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?

Strategic Priority #1: Reduce hospital readmissions. Building upon the success from our HPC Chart 2 grant, Southcoast Health continues to undertake a number of efforts to reduce hospital readmissions. These efforts are beginning to realize positive results. For example, prior to a patient's hospital discharge, a set of activities are consistently performed by a team of hospital case managers, physicians, and unit clerks. Checklists are used to ensure appropriate transfers, medication reconciliations, follow-up appointments, and the identification and fulfillment of any social conditions (when possible). Care navigators are matched to follow and assist patients over the 30-day, post-discharge period to further minimize the risk of adverse events and hospital readmission. In addition, patients are scheduled for follow-up visits (e.g., office, home, or transition clinic) within 5 days given the risk of readmission within 5-7 days (35%) and 10-14 days (60%). We believe that this concerted effort to conduct patient visits and evaluations closer to their discharge date will enable providers the opportunity to identify those who are at early-risk for readmission. In addition, home health and skilled nursing inpatient facility treatment protocols for both chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) are in place to increase the likelihood of patient rescue during decompensation thereby further decreasing the risk for hospital (re)admission.

Strategic Priority #2: Implement clinical efficiencies. By streamlining the workflow in Southcoast Hospitals Group (SHG) facilities and physician offices, we are reducing the cost of delivering seamless care while also decreasing the pressure for increased pricing. *Best Practices Alerts* were established in our electronic health record system, Epic, to assist hospitalist physicians in determining the optimal timeframes during which patients should be seen following hospital discharge. This information is used, in turn, by hospital unit coordinators to schedule post-discharge visits prior to patients departing from the hospital. These required appointment times are now made easier with support from our physicians in the Southcoast Physician Group (SPG) who have blocked their schedules five days, post-discharge to ensure appointment availability. In order to meet scheduling needs, a Transitional Care Clinic was recently established to guarantee patients follow-up appointments should their primary care providers (PCPs) be unavailable. This resource extends beyond the SPG and includes any physician groups in the surrounding region who have SHG discharges. In addition, practice nurses are required to provide a reminder call to the patients within 48 hours of hospital discharge. During the post-discharge visits themselves, providers have newly designed standardized visit templates to enable the PCP to efficiently review data and focus on the priority of the patient's condition/illness. This resource reduces effort involved in reviewing excessive, non-relevant data. Epic Smart Phrases—a charting tool to increase efficiency and note-taking—has been implemented for providers to document call notes and capture any variety of

critical patient information, e.g., home care services in use, medication reconciliation, and so on. Finally, those who are deemed at highest risk for hospital readmission—those with CHF, COPD, pneumonia, acute myocardial infarction (AMI), and open heart surgery patients—are followed for 30 days by care navigators within the Southcoast Health Network (SHN).

By streamlining the pathway of patient movement, i.e., more coordinated discharge planning and post-discharge follow-up (as noted in Strategic Priority #1), we are increasing our overall effectiveness. By working closely with service lines, including but not limited to, cardiac (e.g., CHF), pulmonary (e.g., COPD), and oncology, we are able to identify more efficient care pathways that also lead to better quality of care and improved safety. Standardized reporting is available through Epic to support each workflow in the patient movement process in addition to capture performance metrics across any time period (e.g., daily, weekly, monthly).

Strategic Priority #3: Reduce low acuity emergency department (ED) visits. Through a number of efforts, Southcoast Health has noted a slowing in the growth of ED visits. For example, Southcoast opened 7 new urgent care centers in areas that are located near public transportation routes (e.g., bus) and major shopping areas. In addition, with extensive input and approval from its physicians, Southcoast has also implemented an education marketing campaign called *Where Should You Go?* to inform its patients about the most effective, direct, and desirable route to acquire health care—a patient visits the PCP first. If the PCP is unavailable, the patient visits an urgent care center. If the patient's needs are emergent, then the patient goes to the ED. Patients have shared that they appreciate being informed about how to most efficiently access our health care system.

Strategic Priority #4: Reduce pharmaceutical costs. Most recently, Southcoast pharmacists have reviewed drug cost and utilization data for our patients whose results lead us to believe that there is a significant opportunity to reduce health care expenditures by substantially reducing pharmaceutical costs. As a result of these findings, the pharmacists are engaging with physicians to discuss alternative treatment options that are proven equally effective yet reduced in price. In addition, Southcoast is working with its Information Technology department to create programming that assists with formulary development in order to offer providers guidance on the lowest cost-effective treatments; this intervention is subject to the accuracy and extent of formulary information provided from payers. Finally, our pharmacists have also been visiting "complex" patients who are prescribed a large number of medications. The pharmacists perform an array of tasks to streamline their medication usage and lower costs. These tasks include: reviewing medication lists for those at-risk for adverse reactions, reinforcing the importance of medication compliance (e.g., following instructions), and presenting options for lower cost drug alternatives.

