MOUNT AUBURN CAMBRIDGE INDEPENDENT PRACTICE ASSOCIATION, INC.

MACIPA

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September 26, 2013

Mr. David Seltz, Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

VIA EMAIL AT HPC-Testimony@state.ma.us

Dear Mr. Seltz:

Enclosed please find our written testimony in answer to the questions provided by the Health Policy Commission and the Attorney General's Office.

Sincerely yours,

Barbara Spivak, M.D.
President and Chair of the Board

enclosures

Exhibit B: Responses to Health Policy Commission (HPC) Questions for Written Testimony

Brief Summary

Mount Auburn Cambridge Independent Practice Association, Inc. (MACIPA) is a physician membership organization established in 1985. MACIPA has had risk contracts since the inception of the organization and most recently with CMS for their Pioneer Accountable Care Organization program. The risk is shared with our partner hospital Mount Auburn Hospital. Surplus earned under the contracts is distributed to MACIPA and shared with Mount Auburn Hospital. A significant amount of the surplus goes to support MACIPA's infrastructure that is essential to perform well in risk contracts. MACIPA also subsidizes the cost of the EHR in the physician practices. Understanding and support for the costs involved in providing non-billable services that supports population management and quality improvement expectations is essential.

Statement that signatory is legally authorized to represent MACIPA, signed under pain of perjury

I, Barbara Spivak, MD, the President and Chairman of the Board of the Mount Auburn Cambridge Independent Practice Association, Inc. am legally authorized to represent MACIPA, signed under pain of perjury.

09/27/2013

Barbara Spivak, M.D. Date

Exhibit B – HPC 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?**

   We have developed programs to reduce the cost of patient services including complex care management, disease management, pharmacy management, quality improvement, utilization management, and referral management. We manage, train and support the EHR for over 200 physicians. These programs contribute to controlling health care costs, improving the quality of care and patient outcomes. They are interconnected and together improve the patient experience of health care and care outcomes and reduce cost.

   Complex Care and Case Management - MACIPA is delegated to provide its own case management services for two of the major commercial health plans. The plans require us to comply with NCQA requirements in order to delegate this function to us. The services provided by MACIPA care managers include:

- Care Management services for patients with complex needs at all levels, e.g., home, inpatient, SNF, rehab.
- Utilizing clinical criteria to identify the most cost effective setting for care delivery.
- Directing patients to preferred contracted ancillary providers, when appropriate.
- Ensuring that patients are prepared for discharge from the hospital and understand their post-discharge instructions:
    - Have a follow- up PCP appointment scheduled by the case manager.
    - Understand their medications and how to take them.
    - Understand what symptoms to watch for and what to do if they arise.
    - Patients are called at home by Care Management post discharge.

Together these activities help to keep the patient from being readmitted to the hospital after discharge.

To manage our ACO population effectively, we have embedded Care Managers to specific practices to manage the high risk patient population. Patients are identified as high risk by physician assessment, the use of high risk criteria, and predictive modeling software. The Guided Care Model is our standard of care. NCQA standards for disease management are used for assessment of high risk patients. They are included in our Care Management software application.

We work closely with the skilled nursing facilities (SNFs) where the highest volume of our patients transition from an acute hospital setting. We collaborate with the SNFs to decrease average length of stay and to improve the quality of transitions in care.

We have a Case Manager who works with our preferred SNFs to review and track discharge goals and therapies provided. The Case Manager partners with the physician and the facilities to educate, facilitate, and assist in coordinating care for our patients. We educate the SNFs on our expectations including the services that can be provided when the patient is discharged. We are steadily improving communications and workflows between the facility, Case Manager, and attending physician.

A collaborative effort was also developed and approved by the five Eastern Massachusetts Pioneer ACOs. The work has been motivated by the desire to provide a common vision for quality improvement in nursing home care, and to reduce the need of skilled facilities to respond to multiple sets of potentially conflicting expectations. Many of the criteria should be easily achievable, while others will require some time and additional resources. The goal is to have the collaboration effort among these ACOs serve as a shared blueprint for long-standing quality improvement efforts between our ACOs and nursing facilities and their provider teams.

