Berkshire
Medical Center
BERKSHIRE HEALTH SYSTEMS

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September 11, 2014

Via E-Mail: HPC-Testimony@state.ma.us

Mr. David Selz
Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz,

On behalf of Berkshire Medical Center, Inc., I submit the following written testimony in response to the questions of the HPC in Exhibit B and questions of the AGO in Exhibit C of the Health Policy Commission's request dated August 1, 2014.

Sincerely,

Darlene Rodowicz
Chief Financial Officer

Written Testimony of Berkshire Medical Center, Inc.

1. **Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. Then benchmark for growth between CY2012-CY2013 and CY 2013-CY2014 is 3.6%.** (Answers to subparts a. through d.)

Summary Statement. As is more fully discussed throughout this testimony, and was noted in last year's testimony, in recent years, Berkshire Medical Center ("BMC") and its parent organization, Berkshire Health Systems ("BHS" and together, "BHS/BMC"), have found themselves increasingly in the role of principal provider, supporter and coordinator of health and wellness services for all of Berkshire County. This role carries with it financial and resource challenges that are unreimbursed and much beyond traditional hospital obligations. Despite those substantially expanded burdens, BMC has been able to offer its commercial payers contract rates that during the past several years include increases at or below the Medical CPI. In addition, BMC and other BHS affiliates engage in regular and successful efforts to implement the principals of IHI's Triple Aim and ABIM's Choosing Wisely campaigns in existing work and continue to invest in community wellness programs for the community.

a. **What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY 2013 and year-to-date 2014? Please comment on the factors driving these trends.**
b. **What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the result of these actions?**
c. **What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?**
d. **What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?**

Discussion. As discussed in last year's testimony, BMC/BHS finds itself providing, within lawful limits, resources and support to other, unrelated components of the Berkshire County health services network simply to keep those other components viable and available to county residents. In last year's testimony BMC/BHS highlighted the chronic difficulty the community experiences in recruiting and retaining independent physician practices. In 2014, BMC/BHS found itself once again called upon to expend its resources and efforts to fulfill a sudden need of the community when Northern Berkshire Healthcare(NBH) closed abruptly on March 28, 2014. The closure impacted two hospital sponsored physician groups and a visiting nurse and hospice service in northern Berkshire County and, if allowed to be interrupted, would have impacted thousands of lives. BMC/BHS stepped in to assume the financial obligations of family practice and obstetrics/gynecology group that had been sponsored by NBH at significant operating losses. The family practice group was one of three principal primary groups in the

northern Berkshire region while the ob/gyn group was the only group providing obstetrics services to the community. Along with the support for the physician groups BMC/BHS had to restructure some of its own key operations to meet the needs of the northern Berkshire communities with less than a week's notice. The hospital closure required BMC/BHS to develop staffing models to meet the increased volume demand. The focus was on providing safe and appropriate care. Some staffing demands required the use of contract labor and locums, a practice that BMC/BHS has tried to minimize during normal operations.

BMC/BHS continues to actively engage in workforce development as noted in last year's report. In partnership with the Elms College in Chicopee, BMC/BHS, during 2013 and 2014, continued to fund the ASN to BSN nursing program for its nurses, providing that program on the BMC/BHS campus. This year, BMC/BHS is launching, in partnership with the Elms College, the first class of advance practice nursing students. Ten nurses will be enrolled in this program. BMC/BHS believes that there will be an increasing shift in the model of care and an ongoing shortage of primary care physicians. While this investment should benefit BMC/BHS in the long run the costs of this program are being borne currently by BMC/BHS.

A. Trends in the Market

BMC/BHS continues to see pressure on its operating performance as growth in expenses continue to outpace increases in revenue. For the past several years, BMC/BHS has accepted in its commercial payer contracts increases that are at or below the Medical CPI. Because of the demographics and health status of the population they serves, BMC/BHS are very dependent on government payers, which contracts have seen increases at or below the Medical CPI as well. In FY 2013, approximately 67% of BMC's net revenue came from government payers while another 3.5% was from the health safety net or self-pay, leaving just under 30% of the net revenue from commercial payers. Berkshire County has a very limited participation in the HMO market given the size of the county. According to the Massachusetts Division of Insurance report of HMO membership as of December 31, 2013, Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. had 10,427 covered lives (2.1% of its total lives), about 4,500 of whom are BMC/BHS employees enrolled in its self-insured program; Health New England had 11,877 covered lives(11.4% of its total lives), about 800 of whom are BMC/BHS employees enrolled in its self-insured program; and Tufts Associates HMO, Inc. had 2,439 covered lives(.8% of its total lives). BMC/BHS continues its efforts to control costs while maintaining high quality performance. Building upon the successes reported in last year's testimony, BMC/BHS has embedded Six Sigma/Lean techniques across the organization with an emphasis on using staffing to demand tools. These tools, along with Solucient benchmarking tools, have allowed BMC/BHS to effectively manage FTEs when vacancies occur and while developing its annual operating budgets. While building its annual operating budget, BMC/BHS disregards extraordinary or likely temporary income items, such as the current rural floor adjustment, in order to enforce greater immediate and long term discipline in budgeting and expense reduction. This approach has proven beneficial to the financial stability of BMC/BHS during times of volatility. Fiscal year 2014 has proven to be a tumultuous year from a financial perspective as BMC has experienced a

