Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING AFFILIATE

September 27, 2013

Mr. David Seltz
Executive Director
Health Policy Commission
2 Boylston Street
Boston, MA 02116
Via Electronic Submission

Re: Annual Health Care Cost Trends Testimony

Dear Mr. Seltz:

This letter transmits Cambridge Health Alliance's written testimony in response to the questions from the Health Policy Commission and the Office of the Attorney General in a letter dated August 28, 2013.

I am legally authorized and empowered to represent Cambridge Health Alliance for the purposes of this testimony. I attest, to the best of knowledge, that the attached testimony is accurate and true, and sign this testimony under the pains and penalties of perjury.

Please feel free to contact me should any questions arise.

Sincerely,

Patrick R Wardell

Patrick Wardell
Chief Executive Officer
Cambridge Health Alliance

Enclosure

Cambridge Health Alliance Written Testimony
Exhibit B: Health Policy Commission Questions
September 27, 2013

Questions:

1. Chapter 224 of the Acts of 2012 (c.224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012- CY2013 and CY2013-CY2014 is 3.6%.

Summary: Cambridge Health Alliance (CHA) is undertaking a number of promising activities to improve the way that health care is delivered and coordinated with the goal of achieving the triple goals of improving health, patient experience of care, and cost-effectiveness. CHA is implementing a set of initiatives for 1) effective care management of our patients and management of total medical expenditures and 2) to improve the performance and cost-effectiveness within our health care delivery system. The Commonwealth's reports indicate that CHA is among the lowest reimbursed hospitals by commercial payers. CHA's reimbursement from major commercial payers is approximately $17.1 Million below the average commercial acute hospital rate, and improvement in reimbursement is necessary to support high value care in our communities.

   a. What are the actions your organization has undertaken to reduce the total cost of care for your patients?

Response:

CHA, a major public, safety net health system, is among the lowest reimbursed hospitals by commercial payers; a significant proportion of care that our panel of primary care patients receives is delivered by non-CHA providers who have a higher relative price point for the services rendered. Given these factors, CHA has deployed the following strategies to reduce overall cost of care to our patients:

- **A. Patient -Centered Medical Home (PCMH) clinical model to ensure a tighter connection of the patient to a primary care physician within CHA and greater control over management of the clinical conditions of all our patients. CHA achieved the highest level of NCQA medical home recognition (Level 3) for six of its primary care sites. Several CHA primary care practices are participating in the Massachusetts Patient-Centered Medical Home Initiative, and was recently recognized by the Robert Wood Johnson Foundation of one of the thirty outstanding primary care practices in the country through the *Primary Care Team: Learning from Effective Ambulatory Practices (LEAP) program.***
- **B. Expansion of our clinical model to incorporate Complex Care Management for high risk patients that integrate the ambulatory and inpatient setting. CHA has achieved initial promising results from a risk stratification initiatives to identify high risk patient for complex care interventions with a Medicaid managed care and Commonwealth Care payer cohort. Robust care management activities have led to promising results in improved care coordination and costs avoided of approximately $689,000 for enrolled patients.**
- **C. Modifications to our clinical affiliations and referral patterns to align our services with high quality, lower cost providers within our service area including our recent clinical affiliation with Beth Israel Deaconess Medical Center.**
- **D. Expansion of Accountable Care Organization (ACO) activities which include obtaining claims data to understand membership, diagnosis, total medical expense, utilization, gaps in care and risk profiles of our population.**

E. **Development of our medical and disease management processes to ensure clinically sound and appropriate care for all our patients.**
F. **Alignment of physician compensation strategies to support performance improvement in the following categories: quality, efficiency and effectiveness and patient experience of care,**
G. **Deployment of innovative care models that leverage multi-disciplinary teams and mid-level clinicians such as nurse practitioners and physician assistants to complement physicians.**
H. **Participation in payment strategies that further align our cost containment strategies for our patient population, e.g. Medicare Shared Savings/Pioneer, Dually eligible and the CMS-Community-Based Care Transition Program (CCTP), which is specifically aimed at reducing all cause Medicare Readmissions.**

Finally, it should be noted that as CHA like other providers migrating to a more accountable organization, the costs for developing these capabilities and services, which traditionally have resided within the payer community, are largely unfunded and increase our internal cost to deliver care to our patients. This is incredibly challenging in an environment where CHA's current commercial reimbursement is well below others in the marketplace and below our costs. As expressed in recent Center for Health Information and Analysis report, CHA is one of the lowest relative price providers in Massachusetts with our reimbursement for commercial insurance $17.1 Million annually below the average commercial hospital reimbursement rate. It should be noted that continued pricing disparities in the marketplace, coupled with increasing expectations to invest in infrastructure to support alternative payment models, may have the unintended impact of driving lower cost providers out of the marketplace because the economics are not sustainable.

b. What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?

