CMIPA INC.
An Independent
Physician Association

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September 10, 2015

To Whom It May Concern,

I am the legal and authorized representative of Central Massachusetts Independent Physician Association for the purposes of this testimony.

The testimony that has been provided is complete an accurate to the best of my knowledge and ability.

Sincerely,

Gail Sillman
CEO, CMIPA

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.

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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.
    In CY2014 and YTD 2015 revenues and utilization appear to have remained relatively flat with small increases in hospital outpatient and prescription drugs. Operating expenses increased significantly as the organization made additional investments in IT and staffing. The increase in operating expenses was necessary in order to obtain the resources to be effective in managing patient populations as part of its alternative payment arrangements.

    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?
    The organization has made investments in IT and care management. Specific focus has been on development of a claim data warehouse, integrating clinical data and deploying a care management system. We feel this will assist us in identifying medical cost drivers and enable us to enhance our disease management and care management services.

    c. 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?
    The organization will continue to participate in alternative payment arrangements and will look for opportunities to expand that participation where it is practical to do so. The organization has also entered into a Medicare Shared Savings Program and will be renewing its participation in this program for calendar year 2016. The organization would have liked to begin to manage its PPO population in the same way it has managed its HMO population, but has not been allowed to participate in risk sharing programs because it has not met the threshold for covered lives established by some of the managed care plans.

    d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?
    We would welcome the opportunity to participate in certain PPO risk management products, but this would require that the State build in some protections for the smaller and more efficient provider organizations to participate in these contracts and not force them into larger systems that have expensive built-in cost structures. Examples of such protections include payors offering the opportunity to all groups

with covered lives of at least 5,000, IT support grant for organizations that have between 0-500 physicians or who are not part of a hospital system.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?
   Participation in alternative payment arrangements requires an organization invest in IT systems, analytical staff and care management staff. It is important that an organization does not over extend itself and participate in more alternative payment arrangements than it can effectively manage. Most provider organizations have limited resources so additional infrastructure dollars from the government would be required to level the playing field between hospital owned systems and small provider organizations.

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.
      Our organization implemented a program to reduce expenses related to post-acute care by placing a nurse practitioner in select nursing homes as a way to improve care and reduce length of stay. We also expect to open an urgent care center on our service area that will reduce avoidable ED visits. In addition, we are in the process of developing a high-risk care management patient system that will allow us to better manage our sickest patients. By proactively managing this population, we hope to reduce avoidable readmissions as well.

   b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
      We plan to open two urgent care centers in our service area [in partnership with DocExpress] in the next 12 months and will continue efforts to develop enhanced care management and high-risk patient management systems.

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?
      Since managed care contracts are the result of negotiation between parties, there are many reasons why prices may vary across providers for the same services. One could make the case that it would be acceptable for prices to vary based on a provider's quality or expertise in performing a particular procedure. Some providers, like academic medical centers, may have higher cost structures due to their use of advanced

technology and research capabilities which might justify higher rates. Unacceptable price variation might occur because one of the parties (either payer or provider) possesses undue market power and as a result can force the other to accept rates that vary significantly from the norm.

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.
When patients seek care at higher cost facilities for procedures that could be performed in a lower cost setting, this increases overall cost of care. However, it is often extremely difficult to direct patients to the lower cost providers when they have preconceived notions of which providers or hospitals are considered "the best." When these patients move away from local, low-cost providers, it can threaten the financial sustainability of local, low-cost providers. Ensuring that patients bear some of the cost for making this choice is absolutely necessary.
Furthermore, revisiting the concept of rate setting for provider group budgets would be extremely important. While limiting the heath care growth benchmark to 3.6% is a good first step, it is extremely important to standardize budgets among all provider groups across the state and not lock in inefficiencies that have accumulated in the past. Provider groups should be rewarded or penalized if they perform under or over the network budget. Budgets that are set based upon historical costs lock in a provider's performance and it does not facilitate lowering overall costs. Moreover, it can drive a provider organization out of business if they are so efficient because their budgets will continued to be reduced dramatically even if they perform well below the average network budget.

Provider Fee Schedules should be adjusted so that there is no greater than a 10% delta in the state from the highest to the lowest paid group.

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.

    No specific initiatives at this time.

    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.
    No specific initiatives at this time.

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?
   A small number of our primary care physicians have achieved PCMH recognition and we continue to encourage our primary care practices to pursue PCMH recognition and to adopt as many PCMH concepts as they can. We also have begun participation in a Medicare ACO and are working to develop the care management, referral management and analytical tools necessary to improve the coordination of patient care across all payers.

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 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.

		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	N/A			
	Q2	N/A			
	Q3	N/A			
	Q4	N/A			
CY2015	Q1	N/A			
	Q2	N/A			

Our organization does not receive inquiries directly from patients so no statistics are available.