deterioration in its payer mix with an increase in lower end government payers, a decline in surgical volume, increasing and complex payer rules regarding inpatient short stay/observation admissions (often leaving BMC without a mechanism to receive reimbursement for the services), and the influx of volume from northern Berkshire.

BMC/BHS remains committed to STEEEP principles articulated by the Institute of Medicine (care that is safe, timely, effective, efficient, equitable and patient-centered). BMC/BHS remains committed to providing high quality care with an attention to efficiency and value. In 2014 BMC was recognized as a Truven 100 Top Hospital, an award that looks at quality, patient safety and cost of care. BMC/BHS continue to be recognized by Healthgrades with the Distinguished Hospital Award for Clinical Excellence and Delta CareChex as a Top 100 Hospital in the Nation for Overall Hospital Care.

TME for Berkshire County has not been shared with BMC/BHS in part because the county does not have a physician/hospital organization (PHO) to accept risk. The most recent information available is from 2009 and includes the four western counties of Massachusetts. BMC/BHS believe that the CMS Medicare Spending Per Beneficiary (MSPB) is a reliable measure for BMC/BHS to use as an indicator of costs compared to other Massachusetts hospitals and the hospitals in the nation.

The MSPB episode is defined as all claims with start date falling between 3 days prior to an inpatient PPS hospital admission (index admission) through 30 days post-hospital discharge. The MSPB Measure Performance Rate is the ratio of a hospital's payment-standardized, risk-adjusted MSPB Amount to the median MSPB Amount across all hospitals. An MSPB Measure Performance Rate of less than one indicates that a hospital's MSPB amount is less than the national median spending amount. The table below summarizes BMC's performance over the four most recent measurement periods.

	Measurement Period				Spend/Episode
	May 10-Feb 11	May 11- Dec 11	Jan 12-Dec 12	May 13-Dec 13	May 13-Dec 13
BMC	**1.04**	**1.03**	**1.00**	**0.99**	**$ 19,439.20**
Massachusetts	**1.03**	**1.04**	**1.03**	**1.02**	**$ 20,008.29**
United States	**0.98**	**0.98**	**0.98**	**0.98**	**$ 19,253.48**

BMC/BHS have adopted the Choose Wisely principles promulgated by the ABIM Foundation. During 2013 and 2014 BMC/BHS have focused on unnecessary imaging and laboratory testing. Only one commercial insurance plan is participating in a shared savings arrangement, making initiatives such as Choose Wisely a financial hit to the viability of BMC/BHS, with all of the benefit of such initiatives accruing to the payer.

As discussed in last year's report, BMC/BHS work with other community providers to improve transitions in care between hospital, home and skilled nursing facility. Using data in the MSPB report and with a goal of further reducing unnecessary admissions and readmissions, BMC/BHS

analyzed its data to identify which practices and skilled nursing facilities had the highest incidence of readmissions. BMC/BHS has developed a standing working group to understand the causes of these readmissions and improve care transitions to reduce the readmission rate and improve outcomes for the patient. Efforts to reduce the post-acute care costs include a county wide patient centered medical home initiative, the implementation of the BOOST program (Better Outcomes by Optimizing Safe Transitions) on some BMC nursing units, embedding home care nurses in physician practices, introducing behavioral health telemedicine and focusing on reducing post-hospitalization syndrome.

BMC/BHS will continue to exercise restraint in its delivery approach to help the Commonwealth meet the cost growth benchmark for the coming year. BMC/BHS have received funding from the Prevention Wellness Trust Fund and will be applying for funding from the CHART grant. The CHART grant would assist in the development of a "medical neighborhood" for services that will improve the health and well-being of the residents of northern Berkshire County. The goal of the proposed medical neighborhood is to provide supportive services such as diabetes education, cardiac rehabilitation, and behavioral health on the former NARH campus. Many of these services are either poorly reimbursed or not reimbursable at all but are believed to have a positive impact on patients and their ability to remain home while improving the wellness of the community.

BMC/BHS will continue to expand it involvement with the Canyon Ranch Institute Life Enhancement Program (CRI LEP) as described in last year's report. Since last year BMC has engaged community members in four distinct group programs. BMC/BHS will be expanding this program to southern Berkshire County and northern Berkshire County in the coming year. The CRI LEP helps community members prevent, identify, and address chronic diseases and disease risk while providing lifestyle coaching. The support that team members receive from one another has been positive, with the groups continuing to reconnect long after the formal program has ended.

