SOUTHCOAST
HEALTH SYSTEM

www.southcoast.org

September 1, 2016

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

Dear Mr. Seltz:

Thank you for the opportunity to submit Southcoast Hospitals Group's written testimony to the questions posed by the Health Policy Commission and Office of the Attorney General in conjunction with the State's public hearings concerning the current trends in healthcare costs.

We hope our testimony is helpful to you as we continue to seek collaborative and innovative opportunities to improve healthcare in the Commonwealth. As President and CEO of Southcoast Health System and Southcoast Hospitals Group, I submit under the pains and penalties of perjury. We stand ready to provide further input if necessary.

Sincerely,

Keith A. Hovan
President & CEO
Southcoast Health System
Southcoast Hospitals Group

101 Page Street, New Bedford, MA 02740
508-961-5555

ATTESTATION

SOUTHCOAST HOSPITALS GROUP, INC.

I, Keith A. Hovan, being the duly authorized President and CEO of Southcoast Health System and Southcoast Hospitals Group Inc. (the "Company"), having been duly sworn, do hereby attest that I am legally authorized and empowered to represent the Company for the purposes of the foregoing testimony, and that the foregoing testimony is provided under the pains and penalties of perjury and is true and accurate to the best of my knowledge and belief.

IN WITNESS WHEREOF, I have hereunto set my hand as President and CEO of the Company this 1st day of September, 2016.

Keith A. Hovan
President and CEO
Southcoast Health System and Southcoast Hospitals Group

COMMONWEALTH OF MASSACHUSETTS):ss New Bedford

COUNTY OF BRISTOL)

The foregoing attestation was acknowledged before me this 1st day of September, 2016 by Keith A. Hovan, as President and CEO of Southcoast Health System and Southcoast Hospitals Group, Inc., as his free act and deed.

KIMBERLY M. COON
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES APRIL 2, 2021

Kimberly M. Coon
NOTARY PUBLIC
My Commission Expires: 4/2/2021

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), 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, ATTN: 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)

Southcoast Health's (Southcoast) top three areas of concern are: (1) pharmaceutical expenses, particularly high drug co-pay costs; (2) decreasing revenues from high deductible products and sequestration, disproportionate share hospital (DSH) and wage index reductions; and (3) ensuring that clinical services are accessible and provided in the most appropriate environment. A detailed description of these concerns is included below:

1. Pharmaceutical expenses: As a provider, Southcoast has limited ability to influence the prices that pharmaceutical companies charge for drugs. Furthermore, providers' primary concern is ensuring that patients follow their medication regimen to avoid costly inpatient stays or ER visits. However, higher drug co-pay costs reduce the ability of patients with limited or fixed incomes to purchase the medications they need and, as a result, Southcoast has witnessed fewer patients taking their medications as prescribed.

2. Decreasing revenues from high deductible products and sequestration, disproportionate share hospital (DSH) and wage index reductions: The growing use of high deductible products has resulted in a significant increase in the amount of unrecoverable debts, thus lowering the net revenues for hospitals and physicians, which must then be made up through higher rate renegotiations. As an example, for one commercial payer, we have been tracking write-offs by claim count and amount for the last five years. Total bad debt write-offs for this payer have increased from $588,000 to $1.2 million in that five-year period. The number of claims written off specifically in the over $1,000 category has increased 69%, while the dollar value has increased 98%. At the same time, in the $0 to $500 category, written-off claims have increased by 1%. Individuals are not prepared to pay the higher cost-sharing amounts that these products incorporate. Individuals will only pay their required deductibles or co-pays if the payers (e.g., the creators of the products) collect directly from the patients. The Massachusetts Hospital Association (MHA) has repeatedly supported the passage of legislation that shifts this issue from the providers to payers, where it belongs.

The Centers for Medicare & Medicaid Services (CMS) has also lowered hospital revenues due to sequestration, DSH, and wage index reductions, which, in turn, has influenced hospitals to rely on other payers to make up those shortfalls. However, other non-Federal or State payers are unable to provide the necessary increase without exceeding the benchmark.

3. Ensuring that clinical services are accessible and provided in the most appropriate environment: There continue to be challenges in reducing ED visits altogether, as well as in transferring patients in a timely manner from high cost (acute care) settings into an appropriate next level of care (Skilled Nursing Facility, Rehabilitation Hospital, etc.) or even back to home/family with appropriate levels of in-home support. These delays make the health system less efficient and more costly.

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)

1. Develop a list of high-cost medications and less costly therapeutic alternatives based on direct-to-consumer (DTC) drug advertising and provide the list to appropriate Standard Practice Guide (SPG) practices. While encouraging the use of the therapeutic alternatives, the Federal, State and Commercial payers must focus their considerable strength on gaining concessions from the pharmaceutical industry on price reductions for the most commonly needed and prescribed drugs.

