CAPE COD HEALTHCARE

Michael K. Lauf
President and Chief Executive Officer

September 8, 2014

Mr. David Seltz, Executive Director
Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02111

Submitted electronically to HPC-Testimony@state.ma.us

Dear Mr. Seltz:

Pursuant to your letter dated August 1, 2014 and in accordance with Massachusetts General Laws chapter 6D, § 8, please find included herein Cape Cod Healthcare's responses to the questions outlined in Exhibits B and C. I am legally authorized and empowered to represent Cape Cod Healthcare, Inc. and provide the enclosed testimony.

Please feel free to call Michael G. Jones, Senior Vice President and Chief Legal Officer, at 508-862-5070 should you have any questions.

Sincerely,

Michael K. Lauf
President and CEO

/dal

cc: Stuart Altman, Ph.D., Chair, Health Policy Commission
Margret Cooke, Acting Chief, Health Care Division, Office of the Attorney General
Aron Boros, Executive Director, Center for Health Information and Analysis

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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: Cape Cod Hospital (CCH) as well as other Massachusetts hospitals and interested healthcare stakeholders agree that a reduction in the rate of cost increases is needed. CCH has made, and continues to make, efforts to ensure that care is delivered appropriately at the right time and in the right setting, realizing that doing this may ultimately result in lower patient volume, better quality and lower revenues. It is important to note that controlling costs does not involve only hospitals and physicians. Every aspect of healthcare spending needs to be factored in: government, insurers, employers, medical device, pharmaceutical companies, etc. Industry analysts report hospital costs make up less than 40% of healthcare spending in the Commonwealth. Cost targets that push too fast and/or unrealistically may result in hospital job losses and service cutbacks.
   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.
      Discharges have declined an average of 1.2% per year for FY10- FY13 and 2.5% for FY14YTDJuly. Key outpatient services including OP surgery, imaging, OP oncology, radiation therapy, and rehab have increased. Emergency Room (ER) visits have decreased. Total revenue increased for FY10-FY13 at an average 2.3%, while FY14YTDJuly grew 6.1% compared to prior FYTD. Total expenses for FY10 - FY13 grew an average annual 3.26%, slightly below the 3.6% state benchmark. Salaries, which are mostly determined through market analysis and labor negotiations; grew at the annual rate of 2.1%. Employee benefits, comprised mainly of health insurance, have grown at an annual rate of 6.3%. Health insurance and the percentage that employees contribute are also related to union agreements. Revenue and expense growth in FY14 was driven by the increase in employed physicians.
   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?
      Cape Cod Hospital has made significant investment in health management programs designed to improve quality of care for our community and lower the annual rate of growth. Two notable programs impact emergency room utilization and management of high risk patients. We have opened local urgi-centers staffed by our Hospital ER physicians which has improved access and lowered the cost of care for patients and insurers. We also have convinced more of our physicians to become participating providers and thus lowered out of network costs. In conjunction with Cape Cod Health Network (CCHN), our Physician-Hospital

Organization (PHO), we have developed care coordination programs for patients in our community. This includes an outreach program to prevent avoidable admissions and unnecessary ER visits.

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?

Efforts continue to expand outpatient programs such as the Endo Surgical Center, which provides patients in our community with a lower cost option for services previously performed only in the Hospital. We have further developed our regional outpatient centers across the Cape. We are in the process of more fully integrating all cardiovascular services to provide better coordination of care and improve both the quality and cost of caring for this large segment of our patient population. We continue to invest in information technology. We are partnering with physicians and advancing clinical integration through centralized case and chronic disease management. Additionally, continuous process improvement and diligent expense controls are applied throughout the Hospital.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

The ability for CCH to continue to operate efficiently and within the State benchmark requires the continued support of key stakeholders including our physicians, community leaders, non-union and union personnel as well as union leadership. Streamlined and simplified administrative processes across all payers, including uniform billing, preauthorizations, standardized claims submission and payment policies, would be advantageous. Increased responsibility on the part of payers versus providers to collect patient co-pays and deductibles would be more efficient.

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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: We are an integral component of CCHN, a PHO that was created with the aim of ensuring that our Hospitals and Physicians work together to provide high quality care. Collectively, we share a major goal of moving away from fee-for-service payment as prescribed by PPACA. We have engaged in various contractual arrangements with different payers across the region that promote an integrated model of care to promote quality and improve efficiency while adopting alternative payment methods. Based on our experience, the most significant of these contractual arrangements (at least so far) is the BCBSMA AQC plan. Over time, our providers have seen a significant increase in their AQC scoring and progress in their efforts to be more fully and clinically integrated while improving the quality of care being provided on Cape Cod. Physician participation in CCHN continues to expand.

   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?
Based on our eperience, the current BCBSMA AQC plan is the most promising APM plan which has had a positive impact in improving the quality of the ambulatory services provided to its members (our patients). We have participated in this plan for the last three years. Our ambulatory scores are a measure of the quality of service delivered to our patients based on an annual screening and outcomes. The AQC score rates the quality from 0-5, with 5 being the highest. Our quality performance has improved dramatically from a baseline score in 2010 of 0.08 to 3.2 in 2011, and 4.0 in 2012. CCHN was launched in 2011 with the aim to beome an ACO, prepare for global payments and risk, and participate in APM initiatives. Our investment in the PHO's infrastructure and clinical integration initiatives to provide clinical and administrative support to primary care practies is greater than $5.6M per year. The APM plan work cannot be achieved by the primary care practices without the assistance of CCHN's care coordination, case management, and data analytics staff. These personnel work with member data to provide registries to the primary care offices, as well as assist those offices in scheduling visits, scheduling screenings, and working with the Hospital's case management team to ensure that disharge planning includes a primary care follow up appointment when necessary. This has had a positive impact on reducing readmissions. However, these APM programs have also resulted in additional burdens on Primary Care Physicians (PCP) offices.

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).
Our investment in CCHN has been significant, with an anticipated FY2015 budget of approximately $6M. We currently manage 46,000 members under various APM plans. Staffing for the APMs methods is below national norms. We continue to invest in both technology and staff to meet necessary requirements. Clinical positions include: Clinical/Quality Managers; Ambulatory Case Managers; Referral Management Coordinator and Clinical Quality Coordinators. Administrative support staff include Contract Manager; Network Manager; Data Analysts; Contract Specialist and Administrative Assistants.

A summary of the Risk Analysis the PHO will shoulder for the various risk plans we are participating in is attached. See "CCHC-Overview and Quantification of Financial Risk".

