September 14, 2018

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 13, 2018, and in accordance with Massachusetts General Laws chapter, 6D, § 8, please find included herein Cape Cod Hospital's responses to the questions outlined in HPC pre-filed testimony questions, and including AGO provider Exhibits 1 and 2. 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

cc: Eric Gold, Deputy Chief, Health Care Division, Office of the Attorney General
Ray Campbell, Executive Director, Center for Health Information and Analysis

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.
35T

1. a.1. Workforce Concerns Related to Unfunded Mandates (Nurse Staffing Ratios)

A major area of concern is Ballot Question 1, to require mandatory nurse staffing ratios in all units, at all times. If this referendum passes in November and is subsequently implemented in the state, the impact would be devastating. CCHC estimates the annual impact to implement these ratios will be $34.2M per year for the system, of which $24.2 would be incurred at Cape Cod Hospital. There are many unanswered operational issues embedded in the referendum itself, not the least of which is any given healthcare provider's ability to actually hire additional nurses in light of the current dearth of supply. CCHC would be required to hire an additional 250 RN FTES, in addition to the current RN vacancies. Assuming CCHC even has the ability to recruit this number of nurses, the increased expense relative to the increased hires will drive growth percentages north of the 3.1% increase that is the state's HPC target. In order to meet the growth target, other operational areas will face cutbacks in future investments and service line closures. Service lines which are already vulnerable, such as infectious disease, behavioral health, and obstetric clinics will be at risk of survival. Access to care, such as emergency room care, will be compromised as healthcare providers make difficult choices because of the need to meet unfunded nursing staffing ratios dictated by the referendum, while at the same time endeavoring to maintain financial viability. This ballot question ignores the concept of aligning staffing to patient acuity and does not appropriately recognize the high quality care currently provided at hospitals within the Commonwealth.

1.a.2. Unnecessary Administrative Costs

Cape Cod Healthcare, along with its affiliate Cape Cod Hospital, believes there are significant opportunities to eliminate unnecessary administrative costs in healthcare with policy changes. Additional opportunities exist to decrease unnecessary utilization and increase providers' access to the tools and information needed to retain care in the lowest cost settings.

Hospitals incur significant costs to submit a claim to local health insurers and, moreover, to figure out if the insurer's payment is correct. Introduction of a single claim form and payment

methodology as well as consistent payment policies across health plans in Massachusetts would improve hospitals' efficiency. 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.

1.a.3. Pharmaceutical Spending

The unharnessed rate of pharmaceutical spending is unsustainable. For FYTD 2017-FYTD 2018, pharmaceutical spending at Cape Cod Hospital increased 18% or $6.0M. Total expense has increased 7% or $28.9M. Thus, drug costs represent 21% of the increase in total operating costs over the prior year.

At the system level, for Cape Cod Healthcare, pharmaceutical spending increased 24% or $12.7M year over year for FYTD2017 v FYTD2018. Total expenses increased 7% or $48.2M. Thus, drug costs represent 26% of the increase in total operating costs over the prior year. The most notable increase in pharmacy expense at Cape Cod Healthcare is related to oncology drugs.

The overall increase is driven from increases in both volume and market price(s). Cost increases related to our pharmaceutical spending have a direct impact on Cape Cod Healthcare's profitability given our inability to generate offsetting increases via fixed inpatient DRG payments or in outpatient reimbursements, which are contractually governed. Decreased margins drive less investment in people, plant, and infrastructure.

In light of the exceptional profitability of the pharmaceutical companies themselves, it is time for regulation in the market to slow pricing increases year over year.

b) What are the top changes in policy, market behavior, payment, regulation, or statute your organization would recommend to address these concerns?
35T

1.b.1. Administrative Simplification

A policy to address the credentialing process with commercial payers would go a long way in reducing burden and decreasing administrative costs to providers. The current process is difficult, as each payer requires a great deal of information that is not standardized across payers. Additionally, there is no formal written notification from the plans to providers that applications have been processed and approved. One option would be to require plans to recognize Medicare credentialing as a satisfaction of the plans credentialing.

1.b.2. Patient Responsibility

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 healthcare costs. These costs include such things as accessing primary care regularly, controlling unnecessary utilization, and properly utilizing medication.

As hospitals focus on quality and cost, it would be important to clearly define strategies and benchmarks. This would facilitate consistent measurement of quality across providers.

1.b.3. Pharmaceutical and Medical Supply Costs

Policies which address uncontrolled pharmaceutical and medical supply and device costs (which are beyond the control of providers) will be key to reigning in total healthcare expense.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.
35T

1.c.1. Move Hospital Services to Lower Cost Settings

The 2015 Massachusetts Health Policy Commission 2015 Cost Trends Report found "the price difference for the same service between different settings of care supports the need to explore opportunities to address both price variation and site-neutral payments." CCHC outreach (off-campus) laboratory services are provided to local physicians and patients at 14 off-campus patient service centers throughout Cape Cod. On June 18, 2018, Cape Cod Healthcare (CCHC) transitioned its outreach laboratory testing and diagnostics to Quest Diagnostics.

Partnering with Quest's existing Cape Cod patient service centers provides significantly greater patient access and convenience. Quest delivers the benefits of thousands of clinical laboratory tests, including highly advanced and novel genetic sequencing tests for cancer, neurological disorders and other diseases to patients and physicians. Testing is performed at Quest's full-service, state of the art clinical laboratory in Marlborough, MA.

Michael Lauf, President and CEO of Cape Cod Healthcare, said, "Our cost of providing these services is higher than those of other competitors in the marketplace; insurers and government

payers have demanded that we lower costs and made it clear that they do not expect to continue reimbursing us for the full cost of our testing in the long term."

Quest's costs are lower than hospital outpatient departments. The median price for a basic metabolic panel at a hospital outpatient department was $29, compared to a median price of $12 at Quest.