2. High deductible plans must require subscribers to set aside the deductible amount in a Health Care Spending Account, either through payroll reductions or an alternative method, to ensure that providers will be paid for care rendered. Additionally, insurance companies, rather than providers, should be required to assume the responsibility for the collection of co-payment and deductible balances. With health insurance carriers offering a myriad of products with increasing co-pay and deductible responsibilities to consumers, payers should participate directly in the collection of these payments.

3. Improved care coordination will ensure that patients are transitioned to appropriate levels of care, achieved through such changes as: shortening insurance authorization timeframes and responses; ensuring that insurance benefits (Medicare or MassHealth days) continue until complete care has been provided; maintaining adequate weekend staffing to provide service coordination; extending MassHealth transportation benefits from “curb to curb” drop off to “door to door” drop off, at least for elderly and disabled patients; and adequate funding for social programs that prevent admissions and re-admissions in high cost patient cohorts such as those with chronic disease and co-morbid mental and substance abuse issues.

In addition, a Primary Care Pharmacy Practice is under consideration for development. This would focus either on medication reconciliation or on patient and prescriber education (including academic detailing), using evidenced-based medicine to improve outpatient adherence and outcomes that control costs by minimizing readmissions and emergency room visits. In addition, transition of care (TOC) pharmacists and discharge liaison technicians would work with patients to assist with access to medications, medication cost concerns, and adherence and medication reconciliation issues in transitions to other levels of care or discharge home. This includes working with third-party payers on prior authorizations for medications and various manufacturers’ medication assistance programs that provide free or discounted medications to eligible patients.

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)

Plans to Implement in the Next 12 Months

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

Plans to Implement in the Next 12 Months

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

Currently Implementing

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

Currently Implementing

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

Currently Implementing

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

Currently Implementing

vii. Other: Insert Text Here

viii. Other: Insert Text Here

ix. Other: Insert Text Here

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

1. Behavioral health asset database: Over the last two years, Southcoast, in collaboration with community partners, has worked to develop a comprehensive, searchable database, the Behavioral Health Connect, which includes over 1,000 pages of searchable information on hundreds of clinical and community-based behavioral health assets. The database is accessible through a public website to Southcoast staff, other behavioral health providers, and consumers, and is updated regularly by Southcoast staff based on input from community partners. The goal is to expand communication, increase access to services, facilitate the referral process, and, ultimately, improve care coordination across the Southcoast behavioral health system.

As an ongoing process, we continue to identify new resources and develop system updates based on feedback from community partners. We provide regular outreach and education both internally for Southcoast staff and in the community regarding the availability of the database and how to use it. Last year, we presented to more than one hundred community members and agencies. Usage metrics of the database indicate that from January 1, 2016 through August 1, 2016 there have been 7,923 sessions with 6,300 users and over 13,273 page views, with an estimated 77.2% of sessions being initiated by first-time visitors.

2. Community outreach: Members of our staff participate in an assortment of behavioral health (including substance abuse) coalitions and groups across the region that work to educate key segments of the public about various behavioral health issues, including the misuse of prescription drugs, underage drinking, risk behaviors in youth, maternal mental health, suicide prevention, and overdose prevention. Specific highlights include working with community groups such as the Physicians to Prevent Opioid Abuse and the Building Our Lives Drug-Free (BOLD) coalition in Fall River to coordinate training opportunities for prescribers across the region on treating and assessing pain and safe prescribing, holding prescription take-back events, and working with school departments to determine best methods for educating parents on the risks of addiction after a sports injury. Southcoast also helped fund as well as participated in an educational campaign that featured video and prescription drug educational programs that targeted seniors and youth.

3. Support groups: Southcoast facilities host a variety of behavioral health support groups open to the community across the South Coast region. These include weekly groups aimed at supporting individuals struggling with issues relating to addiction, such as a women-only meeting of Narcotics Anonymous and Learn to Cope, a peer-run group for families of those suffering with an opioid addiction. Together, these groups serve an average of 60 or more individuals per week. In addition to providing peer support, Learn to Cope offers attendees the opportunity to be trained in the use of Narcan (an opioid overdose reversal drug) and supplies them with kits to take home. Additional groups include DBSA (Depression, Bipolar, Support Alliance), Parents Enduring Grief, general bereavement groups, and support for secondary victims of a sexual assault.

