MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 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 and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine 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.

Scheduled hearing dates and location:

Tuesday, October 16, 2018, 9:00 AM
Wednesday, October 17, 2018, 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 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, 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 19, 2018, 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: http://www.suffolk.edu/law/explore/6629.php. 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 livestreamed on the HPC's homepage and 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 (2) 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 section of 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 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, 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.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, and/or 2017 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.**

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, did not receive the email, or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC staff at HPC-Testimony@mass.gov or (617) 979-1400.

HPC Contact Information

For any inquiries regarding HPC questions, please contact HPC-Testimony@mass.gov or (617) 979-1400.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@mass.gov or (617) 963-2030.

HPC Pre-Filed Testimony Questions

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed 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 areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.

Our top areas of concern in continuing to meet this benchmark include:

- Our ability to participate in alternative payment contracts, where the incentives align with the State's goal of reducing total health care spending, has been limited by MassHealth's recent decision to deny Community Care Cooperative's (C3) application to add UMass Memorial Health Care's primary care sites to its ACO in 2019. UMass Memorial Health Care had been planning to add 8 large primary care practices, with over 16,000 MassHealth members to the C3 ACO. Had UMass been able to join the C3 ACO, we would be better positioned to help reduce health care costs in Central Massachusetts. By excluding us from the MassHealth ACO program, UMass Memorial Health Care is being forced to reduce care management and behavioral health services to high risk, high cost MassHealth patients, which will ultimately result in worse patient outcomes and increased costs.
- Question 1, the ballot initiative before voters this November, which would require government-mandated nurse staffing ratios at all Massachusetts hospitals, would drive up costs throughout the state. There is an independent estimate of an increase of over $1 billion in costs in Massachusetts resulting from the passage of this ballot question. In addition, it could force the closure of some clinical services at hospitals, as well as potentially force certain hospitals to close. Question 1 would force us to elevate nurse staffing above all other caregivers. This is not in the best interest of our organization and, more importantly, it is not in the best interest of patient-centered care.
- The continuing rising costs of prescription drugs remains a significant issue as we try to stay below the State's benchmark. This is an issue we have no control over.
- Health systems that serve a high public payer population are experiencing significant reimbursement cuts from Medicare due to

continued ACA reductions. From Medicaid we are experiencing significant Medicaid Managed Care payment rate cuts as we have been forced to contract at MassHealth rates. Traditionally we have been able to cross subsidize our higher payment rates from private, negotiated contracts to cover shortfalls from the public payers. With a continued decrease in the cost growth benchmark, private payers are able to lower their rates with the cost benchmark as their ceiling. The benchmark should not be lowered giving that advantage to the payers while potentially destabilizing the healthcare providers.

b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?
1) We would suggest state policy intervention to limit the impact of the nurse staffing requirements if the ballot question passes as well as continued policy development to control the costs of prescription drugs in Massachusetts. 2) Adequate and flexible behavioral health access and reimbursement need to be prioritized. 3) Appropriate payments for telemedicine to allow further expansion of telemedicine capabilities.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.
Our top priorities to reduce health care expenditures include 1) shifting care from high-cost settings (e.g., academic medical centers) to lower cost settings (e.g., community hospitals) and 2) reducing unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions) and 3) reduce unnecessary utilization of institutional post-acute care.

2) INFORMATION ABOUT ALTERNATIVE CARE SITES

The HPC recently released a new policy brief examining the significant growth in hospital and non-hospital based urgent care centers as well as retail clinic sites in Massachusetts from 2010 to 2018. Such alternative, convenient points of access to health care have the potential to reduce avoidable and costlier emergency department (ED) visits.

