SPAULDING
REHABILITATION HOSPITAL

Submitted Electronically via HPC-Testimony@state.ma.us

September 11, 2015

Dear Ms. Johnson:

Enclosed you will find written testimony for the Spaulding Rehabilitation Network as requested for the upcoming cost trend hearings.

By my signature below, I certify that I am legally authorized and empowered to represent Spaulding Rehabilitation Network for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please direct any follow-up questions to Rebecca Kaiser, Chief of Staff at Spaulding Rehabilitation Network (rkkaiser@partners.org 617-952-5881).

Sincerely,

David Storto
President

Exhibit B: HPC Questions for Written Testimony
Spaulding Rehab Network

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.

       Please see SRN Attachment 1.

    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?

       On May 1, 2015 we informed the Massachusetts Department of Public Health of our plan to close the inpatient service of Spaulding Hospital for Continuing Medical Care (formerly Shaughnessy-Kaplan Rehabilitation Hospital), which included 120 long term acute care (LTAC) beds and 40 skilled nursing facility (SNF) beds. The hospital officially closed on August 1, 2015.

       In view of the higher utilization rates of institutional post acute care and the disproportionate share of LTAC hospitals and beds in the Commonwealth, we anticipate that this reduction in capacity will reduce institutional spending by a significant amount. For patients requiring LTAC services and who will qualify under revised admitting criteria commencing on October 1, 2015, we will use best efforts to utilize the capacity that exists at our Spaulding Cambridge LTAC and with other providers. For patients who no longer qualify, we expect that some will receive care in lower cost SNF settings or be cared for at home with home care services. However, many of these patients are likely to require longer lengths of stay in acute care hospitals that are already capacity constrained. There may also be a greater risk of the readmission of patients with more complex conditions if the post acute level of care provided does not match the patient's need. As a result of these unknowns, it is difficult to predict with certainty the net impact and reduction in spending.

       Please see our response to 3a. for other actions taken.

    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?

       As a member of Partners HealthCare, we participate and support all of the initiatives described in the PHS response.

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

We would be enabled to care for our patients in a more cost-effective manner if there was a lifting or easing of certain CMS regulations that limit our efforts to provide better care more efficiently . These include:

Inpatient Rehabilitation Facility (IRF)

- 42 CFR 412.23(b)(2): 60% percent rule, requiring that 60% of all patients admitted to an Inpatient Rehabilitation Facility come from 13 diagnostic groups
- Intensity of rehabilitation services ("3 hour rule")

Long Term Acute Care (LTAC)

- 42 C.F.R. § 412.23(e)(2) is the 25 day average length of stay requirement for Medicare patients admitted to long term acute care (LTAC) hospitals.
- 42 C.F.R. § 412.534 and .536 is the 25% rule, requiring that no more than 25% of the patients admitted to an LTAC come from a single referring hospital. There has been a moratorium on the enforcement of this rule, but it is scheduled to be fully implemented in October 2017.

Skilled Nursing Facility (SNF)

- 42 C.F.R. § 409.30 (a) (1): 3-day stay rule, requiring that Medicare patients have a 3 day stay in an acute hospital in order to qualify for covered admission to a skilled nursing facility.

Home Health

- 42 CFR 409.42 (a): Homebound Status. Patients must be homebound to receive home health services. This impacts our ability in a more patient centered world to provide the lowest cost resource in the most appropriate setting
- 42 CFR 409.12 and 409.47: Short term acute. Patients with chronic conditions benefit from continual connection and support. An example is providing a home health aide to support exercise, personal care or nurse monthly
- 42 C.F.R. 424.22: Physician face to face attestation: This becomes effective 1/1/11. It place an administrative burden on physicians and home health agencies at financial risk

Telehealth, Telemedicine and Home Monitoring

- 42 CFR 410.78 - The ACO should be able to authorize payment for telehealth services within the scope of responsibilities for ACO covered beneficiaries. Current programs limit the direct payment for these services only to rural health networks. See the following references: Medicare telehealth services, see Chapter 15 of the Medicare Benefit Policy Manual (Pub. 100-2) and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) at http://www.cms.hhs.gov/Manuals and visit http://www.cms.hhs.gov/Telehealth on the Centers for Medicare & Medicaid Services (CMS) website.

