Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING AFFILIATE

September 9, 2014

Mr. David Seltz
Executive Director
Health Policy Commission
2 Boylston Street
Boston, MA 02116
Via Electronic Submission

Re: Annual Health Care Cost Trends Testimony

Dear Mr. Seltz:

This letter transmits Cambridge Health Alliance's written testimony in response to the questions from the Health Policy Commission and the Office of the Attorney General in a letter dated August 1, 2014.

I am legally authorized and empowered to represent Cambridge Health Alliance for the purposes of this testimony. I attest, to the best of knowledge, that the attached testimony is accurate and true, and sign this testimony under the pains and penalties of perjury.

Please feel free to contact me should any questions arise.

Sincerely,

Patrick R Wardell

Patrick Wardell
Chief Executive Officer
Cambridge Health Alliance

Enclosure

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 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 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 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 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school 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 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 Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and 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 other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

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 CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY: Cambridge Health Alliance (CHA) is undertaking a number of promising activities to improve the way that health care is delivered and coordinated with the goal of achieving the triple goals of improving health, patient experience of care, and cost-effectiveness. CHA is implementing a set of initiatives for 1) effective population health management of our patients and management of total medical expenditures and 2) to improve the performance and cost-effectiveness within our health care delivery system. The Commonwealth's reports indicate that CHA is among the lowest reimbursed hospitals by commercial payers. CHA's reimbursement from major commercial payers is approximately $17.1 Million below the average commercial acute hospital rate, and policy action is needed to address payment disparities to improve reimbursement to support high value care in our communities.
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.
      Cambridge Health Alliance (CHA) has experienced a modest increase in volume adjusted costs, well below the benchmark 3.6%. CHA has focused its cost containment efforts on growing its primary care and behavioral health services to the safety net population in order to improve care coordination and the delivery of services in lower cost settings. Inpatient utilization declined approximately 4.7% while outpatient utilization as measured by clinic visits increased by 3.7%. Net patient revenue increased by approximately 12.9% during the same time period, reflecting shifts in contracting and reimbursement strategies between CHA and its major payers. Operating expenses, net of amounts reimbursed to cover costs of non-patient care, increased 4.7%, resulting in only a marginal increase in volume-adjusted costs.

   b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?
      Cambridge Health Allaince (CHA) continues to deploy the following strategfies to provide cost-effective care to our patients:
      A. Patient-Centered Medical Home model of care in primary care as a foundation of population health management and effective care coordination for our patients.
      B. Expanson of our clinical model to incorporate complex care management for high risk patients that integrates ambulatory and inpatient care needs.

C. Modifications to our clinical affiliations and referral patterns to align our services with high quality, lower cost providers within our service area including our ongoing clinical affiliation with Beth Israel Deaconess Medical Center.
D. Expansion of Accountable Care Orgainzation (ACO) activities which include obtaining claims data to understand and respond to factors contributing to total medical expense.

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?
Cambridge Health Alliance (CHA) is undertaking a range of initiatives in innovative care delivery approaches, use of technology, and error reduction including, but not limited to, efforts in care transition, care coordination, care management, behavioral health and physical health integration, and expansion and optimization of Electronic Medical Record and Information Technology tools. Additional detail is provided in Appendix A.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
Toward efforts to improvement population health mangement, greater integration of care for physical health and behavioral health is essential. This efforts are complicated by the carve-outs of behavioral health services by insurers.

Clarification on the roles of ACOs versus insurers in certain activities, including referral authorization and prior authorizations, will assist with reducing redundancy and administrative hurdles in care coordination.

Administrative simplification and standardization, including for referrals, claims processing, and quality measures, are certain ways that policy makers can reduce the administrative burden on providers. For example, we have hundreds of quality measures with definitions that vary across insurers.

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
SUMMARY: Cambridge Health Alliance (CHA) is rapidly advancing our participation in alternative payment methods (APMs) toward better health and cost-effective care. Leading with Medicaid, Dual Eligibles/Senior Care, and Medicare Pioneer collaborations, 45% of CHA's patient panels are in risk-sharing arrangements with additional near-term shifts expected. CHA continues to invest in programs and personnel, information systems, and development of integrated care management and transitions of care processes, and enhancement of referral management functionality to manage under APMs.
    a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other

non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations?
CHA has embraced the strategies necessary for management in an APM environment. The changes in our payer relationships have required CHA to make investments in programs and personnel that were previously not required in the typical fee-for-service environment. These investments include expansion of our electornic medical record and information systems technology to manage to multiple and disparate quality and performance measures, development of integrated care management and transitions of care processes, enhancement of referral management functionality, and expansion of skills necessary to manage and analyze claims data. Operationally, CHA has invested in care transitions, readmission management, post-acute facilitation and complex care management for the express purpose of managing risk, clinical quality, patient outcomes and cost and utilization. Finally, to ensure that care is managed across the continuum CHA has established a clinical affiliation with a high value network through Beth Israel Deaconess Medical Center.

