The principal teaching hospital for Tufts University School of Medicine

Tufts Medical Center

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**EXHIBIT B**
**Health Policy Commission Questions for 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?**
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?**
**c. What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?**
**d. What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?**

Tufts Medical Center is an exceptional, not-for-profit, 415-bed academic medical center that is home to both a full-service hospital for adults and Floating Hospital for Children. Located in downtown Boston, the Medical Center is the principal teaching hospital for Tufts University School of Medicine. Floating Hospital for Children is the full-service children's hospital of Tufts Medical Center and the principal pediatric teaching hospital of Tufts University School of Medicine. Tufts Medical Center is affiliated with seven community hospitals and with New England Quality Care Alliance, its community physicians' network.

Tufts Medical Center's strategic priorities are based on the following key initiatives: (i) The Distributed Academic Medical Center model; (ii) New England Quality Care Alliance (NEQCA); (iii) Quality driven and value-based payment and care delivery and (iv) Physician and hospital integration.

The goal of the Distributed Academic Medical Center Model is to create a regionally comprehensive. Clinically integrated system that delivers, directs and creates access to healthcare in a cost effective, high quality manner. One of its main premises is to increase the amount of care provided in the community by partnering with providers to enhance local capabilities; raising the expertise and level of care that is provided in the community setting. It is our belief that this model proactively shifts care to the most appropriate setting by:

- Developing community programs in partnership with physicians and hospitals
- Exporting teams and expertise into the community
- Integrating health information systems
- Coordinating care from the physician's office to the academic medical center, and then back again to the community physician's office
- Channeling tertiary and quaternary cases to Tufts Medical Center and Floating Hospital for Children

NEQCA is a physician-led management services organization serving independent community and academic physicians in Massachusetts. NEQCA physicians are organized into groups by geography called Local Care Organizations. Physicians maintain their independent practices

and access to local community hospitals for less complex care, with coordinated access to Tufts MC for complex tertiary/quaternary care, such as advanced cardiac treatment, neurosurgery, high risk maternity and other conditions requiring specialized treatments and technologies. NEQCA negotiates managed care contracts on behalf of its physicians and supports its physician practices through initiatives such as integrated electronic health records across all physicians; a patient registry that its physicians use to track and manage patient care; and centralized medical management programs.

NEQCA's ability to coordinate care is important to Tufts MC, as a high percentage of Tufts MC patient volume is attributable to NEQCA physicians. In 2012 discharges attributable to NEQCA, as compared to discharges not attributable to NEQCA, had a higher case mix index (1.91 compared to 1.71), lower average length of stay (4.44 compared to 5.00) and a higher percentage of surgical cases (47% compared to 35%).

Beyond its contracting capabilities, NEQCA has developed focused and complex care management programs for high acuity, high cost patients. NEQCA provides care coordination services for this patient base, supported by informatics and analytical support for caregivers. NEQCA's decision support systems, deployment of patient registries and optimal electronic health records use, ensure providers have the data and support they need to manage care successfully.

Value-based contracting with third-party payers continues to be another key component of the Tufts Medical Center strategy. Both Tufts MC and NEQCA physicians participate in the Blue Cross Blue Shield Alternative Quality Contract (BCBS AQC). Tufts MC was the first academic medical center in Boston to participate in the BCBS AQC.

**2. The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that <u>growth in prices for medical care continues to drive overall increases in medical spending.</u>**
**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?**

Please see response to question 1.

**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?**

**a. What potential opportunities have you identified for such integration?**
There is substantial evidence from national studies that individuals who have mental health and substance use disorders have increased rates of general and specialty medical care use and costs compared to those without such disorders. Publically available data shows increased uses of facilities and emergency care, although physician visits are not increased. These findings are across all payer types – public and commercial and are associated with increased risk of admission for medical causes. While this data shows a correlation it is not necessarily causal and it is likely that there is a bidirectional influence. There is thus a strong need for integration in

primary care, for both pediatric and adult patients, and in hospitals, emergency rooms and specialists offices. The department of psychiatry at Tufts Medical Center is involved in multiple initiatives to integrate care in both primary care and across our hospital. This includes currently implementing a psychiatry program in support of NEQCA's Medical Home Care Management program. Through this contract, our psychiatric physicians are available for telephonic consultation for PCPs seeking information on how to manage medications, on care of complex and co-morbid patients or for advice on how to treat the patient using inpatient or outpatient services. The psychiatrists also provide supervision and support for NEQCA's complex care managers by being available to answer questions and participating in weekly case conferences. Tufts Medical Center's Department of Psychiatry is also participating in a multi-center grant program to have an onsite integrated care manager focused on patients with depression, anxiety and substance abuse, work with high risk patients with diabetes to screen and treat them for these very common behavioral health problems. Our child psychiatry service consults in a similar way to pediatricians via the MCPAP program and though our contract with The Department of Mental Health (DMH) a senior consult psychiatrist provides integrated medical psychiatric evaluations to DMH clients living in group homes.