In addition to the outreach lab transition, over the past several years we have introduced four new urgent care centers, located strategically across the Cape, in order to enhance access and to reduce unnecessary volume at our emergency departments.

Four years ago we entered into a joint venture with a local physician-owned endoscopy center in order to move such non-emergent outpatient procedures to this low-cost setting.

Eight years ago we entered into joint venture arrangements with Shields Healthcare Group in order to coordinate access and reduce the cost for MRI, CT and PET scan services.

1.c.2 Readmission Reduction Efforts

Readmissions are a significant source of healthcare resource cost – and negatively impact patient quality of life. We have employed a number of resources to help drive down the readmission rate and keep the patient population at home.

Every 30-day readmission receives a thorough review with an eye on both utilization and clinically. Though many cases are deemed "not modifiable," due to non-compliance or unrelated issues, there are many which we identify where the readmission team can intervene in transition, clinical practice, or through outpatient services to improve the community care. Once identified, we trend data to look for systemic changes that can be implemented. This process has led to changes in prescribing, follow-up, and added services for patients – and has helped drive the readmission rate down significantly.

We have invested considerable resources in managing readmission reduction. A diverse clinical team reviews every 30-day readmission and evaluates for clinical, operational, and transitional changes that can be employed to both reduce future readmissions, and help the quality of life of the patient. We have also targeted "high risk" readmission DRGs that need more advanced clinical touches in the community, and have established some specialized clinics for these populations, coordinated through our PHO.

1.c.3. Population Health/clinical integration

By the formulation of the Cape Cod Healthcare ACO (a Physician-Hospital Organization or "PHO"), CCHC, on behalf of its hospitals, has partnered with approximately 400 closely-affiliated

physicians in order to integrate clinically and improve the quality and efficiency of care delivery. Noteworthy related initiatives and accomplishments include the following:

Chronic / Complex Disease Management – Facilitated by the support from ambulatory case managers, PCPs and medical specialists coordinate closely in the care of high-risk patients in accordance with some 20 care algorithms developed by the Physician Quality Committee. Objectives include the reduction of inpatient utilization and ED visits in order manage the overall cost of care (i.e., Total Medical Expense or "TME").

Readmits / Transitions of Care – PHO case managers, stationed at the acute care hospitals, engage with patients prior to discharge and notify PHO PCPs of the need for a timely follow-up visit in order to perform medication reconciliation. Currently, in 80% of applicable cases, the follow-up visit occurs 3.9 days following discharge, on average. As a result of these and other efforts, CCHC's readmits are among the lowest in the state.

Regarding our other population health / CI efforts - We are currently working to enhance integration among PCPs and behavioral health providers, developing substance use disorder programs including referrals with PHO and non-PHO MAT providers, integrating our SDOH efforts with applicable community resources.

Integration incentives to physicians - To meet the above goals, we have also developed a complex but nimble physician incentive program in order to facilitate adoption of our clinical integration programs and stimulate investment in practice transformation essential to success in the emerging value-based market. The incentives are in place to manage chronic conditions through risk stratification. PCPs and specialists coordinate patient care through referrals based on risk scoring to determine the best physician to manage a patient's care, be it the PCP or the specialist. We are continuing to refine this process. Through a comprehensive survey, our physicians have agreed that 30% of patients managed by PCPs should appropriately be managed by their specialists. Conversely, 40% of patients managed by specialists would more appropriately be managed by their PCP.

2) INFORMATION ABOUT ALTERNATIVE CARE SITES

The HPC recently released a new policy brief examining the significant growth in hospital and non-hospital based urgent care centers as well as retail clinic sites in Massachusetts from 2010 to 2018. Such alternative, convenient points of access to health care have the potential to reduce avoidable and costlier emergency department (ED) visits.

Question Instructions: *If your organization does not own or operate any alternative care sites such as urgent care centers, please only answer questions (e) and (f) below. For purposes of this question, an urgent care center serves all adult patients (i.e., not just patients with a pre-existing clinical relationship with the center or its providers) on a walk-in (non-appointment) basis and has hours of service beyond normal weekday business hours. Information requested in*

question (a) below may be provided in the form of a link to an online directory or as an appended directory.

a) Using the most recent information, please list the names and locations of any alternative care sites your organization owns or operates in Massachusetts. Indicate whether the site is corporately owned and operated, owned and operating through a joint venture, or a non-owned affiliate clinical affiliate.
35T

2.a. Urgent Care Locations

Urgent Care - Falmouth
Urgent Care
273 Teaticket Highway Falmouth MA 02540
Corporately Owned

Urgent Care - Sandwich at Stoneman Outpatient Center
Urgent Care
2 Jan Sebastian Drive Sandwich MA 02563
Corporately Owned

Urgent Care - Hyannis
Urgent Care
1220 Iyannough Road Hyannis, MA 02601
Corporately Owned

Urgent Care - Harwich at Fontaine Outpatient Center
Urgent Care
525 Long Pond Drive Harwich MA 02645
Corporately Owned

b) Please provide the following aggregate information for calendar year 2017 about the alternative care sites your organization owns or operates in Massachusetts, including those operated through a joint venture with another organization (information from non-owned affiliates should not be included):

2.b. Urgent Care

	Unique Visits CY 2017
Falmouth Urgent Care	15,341
Fontaine Urgent Care	27,432
Hyannis Urgent care	21,452
Stoneman Urgent care	18,191
Total Urgent Care	**82,416**

Proportion of gross patient service revenue that was received from commercial payers, Medicare, MassHealth, Self-Pay, and Other	
Percentage of patient visits where the patient is referred to a more intensive setting of care	

All Sites Combined

Proportion of patient service revenue that was received

	Gross	Net
Commercial	47%	59%
Medicare	27%	19%
MassHealth	21%	20%
Self Pay	3%	1%
Other	2%	1%
	100%	100%

