Atrius Health

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September 27, 2013

BY E-MAIL (HPC-Testimony@state.ma.us)

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Executive Director Seltz:

On behalf of Atrius Health, enclosed please find my written testimony in response to Exhibits B and C (Questions for Written Testimony) of the Health Policy Commission's letter to Dr. Gene Lindsey dated August 28, 2013 regarding written testimony for the upcoming public hearing on health care cost trends.

Please let me know if we can be of further assistance.

Sincerely,

Guy Spinelli, MD
Chairman of the Board
Atrius Health, Inc.

Atrius Health's Written Testimony in Response to Exhibit B of the Health Policy Commission's August 28, 2013 Letter

The reports on which we have been asked to comment reflect months of effort by the Health Policy Commission (HPC), the Center for Health Information and Analysis (CHIA) and the Office of the Attorney General (OAG) and contain detailed data and analyses across a wide variety of topics. Given the comprehensive nature of the reports, and the time and space constraints of this request, it may not be possible to complete a comprehensive review, analysis, and response to the reports. Furthermore, we cannot represent that we have responded to each and every item on which we might have a differing perspective or data. There are also terms within the reports and questions that may mean different things to different people, and we have made certain assumptions about the intended meaning of these terms that are embedded in our responses. For the purposes of this response "we" refers collectively to the Atrius Health participating medical groups unless otherwise noted.

Questions:

1. **Chapter 224 of the Acts of 2012 (c.224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012- CY2013 and CY2013-CY2014 is 3.6%.**

    a. **What are the actions your organization has undertaken to reduce the total cost of care for your patients?**

    Atrius Health and its participating organizations are committed to continuous improvement and are continually mindful of our responsibility as stewards of health care dollars. We take action on a daily basis to contain health care cost focusing on the following three strategies: (i) ensuring that our patients receive care in the right place at the right time; (ii) increased focus on the use of the "right" care (e.g., reducing overuse, misuse and underuse to reduce total cost of care and improve quality); and (iii) improving internal efficiencies to reduce cost.

    Ensure that our patients receive care in the right place at the right time

    - We have increased utilization of our preferred community hospitals and academic medical centers with a focus on moving care into community hospitals wherever appropriate. This enables us to provide the same or better quality of care at lower cost. For example, we have entered into a collaborative agreement with Boston Children's Hospital ("BCH") to redirect more specialty, emergency and hospital care for our pediatric patients from BCH's primary location to their several lower cost community practices.
    - All of the Atrius Health medical groups now offer 24-hour telephone access to patients. In addition, we offer extended weeknight and weekend urgent care hours to reduce the unnecessary use of hospital emergency rooms.

- We continue to work to bring services in-house where the cost is less than at hospital-based facilities and it is more convenient for patients.
- We have re-organized and increased our use of case management nurses to support frail elders and reduce hospital admissions as part of our work as a Medicare Pioneer ACO. In addition, our medical groups conduct ongoing reviews of those patients who are at high risk for hospitalization and pro-actively ensure that treatment is preventive to reduce hospitalization and readmission.
- We have developed a preferred Skilled Nursing Facility program with guidelines and coverage for our patients that have resulted in a reduction in the average length of stay in SNFs.
- We are a participating provider for 2014 in the Integrated Care Organization (ICO) and Senior Care Options (SCO) dual-eligible programs with Commonwealth Care Alliance and Tufts Health Plan respectively. We believe that working with these programs will improve care and reduce cost for our patients who receive benefits from both Medicare and Medicaid.

