Mercy
MEDICAL CENTER

Our mission is to heal. Our passion is to care.

271 Carew Street
P.O. Box 9012
Springfield, MA 01102-9012
413-748-9000
mercycares.com

September 27, 2013

David Seltz, Executive Director
Massachusetts Health Policy Commission
Two Boylston Street
Boston, MA 02116

RE: Testimony for Annual Health Care Cost Trends Hearing - October 1 and 2, 2013

Dear Mr. Seltz:

In response to your letter of August 28, 2013, Mercy Medical Center submits the attached written testimony. Mercy and Sisters of Providence Health System share a compelling mission to be a transforming, healing presence in the communities we serve. With Mercy serving as the hub, SPHS is committed to continued development of a high-value, integrated, patient-centered network. This network utilizes the full SPHS continuum of care, including acute care, behavioral health, primary care, rehabilitation, long-term care, home care, lab services and end-of-life care. The SPHS network includes:

- *Mercy Medical Center*: A 182-bed, acute care hospital located in Springfield. Mercy's hallmark programs include the Sister Caritas Cancer Center, specialized neurosurgery, the Family Life Center for Maternity, a newly-expanded Emergency Department and the state-of-the-art ICU.
- *Weldon Rehabilitation Hospital:* A 60-bed hospital-based rehabilitation center located at Mercy.
- *Providence Behavioral Health Hospital:* The 126-bed behavioral health campus of Mercy, located in Holyoke, is one of the largest providers of acute behavioral health services in the Commonwealth. Services include inpatient and outpatient psychiatric care for children and adults, inpatient substance abuse treatment, outpatient Methadone treatment and Suboxone treatment.
- *Brightside for Families and Children:* Offers a range of social support services for families with psychiatrically distressed children. Services include home-based family stabilization and treatment, community support programs, as well as specialized neuropsychological evaluations.
- *Mercy Internal Medicine Service:* Mercy's pioneering hospitalist program is a group practice composed of Board-Certified hospitalists devoted to providing hospital care, 24/7.
- *Mercy Home Care:* One of the largest home health providers in Western Massachusetts.
- *Mercy Hospice*: patient-centered, culturally-competent, end-of-life care.
- *Mercy Continuing Care Network:* Comprised of six long-term care facilities (including *Farren Care Center* – a specialized facility for individuals who are medically involved and mentally ill), an adult day health program and a soon-to-be-launched PACE program.

I am legally authorized and empowered to represent Mercy Medical Center for the purposes of this testimony. I hereby certify under the pains and penalties of perjury that Mercy has made a diligent effort to respond to the foregoing questions, and that, to the best of my knowledge and reasonable belief, the foregoing answers are true and correct.

Sincerely,

Thomas Robert
Sr. Vice President of Finance and CFO
Sisters of Providence Health System

A member of the Sisters of Providence Health System and Catholic Health East, sponsored by the Sisters of Providence.

Mercy Medical Center - EXHIBIT B: HPC Questions and Written Testimony

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

Mercy is currently engaged several initiatives to reduce the total cost of care for our patients, including the implementation of the Achieving Clinical Transformation (ACT) program, the Delivery System Transformation Initiatives (DSTI) program, and Mission Critical.

ACT initiatives are focused on improving clinical outcomes and enhancing quality and patient safety. ACT underscores the Mercy commitment to high quality patient care and patient satisfaction. Elements of ACT involve gathering information that identifies clinical and patient safety processes that improve outcomes, efficiency and financial performance. Currently, efforts are focused on reducing or eliminating five hospital-acquired conditions as a way to effect the desired clinical transformation. Specifically, these conditions are:

- Catheter-associated urinary tract infections
- Falls resulting in injuries
- Central line infections
- Ventilator-associated pneumonia
- Stages II, III and IV, deep tissue injury and pressure ulcers

Along with these clinical and patient safety processes, the ACT initiative also systematically looks for opportunities to improve operating and financial performance. Examples of activities or processes that will be revised and analyzed include:

- Utilization Management - Length of stay, operating room utilization, readmission within 30 days of discharge, payment denials
- Comprehensive Care Management - Movement through the Continuum of Care
- Clinical Improvement - Prevention of hospital acquired conditions
- System-wide Opportunities - Productivity improvements, information technology enhancements, supply costs and other savings

Mercy's DSTI projects build on and are aligned with the ACT initiatives. The projects are like puzzle pieces converging to shape a vision for the future. Mercy is actively implementing the following DSTI Projects:

- *Enhance Primary Care Capacity and Access*: This project includes a primary and specialty care building expansion on the Mercy Medical Center campus that helps to further develop Mercy's integrated care network with physician groups, enhance patient access and improve care transitions for hospital patients. With a physician-led effort to develop and implement a PCP recruitment and retention strategy for Greater Springfield, combined with a new affiliation agreement with UMASS Medical School, this project is attracting new primary care physicians to the area.
- *Integrate Physical and Behavioral Health Care in Mercy's ED*: This project developed and implemented a new model operational plan that integrates physical and behavioral health care for

patients that present with significant mental health and substance abuse issues (MH/SA) in Mercy's ED. This project has expanded clinical assessment resources into the newly-renovated "Psych Pod" in the Mercy ED. The project has also collected qualitative and quantitative baseline measures for MH/SA patients and is implementing a rigorous quality improvement process to reduce ED length of stay, lower costs, increase ED patient flow and improve the quality of care.

- *Re-engineer care coordination and management (Care Connect)*: This project designed and implemented a new, patient-centered, care coordination and management system that integrates departmental and hospital system workflows to reduce the time it takes to place patients in available beds, treat them effectively and discharge them safely to the next appropriate level of care. The project included the development of the CareConnect Hub that utilizes new IT system architecture, real time applications and new staffing to track all inpatients and ED patients in real time. This project will transform the current state of care management at Mercy Medical Center to reduce case costs, average length of stay, patient flow times, discharge process times, readmission rates, ED holds and the rates of ED patients who leave without being seen, while boosting quality measures and patient satisfaction

- *Patient-Centered Care Transitions for Patients at the Highest Risk of Readmission*: This project designed a patient-centered care management model and intervention for "high-risk" patients with the highest rates of 30-day hospital readmissions, using the STAAR Chart Review Tool. The project will re-engineer the hospital discharge process for all admitted patients and develop a home-based disease management program for all patients identified as "High Risk."

- *Develop Capacities to Alternative Payments (ACO):* This project formalized and attempts to bring to scale the existing, PCP-driven, "virtual ACO" of Mercy and a large physician group into a free-standing legal entity that will as a model for developing relationships with payers for global payment systems. A major focus of the project is to increase HIT connectivity for Health Information Exchanges (HIE) between Mercy Medical Center and collaborating physician groups, to deliver expanded care management, disease management and case management services for larger groups of complex patients/beneficiaries.

