The principal teaching hospital for Tufts University School of Medicine

Tufts Medical Center

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September 25, 2014

VIA ELECTRONIC MAIL

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116
HPC-Testimony@state.ma.us

RE: Request for Written Testimony

Dear Mr. Seltz:
Please find attached Tufts Medical Center's response to the request for written testimony submitted by the Health Policy Commission and the Office of Attorney General.

I am legally authorized to represent Tufts Medical Center in this matter. I am informed and believe such information is accurate, and based upon such information and belief, declare under penalty of perjury, that the statements made herein are true and correct.

Sincerely,

Malisa S. Schuyler

Malisa Schuyler
Director, Government Relations

Enc: Exhibit B and C Responses
Exhibit B and C Appendix
Exhibit C Q1 Excel file
Exhibit C Q2 Excel file

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: Tufts Medical Cetner has seen a steady hold in its revenue picture. We have experienced a significant decline in inpatient volume as payer policies re-categorize traditionally high intenisty inpatient care as outpatient, where procedures and services are often not reimbirsed at a level commenusurate with the high level of compexity and intensity of care and services provided.

   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.
      In this timeframe, Tufts Medical Center has experienced a small increase in revenues and a commensurate incerase in operating expenses. In this same timeframe we have experienced a daramtic decrease in inpatient utilization, accompanied by an increase in outpatient utilizations. The casemix severity of our ou patient utilization has also increased markedly. Much of the driving factors for this shift in inpatient utilization can be attributed to a shift in payer policies categorizing inpatient stays as outpatient or observation status.
   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?
      Tufts Medical Center's has focused on the following priorities to deliver high quality:
      - Developing community programs in partnership with physicians and hospitals
      - Exporting teams and expertise into the community
      - Integrating health information systems
      - Coordinating care from the physician's office to the academic medical center, and then back again to the community physician's office
      - Channeling tertiary and quaternary cases to Tufts Medical Center and Floating Hospital for Children

   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?

Tufts Medical Center has also announced an affiliation with Circle Health. This affiliation will unite organizations who share a demonstrated high quality, lower-cost approach to health care services and an established set of population health management practices and programs. The new system will:

- Create a unique balance of community and academic care, teaching and research.
- Promote effective relationships among community-based and academic physicians and community-based and academic hospitals
- Support collaboration in care coordination and effective implementation of population health management
- It will also help deploy care models closer to where our patients actually live

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

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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: At Tufts Medical Center delivering high quality, safe patient care is our top priority. We have consistently ranked among the top in state and national quality measurements. APMs have helped provide the data and funding to targeted quality programs that have resulted in marked quality achievements. APMs also provide the platform for better alignment of incentives and focused measurement and improvement around specific disease states and quality metrics. APMs that provide robust, timely and complete information about patients provide the best opportunities to truly coordinate care, whereas APMs that carve out specific areas of care, such as behavioral health and pharmacy, lack the funding and data to influence and improve upon some of the most critical areas of care.

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?

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).

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.

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: As Tufts Medical Center's risk contracts are negotiated and managed by New England Quality Care Alliance (NEQCA), we concur with the resposne provided by NEQCA (provided in the Appendix).
   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?

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

   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?

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: The need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs and all other payment methodologies continues to be a concern for Tufts Medical Center. The areas where the most impact could be felt in regard to patient quality, care coordination and cost impact are in the PPO sector and in APMs where certain areas of care are carved out of the overall APM, such as behavioral health and pharmacy care. The lack of information on the PPO population is a significant hindrance to providing more coordinated patient care across a broader population and to better understanding trends in quality, variations in care and cost. This data currently exists with the payers and we would greatly encourage the dissemination of this data if we truly want to make gains in population health.

   ANSWER:

5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.

SUMMARY: As NEQCA handles health plan contracting for Tufts Medical Center, we concur with the answer provided by NEQCA relative to patient attribution: In our experience the most reliable patient attribution models are those in which the patient is required to select a primary care physician. In the absence of a patient driven attribution model and in the absence of a shared methodology applied uniformly across all payers, we believe any attribution model applied to the All Payer Claims Database would be a very good starting point.