<u>Increased focus on use of the "right" care</u>

- Harvard Vanguard Medical Associates has developed an alert system for clinicians at the point of care to electronically notify them about the cost of some tests so that they can do a better job of assessing the benefits and costs of conducting a particular test. For example, patients suspected of having strep-throat are given a relatively inexpensive rapid strep-throat test by a medical assistant. If a clinician then orders a strep throat culture, a message pops up in the electronic medical record (EMR) indicating that the test costs $75 and asking the clinician if the test should be ordered. Clinicians make their own clinical judgments as to whether or not having the additional test result is likely to alter the course of treatment. This enhancement will be available to other Atrius Health medical groups by the end of the year.
- Harvard Vanguard Medical Associates has developed standard work in its pediatrics department to ensure that asthmatic children have a spirometry test and an asthma action plan that is regularly reviewed and refreshed as needed at each well child visit to improve the patient's health by reducing the need for sick visits and emergency room care. Pediatric leadership believes this has resulted in improved outcomes and has reduced unnecessary utilization.
- We have completed a thorough review and implementation of evidence-based guidelines for colorectal screening and have seen a significant improvement in adherence to these guidelines.
- We have worked closely with our hospital partners to create web-based electronic interfaces with the hospitals' EMRs. This gives hospital-based clinicians the ability to review a patient's history of medications, tests and procedures, eliminating the need for duplicative testing of patients, thereby reducing costs. In addition, Atrius Health medical specialty clinicians are able to access the hospital's records following an emergency department visit and/or admission to the hospital, thus allowing for appropriate outpatient follow- up at an Atrius Health medical group.

- We conduct analyses of practice pattern variation and then review with each clinician their individual results as compared with their peers and the evidence-based literature. In the case of routine lab work, for example, we instituted guidelines based on the patient's age, sex and medical conditions and were able to significantly reduce unnecessary routine lab tests and associated costs.

Improving internal efficiencies to reduce cost

- We continue to use Lean process improvements with a focus on refining workflows across the organization to reduce waste, improve efficiency and improve the quality of care. This includes implementing and spreading standard work for clinical and operational processes.

b. What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?

Biggest opportunities to improve the quality and efficiency of care:

- We continue to see opportunities in all of the areas noted above.

Factors that limit our ability to address these opportunities:

- The continued growth of PPO products and the resurgence of fee-for-service payment limit our ability to address these opportunities. Many of the best opportunities for preventative and pro-active care, including clinical pharmacy interventions, care management nurses, telephone communication, home health and web-based advice, are not billable services. Furthermore, because we are not at financial risk for PPO patients, we do not receive claims data from the payers. Despite Chapter 224's requirement for attribution of PPO patients and corresponding release of claims data to primary care providers for improving treatment, this is not happening. We continue to struggle with a system that is split between global payment and fee for service. The market needs to be moved to a greater percentage of global payments to align incentives and help bring down total medical expense.
- Administrative complexity due to variation among health plans related to CPT codes, billing processes, methods for take-backs and recoupments, and the differing co-pays, deductibles, and benefits across health plan products is another factor in reducing efficiency.
- Limited networks, although well intended, at times are superimposed on top of our preferred networks in a way that is disruptive of care coordination and continuity. Carve outs of certain services (behavioral health, eye care, etc.) by health plans similarly disrupt natural referral patterns and can contribute to this disruption.
- For behavioral health in Massachusetts, (1) patients can "self-refer" (e.g. do not require a clinician's referral to see a behavioral health provider), (2) patients have "open access" to all behavioral health providers in a plan's network, and (3) we can receive only limited access to data on behavioral health services due to privacy

laws. These factors impede our ability to manage and coordinate care for our patients with behavioral health and/or substance abuse needs and greatly limits our ability to control costs and quality or take risk for the cost of this care;

- Mandated open networks for emergency room visits and obstetrics/gynecology similarly interfere with coordination of care;
- Defensive medicine caused by fear of malpractice litigation;
- Lack of consumer knowledge and understanding of their choices is critical to improving care coordination and reducing unnecessary costs. The HPC and its staff should play an integral role, in collaboration with other state agencies and private sector partners, in educating consumers about a variety of issues affecting their health care including the role of the primary care physician and team in care coordination, preventive health, how patients can affect the quality of their health, and how to use price information as it becomes available. We believe that a terrific tool that has simple, evidence-based information to engage consumers in healthcare decisions is Choosing Wisely, a set of lists across multiple specialties that encourages physicians, patients and other health care stakeholders to think and talk about medical tests and procedures that may be unnecessary or risky. Consumers need to be educated how their individual behavior and the costs of healthcare have a direct impact on society's ability to provide education and other services in the state.
- New reporting requirements and regulatory restrictions, while well intentioned, add significantly to our overhead and administrative costs.

c. What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?

