NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

September 27, 2013

VIA ELECTRONIC MAIL

David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116
HPC-Testimony@state.ma.us

RE: Request for Written Testimony

Dear Mr. Seltz:

Please find attached New England Quality Care Alliance's (NEQCA) response to the request for written testimony submitted by the Health Policy Commission and the Office of Attorney General.

I am legally authorized by the NEQCA Board to represent NEQCA in this matter. I am informed and believe, and upon such information and belief declare under penalty of perjury, that the statements made herein are true and correct

Sincerely,

Jeffrey I. Lasker, MD
CEO

Enc: Exhibit B Responses
Exhibit C Responses

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EXHIBIT B
Health Policy Commission Questions for Written Testimony

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. <u>The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.</u>

Summary:
NEQCA is lowering costs by directing patients to higher value tertiary providers, like Tufts MC and Floating Hospital for Children, and optimizing medication prescribing by providing data and feedback to physicians to improve prescribing for patients. This is achieving great results; but is limited by the absence of data. Mandated system-wide claims submission and reporting for all medications would improve the ability to reduce costs.

NEQCA is implementing the Patient Centered Medical Home (PCMH) in all NEQCA primary care practices. NEQCA is dedicated to the Triple Aim for all patients, yet we are limited to providing these efforts only to patients in plans that provide claims data and funding for the information technology and people needed to manage patients. The following changes will address this:

- **Access to accurate, timely and comprehensive quality and efficiency data on ALL patients**
- **Reallocate care management resources from payers to actual providers**
- **Close the payment gap**
- **Uniform and transparent payment rules**

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

NEQCA is working on several initiatives to increase the efficiency of care. We are directing patients to higher value tertiary medical centers, such as Tufts MC and the Floating Hospital for Children, which offer high quality care at a lower cost. We are also working to keep care local and in the community wherever possible, both for inpatient services at community hospitals and utilization of local physician services. These initiatives do not negatively affect quality since our network uses high quality community hospitals and specialist physicians. To address a lack of certain specialist physicians in the community, NEQCA and Tufts MC support the *Distributed Academic Medical Center™* model, where we deploy specialists from Tufts MC to the community to keep care local and costs down.

We are also working to optimize medication prescribing through providing data and feedback to physicians that identify opportunities for improving prescribing for patients

with reflux disease, high cholesterol, diabetes, and depression. We do not always expect to save money on medications, but believe that this will prevent complications that could adversely affect health in the future – for example, adding insulin to the regimen of a patient with diabetes may increase drug costs but reduce complications of the illness that could lead to expensive acute or chronic care.

This program is limited by the absence of data for several reasons. First, for patients enrolled in our commercial and Medicare Advantage programs, our pharmacy claims do not include low-cost generic medications. Second, we do not have any data, pharmacy or medical claims for our non-HMO commercial products, or for Medicaid or other governmental payment programs. With a more complete data set we could determine exactly what patients are taking so that we can identify and fill gaps in care and also substitute less expensive and equally-effective medications for patients who need them. Mandated system-wide claims submission and reporting for all medications, including low-cost generic medications, would greatly improve NEQCA's and other systems' ability to manage and reduce costs in this important way. Additionally, NEQCA's efforts in this regard are limited by payors' lack of sharing PPO claims data.