There continue to be many recommended systematic or policy changes that would assist BMC/BHS to operate more efficiently without reducing quality. These include:

- Recognition that there are healthcare organizations like BMC/BHS that, because of the nature of the communities for which they are responsible, have burdens that go well beyond those of a traditional hospital or health system.
- Recognition that the total cost of care or total medical expense in an area such as Berkshire County may include factors beyond the cost of a typical episode of care.
- True transparency in claims data and other appropriate information between providers, insurers and regulators to assure that such data and information can serve as a truly accurate and useful tool for comparison and improvement.

- Development of uniform definitions, quality reporting measures, claims submission and determination processes among insurers in order to eliminate a substantial amount of non-productive overhead cost of providers.

2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.

a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.

As indicated in last year's report BMC/BHS has a patient population that is too small to allow traditional risk contracting. With a maximum potential patient pool of 150,000 and a commercially insured pool of approximately 50,000 divided among 6 primary payers, it would not be actuarially prudent for BMC/BHS to accept traditional risk. As noted last year, BMC/BHS has made it known to its commercial payers that it is open to any "shared savings" payment models. To date, only one payer has entered into this alternative payment model with BMC/BHS.

BMC/BHS have developed and continue to develop innovative models as described in Question 1 (please refer to this year and last year's report for a full description) because of the role BMC/BHS plays in the healthcare delivery system. BMC/BHS continue to pursue these models despite the risk of reducing reimbursement without payers recognizing the fixed costs of the health system and the ongoing, singular benefit to the payers that have not been open to shared savings arrangements.

BMC/BHS have had some limited experience with tiered products that induce patients to seek care at a "lower cost" facility. While these products might work well in more geographically dense communities the tiered products have the effect of requiring long drives of as much as 50 miles or more to facilities outside of the county and in some cases, a delay or avoidance in care.

BMC/BHS would welcome the sharing of clinical data that is reported to be available when organizations enter into these types of risk arrangements. At the moment, payers are not sharing aggregate population reports that would be useful in understanding gaps in care and prevention opportunities. It seems that BMC/BHS are destined to be 'data poor' given the current inability or unwillingness of commercial payers to share that data.. BMC/BHS would welcome this data that could provide a roadmap for its clinicians to further develop care plans for the patients it serves.

BMC/BHS have not conducted any analyses on the implementation of APMs and resulting effects on the non-clinical operations or the impact on the patient population. BMC/BHS is pursuing the development of a PHO which could potential gain access to the clinical data necessary to conduct such an analysis, although that effort is also hampered by the small size of both the local patient population and the local provider population. It is BMC/BHS's intent to explore the feasibility of creating of such an organization while being mindful of the potentially addition of more administrative functions, which could be contrary to the goals of the cost growth benchmark.

3. **Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.**
   a. **In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including particular sub-populations (e.g., pediatric) or those with behavioral health conditions?**
   b. **How do the health status risk adjustment measures used by different payers compare?**
   c. **How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?**

BMC/BHS have not had access to the health status risk adjustment tools used by the Massachusetts payers. However, it does seem that another layer of complexity is being placed on providers to manage under multiple risk adjustment tools. This seems to be contrary to the goals of the cost growth benchmark. It seems logical that one tool should be adopted by the Commonwealth for all payers to use. This would give a more accurate picture of the population over time as patients often move from one plan to another during open enrollment. Changes in the health status risk adjustment may never be fully understood if multiple tools are used across the various payers making it difficult to calculate what interventions have been successful versus the impact of the enrollment changes. One, consistent health status risk adjustment tool with common language, rules and application across the Massachusetts payers would provide transparency and a more accurate measure over time for the population.

4. **A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (II) historic data or population-level data that would be helpful for population health management and/or financial modeling.**

As answered in question 3, BMC/BHS does not receive any actionable data that would elevate the quality of care and efficiency. However, BMC/BHS would like to receive reports that identify gaps in care with a focus on wellness and prevention. BMC/BHS would also like to know what prescriptions have been filled as prescribed and which prescriptions have not been renewed. According to an article in the American Journal of Medicine 24% of patients are not filling initial prescriptions while medications for hypertension and diabetes have non-adherence rates of 25%. Access to real-time information in the providers' hands would be a powerful tool to improve outcomes and reduce readmissions.

5. **C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.**
   a. **Which attribution methodologies most accurately account for patients you care for?**
   b. **What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?**

BMC/BHS does not have any experience with attribution methodologies. BMC/BHS would find the TME values for the Berkshire county zip codes to be relevant and useful in improving quality of care and driving efficiency in the care delivery system. A report similar to the CMS MSPB would be useful in identifying opportunities in the care continuum. Detailed reports outlining gaps in care would also be useful in identifying programs that need further development and community members that would benefit from outreach.

