Exhibit B: HPC Questions for Written Testimony
Submitted by Gosnold on Cape Cod

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.
    Utilization of services remains strong at all service levels (in excess of 90%), particularly in view of the opiate crisis. Revenues (2014 to 2015) will increase 1.9%; expenses 3.8%. The most significant expense increase drivers are technology implementation costs and workforce costs. The lack of professional staff with required competencies to serve the health needs of our population and the increased competition for these professionals due to the influx of private for –profit behavioral health companies coming into the market will place a severe burden on community based mission driven providers to recruit and retain competent staff. We could be in an inflationary wage spiral that could affect our ability to meet the cost growth benchmarks.

    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?
    We attempt to constrain cost increases to match the cost growth benchmark goal of 3.6%. We are trying to better utilize technology to reduce staff needs. Start-up capital costs are challenging for technology upgrades and implementation.

    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?
    We have entered into one performance based contract that ties reimbursement increases to achievement of specific metrics related to readmission rates, length of stay, and cost per episode of care. We also have a bundled rate agreement for a specific population of high utilizers. And we are in discussion for an additional bundled rate agreement that combines services across levels of care and is tied to outcome achievements.

    d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
    Relief from antiquated regulations that micro-manage services and the end of unfunded mandates that add nothing to the quality of care. Also, establishing deemed license renewal status for organizations with Joint Commission Accreditation, thus eliminating the need for licensing visits 6-8 times a year.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?
    a. Lack of sufficient data and data systems/analytics to adequately assess population profiles and associated risks in taking on APMs.

b. Lack of flexibility to adopt innovative approaches that may not fit into licensing regulations that no longer have relevance in today's environment.

c. State service contracts that are funded in categorical service blocks with no accommodation to utilize funds where most needed. Need global contracts that allow for allocation of funds where needed identified patient needs.

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.
        1) We have established a Recovery Management service that provides coaching, system navigational aid, family support, transportation, job search, etc. The service can be provided over time from several months to years if necessary. Pilot results on a sub-population of young adult opiate dependent patients has demonstrated significant reductions in readmissions, improvement in care compliance, and a reduction of social consequence costs (legal, etc.) The service received the Tufts Health Plan Innovation of the Year Award for the outcomes it produced.
        2) In addition to above referenced action, we entered into a P4P contract that held us to specific readmission targets. This arrangement led to the development of a follow-up service to improved post-acute compliance. Such incentives change the way care is considered and delivered. We are entering the second year of that engagement.
        3) We haven't started it yet, but in next two months we will staff selected emergency rooms with addiction specialists and coaches. This will improve access to specialty behavioral health services and reduce ED readmissions by attending to the social determinants that often lead to overuse of the ED.
        4) We have one contract that focuses on high utilizers of care and allows for a community based health worker to remain engaged with this population. We have identified high utilizers of our own services and are using a form of predictive analytics to focus on their care management. These are projects currently in development.

    b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
    Included in above statement. We plan significant expansion of the Recovery Management service and the introduction of technology aids (Smartphone apps) to increase engagement and retention outcomes. However, there is no realistic reimbursement for the scope of this service.

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 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?
The "same services", if defined by the level of care licensing category may not be the same services. For example, the CSS (rehab) level of care in addiction treatment calls for nursing services "four hours a day". Our organization provides this level of care but we provide nursing care 24/7 because we've determined that this better meets patient needs. We provide in program psychiatric services even though the regs only require that there be consultative relationships. Because we have these "additional" services, we tend to admit more compromised patients. Thus, our costs for this level of care are higher than other programs. So there is an issue of 'standards of care" that is sometimes only considered by policy makers who use outdated models or historical costs.

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 most present danger to the financial health and sustainability of community and lower cost providers is the entry into the behavioral health market of private, for –profit providers financed by private equity money. These investor driven initiatives are interested in the private pay and commercial markets and this threatens the mission driven community based providers who cannot survive on public Medicaid or DPH/DMH funding. It will result in a two track system that contradicts the goal of quality health care for all, regardless of socio-economic status.

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.
        1) We have established relationships with several PCP and specialty physician practices to embed BH clinicians in their office to begin screening and early intervention. We have a similar relationship with an FQHC. Services are integrated and delivered in the physician practice in brief, interventional approaches. There is no billing capability for this service if it is provided by an embedded BH clinician employed by a community mental health/addictions clinic.
        2) Our plan with emergency departments is described above and is set to begin by end of CY2015.

    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.
    We plan to expand our relationships with medical practices and hospital systems. We currently provide integrated care in primary care settings, ob/gyn offices, and a pediatric practice, as well as, an FQHC

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?
   Just beginning to have those conversations with the community health centers. Trying to determine how the EMR can generate the data necessary for management of populations.