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.

    From FY 13 to FY 14, UMass Memorial Health Care experienced an increase in revenue of 3.0%. For FY 14 to FY 15, the increase in revenue is running at 2.1%. Both of these are below the Commonwealth's benchmark of 3.6%. Our discharges and observation cases had decreased by 2.0% from FY 13 to FY 14, and in FY 15 they are running at the same level as FY 14. Work RVU's in our Medical Group, which is an indicator of overall volume change, increased by 1.7% from FY 13 to FY 14, and the increase from FY 14 to FY 15 is 1.0%. Our casemix index increased by 1.5% from FY 13 to FY 14, and has increased 1.2% in FY 15. Revenue increased from FY 13 to FY 14 and FY 14 to FY 15 because of some small increases in payer rates along with the overall increases in acuity and volume.

    Operating expenses decreased by 1.2% from FY 13 to FY 14. In FY 15, operating expenses are running at 0.6% above FY 14 expenses. The FY 13 to FY 14 decrease was driven by a reduction of force early in FY 14, which led to FTE's decreasing by 1.9% during that same timeframe. This was partially offset by costs related to the reduction of force. From FY 14 to FY 15, operating expenses have increased only 0.6%, due to continued vigilance regarding expense management. However, even though operating expenses have been flat since FY13, one area where there has been a large increase is in drug costs. From FY 13 to FY 14 drug costs increased by 37% and in FY 15 they are projected to increase another 8%.

    b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

    Since Ch 224 was enacted, we have been managing to the State's healthcare cost trend benchmark, which has been an aggressive target given our payor mix and labor costs. As mentioned in last year's testimony, all payor contract renewals and negotiated increases have been at or below the Commonwealth's benchmark of 3.6%. Additionally, we've applied for an ASC license and recently opened Urgent Care Centers to provide lower cost options within our healthcare system. UMass Memorial has continuously looked for ways to provide the highest quality care in the lowest cost setting. Through our eICU and other telemedicine programs, we are able to provide clinical oversight of critical care patients in our community hospitals as an alternative to these patients being treated in a higher cost, tertiary setting.

Other programs and initiatives that have been implemented since January 1, 2014 that will help us meet the benchmark are the formation of our Medicare MSSP ACO, joining the Medicare Bundled Payment Initiative and implementing the MassHealth PCPR program at 7 of our primary care sites. It is too early to assess the impact that the ACO and BPCI programs have had on our total medical expenses (TME), which would be an indication of how we are doing compared to the benchmark of 3.6% growth. However, we do have some initial metrics on our Medicare Total Joint Replacement bundle. In Calendar Years 2013, our inpatient acute average length of stay (ALOS) was 4.02. Since we implemented the TJR bundle, the ALOS has been 3.26 days. Our readmission rate has gone down from 13% in 2013 and 16% in 2014 to 3% since 4/1/2015. Our percentage of patients discharged to home care instead of more costly settings (SNF or Inpatient Rehab) was 36% in 2013 and 37% in 2014. Since 4/1/2015, that rate has increased to 62%. All of these will help to lower TME, which in turn will help the Commonwealth meet its benchmark for growth. For the PCPR program, we have been unable to assess the impact on TME due to a lack of complete claims data.

At Community HealthLink, we have had a program called MyLink, which had been funded by a Blue Cross Foundation grant. The program utilized community health workers to work with patients with high emergency department utilization in an effort to reduce the unnecessary ED utilization. This model proved to be very successful, not only in reducing ED utilization among the enrolled patients, but also in having a positive impact on the enrollees' quality of life. For the enrollees that were enrolled for a 12 month period, their ED visits decreased 35% compared to the 12 months before enrollment. For enrollees that were in the program for a 24 month period, their decrease in ED visits was 41% when compared to pre-enrollment visits.

Also, as mentioned in last year's testimony, in the most recently available data from CHIA, UMass Memorial Medical Group's TME increased only 1.4% from 2012 to 2013, well within the 3.6% growth benchmark.

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?