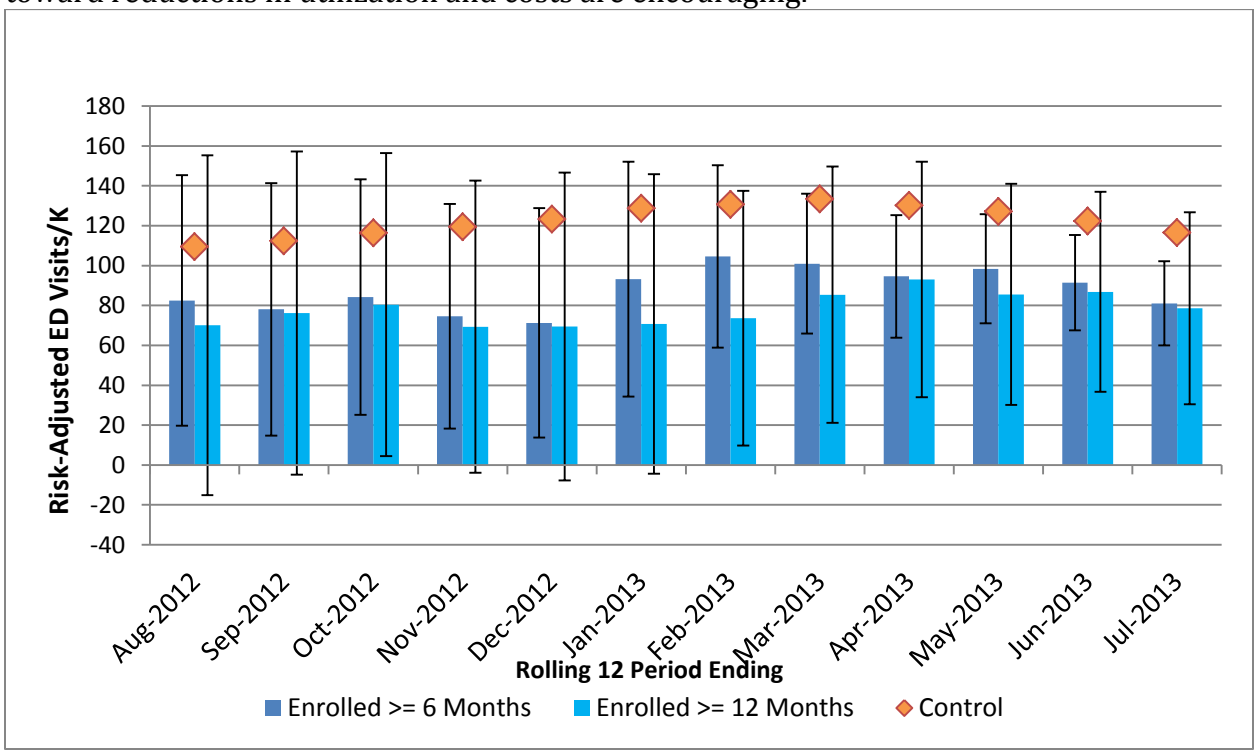
The other major initiative we are pursuing is implementation of Patient Centered Medical Home (PCMH) in all NEQCA primary care practices by the end of 2015. The purpose of the NEQCA Medical Home Program is to support primary care providers in meeting the Triple Aim goals of providing better care and better population health, at lower cost. Having learned from successful implementation of Electronic Health Records and helping those practices achieve Meaningful Use, and with our experience in designing and implementing care management for complex patients, NEQCA's Medical Home Program is poised to scale up and meet its goals.

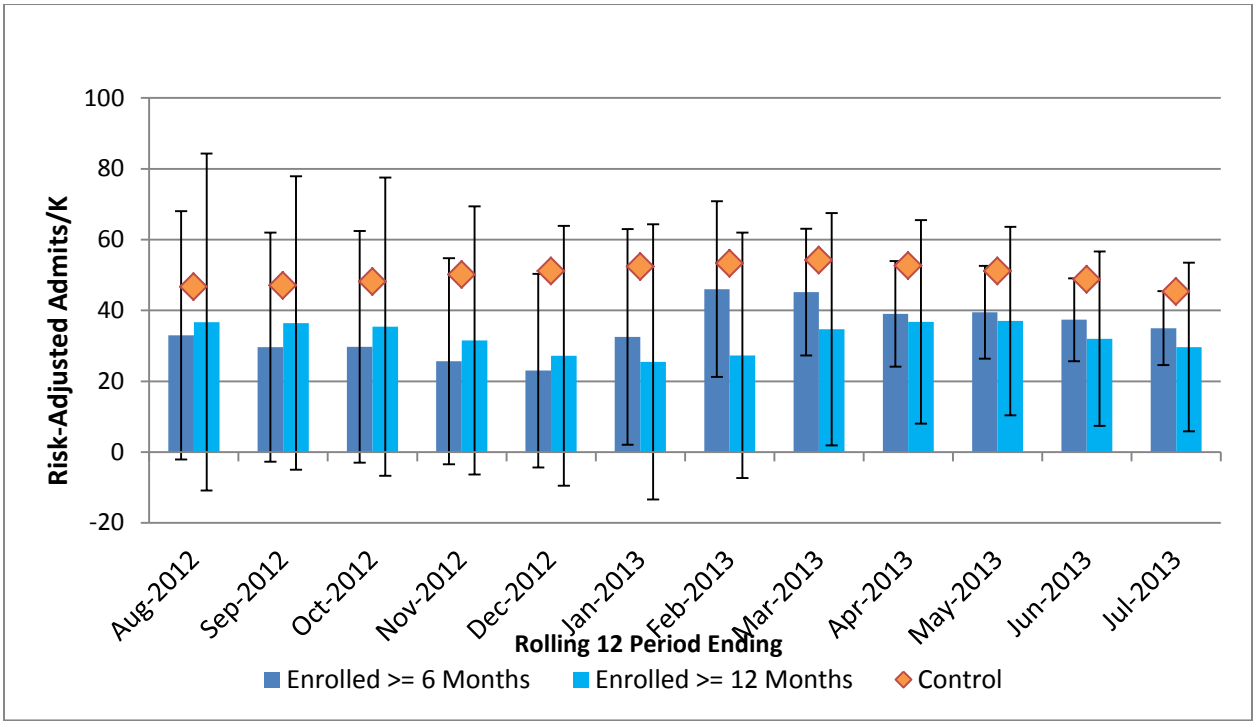
The goals of NEQCA's Medical Home Program are to:

