Beth Israel Deaconess
CARE ORGANIZATION LLC

Affiliated with
Beth Israel Deaconess
Medical Center

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

September 8, 2014

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

Dear Executive Director Seltz,

On behalf of Beth Israel Deaconess Care Organization (BIDCO), enclosed please find written testimony for Exhibits B and C (Questions for Written Testimony) in response to the Health Policy Commission letter to BIDCO dated August 1, 2014.

I hope that the enclosed testimony is helpful to the Commission and to the Office of the Attorney General; we would be happy to provide any additional information that may be helpful to you.

I am legally authorized and empowered to represent Beth Israel Deaconess Care Organization for the purposes of this testimony, and provide the testimony herein under the pains and penalties of perjury.

Very truly yours,

Christina Severin
President and CEO

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Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but if necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY: Our organization changed fundamentally in 2013 when we became Beth Israel Deaconness Care Organization (BIDCO) with both hospital and physician governance structures. The driving factor behind the change was to create an organizational structure that allows BIDCO and our member hospitals and physicians to align their payment structures to achieve overall cost reduction in the care of our patients, and to improve patient care across the entire continuum of care. As the recent Center for Health Information and Analysis (CHIA) report found, BIDCO remains either at or significantly below commercial carrier network averages in terms of total medical expenditures and we are working hard to continue to provide value to patient and families and employers through the initiatives listed throughout this testimony.
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.
      Our revenue, utilization and operating expense trends changed fundamentally in 2011 when Beth Israel Deaconness Physician Organization entered into the first risk-based contracts with commercial carriers and again in 2012, when we entered into the Pioneer ACO model with CMS. Thus, historical reporting of revenue and operating expenses is challenging from CY 2010 to CY 2013. In terms of revenue, our participation in risk contracts has certainly stablized revenue trends over the past few years. In terms of commercial utilization, we've seen a 24% decrease in medical/surgical admissions to our AMC affiliate, BIDMC, from 2012 to 2013. Meanwhile, we've seen an 8% increase in admissions to community hospitals. Our operating expenses are fundamentally different between 2013 and 2012, but recently we've seen a stabilization with growth of risk contracts.
   b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?
      We are intensely focused on expanding, strengthening, and improving primary care delivery to reduce overall system costs. Some specific steps that we have taken are: 1) the development of financial risk sharing between our hospitals and the physicians and 2) investments in a robust data reporting system to identify, analyze and track high-risk patients. The results of both initiatives has been the alignment of incentives across the delivery system and better care at lower costs for our most vulnerable patients.
   c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of

technology and error reduction) to ensure the Commonwealth will meet the benchmark?
BIDCO plans to continuously assess new and innovative risk sharing models to create incenitves for its physicians and hospitals, including bundled payments. We are taking steps to engage our system's providers in both accountability and education around appropriate use of specialty care so we can provide the right care at the right place at the right time.

a. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
Three important policy changes would enable BIDCO to achieve better efficencies and improve quality: 1) require payers to offer PPO and self-insured, risk-based alternative payment arrangements; 2) a stronger regulatory approach to moderate wide price disparties in health care in Massachusetts, particularly in the eastern market; and 3) align quality measurement and patient attribution methodologies across public and private payers. Further, we enourage the Health Policy Commission (HPC) and other state agencies with responsibilities related to C. 224 continue to work in partnership with the provider community and with each other inter-governmentally to ensure no duplication of efforts and to truly achieve the goal of the law - to improve the quality of health care and reduce costs.

