CAPE COD HEALTHCARE

Michael K. Lauf
President and Chief Executive Officer

August 30, 2016

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 July 19, 2016 and in accordance with Massachusetts General Laws chapter 6D, § 8, please find included herein Cape Cod Hospital's responses to the questions outlined in Exhibits B and C. I am legally authorized and empowered to represent Cape Cod Hospital for the purposes of this testimony, and hereby sign the enclosed testimony under the pains and penalties of perjury.

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

Sincerely,

Michael K. Lauf
President and CEO

/dal

cc: Karen Tseng, Chief, Health Care Division, Office of the Attorney General
Steve McCabe, Acting Director, Center for Health Information and Analysis

88 Lewis Bay Road
Hyannis, MA 02601
508.862.5893
fax 508.790.0030
mklauf@capecodhealth.org

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, 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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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 Suffolk, 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 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 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 2, 2016**, 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 from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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, 2014, and/or 2015 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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. 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.

1. **Strategies to Address Health Care Cost Growth.**
   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 has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.
   a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

In its recently released report entitled *Community Hospitals at a Crossroads,* the Health Policy Commission expressed deep concern for the many threats facing community hospitals and the critical role such institutions play in its vision. Although Cape Cod Healthcare's vision for the patients of Barnstable County is consistent with this statement, our long term viability is threatened by a variety of factors; consider the following trends:

- Outmigration and Volumes
  - Declining inpatient volumes and shifts to outpatient services, and
  - Outmigration of care to Boston academic medical centers.
- Reimbursement
  - Decreasing payments from Medicare;
  - Payer mix degradation impact equaling $9M annually;
  - Rising costs of pharmaceutical drugs;
  - Increase in bad debt with the growth of high-deductible plans;
  - Extreme reluctance of employers to subsidize government underpayments any longer, and
  - Losses on physician practices that are not reflected in hospital financials.
- Clinical Integration
  - Cost of preparing for population health and the proliferation of risk;
  - Significant efforts to integrate with physicians to improve quality of care, and
  - Dedication to the health and welfare of our community.

Despite the many challenges, we are dedicated to being "part of the solution," as demonstrated by the following:

- Making significant investment in population health strategies and infrastructure;
- Moving care to low cost local outpatient settings, such as the opening of four urgent care centers and free standing off-site diagnostic imaging and surgical centers;
- Providing critical, tertiary level services to keep care local (e.g., neurosurgery and cardiac surgery), and
- Requiring all physician members of our physician hospital organization (PHO) to participate in Medicaid MCO plans.

In order to evaluate the economic results of the Massachusetts health care industry, a more comprehensive approach should be considered. The entire health care system should be evaluated, versus just one hospital facility. Like Cape Cod Hospital, many hospitals are part of a larger system and thus looking at the economic performance at the consolidated level is a more accurate method of evaluating economic results and condition, as well as the services provided in the community. Many systems have subsidiaries that provide a variety of services such as mental health, long-term care and rehab services, visiting nurse services and outpatient physician office practices that are both financially and clinically supported by the entire system. Looking at a single hospital's financial performance often does not take into account the variety of services provided at the system level that is needed to economically support the many health care needs of the community.

FY15 Compared To FY14

Discharges for FY15 were up 6% or 908 cases over the same period prior year. This increase has been attributed to the evolution of Cape Cod Hospital's clinical capabilities for key service lines, and an increased number of Cape Cod residents choosing to obtain care locally. As a result, key outpatient areas increased 1% in FY15 compared to FY14. Net patient revenue increased 5.3% compared to same period last year. Total expenses increased 3.9% adjusted for volume. Drug costs increased 16% and represent over 25% of the increase in costs over FY14. Excluding the increase in drug costs, which we cannot control, expenses increased 2.9%. Drug cost continues to be a major area of concern going forward as they continue to escalate.

The demographics of our primary service area, defined as Barnstable County or "Cape Cod" are unique in that the population is heavily skewed toward older adults compared to both the Commonwealth and the nation. This segment is large and getting larger. The 2010 U.S. Census reported that residents over age 65 account for 25% of the total Barnstable County population. According to the UMass Donahue Institute projections, this age cohort is expected to grow to 36% by 2035. Cape Cod Hospital will continue to face challenges caring for a population that is getting older and less affluent. The impact of these unique demographics is apparent in Cape Cod Hospital's utilization.

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

Cape Cod Hospital relies heavily on governmental payers for services provided to our patients. In FY15, government payers represented 61% of our revenue compared to 58% in FY14. The government payer percentage is even more significant at 73% for FY15. The Hospital's outpatient payer mix is now similar to several of the Federally Qualified Health Centers in our region, with a heavy reliance on public payers. Many affiliated physicians have assumed a higher percentage of Medicaid patients, compared to some independent groups, in order to promote access for non-commercial patients. Correspondingly, commercial payers' percentage of revenue has decreased from 49% in FY14 to 40% in FY15. These payer trends are consistent with population demographic changes and will continue to challenge Cape Cod Hospital's ability to maintain services given the revenue payer mix, while facing increased demand for services due to the aging population.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

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

Unnecessary Administrative Costs

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

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

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

Policies

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

As mentioned in Section 1 (a), policies which address uncontrolled pharmaceutical and medical supply and device costs will be key to reigning in total health care expense, yet are beyond the control of providers.

2. Strategies to Address Pharmaceutical Spending.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

   i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

- We have developed a process whereby every drug requested by physicians to be added to the formulary must be vetted by the Pharmacy and Therapeutic Committee for approval. This review process includes both clinical judgment and comparative analysis to existing drugs in the formulary.
- In addition, the Pharmacy and Therapeutic Committee and Cape Cod Healthcare physician leaders review drugs that display rapid or unusual cost increases. When clinically appropriate, alternatives can be sought and implemented.

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Currently Implementing

- Hospital quality staff utilizes dashboards and analytic tools to review usage of specific drugs and compare quality outcomes to other hospitals at a service line level. This provides actionable data to determine where the hospital's usage is higher or lower than comparable facilities.
- Cape Cod Hospital continuously analyzes the data sets to identify trends in drug spending by specialty and unit. The Pharmacy and Therapeutic Committee reviews these results and facilitates discussions with department heads (i.e., high IV acetaminophen use in the Emergency Center, certain hospitalists, etc.) to seek solutions, as appropriate.

