Beth Israel Deaconess
CARE ORGANIZATION LLC

Affiliated with
Beth Israel Deaconess
Medical Center

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

September 27, 2013

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Executive Director Seltz,

On behalf of Beth Israel Deaconess Care Organization (BIDCO), enclosed please find written testimony for Exhibits B and C (Questions for Written Testimony) in response to the Health Policy Commission letter to BIDCO dated August 28, 2013.

I hope that the enclosed testimony is helpful to the Commission and to the Office of the Attorney General; we would be happy to provide any additional information that may be helpful to you.

I am legally authorized and empowered to represent Beth Israel Deaconess Care Organization for the purposes of this testimony, and provide the testimony herein under the pains and penalties of perjury.

Very truly yours,

Christina Severin
President and CEO

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Exhibit B Questions

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. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.

a. *What are the actions your organization has undertaken to reduce the total cost of care for your patients?*
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?*
c. *What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?*
d. *What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?*

Summary Response: At the outset, we would note that Beth Israel Deaconess Care Organization (BIDCO) and the founding leaders of BIDCO, including Beth Israel Deaconess Medical Center (BIDMC) and the former Beth Israel Deaconess Physicians Organization (BIDPO), have been strongly supportive of the Commonwealth's efforts to contain the overall growth of health care costs in Massachusetts consistent with overall growth in the state's economy, while improving the quality and efficiency of care delivery. We are concerned, however, that the direction of the Commonwealth's cost containment efforts could have the unintended effect of institutionalizing significant market disparities and dysfunction in place if we fail to focus on the need for correction of these disparities, and on the cost containment goal as an aggregate goal.

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

Our organization was founded in 2012 for the purpose of creating an organizational structure that will allow BIDCO and our member hospitals and physicians to align their payment structures to achieve overall cost reduction in the care of our patients, and to improve patient care across the entire continuum of care. We are intensely focused on expanding, strengthening, and improving primary care delivery in order to reduce overall system costs.

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?*

Currently, BIDCO has commercial risk contracts with BCBS, HPHC and Tufts, and success in those contracts is dependent on managing costs and increasing quality. However, there are strong limiting factors in the current healthcare marketplace. Massachusetts' largest system

perpetually exists in a position of price dominance which creates a diverse array of market inequities. Some examples of the inequities that the continued favorable market treatment creates include a disproportionate abundance of resources this system has to launch new programs, technological updates and upgrades, and other investments in new initiatives that only serve to preserve and further institutionalize its market dominance. Indeed, the Office of the Attorney General's Examination of Health Care Cost Trends and Cost Drivers Report of April, 2013 (AGO Cost Trends Report 2013), notes a number of important areas of concern. The second largest system is owned by a for-profit organization with sizable financial resources. This system has created disruption with maintaining our physician membership despite the demonstration of our success by introducing for-profit incentives within the primary care marketplace that cannot be equaled by our system. This level of competition has required attention of time and resources to compete with aggressive physician recruitment activities and this detracts our full attention on achieving greater efficiencies. The system constraints and proprietary concerns of payers also limit our ability to manage in the risk environment and make needed changes nimbly and efficiently. Administrative complexity, limitations on the type of information payers are willing to share, and variations in timely information-sharing and expertise with managing different models of total cost of care/risk contracts prevail. Many requirements are placed on BIDCO's providers, without reciprocal requirements on the payers.

We strongly feel that the some of the greatest opportunities to improve quality and efficiency of care are in strengthening coordination and communication across our member hospitals and physicians, and creating the technology and other needed infrastructure to enable our participating clinicians to communicate and share clinical information more effectively. Indeed, we are striving toward that goal and aggregating the shared resources of our member organizations to achieve this state of complete and aggregated clinical data collection.

While we are fortunate to have leading national expertise in the area of health information systems and technology, the overarching cost and expense of creating and maintaining this infrastructure is our most significant challenge, which the previously mentioned inequities in the system make these challenges difficult to overcome.

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

In addition to the recommendations outlined in the AGO Cost Trends Report 2013, continued investment in health information technology and infrastructure is essential to our success in improving both efficiency and quality of care. We appreciate Chapter 224's recognition and commitment to such investment, particularly for smaller physician practices and community hospitals.

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

In our efforts to manage the total costs of care, we design our contracts with the payers to ensure that our shared efforts will allow for continued savings for health care purchasers which the payers can pass along through reduced health care premiums.

