NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

Exhibit C
Office of Attorney General Questions for Written Testimony

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.

NEQCA does not possess full financial data for the practices that are members of the organization. We do not possess practice level cost information nor do we have margin data for those practices.

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

Summary:
NEQCA believes there are benefits to risk arrangements, however systemic problems must be addressed. Risk contracts enable NEQCA to invest in important care coordination and care management.

NEQCA has concerns that payer-driven contractual rate differentials are inflating Total Medical Expense for managed HMO products and keeping non-managed PPO products rates artificially low. NEQCA believes elements of the contractual structures are an underlying factor in shift of employer accounts and patients away from HMO managed products and towards unmanaged PPO products. Unless payers agree to level contractual rate structures across managed and non-managed products, NEQCA fears the shift will

continue and will diminish the reach of global budgeting as a payment vehicle and the scope of beneficial population management changes to the system.

NEQCA continues to believe there are benefits to risk arrangements, however there are systemic problems that must also be addressed, as we stated in previous years' testimony. Risk contracts have enabled the New England Quality Care Alliance (NEQCA) network to invest in important care coordination and care management where it otherwise would not have been able to invest. NEQCA is not a full employment model so without access to structural capital outside the fee for service (FFS) revenue stream we could not provide those population management services to members. Structural capital dollars coming from risk contracts are used by a network like NEQCA to change the practice behaviors of a physician to effectively manage the cost trend in a patient-centered manner, to provide case managers and other ancillary health providers directly in physician offices, working directly with physicians, to more effectively manage the health needs for the chronically ill and most medically complex patients in the practice and thereby reduce costs; and to analyze claims and billing data to determine how to achieve effective patient-centered care and to determine if external factors are impacting the medical expense trend.

NEQCA has concerns that payer-driven contractual rate differentials are inflating Total Medical Expense for managed HMO products and keeping non-managed PPO products rates artificially low. NEQCA believes these differential rates structures are an underlying factor in the current shift of employer accounts and patients away from HMO managed products and towards unmanaged PPO products. This troubling shift is diminishing the reach and applicability of global budgeting and risk contracting as a payment vehicle. Unless payers agree to level contractual rate structures across managed and non-managed products, NEQCA fears the shift will continue and will diminish both the reach of global budgeting as a payment vehicle and the scope of beneficial population management changes to the Massachusetts healthcare delivery system.

Should the payer mix continue to shift back toward FFS products, structural capital dollars (infrastructure and quality and efficiency incentive payments) will shrink and the scale of integrated network quality and efficiency population management programs will become limited and more expensive for those employers and patients that remain in managed HMO products (unless the health plans are expected to provide the additional reimbursement necessary to make them operate). NEQCA has serious concerns that this shift will exacerbate a critical problem resulting from the current disparities of payment in the marketplace. Specifically, that providers and systems with higher rates have the capital and reserves to implement quality and efficiency population management services across the board whereas other networks do not. As with all population management, there are some economies of scale that cannot be managed around. For these reasons, NEQCA advocates strongly for systemic change to level contractual rate differentials between managed HMO and unmanaged PPO products.

3. Please explain and submit supporting documents that show how you quantify, analyze, and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human

resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficits cenarios. Include in your response any analysis of how your costs or risk-capital needs would change due to changes in the risk you bear on your commercial or government business.

Summary:

NEQCA currently purchases stop-loss or reinsurance to cover potential catastrophic losses in its risk-based contracts. Accurate quantification and analysis of potential exposure for the network in a risk agreement is fully dependent on access to complete claims data, including information about the actual dollar amounts paid by the health plan for those claims and for the patients served by provider. Health plans do not currently share overall health status adjusted network costs and other groups' costs.

As prudent financial stewards NEQCA currently purchases stop-loss or reinsurance to cover potential catastrophic losses in its risk-based contracts. As a system, NEQCA bears the contractual risk in current global payment agreements, as well as the per member per month costs associated with all the deployed care management services to manage the patient population. NEQCA believes that it would be appropriate for payers to allocate from their reserves the appropriate level of capital to support contractual risk.

In order to accomplish the goals of population health management and the triple aim, the data, structures and incentives to move the needle must all be in place. This does not necessitate global budgeting nor risk agreements; it requires aligned incentives. Risk contracts allow for a general alignment but since current risk arrangements only cover a minority of the population, they are not going to create substantial change. It is also important to understand that entering into a risk contract does not in and of itself result in a transfer of true, long term actuarial population based risk. The risk and potential reward in a contract with a commercial health insurance payer is simply the result of a negotiation between the payer and provider. In the event that a historically high cost entity is able to embed its high costs into a negotiated global budget, all it has done is change the cash flow by which it is paid and it is still not held accountable to overall average cost, but is held only to its own baseline. This continues the disparities of the current market.
NEQCA would also like to observe that accurate quantification and analysis of potential exposure for the network in a risk agreement is fully dependent on access to complete claims data, including information about the actual dollar amounts paid by the health plan for those claims, for the patients served by provider.