Any agreed upon methodology will require transparency and an ability to test and validate the attribution.

a. Which attribution methodologies most accurately account for patients you care for?

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

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: Tufts Medical Center firmly believes quality and safety reporting can bring great value to patient care and in creating a workplace and culture focused on zero defects, with an ability to measure and improve utilizing standardized metrics. We believe quality measures are important, however, the ever increasing number, quality and cost of the reporting requirements have far outstripped the cost of compliance and value to patient care. Please see the Appendix for a full response.

ANSWER:

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: As a provider of tertiary and quaternary levels of care Tufts Medical Center consistently strives to ensure the patient receives the most appropriate care in the most appropriate setting. We have kept even more care in the local community by sending experts to work side by side with physicians and care teams in community hospitals to raise the level of care that can be provided in the local setting – allowing patients to receive high levels of care closer to home, allowing families to stay near their loved ones when they need hospitalization.

This model has proven to be beneficial for our patients, for our organization and for the community providers; our continuously high case mix demonstrates that we are caring for the sickest patients and providing highly complex care that can only be attained in a setting such as Tufts Medical Center and Floating Hospital for Children.

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.

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.

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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: The complexity and intensity of care received by our patients at the Medical Center often means they will require post-acute care. At Tufts Medical Center and Floating Hospital for Children we continuously strive to ensure the care needed by our patients is delivered in the most appropriate 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.

b. How does your organization ensure optimal use of post-acute care?

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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: Tufts Medical Center's Financial Coordination Department has fielded only a small handful of requests for price information in the past year. Please see the Appendix for the full response.

Health Care Service Price Inquiries			
Year	**Number of**	**Number of**	**Average**

		Inquiries via Website	Inquiries via Telephone/In Person	(approximate) Response Time to Inquiries*
CY2014	Q1			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER:

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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: To date tiered and limited network products have had no discernible impact on the flow of patient volume to Tufts Medical Center. Referral practices continue to be dominated by the largest providers and physician groups. The current financial structure of tiered and limited network products does not have a significant enough impact so as to alter patient choice, for example, a patient seeking care at a tertiary or quaternary care institution is likely to surpass the patient deductible portion very quickly, thereby negating any financial incentive a patient may have to seek care at the most cost efficient provider.

    ANSWER:

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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: Tufts Medical Center is dedicated to keeping costs down for all patients, and especially for our high-risk patients. We have integrated care with our Department of Psychiatry and our Primary Care practice for our outpatients, including all specialties and otherd that refer their patients the Department of Psychiatry. Please see the Appendix for the full response.
    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.

    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.

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.

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.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

SUMMARY: Tufts Medical Center's primary care practice has been recognized as a level-3 Patient-Centered Medical Home (PCMH) with distinction by the National Committee for Quality Assurance (NCQA). Please see the Appendix for a full response.

e. 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?

Approximately 80% of Tufts Medical Center Primary Care Physicians are recognized. We have had a number of physicians join our practice since the initial accreditation, and they are not accounted for in the number of physicians recognized. However, the new physicians follow the same procedures and deliver the same high-level of care as all other physicians in the PCMH.

f. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

Approximately 92-95% of our organizations Primary Care patients receive care from accredited PCPs.

g. 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.

We have not statistically analyzed the cost savings impact post accreditation. However, we are confident that patient satisfaction has improved and this is reflected in a significant gains in Press Ganey scores and the CAHPS® PCMH survey.

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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:

ANSWER:

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 attached Exhibit 1 excel file.

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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 attached Exhibit 2 excel file.

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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.

   Risk contracts are negotiated and managed by New England Quality Care Alliance (NEQCA). Please see the full response in the Appendix.

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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.

At Tufts Medical Center we strive to capture and retain information regarding inpatients' and outpatients'primary care and referring physicians primarily for purposes of ensuring more coordinated care and seamless communication across the patient's care team. This information is primarily captured during intake interviews with our patients upon admittance. This data is also anaylzed regularly to determine if patterns exist that will allow us to better understand the origin of our patient referrals and what can be done to create stronger relationships to build clinical bridges and simplify administrative processes with any referring physicians.

