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.

    A significant trend during 2014 and 2015 is the reduction in revenue. Mass Health continues to pay certified home health organizations at a 2007 rate. In 2008, the decrease in the rate of pay for providing services to Medicaid patients for longer than a 60 day episode was reduced by 20%. There is also a penalty when servicing 2 or more members in the same household during the same time period, a reduced rate is paid for each subsequent member in the household. Commercial payers do not pay the full cost of home care services. In addition, Certified Home Health Organizations must hire employees to do insurance authorizations. This is another expense. Medicare continues to add new processes before certified home health care organizations can bill for services. The CMS Physician Face to Face process is an over whelming task to stay on top of and requires the hiring of employees to do that task, in order for the organization to send bills for service to Medicare. In addition, there are processes to follow for rehab assessment frequencies before billing can be done for services. Another trend reflects on types of referrals that we are receiving. For certified Home Health Care the preference is for Medicare referrals to help to defray the cost of caring for the Medicaid patients and for patients whose insurance does not cover the cost of home care services being provided.

    Special clinical services that the Brockton Visiting Nurse Association (BVNA) offers, such as the American Diabetes Association- recognized program, geriatric behavioral health, wound ostomy continence nurse services, and pediatric services receive no differential in payment. Yet those services are more costly to provide due to the increased time per visit and the specialists hired to provide those services (the cost of hiring experts to provide those services).

    Competition remains a challenge with the number of new certified home care agencies all competing for the same patients and especially the Medicare patients.

    Brockton Visiting Nurse Association practices the Triple AIM to provide superior customer service and care, to do population health and to be cost effective.

    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?

    The Brockton Visiting Nurse Association continues to take actions to make the BVNA a cost effective organization, that gives superior care, provides excellent customer service and practices population health. An RFP has been written to fund a "Lean Coach" for the BVNA. We began to utilize the "Lean in Healthcare" methodology the previous year and continue with that process. It is providing the organization with culture change and a much more efficient work flow. Partnering with clinical entities in the community to work on programs that will reduce the acute care hospitalization rate and use of the ERs.

Special programs would be COPD, Heart Failure, Complex Care, and an Ortho program for knees and hips. During the 2014-2015 time frame the average cost per visit decreased by 2.6%, due to the higher volume of business and efficiency.

c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?
The Brockton Visiting Nurse Association is a very "lean" organization. Certified Home Health Organizations including Visiting Nurse Associations are very different from other health systems and organizations. Certified home health care is the least costly form of care. Alternative Payment methods, especially bundled episodic payments are of interest to pursue. The BVNA is in a bundled ortho program, as the post-acute provider. Medicare will continue to pay us (and certified home health agencies) under the current episodic prospective payment model. However, it will be in the interest of hospitals to manage both the inpatient and post-acute care to the best clinical and spending outcomes possible. The Brockton Visiting Nurse Association will continue to control costs through: analyzing metrics, increase productivity, examine alternative payment methods, deliver care in cost effective ways, and continue to partner with health care entities.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
Have Commercial payers and Mass Health develop episodic methods of payments. As mentioned above, additional employees have been hired to manage the authorization of those payers. Even for the Commercial payers there is an administrative expense for the authorization process. In addition, the payment from those payers does not even cover the cost of the home visit!! Medicare and Commercial payers need to follow the lead of recent regulations proposed by MassHealth and cover the cost of Telehealth. This program is successful at keeping patients from being readmitted to the acute care facility. Yet, it is a very expensive program for certified home health agencies to fund (BVNA writes grants to pay for some of telehealth). Medicare still requires patients to be home bound! This is a regulation from 1965! Think of the healing benefit for patients to be able to leave their home environment, yet have home health services to prevent readmission to the acute care facility.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?
In the situation referred to above, I mentioned the orthopedic program. However, Medicare is restricting certified home health care by continuing to have us under the Medicare payment model and following the regulations based on the fee for service model. There is no sharing of the rewards or losses. We are willing to sit at the table and talk about alternative payment methods for certified home health care.