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
SUMMARY: BIDCO participates in global risk contracts with the three major commercial payors in Massachusetts on HMO (and only fully insured with two of the three payors) as well as with CMS for Medicare fee-for-service patients through the Pioneer ACO program. We are working closely with other private and public payors to take on more risk contracts and reduce the use of fee-for-service payment in our delivery system. In our view, the most critical issue in the implementation of alternative payment methods (APMs) is the ability for payors to include self-insured employers, either PPO or HMO, in these models. Two of the three major payors only offer APMs on their fully-insured business, eliminating thousands of patients from access to this care delivery model. This issue further compounds in the PPO space, where a majority of the business is self-insured.

   a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization’s overall quality performance, care delivery practices, referral patterns, and operations?
   BIDCO's participation in global budget contracts with the three major commercial carriers in Massachusetts as well as with CMS through the Pioneer ACO program has significantly improved our quality performance, delivery of care and operations. In fact, our organization was founded in 2012 for the explicit purpose of creating an operational structure that allows our member hospitals and provider groups to enter into these types of payment methodologies that align payment structures between the parties to achieve overall cost savings and quality

improvement across our system - and across the care continuum. Specifically, APMs have allowed us to institute innovative care delivery models such as home influsion therapy and new ED protocols across our system.

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).
   To implement and manage APMs, we had to make certain system-wide investments in electronic medical record and data reporting, management systems and staff. These investments are functions that most physician practices don't have currently have staff for nor do they have the size to implement. We have also increased our care management staffing ratios to focus more efforts on high risk and chronically ill patients. As we have grown and added new hospitals and physician groups, we have seen important economies of scale upon those investments in terms of resources.

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.
   We do not have any data on patients paid for under FFS, BIDCO only holds APM contracts.

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3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.
   SUMMARY: It is important to include risk adjustment measures alongside risk share and other elements of a risk-based contract. However, the risk adjustment methodologies never capture the reality of risk that providers take on in a given patient population and are inadequate as a benchmarking methodology. We strongly support the development of a common risk adjustment normalization methodology by the HPC or CHIA to use across carriers and sub-populations.

   a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?
      Research has widely documented risk adjustment only accounts for a percent of the acuity in a patient population. The measures break down further at the sub-population level such as for very high-risk patients - both pediatric and adult.

   b. How do the health status risk adjustment measures used by different payers compare?
      There are a variety of risk adjustment methodologies used by both public and private payers in Massachusetts. For financial management of risk contracts, we support a population-specific, risk adjustment methodology. However for clinical purposes, we support a single risk adjstment methodology for population management - which normalizes the individual measures used in financial management. We strongly support the development of a common risk adjustment normalization methodology by the HPC or CHIA to use across carriers and sub-populations.

c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?
It is important to include risk adjustment measures alongside risk share and other elements of a risk-based contract. However, as stated earlier, these methodologies never capture the reality of risk that providers take on in a given patient population and are inadequate as a benchmarking methodology.

4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.
SUMMARY: We strongly agree with the call for more actionable and timely data under our risk contracts. We are greatly challenged by the delay in financial performance and trend data from the health plans under our risk contracts. Currently, there is an up to six month delay on the data with our performance against our budget, which is a major challenge. From a management perspective, it would be helpful to receive real-time data on hospital admission or ED use to manage patient care - as well as more timely comparative quality information. Currently, we only receive comparative quality information on the claims-based process measures in the risk contracts regularly (and only from one payor) and overall performance comparison at the end of the calendar year, which is not as helpful in setting and evaluating population health management goals and initiatives.
ANSWER: In terms of budget and financial management, it is critical that we understand from the health plans our performance against our budget without a long time lag and to get trend information on a monthly basis. Further, it is important to receive data on patient-level risk scores. It would also be helpful to better understand our performance relative to peers in terms of overall quality performance on all of our risk contracts in order to set organizational goals and improve population health in a more timely manner. We do receive very timely, daily information such as ED census and admission information from some payors, but not all - it would be most helpful to receive that on all of our patients to ensure the primary care team can best take care of the patient no matter where they are in the health care system.

