September 30, 2013

Mr. David Seltz
Executive Director
The Commonwealth of Massachusetts Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz:

On behalf of Arbour Health System, attached is the requested written testimony in response to questions of the Health Policy Commission (HPC). Arbour Health System is the largest private behavioral health system in Massachusetts and is comprised of the following organizations representing a continuum of inpatient, acute residential, partial hospitalization, outpatient and community-based psychiatric programs for children, adolescents, and adults:
Arbour Hospital, Boston, MA
Arbour-HRI Hospital, Brookline, MA
Arbour-Fuller Hospital, South Attleboro, MA
Lowell Treatment Center, Lowell, MA
The Quincy Center, Quincy, MA
Pembroke Hospital, Pembroke, MA
Westwood Lodge, Westwood, MA
Arbour Counseling Services (including 13 outpatient locations in MA) and Arbour SeniorCare

It is my understanding that this information will be used to assist the HPC in preparing the annual report on statewide spending trends, including underlying factors contributing to growth and strategies to increase the efficiency of the Commonwealth's health care system.

We are submitting this testimony electronically in pdf and Word format to HPC-Testimony@state.ma.us as requested. Should you have any questions regarding this submission, please contact Judith Merel, Regional Director, Business Development, Arbour Health System at 617-390-1224 or at judy.merel@uhsinc.com. As AHS CEO, I am legally authorized and empowered to represent the organizations under its umbrella for the purpose of this testimony, and the testimony has been signed under the pains and penalties of perjury.

Sincerely,

Gary Gilberti
Chief Executive Officer/Arbour Health System

Questions

1. **Chapter 224 of the Acts of 2012 (c224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY 2012-2013 and CY 2013-4 is 3.6%.**

   a. **What are the actions your organization has undertaken to reduce the total cost of care for your patients?**

   Arbour Health System ("AHS") has historically been a highly efficient provider of behavioral health services as indicated by 403 cost reports. AHS organizations have strong administrative oversight with focus on increased efficiency, however, there continue to be opportunities for cost reduction through improved coordination of care, program/network expansion for development of vertically integrated services to support patient access care at the most appropriate level at the most appropriate time, and improved use of health information technology/communication, adoption of evidenced-based practices and integration of medical and behavioral health care.

   The organization has, and will continue to effectively manage the cost of care by addressing the below-listed items (in no order of priority). Additionally, there are other actions that have been taken or planned for consideration that may not be included below.

   Adhering to formularies for medications given that pharmacy expense is a significant driver of inpatient behavioral health cost.
   Management of workers compensation expense through crisis prevention (CPI) education and training.
   Developing alternative services such as acute residential, partial hospitalization and community-based programs to allow patients to be care for in the right setting at the appropriate time.
   Providing centralized services such as Intake, Business Office, Human Resources, etc. which offer economies of scale.
   Leveraging system purchasing power for contracts (lab, radiology, etc.).
   Length of stay management and discharge planning to prevent readmissions.
   Continued implementation of electronic health records/information at sites to improve communication and coordination of care with behavioral health and primary care providers.
   Assessing health conditions, co-morbid or at high risk, amongst behavioral health child and adult populations and assuring care coordination with primary care providers.

   b. **What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?**

   There are opportunities to improve the quality and efficiency of care at AHS facilities. Some of these are noted below, however the list is not all inclusive but represents key

issues across AHS facilities. After each point, the current factors that limit our ability to address these opportunities are noted.