   Most of the initiatives mentioned above in question b are in their early stages and will continue to be more fully implemented throughout the next year. We joined the Medicare MSSP program on 1/1/2015 and are expanding our participation in that as of 1/1/2016 by adding more providers to our ACO. Beginning in January 2016 we will be one of the largest MSSP ACOs in the nation in terms of attributed lives with over 35,000 lives. In the Medicare BPCI program, we implemented the Total Joint Replacement bundle on 4/1/2015, the CABG bundle on 7/1/2015 and will be adding 2 additional bundles (Spinal Fusion Non-Cervical and Cervical Spinal Fusion) on 10/1/15. We are also interested in expanding our bundled payment work by contracting with commercial

payors, however, so far there has been little interest among the payors whose experience in alternative payment models is limited to traditional budgeted capitation models.

The MyLink program described in question 1b proved to be very successful and even though the funding from the Blue Cross Foundation has ended, we are in the process of expanding that program in our system, with the expectation that it will decrease unnecessary ED utilization and in turn, help meet the 3.6% benchmark. We have several other initiatives under way similar to MyLink that we have pieced together grant and other agency funding to implement such as our Medical Home for the Intellectually and Developmentally Disabled (IDD) and our Substance Abuse/Mental Health Counseling for Medically Hospitalized patients. Both of these programs are showing tremendous results in reducing downstream psychiatric and pharmaceutical interventions. We hope to continue the operation and evaluation of these programs to further inform future alternative payment mechanisms to allow for innovative programs such as these that reduce costs and increase quality of life for our patients.

In addition, we are currently in the midst of a large expansion of our population health capabilities to enable us to better manage these programs. Additional information about these population health capabilities can be found in the answer to question 6.

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

Many of the policy changes we included in last year's response are still relevant this year and are repeated here as well as some additional items - encourage provider participation in alternative payment programs without mandating the provider take risk; programmatic reimbursement for care coordination and care management resources; adequate and flexible behavioral health access and reimbursement; easier access to clinical data from external organizations (HIE); continued provider engagement in benefit and program design for new/evolving programs; administrative simplification – eliminate duplication in credentialing by providers and health plans; claims data standardization among all programs, reduction of duplicative administrative efforts (HPC RPO and EOHHS RFI for Provider System Configurations), review of regulations/policies for reasonableness (HPC Material Change Notice).

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

The infrastructure investment required to manage alternative payment arrangements is significant and the payments available for this investment do not cover these costs. Access to real-time data from the payors has always been a challenge and often does not allow us to do the required analyses. And even if we do have some data, the addition of analytical staff is necessary to work the claims data but with limited resources and the push to reduce costs, this is a significant challenge.

Some programs mandate assumption of risk too soon - sometimes before data is available to analyze initial results. A more thoughtful transition to risk would make it more tenable to adopt alternative payment mechanisms. Many different programs and models exist among a number of payors. This increases the level of work involved in implementing and analyzing these new programs and payment models.

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.

    Many of the actions we've taken to ensure that we meet the Commonwealth's 3.6% benchmark (see question 1b and 1c) also impact the four opportunities mentioned above. Our work in care management that cuts across the programs we've implemented over the past 18 months (ACO, BPCI, PCPR) is having an impact on reducing post-acute care spending, reducing avoidable readmissions and reducing avoidable ED visits. The Medicare Total Joint Replacement bundle average length of stay, readmission rate and discharge to home data in the answer to question 1b is evidence of the impact our work in care management is having.

    Within the PCPR program, high risk patients have been identified and our care managers are working directly with those patients to coordinate their care and reduce/eliminate unnecessary spending. We also work with MBHP to refer certain patients to them for care management services in their ICMP program. We are just beginning a program in one of our PCPR clinics specifically designed for our High Risk patients where we will have a multidisciplinary team visit with the patients to specifically design care plans with all providers and the patient collaborating to design the best care plan. Our hope is this will show reduced ED and inpatient utilization and increase the coordination of care and quality of life for these patients.

    With the EOHHS Infrastructure and Capacity Building (ICB) funding we received, we started several successful programs that are focused on improving care for high-risk/high-cost patients. These patients are generally those with both medical and behavioral health issues. One program links patients that present in the ED with medical and behavioral health issues to primary care clinicians; another program addresses the specific needs of inpatients with comorbid medical and substance abuse issues; a third program provides a medical home setting for patients with intellectual and developmental disabilities. It is too early to know the impact on TME, but preliminary results indicate an increase in referrals to primary care physicians, a reduction in inpatient admissions and an improvement in patient satisfaction/quality of life.