Social Work Department - In 2012 we established a social work department. We now have a team of a director and three social workers. A consultative model was selected, and the social worker is the point of contact with the nurse case manager, who works with each of our primary physician Pods.

The social work team has researched the various community support programs available which would benefit our patients. By aligning our efforts with the state-wide network of Aging Services Access Points

(ASAPs), the patients benefit from various services at no cost to them. The philosophy of the program is to provide consumer directed care which supports providing the patient with options, helping the patient understand their options, all while respecting patient choice.

MACIPA Social Workers also work collaboratively with the Mount Auburn Hospital (MAH) Social Workers regarding Medicare ACO patients in order to facilitate seamless transition back to the community. A goal of the Social Work referrals and interventions is decreased utilization, e.g., ER use, hospital admissions, and readmissions.

Electronic Health Record (EHR) – MACIPA implements, trains, hosts and supports member physicians on an electronic health record. Currently, 397 providers and over 1100 staff are using the EHR software provided by MACIPA. We have developed interfaces to the Mount Auburn Hospital system, Meditech, to provide laboratory and radiology test results and department reports (e.g., discharges, History and Physical). We have an interface with Quest Laboratory. We have implemented a community record to improve continuity of care across multiple settings, making information available to our providers who are using the EHR at the point of care. The EHR will continue to improve the quality of care and reduce costs as physicians share information on their patients, see the results of tests that were already performed and are better informed than with paper record systems. Our staff works closely with the staff of the physician practices, holding Superuser and Office Manager meetings on a regular basis. We support our EHR users to achieve Meaningful Use and have an IT Committee of physicians who continue to look for better ways to use the EHR. These services are critical to our performance in risk contracts. While they support our goal of reducing the cost of care, they are nevertheless costly and increase our infrastructure expense.

Coordination of Data – MACIPA has worked hard to improve the quality of care provided to all patients by standardizing specific clinical care processes across our members' practices. We use both data systems and human resources to drive standardization. MACIPA started its Quality Improvement Program in 2004, before any pay-for-performance contracts were in place. Recognizing the need to improve quality through population health management we use an interdisciplinary team including case managers, physicians, nurses and a pharmacist to review areas ripe for quality improvement.

The Quality team recognized that data must drive its efforts. It sought to identify current performance, preferably from MACIPA EHRs, as the data source that most closely represents the 'clinical reality' that we could hope to measure at this time. We implemented an ongoing training program to promote our quality metrics with our Primary Care Physicians. We outlined new measures and provided physicians guidance on workflows that would allow us to begin to measure performance. We offer educational sessions with Specialists on specific measures that need their collaboration.

We remind physicians about existing reporting and performance improvement work including:

- Diabetes Metrics
- Colon, breast, and cervical cancer screening
- Blood pressure control in DM and HTN
- Patient experience improvement work

We have created a Business Intelligence department with Business Intelligence and Data Warehouse Managers. We extract data from the EHR and combine it with claims data and other clinical data to produce reports that help to support the clinical work done by our physicians.

Pharmacy management – Our clinical pharmacist works with physicians to show them alternatives to higher cost drugs and identify harmful drug-drug interactions. The clinical pharmacist provides a MACIPA formulary annually to physicians and tracks the use of generic vs. brand name drugs. The result is lower cost of medications for MACIPA patients, their employers and health plans. Physicians are free to reject the recommendation of the clinical pharmacist in the exercise of their independent medical judgment.

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?

Decreasing the rate of re-admission, the appropriate use of acute care hospitals, long term care facilities and skilled nursing facilities, as well as decreasing length of stay in long term care facilities and SNFs, and decreasing medical errors.