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.
No analysis is available; however, it should be noted that the Hospital's services are available on a 24-hour/7 days a week basis; regardless of insurance or the ability to pay. We treat all patients and expect that the different populations we serve will benefit equally from the progress we are making in clinical integration, quality improvement, and cost effectiveness.

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: In general, we find that health status adjustment mechanisms can be valuable when applied at an aggregate level for sufficiently large populations, in particular, for changes in health status from year to year. We have also found them useful in implementing our care management model based on risk stratification. In particular, we have used HCCs to identify high-risk patients for enrollment in our chronic disease management programs, but only as a starting point. Definitive assessment of risk is based on direct contact with the patient, whether during the office visit or through outreach by our case management staff. Health status measurement mechanisms are clearly limited by the nature and quality of physician documentation and coding which is typically directed towards obtaining appropriate reimbursement for services rendered.
   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?
      Unknown at this time.
   b. How do the health status risk adjustment measures used by different payers compare?
      It is virtually impossible to reconcile the myriad approaches used by the relevant payers. Such attempts by us would likely be confounded by differences in the nature and quality of the claims data available to us from the various plans. For example, two of our most prominent risk arrangements are the BCBSMA AQC contract and the CMS MSSP arrangement. A comparison between CMS, HCC, and BCBSMA's DxCG model would be confounded by the fact that MSSP claims data include only pharmacy claims for beneficiaries with a Part D benefit (approximately one-third of all the population), whereas BCBSMA's data would have pharmacy data for virtually all its members on a prescription basis. We also are impacted by differences in how risk adjustment mechanisms are applied by various plans. For example, under the MSSP, increases to risk status are only applied to "newly enrolled" beneficiaries (not those "continuously enrolled"). Under others, our physicians are forced to comprehensively re-document all illnesses annually and early enough in the year to be captured in risk revenue by year-end.
   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?
      Given the reliance on appropriate documentation and coding in order to accurately capture the illness burden of our population, we have initiated a fairly elaborate educational initiative for our physicians. This impacts our organization and our affiliated physicians in terms of staffing, resources, cost and time. In particular, we have retained a third party consultant to aid us in the education of our physicians and are hiring documentation specialists to reinforce and sustain these initiatives.

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: With the implementation of an Electronic Medical Record (EMR) across our entire provider network, including related Health Information Exchange (HIE) connectivity solutions, our ability to access real-time clinical data will be greatly improved. In the case of retrospective data, we currently receive information in a fragmented manner from a variety of disparate sources, and in many different forms.
   ANSWER: Real-time data for our covered lives includes: 1) Notifications and clinical summary information for admits, discharges and transfers occurring in any acute or subacute inpatient facility state-wide; and, 2) Requests for referrals, authorizations and pre-certifications from the major Massachusetts HMOs. Combined, this information will greatly enhance our ability to manage care transitions, reduce unnecessary utilization and maximize care provided in the community setting. Historic data for our covered lives includes: Access to a single source of claims level data across the major public and private payers in Massachusetts, risk adjusted on a uniform basis allowing for comparison across populations and provider groups. This would include benchmark data for disease prevalence as well as "cost and use" for comparison to other ACOs and "best practice."

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY: Given the significant financial implications of global risk, a definitive and ongoing understanding of the applicable covered lives is essential. Although expansion of risk to non-HMO plans may be desirable, current methods of attribution, whether prospective or retrospective, are insufficient and introduce an additional element of risk outside the provider's control.
   a. Which attribution methodologies most accurately account for patients you care for?
      Even for non-gatekeeper plans, each member should be required to explicitly choose their PCP. If the ACO is accountable for the cost and quality of the covered lives it serves, it seems fundamental that the covered lives should prospectively declare a firm commitment to the PCP of their choice. Members unwilling to do this need not be penalized but merely excluded from the population to be evaluated under the given risk arrangement.
   b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
      Under our MSSP arrangement, approximately one-third (33%) of the beneficiaries attributed to us at the beginning of the year are no longer attributed to us by year-end. Accordingly, considerable time, effort and cost is expended on patients that do not accrue to our financial results. Further, under the MSSP's retrospective attribution a certain portion of our covered lives are reported to us after the performance period has ended. Accordingly, within the context of

attribution based on the "plurality of E&M's" we suggest attribution be applied on both a prospective and retrospective basis and risk be limited only to the lives attributed under both.

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: We are constantly taking steps to ensure our physicians and staff are compliant with the required quality measures. We are working to ensure that all physicians in our organization are EMR functional by August 2015. This, we believe, will go a long way in promoting better quality of care. Notwithstanding, we continue to encounter various issues with the promotion and implementation of this standard.
ANSWER: We are tasked with performing, collecting, collating, analyzing, reporting and auditing on an increasing number of quality measures for our public and private parterships/contracts. A lack of coordination among these initiatives and the absence of standardization among the measures places an overwhelming financial and operational burden on our organization. Given that the measures are not coordinated across outpatient and inpatient settings, each payer has different standards for their members. This is also applicable to some payers with different products. This creates a significant burden for physicians in the form of multiple, uncoordinated and sometimes conflicting requirements for each individual member depending on who insures them. There are several EMRs across our system and this electronic "functionality" does not always create efficient data extraction for multiple competing measures due to varied quality measures and reporting capabilities across systems. We utilize a team of Quality Performance Specialists to support our physicians relative to quality measurement. This requires coordination of measures, implementing process changes in physician offices, education of many disparate information technology systems and maximizing the ability to extract data from the systems. This still requires direct searching of charts for data extraction which is costly and time consuming. There is also an added burden placed on physicians who have been slow to adopt an EMR and still remain dependent on paper records. The cost of these resources is over $1M and includes permanent staff and the use of outside vendors.

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: The July 2014 Cost Trends Report Supplement mentions that in addition to Massachusetts residents using inpatient settings more often for care, residents also receive a higher proportion of their inpatient care at Academic Medical Centers/teaching hospitals than people elsewhere in the U.S. As consolidations noted in the report continue to occur, this trend could improve whereby Community Hospitals' ability to care for a greater percentage of the population could increase, or in some cases the trend could worsen as a result of consolidation and a greater percentage of patients may be cared for at an academic medical center. Academic medical centers expanding into the community without collaborating with the local community hospital could lead only to an increase in patients getting care at the academic medical center.