Question Instructions: *If your organization does not own or operate any alternative care sites such as urgent care centers, please only answer questions (e) and (f) below. For purposes of this question, an urgent care center serves all adult patients (i.e., not just patients with a pre-existing clinical relationship with the center or its providers) on a walk-in (non-appointment) basis and has hours of service beyond normal weekday business hours. Information requested in question (a) below may be provided in the form of a link to an online directory or as an appended directory.*

a) Using the most recent information, please list the names and locations of any alternative care sites your organization owns or operates in Massachusetts. Indicate whether the site is corporately owned and operated, owned and operating through a joint venture, or a non-owned affiliate clinical affiliate.
See 2018 Health Policy Commission Registration of Provider Organization filing for list of alternative care sites and their corporate structure.

b) Please provide the following aggregate information for calendar year 2017 about the alternative care sites your organization owns or operates in Massachusetts, including those operated through

a joint venture with another organization (information from non-owned affiliates should not be included):

Number of unique patient visits	136,618 (Carewell Urgent Care Centers of MA, PC.)

Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	100% (Carewell Urgent Care Centers of MA, PC.)
Percentage of patient visits where the patient is referred to a more intensive setting of care	Not available

c) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the clinical staffing model, including the type of clinicians (e.g., physicians, nurse practitioners, physician assistants, paramedics, nurses). If different models are used, describe the predominant model.
The sites operated by CareWell Urgent Care Centers of MA, PC are staffed with at least one provider (physician, NP or PA). Centers with higher volume may have more than one provider working at any given time. In addition to the providers, locations may be staffed with rad techs, nurses, medical assistants and paramedics.

d) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the method and timeliness of how the medical record of a patient's visit to an alternative care site is shared with that patient's primary care provider (e.g., interoperable electronic health record, secure email transfer, fax). What barriers has your organization faced in sharing real-time information about patient visits to your alternative care sites with primary care providers or other health care providers?
CareWell uses an Athena EMR which has integrations with CareEquality and CommonWell which allows for the direct transfer of medical records from CareWell to participating providers. Most of our affiliated health systems us an Epic Systems EMR which allows the transfer of records to occur the same day as the patient visit. CareWell also faxes records upon request. The company also uses Mass HIway. The biggest barrier is ascertaining with which providers to share the information. Many patients are unsure of who their provider is, what practice they are a member of or if their provider is employed by a health system.

e) Besides establishing alternative care sites, what other strategies is your organization pursuing to expand timely access to care with the goal of reducing unnecessary hospital utilization (e.g., after-hours primary care, on-demand telemedicine/virtual visits).
Ambulatory Surgery Center opened 2018; instituted system-wide single contact point for appointments (1-888-UMASSMD); expansion of telehealth to various service lines.

f) Please comment on the growth of alternative care sites in Massachusetts, including implications for your organization as well as impacts on health care costs, quality, and access in Massachusetts.
While we have expanded our urgent care capacity, we will continue to monitor for unintended consequences, such as keeping patients from going to their primary care physicians, thereby potentially reducing the quality of care.

3) STRATEGIES TO SUPPORT PROVIDERS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS

Earlier this year, the HPC held a special event entitled, *Partnering to Address Social Determinants of Health: What Works?*, where many policymakers, experts, and market participants all highlighted the need for health care systems to partner with community-based organizations to address patients' and

families' health-related social needs (e.g., housing stability, nutrition, transportation) in order to improve health outcomes and slow the growth in health care costs.

a) What are the primary barriers your organization faces in creating partnerships with community-based organizations and public health agencies in the community/communities in which you provide care? [check all that apply]

☒ Legal barriers related to data-sharing
☒ Structural/technological barriers to data-sharing
☒ Lack of resources or capacity of your organization or community organizations
☒ Organizational/cultural barriers
☒ Other: Bi-directional communication (CBOs understanding how to navigate the health system and vice versa), wait time for housing, lack of supportive and recovery focused housing for community members

b) What policies and resources, including technical assistance or investments, would your organization recommend to the state to address these challenges?
There are numerous opportunities to address the identified Social Determinants of Health (SDOH) challenges. In the past year, UMMHC though the introduction of CommunityHELP.net has improved the visibility into specific needs of the geographic locations within the communities we serve. The level of SDOH need outpaces the ability to identify funding, partners, and resources to expand and scale Community Based Organization services to meet geographic and universal community needs that are clearly visible through the CommunityHELP platform. The literature and journalism are packed with stories related to successful pilot efforts to transform care and support for community members. UMass Memorial has historically funded, managed grants and provided workforce support to build similar pilot efforts. Frequently, challenges begin when the pilot effort begins expansion while working to ensure longitudinal fiscal sustainability for successful pilot efforts to grow into full scale programs.

