SSPHO
South Shore Physician Hospital Organization

Written Testimony – September 27, 2013

This submission is in response to your requests pursuant to GL. C. 6D §8 dated August 26, 2013 and August 28, 2013 to provide written testimony on health care cost trends on behalf of South Shore Physician Hospital Organization (SSPHO). Some background on SSPHO will provide meaningful context for the responses to your questions.

SSPHO has been in existence for over 19 years, during many of those years we have had risk agreements with all three of the major health plans. SSPHO was granted a Transitional Period Waiver as a Risk Bearing Provider Organization as of December 31, 2012. SSPHO is comprised of over 400 physicians, close to 90 of who are primary care and the remainder important community specialty care physicians, and our hospital member (South Shore Hospital). The specialty care physicians are a mix of independent community providers and hospital based providers, some of whom are employed by South Shore Hospital.

Please note: Elements of the OAG questions, specifically Question 5, requests confidential payment data that SSPHO considers to include confidential, non-public information of a competitively sensitive nature and SSPHO believes that the release of such information, in whole or in part, may have a detrimental anti-competitive effect on SSPHO. While voluntarily providing such information, SSPHO respectfully requests that such information not be deemed a public record pursuant to GL. C.4 §4.7 Para. 26 and other applicable statutory provisions.
Thank you for this opportunity. SSPHO responses follow on the proceeding pages.

Exhibit B: HPC Questions for Written Testimony

Question 1
Chapter 224 of the Acts of 2013 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 2012-20113 and CY 2013 -2014 is 3.6%

a. **What are the actions your organization has taken to reduce the total cost of care for your patients?**
SSPHO is an active participant in risk arrangements for commercial HMO patients that require the patient to select a PCP and for the providers to operate under a budget. If SSPHO controls costs under that budget, the health plans benefit through a reduction in health care costs for those patients. If SSPHO exceeds that budget, our members have to return a portion of that deficit to the health plans. The SSPHO operating presumption is that these savings, in either form, are passed on to the consumer in the form of reduced premium. SSPHO is limiting the growth of the risk budgets to encourage more effective treatments..

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?**
The biggest opportunity to improve quality and efficiency of care is to identify ways to encourage the provision of care locally rather than referral of patients to more distant, higher cost tertiary facilities when those services could be efficiently performed locally. SSPHO reviews data to identify areas where appropriate care could be provided locally and other possible areas of efficiency, but historical referral and patient preference patterns are slow to respond. Provider and Patient education on the scope and quality of services available locally would assist in this area.

c. **What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?**
There are economies of scale that could be achieved with reduced regulation, which if properly managed could result in cost reduction, and/or higher quality. Encouraging the selection of a primary care practitioner for all lines of business of a health plan– HMO, PPO, POS and indemnity would allow providers to receive and analyze data on all of their commercial patients, instead of the sub-set of HMO patients who are in a risk or capitated model. Such data would allow providers and provider organizations to identify patterns and trends that may affect efficiency and quality outcomes.

d. **What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?**
As noted in 1 (a) above, SSPHO does not have direct contact with the consumer/patient so it must rely on the health plans to return any savings to the consumer in the form of reduced premium and reduction of health plan surplus reserves well above the statutory reserve requirements.

Question 2
The 2013 Examination of Health Care Costs Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive the 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?
SSPHO has begun the process to review and/or renegotiate its contracts with all of the health plans with which it contracts. Included within those discussions are strategies that could reduce the rate of increase in the unit cost of care. However any reduction in the rate of increase in cost does not address other

factors that contribute to costs such as severity of illness or utilization which are also major drivers of the overall trend. One example of actions being taken by SSPHO to impact the growth in costs is a current initiative with SSH on a hospital readmission reduction program. It is premature to evaluate the results as many of these initiatives will take years of data to evaluate and measure efficiency.

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?

a. **What potential opportunities have you identified for such integration?**
SSPHO has begun to identify physician providers (Psychiatrists) who might be interested in joining our organization so we can include behavioral health within the efficiency initiatives. SSPHO recognizes the need for this integration so, as opportunities present themselves in contract discussions, we will explore efficacious ways to include the behavioral/mental health/substance abuse areas into our risk contracts.

b. **What challenges have you identified in implementing such integration?**
At present there are no psychiatrists or other behavioral health providers in SSPHO.

c. **What systemic or policy changes would further promote such integration?**
Ensuring that the health plan reimbursement for this medical specialty and the related fields of clinical psychology is consistent with the reimbursement for other medical specialties. Some plans continue to have separate fee schedules for these providers while other outsource the entire clinical area to a specialized bidder.

