Exhibit B 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?*
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?*
c. *What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?*
d. *What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?*

Summary Response: At the outset, we would note that Beth Israel Deaconess Care Organization (BIDCO) and the founding leaders of BIDCO, including Beth Israel Deaconess Medical Center (BIDMC) and the former Beth Israel Deaconess Physicians Organization (BIDPO), have been strongly supportive of the Commonwealth's efforts to contain the overall growth of health care costs in Massachusetts consistent with overall growth in the state's economy, while improving the quality and efficiency of care delivery. We are concerned, however, that the direction of the Commonwealth's cost containment efforts could have the unintended effect of institutionalizing significant market disparities and dysfunction in place if we fail to focus on the need for correction of these disparities, and on the cost containment goal as an aggregate goal.

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

Our organization was founded in 2012 for the purpose of creating an organizational structure that will allow BIDCO and our member hospitals and physicians to align their payment structures to achieve overall cost reduction in the care of our patients, and to improve patient care across the entire continuum of care. We are intensely focused on expanding, strengthening, and improving primary care delivery in order to reduce overall system costs.

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?*

Currently, BIDCO has commercial risk contracts with BCBS, HPHC and Tufts, and success in those contracts is dependent on managing costs and increasing quality. However, there are strong limiting factors in the current healthcare marketplace. Massachusetts' largest system

perpetually exists in a position of price dominance which creates a diverse array of market inequities. Some examples of the inequities that the continued favorable market treatment creates include a disproportionate abundance of resources this system has to launch new programs, technological updates and upgrades, and other investments in new initiatives that only serve to preserve and further institutionalize its market dominance. Indeed, the Office of the Attorney General's Examination of Health Care Cost Trends and Cost Drivers Report of April, 2013 (AGO Cost Trends Report 2013), notes a number of important areas of concern. The second largest system is owned by a for-profit organization with sizable financial resources. This system has created disruption with maintaining our physician membership despite the demonstration of our success by introducing for-profit incentives within the primary care marketplace that cannot be equaled by our system. This level of competition has required attention of time and resources to compete with aggressive physician recruitment activities and this detracts our full attention on achieving greater efficiencies. The system constraints and proprietary concerns of payers also limit our ability to manage in the risk environment and make needed changes nimbly and efficiently. Administrative complexity, limitations on the type of information payers are willing to share, and variations in timely information-sharing and expertise with managing different models of total cost of care/risk contracts prevail. Many requirements are placed on BIDCO's providers, without reciprocal requirements on the payers.

We strongly feel that the some of the greatest opportunities to improve quality and efficiency of care are in strengthening coordination and communication across our member hospitals and physicians, and creating the technology and other needed infrastructure to enable our participating clinicians to communicate and share clinical information more effectively. Indeed, we are striving toward that goal and aggregating the shared resources of our member organizations to achieve this state of complete and aggregated clinical data collection.

While we are fortunate to have leading national expertise in the area of health information systems and technology, the overarching cost and expense of creating and maintaining this infrastructure is our most significant challenge, which the previously mentioned inequities in the system make these challenges difficult to overcome.

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

In addition to the recommendations outlined in the AGO Cost Trends Report 2013, continued investment in health information technology and infrastructure is essential to our success in improving both efficiency and quality of care. We appreciate Chapter 224's recognition and commitment to such investment, particularly for smaller physician practices and community hospitals.

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

In our efforts to manage the total costs of care, we design our contracts with the payers to ensure that our shared efforts will allow for continued savings for health care purchasers which the payers can pass along through reduced health care premiums.

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?

Summary Response: BIDCO was in part created to establish an accountable care organization (ACO) to enable its members to: 1) care for patients in the most appropriate and cost-effective settings; 2) shift more resources to primary care; and 3) maintain and increase the number of patients who can be cared for in community hospital settings. We would also note that prices paid to BIDCO have not increased beyond the benchmark established under Chapter 224, and our global risk contracting incorporates a balance of payment rates and utilization management.

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?

a. What potential opportunities have you identified for such integration?
b. What challenges have you identified in implementing such integration?
c. What systemic or policy changes would further promote such integration?

