Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts 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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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 Suffolk, 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 (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 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 2, 2016**, 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 from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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, 2014, and/or 2015 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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. 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.

1. **Strategies to Address Health Care Cost Growth.**
   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 has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.
   a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

      Berkshire Health Systems continues to be concerned with managing the cost of providing care to the community we serve. The rate of growth in new technologies and pharmaceuticals, salary and wage growth pressures, and the ongoing subsidization of physician practices as well as community partners are key drivers of Berkshire Health System's overall growth rate.

   b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

      Policy changes in quality and outcome reporting could have the potential of reducing the number of measures being monitored and reported and reduce the administrative cost burden on the Health System. Efforts to improve the government payment rates at levels that are close to the cost of care would help to ensure the Health Systems ability to meet the needs of the community. This is especially true in regions with low density populations and stagnant growth.

2. **Strategies to Address Pharmaceutical Spending.**
   In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.
   a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.
      i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Berkshire Health System strategies towards pharmaceutical spending examine the distinct variances between retail as well as hospital-based, including in-patient care, operations. In regards to education directed towards prescribers in retail operations, there is no formal function in place for continuous education or information sharing. However, employees in retail pharmacy inform prescribers on a routine basis of generic substitutes to assist with minimizing costs for all parties involved. If prescribers are adamant about specific medication, retail pharmacy operations will educate on an individual basis the benefits of alternative generics

for the prescriber in order for the prescriber to learn more about options which are available. These available options are identified by the hospital formulary, a method whereby the medical staff with the help of pharmacy and therapeutic committee selects and evaluate medical agents and their dosage form, to be considered as most useful to patients. The options outlined in the formulary are clinically proven to be proper substitutes for medications as well as financially beneficial for the parties involved in improving the care of patients. It is noteworthy to mention that there are always exceptions with special medication prescriptions and these exceptions will undergo a rigorous evaluation process before issuance of medication.

In regard to the hospital-based pharmaceutical spending, the pharmacy and therapeutics committee continuously educate physicians and prescribers in regards to cost effective therapy and medication options. This educational component is a critical aspect of operations as the pharmaceutical industry and larger pharmaceutical companies have become extremely influential in the decision-making process of physicians. These larger companies have more resources to be allocated towards marketing targeted benefits of products towards customers whereas BHS prefers to utilize these resources to evaluate proper clinical medications needed to treat patients effectively. An example of this is the pharmaceutical industry marketing impacts of acetaminophen substitutes, such as Tylenol, nearly depleted the budgets within weeks.

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

The primary outcome of variations in provider prescribing patterns stems from physician preferences in providing only brand name options for patients. These trends are due to prescribers favorites which have developed over the years. When BHS recognizes the patterns, both retail and hospital-based pharmacy operations will steer prescribers towards the hospital formulary options. It is noteworthy to mention that the individual patient's insurance and as well larger insurance organizations are now beginning to dictate the hospital formulary options available. Insurance organizations have as much influence as the pharmaceutical industry leaders on pharmaceutical spending as BHS has to provide options on the formulary which are covered through patient insurance.

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

On a routine basis, internal best practices are implemented and adhered to for the prescription of high-cost drugs. All drugs classified as high-cost/high-handle require prior authorization before any prescriber or physician will have the ability to issue the medication. This authorization will be obtained by thorough examination of individual patient needs for improved health. These factors include, but are not limited to, considerations of time period of illness, risk, dosage, age, and factors of quality of life. It is also noteworthy to mention that insurance companies must be willing to pay for the cost of medications issued for high-cost drugs. The overall goal is to reduce complications from high-cost drug usage, prevent progression of illness and the maintenance and/or improvement of current health status.

In addition to these best practices, as an organization it is the Health System pharmaceutical department's responsibility to have clinical experts invests significant hours as well as resources towards the examination of clinical effectiveness of each high-cost drug offered. While the pharmaceutical industry invests in advertisement and promotion of high-costs drugs, the priority investment for the Health System is to assist prescribers in making quick and efficient real-time decisions on high-cost drug options which will be clinically beneficial. In addition to marketing and access to the prescribers challenges faced by hospital-based pharmacy operations, internal issues arise when there are attempts to align high-cost drug recommendations to multiple prescribers within one medical discipline as well as throughout a complex healthcare system of multiple disciplines.

