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 and CY2013 and CY2012 and CY2014 is 3.6%. What are the actions your organization has undertaken to reduce the total cost of care for your patients? 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? What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality? What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?**

   A principal rationale for forming Lahey Health was a perceived value gap in our regional marketplace – insufficient access to locally based, high quality and lower-cost care. The ultimate goal is a balanced and coordinated system characterized by optimal distribution of health care services, thoughtful utilization of clinical and financial resources and a regionalized platform for effective population health management. Our most critical cost reduction efforts involve:

   - Restructuring of care network components to comprehensively address accessibility
     - Inclusive of physical care sites, service scope, availability/scheduling, personal, cultural and gender-specific accommodation and multimodal communication channels between patient and provider
     - Deemphasizing the hospital and urban centers as hubs
   - Reorientation toward and substantial investment in the services, providers and infrastructure that prevent illness, proactively identify and diminish risk, and maintain and extend healthy lives
   - Redesign of care models to hardwire multi-specialty integration, team-based approaches and cross-continuum coordination
   - Meaningful and enduring realignment of incentives such that simultaneous achievement of more effective (better quality) and more efficient (less costly) care is possible

   While these strategies accurately describe Lahey Health's long-term approach to reducing health care expenditures, we recognize the transformative and fundamental change required. To remain sustainable in the near-term and incrementally reduce costs, Lahey Health has pursued expense management and operational cost control tactics, many of which were the direct result of the Lahey-Northeast partnership.

   The Lahey-Northeast partnership enabled centralization of services at the system level, built scale and critical mass to more broadly distribute costs and risk, and identified both waste to be eliminated and best practices to be replicated. More detailed descriptions of cost-reduction initiatives and examples of resulting savings are provided below.

   - Consolidation of key functions and infrastructure at the system level, which has resulted in over $4.5M in savings to date (and projected to yield $40M in savings over the first five years of operations)
   - Establishment of system wide leadership positions dedicated to reducing inappropriate utilization and coordinating care - Vice President of Care Management and Medical Director of Care Transitions
   - Organization-wide information technology platform investments in Oracle/PeopleSoft, Orion health information exchange, athenaClarity, and Epic to accelerate information sharing and coordination

- Unified (relevant) cost and quality data reporting and benchmarking, most notably University Healthcare Consortium (UHC)
- Continuous and standard workforce management processes, including metrics-based assessments of open positions
  - Achievement of department staffing levels at or below the University Healthcare Consortium (UHC) 25th percentile
- Creation of supply chain analysis and value-driven group purchasing task forces
- Cultivation of stronger performance improvement capabilities
  - "La^{3}hey Thinking", an internally developed performance improvement system grounded in LEAN thinking and the principle that significant impact can come from modest change. This framework is physician-driven to create and maximize value at the point of service.
  - Six Sigma teams trained at the system level and deployed locally to analyze processes from operating room throughput to appointment scheduling processes
- Identification and systematization of best practices and policies, with emphasis on consistent use of evidence-based standards and clinical resource utilization management
- Establishment of a unified physician management services organization

Additionally, our new system establishes the foundation from which to more effectively pursue long-term cost reduction goals.

- Community and tertiary teaching hospital settings allow for redirection of care to the most clinically appropriate and cost-effective setting
- Contiguous geographic service areas provide opportunities to appropriately distribute care regionally and improve local and lower-cost access
- Combination of service scopes broaden care continuum coverage and enable development of multidisciplinary care models to manage chronic and co-morbid patients more effectively
- Different physician-hospital relationship models create new risk-sharing and incentive alignment opportunities

Primary limiting factors include:

- Capital and operating resource requirements to fund innovation and establish a robust population health management infrastructure
- Current reimbursement model continues to reward volume regardless of value
- Restrictions on sharing of pharmaceuticals among partner organizations
- Consumer perceptions of the relationship between prestige and quality health care

- Reliance on payer claims data to support success under risk-based contracting
- Inherent operational inefficiencies associated with academic mission components

The most impactful systematic or policy changes to reduce costs without reducing quality include:

- Funding to pilot innovative care delivery models
- Improved health plan benefit design to incorporate patient engagement initiatives
- Partial subsidization of primary care and care management resources for the chronically ill
- More timely and comprehensive reporting of payer claims data, particularly for patients with chronic disease
- Limitations on health plan administrative retention and standardization of health plan administrative requirements
- Incentives for payor/provider collaboration and co-investment in care management infrastructure to reduce current duplication of utilization and case management outreach

As a provider only, Lahey Health has limited ability to ensure that reductions in health care costs are passed along to consumers and business, with the exception of our employees, and though indirectly, by maintaining a low-cost position to minimize consumer cost-sharing burden.

