction of the cost of an inpatient academic medical center. These initiatives will be focused on people, programs and digital tools and strategies that can help improve health in communities with health challenges, promote health equity improve clinical outcomes and remove existing barriers to health.*

- ***The Partners Enterprise Data and Digital Health Initiative*** *(****EDDH****) is a five-year strategic digital health initiative to improve patient experience, boost digital innovation and transform clinical care across our system's hospitals. It will engage patients on their health care journeys, build upon Partners foundational investments in data and technology and develop and scale existing digital care projects.*

  As part of this initiative, this past July Partners upgraded its patient portal - Partners Patient Gateway. The site has a new look and feel, is better organized and more intuitive, and the changes will enable patients in the future to access online scheduling, real-time emergency department wait times and broader telehealth options. Later this year, the digital health initiative will expand patient

access to several innovative start-up solutions and novel programs developed at Massachusetts General Hospital and Brigham and Women's Hospital. These programs have already demonstrated success and are revolutionizing the care and treatment of several serious medical conditions by using big data, machine learning and algorithms. Partners will also standardize the way we capture information across the system and coordinate data and analytics professionals from across Partners hospitals, clinics and our health plan. These measures will give clinicians, researchers and staff better access to operational data and help drive improvements in many areas of hospital operations including bed capacity management, asset management, supply chain and clinic operations such as optimization of clinic schedules and access and revenue cycle operations.

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

- *As a provider system we are committed to ensuring appropriate prescribing practices. However, we believe a major impact could be achieved by developing new mechanisms for holding the drug industry and Pharmacy Benefit Managers accountable for price increases for both generic and innovative drugs.*

- *In a healthcare world that is increasingly data driven, there exists an enormous opportunity for the Commonwealth to invest in interoperability solutions. The implementation of the Mass Health ACO also highlights the need for the Commonwealth to improve its data capabilities.*

- *Behavioral health reimbursement continues to fall short of the actual cost of providing care. Providers, like Partners, that continue to make substantial investments in behavioral health services must rely on cross subsidization from other service lines. Not all providers are able to do this however. If payment for behavioral health services was more in line with the true cost of care, more providers would be able to make much needed investments in this area.*

- *On many fronts, Massachusetts is the leader in health care delivery and policy, however when it comes to telehealth we lag other states. Changes in credentialing, payment and coverage policy are needed for greater adoption of telehealth services.*

- *Given today's focus on team-based care centered around a medical home and forecasted or existing shortages in several clinical areas, it is important that the state's scope of practice laws are updated. The laws should reflect the skills and training of today's clinicians and maximize the services they are able to provide patients, particularly for advance practice nurses and nurse practitioners.*

- *Over the past few years, the Department of Public Health (DPH) has made significant changes to the regulations governing the DON program. While many of the revisions have sought to modernize the program to comport with an increasingly dynamic health care market, the underlying DoN statute has not been updated comprehensively since the 1970s. As a result, DPH has limited authority to address elements of the DoN program that have become obsolete. For example, the statute requires DPH to review certain capital*

expenditures associated with routine maintenance and up-keep of health care facilities. This creates an administrative burden for both providers and the Department alike, with little benefit to patients and consumers. We would encourage policymakers to engage with stakeholders in reviewing and updating the DoN statute such that it truly reflects the health care system of today and fosters innovate approaches to creating the health care system of tomorrow.

- *Clinician documentation requirements consume between 20 and 60% of clinicians (i.e., physicians and nurses) time. In an age of computers, this is excessive and wasteful, keeping highly trained and skilled members of the workforce from doing their primary jobs – caring for patients. Regulatory relief in the form of reducing administrative complexity could free very large amounts of time, reduce staffing needs, reduce burnout and turnover, and thus lower the costs of care while improving quality.*

- *The cost of adhering to billing and payment collection requirements (together referred to as revenue cycle) is over 100 times the costs for these processes in other industrialized industries. National estimates place the total annual cost at over $200B. In Massachusetts where all providers are required to take downside risk for cost overruns, such rules produce little to no added value in healthcare. We support efforts to simplify and create greater transparency in billing practices as part of the healthcare system.*

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.

