September 10, 2015

By e-mail: HPC-Testimony@state.ma.us.

Mr. David Seltz
Executive Director
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02116

Dear Mr. Seltz:

Attached is written testimony submitted to the Health Policy Commission on behalf of Arbour Health System regarding health care cost trends. This testimony signatory is legally authorized and empowered to represent Arbour Health System for the purposes of the testimony and testimony is signed under the pains and penalties of perjury.

Should there be any questions regarding this, please contact either myself or Judith Merel, Regional Director, Business Development, at judy.merel@uhsinc.com or 617-390-1224.

Sincerely,

Gary Gilberti
Chief Executive Officer
Arbour Health System

Health Policy Commission
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.

    When comparing revenue, utilization and operating expenses for the same period in FY2014 (January through August) versus YTD Calendar Year 2015 (January through August), the following is applicable for Arbour Health System. Arbour Health System hospitals include Arbour Hospital, Arbour-HRI Hospital, Arbour-Fuller Hospital, Pembroke Hospital and Westwood Lodge. During CY 2015, all of the organizations had varying levels of issues with staff recruitment/retention, including physicians, registered nurses, and mental health workers. These recruitment/retention issues affected bed availability/census which was the predominant reason for shifts in utilization, operating expenses and net revenue.

    Arbour Hospital
    Total net revenue declined slightly from prior year primarily due to volume decreases related to difficulty in recruitment of clinicians and outpatient prescribers.
    Utilization for the hospital's inpatient services including admissions, LOS and ADC remained relative flat from prior year. Outpatient volume declined due to recruitment issues including MDs, PNPs and other clinical staff.
    Operating expenses increased by 3.5% from prior year primarily due to shifts in professional fees, salary and benefits to address recruitment/retention for physicians and clinicians, address building/maintenance expenses, and cover necessary non-reimbursed patient transportation costs.

    Arbour-HRI Hospital
    Total net revenue declined slightly from prior year primarily due to volume decreases related to difficulty in recruitment of physicians and clinicians.
    Utilization for the hospital's Inpatient services including admissions, LOS and ADC remained relatively flat from prior year. Outpatient volume declined due to recruitment issues including MDs, PNPs and other clinical staff.
    Operating expenses decreased by 4.5% from prior year primarily due to limited bed availability/census limitations during this period.

Arbour-Fuller Hospital
Total net revenue declined slightly from prior year primarily due to volume decreases related to difficulty in recruitment of physicians.
Utilization for the hospital's Inpatient services including admissions declined from prior year due to bed availability/census limitations related to MD recruitment needs.
Operating expenses increased by 2% from prior year primarily due to MD professional fees and those specifically related to locum tenens.

Pembroke Hospital
Total net revenue declined significantly from prior year primarily due to volume decreases related to physician recruitment and related census restriction.
Utilization for the hospital's Inpatient services/admissions declined from prior year due to bed availability/census limitations related to MD recruitment needs.
Operating expenses increased slightly by 0.75% from prior year primarily **d**ue to physician professional fees and those specifically related to locum tenens.

Westwood Lodge
Total net revenue declined significantly from prior year primarily due to volume decreases related to difficulty in recruitment of physicians and other clinical staff.
Utilization for the hospital's Inpatient services including admissions declined from prior year due to bed availability/census limitations related to MD and clinical staff recruitment needs.
Operating expenses decreased slightly by 0.25% from prior year.

For all hospitals, operating expenses have been affected by increasing pharmacy costs, information system investments, increasing acuity of patient populations and related need for additional staffing/specialing, and regulatory mandates from federal, state and payer agencies.

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?

Arbour Health System senior leadership has continued to provide strong administrative oversight for operational efficiencies and high quality care. The organizations work to transition patients to the most appropriate level of care and have focused on aftercare/discharge planning to reduce readmission rates.

