MASSACHUSETTS
HEALTH POLICY COMMISSION

2017 Pre-Filed Testimony

Providers

Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, 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 2, 2017, 9:00 AM
Tuesday, October 3, 2017, 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 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, 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 6, 2017, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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 Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube channel following the Hearing.

If you require disability-related accommodations for this Hearing, please contact Andrew Carleen at (617) 757-1621 or by email Andrew.Carleen@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.

Exhibits B and C: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, 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 from 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.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, and/or 2016 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Sandra Wolitzky at Sandra.Wolitzky@state.ma.us or (617) 963-2030.

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.
If a question is not applicable to your organization, please indicate so in your response.

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)
   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?
   Baycare Health Partners (Baycare), the Baystate Health physician-hospital organization (PHO), has been committed to its journey to value-based care and to increasing the use of APMs since the mid-2000s. Our journey has mirrored the movement toward value-based care that has evolved in the US over the past 15 years. Baystate Health participates in multiple commercial value-based contracts—and has done so for several years. Baycare has had value-based agreements with Blue Cross Blue Shield of Massachusetts (BCBSMA) since 2010 (including its Alternative Quality Contract or AQC), and with Health New England (HNE) since 2011 for its commercial members and since 2012 for its Medicare Advantage members. The participants have demonstrated consistently strong performance in these agreements, with over $10 million earned in aggregate in value-based payments in 2015 and settled in 2016 (the most recent full year data available). All of these agreements include robust quality incentive programs. Baycare added more value-based commercial contracts over time with payers including UniCare/GIC, Tufts Health Plan, and Cigna. In aggregate, Baycare commercial value-based contracts currently encompass about 78,000 covered lives, an increase of 16% from 67,000 in 2016.

   While its initial scope was a commercial managed care population, Baycare recognized the need to add public payers to ensure a critical mass of patients was receiving value-based care to truly gain the clinicians' attention. Baycare's subsidiary, Pioneer Valley Accountable Care (PVAC), operates as a Medicare accountable care organization (ACO) that is committed to provide coordinated, high-quality care at lower costs to its attributed Original Medicare beneficiaries and to support the Institute for Healthcare Improvement Triple Aim of reducing the overall cost of care, while improving both the overall health and experience of the community. Between 2013 and 2015, PVAC participated in CMS' Medicare Shared Savings Program (MSSP). Effective January 1, 2016, PVAC was one of the original 18 ACOs nationally that participated in the Next Generation ACO (NGACO) Model, recently launched by the Centers for Medicare & Medicaid Services (CMS) Innovation Center. NGACO is a population-based payment initiative with downside risk for health care organizations and clinicians who are experienced in coordinating care for patients across care settings. In 2017, PVAC is one of 44 NGACOs nationally. Approximately 41,000 Medicare beneficiaries are attributed to PVAC, up

31% from 31,000 beneficiaries in 2016. PVAC has performed well in the NGACO Model, generating strong quality scores, and we anticipate generating shared savings in 2016 at a level that will place PVAC among the top performing NGACOs in the country.

The logical next step in this value-based journey is the addition of Medicaid. With its wholly owned health plan, HNE, and Caring Health, Inc., Baystate Health will participate in the MassHealth Accountable Care Partnership Plan. Named the Be Healthy Partnership, it will serve the wider communities of Greenfield, Holyoke, Springfield and Westfield, bringing together over 40,000 beneficiaries from urban Springfield-based health centers with very high concentrations of individuals on Medicaid coverage. They represent a diverse population, including refugees, homeless individuals and pockets of high concentrations of different ethnic groups

In addition, Baystate Health participates in multiple bundled payment programs, which are payment arrangements that include financial and performance accountability. Through the Bundled Payments for Care Improvement Initiative (BPCI) run by the Centers for Medicare and Medicaid Innovation (CMMI), current bundle initiatives include Model 2 total joint replacement (hip & knee replacement-DRGs 469, 470), Model 2 Coronary Artery Bypass Grafting (CABG) (DRGs 231-236), and Model 2 colorectal surgery (DRGs 329, 330 & 331). Participation in the BPCI demonstration has been successful for Baystate Medical Center, which experienced significant reductions in 90-day costs for both total joint replacement and CABG. Additionally, we experienced significant decreases in hospital expenditures, increasing the operating margin associated with performing CABG procedures. More importantly, indices of quality and patient safety were maintained or improved while increasing engagement with patients and their families. Partnerships with post-acute providers have been strengthened with data sharing, regular educational offerings, and improved coordination of care for patients. In addition to BPCI, Baystate Health has developed three commercial bundles with HNE: obstetrics, total joint-hip and total joint-knee. Further, Baycare is in the process of developing outpatient bundles for select specialty services such as congestive heart failure, chronic obstructive pulmonary disease, and end-stage renal disease, which it expects to launch in January 2018.