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

   See answer to question 1d

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.

      - For more efficient and effective care delivery relative to post-care spending, we evaluate all patients referred using a post-acute assessment tool to determine the appropriate and least costly level of care and we provide the full continuum within Partners Continuing Care (PCC) or refer to other providers. For example, many patients who we conclude could be cared for in a SNF or with home care at a lower cost are referred for admission to one of our LTACs or IRFs. As a matter of fact, in the first three quarters of our fiscal year through June 2015, we redirected 546 patients who were referred to our LTACs or IRFs to our less costly and more clinically appropriate SNF and home care levels of care.

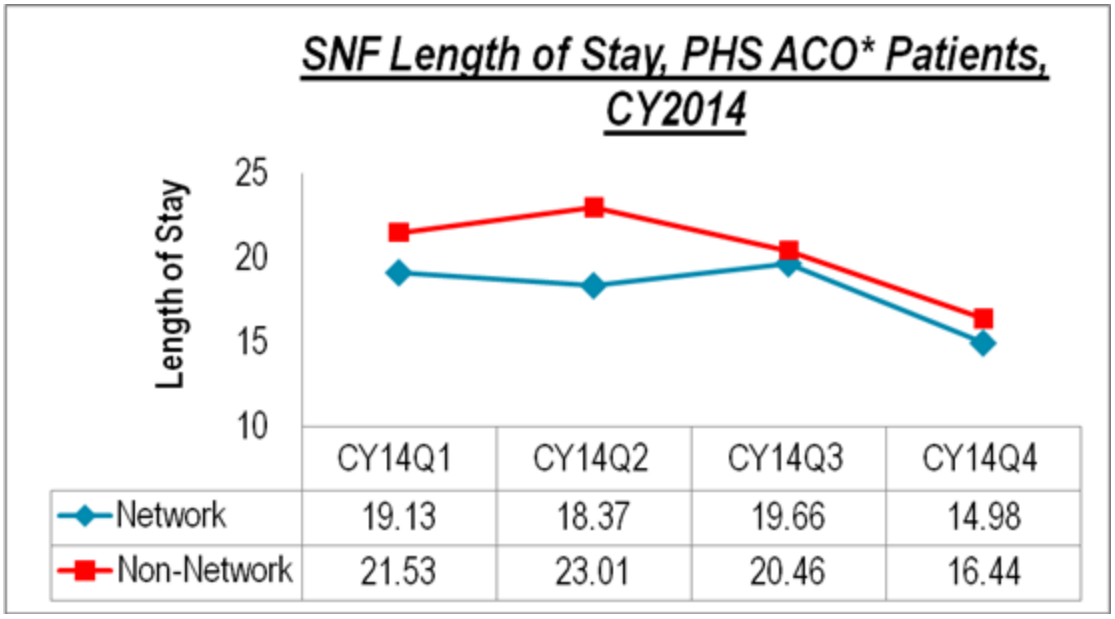
      - Relative to reducing 30 day readmissions and ED visits, we have a number of initiatives underway. Over 8000 patients have been discharged annually from PCC's inpatient facilities of which about 60% are referred from a Partners acute care hospital. The work to mitigate 30 day readmissions from PCC facilities has been organized and coordinated centrally over the past five years through the PCC Acute Transfer Committee (ATC). The PCC ATC has spearheaded several successful system-wide innovative initiatives described below:
        - A system-wide, standardized interdisciplinary case review process including determination of preventability of all PCC patients readmitted back to an acute hospital,
        - Development of a standardized internal post-acute readmission database to record these in-facility readmission reviews,
        - EHR and hand-off communication protocols to improve care transitions between the sending and receiving providers,
        - Development of auditable standardized PCC-to-ED templated hand-off notes to facilitate communication and shared decision-making between ER and post-acute providers for ER disposition with the goal of avoiding unnecessary rehospitalizations.
        - Targeted staff education efforts based on our readmission data.

These efforts have lowered PCC's in-facility relative readmission rates across its entire network by 13% over 2 years. Moreover, to promote system alignment with Partners integrated delivery model, PCC's performance in lowering readmissions has been formally tied to Partners through PCC's participation in the PHS Internal Performance Framework (IPF).