Appendix
HPC Questions for Written testimony
Tufts MC response

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.**

3a. 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 do not sufficiently account for changes in patient population acuity. In the commercial population where the underlying disparities in payments are so prevalent, the risk adjustment is influenced by those underlying payment disparities. The fragmentation of the system at the payment level by health plan and by provider has an influence on the risk adjustment calculation. Utilizing a standard methodology, for example APRDRG, would create a standard of relativity and an ability to generate useful, comparable data that can be validated. Additionally, socioeconomic factors do not seem to be adequately addressed in current health status risk adjustment methods.

3b. How do the health status risk adjustment measures used by different payers compare?

To the extent that we can understand, the various health status risk adjustment measures used by different payers do not easily compare. Because we are not provided with the details of the health risk adjustment methodologies, we know very little about each payer's formula. Each payer's methodology is comparable only to their own membership and is truly only valid for one fixed point in time because of the recalibration that is constantly being done by the payer. Because there is no transparency around each payers formula for health risk adjustment, there is no ability to compare or validate across payers. Since patients move between payers and tend to remain with providers, a uniform and transparent health status risk adjustment would be highly beneficial in managing care.

3c. 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?

NEQCA has seen very little affect from the interaction of risk adjustment measures and other risk contract elements. Patients from populations with socioeconomic challenges can be more difficult to engage in quality and efficiency improvement efforts. These factors are not adequately accounted for in current risk adjustment methodologies.

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.**

Tufts Medical Center firmly believes quality and safety reporting can bring great value to patient care and in creating a workplace and culture focused on zero defects, with an ability to measure and improve utilizing standardized metrics. We believe quality measures are important, however, the ever increasing number, quality and cost of the reporting requirements have far outstripped the cost of compliance and value to patient care.

While there is a move toward electronic data abstraction, the sheer number of measures and the increase from year to year creates an enormous burden. Virtually all the staff in our quality department are dedicated to data collection and reporting. We have both grown the staff and increasingly outsourced additional chart abstraction to vendors. We have expensive subscriptions to Press Ganey, UHC, and other organizations to help aggregate and report the data.

There are differences between the definitions of each quality measure across public and private payers, and the appearance of cherry-picking of certain measures by payers to selective disadvantage of the provider. There are ongoing challenges with "topped-out" measures, where 98% or 99% compliance might be penalized but is clinically meaningless. The various measure sets do not reliably correct for illness severity and case mix, consistently disadvantaging referral centers. Some measures (e.g., some patient safety indicators), while used widely, are of poor scientific validity and could easily be manipulated, thereby negating any comparative value among providers.

Below is an example of some of the organizations to which we currently submit chart abstracted data:

1. The CMS Hospital Inpatient Quality Reporting Program
2. The CMS Hospital Outpatient Quality Reporting Program
3. The CMS Hospital Inpatient Psychiatric Facility Quality Reporting Program
4. MassHealth
5. Blue Cross Blue Shield
6. CDC's National Healthcare Safety Network
7. Multiple patient type/ service line specific registries, many of which are required either at the federal or the state level (i.e., UNOS for transplant patients and the Stroke registry)
8. The Boston Public Health Commission
9. Joint Commission on Accreditation of Healthcare Organizations

There is some overlap in the specific measures required by some of these programs, but it is rather minimal. All of these programs increase their reporting requirements every year. Even if one agency retires a measure that is topped out, other agencies do not necessarily do the same, so the abstraction burden does not decrease, but is ever increasing.

Electronic submission of quality measure data certainly alleviates some of the burden, however, the path to a comprehensive reporting system is long and difficult. A huge number of man-hours are required to sort out which data elements are used in the measure calculations, identification of the fields in the EMR used to feed the measure calculation, creation of fields if they don't exist, making fields mandatory for clinicians and educating clinicians that specific information must be documented in specific fields and nowhere else.

In addition to the cost and burden of manually collecting data by chart abstraction, we spend a great deal of time and energy reviewing and analyzing cases identified by the AHRQ Patient Safety Indicators, which are based on claims data, to ensure the coding of the case is consistent with the physician's documentation. Some payers make this process even more difficult by specifying that the data be reported only for their own patient population.

