NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

EXHIBIT B
Health Policy Commission Questions for Written Testimony

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. <u>The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.</u>

Summary:
NEQCA is lowering costs by directing patients to higher value tertiary providers, like Tufts MC and Floating Hospital for Children, and optimizing medication prescribing by providing data and feedback to physicians to improve prescribing for patients. This is achieving great results; but is limited by the absence of data. Mandated system-wide claims submission and reporting for all medications would improve the ability to reduce costs.

NEQCA is implementing the Patient Centered Medical Home (PCMH) in all NEQCA primary care practices. NEQCA is dedicated to the Triple Aim for all patients, yet we are limited to providing these efforts only to patients in plans that provide claims data and funding for the information technology and people needed to manage patients. The following changes will address this:

- **Access to accurate, timely and comprehensive quality and efficiency data on ALL patients**
- **Reallocate care management resources from payers to actual providers**
- **Close the payment gap**
- **Uniform and transparent payment rules**

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

NEQCA is working on several initiatives to increase the efficiency of care. We are directing patients to higher value tertiary medical centers, such as Tufts MC and the Floating Hospital for Children, which offer high quality care at a lower cost. We are also working to keep care local and in the community wherever possible, both for inpatient services at community hospitals and utilization of local physician services. These initiatives do not negatively affect quality since our network uses high quality community hospitals and specialist physicians. To address a lack of certain specialist physicians in the community, NEQCA and Tufts MC support the *Distributed Academic Medical Center™* model, where we deploy specialists from Tufts MC to the community to keep care local and costs down.

We are also working to optimize medication prescribing through providing data and feedback to physicians that identify opportunities for improving prescribing for patients

with reflux disease, high cholesterol, diabetes, and depression. We do not always expect to save money on medications, but believe that this will prevent complications that could adversely affect health in the future – for example, adding insulin to the regimen of a patient with diabetes may increase drug costs but reduce complications of the illness that could lead to expensive acute or chronic care.

This program is limited by the absence of data for several reasons. First, for patients enrolled in our commercial and Medicare Advantage programs, our pharmacy claims do not include low-cost generic medications. Second, we do not have any data, pharmacy or medical claims for our non-HMO commercial products, or for Medicaid or other governmental payment programs. With a more complete data set we could determine exactly what patients are taking so that we can identify and fill gaps in care and also substitute less expensive and equally-effective medications for patients who need them. Mandated system-wide claims submission and reporting for all medications, including low-cost generic medications, would greatly improve NEQCA's and other systems' ability to manage and reduce costs in this important way. Additionally, NEQCA's efforts in this regard are limited by payors' lack of sharing PPO claims data.

