Boston Medical Center (BMC) is a fully integrated healthcare delivery system that includes:

- *BMC: A 496-bed academic medical center that offers a full range of primary and specialty care services. BMC is the largest safety net hospital in New England and operates the busiest Level I Trauma Center in New England.*
- *Physician Practice Plans: 22 physician practices with over 800 physicians.*
- *Boston HealthNet: Boston HealthNet is a partnership with 14 community health centers. This operation includes over 1,600 physicians and more than 650 primary care physicians. Boston HealthNet provides more than 1.2 million visits per year to 334,000 patients*

Seventy percent of BMC patients are low-income families, elders, people with disabilities, minorities, and immigrants:

- *150,000 patients have Medicaid, subsidized insurance, or no insurance*
- *30% do not speak English as a first language*
- *65% are Boston residents, concentrated in neighborhoods with the greatest level of health disparities*

1. **Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY 2012 – CY 2013 and CY 2013 – CY 2014 is 3.6%**

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

   BMC is continuously taking steps to control costs and increase efficiency. Taking these actions is critical because most BMC patients are insured by Medicaid or subsidized insurance products.

   Over the past three years, BMC has worked aggressively to decrease controllable costs. As shown in BMC's Exhibit C and below, total expenses decreased each year in Fiscal Years 2010, 2011 and 2012. BMC achieved considerable savings in: 1) pharmaceuticals, 2) consulting and management services; 3) medical/surgical supplies; and 4) lab supplies. (see Exhibit C)

Summary	FY10	FY11	FY12	Increase from FY10-FY12	1 Year % Change (FY11 to FY12)	2 Year % Change (FY10 to FY 12)
Total Expenses	$1,004,576	$1,004,075	$1,002,153	$(2,423)	-0.2%	-0.2%

   BMC aims to further reduce costs through its proposed campus consolidation plan. This long-term strategy would involve BMC closing its East Newton facility and consolidating operations into one campus. BMC is further reducing the cost of care by focusing on patient utilization strategies.

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?

BMC is convinced that running faster on the current fee-for-service reimbursement treadmill is not the answer. BMC's goal is to be truly accountable for the health of the patients it serves and to be paid that way. Working today toward that goal, BMC is collaborating with its partners in the state (including our largest payer, MassHealth), its 14 Boston HealthNet community health center partners, and the BMC HealthNet Plan so that it is ready when the payment system transforms. Moving toward Medicaid global payments is critical, as the Commonwealth proposes in the Section 1115 waiver renewal.

Under a global payment system, BMC can invest in services that are essential to lowering costs but are often not reimbursable. For example, BMC has learned that patient navigation and education services are critical to achieving better health outcomes for low-income patients. BMC keeps patients in lower-acuity care settings by investing in care management services, which, for example, ensure patients schedule follow-up appointments and fill prescriptions before they leave the health system. Patient compliance is also increased by BMC's investment in interpreter services that assist 200,000 patients annually in 21 languages.

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

MassHealth must move rapidly toward global payments in an accountable care model. BMC commends MassHealth for proposing, in its draft waiver proposal to the Center for Medicare and Medicaid Services (CMS), to contract directly with Accountable Care Organizations (ACOs).

In advance of a global payment system, shifting toward adequate Medicaid reimbursement for critical services (including behavioral health) is essential. It is also necessary to ensure that safety net health systems receive fair rates for treatment of commercially insured patients (for example, BMC's 2011 relative Blue Cross Blue Shield prices are 22 percent below the median price of all Massachusetts hospitals (CHIA Health Care Provider Price Variation, February 2013, updated March 2013)).

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

Although BMC has been successful in implementing significant operational improvements and cost reduction strategies (see Question 1(a), above), we have experienced limited revenue growth. BMC has not generated surpluses over the past two years and in, FY 2012, BMC was at break even. Given our limited revenue growth, cost reductions allow BMC to maintain critical clinical support services, including necessary investments in technology. We are vigilant about maintaining our ongoing cost reduction strategies so that we can continue to improve the quality and efficiency of, and expand access to, the care we provide.

2. **The 2013 Examination of Health Care Cost Trends and Cost Drivers by the AG'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 growth in prices on medical trend and what has been the result of these actions?**

   Given the low reimbursement rates that BMC receives from its payers, BMC must operate as efficiently as possible; this in turn helps contain medical prices. BMC takes a data-driven approach when choosing projects that will increase quality and efficiency and takes pride in (1) working with patients to stay healthy and avoid higher level, costlier healthcare services; and (2) working creatively to increase efficiency while not comprising quality.