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. Recruitment and reimbursement: As the demand for behavioral healthcare treatment grows, recruiting providers to work at all levels of care continues to be a challenge across the South Coast Region and has led to staff shortages at multiple agencies, including Southcoast. The resulting limited number of outpatient psychiatrists who can provide timely access to follow-up outpatient BH services, as well as prescribe and monitor BH medications, had led to discharged patients remaining in our hospital facilities without proper outpatient support and medical care.

Working with patients that have a mental health or substance use disorder can be challenging as this population often has complex needs that require case management and careful coordination of care by a skilled practitioner. The lack of qualified applicants to fill vacancies in addition to requests for higher pay (due to an increase in supply and demand) has perpetuated this issue. Poor reimbursement for the treatment of behavioral health patients, including support services and technology that improve behavioral health and substance abuse conditions, continues to be a major barrier in providing and increasing access to care. Unequal reimbursement for behavioral health services compared to other health care services can act also as a deterrent in attracting new individuals into the field.

2. Lack of integration of behavioral health into primary care: Primary care providers are increasingly overburdened by the increasing demands of patient care, utilization of the EMR and growing panel sizes. As a result, less time is spent during an in-office encounter teasing out and addressing substance abuse and behavioral issues.

3. Stigma: An enduring stigma surrounding mental health and substance misuse continues to be high, even among medical professionals. Lack of understanding and education of behavioral health illnesses creates many barriers for integration, including a reduced rate of patients seeking help from

medical providers due to fear of being stigmatized and an unwillingness by providers to treat mental health or substance use disorders.

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) are 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. Utilization of Community Health Workers (CHWs) to address social determinants of health in patients with chronic disease.

Southcoast Hospitals Group was extremely fortunate to receive two years of funding from the HPC as part of its Chart Phase 2 award. The Southcoast CHART-2 program proposes to enhance care for patients frequently seeking care in the ED (≥10 visits/12 months) as well as for patients with a personal history of repeated hospitalizations (≥4 IP admissions/12 months). Collectively, these patients are referred to as high utilizers (HUs). The MyCare Team (MCT) model is comprised of Medical Directors, Nurse Practitioners, Registered Nurses, Social Workers, Case Managers and Community Health Workers who are reaching out to the cohort of patients in an effort is to keep patients out of crisis situations, thereby reducing the need for ED visits and possible inpatient admission. In our HU cohort, 65-70% of the HU patients suffer from a mental illness and/or substance abuse.

Proactively or upon presentation at a Southcoast hospital via real-time electronic notification, a HU patient is assigned to an MCT. The MCT attempts to engage the patient and offer assistance with accessing foundational needs, care, and care coordination. Once accepted by the patient, the patient receive enhanced, responsive multidisciplinary care from the MCT that will serve as a time-limited adjunct to traditional primary care and is concentrated on outpatient needs regardless of diagnosis. The services focus on integrated behavioral health, medical, social work, pharmacy, health literacy education and care navigation.

Diabetes management: Southcoast has worked for the past several years to establish a program that links community health workers (CHWs) with our Diabetes Management Program and several Southcoast primary care practices. The goal is to improve management of patients with chronic diabetes through education, community and clinical navigation, and assistance in overcoming barriers posed by social determinants of health, such as transportation, housing, and food security. To date, we have enrolled over 150 patients in the project after screening each one for social determinants of health barriers. Southcoast also works with seven CHWs, all of whom are employed by community partners, thus allowing us to support the work of community partners, while benefiting from their extensive expertise and access to resources in our communities. The CHWs are part of a health care team with Southcoast certified diabetes educators and primary care physicians. Many of the CHWs are bilingual and represent at-risk groups such as veterans and ethnic and racial minorities. CHWs have been successful in helping patients navigate a number of social determinants of health issues including colorectal cancer screening, loss of housing, transportation, immigration status issues, and food security.

Southcoast has demonstrated significant clinical results as we eliminate social barriers to better health management. Outcomes show an average A1c decrease of 2.4% in those who received CHW interventions. Patients achieving the greatest decrease in A1c had both Certified Diabetes Educator (CDE) and CHW interventions. The range of decrease was 3.1% to 6.6% within 6 months. Forty-one percent of patients attained an A1c of under eight. Patient adherence with good self-management also increased, with Diabetes Self-Management (DSME) procedure units improving by 38% in the CHW population (compared with patients who did not have CHW interventions). Diabetes Self-Management no-shows were reduced from 47% to 10% among patients with CHW interventions. This program, which has been carried out successfully in several Southcoast member hospitals and with community partners as CHART Phase 1 and Phase 2, continues to be expanded with the support of grant funding.