iv. Establishing internal formularies for prescribing of high-cost drugs

Similar strategies as previously notated, the organization strives to make evidence-based decisions based on clinical outcomes for patients in the development of the formulary. Unfortunately, formulary options are being influenced by factors such as insurance, pharmaceutical industry marketing and profit margins, and prescriber's brand name preferences. As a result, from an operational perspective it is not possible to offer all of the medical substitute options available and thus it is critical to provide a limited number of best alternatives for selection.

v. Implementing programs or strategies to improve medication adherence/compliance

A significant amount of resources are focused around the improvement of medication adherence and compliance. On a routine basis of approximately twice per month per patient, pharmacy employees conduct follow up conversations with patients regarding compliance of prescription issued and dosage requirements, confirmation that medications are up-to-date and not expired, and the overall management of care recommendations by physicians and prescribers are being adhered to. To further emphasis this element of operations, the pharmacy department is actively involved in the therapy management program which includes education on disease state programs such as diabetes. In addition, another primary program is the discharge dispensing program. The program delivers discharged hospital patients prescriptions before leaving their hospital room, conducts routine follow ups on an as-need basis but no longer than two week interval from discharge. The goal of this effort is to increase compliance, reduce readmission, minimize medication issuance as well as costs to patient, and improve overall health in a timely manner.

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

At this point in time, there are no existing strategies in place in regards to alternative payment contracts with payers and accountability for pharmaceutical spending.

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)
38T

Berkshire Health System has been actively developing strategies to integrate behavioral health care into our operations and clinical delivery system of care. It is noteworthy to mention the most meaningful integration of these services have been grant funded and mission-critical to the organization. Below outlines the primary strategies which are continuing to be pursued:

- *Telepsychiatry: With the support of a grant funding, Berkshire Medical Center was able to develop the required infrastructure to secure videoconferencing and telepsychiatry technology that connects a powerful hub of expertise, attending psychiatrists at Berkshire Medical Center, to over 40 health care settings throughout the Berkshire county. These settings consist of primary care practices, community mental health clinics, E.D.s and five FQHC clinics. Psychiatrists are centralized at Berkshire Medical Center and provide evaluation as well as consultation to patients at primary care practices throughout the region. Psychiatrists are a relatively scarce resource and our network of secure videoconferencing technology efficiently leverages their limited availability across an extremely large rural area. The Behavioral*

Health Department continues to be actively pursuing grant funding and advocating to payers for increased access to behavioral health care.

- *Deployment of Behavioral Health Clinicians to primary care practices: With the support of grant funding, Berkshire Medical Center deploys behavioral health clinicians into the community to work on-site at several local primary care practices. These clinicians, also equipped with telepsychiatry capabilities, provide clinical evaluation and consultation as well as brief, health-focused interventions to patients in the primary care setting. In addition, the behavioral health clinicians assist the primary care practices and clinic staff with the management of patients with challenging behaviors and complex psychosocial issues (i.e. suicide prevention strategies). The presence of the behavioral health expertise in the practice offers opportunities for primary care practices and their staff to build capacity and institutional knowledge as the behavioral health clinicians regularly collaborates on the care of patients in the practice together. Their expertise also plays a critical role in facilitating telepsychiatry consultations to the various practices. The opportunity to deploy this integrated care model allows Berkshire Health System to develop a logical system of care delivery that will be optimal to move toward global payment and capitated care; enabling the providers with the responsibility for overall health of a patient population.*
- *Infrastructure and capacity building (ICB) for substance abuse and chronic pain: With the support of grant funding, Berkshire Health Systems has been able to focus on improving the care for patients with chronic pain and substance abuse, with a specific focus on opioid dependence and addiction. With over 10 primary care practice partners, the model has increased the proficiency of the participating primary care practices to utilize best practices in diagnosis and treatment of this vulnerable and high risk population, increased capacity of the local community mental health system to treat patients identified with substance abuse issues, developed centralized care coordination referral system and includes of an array of alternative, "integrated health" modalities (i.e. acupuncture, Cognitive Behavioral Therapy group for chronic pain, osteopathic manipulation, nutrition, etc.) as sanctioned referral options for the primary care practices and their patients. This innovative model both requires and inserts the integration of behavioral health expertise into the primary care setting. Training provided to primary care practices include education on alliance building, motivational interviewing, medication assisted treatment and screening for substance use disorders.*