1. Improve inpatient reimbursement from key payors including MBHP. Enhanced reimbursement would allow additional resources to address care management, care integration, coordination of care and other services not previously recognized. Barriers including budget/funding from MassHealth to enable rate increases.
2. Reimburse outpatient providers for comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services.
3. Eliminate or minimize utilization management -- develop approaches to manage outlier cases and utilize staff (hospital and payor) to develop crisis plans, identify aftercare placements, assures compliance with treatment plans. Barriers include MCO willingness to shift approaches away from focused utilization management.
4. Use of telemedicine. Opportunities exist to provide evaluation and screening or consultative services through the use of telemedicine. Regulatory restrictions in Massachusetts may prevent use of telepsychiatry which has been proven effective in other states.
5. Eliminate regulatory requirements that add cost but do not affect the quality or outcomes of care based upon evidence-based practices garnered from MA and other states. Example is the requirement to have on-site MD 24/7 for freestanding psychiatric hospitals.
6. Lack of standard requirements and performance specifications from payors. One example is the requirement by MBHP for daily MD oversight of PHP where other payors, including CMS, have less restrictive requirements with same clinical outcomes.
7. Electronic Health records/information implementation. HIT and meaningful use has excluded psychiatric hospitals, however, this is a requirement of CMS and instrumental to care integration. AHS hospitals and outpatients organizations are implementing programs without similar funding support as for medical providers.
8. Ability to manage network to move patents across continuum (affiliations). AHS would like to develop additional levels of care to best manage patients across the continuum, however, certain payors must approve new program development and, at the same time, may not have enough providers in their networks. This results in patients remaining in hospitals for longer lengths of stay or stuck in EDs or hospital beds waiting inpatient or diversionary services.
9. Improve access to state services including DMH beds, residential programs, etc. Patients remain “stuck” in expensive inpatient settings awaiting placement in more appropriate community-based settings.
10. Medically necessary behavioral services including collateral contacts, should be reimbursable outside of the behavioral health setting including in education, community and home settings and should be included in publicly and commercially available health care benefits.

c. What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?

Identified below are some systematic or policy changes that would help organizations such as AHS to operate more efficiency without reducing quality. As noted above, this is list is not all inclusive of changes that may support increased efficiency.

1. Improve alignment of federal and state oversight including with CMS, DMH and DPH.
2. Address state regulations or performance criteria that increase cost but do not enhance quality or outcomes of care.
3. Fund/support EHR implementation -- health information technology and meaningful use were excluded for psychiatric hospitals.
4. Address inconsistent MCO requirements or procedures including for prior authorization and utilization management that increase administrative cost and reduce efficiency.
5. Improve funding of or access to services so they are adequately resourced and do not risk being eliminated or downsized, resulting in access issues and patients "stuck" in EDs or on inpatient units. This includes, but is not limited to, inpatient child and adolescent, state hospital beds, specialty programs (intellectual disabilities, medical-psychiatric services, etc.)
6. Fund primary care in intensive mental health settings such as inpatient, residential and day treatment programs.
7. Address prior authorizations requirements that exist for behavioral but not medical/primary care to create more natural work flow and support care coordination.
8. Support through regulation and payment innovative consultation methods such as video-conferencing and telepsychiatry.

d. What steps are you taking to ensure that any reduction in health care costs is passed along to consumers or businesses?

As a provider with comparatively low average costs and reimbursed per diems compared to other acute care providers, AHS is in the position of reducing health care costs to consumers and businesses if there was greater use of the system. ESPs and other providers who direct care to inpatient, diversionary and outpatient services do not appear to be basing their referral decisions to direct patients to low cost, efficient providers but making decisions based upon access and organizational affiliation or capacity and capability to accept referrals. With the development of large health care systems in MA, there is likely an effort to keep patients within a single provider organization. While this *may* improve care coordination, a directive to keep care in-system may also mean treatment decisions that are not always informed primarily by quality and efficiency considerations. Purchasers should be aware that in addition to network limitations of their insurance products, the expectations of their physician's employment or affiliation arrangement may affect care delivery.

Regulators will have to carefully monitor the level of provider corporate integration that promotes care coordination in order to ensure that consolidations do not result in increased costs, volume concentration at high-clout, high cost providers, or reduced options for consumers to receive care from more efficient providers. AHS would like to be better aligned with purchasers and primary care organizations to support care integration and therefore reduce costs of care that can be passed along to consumers and businesses.

2. The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of the growth in prices on medical trend and what have been the results of those actions?

Actions that the organization has undertaken to address the impact of the growth in prices have been identified in other sections of this testimony. While there have been efforts to address increase costs and growth in prices, it has been difficult to fully measure the results of these actions in terms of increased efficiency or effect on outcomes or quality of care.

3. C. 224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration?

a. What potential opportunities have you identified for such integration?