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).
CHA has not performed any discrete and specific analysis on the impact of APMs on our non-clinical operations. As part of the annual budgeting process, CHA evaluates the need for expansion or contraction of existing non-clinical operations and any requirements for new resources or services that may be needed in an alternative payment environment. Over the last two years, CHA has invested heavily in the establishment of new functions and programs to help manage in an APM environment. Over this next period, CHA will have greater that $10 Million annually invested in complex care management, care transitions, ACO analytical staff, software, medical leadership, clinical partnerships and contracting expertise.
c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.
Over the last year, APMs have been initiated and/or changed substantially for CHA. Consequently, performance results and analytics are not currently available for new alternative payment arrangements. However, for our safety net population, CHA has analysis that demonstrates the impact of our complex care management process on high risk patient populations for two payer cohorts where improvements resulted in cost avoided of approximately $1.7 Million on an annual basis (see below). Our ability to perform this analysis on non-risk based populations is hampered by the lack of claims data to conduct this analysis.

For a Medicaid and Commonwealth Care Managed Care payer population, CHA identified the top 3% highest risk members and assigned all of these patients to complex care managers to conduct follow-up assessment, screening, outreach, and enrollment as appropriate in complex care management services. Overall, CHA

achieved annual costs avoided of approximately $809,000 for those high-risk Medicaid and Commonwealth Care Managed care patients enrolled in complex care management with sufficient pre-and post-intervention enrollment and data.

For a Senior Care Options/Dual Eligibles payer, CHA selected the top 10% highest-risk patients for care management, and all were assigned to care managers and enrolled in active care management. CHA achieved annual costs avoided through risk stratification and care management for a high risk cohort of 75 patients of approximately $881,000, which resulted from a year-over-year 13.8% reduction in total medical expense per member per month (PMPM) or a reduction of $1047 PMPM. An analysis of related utilization trends for this high-risk cohort reveals a reduction of 44.4% in inpatient discharges/1000 year-over-year. At the same time, CHA has demonstrated overall improvements in the care of older adults through quality indicators, including prevention and screening measures.

Across the entire Senior Care Options payer cohort, CHA achieved an overall reduction of 0.3% in claims cost per member per month form the 2012 - 2013 period.

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3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.
   SUMMARY: Health status risk adjustment measures used in establishing risk contracts and other APM contracts remain an evolving state-of-the-art, and are lacking consideration for the resource intensity of behavioral health care conditions and the social acuity of the population, especially for government payer and safety net populations.
   a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?
      Health status risk adjustment measures received from payers account for some changes in acuity, but are still lacking reasonable consideration for behavioral health conditions and socio-economic status. In the absence of detailed risk status information and methodologies used in specific payer applications of risk scores, it is difficult to understand the trends in relative risk of CHA's population vis-à-vis the payer's population and comparison of CHA's population across payers. This is exacerbated when the risk scores from standard commercially available models are modified methodologically by the payer thereby, making the models proprietary information that is not shared nor understood. While percentile rankings produced by some payers help in targeting complex care management activities, these cannot be used for financial analytics as much as the availability of risk scores at a member level. Standardization of risk models and their application would be an enhancement from a provider perspective.

   b. How do the health status risk adjustment measures used by different payers compare?

The level of risk score information received from different payers is not the same, nor are the models and software versions that are utilized. There tends to be more consistency with Medicare-based products, which generally rely on member-level risk score information based on Verisk models and CMS risk indices. In contrast, the commercial and Medicaid payor population risk information varies widely, and generally only reflects a ranking of patients and not actual patient-specific risk scores. Some risk-based indices and detail are more suited for applications in care management activities and financial analytics than others. In addition, continuity of this information depends on payers' data issues and/or risk stratification vendor/version changes.

c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

Risk adjustment measures affect our organization in profound ways. As an increasing proportion of our patient population is covered by alternative payment model contracts, risk adjustment of our population used in payment methods or those based on predictive models for care management developed by payer partners have a large impact on care deployment methodologies, assessments of variation, standardization of care, risk sharing, and financial settlements. For methodologies that use risk-adjusted capitation payments or budgets, these methodologies have a significant and material impact on reimbursement and adequacy of resources to manage population health. The current state-of-the-art in these risk adjustment measures typically do not account for the resource intensity of behavioral health care needs or the social acuity of the population.

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4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.