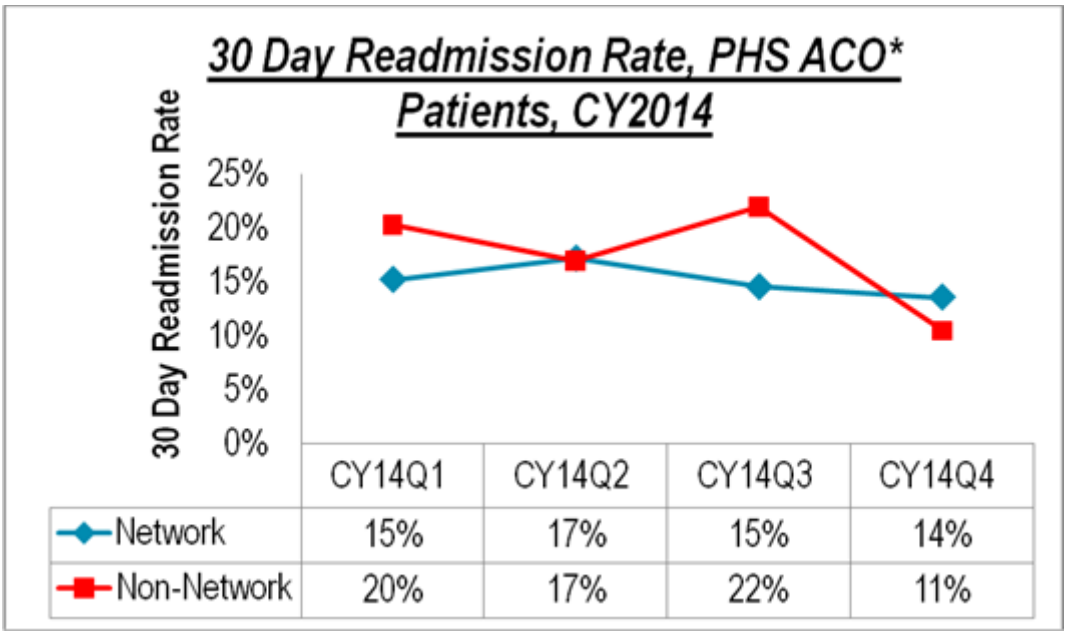
- The SNF Collaborative Network was developed in 2013 for the purpose of creating a scalable and sustainable strategy for improving the quality of SNF care for Partner's patients, while reducing overall episode cost.

- Intended Outcomes:
  - Increase in quality of care and patient satisfaction
  - Decrease readmission rates and LOS (network SNFs vs. non-network SNFs and decrease within network compared to benchmarks)

- As of December 2014 (latest claims data available for the network):
  - SNF Length of stay was 14% lower for ACO patients going to a PHS SNF Network vs. Non Network facilities
  - 30 Day readmission rates were 20% lower for ACO patients going to a PHS SNF Network vs. Non Network SNF



	CY14Q1	CY14Q2	CY14Q3	CY14Q4
Network	19.13	18.37	19.66	14.98
Non-Network	21.53	23.01	20.46	16.44



- While there is variation in post-acute spend that needs to be understood and opportunity that exists to improve efficiency and effectiveness of care, it is important to not lose sight of the opportunity to reduce TME by utilizing more post-acute care as an alternative to higher cost acute hospital care. For example, if the 3-day qualifying stay in an acute hospital in order to be eligible for Medicare coverage in a SNF was waived more often, institutional spend on post acute would obviously increase, but the higher cost acute index stay would be avoided. Moreover, withholding appropriate use of post acute care could prove to be "penny wise and pound foolish" should complications arise or where a patient's functional status is not optimized. In fact, a recent study (see attachment #2) has found that functional status is a better predictor of readmissions than co-morbidities. This suggests an opportunity to more appropriately utilize rehabilitation care to ensure that optimal function is achieved.

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

In addition to continuing the initiatives described above, PCC plans to:

- Continue to grow Outpatient and Home Care operations, as lower cost, appropriate levels of care, for many of our patients.
- Manage demand at Spaulding Charlestown by accepting only the most complex and clinically appropriate patients, while also managing length of stay.

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?

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.

Please see the Partners response to these questions.

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.

   Please see the Partners response to this question.

   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.

   Please see the Partners response to this question.

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?

   Please see the Partners response.