	% referred to more intensive setting of care
Falmouth Urgent Care	5.4%
Fontaine Urgent Care	5.2%
Hyannis Urgent care	5.4%
Stoneman Urgent care	5.1%
Total Urgent Care	**5.3%**

c) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the clinical staffing model, including the type of clinicians (e.g., physicians, nurse practitioners, physician assistants, paramedics, nurses). If different models are used, describe the predominant model.
35T

The CCHC Urgent Care model is one of top quality, staffed with emergency room physicians, a physician assistant or a nurse practitioner, registered nurses, urgent care techs and radiology techs (Hyannis and Falmouth). The model we use daily during our operational hours includes the following: one physician, with one PA or NP, plus three registered nurses (shifts vary), plus one urgent care technician and one Radiology technician.

d) For the alternative care sites your organization owns or operates in Massachusetts, briefly describe the method and timeliness of how the medical record of a patient's visit to an alternative care site is shared with that patient's primary care provider (e.g., interoperable electronic health record, secure email transfer, fax). What barriers has your organization faced in sharing real-time information about patient visits to your alternative care sites with primary care providers or other health care providers?
35T

Upon discharge from one of our Urgent Care Sites, a patient's primary care provider (PCP) will receive a faxed copy of the patient visit details from Cape Cod Healthcare, if the PCP indicated that they would like to receive such faxes. PCPs have the opportunity to opt in or opt out of receiving this information via fax.

In addition, if a patient's PCP is a CCHC PHO provider or a PCP from Duffy Community Health Center, Community Health Center of Cape Cod, and/or Outer Cape Health Center, we will send the PCP an automated notification that will alert them to the following statuses of their patient: has been admitted to the EC/Urgent Care, was discharged from the EC/Urgent Care, was admitted to an inpatient unit from the EC/Urgent Care and/or whether the patient expired during their visit in the EC/Urgent Care. This notification process has been in place since 2013 for the EC and since 2016 for the Urgent Care centers. Notifications are immediate once the trigger of the patient being discharged or admitted has been entered in the patient's record.

e) Besides establishing alternative care sites, what other strategies is your organization pursuing to expand timely access to care with the goal of reducing unnecessary hospital utilization (e.g., after-hours primary care, on-demand telemedicine/virtual visits).
35T

Strategies to Improve Timely Access

To improve access and better meet the demand for primary care in our community, we are introducing Advanced Access for new Primary Care patients. This initiative allows all primary care providers to welcome a select number of new patients every week. We have dedicated new patient coordinators who will find the right provider, in a convenient location, on a day that best fits the patient's schedule. Appointments for the same or next day will be offered to patients who would like to be seen right away, and all new patients will be scheduled within two weeks of their initial call. New patients will also have the option of requesting an appointment online or calling one convenient number to connect with the new patient coordinators.

Transitional Care Management (TCM) program at CCHC is focused on providing high-quality patient handoffs between care settings, and reducing avoidable readmissions. Components of TCM include access to timely follow-up with the patient's Primary Care Physician and other specialists. Other components of TCM include medication reconciliation and care coordination. Cape Cod Healthcare has implemented

standardized tools and methods to communicate necessary information to post-acute providers to promote patient safety and quality care.

Heart Failure Clinic

With the opening of the new Cape Cod Healthcare Heart Failure Clinic , Cape Cod Healthcare has taken an important step to help those diagnosed with heart failure stay active and avoid hospitalization.

Heart failure is a serious diagnosis affecting 5.7 million in the U.S. Heart failure means the heart muscle is not functioning efficiently, which is a debilitating and chronic condition.

The community-based Heart Failure Clinic at the Cardiovascular Center in Hyannis, under the direction of cardiologist and heart failure specialist Amy French MD, is a resource designed to educate and help patients maintain the best possible quality of life and manage their symptoms. Dr. French went to medical school at Tufts University School of Medicine in Boston. She completed a residency in Internal Medicine at Tufts Medical Center, and completed fellowships in Cardiovascular Medicine at Boston Medical Center, and in Advanced Heart Failure and Transplant Cardiology at Tufts Medical Center and Beth Israel Deaconess Medical Center

The Heart Failure Clinic provides access to a multidisciplinary team that includes a cardiologist, nurse practitioner, nutritionist, visiting nurse and pharmacist to treat and educate patients. Once referred to the clinic by their primary care physician, cardiologist or other specialist, patients are offered same-day or next-day appointments, as well as scheduled visits, to manage the symptoms of heart failure.

With no simple diagnostic test for the condition, the Heart Failure Clinic is dedicated to educating patients to recognize the symptoms, which include shortness of breath, swelling of the extremities, rapid weight gain and other signs that the heart is not functioning adequately. The clinic has developed a treatment program to manage the early signs of illness when they appear, warding off the hospital admission that may occur as symptoms worsen.

Our overriding goal is to help keep heart failure patients out of the hospital. We want to provide a home base for patients to learn how to live with their illness and have one-stop access to our multidisciplinary team.

Working with patients and their families, the goal of this team is to modify risk factors for heart failure symptoms and change the course of a patient’s diseases as much as possible.

The Cape Cod Healthcare Heart Failure Clinic is located at the Cardiovascular Center, 25 Main Street, Hyannis.

f) Please comment on the growth of alternative care sites in Massachusetts, including implications for your organization as well as impacts on health care costs, quality, and access in Massachusetts.
35T

Urgent Care Model
The introduction of the four Cape Cod Healthcare Urgent Care Centers has positively improved our patient access and experience within the Cape Cod region.

Access to more affordable care has increased dramatically. The strategy of embedding Urgent Care Centers within the population centers of Hyannis and Falmouth has resulted in more care being delivered in less costly settings. The emergency rooms at Cape Cod Hospital and Falmouth Hospital are treating patients who are most appropriate for an emergent care setting, given that the urgi-care centers are treating patients presenting with lower acuity conditions.