The state should enforce the current requirement under Chapter 224 that health plans attribute members to primary care providers and provide claims data to the providers. In addition, we believe that current restrictions that limit the ability of behavioral health clinicians to share information with other providers pose a significant barrier to the integration of care into the medical home. Finally, the HPC should review all the open access laws regarding behavioral health, OBGYN, and emergency department utilization that limit the ability of a primary care provider to effectively coordinate care.

d. What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?

Atrius Health believes it has a responsibility as a good steward of health care dollars to manage medical cost trends for our patients and employers in the state. As such, many of our activities centered on the coordination of care ensure that patients receive the right care at the right time in the right place, lowering the cost of health care. Many of the initiatives described above result in a reduction of out-of-pocket expenses for consumers and savings for employers. Finally, we are committed to working with the payers to ensure that we receive only market-based increases in our fees.

2. **The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of the growth in prices on medical trend and what have been the results of these actions?**

   The actions that we have undertaken to address the impact of the growth in prices on medical trends are the same as described in our response to 1(a) above to reduce the total cost of care.

   Generally, we are seeing decreases in the total cost of care (and/or rate of growth in total cost of care) as measured internally. Specifically, these are the result of decreases in the number of hospital admissions, the length of stay in Skilled Nursing Facilities, use of certain diagnostic tests and imaging, and increases in the use of preferred facilities and other metrics that drive total cost of care.

3. **C.224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration?**

   Atrius Health fully supports the integration of behavioral health into primary care. We have added a depression screen for all of our elder patients as part of our Medicare Pioneer ACO work. Some of the Atrius Health medical groups have added a behavioral health clinician within the internal medicine department to offer on-site access to patients who need to be seen immediately and to clinicians for consultations. With that said, because of the current reimbursement structure and the short supply of behavioral health clinicians who are willing to work in this type of practice setting, it is difficult for this model to be successful system-wide. We would encourage the HPC to facilitate the integration of behavioral health in the development of its medical home initiative along with supporting changes to the current reimbursement structure for behavioral health and substance abuse.

   a. **What potential opportunities have you identified for such integration?**
      Our experience has shown that the creation of medical homes that fully integrate behavioral and physical health offer better care and outcomes for patients by providing same day access and follow up for patients, potentially resulting in decreased costs for complex patients.

   b. **What challenges have you identified in implementing such integration?**
      There are a number of challenges to full integration of behavioral health and primary care including the current payment structure, low reimbursement, the shortage of behavioral health clinicians willing to work in a large office setting (as compared to a private office where they do not have to accept Medicare and MassHealth patients and can set their own hours) as well as the inability of a patient's health care team to exchange information on all patients, including those with behavioral health and/or substance abuse issues.

c. What systematic or policy changes would further promote such integration?

The current payment structure, so-called behavioral health "carve outs," as well as the inability to exchange patient information for patients with behavioral health and/or substance abuse issues impede the ability to integrate behavioral and physical health. In addition, current health plan policies that prohibit same day appointments for counseling and medication management serve as barriers for patients as well as providers. Finally, the Commonwealth's open access requirement for behavioral health for all insurance products limits the ability for medical homes to integrate behavioral health in the practice in a meaningful way. We would strongly recommend that the HPC works to address these issues.

