

September 10, 2015

Keith A. Hovan
President & Chief Executive Officer

David Seltz, Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Mr. Seltz:

Thank you for requesting Southcoast Hospitals Group's written testimony to the questions posed by the Health Policy Commission and Office of the Attorney General in conjunction with the State's public hearings concerning the current trends in healthcare costs.

We hope our testimony is helpful to you as we continue to seek collaborative and innovative opportunities to improve healthcare in the Commonwealth. Please find attached our responses to the questions in "Exhibit B" and "Exhibit C" and "AGO Hospital Exhibit 1" which as President and CEO of Southcoast Health System and Southcoast Hospitals Group, I submit under the pains and penalties of perjury. We stand ready to provide further input if necessary.

Sincerely,



Keith A. Hovan
President & CEO
Southcoast Health System
Southcoast Hospitals Group

Office of the President

CHARLTON MEMORIAL HOSPITAL
363 Highland Avenue, Fall River, MA 02720
508-679-3131

ST. LUKE'S HOSPITAL
101 Page Street, New Bedford, MA 02740
508-997-1515

TOBEY HOSPITAL
43 High Street, Wareham, MA 02571
508-295-0880

ATTESTATION

SOUTHCOAST HOSPITALS GROUP, INC.

I, Keith A. Hovan, being the duly authorized President and CEO of Southcoast Health System and Southcoast Hospitals Group Inc. (the “Company”), having been duly sworn, do hereby attest that I am legally authorized and empowered to represent the Company for the purposes of the foregoing testimony, and that the foregoing testimony is provided under the pains and penalties of perjury and is true and accurate to the best of my knowledge and belief.

IN WITNESS WHEREOF, I have hereunto set my hand as President and CEO of the Company this 10th day of September, 2014.5.

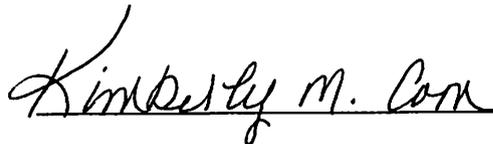


Keith A. Hovan
President and CEO
Southcoast Health System and Southcoast
Hospitals Group

COMMONWEALTH OF MASSACHUSETTS) :ss New Bedford

COUNTY OF BRISTOL)

The foregoing attestation was acknowledged before me this 10th day of September, 2015 by Keith A. Hovan, as President and CEO of Southcoast Health System and Southcoast Hospitals Group, Inc., as his free act and deed.



Kimberly M. Coon
NOTARY PUBLIC
My Commission Expires: 4/2/2021

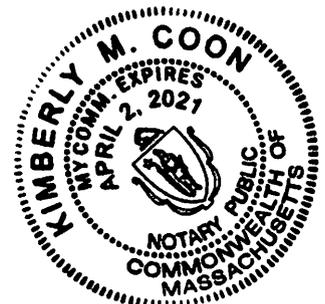


Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: <http://www.suffolk.edu/law/explore/6629.php>. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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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.

Answer 1.a: During the past 12 months, Southcoast Hospitals Group has experienced a 7% increase in inpatient volume compared to the prior fiscal year. This growth is primarily attributable to having aggressively recruited providers into subspecialties where gaps previously existed in the market. In addition, Southcoast has worked diligently to limit the referral of Southcoast patients to higher cost providers.

Hospital outpatient revenue is strong, primarily due to improved access to outpatient subspecialty providers and quality ancillary services.

The Southcoast Emergency Department (ED) volume remains consistent despite the development of Urgent Care Centers in the market. This steady volume is attributable to the persistent lack of adequate access to primary care, expansion of aligned providers in the region, and higher rates of uninsured individuals compared to the state average in communities such as Fall River and New Bedford.

Despite these higher than anticipated volumes, Southcoast has continued to make great strides in reducing unnecessary utilization of services, controlling labor costs and reducing supply expense. Southcoast has continued the Performance Excellence Plan, established in 2013, targeting clinical resource utilization and supply chain management, as well as labor productivity improvements.

