NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

September 25, 2014

VIA ELECTRONIC MAIL

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116
HPC-Testimony@state.ma.us

RE: Request for Written Testimony

Dear Mr. Seltz:

Please find attached New England Quality Care Alliance's (NEQCA) response to the request for written testimony submitted by the Health Policy Commission and the Office of Attorney General.

I am legally authorized by the NEQCA Board to represent NEQCA in this matter. I am informed and believe, and upon such information and belief declare under penalty of perjury, that the statements made herein are true and correct

Sincerely,

Jeffrey I. Lasker, MD
CEO

Enc: Exhibit B and C Responses
Appendix

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: . In all of NEQCA's measurements, metrics are established to calculate and measure trends to ensure the proper amount of resources are being allocated to the appropriate areas to support the overall goals of NEQCA as a high quality, lower cost network achieving the Triple Aim.

   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.

      Given the organizational structure of our affiliated network the operational cost structure of both the provider and practice level is managed by those providers and practices with no insight or oversight by New England Quality care Alliance (NEQCA).

      NEQCA prides itself on tightly managing its operational costs. In overhead departments, managers are challenged to come up with their "key drivers" of cost. Overall, NEQCA calculates overhead rate as well as overall return on investment of the network annually. This ROI metric is managed clsoeley and communicated to the network annually and is used as a guiding light for the organization.

   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?

      See response 1a above.

   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?

      NEQCA provides care management for patients helping the most complex patients have their care coordinated, utilizing nurses to help implement care plans developed by the patient's physicians. Currently, this program is offered to patients with select payers payers and for select products, because of a lack of funding to provide these services for all patients. NEQCA is committed to implementing a "Consistent Model of Care Management" that will allow for care management for all patients regardless of payer using an integrated delivery team that includes: physician(s), care manager(s), care coordinator, pharmacist and other members (psychiatry, etc.) when needed.

NEQCA is also working to improve integration of behavioral health services with primary care. Please see Appendix for additional reponse.

a. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

NEQCA is dedicated to achieving the Triple Aim for all patients and pursuing a "Consistent Model of Care Management", yet we are currently limited to providing these efforts only to patients in plans that provide claims data and funding for the information technology and people needed to manage patients. The following changes will address this:

- Access to accurate, timely and comprehensive quality and efficiency data on ALL patients
- Reallocate care management resources from payers to actual providers
- Close the payment gap
- Uniform and transparent payment rules
- Reduce administrative burden on physician practices

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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: While the prevailing thought is that APMs will promote high quality, efficient and coordinated care, they do not in and of themselves lead to more integrated and high quality care. It has been our experience that APMs can provide the forum for better alignment of incentives and provision of critical patient information that will lead to more coordinated care, measureable increases in specified quality metrics and a reduction in overall cost. However, many APMs being developed today carve out major components that thwart the efforts of truly integrated care in some of the most significant areas of patient care – behavioral health and pharmaceutical care. APMs which exclude behavioral health and/or pharmaceutical services fail to provide data and opportunities for better care management and integration in some of the highest cost, most intense areas of patient care.

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?

NEQCA's physicians continue to demonstrate significant year over year improvement on quality performance measures, ranking among the top for several HEDIS measures in comparison to peer networks. APMs have helped provide the

data and funding to develop more integrated care models and targeted quality programs that have resulted in marked quality achievements throughout the network.

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).

Significant resources are required to manage and execute on successful population health management. This has incurred costs greater than providing care under standard fee for service models. NEQCA does not have recent analysis on the specific non-clinical impact alone. With dedicated resources and appropriate control of care we have been able to effectively improve quality and manage trends, enroll patients in care management and track improvements in specific health measures for our patients. This has resulted, not only in improved health outcomes for our patients, but also in more enhanced and positive patient experiences.

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?

Health status risk adjustment measures do not sufficiently account for changes in patient population acuity. In the commercial population where the underlying disparities in payments are so prevalent, the risk adjustment is influenced by those underlying payment disparities.

