500 Cummings Park
Suite 6500
Beverly, MA 01915

September 27, 2013

Via email: HPC-Testimony@state.ma.us

David Seltz
Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz,

On behalf of Northeast PHO, enclosed please find our written testimony to Exhibits B and C of the Health Policy Commission's letter dated August 28, 2013.

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

Sincerely,

Nicole G. DeVita
Executive Director, Northeast PHO

Exhibit B: Instructions and HPC Questions for Written Testimony

Question 1: **Chapter 224 of the Acts of 2012 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 taken to reduce the total cost of care for your patients?**

Response: There are many actions that we are taking to reduce the total cost of care. We have implemented several programs focusing on providing the most cost-efficient, quality driven healthcare to our provider's patients. Some example of those programs include:

- Medical Management Structure: Medical Director leads physician committees which review cost and utilization data, develop evidence-based guidelines to reduce practice variation, etc.
- Pharmacy management: We have a clinical pharmacist that meets with our physicians to discuss cost effective medication prescribing as well as identifying patients who have gaps in fill rates for their chronic disease maintenance medications.
- Case Management: Examples include case manager calls to our patients being discharged from the hospital and home visits when needed to reduce risk of readmission. We also have nurse case managers embedded in many of our larger practices to assist in the management of high-risk and high-cost patients.
- ED Management: Examples include case manager calls to patients being discharged from the ED, in depth reporting to identify our patients who frequent the ED, extended hours for most of our practices, implementation of an urgent care center and use of ancillary providers such as Minute Clinic.
- Patient Centered Medical Home certification: NCQA Level 3 certification for two additional practices by the end of 2013 will give us a total of four practices with this distinction. Through this initiative, practice-based improvement teams with patient representation, review performance metrics and look for opportunities to increase efficiency, improve access and quality. Practices are also working to improve patient self-management with education and self-management tools to reduce costs by improving health outcomes.
- Quality Improvement: Examples include patient registries that identify gaps in care for patients, extracts from our electronic medical records to the patient registries to populate important information such as lab results, and one on one meetings with our Medical Director and our PCPs to discuss patient specific care. Increased compliance

with recommended care such as Diabetic lab and eye exams may help to reduce complications and prevent hospitalizations.

- Collaboration with our hospital on readmission prevention and appropriate site of care.

As a result of these efforts our growth in healthcare costs has slowed, as measured by our medical expense trend, and our quality has improved, as measured by our scores on from the different payors who track this information. There is a great deal of detail behind each of these programs and we would be happy to sit down with you to discuss each program.

b. **What are the biggest opportunities to improve the quality and efficiency of care at your organization?**

Response: Information Systems, interoperability and improved patient engagement.

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

Response: The following changes would help our organization operate more efficiently without reducing quality:

- Improved Benefit Design and Patient Engagement Incentives: We don't believe the benefit designs in place today adequately engage the patients.
- Copay Waivers : Patients are being asked to pay a copay for visits, such as cardiac rehab, that are important to their disease. Many patients are forgoing important follow up visits with their providers because they can't afford the copay.
- Complete Claims Data: In some instances we are not receiving a complete picture of claims for our patients because of privacy issues. We understand the sensitivity around privacy but it is difficult to manage a patient with a chronic illness if you do not have the full claims history. We also don't receive claims data on all of our patients, e.g. PPO patients or patients who change health plans, therefore we are unable to implement our programs for patients where data is not available.
- Administrative simplification: We recognize that most health plans spend 90% of the premium on the patient but because each health plan has different requirements of the physicians and hospitals this creates administrative complexity for them and their office staff resulting in additional dollars and time being spent on administrative operations in the practice/hospital that could be spent on the patient.
- Eliminate duplication in Medical Management: Health plans make outreach calls to patients for post discharge calls and disease management and send preventive test reminders. We also do these types of programs and it is very confusing to the patient to receive calls and

letters from several different places. We feel if a group has a solid medical management program in place the health plan should discontinue their efforts to medically manage our patients/their members.

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

Response: Northeast PHO is a Management Service Organization which provides contract management services on behalf of its owners: New England Community Medical Group (NECoMG) and Northeast Health System (NHS). Northeast PHO does not bill for medical services so would not directly impact the cost to consumers and businesses. However, through our Medical Management programs and Quality Improvement programs listed in Question 1, our goal is to provide the highest quality care in the most cost-effective manner so that health plans can provide the highest value to consumers and businesses.

Question 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?**

Response: Question 1 identifies the actions our organization has undertaken to address the impact of the growth in prices on medical trend.

Results:

14% reduction in our commercial ED visits/1000

40% increase in E-prescribing

48% reduction in our commercial costs for radiology

Increase in our generic utilization for prescription drugs from 77% in 2009 to 84.30% in 2012

Projected increase in our AQC ambulatory gate score from a 3.1 in 2010 to a 3.7 in 2011 and projected gate score of 4.1 in 2012.

