NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

September 12, 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,

Joseph Frolkis MD, PhD, FACP, FAHA
President and CEO

Enc: Exhibit B and C Responses

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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, 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.

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email 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 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 2, 2016**, 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, and/or 2015 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 Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury 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 Cost 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. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

New England Quality Care Alliance (NEQCA) is a partnership of more than 1,800 community and academic physicians located in practices across eastern Massachusetts, caring for more than 500,000 patients. NEQCA is a leader in helping physician practices of all sizes manage change, build population health capabilities, control costs and improve the quality of patient care. NEQCA is among the highest-quality networks in Massachusetts, and has been recognized for its ability to control healthcare spending.

NEQCA is committed to 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. 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 help shape 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.

As NEQCA works to support physician practices in a range of areas, we continue to be concerned with the ability to drive down healthcare costs in the face of several significant countervailing pressures. Some of those pressures are:

- Increasing fragmentation and variation of payment rules and varying care delivery requirements among and across payers and employers adds undue complexity and exacerbates the administrative burden on physician practices.
- Growing societal/public health issues, such as obesity, unemployment, housing and food security, which physicians have difficulty addressing for individual patients, or at a population health level.
- Increasing pharmaceutical costs.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

As NEQCA carries out its work supporting We suggest the following changes:

- Create greate uniformity across payers, with more standardized measures for payment, quality and care delviery. Creating greater unifromity across all payers will alleviate administartive burden for providers and will give conumsers information that is more easliy comparable across providers, regardless of payer.
- 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.

2. **Strategies to Address Pharmaceutical Spending.**

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Currently Implementing

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Does NOT Plan to Implement in the Next 12 Months

iv. Establishing internal formularies for prescribing of high-cost drugs

Does NOT Plan to Implement in the Next 12 Months

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Does NOT Plan to Implement in the Next 12 Months

vii. Other: Although NEQCA does not have a formal academic detailing program, the NEQCA pharmacy team provides education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives. The avenue in which this information is provided includes a monthly pharmacy based newsletter that is emailed to the entire network and provided to Local Care Organization (LCO) leadership, formal presentations to network leadership and/or network members (on average 1 per quarter), patient medication record reviews (clinically sound and cost effective recommendation provided to physician for individual patients), and medication prior authorization support (alternative treatment options that are clinically sound and cost effective are provided vs. submission of a medication prior authorization.

The NEQCA pharmacy team conducts periodic claims analysis to identify variation in provider prescribing patterns and trends. The findings and high level recommendations are then presented to LCO leadership. Over the past 12 months the NEQCA pharmacy team conducted such an analysis with the results included in LCO specific yearly "efficiency opportunity reports". Additionally a number of similar activities were conducted for various LCOs but with a more specific scope (i.e., for one therapeutic class such as hepatic C agents). Over the next 12 months the NEQCA pharmacy team will conduct another round of yearly "efficiency opportunity reports" as well as a number of more narrowly scoped analysis either at the request of an LCO or as part of a network wide clinical initiative.

The NEQCA pharmacy team has implemented two initiatives targeted at improving medication adherence/compliance. The first initiative is NEQCA's medication prior authorization support program which assists practices in submitting medication prior authorizations. The efficiency in which the NEQCA pharmacy team can submit medication prior authorizations and communicate the result to the practice and patient/caregiver has a positive impact on a patient's ability to attain and take their medication. The NEQCA pharmacy team has also implemented a compliance calling program for patients with a diagnosis of depression and recently started on an antidepressant. In the next 12 months the NEQCA pharmacy team will continue to offer and expand the medication prior

authorization. The NEQCA pharmacy team is currently evaluating the impact of the antidepressant compliance calling initiative.

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viii. Other: Insert Text Here

Click Here

ix. Other: Insert Text Here

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3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

NEQCA continues to be focused on addressing the significant co-morbidity of medical 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 and poor clinical outcomes.

1. NEQCA supports Pediatric practices by embedding Behavioral Health Social Workers (BHSW) in those practices where each BHSW is shared among several 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 BHSW decreases the time to deliver much-needed services, as well as enhance communication between the clinical team and the family. This program has already shown results in reducing Emergency Department (ED) utilization and inpatient admissions.
2. In 2016, NEQCA is planning to build on the success of the Pediatric Behavioral Health program and is piloting the use of a BHSW with adult practices. It is too early yet to show results of this program, but the goals of the program are similar to increase access to inpatient and outpatient behavioral health services, identifying and linking patients, families, and caregivers to behavioral health supports and resources, and reducing ED utilization.

   NEQCA also organizes Let's ACT events to improve integration of care across the community, with participation from network PCPs, community mental health providers, and local schools.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

There are limited and varying resources within each community to address behavioral health needs. Despite the presence of our Behavioral Health Social Workers, sometimes access to appropriate mental health providers within the community does not exist. Another significant barrier, that must be overcome to achieve real success, particularly in pediatric behavioral health, is in breaking down the silos that exist between PCP offices, mental health professionals, and schools. Creating greater ease of communication, collaboration, sharing of patient information and care planning will greatly enhance the level of services for patients and ease the burden of all the stakeholders.

4. Strategies to Recognize and Address Social Determinants of Health.

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

Our organization is actively pursuing Patient Centered Medical Home (PCMH) recognition for all of our eligible PCPs. The National Committee Quality Assurance (NCQA) PCMH 2014 standards highlight "Social Determinates of Health" as a care management strategy to determine High Risk Population.

