BRIGHAM AND WOMEN'S HOSPITAL

HARVARD MEDICAL SCHOOL

Elizabeth G. Nabel, M.D.
President, Brigham and Women's Health Care
Professor of Medicine, Harvard Medical School

Office of the President
75 Francis Street, Boston, MA 02115
Tel: 617-732-5537, Fax: 617-582-6112
Email: enabel@partners.org

Submitted Electronically via HPC-Testimony@state.ma.us

September 11, 2015

Dear Ms. Johnson:

Enclosed you will find written testimony for Brigham and Women's Health Care, as requested for the upcoming cost trend hearings.

By my signature below, I certify that I am legally authorized and empowered to represent Brigham and Women's Health Care for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please direct any follow-up questions to Aimee Golbitz, Office of Government Affairs at Partners HealthCare (agolbitz@partners.org 617-278-1119).

Sincerely,

Elizabeth G. Nabel, M.D.

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), 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 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 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 both days. 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 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 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 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, 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: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University 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 at Kelly.A.Mercer@state.ma.us a minimum of two (2) 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, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits 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 complete your responses in the provided **Microsoft Word** template. 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**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

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.

[Remainder of page intentionally left blank]

Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 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 in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

Brigham and Women's HealthCare (BWHC) is comprised of two hospitals: an academic hospital, Brigham and Women's Hospital (BWH), and a community hospital, Brigham and Women's Faulkner Hospital (BWFH). While operating under two distinct licenses, the two hospitals function as a single entity with integrated clinical, administrative and governance functions. Our strategic plan is to create value for our patients by moving care to the community, lowering utilization and lowering patient expense. We have accomplished this through an overall strategy that we term population health management (PHM) which includes: empowering our primary care practices to become NCQA certified patient-centered medical homes; moving secondary care to BWFH while focusing tertiary and quaternary care at BWH; developing care management programs for our highest risk patients; utilizing the full spectrum of care settings throughout Partners Healthcare (PHS) including primary care, community hospitals, academic hospitals and post-acute care; applying technology to better connect care teams with patients and families; and integration of behavioral health services into all of our care settings.

Accordingly, we have included revenue, utilization and operating expense data for BWH and BWFH for FY14 (10/1/13-9/30/14) and the first two quarters of FY15 (10/1/14-3/31/15).

Brigham and Women's Hospital

					% Change		
Fiscal Year	Cases	Net Patient Service Revenue	Total Costs	Facility	Cases	NPSR	Cost
2014	1,410,086	$ 1,779,301,158	$ 1,609,225,158	BWH	2.2%	1.3%	1.9%
2015 Q1+2	726,619	$ 908,122,002	$ 827,769,002	BWH	3.1%	2.1%	2.9%

Note: Data are collected and analyzed based on BWHC's fiscal year, which runs Oct. 1- Sept. 30. All data above reflect this timeframe.

Brigham and Women's Faulkner Hospital

					% Change		
Fiscal Year	Cases	Net Patient Service Revenue	Total Costs	Facility	Cases	NPSR	Cost
2014	172,644	$ 195,052,000	$ 196,295,000	BWFH	2.8%	8.6%	3.1%
2015 Q1+2	89,600	$ 103,021,000	$ 104,151,000	BWFH	3.8%	5.6%	6.1%

Note: Data are collected and analyzed based on BWHC's fiscal year, which runs Oct. 1- Sept. 30. All data above reflect this timeframe.

In FY14 and FY15, BWHC saw an overall increase utilization, defined as Cases (inpatient discharges, acute treatments/observations (ATOs), and outpatient visits) of 2.3% and 3.1%, respectively. BWH has had an increase in utilization of 2.2% and 3.1% respectively, and BWFH has experienced an increase of 2.8% and 3.8%, respectively, as more patients continue to choose BWHC to receive care. BWHC has had $1,974,353,185 and $1,011,143,002 in net patient service revenue (NPSR) in FY14 and FY15, respectively, which breaks down as 1.3% in FY14 and 2.1% in FY15 for BWH and 8.6% in FY14 and 5.6% in FY15 for BWFH, due to an increasing governmental payer mix and moving more care to the outpatient setting. Operating expenses have been contained and have increased at a lower percentage than overall volume and inflation. Our goal at BWHC is to realign our base costs such that we fund medical inflation at a greater rate than our reimbursement rate, so that we can fund our strategic investments, as defined above, including population health management.

