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)

Increased competition for and cost of staff; the cost of providing health care to staff increasing well beyond 5%; pharmaceutical cost per prescription increasing 10% on average.

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)

Care management/oversight payments with goal towards reduction of high cost emergency department and/or inpatient visits and to eliminate duplication of services.

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)

Currently Implementing

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

Does NOT Plan to Implement in the Next 12 Months

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

Currently Implementing

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

Currently Implementing

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

Currently Implementing

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

Currently Implementing

vii. Other: Insert Text Here

Click Here

viii. Other: Insert Text Here

Click Here

ix. Other: Insert Text Here

Click Here

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)

EBNHC is making substantial investments in expanding its integration of behavioral health and primary care; it's negotiating a merger with its primary Community Mental Health provider; and is partnering with Cherokee Health to expand behavioral health integration models both internally and to its regional peers.

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)

Insufficient reimbursement for behavioral health services; competition for behavioral health providers.

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)

Education & Training Institute – HiSet, ESOL; Kid's Nutrition – community garden, farmers market, Red Cross food distribution.

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)

Finances don't allow us to pay for non-reimbursable services such as nutrition and adult education.

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.

We have a referral arrangement with our partner DSH hospital, Boston Medical Center.

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.
Click here to enter text.

ii. If no, why not?
Information not easily available.

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.
Click here to enter text.

ii. If no, why not?
Information not easily available.

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?
Yes

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.
View only, with patient authorization.

ii. If no, why not?
Click here to enter text.

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)
ACO pilot program with MassHealth; global budgets for PACE and SCO; risk based contracts.

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)
Inconsistency of financial and clinical quality measures across payers; complexity of each arrangement; payment rates.

c. Are behavioral health services included in your APM contracts with payers?
Yes

i. If no, why not?
Click here to enter text.

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.
Decreased focus on key measures; higher costs to align and report measures (IT, clinical oversight)

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).
We have metrics from essentially all of our funding sources. This poses a significant burden that does not advance quality care. We think using Health People 2020 as a standard could improve alignment of metrics and ultimately we believe the focus should be on health outcomes for patients versus process measures.

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.
N/A

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. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider 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. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.
   Pending 9/8/2016

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.
      Inquiries related to price estimates are processed by our Patient Accounts department. Projected services are used as a basis, with our fee schedule for each. Patients are also made aware of financial assistance options.

   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.
      We monitor patient complaints/feedback for issues related to incorrect pricing information. To date, no complaints have been submitted due to untimely or incorrect pricing estimates.

   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?
      Depending upon the services to be provided, the turnaround time for a response can be quick. Delays may occur if the patient is seeking an estimate for multiple or more complex services.

2012

(numbers in millions)	**P4P Contracts**				**Risk Contracts**						**FFS Arrangements**		**Other Revenue**		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	2.20												0.03		
Tufts Health Plan	1.01												0.01		
Harvard Pilgrim Health Care											0.76				
Fallon Community Health Plan															
CIGNA											0.31				
United Healthcare											0.30				
Aetna											0.38				
Other Commercial											4.20				
Total Commercial	**3.21**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**5.95**	**0.00**	**0.04**	**0.00**	**0.00**
Network Health											0.10				
Neighborhood Health Plan	2.89												0.15		
BMC HealthNet, Inc.					4.61		1.45						0.02		
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid	**2.89**	**0.00**	**0.00**	**0.00**	**4.61**	**0.00**	**1.45**	**0.00**	**0.00**	**0.00**	**0.10**	**0.00**	**0.17**	**0.00**	**0.00**
MassHealth	**10.58**												**0.15**		
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Medicare											**3.06**				
Other	**12.73**						**27.11**				**2.63**		**0.32**		
GRAND TOTAL	**29.41**	**0.00**	**0.00**	**0.00**	**4.61**	**0.00**	**28.56**	**0.00**	**0.00**	**0.00**	**11.75**	**0.00**	**0.68**	**0.00**	**0.00**