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.

Tufts Medical Center's Financial Coordination Department has fielded only a small handful of requests for price information in the past year. Most of the requests for price information have come from walk-in patients or patients who have been hospitalized and do not have insurance or do not have adequate insurance coverage.

We have informed all pertinent medical personnel of the law and provided information to help frontline staff and physicians direct any patient inquires to Financial Coordination to help fulfill the information request. The current process of providing a cost estimate to a patient is a manual process requiring a significant amount of data collection, analysis and comparison, with necessary explanation that this charge could change dramatically based on the care necessary at the point of service. The complex nature of the tertiary and quaternary care provided at Tufts Medical Center often means a physician and care team may make care decisions on the spot or may alter a care plan based on the complexities presented upon surgery or as a patient's condition changes, which cannot be included in estimates. Providing an accurate cost assessment requires compiling and cross referencing several different data points, which are not currently synthesized within our organization. We do not have an ability to track how a patient uses the information we provide them; we also remain concerned with the release of charge and pricing information if it is not accompanied with the appropriate quality information to allow a consumer to make a fully informed decision.

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.

11a. 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.
Tufts Medical Center is dedicated to keeping costs down for all patients, and especially for our high-risk patients. We have integrated care with our Department of Psychiatry and our Primary Care practice for our outpatients, including all specialties other that refer their patients the Department of Psychiatry. The Department of Psychiatry has regular consultations with physicians who are members of the Primary Care practice and New England Quality Care

Alliance. The Department of Psychiatry is diligent in its efforts to include the primary physician of our patients who do not receive their primary medical care at Tufts Medical Center. We also participate in the Massachusetts Child Psychiatry Access Project, which enables a child's doctor to access information and resources regarding mental health issues and treatment. Having a psychiatric unit in a general hospital, we have highly trained physicians working on our floors who are experienced in treating highly complicated, comorbid, high-risk patients. We also have integrated medical consultants in house who can consult on our psychiatric in-patients.

11b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

Tufts Medical Center's Department of Psychiatry has a highly qualified Consult Service which is utilized throughout the Medical Center to address patients in other departments who may seem to be having psychiatric emergencies. Our goal at that time is to keep the patients in a familiar environment and minimize the risk to the patient, other patients in the area, and the staff. If necessary, patients in other medical offices can be brought to the outpatient department for an emergent visit. For patients already seeking outpatient care, the department would utilize the patient's payer for referrals to Intensive Clinical Management, partial-hospitalization, intensive outpatient services, etc. If authorized, we would utilize the patient's home resources (family, friends, and other social supports) to help keep the patient safe. Our goal is to provide the patient with the best, most appropriate care possible, in the least restrictive environment at all times.

11c. 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.

Tufts Medical Center is fortunate that we have extensive experience in providing many forms of care on-site; in areas where we may lack expertise, we have an extensive network of individuals/clinics/agencies that we can draw upon. We have collaborated with the Children's Behavioral Health Initiative services for Mass Health children and adolescents with serious emotional difficulty. The biggest barrier to the integration of services is the lack of services in the communities where our patients live, and the absence of payment mechanisms for telephonic consultation and case management. Specialty services continue to close due to lack of funding which leaves inpatient units and general clinics challenged in trying to care best for special populations.

11d. 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.

Tufts Medical Center is dedicated to reporting data as requested. Our Quality Assurance Department handles all data collection and reporting for all services in the hospital, and are glad to work with appropriate State entities.

12 Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

Tufts Medical Center's primary care practice has been recognized as a level-3 Patient-Centered Medical Home (PCMH) with distinction by the National Committee for Quality Assurance (NCQA). The transformation took approximately 3 years and we continue to evolve each day. The first 2 years were spent designing and approving a new staffing model which called for increasing our support staff by 30% and putting the infrastructure in place that is required to achieve accreditation. Because our practice is large, 34,000 patients and 70,000+ visits per year, it is vital for us to have an EMH/Registry that allows us to easily pull data. We also hired a full-time high-level EMR specialist/ data analyst who played a critical part in the transition.