b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

As part of Partners HealthCare (PHS), Brigham and Women's HealthCare (BWHC) is deploying a multi-faceted strategy we term population health management (PHM), to address health care cost trends. PHM strategies include: empowering our primary care practices to become NCQA certified patient-centered medical homes; moving care into the community, including secondary care to Brigham and Women's Faulkner Hospital (BWFH) while focusing tertiary and quaternary care at Brigham and Women's Hospital (BWH); developing care management programs for our highest risk patients; utilizing the full spectrum of care settings throughout PHS including primary care, community hospitals, academic hospitals and post-acute care; integration of behavioral health services into all of our care settings; fostering patient engagement; new technologies, including an integrated electronic health record; and creation of new incentive structures for our care providers and hospitals. All of these efforts have preceded and expanded since January 1, 2014.

We are focused on complex high risk care management, and BWHC has hired care managers, social workers, pharmacists, and community resource specialists who help manage high risk patients. We have initiatied a number of programs around specialist engagement, patient engagement and post-acute care which we discuss below, and these programs have helped us begin to bend the cost curve on total medical expense (TME).

The Epic IT system installation (Partners eCare) has facilitated greater coordination of care across the entire care spectrum..

BWHC is focused on provider cost reduction, termed our "patient affordability" program, which has resulted in $300M reduction in our operating expenses from 2011-2014. We are continuing this continuous improvement process, using lean technology approaches, into FY15 and beyond. To accomplish these goals, we have engaged in a multi-faceted reduction in non-labor and labor expenses which include benchmarking guided labor management, supply standardization/utilization/pricing, employee benefits redesign, and a strategic energy master plan. In addition, moving care into the community at lower cost structures has also led to reductions in operating expenses across BWHC.

Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

Brigham and Women's HealthCare (BWHC) is comprised of two hospitals: an academic hospital, Brigham and Women's Hospital (BWH) and a community hospital, Brigham and Women's Faulkner Hospital (BWFH). While operating under two distinct licenses, the two hospitals function as a single entity with integrated clinical, administrative and governance functions. Our strategic plan is to create value for our patients by moving care to the community, lowering utilization and lowering patient expense. We have accomplished this through an overall strategy that we term population health management (PHM) which includes: empowering our primary care practices to become NCQA certified patient-centered medical homes; moving secondary care to BWFH while focusing tertiary and quaternary care at BWH; developing care management programs for our highest risk patients; utilizing the full spectrum of care settings throughout Partners Healthcare (PHS) including primary care, community hospitals, academic hospitals and post-acute care; and integration of behavioral health services into all of our care settings.

These efforts in PHM are vital to our strategy to move towards value-based care. Accordingly, BWHC, through Partners HealthCare (PHS), is participating in risk-based contracts with 3 commercial payers (Blue Cross/Blue Shield of Massachusetts, Tufts Health Plan, Harvard Pilgrim Health Care) and with CMS~~E~~ in the Pioneer ACO. We will continue these alternate payment methods in FY16 (October 1, 2015-September 30, 2016).

Examples of our focused work in FY16 include: 1) our commitment to transform primary care through patient centered medical homes and high risk care management efforts; 2)implementing a behavioral health integration program in primary care, which supports primary care practices and includes training, enhanced screening, central support for patients and embedded resources in primary care practices to implement collaborative care models; 3)engaging specialists through increased virtual visit and electronic referral management systems, which reduces specialist office visits and provides alternatives to traditional encounter-based visits for specialist care.