2013

(numbers in millions)	**P4P Contracts**				**Risk Contracts**						**FFS Arrangements**		**Other Revenue**		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					2.46								0.02		
Tufts Health Plan					1.29		0.05						0.01		
Harvard Pilgrim Health Care					0.93										
Fallon Community Health Plan															
CIGNA											0.39				
United Healthcare											0.36				
Aetna											0.36				
Other Commercial											4.79		0.00		
Total Commercial	**0.00**	**0.00**	**0.00**	**0.00**	**4.69**	**0.00**	**0.05**	**0.00**	**0.00**	**0.00**	**5.90**	**0.00**	**0.03**	**0.00**	**0.00**
Network Health											0.34				
Neighborhood Health Plan	2.63												0.15		
BMC HealthNet, Inc.					5.26		0.15						0.07		
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid	**2.63**	**0.00**	**0.00**	**0.00**	**5.26**	**0.00**	**0.15**	**0.00**	**0.00**	**0.00**	**0.34**	**0.00**	**0.23**	**0.00**	**0.00**
MassHealth	**11.63**												**0.20**		
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Medicare											**3.33**				
Other	**15.23**						**31.60**				**4.57**		**0.26**		
GRAND TOTAL	**29.49**	**0.00**	**0.00**	**0.00**	**9.94**	**0.00**	**31.80**	**0.00**	**0.00**	**0.00**	**14.15**	**0.00**	**0.71**	**0.00**	**0.00**

2014

(numbers in millions)	**P4P Contracts**				**Risk Contracts**						**FFS Arrangements**		**Other Revenue**		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					2.64		-0.05						0.00		
Tufts Health Plan					1.23		0.00						0.00		
Harvard Pilgrim Health Care					0.96		0.00								
Fallon Community Health Plan															
CIGNA											0.39				
United Healthcare											0.37				
Aetna											0.44				
Other Commercial											6.95		0.00		
Total Commercial	**0.00**	**0.00**	**0.00**	**0.00**	**4.83**	**0.00**	**-0.05**	**0.00**	**0.00**	**0.00**	**8.15**	**0.00**	**0.00**	**0.00**	**0.00**
Network Health											1.25				
Neighborhood Health Plan											3.80		0.07		
BMC HealthNet, Inc.					6.68		0.16						0.03		
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid	**0.00**	**0.00**	**0.00**	**0.00**	**6.68**	**0.00**	**0.16**	**0.00**	**0.00**	**0.00**	**5.05**	**0.00**	**0.11**	**0.00**	**0.00**
MassHealth					**12.81**								**1.62**		
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Medicare											**3.77**				
Other							**35.74**				**20.38**		**0.14**		
GRAND TOTAL	**0.00**	**0.00**	**0.00**	**0.00**	**24.32**	**0.00**	**35.85**	**0.00**	**0.00**	**0.00**	**37.35**	**0.00**	**1.87**	**0.00**	**0.00**

2015

(numbers in millions)	**P4P Contracts**				**Risk Contracts**						**FFS Arrangements**		**Other Revenue**		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					2.50		-0.03						0.00		
Tufts Health Plan					1.18		0.03						0.00		
Harvard Pilgrim Health Care					1.00		0.02								
Fallon Community Health Plan															
CIGNA											0.35				
United Healthcare											0.39				
Aetna											0.38				
Other Commercial											7.01				
Total Commercial	**0.00**	**0.00**	**0.00**	**0.00**	**4.68**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**8.14**	**0.00**	**0.00**	**0.00**	**0.00**
Network Health											1.51				
Neighborhood Health Plan											4.28		0.00		
BMC HealthNet, Inc.											7.29				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**13.07**	**0.00**	**0.00**	**0.00**	**0.00**
MassHealth					**14.17**								**2.16**		
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Medicare											**4.79**				
Other							**38.02**				**21.18**		**0.01**		
GRAND TOTAL	**0.00**	**0.00**	**0.00**	**0.00**	**18.85**	**0.00**	**38.03**	**0.00**	**0.00**	**0.00**	**47.17**	**0.00**	**2.17**	**0.00**	**0.00**