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.
Overall inpatient utilization among Barnstable County residents declined by 5.7% for the period FY2009-FY2012. Based on the most recently available data, 15.9% or 4,352 inpatient cases from Barnstable County were served by academic medical centers or higher cost hospitals in FY12. See attachment "Inpatient Trends". Inpatient utilization specifically for CCH has also declined through FY2014.

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.
In addition to the initiatives described elsewhere in this written testimony, the Hospital's work with the PHO has allowed greater clinical integration with our physicians resulting in an increased coordination of care and standards to further improve the quality and cost-effectiveness of the care provided to the Cape Cod community. The establishment of this clinically integrated organization has also fostered our ability to create new partnerships with our physicians resulting in the creation of both community-located urgi-centers and outpatient centers providing the same level of care previously provided only at the acute care hospital location. This has provided not only better and more convenient access for our patients but also the prospect of lower cost to the patient, insurer and health system.

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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:

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.
Our analyses indicate that our inpatient admission rate is actually less than the State average (19,970.07 compared to 20,008.29)-adjusted for risk. CCH also is a lower cost institution from a total spending perspective, spending 50% of the healthcare dollar on inpatient compared to 50.4% for the rest of the state. We are currently evaluating outliers in the utilization of skilled nursing and home health to ensure appropriate need. We are examinig the potential opportunity to reduce costs for specific surgeries, particularly single joint replacements.

b. How does your organization ensure optimal use of post-acute care?
Currently, CCH uses a team of physician, nursing, physical, occupational and speech therapy, and case management to perform risk assessment on all patients prior to discharge. Their collaboration results in a recommendation for discharge services which is then presented to patients and families for consideration. This team assesses level of care based on risk and need, and the final order is placed by

physicians following family discussion. This ensures optimal use of post-acute care.

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:

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	0	598	12
	Q2	204	610	10
	Q3	367	650	10
	TOTAL:	571	1858	

** Please indicate the unit of time reported.*

ANSWER: We have implemented a patient estimation tool. This tool leverages historical electronic claim files and the corresponding payment files returned from insurance companies to determine estimated charges and allowed amounts. We provide estimates upon request for all elective outpatient visits, same day surgery cases, and elective scheduled admissions. We provide patient estimates at the point of service for certain areas and patients have an opportunity to make a payment at that time. We also provide an estimate for any patient who inquires about the cost of a particular service. We average ten phone inquires for estimates per weekday. Note than response time is presented in minutes.

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: Theoretically, tiered and limited networks were introduced as an effort to drive down cost and lower premiums while promoting a better quality of care. While we remain committed to undertaking actions that will ensure lower costs with better quality of care, unlike other healthcare networks, we have a very unique position which complicates the implementation of these products. We have encountered numerous issues with the tiered products that have hindered the expected or common results, mainly having a negative impact on the member/patient population.

ANSWER: Cape Cod Hospital and Falmouth Hospitals are not high cost. Due to our disproportionate share of patients covered by Medicare or Medicaid, we seek relatively higher payments from private insurers to make up for significant underpayments from Medicare and Medicaid. As a result, we are often tiered as "high cost" by the commercial health plans. This places an undue burden on Cape Cod residents covered by commercial plans as they are typically surprised by the high out of pocket costs while having no other hospitals to choose from within geographic proximity. In fact, CCH has been federally designated as a Sole Community Provider. See Attachment Q10 for MA DHCFP TME Analysis, published 6.29.2011 which revealed that risk-adjusted Barnstable County actually has an average TME. Although tiering is supposed to be based on quality and cost, we find cost is the primary determinant used by the plans.

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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:
    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.
    CCH recognizes that it must treat all needs of its patients to deliver best outcomes. CCH realizes that early identification of behavioral health issues and access to services is of paramount importance. CCH is implementing behavioral health questionnaires in its primary care network to identify those patients most at risk for potential behavioral health problems. CCH collaborates with community health centers to identify frequent users of behavioral health services so treatment can be coordinated in the most effective and efficient care setting. CCH collaborates with the DMH network, private practitioners, its VNA and other home health providers via active case management and discharge planning as it cares for its behavioral health patients across the care continuum.
    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.
    CCH believes that outpatient treatment is most cost-effective and helps to prevent more costly inpatient admissions, readmissions and Emergency Room visits. CCH delivered approximately 30,000 outpatient mental health treatment visits through its Centers for Behavioral Health programs, across three outpatient clinics located in the mid, lower and upper Cape areas. The outpatient clinics typically receive patients from CCH's inpatient unit, off-Cape inpatient units, the CCH primary care network, schools and other community and primary care providers. By providing access to mental health services in outpatient settings, CCH seeks to diagnose, intervene and treat patients earlier in their disease pathway(s) and reduce more costly treatment settings.

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.
The sheer volume of patients presenting to CCH with drug/alcohol abuse and mental health issues is daunting. CCH has established behavioral health sub-units in its Emergency Centers to treat these patients. It is well known that there is insufficient access to psychiatric inpatient beds across the Commonwealth. CCH continues to support both its inpatient and outpatient services for its behavioral health patients. To de-stigmatize mental illness and to increase communication, integration and collaboration, CCH sponsors a Behavioral Health Forum in concert with NAMI, Gosnold, and other community mental health providers focusing on access to services and barriers to integration.

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.
We support the sharing of meaningful data across all services.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
SUMMARY:
    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?
    We have a large existing primary care physician group which utilizes a patient care medical home model. Although not yet certified, this group effectively utilizes the PCMH model and includes PCPs, RNs, care coordinators, integrated specialists and same day triage methods that utilize the PCMH model.
    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
    None at this time, but at least three of our providers are currently pursuing PCMH certification.
    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.
    None at this time.

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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: The report uses national and Massachusetts personal health care expenditures data from 2009, projected forward to 2012. As commented on by the MHA and others, this report may not adequately reflect the changes that have occurred in the Massachusetts healthcare system as a result of the Chapter 224 reform act, the Affordable Care Act, as well as the innovative payment-and-delivery changes that occurred in the healthcare sector leading up to those reform laws.

ANSWER: MHA completed a very detailed review of the report which was submitted to the Commission. While we understand and appreciate the intent of the Commission's efforts, the complexity of the data and analysis does not lend to any clear conclusion. Despite efforts to make meaningful comparisons of costs across states and to adjust for regional cost differences for wages, supplies and other costs, these efforts have not been totally successful. Cape Cod Hospital continues to aggressively manage costs as indicated in our response to other questions above. CCH will continue to partner with physicians to lower costs and improve quality, and otherwise expand services in community outpatient locations to provide less costly, more convenient and timely access for our patients while providing the same level of service and quality provided at the Hospital.