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?**

Lahey Health employs a conservative pricing philosophy relative to the majority of Boston metro-area providers. Prices are reevaluated annually and set at a level just above the insurer's fee schedule amounts. This has three important results:

- Modest, if any, increases in patient cost sharing (a core element of Lahey Health's pricing philosophy)
- Prices are generally much lower than peer organizations
- Minimal year-to-year fluctuations in pricing (FY2012 – FY2013 price increase is approximately 1.3%)

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? What potential opportunities have you identified for such integration? What challenges have you identified in implementing such integration? What systematic or policy change would further promote such integration?**

Lahey Health promotes integration of mental and physical health by directly embedding behavioral health expertise and services into primary and specialty care practices to support holistic and person-centered care. We have historically focused on the adult population, in particular those over age 65+, given the disproportionate impact of behavioral health challenges for this age cohort, and our nationally recognized geriatric primary care and behavioral health providers co-evaluate and co-manage this sub-set of patients.

Our vision is to establish a multidisciplinary and coordinated delivery and management system that engages patients and their families to proactively identify issues and successfully manage both mental and physical health. We aspire to evidence our vision achievement by improving both behavioral and physical health status and reducing the overall cost of care for both providers and patients.

Through the LH&MC Department of Psychiatry and Behavioral Medicine, the robust network of Lahey Health Behavioral Services (LHBS) and the Lahey Health Senior Care (LHSC) (in addition to affiliations with the Massachusetts Behavioral Health Partnership (MBHP) and North Shore Collaborative), Lahey Health continuously looks for opportunities to maximize these relationships to strengthen and further integrate mental and physical health services:

- "Curbside" consultations, co-evaluation and collaborative treatment of patients in conjunction with select specialties and subspecialty programs for which behavioral health issues are prominent, including cardiac rehabilitation, transplantation, and bariatric surgery
- Incorporate psychiatric, emotional/wellness surveys, and substance use evaluations, as well as behavioral health navigators, into our system wide patient centered primary care model, beginning with pilots in select primary care sites
- Educate and train providers to better identify and address behavioral health issues or co-morbidities that may go undiagnosed in a traditional primary care settings
- Facilitate referrals and streamline access to behavioral health consults by leveraging centralized EMR and scheduling capabilities
- Network wide implementation of Epic is intended to advance integration by streamlining access to comprehensive patient health data to improve timeliness and efficacy of decision-making across providers, as well as foster virtual care coordination

Infrastructure and associated costs have been the primary challenges identified in implementing integration plans for behavioral and physical health. Examples include:

- Educating and training, and associated workforce development costs, for clinical and non-clinical providers behavioral and primary care providers
- Establishing a clinical model expansion to a team-based setting that promotes the integration of behavioral and primary care
- Allocation of organizational resources properly to account for fluctuations in patient demand within individual practices
- Integration of and lack of interoperability between multiple, diverse EMRs and the behavioral health system

- Payment and reimbursement policies that do not align incentives to promote integrated care and interfere with the incorporation of behavioral health into care teams
- Concerns over patient privacy and provider sharing
- Prevention and early identification and intervention of behavioral health issues for young children and their families

Lahey Health concurs with Behavioral Health Integration Task Force findings regarding the primary policy changes needed to comprehensively support behavioral and physical health and wellness:

- Incorporating behavioral health payments into alternative payment methodologies to encourage providers to be proactive in planning and reactive to the needs of behavioral health patients
- Ensuring reimbursement across all payors for all child behavioral health screenings
- Aligning performance measures, such as quality, across innovative care delivery models like that patient-centered medical home pilot

4) **C. 224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alterative payment methods. Describe your organization's efforts to promote these goals. What current factors limit your ability to promote these goals? What systematic or policy changes would support your ability to promote more efficient and accountable care?**

As it relates to innovative care delivery, Lahey Clinic's care model since inception – the group practice model – has featured blended specialty co-location, the expectation of team-based care and frequent real-time multispecialty consults. As a system, Lahey Health actively promotes care model innovation and as previously noted, one of our core long-term cost reduction aims is redesign of care models to hardwire integration and coordination. Other promotion efforts include:

- Funding implementation and training costs for health IT hardware, software and tools to more effectively communicate, share information and coordinate care (e.g., Epic, athenaClarity)
- Deploying care model assessment and transformation teams to primary care practices to implement patient centered medical home principles, support patient engagement and self-management, and facilitate practice transformation and NCQA certification
- Providing clinical pharmacist support to physicians to identify opportunities for more cost-effective prescribing practices and pinpoint patients with fill-rate gaps for chronic disease management medications
- Using case managers to schedule post-discharge follow-up appointments and assess home care needs
- Institution of emergency department clinical management protocols such as foot exams for all diabetic patients regardless of reason for visit, dedicated ED case manager follow-up based on risk-profiling and patient engagement assessments
- Integrating translational and comparative effectiveness research seamlessly into patient care
- Dedicating system resources to unified quality, safety and cost performance data capture, tracking, benchmarking and reporting

Alternative payment methodology involvement is detailed throughout Lahey Health's responses in Exhibit C, and include sponsorship of a Medicare Shared Savings ACO, pay-for-performance with cost and quality-based upside potential, pm/pm budget contracts, tiered network participation and CMMI Bundled Payment-for-Care Improvement Program.