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

The following changes have been identified as opportunities that would most effectively support our efforts to reduce health care expenditures.

1. **Eliminate pharmaceutical rebates.** By eliminating pharmaceutical manufacturer rebates to health plans and simply reducing drug prices, health care expenditures would decrease. Because of rebate structure, perverse incentives are established which eliminate true price competition. More specifically, many payers do not apply the rebates to generate lower costs for patients. Likewise, many payers also require accountable care organizations (ACOs) to use specific drugs as a result of rebate incentives. However, the acquired cost savings are never

transferred to the at-risk ACO that is being charged the higher cost. Collectively, the pharmacy industry refers to the array of pharmaceutical rebates and incentives as "DIR fees" (Direct and Indirect Renumeration fees) that complicate a provider organization's ability to understand the true, net drug cost.

2. **Establish telemedicine laws.** A statewide consensus needs to be determined on the inclusion of telemedicine services as a covered benefit in all health insurance products in addition to the types of services that telemedicine can provide, licensing requirements needed for the provision of these allowable services, required payment for these allowable services (compared to in-person payments), and data transfer provisions of visit data to the PCP via electronic health records (EHRs).
3. **Establish observation status rules.** A common policy is needed for all payers for the identification and assignment of patients needing observation status. The rework required in this area could be substantially reduced. Currently, each payer has varying time limits for use of observation, inconsistent notification requirements, and various medical care guidance (e.g., MCG [formerly known as Milliman Care], InterQual, others).
4. **Create common data formats.** Common data formats should be created to enable the delivery of claims information from all payers. By streamlining these formats, this would help reduce IT costs of customizing each data feed. Since hospitals are already required to use common formats for billing and receiving payments, such standardization on the payer side would be very practical. Similarly, use of a common data format to transmit clinical information at a patient level to satisfy clinical quality metric reporting would also reduce IT development costs.
5. **Reduce the number of health plan products**. The number of health insurance products designed by payers to fit into several standard models should be reduced in number. Currently, payers are creating multiple variations of plans/products which add a significant amount of work (e.g., product requirement searches, additional authorizations, pre-certifications, understanding varying medical policies, differing deductibles, copayments, coinsurance, and coverage policies) to providers who are expected to know the nuances and/or are forced to search for them. Unless the payers collect patient payment portions directly, the number of products and their variations should be limited.

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.

As Southcoast Health evaluates its historical quality performance, great strides have been made on a substantial number of processes and outcomes. Almost every metric has increased to the 75th percentile and in some instances, often to the 90th percentile. The initiatives and activities highlighted below have enabled these performance improvements; however, we know that there is still more work to be completed and we intend to utilize new metrics to continually evaluate our performance and outcomes.

1. **Primary Care Providers and Sites.** We recognize at Southcoast Health that primary care is critical to providing high-quality and low-cost care to patients in our service area. We are focused on key areas of access, quality, and total medical expenses (TME), particularly given our increasing volume of patient visits at Southcoast sites— our total number of SPG patient visits (N=973,820) has experienced an annual growth rate of 8%. We continue to invest in improving health care access and fulfilling previously unmet needs. In order to do so, we have recruited PCPs—both physicians and advanced practice providers (APPs) (e.g., nurse practitioners, physician assistants)—to increase availability for patient appointments and capacity across SPG PCPs. More specifically, we have hired an additional 8 MDs/DOs and 14 APPs over the last two years. Furthermore, we have increased the number of urgent care sites in our service areas to enable easy access for low acuity conditions in an effort to divert patients from EDs in the region and to align patients who have no PCP within the Southcoast network. Additionally, a new online scheduling tool was released so that our new and existing patients would have personal digital access and greater convenience.

2. **Patient-Centered Medical Homes.** We are in the process of certifying (or re-certifying) our primary care practices as Patient-Centered Medical Homes (PCMH). This certification ensures that our practices are actively committed to undertaking improvements in quality, access, and the cost of care. As part of this initiative, our primary care practices actively track and measure key quality metrics in the areas of health maintenance and chronic conditions, and work with their practices and centralized staff proactively to engage patients so that quality outcomes are achieved. Additionally, we have targeted transitions of care, in particular, for patients who are discharged from the hospital, to ensure that the coordinated care they need is provided when they leave.

