Submitted Electronically via HPC-Testimony@state.ma.us

September 8, 2014

Dear Ms. Johnson:

Enclosed you will find written testimony for Partners HealthCare as requested for the upcoming cost trend hearings. Please note that since Massachusetts General Hospital, Brigham and Women's Hospital, and McLean Hospital are affiliates of Partners HealthCare System, their responses are identical to the responses submitted by Partners HealthCare. However, where appropriate, hospital-specific data tables are provided.

By my signature below, I certify that I am legally authorized and empowered to represent Partners HealthCare for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please direct any follow-up questions to Aimee Golbitz, Office of Government Affairs at Partners HealthCare (agolbitz@partners.org 617-823-3997).

Sincerely,

Gary L. Gottlieb, MD, MBA
President and CEO

Exhibit A: Notice of Public Hearing

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

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

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

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but if necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

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

If you have any other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

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%.
   SUMMARY: See responses below.
   a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

      See PHS Attachment 1.

   b. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?
      Partners is deploying a multi-faceted strategy to address health care cost trend that includes creation of a sustainable financing mechanism, new incentive structures, a high risk care management program, integrated mental health services, tools for specialist engagement, a post acute strategy, fostering patient engagement, and new technologies. Within primary care, we have funded efforts to certify all 236 practices as Patient Centered Medical Homes (additional information in section 12).

      We continue our efforts in complex high risk care management. Partners has hired 80 nurse care managers, 16 social workers, 3 pharmacists, and 8 community resource specialists who are now managing nearly 10,000 high risk patients. We have initiatied a number of programs around specialist engagement, patient engagement and post acute care which we discuss below.

   c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

      In addition to our committment to transforming primary care through patient centered medical home and high risk care management efforts, we are now implementing a behavioral health integration program in primary care. The Behavioral Health Integration initiative seeks to support primary care practices and will include training, enhanced screening, central support for patients, and embedded resources in primary care practices to implement collaborative care models. We are also continuing our work in engaging specialists through increased virtual visit and electronic referral management systems. These

programs are designed to provide alternatives to traditional encounter based visits for specialist care. Finally, we have entered into a consent agreement with the Massachusetts' Attorney Genera that places a 3.6% ceiling on our Total Medical Expense growth.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

While Partners is committed and will continue to make progress in reducing the growth in health care costs, it does so in the face of serious challenges. Removing these challenges would greatly speed the pace of progress towards lowering health care costs. These challenges include:

- Ability to pursue new partnerships with community hospitals and community physicians
- Reimbursement models with non-aligned incentives (e.g., global budgets based on underlying fee for service payments; and services such as nurse care managers not adequately reimbursed)
- Public payer shortfalls
- Duplicative reporting requirements
- Complex billing policies
- Lack of access to real-time patient claims data
- Labor costs
- Heightened demand for high-cost technology and interventions
- Pricing of new treatments by the pharmaceutical industry (ie – Sovaldi for Hepatitis C)

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. SUMMARY: See responses below.
   a. How have alternative payment methods (APMs) (payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns, and operations? APMs have further supported our integrated care delivery model. In our attempts to promote the best possible care for all our patients and at the same time meet the demands of multiple external contract requirements including APMs, we have

created an internal performance framework (IPF) that uses a single set of performance targets and a single incentive pool for all of our contracts. The IPF rewards member institutions for 1) adopting programmatic initiatives, 2) meeting external quality measure targets, and 3) limiting the growth of medical expense trend.

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g., administrative expenses, resources and burdens).

   We have not conducted any analyses specifically related to the impact of APMs on non-clinical operations.

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid for under APMs and for your overall patient population.

   Because of the evolving health care market and secondary effects of programs implemented, no estimation can precisely predict the program cost or TME reduction at the population level. In building models, we are consulting pilot program data, academic literature, and input from institutional administrators, subject-matter experts, and business analysts to make structured, evidence-based estimations. Our initial analyses demonstrate positive net savings, however our modelling efforts are not yet complete.

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3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.
   SUMMARY: Partners has been a long supporter in the use of health status as a measure in the change of member acuity. Currently we are using the concurrent Verisk DxCG models for use in commercial risk contracts. While we have read and observed some of the limitations of these models they are still the industry leaders in measuring the acuity changes in a population. Partners currently participates in global risk contracts as a form of APM, if different APMs (i.e. bundled payments) are introduced to the market we would evaluate the need and practicality of risk adjustment on a case by case basis.

   a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g., pediatric) or those with behavioral health conditions?