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

While Brigham and Women's Health Care, through coordination with Partners Health Care, is committed to reducing the growth of health care costs, it does so in the face of serious challenges. Removing these challenges would greatly speed the pace of progress towards lowering health care costs. These challenges include:

- Ability to pursue new partnerships with community hospitals and community physicians
- Reimbursement models with mis-aligned incentives (e.g., global budgets based on underlying fee for service payments; and services such as nurse care managers not adequately reimbursed)
- Public payer shortfalls/Health Safety Net
- Duplicative reporting requirements
- Complex, highly variable billing policies
- Lack of access to real-time patient claims data

•Labor costs
•Heightened demand for high-cost technology and interventions
•Pricing of new treatments by the pharmaceutical industry

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

Brigham and Women's HealthCare (BWHC), as a member of Partners HealthCare (PHS), has continued to increase adoption of alternative payment methods. Barriers to further adoption result from a lack of consistency in payer methodology, including:

- Attribution – Commercial payers and Medicare use different methodologies to attribute patients to providers. On the commercial side, patients may have selected a primary care provider (PCP) as a requirement of their HMO product, but may not have engaged with that provider. In these instances, the PCP may not feel accountable for that patient's care and yet the PCP still faces a substantial administrative burden to make sure that patient is seen in the office (in order to better manage that patient's care), even if the patient does not wish to be seen. On the Medicare side, patients frequently move in and out of contracts, resulting in significant "churn," making it difficult for PCPs to be accountable for such patients.

- Calculation of total medical expense (TME) – No standard methodology has been identified and adopted related to how to calculate TME. As a result, an organization like BWHC/PHS may demonstrate dramatically different results across contracts. This lack of consistency makes it difficult for provider organizations and individual providers to trust the performance data and evaluate the true impact of population health management programs. Additionally, the delay in TME performance reporting prevents real-time evaluation and action.

- Reimbursement Models – Reimbursement models are not designed with aligned incentives, such as global budgets, which are actually based on underlying fee for service payments. In addition, there are currently limited or inadequate reimbursements for cost-saving services, including virtual visits, electronic consults, and community health workers.

- Quality metrics – Each contract has established baseline quality metrics utilizing now outdated HEDIS measures. As national care guidelines have changed, the guidelines have moved away from the standard HEDIS measures; meanwhile, NCQA has not adjusted the HEDIS definitions with the same pace or flexibility. As a result, provider organizations face pressure to meet outdated HEDIS definitions in order to perform well on external contracts, while individual providers wish to provide high quality care based on the most current national guidelines.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.

a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

1. Post-acute care – Brigham and Women's Health Care (BWHC) continues to focus on post-acute care by working closely with post-acute providers; BWHC has selected 6 Skilled Nursing Facilities (SNFs), based on a series of criteria including quality performance and volume of referrals, with which we collaborate to ensure high quality, efficient care for BWHC patients in their facilities. - As part of this collaborative relationship, we have established a bi-monthly forum to educate one another on challenges to effective care transitions, as well as to address key issues, including readmissions and transitions of care. In addition, BWHC has hired a care coordination nurse who works to manage SNF care for patients discharged from Brigham and Women's Hospital (BWH). This nurse partners with each SNF to ensure that care plans are established, that lengths of stay are appropriate, and that patients are properly transitioned back to home and to their PCPs. BWHC has also expanded the CMS SNF waiver to allow for patients who clinically do not need an inpatient stay to be referred to a SNF and then followed by a BWHC care coordination nurse once at the facility. Primary care has also implemented processes to follow-up with all of their patients discharged from the emergency department and hospital within a set number of days post-discharge.

2. 30-day readmissions – There are several BWHC programs focused on reducing readmissions. First, clinical leaders from key services (general medicine, cardiology, orthopedics, and CT surgery) receive monthly reports on their readmission rates and detailed data on readmitted patients and when and why they were readmitted. These services--both independently and in conjunction with the hospital's department of quality and safety--have developed multiple programs for care transitions. These include specialized care transition nurses for advanced heart failure patients, an outpatient infusion center for heart failure patients, a cardiology post-discharge program using an app that allows patients to stay better connected to their hospital and outpatient care team, and a pneumonia care redesign program. In addition, BWHC has partnered with an external vendor to provide home visits by pharmacists for high risk patients with complicated medication regimens, following discharge from the cardiology service. This program seeks to conduct medication education and reconciliation aimed at improving medication adherence. In addition, the program works to prepare patients for their follow-up visits with their cardiologist and coordinates care with other members of the patient's BWHC care team. The overall goal of this program is to reduce readmissions in complex cardiology patients. In addition, the BWHC-SNF collaborative mentioned above ~~also~~ aims to prevent readmissions.