5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY: BIDCO strongly supports the attribution of patients to a PCP under a consistent methodology across health plans to enable access to APMs for PPO patients. Currently, each health plan and CMS has their own attribution methodology, which is incredibly complex and resource intensive to manage as a provider. We are working closely with other providers in Massachusetts and the commercial plans on a workgroup to establish guidelines for attribution of patients, and we encourage the HPC to look to the output of that work to help move APMs forward into the PPO realm.

a. Which attribution methodologies most accurately account for patients you care for?
   BIDCO has extensive experience working with CMS' attribution logic for the Pioneer ACO model, under which beneficiaries are attributed to us on an annual basis. As a result of that experience, we support an attribution methodology that allows for patient selection of primary care provider first, allows for a 24-month look-back period of primary care related claims, and uses volume of services to a primary care provider rather than dollars or a "last visit" approach. We also strongly support C. 224's requirement to attribute members to a primary care provider - not to a specialist. CMS currently allows alignment to a specialist, which is challenging for our organization given high referral volume and the difficulty for specialists to take on accountability for patient care across the continuum. C. 224 also requires plans to share data on attributed patients with providers to better manage their care - we are eager to work together with the plans to use, analyze and learn from this data but to date, no plans have begun sharing it.
b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
   BIDCO is working closely with other providers and the commercial plans on a workgroup to establish guidelines for the attribution of commercial PPO patients to physician organizations in an effort to promote improvements in patient care and allow for quality and financial accountability. We suggest that the HPC, CHIA and other regulatory bodies look to the output of that workgroup to regulate the standardization of attribution methodologies across carriers for the purposes of risk contracts and payment.

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6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.
   SUMMARY: We invest significant resources in managing and analyzing the varying quality measures across payers for our risk contracts. We strongly support the development of a common set of quality measures across process, outcome and patient experiences of care domains that all the carriers must use in risk contracts. This policy change will increase engagement of providers by bringing focus and importance to a singular set of quality measures and harness the resources of provider organizations to increase the effectiveness of quality improvement programs.
   ANSWER: We invest significant resources in managing and analyzing the varying quality measures across payers for our risk contracts. A majority of those resources are deployed to ensure that the electronic medical record systems across our providers capture the quality measures in a standard way to increase performance on the measures. The payers also change these measures frequently with updates from measure stewards such as HEDIS, CAHPS, CMS, and change the benchmarks regularly. While we support consistency of quality measures with up to date clinical practice guidelines and continually being held to a high bar of performance, each new measure inclusion and methodology change requires resources to capture the measure consistently across our system. The impact of the work needed to manage the varying quality metrics is that we

must deploy resources to capture data acurately instead of deploying resources to work closely with the practices on actual quality improvement efforts. We strongly support the development of a common set of quality measures across process, outcome and patient experiences of care domains that all the carriers must use in risk contracts. The current regulation around carriers' use of a common set of quality metrics does not apply to risk contracts and does not bind carriers to a specific measure set, rather it defines a broad set of measures, in which the plans may choose measures.

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7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.

   SUMMARY: A founding priciple of BIDCO is the expectation of our providers to use community hospitals whenever clinically appropriate and reserve the use of referral to our AMC facility, Beth Israel Deaconness Medical Center, for only the highest acuity cases. We have seen important shifts in utilization from AMCs to community-based care within our system over the past three years as our community hospital network has grown and our physicians have been incenitivized to keep care local under our risk contracts.

   a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.
      For our commercial members, we've seen a 24% decrease in medical/surgical admissions to our AMC affiliate, BIDMC, from 2012 to 2013. Meanwhile, we've seen an 8% increase in admissions to our community hospital members. Over the past three years, we've seen an even greater increase in use of our community hospital members - close to double and greater decline of AMC inpatient use - close to 30%.
   b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.
      A founding priciple of BIDCO is the expectation of our providers to use community hospitals whenever clinically appropriate and reserve the use of referral to our AMC facility, BIDMC, for only the highest acuity cases. Further, our participation in global budget risk contracts for a majority of the patients that our providers care for aligns the PCPs own incentives with that of using the right care at the right time in the right place - which means keeping care local when appopriate. We regularly analyze trends of our patients' use of other high-cost facilities and share that data with our providers. We also regularly request that payors implement pricing and product changes to align the incentives of patients with providers so patients want to seek care within their physician network.

