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: Wingate has experienced significant cost pressures, that are further complicated by payers limiting rate increases based on Chapter 224, despite rates lagging behind current inflation adjusted levels. Furthermore, provider organiztions, ACOs, and hospitals are shifting costs and risk to other stakeholders in the healthcare system including post-acute care providers.
   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.
      Occupancy levels averaged 1% year over year growth from 2010 through 2012, however, FYE 2013 and YTD 2014, occupancy levels are down by -1% year over year. Contributing factors include increased hospital observation stays, increased competition from home health and assisted living companies and shorter length of stays with increased pressure from Managed Care Organizations and Accountable Care Organizations 'ACOs' to discharge patients sooner from SNFs.
   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?
      Wingate attempts to work with ACO referral partners and Senior Care Option programs as well as referral partners working under bundled payment programs. The results of these programs remain mixed. In order to ensure that the system will work with effective cost savings and efficeincy, a post-acute care provider requires increased volume to subsidize lower rates and to spread the increased risk associated with losses experienced on costly cases; however, increaesd volume is not always experienced. Wingate has also implemented an electronic medical record system in an attempt to become more efficient (see next question).
   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?
      Wingate has invested millions of dollars implementing an electronic medical record system ("EMRS") despite no parity incentive similar to what is paid to "eligible providers." Also, any savings/improvements captured is largley offset by increased costs associated with the need for additional information technology staffing and increased training and monitoring costs.
   d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

The demands of regulatory agencies, both Federal and State, force providers to devote already limited resources to simply comply with regulations verses focusing much needed resources on patient care. We are implementing an EMR program to ease the burden on nursing staff, however, this cost is fully absorbed by skilled providers, where in contrast, hospitals are able to recover much of their cost through the Federal government. Additionally, with ACOs facing increased regulation and requirements, they are looking to shift costs and targeting post-acute care as an area to further pressure cost reductions. This creates a need for more clinical and technological infrastructure in post-acute care with no reimbursable offset.

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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: Wingate has historically been reimbursed predominantly on a per diem basis, which is effectively a risk based payment model requiring effective care management and effeciencies throughout the post-acute care setting.
    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?
    Wingate successfully participated in Medicare Bundled Payment programs. In these programs, we worked closely with inpatient hospitals to provide quality and cost effective care. The model of post-acute care reimbursement in itself is a risk based concept. As a skilled nursing facility, we are generally reimbursed a set per diem rate and are at risk to provide all needed care regardless of actual cost. This type of reimbursement structure is conceptually similar to ACO risk contracts; however, we are faced with a lack of case mix adjustment or inadequate case mix adjustment.
    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).
    Information technology has increased compliance costs, legal and staff costs. The systems required to support APMs increase non-clinical costs despite lower reimbursement, thus increasing cost burdens on SNFs.
    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.
    Limitations with Wingate's current billing system makes it difficult to search for patient information paid under bundled payments as they are recorded under either Medicare or Medicaid and not seperately identified as "bundled paid" or "ACO".

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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: Wingate is faced with various means of risk adjustment, ranging from a determination by payer case manager to no risk adjustment; however, risk adjustment for post-acute care is generally based upon contractual levels of patient acuity determined by payer care management.
   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?
      Health status risk adjustments are generally insufficent for post-acute care providers. Health status continually changes, which makes it critical for accurate assessment from a patient's entrance into the post-acute care environment.
   b. How do the health status risk adjustment measures used by different payers compare?
      Health status risk adjustments vary between payer. For post-acute services, they are generally primitive and rely on a payer care manager to determine a different per diem level of care (skilled vs. sub-acute). This process relies on different clinical opinions, which frequently vary and may not be a timely reflection of a patient's condition.
   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?
      N/A

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4. Another 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: Wingate would benefit from more data provided on patients in our care network.
   ANSWER: Currently, Wingate works alongside ACOs that have access to signifcant amounts of patient data. Wingate currently operates with limited data, pertaining only to the care being performed in our network and limited to discharge data from the referral hospital.

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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: N/A
   a. Which attribution methodologies most accurately account for patients you care for?
      N/A

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

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: Wingate strives for superior clinical quality achievments. Tracking and reporting on quality measures requires significant clinical documentation management efforts.
ANSWER: Reporting of quality measures is difficult across all payers. Each payer generally has different measures along with various formats for reporting, none of which are the same. These result in several different workflows, processes, and protocols required for adequate reporting documentation. These processes impact the organization through increased administrative burden and pressure on clinical staff.

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: Wingate works closely with inpatient care providers and academic medical centers to accept patients into lower cost post-acute settings as soon as appropriate.
   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.
   N/A
   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.
   Wingate contributes to lower utilization of inpatient care through various programs. One is a continued concentration on preventing hospital readmissions. Second, is the Medicare Three Day Waiver, where we are able to accept patients more quickly out of an inpatient setting.