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

   Please see AGO Hospital Exhibit 1. Also, please refer to our published 403B cost reports, IRS 990s and audited financial statements on file with the State.

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

   Please see AGO Hospital Exhibit 2. Also, please refer to our published 403B cost reports, IRS 990s and audited financial statements on file with the State.

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.

   Our PHO is responsible for some 46,000 covered lives. These lives make up approximately $342M of Total Medical Expense (TME) of which $146M involves significant downside risk (exposure estimated at over $8M as per the attached CCHC-Overview and Quantification of Financial Risk). Risk is further mitigated for all covered lives by the population health and care management programs we have developed and implemented and discussed elsewhere throughout this written testimony. These programs include case management and physician incentives designed to manage the cost and quality of patient care (see Exhibit B).

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.

CCH uses test requisitions, prescriptions, written physician orders and EMR fields to ascertain which physicians order tests and procedures for and/or admit their patients for hospital care and services. Such information is essential to providing the best care to each patient and for ensuring that test results, operative reports, discharge summaries and like clinical documentation is communicated to each patient's physicians(s) on a timely basis. Such information also is routinely available to the Hospital through its finance department in terms of EOBs and other payment-related documentation received from managed care companies, state and federal payers, and other similar sources. This information helps the Hospital to assess utilization and facilitates operational, budgeting and long term planning.

HPC Written Testimony - Exhibit B, Question 2b and Exhibit C, Question 3
CCHC - Overview and Quantification of Financial Risk

		- - - Through Steward - - -			
	Commercial	**Tufts Medicare Preferred**	**CCHC Employee Plan [(1)]**	**MSSP**	**Totals**
Covered Lives Under Risk					
BCBSMA	9,828				
Tufts Commercial	2,414				
HPHC (excludes self-insured)	6,684				
Total	18,926	705	7,704	18,736	46,071
Total Medical Expense (TME) at Risk					
BCBSMA	$ 53,070,300				
Tufts Commercial	$ 11,585,600				
HPHC (excludes self-insured)	$ 32,084,000				
Total	$ 96,739,900	$ 4,823,937	$ 54,516,311	$ 195,678,784	$ 351,758,932
Est. of Downside Risk Exposure [(2)]					
BCBSMA	$ (1,592,109)	(capped at 3.0% of Budget)			
Tufts Commercial	$ (1,158,560)				
HPHC (excludes self-insured)	$ (401,050)	(capped at $5.00 pmpm)			
Total	$ (3,151,719)	$ (482,394)	$ (5,451,631)	$ -	$ (9,085,744)

Notes:
1) CCHC has in place Member-specific stop loss with $750,000 per year attachment point.
2) Except where otherwise noted, downside risk exposure indicated equals 10% of TME)

Attachment: Inpatient Trends: Q7a

HOSPITAL	Hospital Type (2)	CY12 Commercial Payer Price Level (Percentile)	Barnstable County FY09	FY10	FY11	FY12	FY09 %	FY10 %	FY11 %	FY12 %
Beth Israel Deaconess Medical Center - East Campus	AMC	74th	850	815	795	807	3.0%	3.0%	2.9%	3.0%
Boston Medical Center - Harrison Avenue Campus	AMC	58th	318	299	275	259	1.1%	1.1%	1.0%	0.9%
Brigham and Women's Hospital	AMC	92nd	1,249	1,246	1,261	1,391	4.3%	4.6%	4.5%	5.1%
Massachusetts General Hospital	AMC	92nd	1,038	872	954	932	3.6%	3.2%	3.4%	3.4%
Tufts-New England Medical Center	AMC	70th	396	410	359	440	1.4%	1.5%	1.3%	1.6%
UMass Memorial Medical Center - Memorial Campus	AMC	79th	29	16	31	19	0.1%	0.1%	0.1%	0.1%
UMass Memorial Medical Center - University Campus	AMC	79th	57	41	44	49	0.2%	0.2%	0.2%	0.2%
		Academic Medical Centers S/T:	*3,937*	*3,699*	*3,719*	*3,897*	*13.7%*	*13.5%*	*13.3%*	*14.2%*
Children's Hospital Boston	Specialty Hospital	95th	409	436	409	421	1.4%	1.6%	1.5%	1.5%
Dana-Farber Cancer Institute	Specialty Hospital	90th	29	31	26	32	0.1%	0.1%	0.1%	0.1%
Martha's Vineyard Hospital	Community Hospital	86th	4	5	-	2	0.0%	0.0%	0.0%	0.0%
		(3) Hospitals with higher costs S/T:	*442*	*472*	*435*	*455*	*1.5%*	*1.7%*	*1.6%*	*1.7%*
		AMCs and HIGHER COST HOSPITALS S/T:	**4,379**	**4,171**	**4,154**	**4,352**	**15.2%**	**15.2%**	**14.9%**	**15.9%**
Baystate Medical Center	Teaching Hospital	60th	5	11	13	10	0.0%	0.0%	0.0%	0.0%
Berkshire Medical Center - Berkshire Campus	Teaching Hospital	81st	3	2	2	6	0.0%	0.0%	0.0%	0.0%
Cambridge Health Alliance - Cambridge Campus	Teaching Hospital	17th	10	9	19	24	0.0%	0.0%	0.1%	0.1%
Cambridge Health Alliance - Somerville Campus	Teaching Hospital	17th	10	-	-	-	0.0%	0.0%	0.0%	0.0%
Cambridge Health Alliance - Whidden Memorial Campus	Teaching Hospital	17th	2	4	4	3	0.0%	0.0%	0.0%	0.0%
Caritas Carney Hospital	Teaching Hospital	34th	23	25	19	14	0.1%	0.1%	0.1%	0.1%
Caritas St. Elizabeth's Medical Center	Teaching Hospital	58th	88	123	125	121	0.3%	0.4%	0.4%	0.4%
Faulkner Hospital	Teaching Hospital	74th	96	110	78	76	0.3%	0.4%	0.3%	0.3%
Lahey Clinic - Burlington Campus	Teaching Hospital	61st	177	169	174	155	0.6%	0.6%	0.6%	0.6%
Mount Auburn Hospital	Teaching Hospital	55th	47	41	35	40	0.2%	0.2%	0.1%	0.1%
Saint Vincent Hospital	Teaching Hospital	56th	14	10	11	12	0.0%	0.0%	0.0%	0.0%
		Teaching hospitals S/T:	*475*	*504*	*480*	*461*	*1.7%*	*1.8%*	*1.7%*	*1.7%*
Massachusetts Eye and Ear Infirmary	Specialty Hospital	47th	32	18	26	33	0.1%	0.1%	0.1%	0.1%
New England Baptist Hospital	Specialty Hospital	48th	342	343	303	367	1.2%	1.3%	1.1%	1.3%
Shriners Hospitals for Children Boston	Specialty Hospital	N/A	-	-	-	3	0.0%	0.0%	0.0%	0.0%
Shriners Hospitals for Children Springfield	Specialty Hospital	N/A	-	-	-	1	0.0%	0.0%	0.0%	0.0%
		Specialty Hospitals S/T:	*374*	*361*	*329*	*404*	*1.3%*	*1.3%*	*1.2%*	*1.5%*
Anna Jaques Hospital	Community Hospital	19th	2	2	5	7	0.0%	0.0%	0.0%	0.0%
Baystate Mary Lane Hospital	Community Hospital	34th	2	-	-	1	0.0%	0.0%	0.0%	0.0%
Beth Israel Deaconess Hospital - Needham	Community Hospital	38th	11	10	10	14	0.0%	0.0%	0.0%	0.1%
Caritas Norwood Hospital	Community Hospital	42nd	84	73	129	76	0.3%	0.3%	0.5%	0.3%
Cooley Dickinson Hospital	Community Hospital	75th	5	8	4	4	0.0%	0.0%	0.0%	0.0%
Emerson Hospital	Community Hospital	48th	6	10	16	3	0.0%	0.0%	0.1%	0.0%
Hallmark Health System - Lawrence Memorial Hospital Campus	Community Hospital	46th	10	5	5	11	0.0%	0.0%	0.0%	0.0%
Hallmark Health System - Melrose-Wakefield Hospital Campus	Community Hospital	46th	7	12	3	9	0.0%	0.0%	0.0%	0.0%
Harrington Memorial Hospital	Community Hospital	45th	1	1	3	-	0.0%	0.0%	0.0%	0.0%
Jordan Hospital	Community Hospital	55th	1,086	1,064	986	893	3.8%	3.9%	3.5%	3.3%
Lowell General Hospital	Community Hospital	34th	4	3	9	6	0.0%	0.0%	0.0%	0.0%
Marlborough Hospital	Community Hospital	47th	3	4	1	2	0.0%	0.0%	0.0%	0.0%
MetroWest Medical Center - Framingham Campus	Community Hospital	41st	12	18	20	26	0.0%	0.1%	0.1%	0.1%
MetroWest Medical Center - Leonard Morse Campus (Natick)	Community Hospital	41st	20	13	10	16	0.1%	0.0%	0.0%	0.1%
Milford Regional Medical Center	Community Hospital	46th	4	10	10	14	0.0%	0.0%	0.0%	0.1%
Milton Hospital	Community Hospital	24th	21	16	12	21	0.1%	0.1%	0.0%	0.1%
Nantucket Cottage Hospital	Community Hospital	70th	2	1	1	2	0.0%	0.0%	0.0%	0.0%
Newton-Wellesley Hospital	Community Hospital	66th	88	117	120	113	0.3%	0.4%	0.4%	0.4%