    All of our population health initiatives will benefit from strengthening our partnership with strategically selected post acute care providers (home health and hospice agencies

and selected skilled nursing facilities (SNFs) that will work cooperatively with our care navigators to get patients out of the hospital and home as soon as possible.

With our ACO readiness ICB funding we were able to identify and evaluate the Skilled Nursing Facilities (SNF) in our area most utilized by our patients. We have created a Preferred SNF Status which is based on quality and cost and have designated 9 SNFs to be our Preferred SNFs. We meet regularly, agree on performance and quality criteria and evaluate statistical data to be sure these criteria are being met. Our patients are now experiencing the value of this program with increased quality and attention when in this transitioning care to home. We round with care managers at these facilities for our ACO patients and hope to expand that to all patients as we expand our population health platform.

In addition, the MyLink program described above has had an impact on decreasing avoidable ED visits, as we expect our recently opened Urgent Care Centers will also do. See the answer to question 1b for MyLink data.

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

Our plan over the coming years is as follows:

We will have at our core a world-class, academic Medical Center where we will take care of our sickest patients and provide services that no one else in the region provides, such as catheter-based heart valve replacement and liver transplantation. The Medical Center will also be where most of our research and educational programs will be housed; both of which will be enhanced by our focus on standardization of care, data transparency and continuous improvement. Our reputation for delivering extraordinary care to the sickest patients in the region, distinction for academic excellence, and our commitment to best-in-class access through 855-UMASS-MD (World Class Access to World Class Doctors) and online scheduling will help attract new patients to all of our practices and facilities.

In addition to having a world-class academic Medical Center, we will have a large network of owned and affiliated community hospitals and community-based primary care and specialty care practices that will provide easy and convenient access to our services at a lower cost point for our patients. These community-based facilities will be augmented with low cost options for low acuity care in our service area, such as urgent care centers and stand-alone ambulatory surgery centers.

In preparation for managing the overall cost, quality of care and service expectations for the communities we serve, we will aggressively build our population health management capabilities, including quality management, predictive modeling and chronic disease management systems through our Accountable Care Organization (ACO) and managed care network, which will increasingly be taking on more risk from payers.

We will use data, as well as our new information technology (IT) system to better integrate the care of patients across the system, understand the health needs of the diverse populations we serve, and standardize the treatment plan for our patients across the system while more accurately predicting the future health care costs and health status of a particular population.

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?

      It needs to be recognized that all providers are not created equal and consideration needs to be given to the complexity of the patient populations they serve, their payor mix, and the breadth and depth of services which may not be directly reimbursed under the current payment methodologies (i.e. eICU, My Care Team diabetes program, CANDO (Center for Autism and Neurodevelopmental Disorders), telemedicine).

      Price variation can be explained by:
      - Rate structure which over time blended rates for IP, undervalued OBs
      - FFS methodology does not recognize eICU, MCT, other services which help reduce costs to health plan but are not compensable/costs are built into other rates
      - Underfunded behavioral health and ancillary rates
      - Disproportionate Share Status
      - Union environment
      - Level 1 trauma center and transplant on-call coverage
      - 24/7 MRI/CT (weekend & evening hours) v. freestanding, level of care differences such as conscious sedation/ 1v1 supervision of pediatric patients

   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.

      Alternative payment models being discussed all have one thing in common. While fundamentally different, they rely on the current FFS payment structure. Pricing an episode of care assumes savings off of FFS equivalent rates. Budgeted capitation assumes a budget based on historical utilization and cost, with assumptions around future trends, and relies on discount pricing to achieve savings.

We need to not only change the payment methodology to align incentives, but more importantly, change the delivery of care model and ensure that payment systems are updated to support this change in delivery of care.

As described in the above responses, UMass Memorial is moving swiftly to alternative payment mechanisms and is committed to improving care management, behavioral health and other strategies to reduce unnecessary levels of acute level care and see patients in lower cost settings. Over time these efforts will, no doubt, demonstrate lower total cost of care. Investment in these programs, analytic capability and EHR development are necessary and need to be taken into account in the pricing strategies in order to advance the population health strategies that will reduce total cost of care in the coming years.