The fragmentation of the system at the payment level by health plan and by provider has an influence on the risk adjustment calculation. Utilizing a standard methodology, for example APRDRG, would create a standard of relativity and an ability to generate useful, comparable data that can be validated. Additionally, socioeconomic factors do not seem to be adequately addressed in current health status risk adjustment methods.

b. How do the health status risk adjustment measures used by different payers compare?

To the extent that we can understand, the various health status risk adjustment measures used by different payers do not easily compare. Because we are not provided with the details of the health risk adjustment methodologies, we know very little about each payer's formula. Each payer's methodology is comparable only to their own membership and is truly only valid for one fixed point in time because of the recalibration that is constantly being done by the payer. Because there is no transparency around each payers formula for health risk adjustment, there is no ability to compare or validate across payers. Since patients move between payers and tend

to remain with providers, a uniform and transparent health status risk adjustment would be highly beneficial in managing care.

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?

NEQCA has seen very little affect from the interaction of risk adjustment measures and other risk contract elements. Patients from populations with socioeconomic challenges can be more difficult to engage in quality and efficiency improvement efforts. These factors are not adequately accounted for in current risk adjustment methodologies.

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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: The absolute lack information on the PPO population is a significant hindrance to providing more coordinated patient care across a broader population and to better understanding trends in quality, variations in care and cost. The incomplete data for patients within managed products and APMs is also a hinderance to better patient care and broader population health management, for example behavioral health and pharmaceutical care. This data currently exist with the payers and we would greatly encourage the dissemination of this data if we really want to make gains in population health and make coordinated care a reality for as many patients as possible. We must question the underlying reticence to making this data available and balance that with the overall public good and the potentially very positive impact on the health of the Commonwealth.

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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: In our experience the most reliable patient attribution models are those in which the patient is required to select a primary care physician. In the absence of a patient driven attribution model and in the absence of a shared methodology applied uniformly across all payers, we believe any attribution model applied to the All Payer Claims Database would be a very good starting point. Any agreed upon methodology will require transparency and an ability to test and validate the attribution.

a. Which attribution methodologies most accurately account for patients you care for?

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for 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: NEQCA is committed to achieving the Triple Aim goals of better health, better care, and lower costs and believe strongly that there need be effective measures of population health, patient experience, and claims costs so that progress towards the Triple Aim can be measured. More needs to be done by all payers to support to the growing costs of gathering and managing the data and reporting processes, and simplification and unification of measure sets would also be helpful.

We frequently here from the physicians in our network about the increased burden they face relative to the various reporting requirements. Many of the smaller practices throughout our network inform us they are seeing a significant amount of time and resources shifted away from patient care and toward compliance for reporting within their practices.

ANSWER: Please see Appendix for the full response.

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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: NEQCA provides its practices with numerous tools and other supports to address inpatient utilization and reliance on high cost academic medical centers. This is reflected in the lower relative TME achieved by NEQCA in relation to other physician groups, as reported by the CHIA. NEQCA's goal is to keep patients in need of hospitalization in their local community hospitals when clinically appropriate.

Some examples of this are our Medical Home Program, where we enable physicians to identify and improve care for some of their high-risk patients, reducing unnecessary hospitalizations, NEQCA has also made reduction of potentially preventable ED visits a quality improvement initiative for the past two years. When tertiary or quaternary care is necessary, we encourage our physiciansto refer patients to our preferred academic medical center, Tufts Medical Center,

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.

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.

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: NEQCA is in the process of developing and implementing a post-acute program which includes expected standards of care for patients who receive post-acute services. In a highly successful post-acute program, identification of complex patients is crucial. Through identification of these individuals, NEQCA will be able to ensure the appropriate level of care as a patient transitions through the continuum after an acute-care hospitalization. We are still in the preliminary efforts of setting this program up and do not have analyses to share.

   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.

   b. How does your organization ensure optimal use of post-acute care?

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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: NEQCA is not a health care provider and is not in a position to provide cost information to patients. However, NEQCA intends on engaging with its affiliated physicians to assist the physicians with compliance with cost transparency requirements.