Health plans do not currently share overall health status adjusted network costs and other groups' costs. The information that is shared primarily exists in the public reporting realm but is methodologically different from the actual contracts and thus only directional at best. This information is critical for transparent comparison of costs among networks and identification of areas for continued improvement. NEQCA advocates for increased data sharing and transparency to allow for prudent decision-making around risk capital.

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).

The health plans have informed NEQCA that they do not supply any provider with the underlying detailed calculations that they use to determine the base health care status for each patient. This limits our ability to design algorithms that will track emerging changes in those members status in the same way the payer calculates them. The payers do however provide NEQCA with the monthly calculated score for each eligible member so that NEQCA can validate the calculated scores when aggregated to the overall health plan level reporting in order to tie to health plan contractual financial data. NEQCA has its own suite of predictive modeling tools embedded into its data warehouse and financial systems that we utilize to drive care management decisions in a common platform across all health plans. While this may not tie exactly to each health plan schema, it does provide a very correlative framework and allows NEQCA to better operationalize its care management functions for those members in our risk contracts. However, this is still limited to relatively small number of insurance products for which we receive data.

W have been utilizing our systems in a universal way focused on our disease management processes for that limited data set, but we have not utilized these systems to run analytics and the carrier/product/geographic areas.

However, in the plan reported data NEQCA has seen significant shifts out of the HMO plans. . NEQCA plans to synthesize the data elements delivered from the plans to determine the impact of the change in membership from the plans; we believe that the account level (employer) movement caused by plans winning or losing accounts, and/or moving accounts may be impacting these results significantly. Until we can get to universal cross product claims/data interchange, the ability to understand the drivers of overall medical costs will be sorely limited and hamper our efforts to deploy those scarce resources in the most effective way to bend overall costs.

5. Please submit a summary table showing for each year 2009 to 2012 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as AGO Exhibit 1 with all applicable fields completed.
Please attempt to provide complete answers. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue. Responses must be submitted electronically using the Excel version of the attached exhibit.

The structure of NEQCA does not allow for an answer as requested in the spreadsheet. The majority of community providers who are part of NEQCA are themselves private practices which control their own billing systems. NEQCA does not provide billing services and does not currently have access to billing data which would be required to answer any of the fee-for-service revenue questions with accuracy on this sheet. We do have some data provided by the health plans at a summary level for all of NEQCA with regards these payments for limited years and we have used that information and other information regarding the practice commercial payer mix and relative contractual rate schedules to extrapolate out the full dollar picture into the commercial space. NEQCA has not extended those analyses into the governmental payor programs to look at direct revenue, managed Medicaid, or any of the non-risk based "commercial Medicare" agreements, and as mentioned do not have access to the billing data for the private practices.

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

NEQCA tracks its expenses in a top down approach first prior to looking at the individual categories of expense. In the 3.5 years 2010-2013 YTD NEQCA has not experienced a raw year over year medical expense trend (i.e. not severity adjusted) that has exceeded the current state benchmark. In addition, when adjusted for severity, NEQCAs adjusted expenses have been below any network trend numbers for the overall trends reported by the health plan for eastern Massachusetts in all but one year individually and cumulatively overall. During this same time frame there have been a sporatic occurance where a large services category has exceeded the levels you have indicated, but there is no one component that has been an ongoing concern across all years. The closest category might be pharmacy costs as it has been over 5% across multiple (but not all) years. Those increases in expenses also correlate with an increase in the percentage of the measured population with pharmacy benefits, and, in addition those expenses may be offsetting medical expenses by controlling for disease states that would otherwise be unmanaged.

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.

Summary:
NEQCA's Patient Centered Medical Home (PCMH) program is an innovative program that strengthens the physician-patient relationship by replacing episodic care with coordinated and continuous care. The *NEQCA Cares* program for its own workforce has a goal of promoting healthy diet and exercise choices in the workplace.

As described in detail in the Exhibit B, Question 1, NEQCA's Patient Centered Medical Home (PCMH) program is an innovative program that strengthens the physician-patient

relationship by replacing episodic care with coordinated and continuous care. Care coordination at the provider level is an essential component of the PCMH program and requires drawing on other NEQCA resources, such as health information technology training and team based models.

NEQCA recently established the NEQCA Cares program for its own workforce, with a goal of promoting healthy diet and exercise choices in the workplace.