Our increase in our total medical expenses for our global payment contract is in the single digits

Question 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?**

Response: In 2012, Northeast PHO worked with Northeast Behavioral Health and Northeast Senior Link to pilot an integrated case management model whereby social workers and behavioral health clinicians

were integrated into the Care Management team for several Primary Care Physician (PCP) offices to evaluate and treat patients requiring behavioral health services. The pilot was successful and the program was extended to additional PCP offices in 2013. In addition, Northeast PHO sponsored PCP training on the SBIRT model (Screening Brief Intervention and Referral to Treatment) and worked with several PCP offices to improve Depression screening, identification and treatment through a Patient Centered Medical Home Initiative.

What potential opportunities have you identified for such integration?
We identified opportunities for earlier identification of behavioral health and substance abuse issues in the PCP practice, improved PCP knowledge of available programs and community resources and therefore earlier and more effective treatment of behavioral health problems within the ambulatory environment.

What challenges have your identified in implementing such integration?
The challenges are: financial- funding to support behavioral health integration; physical space limitations in physician offices; and, system integration. Behavioral health clinicians are more attuned to severe mental health problems, and increased training on how to do short and effective interventions on patients with medical problems that are affected by less severe behavioral health issues would be valuable.

What systematic or policy changes would further promote such integration? Increased funding, improved access to behavioral health clinicians, improved training of primary care and behavioral health staff about screening in Primary Care setting and intervention options, especially for the elderly and adolescents and children.

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

Response

a. **Describe your organization's efforts to promote these goals**. The Risk Sharing Committee has adopted a set of principles which guide decision-making and has developed a set of innovative physician and hospital incentives which are measurable, meaningful and aligned with the Triple Aim (Improving Quality, Reducing Cost and Improving the Patient Experience.) Northeast PHO has also promoted alternative delivery models such as the Patient Centered Medical Home initiative, the Integrated Care Management model outlined in Question 3 and the use of Northeast PHO Nurse Case Managers and Nurse Practitioners to make home visits on High Risk patients.

b. What current factors limit your ability to promote these goals? Our ability to promote these goals is limited by lack of funding for Primary Care practice transformation and behavioral health integration.

c. What systematic or policy changes would support your ability to promote more efficient and accountable care? Increased funding for Primary Care practice transformation and behavioral health integration would improve our ability to promote efficient and accountable care. In addition, reduced duplication of services between health plans and providers as well as waiving co-payments for all disease management related visits and programs would be helpful.

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

Response: The metrics we use include overall and category budget trends year over year as and our operating costs translated into a per member per month cost.

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

Response: NEPHO looks at trends and PMPM costs at our organizational level when doing analysis on our operating costs.

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

Response: This data is not readily available but we do speak with our colleagues to better understand their PMPM operational costs structure.

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

Response: We review our operational costs on a monthly basis vs. budget and share this with our Board bimonthly and adjust as needed. We continually look for economies of scale and also perform ROI analysis on our programs and services.

Question 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.

Response: We are preparing to implement a system or process to provide patients with cost information effective January 1, 2014.

We have attended health plan demonstrations at Massachusetts Hospital Association (MHA). The demonstrations showed how the health plans can calculate and display information for the patients. There are additional sessions that will be sponsored by MHA. We will attend these

sessions to hear more about the new requirement and learn about the best ways to meet the patients' needs.

Internal meetings have occurred to develop an action plan. Leaders have been identified to organize the vendor selection and implementation process. Two vendors will be demonstrating their products. A team will develop an evaluation tool to select the preferred vendor. We also plan to collaborate with the health plans to provide accurate estimates.

There are current processes in place to assist patients with calculating their out-of- pocket costs. We look forward to using a new tool to improve accuracy and help streamline the process.

Question 7: **After reviewing the reports issues 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.**

Response: The Annual Report on the Massachusetts Health Care Market Report, August 2013, provided a comprehensive overview of healthcare coverage and cost in Massachusetts for the commercial market for both the insurer and the provider. Additionally the report provided the variation of quality performance on selected measures. This additional data was helpful.

The variation of relative price for hospital and physician groups appear to be consistent to last year's report showing a continuation of variation of physician and hospital payments. Different mix and site of services

The health status adjusted TME by physician group was helpful. It allowed us to benchmark our PHO to the other physician groups across the state. However, without back up information it is hard to understand why some group's trend is higher than others. Some physician groups listed on page 39 had significant increases in their trend. These increases could have been in the non-claims category resulting from improved quality scores which should not be considered a negative outcome.

Additionally, we know current health status adjustment software is not perfect and there are other factors that can contribute to the variation of TME across physicians networks. A few examples include:

1. Different mix and site of services provided
2. Demographics and socioeconomic factors

Exhibit C:

Question 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.

Response: Northeast PHO (NEPHO) is a for profit Management Service Organization (MSO) which provides management services, including contract negotiation and contract management services for pay-for-performance and other risk contracts, on behalf of its owners: New England Community Medical Group(NECoMG) and Northeast Hospital Corporation (NHC). Contract management services include but are not limited to: case management, analytics and reporting, provider relations, referral management, and quality metrics patient registry support.