The Urgent Care site at the Fontaine Medical Center in Harwich is located at the intersection of Route 6 and Route 137 and services the towns of Chatham, Harwich, Orleans, and Brewster. The Center's volume has increased year after year and Cape Cod Healthcare has recently expanded its overall capacity to better serve summertime spikes in demand. The Urgent Care site in Sandwich is co-located with the Stoneman outpatient center on Route 130 and services the towns of Mashpee, Sandwich, and Bourne.

All four sites offer greater access at less cost to Cape Cod Healthcare's patients. All sites are staffed by Board-certified emergency center physicians who deliver the highest quality care in accessible, convenient locations for our residents and visitors alike.

Integrated Provider Networks
CCHC believes that the cost and quality of care are best managed through integrated provider networks in which patient information is readily shared. This eliminates duplication and promotes care coordination. We also feel strongly that alternative care site entrants into local markets are often designed to cherry pick high-margin services or act as feeder mechanisms to regional / academic medical centers. Accordingly, these function to the detriment of clinical integration and the long-term sustainability of community hospitals, which are dedicated to taking "all comers" 24/7/365. As per our response to Question 1b, CCHC believes in reducing the cost of care by moving care to low-cost alternative sites. And, under our model, these sites function as integrated components of our overall ACO network and are subject to appropriate quality and operational standards.

With respect to freestanding ASCs for example, under our model, these sites function within an overall logical continuum of severity or case mix. This enables us to offload less complex procedures from the hospital and logically stratify our continuum of case mix or procedure complexity across an integrated network of sites. We also take patients from all payers, including Medicaid. In contrast, the typical ASC is a for-profit enterprise designed to maximize financial returns to its owners, served by practicing physicians with tactics and strategies that fit that narrow purpose. Cases are often limited to patients covered by well-paying commercial plans and do not require much in the way of costly equipment and supplies. Such surgeons often prefer doing their higher cost cases in the hospital operating room where equipment and supply costs are absorbed by the hospital under its facility reimbursement.

In summary, alternative sites of care can be valuable components of an overall integrated network and contribute valuably to lowering the overall cost of care. However, for-profit entrants or sites designed specifically to feed other markets fragment the local market and serve to disrupt the integrated care continuum. In light of the fact that "global risk" is the state's chosen approach to bending the cost curve, low-cost care sites are often arbitrage ventures that conflict with the laudable, longer-term objective.

3) STRATEGIES TO SUPPORT PROVIDERS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS

Earlier this year, the HPC held a special event entitled, *Partnering to Address Social Determinants of Health: What Works?*, where many policymakers, experts, and market participants all highlighted the need for health care systems to partner with community-based organizations to address patients' and families' health-related social needs (e.g., housing stability, nutrition, transportation) in order to improve health outcomes and slow the growth in health care costs.

a) What are the primary barriers your organization faces in creating partnerships with community-based organizations and public health agencies in the community/communities in which you provide care? [check all that apply]

- ☐ **Legal barriers related to data-sharing**
- ☐ **Structural/technological barriers to data-sharing**
- ☒ **Lack of resources or capacity of your organization or community organizations**
- ☒ **Organizational/cultural barriers**
- ☐ **Other: Click here to enter text.**

Historically, the local market for such community organizations is not well known and somewhat fragmented. Accordingly, it has taken concerted effort on the part of our provider organization to understand what services are available, which agencies are most effective and who are the right contacts to work with. The challenge at this point is to develop effective working relationships with clarity on roles and responsibilities, related workflows, as well as processes for data exchange (as appropriate). As this work is currently limited to Medicaid patients covered by our Medicaid ACO contract through

Steward Health Choice, legal constraints around the sharing of data have already been addressed.

Two fundamental challenges to developing effective community partnerships relate to engagement on the part of physicians and patients. Many physicians in our provider community do not agree that addressing social determinants of health ("SDOH") is within the scope of their medical practice. In the face of physician burnout, the challenges of EMR adoption and the imperative to transition to value-based care, for many physicians, SDOH is the proverbial "straw." Accordingly, physician resistance to active engagement in these partnerships can be a material obstacle.

On top of physician engagement, patient engagement is also an issue. Current efforts to partner with community organizations are focused primarily on our Medicaid patient population. Sustained and active engagement on the part of Medicaid patients is a challenge and often uncertain. This problem is often confounded by inaccurate and changing patient demographic information that hampers our ability to remain in contact. As these patients provide the "use case" for such community partnerships, the inability to engage patients on a reliable basis presents another material obstacle.

b) What policies and resources, including technical assistance or investments, would your organization recommend to the state to address these challenges?

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The recent prioritization of social determinants of health by the Massachusetts Executive Office of Health and Human Services, Massachusetts Department of Public Health, and Massachusetts Attorney General's Office has provided a framework for healthcare organizations to develop strategies, activities, and partnerships to address issues including housing, violence and crime, social environment, built environment, education, and employment.

The social issues that negatively impact a person's health are systemic, longstanding and often require special skills and competencies to address. Effective partnerships and collaborations to address these issues demand increased organizational capacity, strategic and aligned objectives, purposefully designed coordination, and significant and sustained investment.

The state of Massachusetts plays a critical role in creating the positive conditions for successful multi-sector collaborations that improve health outcomes in neighborhoods, towns, counties, regions, and across the state. Cape Cod Healthcare recommends the following policy and resource considerations by the state:

The state of Massachusetts has the ability to influence policy and regulatory changes in housing, transportation, crime prevention, education, and employment to achieve a broader adoption of a "Health in All Policies" approach across state agencies.

Developing frameworks for multi-sector collaboration will require non-health sectors to have integrated health priorities in their policies, programs and mandates. This will create a bi-directional commitment to common priorities across health and non-health sectors.

SDOH and Physician Practice

Changes to public policy that expand the role of government and its agencies to more effectively address social determinants like housing, nutrition, education and employment would be welcome. This would relieve unwarranted strain on the physician practice represented by SDOH while potentially providing a centralized source for information and resources the provider community could tap into to support population health. The result in our view would be a more rational structure for addressing the wide range of issues affecting this population, while ensuring policy issues don't further destabilize the state's already fragile community of hospitals and physicians.

