CAPE COD HEALTHCARE

Michael K. Lauf
President and Chief Executive Officer

September 8, 2015

Mr. David Seltz, Executive Director
Commonwealth of Massachusetts
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

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

Dear Mr. Seltz:

Pursuant to your letter dated August 6, 2015 and in accordance with Massachusetts General Laws chapter 6D, § 8, please find included herein Cape Cod Hospital's responses to the questions outlined in Exhibits B and C. I am legally authorized and empowered to represent Cape Cod Hospital for the purposes of this testimony, and hereby sign the enclosed testimony under the pains and penalties of perjury.

Please feel free to call me at 508-862-5893 should you have any questions.

Sincerely,

Michael K. Lauf
President and CEO

/dal

cc: Karen Tseng, Chief, Health Care Division, Office of the Attorney General
Aron Boros, Executive Director, Center for Health Information and Analysis

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Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (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.**

Cape Cod Hospital (CCH) has implemented strict expense control while concurrently investing in physicians, programs and technology. These efforts have resulted in increased quality, improved access and growth.

FY14 compared to FY13

Discharges for FY14 were down 3% over the same period prior year. Key outpatient services are mixed for the previously mentioned periods. ER was down 8%, radiology up 1%, radiation therapy down 7% and outpatient surgery was up 2%. Net patient revenue, excluding bad debt, has increased 6% compared to same period last year. Total expenses increased 7%, adjusted for volume; the overall expense increase was 5%. The larger expense categories include salaries, benefits, and drugs which have increased 2%, 1% and 6% respectively. The increase in drug costs of 6% or $1.5M continues to be major area of concern going forward as drug prices continue to escalate.

Ten months fiscal year-to-date 7-31-15 compared to prior year

CCH discharges for the fiscal year ten month period ended July 31, 2015 were up 7% over the same period last year. Key outpatient services including O/P surgery, imaging, O/P oncology, radiation therapy, and rehab are mixed for the previously mentioned periods. ER is up 4%, radiology up 6%, radiation therapy down 4% and outpatient surgery was down 3%. Ten months ending July 31, 2015, net patient revenue, excluding bad debt, has increased 6% compared to same period last year. **Total expenses increased 5%; however, adjusted for volume, the overall expense increase was 2.8%.** The larger expense categories include salaries, benefits, and drugs which have increased 6%, 9% and 18% respectively. The increase in drug costs of 18% or $3.8M continues to be a major area of concern going forward as drug prices continue to escalate. Notably, the steep rise in cost of pharmaceuticals and medical devices are significant factors that are beyond the Hospital's control. The most recent CHIA report also recognized the Pharmacy expense as a significant driver of Total Healthcare Expenditures 2014 versus prior year.

The demographics of our primary service area, defined as Barnstable County or "Cape Cod" are unique in that the population is heavily skewed toward older adults. The 2010 U.S. Census reported that residents over age 65 account for 25% of the total Barnstable County population. This segment is large and getting larger. The 65+ age cohort experienced a net increase of 5.1% from the 2000 Census. According to the UMass Donahue Institute projections, this age group is expected to grow by 26% by 2035 from 53,879

people in 2010 to 67,762 in 2035. Since these projections also predict a drop in overall population in Barnstable County the group will continue to be overrepresented in the general population and residents aged 65+ would account for 36% of the BCTY population in 2035.

Cape Cod Hospital will continue to face challenges caring for a population that is getting older and less affluent.

Cape Cod Hospital relies heavily on governmental payers for services provided to our patients. For FY15YTDJuly, 78% of Cape Cod Hospital inpatient discharges were reimbursed under Medicare, Managed Medicare, Medicaid or Managed Medicaid. In fact, CCH has seen a 12% increase in public payer days for FY11 through FY14 with a corresponding 30% decrease in other payers' days. The increase in Mass Health patient days has been most significant.

Additionally, this high proportion of older adults consumes more health care services, particularly for inpatient services related to diseases and conditions related to aging. For example, the MHA Quarterly Survey of Hospital Utilization showed that participating hospitals reported an average 1.2% decrease of inpatient days for FY14 compared to FY13, where CCH experienced only a 0.6% decrease.

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?

Primary Care and Physician Collaborations

Cape Cod Hospital has actively pursued partnerships with physicians and other healthcare providers in an effort to offer accessible, affordable, high-quality care to our community. Expanding access to primary care is a fundamental goal of Cape Cod Healthcare's Strategic Plan. Cape Cod Healthcare (CCHC) has made additional progress toward this goal by acquiring Emerald Physicians in 2014.

Emerald Physicians offers an innovative model of care to patients that maximizes provider engagement, communication, patient education and coordination of care. This model has demonstrated operational efficiency, as well as high patient, physician and employee satisfaction.

Emerald Physicians is one of the most innovative and progressive practices on Cape Cod. Their physicians and mid-level providers care for over 45,000 patients at 13 locations across Cape Cod.

The high-quality practice model is focused on same-day access for primary care patients. The practice offers Saturday appointments and is planning to expand to Sunday hours to suit patient needs. This real-time approach allows physicians to concentrate on the urgent needs of patients and to avoid unnecessary emergency room visits or hospitalizations. Nurses, mid-level providers and patient advocates work closely with physicians to ensure patients are getting quality care as quickly as possible.

Emerald Physicians applies immediate attention and considerable focus on patients discharged from the hospital or SNF settings. Currently 80% of these patients are seen in the office or at a home visit within 2 business days, and 100% are seen within 7 business days. Additionally, Emerald has been conducting patient home visits since 2011. The practice conducted 1,500 home visits in 2015 and expects to reach 2,000 per year in 2016.

Emerald has a very low 30-day readmission rate of 12.7 % for 2011-2014, as distinct from the national average of shared savings ACO's of 17.7 % for the comparable period. CMS data estimates that the resulting savings in Medicare expense for 2011-13 was approximately $2M per year. Emerald's quality metrics compare favorably with national ACO outcomes for diabetes care and management of cardiovascular disease.

Emerald has organized as a Medicare Shared Savings Program A.C.O. and is set up at the patient level to function as a patient centered medical home. Emerald's application for Patient Center Medical Home (PCMH) certification is currently in process. Emerald continues to develop innovative solutions to not only to further improve access, performance and outcomes, but also to promote warmth and intimacy in their relationship with patients. Emerald's Patient Satisfaction surveys point to the warmth, compassion, competence and responsiveness of Emerald's staff and providers. This is particularly important, as Emerald believes that these traits are vital to promoting patient engagement.

During the past year, Emerald embarked on a major initiative with Cape Cod Health Network (CCHN PHO) to develop systems for population health management and chronic disease management. Emerald has hired 14 full time nurses to support health and wellness in conjunction with primary care teams. CCHN has made financial investments to acquire and implement population health management software systems and to recruit the necessary analytic staff. This effort is expected to lead to significant reductions in the cost of patient care over the next three years. The Emerald model gives CCHC an opportunity to test new models of care and focus on the management of chronic disease.