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:

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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: NEQCA and its providers have experienced no discernible impact as a result of placement in any tiered products. Patients do not seem to be leaving their primary care physicians, nor are they choosing specialist providers based upon their tiers. Tiering is not driving patient choice relative to selection of care providers or setting.

    ANSWER:

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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.
    NEQCA is working to address the significant co-morbidity of physical and behavioral health (BH) illnesses, and to develop programs to address the higher costs for patients with co-morbid illnesses as well as the potentially avoidable suffering. As outlined above, in section 1c, NEQCA has recently obtained and implemented two grants to integrate BH into primary care practices, and preliminary results are encouraging. What is lacking is a sustainable funding source beyond the grants that would support replication and dissemination of these models.

    In addition to integrating BH into primary care, the NEQCA care management program collaborates closely with the Tufts Medical Center Department of Psychiatry, and weekly supervision meetings are held by psychiatrists from Tufts and NEQCA care managers and pharmacy staff. This supervision and
    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.
    NEQCA has made reduction of potentially preventable ED visits a quality improvement initiative for the past two years. Using data on potentially preventable ED visits we have targeted certain diagnoses and parts of the network where this utilization is occurring. We have then worked with selected groups where the problem seems to be more significant to brainstorm ideas on how to reduce these potentially preventable visits. We have also taken a more general

approach to improving access to urgent care by working with our primary care practices to become Patient Centered Medical Homes recognized by the National Commission for Quality Assurance (NCQA). Part of achieving NCQA recognition is having clear policies on after-hours access, and providing every patient and family with information about how to get medical advice and information ou

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.
   Access to care and timeliness to treatment has been a challenge for physicians. Behavioral health resources, including inpatient beds, are frequently not available to patients. Wait times for outpatient services, and limited behavioral health clinicians in certain geography within the network, compound this issue. This is a concern for pediatricians, whose patients often have limited access to insurance coverage for a variety of BH services, ranging from neuropsychiatric testing services for children under the age of 6, to substance abuse and inpatient programs for adolescents. Closer integration of BH and primary care services, through staff like the Behavioral Health Coordinator above has started to improve access by identifying providers who are accepting new patients, reducing the wait time for appointments.
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.

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

SUMMARY: The NEQCA Medical Home Program is a growing program that includes the meaningful use of technology in a modern, efficient practice, with an optimized workflow and a physician-directed care team to help manage the most complex patients. This program supports provider professional satisfaction and allows providers to address the changing healthcare environment while delivering the highest quality patient care, outcomes, and overall experience. Please see the Appendix for the full response.

e. 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?

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

g. 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.

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

   NEQCA does not possess full financial data for the practices that are members of the organization. We do not possess practice level cost information nor do we have margin data for those practices.

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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.

   Summary:

NEQCA's approach to risk management has not changed in the past 12 months. NEQCA currently purchases stop-loss or reinsurance to cover potential catastrophic losses in its risk-based contracts. Accurate quantification and analysis of potential exposure for the network in a risk agreement is fully dependent on access to complete claims data, including information about the actual dollar amounts paid by the health plan for those claims and for the patients served by provider. Health plans do not currently share overall health status adjusted network costs and other groups' costs.

As prudent financial stewards NEQCA currently purchases stop-loss or reinsurance to cover potential catastrophic losses in its risk-based contracts. As a system, NEQCA bears the contractual risk in current global payment agreements, as well as the per member per month costs associated with all the deployed care management services to manage the patient population. NEQCA believes that it would be appropriate for payers to allocate from their reserves the appropriate level of capital to support contractual risk.