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Currently Implementing

- Alteplase protocol specifying contraindications and exclusion criteria for use, timing of administration, consultation with neurologist and review of laboratory values;
- Evidence-based, pre-defined oncology protocols for chemotherapy treatment regimens;
- Protocol in place with clinical parameters, and required physician sign-off sheet in order for pharmacy to dispense Kcentra;
- Rasburicase protocol for single-dose regimen, supported by clinical research, replaces multi-dose orders, also requires oncologist consult;
- Protocols in place for pharmacists to switch intravenous acetaminophen and levothyroxine to oral formulations in appropriate patients after 24-48 hours;
- Consultations with Infectious Disease department are required for certain high-cost antibiotics (i.e., dalbavancin, daptomycin), and
- Thoughtful review to determine where it is clinically appropriate to use generic drugs in our employee health plan.

Plans to Implement

- Cape Cod Healthcare is currently developing/implementing a comprehensive Antibiotic Stewardship initiative in an effort to curb variability among prescribing practices. The initiative, spearheaded by the Department of Infectious Disease, has been designed to encourage appropriate antibiotics, decrease unnecessary antibiotics, reduce Clostridium difficile infection rates, improve and/or maintain local antibiotic resistance patterns, improve patient outcomes, and reduce associated health care costs and length of stays. The initiative is currently in the approval process with the Pharmacy and Therapeutics Committees and is expected to be implemented fully later this calendar year.

iv. Establishing internal formularies for prescribing of high-cost drugs

Currently Implementing

- Automatic therapeutic interchange policy in place for intravenous iron formulation: iron sucrose for all inpatients unless "do not substitute" is ordered by physician.
- Automatic therapeutic interchange: Topical ophthalmic prostaglandin (Xalatan) replaces more expensive, branded products.
- Bio-similar filgrastim (Zarxio) is used for oncology patients rather than filgrastim.

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

- Home medication reconciliation and pharmacy education services are provided following patient discharge.
- Medication reconciliation by pharmacy technician in the Emergency Center, Psychiatric Center, and pre-admissions testing is incorporated to enable accurate discharge medication planning.

Plans to Implement

- "Meds-to-Beds" discharge prescriptions which allow inpatients to receive retail pharmacy fulfillment upon discharge, ensuring patients are following the proper use of medications as prescribed by their physician.

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Currently Implementing

- Through its partnership in its Physician Hospital Organization, Cape Cod Healthcare currently participates in APM contracts with the major commercial payers in Massachusetts. These APM contracts contain financial risk terms in which pharmacy spending is included.

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

1. Multiple Touch Points Integrating Behavioral Health with Medical Health Care

Medical/Surgical units

In 2015, Cape Cod Healthcare (CCHC) identified that 34% of patients admitted to medical/surgical units at Cape Cod Hospital and Falmouth Hospital have a psychiatric diagnosis in their top four discharge diagnosis. At Cape Cod Hospital, patients with a psychiatric diagnosis have a 29% higher average length of stay than those with **no** psychiatric diagnosis. At Falmouth Hospital, patients have a 12% higher average length of stay than those with **no** psychiatric diagnosis. In an effort to improve immediate access to behavioral health care on our medical/surgical units, CCHC has grown our psychiatric consultative service.

CCHC hired a new Medical Director of the Consultation Service (board certified in consultation liaison psychiatry and addiction medicine) who ensures high quality psychiatric care at both Cape Cod Hospital and Falmouth Hospital. By partnering with the medical and social work teams, behavioral health assists in diagnosing, treating, and referring patients to the next level of care.

Oncology

CCHC Oncology Department identified that a high number of their patients are dealing with psychosocial issues either on-going or exclusive to their current cancer diagnosis. Despite referring patients to CCHC's Behavioral Health outpatient clinic, there continued to be a low level of engagement in attending appointments with mental health providers. The Oncology Department determined one primary barrier was the stigma surrounding the need for mental health services when battling cancer. As emotional distress is a strong predictor of poor self-management and high health care dollars, an integrated behavioral health care model was developed to enhance a patient's well-being. An essential first step for CCHC has been to embed a Behavioral Health Department Psychologist one day a week, directly in an office within the Oncology Clinic. Referrals will be made by the oncologists and case managers each week. To augment this integrated care, Cape Cod Hospital's Chief of Psychiatry attends Oncology's weekly Tumor Board to assist in identifying those patients who need additional care.

Cardiac Rehab

Many patients and families experience emotional, physical and psychological challenges post heart-attack (MI) and/or cardiac surgery. CCHC's Cardiac Rehabilitation (Rehab) department identified the need to address patients' distress, depression, anxiety, and anger that often occurs when a patient begins making readjustments to their relationships, work, and environment. By reducing stress and increasing the patient's ability to deal with their life changing event, we believe there will be an additional benefit to the patient's medical outcome. CCHC has realigned their Behavioral Health therapist's location to the Cardiac Rehab site, and now offer evening hours twice weekly. A LICSW and Occupational Therapist lead groups addressing ongoing stress reduction, coping skills, and relaxation techniques.

Physician's Hospital Organization (PHO)

CCHC is actively involved in developing population health approaches to integration of behavioral health and primary care. Over the past year CCHC's Behavioral Health team has partnered with the CCHN PHO to develop a comprehensive approach to patients struggling with major depressive disorder and comorbid medical illness.

By developing a service that offers both medical and behavioral health case management services, CCHC has been able to assist patients in accessing care and decreasing utilization of the Emergency Department for routine, non-urgent care.

Transition Integration with Duffy Health Center (FQHC)

Statistics demonstrate at Cape Cod Hospital's Psychiatric Inpatient Unit that 37% of discharges "no show" for their first aftercare appointment, which in turn is reflected in subsequent Emergency Department visits. Cape Cod Healthcare identified that the highest recidivism occurs for a patients that are homeless or at risk for homelessness. Evidence revealed that 90% of this at risk group did not attend their first outpatient appointment and returned to the ED repeatedly with as high as 69 visits in a year with a statistically significant readmission rate to the Inpatient Psychiatric Unit. In an effort to engage this population of patients, a collaborative, case management, engagement model has been developed with Duffy Health Center ('Duffy'). Twice weekly, Duffy brings a team of providers onto the Inpatient Psychiatric Unit for two to three hours to meet individually with each identified patient and develop a transition discharge plan with wrap- around services. Barriers are identified, a relationship is developed, and appointments made on-site. The Duffy team is comprised of an APRN, Case Manager and Peer Support staff. At present, Duffy states their compliance rate for CCH inpatient psychiatric patients' first appointments has now improved to 74-78%.

