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)

The top area of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts is the widening gap in unwarranted price variation among hospitals and physician groups.

Many governmental and non-governmental reports have consistently found that there is significant price variation among health care providers, both hospitals and physician groups. This unwarranted price variation is primarily due to market clout and size and the impact on the cost of healthcare delivery in Massachusetts and is significant.

Because of this unwarranted price variation, providers at the upper percentiles of the price scale continue to invest in marketing, growth and expansion, human resources, training, new technology, physical plant, information services, etc., while providers at the bottom struggle to maintain their staff and infrastructure. Many of the providers at the bottom of the price scale are smaller community hospitals and their affiliated physician groups; the very providers who are the most cost effective and can provide the vast majority of non-tertiary services. As these smaller providers fail, or are forced to affiliate with larger systems, the cost of providing these basic services is going to continue to accelerate.

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)

The top changes we would propose are:

- Establish regulation that eliminates or severely reduces unwarranted price variation, by establishing, at minimum, a floor for reimbursement below which payers are not allowed to fall for the same type and same quality of services, both for hospitals and physician groups.
- Concurrently, require payers to justify the need for accumulated reserves and use appropriate amounts from these reserves to accomplish compliance with the floor without raising costs to employers/insured until such time as they can effectively deal with the upper echelon of the price scale.
- Establish regulation that obligates payers to have the same level of transparency and disclosure as providers, more specifically, transparency on pricing and tiering.

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

Currently Implementing

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

Does NOT Plan to Implement in the Next 12 Months

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

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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)

1) Patient Navigation and follow-up services for all patients admitted to HMC's Emergency Department with a previous diagnosis related to Behavioral Health.

- Our EHR identifies and flags in real-time all patients (18 year and older) given a BH diagnosis by HMC going back 5years.
- Licensed and masters-level clinicians track patient arrivals and attempt to intervene/assess (between 8am-9:30pm 7days a week) each patient while they are still in the ED. This initial assessment attempts to establish a rapport with patients to reduce anxiety as well as to determine what further resources are needed. The scope of the intervention is purposely broad to address circumstances immediately impacting the current admission. The general goal is to reduce recidivism to the ED for this population. Linkages and referrals are made, as appropriate, to community resources to address BH concerns and other social determinates to health.
- Follow-up phone calls are made, not only to those able/willing to be seen face to face in the ED, to all ED admissions with a history of BH diagnosis within 48hours of discharge.

- *Research suggests that follow up call to hospital visit can reduce by 23.1% 30 day readmission rate. Harrison, Hara, POPE, Young and Rula. Population Health Management Vol 14 issue 1. Pg. 27-32 (Feb 2011).*

- As part of this initiative, a specialty clinic for high utilizers (HU) has been created to address the need of those BH patients who visit the ED more than 10 times in rolling calendar year or that the team feels would significantly benefit from such intensive services.
- High utilizer clinic called Behavioral Health Comprehensive Care Clinic (BHCCC) is comprised of the following disciplines: MD, APRN, Social Worker or Patient Navigator, Community Mental Health Workers and Medical/Administrative Assistant.
- BHCCC services are fully integrated with our ED Patient Navigation and share the goal of reducing recidivism. BHCCC provides a comprehensive array of medical, psychiatric, psychotherapeutic and case-management services for a time-limited basis. The team works collaboratively with existing outpatient providers in a consultative capacity being careful not to replace or complicate the care being currently delivered.
- The team will also link services to appropriate outpatient providers. The scope is again broad so as to meet the comprehensive needs of the patient population. Discharge occurs once the team determines it has provided adequate transitional/stabilization services through a time of acute need and/or has successfully linked the patient to an appropriate level of on-going care.

2) SBIRT-type model (Screening, Brief Intervention, and Referral to Treatment) offering screening for both Depression and Substance Use at all points of entry to the hospital. All eligible patients admitted to ED or to an inpatient floor are screened using two standard tools. Non-eligible patients: Children under 16; Patients not able to be screened as a result of mental/physical status; Patient who already have an identified primary or secondary BH diagnosis; and, women in labor.