In order to accomplish the goals of population health management and the triple aim, the data, structures and incentives to move the needle must all be in place. This does not necessitate global budgeting nor risk agreements; it requires aligned incentives. Risk contracts allow for a general alignment but since current risk arrangements only cover a minority of the population, they are not going to create substantial change. It is also important to understand that entering into a risk contract does not in and of itself result in a transfer of true, long term actuarial population based risk. The risk and potential reward in a contract with a commercial health insurance payer is simply the result of a negotiation between the payer and provider. In the event that a historically high cost entity is able to embed its high costs into a negotiated global budget, all it has done is change the cash flow by which it is paid and it is still not held accountable to overall average cost, but is held only to its own baseline. This continues the disparities of the current market.
NEQCA would also like to observe that accurate quantification and analysis of potential exposure for the network in a risk agreement is fully dependent on access to complete claims data, including information about the actual dollar amounts paid by the health plan for those claims, for the patients served by provider.

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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.

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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.

NEQCA consistently and proactively provides physicians with cost and quality data relevant to our network, however we do not have a process by which we provide specific cost or quality information at the point of referral.

Appendix
HPC Questions for Written testimony
NEQCA response

1c. 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?

NEQCA provides care management for patients helping the most complex patients have their care coordinated, utilizing nurses to help implement care plans developed by the patient's physicians. Currently, this program is offered to patients with select payers and for select products, because of a lack of funding to provide these services for all patients. NEQCA is committed to implementing a "Consistent Model of Care Management" that will allow for care management for all patients regardless of payer using an integrated delivery team that includes: physician(s), care manager(s), care coordinator, pharmacist and other members (psychiatry, etc.) when needed.

NEQCA is also working to improve integration of behavioral health services with primary care. In 2013-14 NEQCA used a Harvard Pilgrim Healthcare (HPHC) Quality Improvement (QI) grant to place a care manager in a large adult primary care practice at Tufts Medical Center to perform screenings for depression and substance abuse for patients with diabetes, and then to offer care management and support for patients who screened positive. This effort successfully identified patients and also led to improvement in depression symptoms. We have been able to continue the program at the practice after the grant ended and are seeking financial support from the payers to be able to offer similar programs across the network. This year NEQCA won another HPHC QI Grant and is using the grant to hire a Behavioral Health Coordinator (BHC) to be shared among several small pediatrics practices in the Woburn area. This is an innovative approach to provide support to patients, families and their pediatricians impacted by delays in entry to behavioral health services, both inpatient and outpatient. The BHC will decrease the time to deliver much-needed services, as well as enhance communication between the clinical team and the family. Although it is too soon to measure the impact of this program, goals include: increasing access to inpatient and outpatient behavioral health services; identifying and linking patients, families, and caregivers to behavioral health supports and resources; and reducing Emergency Department (ED) utilization and containing the need for crisis intervention.

NEQCA is also looking to use technology to improve care of patients with Chronic Heart Failure (CHF), the diagnosis responsible for the greatest number of hospital admissions and readmissions among older adults. Through a grant from the Verizon Foundation and partnerships with Robert Bosch Healthcare, the Cardiovascular Center at Tufts Medical Center, and the Collaborative Health Accountable Care Organization, NEQCA care managers are working with cardiologists and primary care providers to place tablet computers with cellular connections into the homes of patients with CHF that will use a program developed by Bosch to provide daily monitoring of patients and better communication and collaboration with care managers as well as improved access to educational materials about how to manage CHF. Ultimately this should improve self-management of CHF and reduce potentially preventable hospitalizations and ED visits.

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.

NEQCA is committed to achieving the Triple Aim goals of better health, better care, and lower costs and believe strongly that there need be effective measures of population health, patient experience, and claims costs so that progress towards the Triple Aim can be measured. More needs to be done by all payers to support to the growing costs of gathering and managing the data and reporting processes, and simplification and unification of measure sets would also be helpful.

We frequently here from the physicians in our network about the increased burden they face relative to the various reporting requirements. Many of the smaller practices throughout our network inform us they are seeing a significant amount of time and resources shifted away from patient care and toward compliance for reporting within their practices.

NEQCA and its constituent practices (over 200 sites of care) invest significant amounts of resources to manage the data required to report to public and private payers. Creating a uniform measurement set would be extremely helpful, and could make it easier and less expensive for NEQCA and other healthcare providers. There are three sources of data used to measure Quality: insurance claims, medical record data, and patient experience data. Each data source has its own challenges in how it is obtained, and the level of effort required to make sure the data set is complete and accurate.