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 Response: BIDCO was in part created to establish an accountable care organization (ACO) to enable its members to: 1) care for patients in the most appropriate and cost-effective settings; 2) shift more resources to primary care; and 3) maintain and increase the number of patients who can be cared for in community hospital settings. We would also note that prices paid to BIDCO have not increased beyond the benchmark established under Chapter 224, and our global risk contracting incorporates a balance of payment rates and utilization management.

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?
b. What challenges have you identified in implementing such integration?
c. What systemic or policy changes would further promote such integration?

Summary Response: The integration of behavioral and physical health continues to be one of the most significant challenges our organization faces, and we believe this is largely due to the significant under-reimbursement across all payers for behavioral health care services. This chronic underpayment has resulted in a very serious issue with access to behavioral health services in Massachusetts and a chronic shortage of behavioral health providers in the community. This is partially due to an increasingly limited number of behavioral health professionals who will engage in contracts with health insurers due to the issues of payers underfunding reimbursements to behavioral health professionals. Not surprisingly, among those behavioral health providers who do accept health insurance, the capacity to accept new patients is very limited.

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

Enhancing reimbursement for behavioral health and funding for pilot programs that integrate social workers into primary care practices would make a significant difference in our efforts to integrate behavioral health care into our primary care practices. However, as stated, these types of opportunities lack the funding necessary to begin implementation. There are also privacy constraints imposed by the payers due to their interpretations of HIPAA requirements

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

Financial resources and subject matter expertise are the greatest challenge to integrating behavioral health into the primary care setting. This is because to be most effective, resources must be put into the primary care practice itself, and the patient--to--provider ratio must be small enough to be effective. Also behavioral health services are provided across a wide swath of providers in the Commonwealth, with the majority outside of our provider organization, so instituting programs across our risk membership is challenging.

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

We would recommend increasing reimbursement rates for behavioral health for all-payers, commercial and governmental. Although we continue to review the 29 recommendations of the Behavioral Health Task Force, we agree with the persistent barriers to integration outlined in the Task Force Report.

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

a. *Describe your organization's efforts to promote these goals*.
b. *What current factors limit your ability to promote these goals*?
c. *What systemic or policy changes would support your ability to promote more efficient and accountable care*.

Summary Response: While BIDCO's physicians and hospitals have embraced new payment models that hold us accountable for quality, efficiency and health care costs, BIDCO's member organizations continue to have more limited resources to accomplish these goals in an environment where the largest provider's price and market dominance has resulted in significant inconsistency in both resources available for necessary investments, and in the requirements of these alternative payment contracts.

a. Describe your organization's efforts to promote these goals.

BIDCO is participating in global budget contracts with BCBS, HPHC, Tufts Health Plan and the Medicare Pioneer ACO program. In these programs, we are accountable for both the quality of care we provide to our patients as well as the financial cost of these health care services. We have worked hard to improve our quality scores through the addition of resources centrally and at BIDCO locally and at the primary care practice site(s). Additionally, we have deployed clinical tools, such as a unified quality registry to assist practices in meeting quality goals. Furthermore, we have launched discharge transition programs to improve quality by preventing unnecessary readmissions; we have worked with our affiliated hospitals to localize care within the community whenever possible; and we have used practice guidelines to promote standardization and thereby improve the cost effectiveness care. We have also worked with our affiliated hospitals to develop electronic exchange of information among providers to reduce duplication and waste.

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

Technology and staffing infrastructure are critical to our success, and the ability to fund this infrastructure is our most significant challenge. The current health care marketplace, with continued price dominance by the largest health care system, aggressive physician recruitment by competitors, and turnover in at-risk patient panels due to greater shift toward PPO plans by employers (as outlined in the AGO Cost Trends Report 2013) also are a challenge. Health Plan product design imposes limits on the ability of providers to coordinate care within the BIDCO network, and the consumer messaging by payers to patients/members on their ability to go outside of their physician's network increases the difficulty of managing the care of patients. As BIDPO noted last year, the system constraints and proprietary concerns of payers also limit our ability to manage in the risk environment and make nimble and efficient changes. The administrative complexity, limitations on the type of information payers are willing to share, and timeliness and expertise with managing different models of total cost of care/risk contracts are formidable countervailing forces to promoting and achieving the goals of efficient and accountable care.

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

First, we echo the recommendation of the AGO Cost Trends Report 2013, that "the Commonwealth's market-based cost containment efforts, as well as the efforts of health plans, providers, and purchasers, would benefit from greater consistency and fairness in the implementation of risk contracts." The AGO Report details three key provisions that could be

more equitably applied across provider risk contracts, including: 1) implementation of quality incentives, 2) risk adjustments to budgets, and 3) approaches to risk mitigation.