As part of our CHART work and our overall commitment to our patients, we understand the critical need to collaborate and coordinate care with our community partners, inpatient behavioral hospitals and Emergency Services Program providers. Many of the behavioral health patients in our system receive services and treatment from multiple different organizations and agencies. Further, there are a number of BH patients who are not well connected to resources and need our assistance in establishing those connections. We work to constantly improve our discharge documents, a treatment plan, and/or referral to resources that can assist BH patients in accessing outpatient services and connecting to resources within our community network.

2. Addressing food security initiatives and homelessness through farmers' markets, community supported agriculture, and our "Housing First" program.

Food insecurity and homelessness are two prevalent, often related issues that significantly affect community members' health outcomes. First, research has clearly demonstrated that food insecurity contributes to poor health outcomes. For example, it exacerbates chronic health conditions, including mental illness. Bristol County, which encompasses most of the Southcoast's service area, has the highest rate of food insecurity in Massachusetts. Data shows that over 12% of residents (more than 66,650 people) are often unsure of the source of their next meal. Southcoast, in recent years, has developed a number of programs to address food insecurity.

Farmers Markets and Community Supported Agriculture (CSA): Southcoast has had an active Farmers Market/CSA program for the past several years, providing fresh fruits and vegetables for both employees and the community. In 2015, Southcoast conducted 48 markets at four hospital sites, a 100% increase over the previous year. The markets improve direct access to healthy, locally-grown vegetables and fruits while supporting local agriculture. The CSA program, also available to employees and the public, expanded from four to eight sites, including three physician office complexes.

For the first time this year, the Food Services Department, in conjunction with the Community Benefits Department and community partners, engaged in a daily "Food Rescue" effort that distributed hundreds of gallons of soup that was left over in Southcoast hospital cafeterias. This was a collaborative effort with the regional Hunger Commission of the United Way, who picked up the soup from the hospitals and distributed it on a regular basis to approximately 30 regional feeding programs.

This year Southcoast also funded $25,000 in grants to community partners involved in food security issues. These include the development of community gardens, a food security referral program that links vulnerable hospital patients to food security programs in the community, and education on healthy eating on a budget.

Southcoast's healthy food program targeted vulnerable community residents as well as Southcoast patients with chronic disease. Efforts included:

- Weekly delivery of CSA vegetables to vulnerable diabetes patients by community health workers as part of our diabetes management program;
- Sponsorship of a Turkey Drive run by the Salvation Army to provide holiday turkeys to families in Greater Fall River;
- Providing evening meals to over 50 minority young men who are part of a program to address youth risk behaviors in New Bedford (the Food Services Department, along with a grant from the Market Basket Foundation, raised over $5,000 in spring 2015 to help with this effort);
- Collaboration with community partners as part of a regional Food Security Coalition and on various community grant projects to address food insecurity among vulnerable populations, including elderly residents;
- Weekly delivery of fruits and vegetables to a new Mobile Food Pantry operated by United Way of Greater New Bedford and a food pantry in Somerset serving homeless families in Greater Fall River. This helped provide fresh produce to over 500 families in New Bedford and over 200 homeless families in Fall River; and
- Annually providing Thanksgiving dinners to over 200 homeless families who reside in motels in the Greater Fall River area (Somerset and Swansea).

Additionally, recognizing the widespread and enduring issue of homelessness, Southcoast has sought to address it through strategies besides increasing food security for homeless families. Homelessness is a problem throughout our region, but in the town of Wareham, the rate of unsheltered homeless residents approaches the numbers in our larger cities, which have more than triple the total population. Over the past several years, the annual unsheltered homeless count in Wareham has exceeded 25 individuals, with estimates of up to 50 people. Homelessness is exacerbated by the lack of the shelters in the area (with the nearest over 20 miles away) and poor transportation. As a result, individuals often resort to sheltering in the woods.

Southcoast helped form and continues to lead a broad coalition of community partners that has conducted needs analyses and developed an action plan that has been implemented over the past several years. Southcoast staff serve as co-chairs of both the Leadership Council and four working groups—Housing, Intervention, Income, and Employment and Prevention—that were created to address key aspects of homelessness. The coalition embraces a "Housing First" strategy to addressing homelessness, focusing on first providing stable housing for individuals, then offering comprehensive wrap-around services to help them maintain housing.

This past year, the Intervention Working Group executed Memorandums of Understanding (MOUs) among all members and created and shared a working list of chronically homeless residents in Wareham to facilitate case management. This task was accomplished with the assistance of outreach workers who were part of the coalition. Homeless residents were interviewed to determine if they qualified for various federal and state housing programs, and their responses were used to create a prioritized housing list. More than five chronically homeless residents from the list were housed in scattered site housing during 2015. The Committee's overall goal is to house between two and five residents on an annual basis. The Housing Working Group also collaborated with Wareham town officials to identify potential housing sites in town, and is working to develop a system of housing readiness support for homeless residents who are about to receive housing.