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 by hospital.
SUMMARY: Wingate strives to provide the right care for patients in the right setting. We work closely with our referral partners to manage the proper utilization of post-acute care.
   a. Please describe ways that your organization is collaborating with primary care providers and hospitals to (i) optimize appropriate use of post-acute care after hospital discharge and (ii) identify the appropriate setting of care.
   Wingate has integrated with many ACOs and hospitals throughout the state to ensure close communication regarding patient care. This ranges from telephone

conversations for tracking purposes and updates on a patients conditions, to implementing new software to enable patient tracking directly for ACOs.

b. Please describe your organization's efforts to manage the appropriate intensity and duration of post-acute care for your patients.
As noted in response (a), Wingate has various lines of communication with hospital/ACO/Managed Care organization case management to determine the proper setting of care and to update each stakeholder in the care spectrum of the patient's condition and progress.

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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: All prices are included in Wingate's admissions agreement; however, most patients do not request pricing upon admission.

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: Wingate makes pricing available to patients.

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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: Wingate participates with many health plans, ranging from managed Medicare/Medicaid to Commercial plans, many of which include tiered and limited network products.
ANSWER: Tiered and Limited network products affect Wingate through increased administrative burden, particularly in the areas of admissions and billing. It is frequently not clear which product a patient has with their insurance company and we are often not

equipped with the tools from the insurer to better determine the products, levels, and assigned rates. Many insurers list products on their websites, however, there are frequently products not listed or up to date. This has a direct negative impact on our volume due to the burden of determining that we do not accept a particular product; losing a potential patient to a competitor over response time; or face the risk of non-reimbursement for care. This scenario also affects billing, due to inconsistencies between products resulting in the need for audits and special attention from billing staff to understand payment from providers.

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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: Wingate collaborates with multiple psychiatric care providers. These providers assist in providing care plans enabling in house treatment.
    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.
    Wingate facilities contract for psychiatric services. Each facility has a Psychiatrist, Psychiatric Nurse Practioner, and Mental Health Counselers and social workers. Patients are seen regularly, behavioral rounds are done weekly and patients that require counseling obtain these services. Wingate also collaborates with our clinical pharmacist for medication reviews relative to psychoactive medications. Lastly, the team includes activities personnel who are trained in behavioral treatments. This training assists in our planning for activities programs developed to include specific approches for residents, identify antecedents to behaviors and prevent escalations in behaviors.
    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.
    Wingate provides manadatory staff education on behavioral situations, antecedents to behavior dyscontrol and strategies to prevent or minimize these presentations. Wingate, via weekly behavior rounds, identifies patients at risk and immediately develops interventions to prevent decompensation or unexpected emergency room visits. Wingate also has adopted and strongly believes in the INTERACT system, to reduce unnecessary hospitalizations.
    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.
    Wingate is successful in reducing the use of antipsychotic medications and unnecessary hospital admissions. Most of the challenges we see are at the time of discharge. There are limited outside resources available to many of these residents. Non-compliance in this population is also a challenge. To overcome these barriers Wingate conducts care planning meetings within 72 hours of admission; discharge planning is also part of these meeetings. Potential

barriers to discharge are identified early and the team begins immediately to intergrate and plan for all needed services to ensure successful inpatient stays and discharges.

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.
Wingate is willing and has the ability to report discharge data.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY: N/A
    a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?
    N/A
    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
    N/A
    c. 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: The Commission should expand upon other factors impacting variations between Massachusetts health care cost vs. other states as well as conducting a full and complete analysis of the complex and abundant regulatory environment that currently thwarts providers' good intentions of working together to develop innovative healthcare delivery models.
ANSWER: The Commission's prior reports touch upon Massachusetts' uniqueness for being a "medical mecca" given that some of the best hospitals in the nation are located here, however, additional analysis should be exploited to correlate all resulting patterns of utilization and cost. Further, the Commission's July 2014 update identifies only two factors (e.g. Massachusetts' older age profile and higher costs associated with wage levels) to account for a portion of Massachusetts' higher per capita spending on long-term care. Variations in other cost items, such as overall cost of living, cost of real estate and construction, state, county, and municipal tax structures, etc.) need to be analyzed before a determination can be made that there are opportunities for improved efficiency. Finally, the Commission should conduct a broad examination of all regulations that Massachusetts providers are subjected to under various governmental agencies, including without limitation, both federal and state health care operating and payment regulations, OIG regulations, consumer protection regulations and antidiscrimination regulations.

The vastness of the applicable regulations creates confusing crossovers between many bodies of law, leaving providers at risk of unintentional liability and higher costs with continued investments in trying to navigate an expansive body of law that may work against Massachusetts providers and limits their ability to fully focus on quality health care and optimal outcomes.

ACKNOWLEDGEMENT

I hereby acknowledge that I am legally authorized and empowered to represent the named organization, Wingate Healthcare, Inc., for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury.

Tamilyn M. Levin
Chief Financial Officer