      Partners does not support the use of standard Health Status models to measure the acuity of subpopulations. Similar to how an insurance company bears risk, a diverse mix of members and providers are necessary to limit the inherent random variation in health status and member expenses. Some companies have the ability to create models tailored to subpopulations that would need to be implemented for use on subpopulations.

b. How do the health status risk adjustment measures used by different payers compare?

For commercial payers Partners is using concurrent model published by Verisk DxCG, although the version numbers and underlying settings do differ by payer. Generally our trend target with the payer is either set in advance of the performance year or is a comparison to the payer's network trend over the same time period. If the trend target is set in advance we believe it is best to use a health status measurement that measures our own year to year change in health status. If the trend target is a comparison to the payer's network we believe it is appropriate to compare our change in health status to the payer's network change in health status.

c. How does the interaction between risk adjustment measures and other risk contract elements (e.g., risk share, availability of quality or performance-based incentives) affect your organization?

As stated above, Partners is a strong supporter in the use of health status for risk adjustment in our risk contracts and we view it as a critical element with any agreement. Each payer implementing health status models has had a different approach to its use and application. Based on Partners assessment of the payers' approach, we would adjust our level of risk share, maximum risk exposure, and setting of the trend target. A uniform approach among payers would help providers manage global risk contracts and avoid any unforeseen issues.

4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population-level data that would be helpful for population health management and/or financial modeling.

SUMMARY: See response below.

ANSWER:

With respect to real time data, providers will greatly benefit from the flow of data on the health information exchange (Mass HIway). Data such as admission, discharge and transfer information sent to providers in a timely fashion via an HIE can help clinical teams improve care coordination.

With respect to historic data,we were hoping that the state's All Payer Claims Data Base would be a source of more timely information for us to use in managing our population. To date the database is not sufficiently complete or robust for that purpose. We believe continued focus on developing that tool will be welcomed by providers across the Commonwealth and prove to be an essential tool in meeting the goals of 224.

5. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.

SUMMARY: See responses below.

a. Which attribution methodologies most accurately account for patients you care for?

   Patient choice should be considered the gold-standard for patient attribution. Though claims data plays an important role, provider data should play a critical role in validating claims based algorithms. The absence of provider data (e.g. billing, electronic medical records) suggest that there may not be a relationship between the patient and the provider organization. Additionally, as providers move to non-billable services to better coordinate care, provider data will be necessary to demonstrate an ongoing relationship with the patient. Attribution methods should align populations to providers at the beginning of each performance year, allowing the organization to enroll aligned patients into medical management programs.

b. What suggestions does your organization have for how best to formulate and implement attribution methodologies, especially those used for payment?

   There is a benefit to having a common approach to patient attribution. Payers and providers are best positioned to develop these algorithms based on their operational knowledge of health care delivery. These algorithms should build upon evidence from academic literature and current programs such as the Medicare Pioneer ACO. Operational considerations for how patients articulate their primary care clinician choice to payers will need to be defined by payers and providers (especially for PPO products), but should be a priority. Additionally, in order to create accurate attribution algorithms, payers should develop systems to accurately identify physicians and organizations through National Provider Identification (NPI) and Tax Identification Number (TIN).

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6. Please discuss the level of effort required to report required quality measures to public and private payers, the extent to which quality measures vary across payers, and the resulting impact(s) on your organization.

   SUMMARY:

   Partners monitors, reports and endeavors to improve many quality measures reported to public and private payers. The burden of reporting is significant due to the quantity of metrics, the variation among payer specifications and regulatory agencies, and the data sources required. Partners works to align payer measures of quality yet considerable variation remains given the breadth of patients we serve.

   ANSWER:

   Centrally, Partners staff monitor the performance of more than 200 measures, share best practices for quality improvement, shape the development and adoption of meaningful measures and comparative benchmarks, and evaluate and negotiate payer proposals. Partners staff serve as the primary body responsible for chart reviews, claims analysis and reporting performance to payers on behalf of physicians. While Partners manages a majority of the ambulatory quality reporting work centrally (and needs to staff for this work) physician practices are also called upon to supply additional data and reporting to payers, which creates a local burden.