To address patient engagement, Medicaid benefits should be restructured so patients have a so-called "skin in the game." To the degree additional costs to beneficiaries is not realistic, the state should consider enhanced benefits for those who comply with care recommendations and actively engage in related lifestyle change. Provider organizations, like ours that manage under risk, already have staffing, resources and care models that could be leveraged in this regard. For example, a patient who complies with the PCPs chronic disease management care plan might be eligible for enhanced health benefits or other Medicaid benefits that relate to their overall well-being, like housing or nutrition. This approach would presumably be a better fit when it comes to the skills, background and experience of the provider community when compared to those of state agencies. There also may be synergistic benefits as we collaborate on the identification of engaged beneficiaries most ready to improve their health or other aspects of their lives for which they currently rely on state assistance.

AGO Pre-Filed Testimony Questions

1. **For provider organizations: please submit a summary table showing for each year 2014 to 2017 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached AGO Provider 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. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.**

2. **Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.**

    a) **Please use the following table to provide available information on the number of individuals that seek this information.**

Health Care Service Price Inquiries CY2016-2018			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2016	**Q1**		6
	Q2		24
	Q3		10
	Q4		13
CY2017	**Q1**		12
	Q2		3
	Q3		8
	Q4		25
CY2018	**Q1**		45
	Q2		38

b) Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analysis.
Required Question: Click here to enter text.

In 2015, Cape Cod Healthcare implemented a patient estimation tool offered through DaVincian Technologies. Estimates are generated as requested, prior to and/or on the date of service for elective outpatient visits, same day surgery cases, and elective scheduled admissions.

Cape Cod Healthcare also has the capability to generate an estimate on any service using this technology upon inquiry. Cape Cod Healthcare has created a section on our public website (http://www.capecodhealth.org/patientsvisitors/ estimate-the-cost-of-care/) where patients can find the telephone number (1-855-331-2242) to inquire about the price for any service.

To assure accuracy and timeliness, auditing and analysis are performed by the organization's revenue cycle management. A random sampling of each service type is compared against the actual adjudication of those patients' claims to ensure accuracy. The table below demonstrates the Hospital's monitoring accuracy.

Total Estimates April 2018	**690**	
Zero Variance	310	45%
Less than $20	57	9%
Greater than $20	323	46%
Total Estimates Jan - April 2018	**1613**	
Zero Variance	715	45%
Less than $20	113	7%
Greater than $20	785	48%

c) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?
Required Question: Click here to enter text.

Cape Cod Hospital is now able to generate accurate and timely responses to consumer inquiries for price information due to the implementation of patient estimation technology. This technology has automated the calculation and generation of the patient estimate.

3. For hospitals and provider organizations corporately affiliated with hospitals:

a) **For each year 2015 to present, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.**
Required Question: Click here to enter text.

Cape Cod is a seasonal destination and sees upwards of four million visitors each year. Due to this influx of tourists, Cape Cod Hospital provides care for a significant number of out-of-state visitors. In Fiscal Year 2017, out-of-state, commercially-insured patients contributed $4 million to the hospital's total operating margin. Margin from non-Massachusetts' patients does not contribute to Massachusetts' overall total medical expense and thus, has no effect on the Commonwealth's cost trends.

b) **For 2017 only, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as AGO Provider Exhibit 2 with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.**

Required Question: Click here to enter text.

CAPE COD HEALTHCARE

2018 Health Policy Cost Trends Hearing
Pre-Filed Testimony

AGO Scheduled and Exhibits Follow

Please note change in revenue reporting. Since 2015 Cape Cod Healthcare has developed better systems and analytic capabilities. This evolution has led to more refined reporting capabilities such as increased segmentation and classification of revenue. No material changes have been made to revenue reported in total, but classifications between types of contracts and payer classifications have been made and reflect this increased capability.

Exhibit 1 AGO Questions to Providers

2017	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					903,744						51,881,777	24,665,337			
Tufts Health Plan					259,505	152,246					28,999,700	215,454			
Harvard Pilgrim Health Care	21,080,910	6,469,710			506,821	30,226					346,008	(30,226)			
Fallon Community Health Plan											403,080				
CIGNA											7,460,485				
United Healthcare											362,775	793,272			
Aetna											6,341,619				
Other Commercial											22,413,754	175,158			
Total Commercial	21,080,910	6,469,710	-	-	1,670,071	182,471	-	-	-	-	118,209,198	25,818,995	-	-	-
Network Health											3,313,058				
Neighborhood Health Plan											22,332,820				
BMC HealthNet, Inc.											22,481,337				
Health New England											-				
Fallon Community Health Plan											272,687				
Other Managed Medicaid											4,655,680				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	53,055,583	-	-	-	-
MassHealth											16,416,870				
Tufts Medicare Preferred											12,796,571				
Blue Cross Senior Options											10,589,551				
Other Comm Medicare											11,835,901				
Commercial Medicare Subtotal											35,222,023				
Medicare											238,778,654				
Other					781						21,854,189	-			
GRAND TOTAL	21,080,910	6,469,710	-	-	1,670,852	182,471	-	-	-	-	483,536,517	25,818,995			

The Cape Cod Hospital agreement with HPHC has a pay for performance component through which a percentage of the annual fee for service payments must be earned.
For purposes of this document, the total hospital fee for service revenue from HPHC has been reported under P4P Contract category.