The Housing Working Group is currently collaborating with government and environmental agencies to develop a congregate housing project that combines land preservation with housing for approximately six homeless residents. This project will progress further in 2017.

3. Addressing chronic diseases through health screenings in the community.

The Southcoast Health Van continued to play a major role in health outreach in our region. This past year over 4,168 residents visited the van, a 25% increase over the past year. Van staff provided over 13,000 screenings and 350 vaccinations. The Health Van focuses outreach on vulnerable populations in public housing, senior centers, the fishing community, soup kitchens and ESOL programs. Health screenings included cholesterol, blood pressure, blood sugar, body mass index, bone sonometry, oral cancer, and pregnancy and sexually transmitted disease (STI) testing at a number of teen clinics at local high schools. Health information was provided for stroke prevention and cancer education on breast, skin, cervical, prostate, lung and colon cancers.

Van staff participated this year in a cancer disparities outreach project to increase screening rates for colon cancer among vulnerable populations. The van offers a range of cancer screenings and education on cancer prevention, including distribution of colorectal cancer screening kits. There is a low rate of recommended colorectal screening in our region, due to cultural and health access barriers. Kits distributed on the van are processed free of charge at the Southcoast Hospitals lab and provide a basic level of screening that is accessible to all residents. Van staff also made referrals for primary care and other health services and health insurance. The Southcoast Health Van is licensed by the Massachusetts Department of Public Health.

Our data shows that 26% of those screened had abnormal blood pressure and 29% had abnormal cholesterol levels. Seven percent had abnormal blood sugar levels. Our van staff provides extensive education on these risk factors.

The Southcoast Health Van also distributes Stroke Awareness kits, in conjunction with the FAST campaign by the Massachusetts Department of Public Health. This campaign is designed to help residents recognize the signs and symptoms of stroke and act FAST in obtaining treatment. The van targeted African-American residents, who have a high incidence of stroke, at several community events, including a Gospel Festival and a regional Cape Verdean festival in Wareham. In addition to English, materials are also distributed in Portuguese and Spanish.

Finally, the Southcoast Health Van works with a CHW at the Fishing Partnership to coordinate regular health screenings and health insurance outreach with Southcoast's Patient Financial Services Department. An annual head and neck cancer screening on the New Bedford fishing pier this past year resulted in the detection of early cancer in eight patients, one quarter of those screened.

Southcoast was recognized this year by the Massachusetts Department of Public Health and the American Heart Association as a Center for Excellence for stroke care.

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)

1. Health literacy is a significant barrier in addressing social determinant of health issues. Our patient population is extremely diverse, with over 42% of residents in New Bedford (one of our major service areas) classified as "non-white," a 35% increase over the past 10 years. Hispanic residents comprise more than 50% of the population in several block groups in New Bedford and

often have limited English proficiency. Community partners who work with these populations also report that immigrants have low functional literacy levels, even in their native languages. Navigating both the health care system and community resources is a great challenge for these residents. This impacts factors such as educational attainment, chronic disease management, housing and employment, and other issues. Southcoast works closely with community partners, including CHWs, to assess health literacy and develop methods, such as video and audio tools, to help patients navigate physical, emotional, and social determinants of health needs.

2. Coordination of community resources to address social determinants of health can be a challenge as a number of community partners compete for limited grant funding and other resource support. This competition limits collaboration, decreasing the coordination of services that are then sometimes provided in "silos." This, coupled with literacy issues, often makes it difficult for vulnerable residents to access needed services. In recent years, Southcoast has striven to convene and strengthen coalitions to address social determinant of health and health equity issues. These include a Health Equity Committee that is part of the regional CHNA (Community Health Network Area). Also this past year, Southcoast began a grant RFP process to support community partners in targeted and collaborative work.

3. Transportation is both a significant social determinant of health issue and a barrier to overcoming other social determinants of health such as food security, employment and income, and education. The South Coast has a very fragmented public transportation system with poor access on evenings and weekends as well as a lack of connections throughout the region. In fact, it is easier for residents to reach Boston via public transit than much of the South Coast, including our Tobey Hospital service area located at the eastern end of the region. Transportation difficulties impact patients' access to services as well as residents' access to jobs, the region's otherwise ample supply of food sources, higher education, and even basic educational attainment such as high school attendance and graduation. In some vulnerable neighborhoods in our urban centers of Fall River and New Bedford, residents rely heavily on public transit, with over 80% of residents lacking cars. In 2015, Southcoast invested over $90,000 in providing transportation subsidies for patients, and we continue to strongly advocate public transit resources through our participation in several regional transit coalitions.

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.