Summary Response: The integration of behavioral and physical health continues to be one of the most significant challenges our organization faces, and we believe this is largely due to the significant under-reimbursement across all payers for behavioral health care services. This chronic underpayment has resulted in a very serious issue with access to behavioral health services in Massachusetts and a chronic shortage of behavioral health providers in the community. This is partially due to an increasingly limited number of behavioral health professionals who will engage in contracts with health insurers due to the issues of payers underfunding reimbursements to behavioral health professionals. Not surprisingly, among those behavioral health providers who do accept health insurance, the capacity to accept new patients is very limited.

a. What potential opportunities have you identified for such integration?

Enhancing reimbursement for behavioral health and funding for pilot programs that integrate social workers into primary care practices would make a significant difference in our efforts to integrate behavioral health care into our primary care practices. However, as stated, these types of opportunities lack the funding necessary to begin implementation. There are also privacy constraints imposed by the payers due to their interpretations of HIPAA requirements

b. What challenges have you identified in implementing such integration?

Financial resources and subject matter expertise are the greatest challenge to integrating behavioral health into the primary care setting. This is because to be most effective, resources must be put into the primary care practice itself, and the patient--to--provider ratio must be small enough to be effective. Also behavioral health services are provided across a wide swath of providers in the Commonwealth, with the majority outside of our provider organization, so instituting programs across our risk membership is challenging.

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

We would recommend increasing reimbursement rates for behavioral health for all-payers, commercial and governmental. Although we continue to review the 29 recommendations of the Behavioral Health Task Force, we agree with the persistent barriers to integration outlined in the Task Force Report.

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*.
b. *What current factors limit your ability to promote these goals*?
c. *What systemic or policy changes would support your ability to promote more efficient and accountable care*.

Summary Response: While BIDCO's physicians and hospitals have embraced new payment models that hold us accountable for quality, efficiency and health care costs, BIDCO's member organizations continue to have more limited resources to accomplish these goals in an environment where the largest provider's price and market dominance has resulted in significant inconsistency in both resources available for necessary investments, and in the requirements of these alternative payment contracts.

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

BIDCO is participating in global budget contracts with BCBS, HPHC, Tufts Health Plan and the Medicare Pioneer ACO program. In these programs, we are accountable for both the quality of care we provide to our patients as well as the financial cost of these health care services. We have worked hard to improve our quality scores through the addition of resources centrally and at BIDCO locally and at the primary care practice site(s). Additionally, we have deployed clinical tools, such as a unified quality registry to assist practices in meeting quality goals. Furthermore, we have launched discharge transition programs to improve quality by preventing unnecessary readmissions; we have worked with our affiliated hospitals to localize care within the community whenever possible; and we have used practice guidelines to promote standardization and thereby improve the cost effectiveness care. We have also worked with our affiliated hospitals to develop electronic exchange of information among providers to reduce duplication and waste.

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

Technology and staffing infrastructure are critical to our success, and the ability to fund this infrastructure is our most significant challenge. The current health care marketplace, with continued price dominance by the largest health care system, aggressive physician recruitment by competitors, and turnover in at-risk patient panels due to greater shift toward PPO plans by employers (as outlined in the AGO Cost Trends Report 2013) also are a challenge. Health Plan product design imposes limits on the ability of providers to coordinate care within the BIDCO network, and the consumer messaging by payers to patients/members on their ability to go outside of their physician's network increases the difficulty of managing the care of patients. As BIDPO noted last year, the system constraints and proprietary concerns of payers also limit our ability to manage in the risk environment and make nimble and efficient changes. The administrative complexity, limitations on the type of information payers are willing to share, and timeliness and expertise with managing different models of total cost of care/risk contracts are formidable countervailing forces to promoting and achieving the goals of efficient and accountable care.

c. What systematic or policy changes would support your ability to promote more efficient and accountable care?

First, we echo the recommendation of the AGO Cost Trends Report 2013, that "the Commonwealth's market-based cost containment efforts, as well as the efforts of health plans, providers, and purchasers, would benefit from greater consistency and fairness in the implementation of risk contracts." The AGO Report details three key provisions that could be

more equitably applied across provider risk contracts, including: 1) implementation of quality incentives, 2) risk adjustments to budgets, and 3) approaches to risk mitigation.

In addition, the AGO Cost Trends Report 2013 notes that even where quality performance may be measured consistently, quality payment rates vary significantly by provider. Thus, the report concludes, "a consistent formula for gauging quality nonetheless results in widely disparate results for providers, again attributable to multiple negotiations and the leverage of the negotiating parties."