In comparing the current fiscal year-to-date with that of last year, hospital supply and labor costs increased 1.5% while operating revenues have also increased. Southcoast has also reduced length-of-stay (LOS) by .50 days, in part by eliminating avoidable testing delays and employing new approaches with care coordinators to facilitate timely discharge and effective transitions of care.

- 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?

Answer 1.b: Southcoast has continued reorganizing non-clinical support departments and has reduced ancillary service-related costs. The organization remains focused on opportunities to carefully and strategically reduce expenses, as previously mentioned, through the system-wide Performance Excellence Plan.

In CY2014 Southcoast began the implementation of a fully-integrated electronic health record by installing Epic in the majority of its ambulatory practices. The Southcoast journey toward a single

health record for each patient will be realized on October 1, 2015 when all remaining ambulatory practices, all three hospitals and the Southcoast Visiting Nurse Association will transition to Epic. A fully integrated record will promote a high degree of patient safety while reducing redundancy of services and waste throughout the System.

- 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?

Answer 1.c: Southcoast continues to work on alternative payment arrangements with payers that incorporate the Triple AIM goals of reducing costs, while improving patients' health and experience. The success of this endeavor is predicated upon having an adequate number of covered lives in a particular health plan. In the last year, Southcoast reached agreements with two additional health plans to implement strategies for population health management. Southcoast distributes key data to physicians and staff in an effort to identify patients who need more intensive care management, reduce high-cost out-of-network utilization and provide status updates on our quality and cost metrics.

Southcoast has also been working internally on bundled payment arrangements that will promote higher quality and lower cost by reducing variation. Utilizing the payer information received through contracts, Southcoast has been able to review the cost and utilization data with the physician sponsor who guides the creation of bundled arrangements. This information has also highlighted opportunities to improve utilization of skilled nursing or rehabilitation facilities, and reduce readmissions from specific facilities.

Southcoast also recently submitted its renewed application for an additional three-year contract with Centers for Medicare and Medicaid Services (CMS) for the Medicare Shared Saving Program. Southcoast will be meeting shortly with identified skilled nursing facilities (SNFs) to review length-of-stay and readmission data, in order to create alignment with those facilities in support of the Triple AIM goals.

The implementation of an enterprise-wide EHR will also enhance the organization's ability to further standardize the high quality care that is provided to patients across the system. Southcoast has recently purchased software that will link the organization even closer to patients (post-discharge) in order to identify those who might require additional care or services, and provide the ongoing care management they need to avoid costly readmissions.

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

Answer 1.d: One such opportunity would include requiring insurance companies to assume the responsibility for the collection of co-payment and deductible balances rather than providers. With health insurance carriers offering a myriad of products to consumers with larger co-pay and deductible responsibilities, payers should participate in the collection of these payments.

Additionally, payers should not be able to deny payment for claims due to technical difficulties with payer systems related to obtaining prior approval – if the care was appropriately rendered to the subscriber. Further, the provider should not be denied payment for a required service such as ED care, from private and government payers.

An example of such an administrative burden occurred when one of the state’s largest commercial payers established transition-in-care report requirements in its pay-for-reporting agreement with hospitals, while MassHealth nearly simultaneously required transition-of-care reporting requirements, and the requirements were not the same. As a result, hospitals were forced to find a way to combine all requirements into one transition report, or duplicate efforts and provide a transition-in-care report only to discharged inpatients in the commercial plan, and a separate report used solely for MassHealth patients. Since that time, CMS began requiring summary-of-care requirements under its Hospital Conditions for Participation and separately (and differently) under its Meaningful Use Program for EHR incentives with still different and additional requirements than current MassHealth requirements. Data gathering would be streamlined for providers if Medicaid MCO’s were required to follow the same metrics as MassHealth, and Medicare MCO’s the same metrics as Medicare.

Payers should work together to develop standard common definitions. One such example is the need for a standard definition for the term “observation care”. This issue has persisted for some time, and hospitals are still struggling with each payer’s own interpretation and rules.