Introduction of Healthcare Services in Lower Cost Settings

Cape Cod Hospital (CCH) has also partnered with for-profit medical providers such as the Cape and Islands Endoscopy Center (CIEC) and Shields Healthcare. The CIEC collaboration has resulted in improved access, shorter wait times for procedures and cost savings of nearly $1,000 per study. Cape Cod Hospital's collaboration with Shields Healthcare for imaging services, allows patients the flexibility to access MRI testing at a variety of locations, including hospital outpatient or lower cost Independent Diagnostic Treatment Facility (IDTF) locations. These collaborations provide broad geographic access and lower cost alternatives to patients, while maintaining high quality outpatient services such as endoscopy and MRI.

Cape Cod Healthcare, the parent of CCH and affiliated Falmouth Hospital, successfully developed Urgent Care Centers in Harwich and Sandwich respectively. Both centers were developed "off-license", and are

administered by The Medical Affiliates of Cape Cod (the CCHC physician group), resulting in reduced capital development expense, reduced operating costs and lower costs to patients.

The Centers are managed and staffed by physicians and nurses trained in Emergency Medicine. The Centers provide lower cost treatment alternatives to patients who would otherwise have sought care in an expensive emergency room setting. Patient co-pays at the Urgent Care (UC) Centers are reduced compared to their typical ED co-payments. Urgent Care visits are reimbursed at a significantly lower rate than a similar visit to a hospital-based emergency room. The average reimbursement for an UC encounter is $565 less than the average reimbursement for an ED encounter.

The Urgent Care Centers are co-located at our health centers where a patient can be referred to imaging and lab services when needed. Further, any Urgent Care patient who lacks a primary care provider is offered assistance and referral information so the patient may become established with a PCP.

Supply Chain Initiatives

CCH has placed an increased emphasis on supply costs including establishing a Value Analysis Committee whose primary focus is to review opportunities for product standardization and evaluation of both new and substitute products in order to improve patient outcomes while reducing supply costs. Without these efforts, supply costs increases would have been higher. The savings achieved specific to these initiatives were $1.6M in FY14 and $3.4M for the ten month period ended July 31, 2015. Recently in 2015 the Value Analysis Committee was expanded to include additional physicians across several specialties in order to further identify opportunities. In the upcoming FY16 year, a supply savings target of $2.3M has been established.

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?

Cape Cod Healthcare plans to continue to progress with its key initiatives related to CCHN, the Physician Hospital Organization (*PHO – see detail under Questions 2, 3 and 6),* expansion of our primary care network, including Emerald Physicians *(see Question 1)* and significant investments in IT to ensure interoperability to reduce duplicative testing. Finally, Cape Cod Healthcare, the parent of Cape Cod Hospital, will continue to implement new business models, including developing services "off-hospital" license, in order to provide the community with high quality services at a reduced price point.

Technology

Advancements in clinical integration, population health management and assumption of risk require significant infrastructure development, most notably in the area of Information Technology. Cape Cod

Healthcare has and will continue to make significant investments in technology in an effort to improve the quality of care for our patient population as well as reducing costs associated with unnecessary duplication of testing/procedures. To date, we have invested over $12M. These investments include the purchase of Ambulatory EMRs, Patient Portals, HIEs (Health Information Exchange) and Outreach Lab integration with our physician practices' EMRs, Community Health Centers and SNFs. We plan to continue to expand and improve to make investments in future years that will continued to expand access and improve the care of our patients. The following is a summary of our major IT investments:

- dbMotion (HIE) Health Information Exchange: Repository of patient Clinical Summaries from multiple systems available in one location; provides medication profiles, lab results, problem lists, and allergies. (Continuing into FY16)

- Orchard Outreach System: Bi-directional patient orders and results into physician practice and Community Health Centers' EMRs; SNF – portal to send orders and review results.

- eClinicalworks EMR (Electronic Medical Record), PM (Practice Management) and RCM (Revenue Cycle Management) System (FY16 launch)

- Peoplesoft ERP (Enterprise Resource Planning) System (FY16 launch)

- Follow My Health Patient Portal: Improves patients' access to clinical information. Able to communicate with providers.

- ePrescribing System: Reduces medication errors due to illegible handwriting and improves efficiency for providers and patients.

- Aria Oncology System: Clinical oncology documentation system for department including access to patient flow sheet and medication management.

- Urgent Care Centers: Stoneman and Fontaine – Improved access for patient population. Expanded ED Pulsecheck System to 2 additional sites to provide clinicians with same documentation system as CCH and FH EDs.

Clinical integration requires a major investment in technology infrastructure that makes hospital-physician collaboration more possible. These investments include technologies that support coordination of care via an HIE (Health Information Exchange) that connects ambulatory electronic medical records (of both employed and independent physicians), the hospital EMR, pharmacy information systems, labs, etc. The goal is to create a patient longitudinal record that allows physicians, nurses and other providers across the care community to track patient care in every setting and support population health management needs. It requires tools that allow CCHC to run performance analytics on clinical programs, care settings, provider performance, cost utilization and patient engagement. Clinical

integration is not a project with a defined endpoint, but an evolution that will require ongoing financial investments, quality improvement, resources and leadership.

Further Urgent Care Development

Cape Cod Hospital has plans to develop additional Urgent Care centers where needed to serve the Cape's population. These centers not only provide affordable options, but increase accessibility due to convenient locations and extended hours of service. As noted previously, in Question 1, the Urgent Care programs have and will continue to reduce costs. We estimate the development of the two existing Urgent Care Centers has resulted in $4.7M in savings since 2013 and additional development will further reduce Total Healthcare Expenditures.

Management of Benefit Costs

Since January 1, 2014 Cape Cod Healthcare (CCHC) has taken several steps to reduce healthcare costs while maintaining quality and comprehensive health benefit coverage for our workforce. One major initiative was selection of a new third-party administrator (TPA) for our self-funded employee health plan. Our objective to engage a new TPA focused on reduction of expenses and establishment of a strong partnership to increase efficient utilization of our plan and improve the health of our covered population. As a result of our selection, we were able to reduce administrative costs and increase discounts from non-CCHC providers and facilities, resulting in an overall projected savings of $2.4M.

We have also worked concertedly with our collective bargaining units to better educate them on our plan and the growing costs associated with both utilization and plan design. These discussions led to a collaborative effort during recent contract negotiations with both the MNA and SEIU, and helped us to introduce and adopt plan design changes more closely aligned with national benchmarks and our own non-union plan (SEIU changes are pending ratification). Overall, we anticipate that recent plan design changes will assist us in recognizing approximately $900K in additional savings going forward.