Response:

CHA is currently focused on priorities to improve the patient experience of care as well as the financial improvement and efficiency within our delivery system. CHA faces persistent challenges with significant commercial insurance payment disparities and disparities in how its mix of wellness oriented services such as extensive behavioral health services, primary care, and community-based ambulatory and hospital care are poorly reimbursed in the current payment system. If CHA's hospitals were reimbursed the average commercial rate for the patient care we provide for commercially-insured patients, we would realize approximately $17.1 Million in greater annual revenue by commercial insurers to support that care. Improved commercial reimbursement more on par with the average commercial hospital rate is necessary to support the care that CHA provides for its patients and communities.

With adequate reimbursement needs as a preface, CHA has demonstrated high quality services and sustained initiatives to improve the efficiency of care. Since 2008 through the present, CHA has undertaken sustained efforts in performance improvement that have resulted in expense reduction and mitigation and improvement in revenues.

In response to the economic challenges and downward pressure on reimbursement since 2008, CHA implemented a major services reconfiguration of our health care services in 2009 – 2010, which we reported on in prior health care cost trends testimony and will briefly recap here. In our services reconfiguration, CHA consolidated its clinical services footprint while preserving core services needed by our communities. It also increased efficiencies, transitioning from three to two inpatient hospital facilities, "right-sizing" mental health services, and consolidating primary care clinics, while retaining the essential primary, behavioral health, and

acute continuum of care. CHA's reconfiguration was seen not as an endpoint but as a platform for new health care delivery and payment models that afford sustainability for safety net systems and populations. This performance improvement work is ongoing and is integral to our safety net system sustainability and ongoing services to our communities. CHA is currently implementing a multi-year initiative for financial improvement, including reducing costs and increasing revenues, in a manner that supports growth and investment in key areas that will allow us to better serve our communities well into the future.

As part of this effort, CHA, supported by a nationally recognized healthcare consulting firm, is focusing on improvement opportunities based on a comprehensive assessment of our operations to improve the process of providing health care to better support clinicians and employees, operational efficiencies, and collect the revenue available to us for the services we provide. CHA is actively implementing performance improvement in five areas: 1) Revenue Cycle; 2) Supply Chain and Non-Labor Cost; 3) Hospital Productivity; 4) Physician Practice; and 5) Behavioral Health.

c. What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?

Response:

Administrative simplification and standardization, including for referrals, claims processing, and quality measures, are certain ways that policy makers can reduce the administrative burden on providers. For example, we have hundreds of quality measures with definitions that vary across insurers.

Clarification on the roles of ACOs versus insurers in certain activities, including referral authorization and prior authorizations, will assist with reducing redundancy and administrative hurdles in care coordination.

d. What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?

Response:

Health insurers are largely responsible for setting health care premium prices experienced by consumers and businesses. Cambridge Health Alliance is a lower reimbursed provider by commercial insurers, per the Health Care Trends and Cost Drivers reports. As noted above, we strive to provide high value to our patients and communities.

2. The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of the growth in prices on medical trend and what have been the results of these actions?

Response:

CHA has been identified as a low relative price provider and among the lowest reimbursed hospitals by all major Massachusetts commercial insurers in the Health Care Cost Trends reports. The reports indicate persistent and substantial payment disparities for CHA not only on a regional and statewide basis, but it is particularly acute in comparison to other hospitals proximate to our service locations and in the Greater Boston area. Inadequate commercial insurance reimbursement to our hospital for the same level and quality

of service has contributed to financial challenges and operating losses we have incurred. Improvements in reimbursement are necessary.

3. C.224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration?
    a. What potential opportunities have you identified for such integration?
    b. What challenges have you identified in implementing such integration?
    c. What systematic or policy changes would further promote such integration?