Addiction Evaluation and Treatment for Children/Adolescents at a Federally Qualified Health Center

In 2016, the Bureau of Substance Abuse Services (BSAS) awarded Duffy Health Center of Hyannis MA, a three year grant to improve access to substance use treatment for adolescents across a geographically diverse area. Through this grant, the Duffy Health Center will provide substance abuse assessments, medication assisted treatment (MAT) and recovery programs for adolescents in the Barnstable County catchment area. Cape Cod Healthcare is collaborating with Duffy and offering additional grants to support these efforts in FY17.

Barnstable County Regional Substance Abuse Council reported in their 2015 ***Analysis Substance Abuse on Cape Cod: A Baseline Assessment*** that Barnstable County adolescents are at risk for substance abuse. In a recent local survey of two towns, high school students self-reported substance-related behaviors for alcohol, marijuana, heroin, cocaine, ecstasy and the use of over-the-counter (OTC) drugs. Barnstable County high school students are binge drinking, using marijuana and other OTC drugs at high rates. To affect change in the substance use among Barnstable County adolescents, Duffy Health Center has contracted with CCHC to provide child and adolescent psychiatric services and medication assisted treatment (MAT) in the form of Suboxone. Beginning September 1, 2016, the CCHC psychiatrist will have two primary roles at Duffy. As an educator, the CCHC psychiatrist is committed to working closely with Duffy staff to teach, train, and strategically develop their team regarding adolescent addictions and the use of Suboxone in MAT. The CCHC psychiatrist will also perform a high quality substance use disorder assessment for adolescents struggling with addictions. Additionally, the psychiatrist will prescribe Suboxone and treat adolescents, as appropriate.

2. **Immediate Access to Behavioral Health Services for Primary Care Offices, Emergency Departments, and the Community**

To be accessible to our providers and community through immediate access to behavioral health services, Cape Cod Healthcare has initiated two real-time bold strategies through Telemedicine and same-day access. Both are designed to leverage existing behavioral health capacity, reduce the costs associated with emergency department recidivism and boarding through a patient-centered model of localized and integrated treatment planning.

Telemedicine

Cape Cod Healthcare has a proven track record of successfully implementing new models of behavioral health care that improve patient access, quality of care, and reduced cost of delivery. Telemedicine video-conferencing has now been added to CCHC's "tool-box". To expand behavioral health capacity between our two acute care non-profit hospitals, CCHC launched a telemedicine-enabled behavioral health consultation 'hub'. The services are provided by CCHC's licensed independent social workers (LICSW) for sixteen hours per day, seven days a week. Within the next six months, CCHC's goal is to expand this model to telemedicine psychiatry consultation to create an access point for hospital departments, primary care offices, and specialty care providers. The psychiatrists will include CCHC's Chief of Psychiatry, a Consult Liaison Psychiatrist and the Inpatient Medical Director, both of whom are also board certified in Addiction Medicine.

The 2014 – 2016 Cape Cod Hospital and Falmouth Hospital Community Health Needs Assessment report identified that the underlying factors contributing to heavy utilization of CCHC's hospital emergency departments for mental health and substance use disorders included a shortage of available community-based psychiatric and substance treatment providers, extended wait times, transportation barriers for appointments, and a lack of primary care screenings for mental health and substance use disorders. These findings were reconfirmed through physician town hall meetings led by CCHC's Chief of Psychiatry in early 2016.

Falmouth Hospital has had limited psychiatric and substance resources in both its ED and inpatient medical/surgical departments. The lack of services gave rise to high ED boarding hours and little to no psychiatric treatment for the medical/surgical units. Concerned with the long delays before evaluation and/or when treatment was initiated, Falmouth hired a Nurse Practitioner and a LICSW, who are managed by CCHC's Behavioral Health department, to provide mental health assessment and care in the ED including medical/surgical units.

To ensure resources were available on evenings and weekends, we also launched an internal telemedicine program to connect Cape Cod Hospital and Falmouth Hospital for the provision of expanded mental health consultation. The goal was to increase patient satisfaction, provide an earlier point of stabilization of the patient's symptoms, reduce admissions, and strengthen coordination of post-discharge referrals and treatment planning.

The workflow for a telemedicine evaluation begins with the Falmouth Hospital ED physician or nurse discussing with the patient the opportunity to have a mental health or Substance Use Disorder evaluation through Telemedicine. Once education of the patient has taken place, a Telemedicine 'informed consent' is signed and witnessed. Falmouth Hospital calls the 'hub', which is staffed by the CCHC Behavioral Health admissions team. An evaluation time is set, and the CCHC team reviews the Telemedicine procedures with the Falmouth Hospital staff, including setting up the equipment ten minutes before the scheduled evaluation time. The RN brings in the secure, mobile Telemedicine laptop directly to the patient's bedside, which is located within a private room in the ED.

The 'hub' triages the call to the appropriate Telemedicine provider with a reminder to be at the Telemedicine terminal ten minutes prior to commencing the evaluation. The provider of the evaluation is located within a secure and private room located at the Cape Cod Hospital.

Once the live evaluation is completed, the CCHC Telemedicine provider immediately dictates the evaluation into the electronic medical record, including mode of service delivery, all attendees' names, and any technical difficulties or patient challenges that impacted their ability to carry out the consultation. The LICSW communicates with the Falmouth Hospital ED physician to discuss recommendations, create a treatment plan, and jointly determine the disposition.

Same Day Access

According to the National Council for Behavioral Health with the implementation of the Affordable Care Act, Parity, and Medicaid expansion, more people will have access to treatment for mental health services. By 2019, an additional 15 million people will be eligible to enroll in Medicaid; an additional 16 million people will be covered by private insurance. With the increased need for behavioral health services and the understanding that 25% of patients with next-day appointments cancel or do not show up, offering same-day access engages patients and reduces revenue lost revenue necessary to support the program.

