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November 1, 2017

Senator James Welch, Chair  
Senate Working Group on Health Care Cost Containment and Reform  
Massachusetts State House, Room 413B  
Boston, MA 02133

Dear Senator Welch:

On behalf of the Conference of Boston Teaching Hospitals (COBTH) and its member hospital I would like to thank you for the opportunity to provide comments on the recently released health reform proposal put forth the Working Group to address health care costs, access and quality.

By way of background, COBTH is an organization of twelve Boston area teaching hospitals that work together to advance policies that enable them to fulfill their missions of providing quality clinical care, conducting medical research, training health professionals and serving vulnerable populations. Teaching hospitals play a critical role in our healthcare system and provide specialized care not available in other settings. Our hospitals provide onsite and fully staffed standby services for severely ill or injured patients and a significant number of patients are transferred to these hospitals because their illnesses or injuries require a sophisticated level of technology and expertise not available elsewhere in the community. These services include

- burn care
- organ transplants
- comprehensive cancer care
- level I trauma centers
- pediatric neonatal ICUs
- decontamination services

We are pleased that the bill contains many of the priorities that COBTH has advanced during the past several legislative sessions, including the expanded use of telemedicine and the reauthorization of the Prevention and Wellness Fund. In addition, we fully support the proposals' recognition of housing security as a social determinant of health and creation of a housing task force.

With continued uncertainty on the future of the Affordable Care Act and Medicaid funding at the Federal level, the coming months bring an unprecedented level of risk and uncertainty to the health care system both nationally and here in Massachusetts. With this climate in mind, we urge the Senate to be mindful of unintended consequences that could adversely impact access, quality and costs. We look forward to working with you and your colleagues to avoid such unintended consequences.

#### **Facility Fees (section s43, 68, 109, 140, 149)**

COBTH is strongly opposed to the provision of the Senate proposal that would in effect disallow facility fees from being charged for services provided in hospital based outpatient settings. Facility fees are the contractually negotiated recognition that these hospital based facilities are extensions of the hospital with full financial, clinical, and

operational integration and warrant a payment structure that is distinct from the physician fee schedule. The proposed approach fails to take into consideration the many significant differences between outpatient settings not affiliated with a hospital - such as independent physician offices - and hospital based outpatient clinics. Physicians often refer more complex patients to hospital based facilities for safety and quality reasons, as these facilities are better equipped to handle complications and emergencies. Hospital based facilities often include multidisciplinary teams of providers, pharmacy services and access to wrap around services such as social workers and interpreters. Because of their affiliation with a hospital, the licensing and accreditation requirements to operate these hospital based facilities are significantly more complex and costly to meet than would be for a setting not affiliated with a hospital.

The elimination of facility fees fails to address the underlying cost of healthcare and would pose a significant financial threat to many hospitals - both teaching and community - that would ultimately impact access to care currently provided in these settings. COBTH is willing to work with the legislature and policy makers to ensure that patients are aware of status of the facility where they are seeking or receiving care. This may include notifying members of a patient panel when a facility becomes a hospital based facility and, for existing facilities, signage indicating that the location is a hospital based facility and a facility fee may be incurred.

### **Hospital Pricing (Sections 41, 111, 113, 154)**

During last year's deliberations of the Special Commission on Provider Price Variation, consensus emerged on the need for a minimum relative payment level for hospitals. Hospitals with relatively lower commercial payer mix have little or no leverage with commercial carriers and establishment of a floor will force insurers to enter into true negotiations with those hospitals. We are pleased that the Working Group has included a payment floor and support the establishment of a minimum payment floor which, as recommended by the Special Commission, would take into account warranted and unwarranted factors driving price variation.

### **Telemedicine (Sections 43, 73, 92, 94, 96, 97,99,100,115)**

We are encouraged that the Working Group's proposal recognizes the important role that the increased use of telemedicine can play in containing costs while enhancing both access and quality. We have been frustrated that Massachusetts, often a leader in new ways to deliver health care, has lagged behind most other states in the adoption of telemedicine. Thirty three states have adopted what can be termed telemedicine parity laws. While the proposed provisions related to telemedicine makes great advances in incentivizing and allowing the greater use of telemedicine, we have several suggested revisions which we hope the Committee will consider, they include:

- eliminate language that permits insurers to utilize preauthorization for telemedicine services as this presents an barrier to care, particularly for behavioral health services
- expand the definition of telemedicine to encompass both synchronous and asynchronous technologies, including store and forward technologies, coverage for oral health in addition to physical and mental health
- include language (similar to that in section 73) in section 115 that directs the respective boards of registration at DPH and the Office of Consumer Affairs and Business Regulation to promulgate regulations on the appropriate use of telemedicine

## **Out of Network Billing Sections 22, 102, 104, 109, 117, 118, 119, 159)**

We agree that patients should not be surprised and held liable for charges that they unknowingly incur when receiving out of network services at an in-network facility. Fortunately, Massachusetts has a longstanding ban on balance billing which limits patient exposure to and liability for these unanticipated charges. We recognize that a standardized rate of payment should be established to limit these charges. However, we are concerned that establishment of these rates may have the unintended consequence of diminishing hospitals' negotiating leverage or causing providers to join or leave a networks based on their individual circumstances, potentially causing access issues. We also recommend that work be undertaken to identify and address the underlying reasons that certain provider groups and provider types choose not to contract with carriers.

## **Readmissions Section (Sections 5,6,11,13-16,,120, 121, 135, 157)**

Readmission rates have been an issue that providers, payers, and the federal government have been focusing on for several years. While considerable progress has been made, and until last year the rate of readmission had been falling steadily for several years, much work needs to be done to reduce rates further. Hospitals have realized that there are many causes for avoidable readmissions with many of those being caused by factors sometimes beyond the control of the hospital such as lack of transportation, safety and employment

As you are aware, the Affordable Care Act established the Hospital Readmissions Reduction Program, which requires the Centers for Medicaid and Medicare Services (CMS) to reduce payments hospitals with excess readmissions, effective for discharges after October 1, 2012. Following the lead of the Readmission Reduction Program, a number of payers have also incorporated readmission incentives or penalties into their payment methodology.

More recently, the 21st Century Cures Act last year included a provision requiring Medicare to account for patient socio-economic status when it calculated hospital readmission penalties, safety-net providers rejoiced. The CMS reported to Congress in December that hospitals with high rates of patients eligible for both Medicare and Medicaid, who tend to be both poor and very ill, were most penalized under the quality improvement program. Beginning on October 1st of 2018, CMS will begin to assess penalties based on a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid.

Hospitals need to narrow in on those cases where readmission is predictable and preventable rather than try and tackle their all-cause readmission rate. The proposed regulation of all cause readmissions is troubling and adds another set of requirements and penalties onto already existing programs which themselves are undergoing revision, would be counterproductive.

Causes of readmissions vary from hospital to hospital based on a number of factors such as patient population served. As such the ways in which individual hospitals seek to reduce readmissions will also vary. We recommend an approach that takes into account these differences and encourages development and sharing of best practices, such as envisioned in the trailblazer certification process provided for in the bill.

## Wellness and Prevention Fund

We are pleased that the proposal reauthorized the Prevention and Wellness Trust Fund. COBTH has supported the funds and *S1562 An Act to Promote Healthy Alternatives to Sugary Drinks* as a way to continue funding for the Prevention and Wellness Fund.

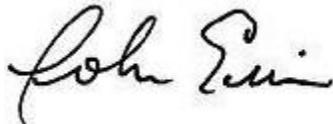
By continuing this mechanism to fund initiatives aimed at addressing some of the underlying drivers of disparities, poor health and high health care costs, the continuation of the Fund recognizes that community based initiatives can play a significant role in addressing these drivers. However, we recommend that the evaluation of the Fund's grantee program conducted by Harvard Catalyst and published earlier this in *Joining Forces: Adding Public Health Value to Healthcare Reform* be reviewed with an eye toward maximizing effectiveness and return on investment of the program.

## Value Based Benefit Design

We support the Working Group's proposal's provisions aimed at requiring carriers to develop products aimed at encouraging the use of value based providers. However, as with any product design, caution must be taken to ensure that patients - especially those with complex and rare medical conditions - have access to the appropriate care without undue burden of travel or out of pocket expenses. In addition, providers must have access to, and input into, the methodology by which carriers will classify providers and services into different tiers or variations of benefit designs.

Thank you for the opportunity to offer comments on this important proposal. We look forward to working with you on our shared interests as the Legislature considers this bill.

Sincerely,



John Erwin  
Executive Director  
Conference of Boston Teaching Hospitals

cc  
Senate President Stanley Rosenberg  
Senator Harriette Chandler  
Senator John Keenan  
Senator Jason Lewis  
Senator Patrick O'Connor  
Senator Karen Spilka