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 above responses. In addition we have provided more detail below.

    UMass Memorial, including Community HealthLink, (CHL), provides a significant number of services/programs designed to integrate behavioral and medical services for our patient population. CHL's psychiatric medical home, our system's participation in the PCPR and One Care initiatives and our embedding of psychiatry, psychology, social work and special case management in our health centers and primary care sites are our examples of outpatient initiatives that we believe will improve outcomes and decrease costs.

    Seven of our primary care practices are participating in the MassHealth PCPR program. Five of those practices have behavioral health providers on site to foster integration of behavioral and medical interventions.

    We have also hired 3 care coordination staff assigned to the PCPR program to monitor high ED utilization as well as other high risk factors for this population. These coordinators work directly with the practices and outside providers such as MBHP.

    For our Medicare ACO beneficiaries, we have established a care team which includes RNs, Social Workers and coordinators. They are coordinating their efforts with in-patient case management, preferred SNF providers and our primary care practices.

    Also, as described in last year's testimony and in above responses, significant areas of collaborative care have been implemented: (1) MyLink Program: coordinated effort

between UMMMC & CHL to respond to individuals with multiple health and social needs who had seven or more ED visits within a year. Patients are assigned care workers who provide interventions such as phone outreach, home visits, limited case management and, linkage to community resources. (2) Implementation in our Psych. ED of the Crisis Triage Rating Scale and referral to CHL: expedited screenings, patient stabilization and movement of patients offsite to CHL for follow up. (3) The operation of the successful Screening, Brief Intervention and Referral to Treatment (SBIRT) program with referral to community based resources. (4) Concerted efforts with CHL and a variety of community based providers to encourage the use of the community based emergency service programs rather than the emergency department use unless safety precautions require a hospital based approach. (5) Participation in the very successful MCPAP program (initially developed at UMass Memorial Medical Center) (6) Developed a very successful Geriatric consultation program modeled after MCPAP (currently closed because of funding) (7) we have worked with a number of community based providers and DDS to develop and operate a very successful Medical Home for individuals with Intellectual Disabilities, co-morbid medical and psychiatric illness and problematic behaviors. First year results demonstrate a significant decrease in ED use and inpatient days (8) Working with DDS we developed an outpatient multidisciplinary evaluation clinic offering a comprehensive outpatient evaluation for Individuals with Intellectual Disabilities, co-morbid medical and psychiatric illness and problematic behaviors which were offered in lieu of hospitalization at a cost of less than 25% of an average hospitalization. Unfortunately this service was closed because of a lack of adequate funding. (9) We provide counseling for patients admitted to our medical inpatient services for patients who have co existing substance abuse or mental health issues based on screening upon admission or prior clinical evidence. This program is showing significant reduction in psychiatric admission following medical admission and care is being provided in the outpatient setting following discharge.

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.

   We will continue the programs noted above and participation in the PCPR program and are also exploring participation in the MBHP practice based care management program (PBCM) for several of our practices with high proportions of MassHealth patients.

   We will continue to develop and refine our care management program for our Medicare ACO beneficiaries including ways to integrate behavioral health services into our resources
   .

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?

UMass Memorial Health Care has established the Office of Clinical Integration (OCI) as the central point for our organization's oversight for care delivery reforms included in models such as PCMH, PCPR and ACO. We believe that such reforms will be most successfully implemented using a population health management approach rather than a siloed programmatic approach.

Population health services that are managed and delivered by OCI:

- Performance improvement. Functions include:
  - Practice improvement facilitation provided by an in-house staff of practice coaches who assist practices in quality improvement and achievement of the goals for PCMH, AQC, PCPR, ACO and other payer programs
  - Outreach coordination to engage patients in their own wellness and prevention services
  - Coding feedback to educate providers about risk stratification opportunities on their patient panels
- Care Delivery Innovation. Functions include:
  - Development, testing and implementation of centralized and practice-based care management models
  - Coordination between primary care and psychiatry for the implementation of integrated behavioral health models
  - Identification of EMR functionality required for successful success tracking and monitoring of timely care management functions
- Reporting and Analytics. Functions include:
  - Practice and provider specific performance reporting on quality measures
  - Development and testing of population health dashboards
  - Development of actionable claims reporting to assist providers with targeted interventions
- IT Strategy and Operations. Functions include:
  - Assessment of reporting and analytics hardware and software needs to support timely and integrated analysis and reporting
  - Identification of data capture and reporting needs for external affiliates participating in managed care network and ACO activities
- Program Operations. Functions include:
  - Project and program management to ensure alignment with system level and program level requirements
- Finance, Compliance and Regulatory. Functions include:
  - Financial analysis of shared savings and risk based contracts
  - Identification of grant opportunities to assist with care delivery transformation and infrastructure development
  - Identification and monitoring of key compliance and regulatory issues
- Clinical Guidelines and Standards. Functions include:

- ➢ Physician led identification and development of evidence-based internal clinical standards for prevalent conditions
- ➢ Regular communication with physicians and practice teams regarded recommended care delivery standards

7. Since 2014, UMass Memorial Health Care (UMass) has completed a number of material changes, including transferring one of its community hospitals to Baystate Health (Baystate), organizing a new Medicare ACO, and moving forward with multiple joint ventures. Please provide information, as described in more detail below, about these recent material changes and attach analytic support for your responses where available.
   a. How have costs (e.g. prices and total medical expenses), referral patterns, quality, and access to care changed after these material changes?
   The short answer is that it is too early to tell in terms of hard data. Claims data lags and we are just beginning to get claims for calendar 2015 when most of our recent material changes have begun to take hold. We are currently expanding our analytical capabilities in terms of both information systems described below and human resources to further utilize our incoming claims data. We will be able to report in a future filing the impact these changes have had on the actual total cost of care.

   As described above, our plan is to continue our movement as evidenced by these material changes to redesign care in a way that is better for our patients, our communities and our people by:
   - Increasing our ability to deliver low acuity care at a reduced price point through creating and expanding access to urgent care centers, an ambulatory surgery center, community-based primary care practices and expanding our virtual medicine capabilities..
   - Clinically integrating the care provided by members of our managed care network, affiliate hospitals, joint ventures and member hospitals so we can better manage the overall cost of care for the populations we serve.
   - Expanding our population health capabilities, including our predictive modeling capabilities, chronic disease management programs and aligning with payers toward the common goal of higher quality lower cost care for our patients.
   - Engaging every one of our caregivers in taking waste out of our core processes, improving the quality of care we deliver, reducing our cost per unit of service and fully deploying our LEAN management system.
   - Increasing the specialty services we provide at our low cost, high quality community hospitals, thereby removing the consumer pull to metropolitan providers including our own medical center.
   - Building our care management platform so we can manage the risk associated with high total medical expenditure (TME) patients and further transition to bundled payments for elective procedures.

   b. What impact has UMass' transfer of ownership of Wing Memorial Hospital to Baystate had on UMass' clinical and financial operations? How have referral patterns changed

among Wing, UMass hospitals, and UMass-aligned physicians since the transfer of ownership?

The continuity of care for the patients in western Massachusetts utilizing the Wing Memorial health care system was the primary concern and thrust for the transfer of ownership of Wing to Baystate. The patients and their families are able to access tertiary care at Baystate and so the transfer made this a more routine and regular system of care for the members of that community. While the UMass Memorial Hospitals have seen a decline in patients coming from that community this was planned for and expected.

c. UMass established a Medicare ACO in 2015 in partnership with community physicians and a community health center. In its notice of material change, UMass stated that the ACO "will use integrated data from payers, lab systems and the UMass Memorial ambulatory electronic health record to identify and address gaps in care, to manage transitions of care and to provide feedback to primary care physicians and practices on key performance indicators." What progress has been made on implementing these processes in the ACO? How is UMass tracking and reporting on improvements in care management, efficiency, and quality performance?

Our new accountable care organization is built on a shared savings payment model. If we are successful in keeping patients home and healthy (through our pharmacy and chronic disease management programs) and reducing the TME of the 30,000+ Medicare beneficiaries attributed to our ACO, we will share in the savings.

