CHA Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

September 11, 2015

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street
Boston, MA 02109
Via Electronic Submission

Re: Annual Health Care Cost Trends Testimony

Dear Mr. Seltz:

This letter transmits Cambridge Health Alliance's written testimony in response to the questions from the Health Policy Commission and the Office of the Attorney General in a letter dated August 6, 2015.

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

Please feel free to contact me should any questions arise.

Sincerely,

Patrick Wardell
Chief Executive Officer
Cambridge Health Alliance

Enclosure

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), 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 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 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 both days. 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 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 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 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, 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: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at 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 at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment 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 complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement 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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Exhibit B: HPC Questions for Written Testimony

1. **Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.**
   a. **What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.**
   Cambridge Health Alliance (CHA) has experienced a modest increase in volume adjusted costs, well below the benchmark 3.6%. In FY 2015, while growing outpatient volume by 3.8%, CHA was able to control overall cost to a growth of 1% for the organization, inclusive of salary increases. CHA has focused its cost containment efforts on growing its primary care and behavioral health services to the safety net population in order to improve care coordination and the delivery of services in lower cost settings.

   CHA's reimbursement from major commercial payers is approximately $15.7 Million below the average commercial acute hospital rate and policy action is needed to address payment disparities to improve reimbursement to support high value care in our communities.

   During CY2014, CHA observed a shift in patient payer mix from Health Safety Net (HSN) patients to MassHealth in both the Inpatient (3.1%) and Outpatient (2.8%) areas. The shift a result of the Temporary Medicaid process instituted during the enrollment process during CY2013. However, CHA anticipates that after the re-enrollment process during CY2015, the patient payer mix will return to more closely resemble pre-Temporary Medicaid levels.

   b. **What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?**
   Since 2014, CHA has expanded its participation in alternative payment models (APMs) that allow CHA the ability to manage the total cost of care for a defined population. Since 2014, CHA has moved from approximately 16% of its panel of primary care patients in alternative payment arrangements that carry downside risk to approximately 57% of its panel in these types of arrangements. CHA has demonstrated the ability to reduce the total cost of care for defined populations in Medicaid, Medicare and Commercial based populations.

   In addition to expansion of APM contracts, CHA continues to develop its clinical capabilities in our Patient-Centered Medical Home and complex care processes by further expanding our ability to identify patients in need of other supports in order to reduce preventable emergency and inpatient utilization. In order to improve the care for our patients and reduce avoidable utilization, CHA has expanded its network to include other community-based providers including preferred provider relationships, such as home health agencies/visiting nurses associations, palliative care and hospice providers, and

skilled nursing facilities. These relationships afford care coordination and management opportunities in community-based settings that are frequently lower cost settings.

c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

CHA will continue to explore the appropriate use of alternative payment methods (APMs) in its portfolio and is actively participating in various forums to address and support the use of these models more comprehensively in the Medicaid population. CHA already participates in the following APM models:

Medicare: Pioneer ACO, Medicare Advantage, Senior Care Options and Elder Service Plans;
Medicaid: Medicaid Primary Care Clinician Program (PCCP) Primary Care Payment Reform and Medicaid Managed Care Organization
Commercial: Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan.

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

- Toward efforts to improvement population health management, greater integration of care for physical health and behavioral health is essential; these efforts are complicated by the carve-outs of behavioral health services by insurers.
- Clarification on the roles of ACOs versus insurers in certain activities, including referral authorization and prior authorizations, will assist with reducing redundancy and administrative hurdles in care coordination.
- Administrative simplification and standardization, including for referrals, claims processing, and quality measures, are certain ways that policy makers can reduce the administrative burden on providers. For example, we have hundreds of quality measures with definitions that vary across insurers.
- Standardization of claims data sets for reporting purposes.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

The following barriers present challenges to the continued progression of alternative payment methods (APMs) for Cambridge Health alliance (CHA).