We have further established a 'Helping Hands' program, which identifies high risk members for targeted clinical engagement. Helping Hands provides concierge services and case management for greater coordination of care and engagement of members. CCHC has also developed a Wellness Program, which recently provided members with free on-site biometric screenings and a personal health assessment (PHA). The data collected from these initiatives not only helped members better understand their potential health risks and steps they can take to improve their health outcomes, but also provided CCHC with aggregate information that will be used for future development of Wellness initiatives and plan design considerations.

Cape Cod Healthcare continues efforts to develop a multi-year, multi-phased health management strategy and to build upon the momentum of the initiatives mentioned above which, collectively, have helped us reduce our incurred loss ratio from 101% in FY14 to 87% YTD FY15. Incurred per member per

month (PMPM) cost for YTD FY15 has dropped 11% from FY14, with the greatest cost improvements being realized by our non-union plans. We still face significant challenges. The annual blended (all staff) cost of coverage for enrollment in a family plan is $30,000, while premium contribution rates for many union employees remains low by industry standards. We will continue our efforts, in conjunction with our organized labor partners, to address our relatively high costs of coverage and utilization.

Further, while we feel our medical costs are trending in the right direction, pharmacy costs are not. This is mostly attributable to the utilization of high-cost Hepatitis-C drugs, Sovaldi and Harvoni, which have represented about a third of our total Rx expense in recent months.

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

We believe there are significant opportunities to eliminate unnecessary administrative costs in healthcare. These include standardization and simplification of billing forms, billing policies and uniform quality measures among various payers.

Take, for example, the costs that hospitals incur both to submit a claim to local health insurers and, moreover, to figure out if the actual payment is correct. Introduction of a single claim form and payment methodology as well as consistent payment policies across health plans in Massachusetts would enable hospitals to eliminate or at least significantly reduce the need for certain non-patient related staffing expense. Currently we must employ analysts to review and ensure that payments received are consistent with the agreed upon contract, or potentially risk loss of revenue. Also, with the current proliferation of high deductible plans, our bad debt expense is increasing as is the administrative cost of pursuing these patient payments. Such patient responsibility payments should be collected by the payers, not providers. Only the payer knows the amount remaining on a patient's annual deductible or the balance of their HSA. These simple changes would be an easy win for everyone. It would also enable providers to focus on bigger issues, like population health, and give insurers an opportunity to contribute meaningfully to healthcare reform.

Additional policies are needed to encourage greater patient responsibility. Education and incentives and/or penalties should be implemented to address areas where patients themselves can have an impact on reducing unnecessary health care costs, such as accessing primary care regularly, controlling unnecessary utilization, and properly utilizing medication.

As mentioned in question 1 above, policies which address uncontrolled pharmaceutical and medical supply and device costs will be key to reigning in total healthcare expense, yet are beyond the control of providers.

Creation of a central repository for state agencies and committees to access information would reduce administrative burden on healthcare providers that are currently required to submit the same information to multiple agencies, for different applications.

Additionally, service line planning could be enhanced if Hospitals could receive more current and less restricted inpatient and ED utilization data from CHIA. Expanding provider access to patient data through CHIA would allow our organization to better identify and respond to outmigration of patients who seek care in higher cost settings that could be provided in the community setting.

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

Cape Cod Health Network (CCHN), the Physician-Hospital Organization (PHO) through which Cape Cod Health Care partners with some 370 community and hospital based physicians, participates in a variety of alternative payment arrangements. These consist primarily of global risk arrangements with embedded quality and patient experience metrics accessed through the Steward Health Care Network (SHCN)'s contracts with the major Massachusetts payers.

In general, we are on a path to risk across all our covered lives under a model of clinical integration and an incentive payment structure that aligns individual physician behavior with system-wide objectives. However, prior to getting into specific barriers to further adoption of such alternative (i.e., risk) payment arrangements, there are two overarching factors that affect our pace of adoption worthy of particular emphasis. First, the vast majority of CCHC's revenue comes from fee-for-service payments. A rush to adoption of risk and related utilization reductions would threaten the viability of the organization overall and the healthcare needs of the community we are dedicated to serving. Accordingly, our approach is to aggressively implement a comprehensive population health program tailored to the particular needs of our patient population along with incremental introduction of utilization management initiatives as appropriate. Under this approach the risk we take on is commensurate with our degree of readiness and at a level that ensures the quality of patient care will not be adversely impacted.

Second, the transformation of our health care delivery system is a tremendous undertaking that requires significant, incremental investment in the form of time, resources and, especially, IT infrastructure. At the same time, we are facing unprecedented downward pressure on revenue dollars. This includes shrinking revenue from our most prevalent payer source, Medicare, under the Affordable Care Act and a cap on commercial rate increases under MA Chapter 224. When considered together, it is clear that these factors are diametrically opposed and impede the pace of adoption.

Aside from these overarching considerations, specific barriers impacting adoption of alternative payment arrangements include the following:

- IT Infrastructure: 100% of the physicians in the CCHN PHO will be live on Meaningful Use (MU) certified EMR by 2015 year end. Both hospitals have clearly been on MU certified EMR platforms for some time and we are currently in the process of rolling out an HIE to provide real-time connectivity across the continuum. However, until physician EMRs in particular have been optimized, i.e., chronic disease algorithms incorporated; related discrete quality data captured and made available for downstream reporting; and, office workflows fully re-engineered, we will not be ready to scale up and take on risk across all our covered lives.

- Physician Culture & Practice Structure: On Cape Cod, much of the physician community is aging and consists of many small / solo practices that make seamless integration a challenge. Older physicians in some instances can be reluctant to change and those nearing retirement know that the pain of such change will not bear dividends for them long term. Despite these structural issues, CCHC has worked closely with the physician community to meet these challenges head on. The result is significant progress under 2 distinct models: a PCMH-type model for the majority of our employed physicians (i.e., group physicians) and an ACO-type model for independent physicians in smaller practices. Despite this demonstrated commitment to our long-term population health objectives, adoption of new payment arrangements cannot outpace our collective readiness which is in large part dictated by physician capacity for change.

- Population / Lifestyle Issues: A key barrier to success under risk is the need for patient lifestyle change and related engagement in their own health and wellness. Because the majority of commercial health coverage is financed through employers, benefit offerings are more a reflection of the employer's need to attract and retain good talent, than to manage the health of its covered lives. Clearly there is a trend toward increased patient cost sharing, but that is not the same as incentivizing members to collaborate more closely with their PCP or to embrace chronic disease management programs (for example). Fundamentally, patient lifestyles and the proliferation of alternative payment arrangements are at odds. There seems to be an emerging expectation that this problem is to be solved by the provider community under penalty of financial deficit. From our perspective, this issue needs to be addressed more thoughtfully by a broader contingent of health system stakeholders if adoption of alternative payment arrangements is to occur in a sustainable manner.

