FENWAY HEALTH

Health Policy Commission, Commonwealth of Massachusetts
50 Milk Street, 8th floor
Boston, MA 02109
Submitted electronically to HPC-Testimony@state.ma.us

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Fenway Health response to Health Policy Commission Questions for Written Testimony

1. *a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on factors driving these trends.*

Thanks to our relationship with the Beth Israel Deaconess Accountable Care Organization (BIDCO), we are able to track year-to-year per member per month (PMPM) expenses for some of our main third party payors. We've had mixed results and have not spotted any significant trend in costs. Despite increasing costs, we have been able to succeed with most of our global contracts by accurately reflecting an increase in patient acuity and complexity (through coding and documentation), which in turn adjusts our global budgets with these payors upwards. For all commercial plans the main driver of cost increases is prescription drugs – this is not surprising considering the large number of patients we have who are taking antiretroviral drugs for HIV treatment, HIV prevention, and HCV treatment. For our Medicare contract, there are no main drivers of cost increases, but inpatient expenses continue to account for over half of total costs. We do not receive similar data for our Medicaid (Masshealth) patients.

Fenway Health has experienced a steady increase in the number of unique patients we see annually, from just over 15,000 in 2010 to nearly 26,000 in 2014. We saw nearly 20,000 patients just in the first 6 months of 2015.

Department	2010	2011	2012	2013	2014	2015*
Medical	14,171	16,276	17,375	17,739	20,130	15,147
TOTAL	**15,218**	**19,199**	**20,337**	**22,086**	**25,709**	**19,694**

*First 6 months (1/1/15-6/30/15) only

Our major theme has been the improvement of quality. Fenway Health has achieved NCQA Level 3 status. We are implementing the Patient Centered Medical Home model. In 2014 we saw nearly 26,000 unique patients. Total

operating expenses are up, as the total number of visits is up. Costs include case managers for patients with the greatest intensity of need. Over the past year we have seen a 4.5% increase in dental visits, a 14% increase in optometry visits, and a 7.7% increase in primary care visits, including medical and behavioral health. We have added commercially insured patients to our panels. About 70% of our patients are commercially insured, and 30% are covered by Medicaid and/or Medicare. From plans from which we get data, our pharmacy expenses (total expenditures on prescription medications) have gone up at least 5% a year. This cannot be explained by changes in generic prescribing rates by our providers. Some of the drugs we are prescribing do not have generic analogues (e.g. HIV antiretroviral medications for HIV, Hepatitis C medication). Expenses have remained flat or have decreased in terms of other cost centers year-to-year. This reflects successful efforts aimed at reducing utilization through care management of high-risk patients.

In 2015 Fenway Health received nearly $125,000 in additional HRSA grants under the Affordable Care Act. This is one of the highest awards given in the Commonwealth of Massachusetts and is something of which we are proud. The grants recognize health center achievements in providing high quality, comprehensive care. Fenway will use these funds to expand current quality improvement systems and infrastructure, and improve primary care service delivery in the communities we serve. Fenway was recognized under the Health Center Quality Leaders, Electronic Health Record (EHR) Reporters, Clinical Quality Improvers, and Access Enhancers categories:

- **Health center quality leaders** received funding if they achieved the best overall clinical outcomes among all health centers, demonstrating a dedication to quality in all aspects of clinical operations.
- **EHR reporters** received funding if they used Electronic Health Records (EHRs) to report clinical quality measure data for all patients, a foundation for quality improvement strategies.
- **Clinical quality improvers** received funding if they showed improvement in one or more clinical quality measures between 2013 and 2014, demonstrating a significant improvement to their patients' health
- **Access enhancers** received awards for increasing the total number of patients served and the number of patients receiving comprehensive services between 2013 and 2014

In terms of costs, the four major payors displayed mixed trends in terms of per patient costs from 2010 to 2013 (calendar year). One payor was essentially unchanged from 2010 to 2013 (a decline of 0.01% over 3 years). One showed a slight increase (an increase of 0.044% over 3 years). One payor displayed 13.4% increase from 2010-2013, or a 4.47% increase per year.

Another payor displayed a 9.9% increase over the same period, or 3.3% per year.

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

1. *b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?*

Actions taken since January 1, 2014:

- Hired a full time nurse care manager to:
    - help care teams identify high risk patients and to better track / make regular contact with these patients;
    - assist with NCQA PCMH Level 3 application for two of our sites;
    - oversee organization's efforts to improve our performance with respect to key clinical quality measures (both process and outcome measures);
    - implement a post ER/hospital discharge follow up care management program among the team nurses (assess patient's health after discharge, perform medication reconciliation, determine next PCP visit date, analyze factors that led to ER/hospital visit occurring);
- Implemented acuity coding improvement effort in the Medical and Behavioral Health departments using coding trainings and chart audits;
- Implemented interventions aimed at decreasing overall medical costs as follows:
    - prescription drug utilization: generic substitution efforts, provider education re: generic and low cost brand name prescribing opportunities, avoidance of brand name medications;
    - specialist utilization: created clinical guidelines for the organization to follow regarding management of key clinical issues responsible for specialist utilization;
        - chronic sinusitis
        - gastroesophageal reflux disease

As a result of these actions, we achieved significant savings (either a decrease in expenses or a decrease in the rate of increase of expenses with respect to the Eastern Network Trend) with most contracts in CY2013, and as a result we received a surplus check from BIDCO comprising a portion of those savings. CY2014 data has not yet been finalized.