In addition, we would recommend early and adequate financial support for infrastructure capacity associated with the shift to alternative payment methods and new models of care delivery, because this infrastructure must be scaled up in order for these models to succeed. We would also encourage greater consistency among commercial payers in common features of alternative payment systems such as development of budgets, calculation of severity adjustments, and selection of quality measures and setting of performance benchmarks.

Finally, while we recognize and appreciate the important role of the Health Policy Commission in monitoring cost growth in the Commonwealth, we are concerned that its potential vigorous scrutiny of all new clinical affiliations is having a chilling effect on market movements and clinical alignments that would otherwise enhance the Commonwealth's cost containment goals and help correct some of the market dysfunction (disparities, negotiating clout) identified by the Attorney General in its 2013 report.

See also our responses to question 7.

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

a. *What unit(s) of analysis do you use to track cost structure (e.g., at organization, practice, and/or provider level)?*
b. *How does your organization benchmark its performance on operational cost structure against peer organizations?*
c. *How does your organization manage performance on these metrics?*

Summary Response: At the organizational level, we conduct regular tracking against our budget for costs, revenue, and patients attributed to our PCPs. While we obtain and use as much information as possible on benchmarks, there is very little benchmarking data available.

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

At the BIDCO organizational level, we manage our operating costs against our operating budget. Our revenue to cover those costs is partially dependent on the number of covered lives represented by our physicians. Because of our structure, we are not tracking operational costs at the practice or provider level, as that function would be carried out by administrative staff at the practices and hospitals.

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

We obtain and use as much information as possible on benchmarks. However, there is very little benchmarking due to the market environment and competition within our market. We also look to trade organizations for this type of benchmarking information.

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

We conduct regular tracking against our budget for costs, revenue and the patient members attributed to our primary care physicians. The ability of our organization to support the programs we have implemented to affect cost and quality of care are dependent on having a stable and adequate risk population, and can be severely impacted by a material switch by a large employer from an HMO into a PPO.

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.

Summary Response: As BIDCO is not a provider, our organization is not implementing this aspect of Chapter 224; BIDCO's Member provider organizations are preparing for implementation by January 1, 2014.

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.

Summary Response. Once again, the Office of the Attorney General's Examination of Health Care Cost Trends and Cost Drivers (April 2013) has provided critically important findings and recommendations on the most important challenges in the current health care market in Massachusetts. The following key finding summarizes our major concern:

"In our 2010 and 2011 Reports, we found that health plans pay providers widely different prices that are not adequately explained by differences in the quality or complexity of care delivered, or other value-based factors. This year's examination underscores this continuing market dysfunction, and finds that where recent progress has been made in linking payments to value, these approaches feature inconsistent payment standards that fail to mitigate historic disparities. In the future, pricing disparities will only increase if providers are all held to the same level of price increases based on state cost growth goals or other benchmarks."

Both the Office of the Attorney General and the Center for Health Information and Analysis have again concluded that significant disparities in pricing persist, which continue to have an impact on our resources, on our ability to maintain our provider network, and on our ability to fund future infrastructure needs, specifically those involving clinical data integration. This is not unexpected. The market-dominant health care system has had over ten years to build up a physician network and administrative infrastructure and amass robust reserves from the higher-than-average compensation it has received. These higher rates are reflected in its higher total medical expense (TME). The higher rate structure has allowed it to build its physician organization, and market itself in ways that physician groups with lower compensation have not had the funds to do, and this has increased its perceived value to the market, including current and future patients. Efforts by the state to put in systems on a go-forward basis to alleviate increasing health care costs would do nothing to eliminate this historical imbalance of rate structures; freezing the inequities that currently exist will not be an appropriate long-term fix. Some market correction is required.

We would also agree with the findings that the health care system in the Commonwealth would benefit from greater consistency and fairness in the implementation of risk contracts.