The care management platform for this program focuses on providing comprehensive care navigation to the high TME patients in the ACO. Our care navigation platform is currently being outsourced to Shields Care Management, which, when scaled and success is reportable will be expanded as an outgrowth of our very successful specialty pharmacy platform. The care management platform includes an initial intake by our specialty pharmacy pharmacists, an offer to participate in our medication adherence program and outreach calls from our care navigators. The care navigators, in coordination with the pharmacists, perform an initial home visit and monthly follow-up visits to assure that our patients have everything they need to manage their chronic diseases and remain home and healthy. The care navigators will also work with patients to assure that they get home as soon as possible after hospitalization and skilled nursing facility (SNF) admissions.

In this fast paced environment we need to put some short terms solutions in place that will plug into our longer range IT Improvement Plan described below. We have or are implementing a number of new software products to enable our ability to use data to support targeted care management for high risk patients, predict where gaps in care exist, enhance patient registries and point of care reminders and overall manage the total cost of care. These products include:

Humedica:

Data Analytics and Reporting tool that include Inpatient, Claims and Ambulatory data. This tool also has the ability to identify high risk populations and predictive modeled scores.

CQS:
Ambulatory Gaps in Care and Outreach list tool to support our ambulatory providers.

Patient Ping:
Real time patient identifier in Inpatient and SNF locations to help support care management.

Care Management Tracking Software:
Combines demographic, claims and socioeconomic data on patients we are actively engaging in care management and tracks care management/coordination activities, notes, care plans, referrals and follow up.

On a larger scale, we are implementing an IT Improvement Plan whose impact spans every major strategic project from improving quality and service, to providing world class access to care and increasing our population health capabilities. Our goal is to increase the dependability, usability and speed of the current system and plan for the migration away from Soarian, our current inpatient medical record platform to *EPIC,* which is a fully integrated electronic health record that will be used across the health system. This should markedly increase caregiver satisfaction and productivity as the current system is extremely inefficient and does not meet the needs of our providers. Our plan is "One Patient - One Record - One Log On" across our health system.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for providers. To the extent that a provider system submitting pre-filed testimony responses is affiliated with a hospital 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	149	0	149	For example - inpatient stays, outpatient specialty clinic visits, surgical procedures, X-rays, CT Scans, MRI's, lab tests
	Q2	125	0	125	Same as above
	Q3	106	0	106	Same as above
	Q4	92	3	95	Same as above
CY2015	Q1	108	0	108	Same as above
	Q2	122	6	128	Same as above

2. Please submit a summary table showing for each year 2011 to 2014 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as **<u>AGO Provider Exhibit 1</u>** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

   See attached

3. Please explain and submit supporting documents that describe (a) the process by which your physicians make and receive patient referrals to/from providers within your provider organization and outside of your provider organization; (b) how you use your electronic health record and care management systems to make or receive referrals, including a description of any technical barriers to making or receiving referrals and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization; (c) how, if at all, you make cost and quality information available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care; and (d) whether your organization, in

referring patients for services, ascertains the status in the patient's insurance network of the provider to whom you are referring the patient, and informs the patient if that provider is not in the patient's insurance network.

As a large, integrated health care delivery system, most planned referrals to specialty providers are to providers within our own organization.

1. When a specialist or other clinical consultant/referral is requested for a patient, the provider creates a *Referral Order* in Allscripts EMR order entry system which is automatically added to the Worklist in Allscripts. The information included in the order is utilized in communication with the identified referral source.
    - The following information is included in the initial Allscripts *Referral Order*:
    - Reason or diagnosis for the referral (e.g. ENT referral for 3 year old with recurrent sinus congestion and snoring)
    - Dropdown tab in Allscripts identifying urgency of the referral (e.g. routine, ASAP, urgent)
    - General purpose of the referral (e.g. referred for diagnostic impression)

2. Tracking the status of referrals
    - Referrals are generated in Allscripts *Referral Order* from a provider for specialist appointment
    - The Front desk team schedules the appointment by calling the specialist if urgent and/or send an Allscripts Referral Order via task to specialty scheduling team if routine.
    - Date/time of appointment is documented in the referral order.
    - Once scheduled by the specialty department the date and time of the appointment is added to the Allscripts Referral Order and it falls off the Worklist indicating the referral process has been completed.
    - If the specialty department is unable to reach the patient after 3 attempts it is sent back to the PCP staff who sent the referral who, in turn, reach out to the patient to keep trying to contact the patient. The staff:
        a. Call patient and ask if there were barriers to getting to the appointment
        b. Give patient phone number to reschedule appointment
        c. Document the outcome in task (ex: still unable to reach, spoke to patient and gave number to reschedule)
        d. "Done" it