For Partners hospitals, the greatest level of effort to report quality measures resides at their institutional level. Each hospital employs a staff of experienced nurses, quality measurement analysts and managers to manually abstract, check, report and monitor data elements on a monthly and quarterly basis. This can require chart reviews of 12,000 and 14,000 patient records at Brigham and Women's and Mass General, respectively, for Centers for Medicare and Medicaid and MassHealth programs alone. Variations among Partners hospitals in resources to support the reporting and improvement initiatives associated with quality measures, coupled with the mandatory nature of this work, compete with other priorities that may have a greater impact on improving the quality and value of patient care.
In the future, Partners new electronic health record systems may obviate the need for some chart reviews. We will leverage this new system to streamline reporting and improve the quality of data beyond that available from claims.

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7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.
SUMMARY: See responses below.
    a. Please attach any analyses you have conducted on inpatient utilization trends and the flow of your patients to AMCs or other higher cost care settings.

        Partners Business Planning conducts biannual analyses volume trends, with a focus on inpatient utilization and shift of care to lower cost observation or outpatient care. See most recent report attached that demonstrates a decline in inpatient volume, especially patients from Massachusetts, and an increase in inpatient case mix index (CMI) as higher acuity cases remain as inpatient, and lower acuity shift to observation.

        Additionally, the Population Health Management Performance Oversight Committee monitors inpatient admission per 1000s and has demonstrated that admissions per 1000 risk lives has decreased in 2014 compared to prior year (ranging from 6% to 26% depending on population and month of admission). (See PHS Attachment 2.)

    b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of these efforts.

        Partners academic medical centers have worked with owned and affiliated community hospitals and ambulatory centers to strengthen local services so that patients could receive care in the community with some or all related services at community rates. Examples include: cancer programs at South Shore, Netwon Wellesley, Milford Hospital, North Shore at Danvers, and Emerson. Brigham and Women's has moved numerous services and volume from their main campus to Faulkner. The plan submitted to HPC for Hallmark/Lawrence Memorial's

conversion to a short stay ambulatory facility operated by the Mass General is an example of plans to move secondary care from Mass General to a community site. Similarly, plans for converting the cancer program at Hallmark under the Mass General license assume transfer of significant business from Mass General to Hallmark at community rates. Finally, we plan to make a significant committment to the development of community based mental health services as part of our restructuring of Union Hospital.

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8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.
   SUMMARY: Partners and its post-acute delivery system, Partners Continuing Care, are leaders in providing high-value care across the continuum, providing direct care at every level of post-acute care (PAC) and collaborating with additional high-quality providers, ensuring optimal matching of patient needs to services.
   a. Please describe and attach any analyses your organization has conducted regarding levels of and variation in the utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high-value setting.
      Through: a) normal hospital operations, b) Pioneer ACO and population health operations; and c) evaluations of bundled payment opportunities, multiple examinations of post-acute variation have been undertaken and are underway. These include variation between Partners hospitals, within/across hospital service lines, our ACO performance versus other ACOs, and our network PAC providers versus non-network providers. Of note, such analyses are rife with challenges, including adequate risk-adjustment that require variables (such as function, cognition, social supports, etc.), which are not typically available in administrative data sets. Further, this population is quite heterogeneous – with varied care needs over varied time periods (e.g. "30 day episodic" view versus lifetime care need/independence measures) for which a one-sized fits all solution is particularly problematic. (See also response to 8b.)
   b. How does your organization ensure optimal use of post-acute care?
      Ensuring optimal post-acute care requires four key steps: 1) assessing patients' needs; 2) having access to high-quality post-acute care services (both understanding quality and partnering with those providers); 3) matching services to those needs; and 4) ensuring a safe transition upon hospital discharge and across the continuum. Multiple efforts are underway across Partners at each step, including innovative assessment tools, unique quality-based collaborations with PAC providers, multiple discharge transition tools, and myriad care redesign efforts to improve care transitions and enhance post-discharge care coordination.

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9. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions,

procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY: See table and response below.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1		151	
	Q2		133	
	Q3		105	
	TOTAL:		389	

** Please indicate the unit of time reported.*

ANSWER: Partners has implemented a patient price estimate process for its hospitals. The current process is largely manual and includes an electronic patient intake form, worksheets for calculating the estimate, and key point of contacts to help address any questions. In the future, the process will be more automated as our new IT system will provide the capability to generate and track these estimates for patients. We will also be exploring the option of receiving these inquiries via a centralized website. We make every effort to provide the estimates within the 48 hour timeframe.