Factors that limit our ability to succeed include:

- We do not receive data on non-risk patients. We think that every patient, regardless of insurance, should have a Primary Care Physician (PCP) of choice. When the patient has a PCP, data can be attributed to that physician and the systems we have set up to support the PCP can be introduced. Contracts that allow us to manage patients in PPO or Physician of Choice (POC) products are essential.
- There is a lack of incentives for patients to align with physicians. There is no benefit design that positively rewards patients for working with us.
- We have limited financial resources to promote programs.
- While we have data from claims and the electronic health record there is still a great deal of data we do not have, particularly from hospitals and facilities other than Mount Auburn Hospital.
- The EHR systems have not caught up with the contracts we have. They are not sophisticated enough for population management, disease registries, and quality improvement efforts and tracking. The result is that much additional work has to be done to make up for these shortcomings,
- There needs to be more employer and patient engagement in wellness programs, e.g., smoking cessation, and obesity programs
- Physicians are paid for performance in quality, but there is a significant time lag, one to two years, between changes in recommended protocols and changes in the quality metrics. This is too long and unacceptable. Measures need to promote the most up to date evidence-based medicine.
- More uniformity is needed amongst the plans and Medicare on quality measures so that PCPs are not burdened with over 100 different measures.

- Hiring of new physicians – both PCPs and specialists – is increasingly difficult in Massachusetts.

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

Promoting more use of local community hospitals. In our case that is Mount Auburn Hospital. Mount Auburn Hospital offers more than the typical community hospital's services since it is also a teaching hospital and is more cost effective than using a quaternary medical center. Insurance products that help move care to lower cost, local community hospitals will help to control cost. On the other hand, patients with complicated procedures that require care in an academic facility should not be penalized, with higher copays, for being sick.

We also believe that all patients should be required to identify a physician of choice. Patients are better served when a Primary Care Physician (PCP) is managing their care. Many patients nowadays are in PPO plans that do not require designation of a PCP. With realignment of a patient and a PCP, preventive care is enhanced, care management for high risk patients can be instituted and gaps in care identified.

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

Unlike other provider organizations in Massachusetts, our contracts have always been risk-based since the inception of our organization. Our contracts are all risk contracts including the newest form of risk contracting, with the Centers for Medicare and Medicaid Services (CMS) and its Center for Medicare and Medicaid Innovation as a Pioneer Accountable Care Organization. Inherent in risk contracts is the goal of providing the appropriate care in the appropriate setting while optimizing quality and reducing cost. Financial savings are theoretically passed on to businesses and consumers.

We are happy to see the Commonwealth of Massachusetts Group Insurance Commission (GIC) is moving in this direction. This is a great starting point and we hope to see continued progress in this direction. We are currently working with two health plans with the GIC's initiative for the development of Integrated Risk Bearing Organizations. While the current model is an attribution versus patient-selection of PCP, the hope is that the GIC moves towards encouraging patients to select a primary care physician or physician of choice.

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?

MACIPA and Mount Auburn Hospital decided to re-negotiate the Alternative Quality Contract with Blue Cross in the fourth year of a five year agreement, cutting it short by a year. We did this to be in line with desired trends. A consequence of the new contract is that we expect a substantial decrease in the surplus we are able to earn, potentially up to 40-50%. We continue to work to control utilization, to provide more coordinated care, to support our physicians in their population management work and to build the staff that can help our physicians to be successful in achieving the triple aim.

3. C. 224 seeks to promote integration of behavioral and physical health. What actions have we undertaken to promote this integration?

a. What potential opportunities have we identified for integration?

We began a new department of Social Work at MACIPA in March 2012. It is now staffed by a Director and three Social Workers. They serve MACIPA's primary care practices on-site on a rotating basis, handling the psycho-social needs of the PCPs patients, connecting them to community services, and coordinating with MACIPA's complex case managers. The social workers do not bill insurers; they are a service provided by MACIPA to our physician members to help fill gaps in care. They have been well received by primary care physicians, their staff and the psychiatrists who are members of MACIPA.

We began participation in the COMPASS project in July 2012, with the Institute for Clinical Systems Improvement (ICSI) of Minnesota. COMPASS is a project funded by CMS to provide specialized services within primary care offices to patients with diagnoses of depression and co-morbidity such as diabetes, hypertension, or congestive heart failure. We have four depression care coordinators who work with the PCPs, the psychiatrists and the patients to ensure that care is coordinated.

We have added the risk for behavioral health services in our contract with Blue Cross and Blue Shield of Massachusetts, beginning January 2014. We believe that the experience we have gained participating in the COMPASS project will be helpful and inform us about what works and what the barriers are to integrate behavioral health services with primary care.

b. What challenges have we identified in implementing integration?