Question 4

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

a. **Describe your organization's efforts to promote these goals.**
SSPHO is actively investigating alternative models, like Patient Centered Medical Home

b. **What current factors limit your ability to promote these goals?**
There is a lack of clear definition of what a PCMH is and there are few reimbursement models that support the creation of that model without the provider community taking all of the business risk.

c. **What systemic or policy changes would support your ability to promote more efficient and accountable care?**
There are significant administrative and infrastructure costs associated with accountable care initiatives and data systems and analysis that are not otherwise reimbursed and represent a significant cost hurdle to provider organizations.

Question 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 organizational, practice, and /or provider level)?**
SSPHO assumes the HPC is referring to the medical expense costs in relation to the risk budgets. We have developed reporting to monitor costs and medical expenses on a PCP level and PMPM

b. **How does you organization benchmark its performance on operational cost structure against peer organizations?**
The health plans have not provided SSPHO with benchmarks that can be used to benchmark or

otherwise monitor or conduct such comparisons. Typically the plans provide trend data relative to a prior period with no point of reference if that prior period was efficient or inefficient. SSPHO is engaging a national actuarial firm to compile and review actionable benchmark data to help develop appropriate performance and cost measures.

c. **How does your organization manage performance on these metrics?**
The benchmark project referenced above was recently initiated and it is estimated that data to provide an accurate performance evaluation will not be available for at least 12 months.

Question 6

Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health services and procedures, including the allowed amount or charge and any facility fee as required by c224.

While SSPHO believes that this Question more directly applies to health plans and facilities, SSPHO is reviewing and identifying the specific requirements for its physician members. SSPHO is educating our physician members on an on-going basis on the various health plan initiatives as they continue to evolve. For now, it is most consistent and efficient to refer patients to their applicable health plan sites, since they have the specifics on patient responsibility, remaining deductible (if any) and allowed services for the specific health benefit plan. In addition, the SSPHO continues to review developments relating to the law and participates in industry and state agency meetings to establish the practical application of this rule in the context of a physician office and variances between the initial preliminary diagnosis and treatment plan and final diagnosis & treatment.

Question 7

After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide commentary on the findings presented in light of your organization's expenses.

In the Office of Attorney General's report Examination of Health Care Cost Drive Trends and Cost Drivers (April 24, 2013) SSPHO is identified as having higher risk budgets that some other providers. These budgets were mutually developed over time with the health plans, based on the historical medical expense and then trended using health plan based data. In recent years we have revisited all of the risk budgets and reduced them, or decreased the trends, where appropriate. However, SSPHO placed most of the member revenue on risk performance as evidenced in the Charts on Page 29 and 30 of the Report and not on the underlying FFS reimbursement that may exist in other provider's risk arrangements or pay for performance models.

SSPHO is not identified in the Annual Report on the Massachusetts Health Care Market (Center for Health Information and Analysis – August 2013) so we have no basis for comment. .

Exhibit C: Office of Attorney General (OAG) Questions

OAG - Question 1
For each year 2009 to present, please submit a summary table showing your operating margin 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 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 contract that incorporate a per member per month budget against which claims costs are settled.

Total Business	2009	2010	2011	2012	Notes
Commercial Risk	100%	100%	100%	100%	SSPHO is only presently contracted for Commercial HMO Risk business. In 2010 it stopped participating in the Tufts Medicare Advantage program, but it was a very small percentage of the total at risk population
Government	0%	0%	0%	0%	
All Other *	0%	0%	0%	0%	

SSPHO has existing risk contracts with BCBSMA HMO Blue, Harvard pilgrim Health Care and Tufts Health Plans. They are restricted to the HMO populations, and in some cases, a subset of that population (i.e. self insured members are excluded and some product design exclusions).
Since SSPHO is a membership organization, we do not track operating margin by health plan. Risk recoveries and quality payments are passed through to the membership based on establish formulas and criteria. The mix of these revenues to those providers total book of business varies widely based on the type of medical services they perform. SSPHO does not collect other revenue data from its members.
* All Other – While SSPHO has some Agreements with these health plans for non-risk products (HMO, POS, PPO), offered to the PHO physician members through a messenger model form of contracting, the SSPHO does not receive revenue data on these non-risk arrangements.

OAG - Question 2
If you entered a contract with a public or commercial payer for payment of health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining withhold returns, surplus paid, and/or deficit charged against you, including contracts that do not support 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 made, or plan to make, to care delivery, operational structure, or 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 opportunity for surpluses.

