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September 27, 2013

Mr. David Seltz, Executive Director
Commonwealth of Mass
Health Policy Commission
2 Boylston Street
Boston, MA 02130

Dear Mr. Seltz:

On behalf of our physician members and volunteer Board of Directors of Central Massachusetts Independent Physician Association ("CMIPA"), we are submitting this written testimony to the Health Policy Commission (HPC) in response to your recent letter dated August 28th, 2013 and in connection with the upcoming public hearings concerning health care costs trends in the Commonwealth.

Below, we offer our response to the questions posed by HPC, in collaboration with the Office of the Attorney General (OAG) and the Center for Health Information and Analysis (CHIA).

Answers to Questions Contained in Exhibit B:

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 CY 2012-CY2013 and CY 2013-CY2014 is 3.6%.**

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

We have a number of different efforts underway to reduce the total cost of care and to ensure that our patients get the right care in the right place at the right time.

CMIPA has transitioned from volume-based reimbursement system to value based by opting into alternative global payment contracts and moving away from traditional fee-for-service payment systems. We have entered into contracts that provide payment alternatives, such as primary care capitation payments, while simultaneously promoting quality.

We have also redirected patients to less resource-intensive settings when clinically appropriate. For example, we have encouraged our physicians to use Worcester Surgical Center, the non-hospital outpatient freestanding surgical center in our community, because it is less expensive. We have shifted our admissions to the non-tertiary local community hospital, Saint Vincent Hospital, because it is less expensive than the tertiary care center, UMass Memorial, for non-tertiary care services.

Finally, we have encouraged our physicians to have their patients seek emergency department (ED) alternatives, and to have them utilize urgent care centers in our community.

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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?**

Our biggest opportunity to improve quality and efficiency of care is to ensure that our patients are receiving their preventative visits and tests yearly, that they are being tested or treated in high quality, lower cost facilities, and that there care in post-acute settings is coordinated with their primary care physician to avoid readmission and unnecessary emergency room visits.

Cost transparency for both our organization and consumers still remain a limiting factor that prevents us from educating our patients and providers to make informed choices when providing care and seeking care. We appreciate the efforts by the state to require cost transparency by the insurers effective October 1st, 2013, but are unsure whether this information will be presented in a meaningful way so that it can be actionable.

Technology integration also remains a major challenge to our organization as patient information from one facility or provider office is still not easily accessible due to limitations in Electronic Medical Records ("EHRs"). The challenge of having disparate clinical systems is the difficulty of creating a way for the systems to communicate with one another. There are solutions that can accomplish this at some level but they are cost prohibitive and rarely fully functional. CMIPA will continue to struggle with population management until interface technology matures, EHR vendors have a universal platform to allow more facile communication with other information systems, and the prices for such technology decrease.

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

We support efforts aimed at bringing greater transparency around cost to the marketplace so that consumers and physicians can make better and informed decisions about these treatment options. We hope that the Chapter 224 will bring about changes so that patients become more informed decision makers, and understand price differences offered by health care systems.

We also need more assistance in paying for the cost of transmitting data to physicians and health care systems, within and outside of Central Massachusetts. It is very expensive for us to be able to extract data from disparate EHRs, and to push critical information to providers, payors, and governmental agencies. We have 17 disparate EHRs within our provider group, and there is no regulation concerning how much an EHR vendor can charge for extracting data and building interfaces with The Massachusetts Health Information Highway (The HIway). There should be regulations imposed upon EHR vendors to standardize how information is stored and then retrieved, and then the amount they charge their physician clients to retrieve such information.

We would like access to the all payors claims database, as this may prove valuable in helping us consolidate our data in a more efficient manner.

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

Currently, our organization is not in the position to ensure that any reduction is passed along to consumers or businesses. However, CMIPA does participate in many limited access insurance products, which provide consumers with cost effective alternatives. CMIPA will also be participating in a Consumer Operated and

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Orientated Plan effective 1/1/2014. The hope is that by decreasing healthcare costs by improved health and utilization of our patients, cost savings could be passed to consumers and businesses in the form of decreased health insurance premium costs.