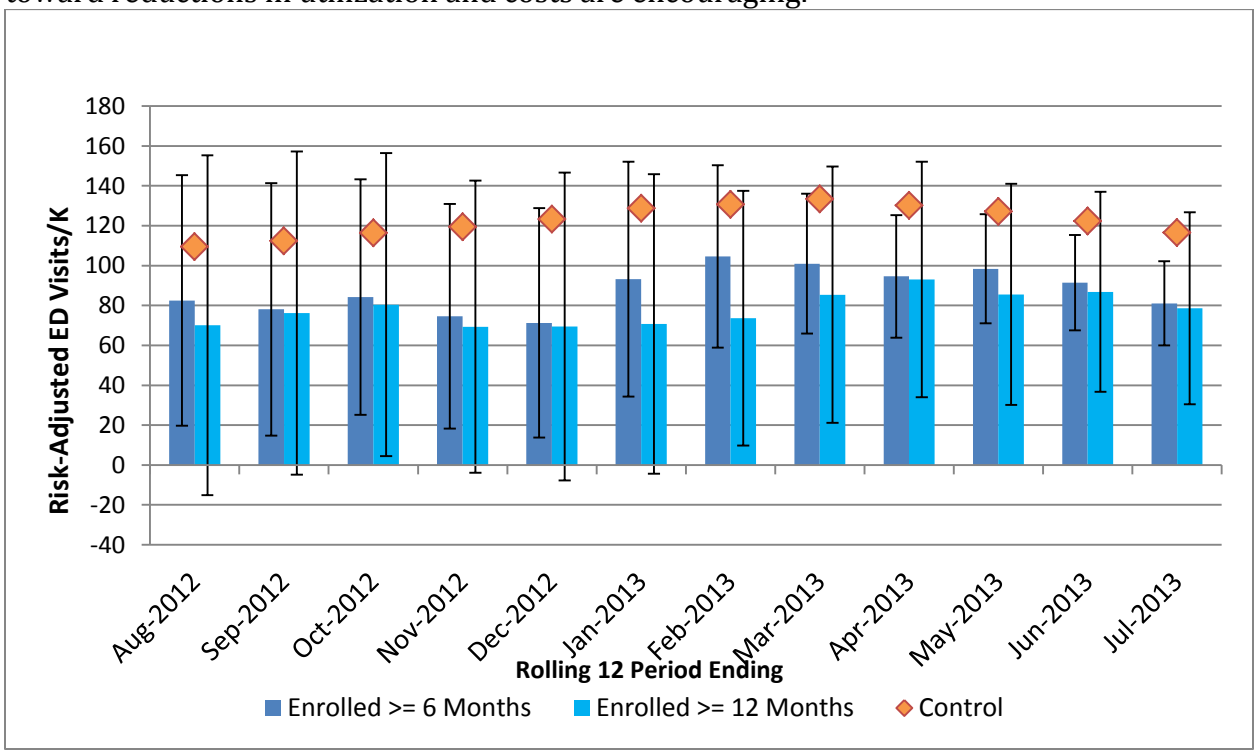
The other major initiative we are pursuing is implementation of Patient Centered Medical Home (PCMH) in all NEQCA primary care practices by the end of 2015. The purpose of the NEQCA Medical Home Program is to support primary care providers in meeting the Triple Aim goals of providing better care and better population health, at lower cost. Having learned from successful implementation of Electronic Health Records and helping those practices achieve Meaningful Use, and with our experience in designing and implementing care management for complex patients, NEQCA's Medical Home Program is poised to scale up and meet its goals.

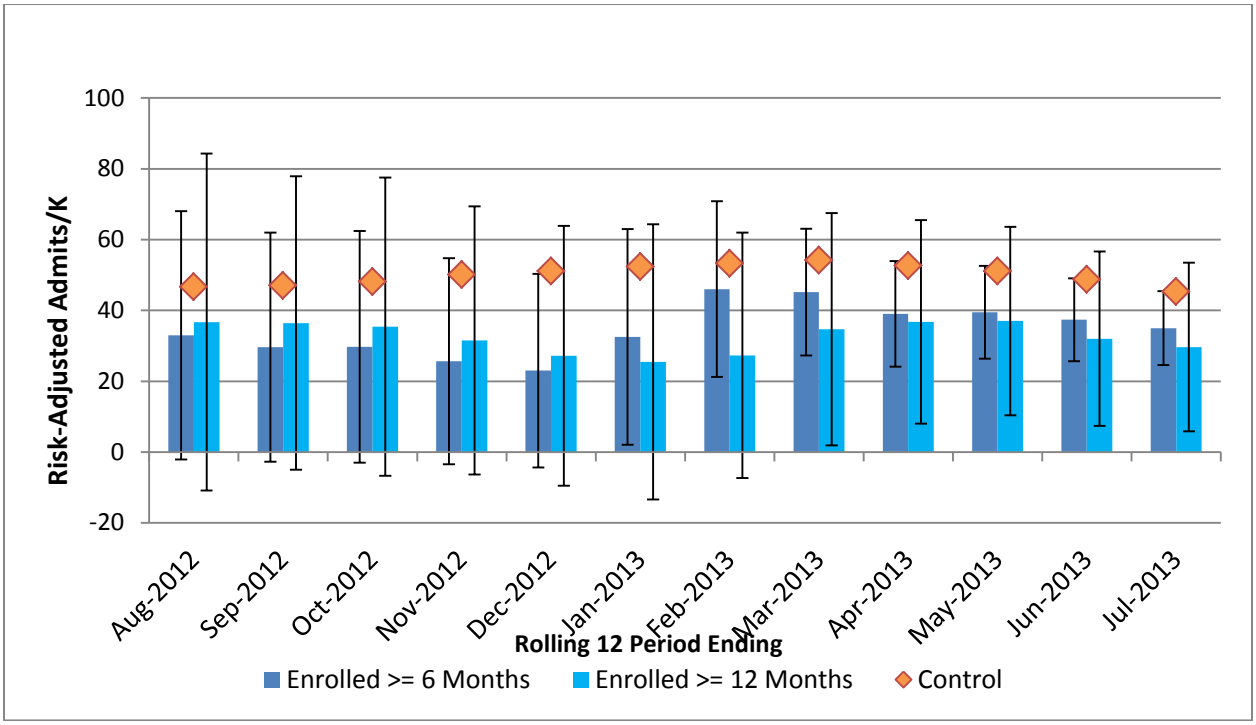
The goals of NEQCA's Medical Home Program are to:

- Achieve Patient Centered Medical Home (PCMH) National Committee for Quality Assurance (NCQA) Recognition Level II or Level III
- Engage with the highest risk patients to support enhanced self-management of health and active participation in treatment
- Improve quality and efficiency performance
- Achieve Meaningful Use Attestation for Electronic Health Records
- Improve provider, staff and patient satisfaction

The NEQCA Medical Home Program is notable for its innovative linkage of three program components: (a) helping practices improve their workflow and adopt a Patient Centered Medical Home "system of care" as recognized by the National Commission on Quality Assurance (NCQA) – submissions for 70 providers are being sent to NCQA by 9/30/13, and this builds on a "corporate submission" which assures that practices on eCW will be nearly 40% of the way to level II recognition; (b) supporting practices to achieve "Meaningful Use" of technology as defined by the Centers for Medicare & Medicaid Services (CMS); and (c) care management for the most complex members, defined through claims-driven algorithms and predictive modeling or referrals from providers. Our care management

program is showing promising results: these three graphs demonstrate that compared to a control group of similar patients not enrolled in the program, the care management group has lower emergency department utilization, fewer hospitalizations, and a trend towards statistically significantly less cost (Total Medical Expense). We expect to be able to calculate meaningful Return on Investment results in a few months and these trends toward reductions in utilization and costs are encouraging.