Most commercial payers utilize the All Payer Grouper for paying case rates. However, providers are required to have three separate versions of the grouper, as some have updated to the latest publication while other companies are using various older versions. Consistency would reduce needless expenses.

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

Answer 2:

Some of the barriers to Southcoast increasing the adoption of APMs include:

- Contract proposals that would require the health system to take downside risk for which there are no provider-based reserves;
- The need for the health system to establish risk reserves before taking downside risk;
- Payers that do not or cannot provide the complete patient claims downloads including pharmaceutical data;
- Payers that do not provide summary and detailed reports on a timely basis;
- The volume of non-standardized risk contracts that create a challenge in adequately operationalizing all of the arrangements in a near simultaneous manner.

Some of these barriers can be addressed by:

- Payers providing complete downloads of claims data, whether in a risk arrangement or not, so that the primary care physician can more effectively manage the care that is needed;

- Payers providing adequate infrastructure monies to providers that enter into alternative payment arrangements;
 - Phase-in a transition to the same weights and groupers for inpatient and outpatient care for all commercial or Medicaid plans. Currently, the hospital has to purchase and monitor five different grouper and weights software;
 - Assign collection of co-payments and deductibles to the payers.
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.

Answer 3.a: In 2012, Southcoast developed a Post-Acute Care Program, which employs a team-based model of care to provide services for our patients in the post-acute setting. Today, the Post-Acute Care Practice – Physicians, supported by Nurse Practitioners/Physician Assistants and a Post-Acute Liaison – follow patients at nine area Skilled Nursing Facilities (SNF). The team communicates directly with each patient's Primary Care Physician (PCP) to ensure the most current medical information is shared as the patient transitions home. Southcoast's Post-Acute Care team meets with SNF leadership on a weekly basis to discuss admissions, discharges, transfers and quality improvement/clinical issues. Once discharged from a SNF, patients receive a follow-up call within 48 hours to ensure any required services have been initiated and medications have been reconciled. Patients also receive an appointment with their PCP within seven days for follow-up care. PCPs receive a discharge summary detailing care during their patient's SNF stay, before the patient arrives for their follow up appointment.

To further support the program, Southcoast has implemented a new Nurse Practitioner On-Call Program to provide after-hours and weekend coverage for 30 Physicians at 16 SNFs. Bi-directional communication has enhanced delivery of care for PCP providers and the Post-Acute Care Nurse providers, working in the post-acute setting. To date, Southcoast's Post-Acute Care Team has established two Post-Acute Specialty Service Lines under the leadership of a Board Certified Cardiologist and Pulmonologist. The cardiac service and pulmonary programs have been aligned to hospital-based programs and integrated into the post-acute setting.

Southcoast Hospitals Group is fortunate to have been awarded up to \$8M from the Health Policy Commission for CHART Phase 2. The organization's primary objectives during the two year grant cycle are to reduce 30-day readmissions by 20% for a cohort of patients admitted four or more times during a 12-month period, and reduce 30-day ED revisits for a cohort of patients treated in the ED ten or more times in a 12-month period. Southcoast care coordination teams continue to focus their efforts on patients who fall outside of the CHART cohort to also improve 30-day readmission rates and reduce revisits to our EDs. Much like the MyCare teams that will be created in CHART Phase 2, the Case

Managers are coordinating services between Southcoast entities, establishing patient centered medical-homes and collaborating with community partners to improve transitions of care.

Southcoast Hospitals Group has initiated monthly meetings with out-of-network multi-specialty groups in the market that utilize hospital services. The goal for this proactive outreach is to improve collaboration, informational handoffs and the sharing of pertinent clinical information. These collaborative meetings have focused Southcoast's attention on mutual goals of patient access, reducing avoidable costs, and improving patient transitions.