Screening Tools:

- The Patient Health Questionnaire-2 (PHQ2). The tool inquires about the frequency of depressed mood and anhedonia over the past two weeks.
- CAGE Questionnaire- 4 questions self –test proven accurate in identifying usage patterns that may reflect problems with alcohol.
- PHQ9- Follow up questionnaire to a positive PHQ2 screen. Used to provisionally diagnosis depression and grade severity of symptoms in general medical and mental health settings. Higher PHQ9 scores are associated with decreased functional status and increased symptoms-related difficulties, sick days and healthcare utilization.
- Substance Abuse and Mental Illness Screener (SAMISS) - Follow up questionnaire to positive CAGE screen. Focus for HMC purposes are on the SA elements of the tool- 7 questions with assigned response values. Positive screens indicated for sums of response greater than 5 (question 1-3), greater the 3 (question 4 or 5), greater than 1 (question 6 or 7).

Workflow:

- Negative PHQ2 requires no further assessment for depression. However, at any time, staff who feel that a patient needs further mental health services have 3 options: a) place an order for Social Work & Assessment Team (SWAT) assessment b) place order for a psychiatric assessment c) place order for level of care evaluation to determine if psychiatric hospitalization is warranted.
- Positive PHQ2 results in an automatic consult order to SWAT. The team of master-level clinicians provides follow-up assessments for each initial screen, i.e., PHQ9 and SAMISS.
- Negative screens result in no further actions
- Positive screens to PHQ9 and/or SAMISS are met with referral to appropriate level of care or community resource.

3) Piloting SBIRT model in Primary Care locations affiliated with HMC under Valley Health Systems. Access to Psychopharmacological consultation to all PCPs affiliated with Western Mass Physician Associates (WMPA).

- Behavioral Health Specialist co-located at the Chicopee Medical Center. Received referral and warm-hand offs from PCP.
- PCP administers PHQ2 and PHQ9 for new patients as well as at the annual patient physical.
- Alcohol Use Disorder Identification Test (AUDIT) administered to patient at annual physical as well as to all new patients.—*10 item screening tool developed by the World Health Organization to assess alcohol consumption, drinking behavior, and alcohol-related problems.*
- When positive screen is determined for either depression or substance use, the BH Specialist connects with the patient. A brief intervention occurs and referrals are made for ongoing Behavioral Health services.
    - *Screening and brief intervention (SBI) is an evidence-based, cost-effective practice to address risky alcohol use, typically using a short validated screening tool followed by a brief counseling session if a patient screens positive. Research shows SBI conducted in primary care outpatient settings significantly reduces alcohol use (Bertholet, Daeppen, Wietlisbach, Fleming, & Burnand, 2005b; Bien, Miller, & Tonigan, 1993; Kaner et al., 2009; Saitz, 2010a), hospitalizations (Fleming, Barry, Manwell, Johnson, & London, 1997b) and mortality (Cuijpers, Riper, & Lemmers, 2004). Alcohol SBI saves an estimated $217.95 per person screened (Barbosa, Cowell, Bray, & Aldridge, 2015)….."If all adults in Massachusetts were screened, it would save an estimated $1.17 billion." – above taken from:* ***The Massachusetts Health Policy Forum ISSUE BRIEF "Reducing Risky Alcohol Use: What Health Care Systems Can Do" No.46, 2016.***

- A Psychiatric APRN is available Monday-Friday during regular office hours for PCPs who may want psychopharmacological consultation for their patients managing behavioral health related symptoms.
- Current planning provides for River Valley Counseling Center, an affiliate under Valley Health Systems, to expand the embedding of Behavioral Health Specialists/SBIRT Pilot to the remaining PCP location under WMPA.

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)

1) Cost related to the provision of integrated service delivery are currently not reimbursed or inadequately reimbursed. Current programming promoting integrated care is supported by grant funds coupled with significant in-kind costs from HMC. Sustainability of each of the three initiatives above will be at risk once grant funding terminates.