Partners does not systematically track the number of inquiries across all its entities, however in the table above we provide our best estimate of the number of inquiries for inpatient services through the end of August 2014 at Brigham and Women's, Mass General, Newton Wellesley, and North Shore Medical Center. Similarly, we have not performed an analysis across the system of the top inpatient procedures. However, preliminary reviews indicate that labor and delivery, joint replacements, and gastric bypass are common inpatient procedures for which price estimates are requested.

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10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization taken (e.g., pricing changes) in response to tier placement and any impacts on volume you have experienced based on tier placement.
SUMMARY:
It is very difficult to analyze the specific impact of these product design mechanisms though we are very interested in doing so. Where our providers are excluded from a limited network product, by definition there is no experience to analyze other than emergency services. Tiering is most often accomplished as a design variation within a product or product category, at a level that we do not capture reliably at patient registration. So we aren't able to break out utilization patterns for patients with tiered

incentives relative to others. However, we have conducted some preliminary analysis, which we discuss below. We believe we need to maintain continued focus on value, cost and quality to address what we understand to be increasing cost concerns by consumers, regardless of changes that may occur to their benefit designs.

ANSWER:

Attached (PHS Attachment 3) is a summary of an analysis related to tiered and limited network product offerings that we conducted in early 2014: a volume analysis that includes a hypothesis that limited or tiered networks may have influenced referral declines. [Note that we did not have any specific data that definitively identified patients in such products to establish a causal relationship.]

As the attached summary shows, there has been a recent decline in HMO membership over time. What may have driven that decline is: (1) increase in the number of lives covered by tiered and limited network products, (2) at-risk providers changing their referral patterns, and 3) patient choice. Anecdotal evidence suggests that patients are responding to differential financial incentives and talking to their doctors about referrals.

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11. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

    SUMMARY: See responses below.

    a. Please describe ways that your organization is collaborating with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.

       Partners has implemented the Integrated Care Management Program (iCMP) within all of its primary care practices. The program addresses improved care coordination and management of individuals with medically chronic, complex and co-occurring behavioral health (BH) conditions. The program uses a team approach whereby BH/medical care managers, primary care, BH providers, other health professionals and patients collaborate in developing a coordinated treatment plan. This model of care necessitates enhanced and strengthened relationships with community-based programs including both hospitals and physicians. The collaboration between Partners and Neighborhood Health Plan (NHP) also allows for adaptation of iCMP to manage high cost/risk Medicaid patients. These interventions address the psycho-social determinants of healthcare.

    b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

       iCMP - This program provides supports for patient health within their communities. Care managers provide timely transitions with essential clinical

information. Community health workers and patient navigators provide case management to support patient adherence with care plans and medication.

Access - Partners has enhanced access to primary care and urgent BH care to divert individuals from unnecessary high cost services. Partners has increased access to suboxone clinics for opiate addiction. Pilots, which assist primary care with identifying and treating patients with depression, use early detection, increased access and treatment compliance to mitigate emergency department/inpatient visits.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

Many of Partners successes derive from the iCMP. It includes centralized information technology systems to provide notification of admissions, discharges and emergency department visits, care management tools (patient registries) to identify and allocate resources for patients, and BH case managers. Partners has also entered into alternative payment model contracts payers to support care management, new technologies, quality and cost efficiency.

Key challenges include changing the culture around treating BH, new technologies (design, payment), and operational support (staffing, training, work flow). We are overcoming these challenges by developing primary care physician champions, additional training, creating clinical incentives, and providing financial/clinical resources.

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

Assuming all providers would be required to provide similar information, Partners would be willing to provide more detailed discharge data. However, before creating additional reporting burdens, there should be a clear understanding on the use of such data and whether or not existing data sources could suffice e.g., the all payers claims database. In developing such a system, it is important to note there is considerable variation in the resources available to support the reporting and improvement initiatives at the local level. Also, every effort should be made to ensure that commercial payers and regulatory agencies streamline data collection efforts to avoid reporting different measures in the same content area to different payers/agencies.