In addition, the AGO Cost Trends Report 2013 notes that even where quality performance may be measured consistently, quality payment rates vary significantly by provider. Thus, the report concludes, "a consistent formula for gauging quality nonetheless results in widely disparate results for providers, again attributable to multiple negotiations and the leverage of the negotiating parties."

In addition, we would recommend early and adequate financial support for infrastructure capacity associated with the shift to alternative payment methods and new models of care delivery, because this infrastructure must be scaled up in order for these models to succeed. We would also encourage greater consistency among commercial payers in common features of alternative payment systems such as development of budgets, calculation of severity adjustments, and selection of quality measures and setting of performance benchmarks.

Finally, while we recognize and appreciate the important role of the Health Policy Commission in monitoring cost growth in the Commonwealth, we are concerned that its potential vigorous scrutiny of all new clinical affiliations is having a chilling effect on market movements and clinical alignments that would otherwise enhance the Commonwealth's cost containment goals and help correct some of the market dysfunction (disparities, negotiating clout) identified by the Attorney General in its 2013 report.

See also our responses to question 7.

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 organization, practice, and/or provider level)?*
b. *How does your organization benchmark its performance on operational cost structure against peer organizations?*
c. *How does your organization manage performance on these metrics?*

Summary Response: At the organizational level, we conduct regular tracking against our budget for costs, revenue, and patients attributed to our PCPs. While we obtain and use as much information as possible on benchmarks, there is very little benchmarking data available.

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

At the BIDCO organizational level, we manage our operating costs against our operating budget. Our revenue to cover those costs is partially dependent on the number of covered lives represented by our physicians. Because of our structure, we are not tracking operational costs at the practice or provider level, as that function would be carried out by administrative staff at the practices and hospitals.

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

We obtain and use as much information as possible on benchmarks. However, there is very little benchmarking due to the market environment and competition within our market. We also look to trade organizations for this type of benchmarking information.

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

We conduct regular tracking against our budget for costs, revenue and the patient members attributed to our primary care physicians. The ability of our organization to support the programs we have implemented to affect cost and quality of care are dependent on having a stable and adequate risk population, and can be severely impacted by a material switch by a large employer from an HMO into a PPO.

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 Response: As BIDCO is not a provider, our organization is not implementing this aspect of Chapter 224; BIDCO's Member provider organizations are preparing for implementation by January 1, 2014.

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

Summary Response. Once again, the Office of the Attorney General's Examination of Health Care Cost Trends and Cost Drivers (April 2013) has provided critically important findings and recommendations on the most important challenges in the current health care market in Massachusetts. The following key finding summarizes our major concern:

"In our 2010 and 2011 Reports, we found that health plans pay providers widely different prices that are not adequately explained by differences in the quality or complexity of care delivered, or other value-based factors. This year's examination underscores this continuing market dysfunction, and finds that where recent progress has been made in linking payments to value, these approaches feature inconsistent payment standards that fail to mitigate historic disparities. In the future, pricing disparities will only increase if providers are all held to the same level of price increases based on state cost growth goals or other benchmarks."

Both the Office of the Attorney General and the Center for Health Information and Analysis have again concluded that significant disparities in pricing persist, which continue to have an impact on our resources, on our ability to maintain our provider network, and on our ability to fund future infrastructure needs, specifically those involving clinical data integration. This is not unexpected. The market-dominant health care system has had over ten years to build up a physician network and administrative infrastructure and amass robust reserves from the higher-than-average compensation it has received. These higher rates are reflected in its higher total medical expense (TME). The higher rate structure has allowed it to build its physician organization, and market itself in ways that physician groups with lower compensation have not had the funds to do, and this has increased its perceived value to the market, including current and future patients. Efforts by the state to put in systems on a go-forward basis to alleviate increasing health care costs would do nothing to eliminate this historical imbalance of rate structures; freezing the inequities that currently exist will not be an appropriate long-term fix. Some market correction is required.

We would also agree with the findings that the health care system in the Commonwealth would benefit from greater consistency and fairness in the implementation of risk contracts.