- Payment /reimbursement practices for BH and Medical services are not integrated nor do they treat patient in a holistic manner. Example of barriers: Limitation on payment for same day billing for some physical health and mental health services; Lack of reimbursement for collaborative care and case-management related to BH services; Lack of reimbursement incentives for screenings (SBIRT) and providing preventative services; Barriers / denial of payment for patients who may be seen by multiple BH treatment providers, etc..

2) Communication between and amongst stakeholders can be problematic. The two cultures, that of Behavioral Health and the broader health care system, remain compartmentalized. The importance of

effective linkages and hand-offs cannot be overstated for this population who feel isolated, fear being stigmatized or, in general, are contemplating whether they need/want help.

- Barriers to communication exist at multiple levels. They include: Insufficient Electronic Health Record (EHR) compatibility between providers; Lack of EHRs for some BH provider's especially smaller or private clinics; Confidentiality restriction/limitation impacting BH population that differs from general medical population i.e. 42 CFR part 2.

3) Lack of resources for Behavioral Health population. Wait lists exist for many behavioral health services. Examples include: While Massachusetts fairs well compared to other states and nationally, there remains a shortage of psychiatry. Substance abuse services are in great demand amidst our current opioid crisis resulting in Medication-Assisted Treatment needs exceeding capacity. Gaps exist in and between levels of care- for example: long-term care of chronically mentally ill, acute-care psychiatric beds especially for specialty populations i.e. children, developmentally impaired, etc.

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)

1) As noted under question 3, HMC's Patient Navigation for the behavioral health population admitted to the ED, whether in-person and during follow-up phone calls, attempts to identify and address a broad array of conditions that impact patients. These inventions include addressing those social determinates of health as housing, food insecurity, social exclusion, unemployment, etc.

2) The BHCCC also provides a comprehensive array of services for high utilizers of the ED that seek to identify and remedy complex socioeconomic and physical conditions that contribute to recidivism. At the forefront of this strategy are our Community Mental Health Workers who, through outreach efforts, come to understand the conditions impacting the patient population and proceed to make the appropriate linkages/referrals.

3) HMC has developed a High Utilization Collaborative comprised of a multi-discipline team from the following departments: Inpatient Nurse Management, Discharge and Transition, Behavioral Health and Administration. This group meets biweekly to review "high risk" cases to identify common trends with the goal of reducing readmissions and eliminating barriers to effective patient care.

The team then reports its findings to a larger community-based stakeholder group. This group comprised of medical, social, and/behavioral health service providers meets monthly. This group's goal is to review the overall care coordination and management process for the HU population and opportunities for further development. The collaborative team works to identify and address treatment and delivery system gaps within the community. As expected, with a focus on the HU population, many of these "systemic issues" are relevant to SDH challenges.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients

1) Patients can be reluctant to disclose and/or unable to recognize SDH factors. Social Workers or other medical staff asking questions related to socioeconomic factors can generate unease and suspicion in some patients. A rapport needs to be established which often takes multiple attempts or even multiple re-admissions to the acute care setting. Addressing the patient's most pressing self-identified issue(s) is paramount to getting a "foot in the door" that can lead to a more comprehensive SDH-sensitive care plan.
2) The complex and interrelated nature of SDH makes them difficult to ameliorate. Childhood trauma, poverty and inequality have no simple fix. Motivation and stages of change, at the patient level, have an impact on where treatment can start. For example substance use can compromise housing and work security… however, depending on individual circumstances, a patient may be unable to address their sobriety.

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.

HMC has recently implemented electronic referral tiers to prevent leakage to high cost academic medical centers and their affiliated partners. The primary tier is setup to prevent leakage from our community hospital system and to coordinate care across the continuum with the goal of providing the highest quality care, at the right cost. The second tier is setup for those services that are not provided by the hospital or its affiliates. The specialty or ancillary services within this tier are with community providers who are aligned with HMC. The third tier is for services that cannot be obtained by providers in the first or second tier. The system is designed to prevent referrals out of the network and forces documentation for those referrals that are placed for healthcare providers outside of the primary tier.

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?