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12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

SUMMARY: Partners has developed multi-year milestones specific to PCMH with a final goal of having all our primary care practices National Committee for Quality Assurance (NCQA) recognized by the end of 2018. To help our primary care network succeed, we have created an

internal framework for practices to begin familiarizing themselves with the key elements of a medical home. In addition, we have created a robust program to assist practices in applying for PCMH recognition through NCQA. The journey towards becoming a patient-centered medical home requires leadership engagement and a commitment from all practice staff. Achieving PCMH recognition can be a large undertaking for a practice and dedicated time should be set aside for implementation.

e. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited as PCMHs by one or more national organizations?
   Partners has a network of 236 primary care practices. Of those 236, 5 practices have met NCQA Level 3 recognition equating to 2% of the total network. Although only 2% of practices are at the highest level of NCQA certification, over 60% of our practices have reached "primed status" meaning they are ready to begin the certification process and nearly 100% of practices are at least half way to achieving primed status.
f. What percentage of your organization's primary care patients receives care from those PCPs or other providers?
   Roughly 3% of our primary care patients receives care from these physicians.
g. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.
   While we have reviewed performance for primary care practices who have begun implementing elements of a patient-centered medical home, we have not yet conducted analyses on the impact any level of PCMH recognition has on quality outcomes and cost of care.

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13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
    SUMMARY: No additional comments.
    ANSWER: No additional comments.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for providers. To the extent that a provider system submitting pre-filed testimony responses is affiliated with a hospital also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing for each year 2010 to 2013 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 Provider 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.

   Completed in Attachment AGO Provider Exhibit 1

   See PHS Attachment 4

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2. Please explain and submit supporting documents that show how you quantify, analyze and project your ability to manage risk under your risk contracts, including the per member per month costs associated with bearing risk (e.g., costs for human resources, reserves, stop-loss coverage), solvency standards, and projections and plans for deficit scenarios. Include in your response any analysis of whether you consider the risk you bear to be significant.

Partners uses two major sources of data to analyze performance in its risk contracts and project risk. Partners receives claims data from the payers, and has the ability to extract clinical data from our electronic health records. Partners uses one or both of these sources to produce reports that approximate its year-end performance in its risk contracts. Reports are produced monthly, and a final settlement report is produced at the end of the contract year. In addition, Partners may rely on interim reporting from the payers.

Partners uses its quarter-end reports to determine whether the network is in a surplus or deficit, and books reserves at its entities to cover any projected losses. A cash retention on physician billing is taken by the payer for some of Partners network participants, which is then returned to Partners Community Healthcare, Inc. (PCHI). PCHI holds a portion of this cash until it is determined that any external losses are covered.

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3. Please explain and submit supporting documents that show the process by which (a) your physicians refer patients to providers within your provider organization and outside of your provider organization; and (b) your physicians receive referrals from within your

provider organization and outside of your provider organization. Please include a description of how you use your electronic health record and care management systems to make or receive referrals, any technical barriers to making or receiving referrals, and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization.

Although Partners does not have one referral management process for the entire system, Mass General and Brigham and Women's have each implemented local referral management systems.

Overall purpose of the two referral management systems are to increase clinical integration, improve access by allowing better triage of patients to the right doc, and reduce TME by avoiding unnecessary referrals and diagnostic tests.

Mass General implemented their system in 2011 with over 350,000 referrals processed, and Brigham and Women's began in 2014 with just over 20,000 processed. Both systems are tied to the electronic health record and managed centrally. Mass General system is also tied to scheduling system.

In addition to facilitating the referral between PCPs and specialists, the referral systems at Mass General and Brigham and Women's allow specialists to communicate with each other. MGH is also able to capture external referrals with their system.

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4. Please explain and submit supporting documents that describe how, if at all, information on cost and quality is made available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care. Include in your response any type of information on costs or quality made available to your physicians through electronic health management, care management, disease management, large case-management or other clinical management programs.

At this time, no cost or quality information is made available to physicians at the point of referral.