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.
Spending on post-acute care: Brockton Visiting Nurse Association is using the Triple AIM and Lean Healthcare to create a less costlier work flow. This is a system for examining every process and determining what needs to change and still have a superior outcome. **Reducing avoidable 30-day readmissions**: Special programs such as Heart Failure, COPD, Complex Care, ADA, Ortho were put in place to prevent readmissions. Brockton Visiting Nurse Association utilizes a program that triggers a home visit when a patient is in the ED during the night shift. The employees at the Brockton Visiting Nurse Association work closely with MDs/PAs/DOs by communicating with them to change medications or treatments to prevent patients from returning to the acute care setting. Medication Reconciliation is a huge part of the process. **Reducing avoidable ED use**: There is a "Call Me First" program before patients go to the hospital the patient calls the visiting nurse, unless the patient is in a crisis situation then immediately calls 911. Another program that is going to be piloted will be a palliative care program to treat patients' symptoms in their home environments rather than going to the ED. The ADA program educates diabetics about how to treat their high blood sugars and low blood sugars rather than going to the ED. That education is so valuable to diabetics and helps them to feel as though they are in control. **Providing focused care for high risk/high cost patients:** The programs that Brockton Visiting Nurse Association has enabled us to work closely with a combination of Acute Care facilities and Medical Groups. Brockton Visiting Nurse Association provides home care services for those patients who are labeled high risk/unstable/utilizing acute care and EDs services rather than making appointment with the PCP. We offer behavioral health to many of these patients in addition to telehealth services. Individual treatment plans are set up based on the high risk factors that the patient presents with during the initial assessment.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
Spending on post-acute care: Brockton Visiting Nurse Association will continue to utilize the Lean Healthcare model to make changes that will make our organization more cost effective. We are focused on metrics that compare us with our competitors, both for profit and not for profit. Flexibility is also important to be able to readjust as the market changes, as reductions in payment occur, as regulations change and as demands change; with the goal being to provide superior services to the population that we care for.
Reducing avoidable 30 day admissions: This is a focus area for every professional that is treating patients who have been admitted to the Brockton Visiting Nurse Association. The metrics for 30 day readmissions and 60 days readmissions are reviewed weekly for the organization as a whole and for each professional provider. EMRs are reviewed on those patients who have been readmitted to an acute facility to determine if that readmission could have been avoided. Education is provided to employees from the chart reviews. A patient who is too unsafe to be in his/her home environment has the option to be transferred to a SNF setting within 30days of the last hospitalization rather than to be readmitted back to an acute care setting. There are also important factors that must be

considered before an acute care facility discharges a patient to his/her home environment so the patient can be safe at home: medication reconciliation before patient leaves the acute care setting, education to patient and care givers (if patient is fortunate enough to have a care giver) about protocols to follow at home, appointment to see the PCP is made before discharge, patient and family are made aware that home care will be provided. This is all part of Care Transitions.

Reducing avoidable emergency department use: continue to do what the Brockton Visiting Nurse Association is doing. Patients who do not have PCPs or are in the habit of seeking care from the ER must be educated in order to change their behaviors.

Providing focused care for high-risk/high-cost patients: Brockton Visiting Nurse Association will continue with the programs that have been instituted just for the purpose of caring for high risk/high cost patients. We have purchased a predictive modeling tool to identify patients at high risk for readmission and ED visits. This is a real time assessment tool.

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?

    Medicare payments for home care are based on an annually set payment rate adjusted for each payment according to the patient's "case mix" score as determined by a clinical assessment. Total price is determined by the case mix adjustment applied to the base and the number of 60 day episodes. The average number of episodes is 1.3. The price difference is based on the case mix index for Medicare home care patients. Medicaid pays fixed per visit class rates across the state so there is no variation in price paid to home health providers. The only variation would be the number of visits the patient receives.

    The HPC's 2014 cost trends report section: "Maximizing Value in Post-Acute Care" suggests that greater efficiency could be gained, perhaps, by looking to current post-referral patterns from hospitals across all post-acute sectors and how the patterns and costs correlate to outcomes and/or values. That analysis would be valuable for the Home Care Alliance of Massachusetts.

    An additional factor contributing to cost variation in certified home care organizations is the lack of either licensure or determination of need in this state for home care. Presently, Massachusetts is one of only five states without either a certificate of need process or licensure for home-based care. The entry into the market each of the past five years of dozens of new certified home health providers has created what is seen as supply far exceeding the demand. In addition many of the new agencies lack the resources to provide the complexity of home care services. Investing in such things as remote patient monitoring or innovative disease management programs can result in readmission rates

being higher than the state or national, unnecessarily sending patients back to higher priced settings.
For certified home care organizations and visiting nurse associations to provide those quality programs which offer so much value, it is a financial investment due to the labor costs for specialty staff, necessary equipment, and the provision of those services 7 days a week.

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.
In home health care, there is intense financial pressure from a number of angles. Medicare has reduced home health payments in each of the last four final rules as a result of the Affordable Care Act. Reductions under sequestration have also had to be absorbed while new regulations have only added costs. The 2007 MassHealth payment rates have as of 2015 fallen far below the cost of providing care. MassHealth rates for therapy services have not been rebased since 1994; home health aide and skilled nursing rates were last rebased in 2005. In that time, we have continued to treat our aides and clinicians as valued employees and had to pay wages that remain competitive. Moreover, consolidation in the healthcare market has led to a marked reduction in referrals to independent, non-profit agencies from once traditionally reliable sources . Such decisions do not seem to based on either efficiency in care or any quality metrics. Any price variation, based on this combined pressure, has a significant impact on our ability to provide care to our patients.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.
    The Brockton Visiting Nurse Association offers a geriatric behavioral health service. It is a costly service and there is no additional payment. The specialist has been able to intervene with patients who wanted to end their lives, assessed patients and determined that they were having behavioral side effects from medications (elloquis) and assisted them to adhere to their treatment plans at home. The specialist knows community resources and has a good communication plan with the PCPs.

    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.
    To continue as stated in 5.a,

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?
   The Brockton Visiting Nurse Association has been in discussion with a Medical Group who is formulating a Medical Home. The program that has been discussed is servicing the diabetic patients. It would be valuable if the concept of certified home health care could be an extension of the PCMH future certifications.

I am 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.

Beverly Pavasaris

President

Brockton Visiting Nurse Association, Inc.

9/11/15