There is an established workflow that has been sketched out by the AllScripts team:

Provider
Provider selects order icon FU/Referral
Provider Selects Problems
Provider searches and selects specific referral Order
Provider selects recipient (provider or practice) if desired
Provider inputs information in mandatory Reason field
Provider adds any notes to the scheduler
Provider saves order

Clinical Staff
Staff navigates to worklist and edits order
Select Recipient
Is Recipient Internal or External ?

Internal- Who will schedule appointment?
Referring Department to Schedule
Contact Patient to schedule appointment
Edit order with updated information
Update Appointment Status
Save order

Send task to Central Scheduling or Send task to Department
Reassign Schedule Appointment Task
Edit order to reflect correct Perform Field
Save Orde r
Central Sched. or Dept. will schedule and complete order

External
Is Recipient able to accept eReferral s?
Yes
Change Record to eReferral (MU 10%)
Click Attachments Tab to be sure Generate SOC is checked (MU 50%)
Click Questions Tab and answer Yes to MU question (MU trigger)
Click Add'l Details Tab- Update Appointment Status
Save order
Check for & Done SOC Acknowled gment Task

No
Click Attachments Tab and Manually Export SOC to chart
Click Questions Tab and answer Yes to MU question
Click Add'l Details Tab. Update Appointment Status
Save order
Navigate to Chart and find SOC document
Send SOC document to recipient as per protocol

The instructions on how the system works in AllScripts are included via our system internet site, attached is a screenshot of that website:

3821_001.pdf

In regards to c) and d): At this time cost and quality information is not included in the information provided for the referral. Provider network information is discussed with the patient and clinic/scheduling staff assist patients to ensure the providers are within the patients insured network.

Exhibit 1 AGO Questions to Providers and Hospitals

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

NOTES:

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

UMass Memorial Medical Center - 2010 (Reported in Millions)

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements			
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue							
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	
BCBSMA	$ 135	$ 103	$ 2.6	$ 2.5												
Tufts											$ 41	$ 22				
HPHC											47	20				
Fallon											74	1				
CIGNA											12	3				
United											14	0				
Aetna											6	15				
Other Commercial											40	20				
Total Commercial	135	103	2.6	2.5	-	-	-	-	-	-	233	80	-	-	-	
Network Health											44					
NHP											14					
BMC Healthnet											26					
Fallon											7					
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	90	-	-	-	-	
Mass Health		69		4.9												
Tufts Medicare Preferred											8					
Blue Cross Senior Options											32					
Other Comm Medicare											46					
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	87	-	-	-	-	
Medicare												309				
All other payers											27	36				
GRAND TOTAL	$ 135	$ 172	$ 2.6	$ 7.4	X	X	X	X	X	X	$ 438	$ 424	X	X	X	$ 1,179

UMass Memorial Medical Center - 2011 (Reported in Millions)

	P4P Contracts				**Risk Contracts**						**FFS Arrangements**		**Other Revenue Arrangements**			
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue							
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both	
BCBSMA	$ 132	$ 105	$ 2.6	$ 2.5												
Tufts	42	23	0.3	0.1												
HPHC											$ 47	$ 23				
Fallon											78	0				
CIGNA											13	3				
United											19	0				
Aetna											6	16				
Other Commercial											34	19				
Total Commercial	173	129	2.9	2.6	-	-	-	-	-	-	197	62	-	-	-	
Network Health											44					
NHP											21					
BMC Healthnet											22					
Fallon											6					
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	93	-	-	-	-	
Mass Health		74		3												
Tufts Medicare Preferred											9					
Blue Cross Senior Options											29					
Other Comm Medicare											44					
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	82	-	-	-	-	
Medicare												319				
All other payes											27	33				
GRAND TOTAL	$ 173	$ 203	$ 2.9	$ 5.6	X	X	X	X	X	X	$ 398	$ 414	X	X	X	1,196