Lastly, in 2014, Southcoast Health System and Acadia Healthcare of Franklin, Tennessee, a national leader in behavioral and addiction care, executed a joint venture to construct a new 120-bed psychiatric facility approximately five miles from the St. Luke's campus. It is anticipated that this new facility, called Southcoast Behavioral Health, will greatly alleviate boarding challenges for psychiatric patients in EDs across the System and the southeastern Massachusetts region.

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

Answer 3.b: As of July 2015, the Southcoast Physician Network (SPN) Care Management Team has been integrated into the Post-Acute Care setting to further enhance care for the Southcoast ACO Medicare Shared Savings Plan patients. The SPN Care Management Team recently began implementation of "Patient Ping", a new technology to enhance real-time communication for patients as they transition from the hospital into a SNF.

The Post-Acute Care teams are focused on patient transitions between the ED and inpatient beds. Within the next year Southcoast will also be implementing a program to improve live hand-offs and ensure smooth transitions for patients identified as high risk. A transition-of-care workgroup has formed and is developing the workflows for this process. The group has representation from hospital Case Management, Southcoast Visiting Nurse Association, Post-Acute Services, SPN/ACO Care Management and Disease Management. The first in a series of meetings with local SNFs to facilitate similar discussions will begin in September 2015.

In the coming months, Southcoast Hospitals Group will launch the MyCare teams funded by CHART Phase 2 and fully open the new Southcoast Behavioral Health facility.

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?

Answer 4.a: As a Disproportionate Share Hospital (DSH), Southcoast is uniquely aware of the challenges that exist with price variation. Unfortunately, price variation among commercial payers often has a more significant impact on community DSH providers than larger, non-DSH hospitals. When data is published indicating the amount each hospital is reimbursed by a payer, those figures should be put into context and adjusted or weighted through the use of a public payer mix factor. Existing reporting methodology does not take this critical issue into account, and therefore provides a less-than-accurate presentation of the significant disparity in rates that exist between high and low-cost providers.

- 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.

Answer 4.b: Based on a review of numerous price variation reports, Southcoast has not identified any substantial change in the rankings of the highest versus lowest paid providers. Many of the reports state similar findings, however, there are very few actionable initiatives being implemented to truly create a more level playing field.

High priced providers will have higher total medical expense budgets, and therefore a greater ability to balance medical expense inflation and utilization changes. However, many DSH providers are located in regions with significant socio-economic challenges, such as a lack of family support and/or involvement, higher levels of poverty, lower levels of educational attainment, a higher prevalence of significant medical conditions and clinical needs, lack of healthy habits and wellness knowledge, and lack of adherence to physician orders, to name but a few. Providing care and support to those afflicted with these challenges is not adequately addressed in the total medical expense budget, yet is the responsibility of Southcoast Case Managers, office staff and community workers. Socio-economic factors should be incorporated as standard elements into budget arrangements for providers who work diligently to meet the full needs of their patients and communities. DSH providers need assistance from the Commonwealth in crafting a fair and equitable pricing methodology that will combine a fair and reasonable margin per case with graduated quality bonus payments for meeting benchmarks related to the care provided.

The ability to negotiate with an increasingly consolidated payer field is also challenging for small or low-cost providers. Unfortunately, the original payment differentials between providers, which Chapter 224 attempted to address, remain incorporated within the current rate structure. It would be beneficial for all payers to work collaboratively with providers to drive down the cost of care while creating a more equitable and balanced rate structure among providers. There are a myriad of potential additional

initiatives that would have the impact of reducing the overall cost of healthcare including standardization of authorizations, referrals, attribution models, product design, quality metrics, collection efforts, and reporting, to name but a few.

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.

Answers: 5a. 1 and 2.

Behavioral Health Resource Database:

This past year, Southcoast, with the assistance of a CHART Phase 1 grant, created Behavioral Health Connect, a comprehensive, searchable resource database designed to help integrate clinical and community care and promote collaboration among behavioral health providers. The database provides detailed information on services as well as a wide range of community resources concerning social determinants of health. This tool is readily available for public use and may be accessed by computer or mobile device by visiting www.southcoast.org/behavioralhealth.