The HPHC P4P provisions were applicable in 2015, 2016 and 2017

Exhibit 1 AGO Questions to Providers

2016	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					934,568						47,510,195	24,338,300			
Tufts Health Plan					801,462	89,534					26,984,421	504,579			
Harvard Pilgrim Health Care	22,706,648	8,082,641			774,064	46,588					169,825	(46,588)			
Fallon Community Health Plan											476,091				
CIGNA											7,585,161				
United Healthcare											402,240	451,277			
Aetna											7,333,247				
Other Commercial											20,037,619	252,774			
Total Commercial	22,706,648	8,082,641	-	-	2,510,094	136,122		-	-	-	110,498,800	25,500,343	-	-	-
Network Health											2,734,866				
Neighborhood Health Plan											19,274,732				
BMC HealthNet, Inc.											19,919,707				
Health New England															
Fallon Community Health Plan											33,179				
Other Managed Medicaid											5,649,798				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	47,612,282	-	-	-	
MassHealth											14,635,066				
Tufts Medicare Preferred							-				15,260,400				
Blue Cross Senior Options											8,946,986				
Other Comm Medicare											6,848,001				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	31,055,387				
Medicare											219,321,852				
Other					3,022		-				22,260,597	-			
GRAND TOTAL	22,706,648	8,082,641	-	-	2,513,116	136,122	-	-	-	-	445,383,985	25,500,343			

The Cape Cod Hospital agreement with HPHC has a pay for performance component through which a percentage of the annual fee for service payments must be earned.
For purposes of this document, the total hospital fee for service revenue from HPHC has been reported under P4P Contract category.

The HPHC P4P provisions were applicable in 2015, 2016 and 2017

Exhibit 1 AGO Questions to Providers

2015	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					803,277						47,707,523	23,433,194			
Tufts Health Plan					668,269						25,714,100	329,666			
Harvard Pilgrim Health Care	22,339,312	8,807,192			957,691						(45,870)				
Fallon Community Health Plan											491,276				
CIGNA											7,130,141				
United Healthcare											383,658	609,672			
Aetna											6,610,012				
Other Commercial											16,448,102	625,470			
Total Commercial	22,339,312	8,807,192	-	-	2,429,237	-	-	-	-	-	104,438,942	24,998,003	-	-	-
Network Health											2,451,604				
Neighborhood Health Plan											12,480,908				
BMC HealthNet, Inc.											18,474,141				
Health New England															
Fallon Community Health Plan											67,367				
Other Managed Medicaid											4,948,655				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	38,422,674	-	-	-	-
MassHealth											15,997,041				
Tufts Medicare Preferred											12,266,492				
Blue Cross Senior Options											7,925,280				
Other Comm Medicare											6,983,600				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	27,175,371	-	-	-	-
Medicare											202,370,562				
Other											22,181,595				
GRAND TOTAL	22,339,312	8,807,192	-	-	2,429,237	-	-	-	-	-	410,586,184	24,998,003	-	-	-

The Cape Cod Hospital agreement with HPHC has a pay for performance component through which a percentage of the annual fee for service payments must be earned.
For purposes of this document, the total hospital fee for service revenue from HPHC has been reported under P4P Contract category.

The HPHC P4P provisions were applicable in 2015, 2016 and 2017

Exhibit 1 AGO Questions to Providers

2014	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					763,846						47,934,909	20,908,269			
Tufts Health Plan					662,076						13,709,523	272,427			
Harvard Pilgrim Health Care					524,898						24,125,663	7,560,362			
Fallon Community Health Plan											945,409				
CIGNA											7,260,235				
United Healthcare											369,885	(773)			
Aetna											6,058,324				
Other Commercial											19,217,284	1,070,264			
Total Commercial	-	-	-	-	1,950,821	-	-	-	-	-	119,621,232	29,810,549	-	-	-
Network Health											1,742,383				
Neighborhood Health Plan											7,598,791				
BMC HealthNet, Inc.											15,283,655				
Health New England															
Fallon Community Health Plan											77,194				
Other Managed Medicaid											4,715,433				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	29,417,458	-	-	-	-
MassHealth											12,959,642				
Tufts Medicare Preferred											11,159,971				
Blue Cross Senior Options											**7,631,742**				
Other Comm Medicare											5,019,365				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	23,811,078	-	-	-	-
Medicare											187,249,990				
Other											32,991,124	-			
GRAND TOTAL	-	-	-	-	1,950,821	-	-	-	-	-	406,050,524	29,810,549	-	-	-

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AGO Exhibit 2

Cape Cod Hospital - 3b Schedule - Fiscal Year 17

Note - Below details are based on Cape Cod Hospitals service line groupings. Data is captured and reported at the Service Line level. These are different from the AGO service category format, as to provide the data in AGO format would require complete system programming.