Summary: As a major provider of behavioral health services and primary care, CHA is implementing a collaborative care model for primary care and behavioral health integration based on the "stepped care" approach. Integration of physical and behavioral health is a priority for our patient populations, and future opportunities have been identified to deploy telemedicine and enhanced care integration in transitions from acute and emergency department settings. Financial and health system barriers present challenges to this model, such as inadequate reimbursement for behavioral health and primary care services, a lack of reimbursement for some core functions such as behavioral health consultations to medical providers and care management, and fragmentation of care due to payer carve-outs of behavioral health.

Response:

CHA is a major provider of both primary care and behavioral health services. We are initiating a collaborative care model to integrate primary care and behavioral health at two primary care sites. We are interested in implementing primary care and behavioral health integration across our entire primary care system in the years ahead. CHA has also identified the promising role of telemedicine in support of the integration of behavioral and physical health.

There are reimbursement challenges with the base reimbursement levels for primary care and behavioral health care services, both of which play a critical role in population health but have been undervalued in today's health care reimbursement system. There are additional reimbursement needs for functions that are not typically reimbursed, such as the consultative role behavioral health clinicians can provide to primary care clinicians within the stepped model of care and care management needs that arise for patients who are screened and identified with behavioral health concerns.

In addition, there are systemic challenges posed to implementing such integration that relate to frequent carve-out of behavioral health services by health insurers to separate vendors. This fragments health care delivery and insurer authorization for services remains distinct for physical and behavioral health conditions. Providers, including primary care providers, do not routinely receive information from insurers that would be helpful in coordinating treatment for behavioral health conditions or follow-up post acute or emergency department setting. It would be valuable for policymakers to work collaboratively to address the financial and systemic barriers.

4. C. 224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative payment methods.
    a. Describe your organization's efforts to promote these goals.

    b. What current factors limit your ability to promote these goals?

c. What systematic or policy changes would support your ability to promote more efficient and accountable care?

Summary: **CHA has adopted innovative delivery models and participates in alternative payment models. Safety net patient population complexity, eligibility and enrollment churn, and reimbursement challenges including for commercial payers are noteworthy factors. Important findings in recent cost trends reports warrant policy action. The Attorney General's report concludes that alternative payment models "fail to mitigate historic disparities," and "risk budgets are based on providers' historic pricing and spending levels, they entrench historic disparities that are not explained by differences in quality or value." Providers, who receive inadequate reimbursement, face impediments with required investments to assume accountable care responsibilities. Policy guidance is needed to ensure that health insurance premium funding flows to provider-based organizations assuming clinical and financial responsibility in alternative payment models.**

Response:

CHA has continued to be supportive and a leader for health care reform. We have promoted these efforts through our participation in various risk and alternative payment arrangements. CHA has furthered our participation in alternative payment models for public payer populations, which together comprise 38% of CHA's panel of primary care patients. These include our recent acceptance into the Medicare Shared Savings Program and the CMS-Community Based Care Transition Program (CCTP) in addition to our alternative payment arrangements with various Senior Care Options and Elder Service Plan for Dually-Eligible Medicare and Medicaid populations, and in Medicaid and Commonwealth Care managed care. We plan to expand our efforts over the coming year with the participation in the Commonwealth's OneCare program for dually eligible populations under the age of 65.

The factors that limit our ability to promote these goals are related to the speed in which we need to invest in the development of people, systems and skills to support these efforts. Supporting these efforts with existing funding streams limits how quickly we can adapt to this change and the level of accountability and risk we can assume.

Given CHA's significant role in caring for Medicaid and low-income patient populations, there are complexities in terms of health status, social determinants of health such as socio-economic status, health literacy, housing stability, and eligibility and enrollment churn that are considerable factors in achieving gains. This is coupled frequently with reimbursement systems that are below the actual costs of care. To successfully manage and control costs associated with this line of business, the stability of the patient population is critical.

There are notable findings in the most recent cost trends reports that point to policy changes to support the promotion of accountable care across the Commonwealth. The Attorney General's 2013 report (page 19) points out that while "recent progress has been made in linking payments to value, these approaches feature inconsistent payment standards that fail to mitigate historic disparities," and that "in the future, pricing disparities will only increase if provider are all held to the same level of prince increases based on state cost growth goals or other benchmarks." Therefore, the price variation exists in both fee-for-service and global payment arrangements. Steps are needed to address dramatic price disparities. The transition to alternative payment methods on their own is not a solution, as "many risk budgets are based on providers' historic pricing and spending levels, they entrench historic disparities that are not explained by differences in quality or value" (page 24).