Claims data provide information about amounts paid and diagnosis codes and show that a payer has paid for a test or visit, implying that it has happened. Claims data are regularly sent from payers to NEQCA when there is a risk contract for those patients, but we do not get data on patients in PPO or indemnity contracts where the members do not choose a Primary Care Provider (PCP). For example, each month Blue Cross Blue Shield of Massachusetts sends NEQCA all of its claims for patients enrolled in HMO products, but they do not provide claims data on PPO patients. In terms of the government payers, we do not get any Medicare data currently, but will soon have data for those enrolled in the Medicare Shared Savings Program Accountable Care Organization (ACO) we are planning to start 1/1/15, and we do not get any Medicaid claims. Without access to claims it is not possible to measure clinical quality or costs.

Clinical data comes from medical records and often has to be extracted either through automated or electronic data extraction, which is especially difficult for NEQCA where we have physicians who use 40 different electronic health records (EHR) and some who are still using paper charts. Because the data are labeled and structured differently in each EHR system, extracting and normalizing the data is a really challenging task, and we are in the process of purchasing a Health Information Exchange (HIE) system which will allow us to gather and connect data across the different EHR systems, a costly undertaking which requires considerable human resources as well. Tufts MC and NEQCA are active in the Mass HIWAY effort, but this is only part of the solution. Support for HIE-related costs and data management need to be shared across payers and providers.

For patient experience data, patients are surveyed on a regular basis, and there are different questionnaires required by different entities so that it is currently impossible to do one survey and meet the needs for practices that are part of a Medicare ACO, and want to achieve Patient Centered Medical Home (PCMH) recognition from the NCQA and also meet contractual

requirements for annual Massachusetts Health Quality Partners (MHQP). Not only are the surveys different, but it is extremely expensive to get data on a regular basis that is at the level of the individual physician, and these costs seem to be going up each year, along with the greater requirements to obtain the data by private and government payers. The recent willingness by the HPC to work with MHQP is helpful, but given that publicly-reported patient experience data are a public good that helps achieve shared goals, more financial support should be made available. Accurate and timely patient experience data is critical to advancing current improvement efforts.

Given the challenges to obtaining the claims, clinical and patient experience data, the current variability in measure sets and requirements by the private and government payers aggravates the difficulty and cost of obtaining data. For example, many of our commercial contracts require us to obtain claims-based measures, which is relatively easy, but the differences between measures (for example, some payers require patients with diabetes to achieve a hemoglobin A1c (measure of blood sugar levels) of less than 8, others less than 9, and for those involved in Medicare ACOs, there is a whole set of diabetes measures and scoring related to performance across all measures and not just on one measure at a time). The variability not only is burdensome, but makes it difficult to clearly communicate clear and simple goals to clinicians and patients, and therefore makes it harder to create targets and goals that are consistent and based on the patient's needs rather than each payer's unique definition of quality and how they provide rewards for achieving targets.

There are also problems with quality measure availability and utility that become clear in the cases of children and hospital quality measurement. Measuring the quality of care of children is challenging because there are many fewer measures available, and because the performance has improved enough on some of these measures that there is no meaningful difference between high and low performers. Work is being done to improve this situation, but more is necessary and efforts to harmonize measures across payers would also be useful. Similarly, for acute care hospitals, the differences between high and low performers mean that a few patients can have significant financial impact for the entire system. Some hospital measures have been retired because of this lack of performance discrimination, but others are still in place, and this is especially challenging since in the case of academic medical centers like Tufts Medical Center, there is no severity adjustment to take into account that many patients are sicker and at higher risk for poor outcomes, or have received care at outside institutions that can have negative consequences for Tufts MC. Moreover, the results of many measures used to measure hospital outcomes are dependent on coding more than actual clinical results.

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

The NEQCA Medical Home Program is a growing program that includes the meaningful use of technology in a modern, efficient practice, with an optimized workflow and a physician-directed care team to help manage the most complex patients. This program supports provider professional satisfaction and allows providers to address the changing healthcare environment while delivering the highest quality patient care, outcomes, and overall experience.