The electronic record does not currently have the capability to incorporate cost and/or quality information on providers affiliated with the organization that is available at the point of referral. However, HMC could manually change the electronic tiers based on provider quality and/or cost information as it becomes available to ensure referrals are driven to lower cost, higher quality affiliated providers.

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?

The electronic record does not currently have the capability to incorporate cost and/or quality information on providers not affiliated with the organization that is available at the point of referral. However, HMC could manually change the electronic tiers based on provider quality and/or cost information as it becomes available to ensure referrals are driven to lower cost, higher quality non-affiliated providers.

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.

HMC provides two options for organizations which are not corporately affiliated or jointly contracting with our organization to retrieve electronic health records.

1. A health information exchange, called HealthConnect, which allows participating organizations read only access to medical summaries and outpatient progress notes. Organizations must agree to the usage terms for the HealthConnect and are limited to see data only on patients that have opted-in to the health exchange.

2. HMC offers a service called P2P which allows any provider to sign up to securely send and receive patient records directly from their EMR or a secure website. The process creates a direct electronic patient information request and requires a manual response from the receiving provider. Data is read-only and limited to criteria selected by the sender. P2P interfaces with the Mass HIway.contracting with our organization to retrieve electronic health records.

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)

Holyoke Medical Center (HMC) currently participates in an up-side risk based contract covering Medicare, Medicaid and Commercial products with one of its largest contracted commercial insurance companies, where it has a sufficient number of patient lives to mitigate the actuarial risk. Through HMC's Physician Hospital Organization (PHO), HMC has joined with another providers to participate in its Medicare Shared Savings Program. Also, through the PHO, all of HMC primary care providers, and a majority of the independent physicians, have obtained Patient Center Medical Home designation. HMC's strategies for increasing its adoption of Alternative Payment methodologies (APMs) include the participation in a Medicare Bundled Payment Program with its contracted Hospitalist group, the creation of a Medicaid ACO under the Massachusetts 1115 Waiver and the expansion of HMC's participation in commercial APMs where partners can be identified to accumulate a sufficient number of patient lives.

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)

The top barrier to increased adoption of APMs is the relative size of the remaining patient population and the availability of partnerships with other providers that make sense culturally, financially and geographically. Of HMC's payer mix, 76% is governmental of which a majority will be, or are already included in the APMs noted in 6a above. In order for HMC to continue to expand its APMs, appropriate partnerships will need to be formed. For any APM to be successful, participating partners need to have the same or similar goals, objectives and within the same geographic area if patients are going to be truly managed.

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.

Reporting quality related data is critical to monitoring performance of healthcare delivery in the state. Although essential, reporting of data and lack of alignment significantly increases the reporting burden on hospitals.

Holyoke Medical center is one of the DSTI hospitals and significantly relies on DSTI funds to stay afloat and to provide the best care to the communities we serve. The DSTI program has significantly

different requirements for submission and monitoring of data for the MassHealth population. Increased/ non-aligned reporting requirements and lack of qualified candidates/ workforce in the region to appropriately abstract and submit data increases financial burdens on the hospital. In order to fulfil our obligations of data submission, we use a combination of in-house resources and a contracted vendor service. We also use a significant number of Information Technology resources and try leveraging our EMR to monitor our performance on regular basis.

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).

In order to decrease the reporting burden, each reporting requirement should be carefully reviewed and aligned with other reporting programs (e.g. CMS). For example: Recently, readmission measures for DSTI hospitals were developed. The State contracted with an external vendor to analyze data for each participating hospital. The methodology for data analysis was similar, but not same as the one used/adopted by CMS. The use of identical methodology (same as CMS) would help to leverage the hospital and state resources in a more productive way. Each hospital will not have to spend resources to develop internal capabilities to develop DSTI specific readmission reports.

The State should move away from measures requiring manual abstraction and adopt outcome measures that can be derived from administrative data similar to Patient Safety Indicators (PSI) developed by Agency for Healthcare Research and Quality (AHRQ). This will help the state to collect data and analyze it without adding excessive data reporting burden on organizations.