The hospitals and outpatient organizations routinely assess behavioral health and substance patients for current co-morbid medical conditions and assess risk of developing co-morbid medical conditions. AHS hospitals have on-site medical consultants and both hospitals and outpatient programs communicate with primary care providers for concurrent care coordination and aftercare planning/communication. The organizations have discussed opportunities to develop outpatient sites as Health Homes or co-location of behavioral health providers with inpatient or outpatient medical providers. In addition, outpatient programs have discussed opportunities to hire on-site primary care providers to support their patient population. As one example of a current initiative, Arbour-Fuller Hospital has a full-time nurse practitioner who provides behavioral health consultative and referral support services at neighboring Sturdy Memorial Hospital.

b. What challenges have you identified in implementing such integration?

Given that AHS is not part of a large medical hospital system in MA that offers both acute care and behavioral health services, there are not natural linkages to support integration of care. As well, behavioral health for certain payors is "carved out" to organizations such as MBHP and Beacon Health Strategies. Payor approaches often do not support or promote care integration -- as an example, reimbursement for behavioral health care and physical health on same day is not currently in place or inpatient and diversionary services are not compensated to support increased or improved medical care.

Providing reimbursement structures that encourage warm handoffs and treatment of medical issues prior to crisis situation will improve health care outcomes and reduce costs. As well, payor requirements for prior authorization often differ between behavioral health and medical services which impeded timely integration or care coordination. Payment for and availability of community-based care coordinators to improve communication to patients and between providers has been lacking -- services such as Community Support Programs provide linkages to BH and primary care but these could be augmented for ongoing care coordination/integration. Availability of behavioral health providers for timely access to services including psychopharmacology has been another challenge that impedes ability to integrate care.

c. What systematic or policy changes would further promote such integration?

Systemic or policy changes that would further promote integration have been noted in response to other questions throughout this testimony. Additionally, regulators will have to carefully monitor the level of provider corporate integration or affiliation that promotes care coordination in order to ensure that consolidations do not result in increased costs, volume concentration at high-clout, high cost providers, or reduced options for consumers to receive care from more efficient providers such as AHS.

4. **C. 224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative payment methods**.

a. Describe you organizations efforts to promote these goals.

Efforts that hospital has made to provide more efficient and accountable care have been outlined in response to other questions throughout this testimony above. AHS does not participate in alternative payment models at this time but has expressed interest in working with MBHP in exploring alternative payment mechanisms.

b. What current factors limit your ability to promote these goals?

As noted above some of the factors limiting ability to promote more efficient and accountable care have been outlined in response to other questions throughout this testimony above. Factors limiting our ability to move to innovative payment methods include concerns that global or capitated payment contracts that seek to increase providers' performance risk also generally increase the level of insurance risk to which providers are exposed. Health plans must make available to providers information that would better enable them to manage risks and coordinate care under all product lines. Many risk providers in Massachusetts may have cared for patient populations that are healthier than average. AHS serves a patient population that has historically been more chronic/acute than other providers. Recognition of variations in populations must be part of the basis on which to proceed -- without consistent and reasonable health status adjustment with recognition of outlier payment or stop loss considerations, must be in place in order for AHS to promote alternative payment models. There must be proven approaches to mitigating provider financial loss -- beyond a certain threshold in a given

year, the cost of caring for a very high cost patient relates more to the patient's intensive health care needs than to any provider's failure in care delivery performance.

Effective care coordination is critical for providers to improve health care delivery. Appropriate data is necessary for providers to effectively coordinate care for patients across all lines of business (HMO and PPO). Health plans should make health care data more readily available to providers to inform their efforts to coordinate patient care regardless of payment arrangements. At this time, AHS does not have access to the data needed to assess alternative payment models.

c. What systematic or policy changes would support your ability to promote more efficient and accountable care?

Again, AHS' response to this question has already been provided in response to other questions as outlined above.

5. What metrics does your organization use to track trends in your organizations' operational costs?

a. What unit(s) of analysis do you use to track cost structure (e.g. at organization, practice, and/or provider levels?

The units of analysis that have been used to track cost structure for the hospitals are currently at the organization level. These have been done using cost per inpatient day. Analysis of mental health or addictions services outpatient or community-based services cost structure would be at the practice or provider level.

b. How does your organization benchmark items performance on operational cost structure against peer organizations?