Ongoing recruitment of qualified staff is needed to operate at full bed capacity. Competitor wage increases related to clinical staff have affected the organization and will likely continue especially with the opening of new inpatient psychiatric beds in Massachusetts and increased competition for limited staff, especially

psychiatrists. Outpatient demand continues including for addictions services and ability to recruit prescribers and clinicians continues to be an issue.

The organization undertakes efforts to negotiate contracts that are fair, recognizing that the organization has historically been a low-cost, efficient provider (and to the extent that they current payment is not keeping pace with inflation factors including related to staff compensation). The Commonwealth needs to assure that organizations that provide services vital to residents of Massachusetts, including mental health and substance abuse, are fairly compensated to continue to provide these essential services. If more resources were directed toward behavioral health providers, there should be a correlated decrease in overall reduction in medical spending especially for the small percentage of patients who are high risk/high cost and have co-morbid conditions.

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?

The organization plans to continue the actions identified above and also look to participate in pilots through managed care organizations relative to alternative payment methodologies including those that offer shared savings opportunities. At this time, payors have expressed limited interest in utilizing APMs for inpatient services provided by Arbour Health System hospitals. There was an effort regarding APM started some time ago by MBHP which does not appear to be currently active – Arbour Health System will be participating in the stakeholder workgroups with MassHealth to review restructuring and payment reform including for behavioral health organizations.

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

There are areas that could be addressed to allow the hospitals to operate more efficiently including: Funding of EHR in private, psychiatric hospitals, improved access to state hospital beds, decreased utilization review from payers and increased self-management in accordance with medical necessity criteria, appropriate use of telemedicine, reimbursement for care coordination/collateral contacts, improve alignment of federal and state oversight including with CMS, DMH and DPH, fund/allow reimbursement for primary care in mental health settings and same day visits, continued implementation of parity amongst all payors and address prior authorization requirements for behavioral health that create more natural workflow and support care/reduce barriers to treatment,

address state requirements or performance criteria that increase cost but do not affect quality or outcomes of care.

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

   The organization has limited alternative payment methods currently (one capitation agreement for limited number of children/adolescent lives) and has not been approached by payers or other organizations regarding participation in APMs. The organization will be participating in the stakeholder workgroups for MassHealth Restructuring and Payment Reforms, specifically related to behavioral health payment and care delivery models. As part of the adoption of these APMs, there must be transparency and sufficient information regarding including case mix, acuity, discharge planning/aftercare placement issues, etc. from payers and providers to make sound decisions on moving forward with alternative payment arrangements. The infrastructure investments and changes to the care model required to enable success for behavioral health under APM contracts include but not limited to: EHR/IT implementation, addition/reimbursement for care coordination (as differentiated from utilization review/management) and accessible outpatient, community-based providers including prescribers.

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.

      The organization is a vertically integrated system with inpatient services, acute residential care, partial hospitalization, intensive outpatient programs, outpatient services and community-based care. The organization has expanded outpatient services locations and, with the opening of a new clinic in October 2015, will have 13 sites in eastern Massachusetts. Many of these sites are or will be licensed by the Department of Public Health Bureau of Substance Abuse Services to offer both mental health and addictions treatment to clients. The organization has been recruiting prescribers and clinicians to meet the demands for service and expand offerings (including home-based) to meet the needs of clients in the least restrictive setting. The availability of these programs provides accessible post-acute, community based treatment. Engaging patients in services, including through community support programs or home-based care, will reduce potentially avoidable 30-day readmissions and avoidable ED use.

      AHS Hospitals have identified opportunities for program expansion that are currently difficult to access due to ongoing demand and limited capacity including,

but not limited to, dual diagnosis acute residential treatment and inpatient development disabilities. Specialty programs that address patient needs, especially those who are high risk/high cost and who may otherwise be "stuck" at "higher" more costly levels of care that do not address their specific needs should be supported by regulators and payors. Innovative programs that address avoidable readmissions, reduce emergency department use and focus on high risk/high cost patients often are not part of the payor benefit plan, fall outside of contracted levels of care, or are note contracted at appropriate rates to be sustainable.