In addition, careful consideration and policy guidance is needed on how health insurance premium dollars should flow in alternative payment models. The Attorney General's report notes that commercial health

plans pay providers different amounts for non-claims based payments (quality payments, funding to support care infrastructure, etc.) to support alternative payment models. Given that greater accountability, responsibility for care management functions, and risk will be assumed by health care providers (than in today's insurance model), consideration should be given to how insurance premium dollars can be directed to the infrastructure and ongoing operational needs of provider-sponsored ACOs. A similar examination of insurer reserves is also warranted in relationship to the new levels of risk considered for ACOs.

5. What metrics does your organization use to track trends in your organization's operational costs?
    a. What unit(s) of analysis do you use to track cost structure (e.g., at organization, practice, and/or provider level)?
    b. How does your organization benchmark its performance on operational cost structure against peer organizations?
    c. How does your organization manage performance on these metrics?

Response:

CHA's hospital network and physician organization track costs on a monthly basis based on an annual budget approved by our Board of Trustees and Finance Committee. Performance metrics are managed and tracked on a daily, weekly, monthly and annual basis at the individual business unit level and managed via a series of monthly operating meetings. Metrics include productivity, staffing, compensation and other expenses. Benchmarks are used where available to compare our performance within the industry to like organizations. These benchmarks are published annually by several organizations (such as the American Medical Group Association, Medical Group Management Association, Sullivan & Cotter for the physician organization, and Cleverley and Associates, Applied Management Systems, FTI Consulting, PatientCareLink, among others for the hospital network).

6. Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee, as required by c.224.

Response:

CHA instituted a process for several years to provide patients with estimates of charges for both hospital and the physician organization services upon request. Generally, such requests are made by self pay patients. This process runs through our Customer Service Department, which allows us the ability to work with the patient to be assured that if the patient has an opportunity to apply for health insurance or services, that it is addressed at that time. We communicate all estimates to the patient verbally as well as in writing. With the implementation of Chapter 224 provisions effective on January 1, 2014, CHA will expand upon its current process to incorporate the new regulations.

7. After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.

Summary: State reports continue to reveal important findings that merit policy actions. Chapter 224 has not fully set forward actions needed in several areas to ensure the availability of high value health care throughout Massachusetts' communities. The Attorney General's report finds "without other fundamental

changes, a shift to global payments may actually exacerbate the price escalation associated with market dysfunction by establishing widely different per member per month rates based on historic pricing disparities," and "in the future, pricing disparities will only increase if provider are all held to the same level of price increases based on state cost growth goals." The February 2013 CHIA report revealed that CHA is the most poorly reimbursed hospital in the aggregate of commercial payers.

<u>Response:</u>
The reports issued by the Attorney General and Center for Health Information and Analysis continue to reveal important recurring findings the merit policy actions.

Aligned with our experience, the Attorney General's Report notes that market dysfunction, including market clout, has resulted in "wide variations in prices that are not explained by differences in quality, complexity of services, or other factors the health care market should reward." (page 6) "Without other fundamental changes, a shift to global payments may actually exacerbate the price escalation associated with market dysfunction by establishing widely different per member per month rates based on historic pricing disparities." (page 6). The Attorney General's report finds that providers with larger commercial market share are associated with higher prices. (page 7) CHA, a major disproportionate share hospital with a smaller commercial payer mix (18%), is highly disadvantaged in attaining adequate commercial reimbursement despite its quality of care.

The Center for Health Information and Analysis report found that the majority of health care payments continued to be made to high priced providers (80% of health care spending for acute hospitals and physicians was concentrated in higher priced providers). This was not surprising to us, but underscored concerns about the adequacy of health care funding dispersed to providers and communities across the Commonwealth. The CHIA report revealed that Cambridge Health Alliance received 0.49% of Total Hospital Payments (2012).

Another finding of the CHIA report is that private health insurance premiums are increasing with lower benefits and beneficiaries are facing more out-of-pocket expenses, including higher deductibles which have increased by 40% between 2009 – 2011. We are seeing the impact of this health benefits design and higher cost-sharing plans in our patient populations. CHA has experienced an increase in bad debt expense of nearly 67% from 2010 to 2012, from $12.8 Million to $21.4 Million, which we believe is attributable in part due to insurance plan design changes with higher deductible and co-insurance requirements.