While Arbour Health System has not begun to benchmark items performance on operational cost structure against peer organizations, the Massachusetts Behavioral Health Partnership (MBHP) recently retained Public Consulting Group (PCG) to complete an analysis of hospital costs. The study was being commissioned to assist in identification of rate increases based upon variations in average per diems from average costs by facility type (private psychiatric and behavioral health units in general acute care hospitals). Data used to make this determination was derived from analysis of 2012 403 cost reports -- information indicates that the private psychiatric hospitals have significantly lower costs than acute care hospitals. On the PCG report, weighted average cost per day from 403 cost reports was $677.58 for private psychiatric facilities and $1,102.59 for general acute hospitals. Acute care hospital actual cost per day was identified as high as $1,768.60 in 2012.

Even with this, it was noted that the private psychiatric facilities are receiving less than 100% cost coverage. The report further noted that payors such as MBHP do not want to underfund these low cost, high quality hospitals as they may close beds and leave higher

cost hospitals who will demand higher funding from payors (ACOs) to cover their costs. As stated in the PCG report, the unintended consequences of underfunding is the forced closure of units resulting in few available beds. With fewer available beds, patients remain stuck in Emergency Departments or may be required to utilize higher cost beds. With fewer beds and higher staff-to-patient ratios, hospitals are forced to turn away individuals in need of care.

In November 2012, the Center for Health Information and Analysis (CHIA) issued a report on Psychiatric Hospital and Acute Hospital Behavioral Health Unit Relative Price Analysis. This examined the relative price and payment data for psychiatric and acute hospitals with dedicated psychiatric care or substance abuse units for Blue Cross Blue Shield of MA, Fallon Community Health Plan, Harvard Pilgrim Health Plan and Tufts Health Plan. The report identified variation in relative "prices" across payers for each hospital but this appeared to be a reflection of negotiated per diems. It is unclear how this data was collected and analyzed as the information does not appear to be wholly accurate based upon knowledge of our system reimbursement/per diems. This report compared facilities with different services and is one of the concerns with benchmarking against "peer organizations". Walden and Arbour-Fuller were included in the top tier, however, both have services including eating disorders and intellectual disabilities that have significantly higher associated costs and therefore agreed upon per diems. This report did not differentiate in any measurable way the variances in patient population/acuity associated with the higher "relative prices."

So while we have not actively taken steps to benchmark items performance on operational cost structure against peer organizations, from this and other cost analysis using published data, it is clear that AHS' actual costs are lower on average than behavioral health units in acute care hospitals. It should also be noted that there are differences in patient acuity for patients in general for freestanding psychiatric hospitals -- our facilities, based upon quantitative and qualitative information, accept higher acuity (intellectual disabilities, assaultive/aggressive/violent, sexualized behavioral, use of electroconvulsive therapy, co-morbid conditions, and other socioeconomic indicators) which have all been associated with higher costs including staffing levels and other ancillary services. There is a vital role in the Commonwealth for AHS hospitals that routinely accept and care for the more acute and chronic mentally ill patient.

c. How does you organization manage performance on these metrics?

AHS hospitals have historically been highly efficient providers as shown by analyses of 403 cost report data. The hospital also reviews metrics, in addition to average cost per day, provided by managed care providers including length of stay, readmission rates, linkages to aftercare providers and communication with primary care practitioners. AHS utilizes information presented by MCOs to develop best practices and performance improvement initiatives to support cost-effective, high quality care.

6. Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee, as required by C. 224.

At this time, the organization has not undertaken nor developed specific plans to provide patients with cost information for health care services and procedures. Patients and their families, upon request, can request information on hospital charges but the vast majority of payments to the hospitals and outpatient services are based upon negotiated per diems, Medicare PPS, standard fee schedules, or capitated payments.

7. After reviewing the reports issue by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.

Given the primary focus of the CHIA report on acute care, the findings have less relevance to behavioral health organizations so it would not be as helpful to comment on these findings from our experience.

