NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

September 15, 2015

VIA ELECTRONIC MAIL

David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02109
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

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.

NEQCA is comprised of nearly 1,800 physicians organized into 15 Local Care Organizations across eastern Massachusetts from Lawrence to Cape Cod, from Boston to I-495, caring for more than 500,000 patients. However, due to 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 NEQCA.

    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?

New England Quality Care Alliance (NEQCA) is a partnership of community and academic physicians dedicated to providing comprehensive, innovative, high quality and affordable health care that brings value to their patients and the community. Our work expands the teaching and research mission of Tufts Medical Center.

The NEQCA network includes solo and group practices, Independent Practice Associations (IPAs), Physician Hospital Organizations, and academic and community physicians. NEQCA physicians are organized into groups called Local Care Organization (LCOs). LCO physicians are on staff at community hospitals throughout eastern Massachusetts, keeping local care at local hospitals while working with and referring to NEQCA colleagues at Tufts Medical Center and Floating Hospital for Children, a lower cost provider, for tertiary care needs. NEQCA uses a robust care management program to manage high acuity patients to decrease avoidable ER visits, avoidable hospital admissions and to moderate total medical expense.

    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?

NEQCA is committed to supporting a full-range of independent physician practices (more than 75% of our Network is comprised of 1-2 physician practices) to ensure their success. We have the ability to work with different size/style community practices and effectively drive and build their population health capabilities. NEQCA helps practices manage change by implementing programs that make it easier for physicians to succeed. The development of specific programs such as our Medical Home Program (inclusive of Patient Centered Medical Home, Meaningful Use, Care Management), Clinical Pharmacy Management and Quality Improvement, position our physicians for value-based payments.

NEQCA has for many years, and will continue, to participate in value based payments (global payments and risk sharing arrangements with payers). In January of 2015 NEQCA's affiliate, NEQCA Accountable Care was selected by CMS to participate in the Medicare Shared Savings Program and we will continue to work with our LCOs to deliver high-quality coordinated care to our Medicare patients.

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

NEQCA supports primary care providers in meeting the Quadruple Aim goals of *providing better care and better population health, at lower cost and to improve the work life of clinicians and practice staff*. However, as we have stated in previous years, we continue to be limited in our ability to provide these services only to patients in plans that provide claims data and funding for the information technology and people needed to manage patients.

We suggest the following changes:

- Ensure providers have 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
- Standardize and make transparent payment rules across all payers
- Reduce administrative burden on physician practices
- Require payers compensate for coordination of behavioral health
- Correct barriers to clinical information sharing between mental health providers and medical providers
- Carve mental health back into global payment contracts

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

For several years NEQCA has encouraged and supported our network of physicians to participate in APMs. NEQCA doctors have reinvested savings from risk-based insurance contracts back into their practices and network infrastructure to fund innovations that will improve patient experience, quality of care, and lower costs; we have been able to do this and keep total cost of care near statewide average. As a network our practices have demonstrated year over year improvements in BCBS AQC Gate Score from 2008-2013, aggressively managing Total Medical Expenses (TME) under budget every year of the AQC contract.

However, as we have stated in previous years, while APMs help in the promotion of 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.

The inability of payers to provide important patient 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. Increased adoption of APMs must be accompanied by an appropriate shifting of resources from the payer to the provider to ensure successful execution. Increased risk sharing on the side of the provider should come with an adequate shifting of the premiuim dollars held in reserves by the payer to mitigate the risk they formerly held, as providers are epxcted to bear this risk and cover deficits that may occur as a result of particiaption in an APM, they should have access to the funds intended for this purpose.

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.

NEQCA provides its practices with numerous tools and other supports to enable physicians to identify and improve care for some of their high-risk patients and reduce unnecessary hospitalizations and reliance on high cost academic medical centers. NEQCA has also made reduction of potentially preventable ED visits a quality improvement initiative for the past several years. This is reflected in the lower relative TME achieved by NEQCA in relation to other physician groups, as reported by CHIA and the recognition our practices receive from the payers for being top performers in re-admission prevenetion.

NEQCA has implemented 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 is able to ensure the appropriate level of care as a patient transitions through the continuum after an acute-care hospitalization.

NEQCA supports its practices in addressing some of the key measures noted above through various programs, such as the Practice Quality Associates (PQAs) program, where PQAs are assigned geographically to provide data, tools, and recommend best practices from around the network. PQAs support enhanced access to physician practices by increasing their office's ability to reach out to patients to remind them of appointments, tests, and follow up scheduling. This program was created in direct response from physician practices not having sufficient resources to complete daily tasks involved with population health management. Another NEQCA program supporting our practices in the care management of highly complex patient populations is the Pharmaceutical Quality and Cost Management program where NEQCA pharmacists help network providers optimize their medication prescribing by developing preferred drug lists, providing the most cost-effective drug choices, reducing costs without sacrificing quality. NEQCA's Pharmacy Program deploys pharmacists to work with physicians to support LCO clinical initiatives by providing data and tools with the goal to improve optimal prescribing. Pharmacists provide information about medications as new drugs are developed or new information (such as changes in labeling or market withdrawals) becomes available.

Other components of support for complex patients include referral management and frequent physician and team meetings to monitor and improve quality of care.