- *Develop Capacities to Manage the Care of Complex Patient Populations (PACE)*: This project is increasing a variety of organizational operating and learning capacities to serve complex patient populations in value-based purchasing and alternative payment systems. From site selection, physical infrastructure development, service mix and employee skills training for managing patients and resources in new payment systems, to new care coordination, cost management and accounting systems.

- *DSTI Learning Collaborative*: Mercy is collaborating with other DSTI hospitals in a Learning Collaborative. DSTI projects have the potential to significantly transform the care experience for Massachusetts residents served by safety net hospitals. As important as individual hospital efforts will be, there is even greater potential value in leveraging the hospitals' efforts for delivery system transformation through the sharing of best practices. Participation in the learning collaborative is providing a forum for DSTI hospitals to learn from other providers that share similar goals and to capitalize on potential synergies in their efforts.

Mercy's Mission Critical is focused on reducing operating expenses and has been ongoing fat Mercy for several years. In recent years, Mercy utilized Mission Critical to reduce operating costs by more than $10 million. The goal of these measures has been to improve the financial performance in order to continue to serve the most important needs of the greater Springfield community. Behavioral health is one of those significant and under-met community needs.

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?

Within its Delivery System Transformation Initiative plan, Mercy is engaged in a wide-range of activities aimed at reducing the total cost of care, improving quality and boosting operational efficiencies. One of the biggest opportunities to improve quality and efficiency of care is Mercy's *Re-engineer care coordination and management (Care Connect)*. A Cross-departmental Hub is now tracking all inpatients and ED patients in real-time. To accomplish this goal, Mercy contracted with Care Logistic™ to develop, with considerable hospital staff input, the new operating system internally known as CareConnect. CareConnect integrates departmental and hospital system workflows, providing actionable data, to both clinical staff and patients, on key performance indicators, such as, but not limited to, length of stay (LOS), patient flow times (e.g., the time it takes to get a patient's bed ready or the time it takes to obtain an MRI), discharge process times, re-admission rates, the number of ED patient holds (ED patients awaiting hospital beds), and patient satisfaction levels upon discharge.

To implement the new CareConnect model, the hospital hired twenty-four new care coordinators and trained more than 300 hospital staff to work within the new and improved model of care management. Since CareConnect went live in April of 2013, hospital staff members in all departments are able to follow each patient throughout his or her stay on a visual board. In the CareConnect Hub there are large-screen monitors displaying each patient's identifier, DRG, risk status and real-time tracking of all scheduled tests and procedures. The underlying objective is to significantly reduce or eliminate the white space in a patient's hospital stay-the time the patient spends simply waiting for a bed or for transportation to radiology. With a transformative care coordination and management system such as CareConnect, hospital staff members are now be able to see how much time has been allotted for each ordered departmental service for each patient.

Mercy is at the beginning of the CareConnect process, but there is growing evidence that the CareConnect will help to reduce average LOS, increase operational capacities, lower case costs, boost quality metrics and improve patient satisfaction scores. Reductions in LOS can be a prime driver to lowering health care costs and increasing operational efficiencies. Other hospitals using the Carelogistics model have reported marked reductions in LOS, reductions in infection rates, such as, central line-associated BSI, ventilator-associated pneumonia and Foley-related urinary tract infection, and surgical site infections.

Financial challenges are the most significant factor limiting Mercy's ability to address transformational opportunities such as CareConnect. With payer mix dominated by Medicaid and lower than average commercial payments, Mercy is low cost provider that also provides high quality care. The most significant challenge that Mercy faces is generating a sufficient operating margin to make the investments necessary to continue transformation.

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

Reimbursement policies related to government and government funded payers should be addressed to assure that payment levels cover the cost of care. Adequate reimbursement rates from MassHealth, MMCOs and Health Safety Net would provide the resources for hospitals like Mercy to operate more efficiently and improve quality.

Reimbursement policies specific to behavioral health services are a significant challenge to more efficient operation for Mercy / Providence Behavioral Health Hospital. A recent analysis conducted by the Public Consulting Group for the Massachusetts Behavioral Health Partnership indicated that for acute care hospitals within the MBHP network rates of reimbursement covered less than 70% of the cost of care. The report used the 403 Cost Reports to quantify cost and it also found that the 403 Reports did not capture all the costs of providing care. The PCG Report validates the experience of Mercy and Providence Behavioral Health Hospital. In 2012, Providence Behavioral Health Hospital had an operating loss of approximately $11.8M prior to supplemental funding (DSH & DSTI). The operating loss on services provided to children and adolescents, included in the total loss, was $4.2M. Adequate rates of reimbursement for behavioral health services would help behavioral health care providers to operate more efficiently and improve quality.

Other policy changes that would encourage efficiency without reducing quality include, include: effectively using community based care for non-emergent and mental and/or substance abuse conditions to provide 24/7 care, and an increased emphasis on the development of strategies for PCP recruitment in urban areas.

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

Mercy has taken several steps to assure that reductions in healthcare costs are passed on to consumers and businesses. Mercy is one of the most cost effective hospitals in Massachusetts as evidenced by the Center for Health Information and Analysis Report, "Health Care Provider Price Variation in the Massachusetts Commercial Market" (February 2013), which showed Mercy to have a blended relative price that is significantly lower than the average relative price for hospitals in Massachusetts. Mercy has also been nationally recognized for delivering high-value care. Cleverly and Associates, a leading health care financial consulting firm specializing in operational benchmarking and performance-enhancing strategies, recognized Mercy as both a "Community Value Top 100" and "Community Value Five-Star" hospital in both 2010, 2011, 2012 and 2013. We are actively engaged in discussions with employers and insurers regarding the development of selective network products which would leverage the Mercy value proposition. These networks would pass along savings to consumers and businesses through lower premiums.

Mercy's accountable care initiatives also pass along costs savings to consumers and businesses. Mercy's Medicare Advantage participation ("virtual ACO") provides that consumers share in the savings associated with accountable care through reduced premiums. Additionally, the Medicare ACO Shared Savings Program, which Mercy is participating in through ACONE, provides that 50% of the savings created through the MSSP would be retained by Medicare. Ultimately, these savings will accrue to tax payers and consumers.