Any revenue from services provided by our physicians and hospitals to their patients is collected by the providers and does not flow through the PHO. Therefore NEPHO would not show any operating margin for the three categories listed above and we do not have access to the operating margins of our providers.

NEPHO operating revenue gain/loss was: $6,476 in 2009, $(31,599) in 2010, $(21,203) in 2011 and $98,523 in 2012

Question 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 return, 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 our opportunities for surplus

Response: NEPHO has been managing risk contracts for many years and over those years our business practices in managing risk and pay for performance have not substantially changed. We continue to provide tools and services to our providers that are essential in assisting them to deliver high quality/cost efficient care to their patients. This will also result in achieving surplus and incentive dollars for our providers from the contracts NEPHO has negotiated on their behalf.

Areas where we have made changes focus primarily around data analytics, IT and reporting. The reason for this change is the data and data tools available to us today are much better than they were ten years ago and making these changes made sense to improve our overall quality and efficiency performance.

NEPHO has made some changes in our care management program. The changes were put in place based on identifying best practices and monitoring data for our care management programs. We

now have care managers embedded in our practices and also have our care managers making home visits. Additionally we have hired a social worker and a behavioral health specialists to work with our care managers and patients.

Our clinical pharmacist has become more involved with patient care and works closely with our patients who are on multiple medications and have multiple chronic conditions.

We do analyze our payer mix. Our analysis of payer mix has shown a decrease in the number of HMO/POS patients we have in the three largest not for profit private insurers in Massachusetts. We believe the decline is due to patients moving to PPO products. We do not receive PPO data from the plans so it is difficult to confirm this shift. Additionally, we have seen an increase in the number of patients enrolled in government plans. Our payer mix changing over the past few years has decreased our opportunities for surpluses. Increases in copayment, coinsurance and deductibles has negatively affected many of our physician practices and hospitals because it increasingly difficult to collect these higher amounts from patients.

Question 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 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 cost or risk capital needs would change due to changes in the risk you bear on your commercial or governmental business.

Response: Northeast has experience in risk contracting and currently has risk for approximately 45K covered lives. For each of our risk contracts we analyze what the extent of our deficit could be. This includes analysis on our budget based risk contracts along with our upside potential for quality initiatives. To financially manage our risk we have a withhold in place for our providers which would help to cover any deficit we may encounter in our risk contracts. We also have stop loss to help mitigate any catastrophic claims we may encounter during the year.

Question 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).

Response: Northeast PHO reviews health status risk scores contained on health plan performance, trend and fund reports. For Tufts Medicare Preferred, Northeast PHO has the ability to track health status risk scores by patient, provider and physician group through reports provided by Optum. Northeast PHO also uses member risk score reports contained in our data warehouse to stratify patient risk and identify members in highest need of nurse case manager intervention.

Question 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 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.

Response: We have completed the summary table to the best of our ability with the data we had. It is important to note that NEPHO is not a provider of service therefore we only have revenue information for the contracts we have risk for and for which the health plans provide us claims data.

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

Response: The NEPHO overall budget decreased by 2.75% between 2010 and 2012. Salaries/ Benefits was the only category with an increase of more than 10% during this time. In 2011 we hired a full time Medical Director and additional quality staff to help manage our contracts. These new hires contributed to the increase in this category.

Question 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.

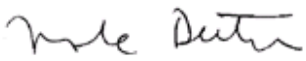
Response: As discussed above NEPHO does not provider so we would not have any patients within our organization. The employees of NEPHO receive their health benefit through Beverly hospital, a member of Lahey Health, and through this health benefit wellness programs are offered. Examples of the programs include:

- All campuses now smoke free.
- Reimbursement to smokers for programs to assist them in stopping smoking.
- Removed all sodas, high fat and high fructose items from vending machines and replaced them with healthier options.
- Offer on site Weight Watcher programs at all sites.
- Offer on site exercise classes at all sites to includes, pilates, yoga, kick-boxing, aerobics, belly dancing, martial arts.
- Provide an on-site EAP program.
- Provide free flu shots.
- Have partnerships with community gyms and fitness clubs to provide discount memberships as well as payroll deduction for the memberships.

- Began biometric screening for wellness in 2012 to establish base line. Will re-screen in 2013 for outcomes.
- Provided $400 health insurance premium incentive to employees who participated in biometric screening.
- Our health insurance provider has dedicated a full time RN to all of our sites to provide support and assistance to employees with wellness issues.
- Have adjusted cafeteria menu to provide healthier choices for employees.

Attestation:

I, Nicole DeVita, am legally authorized and empowered to represent Northeast PHO for the purposes of this testimony, and this testimony is signed under the pains and penalties of perjury.



Nicole G. DeVita, RPh., MHP
Executive Director
Northeast PHO