- Achieve Patient Centered Medical Home (PCMH) National Committee for Quality Assurance (NCQA) Recognition Level II or Level III
- Engage with the highest risk patients to support enhanced self-management of health and active participation in treatment
- Improve quality and efficiency performance
- Achieve Meaningful Use Attestation for Electronic Health Records
- Improve provider, staff and patient satisfaction

The NEQCA Medical Home Program is notable for its innovative linkage of three program components: (a) helping practices improve their workflow and adopt a Patient Centered Medical Home "system of care" as recognized by the National Commission on Quality Assurance (NCQA) – submissions for 70 providers are being sent to NCQA by 9/30/13, and this builds on a "corporate submission" which assures that practices on eCW will be nearly 40% of the way to level II recognition; (b) supporting practices to achieve "Meaningful Use" of technology as defined by the Centers for Medicare & Medicaid Services (CMS); and (c) care management for the most complex members, defined through claims-driven algorithms and predictive modeling or referrals from providers. Our care management

program is showing promising results: these three graphs demonstrate that compared to a control group of similar patients not enrolled in the program, the care management group has lower emergency department utilization, fewer hospitalizations, and a trend towards statistically significantly less cost (Total Medical Expense). We expect to be able to calculate meaningful Return on Investment results in a few months and these trends toward reductions in utilization and costs are encouraging.