The database is the result of extensive research and community outreach completed with more than 140 regional providers in a focused effort to streamline care connections among clinical and community providers, and to increase care completion for patients. An initial needs-assessment conducted at the outset of this project indicated that care coordination between both clinical and community partners, and also among community partners, was challenging and fragmented.

Behavioral Health Connect promotes care coordination and communication across the region's behavioral health care system. Through targeted outreach Southcoast has had the opportunity to provide numerous community presentations and staff trainings to providers and community partners on how to maximize their utilization of the database. Southcoast continues to make enhancements to the database and frequently updates the listing of providers and services; feedback on the database has been resoundingly positive.

Homeless Intervention Group -- Wareham:

Homelessness in Wareham is a significant challenge facing the community, with the number of chronically homeless individuals growing each year and stretching the town's limited resources.

Emergency shelter is available in Wareham through a faith-based initiative only during the colder months.

The number of homeless individuals has increased each year and these temporary shelter services are stretched to capacity. In the most recent year's census of unsheltered homeless individuals the numbers realized in Wareham approached the nearby city of New Bedford, a community almost five times greater in population. Unfortunately, support services for homeless individuals in Wareham are limited and not coordinated.

The Tobey Hospital Emergency Department is utilized frequently by homeless individuals. As part of the needs-assessment process for this initiative, Southcoast determined that four homeless individuals utilized close to \$400,000 worth of medical services at Tobey Hospital during the course of just one 12-month period.

The Homelessness Intervention Group, led by Southcoast staff in conjunction with the Wareham Leadership Council to Prevent and End Homelessness, is a committee of clinical and community providers who meet monthly to address the issues of homelessness within the community. The Intervention Committee includes clinical, housing, and other community and faith-based leaders who work to coordinate wrap-around services for a number of individuals who are chronically homeless. Several agencies have outreach workers who help provide services wherever the homeless may be living. The group utilizes the "housing first" model, establishing stable housing followed by needed wrap-around services. Several individuals have been housed this year.

Community Health Worker Projects:

Southcoast, with financial assistance from several grants, is utilizing trained Community Health Workers (CHWs) as part of the care team in the management of chronic diseases such as diabetes. Several projects have been established over recent years assisting more than 150 chronically-ill patients. The CHWs help patients identify and overcome barriers of care that result from social determinants of health such as lack of housing, transportation, and language and cultural barriers. Many of these patients have behavioral health issues as well as a chronic medical diagnosis. The CHWs, many of whom are also embedded in community partner agencies, help patients access needed community services and provide a link between clinical and community care. CHWs regularly meet with physicians, therapists and other members of the care team to help coordinate care.

Health Promotion Advocate (HPA) Program:

A trained social worker in the St. Luke's ED provides both screenings and referrals for patients with documented substance abuse issues or who are at risk for substance abuse. The HPA utilizes the

Screening, Brief Intervention and Referral to Treatment (SBIRT) model to assess risk, and has developed collaborative referral sources for care in the community. Over the past several years, the HPA has screened and referred thousands of local residents. The HPA also maintains strong collaborative relationships with community partners and serves as a clinical resource for community initiatives that impact substance abuse and other behavioral health issues.

Community Coalitions focused on Behavioral Health:

BOLD-SSTAR / Drug Free New Bedford Coalitions: Southcoast Health plays a leadership role in several coalitions in Fall River and New Bedford whose role is to address our region's higher than average rates of opioid use and overdose. Work on these initiatives is designed to positively impact this issue across the continuum of care, from prescriber practices to coordinated treatment, and to provide support and education for families. The goal of these initiatives is to educate individuals and families within the region on the risk and harms associated with both the use of non-medical prescription drugs and other opioid substances, and decrease access through community collaborations and outreach.