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8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
   SUMMARY: BIDCO is taking important steps to address post-acute care utilization. In our role as a Pioneer ACO caring for FFS Medicare beneficiaries, we are specifically focused

on post-acute care and ensuring that patients are discharged to the most appropriate setting - be it home, a home health agency or a SNF. We have done a significant amount of work within our system to put in place communication and care management protocols when a patient leaves the hospital to try to moderate our rates of post-acute care. In our opinion, APMs and specifically, Medicare and Medicaid APMs, have the largest potential to drive change in post-acute care utilization as the significant payers of post-acute care.

a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.
   BIDCO strives to ensure that patients are discharged to the most clinically appropriate, high-value setting through a variety of clinical initiatives. We do not currently have any analyses that we can share publicly, but we regularly share data on utilization of post-acute care both overall and at specific facilities with our providers and review the variation data internally at the management level.
b. How does your organization ensure optimal use of post-acute care?
   In our experience as a Pioneer ACO, costs associated with post-acute care represent a significant opportunity to be more efficient and improve patient outcomes so we have created a number of initiatives to drive optimal use of post-acute care - be it home with appropriate home services or a SNF. First, in collaboration with Atrius Health, we have evaluated the quality of SNFs in eastern Massachusetts by examining average lengths of stay; communication standards between SNF staff, PCPs and hospital staff; presence of clinical standards around sending patients back to the hospital or home; readmission rates back to the SNF and to the hospital; and CMS star ratings. We strongly encourage referral to the higher quality SNFs by providers in our network - both PCPs and hospital-based providers. Second, we work with dedicated SNF rounding physicians to ensure that our patients receive the highest quality care when in the SNF. Lastly, for our Medicare Pioneer ACO patients, we obtained a 3-day stay waiver so we can directly admit patients when clinically appropriate to a SNF to avoid the 3-day hospital stay payment policy. These waiver admissions are allowed to SNFs that we have a collaborative relationship with and know are commited to high-value care. The waiver program has been popular with our providers, including hospital discharge coordinators and ED managers, as well as with patients and families. We hope to have data on the outcomes of this program in terms of cost and quality of care in the coming months.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

SUMMARY: BIDCO is not a direct provider of medical care, so we do not share prices with patients at this time. However, our indiviudal providers have set up systems to be able to sharing prices with patients.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER: BIDCO is not a direct provider of medical care, so we do not share prices with patients at this time. Our provider members do fully comply with the price transparency requirement of Chapters 224.

10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
SUMMARY: BIDCO supports tiered and limited network products as long as we are able to participate as a system of care. We also strongly support standardization of purchaser and health plan tiering methodology to ensure accuracy, validity and operational feasibility for providers and patients.
ANSWER: BIDCO supports limited network products as long as we are able to participate as a system of care. Some plans have created networks that include our physicians or hospitals, but not both, which causes fragmentation of care and poor patient experience and seriously impedes our ability to provide care as an ACO. We also support insurance benefit designs that align patient incentives with our incentives under APMs - and limited network products have the ability to do that.

Health purchasers and payers that tier at the individual physician level are greatly concerning to us from a statisical validity and operational perspective. We strongly support standardization of purchaser and health plan tiering methodology to ensure accuracy, validity and operational feasibility for providers and patients. The current legislation to standardize health plan tiering processes does not address methodology issues - only quality measures. We have not made any changes to pricing as a result of tier placement nor have we experienced volume shifts as enrollment in tiered plans increases because we are generally in a favorable tier with the commercial health plans.