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)
38T

As noted above, the efforts made to date to integrate BH into Berkshire Health System have been completely grant funded. Over the past several years, there has been increasing recognition that the integration of behavioral health into broader population health has enormous potential to positively impact the quality of care, the patient experience, the cost of care and the provider experience (Quadruple Aim). In spite of the growing evidence of the positive gains to be realized in implementing integrated behavioral health models, significant obstacles continue to impede true optimization of this model. These obstacles include the following:

- *A primary impediment is found in the on-going reimbursement environment. Insurance companies carve out behavioral health to a range of carriers and continue to require prior authorization for basic behavioral health services, while the medical counterpart has no such*

obligation. Independent physical and mental health billing procedures and codes provide additional barriers to clinical and operational elements of healthcare. The lack of clarity and/or certainty about the future of health care reform payment models is an ongoing concern as the organization becomes more reliant on grant funding to implement behavioral health integrated care models. Reimbursement for telepsychiatry services in Massachusetts continues to be undeveloped and is limited to individuals with Mass Behavioral health Partnership (MBHP). Medicare beneficiaries are eligible for telepsychiatry services, but only if the originating site (where patient is situated) is located in a rural Health Professional Shortage Area (HPSA). In Berkshire County, only one town is considered HPSA-eligible: Great Barrington.

- *The use of a HIPPA-compliant and secure videoconferencing network to provide telepsychiatry services to primary care practices in Berkshire County has been highly effective. The obstacle, however, is the growing shortage of psychiatrists as well as the extreme rural region, and telepsychiatry efficiently leverages this scarce resource across a wide geographic area. It has been affirmed by all partners involved that the availability of remote behavioral health services has resulted in an increase of engagement levels with high risk populations. These reasons stems for any of the following attributes: stigma of obtaining treatment at mental health and substance abuse clinics, transportation, lack of familial or other psychosocial support, and extended intervals between scheduling appointments.*

4. **Strategies to Recognize and Address Social Determinants of Health.**

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies) 38T

Berkshire Health System understands that health relates to all conditions in which individuals are born, grow, live, work and age. Health is also determined in part by access to social and economic opportunities; the resources and supports systems available in homes, neighborhoods, and communities; the quality of schooling; the safety of workplaces; the cleanliness of our water, food, and air; the nature and composition of social interactions, interpersonal relationships and much more. The resources which exist in these environments enhance quality of life and are a significant influence on population health outcomes.

As social determinants of health become a predictor of population health, Berkshire Health System has implemented a number of tools and strategies to address the social determinants of health, including the following:

- *Integration of "Health Equity" from the County Health Initiative (CHI) into our existing healthcare strategic and operational framework. The CHI examines factors at an individual or family level stemming from age, safety, access, language, transportation, income, ethnicity, employment, food insecurity, education, gender, and housing. With these additional inputs in mind, BHS focuses upon continuing to direct resources towards the following focus areas:*

- *Tobacco Use, Obesity, Substance Abuse, Depression, Teen Pregnancy, and Motor Vehicle Accidents*

- *Implementation of Community Health Workers (CHW), primarily through grant funded programs, into a developing workforce environment. The object is to embed CHW with a care team to improve patient experience, enhance health outcomes, and reduce healthcare cost. In addition, by having CHWs addressing patients' social determinants of health, connecting them with resources and assisting with their care coordination, the healthcare providers engage more fully on their patient's care and patients or providers experience a higher level of satisfaction.*
- *Incorporation of Culturally and Linguistically Appropriate Services (CLAS) standards into healthcare system operations. These standard practices, requested by all community partners, are developed to provide guidance on how to improve service delivery to clients who may not have sufficient access to care based on race, ethnicity, linguistic capacity or cultural background. While the ultimate goal is to benefit the patient, a secondary beneficiary will be the health of the organization as we will have the ability to provide more comprehensive health services.*
- *Engagement and support in community-wide initiatives focusing on factors of social determinants of health. As a lead agency supporting "Bridges Out of Poverty" program, Berkshire Health System along with several other agencies will support the journey from poverty to sustainability by collaboratively building community resources and removing barriers. The effort's vision is for all people to experience a just, safe and thriving community. The program is a series of ideal best practices and concrete tools with proven results that brings people from all economic classes together to address all causes of poverty in order to build resources, improve outcomes, improve job retention rates, reduce health inequities, and support those who are moving out of poverty.*
- *As a result of the identification of significant barrier stemming from the lack of transportation for residents, the Neighborhood for Health program in Northern Berkshires focuses on care coordination and collocation of services. Neighborhood for Health provides the entire outpatient clinical and community services typically needed to regain health following hospitalization. These services include diabetes education, congestive heart failure clinic, nutrition counseling, expended behavioral health services, substance abuse disorders, outpatient detox center, and smoking cessation. In addition to having the services collocated to improve patient centric approach, care navigation is a critical component to the Neighborhood for Health as patients are offered care coordination services to ease the burden of managing a complex healthcare industry and referral process.*

