Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

1. Strategies to Address Health Care Spending Growth

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. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC presented at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between $279 to $794 million annually.

a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.

i. **Priority 1**: Shift care from high-cost settings (e.g., academic medical centers) to lower-cost settings (e.g., community hospitals)
ii. **Priority 2**: Reduce unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions)
iii. If you selected "other," please specify: Click here to enter text.

b. Please complete the following questions for **Priority 1** (listed above).

i. What is your organization doing to advance this priority and how have you been successful?

Atrius Health continues to bring services and diagnostic testing from hospitals to our lower cost physician offices whenever possible. In addition, we have been increasing utilization of our preferred hospitals, community hospitals and other low cost settings such as free-standing ambulatory surgery centers, telemedicine, and the patients' homes when such settings are clinically appropriate, provide the same or better quality of care at a lower cost, and when the care can be better coordinated and is more convenient for our patients.

Examples of specific initiatives underway at Atrius Health include the following:

- Ambulatory Migration Project – Atrius Health launched the ambulatory migration project initiative earlier this year with the goal of moving appropriate outpatient surgical and endoscopy procedures to high-quality, lower-cost settings that include lower cost hospitals, freestanding Ambulatory Surgical Centers (ASCs), and our own office-based setting. This initiative is estimated to deliver $2M in annual medical expense savings while continuing to achieve excellent clinical outcomes. Prior to embarking on this project, approximately 88% of our ambulatory surgery and 25% of our endoscopy procedures were performed in hospital outpatient departments at a cost of between 50-100% more than procedures performed at freestanding ASCs, which have lower fee schedules/cost and yet provide high-quality care. As of July 31, 2017, we have successfully migrated 1250 cases (375 into the Atrius

Health office setting, 700 to ASC's, and 175 to lower cost hospitals). Thus far, the feedback from our patients has been extremely positive and we remain committed to the goal of moving care to lower cost settings where clinically appropriate.

- Total Joint Replacement (TJR) Program – Atrius Health partnered with Boston Outpatient Surgical Suites (BOSS) to perform total joint replacement surgery in their free-standing ambulatory center (ASC) this spring. Other parts of the country moved appropriate TJR cases to lower cost ASCs about a decade ago, but this is the first time that these are being done in Massachusetts. Patients recover at home with the support of home health nurses and physical therapists. Knee and hip replacements in the Boston area typically range from $25,000-35,000 in inpatient facilities, whereas free-standing outpatient surgery centers typically provide these procedures at a cost that is 40% or more below hospital costs. All three of Boston's local commercial insurers have approved payments for patients receiving total joint replacements at BOSS. This program follows on other efforts that have moved post-acute care for TJR patients from Skilled Nursing Facilities to the patients' homes using home health nursing and physical therapy.
- Telemedicine - Since we implemented a Teledermatology initiative in February 2016, we have completed over 1,000 'e-Derm' consults to our primary care providers. The program was launched to improve the quality of care, increase access and reduce outside referrals to more expensive specialty care. Teledermatology allows a provider to take a picture using a smartphone or tablet and upload the photos directly into the patient's medical record using Epic's mobile technology. The provider takes a clear photo which is embedded in their e-Derm Consult Order, which is subsequently reviewed by a dermatologist, who documents their diagnosis and recommendations, and then passes the chart to an experienced dermatology nurse. The nurse contacts the patient, provides teaching on the diagnosis, skin care, and potential medications/therapy, and arranges a dermatology appointment as required. Once completed, the consult note chart is copied back to the referring provider within 72 hours. The total volume of patient referrals to dermatology remains high (currently more than 3600/month), and we have seen a downward trend in outside referrals. Approximately 50% of teledermatology consults do not result in a patient visit, which has increased access in dermatology to handle more complex dermatological cases. Patients have been delighted with the prompt response to their issues and do not need to pay a second co-pay if the issue can be resolved without a subsequent visit.

  We are using the same process (without pictures) to do e-consults in other specialties, including infectious disease, sleep medicine, neurology.

  We have piloted video visits for behavioral health, urgent care, and provider-to-provider, and will be growing this program in coming months.

ii. What barriers does your organization face in advancing this priority?