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

The greatest barrier to more widespread adoption of APMs is that the majority of the current health care reimbursement system remains fee-for-service (FFS), which rewards providers based on the number of office visits, tests or procedures they perform. All of the value-based contracts in which we participate rely on an underlying FFS chassis, which when combined with continued downward pressure on reimbursement, perpetuates incentives to generate RVUs to maximize cash flow. Because payment is tied to volume, FFS directly contradicts APMs whose incentives are not aligned to the providers' practice patterns. FFS also creates fragmentation, with providers incented to compete with one another, rather than work together for better outcomes. Because providers are rewarded this way, they lack a strong motivation to steer people toward the highest-quality, most cost-effective care. While the movement away from FFS and toward value-based care continues to gain momentum, it remains in an embryonic phase. To change the payment model and shift from FFS to a value based model, much more investment is needed to change health care infrastructure—including claims payment systems, culture, and operational practices. These new payment models are by no means systematic or uniform in design. For most, they are difficult to implement and scale and, to fully realize their potential, require adoption by multiple payers—including public payers. Further, staffing models have been designed to support the FFS model with face-to-face care. Transitioning to population-based care requires a different care team model with new skills and staffing ratios to manage populations and track and coordinate care when patients are not in the physician office.

The design of the new MassHealth ACO promises to break new ground in migrating providers away from this fee for service mindset. Nearly 80% of the patients seen in our participating health centers will transition to the HNE BeHealthy Medicaid Managed Care product under the Track A design. Since HNE is a fully owned Baystate Health subsidiary, there will be minimal incentive to generate

RVU activity that does not explicitly add value in improving quality or reducing total medical expense.

Second, multi-faceted financial barriers to implementing APMs remain daunting. Continuing disproportionate cost pressures on Baystate Health—a recognized early adopter of APMs—continue to challenge the organization's ability to allocate appropriate resources to evolution of models of care. The infrastructure (whether human capital, enabling technology, or other resources) to support population health management is and will continue to be costly. Ultimately, we hope our value-based contracting and ACO activities will be self-supporting, but we encourage payers (whether public or private) to provide adequate infrastructure payments and support to their contracted providers to assist in the implementation. At the same time, providers face the material, unfunded mandate of compliance with numerous regulations such as those required for Risk Bearing Provider Organizations under Chapter 224 and with achieving the HPC's ACO certification as a prerequisite for participating in the MassHealth Accountable Care Partnership Plan. Further, the need (and likely government mandate) to build reserves over time is a significant barrier. As more risk shifts from insurance companies to providers, careful thought should be given to how to avoid having insurance companies and providers maintain duplicate reserves. All of the above are exacerbated by federal mandates, such as MACRA, which require significant investments in infrastructure to comply with the plethora of reporting requirements. It remains unclear whether it will be possible to generate a positive return on these investments.

Finally, APM design continues to place most of the burden on primary care providers while specialists control much of the total medical spend. Until specialists can be more fully engaged in and integrated into APMs, it will be difficult to realize APMs' full potential. We have strived for many years, with limited success, to encourage specialists to be active participants in APMs, and in 2017, specialty engagement in APMs remains one of our ACO's top five strategies for success. Efforts to date include specialist participation in various bundled payment initiatives and participation in value-based contracting, but actionable performance measures for specialists remain elusive. We applaud the GIC's efforts to assemble and release quality and efficiency measures for specialists, and we encourage the GIC to make such data available on a public website as we believe transparency of performance data will drive behavior change and narrow unintended variations in practice patterns.