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)
38T

The social determinants of health are mostly responsible for health inequities - the unfair differences in health status seen within and between individuals. Because of the complex nature of human beings and their existence in varying environments, there are barriers to understanding these concepts and transforming systematic issues into actionable resolutions. These barriers include the lack of a universal screening tool focusing on non-clinical characteristics that interfere with their patients' ability to lead healthy, productive lives. Without this quality process reporting mechanism,

healthcare organizations are unable to conduct comparative evaluations of population health. To magnify the lack of quality standards being measured, there is no centralized care coordination efforts for social determinants of health. In addition, healthcare organizations lack the resource capacity to disseminate social determination of health expertise for local community partner's consumption. If healthcare organizations are not focusing resources on these health-harming critical social conditions, community partners are less likely to take action. As a result, Berkshire Health System continues to witness staggering statistics stemming from the lack of transportation, housing, primary care physicians, financial assistance, food security, and employment (North County statistics; parenthesis will be removed for final version).

5. **Strategies to Encourage High-Value Referrals**.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

Berkshire Health Systems does not interfere in referrals made by providers. Both affiliated and independent providers work collaboratively to meet patient needs. Home care and post-acute care services are rendered by owned and independent agencies, with all having equal access to discharge planning

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If yes, please describe what information is included.
38T

ii. If no, why not?
38T

Berkshire Health System's Electronic Health Record (EHR) Systems currently do not have the functionality to provide cost/quality information to healthcare providers at the time orders or referrals are placed. Berkshire Health System currently utilizes multiple systems and data sources to capture, analyze and report information for cost and quality. It is noteworthy to mention that the initial conversations have been conducted with both primary EHR vendors, Allscripts and Meditech, on how to incorporate and present this information to providers at the point of placing orders and referrals. Both Allscripts and Meditech are extremely interested in continuing conversations on how to develop and incorporate this functionality into their EHRs.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If yes, please describe what information is included.
38T

ii. If no, why not?
38T

Similar to the responses with organizational affiliates, the exact methodology will be carried over to non-corporate affiliated organizations. Berkshire Health System's Electronic Health Record (EHR) Systems currently do not have the functionality to provide cost/quality information to healthcare providers at the time orders or referrals are placed. Berkshire Health System currently utilizes multiple systems and data sources to capture, analyze and report information for cost and quality. It is noteworthy to mention that the initial conversations have been conducted with both primary EHR vendors, Allscripts and Meditech, on how to incorporate and present this information to providers at the point of placing orders and referrals. Both Allscripts and Meditech are extremely interested in continuing conversations on how to develop and incorporate this functionality into their EHRs.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
   i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.
   38T

BHS is in the process of implementing Health Information Exchange (HIE) technology in Berkshire County which incorporates and normalizes information from many Electronic Health Record systems throughout the entire community. This HIE incorporates:

- *Problems, Allergies, Medications & Immunizations*
- *Laboratory Results*
- *Radiology Results*
- *& very extensive Clinical Notes*

The HIE interfaces data from Hospital and Physician Practice Systems. In addition to this, HIE has will be incorporating data from many Provider Organizations not affiliated with BHS as well as from Home Care Service and Long Term Care Services. This robust clinical repository is made available to Healthcare Providers (both affiliated and not affiliated with BHS) at the point of care within their Practice EHR.

ii. If no, why not?
38T

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

Berkshire Health Systems is working with the medical staff to develop a PHO which will allow the Berkshire community to participate in alternative payment models. To date, BHS has entered into a small number of shared savings agreements.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

Berkshire will not be able to enter into APM's until a PHO is established and running. Barriers to the success of the APM's will focus on population size. Berkshire County has fewer residents than the city of Springfield, MA. The geographical size, lack of transportation and population density will introduce a level of risk in Berkshire County that may not be present in other areas of the Commonwealth. Berkshire County has some of the highest level of residents aged 65 or older in the state. The complexities of managing an older population have the risk of slowing Berkshire's adoption of APM's.

c. Are behavioral health services included in your APM contracts with payers?
No
   i. If no, why not?
   Not applicable at this time.