1. The majority of APMs, including those with global budgets, deployed in Massachusetts to-date continue to base reimbursement in large part on the previous fee-for-service system, which includes payment disparities across providers for the same quality and level of health care services and lacks adequate reimbursement for wellness-based services like primary care and behavioral health care. Greater strides are needed to improve reimbursement for wellness services, as current reimbursement structures align reimbursement with more highly specialized care.
2. Payers need to incorporate reimbursement (such as per member per month care management and administrative payments to providers accepting APMs) that recognizes

both the clinical and financial responsibilities undertaken by those accountable providers. The continued need to invest in functions such as ambulatory care management, transitions of care processes, and the technological infrastructure to support and manage population health across multiple individual payer contracts is challenging, especially in the context of inadequate reimbursement for commercial insurance for providers like CHA that are paid well below the average acute hospital relative price.

3. Addressing gaps in the behavioral health and substance abuse continuum of care including in the Department of Mental Health system and for residential and detoxification services are needed to support population health.
4. Part of the solution for an adequate behavioral health care continuum is addressing the continued underfunding of behavioral health services.
5. Appropriate payment models and supports are essential for making progress for Medicaid populations. These models need to reflect the social acuity of Medicaid populations both through the risk adjustment approach and in the design of and funding support for care management requirements. Current payment models, such as Primary Care Payment Reform (PCPR), are unnecessarily burdensome and continue to add costs to providers in a manner that may be streamlined..
6. Complexities in administering different APMs across payers stems from the variation in contract terms and constructs with different contracting entities.
7. Addressing the lack of and/or timeliness of detailed performance reporting on APMs from payers to participating providers to support the management of APMs is pivotal to increasing the adoption of APMs. In addition, it would be helpful to have access to raw claims data in a standard format across all payers, so that provider organizations can work with this information to create consistent reports for effective panel management.
8. Admission, discharge, and transfer reports from payers to providers participating in APMs would be valuable to support real-time patient care coordination opportunities, including opportunities for coordinating care within a high value network. This is essential to participating providers in order to promote quality care in cost-effective, community settings.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.

a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

1) spending on post-acute care

To reduce avoidable spending on post acute care over the last year, CHA has established preferred provider relationships with selected visiting nurses associations (VNAs), palliative care and hospice providers and has actively sought to partner with a more focused group of preferred skilled nursing facilities to improve care coordination efforts. A more focused collaboration with a smaller cohort of skilled nursing facilities will allow CHA to work more intimately with a smaller number of providers on key initiatives to improve the quality, costs and experience of care for our patients. CHA's goal is to manage patients to an appropriate post-acute setting based on the patient's clinical needs.

CHA continues to actively work on initiatives that coordinate care between the acute hospital setting and the post-acute setting to ensure that patients receive the right level of care and that patient treatment plans are communicated upon admission and discharge. As noted below, CHA is actively implementing communication initiatives at the point of care transitions from the acute hospital setting to the post-acute setting to ensure that the patient's care plan is communicated to prevent avoidable readmissions.

2) reducing avoidable 30-day readmissions

To reduce avoidable 30 day readmissions CHA continues to work on improving care transition communication and documentation using a discharge order set, standardization of closed loop communication, patient education and prescription fulfillment services at patient discharge, and use of readmission data to identify improvement opportunities. CHA completed development of electronic medical record (EMR) tools to support improved care transitions to: 1) improve discharge documentation for patients during care transition, 2) implement inter-organizational workflows to ensure provider to provider "closed loop communication" regarding the care transitions for vulnerable patients being discharged to post-acute care setting; and 3) prescription fulfillment services at discharge. CHA advanced efforts to help patients comply with medications post discharge, through patient education and prescription fulfillment services initiatives.

CHA also developed a readmission assessment tool. Readmission information and assessment is reviewed as a component of CHA multi-disciplinary patient rounding practices. CHA developed a patient interview questionnaire in the electronic medical record to identify care transition improvement opportunities. CHA has advanced reporting capabilities to support discharge and readmission improvement initiatives and operational practice changes, and has developed a work plan to guide development of additional analytical capabilities using business analytics software.

Finally, CHA is participating in the Medicare Community Care Transitions Program (CCTP). In this program, high-risk Medicare beneficiaries receive a 30-day care transition support, and about 2500 patients have been enrolled since December 2012. Through community health workers and nurse practitioners, patients receive transition support in the hospital visits, through home visits, and telephone outreach. CHA has achieved a decrease in readmissions of greater than 10% among patients in the hospital to home program, and has been recognized as one of the top five programs nationally. CHA is utilizing the learning from this project for purposes of expansion across its patient population and is currently working with community partners to achieve this result.