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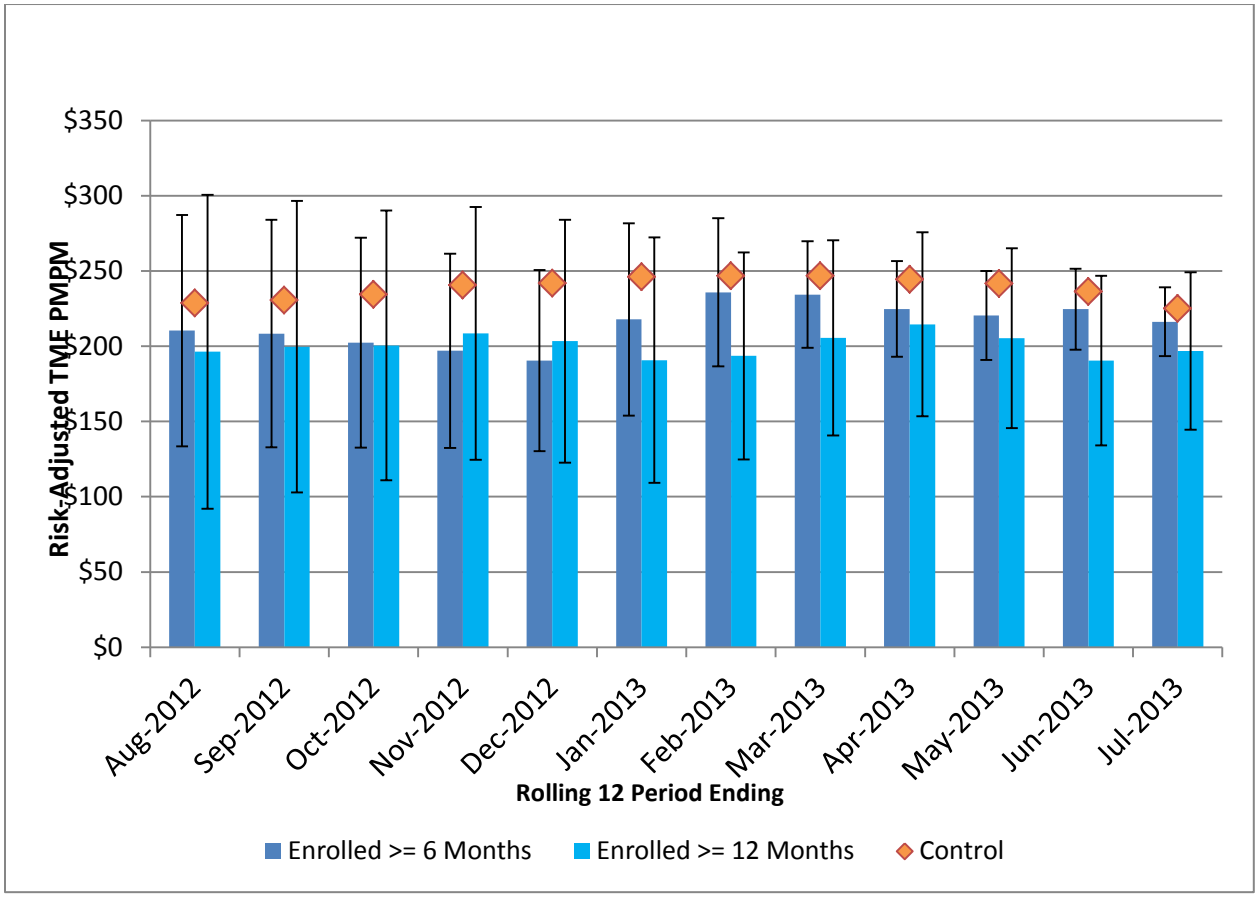
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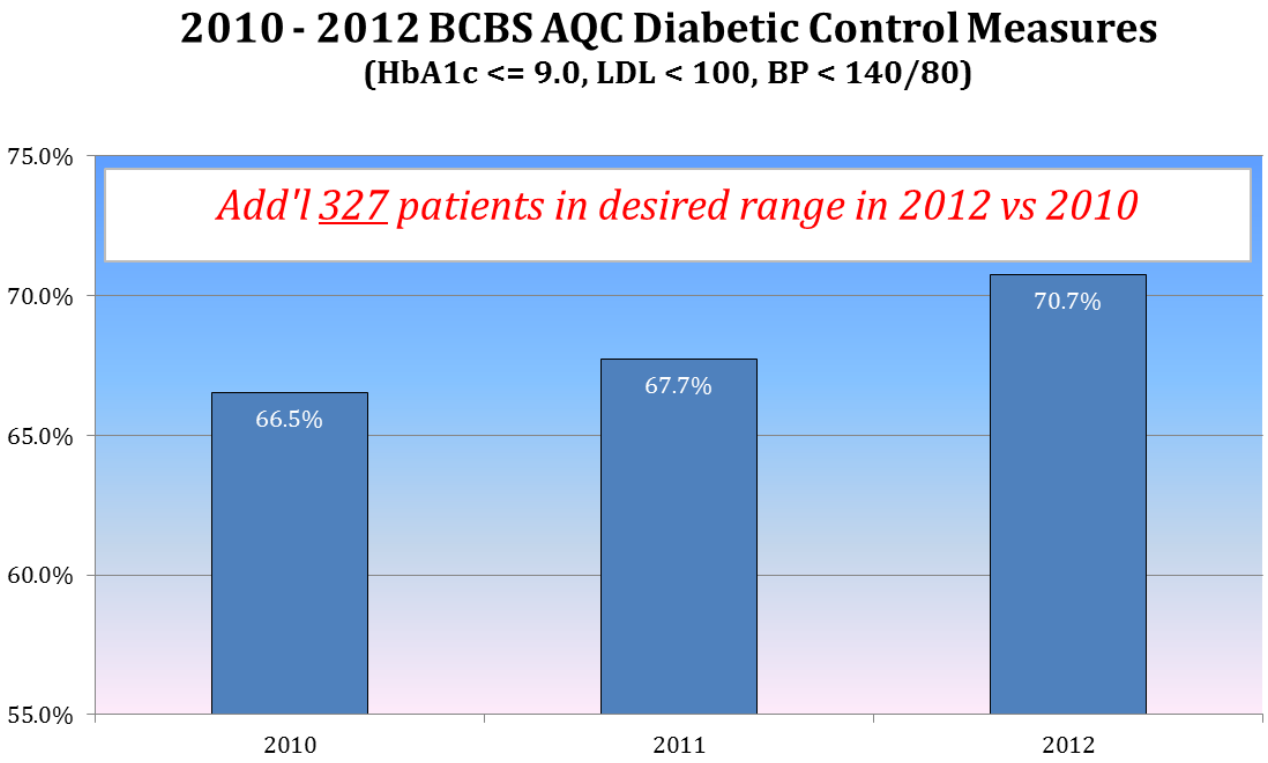
Jul-2013
Rolling 12 Period Ending
Enrolled >= 6 Months
Enrolled >= 12 Months
Control