Through this model, patient care is focused on four levels:

1. Complex Care Management, providing in-home health coaching to the top 3%–5% of the highest-risk patients and coordinating care with the patients' multidisciplinary healthcare team.
2. Chronic Care Management for the next 15%–17% of highest-risk patients, which is staffed by nurse care managers who provide telephonic coaching, management of admissions and transitions of care.
3. Specialized Primary and Network Care in Heart Failure (SPAN-CHF), developed by Tufts Medical Center cardiologists through research interventions and implemented with NEQCA nurses, this program is for patients with congestive heart failure who require individualized assessment and education plans by providing in home monitoring of patients using telehealth technology.
4. Case management embedded at the practice level; Care managers, facilitate the care management needs of members at highest risk for experiencing adverse outcomes in inpatient settings including hospitals, skilled nursing facilities and acute rehabilitation centers.

NEQCA also provides its network of physicians with analytical services, which include report development and data interpretation that delivers critical information to physicians to help them plan for patient visits by flagging those patients who have not met treatment goals across a various quality measures. NEQCA analysts identify areas to deliver care more efficiently and help inform strategies that will allow the network and its physicians to achieve clinical goals.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
Please see response to 3a. above.

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?
    NEQCA concurs with the response provided by Tufts MC relative to price variation: Variations in price should be examined by provider peer group and should only vary due to differences in case mix acuity, health status, quality, socioeconomic status, academic and research costs.

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.

Price variation is a major contributor to the overall cost of care and inappropriately weakens efficient and high quality providers. NEQCA has felt the impact of price variations as we work to build the NEQCA network and to retain and support our current network. Provider groups paid higher prices have a greater ability to shield their physicians from bearing any financial risk associated with a risk arrangement with a payer. The higher prices they receive ensure their physicians will receive expected payments regardless of their quality and efficiency performance. Price variations in global payments and other alternative payments have a significant impact on the amount of funding available for innovation and infrastructure support for community practices.

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.

NEQCA continues to be focused on addressing the significant co-morbidity of physical and behavioral health (BH) illnesses, and to developing programs to address the higher costs for patients with co-morbid illnesses as well as the potentially avoidable suffering. NEQCA has increased provider and patient/family satisfaction and decreased ED and inpatient utilization by integrating pediatric behavioral health coordinators into pediatric practices to better address behavioral health needs of children and teens cared for by NEQCA pediatricians.

Behavioral Health Coordinators (BHC) are shared among several small pediatrics practices. 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 decreases the time to deliver much-needed services, as well as enhance communication between the clinical team and the family. The goals of this program 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.

In all of NEQCA's Patient Centered Medical Home practices behavioral health is a major component integrated into the care and services provided by the practice, as is the screening and data collection for a number of behavioral health measures. This data collection can be challenging depending on the capabilities of an EMR. However, the biggest challenges related to the integration of behavioral health services are:

1. The ability to pay for specialists, such as social workers and other behavioral health experts, to be integrated into the practice.

2. The ability to access behavioral health services and treatment once patients have been identified as needing those services.

    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.
    Please see response to 5a above.

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?

NEQCA is a participant in the CMS MSSP ACO program and has a long-standing commitment to the PCMH model. NEQCA has been working to implement a PCMH model of care since 2008, and has dedicated significant resources to achieving NCQA PCMH status for many of our practices. Currently, 138 physicians across 50+ practice sites are either Level 2 or Level 3 recognized on the 2011 NCQA standards, and another 91 physicians across 32 practice sites are in progress to submit for NCQA recognition for 2015.

NEQCA's Medical Home Program supports primary care providers in meeting the Quadruple Aim goals of *providing better care and better population health, at lower cost and to improve the work life of clinicians and practice staff*. Having learned from successful implementation of Electronic Health Records and helping those practices achieve Meaningful Use, and with our experience in designing and implementing care management for complex patients, NEQCA's Medical Home Program is helping practices meet their goals of delivering outstanding, patient-centered care.

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

- Achieve Patient Centered Medical Home (PCMH) NCQA Recognition Level 2 or Level 3 within a 10-12 month implementation timeline
- 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
- Build quality improvement capabilities into practice work flow.

The NEQCA Medical Home Program is notable for 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 NCQA

(b) supporting practices to achieve "Meaningful Use" of technology as defined by the Centers for Medicare & Medicaid Services (CMS)

(c) care management for the most complex members, defined through claims-driven algorithms and predictive modeling or referrals from providers.

Through the Medical Home program, patients continue to have a relationship with their Primary Care Provider who leads a collaborative team that is collectively responsible for their care. As team members themselves, the patients benefit from the additional personalized support and are encouraged to become more invested in their own care and focused on increased self-management. Practices with two or fewer providers are typically left behind with respect to the implementation of electronic health records or team-based care, due to lack of infrastructure and technical expertise, and higher overhead costs. Because 75% of Primary Care Providers (PCPs) in the NEQCA network work in practices with two or fewer providers, it is particularly important that NEQCA help its small practices.

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				
	Q2				
	Q3				
	Q4				
CY2015	Q1				
	Q2				

NEQCA is not a health care provider and is not in a position to provide cost information to patients. However, NEQCA is available to help its affiliated physicians understand the cost transparency requirements.

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.
   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.

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.

NEQCA does not utilize an electronic health record to make or receive referrals. 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.