   Partners shares the belief that primary care is the bedrock of care delivery transformation and accordingly has made a significant investment in enhancing primary care services throughout the system. In 2012, Partners committed to transforming all primary care practices into nationally-certified Patient Centered Medical Homes. Patient Centered Medical Home is a team-based model of care that improves efficiency, patient access, and clinical quality.

   Partners primary care practices have multi-dimensional care teams that include physicians, nurses, medical assistants, care managers, behavioral health support specialists, social workers, and community health workers. Partners has developed targeted care management interventions to support primary care providers in meeting

the needs of their most complex patients. These programs are implemented system-wide and are monitored for continuous quality improvement through a robust performance management framework.

Improving access is an ongoing challenge, especially for behavioral health providers. We embedded behavioral health resources in our primary care practices to help PCPs manage lower acuity diagnoses so that behavioral health providers have capacity for patients with more complex disorders. In addition, new Epstein Center for Behavioral Health at the North Shore Medical Center(NSMC) will add 54 new beds to the region for psychiatry and behavioral health services. When it opens in October, the Epstein Center directly aligned with Massachusetts General Hospital will be the largest inpatient mental health service embedded in a general hospital in the Commonwealth of Massachusetts, enabling patients to benefit from a wide range of subspecialists available on site. This addition also serves to relieve overcrowding in NSMC's emergency department and free up capacity for patients with critical health issues. Additionally, Partners HealthCare has a variety of virtual health tools designed to improve access via virtual visits, e-visits, and e-consults.

We monitor our progress toward increasing access, improving quality, and reducing total cost of care in a variety of ways. We have seen the cost-trend for our primary care managed patients decline since implementing these initiatives. Additionally, in 2018, the primary driver of our cost-trend was increased price of facility outpatient pharmacy. If we exclude facility outpatient pharmacy, half of the remaining increase in trend was related to an increase in outpatient behavioral health services and preventive exams. This tells us that our efforts to increase access for primary care and behavioral health services are having impact. Similarly, improved performance in patient experience scores and ambulatory quality measures indicate that we are advancing toward our goals.

Lastly, we have an evaluation and research team that evaluates the effectiveness of our care management programs on improving outcomes and reducing costs. We pilot interventions, test for effectiveness, and scale only those interventions proven to have impact.

Partners HealthCare achieved its goal of transforming its primary care practices to PCMH practices in 2018. With transformation completed, sustainability becomes essential. As such, we have developed an advanced primary care framework that pioneers new measurement models to truly hone in on the key components of PCMH that improve quality and efficiency to aid us in our drive toward excellence.

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.

By integrating behavioral health offerings into the primary care setting, Partners has been able to establish the universal competence and skill, and the interdisciplinary primary care teams needed to effectively support patients with behavioral health conditions, including depression, anxiety and substance use disorders. The goal of this integrated approach is to engage patients in the primary care setting who present behavioral health conditions by: (1) seamlessly integrating innovative, evidence-based

population health program models and, (2) supporting primary care providers via accessible training and expert consultations.

Our primary care-embedded behavioral health integrated care teams are anchored by a nonclinical direct service workforce who collaborate with clinicians to deliver a suite of behavioral health interventions within the primary care setting. In addition to resource finding and e-consults, this suite of interventions include:

- *Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) Model - a short term, evidence-based program, offered by a care team engaging with patients in primary care practices or via telephone. The IMPACT program offers screening for symptoms, coaching, behavioral activation, psycho education, support with medication adherence, and psychiatric consultation. It is a treatment-to-target approach.*

- *Screening, Brief Intervention and Referral to Treatment (S-BIRT)- a one-time, sequenced intervention with patients that uses screening for substance use, targeted education about substance use and mental health, and referral (as appropriate) to treatment.*

- *Internet-based Cognitive Behavioral Therapy (iCBT) - an online self-directed course in cognitive behavioral therapy (CBT) offered to patients with low to moderate levels of depression, anxiety and related conditions, to help them self-manage symptoms of those conditions.*

- *Recovery coaching- a peer support model of service to address substance use disorder, is a complement to the Collaborative Care suite of interventions.*

- *Integrated Substance Use Disorder Treatment- In 2018, Partners Behavioral Health Integration piloted the implementation of embedding an addiction medicine team at one primary care clinic, with the potential for more sites to follow. This model increases access for patients to needed specialty care for addictions, bridges care back to primary care for long-term management, and increases the likelihood of positive outcomes through complementary peer support and care coordination.*

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?