Southcoast's work on these coalitions includes:

- Data compilation and analysis of hospital ICD-9 codes, police reports, and other public records to determine the coalition's strategic plans and provide a baseline for future measures;
- Regular educational programs for physicians and other prescribers on prescription practices and optimal use of a statewide database designed to identify over-prescribing of opioid medications;
- Development of Logic models for prescription drug misuse grants as well as the overdose grants. The grants focus on schools and informing students, parents, and teachers about the dangers of prescription drug abuse and misuse. The coalition worked collaboratively to create social media kits and filmed commercials for community education and awareness;
- Promotion of Behavioral Health Connect in the form of coalition training and education as well as coordinating presentations at partner organizations;
- Collaborations with law enforcement in greater New Bedford to increase treatment success for residents who are frequent visitors to our St. Luke's Hospital Emergency Department;

Question 5B: Plans for the next 12 months.

Southcoast continues to refine and update Behavioral Health Connect, train community partners in its use, and utilize the database as a strong framework for collaboration with regional behavioral health coalitions.

The Homeless Intervention Group will continue to maintain and share data on the targeted population with the goal of maintaining housing, developing care plans and minimizing sporadic care such as ED visits.

A further goal is to place five additional residents in housing over the next 12 months in Wareham and provide wrap-around services through the Intervention Committee.

The Intervention Group is also working to identify gaps in resources and partnerships/collaborations, and implement strategies to access expanded resources for the Wareham community. The group is utilizing Southcoast Behavioral Health Connect to assist with this effort.

Southcoast will continue the CHWs-Diabetes Management project, within two Southcoast primary care practices, through resources derived from supportive grants.

The CHART Phase II project will greatly expand the use of trained CHWs as part of MyCare teams at each hospital site, linking clinical and community services across the continuum of care.

The Health Promotions Advocate program will continue serving patients in greater New Bedford through the St. Luke's Emergency Department.

Southcoast will continue its leadership role in the region, and actively participate in coalitions such as BOLD, Drug Free New Bedford and others that are making a positive impact on the health, wellness and quality of life for individuals and families in the region.

CHART Phase II:

As mentioned previously, the Southcoast CHART Phase II program will enhance care across the continuum for patients frequently utilizing our EDs and those who frequently readmit for inpatient care.

The model, based on the Spectrum Health Complex Care Team model, will create multidisciplinary care teams at each hospital site. In addition to a range of clinical staff, these teams will include trained CHWs, who are members of the community, specifically skilled, and trained to assist patients in navigating their care.

High utilization patients will be assigned to a MyCare team. A CHW will engage the patient with an offer of assistance, helping the individual access foundational needs, care, and care coordination. Each patient will receive enhanced, responsive multidisciplinary care from their MyCare team that will serve as a time-limited adjunct to traditional primary care. The services will focus on integrated behavioral health, medical, social work, pharmacy, health literacy education, and care navigation. The program, services and care team are patient-centered, culturally appropriate, responsive, readily available, patient, persistent, and longitudinal in nature; the ultimate goal is to establish full patient stability (medical, social, and behavioral) over time.

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?

Answer 6: Southcoast Health, as a Local Care Organization of New England Quality Care Alliance, has engaged in a full implementation plan to have all primary care practices within Southcoast Physician Group (SPG) and Southcoast Physician Network (SPN) become National Committee for Quality Assurance (NCQA) Level II or III accredited. To date, three practices have been NCQA Level III accredited. Southcoast is in Wave II of implementation and are preparing for accreditation submission for three additional practices in the fall of 2015. Additionally, SPG has engaged with the Care Transformation Collaborative of Rhode Island, whose mission is to lead the transformation of primary care in Rhode Island through integration, quality improvement, patient experience, affordability of care and health outcomes for the populations served. SPG has engaged four primary care practices in this initiative with the intent of NCQA Level II or Level III accreditation.