3) reducing avoidable emergency department (ED) use

CHA, over the past 12 months, convened an interdisciplinary task force that evaluated data and developed recommendations for supportive interventions to address the needs of vulnerable patients with high Emergency Department (ED) utilization, as defined by 8 or more ED visits in a 12 month period. Findings included an average of 14.4 ED visits per patient in this cohort during calendar year 2014. About 38% of the overall ED visits were for behavioral health, including 27% for alcohol-related conditions, 5% for other substance use, and 6% for psychiatric diagnoses. For implementation in SFYs 2016 –

2017, CHA has developed an interdepartmental strategy to improve care delivery, reduce avoidable ED utilization, and track a cohort of patients with an assigned CHA PCP longitudinally to measure reductions to avoidable ED utilization. The interventions include tools to readily identify these high risk patients in the electronic medical record and engage them in CHA's primary care and Complex Care Management programs. For patients who become a part of CHA's primary care panel, they will be apprised of how to access primary care appointments, primary care operating hours, and when it is appropriate to consult with the provider on-call after hours.

4) providing focused care for high-risk/high-cost patients.
During the past 12 months, CHA expanded our primary-care based complex care management (CCM) program with nurse and social work care managers to our twelve core primary care sites. As of June 2015, 690 high risk patients were actively enrolled in complex care management. Along with this expanded CCM approach, our providers and care teams will be supported by visiting nurses that are assigned to each practice for the purposes of managing home care and the reduction of future emergency department and inpatient utilization.

In addition, CHA will implement an evidenced-based approach to measure and advance patient activation, a patient's knowledge, skill, and confidence for self-management of health conditions. This is an important area of focus toward population health goals of the Affordable Care Act and especially for vulnerable patients and high risk patient populations. Measurement through the Patient Activation Measure (PAM)© is a validated tool for measuring the level of patient engagement in their health care, which is an intermediate outcome of care linked to improved health outcomes.[1] Research findings have shown that more activated patients have better health outcomes and better care experiences than less activated patients; furthermore, research has revealed that patient activation can be enhanced over time by interventions, such as tailored coaching.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
1) spending on post-acute care
CHA plans to continue its implementation of the post-acute care collaboration activities outlined above in the response to question a. CHA plans to expand the focus on its care for Dual Eligible populations (Medicare and Medicaid), including those enrolled in CHA's Elder Service Plan.
2) reducing avoidable 30-day readmissions;
CHA is implementing efforts in several critical areas which are synergistic to produce meaningful improvement in care transitions with goals that result in better care and improvement in preventable readmissions. Evidence has shown that a comprehensive and reliable discharge plan, along with post-discharge support, increases the likelihood of successful care transitions, patient engagement, reduces readmission rates, and improves health outcomes. Project elements include: a) development of clear, consistent patient-centered discharge processes with uniform communication and documentation for

[1] Hibbard, Judith, Greene, Jessica. What The Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences; Fewer Data On Costs. *Health Affairs*, 32, no.2 (2013):207-214.

patients and post-acute care teams with input from representatives of CHA's Patient Family Advisory Committee; b) improved patient care transitions through patient education for high prevalence conditions [Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD)] and the high risk medication (warfarin); c) promotion of patient medication safety and compliance post-discharge, through pharmacist-led patient medication education and prescription fulfillment services at patient discharge; d) a standardized care transition process and "closed loop communication" between CHA's acute hospital care team and selected post-acute care facilities; and e) development and implementation of readmission assessment tools, protocol and analytical tools to drive care transitions performance improvements.

3) reducing avoidable emergency department (ED) use
To address avoidable ED use, CHA plans to engage in activities to reduce ED utilization for patients empanelled to CHA who use the ED 8 or more times in a 12 month period CHA will support high-risk primary care patients with high ED utilization through enrollment in complex care management and the development of individualized care plans..

4) providing focused care for high-risk/high-cost patients.
Over the next 12 months, CHA plans to expand its complex care management (CCM) program to add new community health worker support to the CCM and primary care teams to provide assistance to patients in navigating the health care system. CHA will also expand our patient activation initiative to advance patient engagement in managing their own health, based on evidence-based tools and practices.