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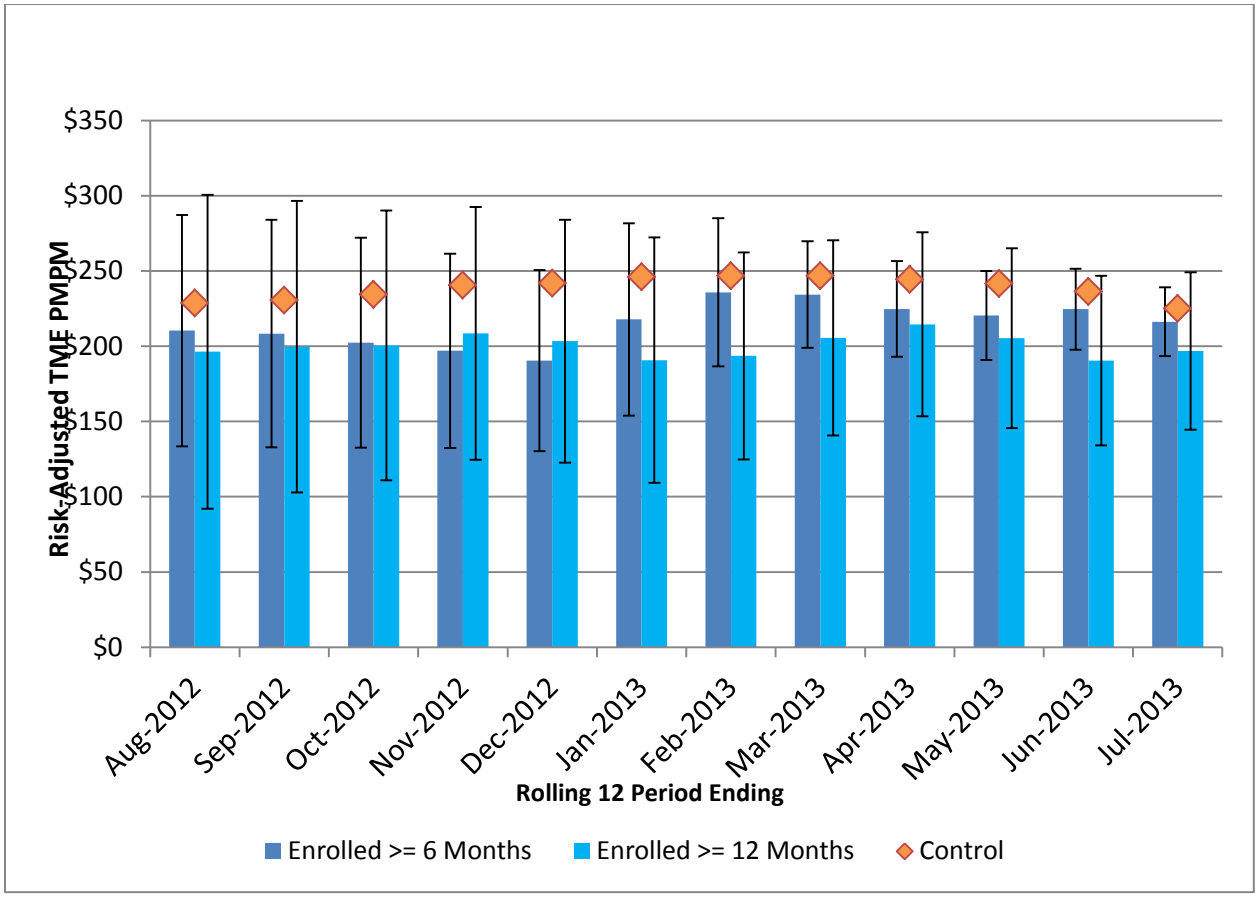
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Rolling 12 Period Ending
Enrolled >= 6 Months
Enrolled >= 12 Months
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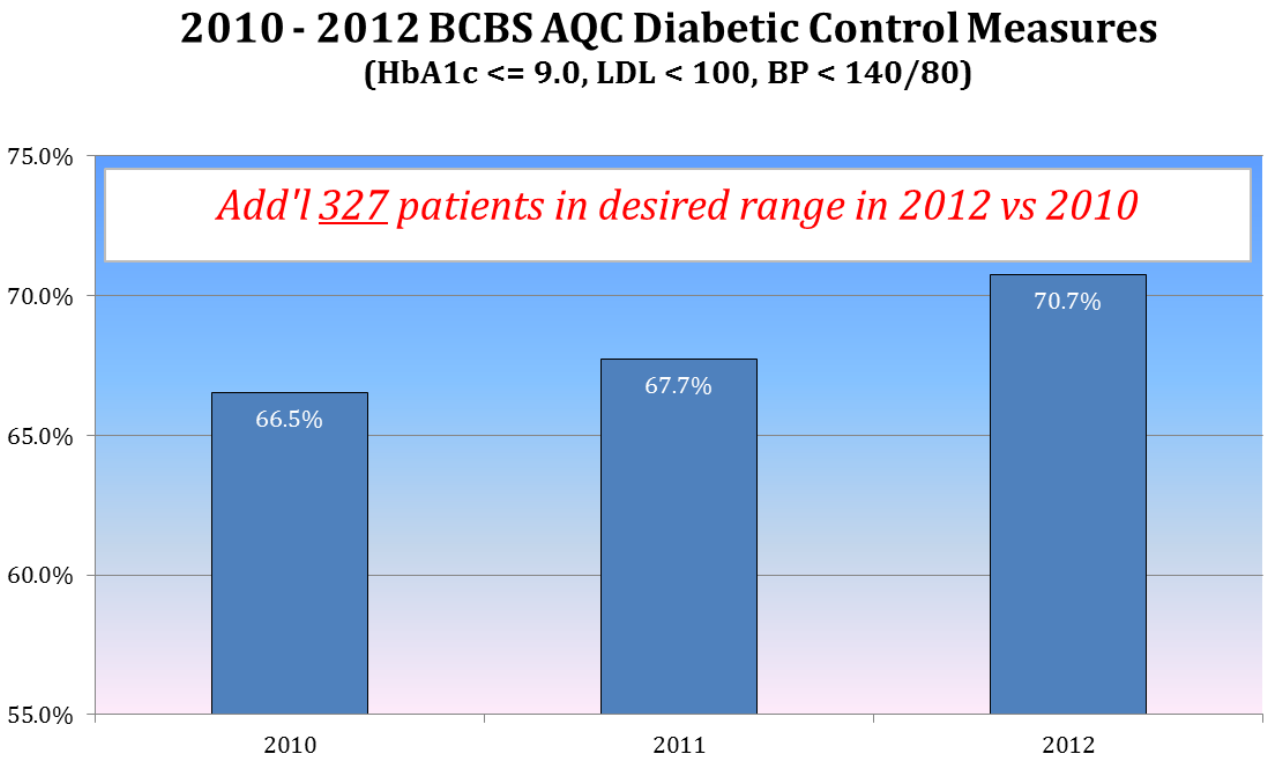
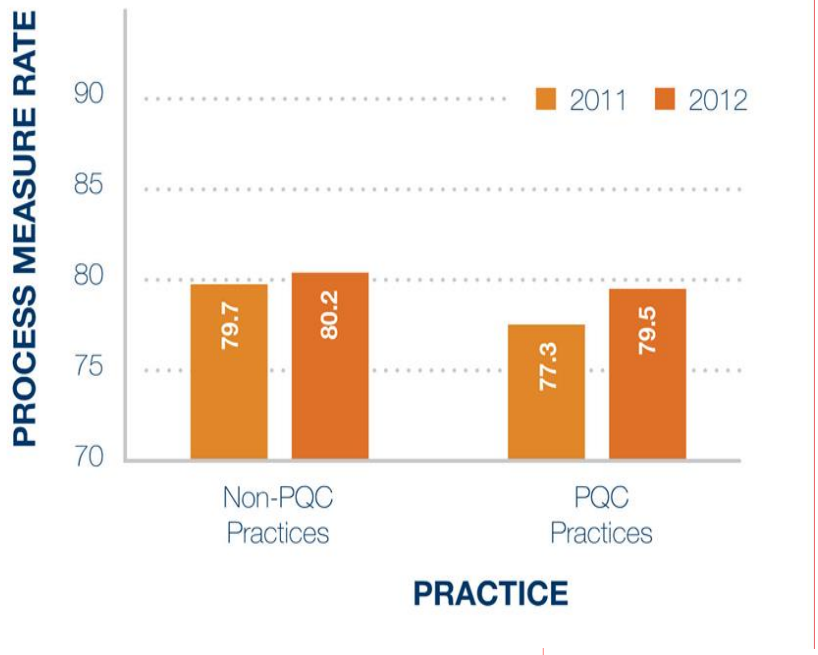
b. What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?