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?*

Mercy Medical Center faces financial challenges that are unique to Massachusetts "Safety-Net Hospitals" because of the hospital's significantly higher percentages of Medicaid patients and significantly lower percentages of patients covered by commercial insurance payers (approximately 28% of Mercy's payments are from Medicaid and Medicaid-like payers and approximately 25% are from commercial payers) Converting a potential liability into an asset, Mercy has used this challenging payer mix to become one of the most cost-effective, acute care hospitals in the Commonwealth. As evidenced by the Center for Health Information and Analysis Health Care Provider Price Variation Reports and the Attorney General Examination of Cost Trends Cost Driver Reports Mercy has prices that are below the relative average for hospitals in Massachusetts. At the same time, Mercy and the Sisters of Providence Health System have pursued a number of strategies as part of our DSTI projects (sited in response to Question 1a.) that target the "triple aim," better care for individuals; better health for populations; and reduced per capita costs.

Mercy has utilized the work of the Center for Health Information and Analysis and the Office of the Attorney General to highlight its value proposition in negotiations with payers. We have also engaged in discussions with payers, businesses and consumers regarding strategies to utilize Mercy and to create more competition to lower prices.

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?*

Mercy's main focus for integrating behavioral and physical health has been in the hospital's Emergency Department (ED). From an organizational perspective, integrating physical and behavioral clinical domains into the ED provides an appropriately-scaled focal point to develop and transfer significant organizational learning for future integration applications throughout the health system and with other partners in the community. Although they share the same hospital license and exist within the same health system, Mercy and its behavioral health campus in Holyoke, Providence Behavioral Health Hospital, this effort integrates the considerable capacities and cultures of both entities within a single physical location. In joining forces with the Mercy ED, Providence Behavioral Health Hospital leverages its formidable array of mental health and substance abuse resources, which include a clinical assessment center, inpatient psychiatric treatment facilities for children, adolescents, adults and older adults, inpatient substance abuse unit, two outpatient Methadone Maintenance Treatment clinics, and other outpatient treatment programs for mental health and substance abuse.

In 2012, the hospital contracted with HealthMETRICS. HealthMETRICS collected and analyzed patient-centered baseline data from a sample of ED patients who presented with significant mental health and/or substance abuse conditions (MH/SA). With baseline data in hand, the project team focused on interventions that aimed to reduce the time a MH/SA patient spends in the Mercy ED. The average ED length of stay baseline for MH/SA patients was 15 hours, 24 minutes. MH/SA patients who were discharged to inpatient settings spend an average of 20 hours, 16 minutes in the Mercy ED. In marked

contrast, ED patients who did not present with MH/SA conditions cycled through the ED in 3 hours, 24 minutes, on average. With these and other baseline measures in mind, the project team focused on interventions that aimed reducing the time to get MH/SA patients to the next appropriate level of care. Project team members devised a "Psychiatric Provider of the Day" and a schedule for on call guidance from Providence Behavioral Health to the clinical team in the Mercy ED. The SBIRT (Substance Abuse Brief Intervention and Referral to Treatment) social worker was reassigned for clinical supervision to a Providence Behavioral Health Hospital care manager. Another significant accomplishment was contracting with the a community-based crisis and mental health organization, for onsite clinical evaluation of MH/SA clients in the Mercy ED, 16 hours-a-day, seven days a week. Providence Behavioral Health Hospital also developed a plan to expand the Clinical Assessment Center to 24/7, providing greater access to MH/SA patients who are seeking inpatient treatment. The Mercy ED and Providence Behavioral Health Hospital clinical teams have also identified the data elements for a MH/SA patient registry. When completed, the MH/SA Patient Registry will be assist ED providers as well as the clinical team at Providence Behavioral Health to more effectively coordinate care for ED patients with significant mental health and substance abuse conditions. Future plans include continuing the integration to optimize performance processes for integrating physical and behavioral health care and to increase the percentage of ED patient "High-End Utilizers" who are assessed for behavioral health issues and referred for appropriate treatment.

b. What challenges have you identified in implementing such integration?

Several challenges were identified in implementing the integration. One challenge involves bridging the "boundaries" that frequently separate physical and behavioral health care. The deployment of behavioral health case workers in the Mercy ED represented a step forward in integrating care and transcending institutional silos. This integration provided the opportunity to operationalize evidenced-based practices in managing psychiatrically distressed patients in the ED.

Another challenge in implementing this integration involved the difficulty of engaging behavioral health patients in the ED to participate in a patient satisfaction survey process. Behavioral health patients typically present in the ED with moderate to severe distressed conditions. The clinical team in the ED continues to experiment with methodologies to engage ED behavioral health patients in the satisfaction survey process to assure that the patients' needs are being met.

c. What systemic or policy changes would further promote such integration?

Several systemic and policy changes could further promote the integration of physical and behavioral health, including: Integrating primary care services into acute care behavioral health settings for person with complex physical conditions; developing in-home behavioral health services for individuals discharged from inpatient behavioral health settings; and, utilization of psychiatric community health workers.

There is evidence to consider a policy and alternate payment system for integrating primary care services into acute care, behavioral health settings for persons with serious mental illnesses and complex physical conditions. The development of integration models that take into account the degree of complexity and relative risk in patients' behavioral health and physical health status would promote such integration. This integration framework uses four distinct quadrants to differentiate the complexity

of patient needs:[1] Quadrant I - Patients with low behavioral health-physical health complexity/risk; Quadrant II - Patients with high behavioral health-low physical health complexity/risk; Quadrant III - Patients with low behavioral health-high physical health complexity/risk; Quadrant IV - Patients with high behavioral health-high physical health complexity/risk.

One focus for systemic/policy change would be a focus on Quadrant IV: Adults with serious mental illness and co-occurring primary care conditions and chronic diseases. A one-stop health care center with a team of physical and behavioral health specialists may provide a more cost effective alternative to the current system. Adults challenged with serious mental illnesses have significantly higher rates of high blood pressure, asthma, diabetes, heart disease and stroke than adults with no mental illnesses.[2] Not only does the diagnosis of diabetes double the prospect of comorbid depression, but also, with their coexistence, the severity of diabetes generally increases.[3] Depression or other mental health conditions frequently interfere with self-management of chronic diseases. For example, a person who has both diabetes and depression is more likely to engage in poor self-management of the disease, in particular, medication non-compliance, physical inactivity, poor nutrition, and smoking.[4] The strong linkage between depression and hyperglycemia[5] has also been confirmed to lead to serious, diabetic complications, such as retinopathy, nephropathy, neuropathy, sexual dysfunction, and macrovascular disease.[6]

Health care utilization patterns are different for adults with serious mental illness. Nearly 48% of adults with serious mental illnesses sought care in hospital Emergency Departments compared with 30.5% of adults without serious mental illness.[7] Inpatient hospital utilization rates nearly doubled for this vulnerable population, with 20.4% of adults with serious mental illness becoming hospitalized, compared to an 11.6% hospitalization rate for adults without serious mental illness.[8] Monthly Medicaid expenditures for beneficiaries with one or more physical conditions are significantly higher for patients treated for mental health or substance abuse issues, compared to Medicaid beneficiaries who do not receive mental health or substance abuse services.[9]

Another systemic change that would promote this type of integration would be the further development of in-home mental health services patients discharged from inpatient psychiatric settings. Discharged behavioral health patients frequently face challenges to obtain access to the next level of care at community mental health centers or outpatient behavioral health departments and group practices.