Finally, we wish to highlight several of the findings and observations of the AGO Report 2013:

<u>The Impact of Provider Price Variation and Market Leverage</u>

- *As described in our prior Reports, without other fundamental changes, a shift to global payments may actually exacerbate the price escalation associated with market dysfunction by establishing widely different per member per month rates based on historic pricing disparities.*
- *CHIA's recent reports highlight the continuing need to address the effects of market leverage identified in our 2010 and 2011 Reports.*
- *Last year, building on Chapter 288 and earlier reforms, the Massachusetts Legislature enacted Chapter 224 of the 2012 Acts, which established significant new systems for measuring and evaluating market performance, including registration of provider*

organizations, cost and market impact reviews, and certification of risk-bearing and accountable care organizations. Chapter 224 created these and other systems to increase public scrutiny of price variation and market performance, but it did not establish a framework for reining in wide price variations. Instead, Chapter 224 created a "special commission to review variation in prices among providers" in 2013.

- *While there are important costs that insurance is designed to pool, such as the cost of chronic or unexpected health events, spreading the cost of unwarranted price variations results in two key dysfunctions: 1) it de-sensitizes consumers from value-based choices; and 2) it diminishes providers' incentives to compete on value.*

<u>Persistent Market Dysfunction and Recommendations for Health Insurers</u>

- *To support meaningful analysis, health plans, DOI and CHIA should develop more consistent product definitions across health plans. With hundreds of product variations in the market (e.g. tiered products that vary significantly in the types of services that are tiered and in the range of cost-sharing differentials) meaningful reporting will require more consistent definitions of product categories. Non claims-based payments can be effective tools for incenting improvements in provider performance. However, as discussed more fully in Part III.A below, given that these payments are among the dozens of provisions that are individually negotiated between health plans and providers of varying sophistication and clout, the resulting financial incentives are not necessarily consistent, predictable, or fair across contracts.*
- *For providers whose PPO rates are not linked to performance, their market clout, rather than measurable performance, continues to drive PPO payment levels. Moreover, the PPO rates of these providers – who are not "held" to any performance standard – typically, exceed the highest achievable PPO rates that could be earned by those providers whose rates ARE linked to performance. For example, comparing the BCBS contracts that have implications for four physician organizations ("PO") affiliated with academic medical centers in Boston shows that for 2013, the PPO rates for Beth Israel Deaconess PO and Boston Medical Center physicians are tied to efficiency and quality performance under the groups' AQC, while the PPO rates for Brigham and Women's PO and Massachusetts General PO physicians are not tied to efficiency or quality performance under Partners HealthCare System and Partners Community HealthCare's AQC. Moreover, even if Beth Israel Deaconess PO and Boston Medical Center physicians could earn the maximum PPO rate available to them through perfect quality scores and high efficiency performance, their rates would still be at least 25% to 30% lower than the PPO rates guaranteed to physicians at Brigham and Women's PO and Massachusetts General PO.*

Recommendations for the Government and Market Participants

- *It is important that the Commonwealth continue to analyze and report on all aspects of provider payments, including how providers are being paid, how much they are being paid, and whether those payments are tied to value.*
- *Market participants, including the state, should develop systems to more consistently and comprehensively measure the performance of different product designs in improving quality and controlling costs.*
- *…Health plans should regularly report and analyze membership, health status, utilization, and TME data for different product designs and payment arrangements.*

Recommendations Regarding Risk Contracts

- *Variation in terms and calculations across risk contracts results from dozens of negotiations between individual health plans and providers of varying sophistication and clout. Inconsistent implementation of certain provisions tends to dilute the impact of any "best practices" that the market may identify for successfully incenting provider performance while managing the transfer of insurance risk to providers. These inconsistencies can result in diminished predictability and fairness for health plans and providers alike.*
- *The Commonwealth's market-based cost containment efforts, as well as the efforts of health plans, providers and purchasers, would benefit from greater consistency and fairness in the implementation of risk contracts.*
- *…AQC quality payment rates and total payouts for equivalent quality achievement vary significantly by provider. Thus, a consistent formula for gauging quality nonetheless results in widely disparate results for providers, again attributable to multiple negotiations and the leverage of the negotiating parties.*
- *[W]e recommend that health plans make available to providers information that would better enable providers to manage risks and coordinate care under all product lines.*
- *Differences in health status adjustments may result in significant differences in dollars added or subtracted from risk budgets from equivalent health status changes. Such differences are in tension with efforts to lower cost and improve quality since they are more reflective of negotiating clout than the best available measures for actual changes in the health status of providers' risk populations.*

Exhibit C Questions

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.

Summary Response: BIDCO operates as an ACO, which incorporates physicians (individual and group practices) and hospitals into one entity for purposes of joint contracting, medical management, quality improvement, and centralized administrative functions such as enrollment and provider relations. Therefore, BIDCO itself does not have an operating margin on payer revenues as it is not providing direct services to patients; only entities that are participating providers in the organization are providing direct medical services to patients.