3. ED utilization – BWHC offers extended weekday hours within all of their primary care practices, and weekend hours at four practices, which are then open to all of our practices to refer patients to. In addition, those patients identified as high risk and enrolled in the high risk care management program (see detail below) can speak with their care management nurses who can advise and triage them appropriately prior to their visiting the ED. The Cardiology ACTIVE infusion center also allows an alternative to the ED for patients with heart failure where they can receive IV diuretics among other therapies.

4. High Risk/High Cost Patients - Partners/BWHC runs a high risk care management program (iCMP) that matches high-risk patients with nurse care managers who work closely with them and their loved ones to develop a customized health care plan to address their specific health care needs. The care managers closely monitor the patients during office appointments and through phone calls and home

visits, and they serve as a liaison between the patient and the many other members of the care team – including the PCP, social worker, pharmacist, and community resources specialist. The care managers also help to arrange transportation, find in-home nursing assistance, and coordinate services such as diagnostic tests, social services, and specialist services.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
    1) Post-acute Care – Brigham and Women's Health Care (BWHC) will continue our SNF collaborative and Primary Care process to follow up with all of our patients discharged from the emergency department and hospital within a set number of days post-discharge. In addition, we will look to:
        a. Hold a broader meeting twice a year that convenes a wider range of SNFs and Long Term Acute Care facilities which BWHC refers patients to
        b. Expand the SNF collaborative to include an additional 1-2 SNFs, with high quality and a large volume of BWHC referrals
        c. Refine an existing dashboard that holds SNFs accountable for readmission rates, length of stays, etc.
        d. Establish additional requirements for being a SNF within the BWHC collaborative (e.g., defined MD/NP team responsible for caring for BWHC patients)

    In addition, BWHC will also expand our overall post-acute strategy to better assess appropriate levels of care; as well as metrics to hold home health care providers accountable for efficient, high quality care of BWHC patients.
    2) 30-day readmissions – BWHC will continue with all of the existing programs and reporting mentioned above. With regard to the SNF collaborative, we will design and launch a readmission review tool that will help facilitate collaborative discussions between BWHC and the SNFs to identify the causes of readmissions and to prevent them.
    3) ED utilization – BWHC will continue with extended hours at primary care practices. In addition, Partners Health Care (PHS) will team with MedSpring Urgent Care to open and operate a number of urgent care clinics – called Partners Urgent Care – throughout eastern Massachusetts over the next five years. The new urgent care centers will have physicians onsite from 9 am to 9 pm daily, including weekends. Patients will be seen on a walk-in basis, or they can schedule advance appointments.
    4) High Risk/High Cost Patients - PHS/BWHC will continue to develop the high risk care management program, including:
        a. Evaluating methods to run the program more efficiently, including but not limited to, piloting the use of Community Health Workers alongside our Neighborhood Health Plan's high risk patients with behavioral and socio-economic challenges
        b. Advancing the use of palliative care in this patient population
        c. Evaluating a lighter touch model for those patients in the "rising risk" category

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
    a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?
    See response in Partners document.

    b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.
    See response in Partners document.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 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.
    a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.
        1) Integrate Physical and Behavioral services– In addition to the iCMP program (discussed above), which helps coordinate care for medically complex patients with behavioral comorbidities, Brigham and Women's Health Care (BWHC) has embedded social workers in every primary care practice since 2012. Together with community resource specialists, who are centralized resources available to all practices, our social workers support our PCPs in treating both already identified high risk patients, as well as other patients referred by PCPs. Additionally, in 2015 Partners HealthCare (PHS)/BWHC has further emphasized the need for integrated behavioral health care; specifically, primary care practices are measured on their utilization of the PHQ-2/PHQ-9 for patients in a risk contract. To support the care of these patents once they are identified as needing behavioral health treatment, Partners/BWHC has begun moving towards a collaborative care model and further embedding psychiatrists, psychologists, behavioral support specialists, and behavioral community resource specialists in each practice. The goal is to have 50% of the network in collaborative care models by the end of 2015.
        2) ED/Inpatient utilization – As mentioned above, BWHC has been addressing ED utilization via extended hours at primary care practices and the use of the high risk care management team. To address inpatient utilization, BWHC has extended the CMS SNF waiver (as mentioned above) that enables Medicare patients to be referred straight to a SNF rather than directly admitted to the inpatient setting or sent to the ED, when an inpatient stay is not needed. In addition, Partners/BWHC has also