11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
SUMMARY: We stongly agree with the Commission that the integration of physical and behavioral health care is critical to caring for patients and managing healthcare costs. As we shared in 2013, the integration of behavioral and medical health continues to be one of most significant challenges our organization faces as we will discuss in part C. Despite access issues to behavioral health providers, BIDCO is working on several initiatives to address the social and medical needs of our high-risk patients through care management, a housecalls program, and through hiring social workers. These programs are a service to help our PCPs care for their patients and are not billed to insurers.
    a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.
    We have taken numerous steps toward integration over the past year. Specifically, we hired a social worker to work closely with our highest need patients to ensure that they are receiving the behavioral health resources they need and to coordinate with both our own nurse care management program and the patients' primary care teams. We are also exploring a partnership with a community behavioral health provider to give access to mental health services to our providers more broadly.
    b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.
    BIDCO has a robust care management structure for all of our highest need patients with the express goal of tending to patients social needs to ensure that they can stay in their home and out of the ED. The care managers are able to leverage community resources to do this - from Visting Nurse Association services to elder care services. For patients in our Pioneer ACO model with Medicare, we have a housecalls program where an NP visits high-risk patients in their homes, where the clinicians can often see other social and environmental factors affecting patients' health. The housecalls NP works collaboratively with the PCP and nurse care manager, if one is assigned, to manage the patient in their home and keep them out of the hospital. We've seen a reduction in ED use and improved patient experience as a result of the program.
    c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.
    The dominant challenge to integrating services has been access to behavioral health services and resources. Unless reimbursement for and the structure of behavioral health services improves, we are greatly stymied in our efforts to truly manage the care of our patients. Another challenge is that data on certain behavioral health services is not made available to us by payers, either under the audpices of privacy or payer practices. We are specifically challenged by the lack of substance abuse data. It is impossible to integrate and manage care for a patient

with behavioral and physical health needs when we only receive information on part of their experience in the health care system.

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

We are willing to report deidentified discharge data about behavioral health admissions if helpful to the Commonwealth in policymaking. However, we often are unaware of behavioral health admissions if they occur outside of our system due to the privacy law interpretations of health plans and CMS as noted in part C.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

SUMMARY: BIDCO does not have a policy or standard around PCMH accreditation within our network. Our community health centers are all accredited and our largest practice, HCA, is accredited.

a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?

10% of our providers are in practices that are accredited as PCMHs.

b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?

We don't currently capture information in this way.

c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

We have not conducted any analyses on the topic.

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13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

SUMMARY: See below.

ANSWER: The Commission's 2013 report and 2014 supplement offer important areas for improvement in the Commonwealth's health care system. We offer commentary on two specific areas identified in the reports: advancing alternative payment methods and fostering a value-based market. We have not seen significant attention from the health plans regarding expansion of APMs beyond the methods related to HMO (and fully-insured members only from two of the three largest carriers) over the past year. Given the Commission's findings on the reduction in enrollment in HMO products and increase in PPO and self-insured products - the ability to implement APMs for those patients is even more critical. We are eager to work with health plans, both commercial and Medicaid, to develop, receive data on and implement APMs for a broader patient population. We fully support the Commission in continued monitoring of trends related to insurance product enrollment and to begin to more closely monitor health plans' adoption of attribution methodologies and implementation of those methodologies in APMs. We also encourage the Commission to investigate the health plan rationale behind excluding self-insured

business in APMs and to work with employers to create the business case for APMs from their perspective. Finally, the discordance of quality measurement across current APMs offered by commercial payors causes unnecessary administrative expenses and wasted resources on the provider side. Quality measurement disalignment also results in an inability to capture what value we are acheiving through our care delivery model when quality is measured in different ways by each payer. We encourage the Commission to support stronger regulatory action around quality measurement alignment across payers as it relates to APMs.