   For example:

   - ***Investing in pharmacy support services**: BMC data revealed that only 60 percent of children admitted for asthma filled prescriptions following hospital discharge. BMC now delivers medication to the bedside and counsels patients and their families on following instructions for taking the medicine. As a result, 90 percent of families leave with medication in hand and an understanding of how to use the medication. This action decreases unnecessary future emergency department visits and hospitalizations.*
   - ***Seeking solutions beyond costly infrastructure or personnel:** BMC addressed the issue of reducing the number of "clinically insignificant" cardiac monitor alarms by using existing technology more efficiently. In a recent pilot program, rather than invest in an expensive centralized system to monitor alarms, BMC took a significantly less costly approach to better manage the alarms. BMC analyzed data and identified alarms that are unnecessary and could be eliminated without sacrificing patient outcomes. The just-released results of that pilot are noteworthy. An overall 89 percent reduction in audible alarms was achieved at pilot alarm sites without additional resources or technology. Staff and patient satisfaction improved. No adverse events related to missed cardiac monitoring events occurred and Code Blues decreased by 50 percent. Nurses and physicians, no longer distracted by non-critical alarms, are quickly aware of acute patient needs.*
   - ***Reducing readmissions:** BMC founded the nationally renowned Project RED (Project Reengineering Discharge), a program that has spread to 300 hospitals nationwide and systematically guides health systems to reduce readmissions. Through the Commonwealth's Section 1115 Waiver – and its Delivery System Transformation Initiative (DSTI) – BMC has worked to refine this initiative for the unique needs of low-income safety net system patients.*

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

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

      BMC's Departments of Family Medicine, General Internal Medicine, and Psychiatry worked together to establish a Behavioral Health Collaborative to launch an integrated

behavioral health model of care. This new model will include service agreements among BMC departments, provider co-location, and co-management of high-risk patients.

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

Health Information Technology: Crafting integrated electronic information systems that allow all medical clinicians access, while ensuring appropriate safeguards to protect mental health and chemical dependency records.

Space: Design and capacity of physical facilities to support a fully integrated model of care.

Workforce Development: Need for extensive staff training to embed behavioral health knowledge and practice into the ongoing work patterns of primary care clinicians and support staff.

Resource Allocation & Funds Flow: Need to depart from traditional, department-based ("silos") determination of resource allocation to a unified program-based decision-making model.

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

Reconfiguration of the reimbursement model that moves beyond payment for individual services to a global payment for the total cost of care.

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

a. Describe your organizations efforts to promote more efficient and accountable care through innovative care delivery models or alternative payment models?

Currently, BMC is working with the Commonwealth in its building-block efforts toward Medicaid accountable care. These efforts include the Patient Centered Medical Home (PCMH) Initiative as well as the Primary Care Payment Reform Initiative. These initiatives are necessary first steps toward the implementation of patient-focused accountable care and a full global payment model in Medicaid.

As MassHealth works toward a full accountable care model, BMC has taken the necessary steps to move toward an ACO structure. This has involved BMC working intensively with its Boston HealthNet community health center partners and the BMC HealthNet Plan to address necessary function and design decisions.

While BMC's commercially insured patients are limited, BMC is also working to expand alternative payment contracts with commercial insurance carriers. Because fewer than 20% of BMC's patients are covered by commercial payers, BMC has not been an early focus for payers moving to alternative payment systems. However, last year BMC signed the Alternative Quality Contract with Blue Cross Blue Shield. BMC has also had a risk-

sharing contract with Tufts Health Plan since 2011. BMC is in the process of expanding its risk-based contracts and is negotiating with payers toward that end.

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

There are steps that can be taken to promote efficient, accountable care as MassHealth moves toward a comprehensive accountable care model. For example, BMC is not able to gain access to MassHealth Primary Care Clinician Plan (PCC) claims data for its primary care patients. Access to this data is key to understanding the total cost of care and utilization. Since roughly 50% of BMC patients are low income and receiving MassHealth or other state subsidized health insurance, BMC's ability to promote accountable care is limited without that data. BMC looks forward to working with the Commonwealth to obtain primary care patient data.

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

As mentioned earlier, BMC believes that Medicaid must allow for global payments that allow health systems to accept accountability for overall patient health and treatment costs rather than simply receiving fee-for-service payments.

Additionally, Medicaid must address insufficient reimbursement rates. The Legislature recognized this challenge in Chapter 224, when it established the Public Payer Commission – a 13-member special commission to review public payer health care reimbursement rates. The commission was scheduled to file results of its study, together with drafts of legislation (if any), by April 2013; however, the commission has not begun work. BMC looks forward to working with the commission to address this important issue.

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

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

At an aggregate level, BMC tracks cost-per-adjusted discharge and uses an internally developed measure, cost-per-adjusted weighted discharge. Organizational goals are set around these metrics.

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

BMC tracks productivity in most variable departments on a bi-weekly basis, using a combination of internal and external benchmarks, including Solucient and Medical Group Management Association (MGMA) measures.

c. **How does your organization manage performance on these metrics?**

Overall cost goals are set at the start of the year and reviewed with management on a monthly basis. In addition, BMC's Position Control Committee uses productivity data prior to posting employee positions. This committee reviews all requested positions (new and replacement) against the budget and evaluates productivity for variable departments.

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 change and any facility fee, as required by 224.**

Patients requesting price information are provided charge information from BMC's charge master. Patients are provided the charge and self-pay policy discount information if requested. For more complex procedures, including day surgery and hospital admissions, BMC works with clinics and physicians to provide estimated charges to the patient.