- Reimbursement by the payers for all of the initiatives described above presents a challenge. Many of these services, such as asynchronous telemedicine are either not billable at all and others are so widely variable in how they are covered that we are unable to implement them fully because the registration process becomes overly cumbersome.
- Higher-cost Academic Medical Centers (AMC's) with brand name recognition building new out-patient facilities in the suburbs is a barrier to moving patients to less expensive settings.
- There is a lack of price and quality transparency tools that are easy for consumers to use and understand.

- Patients sometimes choose care in settings solely based on brand name recognition, regardless of cost or quality.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

- New outpatient facilities in the community that are billing under AMC licenses will increase the cost of care and compete with more cost-effective community hospitals and physicians. Chapter 224 should be modified to require that AMC's submit material change notices to the Health Policy Commission (HPC) in advance of building new outpatient centers in community settings.
- AMC's should be required to limit facility fees in these new facilities to community hospital rates, or facility fees could be eliminated completely (similar to Medicare).
- Urgent care centers affiliated with AMC's should be under the purview of the HPC since these have the ability to refer patients to higher cost hospitals when more advanced care is needed.
- The HPC should examine the cost of oncology services by provider and setting. Some providers are paid twice what others are paid to provide exactly the same services because of their brand or special Medicare exemptions. It is difficult to move patients away from the higher cost facilities that have very strong brands.
- Following the initial passage of Chapter 224, the Health Planning Council was created; however, the Council has not met for several years due to a lack of resources. Atrius Health believes that the Health Planning Council created a unique opportunity to evaluate the availability of health resources statewide in order to ensure that healthcare services meet the needs of residents without duplicating or adding additional costs and should be re-instituted.
- The state should consider implementing site-neutral payments that would considerably reduce the overall cost of care for patients, as Medicare has done.
- The state should require hospitals/skilled nursing facilities to consult with the patient's primary care provider for the preferred referral to home health agencies (while continuing to give patients the choices that Medicare assures). Atrius Health utilizes its home health agency VNA Care which is an integral partner in providing coordinated and more cost effective home health and hospice services to our patients; however we frequently find that hospitals/skilled nursing facilities push patients to their own or other home health care providers.
- When legislation or regulations are being developed relative to payment reform, physician groups not affiliated with a hospital should be considered as to how they can support the shift of care to office-based/home settings.
- State legislation, regulations and policies should be fast-tracked where they will foster innovation in the delivery or care to patients.

c. Please complete the following questions for **Priority 2** (listed above).

i. What is your organization doing to advance this priority and how have you been successful?

Atrius Health has embarked on a number of innovative strategies to reduce unnecessary hospital utilization:

- "Care in Place" – The Care in Place program is a partnership between Atrius Health providers and VNA Care nurses to provide urgent care in the home for older patients who we have

identified as high risk of being hospitalized and who are unable to come in for an office visit, due to lack of transportation or because they feel too ill to travel. For older, frailer patients, hospital treatment may cause further complications that result in longer hospital stays and worse health outcomes. Once the determination is made that the patient needs a same day appointment, and does not need to be sent immediately to an emergency room, the nursing staff can contact the Care in Place VNA Referral line to request an urgent home care visit. A designated VNA nurse will go to the patient's home, provide an assessment (including medication review) and contact the assigned Medical Control Officer (MCO) while in the patient's home to review the patient's condition and develop a treatment plan. The MCO places any necessary orders, documents the visit as an urgent home care encounter, and sends the encounter to the PCP. The PCP team picks up the follow-up care. Care in Place is currently offered 8am to 5pm, with the goal of expanding further in 2017. Of the 458 Care in Place visits provided between January and July 2017, 150 visits (33% of visits) were considered to have avoided an ED encounter. Based on the average cost of an ED visit for this population, and (conservatively) assuming that 50% of these patients would have been admitted to the hospital from the ED, we estimate that ED/hospital avoidance rate results in $763 K in TME savings net of the estimated expense of the Care in Place visit.

