



September 23, 2013

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

To Whom It May Concern,

Please accept this written testimony on behalf of Pioneer Valley Surgicenter, LLC in response to the request on Health Care Cost Trends in the Commonwealth.

If you have further questions or are in need of additional information, please do not hesitate to contact me at lrahm@amsurg.com or 413-788-9700.

Sincerely,

A handwritten signature in black ink that reads "Linda K. Rahm".

Linda K. Rahm, Administrator

Signed under the pains and penalties of perjury on the 23rd day of September 2013

Exhibit B:

Healthcare Cost Trends in the Commonwealth

1.
 - A. Changed our ownership structure to a national corporate partner to capitalize on GPO pricing. Continue to "Insurance Hop" for employee plans to minimize cost increases. Reduced employer contribution to employee benefit plans. Upon analysis of our revenue trend, findings emphasize a direct correlation with procedure volume. We improved efficiency, allowing surgeons to perform more procedures in less time with reduced turnaround time. This increased efficiency allows the provider to deal with crucial tasks such as emergency room coverage and procedures, seeing patients, following up with patients, research and development improving patient care and outcomes. Efficiency and cost savings are paramount for all our employees and part of their orientation and ongoing training. Personnel strive to ensure turnover time between cases is at a minimum, have knowledge and retention(?) of what is expected for each surgical case, and are cross-trained to maximize time and staff scheduling. Efficiency in terms of medical supply usage is also important. Our staff is trained to open only the items that are needed for the case, and wait for the others until there is a request. This adds to our efficiency and how we control costs and maximize revenues. Note however, that because of the disparity in payments between ASC's and HOPD's, this type of efficiency is not an option but a necessity resulting in savings for the payers, the subscribers and the State.
 - B. Implementation and utilization of technology. We now leverage our website to improve "day of procedure" efficiencies by moving information gathering and patient forms further up the patient pathway. Patients access Pre-Operative paperwork and information via the internet and complete the forms prior to entering the facility which streamlines the patient pathway and improves efficiencies and cuts costs. The center has also invested in a report writer application as an initial step towards a "paperless" environment with the belief that this strategy will further enhance efficiencies, reduce supply cost, reduce FTEs and other costs such as record storage.
 - C. That surveyors are more adequately educated in the functionality of the Rules and Regulations surrounding ASC's and patient care practices. The self-imposed and self-interpreted criteria by individual surveyors and surveying bodies creates an unnecessary and burdensome some without consideration of patient care and without research supported data.
 - D. We have been working to promote pricing transparency to all of the stakeholders within our market to promote the utilization of our ASC over more costly alternatives. We also have plans to begin leveraging our quality data to shape our value proposition for patients, payers and referring physicians.
2. For most Medicare covered services, the cost to beneficiaries on a surgical service in an ASC is about half the price they would pay for the same service delivered in a hospital outpatient department. There is significant site of service price variation where savings could be achieved for both beneficiaries and the program if providers had broader access to the ASC setting.

Despite providing identical services, as HOPDs, ASCs are reimbursed by Medicare at only 57% of the HOPD rate and the gap between ASC and HOPD reimbursement is growing. In 2003, Medicare paid ASCs about 86%, on average, of the amount it paid HOPDs. (Source: Representative Sessions and Larson Dear Colleague Letter, June 1, 2011). In 2006 alone, ASC's saved Medicare and its beneficiaries 1.7 billion dollars. The exact same service, provided in a different setting, at a cost savings. Facilitating access to utilization of ASC's will save Massachusetts money.

This leads into the second part of the hypothetical exercise above: imagine that PCPs were free of hospital pressure and control which is driving trend towards greater utilization of services in HOPD settings and greater total medical expense. It is my understanding, garnered through knowledge of trends disclosed by colleagues through my work with the Massachusetts Association of Ambulatory Surgery Center (MAASC)

that hospitals are continuing enter into direct relationships with physicians, whether through direct employment or "affiliations" or "arrangements", whereby referrals are being directed back to the hospitals driving costs upwards.

Massachusetts Health Care Cost Trends Part III: Health Spending Trends for Privately Insured 2006-2008 found that "outpatient spending at hospitals grew 26 percent from 2006-2008, while spending in ASC's declined 14% during that same period. Outpatient care provided in a hospital outpatient department (HOPD) is expensive and less efficient. These exact same procedures can be safely delivered at freestanding ASC's for a fraction of the cost

I believe freestanding Ambulatory Surgery Centers (ASC's) are truly an integral part of slowing the growth in health care costs while maintaining quality of care.