Exhibit C: OAG Questions for Written Testimony

Questions:

1. For each year 2009 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.

Response:

Cambridge Health Alliance (CHA) currently does not have the capability to provide operating margins by payer. At this time, CHA does not have decision support performance management system capabilities with integrated financial performance management, revenue and cost accounting modules that would enable payer-specific operating margin analysis by service category and by insurance plan. CHA is working on developing related capabilities for future use.

Please find attached below in Exhibit C #1 the Center for Health Information and Analysis Financial Performance Indicators Fact Sheet for CHA for FYs 2009 through 2012. This information, including overall annual operating margins, corresponds to CHA's audited financial statements for the hospital provider network.

Cambridge Health Alliance
Exhibit C: #1

Hospital Cambridge Health Alliance	City/Town Cambridge	County Middlesex	Teaching Status[1] Teaching	Fiscal Year End[6] 6/30/2012		Number of Months Data 12	
Financial Performance Indicators	FY08	FY09	FY10	FY11	FY12	MA Industry Median FY12Q3	North East US Median FY10 [2]
Profitability[7]							
Operating Margin	-6.77%	-8.13%	-5.21%	-8.60%	-6.50%	2.39%	1.40%
Non-Operating Margin	1.25%	1.17%	1.17%	1.16%	1.14%	0.59%	0.50%
Total Margin	-5.51%	-6.96%	-4.03%	-7.44%	-5.36%	2.85%	2.30%
Operating Surplus (Loss)	($36,135,269)	($43,169,935)	($25,931,656)	($42,631,694)	($34,599,521)	–	–
Total Surplus (Loss)	($29,448,181)	($36,959,136)	($20,089,183)	($36,884,920)	($28,533,985)	–	–
Liquidity							
Current Ratio	1.12	0.79	1.14	0.59	1.07	1.51	1.58
Days in Accounts Receivable	18	17	16	18	26	39	41
Average Payment Period	91	60	53	51	51	53	60
Solvency/Capital Structure							
Debt Service Coverage (Total) [3]	0.1	-0.5	0.9	-1.4	-0.1	–	3.3
Cash Flow to Total Debt [4]	-0.3%	-5.1%	4.7%	-10.8%	-2.2%	–	15.4%
Equity Financing	40.1%	39.6%	42.8%	31.6%	36.3%	38.8%	43.0%
Other							
Total Net Assets	$164,014,968	$128,340,961	$143,756,672	$81,342,424	$101,082,229	–	–
Assets Whose Use is Limited	$15,258,053	$17,648,909	$19,562,251	$14,702,691	$8,378,650	–	–
Net Patient Service Revenue [5]	$485,330,395	$473,952,650	$442,808,592	$439,533,616	$474,396,724	–	–

FY12 fillings are based on hospital's unaudited or internal financial statements.

Data Sources: Data drawn from CHIA quarterly and annual filings.
CAVEATS: Annual data is reconciled to Audited Financial Statements. CHIA filings may not reflect all of the financial resources available to the hospital – for example, resources available through associations with foundations or parents/affiliates. Financial informatic must be interpreted within the context of other factors, including, but not limited to, management plans, reimbursement changes, market behavior, and other factors affecting performance. Hospitals may not report data for all metrics listed above. Profitability percentages may not add due to rounding.
Notes:
[1] According to the Medicare Payment Advisory Commission (MEDPAC), a major teaching hospital is one with at least 25 FTE residents per 100 inpatient beds.
[2] Northeast US 2010 Median data publishing in the "Almanac of Hospital Financial Operating Indicators", 2012 INGENIX
[3] Blank value indicates a facility with no current long term debt in the period covered. Ratio not reported on a quarterly basis.
[4] Earlier ratios have been revised to return a ratio even if there is no long term debt. Ratio not reported on a quarterly basis.
[5] Net Patient Service Revenue includes Premium Revenue.
[6] The fiscal year for Cambridge Health Alliance, Metro West Medical Center, and Saint Vincent Hospital ends on 6/30, Martha's Vineyard ends on 3/31, and Mercy Medical Center ends on 12/31. The most recently available data as of June 30, 2012 is used for the five hospitals that do not have September 30th year ends.
[7] The Financial Accounting Standards Board issued an update in July 2011 requiring the provision for bad debt to be reported as a deduction from patient service revenue in future statements of operations. While this update is not required to be implemented for al hospitals until fiscal year 2013, some hospitals have early adopted this standard. In order to maintain uniformity of financial data and comparability of financial ratios among hospitals, the Center standardized the data so that expenses and the resulting ratios for all hospitals are calculated by including the provision for bad debt as an expense item.