We have also integrated behavioral health services within our primary care practice to address the mental health needs of patients with coexisting chronic illness and a behavioral health diagnosis. The incidence of coexisting and often unrecognized mental health illness in patients with chronic disease is well documented. Within our practice, primary care clinicians and specialists who practice with us have identified a paucity of mental health services as contributing to reduced medication and visit adherence, impaired self management and poor outcomes in patients with chronic illness and an unidentified or poorly managed behavioral health diagnosis.

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

There are several important barriers to effectively integrating Behavioral Health:

1. Reimbursement for psychiatric and other mental health services is poor. Medicaid is the largest funder of services and increased reimbursement of costs, as it is in federally qualified health center models, is not available in other settings.
2. Lack of space in small practices to have behavioral health care managers onsite;
3. Lack of funding to pay for behavioral health programs in primary care practices, including non face to face consultative telephonic and case management services;
4. Carve outs of behavioral health programs from medical insurance programs. This leads to lack of coordination between providers, cost shifting, discriminatory utilization review and lack of data sharing both between clinicians and at the population level.

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

1. Better funding for behavioral health services to improve access to care and more adequate reimbursement rates;
2. Payment and funding for pilot projects for technology-enabled care to increase access to behavioral health services. This includes payments for video visits between patients and behavioral health professionals; use of in-home devices to support care management interventions (e.g. depression symptom monitoring with daily questions on devices that are monitored by care managers who can intervene earlier when symptoms worsen); use of handheld devices and smartphones for measuring symptom levels and increasing access to educational materials and contact with behavioral health professionals.

3. Funding for research into the relationship between behavioral health diagnoses and higher medical costs. Our data indicate that when compared to age and gender-matched controls, patients with one behavioral health diagnosis have on average 2.5 times the medical costs, excluding behavioral health treatment costs. Such research will help us better understand if people have medical illnesses first and then develop behavioral health problems, or vice versa and help in the design and implementation of effective treatment programs.

**4. C. 224 seeks to promote more efficient and accountable care through <u>innovative care delivery models and/or alternative payment methods.</u>**
**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?**

Please see response to question 1.

**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?**

- **What metrics does your organization use to track trends in your organization's operational costs?**
  At a macro level for the organization, the hospital budget focuses on basic financial cost categories: the number of FTEs, the amount of overtime, the use of supplies, etc. This gives us a high level view of our cost trends; however, as an organization that is committed to continuous improvement we try to tie our improvement efforts to both quality improvement and financial impact. This allows us to continuously work to be more efficient as a provider while improving patient flow, getting patients into the right bed at the right time and improving the overall utilization of services.

  a. **What unit(s) of analysis do you use to track cost structure (e.g., at organization, practice, and/or provider level)?**
     We constantly analyze costs at numerous levels of the organization. Some specific examples include:

     - Total Cost per Patient Day
     - Total Expense per Case Mix Adjusted Discharge
     - Labor Expense / Case Mix Adjusted Discharge
     - Total worked hours per CMI adjusted discharge
     - Total FTEs per adjusted occupied bed
     - Average Length of Stay
     - Average Length of Stay by DRG

- Average Length of Stay by DRG by Provider
- Drug Expense per Patient Day
- Drug Expense per Patient Day by Provider/Service Line
- ICU Utilization
- Ancillary Utilization
- Cost per Operating Room Case
- Supply cost per case

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

We benchmark our cost and utilization against The University HealthSystem Consortium (UHC) which is an alliance of 118 academic medical centers and 299 of their affiliated hospitals representing the nation's leading academic medical centers. The UHC has ranked Tufts Medical Center in the top-25 academic medical centers in the nation for quality and accountability for three straight years, 2010-2012. We are able to benchmark our cost and organizational performance against most of the key metrics outlined above. In addition, we participate in a group purchasing collaborative with Premier that allows us to benchmark our supply spend by unit and contract.

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

We focus our organizational cost, quality and service performance across our core service lines. In each service line, we are organized as a triad of nursing leadership, MD leadership and administrative leadership to identify opportunities for quality improvement, cost reductions or operational efficiencies.

**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.**

Tufts Medical Center is in the process of evaluating the mandate as required by Chapter 224 and assessing our own capabilities to provide patients with cost information upon request. The current process of providing a cost estimate to a patient is a manual process requiring a significant amount of data collection, analysis and comparison, with necessary explanation that this charge could change dramatically based at the point of service. In addition, the complex nature of the tertiary and quaternary care provided at Tufts Medical Center often means a physician and care team may make care decisions on the spot or may alter a care plan based on the complexities presented with upon surgery or as a patient's condition changes, which cannot be included in estimates. Providing an accurate cost assessment will require compiling and cross referencing several different data points, which are not currently synthesized within the organization. We are also very concerned with the release of charge and pricing information if it is not accompanied with the appropriate quality information to allow a consumer to make a fully informed decision.

**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.**