SAINT VINCENT HOSPITAL

STEVEN MACLAUCHLAN
PRESIDENT & CEO

September 11, 2015

Mr. David Seltz
Executive Director
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02111

Via Electronic Mail to: HPC-RPO@state.ma.us

Dear Executive Director Seltz:

Pursuant to your request and in accordance with Massachusetts General Laws chapter 6D & 8, please find included herein Saint Vincent Hospital's responses to the questions outlined in Exhibits B and C. I am legally authorized and empowered to represent Saint Vincent Hospital and provide the enclosed testimony.

Sincerely,

Steven MacLauchlan
President & CEO

CC: Stuart Altman, PhD
Chair, Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02111

Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.
    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?

    c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

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

Saint Vincent, as a member of a national healthcare organization, has been fully engaged for several years in delivering high quality, cost-effective, appropriately local care. Saint Vincent's high value proposition provides a model to be utilized in order to provide high quality, cost-effective patient care services with a health care cost growth trend lower than 3.6% within the Central Massachusetts Market.

a. Saint Vincent has seen the following trends in utilization and expense controls in the last 3 years:

- Volume has shifted from IP to OP
    - Even though patients are being treated for similar diagnosis, treatment plans have become more effective and efficient resulting in shorter lengths of stay
    - The Hospital has acknowledged this trend and implemented a clinical decision/observation unit which has benefited the patient with level of care expectations and improved Hospital throughput operations

    - Even though overall shift to OP is seen throughout the Hospital, the Operating rooms are appropriately being used for higher acuity Hospital services rather than focusing growth on OP surgery that could be performed in an ambulatory setting

- We have continued to focus on managing Total Operating Expenses for the hospital.

One area that remains a challenge is Medicaid reimbursement, which continues to operate under a fee for service model, and allows members to move in and out of Medicaid MCO plans, making risk stratification difficult. Enrollment plans should lock in similarly to Medicare plans, allowing improved management of a more stable population.

b. Actions to ensure meeting the benchmark since 2014 that Saint Vincent has been focused on include providing high quality, cost-effective care, through the following ongoing initiatives that have continued in 2015:
    - LEAN daily management of the hospital in line with Tenet-wide principles of lean and effective healthcare management. Tenet's MA hospitals are a leader in effective LEAN management.
    - Significant internal cost reduction initiatives (including position eliminations and consolidations, consolidation of service lines/locations, work redesign, etc.).
    - Continue participation in risk-based contracts with payers, leading to more effective management of Total Medical Expense (TME).
    - Improving access to primary care physicians
    - Population health management programs

c. Actions we plan to undertake to ensure continued benchmark success:
    - Continued participation in cost and risk shared contracts
    - LEAN daily management in our facilities
    - National purchasing contracts as part of the Tenet Health organization.
    - Utilization of discharge management approaches and models to manage hospital readmissions
    - Strengthening and expanding our ACO
    - Specialty care partnerships for the most effective patient care in a local setting
    - Utilization of best practices established across Tenet hospitals

d. We recommend the following policy changes:
    - Encourage adequate and flexible behavioral health access with appropriate reimbursement.
    - Alternative payment programs, including Medicaid alternative payment programs
    - Greater reimbursement rate equity between community-based and academic-based facilities for the same high-quality care.

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

We see several potential barriers to effective utilization of alternative payment methods for the management of patient populations:

- Limited investment/payments for behavioral health facilities and programs (inpatient and outpatient). Because behavioral health issues create additional complexity when combined with other comorbidities in patient populations, the availability of adequate programs and adequate coverage which allow investment in these programs is essential for risk-based payment methods. Better management of data related to behavioral health as a comorbid condition will also be important for improved management of patients across a patient population group.

- Continued rate inequity among hospitals. Commercial rate consistency and equity, as well as adjustment of Medicare/Medicaid to create more of a level playing field for the utilization of risk-based payment methods across the board.