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 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 Response: BIDCO's risk contracts have focused on medical cost management and quality measure performance and this has caused us to shift the focus of our resources accordingly. Among the changes we have made include intensifying our focus on improving quality measures as a means to improve patient care and satisfaction; increased focus on high risk patients; reviewing practice variation among providers; and new care management programs in a range of areas including after-hours care and urgent care, use of clinical protocols for the most common clinical conditions, enhanced skilled nursing facility care and coverage, improved home care opportunities, enhanced community-based care with our community

providers, and encouraging in-network care to avoid duplication of services. Efforts to expand our covered lives continue, even as patients/purchasers increase migration to PPO products, and PCP practices are in flux throughout the Commonwealth's health systems.

BIDCO has risk contracts with public and commercial payers which incorporate the ability to earn surplus in both upside only and upside/downside agreements. The movement to contracts which focus on medical cost management and quality measure performance has shifted the focus of our resources toward staffing in care management and quality improvement functions. We have also added dedicated resources in technical EMR staff that are focused on the correct documentation of quality metrics into the EMR, and the subsequent collection and assimilation of those quality metric components into a centralized and reportable data repository.

BIDCO has entered contracts for total cost of care, or so-called "risk contracts" with the three major commercial payers and with CMS, the latter as a Pioneer ACO. The focus on these contracts has resulted in a number of changes including:

1) intensified focus on improving our quality measures as a means to improve care to patients and patient satisfaction and thereby investing in significant human resources as well as a network-wide infrastructure of electronic registry and patient outreach function;

2) engagement with a vendor to provide software that allows for patient severity scoring, high-risk patient identification and practice variation functions; and

3) Launching a variety of care management programs to help reduce unnecessary care.

These care management efforts include encouraging and fostering after-hours care including creation of urgent care sites with those payers who allow for such sites; renewed development and use of clinical protocols for most common clinical conditions; collaboration with other networks around Skilled Nursing Facility (SNF) care and coverage arrangements; contracts with home-based care providers to enable patients to have care at home without frequent hospitalizations or emergency room visits; coordination with our affiliated hospitals to coordinate care in the community; and encouraging that care be coordinated within our network to ensure electronic communication and hence reduced duplication of services.

We hope to expand our network of primary care physicians and to expand covered lives, to create the most actuarially sound risk pools and to compensate for the decreasing number of HMO lives in our risk based contracts. This decrease in covered lives can be attributed to both the movement of PCP groups to competitor health care systems as well as the plans' movement of HMO members to 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 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 government business.

Summary Response: BIDCO relies on its own systems and timely payer information to manage our risk. We have designed our risk contracts to limit the risk passed on to participating providers and to establish maximum deficit and surplus levels. In addition, BIDCO has individual patient stop-loss coverage in its major contracts, outside reinsurance in certain contracts, and reserves. We also have internal methods in place to mitigate the financial impact of providers in deficit.

BIDCO creates financial reports that aggregate our performance across all payers. We regularly track liabilities against projected withholds and reserves. The availability of current withhold information from the payers is crucial to our ability to determine if we are able to meet any deficit obligation. Our risk contracts are designed in a way that limits the risk that is passed on to our participating providers. The risk contracts contain maximum surplus and deficit levels. We also have annual individual patient stop loss, which decreases our liability for patients who have medical costs that are more of an insurance risk. We work closely with our reinsurance company to monitor high cost patient liabilities, and again we rely on receiving claims on a timely and complete basis. BIDCO Members also have reserves that it has built up over the years and will continue to fund these reserves from current and future surplus and bonus payments.

BIDCO's risk contracts have stop-loss coverage in all but one payer, and for that one payer we have purchased outside reinsurance.

We have developed an internal financing system that sets PCP group-specific budgets and pools risk across all payer agreements, thereby creating greater risk pools and minimizing the potential for a PCP group to be in deficit.

As part of our performance year 2 as a Pioneer ACO, we were required to have certain levels of financial reserves in place, which we accomplished through an aggregate reinsurance policy.

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).

Summary Response: BIDCO tracks changes across our entire membership each quarter, based on supporting detail provided by the payers. BIDCO also employs a vendor product that identifies patients who may be at high risk for hospitalization, based on a change in their health status or care history. These two sources of information inform our initiation of care management services for our primary care providers to their most vulnerable patients.

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. To receive the Excel spreadsheet, please email HPC-Testimony@state.ma.us.***

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.