- Plan Benefit Design: As noted above, more thoughtful plan benefit designs could facilitate adoption of alternative payment arrangements by increasing accountability on the part of the member. Despite the need for a more balanced approach, Massachusetts seems poised to tip the scales of

accountability further to the disadvantage of the provider community by introducing risk for members covered under PPO plans. The state seems to be taking its cue from CMS' much maligned Medicare Shared Savings Program (MSSP). As per the MSSP, and as currently envisioned for Massachusetts PPO plans, all providers in an ACO are jointly accountable for the care provided to a member, but the member is not even accountable for identifying their PCP. Assumption of risk requires a clear link between the ACO and its assigned population. The attribution methodology contemplated for use in Massachusetts PPO plans does not meet this fundamental standard. Plan benefit designs should evolve over time to provide an overarching structure that support providers in the assumption of risk. In the meantime, this represents another barrier to expanding the adoption of alternative payment arrangements. For example, plan benefit designs should encourage members to seek appropriate preventive care and participate in programs that support health and wellness. For patients with chronic conditions, benefit designs should encourage adherence to written care plans and prescription/drug therapies. For particularly high-risk patients, benefit designs should encourage enrollment in complex care programs and adherence to related recommendations by PCPs, specialists and ambulatory case managers. However, until such time as employers, employees and health plans choose to become effective promoters of population health, plan benefit designs represent another barrier to expanding the adoption of alternative payment arrangements.

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.**

Post-acute Care

Based on our Medicare Spending per Beneficiary (MSPB) report, we identified that a high number of total knee replacement (TKR) and total hip replacement (THR) patients were being discharged to a skilled nursing facility (SNF). Best practice models have shown that current trends include discharge to home versus SNF lead to better outcomes. Our goal is to increase the number of patients who meet criteria to home versus SNF.

This year we began to closely monitor volumes of patients with TKR and THR discharged to SNF versus discharged to home. These patients are monitored using a dashboard tool of orthopedic quality indicators. Our team is currently analyzing data on physician-specific discharge trends. Rehabilitation Services is working with this patient cohort to intervene with early ambulation and discharge planning to include discharge to home. Physicians are also working collaboratively with us to meet this goal for increased discharges directly to home. Patient education has been revised to prepare patients to expect early ambulation and discharge to home with services.

In 2011, Cape Cod Hospital developed an interdisciplinary team to improve hospital SNF coordination of care. The team membership includes 6 SNFs, Elder Services, and The Visiting Nurse Association of Cape Cod (VNA), Physician Office Practice, Case Management, Quality and physician leaders. The team is working to reduce 30-day readmissions to 9% by December 2015. Over the past year CCH's process improvements included nurse to nurse handoff with SNF, as well as development of in-depth analysis tools to assess all SNF, VNA and hospital readmissions. The adoption of this standardized analytic tool will facilitate coordination of care across the region.

Unresolved end of life issues emerged as a major theme related to SNF readmissions. Cape Cod Hospital plans to host a "Quality of Life Summit" later this year. The vision of the Quality of Life Summit is to bring together all those who can positively impact individuals with advanced or chronic illness, their families, caregivers and provider and connect the network of support services to improve quality of life to those individuals. The summit is planned for October 14, 2015. The audience will include community providers, caregivers of people with chronic illness, physicians and others. The program is meant to be the first in a series of programs that will continue to build support around end of life issues and patient choice.

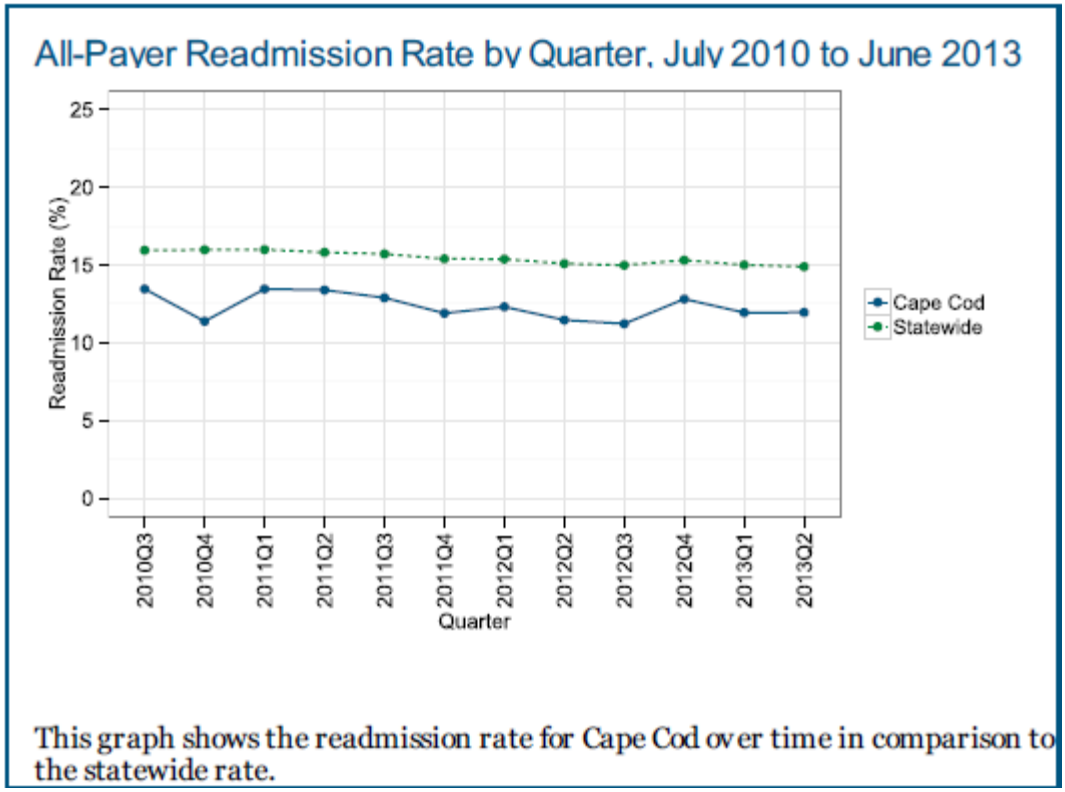
Cape Cod Hospital also conducts ongoing process improvement projects in collaboration with individual skilled nursing facilities. The transparency of the case review discussions at joint meetings has led to case identification for hospital review and action.

In May, 2015, Cape Cod Healthcare sponsored a meeting to address transitions of care issues. All skilled nursing facilities in the region were invited to join in reducing readmissions and participate in the data analysis of their readmitted patients. Enhancing communication between the hospital and SNFs was the primary focus of the meeting.