4. C. 224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative payment methods.

a. **Describe your organization's efforts to promote these goals.**

Atrius Health is committed to delivering efficient and high-quality care to its patients, and has invested significant resources over the past several years to achieve this goal. In addition to managing over half of our payments under global payment arrangements, we have put considerable effort into two major initiatives within our organization:

Patient Centered Medical Homes (PCMH) – The Atrius Health medical groups are certified by the National Committee for Quality Assurance (NCQA) as Level 3 PCMH and represent more than a third of recognized PCMH's in the state. The PCMH model is one that is patient-centered, with an emphasis on care coordination.

Pioneer ACO – In 2011, we applied for and were selected for the Center for Medicare and Medicaid Innovation (CMMI/CMS) Pioneer Accountable Care Organization (ACO) program. The program was designed to encourage primary care providers, specialists, hospitals, and other caregivers to provide better, more coordinated care for Medicare beneficiaries with the long-term goal of saving the national healthcare system up to $1.1 billion over five years. Because Atrius Health has always worked to provide cost-effective high quality health care for its patients, we saw the Pioneer ACO program as a mechanism to allow it to take the next big step toward developing its high performing health system. Substantial progress was made in the first year towards improving the care delivery model and we are seeing early results in quality and efficiency metrics and are beginning to see the total cost of care decrease.

b. **What current factors limit your ability to promote these goals?** –

- Attribution of PPO Patients - While alternative payment methods are gaining momentum among HMO products, the market continues to be moving towards PPO's as noted in reports by CHIA and the AGO. Attribution, although required by Chapter 224, is difficult to do and is not moving as quickly in order to assist providers. We believe that attribution is critical to developing and implementing alternative payment methods. We view the lack of meaningful attribution as a real structural barrier that would be worth discussion.
- Lack of consumer engagement – There continues to be a lack of consumer engagement in the health care cost discussion and insufficient attention paid to the important role that consumers' decisions play in curtailing the rising cost of healthcare. We believe that resources must be spent in this area for a public education campaign if the Commonwealth is to comprehensively address rising healthcare costs. Like providers and payers, consumers need to be equally engaged in efforts to reduce cost and waste.
- Behavioral Health – As discussed above, there are a variety of factors related to patients with behavioral health and/or substance abuse issues that significantly affect our ability to coordinate care in a medical home model.

5. **What metrics does your organization use to track trends in your organization's operational costs?**

We track Total Medical Expense per member per month for risk contracts for Atrius Health, by physician organization as well as by practice site. Each site tracks its total operating expenses down to the provider and encounter level. Using extensive data analytics, we further break down the data to examine closely operating costs, hospital costs, and pharmacy costs as well as outside utilization. These data are closely monitored on an ongoing basis. In addition, we also track "driver metrics" that include hospital admissions, total operating expenses per encounter and the utilization of available clinical time.

a. **What unit(s) of analysis do you use to track cost structure (e.g., at organization, practice, and/or provider level)?**

Most commonly, we use Total Medical Expense per member per month as a measure of tracking cost structure at both the organizational, group and practice site level. Other units of analysis that are tracked are costs per encounter, case-mix adjusted costs per admission, and case-mix adjusted 30 day total costs and others.

b. **How does your organization benchmark its performance on operational cost structure against peer organizations?**

We benchmark our performance on operational costs utilizing information provided by the health plans, as well as other national organizations such as the

American Medical Group Association, Medical Group Management Association as well as the Group Practice Improvement Network. Milliman reports and analysis as well as the Attorney General's Report on Health Care Cost Trends and Cost Drivers are also used to provide benchmark information. In addition, Atrius Health tracks its total medical expense as compared to the Consumer Price Index overall and for medical services for the urban Northeast region. Atrius Health also looks at average network medical expense data when it is provided by the health plans as a benchmark for peer organizations in our area. For the Medicare population, Atrius Health is using Medicare benchmarks provided for the Pioneer ACO.

c. How does your organization manage performance on these metrics?

