Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, 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 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 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 Tuesday, October 7. 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 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 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 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, 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.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk 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 Kelly.A.Mercer@state.ma.us a minimum of two 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. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses 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 begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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**.

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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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY:

   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

   Answer: See Appendix 1A

   b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

      Answer: Actions Include:
      1. Strong administrative oversight with a focus on efficiency
      2. Rapid assessment of patients and transition to the next level of care
      3. Adhering to a medication formulary to contain pharmacy expense
      4. Management of Workers Comp expense through injury prevention training and aggressive return to work practices
      5. Contain employee compensation with average annual increase of 2%
      6. Emphasize aftercare planning to reduce readmissions
      7. Annual comparison of insurance products' costs to ensure competitive pricing

      The above items that are within management's control are managed efficiently and cost effectively. Some expenses are beyond our control, i.e., inflation and cost of products and services, and taxes; recruitment of physicians, etc.

   c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

   Answer: Bournewood Hospital plans to continue the actions described in 1B, above.

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

d. Answer: Systematic or policy changes that would improve efficiency include:

1. Improved access to state hospital beds and state funded, community based treatment resources

2. Decrease U.M. by developing less intensive labor systems

3. Standard requirements and performance specifications from payers

4. Better alignment of federal and state oversight

5. Funding of EHR implentation in specialty hospitals

6. Standard credentialing to eliminate time consuming and duplicative efforts

7. Standard survey process from regulatory agencies to avoid duplication of efforts

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

   a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations? Answer a: Bournewood Hospital has entered into capitated and self-managed UM contracts that decrease the labor involved in frequent review of patient status. Quality of care, length of stay, and transition to non-hospital based services post discharge are essentially the same as for patients in traditional fee-for-service UM models. Referral patterns are not affected. Operations are positively impacted by decreased labor in UM.
   b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).

Answer b: No analysis of the APMs is available; however, we have not experienced any significant impact on non-clinical operations.

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

   Answer c: No analysis is available.

3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.
   SUMMARY: Answer: At this time, Bournewood is not involved in APM contracts with risk factors.
   a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

   b. How do the health status risk adjustment measures used by different payers compare?

   c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

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

ANSWER: Bournewood has limited experience with APMs. However, we collect data from current providers including length of stay, readmission rates, linkages to aftercare providers, and communication with primary care practitioners. Real time data that could be helpful in anticipating and managing patient care would include patient acuity, intellectual disabilities, assaultive/aggressive/violent behavior, sexualized behavior, state agency involvement, personal and insurance resources available to support post-discharge care.

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY:
   a. Which attribution methodologies most accurately account for patients you care for?

Answer: Patient's primary care providers are identified by referral sources, patients, family, and friends. Some patients have not complied with insurance company requirements to select the primary care provider.

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

Answer: We have no suggestions.

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

ANSWER: Data entry requirements for hospital staff have increased due to the needs of providers for data relative to their identified quality measures. This increased workload heavily depends upon expansion of technology infrastructure and expenses for consultants. The demands of payors have led to an increase in UM Department workload and responsibilities.

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7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.
SUMMARY:

a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.

Answer: Bournewood is an inpatient facility and as such, receives referrals for admission but does not have patient flow to AMCs or other higher cost settings.

b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.

Answer: We divert patients to partial hospital level of care and monitor length of stay.

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8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
SUMMARY:

Answer: Post-acute care is essential for behavioral health and substance abuse patients. Hospitalization focuses on stabilization of acute symptoms in transition to a less restrictive level of care. The goal of discharge planning is to ensure continued supports for patients in less expensive, community settings.

a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.

Answer: The hospital's treatment teams create individual treatment and aftercare plans for patients that take into account patients' insurance, other resources, availability of services in their communities, and interpersonnal support systems.

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

Answer: We monitor the percentage of patients with discharge plans and communication of those plans to the next level of care. We collect data regarding competion of aftercare plans and strive to achieve greater than 90% in this area. Bournewood utilizes partial hospital and intensive outpatient programs, traditional outpatient services, and resources of other organizations providing services in the community. We stress with patients the importance of follow-up and aftercare, and include families in these discussions.

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

SUMMARY:

Answer: All of Bournewood's patients' costs of services are predetermined on a contractual basis with their respective insurance carriers, MCO, or public funding (Medicare and Medicaid). Rates are all inclusive and only vary as a result of negotiations with various providers or as arbitrarily set by state and federal government agencies. For the very limited number of patients with deductible and co-pays, the hospital explains to each patient their financial obligations associated with treatment services. Bournewood Hosptial provides detailed statements of account to patients who request the same.

Health Care Service Price Inquiries				
Year		**Number of Inquiries via Website**	**Number of Inquiries via Telephone/In Person**	**Average (approximate) Response Time to Inquiries***
CY2014	**Q1**			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER:

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

ANSWER: Bournewood is a specialty hospital and is not impacted by tiered or limited networks.

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11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic 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.
SUMMARY:
    a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.

    Answer: Our clinical staff routinely assesses behavioral health and substance abuse patients for current co-morbid medical conditions and assesses the risk of developing co-morbid medical conditions.

    b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

    Answer: Bournewood utilizes advance practice nurses on site everyday to perform routine admission physical exams and provide medical consultations as requested by our physician and nursing staff. This decreases the necessity of

sending patients to medical facilities for co-morbid care that can be provided concurrently with their psychiatric care while in this hospital.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

   Answer: Payor approaches often do not support or promote care integration. Reimbursement for behavioral and/or medical care on the same day is not allowed.

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

Answer: Bournewood reports discharge data as requested, usually by accrediting or regulatory agencies.

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

Answer: Bournewood has no experience with the implemention of the patient centered medical home model.

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

Answer: As a psychiatric hospital, we do not employ primary care providers or other providers affiliation with PCMHs.

f. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
   N/A
g. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.
   N/A

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

Answer: Given that Health Policy Commission's primary focus is on acute care, the findings have less relevance to behavior health organizations. We do not have sufficient experience to comment meaningfully on the report and findings.

ANSWER: As above.