SUMMARY: Routine access to timely and actionable data that has some standardization is important to effective population health management.

ANSWER: With APMs, it is essential to understand in real time the care that is being accessed by patients and the related disposition of patients. This information includes more timely patient enrollment, daily authorizations, referrals, emergency department and inpatient admissions and discharges (acute and post-acute) data. For population health management and/or financial planning, all claims data inclusive of behavioral health, substance abuse and pharmaceutical claims is needed. In addition to claims data, having predictive risk scores, gaps in care, and other non-claims based social, economic and demographic data (e.g. language, income, housing status, etc.) would be necessary to have a more complete understanding of our patient population.

5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY: Cambridge Health Alliance (CHA) believes that primary care provider relationships and patient engagement in their health care is at the foundation of population health improvement. Therefore, we support member attribution methods that are based on the patient's selection of a specific primary care provider or practice as a generally preferred approach.
   a. Which attribution methodologies most accurately account for patients you care for?
      The attribution method that is the most accurate and is generally preferred by our providers is the patient selection of a specific primary care provider.
   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
      CHA would prefer that the plans require the selection of a primary care provider versus an arbitrary calculation based on a patient's historical utilization of care. Patient selection would actively engage the patient, and encourage the patient to commit to a consistent partnership in primary care for management of their health care needs. If attribution is to continue or is required, the dominance of claims by a primary care provider (only) would be the preferred method.

6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.
   SUMMARY: A substantial level of effort and resources are required to report health care quality measures, currently in the range of 500 quality metrics that vary across private and public payers. Opportunities for greater standardization and use of evidence-based, validated measures are important to alignment, to administrative simplification, and to effectively deploy administrative resources.
   ANSWER: Cambridge Health Alliance (CHA) expends a substantial level of effort and resources to report on the health care quality measures, currently in the range of 500 distinct quality metrics that vary across public and private payers. These metrics frequently have different definitions that are subject to change over time, measurement standards or periods, data requirements, and relate to subpopulations of patients by specific payer cohort. Designing the clinical and information systems to capture the quality data, building information technology reporting capabilities, training and requiring clinicians to capture the quality data in the information systems often through new reportable fields they must populate in the electronic medical record, abstracting the data and chart reviews for those measures where fields in electronic medical records do not have reportable fields for the measure, and reporting these metrics requires health care resources across many spectrums of health care, including adding administrative requirements for clinical practices.

   Regarding metric targets, some metrics have such small denominators given the low incidence of the clinical events that a small change in either numerator or denominator,

even 1 or 2 cases, can result in an apparent change in metric performance which is just due to the mathematics of small numbers.

To reduce the burden and increase the meaningfulness of quality reporting, the following recommendations are suggested for consideration:

- Metrics should, to the greatest extent possible, use validated, standard definitions and allow for multi-year reporting of those measures to chart progress.
- Metrics should drive performance that is clinically-indicated and evidence-based.
- For clinically important but small denominator metrics, the metric target should be set at a realistic threshold of achievement rather than at a progressive percentage improvement.

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7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.
   SUMMARY: Cambridge Health Alliance (CHA) continues to deploy a number of strategies to help manage our patient's access to care in a lower cost setting, including continuity of all appropriate care within CHA system, and for services that CHA does not provide, leveraging our clinical partnerships capabilities to provide these services locally in a community setting before considering the use of academic medical centers.
   a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.
      Given that the majority of CHA's patient population is in a range of government payers, access to this claims-based information is limited. Upon routine claims data made available in the future, this is an important opportunity for analysis.
   b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.
      CHA has deployed a number of strategies to help manage our patient's access to care in a lower cost setting. These actions include ongoing conversations with our providers to manage all appropriate care within the CHA system and with our patients about the benefits of coordinated care. For services that CHA does not provide directly we leverage our clinical partners' capabilities to provide these services locally before considering the use of an academic medical center.

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8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
   SUMMARY: CHA has a variety of strategies to ensure appropriate use of post-acute care, assessing for each patient in the inpatient setting the appropriate level of care, utilization review, severity of illness, course of treatment, and appropriate discharge planning. In addition, CHA collaborates with community based organizations to manage transitions of care from an acute care setting to a clinically appropriate post-acute setting.

a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.
CHA performs a daily utilization review for each patient in the inpatient setting to assess appropriate level of care and anticipate discharge needs. In addition, a multi- disciplinary team comprised of physician hospitalists, nursing staff, case mangement/social work, physical therapy/occupational therapy, pharmacy and nutrition meet each morning to assess each patient's severity of illness, evaluate the course of treatment and formulate discharge plans. The goal is to discharge each patient to the most appropriate, least intensive post-acute setting possible, considering medical, psychosocial, and resource factors that will optimize each patient's recovery. CHA confirms this assessment with the receiving post-acute provider and the patient's payer.