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

First, we have previously noted the inherent challenges in further adopting APMs when providers still have one foot firmly planted in the FFS world and the other in the value-based world. Until APM agreements cover a critical mass of patients, it will not make financial or operational sense for providers to change their workflows fully to align with a value-based delivery system. We acknowledge that the Commonwealth of Massachusetts recognizes this challenge and, for several years, has been encouraging commercial payers to transition away from FFS toward APMs. It is not enough, however, for a payer simply to roll out its own flavor of APM within its provider network. Rather, payers should be encouraged to offer APMs of similar design to ease the administrative burden of implementation on the providers who are being asked to assume considerably more risk under these APMs—much as the Group Insurance Commission did in mandating that the commercial carriers adopt a uniform provider tiering methodology in its Clinical Performance Improvement Initiative. To succeed in risk contracts or APMs, providers require the agreements to have a consistent design, (e.g., similar budget constructs, quality and efficiency measures, care protocols, risk mitigation programs). Payers should be encouraged to provide adequate infrastructure payments and support to their contracted providers to assist in APM implementation, and accelerate their adoption.

Second, we encourage removal of the significant financial barriers that are impeding APM adoption. Consideration should be given to the unfunded mandates providers face in complying with regulations such as the Risk Bearing Provider Organization (RBPO) and Registration of Provider Organizations (RPO) regulations. The Massachusetts Hospital Association and others have clearly

documented where these regulations require duplication of effort—both with requirements of other state agencies and health plans. Further, if an organization or one of its subsidiaries participates in the MSSP or NGACO Model, we feel strongly that applying for ACO certification at the state level should be optional. CMS has a robust application process and ongoing compliance and monitoring program for its ACOs, and having to duplicate these efforts at the state level creates additional administrative expense and burden without adding commensurate value. Amending the regulations to reduce these and similar administrative burdens would free up resources that could be directed to APM adoption.

Perhaps the greatest barrier is the need to build reserves over time. Many risk-bearing entities, such as our PHO, are structured as taxable entities, and existing tax laws make it considerably more difficult for them to build reserves to the same extent and as rapidly as their not-for-profit counterparts. In other words, assuming 40% of their profits are taxed, taxable RBPOs need to generate two-thirds greater profits to accumulate the same reserves as a tax-exempt entity. Regulations governing provider reserves should reflect this hurdle, perhaps allowing for lower reserve thresholds or longer time periods for reserve accumulation for taxable RBPOs. As more risk shifts from insurance companies to providers, careful thought should be given to how to avoid having insurance companies and providers maintain duplicate reserves.

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?
   Baystate Health and Baycare and its subsidiaries have a multi-pronged approach to managing acute care utilization, including reducing unnecessary hospital utilization. First, we have implemented an **acute care alternatives program** at Baystate Medical Center (BMC). Its goal is to reduce avoidable admissions for Ambulatory Condition Sensitive Admissions (ACSAs) and decrease the intensity of resource utilization while improving clinical outcomes and patient experience. The ACO hired an internist to work collaboratively with the Emergency Department at BMC. The top diagnoses for admission diversion thus far have been weakness, non-surgical fractures, mechanical falls, musculoskeletal pain, and urinary tract infections. Preliminary results have been so positive, with demonstrated cost savings and overwhelmingly positive patient experience results, that efforts are underway to expand it to other Baystate facilities as well as other regional hospitals.

   Second, Baycare and PVAC have a robust **practice-based care management program** to help ensure optimal acute care utilization while improving the health of the population, the patient experience, and the total cost of care. Registered nurse care managers and medical assistant level outreach workers/care coordinators are embedded in the primary care practices participating in our APM contracts. They support patients with understanding their medical conditions and how to have the best quality of life, education of disease, self-management, assessment of needs, elimination of barriers to care, and coordination of care across delivery sites while enhancing the value the practices provide to the population for which they are accountable. Further, interdisciplinary care teams span the continuum of care. In other words, the Baystate hospital-based care managers and social workers engage with the Baycare/PVAC outpatient care managers to ensure timely, accurate and meaningful communication upon transition from hospital to community and to avoid unnecessary readmissions. They also collaborate with the Baystate Home Health (BHH) staff who perform a warm transition for appropriate high-risk patients from the hospital setting—a critical step to avoiding readmission. Upon discharge, our hospitalists focus on determining the most appropriate next site of care and make a concerted effort to ask “why not home,” and the collaboration described above is necessary to ensure successful transitions to the home. One additional feature of many of our medical home practices is the presence of embedded behavioral health providers. Early intervention around behavioral health needs for patients with chronic medical conditions can enhance adherence to treatment plans and reduce hospital utilization.