launched the Partners Mobile Observation Unit, which is currently staffed by two nurse practitioners and can be utilized by the ED, a PCP, or high risk care manager to visit a patient at home the day following an ED visit and for a short period of time after. This mobile unit is an effort to minimize the need for inpatient care by bridging the gap between acute care and primary care. As mentioned above, primary care has also implemented processes to follow-up with all of their patients discharged from the emergency department and hospital within a set number of days post-discharge. As mentioned above, the Cardiology ACTIVE infusion center also allows an alternative to the ED or inpatient stays for patients with heart failure, where they can receive IV diuretics, among other therapies.

b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.
    1) Integrate Physical and Behavioral – Brigham and Women's Health Care (BWHC) will continue to move towards a fully functional collaborative care model in each of its primary care practices. The goal is to find the right combination of resources—psychiatrists, psychologists, social workers, behavioral support specialists, and behavioral community resource specialists—that is appropriate for each practice culture and set of patient demographics. In addition, we will further measure and evaluate data to advance treatments and pathways related to the diagnoses of depression, anxiety, and substance abuse disorders. In addition, Partners HealthCare (PHS)/BWHC will start designing and implementing a cognitive behavioral therapy program. Lastly, as mentioned above, BWHC is piloting a community health worker program in our health centers to better meet the behavioral and socio-economic challenges of our high risk patients within our Neighborhood Health Plan risk contract.
    2) ED/Inpatient utilization – As mentioned above, BWHC will further address ED utilization with the development of a joint venture with MedSpring Urgent Care to open and operate a number of urgent care clinics. With regard to inpatient utilization, BWHC will continue to expand the use of the CMS SNF waiver, as clinically appropriate. BWHC will also expand the use of the Partners Mobile Observation Unit. In addition, BWHC is actively monitoring inpatient admissions, including evaluating our high risk care management programs' impact on inpatient admissions. Primary care will continue to evolve their processes related to patient outreach following a discharge from the ED and/or hospital.
    3) The investment in the Epic electronic health record is a medium in which care teams can effectively coordinate care better through easily accessible data, decision support, and efficient communication.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific

capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

Partners Health Care (PHS) has developed multi-year milestones specific to PCMH with a final goal of having all our primary care practices National Committee for Quality Assurance (NCQA) recognized by the end of 2018. To help our primary care network succeed, we have created an internal framework for practices to begin familiarizing themselves with the key elements of a medical home. In addition, we have created a robust program to assist practices in applying for PCMH recognition through NCQA.

At Brigham and Women's Health Care (BWHC) specifically, we began the journey toward PCMH prior to the Partners developed programs. To date, BWHC has 3 of its 14 practices designated as NCQA Level 3 Medical Homes. In addition, more than 70% of the Primary Care Physicians at BWHC have reached "primed status;" an internal status designated by Partners, which recognizes these practices as being ready to begin the NCQA certification process. BWHC is on track to meet the goal of all practices NCQA recognized by 2018.

Exhibit C: Instructions and AGO Questions for Written Testimony

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

1. Please provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.

BWHC*		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website**	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1	IP: not tracked OP: not tracked	N/A	N/A	Not tracked
	Q2	IP: not tracked OP: not tracked	N/A	N/A	Not tracked
	Q3	IP: 27 OP: 69	N/A	96	IP: Natural Childbirth, Cesarean Section, Hysterectomy, Gastric Bypass, Knee Replacement, Hernia Repair, Mastectomy OP: MRI (various), X-ray (various), CT scan, Dermatology office visits, Removal of Skin Lesion, Colonoscopy. Mammogram, Arthroscopy, Ultrasound
	Q4	IP: 48 OP: 111	N/A	159	
CY2015	Q1	IP: 37 OP: 117	N/A	154	
	Q2	IP: 44 OP: 85	N/A	129	

*includes Brigham and Women's Hospital and Brigham and Women's Faulkner Hospital
**Website directs patients to call Patient Billing Solutions to request an estimate; this information is included in the telephone inquiries

2. Please submit a summary table showing for each year 2011 to 2014 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 Hospital Exhibit 1** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.
   See Attachment #1

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.