6. **Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.**

   BMC/BHS has experienced a real explosion in the number and variety of quality measures that are reported on an annual basis. The lack of consistency between payers and reporting agencies has put a heavy cost and effort burden on the quality and performance improvement operations of BMC/BHS. The tables below illustrate the increase in reporting requirements between 2008 and 2014.

<u>2008 Quality Initiatives & Reporting</u>

- National, Quality Initiative (CMS)
- NQF
- AHRQ
- Leapfrog
- Patient's First
- IHI
- 100 Top Hospitals
- AHA - Get With The Guidelines (GWTG)
- Joint Commission, National Pt Safety Goals, Core Measures

<u>2014 Quality Initiatives & Reporting</u>

- MA - PatientCareLink
- Leapfrog
- 100 Top Hospitals
- GWTG
  - AMI/M:L
  - AFIB
  - HF
  - Stroke
  - AFIB
  - Resuscitation

- Joint Commission
    - Pt Safety Goals,
    - Core Measures (2 additional measure sets required in 2014)
    - Orthopaedic T.J.C. Certification
- CMS – IQR and OQR public reporting
- CMS – HAC's, PSI-90, HAI, Readmission
    - VBP
    - PQRS
    - Meaningful Use
- NEOB
- STAAR
- Project BOOST
- CCTP
- SG2
- CareChex
- Healthgrades
- AHRQ
- IHI
- SCORE – Stroke collaborative
- Partnership for Patients (Health Engagement Network - HEN)
- NHSN Mandatory Reporting
- NSQIP
- CUSP- surgery
- Bariatric Surgery
- Commission on Cancer
- MassHealth P4P
- BCBS P4P
- COEMIG
- Triple Aim
- NQF
- County Health Rankings

The staffing requirements also increased with this reporting demand as illustrated below. Uniform reporting would help to mitigate the effort required to meet this growing need.

	FY 2010	FY 2014
Quality Assurance	**3.25**	**3.97**
Performance Improvement	**12.14**	**16.13**
	15.39	**20.1**

7. **An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.**
    a. **Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other high cost care settings.**
    b. **Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.**

BMC/BHS uses Sg2 tools to track trends in inpatient DRG service lines. The tool uses historical data and then applies a series of assumptions regarding the various service lines including community demographics, impacts of healthcare reform, new technology, and evidence-based research to estimate the future demand for the various service lines. This information is used to inform annual budgets and the development or shrinkage of clinical programs over time. BMC/BHS periodically review inpatient market data, using publicly available data to monitor market share. . BMC/BHS work collaboratively with academic medical centers to coordinate a patient's care for services that are not and should not be provided at BMC. Examples include a collaborative partnership with Baystate Medical Center for NICU services and interventional cardiology. In the case of interventional cardiology, some of the BMC cardiologists have privileges at Baystate and can follow their patients to Baystate for care. In the majority of cases, the patients are referred back to the BMC cardiologists for ongoing management once the major procedure has been completed.

8. **The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.**
    a. **Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.**

BMC uses the following table from the CMS report on the hospital specific Medicare spending per Beneficiary (MSPB) Measure. This table is for the period May 1, 2013 to December 1, 2013.

	Claim Type	Your Hospital		State	Nation
		Spending per Episode	Percent of Spending	Percent of Spending	Percent of Spending
3 Days Prior to Index Admission	*Total Pre-Index*	*620*	*3.4%*	*3.4%*	*3.2%*
	Home Health Agency	16	0.1%	0.1%	0.1%
	Hospice	0	0.0%	0.0%	0.0%
	Inpatient	2	0.0%	0.0%	0.0%
	Outpatient	115	0.6%	0.5%	0.6%
	Skilled Nursing Facility	2	0.0%	0.0%	0.0%
	Durable Medical Equipment	8	0.0%	0.0%	0.0%
	Carrier	477	2.6%	2.7%	2.5%
During-Index Admission	*Total During-Index*	*8,889*	*48.8%*	*50.4%*	*54.1%*
	Home Health Agency	0	0.0%	0.0%	0.0%
	Hospice	0	0.0%	0.0%	0.0%
	Inpatient	7,734	42.5%	43.4%	46.3%
	Outpatient	0	0.0%	0.0%	0.0%
	Skilled Nursing Facility	0	0.0%	0.0%	0.0%
	Durable Medical Equipment	24	0.1%	0.1%	0.1%
	Carrier	1,132	6.2%	7.0%	7.7%
30 Days After	*Total Post-Index*	*8,707*	*47.8%*	*46.2%*	*42.7%*
	Home Health Agency	901	4.9%	5.2%	3.8%