To reduce reporting burden on each individual hospital, the State should also consider developing an analytical support group at the State level that can provide data analysis to hospitals in a consistent and timely manner. This will centralize the data analysis function and will help hospitals to reduce the cost of developing in-house analytical expertise and infrastructure. Currently, the State provides some reporting to the hospitals on regular basis. This information, although helpful, is too old to take immediate steps towards corrective actions and improvement efforts.

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.

Click here to enter text.

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.

Operating Margin got each of the three categories:

	FY2012	FY 2013	FY 2014	FY 2015	FY 2016 Estimated
Commercial					
Inpatient	-28.10%	-32.65%	-28.82%	-24.58%	-15.41%
Outpatient	10.96%	12.21%	12.93%	7.12%	10.85%
Government					
Inpatient	-13.22%	-13.41%	-18.65%	-21.76%	-22.15%
Outpatient	-10.52%	-3.08%	2.77%	2.34%	-1.42%
All other					
Inpatient	-348.60%	-330.35%	-344.93%	-211.12%	-214.97%
Outpatient	-100.42%	-67.94%	-46.41%	-53.87%	-55.92%

Percentage of total business represented by each category:

	FY2012	FY 2013	FY 2014	FY 2015	FY 2016 Projected
Commercial	25.23%	24.21%	22.89%	22.18%	22.99%
Government	73.17%	74.32%	75.80%	76.70%	76.02%
All other	1.60%	1.47%	1.31%	1.12%	0.99%

Commercial includes primarily, Cigna, Connecticare, Fallon, Health New England, Harvard Pilgrim, Tufts, United Healthcare, Blue Cross, Aetna, Auto Accident and Industrial accident.

Government includes primarily Medicare, Medicaid, Champus, GIC, Medicare MCOs (Blue Cross, Commonwealth Care Alliance, Fallon, Health New England, Navicare, Tufts, United Health Care), Medicaid MCOs (Boston Medical Center Healthnet, Neighborhood Health Plan, Network health, Health New England) and Veterans.

All other includes primarily Patient Pay.

Holyoke Medical Center's commercial payer mix is centered on two major payers; Blue Cross and Blue Shield of Massachusetts (BCBS) and Health New England (HNE). Of these two plans, BCBS represents the plan with the largest HMO and PPO population. The PPO plan reimbursement is at a higher rate than that of the HMO plan as PPO plans are

generally less managed and patients are allowed more freedom to select providers and obtain covered services without referrals. HMC does not have any capitated contracts. The following table shows the difference in margin from HMO and PPO business.

	FY2012	FY 2013	FY 2014	FY 2015	FY 2016 Estimated
HMO	5.57%	12.01%	6.84%	9.29%	14.23%
PPO	8.35%	8.39%	6.61%	6.16%	0.55%

Holyoke Medical Center is a subsidiary of Valley Health Systems, Inc. (VHS). VHS also includes Western Mass Physician Associates, Inc. (WMPA), a physician practice company that provides primary care, pediatrics, midwifery and OB/GYN services. 70.4% of WMPA's revenue is from governmental payers primarily Medicare. River Valley Counseling Center, Inc. (RVCC) is an outpatient behavioral health and school based clinic that receives 81% of its revenue from governmental payers, primarily Medicaid. The Holyoke Visiting Nurse Service (HVNA), a home health agency, receives 82% of its revenue from government payers, primarily Medicare. As these organizations are essential components of HMC's integrated delivery system and are supported by HMC and/or VHS, HMC is providing the following operating margin information to provide a full picture of the financial environment.

	FY2012	FY 2013	FY 2014	FY 2015	FY 2016
WMPA	-44.69%	-37.09%	-25.27%	-33.82%	-29.76%
RVCC	3.86%	-2.44%	-12.40	-15.29%	-4.39%
HVNA	-.05%	-4.66%	-1.90%	4.37%	7.00%

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.

    Holyoke Medical Center established a Patient Financial Obligation inquiry phone line where patients are directed for information on pricing, reimbursement and their financial responsibility. Since Chapter 224, we have centralized the process and keep a record of the inquiries. Patients receive a response within 2 business days.

    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.
    There is no formal monitoring system in place as of yet.

    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?
    No barriers as of yet.