2011 - BWH	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/(Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 88.1		$ 6.9		$ 49.7	$ 2.1					$ 67.8	$ 265.3			
Tufts Health Plan	$ 22.7		$ 1.5		$ 1.2	$ -					$ 22.9	$ 41.1			
Harvard Pilgrim Health Care	$ 33.8		$ 2.2		$ 1.5	$ 0.1					$ 62.2	$ 52.0			
Fallon Community Health Plan											$ 8.4				
CIGNA											$ 33.4	$ 0.4			
United Healthcare												$ 62.1			
Aetna											$ 47.9	$ 9.7			
Other Commercial												$ 82.5			
Total Commercial	$ 144.6		$ 10.7		$ 52.4	$ 2.2					$ 242.6	$ 513.1			
Network Health											$ 19.7				
Neighborhood Health Plan											$ 37.6				
BMC HealthNet, Inc.											$ 1.5				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											$ 58.8				
Mass Health											$ 47.6				
Tufts Medicare Preferred											$ 21.7				
Blue Cross Senior Options											$ 4.6				
Other Comm Medicare											$ 7.3	$ 33.9			
Commercial Medicare Subtotal											$ 33.6	$ 33.9			
Medicare [1]												$ 353.5			
Other [1]												$ 108.5			
GRAND TOTAL	$ 144.6		$ 10.7		$ 52.4	$ 2.2					$ 382.6	$ 1,009.0			

Notes:

[1] Revenue reported in $Millions.

[2] Data includes BWH.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account. Revenue for services provided to PHS employees/dependents currently available only for PHS providers in total; above $s estimated based on PHS in total revenue for services provided to PHS employees/dependents as a proportion of payer revenue.

[7] Revenue from Risk Contracts for Budget Surplus/(Deficit) and Quality Incentives currently available only for PHS providers in total; therefore, not included in hospital-specific submission.

2012 - BWH	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/(Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 22.0		$ 1.7		$ 50.3	$ 63.9	n/a		n/a		$ 100.7	$ 237.0			
Tufts Health Plan	$ 5.7		$ 0.4		$ 12.3	$ 0.9	n/a		n/a		$ 33.7	$ 44.5			
Harvard Pilgrim Health Care	$ 8.4		$ 0.6		$ 16.2	$ 1.5	n/a		n/a		$ 76.4	$ 64.8			
Fallon Community Health Plan											$ 9.6				
CIGNA											$ 40.5	$ 0.2			
United Healthcare												$ 58.5			
Aetna											$ 56.1	$ 10.3			
Other Commercial												$ 82.1			
Total Commercial	$ 36.1		$ 2.7		$ 78.8	$ 66.3					$ 317.1	$ 497.5			
Network Health											$ 12.1				
Neighborhood Health Plan											$ 31.8				
BMC HealthNet, Inc.											$ 0.9				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											$ 44.9				
Mass Health											$ 55.5				
Tufts Medicare Preferred											$ 23.9				
Blue Cross Senior Options											$ 5.6				
Other Comm Medicare											$ 5.7	$ 33.7			
Commercial Medicare Subtotal											$ 35.3	$ 33.7			
Medicare [1]						$ 44.2		n/a				$ 331.0			
Other [1]												$ 113.0			
GRAND TOTAL	$ 36.1		$ 2.7		$ 78.8	$ 110.5					$ 452.8	$ 975.2			

Notes:

[1] Revenue reported in $Millions.

[2] Data includes BWH.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-

[7] Change from 2014 submission – Revenue under Risk Contracts and FFS Arrangements for Medicare has been restated with updated information.

