Riverside Community Care's Testimony in Response to HPC's Questions for Written Testimony

On behalf of Riverside Community Care, I, Marsha Medalie, Executive Vice President and Chief Operating Officer, am submitting the following written testimony in response to the Health Policy Commission's questions for providers. I am legally authorized and empowered to represent Riverside Community Care for the purposes of this testimony.

Riverside is a large, Massachusetts, non-profit, community-based behavioral healthcare and human services organization operating in much of eastern and central Massachusetts. Through our predecessor organizations we have been providing behavioral health services since the 1950s. Today, Riverside operates over 100 programs with behavioral healthcare hubs in Cambridge/Somerville; Newton/Needham; Norwood/Dedham; Upton/Milford; and Wakefield/Lynnfield. We provide trauma response and suicide prevention statewide.

Riverside provides compassionate, locally-based, integrated care to individuals, families and communities and serves persons of all ages, races, income levels, and insurance statuses. We assist individuals with varying degrees of need including those seeking individual, group or family therapy and 24 hour emergency services. We strive to ensure that services are accessible to all who need them in the communities that we serve.

We have been actively involved with the state's forums on healthcare reform and MassHealth ACO planning and have been striving to ensure that our organization grows flexibly and effectively to continue to meet the needs of the individuals and the communities we serve with cost-effective care.

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)

      While we support setting a health care cost growth benchmark, the benchmark should not be interpreted as applicable to behavioral health services. This area has been significantly underfunded and under- utilized for decades and it is likely that increased investment and spending in behavioral healthcare will help reduce the overall cost of healthcare.

   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)

      First, we believe that the State should require hospital systems to contract with existing community based providers of behavioral health services that meet certain threshold standards of quality and should eliminate incentives for hospital systems to develop or duplicate such services. Community based providers have longstanding expertise in the community service systems and natural supports and can provide community based services more cost-effectively than can the hospitals. To allow the hospitals to displace existing services erodes and likely could lead to the loss of these more cost-effective providers at the ultimate sacrifice of patients, whose choices would become more limited, less expert, and more costly.

Second, we believe that the state must move forward expeditiously to alleviate the regulatory burdens on providers that are attempting to increase capacity to provide mental health and addiction services and better integrate their delivery with existing medical services. We recommend that the state utilize recommendations provided by the Association for Behavioral Healthcare (ABH), the trade association representing the vast majority of community based behavioral health providers. ABH has submitted suggestions regarding MassHealth and Department of Public Health regulations that impede efficient service delivery and create barriers to integration.

Additionally, we recommend that MassHealth reimburse telebehavioral health and in particular telepsychiatry delivered to individuals in offices or their homes to address both the shortage of behavioral healthcare prescribers and to reduce the cost of this service.

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.

N/A

   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)
   ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends
   iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs
   iv. Establishing internal formularies for prescribing of high-cost drugs
   v. Implementing programs or strategies to improve medication adherence/compliance
   vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

   vii. Other
   viii. Other

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)

Riverside is a community based behavioral health provider and has been working to establish deep relationships with medical healthcare systems - partnering to better integrate care. For more than a decade we have provided a Behavioral Health Urgent Care Center for the physician practices associated with Milford Regional Medical Center in southern Worcester County and with UMass

Medical Center in Uxbridge. Besides this successful model, we have had limited success partnering with hospital systems, placing only a few clinicians in healthcare settings to date. This is principally because the hospital systems do not have an incentive to partner with community based providers and unfortunately, instead many have embarked on duplicating the community based service delivery within their hospital system. Please see our response in question 1 regarding the importance of requiring hospital systems to buy behavioral health services from community providers rather than build them themselves.

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)

N/A. Riverside is a community based behavioral health provider.

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)

      N/A

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

      N/A

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. N/A
   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.

   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?
      i. If yes, please describe what information is included.

      ii. If no, why not?

   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?
      i. If yes, please describe what information is included.

      ii. If no, why not?

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

    ii. If no, why not?

