Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The Hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled Hearing dates and location:

Monday, October 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, and/or 2015 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

If a question is not applicable to your organization, please indicate so in your response.

1. **Strategies to Address Health Care Cost Growth.**
Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.
    a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern).

    1) Pharmacy cost across the board, generics, brand name, and specialty drugs are going up with no control over price.
    2) Unmet behavioral health needs to manage addiction and opioid crisis.
    3) The costs of end of life care specifically the last 3 months of care.

    b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

    1) Regulatory controls on drug pricing and direct to consumer advertising.
    2) Limiting health plans behavioral health benefit carve outs.
    3) Price transparency alone is not enough to advise consumers on cost and outcomes.

2. **Strategies to Address Pharmaceutical Spending.**
In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.
    a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.
        i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

        Currently Implementing

        ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

        Currently Implementing

        iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

        Currently Implementing

iv. Establishing internal formularies for prescribing of high-cost drugs
Currently Implementing

v. Implementing programs or strategies to improve medication adherence/compliance
Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending
Currently Implementing

vii. Other: Clinical pharmacist provide consultation and medication reconciliation on complex patients
Currently Implementing

viii. Other: Clinical pharmacist provides prior authorization on high cost drugs
Currently Implementing

ix. Other: Clinical pharmacist provide academic detailing on appropriate opioid prescribing
Currently Implementing

3. **Strategies to Integrate Behavioral Health Care.**
Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

1) Behavioral providers embedded in primary care sites.
2) Behavioral providers embedded in pediatrics to focus on therapies for ADHD and Autism.
3) Identifying high utilization patients with comorbid conditions for care management.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

1) There continues to be a firewall for clinical information sharing.
2) Behavioral health carve outs are not integrated with medical group practice which results in a high cost low reimbursement specialty.

4. **Strategies to Recognize and Address Social Determinants of Health.**
There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

1) Reliant Medical Group employs five full time social worker staff with one specifically assigned to the pediatric population. All patients referred to care management are assessed for health and SDH upon enrollment.
2) Our most complex patients are enrolled by a home visit to ensure a complete picture of the patient's needs is obtained. Social workers are brought in when there is a suspected need.
3) The social worker coordinates with community resources to provide housing, protection from domestic violence and other social and economic conditions.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

1) The lack of community resources is one of the top barriers to addressing SDH. Central MA has limited available shelters and low income housing.
2) The patients are wary of communicating issues and avoid seeking medical care.
3) There are more resources for seniors than other populations which can make assisting the younger population more difficult.

5. **Strategies to Encourage High-Value Referrals**.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

Reliant Medical Group has a centralized referral management department that directs referrals to high value care in specialty, ancillary care, and healthcare systems.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting that is available at the point of referral?
Yes
   i. If yes, please describe what information is included.

   Reliant Medical group does not currently incorporate provider cost and quality information although our EHR has a default set up to prioritize internal or high value external referrals.

   ii. If no, why not?
   38T

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting that is available at the point of referral?
Yes
   i. If yes, please describe what information is included.

   Our EHR has a default set up to prioritize internal or high value external referrals.

   ii. If no, why not?
   38T

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
Yes
   i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.

Reliant Medical Group has a robust interface with our hospital partners, emergency departments, and home health providers. We share our clinical information as "read only" from our EHR to support safe referrals and transitions of care.

ii. If no, why not?
38T

6. **Strategies to Increase the Adoption of Alternative Payment Methodologies.**
In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

33% of Reliant Medical Group's patient population represents 80% of our revenue through the adoption and implementation of various alternate payment methodology. Our contracts include: percent of premium, budgeted capitation, global budgets with both upside and downside risk, shared risk, and Medicare ACO track 3.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

Reliant welcomes the opportunity for adopting of APMs and currently has global risk arrangements with the major MA payer and participates in a Medicare MSSP track 3.

Payments from payers are based on historic traditional billable professional services only and does not cover the cost and investments to the Population Health infrastructure to manage care in the APMs. This infrastructure includes; care management, referral management, utilization management, drug management, quality management, and analytics.