2. If you have entered a contract with a public or commercial payer for payment for health care services that incorporates a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk (hereafter "risk contracts"), please explain and submit supporting documents that show how risk contracts have affected your business practices, including any changes you have made, or plan to make, to care delivery, operational structure, or to otherwise improve your opportunities for surpluses under such contracts, such as any changes to your physician recruitment or patient referral practices. Include in your response any analysis of the impact of changes in your service mix, payer mix, or patient member type (e.g., HMO v. PPO, fully-insured v. self-insured) on your opportunities for surpluses.

<u>Summary:</u> CHA is participating in risk-based contracts for several payers. We are striving to improve health outcomes and wellness of our panel of patients through our care model and initiatives and to promote the cost-effectiveness of care. We have focused on effective care coordination including medical and behavioral health care within a community-based care continuum where possible, clinical affiliation with high value providers for services that we do not offer, complex care management for high risk patients, and on preventable readmissions, among other efforts.

Response:

Risk contracting has impacted CHA's business in a number of ways, much of which is outlined in the response to Exhibit B, question 1a. In addition, these contracts have impacted our approach to our business practices in the following ways:

a. **Requirements to utilize CHA services first and then preferred partners for services CHA does not offer because to advance greater clinical integration and care coordination, higher quality and more cost-effective pricing;**
b. **More focus on the performance of our primary care and behavioral health network, specifically focused on increasing patient access and care coordination to provide for effective outpatient management of health conditions and reduce avoidable utilization of inpatient and emergency department levels or care or other specialized services;**
c. **Integration of our primary care and behavioral health business lines to improve health and provide comprehensive care management to our patients;**
d. **Re-evaluation of our service portfolio to determine the best options for providing care to our patients;**
e. **Focused efforts on reducing preventable readmissions for all payers.**

We do not anticipate that our risk contracting effort will have a material change on our payer or patient mix. However, we do feel that in order to be efficient and to provide a uniform standard of care for our patients that the core principles identified above need to be available to all of our patients regardless of payer or contract status.

3. Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or government business.

Summary: CHA is using a range of financial and analytical strategies for assessing and quantifying risk. Medical expenditure budgets under global contracts are formulated based on historical total medical expense trends, adjusted for the relative risk of our patient population. This information for the most part is provided by insurers and incorporates a range of stop loss coverage. In recognition of the fact, that alternative payment models will continue to be a major influencer of CHA's financial and operational status, CHA has established a clinical affiliation with Beth Israel Deaconess Medical Center and contracting relationship with Beth Israel Deaconess Care Organization to help develop this aspect of our business.

Response:

CHA is using a range of financial and analytical strategies for assessing and quantifying risk. Medical expenditure budgets under global contracts are formulated based on historical total medical expense trends, adjusted for the relative risk of our patient population. This information for the most part is provided by insurers and incorporates a range of stop loss coverage. CHA receives a range of varying financial and quality reports and claims data from each payer and these are utilized to assess our risk and manage our patient population. In recognition of the fact, that alternative payment models will continue to be a major influencer of CHA's financial and operational status, CHA has established a clinical affiliation with Beth Israel Deaconess Medical Center and contracting relationship with Beth Israel Deaconess Care Organization (BIDCO) to help

develop this aspect of our business. We anticipate that over time this relationship will help CHA develop and support the necessary capabilities to be successful in an alternative payment environment.

Provider-based organizations are reliant on obtaining the necessary data to assess such risk arrangements from payers, including several years of underlying total medical expenditures and claims data from payers for a provider's primary care panel of patients. Providers need resources passed down by insurers for assuming new administrative, financial, and care management responsibilities under risk arrangements.

4. Please describe and submit supporting documents regarding how, if at all, you track changes in the health status of your patient population or any population subgroups (e.g., subgroups by carrier, product, or geographic area).

Summary: CHA is taking important steps in building our capacity to address the population health needs of our community and patient population within an Accountable Care Organization framework. Toward this end, CHA has developed the initial capacity to systematically support population health work and to monitor the health status of our patient population and its relationship the population health of communities within the hospital's service area through the deployment of a data analytic tool (that integrates data from CHA's data warehouse and Electronic Medical Record).