To meet CCHC's current and overwhelming demand to provide same-day service to PCP offices, CCHC's Outpatient Behavioral Health Clinic has initiated medical psychiatric evaluations on the same day they are requested. This process has greatly improved CCHC's provider and patient satisfaction as well as operational efficiencies. Same-day access has dramatically improved patient engagement, while also reducing no shows for first appointments. The Psychiatrist or Nurse Practitioner (NP) evaluates, prescribes medication treatment and sets the next appointment expectations. To close the feedback loop, the CCHC Psychiatrist/NP communicates back to the PCP the assessment results and prescribed medication. The goal of each encounter is to stabilize the patient and refer back to the PCP to continue their treatment.

For non-profit hospital systems such as Cape Cod Healthcare, the cost of behavioral health integration also depends on the dedication and continued commitment of a trained behavioral health team. Over the last two years, the behavioral health team has been supported and encouraged to develop services and improve the quality of care delivered. Reaching out to build relationships with community providers and launching new services has enhanced CCHC's ability to attract highly qualified psychiatrists and APRNs. Within the last year, CCHC has increased staffing of both psychiatrists and advance practice RNs. In a time of psychiatry shortage, this is indeed significant.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

Hidden Costs of Mental Health Parity

We often associate lack of mental health parity with prior authorizations and the transfer of patients to an acute facility. However, most of the negative impact is the hidden costs to the acute care system that affect the ability to be effective stewards in managing the expenditures of psychiatric care.

To meet an Inpatient or Partial Hospital level of care, patients must meet explicit criteria to receive a prior authorization with subsequent (frequent) concurrent utilization reviews during their stay. The commercial and state payers rigid medical management techniques conducted from a telephone review of symptoms is time consuming and unnecessary. Approval of continued stay is based highly on the skills of the Cape Cod Hospital's Utilization Review personnel's ability to articulate the patient's symptoms and the skill of the receiving medical review agent. To add greater complexity, approval of medical necessity by the agent does not guarantee payment.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted to ensure that treatment limitations for mental health are not more restrictive than medical/surgical benefits. However, in its current state, the prior authorization and concurrent review process often precludes many individuals from receiving meaningful psychiatric treatment and/or continued stay for stabilization. For example, a patient on day five of an inpatient stay affirms that they are not suicidal for the first time, indicating that the "new" medication may be taking effect. In most cases, the medical review agent determines that discharge should commence the following day. When in truth, the patient requires an additional 48 hours to ensure stabilization. This decision often results in a patient becoming a "revolving door" of psychiatric crisis and succeeding ED visits.

Some resistance to enacting mental health parity appears to reside in theory that parity would promote inefficient use of psychiatric beds. The consequence would be demonstrated by inpatient beds filling up more quickly and patients having longer lengths of stay, thereby exacerbating ED boarding. This conjecture is in direct contradiction to nation-wide statistics that demonstrate excessive ED boarding hours, difficulty gaining prior inpatient authorizations, and disputes surrounding continued stays. Statistical evidence at Cape Cod Hospital demonstrates that this premise is not founded. Medicare does not require a prior authorization or concurrent review. Cape Cod Hospital data demonstrates that patients with Medicare, compared to commercial and state insurances, have the same length of ED boarding time with an average length of inpatient stay of 7.6 days.

At Cape Cod Hospital, the time lost for prior authorizations is insignificant at only 1-1.5 hours. Yet, the total price impact for the process of the prior authorization and concurrent utilization review aggregates to an impressive sum.

Inpatient Psychiatric Unit	**Partial Hospital – 50 patients**
$66,648 – Prior Authorization $115,520 – Concurrent Review $62,400 – MD Time $244,568	$33,324 – Prior Authorization $28,880 – Concurrent Review $62,400 – MD Time $126,604

The expenses above do not reflect the total cost of the medical review agents to each commercial and state payer. Considering medical review agents attend to numerous calls throughout the state and/or country, their personnel expense is considerable and contributes to the overall cost of insurance and mental health care dollars.

Encouraging acute care hospitals to self-manage their admissions and continued Inpatient and Partial Hospital stays would significantly reduce time and monies spent. Accountability for each organization could be developed to mirror the process that MBHP adheres to, whereby statistical data is gathered to monitor compliance. For those facilities that are consistently outside the accepted norm, the prior authorization/concurrent review could be mandated for six months to one year. The unwieldy process could be lifted once the organization demonstrates efficiency.

Chapter 52: Patients perceived and real stigma of accessing ED substance evaluation and community services after Opioid over dose and the unfunded costs.

When Governor Baker signed into law Chapter 52: An Act Relative to Substance Use, Treatment, Education, and Prevention, he positively changed the future of many individuals struggling with addictions. Endorsing the State to direct their focus on engagement, evaluation, and community treatment for substance use disorders (SUD), the bill indirectly addresses the barrier of social stigma, which prevents many individuals from seeking help.
In the few short weeks since the bills enactment on July 1, 2016, Cape Cod Healthcare has already identified three internal and external barriers. The first addresses patients arriving to the ED with an identified opioid overdose and agreeing to the substance use disorder evaluation (SUDE). The second is the access to treatment and lack thereof within the Cape Cod community. The third barrier is the unfunded service of providing a SUDE by an independent licensed clinician.

In July, 2016, twenty-three patients presented after Narcan in the field or in the ED. Of these patients only two accepted the substance use disorder evaluation (SUDE) and treatment plan. In review of this small sampling, one notable factor plays a role in this small window of opportunity. The dynamic viewpoint is reflected in the patient's belief that they can control their problem and perceived stigma associated with their illness.

Nationally, substance use disorders are the most highly stigmatized illnesses that present to every ED or PCP office. Stigmatizing attitudes are widely accepted and we see this reflected in how an individual struggling with SUDs sees him or herself as well as their reluctance to engage in help. In 2012, *Addiction Medicine* reported that between 70-80% of people with diabetes receive treatment, but only about 1 in 10 with alcohol/drug addiction accepts any treatment. Even if the individual does accept treatment, once 'detox' is complete, the individual is placed back in the same environment and community that perpetuated the addiction.

Historically, emergency medicine has not had the formal training in understanding their pivotal role in the recovery of patients with substance use disorders. To date, Psychiatry is an elective rotation in the residency for ED physicians. Engagement and motivational interviewing are unlearned soft skills in favor of highly refined skills in managing trauma, cardiac, and acute medical illnesses. In the white paper, *Emergency Department attitudes toward mental illness,* Hadfield (2009) describes emergency staff as having a perceived lack of skills, which in effect is a barrier to engaging presenting patients.