There are significant financial challenges. Psychiatrists have dis-enrolled from managed care as insurers carved out their behavioral health services, required multiple approvals, limited visits, imposed onerous administrative requirements on them and underpaid them. Patients must pay for services out of pocket. Getting psychiatrists and psychologists to participate in managed care plans is a challenge.

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

The payment model needs to move towards reimbursement to physicians for non-billable services essential to providing quality patient care. Many PCPs now have social workers, case managers and behavioral health providers in their offices as part of their team. However the services they provide are not billable. Additional time is spent by the PCP and case managers supporting family meetings in settings such us skilled nursing facilities. The services themselves are time consuming, and need to be billable to the insurer. Insurers must also reimburse psychiatrists who work with PCPs to provide behavioral health services and psychopharmacology advice to the PCPs for their patients. It is too expensive for them to provide these services *gratis*.

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.

MACIPA was the first physician organization in Massachusetts to sign an Alternative Quality Contract with Blue Cross and Blue Shield of Massachusetts in 2009. We continue to participate in the AQC and as

noted above, renegotiated our contract early to be more in line with desired trends. Many other physician organizations and hospitals have sought our advice on how to engage physicians in care coordination and quality improvement efforts, what type of services should be provided and the staff needed to provide these. We have a good reputation as an innovative, risk taking organization that develops its own solutions to managed care issues.

MACIPA is one of the original thirty-two organizations nationwide participating in CMS's first Pioneer Accountable Care Organization program contracts for Medicare beneficiaries. We were chosen in a highly competitive selection process. We are one of the thirteen organizations of the thirty-two that saved money for Medicare in the first year of the program due to our efforts to improve the quality of care, the health of populations and to reduce per capita costs.

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

It is difficult for PCPs to support population management goals. Systems such as the available electronic health records (EHR) are not sophisticated enough to support true integration.

In addition to centralized functions performed by MACIPA staff, there are costs at the physician practice level that are not accounted for. Practices now provide population health management, and work with nurse care managers to provide enhanced services for patients, none of which are directly reimbursed in our fee-for-service world. As our surpluses will be greatly diminished in future years, our ability to support these functions may become limited.

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

We need to have risk reserves but as a for-profit company we are taxed on any funds that we retain for reserves. There needs to be a policy change to allow organizations such as MACIPA to build reserves without losing a substantial part of it to taxes.

The many new expectations that are made of physicians are costly. There is a general lack of understanding that the infrastructure and staff needed to perform well in a risk contract is expensive. IT systems, creation of data and reports, tracking quality improvement efforts, the services of nurse case managers, social workers and health coaches, all of whom are not providing billable services, need to be supported by payers. We have spent millions on IT costs since we began to implement electronic health records for our physicians and provide the servers and staff to support it. Those costs will continue as maintenance and support costs are high. We are only beginning to implement health information exchange, no less interoperability with other systems. Reinsurance costs have risen dramatically. The Patient Centered Medical Home (PCMH), which is encouraged by state and federal authorities, will increase costs for physicians.

We need uniformity amongst the plans and federal government program on quality improvement measures so that PCPs are not burdened with over 100 measures. There need to be patient incentives to improve their own health.

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

We review our operating expenses regularly, and have also calculated these on a PMPM basis. Our costs are reasonable compared to other organizations, to Medicare Advantage provider groups and other Pioneer Accountable Care Organizations.

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

We develop a MACIPA operating budget annually, with approval from our Finance Committee and Board. We report actual to budget financial performance to them monthly. Physician members of MACIPA run their own practices, we do not own or operate them, they are separate businesses. We do not track the cost structure of individual or group practices yet we are aware that these typically run as lean as possible.

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

CMS provided some data to Pioneer ACO participants in the summer 2013 about the infrastructure costs incurred by 6 Pioneers during the first year of the program, 2012, as well as the financial performance, surplus or loss, for these. Aside from that, we do not have access to the operating costs of peer organizations regarding the cost of their commercial contracts.

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

Not applicable.