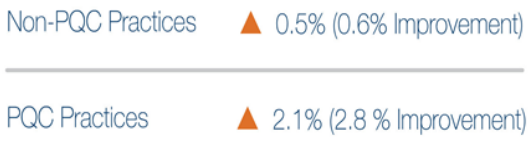
NEQCA's goal is to accomplish the three Triple Aim goals of better health, better care, and lower cost, through providing support for our physicians and their teams to use technology and team-based care to provide better prevention and wellness programs for our patients. The biggest opportunities for quality improvement differ for pediatric and adult patients: for children it is providing consistent preventive care and improved behavioral health care, and for adults it is better management of chronic illnesses like diabetes, especially for patients with multiple chronic conditions and those who have both physical and behavioral health diagnoses. Implementation of the Medical Home program is designed to address the need for both kinds of infrastructure – information systems to track and manage population health and improve communication and coordination between providers, and team members to assist in quality improvement activities and provide care for the most complex patients and their families. Over the past several years NEQCA has demonstrated consistent and sustained improvement in quality measures. This graph shows how care for patients with diabetes improved from 2010-2012:



In 2012 NEQCA developed the Practice Quality Coordinator (PQC) program to provide support for practices to improve their quality scores. Starting in the fall, PQCs were deployed to practices in the lower half of network performance to provide help with

outreach to patients and to provide staff with coaching on improving workflow. The results had a significant impact on quality: practices with PQCs improved 4 times as much compared to non-PQC practices, as this graph shows:





Process Measure Rate = completion rates for cancer screening, diabetes, well-child and related screening measures.

The biggest factor that limits our ability to expand programs that have demonstrated success is lack of resources to provide the same service for all patients. As the Attorney General and CHIA reports have demonstrated consistently, NEQCA has been at or below average in payments from payers compared to other networks for the past decade. This disparity in payments limits our ability to implement services regardless of payer, both because of a lack of cash reserves to support the cost of information technology and care teams and because of varying levels of willingness of payers to share risk.