---

[1] Maurer, B. (2006). Behavioral Health Primary Care Integration: The Four Quadrant Model and Evidence-Based Practices. National Council for Community Behavioral Healthcare. Rockville, MD.

[2] Center for Behavioral Health Statistics and Quality. (2011). Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings (NSDUH Series H-41, HHS Publication No. SMA 11-4658). Rockville, MD: Substance Abuse and Mental Health Services Administration.

[3] Anderson, R.J., Freedland, K.E., Clouse, R.E., Lustman, R.E. (2001), "The Prevalence of Comorbid Depression in Adults with Diabetes: A Meta-Analysis," *Diabetes Care* 24 (6): pages 1069-1078.

[4] Lin, E.H., Katon, W., Von Korff, W.J., *et. al.* (2004), "Relation of Depression and Diabetes Self-Care, Medication Adherence, and Preventive Care." *Diabetes Care 27: pages 2154-2160.*

[5] Lustman, P.J., Anderson, K.E., *et. al.* (2000), "Depression and Poor Glycemic Control: A Meta-Analytic Review of the Literature." *Diabetes Care* 23 (7): pages 934-942.

[6] De Groot, M., Anderson, R., Freedland, K.E., *et. al.* (2001), "Association of Depression and Diabetes Complications: A Meta-Analysis." *Psychosomatic Medicine* 63 (4): pages 619-630.

[7] *Ibid.*

[8] *Ibid.*

[9] SAMHSA. (2010). Mental Health and Substance Abuses Services in Medicaid, 2003.

Providence Behavioral Health Hospital is now actively engaged with a number of stakeholders, including the Massachusetts Behavioral Health Partnership (MBHP) and its Care Management Region 2 Emergency Service Providers (ESPs) and MassHealth Managed Care Organizations to boost the quality of behavioral health care for MassHealth and other consumers, especially in their transitions from inpatient psychiatric care back to the community setting. Though the discharge guidelines[10] are clear to facilitate immediate access, within seven (7) days, to psychiatric appointments in the community, patients and providers typically face numerous barriers to complete and sustain a strong and timely care transition. If a discharged patient misses the first scheduled psychiatric appointment and then runs out of medication, psychiatric symptoms are likely to worsen. When psychiatric symptoms worsen, in the absence of community-based mental health treatment, psychiatric hospital and/or skilled nursing facility re-admissions are more likely.

This type of initiative would provide patients who are discharged from inpatient psychiatric hospitalization with home-based, mental health "bridging services" to ensure strong and sustained care transitions to community-based mental health treatment and support services. Immediate goals include stabilizing psychiatric symptoms, providing medication management and deliver training for caregivers. Long term goals, include avoiding preventable inpatient psychiatric hospitalization and/or nursing home placement and sustained access to community-based mental health and supportive services. The range of services provided to each patient would be individualized, based upon a comprehensive, in-home assessment. Experienced, Advance Practice Psychiatric Nurses could coordinate bridging efforts with primary care physicians, psychiatrists, other care providers and family members to establish or reestablish a strong and sustainable connection with community-based psychiatric, mental health and supportive services.

Another systemic/policy change that would promote this type of integration would be the utilization of Community Health Workers (CHWs). CHWs could be a missing link for lowering costs and improving health outcomes for vulnerable patient populations, especially those with serious mental illnesses and co-morbid chronic physical conditions. Costs associated with CHWs could be factored into alternative payment methods. There is growing evidence that CHWs serve as the essential "glue" to help vulnerable patients to navigate and develop stronger connections within a complicated health care delivery system,[11] and to reduce the utilization of hospital EDs and costly specialty services.[12] CHWs could extend the healing influences of physical and behavioral health providers, beyond their office and hospital settings, into neighborhoods, homes and everyday lives of patients, promoting preventive health and wellness interventions, helping newly-discharged patients understand the dynamic interdependence of their physical and behavioral health conditions and comply with the various elements prescribed in their individualized medical and behavioral health plans.

---

[10] National Committee for Quality Assurance (NCQA). HEDIS 2012: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2011. various p.

[11] Rahman, A. *et. al.* (2008). Cognitive behavior therapy-based interventions by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomized controlled trial. *The Lancet,* 372, 902-09.

[12] Nemcek, M. and Sabatier, R. (2003). State of evaluation: community health workers. *Public Health Nursing,* 20(4), 260-270.

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.**

Mercy counts itself among the early adapters of accountable care through innovative delivery models and alternate payments. Driven by growing concerns over spiraling health care costs and the uneven quality of care for unmanaged Medicare patients, Mercy, in partnership with Hampden County Physician Associates (HCPA), developed, what Eliot Fisher and others have referred to as a "virtual ACO." The goals were: to improve care and reduce costs; improve the management of chronic disease; reduce hospital admissions and preventable readmissions; boost patient satisfaction; and manage financial risk for performance under a global payment arrangement. Performance incentives were aligned so that health cost savings were shared by patients, physicians, the hospital and the insurance payer, but only if quality and cost effectiveness benchmarks were achieved.

This "virtual ACO" instituted, in a "real world" urban setting, what the Brookings Institute recommended for "bending the health care curve," by integrating care management, care delivery and disease management into a single, high-performance network. This network reduced hospital admissions and readmissions and optimally managed chronic disease to improve care and reduce costs. Mercy and HCPA entered into a risk arrangement with a Managed Medicare plan and assumed care coordination and financial responsibility for 6,000 members. A structural framework was designed and key competencies developed by the physician group and community hospital to closely manage care, deliver disease management services to the top 3% (160) "high-risk" patients and provide quality oversight and medical direction, while effectively managing costs.

Quality results were exemplary. For example: utilization decreased to 173 admissions per thousand, compared to 380 admissions per thousand in a comparable, unmanaged Medicare population; hospital length of stay averaged 5.8 days compared to 6.2 days in an unmanaged population; the percentage of patients readmitted within 30 days in the program population was 9.8%, compared to 16.4% in other Managed Medicare systems and 20% in unmanaged Medicare; and patient satisfaction was high, with over 86% rating the program excellent or very good in overall satisfaction. Financial performance was equally exemplary, with overall, spending for the program population 12.8% lower than an unmanaged population of the same size.