4. **As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.**
    a. **In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?**
    Acceptable reasons for price variation include factors which increase the cost of providing services to patients and communities and which are necessary to provide adequate access to quality care and to meet societal and policy objectives. Examples of reasonable contributors to price variation beyond the underlying direct costs of services include costs associated with training the healthcare workforce of the future, infrastructure costs necessary to provide adequate geographic and emergency services access, costs necessary to meet regulatory and patient safety requirements, and costs which contribute to adequate returns necessary to invest in innovation and performance improvement. Many of these incremental costs will be higher as a percentage of total costs in smaller institutions and it is difficult to increase their efficiency over a smaller base of services. Unacceptable reasons for price variation include those which stem from

greater negotiating leverage in the market and excess returns over those necessary for reasonable investment in items outlined previously.

b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

To the extent price variation has resulted in payments to some providers in excess of what is the reasonable cost of providing care and meeting the objectives outlined above, these excess payments have increased the overall cost of care and increased pressure on purchasers to reduce payments elsewhere, to the detriment of providers without market leverage. These providers are generally smaller yet must make ongoing investments to meet market wage conditions and regulatory requirements disproportionate to their size. Consequently, their financial position is weaker over time. Conversely, providers with strong market power can continue to demand higher prices creating a cycle of ever increasing price pressure and financial decline of smaller community and lower cost providers.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 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.

a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

Over the past 12 months, CHA advanced its initiative to integrate behavioral health care into the primary care setting. Following CHA's Stepped Care Model wherein behavioral health specialist and primary care services are matched to the appropriate level of complexity and acuity of patient need, CHA initiated primary care and behavioral health integration, including for substance use, in six primary care sites. Initial implementation activities included creation of site-specific leadership teams, site-specific self-assessments of core model element capabilities, and site specific implementation work plans. CHA initiated specialized training for primary care and integrated behavioral health staff and deployed integrated behavioral health therapists and psychiatrists into the initial six primary care sites to provide direct patient care services and team consultations.

Patients are able to attain initial mental health assessments (often at the time of their primary care visit) and short-term care through introductions made by their primary care team to integrated behavioral health clinicians and staff. Primary care teams and integrated behavioral health staff are developing collaborative operations, patient care workflows, and tools to screen and treat patients for high prevalence behavioral health conditions alongside primary medical care.

CHA also updated its stepped model of care and core model elements to reflect new roles and approaches to providing behavioral health care in the primary care setting based on

prior experience. CHA developed and implemented a standardized integrated behavioral health screening tool (adult wellbeing questionnaire and alcohol and substance use screening) to identify high prevalence behavioral health conditions in the primary care patient population.

b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

CHA will expand primary care and behavioral health integration model, including for substance use, across its core primary care system (currently 12 primary care sites). To address the behavioral health needs of CHA's entire primary care population, CHA will develop and implement a model for behavioral health integration within primary care that is scalable across all primary care settings with appropriate modification based on the local primary care site and patient population characteristics. CHA is deploying a tele-psychiatry component to support the integration of behavioral health into the primary care setting.

Increasing identification of behavioral health disorders requires significant care management in order to facilitate population health. CHA plans to address these challenges through the following initiatives: 1) maximizing the management of behavioral health care appropriately delivered through our primary care teams (with timely behavioral health clinical consultation and support); 2) integrating licensed behavioral health clinicians and a new Care Partner role to facilitate care coordination and community resources (e.g. self help groups); 3) maximizing the utilization of approaches found in chronic disease models including low intensity interventions (self care plans, patient activation, motivational interviewing); 4) maximizing the use of technological innovations; and 5) developing collaborations and referral relationships with specialized/ high intensity behavioral health programs for patients needing more intensive behavioral health services.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

CHA continues to make significant progress to expand the Patient-Centered Medical Home (PCMH) model in primary care. As of June 2015, ten of CHA's twelve of core primary care practice centers have achieved National Committee for Quality Assurance (NCQA) Level 3 Patient-Centered Medical Home recognition, the highest level. CHA's early NCQA recognized medical homes have shown better quality, access, and patient experience scores than other CHA practices.