During the past year, EC case managers have worked more closely with the SNFs to identify and facilitate returns when patients do not meet criteria for an acute hospital admission. We have also instituted a process improvement project to improve communication between SNFs and EC physicians. All SNFs now use a bright orange envelope that contains all necessary transition documents. This PI originated directly from EC physician input and, as a result, has further enhanced coordination of care. We plan to continue to work closely with our post-acute providers in the next year and expect a further reduction in our readmission rate.

Progress in Reducing Re-admissions

Cape Cod Healthcare, comprised of Cape Cod Hospital and Falmouth Hospital, has been among the state leaders in readmissions management for multiple years, and continues to trend strongly downward. Since mid-year 2010, Cape Cod Hospital has achieved an All-Payer Readmission rate below the MA statewide rate.

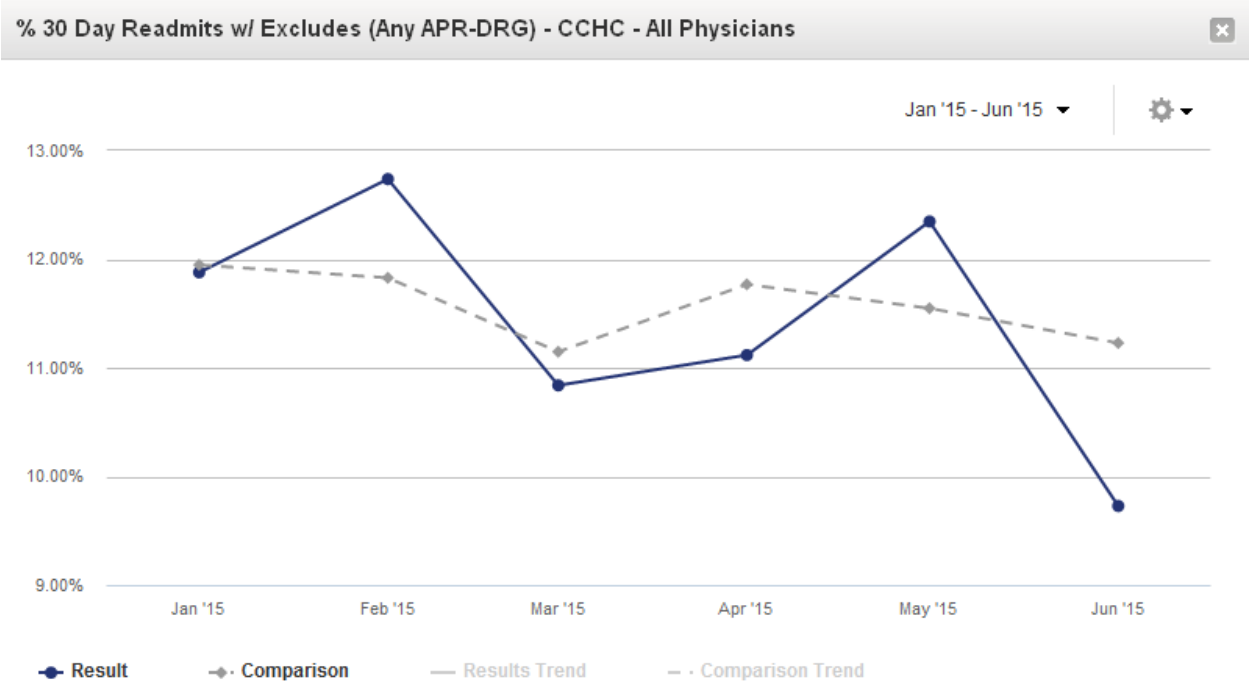


Source: Center for Health Information and Analysis (CHIA) - Hospital-Wide Adult All-Payer Readmissions in Massachusetts: 2011-2013; first annual report on hospital-wide all cause readmissions in the Commonwealth.

Both institutions utilize a "Quality Oversight" strategy – with dedicated physician-led committees that review, on a monthly basis, the most pertinent drivers of hospital readmissions. This committee then forms working sub-committees which bring specialists into the conversation to evaluate clinical processes, transitions of care, and best practice and create order sets and clinical pathways to report back to Oversight.

The process has been extremely successful in its first year – and has created new pathways for (among many) sepsis, hemorrhagic stroke, pulmonary embolism – and helped decrease the readmission rate significantly.

Cape Cod Hospital has made significant progress in reducing 30 –day readmissions to below 10%. The following table depicts recent progress for APR-DRG 30 Day readmissions from January – June 2015, compared to Massachusetts Crimson hospitals dataset for similar APR-DRGs**.**



Cape Cod Hospital utilizes a variety of business intelligence reports to track nightly inpatient census, admissions and discharges. Additionally, the Hospital also provides daily notification to area Federally Qualified Health Centers (FQHCs) in our region to facilitate post-acute management of the patients for which they provide primary care.

EC Falls Initiative

This year, the Cape Cod Hospital Emergency Center (EC) created a Falls Prevention team with the goal to reduce all preventable falls. The team revised the EC Falls Risk Assessment tool and related policies on intervention. A new policy was implemented which requires EC staff to remain with patients while toileting. Inpatient falls are reviewed monthly to identify additional opportunities to prevent falls. This project will continue in FY2016.

Pressure Ulcers

Cape Cod Hospital conducts pressure ulcer prevalence studies monthly, and the results are reviewed by Nurse Managers, Clinical Leaders, and Nursing leadership. Our efforts to prevent pressure ulcers focus on accurate skin assessment on admission, identification of patients at risk for pressure ulcers, and implementation of appropriate prevention strategies. The Braden Scale assessment is performed on admission and daily to identify patients at risk, with specific interventions based on sub-scores as well as the overall score. A wound care nurse specialist (WOCN) is available 7 days a week for consultation. To enhance this program, we are also developing an internal group of staff nurses with special expertise, available 24 hours a day to advise and assist with skin issues as they arise. New products for the prevention and treatment of pressure ulcers have been researched and acquired as appropriate, with

standardization of skin care carts on every unit. Nursing, Quality, and Education have also worked closely with the IT department, and documentation options for skin assessments were modified to increase the accuracy of reporting and staging pressure ulcers. These initiatives are on-going, and regularly updated or revised, based on data from our monthly prevalence studies and feedback from Nursing, as part of the hospital's commitment to continuous quality and safety in patient care.

CCHC and CCHN PHO Initiatives for Complex Care Management

CCHC has implemented a number of initiatives to reduce 30-day readmissions with considerable success to date. First and foremost, we have contracted with third party vendor, Dovetail, to visit high-risk patients in the home immediately post-discharge. Such home visits include both a nurse and a pharmacist. The pharmacist meets with the patient to assess his/her understanding of the prescription regimen and to perform essential medication reconciliation. The nurse assesses other home-based risk factors, like fall risk for example, and will connect patients with ambulatory case management if a more protracted regimen of patient oversight is warranted. In the most recent 12 months, the cost of these services was approximately $1M.