Over the next several years, a highly integrated care management system was developed and refined as part of two Medicare Advantage programs. This innovative – patient centered – healthcare delivery system has delivered to its Medicare Advantage members a high value health care experience: out-of-pocket cost savings, added benefits not covered by Medicare, improved quality outcomes (using HEDIS and severity adjusted mortality measurements), and improved satisfaction. It has also provided the physicians (PCPs and specialists) and hospitals with added information about their patients improved quality. It has helped that two insurance intermediaries involved in the program maintain NCQA national top five in class quality rankings – while reducing annual healthcare expenditures by approximately 15 to 20% when compared to unmanaged Medicare metrics in the Greater Springfield area.

Building upon these innovative care delivery and alternative payment organizational experiences and infrastructure, Mercy is now into its third full-year of implementing a project for the Commonwealth's Delivery System Transformation Initiative program. Project activities aim to develop governance, administrative and operations capacities to accept global payments and alternate payments. The thrust of project activities centered on formalizing the legal status of a PCP-driven, accountable care

organization, as a collaboration of Mercy, Hampden County Physician Associates, Accountable Care Associates, LLC, Noble Hospital and Independent Practice Associates into a free-standing legal entity - Accountable Care Organization of New England (ACONE). Recent accomplishments include:

- Mercy collaborated with CareEvolution™, a developer of a proprietary Health Information Exchange (HIE) platform, services and related products. The HIE project scope includes linking the electronic health records (EHRs) of ambulatory, acute and post-acute care health care providers, thus allowing patient data to move with each patient through the continuum of care.
- Mercy's HIE platform now includes a data warehouse that powers multiple tools and applications, including a patient portal, payer source data, clinical source data and an array of online analytics processing features.
- Mercy continues to work with ACONE to build new reporting capacities for the hospital's Emergency Department. Expanded reporting applications include "flagging" the admission screen, whenever a future ACONE beneficiary is admitted to the hospital's ED, to allow for improved care coordination following hospital discharge.
- CareEvolution™ is now live in several physician groups in Greater Springfield.
- Accountable Care Organization New England members have successfully collaborated in developing quality and cost metrics and reporting mechanisms that have been the cornerstone of successful clinical quality, appropriate utilization and cost management in the Medicare Advantage program.
- On January 20, 2013, Accountable Care Organization of New England was selected by the Centers for Medicare and Medicaid as one of 106 new Accountable Care Organizations (ACOs) in Medicare.

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

A central challenge in ACO project implementation is to identify a sufficient number of common goals among a diverse group of current and potential collaborators and partners. Most community-based physician groups tend to be independent in employing and managing their physicians. However, Mercy's experiences with ACO development indicate that new health reform policies and requirements for greater value and higher quality are beginning to attract many physician groups in Greater Springfield toward greater alignment, connectivity and collaboration with hospitals to leverage better health outcomes for their patients and to meet more stringent payer requirements. Still, a recent Massachusetts Medical Society Satisfaction Survey Report[13] found that only 32.5% of survey respondents "strongly agree" or "agree" that they are ready to enter into new contracts with hospitals and other physician groups under a global payment contract—a marked decrease from the 2012 survey results, when 56.3% of survey respondents indicated readiness. A likely challenge for many physicians appears to be the issue of risk. A majority of physicians responding to the survey were "very concerned" about risk adjustment and the ability of an integrated delivery system or ACO to manage risk.[14]

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

Several systemic and policy changes could support our ability to promote more efficient and accountable care, including: reducing risk for providers to develop accountable care delivery for Medicaid and complex patient populations; increasing the supply of PCPs in Western Massachusetts;

---

[13] Accessed from: http://www.massmed.org/News-and-Publications/Research-and-Studies/2013-Member-Satisfaction-Survey-Report/
[14] *Ibid*

and incentivizing Medicaid beneficiaries to access primary care through PCPs and diminish hospital emergency department utilization.

Utilization data indicate that Medicaid beneficiaries often have significant challenges related to relatively poor health status, poverty, behavioral health issues, health habits and numerous access barriers that frequently undermine treatment plans. When some adult, Medicaid beneficiaries finally obtain access to primary care, health care utilization costs may trend upward because of new diagnoses and previously untreated conditions. Additionally, there is an insufficient supply of PCPs, especially for Medicaid beneficiaries. Many physicians in the Greater Springfield area, for example, are reluctant to accept more Medicaid patients, partly because of what they perceive to be relatively low reimbursement rates. Compounding this market dynamic, access to PCPs in Greater Springfield is particularly restricted by relatively long average wait times (especially for new patients) and MassHealth acceptance. In 2013, average new patient wait times in Hampden County were 48 days for Internal Medicine and 58 days for Family Medicine.[15] By default, hospital Emergency Departments are now providing what most MassHealth beneficiaries perceive to be "primary care," as it is accessible when they need it for little or no co-payment. Since 2005 the volume in Mercy's ED has increased from approximately 45,000 annual visits to approximately 78,000 visits, with nearly one-half of those visits being for non-emergent care.

Future systemic or policy changes that would support the promotion of more efficient and accountable care, include: reducing the risks for providers to develop accountable care delivery for Medicaid and complex patient populations; increasing the supply of PCPs in Western Massachusetts; and incentivizing Medicaid beneficiaries in future accountable care plans to access primary care through PCPs and diminish hospital ED utilization.

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)?**

Mercy utilizes several statistics when analyzing cost structures within all operating units. The global statistics Cost per Adjusted Discharge and Cost per Adjusted Day are used to determine the overall cost structure of the organization as related to volume. Additional statistics are utilized that further breaks down the costs by type. These include: Salary & Benefits as a Percent of Total Revenue, FTEs per Adjusted Occupied Bed, Benefit as a Percent of Salaries and Wages, Overtime Percent of Total Salaries, Salary per FTE, Supply Expense as a Percent of Net Patient Revenue, Drug Expense as a Percentage of Net Patient Revenue, Bad Debt as a Percent of Gross Revenue, and Purchased Services, Professional Fees and Other Expenses as a Percent of Total Expenses. Further all costs at the sub-account level are reviewed as compared to budget and prior years. These measures are reviewed for the hospital as a whole and for each operating unit within the hospital.

Also, all units of the hospital utilize a productivity tool called Visionware which measures the number of productive hours within a designated time period as a ratio with the units of service provided during

---

[15] Massachusetts Medical Society. (July 2013). *Massachusetts Medical Society Patient Access to Care Study*, 6. Retrieved July 18, 2013, from http://www.massmed.org/patientaccess.

that time period.   This tool is used to adjust staffing for lower levels when volume is low and higher levels when volume is above expected levels.

All cost and productivity measures include a similar analysis of quality measures designed so that patient care levels are maintained during swings in volume.

b. How does your organization benchmark its performance on operational cost structure against peer organizations?