3. **Behavioral Health Care Pilot.** The integration of behavioral health services within primary care has been shown to improve the detection, diagnosis and treatment of behavioral health disorders, including behavioral health and physical problems, in a comprehensive, coordinated, and collaborative manner that can improve the overall quality of patient care. Therefore, we have initiated a pilot program this year to embed behavioral health providers (e.g., APPs, licensed independent clinical social workers [LICSW]) into a number of our primary care practices in an effort to increase accessibility to our primary care patients. These providers assist with medication management, initial intake, and diagnostics, as well as conduct brief psychotherapy visits.

4. **New Staffing and Enhanced Roles.** Over the last year, Southcoast Health has filled a number of new positions to support our primary care practices and providers while existing roles have been enhanced to provide more coordinated care across the patient journey. More specifically, the following positions have been added or enhanced:

    a. A **Physician-Chief Medical Information Officer** was hired by the Southcoast Health System whose focus is dedicated to simplifying our data collection efforts for important data elements so that data-driven decision-making results in improved quality and efficiencies.

    b. **Information Technology teams** are available to provide support to new physicians in their understanding and utilization of our EHR system (Epic).

c. **Medical Documentation Specialists** were added to improve information collected by our EHR system (Epic) on diseases/conditions that is needed by other providers and/or for regulatory filings.

d. **Pharmacists** review patients' medical prescriptions and discuss options for changes with their PCPs to enhance medication adherence and potentially reduce costs.

e. **Care Navigators** work closely with Southcoast practices to increase the number of hospital discharges scheduled for PCP follow-up visits within the desired five-day timeframe to reduce the number (and risk) of readmissions and associated costs.

f. **Behavioral Health Workers** assist patients with identifying community services recommended by their PCPs. Additionally, an online catalogue, called *Behavioral Health Connect*, was created to offer information and improve access to a comprehensive listing of providers and services.

g. **Practice Quality Coordinators** are assigned to each practice, to close the gaps in care, cue up testing as needed for patients, and work with individual doctors to improve their performance with clinical quality measures.

5. **Other Activities.** Additional activities have been implemented across Southcoast Health to bolster our strategic goal of supporting and investing in primary care. For example,

    a. **Mandatory training and standardized procedures** for medical technicians and office staff were implemented.

    b. **Renovations and relocations** have been undertaken of offices and practices to provide improved and more attractive facilities or greater convenience. The relocations are intended to improve accessibility for patients and provide ancillary services on-site or nearby. For example, a recent relocation occurred for the Borden practice whose new address now offers enhanced services and better parking and elevators.

    c. **Centralized functions** have been implemented to increase efficiency for certain practice needs. For example, Centralized Scheduling has been established to reduce administrative burden at individual practice locations and thereby increase time dedicated to actual patient care.

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.

Our top strategy for supporting and increasing investment in behavioral health care includes diversifying our activities to reach the very high percentage of individuals faced with behavioral health issues in our region (compared to other communities). This cohort is typically plagued with substantial social determinants of health issues and while we do not know if our activities are reducing costs, we recognize that there is a severe lack of services to meet their needs that desperately need attention.

- Southcoast Health is part owner of a new 144-bed psychiatric hospital that provides inpatient adult and adolescent treatment for individuals with mental health diagnoses.

- We have added behavioral health physicians, advance practice nurses (APNs), and LICSWs into our hospitals given the significant prevalence of behavioral health cases and their needs across our network.
- We are piloting the inclusion of APNs and LICSWs in our offices to provide behavioral health transition care until long-term providers can support them.
- Our Community Benefits team collaborates with more than 100 community partners to understand, prioritize, and develop programming and administer community grants to address the most pressing needs of our region. These programs focus on reducing high rates of chronic disease and increasing access to care, safe and affordable housing, transportation, healthy and affordable food and education, and employment opportunities.

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?