3. NA in ASC setting

4. A. I feel as an ASC we are a critical part of the solution to both problems of increasing total medical cost and wide variability seen across physician groups. Imagine for a moment, that the PCPs in the Commonwealth had both pricing transparency of those services that they refer their patients for and were free of hospital pressure. I believe under these conditions, PCPs and patients would both refer and seek care in high quality lower cost settings. The Pioneer Valley Surgicenter and the other Massachusetts ASCs would be favored and fully leveraged in our state healthcare delivery system to do just that: provide the exact same services as HOPDs at the same quality or better, for far less of a cost to the payers and patients driving down the total medical expense.

I feel patients with full knowledge of pricing and quality will make real consumer driven choices on where they receive their care and further expand competition within the healthcare delivery system reducing the growth of TME. We have been working to promote pricing transparency to all of the stakeholders within our market to promote the utilization of our ASC over more costly alternatives. We also have plans to begin leveraging our quality data to shape our value proposition for patients, payers and referring physicians.

- B. The ASC finds it difficult to add physicians to our credentialed and privileged staff because hospitals continue to enter into direct relationships with physicians, whether through direct employment or "affiliations" or "arrangements", whereby referrals are being directed back to the hospitals driving costs upwards.

C. Systemic and policy changes needed

- Produce legislation that prohibits exclusive referral arrangements between hospitals and their employed physicians or physician groups. All physicians, whether hospital owned or not should be allowed to access the lower cost service that maintains equal or greater quality service to that of the hospital. Currently surgeons are not able to utilize the ASC.
- HOPD should be paid at the same rate at ASC's.
- Further pricing transparency and incentives are needed to encourage the use of lower cost high quality options. As described above, I am afraid with the growing trend of hospital system expansion and control over the "patient referral pathway" thru hospitals both employing and having control over where PCPs and Specialists send their patient referrals, we will see further increases to total medical cost and growing that expense variability across physicians groups. Physician groups employed or aligned with controlling hospital systems will drive referrals internally to HOPDs and other more costly healthcare delivery options. Independent ASCs will be bypassed, weakening their position in the fabric of healthcare, resulting in missed savings opportunities for both payers and patients.
- Amend current Determination of Need guidelines to allow for the growth of existing ASC's and for the development of new facilities.

- Amend long-standing Mass Health regulations that restrict contracting to licensed, multispecialty entities only.
 - An Oversight Entity/Board should be established to implement and monitor payment reform, within but not subject to the control of the Exec. Office of Health and Human Services (EOHHS). The Board should include practicing primary and specialty care physicians.
 - The MAASC should have a place on the ACO Board and/or Advisory Committee. As the only statewide association representing the 62 licensed single and multi-specialty ASC's, it is an important, component of the healthcare delivery system. Moreover, as the high cost of outpatient care, due in part to the overutilization of hospital outpatient departments, has been identified as a problem with the current system, a representative of the MAASC will provide balance to the hospital voice on the Committee and help the Committee "think outside the box" in addressing outpatient care costs. (Source: MAASC Comments to the Health Care Quality and Cost Council, Payment Reform Committee Public Hearing, December 2, 2010)
 - Prevent hospitals from participating in ownership of health insurance companies. Or require hospital owned insurance, through regulation, to contract with ASC's in their subscriber's service area. Currently those patients are required to get services from the higher cost health care option (HOPD's) as opposed to the choice of a less expensive alternative.
 - Look at an overhaul of properly paying hospitals for their services and stop cross subsidizing.
 - In addition to hospitals are entering into direct relationships with physicians, whether through direct employment or "affiliations" or "arrangements", whereby referrals are being directed back to the hospitals, I have witnessed an addition strategy to control the "patient referral pathway" and limit competition. Hospitals are now creating their own limited network insurance plans essentially allowing them to eliminate any lower cost competition within their marketplace by simply refusing to offer a contract to any willing provider. I have seen this practice significantly impact our business first hand as a local health system's limited network insurance plan market share continues to grow while at the same time, repeatedly rejects our requests to enter their limited network as a willing provider. Compounding the patient control issue that we are facing, it appears they are expanding their arrangements with PCPs and specialist as well as their procedure delivery infrastructure. If these trends are left unchecked, monopolies will be created as patients will be under the control of large hospital systems controlling the patient referral pathway thru their expanding physician provider networks and/or limited network insurance plans.
5. A. Our ASC tracks cost on a monthly basis with YTD analysis comparative to previous years. We track center expenses as a whole, by specialty and periodically at an individual physician level. Units of measure are cost per procedure, cost per case, salaries and benefits per procedure, medical supplies per procedure, variable expense per procedure and fixed expense per procedure.
- B. We benchmark our expenses against our corporate peers monthly.
- C. The data and benchmarks are reviewed monthly by administration and review quarterly by the Board for analysis and discussion of added expense controls.
6. Our center provides brochures with information to access to information as well as the directions to secure information regarding their insurance plan, cost and center cost. The center has a detailed website that direct them to a means of answering their questions. In addition, calls are made prior to the procedure and the patient is informed of any potential payment responsibility based on provided health insurance information.
7. All comments are incorporated above