b. How does your organization ensure optimal use of post-acute care?
CHA's Community Based Care Transitions Program (CCTP), which was developed over three years ago, is a partnership with Aging Services Access Points (ASAPs) and Visiting Nurses Associations (VNAs). The CCTP, in coordination with CHA's Case Management Department, endeavors to manage transitions of care from an acute care setting to a clinically appropriate post-acute setting. While the CCTP began with the Medicare population, this level of acute to post-acute care transition management is being considered for the non-Medicare population.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY: CHA continues to provide patients with estimates for charges and their responsibility and has formalized its processes to comply with related Chapter 224 requirements. Requests for estimates are most often initiated via phone call to the Revenue Cycle Customer Service Department, although they may also be initiated via our website. Patients who call without insurance are assisted in obtaining available coverage, and those who have insurance are provided contact information to allow them to confirm their estimated personal obligation directly with their insurance company.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1	1	62	24
	Q2	2	37	24
	Q3	3	26	24*
	TOTAL:	6	125	

** Please indicate the unit of time reported.*

ANSWER: The majority of pricing requests relate to outpatient diagnostic testing (colonoscopy, CT/MRI). CHA retains copies of all price estimates and will work with patients to resolve discrepancies with final patient obligations once services have been rendered. To date, these discrepancies have not been significant, and CHA has not initiated a formal analysis of their accuracy.

* Average Response Time of "24" is in hours. If patients know the specific CPT code of the service they are seeking, response is same day. If not, the response is < 48 hours.

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10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
SUMMARY: CHA has found that tiered and limited networks disrupt integrated care plans and integrated medical records systems, referral patterns, quality improvement and outcomes management for our patients. The impact of limited networks for CHA is disproportionately experienced by our Medicaid population.
ANSWER: Tiering disrupts the efficiency and quality improvements that depend on integrated systems of care. Providing financial incentives that may fragment patient care by going to multiple health care entities likely increases cost by disrupting integrated care plans, integrated medical records systems, quality improvement and outcomes management.
When physician groups and hospitals are operating as integrated systems, tiering physicians and hospitals separately can create unexpected financial outcomes for patients who often do not understand what ratings they have to review to determine co-pays. Additionally, CHA specifically has been adversely impacted by the tiering of networks largely because of the arbitrary, inconsistent approach payers have taken to deploy this strategy. Often the metrics are not consistent between payers, generally lack transparency, and providers tend to be notified after the fact in terms of the tiering methods.

Limited networks over the last year have required that CHA reconsider referrals patterns for specialty and tertiary care. In addition, these changes have often conflicted with our clinical or academic program alignment. In many cases, theses limited networks have served to shift business from higher cost organizations. In all cases, when CHA is faced with market influencers as described above, we internally re-evaluate our referral and resulting business strategies. Finally, the impact of limited networks for CHA is disproportionately experienced by our Medicaid population.

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11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    SUMMARY: CHA, as a provider of regional behavioral health services along the full continuum of inpatient and outpatient care, is implementing a range of innovative collaborative and integrated care initiatives for behavioral health patients, such as a primary care and behavioral health integration model for adults and pediatrics, an initiative along the community-based care continuum to provide integrated medical and behavioral health care to older adults including those dually eligible for Medicare and Medicaid, enhanced registry tools designed to manage high prevalence behavioral health conditions based on evidenced-based protocols, and deployment of new comprehensive behavioral health screening tools.
    a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.
       CHA provides high quality integrated care focused on population health through its integrated health care system including regional behavioral health services along the full continuum of inpatient and outpatient care. CHA is implementing a primary care and behavioral health integration model for adults and pediatrics on a phased basis across all of its core primary care centers. In addition, CHA is implementing an initiative along the community-based care continuum to provide integrated medical and behavioral health care to older adults including those dually eligible for Medicare and Medicaid to improve health outcomes, quality, and the cost-effectiveness of care.
    b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.
       Central to CHA's collaborative care model is a framework of “Stepped Care” in which the complexity of the patient’s behavioral health condition is matched with the appropriate level and intensity of care. New technology and tools, including enhanced registry tools, are designed to manage high prevalence behavioral health conditions based on evidenced-based protocols, such as the population receiving depression screening and follow-up care. Key to success is early identification of the patient’s behavioral health needs through improved screening rates for high-prevalence behavioral health conditions via the deployment of a new comprehensive behavioral health screening tool. The goals are improved

utilization of behavioral health services and treatment to promote wellness, and reduce unnecesary use of emergency and inpatient services.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.
   An initial program assessment of activities through SFY 2013 highlighted a number of opportunities to improve patient care and advance the primary care–behavioral health integration effort, such as further defining integration objectives to ensure that CHA moves beyond co-located care to care that is fully integrated into primary care culture, workflows, and clinical outcomes; development and systematic use of a mental health registry with initial focus on depression to track and manage mental health conditions and follow-up monitoring of clinical indicators; and refining training strategy for primary care and mental health clinicians in effective integrated care approaches.