To better support our primary and behavioral health needs, there are several strategies that would be most beneficial as top contract features or payer strategies:

- **Improved Payments.** Improved payment to behavioral health care providers—psychiatrists, psychologists, MSWs and LICSWs—by Medicare and Medicaid is needed. The supply of behavioral health care providers is not sufficient to meet the demands of our patient populations; therefore, we need to encourage more prospective providers to enter the field of psychiatry. Increasing payment would be one strategy to increase supply because without more providers, the field will remain sorely understaffed. Medicaid, in particular, does not provide sufficient reimbursement for behavioral health services which is detrimental for behavioral health outcomes since many patients in need of this type of healthcare are eventually covered by Medicaid. Furthermore, commercial levels of reimbursement are sorely inadequate for behavioral health networks causing them to fail to breakeven in their total costs and gains.
- **Service Standards.** Health plans utilize behavioral health benefit networks for access to any provider but then relinquish patients back into the system thereby compounding the problem of supply and demand. Service standards are needed for behavioral health providers to be exclusively contracted with insurance plans.
- **Psychiatric Telemedicine Licensure.** Primary care would significantly improve if consistent coverage and licensure of psychiatric providers were established for telemedicine visits. In addition to increasing access to psychiatric services, a number of benefits would be quickly realized including: patient compliance for scheduled visits, potential cost savings from a reduced number of inpatient visits, and more timely and accurate visit information transfer from psychiatric telemedicine visits into patient EHRs.

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?

There are a significant number of efforts that could be implemented to increase investments in primary and behavioral health care. Specifically, in order to improve our current PCP and behavioral health care provider shortages, there needs to be: 1) additional training programs; 2) increased loan forgiveness for new providers; 3) administrative simplification for authorizations required for visits and inpatient care; 4) incentives for team-based care recognizing that all members of an office/practice are patient caregivers at some level; and 5) resetting primary care and behavioral health care fee schedules to increase reimbursement for these critical positions and the services they provide.

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	Major 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	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)	Not a Significant Factor

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

4. REDUCING ADMINISTRATIVE COMPLEXITY:

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

Area of Administrative Complexity	Priority Level
Billing and Claims Processing – processing of provider requests for payment and insurer adjudication of claims, including claims submission, status inquiry, and payment Comments: If insurance companies organized real-time adjudication of payment of clean claims—like other industries—the administrative cost would be reduced for both providers and plans. For example, at the time of visit checkout, a bill could be transmitted to the payer, adjudicated immediately, and returned within minutes with an Explanation of Benefits (EOB) and the owed amount. The patient could receive his/her EOB and copays/coinsurance/ deductibles could be collected in real-time. No further billing administration would be necessary for an estimated 60% of claims thereby reducing the amount of bad debt for providers and administrative office cost for payers. In the meantime, we are working to improve our current systems by tracking inappropriate payments so that the need for future appeals and settlements are eliminated.	Medium
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes Comments: This is becoming increasingly important from both a financial and a clinical standpoint. Comprehensive documentation with a complete problem list assures that all of the patient's conditions are reviewed and addressed each year, a key element to risk adjusting the population as needed. Higher risk patients represent higher costs of care. If value-based risk does not have appropriate risk-adjusted budget targets, then only the groups who care for non-complex patients can succeed in value-based risk agreements. This has required additional coders, physician/coder education, more comprehensive patient visits, and information builds to make it easier to identify missing data in the identification of disease states. Documentation has to be redone each year since some codes are not carried over year from year. This effort results in providers maintaining up-to-date problem lists but is also an unnecessary and duplicative documentation burden.	High
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician Comments: While this is important, it is not a priority as current processes are generally working.	Low

Area of Administrative Complexity	Priority Level
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations Comments: EHR interoperability is a major issue for patient care and Medicare penalty programs. From a patient care perspective, if the state mandated that all EHRs maximally share information with other systems through an exchange, savings of time, costs, and missed clinical issues would be realized and available at the time of patient care. Currently, levels of information shared by organizations are varying—for instance, some only share minimal data signaling that their priority is their business interest over useful patient information—thereby increasing the costs to care for patients. Systems that cannot share, coupled with providers who are unwilling to use these functions, increase the cost of caring for patients.	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 Comments: Over the last ten years, eligibility and benefit verification systems have greatly improved as a result of established linkages to the correct payer's database, and more accurate coverage data to the providers' business offices. However, in the meantime, the growth of medical and financial claim audit companies—hired by health insurance organizations—has complicated benefit verification. These aggressive audit companies are frequently haggling hospitals and providers in their efforts to deny services and/or negotiate for lower payments. Health insurers that hire these subcontracted companies are then commonly unavailable or untimely in resolving audit issues created by these companies which, in turn, adds undue burden on our provider business offices. For example, Southcoast Health has involved up to four internal departments, in addition to the subcontracted audit company, and health plan to resolve denials and inaccurate payments. A recent situation took >12 months to resolve; all denials were eventually reversed and payment was finally made. As a result of examples like these, we believe that subcontracts to these audit companies should not be permitted unless the subcontractor can guarantee that a complete understanding of the contracted reimbursement structure is known in advance.	Medium