In terms of fostering a value-based market, we applaud the Commision's and Attorney General's transparent and important reporting on the disparities in health care pricing among like-institutions in Masachusetts. However, we have not seen significant movement toward moderating the disparities over the past year from health plans, other providers or regulatory agencies - and in fact, the AG's settlement with Partners Healthcare institutionalizes the significant price disparities and allows the largest provider system to grow to a level that dominates the eastern market. As a system, we continue to focus on fair and competive pricing and controlling health care costs as an Accountable Care Organization by addressing the inpatient care trends at academic medical centers vs. community hospitals, the post-care trends as well as the behavioral health costs that the Commission found in its 2014 supplement report. We are addressing these utilization issues through the variety of initiatives mentioned in this testimony with great success. We thank the Commission for the opportunity to participate in the discussion on this critical set of issues facing our health care system and look forward to continued collaboration.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for providers. To the extent that a provider system submitting pre-filed testimony responses is affiliated with a hospital also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing for each year 2010 to 2013 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 Provider 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.

   Completed in Attachment AGO Provider Exhibit 1

   Please see attachment AGO Provider Exhibit 1. Please also note that we did not include data from 2010, 2011 and 2012 due to the nature of our organization changing fundamentally at the end of 2012 when we became BIDCO.

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2. 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 whether you consider the risk you bear to be significant.

   As shared last year, BIDCO relies on its own reporting systems and timely payer information to manage our risk. We have designed our risk contracts to limit the risk passed on to participating providers and to establish maximum deficit and surplus levels. In addition, BIDCO has individual patient stop-loss coverage in its major contracts, outside reinsurance in certain contracts, and reserves. BIDCO's physician member arm also has reserves that it has built up over the years and will continue to fund from current and future surplus payments. We also have internal methods in place to mitigate the financial impact of providers in deficit. We have developed an internal financing system across all payer agreements, thereby creating greater risk pools and minimizing the potential for a PCP group to be in deficit.

   BIDCO creates financial reports that aggregate our performance across all payers and regularly tracks liabilities against projected withholds and reserves.

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3. Please explain and submit supporting documents that show the process by which (a) your physicians refer patients to providers within your provider organization and outside of your provider organization; and (b) your physicians receive referrals from within your provider organization and outside of your provider organization. Please include a description of how you use your electronic health record and care management systems to make or receive referrals, any technical barriers to making or receiving referrals, and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization.

We strongly encourage our providers to keep referrals within the BIDCO system. To that end, we have agreements with several payers to waive prior authorizations for referrals within BIDCO. For referrals outside of our network, the PCP must sign off on the referral, which can be done through the electronic medical record system in some of our systems. In other systems, the referral process is still a phone call and manual information exchange. For some plans, if a BIDCO provider makes a referral to a non-participating provider outside of a plan's network, it is sent to our Medical Director to make a determination about whether or not it is allowed.

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4. Please explain and submit supporting documents that describe how, if at all, information on cost and quality is made available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care. Include in your response any type of information on costs or quality made available to your physicians through electronic health management, care management, disease management, large case-management or other clinical management programs.

As stated in question 3, we strongly encourage our providers to keep referrals within the BIDCO system and to use community based providers whenever clinically appropriate. We do not share cost and quality information with providers at the point of referral at this time. However, we regularly share information on cost differentials between providers as well as variance on costs of care or treatment for specific episodes of care with our physicians.

Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate 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 subject you to very limited or minimal "downside" risk.
6. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
8. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.

9. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
10. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
11. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2013

	Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	75,484,789	N/A	1,031,535	N/A	*	N/A	N/A	N/A	N/A	N/A	N/A
Tufts Health Plan	23,311,109	N/A	(239,690)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Harvard Pilgrim Health Care	29,200,493	N/A	2,961,839	N/A	*	N/A	N/A	N/A	N/A	N/A	N/A
Fallon Community Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CIGNA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
United Healthcare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Commercial	127,996,391	N/A	3,753,684	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Network Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Neighborhood Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
BMC HealthNet, Inc.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Health New England	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Fallon Community Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Managed Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Managed Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MassHealth											
Tufts Medicare Preferred	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blue Cross Senior Options	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Comm Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Commercial Medicare Subtotal	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicare	117,564,730		10,384,697								
Other											
GRAND TOTAL	245,561,121		14,138,381								

* Final quality settlement amounts not yet finalized for 2013 - expected in October/November 2014.