   Barriers include carve-out behavioral health vendors utilized by some payers that fragment physical health and behavioral health care.

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.
   CHA has the ability to provide behavioral health inpatient discharge data, subject to regulatory and health information privacy (HIPAA) compliance. Payers should carry out their responsibilities in sharing data and appropriate communications to help facilitate behavioral health post-discharge and post-emergency department follow-up care. Primary care providers and behavioral health clinicians caring for a patient often do not receive this information, especially if the care is rendered within an external provider system.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
    SUMMARY: CHA has made significant progress to expand the PCMH model in primary care as a foundation for improving health care delivery, promoting health, and panel management in alternative payment models. As of June 2014, seven of twelve of CHA's core primary care practice centers have achieved National Committee for Quality Assurance (NCQA) Level 3 Patient-Centered Medical Home recognition, the highest level. CHA's early NCQA recognized medical homes have shown better quality, access, and patient experience scores than other CHA practices.
    a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?
       As of June 2014, seven of twelve of CHA's core primary care practice centers have achieved National Committee for Quality Assurance (NCQA) Level 3 Patient-Centered Medical Home recognition, the highest level. About 70 of

CHA's 128 primary care providers (55%) are working in a nationally recognized PCMH.

b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
   As of June 2014, 56% of CHA's primary care panel patients received care from practices accreditied as PCMHs.
c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.
   CHA has made significant progress to expand the PCMH model in primary care as a foundation for improving health care delivery, promoting health, and panel management in alternative payment models. Seven CHA primary care sites have achieved the highest level of NCQA PCMH Recognition, Level 3. Over 57,000 patients are assigned to primary care medical home care teams. Two additional primary care sites have begun the transformation process this year.

   CHA's early NCQA recognized medical homes have shown better quality, access, and patient experience scores than other CHA practices according to a recent Commonwealth Fund case study. The Robert Wood Johnson Foundation recently recognized CHA as one of thirty outstanding primary care practices through the Primary Care Team: Learning from Effective Ambulatory Practices program.

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13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
    SUMMARY: CHA has been indentified as a low relative price provider and among the lowerst reimbursed hosptials by all major Massachusetts commercial insurers in the Health Care Cost Trends Reports. These reports indicate persistent and substantial payment disparities for CHA not only on a regional and statewide basis. Rate disparities in our service area and in Greater Boston are particularly problematic, where some area hospitals have a relative price that is 2 times or greater than the rates paid by private insurers to CHA. Inadequate commercial insurance reimbursement to our hospital for the same level and quality of service has contributed to financial challenges and operation losses we have incurred. Improvements in reimbursement levels are necessary to sustain CHA as a high-value provider and promote an efficient, high-quality health care delivery system in our service area.
    ANSWER: CHA has been indentified as a low relative price provider and among the lowerst reimbursed hosptials by all major Massachusetts commercial insurers in the Health Care Cost Trends Reports. These reports indicate persistent and substantial payment disparities for CHA not only on a regional and statewide basis, but it is particularly acute in comparison to other hostpials proximate to our service locations and in the Greater Boston area. Inadequate commercial insurance reimbursement to our hospital for the same level and quality of service has contributed to financial challenges and operation losses we have incurred. Improvements in reimbursement level are

necessary to sustain CHA as a high-value provider and promote an efficient, high-quality health care delivery system in our service area. Rate disparities have been proven not to self-correct, will drive up costs, and will have consequences on health care access in our communities. Policy action is needed to address the problem that will threaten access to statewide health care over time and undermines population health management efforts. Recent market acquisitions proposed by market dominant health care systems are evidence of these challenges and the need for policy action, and they point to reduced availability of affordable local healthcare alternatives in the communities north and south of Boston as proposed.

Specifically, there are reimbursement challenges with the base reimbursement levels for primary care and behavioral health care services, both of which play a critical role in population health, but have been undervalued in today's health care reimbursement system. There are additional reimbursement needs for functions that are not typcially reimbursed, such as care management and care coordination personnel and activities, the consultative role behavioral health clinicians can provide to primary care clinicians in managing overall integrated care, the administrative requirements of managing in alternative payment methods, and medical home support payments.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing for each year 2010 to 2013 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 Hospital 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.