The process to achieve this level of PCMH is significant, one example of the amount of effort required in the more than 50+ requirements by NCQA can be a seen in the requirement that practices prove that they follow-up with patients who miss important appointments. Our specialist was able to work with the administration and clinical team to develop alert systems when an important appointment is missed, create a template to accurately and systematically track the outreach, and prove our compliance rate.

12a. 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?

Approximately 80% of Tufts Medical Center Primary Care Physicians are recognized. We have had a number of physicians join our practice since the initial accreditation, and they are not accounted for in the number of physicians recognized. However, the new physicians follow the same procedures and deliver the same high-level of care as all other physicians in the PCMH.

12b. . What percentage of your organization's primary care patients receives care from those PCPs or other providers?

Approximately 92-95% of our organizations Primary Care patients receive care from accredited PCPs.

12c. 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.

We have not statistically analyzed the cost savings impact post accreditation. However, we are confident that patient satisfaction has improved and this is reflected in a drastic increase in Press Ganey scores and the CAHPS® PCMH survey.

Exhibit C.

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.

NEQCA's approach to risk management has not changed in the past 12 months. NEQCA currently purchases stop-loss or reinsurance to cover potential catastrophic losses in its risk-based contracts. Accurate quantification and analysis of potential exposure for the network in a risk agreement is fully dependent on access to complete claims data, including information about the actual dollar amounts paid by the health plan for those claims and for the patients served by provider. Health plans do not currently share overall health status adjusted network costs and other groups' costs.

As prudent financial stewards NEQCA currently purchases stop-loss or reinsurance to cover potential catastrophic losses in its risk-based contracts. As a system, NEQCA bears the contractual risk in current global payment agreements, as well as the per member per month costs associated with all the deployed care management services to manage the patient population. NEQCA believes that it would be appropriate for payers to allocate from their reserves the appropriate level of capital to support contractual risk.

In order to accomplish the goals of population health management and the triple aim, the data, structures and incentives to move the needle must all be in place. This does not necessitate global budgeting nor risk agreements; it requires aligned incentives. Risk contracts allow for a general alignment but since current risk arrangements only cover a minority of the population, they are not going to create substantial change. It is also important to understand that entering into a risk contract does not in and of itself result in a transfer of true, long term actuarial population based risk. The risk and potential reward in a contract with a commercial health insurance payer is simply the result of a negotiation between the payer and provider. In the event that a historically high cost entity is able to embed its high costs into a negotiated global budget, all it has done is change the cash flow by which it is paid and it is still not held accountable to overall average cost, but is held only to its own baseline. This continues the disparities of the current market.
NEQCA would also like to observe that accurate quantification and analysis of potential exposure for the network in a risk agreement is fully dependent on access to complete claims data, including information about the actual dollar amounts paid by the health plan for those claims, for the patients served by provider.

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.

Tufts Medical Center

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	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	Notes:
	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		
BCBSMA	50,503,721	60,933,530	967,662	1,167,499												113,572,412	
Tufts					40,001,711		(220,000)				-					39,781,711	do not distinguish HMO v. PPO, reported all as HMO
HPHC	32,677,763		164,210													32,841,973	do not distinguish HMO v. PPO, reported all as HMO
Fallon												2,663,087				2,663,087	no delineation by product, reprt as PPO
CIGNA												7,058,014				7,058,014	no delineation by product, reprt as PPO
United												8,567,446				8,567,446	no delineation by product, reprt as PPO
Aetna												8,576,627				8,576,627	no delineation by product, reprt as PPO
Other Commercial												19,929,164				19,929,164	no delineation by product, reprt as PPO
Total Commercial	83,181,484	60,933,530	1,131,872	1,167,499	40,001,711	-	(220,000)	-	-	-	-	46,794,338	-	-	-	232,990,434	no delineation by product, reprt as PPO
																-	
Network Health											11,456,401					11,456,401	do not distinguish HMO v. PPO, reported all as HMO
NHP											25,897,957					25,897,957	do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											7,774,021					7,774,021	do not distinguish HMO v. PPO, reported all as HMO
Fallon											318,299					318,299	do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											45,446,678					45,446,678	do not distinguish HMO v. PPO, reported all as HMO
																-	
Mass Health		53,462,969		370,089											500,000	54,333,058	classified all as PPO
																-	
Tufts Medicare Preferred					14,083,554		(71,000)									14,012,554	do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											3,339,108					3,339,108	do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											9,412,105					9,412,105	do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					14,083,554						12,751,213					26,834,767	do not distinguish HMO v. PPO, reported all as HMO
																-	
Medicare												138,083,016				138,083,016	classified all as PPO
																-	
All Other Payors												25,065,844				25,065,844	includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	83,181,484	114,396,499	1,131,872	1,537,588	54,085,265	-	(220,000)	-	-	-	58,197,891	209,943,198	-	-	500,000	522,753,797	