Hospital Discharge	Hospice	77	0.4%	0.4%	0.6%
	Inpatient	2,405	13.2%	13.5%	13.3%
	Outpatient	805	4.4%	3.7%	3.4%
	Skilled Nursing Facility	3,407	18.7%	17.2%	15.5%
	Durable Medical Equipment	92	0.5%	0.4%	0.5%
	Carrier	1,021	5.6%	5.9%	5.5%

As referenced in question 1 above, BMC's MSPB is lower than the statewide average MSPB and equal to the national MSPB. Variations in the site of care can be seen with the Inpatient spending per episode being lower than the state and national percent of spending, while the skilled nursing facility percent of spending per episode is higher at BMC than the state and national percent of spending per episode. It was noted in last year's report that BMC/BHS work with post-acute care providers to improve transitions of care between the hospital and skilled nursing facility. The discharge dispositions are reviewed with the transition team on a regular basis for appropriateness and opportunities to improve the transitions.

b. How does your organization ensure optimal use of post-acute care?

The discharge disposition is based on the needs of the patient and the support available. This decision is reached with input from the patient, the family or care giver, the physician, the primary nurse, the case manager and any consulting providers including palliative care and hospice with reference to the MOLST (medical orders for life sustaining treatment) form. Additional elements are derived from the eligibility criteria established by the receiving service/facility.

Efforts to reduce the post- acute care costs include

- Community-based Care Transition Program
- BOOST – Better outcomes by optimizing safe transitions
- Patient Centered Medical Home
- Prevention & Wellness Trust Fund
- Integrated Care Division – Acute, home health & long term care (LTC)
- Telemedicine – Behavioral health & LTC
- Focus on reducing Post-hospitalization Syndrome – Nutrition, noise, lessen disruption, physical therapy

9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, and analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

The majority of BMC's patient inquiries regarding price estimates are referred to the admitting department of BMC. Most inquiries concern cosmetic procedures not covered by insurance. The admitting department works with the respective clinical areas to provide the most accurate estimate of total charges for the specific request. With many surgical procedures, it is possible that the final procedure rendered could be different than estimated due to the scope of work not being fully appreciated until the surgeon is able to perform the case and open the surgical site.
This charge transparency allows patients to make an informed decision about the service they are considering. Those patients covered through health insurance are provided the total charges billed to health plans. The variance in the types of plan and coverage scope purchased by the consumer results in a range of patient payment obligations.

There are approximately six inquiries per quarter. All inquiries have been via telephone. The BMC response to patients is within forty-eight hours.

10. **Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization has taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.**

BMC/BHS has had some limited experience with tiered products that induce patients to seek care at a "lower cost" facility. While these products might work well in more geographically dense communities the tiered products have the effect of requiring long drives to facilities outside of the county as much as 50 miles or more away and in some cases, higher cost to the patient, and delay or avoidance of care.

11. **The commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.**
    a. **Please describe ways your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.**
    b. **Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.**
    c. **Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.**
    d. **There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organizations willingness and ability to report discharge data.**

a. BMC's Department of Psychiatry and Behavioral Sciences has partnered with and independent community mental health and substance abuse services in the county since 1994, especially

through a local agency currently known as the Brien Center. BMC provides board certified psychiatrists to back up both the emergency behavioral health system in the county and the community mental health system 24 hours per day and 365 days per year. The Department Chair's office has made the psychiatric coverage schedule for both the hospital and the Brien Center's Emergency Services Program (ESP) since 1994. The Chair of Psychiatry at BMC holds a multi-disciplinary and multi-agency meeting every two weeks with the medical and nursing leadership of the emergency department at BMC, the inpatient psychiatry units and the Brien Center's ESP team every two weeks to review adverse events, near misses and any opportunities for improving the system. This approach has led to greater safety, fewer mental health patients characterized as "boarding" in the ED and lower lengths of stay in the BMC ED compared to other parts of the Commonwealth. The Health Policy Commission recently shared data indicating that of 27 community hospitals in the Commonwealth eligible for CHART funding, BMC had one of the lowest percentages of mental health and substance abuse patients compared with medical and surgical patients "boarded" in the ED for periods greater than 12 hours while awaiting admission or placement (less than 30% for BMC compared to a state average of around 50%). The collaboration of BMC and the Brien Center over the past two decades has led to a greater certainty that only patients truly requiring hospitalization are admitted.

Since 1995, BMC's psychiatry department has also recruited, hired and employed all the psychiatrists and advanced practices nurses who are then leased to Brien Center. The Brien Center had asked for this service because it had extraordinary difficulty recruiting high quality psychiatrists and advanced practice nurses to serve the community.