   Completed in Attachment AGO Hospital Exhibit 1

   AGO Hospital Exhibit C, Question #1, Exhibit 1 incorporates total revenue for CHA's Hospital and Physician network. In some circumstances, risk arrangements may not incorporate both our hospital and physicians, and data represents an aggregated result of these contracts. The data is supplied in total (not apportioned by HMO and PPO), as systems are not presently in place to track to this level. The data exhibits the level of reporting in place during a particular fiscal year. Therefore, conclusions should not be drawn about the relative changes in reimbursement or shifts in payer-related activity year-over-year.

2. For each year 2010 to present, please submit a summary table showing for each line of business (commercial, government, other, total) your inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as AGO Hospital Exhibit 2 with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

   Completed in Attachment AGO Hospital Exhibit 2

   Cambridge Health Alliance (CHA) is unable to complete this exhibit because it does not have a cost accounting system in place at this time. While it might be possible to make estimates of the contribution margin by payer by service utilizing ratios from sources such as the Medicare cost report, these estimates would not be an accurate assessment of costs at the individual patient, and therefore aggregated payer level. Given the level of assumptions necessary to develop this type of analysis, if possible, the results would not be comparable across providers. We have provided the margin data at the total provider level. Please find attached in Exhibit C #2 the Center for Health Information and Analysis Financial Performance Indicators Fact Sheet for CHA for Fiscal Years 2010 through 2013.

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., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.

Cambridge Health Alliance (CHA) is using a range of financial and analytical strategies for assessing and quantifying risk. Medical expenditure budgets under global contracts are formulated based on historical total medical expense trends, adjusted for the relative risk of our patient population. This information for the most part is provided by insurers and incorporates a range of stop loss coverage. In recognition of the fact that alternative payment models will continue to be a major influencer of CHA's financial and operational status, CHA has established a clinical affiliation with Beth Israel Deaconess Medical Center and contracting relationship with Beth Israel Deaconess Care Organization to help develop this aspect of our business.

4. Please explain and submit supporting documents that show how you analyze and track the volume of inpatient and outpatient referrals to your hospital and the associated revenue from those referrals by particular physicians or provider groups. Please include a description and examples of how your organization uses this information.

Cambridge Health Alliance (CHA) operates with a largely employed physician model, employing or contracting with the majority of physicians who utilize CHA services. Consequently, the tracking of referral volumes is more related to what is referred to external providers than what is referred to CHA for services.

Appendix A

Answer to Question 1.C. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology, and error reduction) to ensure the Commonwealth will meet the benchmark.

Cambridge Health Alliance (CHA) is undertaking a range of initiatives in innovative care delivery approaches, use of technology, and error reduction including, but not limited to, the following:

- Patient safety: CHA is implementing a number of systems-based approaches to improve patient safety. These include the deployment of the Beacon system to increase safety in chemotherapy. deployment of bar coding technology for medication administration to improve safety and to decrease medication errors, and deployment of a new inpatient nurse call system. CHA is upgrading the IT Risk Management system, RL Solutions.
- Care Transitions: CHA is advancing comprehensive initiatives to improve care transitions and readmission prevention. Hospital to Home (H2H) has enrolled 1000 patients; 1000 hospital visits, 600 referrals to VNA, 700 home visits, 2000 outreach phone calls. The Readmission Rate has decreased by 14% from a baseline of 21.8% (in 2010) to 18.8% (through 4/13).
- Care Coordination and Care Management: CHA is implementing a number of care coordination and care management initiatives toward population health management and effective care for ambulatory-sensitive conditions. These include complex care management for high-risk patients across 7 of our primary care centers, with plans for system-wide spread over the next year, with promising early results based on initiatives for 2 populations. Robust care management activities have lead to promising results in improved care coordination and costs avoided of approximately $1.7 Million for identified high risk patients in Senior Care Options/Dual Eligibles and Medicaid and Commonwealth Care payer cohorts.

  CHA is deploying a multi-year referral management initiative to promote coordinated care within a high-value network of providers and provide community-based care where possible. CHA is also implementing Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) to engage patients in advanced directives and to improve end-of-life care.
- Behavioral Health and Physical Health Integration: CHA is implementing a portfolio of initiatives to advance the overall health of patients by integrating behavioral health and physical health care.
- Expansion and Optimization of Electronic Medical Record and Information Technology tools: CHA is currently working to expand the use of our EMR in specialty care areas including within our Elder Service Plan for frail elders dually eligible for Medicare and Medicaid. CHA is also actively working to optimize our EMR to increase effectiveness and practice efficiencies by improving the interfaces between the hospital information system and our EMR to allow the automatic flow of information, developing a portal with our clinical affiliates to link access of medical records, and implementing an automated interface between our EMR and the Mass HIway; the Massachusetts Health Information Highway.