Acute Hospitals Only (MGH, BWH, BWFH, NSMC, NWH)
Does not include MD data or DFCI patients
Data is Fiscal Year based
FY2010 - 2013 (Oct - Sept) is based on reconciled data, FY14 Q2 (Oct - Mar) is based on live data

Fiscal Year	Cases	Net Patient Service Revenue	Total Costs
2010	4,513,012	$ 4,411,415,783	$ 4,124,969,576
2011	4,531,087	$ 4,604,932,221	$ 4,308,265,816
2012	4,681,752	$ 4,852,042,986	$ 4,532,245,849
2013	4,643,990	$ 5,011,057,203	$ 4,722,569,695
2014 Q2	2,277,586	$ 2,521,776,095	$ 2,351,389,889

Financial Definitions
Net Patient Service Revenue = Contracted Payer Net Revenue - Free Care - Bad Debt - Denial - HSN Assessment +
Total Costs = Direct + Indirect

· HSN Receipts

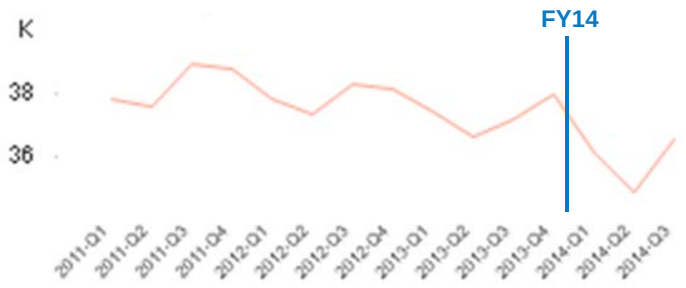
PHS Acute inpatient volume continues to decline in FY14 (through Q3) while observation growth has flattened

FY13YTD-FY14YTD

PHS Acute Inpatient -3%

PHS Acute Observation[1] 0%

Inpatient volume decline has accelerated in FY14YTD



	Total Cases	% Total	% Δ
Inpatient	107,700	81.5%	-3.2%
Observation	24,482	18.5%	-0.1%
Total	132,182	100.0%	-2.5%

- From FY10 to FY13, PHS combined observation and inpatient grew +3%; However, PHS observation and inpatient volume declined in FY14YTD (-3%), outpacing market decline of -1% as reported in Area Hospital Survey
  - PHS observation volume as share of combined inpatient and observation stabilized at 18.5% in FY14YTD while the market continued to see a growth in observation cases (+9%), reaching 22% of combined Inpatient + Observation
- PHS inpatient declined less than overall market decline (-3% compared to -4%)
  - Inpatient volume decline was driven by NSMC and BWH (-9% and -8%) and offset by BWFH, NWH and MGH (+3%, +2% and +1% respectively)
  - Largest percentage inpatient decline seen in gynecology, NICU, urology and Addiction Recovery
- As was seen previously, inpatient discharge days declined slightly (-1%) while CMI grew (+2%)
- Outpatient volume was flat (-0.6%), compared to +3% growth seen from FY11 to FY13

1) Source: Healthcare Directions, August 21, 2014 and Area Hospital Survey FY14Q3
2) FY13YTD and FY14YTD include fiscal quarters 1-3
3) Observation volume in Area Hospital Survey does not match Healthcare Directions due to definitional differences. For example, using PHS observation definition FY14 % observation is 18.5%, however, PHS data submitted to the Area Hospital Survey reflects observation as 20% of total observation and inpatient.

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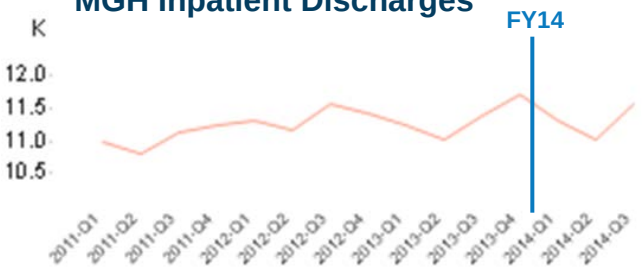
While in total inpatient volume declined, MGH, BWFH and NWH volume increased. Decline seen in both MA and regionally.

FY13YTD-FY14YTD	IP
MA volume	-3%
Other NE & NY volume	-2%

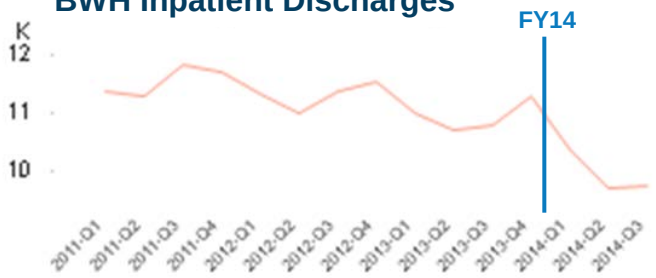
MA Inpatient volume decline has accelerated in FY14 YTD

MGH Inpatient Discharges



MGH inpatient volume increased (+0.7%, +244 cases) with a slight decline in CMI (-0.5%). Patient days also increased slight (+0.5%). Growth was seen in medical and other non-surgical cases. Surgical discharges declined by -5%.

