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:
   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.
      CMIPA is comprised of many independent physician practices and has only recently entered into alternative payment arrangements as an organization. As such, we have not had the data nor the ability to aggregate and analyze historical trends in total revenue, utilization and operating costs for our practices in total. We are in the process of developing a data warehouse so that as we move forward and are provided with updated claim and utilization data from the payers we will be able to better evaluate the effect of our efforts on total medical expense and utilization trends.
   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?
      CMIPA has continued to transition from volume-based reimbursement to value based payment with many of its payer contracts by opting into alternative quality contracts, including at-risk global payment and primary care capitation.

      We continue to direct our patients to less resource-intensive and more cost-effective settings when clinically appropriate. Such shifts include the use of a local free-standing ambulatory surgical center, Worcester Surgical Center, and admissions to a local community hospital, Saint Vincent Hospital, rather than sending these patients that do not require tertiary level of care to UMass Memorial Medical Center. We continue to encourage our physicians to have their patients seek alternatives to emergency department care when clinically appropriate by utilizing urgent care centers.
   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?
      New initiatives that the organization plans to undertake between now and OCtober 1, 2015 include the development of a skilled nursing facility program. We continue to develop and enhance our comprehensive claims data warehouse so that we are more efficiently able to monitor utilization and referral patterns and develop effective population health maangement efforts.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
Ongoing efforts to standardize and simplify administrative polices and procedures of the payers will help to improve staff and physicians' efficiency. An example would be the DOI requirement to develop standardized prior authorization forms for a number of different services.

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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:
    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?
    With the introduction and growth of APMs into our payer contracts, there has been an increased focus throughout our physician practices on quality and HEDIS-based clinical performance measures and increased efficiency by striving to keep services within network and with low-cost, high-quality providers.
    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).
    CMIPA has not conducted formal analyses on the implementation of APM's, though we recognize the need to devote a significant amount of staff time to the organization, collection and analysis of data regarding our physicians performance under such contract and will likely need to hire additional staff to continue these efforts.
    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.

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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:
    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?
    One challenge with health status risk adjustment measures is that they are subject to variation based on the coding practices of the physician, thus often giving an inadequate picture of the patients complexities. Health status risk adjustment

measures are lagged substantially, thus can also represent an inaccurate picture of the population at the current time.

b. How do the health status risk adjustment measures used by different payers compare?
We have not spent time analyzing the difference in measures across payers.

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?
We are increasingly focused on ensuring that providers have a solid understanding of coding principles that affect risk adjustment and its impact on our total medical expense budgets. We will devote more resources to provider education over the next year in this area.

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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:
ANSWER: Pricing transparancy as well as medical expense and performance benchmarks across provider groups would be very helpful to our organization in understanding our practice pattern variations and where we might focus our improvement efforts. The sharing of clinical best practices should be fostered and encouraged by the state.

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5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY:

a. Which attribution methodologies most accurately account for patients you care for?
Many of the patients cared for by CMIPA physicians have chosen a CMIPA primary care physician. The patient's choice of a PCP is the most accurate method of attribution.

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?
The best method of attribution is to link a patient to a primary care physician. In cases where the patient is not required to chose a PCP, his or her visits to a particular PCP would be used to link that patient to a provider network.

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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:

ANSWER: Although the quality measures required by private payers in particular are often the same or similar, there is still a tremendous amount of effort required on the part of CMIPA. Although we have rolled out an initiative to encourage many of our physicians (namely primary care providers) to consolidate into a single EMR, they are still existing today on upwards of 17 unique systems. Staff must manipulate data sent to us by private payers to create individual physician reports that can then be managed by physician/practice staff. Data being sent back to CMIPA is also often paper-based and requires additional staff manipulation to be useful for any meaningful analysis and/or for reporting back to payers. We have also devoted a significant amount of IT consultant time to finding ways to reduce our manual data management requirements as well as being able to accurately assess the IPA's performance in real-time.

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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. 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.
      Although we have not conducted formal in-depth analysis of inpatient utilization in AMCs, CMIPA on an ongoing basis monitors potential avoidable or unnecessary admissions to high cost AMC's that may have been appropriately managed at our in-network lower cost facility.
   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.
      CMIPA Medical Management staff meet with physicians approximately every 6-8 weeks, and as part of the standard package of reports, review the physicians' overall percent of hospital admissions going to our preferred low-cost provider as well as the detail of cases that were admitted elsewhere. We have found that physicians are very receptive and respond well to seeing their own trends. After an initial shift to our preferred facility in 2013, we have seen rates remain stable this calendar year, with certain physician groups (ex. pediatricians) continuing to refer patients to the tertiary facility due to clinical reasons felt to be in the patients best interest.

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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:
   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.

CMIPA has not conducted formal analysis on the use of post-acute care by different hospitals at the point of discharge.

b. How does your organization ensure optimal use of post-acute care?
As of July, CMIPA has created a skilled nursing program staffed by physicians and a nurse-practitioner that will manage a significant portion of CMIPA's patients in the post-acute care setting. Her focus will initially be on managing patients with the goal of efficient and appropriate discharge planning so that utilization in the post-acute setting.

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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:

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: We have found that most inquires by patients for cost estimates have been directed toward insurers, hospitals or other facilities where higher cost procedures are typically performed. We do not compile statistics on the number of those cost estimate inquiries.

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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:
ANSWER: CMIPA aims to refer patients to low-cost providers when clinically appropriate, though are doing so without referring specifically to tiering information made available by health plans. CMIPA has not experienced and cannot quantify any volume changes based on our tiering.

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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:
    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.
    CMIPA has not yet developed formal collaborations with other providers to intergrate physical and behavioral health care services.
    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.
    Although we have not yet developed formal programs to manage behavioral health patients, CMIPA works to coordiate care with other providers to the best of our ability.
    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.

    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.
    CMIPA believes that willingness to share data is integral for improvement and would participant in efforts laid out by the state in this regard, however at the current time our organization has limited behavioral health information to report. As a small organization, we are often faced with limited resources when responding to such requests and would like this to be taken into consideration when breadth, scope and timelines of such projects are developed.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.
    SUMMARY:
    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?
    Within CMIPA, one primary care practice (out of 27 practices providing primary care) has achieved PCMH accreditation.
    b. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
    Roughly 6% of CMIPA patients receive primary care at this PCMH recongnized practice.

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.
CMIPA has not conducted formal analysis on the impact of PCMH recognition or accreditation, however we recognize the value of many of the PCMH concepts and would want our practices to incorporate such concepts into their operations going forward.

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:
ANSWER:

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

CMIPA is in the process of developing a comprehensive claims data warehouse that will allow us to perform timely and accurate reporting on utilization and expense moving forward.

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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.

CMIPA will be registering as a Risk-Bearing Provider Organization with the Health Policy Commission and will be conducting further analysis in regards to our management of downside risk under our payer contracts. We will employ a certified actuary to assist us in this process.

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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.

CMIPA physicians exist on numerous separate and disconnected EMR systems, however our Medical Management staff provide updated information on physician referral patterns in face-to-face visits with providers. We monitor our out-of-network leakage via monthly utilization reports and make efforts to refer patients within network whever possible.

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.

Physicians are educated as to who the CMIPA in-network, low-cost and high-quality providers are and referral trends to these providers are monitored and reviewed in conjunction with them by CMIPA Medical Management staff. We do not have specific documents to describe this process.