UMass Memorial Medical Center - 2012 (Reported in Millions)

	P4P Contracts				**Risk Contracts**						**FFS Arrangements**		**Other Revenue Arrangements**		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO	Both
BCBSMA	$ 113.7	$ 103.2	$ 2.6	$ 2.5											
Tufts	$ 40.2	$ 21.0	$ 0.3	$ 0.1											
HPHC	$ 42.9	$ 26.7	$ 0.3	$ 0.1											
Fallon											77.7	0.5			
CIGNA											13.7	10.3			
United											19.2	0.3			
Aetna											5.5	14.5			
Other Commercial											45.4	22.5			
Total Commercial	196.8	150.9	3.2	2.7	-	-	-	-	-	-	161.5	48.2	-	-	-
Network Health											47.9				
NHP											16.3				
BMC Healthnet											15.8				
Fallon											7.3				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	87.3	-	-	-	-
Mass Health		86.1		3.0											
Tufts Medicare Preferred											10.0				
Blue Cross Senior Options											26.7				
Other Comm Medicare											41.8				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	78.5	-	-	-	-
Medicare												329.3			
All other payers											29.7	42.4			
GRAND TOTAL	$ 196.8	$ 237.0	$ 3.2	$ 5.7	X	X	X	X	X	X	$ 357.0	$ 419.9	X	X	X

1,220

UMass Memorial Medical Center - 2013 (Reported in Millions)

	P4P Contracts				**Risk Contracts**						**FFS Arrangements**		**Other Revenue Arrangements**		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO	Both
BCBSMA	$ 47.9	$ 90.8	$ 2.6	$ 2.5	57.0		(2.6)								
Tufts	$ 48.2	$ 16.1	$ 0.3	$ 0.1											
HPHC	$ 51.6	$ 22.1	$ 0.3	$ 0.1											
Fallon											75.6	0.8			
CIGNA											13.7	3.7			
United											13.0	3.5			
Aetna											5.4	18.1			
Other Commercial											44.8	22.0			
Total Commercial	147.8	128.9	3.2	2.7	57.0	-	(2.6)	-	-	-	152.6	48.0	-	-	-
Network Health											48.3				
NHP											16.0				
BMC Healthnet											16.2				
HealthNE											0.2				
Fallon											7.9				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	88.6	-	-	-	-
Mass Health		79.7		2.0										5.7	
Tufts Medicare Preferred											10.6				
Blue Cross Senior Options											26.7				
Other Comm Medicare											45.9				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	83.2	-	-	-	-
Medicare												313.1			
All other payers											29.0	41.1			
GRAND TOTAL	$ 147.8	$ 208.6	$ 3.2	$ 4.7	$ 57.0	X	$ (2.6)	X	X	X	$ 353.4	$ 402.2	X	$ 5.7	X

UMass Memorial Medical Center - 2014 (Reported in Millions)

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO	Both
BCBSMA	$ 45.9	$ 88.7	$ 2.1	$ 1.8	60.6		(6.5)								
Tufts	$ 43.2	$ 14.4	$ -	$ -											
HPHC	$ 51.3	$ 22.0	$ 0.1	$ 0.0											
Fallon											79.2	0.9			
CIGNA											14.9	4.0			
United											13.3	5.0			
Aetna											5.2	18.6			
Other Commercial											55.7	27.5			
Total Commercial	140.4	125.1	2.2	1.8	60.6	-	(6.5)	-	-	-	168.3	56.0	-	-	-
Network Health											59.4				
NHP											22.7				
BMC Healthnet											13.8				
HealthNE											0.2				
Fallon											10.3				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	106.4	-	-	-	-
Mass Health		100.9		1.3										5.7	
Tufts Medicare Preferred											16.4				
Blue Cross Senior Options											27.0				
Other Comm Medicare											47.1				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	90.5	-	-	-	-
Medicare												323.1			
All other payers											29.8	44.6			
GRAND TOTAL	$ 140.4	$ 226.0	$ 2.2	$ 3.1	$ 60.6	X	$ (6.5)	X	X	X	$ 395.0	$ 423.7	X	$ 5.7	X