Additionally, NEQCA has seen an increased shift from HMO plans to PPO plans, with significant negative impact on our ability to manage these populations. Specifically, enrollment in the Blue Cross Blue Shield HMO program dropped over 30% over the past three years. Every patient that shifts from BCBS HMO (the Alternative Quality Contract

or AQC) to PPO plans results in losses to our network: both in terms of loss of infrastructure payments, and loss of access to data, since Blue Cross, like most payers, refuses to share data on PPO patients even though use of primary care attribution models and automated assignment to PCPs could be used to determine how to share data and infrastructure payments. The Commonwealth should require data sharing from all payers and regular access to these data for providers in a format that is actionable.

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

NEQCA is dedicated to reaching the Triple Aim for all patients, yet are limited in the scope of some of our care management and quality improvement initiatives to patients enrolled in plans that provide claims data and adequate funding to pay for the information technology and people needed to manage populations of patients. Here is a brief list of changes that would allow NEQCA to operate more efficiently without sacrificing quality:

1) **Access to comprehensive data:** Access to accurate and timely and comprehensive quality and efficiency data on all patients will assist in managing populations through better targeting patients who need care management and other programs to support better health and for more accurate predictive modeling of future costs and opportunities to prevent them.
2) **Reallocate care management resources:** Health plan care management s resources should be shifted to appropriate provider organizations to implement care delivery redesign and to provide integrated care management at the practice level.
3) **Close the payment gap:** The current payment rate differentials are unsustainable. The market of high cost "haves" and low cost "have-nots" only serves to marginalize high quality, efficient providers, leaving a market dominated by high cost providers who continue to drive an increase in costs. If high cost healthcare systems continue to grow, they will either absorb lower cost systems and demand higher payment rates for those providers, or drive lower-cost providers with less capital and human resources out of business. Insurers should prove that they are not discriminating against hospitals and physicians with more than a 15% Medicaid mix and are paying them a market-competitive rate, which should be at least at the average of other hospitals in their markets and peer groups. As price variations are addressed, providers must be grouped and analyzed by appropriate peer group, e.g. Academic medical Centers (AMCs), and Community Hospitals. Once the payment gap is addressed, global payment contracts could be effective in aligning incentives to achieve high quality and efficient health care.
4) **Uniform and transparent payment rules:** A uniform base payment format, such as a single base fee schedule, claims submission format, and payment policies and procedures across all payers will help drive balance and transparency in the market. Instituting a uniform base payment format will help create true "apples to apples" comparisons, will allow providers and payers to negotiate inflators and deflators on

a standard fee schedule, will remove incentives for perverse contracting practices and arbitrary supplemental payments, and will create substantial savings through administrative efficiencies. Chapter 224 addresses some of these issues, but more needs to be done to implement the necessary regulations to move these important initiatives ahead.

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

NEQCA shares savings in all of its current contracts with its payer partners, but has no way to directly influence premium rates to reduce costs to consumers. Plans should be required to share at least a portion of savings they receive due to better provider performance with their accounts, who can in turn pass on savings to their employees, or in the case of Medicare Advantage plans, offer richer benefits packages or lower premiums to enrollees.

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:
The impact of a fixed percentage increase across the board only serves to widen the disparity in rates and make it harder for high value networks to achieve marked results in improvements to overall population health, enhanced patient experiences and lowering of overall costs.

NEQCA has limited opportunity to affect increases in prices, since most fee schedules are negotiated between non-NEQCA providers and insurers. NEQCA physicians admit to 16 community hospitals, none of which are owned by Tufts Medical Center or NEQCA, and only one of them contracts jointly with our system to provide care to commercially-insured enrollees. Because of the disparities in rates described above, the impact of a fixed percentage increase across the board only serves to widen the disparity in rates and make it harder for high value networks to achieve Triple Aim goals.

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?