Attachment: Inpatient Trends: Q7a			Barnstable County							
Northeast Health System - Addison Gilbert Campus	Community Hospital	42nd	1	1	-	1	0.0%	0.0%	0.0%	0.0%
Northeast Hospital - Beverly	Community Hospital	42nd	4	10	12	13	0.0%	0.0%	0.0%	0.0%
South Shore Hospital	Community Hospital	76th	128	133	143	122	0.4%	0.5%	0.5%	0.4%
Steward - Nashoba Valley Medical Center	Community Hospital	34th	2	2	2	-	0.0%	0.0%	0.0%	0.0%
Sturdy Memorial Hospital	Community Hospital	64th	4	4	11	6	0.0%	0.0%	0.0%	0.0%
Winchester Hospital	Community Hospital	45th	13	17	11	4	0.0%	0.1%	0.0%	0.0%
		Community Hospitals S/T:	*1,520*	*1,534*	*1,523*	*1,364*	*5.3%*	*5.6%*	*5.5%*	*5.0%*
Brockton Hospital	Community, Disproportionate Share Hospital	35th	26	20	20	26	0.1%	0.1%	0.1%	0.1%
Cape Cod Hospital (1)	Community, Disproportionate Share Hospital	82nd	15,220	14,377	14,790	14,208	52.9%	52.5%	53.0%	51.9%
Caritas Good Samaritan Medical Center - Brockton Campus	Community, Disproportionate Share Hospital	44th	114	104	84	104	0.4%	0.4%	0.3%	0.4%
Caritas Holy Family Hospital and Medical Center	Community, Disproportionate Share Hospital	34th	2	5	3	3	0.0%	0.0%	0.0%	0.0%
Caritas Saint Anne's Hospital	Community, Disproportionate Share Hospital	49th	12	12	22	24	0.0%	0.0%	0.1%	0.1%
Clinton Hospital	Community, Disproportionate Share Hospital	42nd	1	1	2	2	0.0%	0.0%	0.0%	0.0%
Fairview Hospital	Community, Disproportionate Share Hospital	75th	1	1	-	1	0.0%	0.0%	0.0%	0.0%
Falmouth Hospital	Community, Disproportionate Share Hospital	77th	5,762	5,421	5,627	5,403	20.0%	19.8%	20.2%	19.8%
Franklin Medical Center	Community, Disproportionate Share Hospital	58th	2	-	2	1	0.0%	0.0%	0.0%	0.0%
Health Alliance Hospital - Burbank Campus	Community, Disproportionate Share Hospital	51st	1	-	-	-	0.0%	0.0%	0.0%	0.0%
Health Alliance Hospital - Leominster Campus	Community, Disproportionate Share Hospital	51st	3	-	1	3	0.0%	0.0%	0.0%	0.0%
Heywood Hospital	Community, Disproportionate Share Hospital	22nd	7	3	2	1	0.0%	0.0%	0.0%	0.0%
Holyoke Medical Center	Community, Disproportionate Share Hospital	28th	2	5	2	1	0.0%	0.0%	0.0%	0.0%
Lawrence General Hospital	Community, Disproportionate Share Hospital	25th	3	2	4	3	0.0%	0.0%	0.0%	0.0%
Mercy Medical Center - Springfield	Community, Disproportionate Share Hospital	29th	2	3	3	2	0.0%	0.0%	0.0%	0.0%
Morton Hospital and Medical Center	Community, Disproportionate Share Hospital	27th	28	37	18	39	0.1%	0.1%	0.1%	0.1%
Noble Hospital	Community, Disproportionate Share Hospital	15th	2	1	-	2	0.0%	0.0%	0.0%	0.0%
North Adams Regional Hospital	Community, Disproportionate Share Hospital	65th	-	1	1	-	0.0%	0.0%	0.0%	0.0%
North Shore Medical Center - Salem Campus	Community, Disproportionate Share Hospital	72nd	4	3	11	5	0.0%	0.0%	0.0%	0.0%
North Shore Medical Center - Union Campus	Community, Disproportionate Share Hospital	72nd	12	1	4	5	0.0%	0.0%	0.0%	0.0%
Quincy Medical Center	Community, Disproportionate Share Hospital	19th	22	38	29	25	0.1%	0.1%	0.1%	0.1%
Saints Memorial Medical Center	Community, Disproportionate Share Hospital	12th	2	4	2	4	0.0%	0.0%	0.0%	0.0%
Southcoast Hospitals Group - Charlton Memorial Campus	Community, Disproportionate Share Hospital	53rd	23	34	34	43	0.1%	0.1%	0.1%	0.2%
Southcoast Hospitals Group - St. Luke's	Community, Disproportionate Share Hospital	53rd	68	62	102	113	0.2%	0.2%	0.4%	0.4%
Southcoast Hospitals Group - Tobey Hospital Campus	Community, Disproportionate Share Hospital	53rd	620	614	623	692	2.2%	2.2%	2.2%	2.5%
Steward - Merrimack Valley Hospital	Community, Disproportionate Share Hospital	20th	1	2	-	-	0.0%	0.0%	0.0%	0.0%
Wing Memorial Hospital and Medical Centers	Community, Disproportionate Share Hospital	23rd	-	1	1	3	0.0%	0.0%	0.0%	0.0%
		Community, Disproportionate Share Hospital S/T:	*21,940*	*20,752*	*21,387*	*20,713*	*76.3%*	*75.8%*	*76.6%*	*75.7%*
Caritas Good Samaritan Medical Center - NORCAP Lodge Campu	Unknown		76	62	50	62	0.3%	0.2%	0.2%	0.2%
Mercy Medical Center - Providence Behavioral Health Hospital C	Unknown		3	2	2	-	0.0%	0.0%	0.0%	0.0%
		Unknown S/T:	*79*	*64*	*52*	*62*	*0.3%*	*0.2%*	*0.2%*	*0.2%*
		All Other S/T:	**24,388**	**23,215**	**23,771**	**23,004**	**84.8%**	**84.8%**	**85.1%**	**84.1%**
TOTAL			***28,767***	***27,386***	***27,925***	***27,356***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Notes:

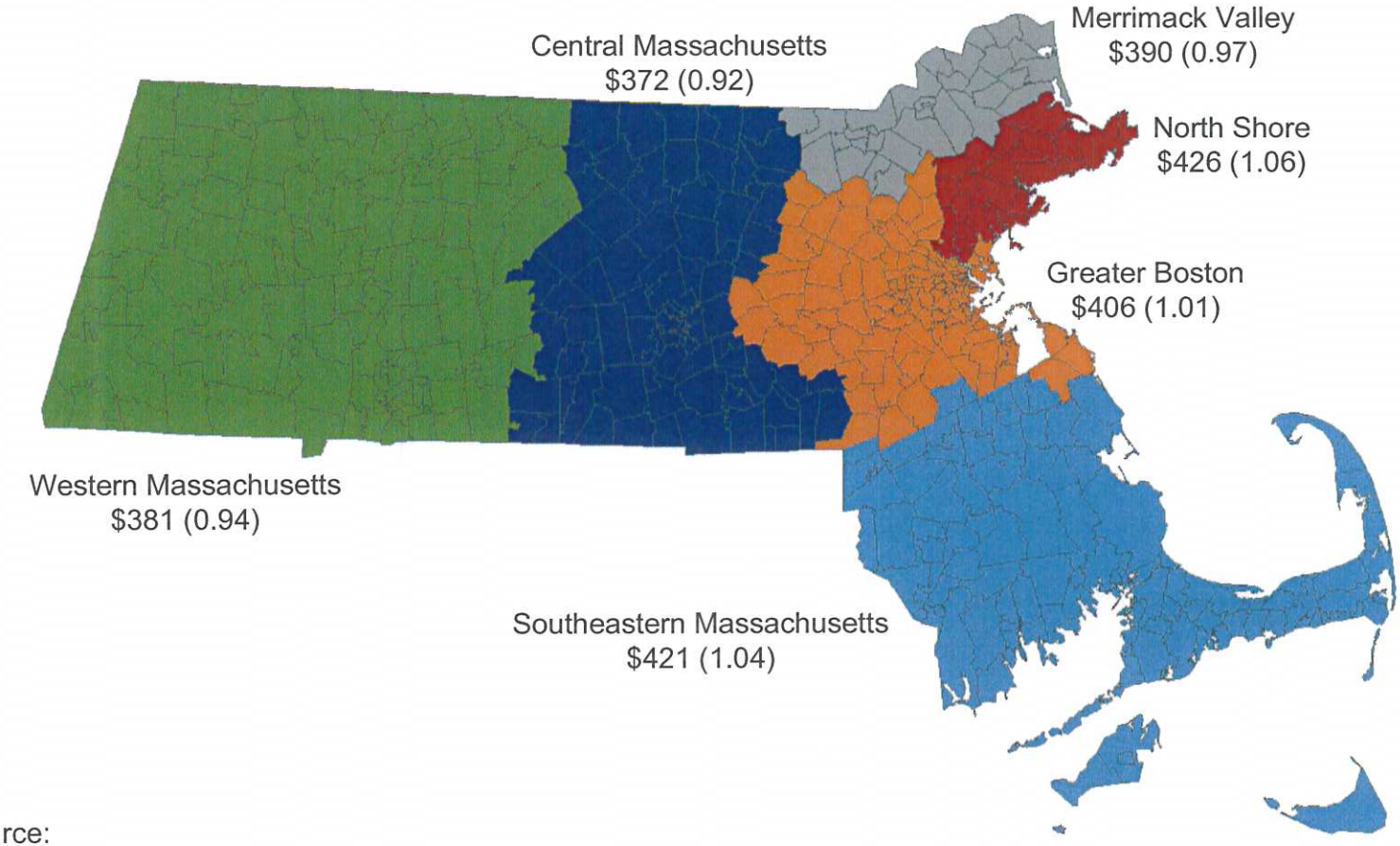
1. Residents, over the age of 65, represent 25% of the total population in Barnstable County. This is significantly higher than Massachusetts at 13.8% and the United States at 13%.
   The 65+ group has grown by 5.1% since 2000. This trend will only escalate as the baby boomers, who represent another 25% of the Barnstable County population, age-in.
   This Medicare population presents an increased demand for healthcare services, resulting in patients with higher complexity and/or acuity cases at Cape Cod Hospital .
2. Hospital Types include: Academic Medical Center (AMC); Teaching Hospital; Specialty Hospital; Community Hospital; and Community, Disproportionate Share Hospital - classification and category types based on Centers for Health Information & Analysis, Massachusetts Acute Hospital Profiles (those listed as Unknown were not found through Center for Health Information & Analysis)
3. Hospitals considered "higher cost" are identified as those hospitals with a higher CY12 Commercial Payer Price Level than CCH (CCH = 82nd percentile)