Southcoast Physicians Group and the Southcoast Physician Network are able to provide quality, high-value care at a local level in most situations because of the caliber and the abilities of the physicians. Should the occasion arise requiring expertise not available within our network, our physicians have the ability to refer to specialists in academic medical centers in Boston and Providence or community providers that will meet the specific needs of the patient.

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.
39T

ii. If no, why not?

No, our newly implemented electronic medical record system does not incorporate either cost or quality information at the point of referral. While it is technically possible to integrate cost and/or quality data at the point of referral, doing so would require custom development and/or third party integration. Normalized data that would inform achieving lowest cost/highest quality referral for specific health conditions will require standardizing data that is currently fragmented and not easily accessible.

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.
39T

ii. If no, why not?

No, our newly implemented electronic medical record system does not incorporate either cost or quality information at the point of referral. While it is technically possible to integrate cost and/or quality data at the point of referral, doing so would require custom development and/or third party integration. Normalized data that would inform achieving lowest cost/highest quality referral for specific health conditions will require standardizing data that is currently fragmented and not easily accessible.

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.

Interface Connection	**Type**	**Special Conditions**
Greater New Bedford Community Health Center	Lab Results	Requires connectivity implementation
Affiliate Dr. Amy Wiegandt	Lab Results	Requires connectivity implementation
OB Associates	Lab Results	Requires connectivity implementation
Health First	Lab Results	Requires connectivity implementation

Southcoast Women's Care	Lab Results	Requires connectivity implementation
Lab Results to SSTAR Clinic	Lab Results	Requires connectivity implementation
Truesdale Nephrology	Lab Results	Requires connectivity implementation
OB/GYN Associates	Lab Results	Requires connectivity implementation
Highland Pediatrics	Lab Results	Requires connectivity implementation
Epic Care Everywhere EMR Integration with all U.S. Epic Clients (Regional: Integra Community Care Network, Lifespan, Partners, BMC, Lahey, Atrius)	EMR/CCD Integration	Limited to Epic Clients
Surescripts HISP Connectivity, enabling DIRECT clinical data exchange with community affiliates/non affiliates	EMR/CCD Integration	Group must be using ONC certified EMR
Epic Link	View Only of the Southcoast EMR	Requires signing Southcoast Data Use Agreement

ii. If no, why not?
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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 Health Maintenance Organization (HMO) population and 33% of the state Preferred Provider Organization (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)

1. Southcoast continues to work on alternative payment arrangements with payers that incorporate the "Triple Aim" goals of reducing costs, while improving patients' health and experience. This is predicated upon having enough covered lives in a particular health plan. In the last year, Southcoast has been working on new agreements with four more plans to work on population management. Southcoast distributes key information to physicians and staff to try to reduce the use of high cost providers; identify patients that need more intensive care management; reduce high-cost out-of-network utilization; and provide status updates on our quality metrics. Southcoast also recently renewed its application for another three-year contract with CMS for the Medicare Shared Saving Program. We have been meeting with some of the skilled nursing facilities ("SNFs") to review the length-of-stay (LOS) and readmission data, so that they clearly understand our intention to work with facilities that support the Triple Aim goals.

2. Southcoast has additionally been working internally on a bundled payment arrangement, which we hope to be the jumping off point for more in the future. Using the payer information we receive through our contracts, we have been able to fully review the cost and utilization data with the Physician Sponsor who is guiding us in the creation of bundled arrangements. This information has

highlighted the utilization of skilled nursing or rehabilitation facilities as well as the readmissions from specific facilities. For example, historical Southcoast data has shown that the number of Medicare patients going to a SNF for a hip or knee replacement (without any complications) was 75%, whereas nationally it is closer to 41%. This type of information has helped us set goals and care guidelines to increase the use of discharges home or with home health care support. In regards to hip/knee readmissions to an acute setting for this same population, we know that 6.8% of cases are returning to us, whereas in a well-managed environment, that amount should be closer to 4.2%. This information has allowed us to meet with our regional SNFs and announce which maintain an excellent readmission rate, which causes the remaining SNFs to request their data so that they can continue to receive our patients.

3. Lastly, Southcoast is building an internal data warehouse and reporting mechanism, which will incorporate payer data and provide key informational reports that will identify high risk patients needing enhanced care management, monitor quality metric results on a patient by payer basis, support our post-acute network, and pursue a variety of other activities.

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)

Some of the barriers to our organization increasing the adoption of APMs include:

1. Payer contract proposals that want the health system to take downside risk immediately;
2. Payers who do not provide the complete patient claims downloads, including pharmaceutical data, on a timely basis; and
3. Inadequate funding from payers to support the resources needed to adequately operationalize all of the arrangements.