Area of Administrative Complexity	Priority Level
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member Comments: Prior authorization of prescribed procedures, services, or medications has become an increasing challenge for providers (e.g., offices and hospital departments) to ensure that they will be paid in advance of fulfilling the order. More specifically, challenges arise from a number of nuances—many health insurers lack evening and weekend staffing resulting in authorization delays and denials; or inexperienced authorization reviewers who are not qualified to serve in a decision-making role. As a result of examples like these, second-level appeals are required thereby increasing costs and time but frequently resulting in denials that are then reversed. A tremendous cost savings could be realized if health plans collectively determined a standard set of services that always needs prior authorization as well as a guarantee that only qualified reviewers (e.g., those within a relevant medical discipline) are used for reviewing appeals of denied authorizations.	Medium
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization Comments: Provider credentialing experiences occasional issues but in general, the process works well. As a result of the creation of the HealthCare Administrative Solutions, Inc. (HCAS) centralized provider credentialing process in Massachusetts, credentialing of most providers has improved. However, behavioral health provider credentialing by behavioral health networks is the one exception and can take 6-9 months—this is the worst-case scenario—for the provider to be added to the plan's panel.	Low
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network Comments: Websites are not updated by providers in a timely manner even if forms and/or data have been received. However, HCAS has selected CAQH's DirectAssure product that was developed to increase the accuracy of health plan provider directories so that providers can directly enter and submit their data for sharing with participating health plans. It is currently being implemented but when complete, we believe that it will greatly enhance the website information as well as establish more streamlined processes.	Low

Area of Administrative Complexity	Priority Level
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 Comments: Quality measurement and reporting continues to grow as administrative burden. Each health plan has its own array of metrics with an added complexity of similar-sounding metrics but different specifications. All venues–hospitals, home health care, physician offices, and post-acute care facilities—are experiencing this complexity. However, hospital and physician metrics are the most egregious and require a substantial number of individuals and information system efforts to capture, report and improve on constantly changing metrics and achievement thresholds. The state initiative to standardize is a step in the right direction; however, most of the plans are still applying their own choices, including MassHealth.	High
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication Comments: A tremendous amount of time is wasted on providing supporting documentation and online/phone communication for referral approvals. Physician practices and hospitals were not designed (and are not compensated) to facilitate all of the administrative burden created by health plans that is intended to reduce costs. Authorization of referrals needs to be made in a more timely manner and perhaps eliminated if the population is in a risk-sharing contract.	Medium
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks Comments: Entire teams of personnel who are dedicated to understanding patient benefit designs are now required to ensure payment and to help patients understand their benefits. Our response to question 1B addresses the need to reduce the number of health care product designs.	Medium

Area of Administrative Complexity	Priority Level
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 Comments: Each payer has different reimbursement methodologies, different groupers, weights, hierarchies of service payments, and so on. However, Medicare uses only one group and the same weights for inpatient care and another one for outpatient care. On the other hand, even the MassHealth Diagnostic Related Group (DRG) and Enhanced Ambulatory Patient Group (EAPG) reimbursement mechanisms became non-standardized. Most healthcare systems cannot afford to purchase all of the different groupers while others are proprietary by the health plans themselves and therefore, not available for purchase. As a result of these incongruences, resources are wasted and more staffing is needed to analyze these different methods. A common structure is desperately needed for commercial payers. Components of Total Medical Expense (TME) budgets are as varied as the number of providers. There is often little leeway in proposing or changing the methodology of these budgets. As previously mentioned, quality metrics, thresholds, and reporting timelines are highly variable too. Furthermore, TME data files differ by payer so hospitals and ACOs are forced to customize each payer's data at their own expense in order to transfer and then analyze the data. In addition, payers frequently revise previously negotiated contract terms and provider manual policies and then communicate such changes with a mere e-mail notification. It is not only unfair and costly but it increases the risk of errors and it is unreasonable for every health system to manage every single payer policy change. Instead, we need greater uniformity on activities needed by all health care plans. Many large insurers have acknowledged that care provided in these settings reduces overall costs, but the lack of rate parity prevents smaller systems from [expanding services/surviving/increasing access points] to further reduce the Commonwealth's health care spending. A health system or provider group that is smaller struggles to achieve adequate payer terms and payments, both of which should not be the case. As a result, smaller health systems and provider groups are harmed and frequently seeking shelter from larger networks. Payers have been unable or unwilling to create a more level playing field among providers—perhaps it is time that the State review historical data and determine if the situation has improved since the data was first published.	Medium