Southcoast ACO: Southcoast Accountable Care Organization (ACO) is participating in the Medicare Shared Savings Program administered by the Centers for Medicare and Medicaid Services (CMS). The initial three-year performance term, ending on or around December 31, 2015, has been renewed for another three-year term; currently, there are 19,800 beneficiaries in the Southcoast ACO. Southcoast ACO is actively involved in (1) clinical quality improvement and quality management; (2) utilization review, including precertification procedures, referral processes or protocols, and reporting of clinical encounter data; (3) beneficiary complaint, grievance, and appeal procedures; and (4) care management efforts geared towards caring for our high risk population. Southcoast ACO participates in all electronic health records and data sharing or exchange programs. Southcoast ACO's mission is to develop a network that will educate and motivate the participating members to improve population health, enhance the experience of patient care (quality and satisfaction) and control total medical expense. As we collectively step into the Value-Based Purchasing (VBP) model of care, there undoubtedly will be price erosion in the setting of health insurance exchanges and narrower networks. Southcoast is preparing for ACO/VBP population health management by laying strong infrastructure support through a network of team-based care management, transitions-of-care, high performing post-acute care networks, and VNA services. Additionally, expansion of community resource partnerships to enhance behavioral health and social care management is underway. Strong IT support through a robust EHR (Epic), interoperability, a population health analytics platform, and an anticipated data warehouse system installation, are additional tools that will be utilized to manage the population of 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.

		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	N/A	N/A	N/A	N/A
	Q2	N/A	N/A	N/A	N/A
	Q3	N/A	N/A	N/A	N/A
	Q4	N/A	N/A	N/A	N/A
CY2015	Q1	N/A	N/A	N/A	N/A
	Q2	N/A	N/A	N/A	N/A

By observation, Southcoast receives very few consumer inquiries, which are not formally tracked. Southcoast responds promptly to consumer inquiries, attempting to provide requested information to the consumer on the day the inquiry is made.

Southcoast uses a cost estimator tool to provide timely information to consumer inquiries, and has worked with payers and the Massachusetts Hospital Association to review other online web tools that may be useful. Southcoast also provides contact information for most significant third party payers to patients as they often request this information to determine their out-of-pocket expenses when there is a deductible or co-insurance involved with their plan.

2. 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.

Please see attached.

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.

2011

Note: Southcoast does not separate revenues into HMO and PPO categories. This is for Southcoast Hospitals Group.

	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	Both
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO					
Blue Cross Blue Shield	\$ 94,502,290	X	\$ 1,567,854	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	\$ 22,418,577	X	\$ 10,000	X	\$ 40,000	X	X	X	X	X	X
Harvard Pilgrim Health Care	\$ 54,317,084	X	\$ 274,287	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	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	\$ 2,550,546	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	\$ 12,657,268	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	\$ 7,517,272	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	\$ 27,423,991	X	X	X	X
Total Commercial	\$ 148,819,374	X	\$ 1,842,141	X	\$ 22,418,577	X	\$ 10,000	X	\$ 40,000	X	\$ 50,149,077	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	\$ 21,576,243	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	\$ 50,903,070	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	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	\$ 5,348,588	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	\$ 77,827,901	X	X	X	X
MassHealth	\$ 36,224,637	X	\$ 1,023,485	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	\$ 16,287,486	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	\$ 2,657,420	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	\$ 21,844,442	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	\$ 40,789,348	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	\$ 240,546,436	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	\$ 22,052,060	X	X	X	X
GRAND TOTAL	\$ 185,044,011	X	\$ 2,865,626	X	\$ 22,418,577	X	\$ 10,000	X	\$ 40,000	X	\$ 431,364,822				

2012

Note: Southcoast does not separate revenues into HMO and PPO categories. This is for Southcoast Hospitals Group.