Mercy utilizes a benchmarking firm called Premier which compares the previously mentioned units of measure with hospitals offering similar services and size across the country. Premier takes the data provided by hundreds of hospitals across the country and calculates a range of performance which member hospitals can benchmark against. Mercy has a current goal for each operational unit to meet the benchmark of the 25th percentile for staffing and cost with a stretch goal of meeting the 10th percentile. In addition Mercy is measured on the previously mentioned units against other hospitals in the CHE Trinity Health System.

c. How does your organization manage performance on these metrics?

Mercy managers are challenged to be owners of their units in all aspects including cost control. The management team received the relevant data timely in order to manage their costs to their current volumes. Managers are accountable to explain all variances from expected each month. Managers meet monthly with the CFO, CNO and Director of Finance to review the productivity results. This promotes accountability and a forum for managers to share ideas regarding cost control.

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.

Chapter 224 requires payers and providers to disclose the allowed amount or charge of an admission, procedure, or service to patients upon request. For providers, this requirement is effective January 1, 2014, Payers will also have to be able to provide this information via a toll free number and a website. SPHS is reviewing options for the best reimbursement calculator now to enable staff to determine the allowed amounts in order to assist the patient and comply with the law. We will be training admission and customer service staff on the process, and will be working with the payers to assist patients by helping them access their insurance websites and toll free numbers.

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.

The Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013) Reports build upon the findings from previous reports of health care cost trends reports from the Attorney General (June 2011 Report - Examination of Health Care Cost Trends and Cost Drivers), Center for Health Information and Analysis (November 2012 and February 2013 Reports - Health Care Provider Price Variation in the Massachusetts Commercial Market). The recent reports highlight several significant findings that reflect the experience of Mercy, including:

- Commercial health plans continue to pay providers widely different amounts to care for patients of comparable heath.
- The majority of Massachusetts commercial health plan payments continue to go to high priced providers. In recent years, the highest prices 25% of providers received 50% of commercial payments.

These reports highlight Mercy as among the lower reimbursed hospitals by commercial insurers in the Massachusetts. Additionally, as referenced in Question 2, Mercy is challenged a payer mix that includes a significantly higher percentages of Medicaid patients and significantly lower percentages of patients covered by commercial insurance payers. Mercy's payer mix and its status as one of the lower reimbursed hospitals by commercial payers have challenged Mercy to become one of the most cost-effective, acute care hospitals in the Commonwealth. It also highlights the need for payer rate improvements for organizations like Mercy that are paid significantly below the statewide average. This low payment status will create additional challenges current rates of payment are used as a baseline for participating in new alternative payment models.

Mercy Medical Center - EXHIBIT C: OAG Questions and Written Testimony

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.**

The analysis below was performed at a high level using the Mercy's overall cost-to-charge ratio applied to all payers and contains the margins by payer group.

	2009		2010		2011		2012	
	Operating Margin	Percent of Total	Operating Margin	Percent of Total	Operating Margin	Percent of Total	Operating Margin	Percent of Total
Commercial	$ 3,422,830	19%	$ 4,325,311	23%	$ 5,254,412	18%	$ 5,134,101	18%
Government	$ (6,635,856)	73%	$ (10,757,030)	67%	$ (9,670,016)	74%	$ (2,135,867)	73%
All Other	$ (1,407,247)	8%	$ (3,127,986)	10%	$ (928,495)	8%	$ 831,033	10%
	$ (4,620,273)	100%	$ (9,559,705)	100%	$ (5,344,100)	100%	$ 3,829,268	100%

Notes:

(1) The above includes margins only for revenues classified as patient service revenue.

(2) Supplemental governmental funding such as DSTI and Essential Community Provider Trust funds is recorded in other operating revenues and not included above. Those amounts total $10,567,345 in 2010; $7,767,345 in 2011; and $15,213,334 in 2012.

(3) *All Other* includes workers compensation and margins related to Medicare Advantage (MA) patient revenues.
It does not include the hospital fund settlements and other settlements related to the MA plans.
Those amounts total $888,781 in 2009; $3,707,513 in 2012; $1,883,713 in 2011; and $876,404 for 2012.

(4) The above includes the impact of the Nantucket rural floor wage reclassification that was effective October 1, 2011.
The additional reimbursement in 2011 related to this change was $2,249,889 in 2011 and $12,146,384 in 2012.

(5) Payer Groupings:

Commercial	Government	All Other
BC ELECT PPO	COMMONWEALTH CARE	BLUE CARE 65
BC INDEMNITY	DMH	OTHER MANAGED MEDICARE
BC OUT OF STATE	DPH	TUFTS MEDICARE PREFFERRED
BLUE HMO	HEALTH NET	WORKERS COMP
CIGNA	HEALTH SAFETY NET	
OTHER COMMERCIAL INSURANCE	MBHP	
HEALTH NEW ENGLAND	MEDICAID/OTHER GOV'T	
OTHER HMO/PPO	MEDICARE	
TUFTS COMMERCIAL	MEDICARE PSYCH	
	MEDICARE REHAB	
	OTH GOVT/VETERANS SVCS	
	OTHER MANAGED MEDICAID	

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.**

Mercy Medical Center and Hampden County Physician Associates (HCPA) entered into a risk arrangement with a Managed Medicare plan and assumed care coordination and financial responsibility for Medicare beneficiaries. A structural framework was designed and key competencies developed to closely manage care and utilization, deliver disease management services to the top 3% (160) "high-risk" patients and provide quality oversight and medical direction, while stringently managing costs. To manage risk effectively, an integrated care system was devised that reduced overall utilization of inpatient admissions, SNIFs and hospital readmission rates. The model of care delivery shifted from hospital-based service to network PCPs, giving PCP more responsibility to manage effective care in a timely fashion. A key element in the design is to assign a Risk Adjustment Factor (RAF) to each covered patient. RAF scores are severity ratings and are based upon spending/utilization histories and actuarial calculations. Adaptability is a vital feature of our integrated care model, enabled by real-time EHRs powered by *CareScreen™* software and a robust HIE, connecting home nurses with PCPS and PCPs with Mercy Medical Center Hospitalists.

Nurses on the case management team track all communication and utilization with ACO members and are able to notify a PCP, for example, that a patient has been discharged from Mercy Medical Center to her home or a skilled nursing facility. In another example, a case manager will alert the hospital-based rounding teams from the physicians group that a patient has just been admitted to Mercy. Case managers make use of *CareScreen™* and McKesson software that have built-in InterQual and NCQA standards. With the guidance of the clinical team, utilization management relies on evidence-based medical criteria for gauging the medical necessity of ED visits, hospital admissions and obtaining test results from patients. Tracking patient data with metrics from National Committee for Quality Assurance, CMS and other best practice guidelines for quality measures, the new care management model utilizes data warehousing reports to alert PCPs and nurse managers about lapses in test tracking. For example, when a patient with diabetes misses an HbA1c testing interval, an electronic notice will go to the patients PCP and endocrinologist, prompting a reminder to the patient.