BWH Inpatient Discharges



BWH inpatient volume decline is driven in part by shift of cases to BWFH. In FY14YTD, BWFH has seen inpatient growth of 103 cases compared to BWH inpatient decline of 2,621 cases. Surgical cases saw the slowest decline at -3.2%, relative to the overall decline of -8.1%.

Other NE & NY Inpatient volume started to decline in FY14 YTD

	Current Cases	% of Total (IP)	Base Cases	Abs Δ	% Δ	CMI	% Δ
Surgical Discharges	4,498	54.4%	4,759	-261	-5.5%	5.77	3.5%
Other IP Discharges	709	8.6%	737	-28	-3.8%	1.44	4.7%
Medical Discharges	3,063	37.0%	2,938	125	4.3%	2.23	2.6%
Totals	8,270	100.0%	8,434	-164	-1.9%	4.09	1.6%

Surgical discharges declined by -5.5% while medical discharges grew 4.3%.

- While MA inpatient volume declined -3% from FY10 to FY13, decline has accelerated to -3% in the first 9 months of FY14 alone
- From FY10 to FY13, other NE & NY inpatient volume grew +11%. About half of this growth occurred between FY10 to FY11. In FY14YTD, NE & NY inpatient volume has started to decline
- MA volume decline is spread across service types while other NE & NY inpatient decline is concentrated in surgical discharges
- CMI has grown by ~2% in both geographies

1) Source: Healthcare Directions, August 21, 2014
2) FY13YTD and FY14YTD include fiscal quarters 1-3

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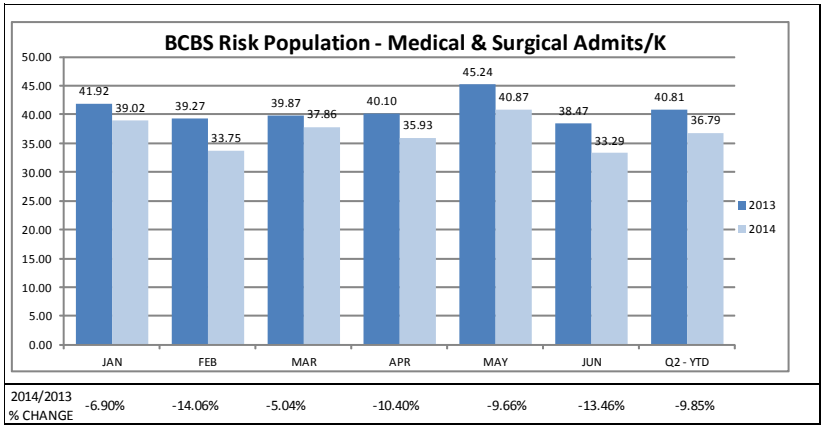
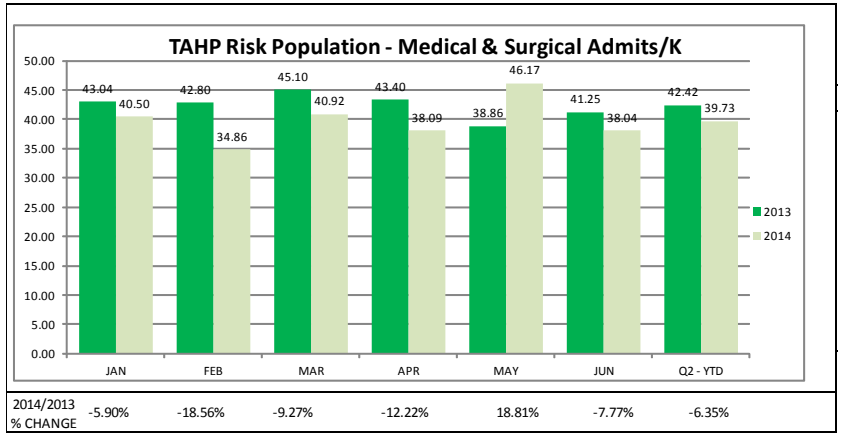
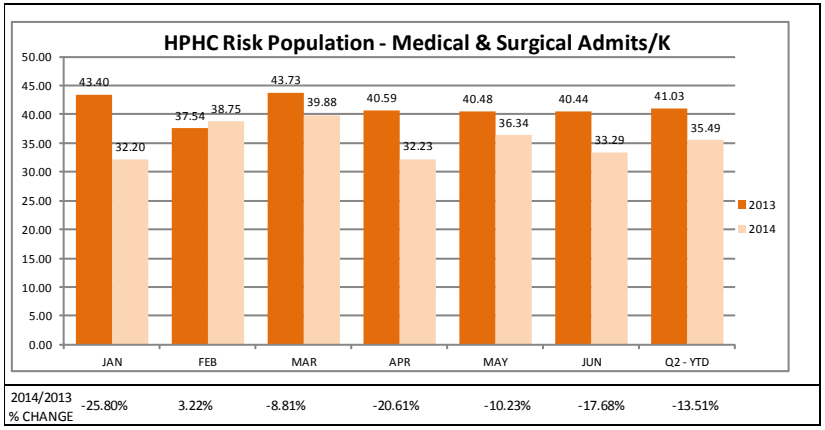
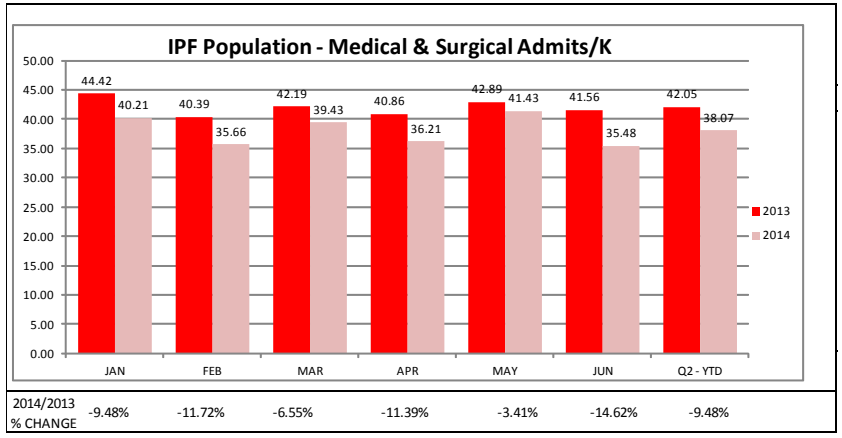
Q1 2014 Performance Update Performance Oversight Committee
Q2 2014 Discharges