7. Strategies to Improve Quality Reporting.

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.
38T

Berkshire Health System faces increasingly incongruent data collection and reporting requirements from a wide variety of public and private organizations. These organizations include payers, regulatory agencies, and third party healthcare rating systems. There is an array of unresolved data collection issues, including variations in measures across the various quality reporting systems, resulting in duplications of effort, increased expense, and forgone opportunities. These systematic and policy-driven variances present a magnitude of challenges in the alignment of quality reporting processes. These challenges include, but are not limited to:

- *Broad diversity of outcome measures across quality reporting and performance measurement systems causes uneven monitoring of quality in health care. The collection and reporting requirements that utilize varied taxonomies and data definitions are affecting the quality of data collected, causing difficulty viewing, communicating, and using data. The taxonomy or specification details, including population categories, of the measures are often not given or vaguely stated leaving healthcare systems having to use resources to interpret the measure. The*

variations also create additional costs to validate transmitted data and continually update forms and systems as collection metrics change in uncontrolled and disorganized methods. As result, the required reporting timelines, including payers, regulators, and third party healthcare rating systems, trigger a continuous cycle of duplicated work efforts.

- *Staffing resources often must increase in conjunction with reporting requirements due to the differences in reporting requirements set by the various requestors of performance and quality data. This causes an increase not only in the number of staff required but also the amount of institutional knowledge needed to maintain ever-changing quality reporting standards.*
- *Trend in utilizing electronic reporting data collection methods for quality measures has only increased the burden of the quality reporting process. Resources must now be allocated to monitor and even train direct service employee workflow. If the data is not captured accurately or not positioned in the required fields, it will not be reported.*
- *Sheer number of required and/or recommended quality measures has significantly increased. Often times a common misunderstanding, where there will only be one measure, however that one measure actually represents multiple individual measures that are required to answer the requested measure.*
- *Once required and/or recommended data is reported to payer, regulator or third party healthcare rating systems, it is not resubmitted back to the organization for evaluation in a timely manner. Once received, the quality data which was reported on is obsolete.*
- *Implementation of healthcare information systems is largely uncoordinated across providers in the same organization and between organizations, regionally and nationally.*
- *Third party healthcare rating systems lack alignment with payers and regulators standards, leading to internal and external miscommunication of the quality of healthcare services provided.*

The aforementioned challenges cited above increases the burden of quality reporting process and in theory are rooted in a reactionary methodology. As a result, organizations have less time for improvement of monitoring and implementing efficient operational quality measures.

To combat the issues, Berkshire Health Systems has developed an operational dashboard based on the Institute of Medicine (IOM) principles of Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered (STEEEP). The dashboard is available to all employees through an online portal and includes benchmarking strategies, links to more granular quality data, including definitions and primary measures, for each clinical discipline. The dashboard provides timely quality data evaluation with only two months in arrear in comparison to required reporting feedback received up to two years after date of submission. In addition to the operational dashboard, the Quality Department directly aligns employment positions and day-to-day job responsibilities with direct clinical services. As a result, the employees have streamlined communications with specific clinical disciplines or strategic healthcare objectives. The last strategy implemented and continuously monitored is the automation of the score card information. The automated scorecard extracts data from several systems providing senior leadership and clinical leaders with accurate, timely information to make more informed strategic and operational decisions.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

38T

The urgency to resolve these challenges stem from varying rationales. First and foremost, patients are more active consumers who want to be fully engaged in their care. In addition, regulators and payers are demanding performance-based results on which to base reimbursement and utilization decisions. The following suggested strategies promote alignment of quality reporting processes in attempts to standardize requirements and minimize inefficiencies:

- *Reaching national agreement by a single lead agency to determine the basic, uniform data set to serve as a starting point from which to measure health care quality, a minimum number of required quality data, and an agreed upon time period for evaluation purposes.*
- *Development of common definitions and terminology for quality reporting and performance measurement.*
- *Development of standardized reporting formats, alignment of timelines (frequency and date), for required reporting, and size of sample populations required from payers, regulators, and third party healthcare rating systems.*
- *Development of guidelines for establishing, validating, and approving metrics required from payers, regulators, and third party healthcare rating system to measure and report quality. If measures are required to be revised, the revised metrics must be communicated back to healthcare agencies in a timely manner.*
- *Recommend payers, regulators, and third party healthcare rating systems include quality measures regarding social determinants of health and behavior health. Although there are many geographical areas which these factors do not play a significant role in quality reporting, many regions are drastically impacted by these overlooked data inputs.*
- *Replace annual data analysis and reporting with more current quarterly quality data.*