	Medicare				Medicaid				Commercial				All Other				Total			
	IP		OP		IP		OP		IP		OP		IP		OP		IP		OP	
Service Lines	**Inpatient Revenue**	**Inpatient Margin**	**Outpatient Revenue**	**Outpatient Margin**	**Inpatient Revenue**	**Inpatient Margin**	**Outpatient Revenue**	**Outpatient Margin**	**Inpatient Revenue**	**Inpatient Margin**	**Outpatient Revenue**	**Outpatient Margin**	**Inpatient Revenue**	**Inpatient Margin**	**Outpatient Revenue**	**Outpatient Margin**	**Inpatient Revenue**	**Inpatient Margin**	**Outpatient Revenue**	**Outpatient Margin**
Behavioral	$ 4,503,329	$ (1,474,894)	$ 272,308	$ (488,163)	$ 3,575,628	$ (1,380,942)	$ 851,011	$ (225,600)	$ 3,443,511	$ 939,723	$ 1,102,608	$ 313,875	$ 444,009	$ (71,928)	$ 7,891	$ (11,111)	$ 11,966,476	$ (1,988,041)	$ 2,233,818	$ (410,999)
Cardiac	$ 46,948,256	$ (912,857)	$ 13,940,887	$ (449,917)	$ 4,640,993	$ (195,228)	$ 1,242,493	$ (329,368)	$ 11,973,296	$ 3,689,940	$ 8,679,610	$ 5,203,352	$ 1,082,318	$ (346,978)	$ 412,434	$ (55,819)	$ 64,644,864	$ 2,234,877	$ 24,275,424	$ 4,368,249
Imaging	$ -	$ -	$ 9,952,816	$ (844,546)	$ -	$ -	$ 6,801,842	$ 3,148,912	$ -	$ -	$ 17,988,470	$ 10,578,814	$ -	$ -	$ 970,170	$ 300,204	$ -	$ -	$ 35,713,298	$ 13,183,384
Lab	$ -	$ -	$ 8,017,449	$ (3,819,430)	$ -	$ -	$ 2,532,766	$ (754,671)	$ -	$ -	$ 13,839,053	$ 5,902,887	$ -	$ -	$ 1,126,511	$ (322,984)	$ -	$ -	$ 25,515,779	$ 1,005,802
Medical	$ 60,797,916	$ 4,100,502	$ 7,245,932	$ (4,314,731)	$ 8,868,926	$ 44,330	$ 1,619,094	$ (1,104,031)	$ 14,714,525	$ 6,648,631	$ 3,938,171	$ (35,877)	$ 2,275,957	$ (134,581)	$ 457,282	$ (24,975)	$ 86,657,324	$ 10,658,882	$ 13,260,478	$ (5,479,614)
Neuroscience & Pain	$ 17,059,871	$ 3,280,932	$ 4,924,127	$ 206,717	$ 2,188,071	$ 76,463	$ 905,377	$ (192,760)	$ 6,582,500	$ 3,088,030	$ 3,484,941	$ 1,811,111	$ 992,031	$ 169,452	$ 665,355	$ 244,484	$ 26,822,473	$ 6,614,877	$ 9,979,800	$ 2,069,552
Oncology	$ 3,520,340	$ 473,049	$ 27,221,041	$ (9,910,776)	$ 366,607	$ 49,228	$ 3,118,190	$ (1,865,333)	$ 893,534	$ 417,115	$ 13,527,110	$ 3,501,071	$ 119,407	$ 15,532	$ 658,386	$ (244,288)	$ 4,899,888	$ 954,923	$ 44,524,727	$ (8,519,327)
Orthopedics	$ 17,228,525	$ 1,255,126	$ 3,742,871	$ (414,812)	$ 1,336,988	$ (157,079)	$ 537,387	$ (1,028,027)	$ 6,504,393	$ 2,684,978	$ 6,985,276	$ 2,926,434	$ 482,824	$ 13,681	$ 718,849	$ (20,483)	$ 25,552,730	$ 3,796,707	$ 11,984,383	$ 1,463,112
Pain Medicine & Rehab	$ -	$ -	$ 1,096,214	$ (1,593,546)	$ -	$ -	$ 2,500,239	$ 382,061	$ -	$ -	$ 2,695,201	$ 715,547	$ -	$ -	$ 575,240	$ 39,212	$ -	$ -	$ 6,866,894	$ (456,726)
Surgical	$ 18,939,338	$ 2,690,230	$ 7,486,290	$ (3,430,587)	$ 2,824,158	$ (749,648)	$ 2,307,557	$ (3,219,852)	$ 5,905,085	$ 2,118,444	$ 14,335,612	$ 5,885,485	$ 639,826	$ (211,657)	$ 679,192	$ (1,258,877)	$ 28,308,408	$ 3,847,368	$ 24,808,652	$ (2,023,832)
Emergency Room	$ -	$ -	$ 20,583,557	$ (3,153,698)	$ -	$ -	$ 14,486,162	$ (2,535,128)	$ -	$ -	$ 29,191,547	$ 16,486,771	$ -	$ -	$ 9,183,670	$ 3,564,030	$ -	$ -	$ 73,444,935	$ 14,361,975
Woman and Children	$ 368,486	$ (60,524)	$ 151,124	$ (71,360)	$ 6,784,418	$ (2,678,698)	$ 1,984,547	$ (97,802)	$ 5,826,590	$ 301,153	$ 1,820,321	$ 188,368	$ 240,370	$ (125,609)	$ 123,248	$ (34,587)	$ 13,219,864	$ (2,563,677)	$ 4,079,239	$ (15,380)
Total	**$ 169,366,062**	**$ 9,351,564**	**$ 104,634,615**	**$ (28,284,850)**	**$ 30,585,788**	**$ (4,991,574)**	**$ 38,886,665**	**$ (7,821,599)**	**$ 55,843,434**	**$ 19,888,015**	**$ 117,587,921**	**$ 53,477,839**	**$ 6,276,743**	**$ (692,089)**	**$ 15,578,227**	**$ 2,174,804**	**$ 262,072,027**	**$ 23,555,917**	**$ 276,687,428**	**$ 19,546,195**

	Total Margin
Cape Cod Hospital	**$ 43,102,112**
Other Entities	**$ (14,778,140)**
Net Margin	**$ 28,323,972**

* Other Entities includes Physician Groups, Falmouth Hospital, Outpatient Mental Health Provider

Cape Cod Hospital - 3a1 Schedule

F/Y Payer Group	Margin $	% of Total NPSR
FY17		
Commercial	$ 73,365,855	32%
Medicare	$ (18,933,286)	51%
Medicaid	$ (12,813,172)	13%
Other	$ 1,482,715	4%
Margin	**$ 43,102,112**	**100%**
Other Entities	**$ (14,778,140)**	
Net Margin	**$ 28,323,972**	

F/Y Payer Group	Margin $	% of Total NPSR
FY16		
Commercial	$ 69,975,503	34%
Medicare	$ (16,703,900)	50%
Medicaid	$ (15,948,183)	12%
Other	$ 1,615,627	4%
Margin	**$ 38,939,047**	**100%**
Other Entities	**$ (414,910)**	
Net Margin	**$ 38,524,137**	

F/Y Payer Group	Margin $	% of Total NPSR
FY15*		
Commercial	$ 67,135,664	35%
Medicare	$ (21,869,544)	49%
Medicaid	$ (13,731,529)	12%
Other	$ 1,673,625	5%
Margin	**$ 33,208,217**	**100%**
Other Entities	**$ (2,306,102)**	
Net Margin	**$ 30,902,115**	