Response:

CHA is taking important steps in building our capacity to address the population health needs of our community and patient population within an Accountable Care Organization framework. Toward this end, CHA has developed the initial capacity to systematically support population health work and to monitor the health status of our patient population and its relationship the population health of communities within the hospital's service area through the deployment of a data analytic tool (that integrates data from CHA's data warehouse and Electronic Medical Record). At this time, CHA is able to readily utilize data we have within our delivery system and about community health. This work is integral to preparations for alternative payment models, as policymakers have expressed interest in developing indicators for how new accountable care organizations are charting the course for improvements in the Triple Aim. One area that has been identified is the "measurement of and fixed accountability for the health status and health needs of designated populations." The population health data analytic tool allows us to understand the profile of our entire primary care population: demographics, morbidities, hospital and emergency room utilization (CHA inpatient and outpatient locations only), as well as other elements including weight status, tobacco use status, residence/zip code, primary care site affiliation, and medical home utilization. The tool has also allowed us to compare the health status of our panel of primary care patients to the leading health indicators of our target communities. In addition, the tool allows us to look at each fiscal year separately so that we can examine progress over time.

Greater and more standardized data from payers is necessary to account for information that may be gleaned from the full complement of claims data and TME for the patient populations.

CHA has also begun payer-specific risk stratification efforts in collaboration with payers through alternative payment arrangements. These efforts are yielding meaningful opportunities to identify the risk status of populations and identify high risk patients that may benefit from complex care management.

5. Please submit a summary table showing for each year 2009 to 2012 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Exhibit 1 with all applicable fields completed.

Please attempt to provide complete answers. 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. **Responses must be submitted electronically using the Excel version of the attached exhibit. To receive the Excel spreadsheet, please email HPC-Testimony@state.ma.us.**

Response:

Exhibit C, Question #5 incorporates total revenue for CHA's Hospital and Physician network. In some circumstances, risk arrangements may not incorporate both our hospital and physicians, and data represents an aggregated result of these contracts. CHA's physicians participate in risk contracts with commercial payers (Blue Cross Blue Shield, Harvard Pilgrim, and Tufts Health Plan), while its hospitals remain under fee-for-service or pay-for-performance contracts. The data is supplied in total (not apportioned by HMO and PPO), as systems are not presently in place to track at this level. The data exhibits the level of reporting in place during a particular fiscal year. Therefore, conclusions should not be drawn about the relative changes in reimbursement or shifts in payer-related activity year-over-year.

6. Please identify categories of expenses that have grown (a) 5% or more and (b) 10% or more from 2010 to 2012. Please explain and submit supporting documents that show your understanding as to the factors underlying any such growth.

Summary: CHA is undertaking rigorous multi-year financial improvement initiatives. This builds on a major services reconfiguration that reduced annual hospital operating expenses by $42.8 Million between FYs 2009 and 2010, where service line expenses were reduced by 8.4% and the workforce decreased by 13%. Since then, CHA has maintained expense mitigation improvements while facing health care inflation, targeted investment needs, and reimbursement cuts in Medicare and Medicaid. CHA's total service line expenses increased by 8.4% between FYs 2010 and 2012, with annual increases of 2.8% and 5.5% in FYs 2011 and 2012 respectively, related to growth in inpatient and outpatient care. Targeted investments were made in primary care, ACO and Patient-Centered Medical Home development, and information technology requirements.

Response:

CHA is undertaking rigorous multi-year financial improvement initiatives, including those focused on operating expenses and efficiencies. This builds on intensive work CHA led in recent years including a major services reconfiguration that reduced annual hospital operating expenses by $42.8 Million between FY 2009 and FY 2010. CHA reduced its service line expense by 8.4% and reduced its workforce by 449 full time equivalent (FTEs) below 2008 levels (13% decrease) in FY 2010 in direct relationship to the reconfiguration.

Since that time, CHA has worked to maintain those expense mitigation improvements while facing health care industry inflationary pressures, the need to make targeted investments, and downward pressure on government payers including Medicare and Medicaid. CHA has held inpatient expenses to less than 1% inflation in the two year period (2010-2012). Volume-adjusted outpatient expenses have been limited to a 2.6% increase in FY 2011 and 1.6% increase in FY 2012.