Summary:
NEQCA currently has a behavioral health program in support of its Medical Home Care Management program through a contract with the Department of Psychiatry at Tufts Medical Center.
The barriers to this innovative program are:

- Shortage of behavioral health providers
- Lack of space in small practices to have care managers onsite

- Lack of funding to pay for behavioral health programs in primary care practices
- Carve outs of behavioral health programs from medical insurance programs. This leads to lack of coordination between providers and a lack of data sharing between clinicians and at the population level

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

The greatest need for integration is in primary care, for both pediatric and adult patients. NEQCA is currently implementing a behavioral health program in support of its Medical Home Care Management program, through a contract with the Department of Psychiatry at Tufts Medical Center. Through this contract, psychiatrists are available for telephonic consultation for PCPs seeking information on how to manage medications or for advice on how to treat the patient using inpatient or outpatient services. The psychiatrists also provide supervision and support for NEQCA's complex care managers by being available to answer questions and participating in weekly case conferences. We also participating in a multi-center grant program to have an onsite integrated care manager focused on patients with depression, anxiety and substance abuse, work with high risk patients with diabetes to screen and treat them for these very common behavioral health problems.

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

There are several important barriers to effectively integrating Behavioral Health:
1) Shortage of behavioral health providers: few are willing to accept insurance, and as a result, there are significant problems with access to psychiatry and other behavioral health programs. Access to behavioral health professionals for children is even more challenging than for adults.
2) Lack of space in small practices to have care managers onsite;
3) Lack of funding to pay for behavioral health programs in primary care practices;
4) Carve outs of behavioral health programs from medical insurance programs. This leads to lack of coordination between providers, and lack of data sharing both between clinicians and at the population level.

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

1. Better funding for behavioral health services to improve access to care;
2. Payment and funding for pilot projects for technology-enabled care to increase access to behavioral health services. This includes payments for video visits between patients and behavioral health professionals; use of in-home devices to support care management interventions (e.g. depression symptom monitoring with daily questions on devices that are monitored by care managers who can intervene earlier when symptoms worsen); use of handheld devices and smartphones for measuring symptom levels and increasing access to educational materials and contact with behavioral health professionals.
3. Funding for research into the relationship between behavioral health diagnoses and higher medical costs. Our data indicate that when compared to age and gender-matched controls, patients with one behavioral health diagnosis have on average 2.5 times the medical costs, excluding behavioral health treatment costs. Such research

will help us better understand if people have medical illnesses first and then develop behavioral health problems, or vice versa and help in the design and implementation of effective treatment programs.

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

Summary:
NEQCA's risk contract structures and internal funds flow policies align incentives between the providers and the health plans to reward those with higher quality outcomes delivered at an efficient cost.
Another innovative and efficient care delivery program executed by NEQCA is the Medical Home program which includes the following components:

- **Meaningful Use of Electronic Health Records**
- **Patient Centered Medical Home (PCMH) System of Care, as measured by the National Committee for Quality Assurance (NCQA) as a PCMH**
- **Care Management for the most high-risk, complex patients**

NEQCA is concerned that the significant movement of business out of managed HMO products and back into the unmanaged PPO fee-for-service business will seriously dilute its efforts to improve quality and efficiency.

a. Describe your organization's efforts to promote these goals.
NEQCA maintains a "Triple Aim" goal to improve the health of a population of patients; improve the patient's experience of care, including quality, access and reliability; and reduce the rate of growth of costs of care. In order to meet this goal, NEQCA supports a Medical Home program. The Medical Home program enables physicians to improve care for high-risk patients who have chronic and high cost illnesses that require significant resources to treat. The NEQCA Medical Home program includes three individual components:

- **Meaningful Use of Electronic Health Records** (EHRs). The goal of the program is to promote adoption and use of EHRs to reduce cost and improve the quality and measurement of care;
- **Patient Centered Medical Home (PCMH) System of Care, as measured by the National Committee for Quality Assurance (NCQA) as a PCMH**. These NCQA standards provide guidance for provider workflow processes that support the delivery of high quality care, manage medical expenses, improve patient health, and increase physician and staff satisfaction as well as patient engagement; and
- **Care Management for the most high-risk, complex patients**. Care Management provides additional help to primary care physicians to assist them in managing the highest-risk patient with the identified HMO population. High risk patients have complex needs and require significant time from their primary care practices. Under the guidance of the physician, the Care Management Team (consisting of an Integrated Care Manager [RN], Associate Integrated Care

Manager [LPN], Clinical Pharmacist, Care Coordinator, and Behavioral Health Support) completes a patient assessment and collaboratively develops an individualized care plan that focuses on medical intervention and measureable patient education. The care plan supports increased self-management by the patients, better coordination of care, use of community resources and improved adherence with testing and treatment, all of which result in optimal patient health outcomes in a cost-effective manner.