There are no specific studies or analyses that AHS has conducted on efforts but there is collaboration with payors who do utilize monthly/quarterly reports which identify outcomes of interventions with the goal of providing more effective, cost efficient care. Some of these payors are collaborating on efforts that range from appointment reminder programs for outpatient services to funding intensive care coordinators in the outpatient centers for a subset of high risk/high cost members.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
    1. In the case of behavioral health services, increased spending on post-acute services will have an impact on recidivism and use of high cost (ED, inpatient) settings. This includes recruitment/retention of staff to meet demand for services and provide urgent availability, provision of community-based services such as in homes and schools to provide a more accessible setting for service delivery, investment in electronic health records to better communication with primary care and other support/wraparound service providers, addition of care coordinators to assist clients with non-health related issues that affect compliance with health care including housing, food, transportation, employment, etc. AHS plans on investing in electronic records, expanding program offerings and working with payors on programs that enhance care coordination capabilities.
    2. The hospitals are making improvements in treatment and discharge planning approaches to reduce avoidable 30 day readmissions. As well, hospitals are assuring provision of timely aftercare appointments, enhanced use of CSP, FST and other community support services where covered/authorized by payors to improve compliance and developing more effective crisis plans.
    3. The items noted above also serve to reduce avoidable ED visits.
    4. The outpatient services programs, as noted elsewhere is this response, intend to participate in a pilot program with a specific payor to address high risk/high cost members through a coordinator program that includes nurses at the health plan to address medical issues, program managers/engagement specialists at the behavioral health carve out to address BH services, and an on-site care coordinator to develop and execute a members action plan and be the primary point of contact for the member. One AHS hospital intends to

expand a program currently in place that offers behavioral health services/consultation to patients in acute care hospitals who have co-morbid medical/behavioral issues. This program provides an opportunity to evaluate a patient while in inpatient medical treatment and collaborate with the hospital staff/PCP on a behavioral health treatment plan and psychopharmacological interventions including those with complex medication requirements.

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?

       Price, or reimbursement, does vary across providers specifically from contracted managed care organizations. Most of these payments are historical and have not been adjusted for medical cost increases (including for physician expense, pharmaceutical costs, and other significant non-covered per diem costs such as transportation, interpreter services, specialing, etc.) nor recognize patient case mix/acuity, performance indicators/outcomes measures, etc. Prices for the same services need to be adjusted for complexity and intensity of resource use needed to treat or stabilize a patient.

    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.

       There is significant price variation in Massachusetts and high cost providers, while affecting the overall costs of care, do not necessarily provide better outcomes relative to community and/or lower cost providers. Provision of services/directing of patients to effective and efficient providers with positive outcomes such as Arbour Health System will support their financial health and sustainability and serve to reduce cost to the Commonwealth.

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.

The hospitals routinely evaluate mental health and addictions patients for co-morbid medical conditions or risk of development of a co-morbid medical condition. Hospitals perform physical examinations upon admission. As well, each hospital has medical staff/consultants (internists, etc.) on staff who provide consultations as requested by psychiatrists and nursing staff. Reimbursement for mental health/addictions services on the same day of care is not currently allowed. The organization does communicate with PCPs during care and/or upon discharge. As noted in another answer, one AHS hospital collaborates with an acute care hospital to provide on-site services in an effort to integrate physical and behavioral health care services and the outpatient programs intend to participate in a pilot related to high risk/high cost outpatients.

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.

The outpatient services programs of Arbour Health System are in the process of working with one insurance plan on participating in a program to better integrate behavioral health and physical services including use of a care coordinator to assure compliance with treatment plans for a subset of patients with complex, co-morbid conditions. This includes patient connection with community-based care to avoid unnecessary utilization of EDs and inpatient care. The program seeks to offer additional investment to outpatient providers with the goal of ensuring treatment compliance with medical and behavioral plans, addressing housing, food, transportation, and other social issues, to reduce recidivism and utilization of high cost programs such as EDs and inpatient care. This program plans to share savings with providers and incorporate certain quality outcomes thresholds.