More recently, as a complement Dovetail's work, PHO case managers have begun notifying the PCP of high-risk patients discharged from the hospital (from either the ED or the inpatient setting) in order for the PCP to follow up and see the patient in the office in a timely manner. The PHO's target for timely in-office follow up is 3 business days. PCPs are rewarded financially under the PHO's incentive model for success in this activity.

The result has been a reduction in all cause 30-day readmission to below the statewide benchmark. Additionally, we were just informed by Tufts Health Plan that we were the top performer in their network for reducing readmissions in 2014.

Reducing unnecessary use of the ED is a key focus of the PHO and its clinical integration program for population health. Toward this end we have taken a variety of steps over the last 12 months. The PHO has begun to closely monitor ED usage patterns including so-called frequent fliers. However, our overall approach to prevention of such undesirable utilization is through risk stratification, enrollment of the highest risk patients in complex care case management and implementation of chronic care algorithms for patients with so called ambulatory sensitive conditions (i.e., conditions that if managed effectively in the outpatient setting, will result in ED and inpatient utilization reductions). This approach is proactive; and, in contrast to traditional utilization management (UM) programs, makes ED utilization reduction a natural byproduct of a healthier, and better managed population. Also key to ED utilization reduction is patient access to PCP and specialist office visits.

With respect to PCP access, CCHC's acquisition of Emerald Physicians has been a major step forward. In the most recent 12 months Emerald has grown to a 25-physician, primary care group. Emerald functions under a highly productive and evolved PCMH-type model of care delivery and offers same day access for

urgent care visits. The PHO is considering similar access requirements for its other PCPs, but in the meantime, has already taken major steps to improve timely access to specialty care. As part of our risk stratification approach, care for patients with ambulatory sensitive chronic conditions is divided between PCPs and medical subspecialists based on severity. In particular, less complex patients are referred (by the specialist) back to the PCP in order to free up access to specialty care for more complex patients. We believe such improvements to access will enable our more complex patients to receive timelier, ongoing care from medical subspecialists, therefore, reducing the need for ED visits. Another major step CCHC has taken to reduce ED visits is by introducing two urgi-care centers in Sandwich and Harwich. Reimbursement per visit for care provided in this setting is approximately 77% less than in the hospital ED. We estimate that this innovation has generated cost savings of approximately $4.7M in the most recent 12 months.

By closely monitoring ED usage patterns, providing proactive well-coordinated care, and by improving access, including access to less costly urgi-care centers, CCHC and the PHO are in the process of implementing a comprehensive plan for reduction of ED utilization.

Over the most recent 12 months, we have continued to enhance our focus on the care for high-risk/high-cost patients. With support of Optum, our data and analytics vendor and its proprietary risk stratification software, PHO staff identifies high risk patients suitable for our Complex Care, case management program. Overall, this program focuses on the 12% of our patient population that represent about 50% of the medical spend (or TME). Our primary attention is on patients with so called "ambulatory sensitive," chronic conditions (i.e., conditions that if managed effectively in the outpatient setting, will result in ED and inpatient utilization reductions). Once suitable patients have been identified, our ambulatory case managers reach out in order to enroll them into the program. We partner with Dovetail in this activity also. Dovetail's case management staff enrolls the top 3 – 5% of patients at highest risk of an adverse / costly health event in the relatively near term. PHO case managers reach out to the balance of high risk patients up to the 12% noted above. Case managers work closely with the PCP to develop and implement a care plan tailored to each patient's specific needs. The typical care plan ensures that care is administered in accordance with the PHO's chronic disease algorithms, that the patient is well educated on the nature of his/her condition(s) and that appropriate community resources are brought to bear, in particular, for patients with confounding psycho/social issues. Preliminary analysis indicates that complex case management has reduced TME for the highest-risk cohort of patients by some 25%.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

In FY2016, Cape Cod Hospital will continue to implement the programs described above.

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?**

Both regulators and healthcare providers would agree that pricing and pricing transparency are important to enable the general public to make important healthcare decisions. Any new proposed pricing structure cannot be implemented without an in-depth understanding of each provider's cost structures. Cost structures are influenced by many factors including labor structure, existence of labor agreements, employee benefit programs, patient demographics, socio-economics of service area, payer mix, and availability of primary care physicians, quality and scope of services provided. These are just a few of dozens of factors. Imposing a payment system that establishes one price for the same services without accounting for the factors described above would result in a major operational and economic disruption. This disruption would likely cause irreversible negative results to the community as it relates to healthcare availability, employment and the overall regional and local economy.

    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.**

As the name suggests, "community" hospitals were originally formed to meet the unique needs of the community each serves. Accordingly, community hospitals are a reflection of their community including the particular community's economic characteristics. This is fundamental to what makes each community hospital unique and one reason why paying the same rate across all hospitals defies logic. For example, staff wages may be a reflection of what it costs to buy a house in the community or, alternatively, because hospital staff is unionized. Hospitals that take care of a disproportionate number of low income patients might need higher commercial payment rates to make up for government underpayments. In addition to differences in payer mix, differences in service mix must also be considered. Hospitals that provide psych services, or that have other noteworthy service lines that lose money, need higher payments for the other services in order to remain viable. Clearly, there are legitimate differences among community hospitals that contribute to significant differences in cost. Introducing simplistic payment reforms that ignore such nuances put the already shaky finances of our hospital system further risk.

Providers caring for a disproportionate share of publicly funded patients will strive for higher prices from commercial insurers to offset lower than cost payments from Medicare and Medicaid. If not, deficits would occur, the hospital would close, and the community would be forced to travel to urban areas for care—highly probable more expensive care for both public and private payers.

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.**

In the last 12 months, after a year of research and preparation with 14 disciplines, Cape Cod Hospital introduced a novel system of care for behavioral health patients presenting to the Emergency Department (ED). With ED boarding hours hovering at 26 hours, Cape Cod Hospital embedded a behavioral health team of psychiatrists and Nurse Practitioners (NP) in their ED to evaluate, treat, and monitor patients with acute psychiatric emergencies. Unduplicated in the U.S., these services include a psychiatric evaluation, ongoing short-term treatment, and reassessment before a decision is made regarding whether a patient will require further inpatient hospital treatment or if the patient's acute psychiatric and/or substance abuse symptoms can be stabilized so the patient can be safely discharged from the hospital.