Lack of patient engagement. It is very important that the patient be engaged in the care and treatment plan. Transparency of costs and quality of care are important for the patient to understand to help them manage their care effectively in a complex healthcare system. Patients that are enrolled in insurance products that do not require the selection of a primary care physician also leads to lack of care coordination and the inability to effectively manage care under a risk arrangement. Some proposed solutions to addressing this barrier includes: requiring patients to designate a primary care physician rather than using statistical attribution rules based on fee-for-service claims to assign them retrospectively, use of value based benefit designs to enable and encourage patients to improve their health, adhere to treatment plans, and choose high value providers and services by making widely available to them transparency tools on cost, quality, outcome, etc.

c. Are behavioral health services included in your APM contracts with payers?
Yes

With selected contracts.

i. If no, why not?

38T

7. **Strategies to Improve Quality Reporting.**
At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.
    a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

    Reliant Medical Group has different pay for performance metrics and targets for each contract and Medicare MSSP. This takes considerable resources to produce internal reports and external reports that are accurate. We spend up to a year after the performance year to reconcile dates with the payers. Reliant agrees that it is important to report on quality outcomes but this lack of alignment we believe only adds to the cost of providing high value care without any clear clinical benefit.

    b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

    1) Standardize both metrics and targets for all payers to be reported on an annual basis. There are often unintended consequences for patient that do not want to complete testing(high deductibles and co-pays)
    2) Develop quality measures for all the conditions and procedures that drive significant amounts of costs in the system.
    3) Use of outcomes measures over process measures to allow providers the flexibility to redesign care and support effective patient choice.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.

    Ensuring that patients and healthcare providers caring for our patients have all the information they need in order to make informed and appropriate decisions is crucial to our ability to provide optimally effective care. This requires the availability of patient information both during transitions of care as well as shared care among patients and multiple healthcare providers. The MA HIway, Relationship Listing Service, and the state's secure electronic health information exchange components were designed to facilitate this coordination of care. The Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security rules provide for superb protection of patient health information around our country and requires specific patient consent only for release of psychotherapy notes. However, regulations in Massachusetts that go above and beyond HIPAA interfere with our ability to use the MA HIway or even other electronic means of secure exchange to care for our patients. These include:

1) Patients must "opt-in" multiple times to authorize each of their healthcare providers to use the MA HIway to securely exchange their data. Instead, the MA regulations should be changed to have patients educated and opted-in by default, and then have them given the opportunity to "opt-out".
2) Release of genetic test results requires a separate and specific patient consent in Massachusetts.
3) Release of information regarding HIV testing (the fact that it was done, normal results, or positive results) requires a separate and specific patient consent in Massachusetts for every release of records.
4) Social workers' notes cannot be shared with other healthcare providers without a separate and specific patient consent in Massachusetts
5) Unlike other insurers, patients with Massachusetts Medicaid insurance cannot have any of their mental health provider notes (well above and beyond psychotherapy) released without a separate and specific patient consent

Navigating these rules is an unnecessary burden to patients and healthcare providers, making it extremely difficult to legally share patient information among the patient's healthcare providers, interfering with the coordination of care, reducing quality of care, and increasing healthcare costs.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. 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.
   See separate sheet for AGO Provider Exhibit 1

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.
   When a patient inquiry is received we determine CPT code(s) based upon information provided by a patient or potential patient. If the patient is already internal, we can review the patient's medical record or speak with provider's office to ensure appropriate selection of CPT based upon the services being considered. For our Radiology Department, we utilize an external software (Recondo SurePay Health) that provides our Charge, Contractual Rate, patient copay/deductible/coinsurance as provided by the patient's insurance plan. For all other lines of service, we utilize Experian/Medical Present Value contract management software to provide our Charge and our Contractual Rate based upon the patients insurance plan. Information is typically provided to a patient real time or within 24 hours of request. These processes were put in place at the time Chapter 224 was introduced to ensure that Reliant would be compliant. If a patient is simply inquiring about our Charge, all Reliant office locations can access the fee schedule and provide that information real time.