In Barnstable County, there is a lack of treatment beds for substance use disorders. With limited bed capacity at the only Inpatient treatment facility, Gosnold, the majority of our patients presenting to the ED are treated off-Cape in geographically distant programs. Additionally, the patients requesting or accepting treatment must wait in the ED for bed availability. Regrettably for many, by the time the patient has been accepted for treatment, they have 'detoxed' and are no longer eligible for inpatient services. For those fortunate few who received substance use disorder treatment, they must return to a community that has limited programs to support their new-found sobriety. Unfortunately, the Barnstable County community system's infrastructure has not been built to reinforce recovery.

Lastly, the requirement of an evaluation by an independent licensed clinician trained in addictions and substance use disorder treatments is daunting and unfunded. At Cape Cod Hospital, the ED has one part-time licensed independent social worker (LICSW) who can perform substance evaluations. The three other case managers are not independently licensed. To achieve the Chapter 52 goals, CCH has hired a dedicated LICSW to perform evaluations seven days a week, as well as 'Recovery Navigators' to engage patients in accessing recovery-oriented substance use disorder treatment, resources, and community recovery groups. The cost of this endeavor to meet the bill's requirement is currently estimated at $292,600 and will likely grow given the magnitude of addiction in the region.

Redundancy of ESP evaluations in the ED

All patients who have Medicaid, MassHealth or are uninsured must be evaluated by an independent team of providers <u>even if the hospital is providing these evaluations at a much higher clinical level</u>. This service exposes patients to massive redundancy in the ED, when a lower cost, higher service can be provided.
When the Emergency Service Program (ESP) was originally brought into emergency departments to perform crisis evaluations, there was a true impact. The psychiatric evaluation could be performed by a qualified clinician at the bedside without the patient needing to be transported to an off-site crisis center. At the completion of the evaluation, a bed search commenced or the patient was connected to community services.

Due to the augmentation of psychiatric care in the Cape Cod Hospital Emergency Department (ED), the ESP *evaluation* has become a bottleneck in our present system. Currently, the time from ESP notification to completion of the evaluation is between five and sixteen hours. At the time of the ESP clinician's arrival to the bedside, a high quality, Cape Cod Behavioral Health Department psychiatric evaluation has been concluded and dictated by the psychiatric nurse practitioner (NP), therefore creating a redundancy in service. However, it is important to note that the ESP *post-evaluation* case management with connections and outreach to the community still continues to be a valuable resource.

Under this model, all behavioral health patients remain in the ED, but are admitted to the "Psychiatric Observation" service under the Chief of Psychiatry. Patients receive treatment and intensive monitoring. However, regardless of the high level of care and service Cape Cod Hospital is providing, the ED is still required to call the ESP clinician to perform their evaluation rather than accepting the psychiatric team's assessment. The ESP providers are not credentialed at Cape Cod Hospital and very few are independently licensed with the state. This often results in long and unnecessary delays for the patient.

At times, the ESP evaluation is in direct conflict with the psychiatric team's judgment. After short-term treatment, medication adjustment, and reassessment, the NP frequently concludes that the patient may go to a less restrictive level of care and can be safely discharged from the hospital. However, the ESP clinician in the majority of cases determines that the patient needs psychiatric inpatient level of care. The divergence between the two team's assessments typically ensures that the patient will remain in the ED until an inpatient bed is found and the patient transferred. This is an unnecessary use of valuable resources and affects the bed availability for those most acutely ill.

Cape Cod Hospital's psychiatric observation care has resulted in a sizeable reduction in Emergency Department boarding hours, and preserved psychiatric beds for the most acute patients. Following the medical 'observation' archetype, Cape Cod Hospital has been able to bill for both the evaluation and hourly care up to 48 hours. The reimbursement for our psychiatric services has partially supported the cost of the psychiatric NPs and Psychiatrists. This model has demonstrated effectiveness and could be duplicated.

Addiction Medicine: Closing the Gap between Science and Practice, June 2012, the National Center on Addiction and Substance Abuse at Columbia University, NY, NY.

Hadfield, K., Brown, D., Pemborke, L., & Hayward, M (2009). Analysis of emergency doctor's responses to treating people who self-harm. *Qualitative Health Research, 19*(6), 755-65.

4. **Strategies to Recognize and Address Social Determinants of Health.**

   There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

   a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

Cape Cod Hospital is pursuing the three following strategies to understand and address the social determinants of health (SDH) for our patients: 1) strategic collaboration with federally qualified health centers operating in our region, 2)conduct comprehensive community health needs assessments and health improvement planning for the service area, and 3) perform SDH screenings across various health care delivery settings, including the emergency department, inpatient departments and outpatient settings.

Strategic collaboration with each of the four Federally Qualified Health Centers (FQHCs) operating in Barnstable County positions Cape Cod Hospital to work beyond the acute care delivery environment to address the SDH of uninsured, vulnerable and medically underserved patients. As patient-centered home models of care, our FQHC partners systematically screen, track, report and address the SDH as well as upstream causes of poor health in shared patients. CCHC works collaboratively with FQHCs to improve patient access and care coordination through continuous funding and in-kind support of behavioral health services, complex care coordination, access and enrollment, physician recruitment and electronic health information integration.

We support the development and implementation of a statewide, standardized health assessment tool by all community health centers which could be incorporated into risk assessments for ACOs and MCOs to provide documentation and research value to adjust risk, monitor SDH changes and needs for patients, and improve coordination between agencies.

Cape Cod Hospital, in partnership with Falmouth Hospital, conducts comprehensive community health needs assessments for the service area of Barnstable County every three years. SDH data is included in the assessments. Content is sourced through publically available data along with input from residents, public health experts, and representatives of low-income, vulnerable and medically-underserved populations. SDH indicators such as income, employment, education, housing and household status, race, ethnicity, language, violence, food access, and behavioral risk factors are assessed. These indicators influence the development of hospital planning and community benefits strategies to impact the significant health needs of the service area. In FY15, the Hospital provided community benefits funding for projects that addressed SDH issues, including safe-space walking programs, nutritious food access programs such as farmers markets and food pantry programs, transportation from geographically isolated areas in the region, health insurance enrollment and re-enrollment programs, and language interpreter services in community-based physician offices.