SSPHO was created to be a vehicle for risk contracting for the south shore communities, centered around South Weymouth. Therefore risk contracting, as defined by this question, has not changed our business practices; it is one of our core reasons for existence and a foundation of our business model. That said, SSPHO has continued to evolve over the past 19 years and the industry changed to offer a more diverse set of benefits to their members, our patients. We continue to explore the new forms of practice models, but since our physician population is primarily made up of independent practices; our role is more administrative and advisory in nature. We collect and compile information on evolving models such as the Patient Centered Medical Home and offer educational sessions to our members. The lack of viable reimbursement models that support the intensive human resource effort necessary for these models is a

barrier to these smaller independent practices. On the last section of the question, SSPHO is made up of HMO patients so as the population shifts from this insurance product to PPO and POS types of products, the funding for the risk surplus payments is negatively affected.

OAG - 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 the per member per month cost 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 costs or risk-capital needs would change due to changes in the risk you bear on your commercial or governmental business.

For the 3 commercial payers that SSPHO contracts with, SSPHO has always been in a surplus condition. It has not had to rely on the standard risk mitigation strategies of withholds offsets, caps on maximum liability per patient, or risk reserves. However withholds have been in place to offer protection and liquidity to the providers in the event of a deficit. SSPHO has recently reduced or eliminated withholds since they had never been called upon to satisfy a deficit. It has taken advantage of individual stop loss (reinsurance) either offered by the health plans or in the open market. We are actively moving to a reserve strategy, in part due to the recently enactment of Ch 224 of 2012 and the Division of Insurance efforts on risk bearing provider organizations.

OAG - 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).

SSPHO receives population based health status reports from the health plans in the context of established adjustments in the risk budget. Some reports are simple Age/Sex adjustment factors and one health plan provides a health status adjusted report. These are reported at the Primary Care Physician level and for SSPHO in the aggregate. Most of these reports are quarterly with a run out period. Since the reports are time lagged, and the data is at least a few months old, the data is not utilized for medical management. The reported SSPHO health status data generally does not vary widely from the health plans' overall health status data and any significant change has been attributed to the addition or departure of physician groups. Within the past year, SSPHO purchased a software tool in its data warehouse that calculates the health status of each patient. That data is available to each provider who uses the tool for their own analysis. We are still developing useful reporting options using this tool.

OAG - 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 for whom you were not able to report a category (or categories) of revenue.

Please see the attached Table for SSPHO's limited response to this confidential business and competitively sensitive data. As previously noted on page 1 of this submission, SSPHO requests that this data be classified as not a public record pursuant to . GL. C.4 §4.7 Para. 26 and other applicable statutory provisions. SSPHO only receives data for HMO risk business where our providers are at financial risk. As such any data available to SSPHO and submitted in response to this Question 5 is extremely limited in scope. Each SSPHO participating provider, as an independent entity, has a different patient and payor mix, so the ratio of HMO Risk business to their full line of business cannot be quantified by SSPHO.

For a majority of the payers listed on the chart supplied by the OAG, SSHPO has no data to provide.

OAG - Question 6

Please identify categories of expense 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.

SSPHO is on the smaller side of risk bearing organizations and as such as subject to wider variability in TME from one year to the next. This is true for total medical expense, when one "good" year could drive a trend analysis to imply a successful program, when it could be random variation. This migrates to the expense categories as well. In the years 2010 to 2012, SSPHO's TME trend when all plans are combined was 0.7% (2010 to 2011= -3.85% and 2011 to 2012 = 4.71%). (a) During that same 3 year period SSPHO experienced 5% or more growth in the following expense categories: Inpatient; Observation; Pharmacy and Ancillary Services.

(b) During that same 3 year period SSPHO experienced 10% or more expense growth in the following expense categories: Inpatient; Observation and Ancillary Service.

The change in Inpatient appears to be a mix of unit cost growth and utilization. SSPHO experienced some major cases that triggered stop loss, which dramatically affects the TME trends, due to a spike in a measurement period. The shift to observation seems to be driven by CMS policy on inpatient admission and commercial health plans mirroring that policy, with some time lag. Observation utilization rates also increase when there is a logjam in emergency departments, however we cannot support that conclusion since our dataset is limited to HMO patients. SSPHO view increases in pharmacy and ancillary services as a positive sign that suggest more ailments are being treated medically or through therapy or home services.

OAG - Question 7

Please describe and submit supporting documents regarding any program you have to 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 analysis you have conducted regarding the cost benefit of such wellness programs.

Presently SSPHO is not promoting a specific wellness program. Our patient base is HMO patients and they normally have a form of wellness program included in their personal health insurance benefits, or through their employer. We have not undertaken a survey of these programs or evaluated their efficacy. SSPHO does not have any direct employees and therefore cannot respond to the third sub-question.

Attestation: The below signatory is legally authorized and empowered to represent the South Shore Physician Hospital Organization for the purposes of this written testimony, and the testimony is signed under the pains and penalties of perjury.

South Shore Physician Hospital Organization

By: Matthew Whalen, Executive Director

September 27, 2013

Sent to the following in Microsoft Word and PDF format

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