The barriers to and policy initiative recommendations associated with care model innovation and alternative payment approaches mirror those cited in the response provided to Exhibit B, question 1.

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

As a member of UHC, Lahey Health tracks operational costs on multiple metrics and at multiple levels throughout the organization – system level, facility level, department level, operating unit or cost center level, practice level and provider level. Furthermore, operating cost metrics are incorporated into incentive compensation methodology, including at the system level. Some examples of key metrics tracked include[1:]

- Adjusted cost per discharge
- Price per discharge and patient day
- Average length of stay
  - In 2012, LH&MC was the lowest cost academic hospital nationally[2]
  - Additionally, for at least the last eight quarters of measure, LH&MC has performed in the top quartile or better[3] on all UHC hospital wide cost, price and average length of stay metrics
- Labor, supply and drug expenses per patient
- Operating costs per member per month (specific to risk contracts)

[1] Indicators listed are all case mix and wage index adjusted; certain metrics apply more complicated formulas to determine intensity or weighting factor. The same metrics can be tracked at multiple levels of the organization.
[2] Out of 116 academic medical and major teaching hospitals, or 95% of all academic/teaching hospitals nationally. Source: University HealthCare Consortium, Q1-Q4, 2012.
[3] For cost and price metrics, the top quartile is the 25th percentile; for quality and safety indicators, the top quartile is the 75th percentile.

LH&MC is a member of multiple benchmarking organizations including UHC and Council on Teaching Hospitals (COTH). As of 2013, all Lahey Health partners have been integrated on the UHC platform to streamline reporting, ensure consistency and accurately capture system wide performance. As highlighted in Exhibit B-5, Attachment A, UHC quarterly efficiency reports measure comparative efficiency by area; costs per unit in pharmacy, supply chain, and CMI adjusted costs and expenses per case; and compares Lahey Health metrics to teaching, academic, and community hospitals.

In addition, Lahey Health routinely leverages publically available national and state performance data to derive meaningful benchmarks. These sources include CHIA, HPC and the OAG at the state level, and Centers for Medicare & Medicaid Services (CMS) Core Measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Physician Quality Reporting System (PQRS), Healthcare Effectiveness Data and Information Set (HEDIS) and the Agency for Healthcare Research and Quality (AHRQ) at the national level.

Lahey Health and its members manage metrics performance in the following ways:

- Lahey Clinic has developed incentive compensation targets (for 900+ physicians and managers) that are outcomes based and reflect our relative performance on value (cost/quality) indicators as well as experience of care indicators
- We utilize multiple data capture, tracking and benchmarking tools and systems to comprehensively monitor, report, and compare performance (see metrics and benchmarking sources identified above)
- Transparent exchange of performance metrics across the organization at quarterly town hall meetings

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.**

In collaboration with health plans and prior to January 1, 2014, Lahey Health will finalize its cost information disclosure process. Lahey Health plans to estimate costs at the CPT code level using fee schedules, and provide responses within two working days of request. For our insured patients, we will also indicate the respective health plan's toll-free phone number and website resources.

We address patient requests for cost information today and are able to support accurate estimates of out-of-pocket expenditures. Further, Lahey Health representatives attended a recent Massachusetts Hospital Association (MHA) seminar on the topic, and are currently establishing the vendor selection process and implementation timeline.

Lahey Health plans to make investments in infrastructure as well as human resources – an anticipated addition of two (2) additional patient navigator FTEs who will support this requirement through focusing on communicating with patients about their care, benefits, and out-of-pocket expenses.

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.**

Perhaps the most striking difference between the two reports is in identification of the core driver of health care costs in Massachusetts. The OAG report attributes rising health care costs to provider price increases. In contrast, the CHIA report concludes that actual medical expenses borne by providers rose 3.8% annually, but insurer retention (funds not spent on medical care, but retained for administrative expenses and profits) increased more than 20% in each of the last two years. Therefore, while actual medical expenses recently have been increasing at roughly the rate of inflation, premiums continue to rise at a rate about one-third higher, largely due to non-medical cost growth.

As always, and as reflected in our response to question 1, Lahey Health takes its responsibility to control health care costs very seriously, and sees delivery network restructuring, reorientation toward proactive health care services, care model redesign, and incentive realignment as critical elements of driving sustainable change.