This collaborative effort between the ED and Behavioral Health team was put into action to improve psychiatric crisis stabilization at an earlier decision point in the patient's care. After 10 months of continual improvement and process design, the striking results include a decline in redundant initial evaluations from 5 to 2, a decrease in prolonged boarding times from an average of 26 hours to 14, as well as an increase to 47% in discharges to home or less intensive services due to the reduction of the patient's symptoms. An unintended, positive outcome was a decrease in the need for transfers to an inpatient psychiatric facility. As Cape Cod Hospital has the only 20 acute psychiatric inpatient beds available, the process improvement has saved existing beds for the most acutely ill.

What makes this endeavor unique is the behavioral health patient is receiving an inpatient unit psychiatric level of care in an emergency department while being cared for by two teams working in synergy for the best care of the patient. The Cape Cod Healthcare behavioral health team provides intensive treatment 16 hours a day/7 days a week. From 11pm to 7am, their care is overseen by the ED physician for any psychiatric emergency. The psychiatrist on-call is available for routine medications and questions.

Upon arrival, the ED physician begins the medical clearance process and provides a verbal hands-off to initiate a transfer of care to a psychiatrically trained nurse practitioner. Although residing in the ED, the individual has now become a patient of the psychiatric department. The NP performs a high quality psychiatric evaluation, enters orders into a separate electronic medical record, completes medication reconciliation, prescribes and treats the patient. Reassessment is an ongoing process such that once stabilized; the patient can be discharged home, provided appointments to a continuum of services or transferred to an inpatient facility.

Located in the 9 bed "Purple Zone" of the ED, behavioral health patient's daily care is provided by trained ED nurses, CNAs and ED techs. Built in 2010, the "Purple Zone" is a quiet environment separate from the chaos of the main ED. Here, medical care continues by the Psychiatrists and Nurse practitioners as well as ED RNs who complete psychiatric nursing assessments every shift while closely monitoring the patient's symptoms. If it is determined that that the patient most likely will need a transfer to an inpatient psychiatric facility, a bed search commences. Team collaboration and partnership is an essential part of the story.

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.

Concurrently, Cape Cod Hospital is working towards building a robust community mental health system that fosters a continuum of care for behavioral health patients. To avoid unnecessary utilization of the ED and to preserve inpatient beds for the acutely mentally ill, Cape Cod Hospital has created a grass-root team comprised of the police department, probation, DMH, and local non-profit mental health organizations. The 'Community Interventions Team' (CIT) meets bi-weekly to develop community "care-plans" for high risk/high ED utilizers. In the next 12 months, CIT is integrating the "care-plan" into the Cape Cod Hospital electronic medical record, so all clinical staff will have access to the patient's community wellness plan.

Working together with law enforcement is essential as they are often the first responders prior to the patient's arrival in the ED. With specialty training in de-escalation, the police department has now been able to successfully avoid transporting a population of patients to the ED. Moreover, Cape Cod Hospital is refining a system, whereby the police can call directly to the Psychiatric Nurse Practitioner to discuss the case prior to arrival to the ED. This method will streamline communication and as a result expedite the psychiatric treatment of the patient struggling with mental health issues.

Additionally, the police department has also volunteered to transport chronic mentally ill patients for their monthly, long-acting Invega Sustenna injections to Cape Cod Hospital. Although this is a small population of patient, this process has decreased the ED recidivism for our high risk mentally ill patients.

High quality care and evaluations in the time of crisis can reduce the need for inpatient psychiatric admissions. In the state of Massachusetts, the ED psychiatric assessments have historically been performed by less experienced or unlicensed clinicians. This often results in more psychiatric inpatient admissions as the clinicians are less likely to feel comfortable discharging a patient to home than a highly experienced psychiatrist. In the next 12 months, Cape Cod Healthcare will be actively working with the DMH ESP team to develop an ED crisis evaluation system, whereby the two teams will focus on skill, capacity, and timeliness of service. This shared responsibility and accountability will make available additional time for the ESP team to initiate more comprehensive mental health services upon discharge from the ED.

The Hospital has made a commitment to invest in and support the following initiatives possible in the next 12 months:

- Hiring of Mental Health Specialists (MHS) for the "Purple Zone" of the ED. The MHS are highly skilled and trained in the prevention of escalation techniques, which will further contribute to the declining restraint and "Code S" rate in the ED. In addition, their ability to identify and resolve environment safety issues in real-time will avoid many risk management issues found in most ED environments. The MHS will be supervised by the Psychiatric Nurse Manager.
- Hospital internal data demonstrates that 34% of all patients on the medical/surgical units of Cape Cod Healthcare have a psychiatric diagnosis in their top 4 discharge codes. As a result of this finding, the Hospital is planning additional investment to hire a Psychiatric Consult Liaison Psychiatrist to lead comprehensive evaluations and treatment to the medical/surgical units, thereby decreasing LOS and sitter costs.
- 10% of ED patients are treated for mental health issues. Additional psychiatric nurse practitioners are now in the process of being hired. Due to the low number of available psychiatrists in the country, the hiring of Nurse Practitioners (under direct and constant supervision of the Chief of Psychiatry) is a low cost alternative to increase evaluation and treatment capacity at Cape Cod Healthcare.
- To decrease wait times in the Behavioral Health Outpatient Clinics, the Hospital has budgeted additional resources for FY16 to create walk-in capacity. Same day outpatient treatment of patients in psychiatric crisis will also decrease admissions and improve ED capacity.
- Finally, The Cape Cod Healthcare behavioral health team will also go live with Telemedicine for to increase access to psychiatrists by November 2015. This level of expertise will expedite care in the EDs as well as on the medical/surgical units of both hospitals.

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?**

CCHN in partnership with CCPP and CCHC are in the process of transforming the way care is delivered on Cape Cod in order to ensure high quality care in both the hospital and community settings while addressing access and affordability. This includes the development of a comprehensive population health model through clinical and financial integration that enjoys active involvement by all major, care-delivery stakeholders. This is not a nebulous plan for the future, but a process actively underway with the attainment of many key competencies and accomplishments already "under our belt."

Overview: Our model includes implementation of chronic disease standards for the "actionable" patient conditions most prevalent in our community; risk stratification analytics to help identify these and other high-risk patients right for intervention by our ambulatory case managers; physician incentives for PCPs, medical subspecialists and surgical subspecialists to align physician behavior with our population health and cost management objectives; partnership with 8 particular community SNFs that, based on our analysis, provide the highest quality of care available in Barnstable County and provide the particular array of services required to meet the needs of our patient population. Our overall clinical integration / population health program ("CI") program includes the following noteworthy elements:

- Population risk stratification
- Chronic disease management
- Patient registries
- Referral management
- Standardized care protocols / algorithms
- Physician and hospital MU certified EMRs
- Electronic health information exchange
- Integration with select local SNFs and VNA
- Centralized ambulatory case management
- Data and analytics platform
- Robust physician incentives aligned with CI objectives
- Physician-driven, organizational structure and governance
- Third party payer risk contracts that support our CI objectives.