Encourage healthcare providers to reflect more upon their own target population served instead of evaluating quality measures against dissimilar geographic populations which have varying characteristics.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.
38T

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. For each year 2012 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.
   38T

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.
      38T

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.
      38T

   c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?
      38T

Berkshire Medical Center
Operating Margin by Payor
For Fiscal Year Ending September 30, 2012

Exhibit C: AGO Questions for Written Testimony

2012

Payors	Fiscal Year	Commercial Operating Margin ($)	Government Operating Margin ($)	All Other Operating Margin ($)	Total Operating Margin ($)
AETNA	2012	2,536,850			**2,536,850**
BEACON	2012		-1,884,656		**-1,884,656**
BLUE CROSS/BLUE SHIELD	2012	8,350,209			**8,350,209**
BOSTON MEDICAL HEALTHNET PLAN	2012		3,945,935		**3,945,935**
CAP DISTRICT PHY HEALTH PLAN	2012	834,621			**834,621**
CHAMPUS	2012		-82,361		**-82,361**
CIGNA	2012	2,682,130			**2,682,130**
COMMERCIAL INSURANCE	2012	935,295			**935,295**
COMMONWEALTH CARE HEALTH PLAN	2012			248,461	**248,461**
FALLON	2012	1,242,029			**1,242,029**
FREE CARE	2012			-3,457,166	**-3,457,166**
HARVARD COMMUNITY HEALTH PLAN	2012	758,899			**758,899**
HEALTH NEW ENGLAND	2012	6,234,923			**6,234,923**
HMO BLUE	2012	11,675,389			**11,675,389**
HNE MCO	2012		-238,389		**-238,389**
HNE MEDICARE ADVANTAGE	2012		-214		**-214**
HOSPICE	2012	-186,808			**-186,808**
LEGAL	2012	2,081,988			**2,081,988**
MASS BEHAVIORAL HEALTH PLAN	2012		-2,071,141		**-2,071,141**
MASS MEDICAID	2012		-4,647,202		**-4,647,202**
MEDICARE	2012		-1,048,015		**-1,048,015**
MEDICARE HMO	2012		-322,851		**-322,851**
MEDICARE HMO BLUE CROSS	2012		45,241		**45,241**
MVP	2012	1,213,095			**1,213,095**
NEIGHBORHOOD HEALTH PLAN MCO	2012		63,607		**63,607**
NETWORK HEALTH MCO	2012		246,954		**246,954**
OTHER GOVERNMENT	2012		-644,488		**-644,488**
OTHER HMO	2012	346,339			**346,339**
OUT-OF-STATE BLUE CROSS	2012	69			**69**
OUT-OF-STATE MEDICAID	2012		-277,532		**-277,532**
SELF-PAY	2012			98,770	**98,770**
STATE GRANTS	2012			-33,574	**-33,574**
TUFTS HEALTH PLAN	2012	4,397,369			**4,397,369**
UNICARE	2012	749,558			**749,558**
UNITED HEALTHCARE	2012	5,679,771			**5,679,771**
WORKERS' COMPENSATION	2012		-707,894		**-707,894**
Grand Total	**2012**	**49,531,727**	**-7,623,005**	**-3,143,509**	**38,765,212**

Berkshire Medical Center
Operating Margin by Payor
For Fiscal Year Ending September 30, 2013