* Other Entities includes Physician Groups, Falmouth Hospital, Outpatient Mental Health Provider

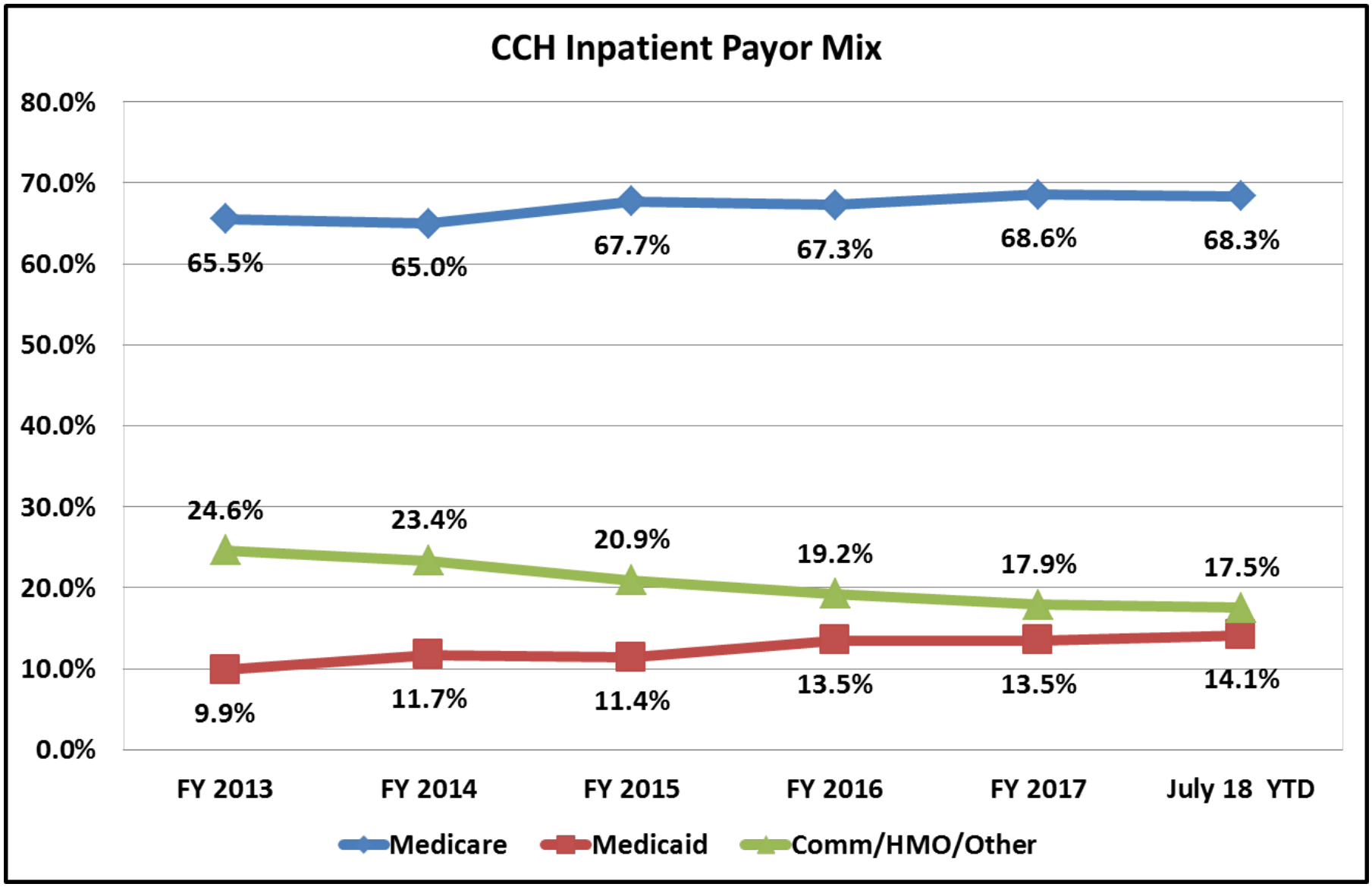
HPC Ex 1			
CCH FY15 - FY17			
Top Payers, per HPC Payer Groupings			
Commercial			
	Blue Cross HMO		
	Harvard Pilgrim HMO		
	Blue Cross PPO		
	CCHC Employee Plans		
	Harvard Pilgrim Healthcare		
	Tufts HMO		
	Aetna		
	BlueCross Federal		
	Harvard Pilgrim PPO		
	NHP Commercial		
	United Healthcare		
	Cigna Carelink		
	Tufts		
	Cigna		
Medicaid			
	Masshealth Standard		
	Boston Medical Center Plans		
	Network Health		
	Neighborhood Healthplan		
	Masshealth Limited		
	Celticare		
Medicare			
	Medicare A		
	Blue Cross Medicare PPO		
	Tufts Medicare Preferred		
	United Medicare		
	Fallon Medicare		
	Aetna Medicare		
Other			
	Motor Vehicle		
	Workers Compensation		
	Self Pay		

CAPE COD HEALTHCARE

2018 Health Policy Cost Trends Hearing
Pre-Filed Testimony

AGO Additional Data

Cape Cod Healthcare continues to experience downward pressure on its commercial payor mix. Cape Cod Healthcare's primary service area, Barnstable County, demographics forecast more growth in an already aging population. Cape Cod Healthcare's commercial payor mix will continue to decline while its, lower reimbursing, government payor mix grows.


CCH Inpatient Payor Mix
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
65.5%
65.0%
67.7%
67.3%
68.6%
68.3%
24.6%
23.4%
20.9%
19.2%
17.9%
17.5%
9.9%
11.7%
11.4%
13.5%
13.5%
14.1%
FY 2013
FY 2014
FY 2015
FY 2016
FY 2017
July 18 YTD
Medicare
Medicaid
Comm/HMO/Other