Third, we have a robust **post-acute care program**, including close partnerships with a preferred network of skilled nursing facilities (SNFs). Not only does this program promote optimal quality and utilization in the post-acute setting, but it supports avoidance of acute-care hospital readmissions and unnecessary bounce-backs to the emergency departments from the SNFs. We lead bimonthly transitional care quality improvement meetings with every post-acute provider that focus on improving communication and transitions across episodes of care. Readmission root cause analyses identify improvement opportunities, which inform practice modifications at the hospital, SNF, BHH, and community practice levels. We also collaborate closely with non-Baystate hospitals to ensure we develop aligned strategies and goals regarding our common post-acute partners. We have standardized transition communication processes. The following example illustrates how these post-acute partnerships and emphasis on care coordination can be effective in avoiding unnecessary hospital utilization: A frail elderly patient recently fell in her home. She saw her physician who determined her bad sprain did not require hospitalization. Our care manager followed up and determined that she was deteriorating rapidly at home and needed rehab services. Working with the woman's Medicare Advantage plan, our care manager arranged a direct admit to a SNF, thereby avoiding an acute care admission.

Further, our ACO and BMC are collaborating on several organized **care models** that focus on transitional care and acute disease management to prevent readmissions and enable safe transitions to the community. These interrelated programs are directed at providing high-value, coordinated care across all care continuum sites. They include: a COPD Inpatient Pilot, which is intended to ensure tight care coordination and standardized, evidenced-based care for high-risk COPD patients; an Acute Heart Failure Pathway, which helps ensure the provision of standardized, evidenced based care across all Baystate Health hospitals for every patient, every time; and PVAC's Home Visit Pilot, which focuses on reducing acute care readmissions of high-risk patients through the use of preventative care home visits after a hospital or SNF discharge.

ii. What barriers is your organization facing in advancing this priority?
First, the 3-day SNF rule, whereby a patient must have a qualifying inpatient stay for at least 3 midnights before Medicare and many other payers will reimburse a SNF admission, is a significant barrier. Potentially avoidable hospital admissions often occur as a required entry path to a SNF for patients not needing hospitalization and for diagnoses such as dehydration, community acquired pneumonia, COPD, urinary tract infection, and heart failure. Some of these admissions could be more effectively managed in a less intensive, more appropriate SNF setting. Many partnering SNFs are well equipped to manage stable cases in the frail elderly population who currently use unnecessary acute services.

Second, as noted earlier, the infrastructure—including the human capital, enabling technology, and other resources—required to finance population health initiatives such as our acute care alternatives, practice-based care management, and post-acute care programs described above are and will continue to be substantial. None of these expenses are reimbursed through the existing FFS payment system. It remains to be seen whether APMs can generate sufficient non-FFS revenue in the form of shared savings or surpluses to adequately support the population health infrastructure and interventions that are necessary not only to reduce unnecessary hospital utilization but also to successfully implement APM contracts and models of care.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
First, elimination of the 3-day SNF rule would support reducing unnecessary hospital admissions; lowering the average length of stay; and improving care integration, quality assurance, and patient safety. Waiving the 3-day SNF rule supports the right acuity and location of quality care while avoiding the cost and potential harms of unnecessary inpatient stays. Such a waiver also would allow patients with significant social stressors access to appropriate SNF care and avoidance of unnecessary hospitalizations. Frail elders and their families often need respite care or skilled nursing, palliative, or

ancillary care at a level higher than can be provided safely at home. Waiving the 3-day SNF rule would enable them to access this care directly. Further, such a waiver would decrease unnecessary hospital days. As soon as their medical condition warrants, patients should be able to transition to a SNF without financial implications or penalties. This improves the experience of care and promotes patient safety. While hospital safety has improved, studies show that considerable risk of harm still exists in this high intensity setting. Waiving the 3-day SNF rule would promote harm avoidance by mitigating the risks of hospital-associated conditions such as CAUTI, pressure ulcers, hospital associated infections, DVTs, and delirium. Transitioning patients more appropriate for SNF level care out of the hospital increases access to acute care hospital beds that then can be more efficiently used for appropriate populations of patients in need.