In addition, we have enhanced our care management of high risk patients. Concurrently we have improved coding and documentation to ensure we

capture the complexity of our patient population – many of whom have HIV infection, hepatitis C infection and other chronic conditions. We have refined specialist referral procedures to decrease unnecessary specialist utilization. Many of our patients don't have enough coverage in pharmacy. We pay for this coverage gap for our underinsured patients.

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

1. *c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark?*

Actions to be taken between now and October 1, 2016:

- Continue to implement the actions taken in 2014 and 2015, described above; in addition, we will:
    - implement a more rigorous specialty utilization process, at least for high cost or high volume specialties;
        - refine our list of specialists so it highlights those providers who excel in terms of access, communication, cost effectiveness, and quality of care;
        - issue new clinical guidelines for other key conditions: low back pain, knee injuries/pain, psychiatric conditions, acne;
        - improve data sharing within our ACO to lead to more effective results, so that we can compare specialist performance, cost, generic prescribing, etc.;
    - implement a recall system within the organization that will retain both sick and healthy patients in more regular care as this will affect our acuity scores positively most of the time;
    - continue to invest in care management efforts by the organization and in collaboration with other organizations in the community;
        - CCA OneCare: for dual eligible (Masshealth/Medicare) <65 y.o.
        - CCA or other SCO: for dual eligible (Masshealth/Medicare) > 65 y.o.
        - Masshealth Integrated Care Management Program
        - BIDCO NP Home Visit Program: for Medicare patients
    - ensure smooth transition to ICD10 coding system, as this will affect our acuity scores in a positive manner.

We have risk contracts with major payors (Blue Cross Blue Shield, Medicare Pioneer Program etc.) to share savings. We have developed clinical guidelines that standardize care of the most common conditions across clinic sites. We will reduce specialist utilization. We will reduce the high cost of radiology. We

will further engage specialists directly to encourage them to adhere to principles to ensure quality but lower cost (e.g. communication, accessibility, judicious use of tests, prescriptions).

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

1. *d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?*

A key change would be to have utilization data more readily available, in a timelier manner. There is usually a delay of 3 to 6 months, as it is claims based.

It would also be helpful if we could improve the accuracy of payor data. Currently we have to substantially scrub most reports we get in order for them to be of value to our providers – often there is the wrong PCP, multiple entries for one patient, etc.)

The data from payors often contains a lot of extraneous information in the utilization data as it is currently configured. For example, the Primary Care Provider (PCP) on data reports from vendors is often incorrect. When this mistake occurs the Provider Patient Variation Analysis (PPVA) is hard to do. The PCP must be corrected and the PPVA redone. However, changing PCP for most insurances is an extremely cumbersome process and not always under provider control.

Other changes that would be helpful include the following:

- increase reimbursement/incentive monies available to primary care organizations so that we can invest those increased payments into hiring key non-medical/non-clinical staff who will help us keep our health care costs down and our patients healthy (integrated behavioral health specialists, nonclinical case managers, health navigators);
- improve the user interface of the data tools that are available for organizations like ours to better assess utilization and performance;
- keep working on integrating IT systems so that we can spend less time collecting or inputting data and more time analyzing it and taking action based on our analyses.

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

2. *What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?*

We've been a model for adopting alternative payment methods. About one third of our patients are covered by these contracts. One barrier is interoperability within the system. Every episode of care outside Fenway Health is a challenge. This makes tracking utilization hard in real time. We need to wait for the payor to report the utilization, which can mean a delay of three months or more. If insurers had better data systems and we could access utilization data in real time with real time tracking that would help. Another barrier is that some payors require that, for some procedures, a Fenway patient whose PCP is not a Fenway doctor must change their PCP. If the patient doesn't do this, Fenway Health doesn't get paid.

Population management requires systems and staffing that have greatly increased the cost for the primary care clinician. There are few resources in the system to cover these costs, so, currently these efforts are being paid for by grants and fundraising. This is not sustainable. While many argue that there are ample resources in the system to cover these costs if we only practiced more efficiently, in most ACOs primary care is not in a position to access these resources. In the future, payors should restructure their reimbursement models to "funnel" resources directly (via subcap or other methods) to support critical and chronically under-resourced care (e.g. primary care and behavioral health) and care management. These resources must be sufficient to support these efforts in their entirety.