Through the Medical Home program, patients will continue to have a relationship with a Primary

Care Provider leading a collaborative team that is collectively responsible for their care. As team members themselves, the patients will benefit from the additional personalized support and will be encouraged to become more invested in their own care and focused on increased self-management. Studies have shown that the overall satisfaction of physician and practice staff increases with the implementation of a Medical Home model. The NEQCA Medical Home Program utilizes the deployment of teams of NEQCA-employed care managers, electronic health record experts, care coordinators and other skilled professionals to provide additional support for each office in the transformation into a Medical Home.

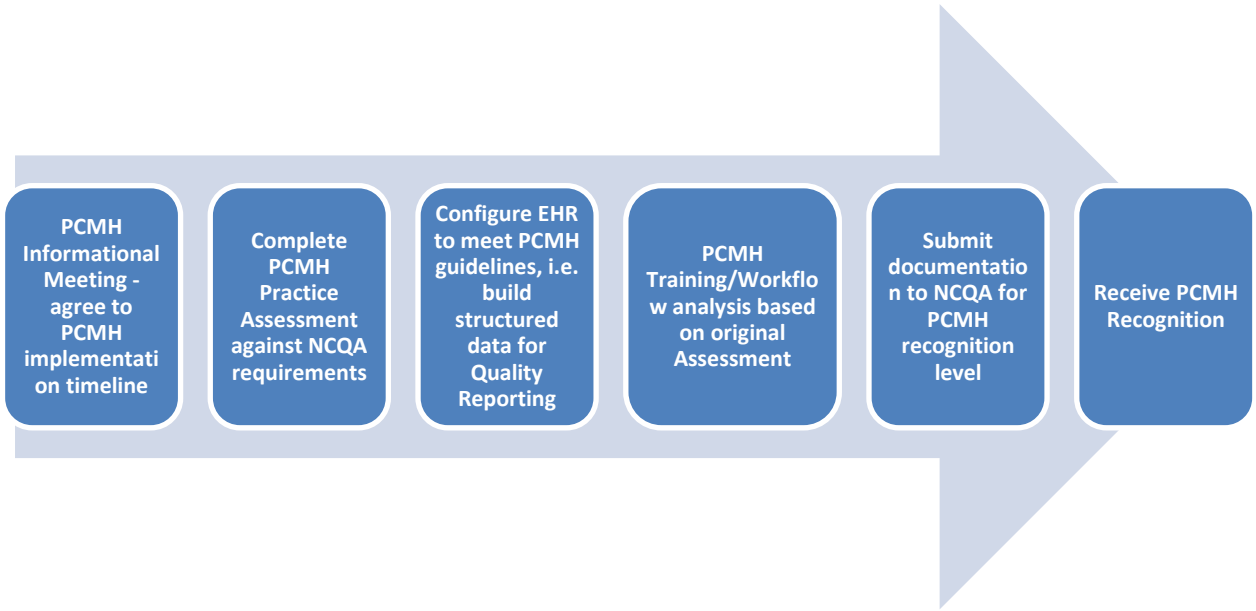
The goals of NEQCA's Medical Home Program are to:

- Achieve Patient Centered Medical Home (PCMH) National Committee for Quality Assurance (NCQA) Recognition Level II or Level III
- Engage with the highest risk patients to support enhanced self-management of health and active participation in treatment
- Improve quality and efficiency performance Achieve Meaningful Use Attestation for Electronic Health Records
- Improve provider, staff and patient satisfaction

The NEQCA Medical Home Program distinguishes itself by its innovative linkage of three program components: (a) helping practices improve their workflow and adopt a Patient Centered Medical Home "system of care" as recognized by the National Commission on Quality Assurance (NCQA); (b) meaningful use of technology; and (c) the addition of care team members to help manage the most complex patients. Each component of the Medical Home program is important. The NCQA has set a national standard for excellence in physician practice implementation of Patient Centered Medical Homes and all patients will benefit from receiving their care from practices who meet this standard. In addition, patients will benefit from Meaningful Use support as PCPs who successfully meet the Meaningful Use standards program criteria are better able to use their Electronic Health Records (EHRs) to manage populations of patients. Meaningful Use is the set of standards defined by the Centers for Medicare & Medicaid Services (CMS), and is an Incentive Program that governs the use of Electronic Health Records (EHR) and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria; for example; ePrescribing, electronic health exchange of patient information, and submission of the Clinical Quality Measures to CMS.