Second, see our response to 1.b.iii above for our thoughts on enabling the provision of adequate infrastructure to assist in APM implementation.

We would also recommend that the state provide additional resources for providers and their patients to target and address social determinants of health. Addressing social determinants can have a significant impact on health outcomes and thus can help reduce unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, and readmissions) and improve total cost of care.

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): Click here to enter text.

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

Our primary care providers have been in risk contracts (through our PHO) for over nine years, and the providers get regular feedback on the total cost of care for these patients. Value-based care is important to our providers and they utilize services in the community balancing the individual needs of the patient, the quality of the service, and the cost of care. Additionally, as there is increased awareness about the social determinants of health, the care management staff and providers regularly partner with community support agencies and social services to ensure patients receive a full spectrum of local care and support. In the post-acute care arena, there continues to be ongoing work to develop a high value network for post-acute facilities. Community facilities are evaluated for quality of care, length of stay, as well as communication. This information is regularly utilized by the hospital case management staff that helps patients determine where they will go after discharge.

In terms of patient perception of quality and patient preference, significant work has been done via our Joint CHART 2 telemedicine grant, the aim of which is to keep appropriate patient care local at the community hospitals, versus transfer to more expensive AMCs. Through the use of telemedicine consults between

Baystate Health specialists and community hospital patients, particularly in Neurology and expanding to other services, significant numbers of transfers to AMCs have been avoided. In addition, assurance is being provided to both patients and providers that consulted patients are appropriately receiving needed care locally, and that specialists are available for consult if needed. As an example, in the case of tele-Neurology consults, at Baystate Franklin Medical Center, of 182 consulting physicians surveyed, 85% agreed that were tele-consult capability not available to the community hospital, the patient would have been transferred to Baystate Medical Center.

Baystate Health has also committed to a regional model of care, in which dozens of specialists travel each day to our community hospitals in Greenfield, Palmer and Westfield. The model of having a single large group covering our entire service area has helped us get away from the fragile model of a single specialist or two in each area employed by each hospital, and it has allowed us to keep basic care local to a much greater degree. In addition to specialist presence on designated days of the week, our hospital medicine group has merged in to one across all four hospitals, allowing us to swing staff to the communities in times of shortage. It has also enabled us to train our hospitalists in the basics of critical care management, increasing their confidence in keeping patients in the regions rather than transferring them to the academic medical center. We have also implemented a common quality and safety measurement and improvement system across the system, to ensure that none of these initiatives has an adverse impact on quality or safety.

Baystate has funded, established and participates in the Pioneer Valley Information Exchange (PVIX), an IHE-standards conforming Health Information Exchange (HIE). This private regional HIE is used to connect affiliated and non-affiliated healthcare organizations across the western Massachusetts community to exchange Clinical Care Documents. The HIE also delivers lab orders and results between Baystate Reference Labs and community-based non-employed provider groups that utilize these lab services. Additionally, Baystate provides access to both employed and private provider groups for both hospital- and office-based patient 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)	0%
Salary	95%
Panel size	3%
Performance metrics (e.g., quality, efficiency)	1%
Administrative/citizenship	.5%
Other	.5%

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

	%
Productivity (e.g., RVUs)	6%
Salary	90%
Panel size	0%
Performance metrics (e.g., quality, efficiency)	2%
Administrative/citizenship	1%
Other	1%

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

Beginning in October 2016, Baystate implemented a new payment model for primary care physicians that transitioned away from incentivizing patient visit volume (as measured by wRVUs), and focused on patient panel-based incentives in order to improve patient access. Initial results have shown a marked decline in provider visit volume / wRVU generation and associated declines in revenue which has created financial challenges for the organization.

Due to Baystate's commitment to participation in alternative payment and risk contracts (APM's), we are continually reviewing provider compensation models in an effort to reward value (quality and outcomes) over volume driven metrics; however, as discussed in Exhibit B, Section 1(b)(ii) above, this is a delicate balance given the underlying fee-for-service basis for many of the APM's.

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. 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 AGO Provider Exhibit 1.

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?

   Our provider group has created an environment where primary care providers are very conscious of value-based care, and they utilize services balancing the individual needs of the patient, the quality of the service, and the cost of care. Patient preferences and input are solicited and respected.

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