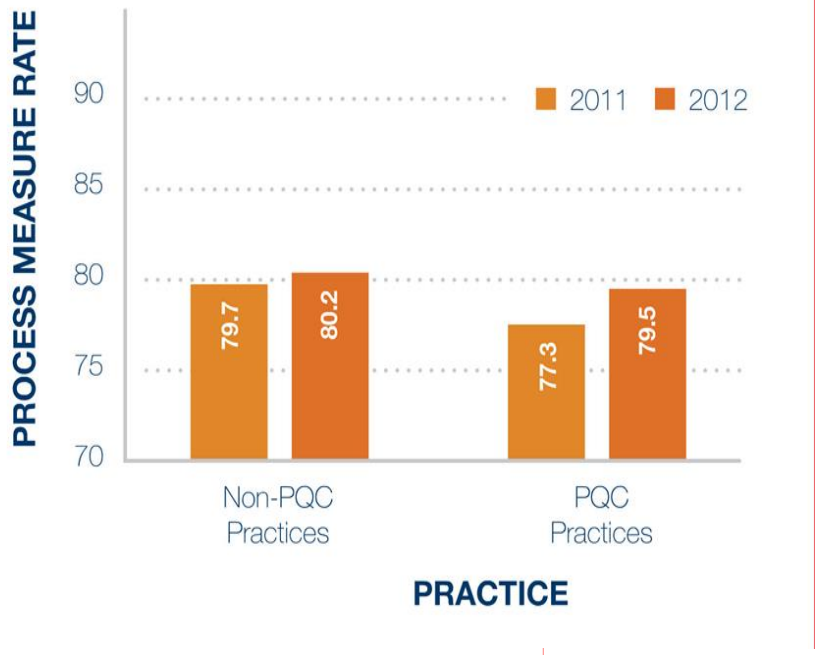
b. What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?

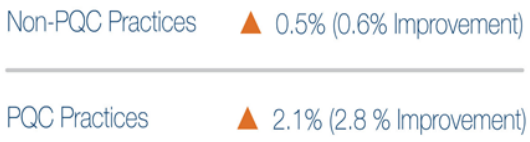
NEQCA's goal is to accomplish the three Triple Aim goals of better health, better care, and lower cost, through providing support for our physicians and their teams to use technology and team-based care to provide better prevention and wellness programs for our patients. The biggest opportunities for quality improvement differ for pediatric and adult patients: for children it is providing consistent preventive care and improved behavioral health care, and for adults it is better management of chronic illnesses like diabetes, especially for patients with multiple chronic conditions and those who have both physical and behavioral health diagnoses. Implementation of the Medical Home program is designed to address the need for both kinds of infrastructure – information systems to track and manage population health and improve communication and coordination between providers, and team members to assist in quality improvement activities and provide care for the most complex patients and their families. Over the past several years NEQCA has demonstrated consistent and sustained improvement in quality measures. This graph shows how care for patients with diabetes improved from 2010-2012:



In 2012 NEQCA developed the Practice Quality Coordinator (PQC) program to provide support for practices to improve their quality scores. Starting in the fall, PQCs were deployed to practices in the lower half of network performance to provide help with

outreach to patients and to provide staff with coaching on improving workflow. The results had a significant impact on quality: practices with PQCs improved 4 times as much compared to non-PQC practices, as this graph shows:





Process Measure Rate = completion rates for cancer screening, diabetes, well-child and related screening measures.

The biggest factor that limits our ability to expand programs that have demonstrated success is lack of resources to provide the same service for all patients. As the Attorney General and CHIA reports have demonstrated consistently, NEQCA has been at or below average in payments from payers compared to other networks for the past decade. This disparity in payments limits our ability to implement services regardless of payer, both because of a lack of cash reserves to support the cost of information technology and care teams and because of varying levels of willingness of payers to share risk.