With its emphasis on wellness and prevention, our integrated care model includes a robust emphasis on disease management, especially for patients who manage such chronic and frequently costly conditions as CHF, COPD and Diabetes. Both caregivers and patients with these and other serious conditions will receive a steady stream of personalized, disease management instruction so they will be able to better manage these serious challenges and avoid complications that require hospital stays. For many patients and care givers, these disease management instructional sessions will take place in their homes or prior to discharge. Once the patient and his or her caregiver are alert to key warning signs of a worsening condition, they will understand when to call their doctor or nurse immediately. Some patients and caregivers will be equipped with telemedicine devises to report key diagnostic-specific metrics such as

weight, salt intake and blood pressure. Nurse case managers will monitor patient data sets in real-time and, as downward trends indicate, dispatch a home nurse to the patient's home to prevent an avoidable hospital admission. Once in a patient's home, the nurse can assess the patient's condition and consult with the patient's primary care physician.

Data warehousing drives continuous medical monitoring of all patient claims data for monthly claims and compares aggregate claims data with test results, medication data and other clinical information entered from PCP Electronic Medical Records and paper charts, as well as with data entered by the hospital. Data mining and rigorous analysis are key elements in controlling costs due to improper utilization and deviations from evidence-based practices and quality targets.

This proven infrastructure, developed for the "virtual" ACO programs is now being used for the Accountable Care Organization of New England, LLC (ACONE) which is participating in Medicare Shared Savings Program. ACONE represents a partnership between a physician IPA, Mercy Medical Center, Accountable Care Associates (ACA), and Noble Hospital. ACONE is focused on five transformative goals: to improve care and reduce costs; advance the management of chronic disease; reduce hospital admissions and preventable readmissions; boost patient satisfaction; and manage financial risk for performance under a global payment arrangement. This integrated model of care delivery and payment reform is precisely what leading authorities like Fisher have pointed to as a remedy for the overuse, high-cost and low-value of medical care in a fragmented health care system. ACONE is operating in urban, suburban and rural settings of Hampden, Hampshire and southern Franklin Counties and will integrate care management, care delivery and disease management into a single, high-performance network that reduces hospital admissions and readmissions and optimally manages chronic disease to improve care and reduce costs for 40,000 or more Medicare beneficiaries.

ACONE's innovative approach to care delivery and its operational competencies make it capable of achieving the goals of the "triple aim" and incorporates several key features:

- Physician-driven, PCP-driven
- Delivers evidence-based, patient-centered care
- Emphasizes wellness and prevention
- Provides disease management for patients and caregivers
- Designed to benefit both the Medicare member and the larger community
- Utilization management approaches to ensure appropriate hospital admissions
- Features medical home-type activities like test tracking and referral tracking
- Focus on patient satisfaction
- Tracks and reports quality data on patients' medical conditions via data warehouse
- Automated monitoring of patients' claims data and clinical information
- Alerts PCPs with real-time reports so patients whose medical conditions are trending downward get immediate interventions from a home-based clinical team.
- Integrated care with strong transitions from provider to provider, and across both inpatient and outpatient settings.

ACONE infrastructure includes: claims and clinical data management, case management, complex disease management, contracting support, network development, network maintenance, risk assessment, reinsurance recoveries, dedicated hospital rounding, dedicated rehabilitation and nursing home rounding, quality oversight, medical director and other physician leadership, web-based clinical information sharing, member satisfaction reporting, multilevel provider trending and education,

utilization monitoring, financial monitoring, and regulatory compliance oversight components. Key features of this infrastructure include the integration of patient care rounding services, case management, and disease management services – and the further integration of these services with the PCP practices using unique physician consultations. The implementation of this infrastructure has led to expertise in: chronic disease management, psychosocial and other member needs assessments, end-of-life care, quality of care measurements, acute and chronic care value assessments, facility value assessments, provider practice pattern evaluation, and member satisfaction. An innovative set of physician co-management and consultative services has been developed for hospital, outpatient, and home environments. Case management and disease management programs, developed locally, are highly proactive, use an innovative and validated set of clinical protocols, utilize specially trained Mercy in-home providers in combination with specially trained physicians, and follow all NCQA guidelines.

The diagram below provides a representation of the structure of the Mercy contracts that incorporate per member per month budget against which claims are paid**.**

Strategic Collaboration
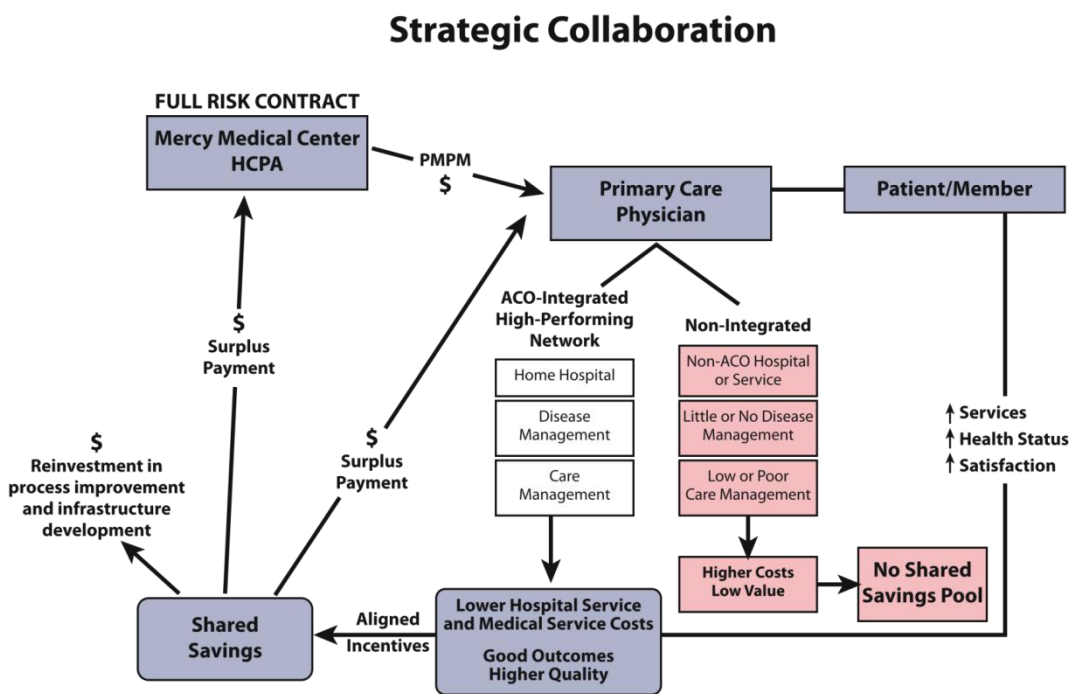
3. **Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, 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.**

Mercy's exposure on risk contracts is limited to its participation in Medicare Advantage ("virtual ACO") plans. These plans cover approximately 6,000 members and Mercy has risk associated with member utilization (direct cost) and ineffective cost control (excessive "out-of-network "referrals for example)

depleting the hospital surplus fund or medical service fund pools. Initial per-member/per-month payments somewhat mitigate financial risk but would not sustain the model if either variable was not well-managed. Baseline historical revenue and utilization data is analyzed on an annual basis for the member population. Revenue projections are compared to projected administrative and clinical costs to determine financial risk, prior to care coordination interventions. A sensitivity analysis related to the impact of care coordination interventions on the cost of care is also conducted on an annual basis. Reinsurance is purchased to mitigate unanticipated costs.