[8] Revenue from Risk Contracts for Budget Surplus/(Deficit) and Quality Incentives currently available only for PHS providers in total; therefore, not included in hospital-specific submission.

2013 - BWH	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/(Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					$ 58.7	$ 72.2	n/a		2013 not settled yet		$ 108.3	$ 264.4			
Tufts Health Plan					$ 16.4	$ 1.0	n/a		2013 not settled yet		$ 34.0	$ 49.9			
Harvard Pilgrim Health Care					$ 22.2	$ 1.6	n/a		2013 not settled yet		$ 80.1	$ 67.1			
Fallon Community Health Plan											$ 11.3				
CIGNA											$ 47.9	$ 0.6			
United Healthcare												$ 59.8			
Aetna											$ 58.0	$ 9.7			
Other Commercial					$ 1.3							$ 120.8			
Total Commercial					$ 98.7	$ 74.7					$ 339.6	$ 572.5			
Network Health											$ 16.1				
Neighborhood Health Plan					$ 1.8		n/a		n/a		$ 26.7				
BMC HealthNet, Inc.											$ 1.7				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											$ 44.6				
Mass Health											$ 55.4				
Tufts Medicare Preferred											$ 22.0				
Blue Cross Senior Options											$ 7.1				
Other Comm Medicare											$ 7.2	$ 14.8			
Commercial Medicare Subtotal											$ 36.3	$ 14.8			
Medicare [1]						$ 47.5		n/a				$ 349.5			
Other [1]												$ 122.3			
GRAND TOTAL					$ 98.7	$ 122.2					$ 475.9	$ 1,059.0			

Notes:

[1] Revenue reported in $Millions.

[2] Data includes BWH.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account. Revenue for services provided to PHS employees/dependents currently available only for PHS providers in total; above $s estimated based on PHS in total revenue for services provided to PHS employees/dependents as a proportion of payer revenue.

[7] Change from 2014 submission – Revenue under Risk Contracts and FFS Arrangements for Medicare has been restated with updated information.

[8] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue for services provided via risk agreement with Neighborhood Health Plan.

[9] Revenue from Risk Contracts for Budget Surplus/(Deficit) and Quality Incentives currently available only for PHS providers in total; therefore, not included in hospital-specific submission.

2014 - BWH	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/(Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					$ 59.9	$ 75.6	n/a		n/a		$ 96.9	$ 269.5			
Tufts Health Plan					$ 16.4	$ 1.0	n/a		n/a		$ 34.1	$ 50.9			
Harvard Pilgrim Health Care					$ 15.9	$ 1.4	n/a		n/a		$ 81.3	$ 64.8			
Fallon Community Health Plan											$ 15.8				
CIGNA											$ 50.6	$ 0.5			
United Healthcare												$ 68.4			
Aetna											$ 60.2	$ 8.5			
Other Commercial					$ 6.8						$ 21.5	$ 114.0			
Total Commercial					$ 99.0	$ 78.0					$ 360.3	$ 576.6			
Network Health											$ 6.2				
Neighborhood Health Plan					$ 16.5		n/a	n/a			$ 29.6				
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$ 5.7				
Total Managed Medicaid					$ 16.5						$ 41.5				
MassHealth											$ 56.6				
Tufts Medicare Preferred											$ 19.8				
Blue Cross Senior Options											$ 8.1				
Other Comm Medicare												$ 21.8			
Commercial Medicare Subtotal											$ 27.9	$ 21.8			
Medicare						$ 49.5		n/a				$ 361.5			
Other												$ 86.9			
GRAND TOTAL					$ 115.6	$ 127.5					$ 486.3	$ 1,046.8			

Notes:

[1] Revenue reported in $Millions.

[2] Data includes BWH.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account. Revenue for services provided to PHS employees/dependents currently available only for PHS providers in total; above $s estimated based on PHS in total revenue for services provided to PHS employees/dependents as a proportion of payer revenue.

[7] Revenue from Risk Contracts for Budget Surplus/(Deficit) and Quality Incentives currently available only for PHS providers in total; therefore, not included in hospital-specific submission.