These barriers may be addressed through the following:

- To give providers time to acclimate to risk arrangements and the operational processes that are necessary to manage the care needed, the State could give providers surplus-only arrangements during their first contract;
- The State could encourage that health plans provide complete downloads of claims data, whether in a risk arrangement or not, if desired, so that the primary care physician can more effectively manage the care that is needed;
- The health plans should be required to give an adequate amount of infrastructure monies to those that enter alternative payment arrangements. The monies that were previously used at a corporate level would be best used at the local Accountable Care Organization (ACO) level;
- The State could also encourage that the plans use their internal resources (i.e., actuaries) to establish the risk reserve levels that are appropriate for a given contract. Most hospitals cannot afford to hire an actuary for each contract that is being evaluated;
- The State could phase in a transition to the same weights and groupers for inpatient and outpatient care for all Commercial or Medicaid plans. Currently, the hospital has to purchase and monitor five different grouper and weights software, which is an added financial burden; and
- The State could assign collection of co-pays and coinsurance and deductibles to the insurance companies that created the high cost sharing products, so that the providers can focus completely on the health and welfare of the patients. This would reduce a

provider's bad debts and allow those resources to be used instead for patient care services.

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

Yes—but not always

i. If no, why not?

If behavioral health services are not included in the contract, it is likely due to the payer subcontracting that particular service to a company, which specializes in the management and control of such services, such as Beacon or United Behavioral Health.

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., full-time employees and the 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.

When a payer fails to utilize either the Massachusetts Standard Quality Measure Set (SQMS) or the core quality measures collaborative between CMS and Americas Health Insurance Plans, organizations are faced with creating strategies, internal reporting and oversight for one-off metrics. An example of this situation exists today within the MassHealth Hospital Quality Request for Application (RFA), which requires pay-for-performance reporting for Care Coordination measures known as CCM-1 and CCM-2; CCM-3 is also required and is included within the current SQMS. At the present time, however, the CCM measures are duplicative but not equivalent to CMS Meaningful Use (MU) requirements for hospitals. The current situation requires hospitals to build custom reports that expand on MU requirements in a manner that causes information overload and duplication for provider practices that receive these documents when a patient is discharged from the hospital setting. Provider practices express concern that the current documents may in fact result in patient safety issues due to the volume of transmitted data. In addition, standard file transmissions (electronic health record EHR to EHR) are standardized, national files and cannot be customized to include data elements within the MassHealth requirements. A hospital cannot meet both MU requirements and MassHealth requirements without transmitting duplicative information to provider offices and other providers of care who will follow the patient after hospital discharge. As a result, the requirements create administrative burden, EHR system maintenance costs and potential patient safety concerns by the receiving provider when excessive volume of information is received from hospitals.

Payers should not be permitted to modify existing, nationally recognized measures for purposes of a specific patient population within the payer. Modifying an existing measure by replacing or changing specific elements of the measures' technical specifications may result in non-repeatable and unreliable results.

A second, growing issue involves payers who survey their members, typically on an annual basis, with a patient experience survey. Not all payers may use the same survey tool. Not all payers inform the provider organization when surveys will take place. Southcoast utilizes a nationally recognized

vendor for its own ongoing patient experience survey and improvement efforts. When payers use their own system, patients may receive double-surveys, overhead costs to the health care system are increased and annual pulse surveys are not actionable for the provider organization and therefore provide little value.

A small number of payers require or endorse Leapfrog Survey participation. For data comparison purposes, Leapfrog surveys are not administered to all hospitals in all states, thereby eliminating proper performance comparisons across organizations. While an audit process is available for Leapfrog surveys, the degree of audit and validation of these publicly reported data elements may or may not be reliable. Therefore, Massachusetts payers may wish to discontinue use of the Leapfrog Survey, in whole or in part, within payer contracts, and convert to truly national and well-accepted quality measures from CMS, the National Quality Forum (NQF), the Healthcare Effectiveness Data and Information Set (HEDIS) and similar well-respected organizations.

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).

During payer contract negotiations, Southcoast leaders focus on standard quality measures with an effort to standardize the most commonly used measures among payers in order to effectively drive population health management across all payers. Even with these early efforts in place, Southcoast manages over 350 quality measures between payers and regulatory/accreditation organizations. In the case of MassHealth, input is provided via the Hospital Quality Advisory Committee to the greatest extent possible. When applicable, the Massachusetts Hospital Association may be requested to participate in MassHealth quality reporting requirements.

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.