7. **After reviewing the reports issued by the AG and CHIA, please provide any commentary on findings presented in light of your organization's experience.**

While the primary focus of the AG and CHIA has been commercial payers, BMC looks forward to working with the Commonwealth as it turns its attention to public payers and advances adequate reimbursement policies and payment reform in this area. As the CHIA report highlights, there are significant disparities in hospital relative prices; BMC continues to rank at the bottom of academic medical center prices. This gap in prices must be addressed to lower the overall cost of Massachusetts healthcare.

Office of the Attorney General Questions

1. **For each year 2009 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.**

   See Exhibit A

2. **If you have entered a contract with a public or commercial payer for payment for health care services that incorporates a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any downside risk" (hereafter "risk contracts"), please explain and submit supporting documents that show how risk contracts have affected your business practices, including any changes you have made, or plan to make, to care delivery, operational structure, or to otherwise improve your opportunities for surpluses under such contracts, such as any changes to your physician recruitment or patient referral practices. Include in your response any analysis of the impact of changes in your service mix, payer mix, or patient member type (e.g., HMO v. PPO, fully insured, v. self insured) on your opportunities for surpluses.**

   Because most BMC patients are publicly insured, the organization has not had the opportunity to engage in risk contracts to the extent commercial providers have. While BMC has only recently entered into risk arrangements with commercial carriers, it anticipates that these contracts will give a preview of the dramatic changes in business practices, care delivery, and operational structure that it expects when the Commonwealth moves toward alternative payments in Medicaid.

3. **Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., cost for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or government businesses.**

   Given that BMC is relatively new to managing risk, coupled with the fact that commercial payers do not represent a large part of BMC's total payer mix, it is still analyzing the appropriate balance and complement of resources needed to manage risk contracts. In some ways it will be difficult for BMC to tease out the precise costs of bearing risk, as it leverages the efforts of existing staff in areas across BMC where possible. BMC was not at a deficit for its risk contracts in 2012.

4. **Please describe and submit supporting documents regarding how, if at all, you track changes in the health status of your patient population or any population subgroups (e.g., subgroups by carrier, product, or geographic area).**

   Tracking data related to the health status of patients is a key component in providing appropriate care. BMC produces data and tracks patients through the following registries: (1) primary care (PCMH); (2) sickle cell disease; (3) HIV; (4) diabetes; (5) obesity; (6) thyroid; and (7) hypogonadism. Tracking is done principally by clinical condition, but certain clinical quality measures are also reported and segregated by payer.

   In addition, BMC maintains an enterprise data warehouse that it uses to assess gaps in care and quality. Finally, for many commercial payers, BMC receives and reviews claims-based information on a variety of population-based quality metrics.

5. **Please submit a summary table showing for each year 2009 to 2012 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. 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.**

   See Exhibit B

6. **Please identify categories of expenses that have grown (a) 5% or more and (b) 10% or more from 2010-2012. Please explain and submit supporting documents that show your understanding as to the factors underlying such growth.**

   See Exhibit C

   Over the past three years, BMC has worked aggressively to decrease controllable costs. As shown in BMC's Exhibit C and below, total expenses <u>decreased</u> each year in Fiscal Years 2010, 2011 and 2012.

   However, the following categories of expenses have grown more than five and ten percent:

   - *<u>Employee Benefits</u>: a two-year increase of 8.5 percent is primarily attributable to health insurance, which is the result of increases in provider prices, specialty drugs, and utilization of services. Additionally, pension expenses have increased due to defined benefit plan contributions.*
   - *<u>Insurance</u>: a two-year cost increase of 122 percent is primarily attributable to malpractice insurance.*
   - *<u>Interest expense</u>: a two-year cost increase of 98 percent is attributable to BMC refinancing its Series A bonds and expensing its Series C issuance cost. Also, BMC opened its Shapiro Ambulatory Center, contributing to this expense.*
   - *<u>Other expenses</u>: a two-year cost increase of 19 percent is not a true cost increase but rather the result of re-assigning license fees from "Purchased Services" to the "Other Expenses" category.*

7. **Please describe and submit supporting documents regarding any programs you have that promote health and wellness (herein "wellness programs" for 1) patients for whom you are the primary care provider; 2) patients for whom you are not the primary care provider; and 3) employees. Include in your response the results of any analyses you have conducted regarding the cost benefit of such wellness programs.**

   BMC has numerous programs that promote wellness for patients. They include smoking cessation programs and a food pantry/cooking demonstration kitchen for patients who receive a clinical referral. The food pantry alone serves over 7,000 families each month. BMC also provides comprehensive preventive and wellness care, including routine physical exams and immunizations. Screenings and health counseling are provided for HIV, cholesterol, high blood pressure, heart disease, sexually transmitted diseases, addiction, diabetes and cancer.

   BMC also has numerous programs that promote employee wellness, which are collected on a newly-launched employee wellness website. They include nutrition information and access to free cooking classes, mind/body education and stress reduction courses, yoga classes, exercise assessment, sleep assessments and tips, and an employee assistance program.