Collectively, these sites have 86% of CHA's primary care patient panel empanelled to primary care teams, a foundational element of the PCMH model of care to achieve accountability for improving population health.

CHA has made significant progress to expand the PCMH model in primary care as a foundation for improving health care delivery, promoting health, and panel management in alternative payment models. Of particular focus over the past twelve months has been: primary care - behavioral health integration, creating an established process for the transfer of medical records from outside institutions, and providing patient-specific educational materials through the electronic medical record.

CHA plans to continue to expand our NCQA certification for all twelve core primary care practice centers.

In terms of developing Accountable Care Organization (ACO) capabilities CHA is advancing participation in alternative payment models toward better health and cost-effective care. Leading with Medicaid, Dual Eligibles/Senior Care, and Medicare Pioneer Collaborations, 57% of CHA's patient panels are in risk-sharing and other alternative payment arrangements.

CHA is working as part of a larger, high-value (high quality, lower cost) Accountable Care Organization network on commercial risk-sharing contracts and the Medicare Pioneer ACO model. CHA is working directly with Medicaid on alternative payment models, including participation in Medicaid Primary Care Payment Reform and a Medicaid Managed Care risk-sharing arrangement. Overall, CHA is currently responsible for managing Total Medical Expense (TME) of ~$327 Million annually.

CHA commenced risk-based arrangements with government payer populations. Initial and new strategies have been deployed to impact population health management in terms of quality and cost/utilization results. Summarized below are notable strategies, some have been tailored to specific populations.

- Complex care management for high risk patients;
- Emergency department and inpatient utilization;
    - Electronic alerts for panel patients presenting to CHA inpatient/emergency care;
    - New deployment of urgent care approaches, expanded primary care access, and after-hours triage;
    - New focus on evidence-based practices for ambulatory-sensitive conditions; and
    - New high utilizer initiatives, including emergency department interventions for vulnerable populations.
- Referral management and community-based care in high value network;
- Promote continuity of care and limit outmigration to higher cost settings; and
- Expanded community-based partnerships such as with preferred home health, palliative care, ACO, behavioral health/ substance use, skilled nursing facilities, and other community providers.

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 provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.**

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1	57	0	57	See below
	Q2	33	0	33	See below
	Q3	41	0	41	See below
	Q4	33	0	33	See below
CY2015	Q1	77	0	77	See below
	Q2	77	0	77	See below

The types of services to which consumer inquiries pertained were consistent quarter to quarter during CY 2014 and the first half of CY 2015. The types of services that were the subject of consumer inquiries included: physical exams, prenatal services, radiology services, laboratory services, colonoscopies, and vaccinations.

2. **Please submit a summary table showing for each year 2011 to 2014 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 <u>AGO Hospital Exhibit 1</u> with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.**

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

Exhibit 1 AGO Questions to Providers and Hospitals

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

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
8. **Other Revenue Arrangements** are arrangements for revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as managements fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2010 **Cambridge Health Alliance Exhibit C, Question 1,**

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

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

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

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

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

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* For these contracts the physicians organization is the only participant

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

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

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* For these contracts the physicians organization is the only participant

2013 **Cambridge Health Alliance Exhibit C, Question 1,** **Dollars are shown in Millions.**

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

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

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

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

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	ALL		ALL		ALL		ALL		ALL		ALL		ALL		Both
BCBSMA *					27.8		0.2		0.3						
Tufts *					11.8		0.1								
HPHC *					11.2		0.1								
Fallon											0.1				
CIGNA											1.9				
United											3.7				
Aetna											3.0				
QHP											0.5				
Other Commercial											26.5				
Total Commercial					50.8		0.4		0.3		35.7				
Network Health					38.2										
NHP											17.5				
BMC Healthnet											1.1				
Fallon											0.5				
Care Plus plans											7.0				
Total Managed Medicaid					38.2						26.1				
Mass Health	29.30		0.80		24.8						4.1				
Tufts Medicare Preferred					0.4						0.8				
Blue Cross Senior Options											0.5				
Other Comm Medicare					11.0						6.2				
Commercial Medicare Subtotal					11.4						7.5				
Medicare											80.7				
GRAND TOTAL	29.3		0.8		125.2		0.4		0.3		154.1				

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* For these contracts the physicians organization is the only participant