- Clinical Risk Predictor Initiative – Utilizing historical claims data and predictive modeling, we have been able to identify patients who are at a higher risk of being admitted to the hospital within the next six months. These patients are flagged internally and are triaged to be seen immediately in the office or are referred to special programs referenced above. In addition, we also identify adult and pediatric patients eligible for end-of-life/palliative care using this same type of modeling.
- Urgent Care/Telecomm – We provide telephone access to an advanced practice clinician 24-hours/day, 7 days/week, as well as providing extensive same-day appointments and extended weeknight and weekend urgent care hours to reduce the unnecessary use of hospital emergency rooms.
- Skilled Nursing Facilities (SNFs) – Under our Medicare Advantage program and with a NextGen waiver, we are able to avoid the requirement for a 3-day hospital stay prior to SNF admission and can admit patients directly for SNF care. We continue to work closely with our preferred SNFs that offer high quality care and are committed to patient satisfaction. Many of these SNFs have an Atrius Health affiliated physician or advanced practice clinician on-site caring for Atrius Health patients. Medical staff at the SNF has the ability to obtain the patient's current medical record from our EMR, allowing for better communication about the patient's health status and medications between the SNF and the patient's primary care provider. Preferred SNFs are expected to adhere to a list of expectations by Atrius Health to improve care and have agreed to comply with these expectations including sending a discharge summary to the PCP, thus improving care transitions. Home health may be provided after the SNF visit. On average we have reduced the cost of SNF stays by approximately $4k per stay for managed SNFs with our own coverage as compared with care that is not managed.
- Medically Home Program – In May 2017, Atrius Health launched the pilot phase of the Medically Home Program (the "Program") in close collaboration with VNA Care and Medically Home Group to provide acute care for selected patients in the home. Research shows older adults want to avoid hospitalization to maintain their autonomy, independence and functional status. Unfamiliar routines associated with hospitalization worsen cognitive and physical decline. Being home, on the other hand, ensures mobility and better mental health. The Program is a hybrid high-touch and high-tech model of care, combining face-to-face clinician visits with remote monitoring, video visits, and frequent telephone and virtual check-ins.

ii. What barriers is your organization facing in advancing this priority?

- To date, despite significant input from a variety of stakeholder groups from throughout the state, the Department of Public Health (DPH) has yet to promulgate regulations implementing Mobile Integrated Health (MIH) due to a lack of sufficient resources to implement the program. While we currently utilize nursing staff in our Care in Place program, we are very interested in using paramedics for this program which will result in additional cost savings.
- The state should require that home health nursing be billable for patients who do not meet CMS criteria for homebound patients on an ongoing basis, but who are not able to be transported to a physician office when they are ill.
- Similar to above, many of these services are not billable. Without claims the Commonwealth is underestimating the cost of care which shifts plans and employers to providers when these services cannot be billed.
- Patients do not have sufficient financial incentives to encourage them to utilize lower-cost options instead of the ED when the ED is not clinically warranted.
- There is a lack of state regulatory and policy initiatives to allow for more innovations to promote care of patients at home.
- There is resistance by some hospitals to allow our case managers in their EDs to facilitate care coordination of our patients, including directing them to a lower cost option for care.
- Current state requirements that require patients to be transported to an ED when calling 911, although sometimes lower acuity settings might be more appropriate and less costly.
- Payment model incentives continue to encourage hospitals to admit patients.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

- The state should fund implementation of the MIH Program.
- The state should require hospitals to provide the HIT interoperability that would allow community providers to view the medical records of their own patients.
- There should be better financial incentives to persuade patients to utilize alternative settings for receiving care.
- The state should enforce the provisions of Chapter 224 to require health plans to require their members to attribute their members to PCP's for PPO products. This would support PPO products becoming APM's and help with coordinating these patients' care even if no referral is required.

2. STRATEGIES TO REDIRECT CARE TO COMMUNITY SETTINGS

The HPC has identified significant opportunities for savings if more patients were treated in the community for community-appropriate conditions, rather than higher-priced academic medical centers.

a. What are the top barriers that you face in directing your patients to efficient settings for community-appropriate care rather than to more-expensive settings, such as academic medical centers? (select all that apply)

☒Patient perception of quality
☒Physician perception of quality
☒Patient preference
☐Physician preference
☒Insufficient cost-sharing incentives

☒Limitations of EMR system
☒Geographic proximity of more-expensive setting
☐Capacity constraints of efficient setting(s)
☐Referral policies or other policies to limit "leakage" of risk patients
☒Other (please specify): Insufficient patient education of patients of the products they buy. Advertising/brand of certain higher cost settings. Lack of meaningful quality measures to help patients truly evaluate the quality of services in different settings. The lack of a community hospital in downtown Boston.

b. How has your organization addressed these barriers during the last year?