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

MACIPA does not provide clinical services to patients; it is our physician members who do. We expect that insured patients who ask questions about the cost of health care services and procedures will be referred to their insurer which will provide the information on the allowed amounts. Uninsured patients will be informed by the provider – either physician, hospital or other facility – of the appropriate charges.

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.

The movement towards ACOs has pushed providers – both hospitals and physicians – to merge into larger groups with the belief that bigger is better and that there is safety in numbers. The AG needs to evaluate whether this strategy has in fact lowered the trend in health care cost and improved quality and whether smaller institutions will continue to have a vital and sustainable role in the state.

Exhibit C: Office of the Attorney General Questions (OAG) for Written Testimony

1. **Submit a summary table for each year from 2009 to present showing our operating margin for each of the following 3 categories, and the percentage each category represents of our total business:**
    a. **Commercial business**
    b. **Government business**
    c. **All other business**

    Include in your response a list of the carriers or programs included in each of the 3 margins, 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 pmpm budget against which claims costs are settled.

    MACIPA was established in 1985. Until last year, we held risk strictly in commercial HMO models reimbursed through contracts that incorporate a per member per month (PMPM) budget against which claims costs were settled. Our commercial contracts included Blue Cross Blue Shield, Tufts Health Plan, and Harvard Pilgrim Health Care. We have contracted with Tufts Medicare Preferred since 1994. In 2012, we entered into a Medicare Pioneer ACO contract with the CMS in. However, the 2012 Pioneer ACO settlement did not occur until August 2013. The following is a summary table of our margin for the commercial business:

	2009	2010	2011	2012
Margin	1.90%	0.44%	2.89%	4.03%

2. **If you have a contract with a public or commercial payer for health care services that incorporates a per member per month budget against which claims costs are settled, please explain and submit supporting documents that show:**

    How risk contracts have affected your business practices, including any change 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 changes to your physician recruitment or patient referral practices.

    Our business is built around risk contracts since our inception in 1985.

    Care delivery support

    We support our primary care practices that are working to become accredited as Patient Centered Medical Home practices. We have had a staff person and consultants to help the practices make the needed changes in their practice, work flow, policies and procedures and advise them on preparing the documentation for the application. In August 2013 we hired a full time facilitator to work with practices on this. We are committed to helping practices make this transition.

    We provide a variety of support services to our physicians including case management, complex case management, SNF case management and Social workers. We have embedded complex case managers (RN's) in primary care practices so that they are closer to the patients and the physicians

and are able to have a "warm handoff" introduction from the physician. They work as part of the practice's team. We are able to focus on the sickest and frailest patients through the referrals made by the physicians and also on our use of software that can identify the neediest patients.

We created a department of Social Work in March 2012 and now have three (3) social workers and a director of social work. The social workers are assigned to multiple primary care practices and provide valuable service for the psycho-social needs of the patients. The social workers connect the patients with community based services which are often free or at low cost. We provide case management services at Mount Auburn Hospital for some of our risk patients. We also employ a case manager who follows our patients at high volume Skilled Nursing Facilities and have seen the average length of stay decrease at these because of our efforts.

We manage, implement, host, upgrade, and train physicians on the electronic health record that MACIPA provides to our members. MACIPA's Quality Improvement department provides data, registries and other reports to our physicians to support population management efforts. As more risk contracts contain a quality improvement component this has become ever more important. The BCBS MA Alternative Quality Contract and the CMS/CMMI Pioneer Accountable Care Organization contract both contain substantial quality improvement criteria and requirements.

Physician recruitment

MACIPA does not recruit physicians to become members of the organization. Recruiting is done by employers of physicians such as Mount Auburn Hospital's Mount Auburn Professional Services (MAPS) organization, Cambridge Health Alliance's Physician Organization, and by the individual private practices that have physicians who are members of MACIPA. We do not recruit physicians because we do not employ physicians practicing medicine. We have six (6) Medical Directors who are all part time at MACIPA working in areas such as IT and reporting projects, quality improvement, physician education and outreach, helping other practices become PCMH certified and championing clinical projects with their colleagues.