Exhibit C: AGO Questions for Written Testimony

2013

Payors	Fiscal Year	Commercial Operating Margin ($)	Government Operating Margin ($)	All Other Operating Margin ($)	Total Operating Margin ($)
AETNA	2013	2,672,577			**2,672,577**
BEACON	2013		-2,306,517		**-2,306,517**
BEACON/GIC	2013		-2,995		**-2,995**
BLUE CROSS/BLUE SHIELD	2013	8,147,356			**8,147,356**
BOSTON MEDICAL HEALTHNET PLAN	2013		1,204,198		**1,204,198**
CAP DISTRICT PHY HEALTH PLAN	2013	945,998			**945,998**
CHAMPUS	2013		-64,526		**-64,526**
CIGNA	2013	2,374,277			**2,374,277**
COMMERCIAL INSURANCE	2013	128,513			**128,513**
COMMONWEALTH CARE HEALTH PLAN	2013			-130,034	**-130,034**
FALLON	2013	1,652,449			**1,652,449**
FREE CARE	2013			-3,312,627	**-3,312,627**
HARVARD COMMUNITY HEALTH PLAN	2013	1,011,969			**1,011,969**
HEALTH NEW ENGLAND	2013	6,452,030			**6,452,030**
HMO BLUE	2013	10,869,682			**10,869,682**
HNE MCO	2013		-128,824		**-128,824**
HNE MEDICARE ADVANTAGE	2013		-42,865		**-42,865**
HOSPICE	2013	42,270			**42,270**
LEGAL	2013	2,791,096			**2,791,096**
MASS BEHAVIORAL HEALTH PLAN	2013		-2,178,815		**-2,178,815**
MASS MEDICAID	2013		-3,323,445		**-3,323,445**
MEDICARE	2013		-12,612,604		**-12,612,604**
MEDICARE HMO	2013		70,134		**70,134**
MEDICARE HMO BLUE CROSS	2013		95,930		**95,930**
MVP	2013	939,865			**939,865**
NEIGHBORHOOD HEALTH PLAN MCO	2013		102,451		**102,451**
NETWORK HEALTH MCO	2013		208,657		**208,657**
NORTH AMERICAN ADMINISTRATORS	2013	285			**285**
OTHER GOVERNMENT	2013		-365,194		**-365,194**
OTHER HMO	2013	243,561			**243,561**
OUT-OF-STATE BLUE CROSS	2013	1,161			**1,161**
OUT-OF-STATE MEDICAID	2013		-398,376		**-398,376**
SELF-PAY	2013			1,721,638	**1,721,638**
STATE GRANTS	2013			-32,992	**-32,992**
TUFTS HEALTH PLAN	2013	4,003,458			**4,003,458**
UNICARE	2013	808,967			**808,967**
UNITED HEALTHCARE	2013	5,220,004			**5,220,004**
WORKERS' COMPENSATION	2013		-702,467		**-702,467**
Grand Total	**2013**	**48,305,518**	**-20,445,258**	**-1,754,016**	**26,106,244**

Berkshire Medical Center
Operating Margin by Payor
For Fiscal Year Ending September 30, 2014

Exhibit C: AGO Questions for Written Testimony

2014

Payors	Fiscal Year	Commercial Operating Margin ($)	Government Operating Margin ($)	All Other Operating Margin ($)	Total Operating Margin ($)
AETNA	2014	3,281,312			**3,281,312**
BEACON	2014		-1,735,762		**-1,735,762**
BEACON/GIC	2014		76,392		**76,392**
BLUE CROSS/BLUE SHIELD	2014	9,218,291			**9,218,291**
BOSTON MEDICAL HEALTHNET PLAN	2014		-1,839,522		**-1,839,522**
CAP DISTRICT PHY HEALTH PLAN	2014	1,111,822			**1,111,822**
CELTICARE MCO	2014		26,497		**26,497**
CENPATICO	2014		-138,290		**-138,290**
CHAMPUS	2014		-39,009		**-39,009**
CIGNA	2014	3,092,287			**3,092,287**
COMMERCIAL INSURANCE	2014	122,245			**122,245**
COMMONWEALTH CARE HEALTH PLAN	2014			205,465	**205,465**
FALLON	2014	2,660,318			**2,660,318**
FREE CARE	2014			-1,371,591	**-1,371,591**
HARVARD COMMUNITY HEALTH PLAN	2014	1,244,977			**1,244,977**
HEALTH NEW ENGLAND	2014	7,114,486			**7,114,486**
HMO BLUE	2014	14,365,771			**14,365,771**
HNE MCO	2014		-397,029		**-397,029**
HNE MEDICARE ADVANTAGE	2014		38,462		**38,462**
HOSPICE	2014	-121,682			**-121,682**
LEGAL	2014	1,987,445			**1,987,445**
MASS BEHAVIORAL HEALTH PLAN	2014		-2,007,221		**-2,007,221**
MASS MEDICAID	2014		-4,670,954		**-4,670,954**
MEDICARE	2014		-17,652,098		**-17,652,098**
MEDICARE HMO	2014		-735,509		**-735,509**
MEDICARE HMO BLUE CROSS	2014		-14,116		**-14,116**
MVP	2014	1,355,344			**1,355,344**
NEIGHBORHOOD HEALTH PLAN MCO	2014		570,578		**570,578**
NETWORK HEALTH MCO	2014		298,879		**298,879**
NORTH AMERICAN ADMINISTRATORS	2014	293			**293**
OTHER GOVERNMENT	2014		-368,436		**-368,436**
OTHER HMO	2014	216,244			**216,244**
OUT-OF-STATE BLUE CROSS	2014	3,417			**3,417**
OUT-OF-STATE MEDICAID	2014		-901,834		**-901,834**
QHP BMCHNP	2014	-340			**-340**
QHP CELTICARE	2014	-1,016			**-1,016**
QHP NETWORK	2014	-3,437			**-3,437**
SELF-PAY	2014			664,816	**664,816**
STATE GRANTS	2014			-14,880	**-14,880**
TUFTS HEALTH PLAN	2014	5,022,696			**5,022,696**
UNICARE	2014	773,800			**773,800**
UNITED HEALTHCARE	2014	5,103,234			**5,103,234**
WORKERS' COMPENSATION	2014		-1,215,997		**-1,215,997**
Grand Total	**2014**	**56,547,506**	**-30,704,970**	**-516,189**	**25,326,347**