Additionally, NEQCA has seen an increased shift from HMO plans to PPO plans, with significant negative impact on our ability to manage these populations. Specifically, enrollment in the Blue Cross Blue Shield HMO program dropped over 30% over the past three years. Every patient that shifts from BCBS HMO (the Alternative Quality Contract

or AQC) to PPO plans results in losses to our network: both in terms of loss of infrastructure payments, and loss of access to data, since Blue Cross, like most payers, refuses to share data on PPO patients even though use of primary care attribution models and automated assignment to PCPs could be used to determine how to share data and infrastructure payments. The Commonwealth should require data sharing from all payers and regular access to these data for providers in a format that is actionable.

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

NEQCA is dedicated to reaching the Triple Aim for all patients, yet are limited in the scope of some of our care management and quality improvement initiatives to patients enrolled in plans that provide claims data and adequate funding to pay for the information technology and people needed to manage populations of patients. Here is a brief list of changes that would allow NEQCA to operate more efficiently without sacrificing quality:

1) **Access to comprehensive data:** Access to accurate and timely and comprehensive quality and efficiency data on all patients will assist in managing populations through better targeting patients who need care management and other programs to support better health and for more accurate predictive modeling of future costs and opportunities to prevent them.
2) **Reallocate care management resources:** Health plan care management s resources should be shifted to appropriate provider organizations to implement care delivery redesign and to provide integrated care management at the practice level.
3) **Close the payment gap:** The current payment rate differentials are unsustainable. The market of high cost "haves" and low cost "have-nots" only serves to marginalize high quality, efficient providers, leaving a market dominated by high cost providers who continue to drive an increase in costs. If high cost healthcare systems continue to grow, they will either absorb lower cost systems and demand higher payment rates for those providers, or drive lower-cost providers with less capital and human resources out of business. Insurers should prove that they are not discriminating against hospitals and physicians with more than a 15% Medicaid mix and are paying them a market-competitive rate, which should be at least at the average of other hospitals in their markets and peer groups. As price variations are addressed, providers must be grouped and analyzed by appropriate peer group, e.g. Academic medical Centers (AMCs), and Community Hospitals. Once the payment gap is addressed, global payment contracts could be effective in aligning incentives to achieve high quality and efficient health care.
4) **Uniform and transparent payment rules:** A uniform base payment format, such as a single base fee schedule, claims submission format, and payment policies and procedures across all payers will help drive balance and transparency in the market. Instituting a uniform base payment format will help create true "apples to apples" comparisons, will allow providers and payers to negotiate inflators and deflators on

a standard fee schedule, will remove incentives for perverse contracting practices and arbitrary supplemental payments, and will create substantial savings through administrative efficiencies. Chapter 224 addresses some of these issues, but more needs to be done to implement the necessary regulations to move these important initiatives ahead.

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

NEQCA shares savings in all of its current contracts with its payer partners, but has no way to directly influence premium rates to reduce costs to consumers. Plans should be required to share at least a portion of savings they receive due to better provider performance with their accounts, who can in turn pass on savings to their employees, or in the case of Medicare Advantage plans, offer richer benefits packages or lower premiums to enrollees.

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:
The impact of a fixed percentage increase across the board only serves to widen the disparity in rates and make it harder for high value networks to achieve marked results in improvements to overall population health, enhanced patient experiences and lowering of overall costs.

NEQCA has limited opportunity to affect increases in prices, since most fee schedules are negotiated between non-NEQCA providers and insurers. NEQCA physicians admit to 16 community hospitals, none of which are owned by Tufts Medical Center or NEQCA, and only one of them contracts jointly with our system to provide care to commercially-insured enrollees. Because of the disparities in rates described above, the impact of a fixed percentage increase across the board only serves to widen the disparity in rates and make it harder for high value networks to achieve Triple Aim goals.

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?

Summary:
NEQCA currently has a behavioral health program in support of its Medical Home Care Management program through a contract with the Department of Psychiatry at Tufts Medical Center.
The barriers to this innovative program are:

- Shortage of behavioral health providers
- Lack of space in small practices to have care managers onsite

- Lack of funding to pay for behavioral health programs in primary care practices
- Carve outs of behavioral health programs from medical insurance programs. This leads to lack of coordination between providers and a lack of data sharing between clinicians and at the population level

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

The greatest need for integration is in primary care, for both pediatric and adult patients. NEQCA is currently implementing a behavioral health program in support of its Medical Home Care Management program, through a contract with the Department of Psychiatry at Tufts Medical Center. Through this contract, psychiatrists are available for telephonic consultation for PCPs seeking information on how to manage medications or for advice on how to treat the patient using inpatient or outpatient services. The psychiatrists also provide supervision and support for NEQCA's complex care managers by being available to answer questions and participating in weekly case conferences. We also participating in a multi-center grant program to have an onsite integrated care manager focused on patients with depression, anxiety and substance abuse, work with high risk patients with diabetes to screen and treat them for these very common behavioral health problems.