SDH screenings are conducted for patients at three access points: the emergency department (ED), upon admission to the hospital, and across hospital-affiliated outpatient primary care settings. In the ED, screening for domestic violence and threats to safety are assessed for each patient. In addition, physicians and nurses request a social work assessment based on their assessment and the circumstances of each patient.

A new SDH assessment process was established in April 2016. A brief assessment is conducted by a case manager which identifies specific psychological or social indictors that trigger a need for a more in-depth interview. The interview is performed by a licensed social worker who assesses issues such as nutrition, home environment, housing status, disability and literacy (verbal and written). In primary care offices, routine screenings for SDH are conducted during patient visits. In the hospital setting, referrals to needed community-based services are made by licensed social workers and in the primary care offices, a patient advocate or nurse will often provide needed referrals. While we will continue to address these determinants, we do not agree that addressing SDHs is a *core* competency of health systems. Rather, we believe this is a community issue, and health systems must participate fully and contribute to finding solutions within the broad context of our community.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

The top barriers the hospital encounters in understanding and addressing the SDH for patients include: 1) addressing systematic SDH challenges that fall outside the core mission of our hospital and workforce, 2) the need for a cross-sector 'Health In All Policies' approach to address SDH and health inequity in SDH policy and funding decisions, and 3) the lack of resource investment by managed care organizations to address SDH across all subscribers.

Cape Cod Hospital addresses the significant regional health and disease priorities as determined by a health needs assessment through community benefits activities and hospital implementation strategies. These activities align with our charitable mission and leverage the core competencies of our facilities and workforce.
SDH are often steeped in long-standing national, regional, and local social challenges which are in need of systemic change and sustained investment. Expertise and competencies related to transforming transportation, housing, economic development, and education must be applied by qualified organizations.

Cross sector partnerships could be encouraged and supported by adopting a "Health in All Policies" approach to ensure that non-health sector policy decision-making and funding decisions are informed about how to integrate health and health equity into national, regional and local strategies to address systemic SDH issues.

A particular challenge has emerged as managed care organizations are investing only in addressing SDH needs of subscribers who carry risk for the insurer, rather than all subscribers. Insurers should widen their investment scope to support broad use of case managers and community-clinical linkages between health care providers and the community-based organization and social service agencies to address SDH most efficiently and effectively.

Additional Challenges Identified:

1) The need exists for a state-wide database of current information about available resources that range from availability of substance use disorder treatment options to programs and contacts that address specific SDH issues such as housing and food insecurity.

2) We observe Insurer case/care managers referring their subscribers back to the ER when they encounter a situation that they cannot solve or find a resource to assist a patient.

3) There is a general lack of available resources and coordinated case management to address complex nature of SDH impacting patients at a local level.

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

Cape Cod Healthcare (CCHC) does not believe that the practice of referring to out of network specialists identified through publically available information or through a vendor's proprietary rubric guarantees quality. CCHC believes that affiliation matters. The System feels strongly that in order for effective population health programs to take hold and ultimately bend the cost curve, care needs to be delivered by a tightly integrated network of providers practicing both at the top their respective licenses and under agreed upon, evidence-based care standards. This model implies that PCPs and specialists develop strong working relationships over time and that PCPs have a solid understanding of the interests and capabilities of those specialists to whom they refer. To Cape Cod Healthcare, this approach is vastly superior to referring to specialists unfamiliar to the PCP no matter the accompanying data or definitions of value. To support our approach, Cape Cod Healthcare is currently in the process of acquiring a state-of-the-art, referral management system for use across all risk lives and other applicable plans. The focus of this system will be to, again, keep care local, but also to enable our organization to monitor access and measure the quality of the referral overall including the nature of the clinical information flowing back to the PCP. The system will also enable newer PCPs to access and learn of subspecialty interests within Cape Cod Healthcare's network and, accordingly, the collective capabilities within Cape Cod Healthcare's ACO overall. Cape Cod Healthcare's ability to keep care local is supported by the variety of tertiary-level services available within the Cape Cod Healthcare system, most notably neurosurgery and cardiac surgery programs. Finally, CCHC would respectfully submit that tiering does not necessarily ensure quality outcomes and in fact can push patients into settings that are not well integrated, thus resulting in less coordinated and more costly care management.

Cape Cod Healthcare has also taken the following steps to provide increased access to patients in lower cost settings:

- Joint ventures with Shields for MRI, CT, PET scan and Falmouth Radiation Oncology services;
- Joint ventures with local physician group on a physician-based ancillary endoscopy center;
- Acquisition of low-cost physician-based ambulatory surgery center which will now begin to accept Medicaid patients, and
- Opening of four outpatient urgent care sites staffed by board certified emergency care physicians.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

i. If yes, please describe what information is included.
38T

ii. If no, why not?

Currently Cape Cod Healthcare's EHR system does not incorporate cost/quality information regarding affiliated (i.e., in-network) providers. As internal provider incentive models evolve, transparency regarding specialist performance on key population health metrics will be made readily available. Whether this information will be made available via our referral management systems or EMR, is yet to be determined.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

i. If yes, please describe what information is included.
38T

ii. If no, why not?

Currently Cape Cod Healthcare's EHR system does not incorporate cost/quality information regarding non-affiliated (i.e., out-of-network) providers. Also, Cape Cod Healthcare does not believe use of publically available cost/quality data for this purpose is an effective strategy to either improve the quality of care or to bend the cost curve. Rather, we believe integration and clinical coordination and case management will result in quality and cost advancements.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.

Physicians based at Cape Cod Hospital and Falmouth Hospital, i.e. hospitalist medicine, emergency medicine, and behavioral health, are utilizing built interfaces that allow access to "view only" electronic health records at local Federally Qualified Health Centers and a tertiary health facility. This clinical integration has been a central focus of our Physician Hospital Organization (PHO).

Each of the four of the Cape's Federally Qualified Health Centers operating on Cape Cod, and numerous independent providers have similar "view only" access. Additionally, a limited number of providers outside the service area also have "view only" access to our EMRs.

Health Center and independent practitioner access to Cape Cod Hospital and Falmouth Hospital electronic medical records is conditional upon adherence to Cape Cod Healthcare's Information Systems security, confidentiality, and access policies and procedures.

ii. If no, why not?