- Access to primary care. Continuing to provide access to primary care, particularly in low-income areas, will be critical to effective utilization of alternative payment methodologies.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
    a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

       Managing 30 day readmissions and reducing avoidable ED use have been key areas of focus for Saint Vincent over the last year. Readmissions are tracked monthly, and are included in the hospital scorecard. Root cause analysis for months with higher than expected readmissions are performed, to understand the drivers and types of patients most impacted. For ED users, access to primary care is validated (do they have a PCP), and if there is not a current PCP for the patient, recommendations are made available to the patient. Additionally, follow up calls and providing contact information for patients at high risk for readmission continues. Partnering with post-acute providers for patient care is another area of focus targeting reduction in readmissions.

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

       We will continue to utilize these same strategies over the next 12 months to continue to make improvements.

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and

by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.

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

   There should be greater consistency across providers. The wide variation in prices paid is historical, and a holdover from an outdated fee for service model, in need of adjustment.

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.

Price variation drives up the overall cost of care, and creates a continued inequity between Academic and community hospitals. While greater consumer engagement in health care spending will continue to drive efficiency, particularly as more consumers/employers participate in tiered or limited network products, and are more aware of health care costs, as well as their required contribution or copay, this alone is not adequate to address the continued adjustment that is needed. Reimbursement inequity impacts the sustainability of community providers, particularly in high-need, low-reimbursement areas such as behavioral health.

Investment in behavioral health, while necessary to meet the needs of the community, is not reimbursed at a sufficient level to invest in the programs and facilities needed to effectively manage behavioral health resources at both Saint Vincent and MetroWest. The lack of adequate treatment options continues to result in behavioral health patients boarding in the ED, or utilizing inpatient care when no appropriate outpatient care is available. We continue to invest in both inpatient and outpatient behavioral health programs to address these needs. Our observation is that of the Top 20 episodes by contribution to growth, 6 are behavioral health related. Better management/coordination of care with appropriate reimbursement can significantly contribute to lowering the cost growth curve increase. The Behavioral Health concentration of care in ED is directly related to an underinvestment in behavioral health programs due to poor reimbursement. Because our mission is to provide for the overall health of our communities, we continue to invest in behavioral health despite the gap in reimbursement. This places an unequal burden on community hospitals, where many of these patients are frequently seen.

As we plan for 2016, Saint Vincent, by providing high quality, cost-effective local care is focused on stemming the outmigration of care to higher cost facilities and will continue to focus on being the high value care provider in Worcester.

5. The Commission has identified that 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. 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 that your organization has collaborated with other providers over the past 12 months 1) to 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 expanded our inpatient behavioral health capabilities at Saint Vincent and MetroWest, and work collaboratively to place patients waiting in the ED into available beds across the two facilities. Additionally, we partner with community behavioral health organizations to provide follow-up and support for patients as they transition out of an inpatient setting.

b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

   We will continue to invest in behavioral health services and expansion in 2016 across our two hospitals, and continue to collaboratively manage ED patients with behavioral health needs across our hospitals and with our community partners.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

We have utilized Patient-Centered Medical Home principles since 2011 in our employed primary care physician practices. Our ACO organizations also utilize care coordination and interdisciplinary teams to manage the health of our patients.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.

2. Exhibit C - #1

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1	146	0	146	CT, MRI, Vasc Studies, Deliveries, Surgeries
	Q2	138	0	138	CT, MRI, Vasc Studies, Deliveries, Surgeries
	Q3	135	0	135	CT, MRI, Vasc Studies, Deliveries, Surgeries
	Q4	118	0	118	CT, MRI, Vasc Studies, Deliveries, Surgeries
CY2015	Q1	132	0	132	CT, MRI, Vasc Studies, Deliveries, Surgeries
	Q2	128	0	128	CT, MRI, Vasc Studies, Deliveries, Surgeries

3.

4. Please submit a summary table showing for each year 2011 to 2014 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. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

Spreadsheet submitted as separate attachment.