Since 2006, the BMC Department of Psychiatry has partnered with DPH's Suicide Prevention Program to do gatekeeper trainings for PCP's, crisis clinicians, emergency responders, probation officers, clergy, visiting nurses and others. The department has worked with DPH to develop a curriculum on suicide prevention for medical students and psychiatry residents in training. The partnership has also included developing a one question screening tool for nurses in medical and surgical settings to screen for depressed mood, and if that screen is positive for follow-up with a social worker doing a PHQ-9. This has led to thousands of medical and surgical patients being screened for comorbid depression, and if depression is present for that to be treated. We have learned that about 47% of patients who answer yes to the one question will have a moderate, moderately severe or severe depression and that about 31% who answer yes to the one question actually have some element of suicidal thinking. BMC is currently extending these approaches into primary care settings with the help of a depression care manager. The department has for many years now had a social worker, psychiatrist and psychiatric resident working in two of the major primary care practices in the county, and current plans are underway to expand the model to serve other primary care practices. With the support of a generous grant of the Attorney General the department hopes to extend the help to primary care by utilizing telepsychiatry.

Many departments of BMC have also participated in a community pain initiative among providers of care at the hospital and in the community and with schools, law enforcement,

pharmacies and the DPH Drug Control Program. The twin goals of that effort have been proper treatment of pain while reducing adverse events from medication misuse and/or diversion. A model pain manual was developed and is available on-line through our library and rates of doctor-shoppers have dropped since we have initiated the program. We have also presented at numerous national forums on this topic including the American Psychiatric Association national annual meeting in May, 2008.

b. All of the work described above by integrating assessment and care among primary care, psychiatry, the community mental health system and the emergency department has allowed our department to achieve high rates of diversion from emergency settings, short lengths of stay and low rates of readmission (as reported back to BMC by Medicaid providers) compared to the rest of the state. There is a QI process built into the work among the various divisions of the medical center and the major provider of community mental health and substance abuse services.

c. Poverty, domestic violence, drug abuse and unemployment are major factors putting the citizens of our county at especially high risk. Shortages of psychiatrists have also been a problem. Funding that has been fee for service rather than using payment mechanisms to support innovative approaches such as the depression care manager have also been problematic. The grants from DPH, the Attorney General and others are allowing us a way to explore overcoming barriers to access and to leverage the scarce psychiatric resources needed to support behavioral health integration into primary care and emergency services and to provide the safest and best care for the residents of our county.

d. Our organization would like to be able to participate in statewide quality and safety initiatives that would allow us to more effectively treat our patients and adopt the best practices.

12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

One year ago, BMC/BHS arranged for TransforMED to instruct and mentor 11 adult or family primary care practices in Berkshire County in the transformation necessary for 2015 applications to NCQA for Patient Centered Medical Home certification. This initiative will drive to:

1. Improve patient access and population health management for diabetes, hypertension and tobacco dependence, while maintaining and/or improving physician workload through improved office efficiency,
2. Create a culture of continuous quality improvement (NCQA recognition), and
3. Improve the safety, timeliness, effectiveness, efficiency, equitability, and patient centeredness (STEEP) of follow up care for high risk patients and patient post hospital discharge.

a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations.

6.5% (2 FQHC practices)

b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

4%

b. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and cost of care.

No analyses have been completed during the development phase of the practice transformations.

13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

BMC/BHS appreciate the work being done by HPC and CHIA to develop meaningful reports that can help communities and providers improve the quality of care and efficiency in the Commonwealth's healthcare delivery system. Many of the issues raised in the HPC's 2013 Cost Trends Report and the July 2014 Supplement ring true for BMC/BHS. As has been stated in the responses to the previous questions BMC/BHS are working diligently to improve quality and reduce unnecessary admissions and readmissions through the care transitions work and six sigma projects regarding readmissions. This work will also drive efficiency for the BMC/BHS. Additionally, the Choose Wisely program is being embedded in the work of the clinicians to reduce the amount of unnecessary testing. The community physician groups are working diligently to convert their groups into patient centered medical homes. As has also been mentioned in earlier responses, the providers of Berkshire County are operating with a limited data set, reflecting activity that has been rendered by the BHS providers. The community is lacking a robust set of data that would identify gaps in care, duplicate care, and pharmaceutical utilization, and opportunities for wellness and prevention interventions.

BMC/BHS is interested in learning and using its community TME information. The most recent report on TME, used in the 2013 Cost Trends Report, reflects TME rates using only three commercial payers. While these payers may represent the majority of the commercial payers in other parts of the Commonwealth, only one of the identified payers has sufficient covered lives to be able to provide a TME for the county, but even that payer has data on only a small fraction of the county population. The same problem that existed in the initial TME published using 2009 data appears to remain in the more recent TME calculations. At the present time (and perhaps for the foreseeable time), there is no risk bearing PHO organization in Berkshire County (for the reasons previously stated) that would act as the collector of this meaningful data for the community. BMC/BHS recognize that in different communities TME must be attributed to PCPs and that use patterns between multiple hospital systems must be considered. In Berkshire County this is not the case. TME information using Berkshire County zip codes would be extremely informative allowing BMC/BHS to work with all providers to strive for the IHI's Triple Aim.