Summary Response: Between 2010 and 2012, BIDCO operating expenses have grown to support our movement into risk-based contracts that also have a strong link to quality results. Each of our main categories of expense increased more than 10% to accommodate the infrastructure needed to be successful in global budget contracts. The main areas of increase were in staff to support care management, analytic capabilities and clinical/EMR technical support; increased office space; our investment in PCP groups and PCP leadership; consultant services; and the purchase of vended software application services for high risk patient identification and provider variation analytics.

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 Response: BIDCO's participating providers, including a hospital and physicians, have their own health and wellness programs for their patients and employees, and we have included some examples below. These health and wellness programs range from efforts to manage chronic disease, to programs to address substance abuse, stress, pain-management, and weight management and control for patients. BIDCO staff participate in the BIDMC employee health and wellness offerings formally launched this year and described below.

BIDCO's diverse hospital and physician participating providers, including individual PCP and specialist practices, may have their own health and wellness programs for both patients and employees. We have outlined below some programs available to a) patients in the primary care practice Health Care Associates, b) BIDMC employees, and c) Bowdoin Street Health Center employees.

Health Care Associates has various programs available to patients who have chronic diseases such as diabetes, hypertension, asthma and COPD, and weight management. There are also social work group programs to help patients address and manage substance abuse, stress, pain management, and weight-related health issues.

BIDCO employees are able to take advantage of the significant health and wellness programs available to BIDMC employees. BIDMC is entering its second year of this effort, and does not have cost benefit data on the programs described. The first year focus of BIDMC's efforts was on employee participation.

Below is an overview of the wellness programs offered to employees in 2013, which will be offered in 2014, along with additional programs. BIDMC also has an onsite fitness center, a robust employee assistance program (EAP), a portal page dedicated to employee health and wellness, and external web pages dedicated to patient and employee health and wellness information.

- Biometric Screenings (Feb – Mar): Conducted on-site by BIDMC's health plan, and consisting of blood pressure, height and weight for BMI, non-fasting glucose, and cholesterol finger stick – total and HDL. Participants had the option to review their results with a health plan counselor.

- On-line Health Questionnaire (Mar-Dec): Provided by BIDMC's health plan to all benefit-eligible employees.

- Weight is Over (Mar-May): Eight-week weight management program led by Exercise Physiologists, Tanger Be Well Center (located on site at BIDMC) and Registered Dieticians, Nutrition Services department. Individuals and teams (up to 5) participated with the goal of reducing their body weight by 5%.

- Be Well, Walk Well (Jun-Aug): Six-week walking program. Individuals and teams of up to 10 participated. Pedometers were distributed to all participants. The goal was to increase the weekly number of steps by 50% from the baseline week.

- Wellcoin (May-Dec): On-line program that rewards employees for participating in healthy activities. Employees earn Wellcoins for reporting the activity and substantial bonuses for verifying that they did it. Participants can redeem Wellcoins for rewards provided by BIDMC.

  Webpage Links:

  Health and Wellness Education (with more links to educational videos, information, and podcasts):

  http://www.bidmc.org/AboutBIDMC/TangerBeWellCenter/HealthandWellnessEducation.aspx

  iHealth (with an extensive health library, interactive tools, newsletter sign-up and more):

  http://www.bidmc.org/YourHealth.aspx

Bowdoin Street Health Center (BSHC) also participated in a "Workplace Wellness Challenge" with "Boston Moves for Health," which was a multi-tiered approach to incorporating different avenues of health and wellness into the workplace environment and in the daily lives of staff, with particular attention to long-term sustainability. BSHC is now exploring how to inspire change in their diverse patient population, given the success and enthusiasm for this program.

Comment on the Center for Health Information and Analysis (CHIA) Annual Report on the Massachusetts Health Care Market. We continue to appreciate CHIA's evolving work, including its production of the Annual Cost Trends Report, Provider Price Variation Reports, and Hospital Financial Performance reports, all of which shed important light on the Commonwealth's health care market. CHIA's "Cost Trends" Report, however, provides a very broad overview of the Massachusetts health care market, and stands in sharp contrast to the in-depth analysis and approach of the Office of the Attorney General. We believe that regulators, policy makers, and

the general public would benefit from continued clarity and refinement of the CHIA reports, and specifically, we recommend the following:

1) Common Definitions of Key Market Terms. CHIA should clearly and specifically define the various entities within its examination, including, for example, a definition of "health system." Such definitions would improve public understanding of the nature and functioning of such entities. It is relevant, for example, to understand whether a "health system" is engaged in system-level contract negotiations with payers, and whether all "health system" participants share common characteristics that are relevant to CHIA's examination of cost trends and cost growth in the Commonwealth.
2) Illuminate Key Findings. CHIA's Cost Trends Report has made key findings that, when read in isolation from critical data and factual information, are not beneficial to the reader's clear understanding of the Massachusetts health care market and underlying tensions and dysfunction.
3) Clarify Clear "Exceptions" to CHIA's General Findings. CHIA makes a number of general findings relative to providers that tend to obscure the clear and important exceptions to these general findings. CHIA also fails to note that such exceptions exist. We believe that illuminating these exceptions is critically important to the public's understanding of cost growth and cost trends in the Commonwealth. For example, CHIA has found that "higher prices were also associated with … those [hospitals] affiliated with larger health care systems." Such is not the case with key community hospitals in the Commonwealth that are members of larger providers or health systems, and CHIA should strive to make these exceptions clear. Otherwise, the public has not been provided with a clear and fair understanding of the market and its participants.

We look forward to working with CHIA in our shared goal of providing useful and clear information on cost trends in the Commonwealth.

2010

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	123,278,000	127,762,000			-	-					80,633,533	38,349,260	3,109,045	-	-
Tufts	-	-			28,584,885	-					43,604,179	34,787,402	1,748,588	-	-
HPHC	116,705,689	40,657,000			-	-					14,155,470	19,691,723	2,877,346	-	-
Fallon	-	-			-	-					1,303,000	4,771,781	-	-	-
CIGNA	-	-			-	-					41,040	12,206,021	-	-	100,000
United	-	-			-	-					3,107,388	13,659,275	-	-	-
Aetna	-	-			-	-					8,458,204	15,965,639	-	-	-
Other Commercial	-	-			-	-					-	55,116,738	-	-	-
Total Commercial	239,983,689	168,419,000	-	-	28,584,885	-	-	-	-	-	151,302,815	194,547,839	7,734,979	-	100,000
	-	-			-	-					-	-	-	-	-
Network Health	-	-			-	-					17,129,713	59,923	-	-	-
NHP	-	-			-	-					19,743,124	309,143	-	-	-
BMC Healthnet	-	-			-	-					7,559,978	1,660,294	-	-	-
Fallon	-	-			-	-					162,470	8,145	-	-	-
Total Managed Medicaid	-	-			-	-					44,595,285	2,037,504	-	-	-
	-	-			-	-					-	-	-	-	-
Mass Health	-	-			-	-					32,381,000	28,773,960	-	-	-
	-	-			-	-					-	-	-	-	-
Tufts Medicare Preferred	-	-			-	-					21,279,106	408,000	-	-	-
Blue Cross Senior Options	-	-			-	-					5,619,265	1,954,000	216,935	-	-
Other Comm Medicare	-	-			-	-					12,722,624	30,588,000	12,875	-	-
Commercial Medicare Subtotal	-	-			-	-					39,620,995	32,950,000	229,810	-	-
	-	-			-	-					-	-	-	-	-
Medicare	-	-			-	-					-	332,799,278	-	-	-
	-	-			-	-	-	-	-	-	-	-	-	-	-
GRAND TOTAL	239,983,689	168,419,000	-	-	28,584,885	-	-	-	-	-	267,900,095	591,108,581	7,964,789	-	100,000

Explanatory Notes:

1) Revenue reflects BIDCO physicians for risk-based contracts, and HMFP and BIDMC for all payers. Exception is Tufts contract, where contract exists between BIDMC, BIDPO and Tufts, and "other commercial Medicare" category where adequate information is not provided from payer to delineate physicians into provider systems.

2) BIDMC revenue reflects paid amounts

3) Risk and quality settlements have not occurred for commercial plans. Some quality payments were made on an interim basis.

4) Due to confidentiality agreements provisions contained within third party payor contracts, we have combined surplus/deficit revenue and quality incentive revenue with other revenue

We would be happy to work with the Office of the Attorney General further if other information can be provided.