Exhibit 1 AGO Questions to Hospitals

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide
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
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an
8. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or

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	$21M	$17M	$ 0.56	$ 0.43	X	X	X	X	X	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	$5M	$3M	X	X	X
Harvard Pilgrim Health Care	$6M	$5M	$ 0.06	$ 0.04	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	$40	$ 0.09	$4M	X	X	X	X	X	X	X	X	X	X	X	$2M
CIGNA	X	X	X	X	X	X	X	X	X	X	$2M	$2M	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$2M	$ 0.40	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$2M	$ 0.70	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	$4M	X	X	X
Total Commercial	$67M	$22M	$5M	$ 0.47	X	X	X	X	X	X	$11M	$10	X	X	$2M
Network Health	X	X	X	X	X	X	X	X	X	X	$6M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$2M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$2M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	$7M	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$17M	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	15M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X		$5M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X		$ 0.80	$1M	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$83M	X	X	X	X
Commercial Medicare Subtotal											$89M	$1M			
Medicare	X	X	X	X	X	X	X	X	X	X	X	$63M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	X	$23M	X	X
GRAND TOTAL	$67M	$22M	$5M	$ 0.47	X	X	X	X	X	X	$132M	$74M	$23M	X	$2M

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	$20M	$16M	$ 0.56	$ 0.47	X	X	X	X	X	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	$6M	$5M	X	X	X
Harvard Pilgrim Health Care	$9M	$6M	$ 0.07	$ 0.05	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	$44M	X	$1M	X	$5M	X	X	$ 0.15	X	X	$2M
CIGNA	X	X	X	X	X	X	X	X	X	X	$2M	$2M	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$2M	$ 0.50	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$2M	$ 0.60	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	5M	X	X	X
Total Commercial	$29M	$22M	$ 0.63	$ 0.52	$44M	X	$1M	X	$5M	X	$12M	$13M	X	X	$2M
Network Health	X	X	X	X	X	X	X	X	X	X	$7M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$2M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	$7M	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$17M	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	$15	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X		$3M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X		$1M	$1M	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$88M	X	X	X	X
Commercial Medicare Subtotal											$92M	$1M			
Medicare	X	X	X	X	X	X	X	X	X	X	X	$72M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	X	$22M	X	X
GRAND TOTAL						X		X		X					

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	$22M	$19M	$ 0.67	$ 0.56	X	X	X	X	X	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	$7M	$6M	X	X	X
Harvard Pilgrim Health Care	$11M	$8M	$ 0.18	$ 0.14	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	$45M	X	$ 0.02	X	$5M	X	X	$ 0.20	X	X	$1M
CIGNA	X	X	X	X	X	X	X	X	X	X	$2M	$ 0.44	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$2M	$ 0.45	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$2M	$ 0.89	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	$5M	X	X	X
Total Commercial	$33M	$27M	$ 0.85	$ 0.70	$45M	X	$ 0.02	X	$5M	X	$13M	$13M	X	X	$1M
Network Health	X	X	X	X	X	X	X	X	X	X	$7M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$1M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$3M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	$8M	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$19M	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	$16M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X		$7M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X		$2M	$4M	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$87M	X	X	X	X
Commercial Medicare Subtotal											$96M	$4M			
Medicare	X	X	X	X	X	X	X	X	X	X	X	$75M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	X	$22M	X	X
GRAND TOTAL	$33M	$27M	$0.85	$0.70	$45M	X	$0.02	X	$5M	X	$144M	$92M	$22M	X	$1M

2014

	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	$25M	$21M	$ 0.75	$ 0.63	X	X	X	X	X	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	X	X	X	X	X	X	$6.6M	$6.5M	X	X	X
Harvard Pilgrim Health Care	$12M	$7M	$ 0.24	$ 0.14	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	$46M	$ 0.26	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	$2M	$ 0.75	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	$2M	$ 0.27	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	$3M	$ 0.96	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	$10M	X	X	X
Total Commercial	$37M	$28M	$ 0.99	$ 0.77	X	X	X	X	X	X	$60M	$18M	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	$9M	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	$2M	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	$5M	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	$11M	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$2M	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	$29M	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	$19M	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X		$53M	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X		$3M	$4M	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	$35M	X	X	X	X
Commercial Medicare Subtotal											$91M	$4M			
Medicare	X	X	X	X	X	X	X	X	X	X	X	$85M	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	X	$10M	X	X
GRAND TOTAL	$37M	$28M	$0.99	$0.77	X	X	X	X	X	X	$199M	$107M	$12M	X	X