Patient referral practices

Wherever possible, we try to keep the services provided to our patients within the MACIPA network. There are several reasons for this. Coordination of care is better when the patient is being seen within our network. Most of our physicians participate in the same electronic health record (EHR) and are able to share information with each other through the EHR, which includes an interface with Mount Auburn Hospital's (MAH) information systems. Services provided at MAH are less expensive than the same procedures provided at a downtown medical center, so the overall cost will be less as well. We refer patients to a small number of Skilled Nursing Facilities (SNF) that work with us to develop a clinically appropriate discharge plan with a shorter length of stay, and enhanced services at home. The services we have built to support these efforts – complex case managers, SNF case manager, social workers, information available in the EHR – can be used to provide a coordinated approach with a managed care philosophy.

Include in your response any analysis of the impact of changes in your service mix, payer mix, or patient member type (e.g., HMO vs. PPO, fully –insured vs. self-insured) on your opportunities for

surpluses.

We have not had a change in our service mix. However, we have witnessed continued decrease in HMO membership over the past few years. We suspect these members have shifted into a PPO product. The decrease in patients has caused a relative per member per month increase in cost to running our organization.

In 2012 we had a change in our payer mix and patient type mix. The change came about in the form of the Contract with CMS for the Pioneer Program. The addition of this contract led to an increase in the MACIPA infrastructure to support the activities necessary to manage this new program. This new contract does not give us infrastructure funding and as such MACIPA had to subsidize the added costs from surplus from other contracts. The Pioneer contract does give us an ability to earn surplus and we were fortunate to earn some small amount of savings that will be used to fund the costs.

We have felt the impact with the changes in patient mix combined with the decrease in HMO membership. We have found there is more opportunity to coordinate care with an HMO patient who has a Primary Care Physician. A PPO patient is not required to have a PCP and has more flexibility to opt out of the system, or choose a physician or facility (hospital, SNF, rehab) outside of our network. Requiring patients to designate a physician of choice would improve our ability to have more integrated care.

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: Costs for human resources, reserves, stop-loss coverage, Solvency standards, Projections and plans for deficit scenarios.**

We have built up our expertise in risk contracting and what it takes to perform well over the past two decades. We create projections at the time the contract is being negotiated about the potential to develop a surplus. Once the contract is underway, the health plans provide regular, lagged, reports of financial performance to the budget. We track those patients who are likely to hit the stop-loss threshold and can gauge that performance. Over the years we have built a strong staff and infrastructure that support our mission of improving the quality of care, reducing cost and improving the health of populations.

We receive lagged fund reports on a monthly basis from the payers showing our performance against budget. Based on our analysis of claims, we put utilization management programs together, identify opportunities for improvement and act on them. We purchase reinsurance on the open market, which is less expensive than buying it from the payer. Reinsurance covers and protects us from catastrophic cases.

We take a number of factors into account when figuring out whether a budget offered by a payer will be sufficient to be successful. We look at the immediate prior year's performance, the payer's statewide premium as available from the Division of Insurance, and the member relativity factor. We make assumptions about the likely increases in facility reimbursements at the hospitals we utilize and other facilities and providers our patients utilize. We make assumptions about ancillary service increases, pharmacy costs based on national/statewide trends and our own trend, price and utilization assumptions for mental health, out of area expenses, IBNR as compared to prior years. Many of these factors are estimates. We have the claims data to review how costs have trended over multiple years.

We factor in reinsurance premium expenses for those plans that give us the option to buy reinsurance on the open market. If we are aware of large outstanding claims from the prior year that will be expensed against the next year, they are included.

We seek advice from an actuary periodically regarding the level of reserves that are appropriate given the amount of risk we have in our contracts. The Physician Participation Agreement (PPA) that binds each physician member to MACIPA describes the way in which a deficit would be paid back by the physicians in the event that MACIPA had a deficit beyond the withheld amount and the reserves we hold. MACIPA has a Line of Credit with the Cambridge Savings Bank. All of these, the withhold, risk reserves, reinsurance, physician liability and limit of liability, and the line of credit, represent MACIPA's "contingency plan" in the event that we run a deficit. We have been fortunate that we have not had an overall deficit and have never had to exercise these resources.

