Beth Israel Deaconess Hospital
Plymouth

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Submitted Electronically via HPC-Testimony@state.ma.us

September 11, 2015

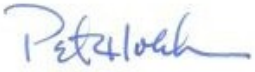
Dear Ms. Johnson and Ms. Mercer,

Enclosed please find the responses of Beth Israel Deaconess Hospital-Plymouth, Inc. to the written testimony requested by the Health Policy Commission and found in a letter from Executive Director David Seltz to Mr. Peter Holden on August 6, 2015.

Please note that I am empowered to represent Beth Israel Deaconess Hospital-Plymouth, Inc. for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please do not hesitate to contact me if you have any additional follow-up questions or Jason Radzevich in my office at jradzevich@bidplymouth.org or 508-830-2005.

Very truly yours,



Peter Holden, President & CEO
Beth Israel Deaconess Hospital - Plymouth, Inc.

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.

REVENUE:

During CY 2014, BID-Plymouth experienced a slight increase in net patient service revenue (NPSR) of 0.9% derived mostly from volume growth in outpatient services and casemix on inpatient stays. Year-to-date CY 2015 the Hospital has experienced an increase in NPSR of 11.8% derived mostly from an increase in casemix and volume growth in both inpatient and outpatient services. Only approximately 2% of the increase can be attributable to rate increases across all payers. As evidenced by reports issued from CHIA, BID-Plymouth continues to be disadvantaged in the MA healthcare market with reimbursement rates significantly lower than our closest community hospital competitors, South Shore Hospital and Cape Cod Hospital.

UTILIZATION:

During CY 2014, BID-Plymouth experienced continued decline in inpatient admissions of 1.7%, a significant improvement over the steep reductions experienced in recent prior years. Reductions in inpatient utilization are attributable to ongoing efforts to reduce unnecessary admissions and readmissions, an increase in patients assigned observation level-of-care, and conversion of certain services from inpatient to outpatient sites of service. Though the CY 2014 net result was a decline in inpatient admissions, trends started to shift toward volume growth during the second calendar quarter of CY 2014. The primary factors in the volume trend shift were the Hospital's affiliation with BIDMC on January 1, 2014 along with an aggressive physician recruitment strategy in both primary and specialty care. In addtion to discharge volume the Hospital continued to experience a higher acuity evidenced by a 3.5% increase in casemix of hospitalized patients. Outpatient utilization during the same period has increased. Year-to-date CY 2015 the Hospital has continued to experience positive growth trends in both inpatient and outpatient services. Inpatient volume has grown 9% over the same 7 month CY 2014 period with a 2.8% increase in casemix. Outpatient services have grown 7% over the same 7 month CY 2014 period.

OPERATING EXPENSES:

During CY 2014, BID-Plymouth exerienced 1% reduction in operating costs attributable to a reduction in force in May 2014 and a focused cost reduction initiative executed throughout the year. In total, these two items generated cost savings of more than $1.4 million. During year-to-date CY 2015, BID-Plymouth operating costs have increased by 6.3% driven by variable costs related to growth in patient volumes across the majority of services. The increase would have been

higher but CY 2015 cost savings intiatives have generated more than $1 million in savings to this year and more than $1.7 million on an annualized basis. The most significant driver in CY 2015 was a change in group purchasing organizations (GPO) as BID-Plymouth joined the BIDMC GPO, VHA/Novation, which allowed BID-Plymouth to benefit from pricing available to BIDMC.

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?

As stated in last year's testimony, since April 2012 and through CY 2014, BID-Plymouth (then Jordan Hospital) has been a participant in Jordan Community ACO (JCACO), a Medicare Shared Savings Program Accountable Care Organization. Through this initiative, PBMA, a large primary care physician practice, partnering with the hospital and soliciting specialty physician involvement, has fostered meaningful care integration for the first time in Plymouth County. Through effective care management and enhanced clinical attention, JCACO has achieved dramatic results in the community of patients attributed to the ACO: 20% reduction in hospital utilization, 30% reduction in SNF cost, improved management of complex populations for approximately 100 patients with the highest risk profiles, reduction in costs of almost $2.3 million, and 100% completion of the CMS quality goals.

On January 1, 2014, BIDMC became the sole corporate member of Jordan Health Systems and Jordan Hospital. Jordan Hospital was renamed Beth Israel Deaconess Hospital-Plymouth, Inc. (BID-Plymouth). Through this affiliation, BIDMC is making strategic investments to support continued expansion of the BID-Plymouth primary care network and clinical capabilities. During CY 2014, BID-Plymouth continued to participate in the above mentioned JCACO with PBMA. As of January 1, 2015, JCACO did not meet the required number of covered lives to host a Medicare Shared Savings ACO so the aforementioned initiative with PBMA was eliminated.

Also in CY 2014 both BID-Plymouth and all employed BID-Plymouth physicians became corporate members of Beth Israel Deaconess Care Organization (BIDCO). This affiliation allowed BID-Plymouth and it's employed physicians to participate in the CMS Pioneer ACO product as well as BIDCO's commercial risk arrangements. (See responses from BIDCO for more details). This participation has helped align both the Hospital and physicians in their pursuit for better healthcare, better health, and better value.