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?

Arbour Health System organizations do not have experience with the implementation of Patient Centered Medical Homes. The system would like to participate in the development of PCMHs with a focus on primary care and behavioral health, and staff would need to be available and compensated to provide care management/collateral contact/care coordination. As well, the organization does not have experience with Accountable Care Organizations (ACOs) and is interested in developing relationships for ACO participation. AHS is well positioned given the ability to manage mental health and

addictions care across a continuum and as a cost-efficient provider of services. Currently, data is collected in concert with most major MCOs on more readily measureable indicators such as length of stay, readmission rates, PCP communication, etc. and, for a smaller number of MCOs indicators that reflect case mix, state agency involvement, etc. More comprehensive utilization/financial data would be needed to successfully implement these models some of which is not available to AHS but held by payors. In addition, the organization would need the resource infrastructure to support PCMH or ACOs including staffing and IT for the delivery of coordinated, patient centered, high quality care in the appropriate setting(s).

September 10, 2015

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    Arbour Hospital
    Total net revenue declined slightly from prior year primarily due to volume decreases related to difficulty in recruitment of clinicians and outpatient prescribers.
    Utilization for the hospital's inpatient services including admissions, LOS and ADC remained relative flat from prior year. Outpatient volume declined due to recruitment issues including MDs, PNPs and other clinical staff.
    Operating expenses increased by 3.5% from prior year primarily due to shifts in professional fees, salary and benefits to address recruitment/retention for physicians and clinicians, address building/maintenance expenses, and cover necessary non-reimbursed patient transportation costs.

    Arbour-HRI Hospital
    Total net revenue declined slightly from prior year primarily due to volume decreases related to difficulty in recruitment of physicians and clinicians.
    Utilization for the hospital's Inpatient services including admissions, LOS and ADC remained relatively flat from prior year. Outpatient volume declined due to recruitment issues including MDs, PNPs and other clinical staff.
    Operating expenses decreased by 4.5% from prior year primarily due to limited bed availability/census limitations during this period.

Arbour-Fuller Hospital
Total net revenue declined slightly from prior year primarily due to volume decreases related to difficulty in recruitment of physicians.
Utilization for the hospital's Inpatient services including admissions declined from prior year due to bed availability/census limitations related to MD recruitment needs.
Operating expenses increased by 2% from prior year primarily due to MD professional fees and those specifically related to locum tenens.

Pembroke Hospital
Total net revenue declined significantly from prior year primarily due to volume decreases related to physician recruitment and related census restriction.
Utilization for the hospital's Inpatient services/admissions declined from prior year due to bed availability/census limitations related to MD recruitment needs.
Operating expenses increased slightly by 0.75% from prior year primarily **d**ue to physician professional fees and those specifically related to locum tenens.

Westwood Lodge
Total net revenue declined significantly from prior year primarily due to volume decreases related to difficulty in recruitment of physicians and other clinical staff.
Utilization for the hospital's Inpatient services including admissions declined from prior year due to bed availability/census limitations related to MD and clinical staff recruitment needs.
Operating expenses decreased slightly by 0.25% from prior year.

For all hospitals, operating expenses have been affected by increasing pharmacy costs, information system investments, increasing acuity of patient populations and related need for additional staffing/specialing, and regulatory mandates from federal, state and payer agencies.

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?

Arbour Health System senior leadership has continued to provide strong administrative oversight for operational efficiencies and high quality care. The organizations work to transition patients to the most appropriate level of care and have focused on aftercare/discharge planning to reduce readmission rates.

Ongoing recruitment of qualified staff is needed to operate at full bed capacity. Competitor wage increases related to clinical staff have affected the organization and will likely continue especially with the opening of new inpatient psychiatric beds in Massachusetts and increased competition for limited staff, especially

psychiatrists. Outpatient demand continues including for addictions services and ability to recruit prescribers and clinicians continues to be an issue.