Exhibit C: Instructions and AGO Questions for Written Testimony

1. **Please submit a summary table showing for each year 2010 to 2013 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Hospital Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.** (See PDF Exhibit 1).

2. **For each year 2010 to present, please submit a summary table showing for each line of business (commercial, government, other, total) your inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as AGO Hospital 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.** (See PDF Exhibit 2).

3. **Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.**

BMC/BHS have not developed any models that would quantify, analyze or project the ability to manage risk under risk contracts at this time, give the small size of both the patient and provider population. BMC/BHS is beginning to explore the development of a local PHO that may be able to consider some risk-type arrangements.

4. **Please explain and submit supporting documents that show how you analyze and track the volume of inpatient and outpatient referrals to your hospital and the associated revenue from those referrals by particular physicians or provider groups. Please include a description and examples of how your organization uses this information.**

BMC/BHS does not track the volume of referrals for inpatient or outpatient services by physician. BMC/BHS can track the ordering physician for outpatient services. BMC/BHS relies on the information from Sg2 to develop long term plans for service line growth and contraction using national trends and expected changes in the healthcare delivery system.
BMC/BHS registers all inpatient admissions with a hospitalist as the admitting physician. There is a field in the system that captures the PCP but since the orders are not placed by the PCP BMC is not always confident that this field is updated regularly.

Exhibit 1 AGO Questions to Hospitals

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
8. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	35,629,716	22,356,319	1,178,774	742,781											
Tufts Health Plan											8,384,154				
Harvard Pilgrim Health Care											1,326,994				
Fallon Community Health Plan															
CIGNA											3,960,124				
United Healthcare											9,620,707				
Aetna															
Other Commercial											42,680,367				
Total Commercial	35,629,716	22,356,319	1,178,774	742,781							65,972,344				
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.											18,454,503				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											1,754,487				
Total Managed Medicaid											20,208,990				
MassHealth	14,810,333		48,389												
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare	123,168,546		45,767												
Other											17,747,168				
GRAND TOTAL	173,608,595	22,356,319	1,272,930	742,781							103,928,503				

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	33,972,912	22,869,807	1,231,591	848,102											
Tufts Health Plan											10,082,218				
Harvard Pilgrim Health Care											1,897,505				
Fallon Community Health Plan											2,281,629				
CIGNA											5,356,185				
United Healthcare											10,222,319				
Aetna											4,524,286				
Other Commercial											37,913,815				
Total Commercial	33,972,912	22,869,807	1,231,591	848,102							72,277,957				
Network Health															
Neighborhood Health Plan											169,564				
BMC HealthNet, Inc.											22,636,878				
Health New England					1,006,790		146,179								
Fallon Community Health Plan															
Other Managed Medicaid											4,074,351				
Total Managed Medicaid					1,006,790		146,179				26,880,793				
MassHealth	14,566,864		435,705										415,102		
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare	130,011,965		100,687												
Other											19,486,233				
GRAND TOTAL	178,551,741	22,869,807	1,767,983	848,102	1,006,790		146,179				118,644,983		415,102		

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	31,664,165	20,967,086	1,126,432	724,526											
Tufts Health Plan											9,675,189				
Harvard Pilgrim Health Care											1,347,587				
Fallon Community Health Plan											2,474,508				
CIGNA											5,413,537				
United Healthcare											11,384,765				
Aetna											5,215,018				
Other Commercial											39,116,529				
Total Commercial	31,664,165	20,967,086	1,126,432	724,526							74,627,133				
Network Health											1,085,018				
Neighborhood Health Plan											207,497				
BMC HealthNet, Inc.											23,778,140				
Health New England					730,910		72,039								
Fallon Community Health Plan															
Other Managed Medicaid											4,438,590				
Total Managed Medicaid					730,910		72,039				29,509,245				
MassHealth	14,689,387		742,524												
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare	147,025,918		77,527												
Other											21,805,282				
GRAND TOTAL	193,379,470	20,967,086	1,946,483	724,526	730,910		72,039				125,941,661				

2013

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	32,141,762	20,889,506	1,139,699	745,424											
Tufts Health Plan											8,458,107				
Harvard Pilgrim Health Care											1,891,759				
Fallon Community Health Plan											3,244,976				
CIGNA											5,125,103				
United Healthcare											10,078,842				
Aetna											5,823,548				
Other Commercial											37,580,807				
Total Commercial	32,141,762	20,889,506	1,139,699	745,424							72,203,142				
Network Health											1,719,918				
Neighborhood Health Plan											317,941				
BMC HealthNet, Inc.											22,473,726				
Health New England					1,429,376										
Fallon Community Health Plan															
Other Managed Medicaid											4,149,923				
Total Managed Medicaid					1,429,376						28,661,507				
MassHealth	14,933,592		702,442												
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare	152,621,238														
Other											23,124,723				
GRAND TOTAL	199,696,592	20,889,506	1,842,142	745,424	1,429,376						123,989,372				