Atrius Health conducts ongoing reviews of this data with senior staff and medical executives and has a robust Medical Management Department that provides ongoing strategy and analytics to all of our groups and sites. The Medical Management program also shares reports across all groups in order to encourage the spread of best practices. Specific performance measures related to cost are built into physician and executive level compensation packages at an organizational level. Each group is provided with a bi-monthly executive level tracker that shows its performance on Total Medical Expense. When total medical expenses are not on target, the groups' executive leaders are asked to provide countermeasures that are being put in place to remediate. These are documented and presented to the Atrius Health Board as part of an Executive Summary prior to each Board Meeting.

6. Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee, as required by c.224.

On or before January 1, 2014 we will be implementing a pricing tool to estimate a patient's out of pocket expense for office visits and procedures. We have purchased enhancements to certain software (at a cost of approximately $50,000 per year on top of the cost of the underlying software license) that has the capability of providing detailed, contract-based payment information to determine the cost of the physician portion of these services. This software will allow for the accurate calculation of insurance "allowables" for most major payers in the state and will allow us to determine applicable deductibles, co-insurance and other patient responsibilities. Patients will be informed that these are estimates and that their insurance company can provide the most accurate estimate of out-of-pocket expenses.

7. After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.

With respect to the 2013 Annual Report on the Massachusetts Health Care Market filed by the Center for Health Information and Analysis (CHIA), we are troubled by the reduction in enrollment in HMO products between 2011 and 2012 as well as the continued heavy reliance on fee-for-service products at a time when the state is promoting alternative payment methods. We believe this is a troubling trend that the HPC and other agencies should closely monitor. Absent from the report is a recognition that the progress made by certain physician groups, such as the Atrius Health medical groups, in reducing costs by redirecting patients to lower cost, but high quality, community and urban hospitals continues to be offset by the significantly higher fees charged by certain other hospitals and other providers. We would also note that relative to other providers (Figure 25) our adjusted Total Medical Expense increases between 2010 and 2011 are generally lower than the other providers noted in the report and we expect to see that trend continue in 2012.

With respect to the 2013 Examination of Health Care Cost Trends and Cost Drivers released earlier this year by the Attorney General's Office, we would note that much of the analysis related to providers focused on Blue Cross Blue Shield of Massachusetts with which we have an enhanced fee schedule because of the investments necessary to invest in the transformation to a new healthcare delivery system of care. For the other major products in the state, Atrius Health is average or below average when compared to other providers.

I, Guy Spinelli, M.D, depose and state under pains and penalties of perjury the following: I am Chairman of the Board of Atrius Health, Inc. I sign the above responses for and on behalf of Atrius Health, Inc., and am duly authorized to do so. I attest that the factual statements set forth in the foregoing responses are true and accurate to the best of my knowledge. The facts stated in the foregoing responses are not all within my personal knowledge, and those facts which are not within my personal knowledge have been assembled by authorized Atrius Health, Inc. employees and/or counsel, and I am informed and believe that they are true.

Guy Spinelli, MD
Chairman of the Board
Atrius Health, Inc.

Atrius Health's Written Testimony in Response to Exhibit C of the Office of the Attorney General's August 28, 2013 Letter

Questions

1. **For each year 2009 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business. Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.**

   Atrius Health does not measure operating margins in this way. We have instead provided our consolidated financials that show our total operating margin in (Appendix 1.)

2. **If you have entered a contract with a public or commercial payer for payment for health care services that incorporates a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk (hereafter "risk contracts"), please explain and submit supporting documents that show how risk contracts have affected your business practices, including any changes you have made, or plan to make, to care delivery, operational structure, or to otherwise improve your opportunities for surpluses under such contracts, such as any changes to your physician recruitment or patient referral practices. Include in your response any analysis of the impact of changes in your service mix, payer mix, or patient member type (e.g., HMO v. PPO, fully-insured v. self-insured) on your opportunities for surpluses.**

   Please refer to our response submitted in 2011 to the Division of Health Care Finance and Policy.