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)

Riverside is a pilot site and supporter of the MassHealth APM method of reimbursement for the Community Service Agency (CSA) program which we provide - part of the Children's Behavioral Health Initiative (CBHI) bundle of services for children with serious emotional disturbances and their families. We recommend that this successful APM be extended to all CSA programs and the In Home Therapy services as well. We also recommend that a similar process for developing an adequate APM be adopted by the state/MassHealth for Behavioral Health Community Partner rates planned within the ACO demonstration waiver. The APM should be sufficient to allow for a mix of telephonic and face to face community based contacts to facilitate establishing linkages between an individual's behavioral health and primary care clinicians, enable clinician participation in team meetings and to make contacts with individuals' providers, family members and others, and to enable care management providers to follow individuals into whatever setting they may be in, including inpatient psychiatric hospitals. We strongly recommend that community based behavioral healthcare providers be consulted in the development of any such APM to ensure full information is utilized to result in adequate rates.

We are also in the process of developing, and urge all payers, both public and commercial to work with us in adopting case rates for the provision of collaborative care management

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)

1) The lack of financial support for behavioral health providers to implement Electronic Health Record systems and the unavailability of mechanisms to readily communicate patient information between different EHR systems (across providers).
2) Proposed rates are often based on existing depressed rates (through inadequate and misleading Uniform Financial Reports – UFR) and this is an insufficient starting point. Related to this, insurers' proposed APMs often include unreasonable expectations for service provision relative to inadequate levels of reimbursement. We have seen this repeatedly when payers have approached us about alternative care models that, if adequately funded, could provide needed care management and coordination and reduce overall cost.

3) The historic underfunding of behavioral healthcare has hobbled our ability to bear risk in alternative payment models.

c. Are behavioral health services included in your APM contracts with payers?
   1) If no, why not? N/A

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.

While perhaps not directly related to feedback the HPC received in prior Cost Trend Hearings, it is important to mention the problems that frequently occur in quality reporting on behavioral health measures. Often, particularly in federal quality reporting there are few appropriate measures of the effectiveness of behavioral health service delivery. The few measures that are utilized (for example in the CMS Physician Quality Reporting System (PQRS)) tend to be either weak indicators of actual quality or require an inordinate administrative effort and cost to gather the data associated with them. Additionally, it will be important to develop meaningful ways to measure behavioral health care integration, access to, and appropriate utilization of behavioral healthcare as the state moves ahead with ACO development, and critical to do so in ways to that do not impose excessive administrative or cost burdens on providers.

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

We strongly suggest that community based behavioral healthcare providers be included in discussions about which measures are most appropriate and the differential burdens that various measurement processes may impose. The Association for Behavioral Healthcare (ABH), the trade association the majority of community providers belong to could help facilitate such a dialogue.

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.

We again want to emphasize the importance of requiring hospital systems to partner with community based behavioral healthcare providers rather than build behavioral healthcare capacity separate from the existing system of care.

Exhibit C: AGO Questions for Written Testimony

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

1. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

   Please see attached.

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.

      We post outpatient rates in all of our outpatient centers and also provide them in hard copy to our clients when requested.

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

      We update our outpatient rate information whenever there are changes.

   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?

      N/A

I assert that I have signed this testimony under the pains and penalties of perjury.

_____Marsha Medalie_____

Marsha Medalie
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Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate 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 subject you to very limited or minimal "downside" risk.
6. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
8. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.

9. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
10. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
11. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2012

US$000s	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue		Stated in US$000s				
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											$ 1,436	$ 359			
Tufts Health Plan											$ 366	$ 91			
Harvard Pilgrim Health Care											$ 598	$ 150			
Fallon Community Health Plan											$ 308	$ 77			
CIGNA											$ -				
United Healthcare											$ 487	$ 122			
Aetna											$ -				
Other Commercial											$ 430	$ 108			
Total Commercial											$ 3,626	$ 906			
Network Health											$ 2,131	$ -			
Neighborhood Health Plan											$ 1,611	$ -			
BMC HealthNet, Inc.											$ 345	$ -			
Health New England											$ -	$ -			
Fallon Community Health Plan											$ -	$ -			
Other Managed Medicaid											$ 8,162	$ -			
Total Managed Medicaid											$ 12,249	$ -			
MassHealth											$ 4,234	$ -			
Tufts Medicare Preferred											$ -	$ -			
Blue Cross Senior Options											$ -	$ -			
Other Comm Medicare											$ -	$ -			
Commercial Medicare Subtotal											$ -	$ -			
Medicare											$ 888	$ -			
Other											$ 1,313	$ -			
GRAND TOTAL											$ 22,310	$ 906			