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 Provider 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. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

   Exhibit 1 grids for CY2013 and CY2014 are attached to this submission. No data is available prior to CY2013. Reliable physician claim-based revenue is only available for CY2014.

3. Please explain and submit supporting documents that describe (a) the process by which your physicians make and receive patient referrals to/from providers within your provider organization and outside of your provider organization; (b) how you use your electronic health record and care management systems to make or receive referrals, including a description of 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; (c) how, if at all, you make cost and quality information available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care; and (d) whether your organization, in referring patients for services, ascertains the status in the patient's insurance network of the provider

to whom you are referring the patient, and informs the patient if that provider is not in the patient's insurance network.

Currently the CMIPA process of making referrals is not centralized. Each physician has the ability to refer patients to a specialist of their choosing. However, physicians are encouraged to refer within our provider network. Generally, speaking referrals are sent through electronic health record or fax.

CMIPA relies on payers to provide real-time data at the point of referral. CMIPA provides reports that delineate lower versus higher cost options for certain providers post facto in both office and group meetings with providers.

CMIPA physicians do provide real-time payer information to patients with regard to referrals.

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

	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															
Tufts Health Plan															
Harvard Pilgrim Health Care			INFORMATION NOT AVAILABLE FOR THS TIME PERIOD												
Fallon Community Health Plan															
CIGNA															
United Healthcare															
Aetna															
Other Commercial															
Total Commercial															
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid															
MassHealth															
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare															
Other															
GRAND TOTAL															

2012

	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															
Tufts Health Plan															
Harvard Pilgrim Health Care			INFORMATION NOT AVAILABLE FOR THS TIME PERIOD												
Fallon Community Health Plan															
CIGNA															
United Healthcare															
Aetna															
Other Commercial															
Total Commercial															
Network Health															
Neighborhood Health Plan															
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid															
MassHealth															
Tufts Medicare Preferred															
Blue Cross Senior Options															
Other Comm Medicare															
Commercial Medicare Subtotal															
Medicare															
Other															
GRAND TOTAL															

2013 **CMIPA**

	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	x	x	x	x	**x**	x	**$1.97M**	x	**$2.38M**	x	x	x	**$1.1M**	x	x
Tufts Health Plan	x	x	x	x	**x**	x	**$.151M**	x	**$0**	x	x	x	**$.046M**	x	x
Harvard Pilgrim Health Care	x	x	x	x	**x**	x	**$0**	x	**$.120M**	x	x	x	**$.081M**	x	x
Fallon Community Health Plan	x	x	x	x	**x**	x	**$.446M**	x	**$0**	x	x	x	**$.195M**	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Total Commercial	x	x	x	x	x	x	**$2.56M**	x	**$2.5M**	x	x	x	**$1.5M**	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	x	**$.051M**	x	x
Health New England	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Fallon Community Health Plan	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Other Managed Medicaid	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Total Managed Medicaid	x	x	x	x	x	x	x	x	x	x	x	x	**$.051M**	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	x	**($.188M)**	x	**$0**	x	x	x	**$.061M**	x	x
Blue Cross Senior Options	x	x	x	x	x	x	**$.014M**						**$.030M**		
Other Comm Medicare	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Commercial Medicare Subtotal							**$.014M**		**$0**				**$.091M**		
Medicare	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
GRAND TOTAL	x	x	x	x			**$2.39M**		**$2.5M**				**$1.64M**		

2014 **CMIPA**

	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	x	x	x	x	**$5.13M**	x	**$2.1M**	x	**$1.1M**	x	x	x	**$.900M**	x	x
Tufts Health Plan	x	x	x	x	**$1.17M**	x	**$.278M**	x	**$0**	x	x	x	**$.039M**	x	x
Harvard Pilgrim Health Care	x	x	x	x	**$2.64M**	x	**$.162M**	x	**$.063M**	x	x	x	**$.068M**	x	x
Fallon Community Health Plan	x	x	x	x	**$3.25M**	x	**$.770M**	x	**$0**	x	x	x	**$.337M**	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Total Commercial	x	x	x	x	**$12.19M**	x	**$3.3M**	x	**$1.16M**	x	x	x	**$1.34M**	x	x
Network Health	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	x	**$.065M**	x	x
Health New England	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Fallon Community Health Plan	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Other Managed Medicaid	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Total Managed Medicaid	x	x	x	x	x	x	x	x	x	x	x	x	**$.065M**	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Medicare Preferred	x	x	x	x	x	x	**$0**	x	**$0**	x	x	x	x	x	x
Blue Cross Senior Options	x	x	x	x	x	x	x	x	x	x	x	x	**$.009M**	x	x
Other Comm Medicare	x	x	x	x	x	x	**$.130M**	x	x	x	x	x	x	x	x
Commercial Medicare Subtotal	x	x	x	x	x	x	**$.130M**	x	x	x	x	x	**$.009M**	x	x
Medicare	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
GRAND TOTAL							**$3.4M**		**$1.16M**				**$1.42M**		