Challenges related to the ability to share Protected Health Information with Community-based Organizations that are targeting the improvement of clinical outcomes without insight into the population's clinical status is also a barrier to forming and evaluating these investments and partnerships. These technical barriers stifle innovation, create barriers in demonstrating the clinical and social effectiveness of community-based programs and more effectively meeting the needs of the population in the most efficient, safe and culturally appropriate manner.

The state's siloed, disparate and convoluted approach to obtain services and the systems to sustain community member support for human needs and situations continues to fall short for the most under-served, vulnerable members of the communities served by UMass Memorial Health Care. Lack of stable, long term financial support for these programs to clinically manage and coordinate these community members longitudinally is also a major contributing factor. There is a lack of professionals with clinical knowledge who understand the health care system to guide these community members in appropriate health system interactions and utilization.

The state's approach to meeting the basic needs (housing, transportation and food) of the most vulnerable individuals and families in marginalized communities lacks interagency coordination. This leaves persons in need without a clear path to the services and support that can address their needs. This is especially true in the domains of housing and transportation within the region.

1. For provider organizations: please submit a summary table showing for each year 2014 to 2017 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

2. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.

   a) Please use the following table to provide available information on the number of individuals that seek this information.

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**	9	103
	Q2	9	79
	Q3	15	81
	Q4	19	64
CY2017	**Q1**	12	75
	Q2	19	87
	Q3	12	62
	Q4	16	38
CY2018	**Q1**	13	78
	Q2	12	62
	TOTAL:	136	729

   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.

   The UMass Memorial Patient Financial Counseling Department coordinates all patient pricing requests for price estimates. All requests are tracked in a database to determine the number, type and nature of the request and the turnaround time. The department management team monitor this information monthly.

   The turnaround time is monitored both from the date and time of the initial request and from the date that there is sufficient data, such as CPT and procedures.

c) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

The largest barrier to providing a timely and accurate price estimate is to have sufficient information at the time of the initial requests. CPT, procedure and IDC-10 codes are necessary to determine the service that is requested and the complexity.

The Financial Counselors work with the health care providers to obtain the necessary information to provide a more accurate estimate.

3. For hospitals and provider organizations corporately affiliated with hospitals:

a) For each year 2015 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.

A file including FY 15 through FY 17 data for UMass Memorial Medical Center as requested above has been attached. We cannot report similar data for our second largest hospital (HealthAlliance) as they did not have a cost accounting system in place

b) For 2017 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.

A file including FY 17 data for UMass Memorial Medical Center has been attached. We cannot report similar data for our second largest hospital (HealthAlliance) as they did not have a cost accounting system in place.

UMass Memorial Medical Center

	FY 2015		FY 2016		FY 2017	
Payor Group	**Total Margin**	**% of business**	**Total Margin**	**% of business**	**Total Margin**	**% of business**
Commercial	115,847,231	29.9%	123,059,718	28.9%	134,111,951	29.2%
Medicaid	(57,318,118)	23.3%	(50,660,274)	24.1%	(59,919,387)	23.1%
Medicare	(24,709,278)	36.9%	(42,135,780)	37.6%	(73,071,188)	38.5%
Other	(19,278,179)	9.9%	(12,211,887)	9.3%	(10,557,296)	9.2%
Grand Total	**14,541,656**	**100.0%**	**18,051,777**	**100.0%**	**(9,435,920)**	**100.0%**

Notes -

- These reports are for internal analytical purposes only.
- Net Revenue and Cost calculations employ numerous allocations in order to report them at the payer and service line level. The methodology employed by UMass Memorial Medical Center is an internal allocation methodology which limits comparability to other hospitals.

· Special Medicaid payments made to the medical center as an "essential MassHealth hospital have been excluded from this analysis due to the unique nature of the payments.

- Service line groupings are based on a set of internal groupings used by UMass Memorial Medical Center.
- Certain unique medical education costs have been excluded from this analysis.