Exhibit B: HPC Questions

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: Increase the use of alternative payment methods (APMs)** Required Answer: Choose an item.
   ii. **Priority 2: Reduce unnecessary hospital utilization**: Required Answer: Choose an item.
   iii. If you selected "other," please specify: Click here to enter text.

b. Please complete the following questions for **Priority 1** (listed above). **Increase the use of alternative payment methods (APMs)**

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

We believe Fee For Service is the wrong chassis to allow us (and other providers) to provide the right care, so we push all our payers to provide value based arrangements- eg primary care capitation +/- bonuses for performance, shared savings, all the way to full percent of premium arrangements. This fundamentally changes the job we can do- from doing/coding more and focusing on transactions, to focusing on relationships- having a population of people we are responsible for, and being able to do whatever it takes to improve their health and keep them out of trouble (ie hospital, ER, etc). We have been successful with several payers including the GIC (via Unicare), the New England Carpenters Fund, and Tufts Health Plan Medicare Preferred in Massachusetts in getting such arrangements. This payment model has allowed us to create a wholly different model of care which has lead to dramatic improvements in experience, health, and lower costs.

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

Many of the large payers in Massachusetts, despite their rhetoric, are not willing (or perhaps not able) to shift into these sorts of payment models, even for an organization like ourselves with proven infrastructure and history of being able to execute in such an arrangement. Virtually all the APMs being offered, eg the Blue Cross AQC, are still based on Fee For Service (FFS). FFS is simply the wrong way to pay for primary care, and we would love for the payers in the state to stop making excuses and move faster to offer real alternatives.

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

Any policy pressure on payers to offer non-FFS based alternative payment models to providers ready to take this on would help move the market forward. For instance, the HPC could require all major payers to offer at least one payment option which was not based on FFS.

c. Please complete the following questions for **Priority 2** (listed above). **Reduce unnecessary hospital utilization**

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

Our whole clinical and service model is built to engage patients, improve their health, and reduce unnecessary use of the hospital and other downstream care settings. We spend time and build teams and processes to engage with our patients, for instance building a shared care plan to identify what we will work on together to improve their health. We provide access by text, email and video in addition to face to face visits. We give everyone a personal health coach who comes from their community and speaks their language to help them execute on our plans. We have a behavioral health specialist in each practice to help with mental health barriers, and social workers to help with social barriers. We help patients help each other in groups. We reach out proactively to patients; integrate population, case, and transition management into primary care; and carefully help our patients navigate the downstream system. We do a lot of virtual doctor to doctor consultations to avoid unnecessary specialist care, and co-manage with hospitalists when our patients are in the hospital. All this has resulted in 30-40% drop in hospitalizations relative to matched controls, as well as dramatic drops in ER and specialist utilization.

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

The biggest barrier is getting payers to pay us differently (see Priority 1 above) to allow us to make the sorts of investments needed to deliver this sort of care. We sometimes have barriers to be able to co-manage once people are in the hospital, and with health system & provider consolidation, have harder times finding willing downstream partners who want to re-engineer care to reduce unnecessary utilization.

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

By far the biggest help would be to pressure/require payers to pay differently to enable the up-front work to engage and manage patients optimally in the outpatient setting to reduce the need for hospitalizations and other downstream utilization. This includes moving away from Fee For Service and sharing risk/savings with provider groups, and also increasing the percent of total healthcare spending going to primary care (as Rhode Island has done). In addition, creating notification systems so we can know when our patients are in the hospital or ER real time would be very helpful, as would ensuring primary care physicians could visit and be a part of the care of their patients when hospitalized.

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): Lack of transparency on price differences

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

We try to engage our patients in shared decision making to determine where to get care- we believe the question should not be whether these high priced academic centers are wholly in or out of network, but in what situations given the often large price discrepancies it makes sense to use them. It is still way too hard to get real prices for patients- even as a physician, and hard to find freestanding alternatives.

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)	
Salary	100%
Panel size	
Performance metrics (e.g., quality, efficiency)	
Administrative/citizenship	
Other	

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

n/a- we do not employ specialty physicians

	%
Productivity (e.g., RVUs)	
Salary	
Panel size	
Performance metrics (e.g., quality, efficiency)	
Administrative/citizenship	
Other	

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

None at this time

Exhibit C: AGO Questions for Written Testimony

1. 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. Required Question.

   See table included. Note all figures submitted are in whole dollars.

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?

   We do not have a fixed list of preferred referral partners. As Primary Care physicians, we believe our job is to help our patients navigate the healthcare system, and that we work for them and not any particular health system. We use data we can obtain on quality and efficiency of providers as well both our clinical experience judgment, and the accumulated experience of our patients to determine the best referral for each situation for each patient. We are not affiliated with or part of any health system (which is increasingly rare in the Commonwealth). We do of course tend to send people to specialists who are in network with their insurance carrier unless there is a good reason not to do so.

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)? Required Question.

   ☐ Yes ☒ No

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

   ☐ Yes ☐ No