   In addition, with respect to the Medicare Pioneer ACO contract, which we entered into in 2011, we have not made any changes in physician recruitment or patient referral practices. We continue to work to improve care for our Medicare patients such that unnecessary hospital admissions and readmissions are avoided. To do this, we are instituting physician-led team-based reviews of our high risk patients to ensure that each has an individualized care plan. We have also developed collaborative relationships with our newest affiliate, VNA Care Network & Hospice to improve the communication between home health care and our primary care physicians.

   Finally, we routinely analyze the impact of changes in service mix, payer mix and patient member type to identify strategic opportunities to improve value and reduce waste. We have provided these analyses to the Attorney General's Office through separate filings.

3. **Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts, including**

the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or government business.

Please refer to our response submitted in 2011 to the Division of Health Care Finance and Policy.

In evaluating our additional investment needs for the Pioneer ACO, we looked at our spending on infrastructure such as care management, clinical pharmacy, outreach, etc. per member per month for our Medicare Advantage patients and assumed that we would spend a proportionate amount for the Medicare FFS patients attributed to us. Additionally, in 2012 we added a number of positions for project management and data analysis and other resources have been redirected to support these efforts.

4. **Please describe and submit supporting documents regarding how, if at all, you track changes in the health status of your patient population or any population subgroups (e.g., subgroups by carrier, product, or geographic area).**

   Harvard Vanguard Medical Associates has software that utilizes DxCG models for health status assessment based on the group's financial claims data. Since the DxCG score is an individual patient level score, a health status score can be calculated on any sub-population that we want to examine. DxCG scores are not generally as helpful when exploring the pediatric population, so its application is currently focused on adult patients and sub-populations.

5. **Please submit a summary table showing for each year 2009 to 2012 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Exhibit 1 with all applicable fields completed. Please attempt to provide complete answers. 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. Responses must be submitted electronically using the Excel version of the attached exhibit. To receive the Excel spreadsheet, please email HPC-Testimony@state.ma.us.**

   Please refer to Appendix 2.

6. **Please identify categories of expenses that have grown (a) 5% or more and (b) 10% or more from 2010 to 2012. Please explain and submit supporting documents that show your understanding as to the factors underlying any such growth.**

   See the chart at Appendix 3 for the consolidated operating expense trends for the period of 2010-2012:

7. Please describe and submit supporting documents regarding any programs you have that promote health and wellness (hereinafter "wellness programs") for (1) patients for whom you are the primary care provider; (2) patients for whom you are not the primary care provider; and (3) employees. Include in your response the results of any analyses you have conducted regarding the cost benefit of such wellness programs.

(1) While some of the medical groups of Atrius Health offer limited programs that promote health and wellness such as diabetes education classes, we do not have specific wellness programs. Rather, our clinicians continually promote health and wellness as they care for the patients. For example, at some of our sites we offer nutritional consultation, shared medical appointments to work with our pediatric patients that need to learn healthy lifestyles, and at all sites we routinely outreach and screening for our diabetic patients.
(2) The programs described in our response above to questions7(1) are open to any patients of our practices. We do not have programs for patients whom we do not care within our practices. Many of our health education classes are open to the public.
(3) Many of our participating organizations offer employees incentive programs throughout the year to promote health and wellness, including health screenings, health coaching, weight loss programs and walking programs. We have not conducted any cost benefit analyses of these efforts.

I, Guy Spinelli, M.D, depose and state under pains and penalties of perjury the following: I am Chairman of the Board of Atrius Health, Inc. I sign the above responses for and on behalf of Atrius Health, Inc., and am duly authorized to do so. I attest that the factual statements set forth in the foregoing responses are true and accurate to the best of my knowledge. The facts stated in the foregoing responses are not all within my personal knowledge, and those facts which are not within my personal knowledge have been assembled by authorized Atrius Health, Inc. employees and/or counsel, and I am informed and believe that they are true.

Guy Spinelli, MD
Chairman of the Board
Atrius Health, Inc.