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	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	Notes:
	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		
BCBSMA	45,177,828	59,080,326	2,382,286	3,115,383												109,755,823	
Tufts					38,285,050		(105,000)				-					38,180,050	do not distinguish HMO v. PPO, reported all as HMO
HPHC	35,895,959		180,382													36,076,341	do not distinguish HMO v. PPO, reported all as HMO
Fallon												2,695,712				2,695,712	no delineation by product, reprt as PPO
CIGNA												5,227,296				5,227,296	no delineation by product, reprt as PPO
United												9,017,879				9,017,879	no delineation by product, reprt as PPO
Aetna												7,236,219				7,236,219	no delineation by product, reprt as PPO
Other Commercial												22,616,133				22,616,133	no delineation by product, reprt as PPO
Total Commercial	81,073,787	59,080,326	2,562,668	3,115,383	38,285,050	-	(105,000)	-	-	-	-	46,793,239	-	-	-	230,805,453	no delineation by product, reprt as PPO
																-	
Network Health											12,741,326					12,741,326	do not distinguish HMO v. PPO, reported all as HMO
NHP											29,075,375					29,075,375	do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											6,666,457					6,666,457	do not distinguish HMO v. PPO, reported all as HMO
Fallon											650,399					650,399	do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											49,133,557					49,133,557	do not distinguish HMO v. PPO, reported all as HMO
																-	
Mass Health		47,349,665		1,750,824											526,849	49,627,338	classified all as PPO
																-	
Tufts Medicare Preferred					16,971,787		(413,400)									16,558,387	do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											2,959,026					2,959,026	do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											9,800,369					9,800,369	do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					16,971,787						12,759,395					29,731,182	do not distinguish HMO v. PPO, reported all as HMO
																-	
Medicare												151,092,783				151,092,783	classified all as PPO
																-	
All Other Payors												26,061,894				26,061,894	includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	81,073,787	106,429,991	2,562,668	4,866,207	55,256,837	-	(105,000)	-	-	-	61,892,952	223,947,916	-	-	526,849	536,452,207	

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	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			Grand Total	Notes:
	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		
BCBSMA	43,233,460	62,928,587	2,219,466	3,230,551												111,612,064	
Tufts					40,246,659		(250,000)				-					39,996,659	do not distinguish HMO v. PPO, reported all as HMO
HPHC	40,293,154		243,218													40,536,372	do not distinguish HMO v. PPO, reported all as HMO
Fallon												2,378,254				2,378,254	no delineation by product, reprt as PPO
CIGNA												4,805,869				4,805,869	no delineation by product, reprt as PPO
United												12,051,403				12,051,403	no delineation by product, reprt as PPO
Aetna												7,902,093				7,902,093	no delineation by product, reprt as PPO
Other Commercial												23,232,200				23,232,200	no delineation by product, reprt as PPO
Total Commercial	83,526,614	62,928,587	2,462,685	3,230,551	40,246,659	-	(250,000)	-	-	-	-	50,369,819	-	-	-	242,514,914	no delineation by product, reprt as PPO
																-	
Network Health											11,109,059					11,109,059	do not distinguish HMO v. PPO, reported all as HMO
NHP											14,194,715					14,194,715	do not distinguish HMO v. PPO, reported all as HMO
BMC Healthnet											7,196,100					7,196,100	do not distinguish HMO v. PPO, reported all as HMO
Fallon											179,908					179,908	do not distinguish HMO v. PPO, reported all as HMO
Total Managed Medicaid											32,679,782					32,679,782	do not distinguish HMO v. PPO, reported all as HMO
																-	
Mass Health		53,980,955		3,510,173												57,491,128	classified all as PPO
																-	
Tufts Medicare Preferred					16,517,115		(130,800)									16,386,315	do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											3,696,645					3,696,645	do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											11,297,093					11,297,093	do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal					16,517,115						14,993,738					31,510,853	do not distinguish HMO v. PPO, reported all as HMO
																-	
Medicare												166,333,188				166,333,188	classified all as PPO
																-	
All Other Payors												20,753,361				20,753,361	includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	83,526,614	116,909,542	2,462,685	6,740,724	56,763,774	-	(250,000)	-	-	-	47,673,520	237,456,368	-	-	-	551,283,226	