We believe specialty and ancillary care delivered by Atrius Health provides high value and quality care for our patients; however, we will always need to partner with high value community providers to augment our internal capacity. Atrius Health is committed to referring patients to high value specialty care, ancillary care, and community providers. Our expectations for high value care include high quality and appropriateness of clinical care (minimal misuse, overuse, and under-use), the quality and timeliness of communication with our providers, the service experience of our patients with those specialty providers, and the appropriate stewardship of Atrius Health resources when caring for our primary care patients.

In addition, we have made significant efforts to identify and establish relationships with high quality, lower cost hospitals, community hospitals, and post-acute providers, about which we then educate our providers and encourage them to use as clinically appropriate.

Over the past year Atrius Health embarked on a strategic initiative to facilitate and encourage our patients to utilize clinically appropriate, high quality community-based settings that are less expensive. We launched a call center that assists in scheduling appointments and processing referrals for specialty care and advanced imaging for patients, with an emphasis on using access we have created within internal specialties and at our preferred partners. Despite our efforts, we still find that patients frequently do not understand the health insurance products they have, and there is a persistent impression by our patients that Boston-based academic medical centers provide higher quality health care.

3. INFORMATION ON PHYSICIAN COMPENSATION MODELS

Please answer the following questions regarding the current compensation models for your *employed* physicians. Indicate N/A if your organization does not employ physicians. ☐N/A

a. For **primary care physicians**, list the approximate percentage of total compensation that is based on the following:

	%
Productivity (e.g., RVUs)	50-70%
Salary	0-5%
Panel size	20-40%
Performance metrics (e.g., quality, efficiency)	5-10%
Administrative/citizenship	5-25% depending on role (in addition to clinical comp)
Other	

b. For **specialty care physicians**, list the approximate percentage of total compensation that is based on the following:

	%
Productivity (e.g., RVUs)	46% - 92%
Salary	0% - 50%
Panel size	0%
Performance metrics (e.g., quality, efficiency)	2% - 8%
Administrative/citizenship	5% - 20% depending on role (in addition to clinical comp)
Other	

c. Describe any plans to change your organization's compensation models for primary care and/or specialty care physicians that you employ.

None. Compensation plans for Atrius Health physicians changed earlier this year. This information is reflected in our responses above.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030. **If a question is not applicable to your organization, please indicate so in your response.**

1. P

Please submit a summary table showing for each year 2013 to 2016 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **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.

See Attached.

Atrius Health is unable to provide Claims-Based Revenue or Budget Surplus (Deficit) Revenue because that is not how we are paid on our commercial risk contracts. Instead, we are paid an estimated net capitation revenue on a monthly basis that is adjusted as needed during the year based on a review of claims paid to providers outside of Atrius Health (i.e. total budget or gross capitation revenue minus claims paid outside of Atrius Health equals net capitation revenue) with the goal of having the smallest possible settlement at year-end. We do not receive (nor do the plans perform, to the best of our knowledge) an assessment of our claims priced at our PPO pricing in comparison to a final budget.

2. **When primary care providers within your organization (including, e.g., newly-acquired practices) change their preferred referral partners, are patients notified of such changes? If so, what information is shared with patients, and when?**

Yes. When practices have joined Atrius Health (most recently PMG Physician Associates on June 1, 2017), letters are sent to patients informing them that they are now part of the Atrius Health system where they are able to access additional locations and have more options for both primary and specialty care. In the case of PMG Physician Associates, there were no changes to the area community hospital that patients would typically be referred to (i.e., Beth Israel Deaconess Hospital in Plymouth) so patients were told that they could continue to utilize the same hospital as previously.

3. **Do you participate in any provider-to-provider "discount arrangements" (e.g., a form of preferred provider relationship that includes a discount or rebate from one provider to another in connection with health care services furnished under the agreement)?**

☒ Yes ☐ No

If so, do you notify patients' insurers of such arrangements?

☒ Yes ☐ No