Exhibit 1 AGO Questions to Providers and Hospitals

Please email HPC-Testimony@state.ma.us to request an Excel version of this spreadsheet.

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. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **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.
6. **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 do not subject you to any "downside" risk.
7. **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.
8. **Other Revenue Arrangements** are arrangements for revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as managements fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **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.
10. **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.
11. **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.
12. **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.

2010 **Cambridge Health Alliance Exhibit C, Question 1, September 8, 2014**

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	ALL		ALL		ALL		ALL		ALL		ALL		ALL		Both
BCBSMA *	22.7		0.2		9.4								1.4		
Tufts *					3.4						6.0		0.5		
HPHC *					3.6						4.8		0.5		
Fallon											0.1				
CIGNA											0.8				
United											2.1				
Aetna											2.5				
Other Commercial											20.0				
Total Commercial	22.7		0.2		16.4						36.3		2.4		
Network Health											34.3				
NHP											10.2				
BMC Healthnet											0.9				
Fallon															
Total Managed Medicaid											45.5				
Mass Health	55.7		0.7								7.9				
Tufts Medicare Preferred					0.4						1.5				
Blue Cross Senior Options											0.8				
Other Comm Medicare											5.0				
Commercial Medicare Subtotal					0.4						7.3				
Medicare											75.0				
GRAND TOTAL	78.4		0.9		16.8						172.0		2.4		

*** The risk for these contracts are settled in the aggregate, results were prorated across these payors for purposes of estimating impact**

*** For these contracts the physicians organization is the only participant**

2011 Cambridge Health Alliance Exhibit C, Question 1, September 8, 2014 Dollars are shown in Millions.

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	ALL		ALL		ALL		ALL		ALL		ALL		ALL		Both
BCBSMA *	24.1		0.3		8.9		0.6						0.7		
Tufts *					3.2		0.2				5.8		0.3		
HPHC *	6.0		0.1		3.6		0.2						0.3		
Fallon															
CIGNA											1.0				
United											2.7				
Aetna											2.7				
Other Commercial	0.2										17.2				
Total Commercial	30.3		0.4		15.7		1.0				29.4		1.3		
Network Health					34.9										
NHP											12.4				
BMC Healthnet											0.6				
Fallon															
Total Managed Medicaid					34.9						13.0				
Mass Health	59.9		2.1								7.2				
Tufts Medicare Preferred					0.5						2.2				
Blue Cross Senior Options											0.7				
Other Comm Medicare											6.8				
Commercial Medicare Subtotal					0.5						9.7				
Medicare											77.0				
GRAND TOTAL	90.2		2.5		51.1		1.0				136.3		1.3		

* The risk for these contracts are settled in the aggregate, results were prorated across these payors for purposes of estimating impact

* For these contracts the physicians organization is the only participant

2012 Cambridge Health Alliance Exhibit C, Question 1, September 8, 2014 Dollars are shown in Millions.

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	ALL		ALL		ALL		ALL		ALL		ALL		ALL		Both
BCBSMA *	24.1		0.3		8.6		0.9						0.6		
Tufts *					3.2		0.3				4.1		0.2		
HPHC *	5.6		0.1		3.7		0.4						0.3		
Fallon															
CIGNA											1.2				
United											3.1				
Aetna											2.5				
Other Commercial	0.2										22.7				
Total Commercial	29.9		0.4		15.5		1.6				33.6		1.1		
Network Health					33.7		(3.8)				5.7				
NHP											13.1				
BMC Healthnet											0.5				
Fallon															
Total Managed Medicaid					33.7		(3.8)				19.3				
Mass Health	63.5		2.0								7.4				
Tufts Medicare Preferred					0.4		0.1				2.0		0.1		
Blue Cross Senior Options											0.8				
Other Comm Medicare											9.5				
Commercial Medicare Subtotal					0.4		0.1				12.3		0.1		
Medicare											89.8		0.2		
GRAND TOTAL	93.4		2.4		49.6		(2.1)				162.4		1.4		

* The risk for these contracts are settled in the aggregate, results were prorated across these payors for purposes of estimating impact