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.
   Accuracy: The external software utilized in our Radiology department is monitored by the vendor. They review the estimates filled vs how the payer adjudicated the claim. The software utilized in all other lines of service is monitored internally within the central business office to ensure contracted rates and payment rates are accurate. As noted above, most patient requests for pricing are filled real time/at time of inquiry. Our internal policy indicates a 24 hour turnaround time from date of request. We track the number of inquiries received within our Central Billing Office to include date of call, inquiry, date of response. The volume is quite low and responses are less than 24 hours.

   c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?
   We do not experience barriers in providing our Charge and contracted allowed amount when requested by a patient. The only area where there could be accuracy issues is in the selection of the CPT code(s) for the possible service/procedure should another service actually added at the time the service is rendered.

Exhibit 1 AGO Questions to Providers and Hospitals

Please email HPC-Testimony@state.ma.us to request an Excel version of this spreadsheet.

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate 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.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
8. **Other Revenue Arrangements** are arrangements for revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as managements fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

Reliant Medical Group

AGO Provider Exhibit 1 (Question 2)

2014

	P4P Contracts				**Risk Contracts**				**FFS Arrangements**		**Other Revenue Arrangements**		
	Net Cap Revenue		Incentive-Based Revenue		Net Cap Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					74,372,928		2,708,596		2,880,687				
BCBSMA PPO										13,144,066			
Tufts FI					12,495,205		432,837						
Tufts SI					Combined				1,654,610				
Tufts PPO (incl. CareLink)				73,886						1,972,253			
HPHC FI					22,163,254				865,328				
HPHC SI									3,050,482				
HPHC PPO (incl. Passport & Independence)										4,465,261			
NHP Comm													
Fallon					121,066,346		882,343		14,544,306				
Aetna										2,851,648			
Other Commercial (Any remaining payors not listed above - lump together)									28,564,756	6,212,337			
Total Commercial	-	-	-	73,886	230,097,733	-	4,023,776	-	51,560,169	28,645,565			
Fallon Medicaid					19,881,759				1,793,649				
Total Managed Medicaid													
Medicaid FFS										7,013,287			
Tufts Medicare Preferred					162,351,839				366,649				
Medicare Advantage									5,686,788				
Commercial Medicare Subtotal													
Medicare FFS										17,477,265			
GRAND TOTAL	-	-	-	73,886	412,331,331	-	4,023,776	-	59,407,255	53,136,117			

Sources of Information:

Net Collection Analysis was used for FFS Arrangements

All Product Analysis was used to obtain Net Cap Revenue and Quality Incentives

PVV was used as a cross check of Net Cap Revenue

AGO Provider Exhibit 1 (Question 2)

2015

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Net Cap Revenue		Incentive-Based Revenue		Net Cap Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					114,430,964		2,170,312		3,667,974				
BCBSMA PPO										25,051,217			
Tufts FI					21,860,707		950,496		Combined				
Tufts SI					Combined				3,796,817				
Tufts PPO (incl. CareLink)				312,824						4,456,615			
HPHC FI					35,040,304		163,182		1,213,742				
HPHC SI									6,249,933				
HPHC PPO (incl. Passport & Independence)										8,063,887			
NHP Comm													
Fallon					115,208,184		820,296		16,331,866	417,063			
Aetna										5,005,891			
Other Commercial (Any remaining payors not listed above - lump together)									34,442,992	9,028,883			
Total Commercial	-	-	-	312,824	286,540,159	-	4,104,286	-	65,703,324	52,023,556			
Fallon Medicaid					22,101,827				3,288,056	Combined			
Total Managed Medicaid													
Medicaid FFS									9,193,359	Combined			
Tufts Medicare Preferred			Combined	357,889	175,072,374		95,460		225,055				
Medicare Advantage									6,448,011	Combined			
Commercial Medicare Subtotal													
Medicare FFS									Combined	21,826,093			
GRAND TOTAL	-	-	-	670,713	483,714,360	-	4,199,746	-	84,857,806	73,849,648			

Sources of Information:

Net Collection Analysis was used for FFS Arrangements

All Product Analysis was used to obtain Net Cap Revenue and Quality Incentives

PVV was used as a cross check of Net Cap Revenue

DME, Optics, SEE and Scope Subsidiary revenues were dropped into Commercial Other