The organization undertakes efforts to negotiate contracts that are fair, recognizing that the organization has historically been a low-cost, efficient provider (and to the extent that they current payment is not keeping pace with inflation factors including related to staff compensation). The Commonwealth needs to assure that organizations that provide services vital to residents of Massachusetts, including mental health and substance abuse, are fairly compensated to continue to provide these essential services. If more resources were directed toward behavioral health providers, there should be a correlated decrease in overall reduction in medical spending especially for the small percentage of patients who are high risk/high cost and have co-morbid conditions.

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?

The organization plans to continue the actions identified above and also look to participate in pilots through managed care organizations relative to alternative payment methodologies including those that offer shared savings opportunities. At this time, payors have expressed limited interest in utilizing APMs for inpatient services provided by Arbour Health System hospitals. There was an effort regarding APM started some time ago by MBHP which does not appear to be currently active – Arbour Health System will be participating in the stakeholder workgroups with MassHealth to review restructuring and payment reform including for behavioral health organizations.

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

There are areas that could be addressed to allow the hospitals to operate more efficiently including: Funding of EHR in private, psychiatric hospitals, improved access to state hospital beds, decreased utilization review from payers and increased self-management in accordance with medical necessity criteria, appropriate use of telemedicine, reimbursement for care coordination/collateral contacts, improve alignment of federal and state oversight including with CMS, DMH and DPH, fund/allow reimbursement for primary care in mental health settings and same day visits, continued implementation of parity amongst all payors and address prior authorization requirements for behavioral health that create more natural workflow and support care/reduce barriers to treatment,

address state requirements or performance criteria that increase cost but do not affect quality or outcomes of care.

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

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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.

      The organization is a vertically integrated system with inpatient services, acute residential care, partial hospitalization, intensive outpatient programs, outpatient services and community-based care. The organization has expanded outpatient services locations and, with the opening of a new clinic in October 2015, will have 13 sites in eastern Massachusetts. Many of these sites are or will be licensed by the Department of Public Health Bureau of Substance Abuse Services to offer both mental health and addictions treatment to clients. The organization has been recruiting prescribers and clinicians to meet the demands for service and expand offerings (including home-based) to meet the needs of clients in the least restrictive setting. The availability of these programs provides accessible post-acute, community based treatment. Engaging patients in services, including through community support programs or home-based care, will reduce potentially avoidable 30-day readmissions and avoidable ED use.

      AHS Hospitals have identified opportunities for program expansion that are currently difficult to access due to ongoing demand and limited capacity including,

but not limited to, dual diagnosis acute residential treatment and inpatient development disabilities. Specialty programs that address patient needs, especially those who are high risk/high cost and who may otherwise be "stuck" at "higher" more costly levels of care that do not address their specific needs should be supported by regulators and payors. Innovative programs that address avoidable readmissions, reduce emergency department use and focus on high risk/high cost patients often are not part of the payor benefit plan, fall outside of contracted levels of care, or are note contracted at appropriate rates to be sustainable.

There are no specific studies or analyses that AHS has conducted on efforts but there is collaboration with payors who do utilize monthly/quarterly reports which identify outcomes of interventions with the goal of providing more effective, cost efficient care. Some of these payors are collaborating on efforts that range from appointment reminder programs for outpatient services to funding intensive care coordinators in the outpatient centers for a subset of high risk/high cost members.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
    1. In the case of behavioral health services, increased spending on post-acute services will have an impact on recidivism and use of high cost (ED, inpatient) settings. This includes recruitment/retention of staff to meet demand for services and provide urgent availability, provision of community-based services such as in homes and schools to provide a more accessible setting for service delivery, investment in electronic health records to better communication with primary care and other support/wraparound service providers, addition of care coordinators to assist clients with non-health related issues that affect compliance with health care including housing, food, transportation, employment, etc. AHS plans on investing in electronic records, expanding program offerings and working with payors on programs that enhance care coordination capabilities.
    2. The hospitals are making improvements in treatment and discharge planning approaches to reduce avoidable 30 day readmissions. As well, hospitals are assuring provision of timely aftercare appointments, enhanced use of CSP, FST and other community support services where covered/authorized by payors to improve compliance and developing more effective crisis plans.
    3. The items noted above also serve to reduce avoidable ED visits.
    4. The outpatient services programs, as noted elsewhere is this response, intend to participate in a pilot program with a specific payor to address high risk/high cost members through a coordinator program that includes nurses at the health plan to address medical issues, program managers/engagement specialists at the behavioral health carve out to address BH services, and an on-site care coordinator to develop and execute a members action plan and be the primary point of contact for the member. One AHS hospital intends to