2010

	Commercial				Government				All Other				Total			
Service Category	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)	Inpatient Revenue ($)	Inpatient Margin ($)	Outpatient Revenue ($)	Outpatient Margin ($)
Burns																
Cardiology Total																
Invasive																
Medical																
Cardiac Surgery																
Dental																
Dermatology																
Endocinology																
Gastroenterology																
General Medicine																
General Surgery																
Gynecology																
Hematology																
Infectious Disease																
Neonatology																
Nephrology																
Neurology																
Neurosurgery																
Normal Newborns																
Obstetrics																
Oncology																
Ophthalmology																
Orthopedics																
Otolaryngology																
Psychiatry																
Pulmonary																
Rehab																
Rheumatology																
Transplant Surgery																
Trauma																
Urology																
Vascular Surgery																
Other Inpatient																
Imaging																
Other Treatments																
Laboratory																
Ambulatory Surgery																
Therapies																
Office Visits																
Observation																
Other Outpatient																
GRAND TOTAL	**39125637.31**	197807.4799	95262968.16	39596549.97	96343402.5	-20361502.2	64755362.36	-17035881.1	4453151.411	-1526371.3	9297525.227	1620337.444	139922191.2	-21690066	169315855.7	24181006.31

2011

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**
Burns																
Cardiology Total																
Invasive																
Medical																
Cardiac Surgery																
Dental																
Dermatology																
Endocinology																
Gastroenterology																
General Medicine																
General Surgery																
Gynecology																
Hematology																
Infectious Disease																
Neonatology																
Nephrology																
Neurology																
Neurosurgery																
Normal Newborns																
Obstetrics																
Oncology																
Ophthalmology																
Orthopedics																
Otolaryngology																
Psychiatry																
Pulmonary																
Rehab																
Rheumatology																
Transplant Surgery																
Trauma																
Urology																
Vascular Surgery																
Other Inpatient																
Imaging																
Other Treatments																
Laboratory																
Ambulatory Surgery																
Therapies																
Office Visits																
Observation																
Other Outpatient																
GRAND TOTAL	**43587515.62**	3583996.497	98625459.38	44215611.62	101115966.1	-24200909.9	73542269.79	-10536643.1	3826286.961	-2246601.54	11261180.41	3406621.014	148529768.7	-22863514.9	183428909.6	37085589.52

2012

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**
Burns																
Cardiology Total																
Invasive																
Medical																
Cardiac Surgery																
Dental																
Dermatology																
Endocinology																
Gastroenterology																
General Medicine																
General Surgery																
Gynecology																
Hematology																
Infectious Disease																
Neonatology																
Nephrology																
Neurology																
Neurosurgery																
Normal Newborns																
Obstetrics																
Oncology																
Ophthalmology																
Orthopedics																
Otolaryngology																
Psychiatry																
Pulmonary																
Rehab																
Rheumatology																
Transplant Surgery																
Trauma																
Urology																
Vascular Surgery																
Other Inpatient																
Imaging																
Other Treatments																
Laboratory																
Ambulatory Surgery																
Therapies																
Office Visits																
Observation																
Other Outpatient																
GRAND TOTAL	**40506504.61**	5614405.168	97202793.94	45158925.17	115779823.2	-6692993.7	74353368.15	-9024204.36	4622254.764	-1995233.19	12927380.46	5704313.146	160908582.6	-3073821.72	184483542.5	41839033.96

2013

	Commercial				Government				All Other				Total			
Service Category	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**	**Inpatient Revenue ($)**	**Inpatient Margin ($)**	**Outpatient Revenue ($)**	**Outpatient Margin ($)**
Burns																
Cardiology Total																
Invasive																
Medical																
Cardiac Surgery																
Dental																
Dermatology																
Endocinology																
Gastroenterology																
General Medicine																
General Surgery																
Gynecology																
Hematology																
Infectious Disease																
Neonatology																
Nephrology																
Neurology																
Neurosurgery																
Normal Newborns																
Obstetrics																
Oncology																
Ophthalmology																
Orthopedics																
Otolaryngology																
Psychiatry																
Pulmonary																
Rehab																
Rheumatology																
Transplant Surgery																
Trauma																
Urology																
Vascular Surgery																
Other Inpatient																
Imaging																
Other Treatments																
Laboratory																
Ambulatory Surgery																
Therapies																
Office Visits																
Observation																
Other Outpatient																
GRAND TOTAL	**40427431.63**	5509097.564	96180810.4	41680311.03	114912013.8	-11732064.3	86968448.11	-8175383.55	813226.3806	-1771472.68	4548674.115	595756.8059	156152671.8	-7994439.46	187697932.6	34100684.29