2013

US$000s	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue		**Stated in US$000s**				
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											$ 1,359	$ 340			
Tufts Health Plan											$ 434	$ 108			
Harvard Pilgrim Health Care											$ 680	$ 170			
Fallon Community Health Plan											$ 385	$ 96			
CIGNA											$ -	$ -			
United Healthcare											$ 543	$ 136			
Aetna											$ -	$ -			
Other Commercial											$ 558	$ 140			
Total Commercial											$ 3,959	$ 990			
Network Health											$ 2,377	$ -			
Neighborhood Health Plan											$ 1,956	$ -			
BMC HealthNet, Inc.											$ 419	$ -			
Health New England											$ -	$ -			
Fallon Community Health Plan											$ -	$ -			
Other Managed Medicaid											$ 9,666	$ -			
Total Managed Medicaid											$ 14,418	$ -			
MassHealth											$ 4,636	$ -			
Tufts Medicare Preferred											$ -	$ -			
Blue Cross Senior Options											$ -	$ -			
Other Comm Medicare											$ -	$ -			
Commercial Medicare Subtotal											$ -	$ -			
Medicare											$ 1,031	$ -			
Other											$ 2,003	$ -			
GRAND TOTAL											$ 26,047	$ 990			

2014

US$000s	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue		Stated in US$000s				
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											$ 1,805	$ 451			
Tufts Health Plan											$ 420	$ 105			
Harvard Pilgrim Health Care											$ 814	$ 204			
Fallon Community Health Plan											$ 478	$ 120			
CIGNA											$ -	$ -			
United Healthcare											$ 666	$ 166			
Aetna											$ -	$ -			
Other Commercial											$ 779	$ 195			
Total Commercial											$ 4,962	$ 1,241			
Network Health											$ 2,911	$ -			
Neighborhood Health Plan											$ 2,339	$ -			
BMC HealthNet, Inc.											$ 501	$ -			
Health New England											$ -	$ -			
Fallon Community Health Plan											$ -	$ -			
Other Managed Medicaid											$ 8,519	$ -			
Total Managed Medicaid											$ 14,270	$ -			
MassHealth											$ 4,533	$ -			
Tufts Medicare Preferred											$ -	$ -			
Blue Cross Senior Options											$ -	$ -			
Other Comm Medicare											$ -	$ -			
Commercial Medicare Subtotal											$ -	$ -			
Medicare											$ 1,293	$ -			
Other											$ 1,743	$ -			
GRAND TOTAL											$ 26,801	$ 1,241			

2015

US$000s	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue		Stated in US$000s				
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											$ 1,766	$ 441			
Tufts Health Plan											$ 390	$ 97			
Harvard Pilgrim Health Care											$ 815	$ 204			
Fallon Community Health Plan											$ 532	$ 133			
CIGNA											$ -	$ -			
United Healthcare											$ 668	$ 167			
Aetna											$ -	$ -			
Other Commercial											$ 751	$ 188			
Total Commercial											$ 4,922	$ 1,230			
Network Health											$ 2,922	$ -			
Neighborhood Health Plan											$ 2,682	$ -			
BMC HealthNet, Inc.											$ 575	$ -			
Health New England											$ -	$ -			
Fallon Community Health Plan											$ -	$ -			
Other Managed Medicaid											$ 8,342	$ -			
Total Managed Medicaid											$ 14,521	$ -			
MassHealth											$ 4,544	$ -			
Tufts Medicare Preferred											$ -	$ -			
Blue Cross Senior Options											$ -	$ -			
Other Comm Medicare											$ -	$ -			
Commercial Medicare Subtotal											$ -	$ -			
Medicare											$ 1,370	$ -			
Other											$ 1,880	$ -			
GRAND TOTAL											$ 27,237	$ 1,230			