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**

In 2010 and 2013, Mercy Medical Center conducted Community Health Needs Assessments that served to establish baselines measures for demographic and health status indicators in its primary service area. The data encompass a broad range of sources, including results from the University of Wisconsin/Robert Wood Johnson Foundation "County Health Rankings" for Hampden County, Massachusetts Department of Public Health, Behavioral Risk Factors Surveillance System, ZIP Code-Level Analyses of Ambulatory Care Sensitive Conditions, Pioneer Valley Planning Commission, among several others. Significantly, the 2013 Community Health Needs Assessment was designed and conducted in collaboration with the Coalition of Western Massachusetts Hospitals (Mercy Medical Center, Baystate Medical Center, Baystate Franklin Medical Center, Baystate Mary Lane Medical Center, Cooley Dickinson Hospital and Wing Memorial Hospital. Listed among the major findings for Mercy Medical Center's primary service area population is a prioritized list of Community Health Needs. A copy of the 2013 Community Health Needs Assessment is enclosed.

In related population health activities, Mercy Medical Center annually develops and reports on its Community Health Improvement Plan and submits to the Massachusetts Attorney General its report of Community Benefits. Copies of our 2013 Community Health Improvement Plan and the 2012 Community Benefits Report to the Attorney General are enclosed.

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.**

Please see attached Mercy Exhibit C – Question 5

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.**

Response:

	2010	2011	2012	Variance	% Change
Salaries	84,124,452	87,762,624	94,160,617	10,036,165	11.9%
Benefits	15,917,579	16,942,738	17,736,608	1,819,029	11.4%
Physician Fees	1,916,238	1,889,460	2,250,933	334,695	17.5%
Prof Fees & Purch Services	23,718,487	25,002,866	28,719,442	5,000,955	21.1%
System Assessment	21,135,329	21,803,274	23,452,560	2,317,231	11.0%
Medical Supplies	19,106,555	18,101,798	19,323,927	217,372	1.1%
Drug Cost	7,267,788	7,646,919	12,381,888	5,114,100	70.4%
Depreciation	8,109,971	8,256,777	8,555,523	445,552	5.5%
Interest	1,711,173	1,644,787	1,639,240	(71,933)	-4.2%
Bad Debt	6,739,868	3,831,179	(1,510)	(6,741,378)	-100.0%
Insurance	2,063,902	2,324,436	2,024,814	(39,088)	-1.9%
Other Expenses	12,512,924	12,824,263	12,494,581	(18,343)	-0.1%
Total Expenses	204,324,266	208,031,121	222,738,623	18,414,357	9.0%

- Salaries increased 11.9% due to cost of living increases and additional personnel for program expansions and implementation of the *Care Connect* care management implementation.
- Benefits increased 11.4% which is in line with salary increases.
- Physician fees increased 17.5% due to contract renewals with Emergency Physicians, ICU Intensivists and Behavioral on-call physicians.
- Professional fees increased 21.1% due mostly to the expansion of cardiology and oncology services serviced through professional contracts; costs associated with the electronic medical record system and increased service contract costs.
- System Assessment relates to fees paid to Sisters of Providence Health System (SPHS) for support services such as finance, IT, human resources, risk, quality, compliance, billing, etc. There was a change in the allocation methodology that increased the assessment for The Mercy Hospital, Inc. The actual costs for these functions within SPHS decreased from 2010 to 2012.
- Drug costs increased by 70.4% due to the increase in infusions from the significant expansion of Mercy's oncology services

- Depreciation increase relates to the capital improvements made during this period netted with assets that became fully depreciated.
- Bad Debt was reclassified to net patient revenue during this period.

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.**

Mercy Medical Center features a number of ongoing programs that promote health and wellness for patients for whom the hospital is the primary care provider, patients for whom it is not the primary care provider and for our employees. Here are some notable examples:

- HealthyDirections: Mercy Medical Center and Sisters of Providence Health System recently partnered with Health New England to bring the HNE HealthyDirections employer wellness program to Mercy/SPHS. The outcomes-based program promotes a culture of health and allows for the availability of premium differentials available under the ACA and other incentives under the Massachusetts Tax Credit Incentive program. Program highlights include a kickoff event, biometric health screenings, online personal health records and activity challenges that promote healthy lifestyles.
- Healthy Balance Events: a public listing on the hospital's web site (www.mercycares.com) of Health and Wellness Programs offered by the Sisters of Providence Health System for Western Massachusetts' citizens. The September 2013 listing features a number of wellness programs and classes, including: CPR, Diabetes Education, Diabetes Exercise, Cholesterol and Blood Glucose Screening, A *Baby Café*-Breastfeeding Promotion and Support, Breastfeeding Class, Childbirth Class, Prenatal Exercise Class, Postnatal Exercise Class and Pregnancy Exercise Class.
- Mercy Wellness Center: a new partnership between Mercy and Healthtrax® Fitness & Wellness. Within the East Longmeadow location is the newly renovated fitness facilities of Healthtrax as well as a satellite Weldon Physical Rehabilitation clinic, and a community health education classroom. Merging health care and fitness services within the existing Healthtrax facility will better serve the surrounding community of East Longmeadow. All regularly scheduled SPHS employees are eligible for a substantial discount at Healthtrax® Fitness & Wellness and membership dues can be set up as a payroll deduction.
- MyHealth Patient Portal: The MyHealth patient portal provides all Mercy patients online access to their health information, whenever it is needed. Patients can use MyHealth to access their health information, including laboratory and imaging results.
- Health Coach: An ongoing health promotion and education series sponsored by Mercy, featuring physician-led presentations on a variety of health topics.
- *Balance Magazine*: A publication of the Sisters of Providence Health System, featuring a number of health and wellness topics. *Balance Magazine* is published in the Spring and Fall and mailed to all households in Mercy's primary service area, as well as other locations throughout the region.