Human resources, salaries and benefits, are our biggest expense. Salaries for RNs, experienced IT professionals, staff with expertise in contract negotiations, data analysis and reporting are high. As more organizations in Massachusetts have taken on risk contracts, it has become more competitive, and expensive, to attract and retain these professionals. Our staff has grown substantially as additional services to support our members became necessary. These now include a large IT department to support the electronic health record used by our physicians. Data warehouse and business intelligence staff is essential to mine the data for the information we need to identify the sickest, frailest patients. Providing preventive health services and population management means that our physicians need information and registries on their patient panels so that they know what each patient needs and work to provide those services and procedures. Our clinical staff works with the patients identified by the tools and reports to coordinate care. All of these services are essential to perform well within risk and they are expensive.

Reserves

We have built risk reserves over many years against the day when we might have an overall deficit in all of our risk contracts. We were also required in our Pioneer ACO contract to provide a financial guarantee, a type of escrow account, with CMS as the beneficiary, this year. The problem with reserves for a for-profit organization, is that when we retain funds to put aside for reserves, we have to pay taxes on them, so a great deal of the money is paid in taxes. This puts physician organizations who have taken the risk away from insurance companies at a disadvantage compared to the insurance company. We would like to have the state and federal governments change the requirements and waive taxes on reserves.

Solvency standards

We have gotten actuarial advice at various times about how much we should have in reserve based on the level of risk that we hold. Based on the requirements set by C. 224, we expect to seek advice as required. Our calculations show that we have an average of 5% of the global budget for our commercial risk contracts set aside in our reserves.

Projections and plans for deficit scenarios

We have built Reserves over many years and have provided a financial guarantee where required. There are opportunities to terminate our Pioneer ACO contract if the early financial reports show a significant deficit, therefore, minimizing our losses.

MACIPA PMPM Costs:

2012	PMPM
Human Resources	$12.17
Reserves	$13.46
Stop-Loss costs	$4.40

Include 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.

We have not had any major changes in our commercial business with regard to risk because all our contracts since the inception of MACIPA have been risk contracts. MACIPA funded its risk reserves at a time where there was more membership in the HMO products. MACIPA has experienced a decrease in membership in risk contracts, but has maintained the same level of risk reserves.

With the addition of the CMS Pioneer contract, CMS has specific requirements for a risk reserve which MACIPA has been able to meet.

4. 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, geographic area.

We receive reports from the health plans that help us in tracking health status of the overall patient population.

5. Please submit a summary table showing for each year 2009-2012 your total revenue under:

- **pay for performance arrangements**
- **risk contracts**
- **other fee for service arrangements according to the format and parameters provided and attached (AGO Exhibit 1)**

If you can't provide complete answers, explain the reasons why

Include in your response any portion of your physicians for whom you were not able to report a category of revenue

A summary table in Excel spreadsheet is submitted. Please see the footnotes at the bottom of each worksheet.

5. Please identify categories of expenses that have grown

a. 5% or more

b. 10% or more from 2010 to 2012

Operational costs have increased over the past few years as a result of the additional infrastructure needed to support us in meeting the goals of our extensive contracts.

With respect to total medical expense in our major contracts for our risk population, we have experienced trends indicating less than 5% growth in total medical expenses.

6. Describe and submit supporting documents regarding any programs we have that promote health and wellness

1) For patients for whom we are PCP
2) Patients for whom we are not PCP
3) Employees

Include the results of any analyses we have conducted regarding the cost benefit of such wellness programs.

With a focus on patient health and wellness, MACIPA is actively helping practices to implement the Patient Centered Medical Home (PCMH) model. One of the key elements of this program is to promote patient wellness at the practice level. As an example, one of our family medicine practices have instituted a wellness blog, a group forum for weight management, and various other programs developed to promote continued health and wellness.

In an effort to promote healthy living for our employees, our employee benefits broker publishes a monthly wellness newsletter to all employees – Live Well, Work Well. MACIPA employees are eligible for free, unlimited access to an onsite gym at our office. Employees who are covered under our employer health plan are eligible to earn a $150 annual credit for joining an external gym. MACIPA also offers annual flu shots to all employees.

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.