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

3. *Four key opportunities to increase efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department use; and 4) provide focused care for high risk/high cost patients.*

    a. *Please describe your organization's efforts over the past 12 months to address each of these four areas.*

We are doing all of these. We get notified when a patient is admitted. We follow them. We reduce ER visits by having them come here for follow-up care; we manage them post-discharge. Working with patient care managers, we manage high-risk, high-cost patients (vigorously.

Specifically, our organization's efforts in last 12 months have included:

- post acute care spending: SNF waiver program through BIDCO allows select Medicare patients to bypass the usually required 3 night stay in an acute care facility (like a hospital);
- reducing avoidable 30 day readmissions: post-discharge follow up work by team nurses as mentioned above; Enhanced Care Patient

Registry for high risk patients as mentioned above (goal is for these patients to get on average one physical or electronic touch per month from a member of their care team);
- reducing avoidable ER use: post-discharge follow up work by team nurses as mentioned above; Enhanced Care Patient Registry for high risk patients as mentioned above;
- focused care for high risk/high cost patients: as above.

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

During the next 12 months we will be focusing on several areas. First, we will continue to strengthen our referral process by evaluating specialist performance regarding quality and costs, and based on these data directing care to a limited number of high quality and efficient specialists. Second, we will reduce the number of referrals by increasing our ability to provide some of these services in a primary care setting. Third, we will continue to develop and refine the management of common conditions in order to decrease provider variability. Fourth, we will focus on transitions in care. Finally, we will continue to manage pharmacy costs by maintaining a formulary and monitoring utilization across our providers. Other planned organizational efforts for the next 12 months include:

- post acute care spending: we are going to review the many SNF's in our service area and pick a few to have an ongoing relationship with;
- reducing avoidable 30 day readmissions: we are collaborating with BIDMC (our partner hospital) on their Post-Acute Care Transitions (PACT) Program, which will provide more hands on care management to patients admitted there;
- reducing avoidable ER use: we are compiling a list of our ER high utilizers and developing specialized care plans for them aimed at decreasing this utilization;
- focused care for high risk/high cost patients: we are continuing to nurture the growth and development of our care teams with the goal of making some of the registry work a daily phenomenon as opposed to something that only happens during a monthly care team meeting.

We will continue to manage these patients proactively to ensure quality of care and reduce costs.

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

4. *Question about prices for same services varying significantly across different provider types.*

    a. *In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?*

Payors pay Massachusetts General Hospital, for example, 30-40% more for the same service than Beth Israel Deaconess Hospital. This difference is based on historic reimbursement trends, MGH's unique reputation, as well as its position within the family of Massachusetts hospitals and the fact that payors have not acted to reverse or challenge this structure. In our view Beth Israel Deaconess Hospital and Fenway Health have equally world class reputations. Fenway has unique experience in treatment of LGBT patients and patients living with HIV.

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

    b. *Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.*

Due to government payors reimbursing for services at lower than provider's cost, the community at large pays more. The burden of the variability of charges causes an inequity among the providers of services and patients who pay higher co-pays and deductibles.In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

5. *Spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. Higher spending concentrated in EDs and inpatient care.*
    a. *How has your organization collaborated with other providers over the past 12 months to 1) integrate physical and behavioral health care services and provide care across a continuum, to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care?*

We have invested heavily in increasing the number of behavioral health specialists and non-clinical case managers embedded on our medical floors and available for rapid screenings, assessments, and interventions. We currently have approximately 10 FTEs of these staff members for our 26,000 patients. These staff members also participate in our monthly care team meetings, checking in with each care team about any high risk behavioral

health patients requiring a touch that month. For several years we have had behavioral health staff practice within primary care clinical practice. The behavioral health staff are part of the medical teams. They attend medical meetings and departmental meetings, as well as remain in the behavioral health department. This integration has meant that a range of patient problems can be responded to in real time and in person. We believe that this has reduced ER utilization and inpatient care. Colocation within the medical department has meant that the medical provider can connect patients to a behavioral health care provider on the spot.

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

b. Plans for next 12 months to 1) integrate physical and behavioral health care services and provide care across a continuum, to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

Planned efforts for next 12 months include, in addition to continuing the practices described above:

- explore the possibility of including a psychiatrist in our integrated BH system;
- explore the possibility of offering Medication Assisted Treatment of Addiction (MATA) within the Medical Dept (for alcohol and opioid addiction).

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

6. PCMH, ACOs—what specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

Fenway Health is a PCMH, NCQA Level 3. We are part of BIDCO. We stress quality and try to be as efficient and as accessible as possible.

- We actively participate in the functioning of BIDCO (PCP Advisory Committee, Board of Managers);
- We utilize data tools (our own EMR, a population health management software tool called Athena Health) to monitor our progress;
- We hold monthly meetings with our medical providers to provide education and updates regarding PCMH/ACO developments and performance within the organization.

In addition, please refer to the submission from Beth Israel Deaconess Care Organization for further response to this question.

Should you have any further questions or seek elaboration on any of our responses, please contact me at 617-927-6170 or sboswell@fenwayhealth.org.

Sincerely,

Stephen Boswell, MD, FACP
President & CEO
Fenway Health