Arbour Health System does share many of the concerns raised by the Attorney General (AG) in the report dated April 2013. Most pertinent to AHS are issues raised related to providers. Specifically, AHS supports the AG's key points, including but not limited to those derived from the report in the following areas:

a. Variation in each of these contract provisions may materially affect the potential compensation and the levels of risk exposure for providers. Certain Massachusetts providers have a long history of risk contracting, while others are new to the practice. The fair and consistent application of these provisions across providers may significantly impact whether individual providers are successful in managing risk.

b. With respect to quality incentives, tying payment to value-based factors like quality performance is an important tool for improving market function and incentivizing providers to improve quality and reduce costs. Each of the major health plans does approach quality incentives inconsistently across their provider contracts. Although health plans may reasonably approach quality incentives and measures in different ways, and even focus on certain measures for select providers but not others (who already perform well on those measures), payment for quality performance should be more consistent.

c. Global payment contracts that seek to increase providers' performance risk also generally increase the level of insurance risk to which providers are exposed. The Commonwealth must monitor and limit the transfer of insurance risk to providers. Health plans must make available to providers information that would better enable them to manage risks and coordinate care under all product lines. Many risk providers in Massachusetts have historically been higher paid and have cared for patient populations that are healthier than average. That historic experience of generous

budgets and healthy populations is not a sound basis on which to proceed without consistent health status adjustment as risk contracts are implemented more widely.

d. In general, the major commercial health plans and CMS evaluate a provider's ability to bear financial risk in different ways, with varying considerations and requirements. There must be proven approaches to mitigating provider financial loss such as: (1) claims truncation; (2) individual stop loss insurance policies; and (3) aggregate stop loss insurance policies. Beyond a certain threshold in a given year, the cost of caring for a very high cost patient relates more to the patient's intensive health care needs than to any provider's failure in care delivery performance. The use of claims truncation helps reduce a provider's exposure to unusual costs associated with a patient's intensive health care needs that are beyond the provider's control.

e. Effective care coordination is critical for providers to improve health care delivery. Appropriate data is necessary for providers to effectively coordinate care for patients across all lines of business (HMO and PPO). Health plans should make health care data more readily available to providers to inform their efforts to coordinate patient care regardless of payment arrangements.

Below are examples of key data which health plans hold and should more readily share with providers.

1. Claims data to support provider care of all patients.
2. Information on projected membership growth and shifts in various products and benefit designs throughout the contract period.
3. Data to enable providers to analyze the impact of contract terms before executing contracts and during the course of contracts.

f. Providers in Massachusetts are exploring different ways of affiliating and consolidating. The impact of provider alignments on health care costs and quality should be measured and monitored – particularly alignments that may affect access to care, limit the effectiveness of other approaches to lowering costs, or enhance providers' market clout. Provider alignments may also "mute" the impact of product design in encouraging care at more efficient providers. Contractual expectations among hospitals, physicians, and other providers may result in a physician consistently referring patients "in-system," even when lower- cost care options are available. While keeping patients within a single provider organization *may* improve care coordination, a directive to keep care in-system may also mean treatment decisions that are not always informed primarily by quality and efficiency considerations. Purchasers should be aware that in addition to network limitations of their insurance products, the expectations of their physician's employment or affiliation arrangement may affect care delivery.

Regulators will have to carefully monitor the level of provider corporate integration that promotes care coordination in order to ensure that consolidations do not result in increased costs, volume concentration at high-clout, high cost providers, or reduced options for consumers to receive care from more efficient providers.

Arbour Health System supports the move towards integration including identification of various models of integration that rely on evidence or best practice for effective care. The transition to risk bearing payment models from fee for service need to be carefully assessed so patients are provided services in the most appropriate setting, address outlier management and acuity, especially for AHS. AHS manages some of the most acute behavioral patients throughout the system in settings including the state's only inpatient adult developmental disabilities unit and a high intensity inpatient program for patients who are violent, aggressive, and have highly sexualize behavior. Patients in behavioral health await other settings including those managed by DCF and DMH (state hospital beds) which affect length of stay and costs not in control of the provider. If alternative approaches such as global payment or capitation are the new "models" of reimbursement, providers cannot be penalized for accepting the most acute patients, with long lengths of stay dependent upon other organizations for post discharge acceptance such as state agencies, which put organizations such as AHS at significant financial risk. With large payors and networks such as Partners, Steward and others, it will be important to assure that behavioral health and substance abuse providers are included in discussions to ensure adequate access to care with assurances that payment structures are adequate to support providers for the future.