Because over 80% of Primary Care Providers (PCPs) in the NEQCA network work in practices with two or fewer providers, it is particularly important to our patients that NEQCA develop these integrated systems of care. Practices with two or fewer providers are typically left behind in the health care industry with respect to implementation of electronic health records or team-based care, due to lack of infrastructure and technical expertise, and higher overhead costs. The Patient Centered Medical Home System of Care (PCMH SOC) component of NEQCA's Medical Home Program helps NEQCA primary care practices, especially small practices that typically lack expertise and resources, through the difficult set of tasks required to manage populations of patients in a patient-centered environment that is necessary to be successful as our healthcare system evolves from fee for service to global budgeting and capitation. The PCMH SOC program

component helps practices meet NCQA recognition standards by making modifications to office workflow processes that aid the delivery of high quality care, managing medical expense, improve patient health, and increasing physician and staff satisfaction as well as patient engagement. The SOC Team also includes a Practice Quality Coordinator (PQC), who helps the practices develop and implement performance improvement projects. PQCs also provide ongoing monitoring to assure that once a practice has met NCQA recognition that it will continue to use the new workflows and improve performance on quality measures. PCPs at NEQCA's practices are expected to deliver high quality care at a lower cost while at the same time enhancing patient experience.



The entire process of a practice to achieve NCQA recognition takes approximately 10-12 months. Each NEQCA practice identifies a physician and operations champion who conducts workgroup meetings and also helps to create consensus throughout the practice and helps to implement improvement and change.

NEQCA is very interested in the Patient Centered Medical Home Certification Criteria developed by the Health Policy Commission and looks forward to participating and collaborating at the state level. NEQCA also welcomes and encourages participation by the payers in the PCMH Certification process. Payers hold the keys to greater deployment of high quality, efficient, patient focused care delivery in the form of patient data and financial resources. . It has become apparent through NEQCA's work with practices on implementing the PCMH SOC that sustaining the improvements will require continued practice focus and continued practice support through ongoing coaching and providing resources.

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?

a.

NEQCA Eligible PCPs:	432
PCMH Recognized PCPs:	70 (as of 9/1/2014)
Total %:	**14%**

- ✓ NEQCA is on track for an additional **82** providers to be recognized by the end of 2014, which would increase the percentage to **35%**.

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

17.3% of our patient's receive care from PCPs who have been recognized as a PCMH. However, this total is inclusive of the following insurances only, as we are limited to data that is part of claims registry (BCBS, Fallon, HPHC, Tufts, and Tufts Medicare Preferred). Therefore, all government and some of the commercial payers patient panels are not represented in this percentage.

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.

In 2013, we submitted 8 practices, which included 53 physicians for PCMH recognition. We compared those 8 practices Diabetes HEDIS performance from 2012 to 2013 (2013 being the PCMH implementation year). Below is the summary of that data. Although Diabetes was a focus in our PCMH Implementation, we cannot attribute this improvement only to the PCMH Implementation process as there were several Quality Initiatives and Programs at NEQCA working on these measures. We hope to be able to do a more thorough analysis as we have a larger number of practices achieve PCMH recognition.

2012 vs. 2013 Diabetic HEDIS Performance in PCMH Recognized Practices (2013 being the PCMH Year)

Overall Highlights

- 5/8 practices showed overall improved performance on the Diabetic HEDIS measures
- All practices improved in 2 or more measures
- 5/8 practices improved in 4 or more measures
- All practices had double-digit improvement in at least 1 measure