Southcoast's recommendations address a wide range of areas, all focused on improving health care cost trends. First, to address the growth in pharmaceutical prices (a), Southcoast advocates developing a list of high cost medications to be substituted with less costly therapeutic alternatives while fighting for price reductions; mandating that insurance companies collect owed fees while also requiring subscribers to maintain their deductible amount in a Health Care Spending Account; and ensuring that patients receive care in the most appropriate environment while transition of care (TOC) pharmacists promote medication reconciliation and adherence. To enhance the integration of behavioral health care (b), Southcoast is developing a comprehensive database to improve care coordination across the Southcoast behavioral health system; increasing community outreach and education; and hosting a variety of behavioral health support groups that are open to the community. Next, Southcoast seeks to address social determinants of health (c) by linking community health workers (CHWs) with chronic disease patients for straightforward and effective disease management, leading various initiatives to address food insecurity as well as a coalition of community partners to provide housing and services to reduce homelessness, and increasing mobile, preventative screenings for early detection and effective treatment of disease. Southcoast further promotes the adoption of alternative payment methods (d) through strategically providing care in-network when possible to reduce prices, developing agreements with other plans (including a

bundled payment arrangement), and compiling data to inform key reports to improve care. Adding to this objective, finally, Southcoast has sought to standardize quality measurements while ensuring consistent, quality reporting (e). Overall, these recommendations and strategies are targeted both at Southcoast patients and vulnerable residents, emphasizing Southcoast's commitment to improving healthcare throughout the community.

In addition, through our CHART-2 project efforts, we have identified four main BH-related barriers that inhibit proper management of hospital services by patients with BH issues. In particular, patient need exceeds available resources in the areas of timely access (same day or next day) admission for inpatient alcohol detoxification services, access to inpatient BH beds for patients who are dual diagnosis (medical and behavioral issues), and timely access to outpatient BH providers for clinical assessment, medication prescribing, and therapy/counseling services. On top of these issues, payer reimbursement, including the Massachusetts Medicaid program and its MCOs for Community Health Worker services, should work with medically and behaviorally complex patients who cannot navigate the healthcare system on their own. Preliminary findings from CHART-2 efforts demonstrate that CHWs can favorably impact patient care and reduce acute care hospital and emergency department utilization rates.

Exhibit C: AGO Questions for Written Testimony

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

	2012	**2013**	**2014**	**2015**	**2016**
Commercial Business	29.6%	27.2%	29.6%	30.5%	27.6%
Government Business	-6.2%	-8.9%	-6.4%	-1.9%	-5.7%
Other Business	0.3%	-7.5%	12.7%	14.9%	14.5%
Total	6.0%	2.8%	5.7%	8.2%	4.1%

Percentage of Total Business

	2012	**2013**	**2014**	**2015**	**2016**
Commercial Business	26%	25%	25%	25%	24%
Government Business	69%	70%	71%	72%	73%
Other Business	5%	5%	4%	3%	3%
Total	100%	100%	100%	100%	100%

Commercial Business	**Government Business**	**Other Business**
Blue Cross of MA	Medicare	Work Comp
BC Mgcare	Medicare Mgcare	Free Care
Blue Cross RI	Medicaid	Self Pay
Commercial	Medicaid Mgcare	
Mgcare	Other Gov't	
HMO/PPO	Champus	
Harvard Pilgrim		
United Health		
Tufts		

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.

Southcoast utilizes the MedAssets Harvest system to determine prices for admissions, procedures, and services. These gross prices are periodically updated, particularly as charges are revised and new procedures added. This master pricing list is available internally to our Scheduling and Customer Service staff via our intranet.

We have identified our most common services and procedures and maintain the average price for each, along with a high-low range of possible outcomes. As consumers inquire, we communicate the average price and the price range to them.

We will also advise the consumer to share this pricing data with their health insurance provider to receive an estimate of their out-of-pocket expense associated with the service or procedure. If the consumer does not have health insurance, we will provide information related to our discounting policy for self-insured patients.

If a requested service or procedure is not on the existing list, we will compute the price and provide the pricing information to the consumer within one business day. This new procedure is then added to the master list.

While this process was in place prior to Chapter 224, we have expanded the procedure and service list significantly over time.

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.

With our recent change to the Epic electronic billing system, we are planning on creating a log of all inquiries to determine how many people actually schedule the service or procedure and the accuracy of our pricing estimates. Additionally, we have in place an active and regular secret shopper program that helps ensure that we are informed of the quality of our patient services.

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?

The requests for pricing have been infrequent, about 1 to 2 per week. Many of the requests are related to cosmetic procedures. We have been able to respond to most requests in a timely manner. One barrier is the specific description of the service. There are significant differences in price based on a seemingly small change in the description of the service. Also, variations in surgical procedures may lead to more operating room time than originally estimated. Making the consumer aware of the price range for the service or procedure has been helpful in accommodating the potential for price variation.