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 for medical trend and what been the results of these actions?**

Our organization has taken many actions to address the impact of the growth in prices on the medical trend including:

A. Partnering with the local community hospital and the freestanding outpatient surgical center that provides high quality lower cost care and encouraging our providers to provide patients with this high quality, lower cost alternatives.
B. Providing our providers with information regarding ED use and the alternative care at Urgent Care Centers.
C. Monthly Utilization Review Meetings to provide information regarding costs and quality.
D. Meeting individually with our providers every six weeks sharing information regarding utilization and quality measures specific to the provider and the provider's patients.
E. Working with local skilled nursing facilities (SNF) to decrease the length of stay (LOS) and increase communication with our providers to reduce hospital readmissions and cost.

3) **Chapter 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?

Currently CMIPA has taken a limited approach to the integration of behavioral and physical health.

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

In the past, we were the recipient of a Harvard Pilgrim Health Care grant, whereby we sought to improve the screening for and management of major depressive disorder in adults in the primary care setting. While the implementation of screening for depression was successful, we found it difficult to secure appointments with behavioral health professionals on a timely basis. There are currently scarce resources in the community for behavior health, and patients my need to wait several weeks for a non-urgent appointment. Furthermore, we are at risk for behavioral health services for most of our contracts, and we have no control or impact over the network.

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

As we do not have mental health professionals who are part of our organization, and have little impact on the delivery of mental health services in our community, we would welcome a state mandate that requires health insurance companies to retain this risk in their risk sharing contracts and to ensure that they provide a broad enough network to deliver adequate behavioral health services in the Central Massachusetts community.

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

CMIPA has entered into several global payment contracts over the past year with innovative care delivery models. These contracts include risk, capitation, and pay for performance.

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

To promote the goals of efficiency and accountability, CMIPA has membership standards including mandatory monthly meeting attendance at UR meetings to promote further education of our members. CMIPA also provides our physicians with quarterly report cards to allow physicians to self-monitor the quality care provided to patients and the cost of that care. We meet individually with our providers every six weeks sharing information regarding utilization and quality measures specific to the provider and the provider's patients

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

Currently, it is extremely difficult to receive actionable data at both the enterprise and the provider level to facilitate change. We are building a system that will combine claims data and EHR data side-by-side, but it is very expensive and requires continuous quality assurance to ensure that the data entered and distributed is accurate. The lack of standardization in the EHR fields creates additional expense and utilization of our scarce organizational resources. Also, there is a dearth of data from PPOs, which creates challenges for our organization in monitoring these patients.

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

Health plans, including PPOs, should be able to provide all organizations, physicians and patients with cost information for their health care. Data continues to remain a pivotal issue within our organization.

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

CMIPA looks at many cost indicators, including total medical expense (TME), Average Length of Stay (ALOS), Inpatient and Outpatient costs, patient 30 day acute care readmissions and quality indicators such as HEDIS scores.

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

We track costs and quality measures whenever possible at the organization level, practice and provider levels.

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

We mark our benchmarks against both national indicators and as well as network indicators.

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

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Our Medical Management team provides opportunity lists to providers for them to be aware of quality metrics that have not been met, quarterly report cards for self-monitoring, monthly UR meetings for open discussions around quality and efficiency as well as six week follow up visits at PCP offices to provide additional levels of details. In the near future, CMIPA will be aggregating real time EHR data and claims data to deliver more in depth information at the provider level.

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

We will be notifying our provider offices of the health insurers' contact information and web sites where they can obtain cost information.

We also publish directories so that our physicians know which providers our associated with our organization, and which providers are not.

We have recently hired a full time data analyst to review and analyze claims data including costs and expect to provide information to our providers to educate patients about their options when ordering tests or procedures for them.

We understand that the payors have invested heavily in systems that will aid with cost transparency for the consumers. It would be great if the providers could access these systems as well, and share this information when there is a patient visit so that they don't also have to invest in these very costly systems.

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.**

No comment at this time.

We thank you for involving us in this very important process, and we look forward to a continued dialogue with you on how best to improve the health care system.

The below signatory is legally authorized and empowered to represent Central Massachusetts Independent Physician Association for the purposes of this testimony and is signed under the pains and penalties of perjury.

Regards,

Wayne B. Glazier, MD

cc: Gail D. Sillman, Executive Vice President
Paul Bergeron, MD, Chief Medical Officer