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

There are several important barriers to effectively integrating Behavioral Health:
1) Shortage of behavioral health providers: few are willing to accept insurance, and as a result, there are significant problems with access to psychiatry and other behavioral health programs. Access to behavioral health professionals for children is even more challenging than for adults.
2) Lack of space in small practices to have care managers onsite;
3) Lack of funding to pay for behavioral health programs in primary care practices;
4) Carve outs of behavioral health programs from medical insurance programs. This leads to lack of coordination between providers, and lack of data sharing both between clinicians and at the population level.

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

1. Better funding for behavioral health services to improve access to care;
2. Payment and funding for pilot projects for technology-enabled care to increase access to behavioral health services. This includes payments for video visits between patients and behavioral health professionals; use of in-home devices to support care management interventions (e.g. depression symptom monitoring with daily questions on devices that are monitored by care managers who can intervene earlier when symptoms worsen); use of handheld devices and smartphones for measuring symptom levels and increasing access to educational materials and contact with behavioral health professionals.
3. Funding for research into the relationship between behavioral health diagnoses and higher medical costs. Our data indicate that when compared to age and gender-matched controls, patients with one behavioral health diagnosis have on average 2.5 times the medical costs, excluding behavioral health treatment costs. Such research

will help us better understand if people have medical illnesses first and then develop behavioral health problems, or vice versa and help in the design and implementation of effective treatment programs.

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

Summary:
NEQCA's risk contract structures and internal funds flow policies align incentives between the providers and the health plans to reward those with higher quality outcomes delivered at an efficient cost.
Another innovative and efficient care delivery program executed by NEQCA is the Medical Home program which includes the following components:

- **Meaningful Use of Electronic Health Records**
- **Patient Centered Medical Home (PCMH) System of Care, as measured by the National Committee for Quality Assurance (NCQA) as a PCMH**
- **Care Management for the most high-risk, complex patients**

NEQCA is concerned that the significant movement of business out of managed HMO products and back into the unmanaged PPO fee-for-service business will seriously dilute its efforts to improve quality and efficiency.

a. Describe your organization's efforts to promote these goals.
NEQCA maintains a "Triple Aim" goal to improve the health of a population of patients; improve the patient's experience of care, including quality, access and reliability; and reduce the rate of growth of costs of care. In order to meet this goal, NEQCA supports a Medical Home program. The Medical Home program enables physicians to improve care for high-risk patients who have chronic and high cost illnesses that require significant resources to treat. The NEQCA Medical Home program includes three individual components:

- **Meaningful Use of Electronic Health Records** (EHRs). The goal of the program is to promote adoption and use of EHRs to reduce cost and improve the quality and measurement of care;
- **Patient Centered Medical Home (PCMH) System of Care, as measured by the National Committee for Quality Assurance (NCQA) as a PCMH**. These NCQA standards provide guidance for provider workflow processes that support the delivery of high quality care, manage medical expenses, improve patient health, and increase physician and staff satisfaction as well as patient engagement; and
- **Care Management for the most high-risk, complex patients**. Care Management provides additional help to primary care physicians to assist them in managing the highest-risk patient with the identified HMO population. High risk patients have complex needs and require significant time from their primary care practices. Under the guidance of the physician, the Care Management Team (consisting of an Integrated Care Manager [RN], Associate Integrated Care

Manager [LPN], Clinical Pharmacist, Care Coordinator, and Behavioral Health Support) completes a patient assessment and collaboratively develops an individualized care plan that focuses on medical intervention and measureable patient education. The care plan supports increased self-management by the patients, better coordination of care, use of community resources and improved adherence with testing and treatment, all of which result in optimal patient health outcomes in a cost-effective manner.

NEQCA's risk contracts have served as a platform for it to create an integrated system with incentives to improve quality and efficiency of care, along with the patient's experience of care. NEQCA's risk contract structures and internal funds flow policies have allowed the alignment of incentives between the providers and the health plans to reward those with higher quality outcomes delivered at an efficient cost.

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

NEQCA is concerned that the significant movement of business out of managed HMO products and back into the unmanaged PPO fee-for-service business will seriously dilute its efforts to improve quality and efficiency. Physicians within NEQCA aspire to provide payer blind care management, however this is not possible if the patient data and resources for infrastructure are not provided equally across the varying insurance products.