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	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue			Grand Total	Notes:
	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	39,487,233	59,589,394	1,859,789	2,806,570												103,742,986	
Tufts Health Plan					47,011,237		-250,000									46,761,237	do not distinguish HMO v. PPO, reported all as HMO
Harvard Pilgrim Health Care	41,582,848		335,346													41,918,194	do not distinguish HMO v. PPO, reported all as HMO
Fallon Community Health Plan												3,039,417				3,039,417	no delineation by product, reprt as PPO
CIGNA												4,859,619				4,859,619	no delineation by product, reprt as PPO
United Healthcare												10,776,601				10,776,601	no delineation by product, reprt as PPO
Aetna												8,307,004				8,307,004	no delineation by product, reprt as PPO
Other Commercial												23,675,005				23,675,005	no delineation by product, reprt as PPO
Total Commercial	81,070,081	59,589,394	2,195,135	2,806,570	47,011,237	0	-250,000	0	0	0	0	50,657,646	0	0	0	243,080,063	
Network Health											10,668,767					10,668,767	do not distinguish HMO v. PPO, reported all as HMO
Neighborhood Health Plan											16,630,435					16,630,435	do not distinguish HMO v. PPO, reported all as HMO
BMC HealthNet, Inc.											6,243,495					6,243,495	do not distinguish HMO v. PPO, reported all as HMO
Health New England																0	
Fallon Community Health Plan											136,215					136,215	do not distinguish HMO v. PPO, reported all as HMO
Other Managed Medicaid																0	
Total Managed Medicaid	0	0	0	0	0	0	0	0	0	0	33,678,912	0	0	0	0	33,678,912	do not distinguish HMO v. PPO, reported all as HMO
MassHealth		52,143,015		1,917,031												54,060,046	classified all as PPO
Tufts Medicare Preferred					19,308,848		-509,030									18,799,818	do not distinguish HMO v. PPO, reported all as HMO
Blue Cross Senior Options											4,361,578					4,361,578	do not distinguish HMO v. PPO, reported all as HMO
Other Comm Medicare											14,083,270					14,083,270	do not distinguish HMO v. PPO, reported all as HMO
Commercial Medicare Subtotal	0	0	0	0	19,308,848	0	-509,030	0	0	0	18,444,848	0	0	0	0	37,244,666	
Medicare												169,831,609				169,831,609	classified all as PPO
																0	
Other												22,096,836				22,096,836	includes Comm Conn + GIC + Wcomp+ OOState Mediciaid + Other, classified all as PPO
GRAND TOTAL	81,070,081	111,732,409	2,195,135	4,723,601	66,320,085	0	-759,030	0	0	0	52,123,760	242,586,091	0	0	0	559,992,132	

Tufts Medical Center
Health Policy Comission

Response to Exhibit C, Question # 2

	FY 10		FY 11		FY 12		FY 13	
	Operating Margin	% of Business	Operating Margin	% of Business	Operating Margin	% of Business	Operating Margin	% of Business
Commercial	13,876,998	45%	15,581,316	44%	20,543,650	44%	26,327,530	40%
Government	-18,430,118	55%	-5,827,633	56%	-16,201,790	55%	-18,657,402	58%
Other	5,312,120	0%	594,317	0%	-293,860	0%	-2,318,128	2%
Total	759,000	100%	10,348,000	100%	4,048,000	100%	5,352,000	100%