Berkshire Medical Center
Operating Margin by Payor
For Fiscal Year Ending September 30, 2015

Exhibit C: AGO Questions for Written Testimony

2015

Payors	Fiscal Year	Commercial Operating Margin ($)	Government Operating Margin ($)	All Other Operating Margin ($)	Total Operating Margin ($)
AETNA	2015	3,055,216			**3,055,216**
BEACON	2015		-1,574,663		**-1,574,663**
BEACON/GIC	2015		-104,555		**-104,555**
BLUE CROSS/BLUE SHIELD	2015	11,620,683			**11,620,683**
BOSTON MEDICAL HEALTHNET PLAN	2015		-2,566,539		**-2,566,539**
CAP DISTRICT PHY HEALTH PLAN	2015	1,286,723			**1,286,723**
CELTICARE MCO	2015		-230,587		**-230,587**
CENPATICO	2015		-102,709		**-102,709**
CHAMPUS	2015		18,698		**18,698**
CIGNA	2015	3,996,885			**3,996,885**
COMMERCIAL INSURANCE	2015	-343,928			**-343,928**
COMMONWEALTH CARE HEALTH PLAN	2015			145,598	**145,598**
FALLON	2015	1,665,700			**1,665,700**
FREE CARE	2015			-1,761,874	**-1,761,874**
HARVARD COMMUNITY HEALTH PLAN	2015	3,066,275			**3,066,275**
HEALTH NEW ENGLAND	2015	8,402,222			**8,402,222**
HMO BLUE	2015	16,981,961			**16,981,961**
HNE MCO	2015		-1,365,274		**-1,365,274**
HNE MEDICARE ADVANTAGE	2015		-24,040		**-24,040**
HOSPICE	2015	-155,213			**-155,213**
LEGAL	2015	2,372,146			**2,372,146**
MASS BEHAVIORAL HEALTH PLAN	2015		-2,508,000		**-2,508,000**
MASS MEDICAID	2015		-6,744,160		**-6,744,160**
MEDICARE	2015		-19,225,014		**-19,225,014**
MEDICARE HMO	2015		-518,836		**-518,836**
MEDICARE HMO BLUE CROSS	2015		15,318		**15,318**
MVP	2015	1,005,282			**1,005,282**
NEIGHBORHOOD HEALTH PLAN MCO	2015		1,314,644		**1,314,644**
NETWORK HEALTH MCO	2015		883,975		**883,975**
OTHER GOVERNMENT	2015		-315,119		**-315,119**
OTHER HMO	2015	288,028			**288,028**
OUT-OF-STATE BLUE CROSS	2015	-146			**-146**
OUT-OF-STATE MEDICAID	2015		-731,705		**-731,705**
QHP BEACON	2015	-7,582			**-7,582**
QHP BMCHNP	2015	-225			**-225**
QHP CELTICARE	2015	147,159			**147,159**
QHP HNE	2015	445,183			**445,183**
QHP NETWORK	2015	549,938			**549,938**
SELF-PAY	2015			1,932,833	**1,932,833**
STATE GRANTS	2015			-365,929	**-365,929**
TUFTS HEALTH PLAN	2015	5,199,054			**5,199,054**
UNICARE	2015	346,235			**346,235**
UNITED HEALTHCARE	2015	6,522,565			**6,522,565**
WORKERS' COMPENSATION	2015		-999,641		**-999,641**
Grand Total	**2015**	**66,444,159**	**-34,778,208**	**-49,372**	**31,616,579**