expand a program currently in place that offers behavioral health services/consultation to patients in acute care hospitals who have co-morbid medical/behavioral issues. This program provides an opportunity to evaluate a patient while in inpatient medical treatment and collaborate with the hospital staff/PCP on a behavioral health treatment plan and psychopharmacological interventions including those with complex medication requirements.

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?

       Price, or reimbursement, does vary across providers specifically from contracted managed care organizations. Most of these payments are historical and have not been adjusted for medical cost increases (including for physician expense, pharmaceutical costs, and other significant non-covered per diem costs such as transportation, interpreter services, specialing, etc.) nor recognize patient case mix/acuity, performance indicators/outcomes measures, etc. Prices for the same services need to be adjusted for complexity and intensity of resource use needed to treat or stabilize a patient.

    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.

       There is significant price variation in Massachusetts and high cost providers, while affecting the overall costs of care, do not necessarily provide better outcomes relative to community and/or lower cost providers. Provision of services/directing of patients to effective and efficient providers with positive outcomes such as Arbour Health System will support their financial health and sustainability and serve to reduce cost to the Commonwealth.

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.

The hospitals routinely evaluate mental health and addictions patients for co-morbid medical conditions or risk of development of a co-morbid medical condition. Hospitals perform physical examinations upon admission. As well, each hospital has medical staff/consultants (internists, etc.) on staff who provide consultations as requested by psychiatrists and nursing staff. Reimbursement for mental health/addictions services on the same day of care is not currently allowed. The organization does communicate with PCPs during care and/or upon discharge. As noted in another answer, one AHS hospital collaborates with an acute care hospital to provide on-site services in an effort to integrate physical and behavioral health care services and the outpatient programs intend to participate in a pilot related to high risk/high cost outpatients.

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.

The outpatient services programs of Arbour Health System are in the process of working with one insurance plan on participating in a program to better integrate behavioral health and physical services including use of a care coordinator to assure compliance with treatment plans for a subset of patients with complex, co-morbid conditions. This includes patient connection with community-based care to avoid unnecessary utilization of EDs and inpatient care. The program seeks to offer additional investment to outpatient providers with the goal of ensuring treatment compliance with medical and behavioral plans, addressing housing, food, transportation, and other social issues, to reduce recidivism and utilization of high cost programs such as EDs and inpatient care. This program plans to share savings with providers and incorporate certain quality outcomes thresholds.

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?

Arbour Health System organizations do not have experience with the implementation of Patient Centered Medical Homes. The system would like to participate in the development of PCMHs with a focus on primary care and behavioral health, and staff would need to be available and compensated to provide care management/collateral contact/care coordination. As well, the organization does not have experience with Accountable Care Organizations (ACOs) and is interested in developing relationships for ACO participation. AHS is well positioned given the ability to manage mental health and

addictions care across a continuum and as a cost-efficient provider of services. Currently, data is collected in concert with most major MCOs on more readily measureable indicators such as length of stay, readmission rates, PCP communication, etc. and, for a smaller number of MCOs indicators that reflect case mix, state agency involvement, etc. More comprehensive utilization/financial data would be needed to successfully implement these models some of which is not available to AHS but held by payors. In addition, the organization would need the resource infrastructure to support PCMH or ACOs including staffing and IT for the delivery of coordinated, patient centered, high quality care in the appropriate setting(s).