* For these contracts the physicians organization is the only participant

2013 Cambridge Health Alliance Exhibit C, Question 1, September 8, 2014 Dollars are shown in Millions.

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	ALL		ALL		ALL		ALL		ALL		ALL		ALL		Both
BCBSMA *	23.33		0.50		9.46		0.90						0.41		
Tufts *					3.57		0.36				7.09		0.20		
HPHC *					3.69		0.38				4.93		0.20		
Fallon											0.14				
CIGNA											1.64				
United											4.17				
Aetna											2.59				
Other Commercial											21.92				
Total Commercial	23.33		0.50		16.71		1.64				42.47		0.81		
Network Health					35.75		(2.31)				6.38				
NHP											13.90				
BMC Healthnet											0.98				
Fallon											0.06				
Total Managed Medicaid					35.75		(2.31)				21.33				
Mass Health	55.85		0.70								7.42				
Tufts Medicare Preferred					0.38		0.10				2.00				
Blue Cross Senior Options											0.56				
Other Comm Medicare					5.64		0.64				6.02				
Commercial Medicare Subtotal					6.02		0.74				8.58				
Medicare											85.61		0.05		
GRAND TOTAL	79.19		1.20		58.49		0.07				165.40		0.87		

* The risk for these contracts are settled in the aggregate, results were prorated across these payors for purposes of estimating impact

* For these contracts the physicians organization is the only participant

Cambridge Health Alliance
Exhibit C: #2

Hospital Cambridge Health Alliance	City/Town Cambridge	County Middlesex	Teaching Status[1] Teaching	Fiscal Year End[6] 6/30/2013		Number of Months Data 12	
Financial Performance Indicators	FY09	FY10	FY11	FY12	FY13	MA Industry Median FY13Q3	North East US Median FY11 [2]
Profitability[7]							
Operating Margin	-8.13%	-5.21%	-8.60%	-6.50%	-4.95%	1.58%	2.02%
Non-Operating Margin	1.17%	1.17%	1.16%	1.14%	1.21%	0.95%	0.12%
Total Margin	-6.96%	-4.03%	-7.44%	-5.36%	-3.73%	2.99%	2.44%
Operating Surplus (Loss)	($43,169,935)	($25,931,656)	($42,631,694)	($34,599,521)	($26,440,812)	–	–
Total Surplus (Loss)	($36,959,136)	($20,089,183)	($36,884,920)	($28,533,985)	($19,956,270)	–	–
Liquidity							
Current Ratio	0.79	1.14	0.59	1.07	1.04	1.49	1.60
Days in Accounts Receivable	17	16	18	26	26	42	43
Average Payment Period	60	53	51	51	53	56	63
Solvency/Capital Structure							
Debt Service Coverage (Total) [3]	-0.5	0.9	-1.4	-0.1	0.8	–	3.5
Cash Flow to Total Debt [4]	-5.1%	4.7%	-10.8%	-2.2%	7.7%	–	16.0%
Equity Financing	39.6%	42.8%	31.6%	36.3%	29.1%	42.9%	44.1%
Other							
Total Net Assets	$128,340,961	$143,756,672	$81,342,424	$101,082,229	$74,744,931	–	–
Assets Whose Use is Limited	$17,648,909	$19,562,251	$14,702,691	$8,378,650	$8,045,061	–	–
Net Patient Service Revenue [5]	$473,952,650	$442,808,592	$439,533,616	$474,396,724	$467,066,636	–	–

FY13 fillings are based on hospital's unaudited or internal financial statements.

Data Sources: Data drawn from CHIA quarterly and annual filings.

CAVEATS: Annual data is reconciled to Audited Financial Statements. CHIA filings may not reflect all of the financial resources available to the hospital – for example, resources available through associations with foundations or parents/affiliates. Financial information must be interpreted within the context of other factors, including, but not limited to, management plans, reimbursement changes, market behavior, and other factors affecting performance. Hospitals may not report data for all metrics listed above. Profitability percentages may not add due to rounding.

Notes:

[1] According to the Medicare Payment Advisory Commission (MEDPAC), a major teaching hospital is one with at least 25 FTE residents per 100 inpatient beds.

[2] Northeast US 2011 Median data publishing in the "Almanac of Hospital Financial Operating Indicators", 2013 OPTUM

[3] Blank value indicates a facility with no current long term debt in the period covered. Ratio not reported on a quarterly basis.

[4] Earlier ratios have been revised to return a ratio even if there is no long term debt. Ratio not reported on a quarterly basis.

[5] Net Patient Service Revenue includes Premium Revenue.

[6] The fiscal year for Cambridge Health Alliance, Mercy Medical Center, Metro West Medical Center, and Saint Vincent Hospital ends on 6/30, and the Steward Hospitals ends on 12/31. The most recently available data as of June 30, 2013 is used for the hospitals that do not have September 30th year ends.

[7] Beginning with FY13, the provision for bad debt is reported as a deduction from patient revenue. This format differs from FY12 where this amount is reported as an expense.