Year-to-date CY 2015, BID-Plymouth continues to align with physicians through BIDCO. As of January 1, 2015, Plymouth Medical Group(PMG), a large primary care physician practice, elected to join BIDCO which aligns them strategically with the Hospital. Though this group already utilized BID-Plymouth as the primary Hospital for their patients, participation in BIDCO will improve our ability to jointly manage population health within our community, to better control

healthcare spending, and to collaboratively focus on providing a higher quality of care within the community.

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?
Through BID-Plymouth's membership in BIDCO, we continue to engage payers in contracting under alternative payment methods. For detailed information on these efforts please refer to the BIDCO response to this questionnaire.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
Our response to this question has not changed from the prior year submission. Policies and regulations that promote administrative simplification and standardization would significantly improve our ability to operate more efficiently. Variation among payers and frequent changes in billing/payment rules, quality/safety measures and the timing/format of reporting requirements necessitates dedicated staff and internal procedures in the areas of patient registration, patient accounts, medical records coding and review, case management, quality review and analysis, and managed care contracting and analysis. Administrative simplification will enable us to redirect resources from simply meeting the variety of demands from payers to making meaningful improvements in the quality and delivery of care to our patients, families and community.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?
All reimbursement contracting for BID-Plymouth is now performed through BIDCO. Please see BIDCO's response to this question.

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.
    Please see BIDCO's response to this question.

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

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?

Acceptable Reasons:

Geographic wage disparity
Union vs. non-union labor pool
Disproportionate share of public reimbursement to total reimbursement
Level of achievement in healthcare quality benchmarks
Investment/commitment to global budgets / alternative payment methods
Teaching vs. Non-teaching organizations

Unacceptable Reasons:

Historically negotiated reimbursement rates

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.

The BID-Plymouth response does not differ from that of BIDMC. Unjustified and dramatic variation in prices paid to like providers continues to have a significant impact on the healthy functioning of the health care market in Massachusetts, both for low-cost community providers, and for providers of similar size and capability who provide precisely the same services and fulfill the same mission at dramatically different prices within the market. Unjustified price variation has contributed to the historic destabilization of hospitals, including community hospitals, those that serve disproportionate numbers of low income patients, and some academic medical centers. It is also clear that price variation is a major contributor to the growth of health care costs in the Commonwealth. This market dysfunction has been harmful to consumers in the Commonwealth, particularly in communities where access to care has eroded or disappeared.

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.

During CY 2014 and year-to-date CY 2015 BID-Plymouth has been developing an outpatient behavioral health system to address a severely underserved population in our community. Our focus on complex Medicare patients, and recently as part of CHART initiatives, the dual eligible and behavioral health populations, has proven to be successful – increasing access to services and decreasing readmissions. Additionally, these efforts have led to the establishment of the first integrated behavioral health and primary care practice pilot in the community. With the support of CHART Phase 2, during CY 2015 BID-Plymouth continues to expand the scope of services provided through this program.

b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.
Over the next 12 months we plan to expand the BID-Plymouth Complex Patient Program to all dual-eligible patients who access care in our community. This includes expansion of our Integrated Care Initiative which co-locates behavioral health practitioners within primary care offices in the community. This is being done collaboratively with BID-Plymouth's two largest affiliated physician groups, Plymouth Bay Medical Associates and Plymouth Medical Group.

To enhance BID-Plymouth's ability to manage patients presenting in our Emergency Department with behavioral health needs, we are in the process of staffing a behavioral health team within the Emergency Department.

Finally, we have partnered with an outpatient Substance Abuse Program, which recently occupied space within the Hospital's on-campus outpatient medical office building.

Our belief is the combination of these efforts will improve integration of physical and behavioral health care services within the BID-Plymouth community and ultimately reduce utilization of unnecessary ED and inpatient care.

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?
In addition to the coordinated care efforts mentioned in response to question #5, we continue to collaborate with BIDCO in our ACO strategy. Please see the responses from BIDCO to gain a better understanding of the BIDCO coordinated ACO strategy.

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	25	0	25	Maternaty, Surgery, Diabetes ED, Pharm Injectable, Cardiac Rehab, Radiology, Cardiology, MRI
	Q2	38	0	38	Radiology, Pulmonary Rehab, Breast Center, ER, LAB, Maternity
	Q3	20	0	19	Phys. Therapy, Maternity, Surgery, Vascular Med, Radiology
	Q4	27	0	27	Maternity, Radiology, MRI, Surgery, Breast Center, Diabetes Education, Sleep Study
CY2015	Q1	27	0	27	Pulmonary Rehab, Radiology, MRI, LAB, Cardiology, Surgery, Pharm Injectable, Diabetes Ed, Cardiac Rehab, Physical Therapy
	Q2	32	0	31	Sleep Study, Breast Center, Maternity, MRI, Cardiology, Surgery, LAB, Radiology

Explanations of Unresolved Inquiries:

CY 2014 - Q3: A consumer requested pricing for a laboratory test which is not performed at BID-Plymouth therefore no pricing could be provided.

CY 2015 - Q2: Patient did not have adequate information to determine a comprehensive price. BID-Plymouth requested patient request additional information from the referring physician and call back for pricing. Patient never called back.

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 BIDCO's response to this question.