Payer reimbursement of evidence-based models (and investment in evaluation of innovative models) can ensure sustainability of efforts to reduce costs and improve quality. Today the costs are born by providers which limits the scalability of effective interventions.

Partners has made great strides toward integrating behavioral health into medical care. This work is made more challenging by payer's use of behavioral health carve-outs. The

split payment model is antithetical to an integrated clinical model. Often we are trying to manage patients without any view into our patients' behavioral health utilization.

The current crisis in behavioral health access is the product of historically low reimbursement for these services. Because payers have been unwilling to engage in revising their fee schedules to address this issue, Partners reallocates revenue to these service lines internally.

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?

Payment policies should adequately reflect the value of primary care. Payments to primary care providers should not be limited to direct health care services. Payment policies should be expanded to include non-face-to-face services and population-based care management and behavioral health support services.

Physician burnout is a pressing concern among primary care providers. Policies and regulations should be geared toward reducing the administrative complexity of delivering high-quality care to ensure that primary care physicians can operate at the top of their licenses.

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	Not a Significant Factor
Aging of your patients	Not a Significant 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)	Minor 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

Factors	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	High
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	Medium
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	Medium
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

Area of Administrative Complexity	Priority Level
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	Low
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.

   See attached – MGH AGO Exhibit 1.

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.

      Note: The numbers provided below are for all of Partners HealthCare System. We do not have data available at just the MGPO level.

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**	NA	1,300
	Q2	NA	1,450
	Q3	NA	1,513
	Q4	NA	1,614
CY2018	**Q1**	NA	1,854
	Q2	NA	2,115
	Q3	NA	2,100
	Q4	NA	2,049
CY2019	**Q1**	NA	2,124
	Q2	NA	1,655
	TOTAL:		17,774

**Please note, an issue was discovered in our reporting that has been corrected for this report out. As a result, the totals for CY2017 and CY2018 Q1 and Q2 have been updated. In addition, we do not have a way for patients to submit a written request (via an online form or secure email). All requests are by phone or in person.*

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.

Currently MGH, NWH, NSMC, BWH, BWFH, CDH, NCH, and MVH are all using the Epic Patient Estimate Functionality. An Estimate request comes in through Customer Service, Registration, Admitting or Physician Practices. The staff member who receives the request completes an electronic intake form with the patient's information. They will then send a secure email with this information to the appropriate Patient Access Patient Estimate mailbox for the entity which will be providing the services. When the financial counselors receive estimate requests via the email box for their entity, they enter them into Epic. There are two reports established that show progress on the estimates: estimates in process and finalized estimates. This allows the managers to ensure that we are meeting the 48-hour timeframe for providing an estimate for a patient. From a support perspective, we do periodic quality review of this data to ensure that the estimates are being done accurately in Epic.

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?

We do not encounter barriers to successfully providing patients with estimates within the 48-hour timeline. We have firm process in place for triaging of the estimate requests then providing them to the appropriate entity for the estimate to be created and provide to the patient. The mailboxes utilized by the financial counselors are managed locally and multiple people have access to them if there is an issue. We also have a coding email box that is managed by the Partners coding team if there is a coding related question (such as a DRG request). In addition, since going live with Epic we have a support structure in place to ensure that if there are system related questions or issues those are dealt with by the Partners eCare team.

In FY20, as part of the Partners Digital Health Strategy, patients with a Partners Patient Gateway / Epic MyChart account will have the ability to log in to their account and view the estimates they requested that were generated by Parnters staff. In addition, they will be able to create an estimate themselves, for several services. Work is underway to determine what services will be available for the patient to generate a self-service estimate. This will make the estimate process faster and easier for the patient.

The most significant challenge with estimates is that the care a patient receives may change during the care/treatment/service based on the clinical decision making of the physician or provider. If the patient requires additional clinical care or testing than initially anticipated, the estimate may not be accurate. We try to explain this to each patient, but it is not clear that they always fully understand the impact. In addition, we are only as accurate as the payer systems are updated. If the insurer does not have up to date accurate information about the patient's deductible status or benefit structure, we may not be giving the patient the most accurate estimate.

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 attached – MGPO AGO Exhibit 2.

   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 attached – MGPO AGO Exhibit 2. We do not have this information available by major service category.