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

Cape Cod Health Network (CCHN), the Physician-Hospital Organization (PHO) through which Cape Cod Healthcare partners with some 375 community and hospital based physicians, participates in a variety of alternative payment arrangements. These consist primarily of global risk arrangements with embedded quality and patient experience metrics accessed through the Steward Health Care Network (SHCN)'s contracts with the major Massachusetts payers. CCHN is also taking active steps to prepare for risk through the State's pending Medicaid ACO program as well as MACRA.

The first strategy for adoption of Alternative Payment Models (APMs) involves implementation of a standard population health model that addresses health and wellness needs of Barnstable County. CCHN does not feel it is appropriate or feasible to meet the needs of the community by implementing different approaches for each risk contract in which it participates. As this model is complex and designed to be successful in the longer term, CCHN is implementing first at a manageable scale with plans to "scale up" and expand the model to all covered lives once ready. The Network will be ready once a centralized infrastructure is fully in place and provider in-office workflows and access have adapted to the needs of population health and provider EMRs, in particular, have been optimized.

Main aspects of this model include the following components:

- Management of fourteen chronic conditions most prevalent on the Cape that span eight medical specialties;
- Ambulatory case management that covers complex and chronic patients as well as transitions of care. This program includes centralized and embedded practice staff as well as home visits by both nurses and a pharmacist;
- Physician incentives related to cost, quality, patient experience and documentation for PCPs medical subspecialists and surgeons, and
- Data and analytics to support risk stratification, provider performance reporting, as well as the financial aspects of managing under risk.

In order to maximize participation and the active engagement of the providers in the PHO, CCHN assumes the downside risk under the various risk arrangements in which we participate. Under this, the second APM adoption strategies, physicians can concentrate on the business of delivering high-quality care with the support of the PHO and without fear of a negative financial impact to their practice based on factors, in many instances, out of their control. Because of the goodwill generated by this approach, CCHN is able to engage its physicians (employed and independent) as active, jointly accountable partners in the Network's population health plans; this includes their agreement to the following necessary, yet disruptive, changes to their practices:

- Participation in all ACO contracts including contracts those with Medicaid MCOs;
- All physicians will be required be live on a MU certified EMR by 12/31/16, and
- PCPs are required to accommodate up to three unscheduled patients per day.

The third strategy for adoption of APMs is to develop and implement a five-year financial plan across the system that takes into account a measured and deliberate transition to risk across all covered lives in the PHO. A rush to adoption of risk and related utilization reductions would threaten the viability of the organization overall and the health care needs of the community we are dedicated to serving. The approach is to aggressively implement a comprehensive population health program tailored to the particular needs of the Network's patient population along with incremental introduction of utilization management initiatives as appropriate. As CCHN evolves, the risk it takes on will be commensurate with the degree of readiness and at a level that ensures the quality of patient care will not be adversely impacted. Accordingly, the degree of risk taken on for each covered life will increase over time. Initially, CCHN needs to hedge against the possibility of catastrophic losses. But ultimately, CCHN cannot be profitable under risk unless utilization reductions are offset by a surplus share and the reduction in variable cost.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

Adoption of APM's represents a complete paradigm shift in terms of how health care is financed and delivered. Convention would suggest that, to get it right, significant and ongoing investment is an obvious imperative. On the contrary, Cape Cod Healthcare is facing unprecedented downward pressure on revenue dollars. Payment rates from government sources are in decline and private insurers are following suit as part of so called "transparency" that, ironically, includes no public information regarding government underpayments. The transformation of our health care delivery system is a tremendous undertaking that requires significant, incremental investment in the form of time, resources and, especially, IT infrastructure. It is clear that these factors, i.e., declining payments and the need for investment, are diametrically opposed and impede the pace of APM adoption.

Another barrier impeding APM adoption relates to plan benefit design. In particular, more thoughtful plan benefit designs could facilitate adoption of alternative payment arrangements by increasing accountability and engagement on the part of the member. Despite the need for a more balanced approach, Massachusetts seems poised to tip the scales of accountability further to the disadvantage of the provider community by promoting risk for commercial PPO members and Medicaid eligibles. Similar to the much-maligned Medicare Shared Savings Program (MSSP), under PPO risk, ACO providers are jointly accountable for the care provided to the member, but the member is not even accountable for identifying their PCP. In the case of Medicaid, providers will be accountable for member health and wellness while the member will have virtually "no skin in the game." If the payer and provider visions on this issue were aligned, plan benefit designs would encourage members to seek appropriate preventive care and participate in programs that support health and wellness. For patients with chronic conditions, benefit designs should encourage adherence to written care plans and prescription/drug therapies. For particularly high-risk patients, benefit designs should encourage enrollment in complex care programs and adherence to related recommendations by PCPs, specialists and ambulatory case managers.

Until such time as plan benefit designs evolve and provide an overarching structure to support provider assumption of risk, the lack of member accountability and engagement represents another barrier to APM adoption.

Although over the past several years Cape Cod Healthcare has made significant investments in IT to support clinical integration and the transition to population health, it will not be able to "scale up" and take on full risk across all payers until current workflows are more responsive to the demands of population health and systems are more fully integrated and optimized. For example, in the case of the ambulatory setting, physician EMRs must include embedded templates consistent with the Cape Cod Health Network's chronic disease algorithms to facilitate the ready capture of discrete quality data for downstream reporting. Regarding ambulatory case management, nurses need to be alerted to patients in distress based on warning signs specific to each patient and the condition being tracked. It is not feasible to monitor all covered lives all the time. On the contrary, it is essential to identify those most at risk and monitor their health and wellness by exception and be notified while there is still time to intervene. As envisioned, an integrated and optimized system will function as a complex web of interconnectivity in which providers of varying capacities coordinate and task one another seamlessly, while functioning at the top of their licenses. Only by development of such infrastructure will providers achieve sufficient capacity to both assume the broader scope implied by population health while enhancing patient access. Until such processes and systems are fully in place, Cape Cod Healthcare will not be ready to scale up and assume risk across all its covered lives.

c. Are behavioral health services included in your APM contracts with payers?
   Yes
   i. If no, why not?

7. **Strategies to Improve Quality Reporting.**

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

Quality transparency, reporting and tracking is integral to achievement of Cape Cod Healthcare's mission and vision.