Area of Administrative Complexity	Priority Level
Other, please describe: Pharmaceutical Formulary Variability and Rebates Comments: The variability of formulary by plan increases difficulty for providers to know what to prescribe for patients. Furthermore, approved formulary items are constantly changing and these changes create substantial burden as drugs move to/from prior authorization status and covered item status. As a result, and because no single solution exists (of which we are aware), ordering medications for patients that match their approved drug formulary is challenging. The impact of inadvertently prescribing non-formulary items creates work and re-work for multiple parties (e.g., patient, prescriber, prescriber office staff, retail pharmacy) which cause delays in prescription filling and the associated implementation of medication therapy for patients. In addition, a frustrating and associated factor in payer drug formularies is the variability in market pricing for similar (and even identical) medications. The lowest cost drugs that are available on the market today may not be on a payer's approved formulary (or not viewable to physicians who are doing the prescribing). In many cases, rebates are being given to those who would order more expensive drugs thereby resulting in higher health care costs. Patients and employers are not realizing the value of these rebates, and the overall cost of care is higher than it needs to be. With the evolution of high-cost biologic agents, formulary consistencies and a fair rebate system are now a high priority. **Recommended Considerations for the State:** • Accelerate discussions and actions about controlling the rising cost of drugs. • Ban the acceptance of drug-related rebates to payers/payer plans and pharmacy benefit managers (PBMs) with a corresponding allowance for provider organizations and retail pharmacies to fill a prescription with the available, lowest cost, equivalent medication. • Aggregate payer and plan approved drug formularies as a single source of current, updated reference with integration into prescribers' medical record systems to enable efficient, cost-effective and patient cost-affordable prescribing of a patient's payer plan-approved drugs.	High

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 the attached AGO Provider Exhibit 1 from Southcoast Health.

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.

We do not have accurate data on whether the source of the inquiry was in writing, by phone or in person. Based on the assumption that most of the inquiries are by phone, we have estimated the allocation.

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**	3	5
	Q2	7	15
	Q3	13	29
	Q4	15	35
CY2018	**Q1**	12	29
	Q2	10	24
	Q3	14	33
	Q4	19	45
CY2019	**Q1**	30	69
	Q2	42	97
	TOTAL:	165	381

   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, we do not have a process for logging and monitoring the accuracy of the responses. With our recent change to the Epic electronic billing system, we are planning to create a log of all inquiries to determine how many people actually schedule a service or procedure along with the accuracy of our pricing estimates. We expect that all requests for information will be completed within 24 hours.

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?

Barriers to accurate and timely responses to consumer inquiries for price information include: 1) differences in descriptions of a service—even a difference that is seemingly small—may result in significant differences in price; 2) variations in surgical procedures may lead to more operating room time than that which was originally estimated; and 3) non-clinical staff are tasked with providing accurate price information. For example, these staff may lack:

- Familiarity with a specific type of test, procedure, visit or surgery, i.e., CAT scan
  - Is it a CAT scan of the pelvis alone or of the pelvis and abdomen?
  - Is the CAT scan with or without contrast?
  - Is it to be performed on a CT, PET, or SPECT machine?
  - Is there a patient risk for an allergic reaction that could require a different type of scan?
- Awareness of the patient's billing status
  - Has the patient met his/her annual deductible?
- Awareness of the patient's existing medical conditions that could impact the service
  - Could the patient require recovery time or observation?
- Confirmation of the exact benefit coverage/plan a patient has in order to confirm the patient's understanding of what is covered or non-covered

We are working to address these types of issues including but not limited to: 1) we purchased new software that will query payers for coverage and deductible information; 2) we are working to ensure that our specific contractual payment rates are loaded and then linked with Epic to see if the orders provide any more specificity on the exact service needed. If providing estimates to consumers is required by both providers and the payers, then efforts are being duplicated and patients risk receiving different estimates. It should be the responsibility of the payers—not the providers—to supply patients with this type of information.

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.

      Please refer to the attached Excel spreadsheet for the summary table for this question.

   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.