2010

	P4P Contracts				Risk Contracts**						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue (a)		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	X	X	X	X	$15.14M	X	$8.61M	X	$5.28M	X	X	X	$2.86M	X	X
Tufts	X	X	X	X	$4.70M	X	$2.23M	X	X	X	X	X	$0.73M	X	X
HPHC	X	X	X	X	$4.21M	X	$4.36M	X	X	X	X	X	$0.60M	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	$0.02M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$24.05	X	$15.20M	X	$5.28M	X	X	X	$4.21M	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC Healthnet	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred (b)	X	X	X	X	$5.95M	X	$1.72M	X	$0.08M	X	X	X	$1.31M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	$0.02M	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$5.95M	X	$1.72M	X	$0.08M	X	X	X	$1.33M	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$30.00M	X	$16.92M	X	$5.36M	X	X	X	$5.54M	X	X

Notes:

(a) Claims-Based Revenue: MACIPA does not bill or receive physician claims. Claims-based revenue are received by physicians/practices directly. The numbers provided are per claims data files received by MACIPA.

BCBS includes HMO and POS claims data

Tufts provides claims payment data for HMO products only

HPHC provided claims data for HMO products only in 2010

(b) Tufts Medicare Preferred: Primary Care Physicians (PCP) contracted with Tufts for the TMP product. MACIPA charges the PCP a PMPM management fee to provide administration and management services.

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2011

	P4P Contracts				Risk Contracts**						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue (a)		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	X	X	X	X	$14.45M	X	$10.26M	X	$5.35M	X	X	X	$2.62M	X	X
Tufts	X	X	X	X	$4.63M	X	$3.65M	X	X	X	X	X	$0.74M	X	X
HPHC	X	X	X	X	$11.72M	X	$4.36M	X	X	X	X	X	$0.59M	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	$0.02M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$30.80M	X	$18.27M	X	$5.35M	X	X	X	$3.97M	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC Healthnet	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred (b)	X	X	X	X	$6.31M	X	$2.58M	X	$0.02M	X	X	X	$1.45M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	$0.04M	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$6.31M	X	$2.58M	X	$0.02M	X	X	X	$1.49M	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$37.11M	X	$20.85M	X	$5.37M	X	X	X	$5.46M	X	X

Notes:

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Tufts provides claims payment data for HMO products only

HPHC provided claims data for HMO and POS in 2011 and 2012

(b) Tufts Medicare Preferred: Primary Care Physicians (PCP) contracted with Tufts for the TMP product. MACIPA charged the PCP a PMPM management fee to provide administration and management services.

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2012

	P4P Contracts				Risk Contracts**						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue (a)		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA	X	X	X	X	$11.60M	X	$9.66M	X	(c)	X	X	X	$2.51M	X	X
Tufts	X	X	X	X	$4.88M	X	$3.47M	X	X	X	X	X	$0.70M	$0.03M	X
HPHC	X	X	X	X	$15.34M	X	$4.33M	X	X	X	X	X	$0.59M	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	$0.01M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$31.82M	X	$17.46M	X	(c)	X	X	X	$3.81M	$0.03M	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NHP	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC Healthnet	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mass Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred (b)	X	X	X	X	$5.96M	X	$2.67M	X	$0.06M	X	X	X	$1.55M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	$0.04M	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$5.96M	X	$2.67M	X	$0.06M	X	X	X	$1.59M	X	X
Medicare	X	X	X	X	X	X	$1.01M	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$37.78M	X	$21.14M	X	$0.06M	X	X	X	$5.40M	$0.03M	X

Notes:

(a) Claims-Based Revenue: MACIPA does not bill or receive physician claims. Claims-based revenue are received by physicians/practices directly. The numbers provided are per claims data files received by MACIPA.

BCBS includes HMO and POS claims data

Tufts provides claims payment data for HMO products only

HPHC provided claims data for HMO and POS in 2011 and 2012

Pioneer ACO Medicare claims are not inclusive of all claims data due to CMS data issues

(b) Tufts Medicare Preferred: Primary Care Physicians (PCP) contracted with Tufts for the TMP product. MACIPA charged the PCP a PMPM management fee to provide administration and management services.

(c) BCBS Quality Incentive Revenue for 2012 is not available. Settlement will be calculated by BCBS in November 2013.

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