Currently Cape Cod Hospital, in addition to the required elements from CMS, ACC, and MassHealth- all of which have different diagnostic centered areas of concentration, subscribes to eight separate registries. We report on twenty-four separate core measures, all requiring manual abstraction, validation, and clinical disruption for clarification.

The complexities of disparate reporting requirements to different insurance vendors, the wide variety of methodologies and reporting time periods increase the administrative burden. The disparity between the multiple required registries and core measure elements causes significant financial and clinical disruption to the system. Elements are extremely specific, and despite discrete data fields, most often require manual chart abstraction. Information Technology is not sophisticated enough at this time to routinely utilize "scrapers" to harvest information from free-text physician documentation.

Commercial and public "quality reporting" websites have consistently and aggressively marketed directly to consumers, each with their own methodologies and measurement focus, and then charge sales fees to hospitals to become preferred vendors for advertising rights to their products.

To address the challenges for the upcoming fiscal year 2017, Cape Cod Hospital has designated 13.7 FTEs, and almost $2.3M in resources to quality reporting efforts.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

There has been significant push back from the medical community regarding the creation of registry "template driven" documentation because this approach loses much of the integrity of the patient-centered story in the record.

Quality measurement in the national and local arenas needs to mimic those strategies that we use at the local hospital level. At Cape Cod Hospital, we look at the "drivers" of quality based on negative impact to the patient's quality of life and experience, and focus efforts in these areas. Standardized quality reporting services – with standardized IT reporting systems, standardized time frames, and focused goals that are based on patient need – would help relieve the undue burden on the hospital, and eliminate the "commercialism" of quality efforts. Certainly quality should remain focused on the triple aim, but should be prioritized based on "drivers" of poor outcomes, experiences and process and not on financial metrics that drive the cost to the system.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.

Labor Expense

Labor related challenges cannot be ignored as hospitals strive to meet the 3.6% cost growth benchmark. For the fiscal year 2015, non-provider salary expense was 34% of total expenses for Cape Cod Hospital. There are a number of challenges hospitals are currently facing and more on the horizon that will affect hospitals' ability to meet the benchmark of 3.6%.

1. Burgeoning issues related to social and behavioral health are requiring increased personnel in many areas within our organization. This increase typically does not result in any incremental revenue to offset the additional cost of care provided.

    a. One-on-one staff support in the Emergency Department and on the Medical/Surgical floors accounted for $1.2M in additional staff. Cape Cod Hospital has tried to stem this rising cost with video technology, which monitors patients remotely and connects them to staff on the floor.
    b. Increased observation within our Emergency Department resulting in increased length of stay which has not only affected the increase noted above but has resulted in increased costs with our physicians, social workers and security and most notably in nursing. The addition of FTEs needed negatively impacted the Hospital's labor cost by nearly $1M annually.

2. Legislation that requires CCH to provide benefited time to per diem staff has increased our labor expense. The hourly salary rates previously contracted with these staff was at a premium rate, assuming no benefits. This new legislation requires provision of forty hours of sick time per year. This will result in an increase in expense of both sick time granted and the additional expense of covering this vacancy with premium pay. We estimate the impact on costs to be an additional $900,000 annually.

3. Cape Cod Hospital's aging workforce poses special challenges. The current age of employed physicians and nurses within the United States is 53 years old. This aging workforce, combined with an overall growing shortage of RNs, has resulted in in increased expense. Cape Cod Hospital has needed to expand novice training, and fill critical vacancies with premium rate "traveling nurses".
    a. In FY15 the hospital spent $3M filling critical need vacancies with contract nurses, in comparison to $1.6M spent in FY14.
    b. During FY15 Cape Cod Hospital spent $1M in training costs and we expect to spend $1.6M for FY16. As a larger segment of the workforce retires over the next decade, the Hospital will be forced to fill vacancies with less experienced nurses. The Hospital will necessarily need to increase education, mentoring and training expenses. Cape Cod Hospital will continue to have to staff resource nurses on off shifts where due to contract language, most of the Hospital's less experienced nurses are scheduled. Each additional nurse to cover evening and night shifts seven days a week will increase costs $385,000, annually.

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

Exhibit C: AGO Questions for Written Testimony

1. For each year 2012 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

FY/Payer Group	Margin		% of Total NPSR
FY12	**$35,920,618**	**9%**	
Commercial	61,825,010		42%
Government	(26,451,505)		56%
Other	547,112		2%
FY13	**$19,712,301**	**5%**	
Commercial	55,462,110		36%
Government	(35,934,234)		61%
Other	184,425		3%
FY14	**$24,856,698**	**6%**	
Commercial	58,728,469		37%
Government	(34,483,526)		61%
Other	611,755		2%
FY15	**$33,208,217**	**7%**	
Commercial	60,255,922		35%
Government	(27,663,989)		63%
Other	616,284		2%

HPC Ex 2			
CCH Fy12 - Fy15			
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		
Government			
	Medicare A		
	Masshealth Standard		
	Tufts Medicare Preferred		
	Boston Medical Center		
	Blue Cross Medicare PPO		
	BMC CommonwealthCare		
	BMC CarePlus		
	Network Health		
Other			
	Motor Vehicle		
	Workers Compensation		
	Self Pay		

It is worthy to note that as a seasonal destination, Cape Cod experiences more than five million visitors each year. As a result of this influx of tourists and significant numbers of part-time residents, Cape Cod Hospital provides care to a significant amount of out-of-state visitors. For FY15, these out of state, commercially- insured patients contributed $5.5M, or 15%, 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 health care cost trends.

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
    a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

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/patients-visitors/estimate-the-cost-of-care/) where patients can find the telephone number (1-855-331-2242) to inquiry on the price for any service.

    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 analyses.

To assure accuracy and timeliness, auditing and analysis is 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 June 2016	**722**	**% Accuracy**
Zero $ Variance	**322**	**45%**
Less than $20	**127**	**18%**
Greater than $20	**273**	**38%**

As issues are identified, we work with the vendor to resolve these discrepancies. Response timeliness is achieved through the organization's process; specifically, estimates are provided at the time of patient inquiry.

    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?

With the implementation of the patient estimation technology that automates the calculation and generation of the patient estimate, Cape Cod Healthcare is able to generate accurate and timely responses to consumer inquiries for price information.