2011

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	119,669,000	125,549,000			54,431,351	-					17,086,998	34,420,579	11,647,225	-	-
Tufts	-	-			28,406,311	-					42,240,970	35,140,999	1,000,856	-	-
HPHC	124,775,754	48,290,000			-	-					11,720,491	20,575,556	3,045,223	-	-
Fallon	-	-			-	-					1,746,000	4,801,882	-	-	-
CIGNA	-	-			-	-					14,969	11,336,811	-	-	-
United	-	-			-	-					2,759,264	14,941,121	-	-	-
Aetna	-	-			-	-					11,853,557	14,143,643	-	-	-
Other Commercial	-	-			-	-					8,337	55,810,759	-	-	-
Total Commercial	244,444,754	173,839,000			82,837,662	-					87,430,585	191,171,350	15,693,304	-	-
	-	-			-	-					-	-	-	-	-
Network Health	-	-			-	-					18,229,181	-	-	-	-
NHP	-	-			-	-					23,219,271	-	-	-	-
BMC Healthnet	-	-			-	-					8,478,347	-	-	-	-
Fallon	-	-			-	-					245,764	-	-	-	-
Total Managed Medicaid	-	-			-	-					50,172,563	-	-	-	-
	-	-			-	-					-	-	-	-	-
Mass Health	-	-			-	-					32,272,000	27,056,651	-	-	-
	-	-			-	-					-	-	-	-	-
Tufts Medicare Preferred	-	-			-	-					31,154,901	182,000	-	-	-
Blue Cross Senior Options	-	-			-	-					6,547,452	4,890,000	249,010	-	-
Other Comm Medicare	-	-			-	-					10,042,353	15,742,000	344,865	-	-
Commercial Medicare Subtotal	-	-			-	-					47,744,706	20,814,000	593,875	-	-
	-	-			-	-					-	-	-	-	-
Medicare	-	-			-	-					-	357,396,300	-	-	-
	-	-			-	-					-	-	-	-	-
GRAND TOTAL	244,444,754	173,839,000	-	-	82,837,662	-	-	-	-	-	217,619,854	596,438,301	16,287,179	-	-

Explanatory Notes:

1) Revenue reflects BIDCO physicians for risk-based contracts, and HMFP and BIDMC for all payers. Exception is Tufts contract, where contract exists between BIDMC, BIDPO and Tufts, and "other

2) BIDMC revenue reflects paid amounts

3) Risk and quality settlements have not occurred for commercial plans. Some quality payments were made on an interim basis.

4) Due to confidentiality agreements provisions contained within third party payor contracts, we have combined surplus/deficit revenue and quality incentive revenue with other revenue arrangements. We would be happy to work with the Office of the Attorney General further if other information can be provided.

2012

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	103,381,000	129,618,000			31,415,566	-					15,666,301	35,567,657	2,959,648		-
Tufts	-	-			23,788,443	-					36,855,923	39,653,643	648,971	-	-
HPHC	87,018,000	62,825,000			18,220,071	-					15,059,138	21,115,558	2,199,686	-	-
Fallon	-	-			-	-					1,557,000	5,442,175	-	-	-
CIGNA	-	-			-	-					29,142	12,054,809	-	-	-
United	-	-			-	-					2,849,802	17,260,185	-	-	-
Aetna	-	-			-	-					14,048,350	10,950,236	-	-	-
Other Commercial	-	-			-	-					220	53,213,996	-	-	-
Total Commercial	190,399,000	192,443,000	-	-	73,424,080	-	-	-	-	-	86,065,877	195,258,258	5,808,305		-
	-	-			-	-					-	-	-	-	-
Network Health	-	-			-	-					27,770,166	-	-	-	-
NHP	-	-			-	-					28,118,851	-	-	-	-
BMC Healthnet	-	-			-	-					7,272,758	-	-	-	-
Fallon	-	-			-	-					389,481	-	-	-	-
Total Managed Medicaid	-	-			-	-					63,551,256	-	-	-	-
	-	-			-	-					-	-	-	-	-
Mass Health	-	-			-	-					35,851,000	27,225,772	-	-	-
	-	-			-	-					-	-	-	-	-
Tufts Medicare Preferred	-	-			-	-					30,305,773	269,000	-	-	-
Blue Cross Senior Options	-	-			-	-					4,998,096	4,821,000	153,530	-	-
Other Comm Medicare	-	-			-	-					10,119,260	13,149,000	207,663	-	-
Commercial Medicare Subtotal	-	-			-	-					45,423,130	18,239,000	361,193	-	-
	-	-			-	-					-	-	-	-	-
Medicare	-	-			46,444,392	-					-	341,001,399	7,779,970	-	-
	-	-			-	-					-	-	-	-	-
GRAND TOTAL	190,399,000	192,443,000	-	-	119,868,472	-	-	-	-	-	230,891,262	581,724,429	13,949,468		-

Explanatory Notes:

1) Revenue reflects BIDCO physicians for risk-based contracts, and HMFP and BIDMC for all payers. Exception is Tufts contract, where contract exists between BIDMC, BIDPO and Tufts, and "other commercial Medicare" category where adequate information is not provided from payer to delineate physicians into provider systems.

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