	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	Both
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO					
Blue Cross Blue Shield	\$ 87,639,392	X	\$ 1,429,113	X	X	X	X	X	\$ 847,858	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	\$ 20,791,972	X	\$ 10,000	X	\$ 40,000	X	X	X	X	X	X
Harvard Pilgrim Health Care	\$ 58,412,633	X	\$ 294,768	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	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	\$ 2,968,977	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	\$ 13,928,622	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	\$ 7,253,310	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	\$ 27,405,180	X	X	X	X
Total Commercial	\$ 146,052,025	X	\$ 1,723,881	X	\$ 20,791,972	X	\$ 10,000	X	\$ 887,858	X	\$ 51,556,089	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	\$ 21,471,030	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	\$ 45,934,721	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	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	\$ 10,562,855	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	\$ 77,968,606	X	X	X	X
MassHealth	\$ 34,355,491	X	\$ 1,617,684	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	\$ 15,229,759	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	\$ 3,401,949	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	\$ 24,514,650	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	\$ 43,146,358	X	X	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	\$ 254,601,820	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	\$ 21,555,762	X	X	X	X
GRAND TOTAL	\$ 180,407,516	X	\$ 3,341,565	X	\$ 20,791,972	X	\$ 10,000	X	\$ 887,858	X	\$ 448,828,635	X	X	X	X

2013

Note: Southcoast does not separate revenues into HMO and PPO categories. This is for Southcoast Hospitals Group.

	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	\$ 83,462,036	X	\$ 1,411,876	X	X	X	X	X	\$ 550,824	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	\$ 21,105,346	X	\$ 10,000	X	\$ 40,000	X	X	X	X	X	X
Harvard Pilgrim Health Care	\$ 57,449,851	X	\$ 336,638	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	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	\$ 3,385,716	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	\$ 12,388,820	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	\$ 7,968,085	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	\$ 34,360,996	X	X	X	X
Total Commercial	\$ 140,911,887	X	\$ 1,748,514	X	\$ 21,105,346	X	\$ 10,000	X	\$ 590,824	X	\$ 58,103,617	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	\$ 18,481,884	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	\$ 49,328,754	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	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	\$ 12,844,278	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	\$ 80,654,916	X	X	X	X
MassHealth	\$ 38,641,858	X	\$ 40,000	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	\$ 15,728,500	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	\$ 3,645,277	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	\$ 30,867,924	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	\$ 50,241,701	X	X	X	X
Medicare	\$ 254,753,296	X	\$ 359,272	X	X	X	X	X	X	X	X	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	\$ 22,752,585	X	X	X	X
GRAND TOTAL	\$ 434,307,041	X	\$ 2,147,786	X	\$ 21,105,346	X	\$ 10,000	X	\$ 590,824	X	\$ 211,752,819	X	X	X	X

2014

Note: Southcoast does not separate revenues into HMO and PPO categories. This is for Southcoast Hospitals Group.

	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	Both
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO					
Blue Cross Blue Shield	\$ 84,743,873	X	\$ 1,444,883	X	X	X	X	X	\$ 309,839	X	X	X	X	X	X
Tufts Health Plan	X	X	X	X	\$ 21,320,506	X	X	X	X	X	X	X	X	X	X
Harvard Pilgrim Health Care	\$ 58,638,628	X	\$ 336,145	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	X	X	X	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	\$ 3,935,754	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	\$ 12,281,046	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	\$ 7,556,452	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	\$ 33,158,855	X	X	X	X
Total Commercial	\$ 143,382,501	X	\$ 1,781,028	X	\$ 21,320,506	X	X	X	\$ 309,839	X	\$ 56,932,107	X	X	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	\$ 22,274,020	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	\$ 49,575,918	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	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	\$ 17,406,047	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	\$ 89,255,985	X	X	X	X
MassHealth	\$ 43,629,455	X	\$ 1,331,275	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred	X	X	X	X	X	X	X	X	X	X	\$ 13,740,328	X	X	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	\$ 3,968,948	X	X	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	\$ 25,722,764	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	X	X	X	X	X	X	\$ 43,432,040	X	X	X	X
Medicare	\$ 264,432,676	X	\$ 1,954,723	X	X	X	X	X	X	X	X	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	\$ 11,190,469	X	X	X	X
GRAND TOTAL	\$ 451,444,632	X	\$ 3,735,751	X	\$ 21,320,506	X	X	X	\$ 309,839	X	\$ 200,810,601	X	X	X	X