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

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

Summary:

NEQCA develops metrics around the population health programs that we institute to manage the health of those populations risk agreements. Metrics such as NEQCA's "efficient use of resources" metric aim to benchmark the ideal amount of patients that should be enrolled in a care management program per provider so the network can manage accordingly.

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

Given the organizational structure of our affiliated network the operational cost structure of both the provider and practice level is managed by those providers and practices with no insight or oversight by NEQCA. NEQCA is in the process of developing a voluntary survey that will be distributed, tabulated, and delivered to participating practices as a way to benchmark their performance to others in the network and potentially the region and state. This survey will center on volume metrics, revenue, staffing levels, operational cost ratios, physician compensation ratios, rent costs, etc. NEQCA is also contemplating a survey such as this for the local care organizations (LCOs) as a way to provide valuable benchmarking data to the LCO's, as well the entire network.

As it relates to network costs, NEQCA develops metrics around the population health programs that we institute to manage the health of those populations risk agreements. Metrics such as NEQCA's "efficient use of resources" metric aim to benchmark the ideal amount of patients that should be enrolled in a care management program per nurse so the network can manage accordingly. These population health initiatives are expensive to administer, so ROI metrics are developed to make sure that these programs are getting to their intended results. Metrics around admits/1000, ED usage, and decreased TME are used in many of the population health initiatives that NEQCA undertakes. These metrics are evaluated against a control group to evaluate the programs. Many of the programs that NEQCA has developed are showing very favorable ROI. Ideally, the physicians in our network would be able to roll these programs out to all their patients as they believe this will be an instrumental component of realizing the triple aim. However, given the decrease of the HMO population to more PPO plans coupled with the lack of the ability to take attributed risk on the PPO population, this desired end point is currently not possible.

NEQCA also prides itself on tightly managing its operation costs. In overhead departments, managers are challenged to come up with their "key drivers" of cost. In all of its measurements, metrics are established to calculate and measure trends to ensure the proper amount of resources are being allocated to the appropriate areas to support the overall goals of NEQCA as a high quality, lower cost network achieving the Triple Aim. Overall, NEQCA calculates their overhead rate as well as their overall return on investment of the network annually. This ROI metric is communicated to the network annually and is used as a guiding light for the organization.

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

Given NEQCA's unique fit in the marketplace as a primarily non employed, affiliated, physician network, there are very few, if any, comparable organizations by which to benchmark. With the large academic employed practice in our network, The Tufts Medical Center Physicians Organization, they use UHC's (United Health Consortium) FPSC (Family Practice Solutions Center) benchmarking, Sullivan and Cotter's benchmarking data, and MGMA's (Medical Group Management Association) benchmarking data. Each one of these organizations provides both compensation metrics, revenue analytic metrics, and operational cost benchmarks that can be used to measure an organization's performance

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

Internal and external reporting has been developed to track performance to the many metrics discussed in section 5.a. NEQCA reports out on these various network wide cost metrics on a monthly basis to management. The "efficient use of resources" metrics and various ROI metrics associated with the population health programs at the network level are reported out monthly to management and quarterly to the NEQCA Finance Committee, which is a sub-committee to the NEQCA Board of Directors.

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:
NEQCA is not a health care provider and is not in a position to provide cost information to patients.

NEQCA is not a health care provider and is not in a position to provide cost information to patients. However, NEQCA intends on engaging with its affiliated physicians to assist the physicians with compliance with cost transparency requirements.

NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

Exhibit C
Office of Attorney General Questions for Written Testimony

1. For each year 2009 to present, please submit a summary table showing your operating margin for each of the following three categories, and the percentage each category represents of your total business: (a) commercial business, (b) government business, and (c) all other business.
Include in your response a list of the carriers or programs included in each of these three margins, and explain and submit supporting documents that show whether and how your revenue and margins are different for your HMO business, PPO business, or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

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

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

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

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

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

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

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

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

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

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

Summary:

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

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

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

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

4. Please describe and submit supporting documents regarding how, if at all, you track changes in the health status of your patient population or any population subgroups (e.g., subgroups by carrier, product, or geographic area).

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

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

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

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

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

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

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

7. Please describe and submit supporting documents regarding any programs you have that promote health and wellness (hereinafter "wellness programs") for (1) patients for whom you are the primary care provider; (2) patients for whom you are not the primary care provider; and (3) employees. Include in your response the results of any analyses you have conducted regarding the cost benefit of such wellness programs.

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

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

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

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