CHA's total service line expenses increased by 8.4% between FY 2010 and FY 2012, with a 2.8% increase in FY 2011 over the prior year and 5.5% in FY 2012 over the prior year. A contribution to the service line increase was growth in inpatient (6.6%) and outpatient (3.5%) care during this period.

Between FY 2010 and FY 2012 CHA has incurred a 7.6% two-year increase in supplies and other non-staffing expenses (a 3.7% annual increase in FY 2011 and a 3.8% annual increase in FY 2012), in part to support volume growth.

Total staffing expense represents 69% of overall service line expenses. Total staffing expense increased by 8.8% from FY 2010 to FY 2012, or 2.4% in FY2011 and 6.3% in FY2012. About 31% of the staffing expense increase is attributable to increases in benefits, expenditures for which grew by 13% from FY 2010 to FY 2012. A considerable contributor to the benefits increase is CHA's responsibility for post-retiree health benefits for the subset of its employees related to the former municipal hospital, which grew by 48% from FY 2010 – 2012. CHA has taken significant measures to constrain hospital salary inflation over this period (2010-2012) by implementing a freeze on wage and union step increases and reducing manager benefit time by five days in FY 2010, limiting salary increases to 2.5% for six months in FY 2011, and again freezing non-union staff salaries in FY 2012. As a public hospital, CHA has a significant proportion of unionized staff with approximately 69% of its employees represented in 14 collective bargaining units. Contractual union step increases range from 2% to 4.5% annually in FY 2012.

CHA has made targeted investments both in personnel and capabilities in key areas to support increasing community needs and access, such as primary care. In addition, CHA has made targeted investments in Accountable Care Organization and Patient-Centered Medical Home capabilities such as risk stratification and panel management, and significant information technology investments to achieve federal Meaningful Use requirements and to support dental services information technology systems and revenue cycle.

CHA had an increase of 66.9% in bad debt expense from $12.8 million in FY10 to $21.4 million in FY12. Some portion of this increase is believed to be attributable to the growth in prevalence of high-deductible health plans and greater beneficiary cost-sharing, which in many instances translates into de facto rate reductions to providers as patients face hardship and are unable to make their copayments.

7. Please describe and submit supporting documents regarding any programs you have that promote health and wellness (hereinafter "wellness programs") for (1) patients for whom you are the primary care provider; (2) patients for whom you are not the primary care provider; and (3) employees. Include in your response the results of any analyses you have conducted regarding the cost benefit of such wellness programs.

Summary: **With our public and community health orientation, CHA is promoting health and wellness for our patients including those who are on our primary care panels and those who utilize services within our organization. We collaborate with public health and community organizations to promote the health of our overall communities. This year, CHA was recognized for its public health and clinical care collaborations with the City of Cambridge, through the inaugural Robert Wood Johnson Foundation Roadmaps to Health Prize, awarded to six communities across the country for outstanding community partnerships that help residents live healthier lives. We have also launched an employee wellness campaign.**

Response:

CHA's delivery system is largely comprised of wellness oriented services, including significant primary care and behavioral health services. Our advancing Patient-Centered Medical Home model of care is focused on promoting the health and wellness of our primary care population. Through this model, we are initiating innovations to improve the integration of behavioral health services with primary care, deploying primary care-based complex care management for high risk populations, improving chronic disease care such as diabetes, and population health. For patients for whom we are not the primary care provider, CHA makes

efforts to connect unaffiliated patients with primary care, including those patients presenting in an emergency or acute care setting.

Cambridge Health Alliance offers an array of wellness oriented benefits to CHA employees and their families. CHA is promoting fitness through several initiatives including employee discounts for membership in a variety of local fitness clubs and YMCAs, a CHA Walking Club initiated in 2013 and supported the organization of CHA teams that participated in the Boston Heart Walk held on September 7, 2013. CHA also offers the Quit For Life® program tobacco cessation benefit to all CHA employees, spouses and eligible adult household members. On our intranet, CHA publishes links to local wellness resources including:

- **Wellness Calendar that lists events such as Farmer's Markets and Community SA pick-up locations and times for communities within our primary service area.**
- **Physical Activity and Exercise directory of community programs, including Cambridge in Motion, a Somerville Family Resource Guide, lists of parks and playgrounds in our primary service area towns, and more.**
- **Hosts a CHA Wellness Blog.**