Sources: Hospital Type & Commercial Payer Level - Center for Health Information & Analysis, Massachusetts Acute Hospital Profiles
(http://www.mass.gov/chia/researcher/hcf-data-resources/massachusetts-hospital-profiles/massachusetts-acute-hospital-profiles.html)
Inpatient discharge data from MA Health Data Consortium FY09-FY12

Question 10 Exhibit

Commercial unadjusted TME and relative TME by region

Medical spending varied by region relative to the statewide average, from $372 PMPM in central Massachusetts to $426 PMPM in the North Shore region.

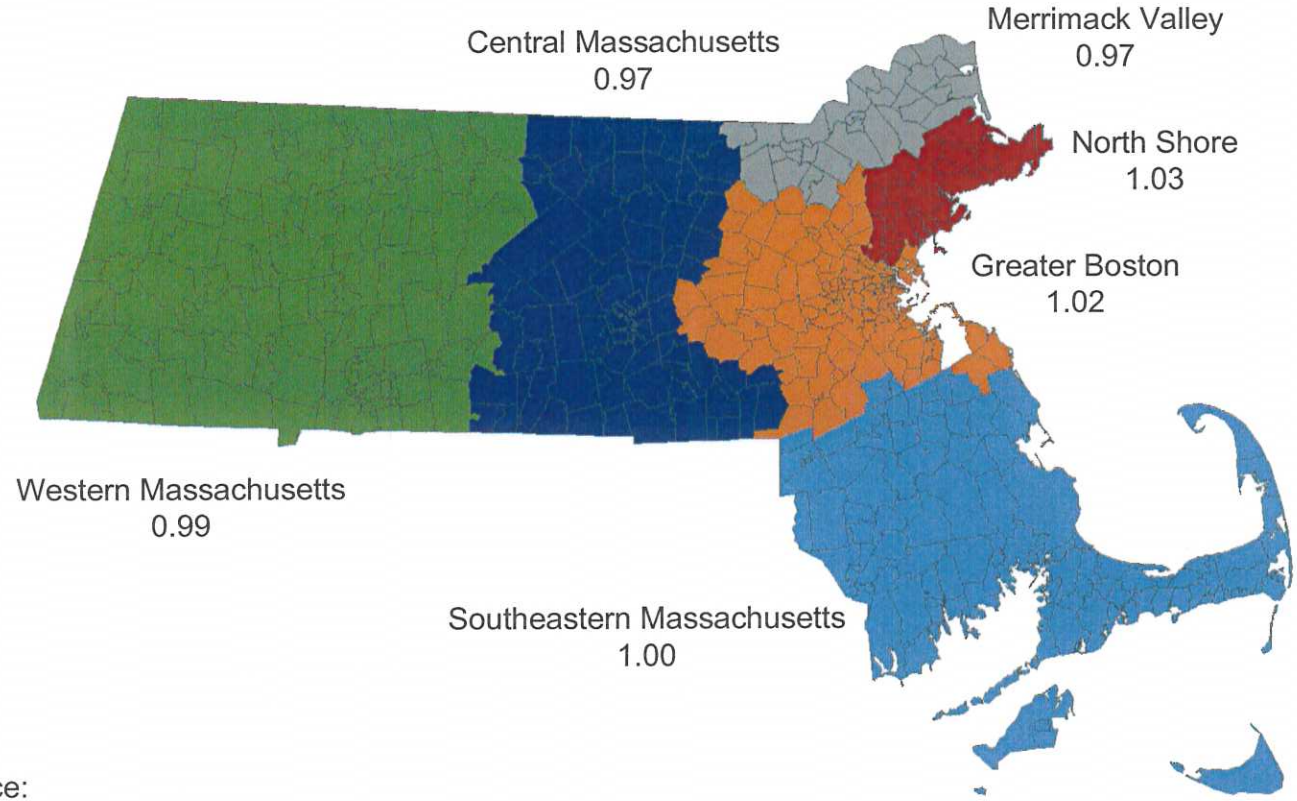


Source:
Division of Health Care Finance and Policy
MA Total Medical Expenses Analyses
June 29, 2011

Question 10 Exhibit

Health status adjusted relative TME by region

When adjusted for member health status, the regional variation in TME is narrowed. Central Massachusetts, western Massachusetts, and Merrimack Valley remain lower TME areas. Southeastern Massachusetts reflects average level relative TME, while Greater Boston and the North Shore remain higher TME.