In total, CCHC's investment in the PHO, care transitions and complex care management to date equal some $14.4M. This does not include amounts invested in ambulatory EMR or Health Information Exchange systems.

Below, is a description of some key accomplishments and competencies developed to date along with selected noteworthy aspects of our care delivery model:

Collaboration Platform: In partnership with our physician partners CCHC developed and implemented a new PHO / ACO in 2011. Since that time we have worked together in a spirit of transparency in order to build trust and a sense of common purpose on the road to a robust and progressive program for population health / clinical integration. Key to the partnership is active physician engagement and leadership including contributions through the Quality, Utilization, Clinical Integration and Governance Committees. Contributions from CCHC focus on infrastructure, education and joint development of an informed long term strategic vision. CCPP physician leadership has helped implement stringent physician standards regarding timely EMR adoption, participation in managed Medicaid plans and adherence to quality standards and clinical protocols. This highly functional, collaboration platform is perhaps our most important accomplishment to date and positions us well to take on the considerable challenges of health care / payment reform. Status: Implemented and Operational.

Care Model: Under our care model we stratify our population based on claims data and predictive modeling and enroll high-risk patients in our ambulatory case management / complex care program. This cohort of patients accounts for 12% of the population and approximately 50 percent of TME. To complement this centralized support structure, our physicians have come together to develop twelve (and counting) clinical algorithms addressing those "ambulatory sensitive conditions" most prevalent in the community. The algorithms enable PCPs and specialists to effectively coordinate care as each algorithm delineates how to assess severity and includes criteria specifying when to involve the specialist. Based on this approach, relatively low risk patients are cared for by the PCP and relatively high risk (i.e., complex) patients are managed by the applicable medical subspecialist. Further, patient care takes place in the most effective / efficient setting and specialist access is "freed up" to ensure timely access for those patients most in need. Status: Implemented and Operational.

Physician Incentives: To support global risk we have developed and are implementing robust physician incentives designed to reward physician behavior aligned with our objectives for efficiency of care, quality and patient experience. PCPs and medical subspecialists are incentivized for referrals into our complex care program, seeing patients in the office post-discharge in a timely manner and for reducing ED and inpatient utilization for patients with the ambulatory sensitive conditions of focus. As a precursor to bundled payments, surgical subspecialists are incentivized for working together and reducing hospital costs for OR supplies and equipment. All specialties are eligible for payments on cost-based initiatives only by meeting threshold levels of performance on select quality metrics. Under our

model, dollars earned by PCPs, medical subspecialists and surgical subspecialists are pooled together. Individual physicians are eligible to earn incentive dollars based on their measureable contribution to our overall cost savings and other value-based objectives. By pooling the dollars in this manner, each physician benefits from the participation of all others and inaction by any one physician serves to the financial detriment of all others. This type of financial integration complements clinical integration and puts physicians across specialties on a "common currency" in terms of measurable contribution to our value-based goals. Status: Implementation underway; 1st payout Q1 2016.

EMR Adoption: We believe the broad adoption of EMR along with the right connectivity solution will enable us to reduce duplication of care and "scale up" our population health model across all covered lives. Regarding EMR, all CCPP physicians are required to "go-live" on a MU certified EMR by the end of 2015 in order to remain in the organization. We expect 100% of our physicians meet this threshold requirement. To address the issues of connectivity in an environment of multiple EMRs, we are in the process of rolling out an industry leading HIE to be largely subsidized by CCHC. Once fully implemented, the HIE will: enable our physicians to access community-wide clinical data at the point of patient care; inform PHO staff in real-time of patients being admitted to a local SNF or hospital; allow us to combine claims and clinical data to better stratify our patient population in terms of risk; and, facilitate retrospective analysis in order to monitor compliance with our CI initiatives and monitor the health of the population overall. Status: Active implementation underway.

Progress / Success To Date: In terms of adoption of risk / alternative payment arrangements, as of January 2015, we have approximately 33,500 covered lives and manage approximately $200M in TME. Our success in the management of risk is evidenced by the surplus payouts we receive through our Steward contracts with the major Massachusetts commercial plans (*see AGO Exhibit 1).* In terms of quality, our 2014 aggregate quality score under Blue Cross' AQC contract is approximately 3.7 out of a possible 5.0. And, our 2014 aggregate quality score under CMS' MSSP arrangement equaled 90% (out of a possible 100%).

In summary, we are moving forward aggressively and are currently implementing a progressive and robust population health / clinical integration model to enable us to meet the challenges of health care / payment reform. Accomplishments to date include broad adoption of alternative payment arrangements, primarily in the form of global risk, and implementation of internal incentive / alternative payment arrangements to reward our physician partners for performance on value-based care. Once we fully roll out and optimize physician EMRs we should be ready "scale up," and expand the scope of risk we undertake while applying our population health model across all our covered lives.

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	598	0	598	All clinical services rendered such as lab, radiology, same-day surgery (SDC), rehab, CT, MRI, injections, medications
	Q2	610	0	610	Same as above.
	Q3	650	0	650	Same as above.
	Q4	504	0	504	Same as above.
CY2015	Q1	349	0	349	Same as above.
	Q2	659	0	659	Same as above.

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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 **AGO Hospital Exhibit 1** 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.
37T

Cape Cod Hospital AGO Hospital Exhibit C-1
Fiscal Year Ending 09/30/14 - Cape Cod Hospital

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					26,006,302		775,173		955,815			47,751,771			
Tufts Health Plan					10,076,584		129,480					3,943,010			
Harvard Pilgrim Health Care					23,877,830		150,663					6,088,652			
Fallon Community Health Plan											868,707	-			
CIGNA											8,075,261	913,982			
United Healthcare											-	6,763,831			
Aetna											-	6,570,459			
Other Commercial											-	41,833,663			
Total Commercial					59,960,716	-	1,055,316	-	955,815	-	8,943,968	113,865,368			
Network Health											4,704,074	-			
Neighborhood Health Plan											4,119,991	-			
BMC HealthNet, Inc.											14,714,317	-			
Health New England															
Fallon Community Health Plan Managed Medicaid											65,284	-			
Other Managed Medicaid											1,165,774	-			
Total Managed Medicaid											24,769,440	-			
MassHealth											16,905,405	-			
Tufts Medicare Preferred											10,281,015	-			
Blue Cross Senior Options											5,169,884	1,988,116			
Other Comm Medicare											4,653,846	-			
Commercial Medicare Subtotal											20,104,745	1,988,116			
Medicare											176,758,962	-			
Other											18,169,127	-			
GRAND TOTAL	-	-	-	-	59,960,716	-	1,055,316	-	955,815	-	265,651,647	115,853,484			

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

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

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

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

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

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

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

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

Exhibit 1 AGO Questions to Hospitals

NOTES:

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