- PCMH is the current strategy to pursue the adoption of planning for this particular population of patients. However, as of today, we have been unable to effectively address this component due to the lack of previously documented "social determinants of health" to then pull data to include these patients as being one of the criteria for high risk care management strategy from a PCMH – In Office workflow strategy.
- Our practices have routinely adopted the PCMH Care Management strategies of identifying patients that meet the below criteria, which are:
    - Behavioral health conditions
    - Poorly controlled or complex conditions
    - Referrals by outside organizations

  Care Management plays a critical role in addressing non-medical issues related to the social determinants of health. Care Managers include as a part of their initial and ongoing assessments, questions for patients related to the availability of food, housing, clothing, literacy, and health literacy as well as access to healthcare resources (including health insurance gaps in coverage, access to PCPs and specialists, etc.). Based upon these assessments, the care managers develop individualized care plans to mitigate problems that have been identified in the assessments. Care Managers proactively advocate for preventative and secondary care to reduce crisis and more costly care.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

- Electronic Medical Records' inability to document and track and flag patients that have been identified as having a "social determinant of health" leaves a gap in the flow of information, forcing providers to engage in addressing these needs in a "one-off" manner vs. considering the needs both at an individual level and a population health level.
- Social Determinants of Health are very important factors in determining the risk factors and health needs of a patient; however they are not accounted for in any risk adjustment models.

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

One of NEQCA's core tenets is to keep care local; it is a value that is consistently reinforced by our leadership and by our Local Care Organizations. Providers in our network are informed and reminded through regular and consistent communication, both written and verbal, to keep appropriate care in the community whenever possible and to only refer to Tufts Medical Center for tertiary and quaternary care. We support alliances with non-hospital-based imaging and lab providers in the community. Network integration initiatives with the providers in our organization include meetings with community hospital leadership and specialists in the community, regardless of their system affiliation, to reinforce the goal of keeping care local when possible.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

i. If yes, please describe what information is included.
Click here to enter text.

ii. If no, why not?
Click here to enter text.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

i. If yes, please describe what information is included.
Click here to enter text.

ii. If no, why not?
Click here to enter text.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
Yes

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.

The overall philosophy of NEQCA is to keep care local where appropriate and to send patients requiring tertiary care to Tufts MC. Aligning with that strategy, the NEQCA Healthcare Information Services (HIS) team works to support two different types of communications.

1. In order to communicate lab results, radiology results, and discharge summaries, the NEQCA HIS team supports EHR integrations for each of its eClinicalWorks practices both to a primary reference lab as well as a community hospital. This has included integration projects with more than 3 community hospitals that NEQCA does not have a direct affiliation with, including Cape Cod Healthcare, Beth Israel Deaconess Milton, and Beth Israel Deaconess Plymouth. These interfaces are developed so that results are delivered back to the ordering provider. There are additional community hospitals that NEQCA has directly reached out to in the interest of future integration.
2. In addition to specific communication of results, the NEQCA HIS team works with individual practices to support their connection to the MassHIWay in order to send clinical information to support referrals. For some providers who are not connected to the MA HIWay, direct messaging through their EHR is also an option. Both the MA HIWay and Direct Messaging methods are agnostic to which network a provider is affiliated with.

ii. If no, why not?
Click here to enter text.

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

As we have stated in past testimony, NEQCA has for many years and continues to, encourage and support our network of physicians to participate in Alternative Payment Methodologies (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. 52% of our eligible PCPs are level II or Level III Patient Centered Medical home certified and we continue to expand the number of payers with whom we have APM contracts, now including Cigna and UniCare. As a network our practices have demonstrated year over year improvements in BCBS AQC Gate Score from 2008-2014, aggressively managing Total Medical Expenses (TME) under budget every year of the AQC contract.

Over 300 NEQCA physicians from 67 practices from across the network are participating in NEQCA's Medicare Shared Savings Program ACO, NEQCA Accountable Care, Inc. In its first performance year, 2015, the ACO successfully reported on all 33 of the required quality measures and achieved a higher than anticipated amount of savings, resulting in the ACO earning 50% of those savings, approximately $3.75 million.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

As we have also 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. Another significant hurdle to greater adoption and success in APMs exists in the disconnect between PCPs being held accountable for the total cost of care for their patients, but having little to no ability to control the costs of the specialists or hospitals those patients choose to utilize.

c. Are behavioral health services included in your APM contracts with payers?
No
   i. If no, why not?
   Click here to enter text.

7. Strategies to Improve Quality Reporting.

At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

The continued practice of each health plan's quality measurement of their own members (or a sub set of those members) is potentially creating differential results by health plan that are not indicative of the overall quality of the provider measured. Quality results by plan for the same provider offer no value to the accounts or to the member.
It is possible that a physician may get quality marks from one health plan that differ from another health plan's quality marks, only as a result of different statistical analysis. The overall quality of care provided by this physician did not vary, however the accounting of it may differ based on the member numbers impacting the result by health plan. This presents a misleading and incomparable quality picture.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

Use the largest gross aggregated set of data from multiple plans and determine quality results from the larger data set, and simplify all health plan differential offerings in MA using that information.
Use of the all payor data set to produce overall quality results (for example, as MHQP does) which will provide much greater accuracy as to the actual differences between providers.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.
Click here to enter text.

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 Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please submit a summary table showing for each year 2012 to 2015 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.

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.

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
    a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.
    Required Question: Click here to enter text

    b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.
    Required Question: Click here to enter text

    c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?
    Required Question: Click here to enter text

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.