Source:
Division of Health Care Finance and Policy
MA Total Medical Expenses Analyses
June 29, 2011

Cape Cod Hospital AGO Hospital Exhibit C-1
Fiscal Year Ending 09/30/10

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											27,557,600	41,818,892			
Tufts Health Plan											8,381,387	14,803,147			
Harvard Pilgrim Health Care											28,074,785				
Fallon Community Health Plan											1,445	5,786			
CIGNA											3,880,003				
United Healthcare												5,157,821			
Aetna												6,719,227			
Other Commercial												16,568,192			
Total Commercial											67,895,220	85,073,065			
Network Health											-				
Neighborhood Health Plan											1,998,779				
BMC HealthNet, Inc.											7,601,261				
Health New England											-				
Fallon Community Health Plan											-				
Other Managed Medicaid											-				
Total Managed Medicaid											9,600,040				
MassHealth											17,546,461				
Tufts Medicare Preferred											8,771,575				
Blue Cross Senior Options											5,209,405				
Other Comm Medicare											3,544,099				
Commercial Medicare Subtotal											17,525,079				
Medicare											172,687,988				
Other											23,716,318				
GRAND TOTAL											308,971,106	85,073,065			

Cape Cod Hospital AGO Hospital Exhibit C-1
Fiscal Year Ending 09/30/11- Cape Cod Hospital

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield											24,837,721	44,276,240			
Tufts Health Plan											7,578,692	20,973,778			
Harvard Pilgrim Health Care											31,203,692				
Fallon Community Health Plan											224,345	85,762			
CIGNA											4,020,251				
United Healthcare												6,546,824			
Aetna												6,630,940			
Other Commercial												15,967,466			
Total Commercial											67,864,701	94,481,010			
Network Health											633,802				
Neighborhood Health Plan											1,758,446				
BMC HealthNet, Inc.											7,384,978				
Health New England											-				
Fallon Community Health Plan											-				
Other Managed Medicaid											530,276				
Total Managed Medicaid											10,307,502				
MassHealth											10,933,185				
Tufts Medicare Preferred											8,897,641				
Blue Cross Senior Options											5,386,773				
Other Comm Medicare											3,513,027				
Commercial Medicare Subtotal											17,797,441				
Medicare											173,124,490				
Other											25,984,287				
GRAND TOTAL											306,011,606	94,481,010			

Cape Cod Hospital AGO Hospital Exhibit C-1
Fiscal Year Ending 09/30/12 - Cape Cod Hospital

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					21,388,417		828,575		1,182,114			69,885,043			
Tufts Health Plan											8,252,188	6,708,208			
Harvard Pilgrim Health Care											36,542,983				
Fallon Community Health Plan											500,699	78,658			
CIGNA											4,186,073				
United Healthcare												7,648,554			
Aetna												6,657,875			
Other Commercial												16,086,979			
Total Commercial		-	-	-	21,388,417	-	828,575	-	1,182,114	-	49,481,943	107,065,317			
Network Health											1,819,563				
Neighborhood Health Plan											1,929,609				
BMC HealthNet, Inc.											7,856,140				
Health New England											-				
Fallon Community Health Plan											-				
Other Managed Medicaid											681,882				
Total Managed Medicaid											12,287,194				
MassHealth											16,128,743				
Tufts Medicare Preferred											9,775,090				
Blue Cross Senior Options											6,097,000				
Other Comm Medicare											2,871,272				
Commercial Medicare Subtotal											18,743,362				
Medicare											177,482,495				
Other											28,366,033				
GRAND TOTAL					21,388,417		828,575		1,182,114		302,489,770	107,065,317			

Cape Cod Hospital AGO Hospital Exhibit C-1
Fiscal Year Ending 09/30/13 - Cape Cod Hospital

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					23,926,769		984,963		892,094			33,483,462			
Tufts Health Plan											6,852,815	6,739,239			
Harvard Pilgrim Health Care											28,827,840	5,466,126			
Fallon Community Health Plan											676,448				
CIGNA											7,417,556	580,816			
United Healthcare												8,122,617			
Aetna												6,696,313			
Other Commercial												31,008,936			
Total Commercial	-	-	-	-	23,926,769	-	984,963	-	892,094	-	43,774,659	92,097,509			
Network Health											-				
Neighborhood Health Plan											1,734,315				
BMC HealthNet, Inc.											8,441,636				
Health New England											-				
Fallon Community Health Plan											-				
Other Managed Medicaid											738,091				
Total Managed Medicaid											10,914,042				
MassHealth											21,832,897				
Tufts Medicare Preferred											9,995,130				
Blue Cross Senior Options											5,863,824				
Other Comm Medicare											3,367,069				
Commercial Medicare Subtotal											19,226,023				
Medicare											182,931,048				
Other											24,840,947				
GRAND TOTAL	-	-	-	-	23,926,769	-	984,963	-	892,094	-	303,519,617	92,097,509			

Exhibit 1 AGO Questions to Hospitals

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 subject you to very limited or minimal "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** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
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.

Cape Cod Hospital AGO Hospital Exhibit 2

Per Audited Financial Statements

All Payers	Adult		Pediatrics		Adult + Pediatrics	
	IP NPSR	OP NPSR	IP NPSR	OP NPSR	Total NPSR	Total Operating Margin
FY10	184,347,016	195,425,352	5,282,461	8,989,346	394,044,175	7%
FY11	198,453,307	187,924,828	5,199,545	8,914,936	400,492,616	7%
FY12	210,120,451	207,840,276	5,871,269	9,122,197	432,954,193	8%
FY13	198,193,927	209,402,878	5,334,560	8,489,587	421,420,952	5%

COMMERCIAL	Adult		Pediatrics		Adult + Pediatrics
	IP NPSR	OP NPSR	IP NPSR	OP NPSR	Total NPSR
FY10	37,460,069	106,733,111	1,982,156	6,792,949	152,968,285
FY11	57,482,020	106,585,220	1,742,116	6,728,187	172,537,543
FY12	64,794,305	114,253,333	2,029,516	6,727,559	187,804,713
FY13	52,320,004	102,100,979	1,506,641	5,748,372	161,675,995

Government	Adult		Pediatrics		Adult + Pediatrics
	IP NPSR	OP NPSR	IP NPSR	OP NPSR	Total NPSR
FY10	142,781,448	78,676,362	3,266,073	2,113,494	226,837,377
FY11	136,997,228	75,953,089	3,456,887	2,109,749	218,516,953
FY12	141,462,007	87,673,846	3,841,083	2,320,620	235,297,556
FY13	140,865,479	99,171,271	3,819,369	2,453,213	246,309,332

All Other	Adult		Pediatrics		Adult + Pediatrics
	IP NPSR	OP NPSR	IP NPSR	OP NPSR	Total NPSR
FY10	4,105,499	10,015,879	34,232	82,903	14,238,513
FY11	3,974,058	5,386,520	542	77,000	9,438,120
FY12	3,864,140	5,913,096	670	74,018	9,851,924
FY13	5,008,444	8,130,628	8,550	288,002	13,435,624

Note:

Cape Cod Hospital internally grouped primary payers into the AGO Exhibit 2 using three major payer groups specificed in the Health Policy Commission template.