Finally, we wish to highlight several of the findings and observations of the AGO Report 2013:

<u>The Impact of Provider Price Variation and Market Leverage</u>

- *As described in our prior Reports, without other fundamental changes, a shift to global payments may actually exacerbate the price escalation associated with market dysfunction by establishing widely different per member per month rates based on historic pricing disparities.*
- *CHIA's recent reports highlight the continuing need to address the effects of market leverage identified in our 2010 and 2011 Reports.*
- *Last year, building on Chapter 288 and earlier reforms, the Massachusetts Legislature enacted Chapter 224 of the 2012 Acts, which established significant new systems for measuring and evaluating market performance, including registration of provider*

organizations, cost and market impact reviews, and certification of risk-bearing and accountable care organizations. Chapter 224 created these and other systems to increase public scrutiny of price variation and market performance, but it did not establish a framework for reining in wide price variations. Instead, Chapter 224 created a "special commission to review variation in prices among providers" in 2013.

- *While there are important costs that insurance is designed to pool, such as the cost of chronic or unexpected health events, spreading the cost of unwarranted price variations results in two key dysfunctions: 1) it de-sensitizes consumers from value-based choices; and 2) it diminishes providers' incentives to compete on value.*

<u>Persistent Market Dysfunction and Recommendations for Health Insurers</u>

- *To support meaningful analysis, health plans, DOI and CHIA should develop more consistent product definitions across health plans. With hundreds of product variations in the market (e.g. tiered products that vary significantly in the types of services that are tiered and in the range of cost-sharing differentials) meaningful reporting will require more consistent definitions of product categories. Non claims-based payments can be effective tools for incenting improvements in provider performance. However, as discussed more fully in Part III.A below, given that these payments are among the dozens of provisions that are individually negotiated between health plans and providers of varying sophistication and clout, the resulting financial incentives are not necessarily consistent, predictable, or fair across contracts.*
- *For providers whose PPO rates are not linked to performance, their market clout, rather than measurable performance, continues to drive PPO payment levels. Moreover, the PPO rates of these providers – who are not "held" to any performance standard – typically, exceed the highest achievable PPO rates that could be earned by those providers whose rates ARE linked to performance. For example, comparing the BCBS contracts that have implications for four physician organizations ("PO") affiliated with academic medical centers in Boston shows that for 2013, the PPO rates for Beth Israel Deaconess PO and Boston Medical Center physicians are tied to efficiency and quality performance under the groups' AQC, while the PPO rates for Brigham and Women's PO and Massachusetts General PO physicians are not tied to efficiency or quality performance under Partners HealthCare System and Partners Community HealthCare's AQC. Moreover, even if Beth Israel Deaconess PO and Boston Medical Center physicians could earn the maximum PPO rate available to them through perfect quality scores and high efficiency performance, their rates would still be at least 25% to 30% lower than the PPO rates guaranteed to physicians at Brigham and Women's PO and Massachusetts General PO.*

Recommendations for the Government and Market Participants

- *It is important that the Commonwealth continue to analyze and report on all aspects of provider payments, including how providers are being paid, how much they are being paid, and whether those payments are tied to value.*
- *Market participants, including the state, should develop systems to more consistently and comprehensively measure the performance of different product designs in improving quality and controlling costs.*
- *…Health plans should regularly report and analyze membership, health status, utilization, and TME data for different product designs and payment arrangements.*

Recommendations Regarding Risk Contracts

- *Variation in terms and calculations across risk contracts results from dozens of negotiations between individual health plans and providers of varying sophistication and clout. Inconsistent implementation of certain provisions tends to dilute the impact of any "best practices" that the market may identify for successfully incenting provider performance while managing the transfer of insurance risk to providers. These inconsistencies can result in diminished predictability and fairness for health plans and providers alike.*
- *The Commonwealth's market-based cost containment efforts, as well as the efforts of health plans, providers and purchasers, would benefit from greater consistency and fairness in the implementation of risk contracts.*
- *…AQC quality payment rates and total payouts for equivalent quality achievement vary significantly by provider. Thus, a consistent formula for gauging quality nonetheless results in widely disparate results for providers, again attributable to multiple negotiations and the leverage of the negotiating parties.*
- *[W]e recommend that health plans make available to providers information that would better enable providers to manage risks and coordinate care under all product lines.*
- *Differences in health status adjustments may result in significant differences in dollars added or subtracted from risk budgets from equivalent health status changes. Such differences are in tension with efforts to lower cost and improve quality since they are more reflective of negotiating clout than the best available measures for actual changes in the health status of providers' risk populations.*