NEQCA's risk contracts have served as a platform for it to create an integrated system with incentives to improve quality and efficiency of care, along with the patient's experience of care. NEQCA's risk contract structures and internal funds flow policies have allowed the alignment of incentives between the providers and the health plans to reward those with higher quality outcomes delivered at an efficient cost.

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

NEQCA is concerned that the significant movement of business out of managed HMO products and back into the unmanaged PPO fee-for-service business will seriously dilute its efforts to improve quality and efficiency. Physicians within NEQCA aspire to provide payer blind care management, however this is not possible if the patient data and resources for infrastructure are not provided equally across the varying insurance products.

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

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

Summary:

NEQCA develops metrics around the population health programs that we institute to manage the health of those populations risk agreements. Metrics such as NEQCA's "efficient use of resources" metric aim to benchmark the ideal amount of patients that should be enrolled in a care management program per provider so the network can manage accordingly.

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

Given the organizational structure of our affiliated network the operational cost structure of both the provider and practice level is managed by those providers and practices with no insight or oversight by NEQCA. NEQCA is in the process of developing a voluntary survey that will be distributed, tabulated, and delivered to participating practices as a way to benchmark their performance to others in the network and potentially the region and state. This survey will center on volume metrics, revenue, staffing levels, operational cost ratios, physician compensation ratios, rent costs, etc. NEQCA is also contemplating a survey such as this for the local care organizations (LCOs) as a way to provide valuable benchmarking data to the LCO's, as well the entire network.

As it relates to network costs, NEQCA develops metrics around the population health programs that we institute to manage the health of those populations risk agreements. Metrics such as NEQCA's "efficient use of resources" metric aim to benchmark the ideal amount of patients that should be enrolled in a care management program per nurse so the network can manage accordingly. These population health initiatives are expensive to administer, so ROI metrics are developed to make sure that these programs are getting to their intended results. Metrics around admits/1000, ED usage, and decreased TME are used in many of the population health initiatives that NEQCA undertakes. These metrics are evaluated against a control group to evaluate the programs. Many of the programs that NEQCA has developed are showing very favorable ROI. Ideally, the physicians in our network would be able to roll these programs out to all their patients as they believe this will be an instrumental component of realizing the triple aim. However, given the decrease of the HMO population to more PPO plans coupled with the lack of the ability to take attributed risk on the PPO population, this desired end point is currently not possible.

NEQCA also prides itself on tightly managing its operation costs. In overhead departments, managers are challenged to come up with their "key drivers" of cost. In all of its measurements, metrics are established to calculate and measure trends to ensure the proper amount of resources are being allocated to the appropriate areas to support the overall goals of NEQCA as a high quality, lower cost network achieving the Triple Aim. Overall, NEQCA calculates their overhead rate as well as their overall return on investment of the network annually. This ROI metric is communicated to the network annually and is used as a guiding light for the organization.

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

Given NEQCA's unique fit in the marketplace as a primarily non employed, affiliated, physician network, there are very few, if any, comparable organizations by which to benchmark. With the large academic employed practice in our network, The Tufts Medical Center Physicians Organization, they use UHC's (United Health Consortium) FPSC (Family Practice Solutions Center) benchmarking, Sullivan and Cotter's benchmarking data, and MGMA's (Medical Group Management Association) benchmarking data. Each one of these organizations provides both compensation metrics, revenue analytic metrics, and operational cost benchmarks that can be used to measure an organization's performance

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

Internal and external reporting has been developed to track performance to the many metrics discussed in section 5.a. NEQCA reports out on these various network wide cost metrics on a monthly basis to management. The "efficient use of resources" metrics and various ROI metrics associated with the population health programs at the network level are reported out monthly to management and quarterly to the NEQCA Finance Committee, which is a sub-committee to the NEQCA Board of Directors.

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:
NEQCA is not a health care provider and is not in a position to provide cost information to patients.

NEQCA is not a health care provider and is not in a position to provide cost information to patients. However, NEQCA intends on engaging with its affiliated physicians to assist the physicians with compliance with cost transparency requirements.