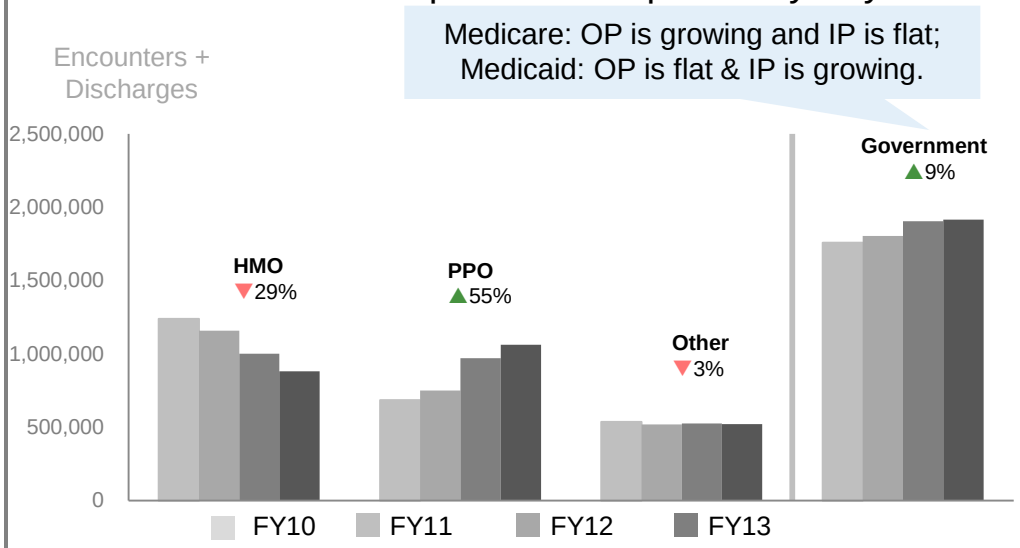


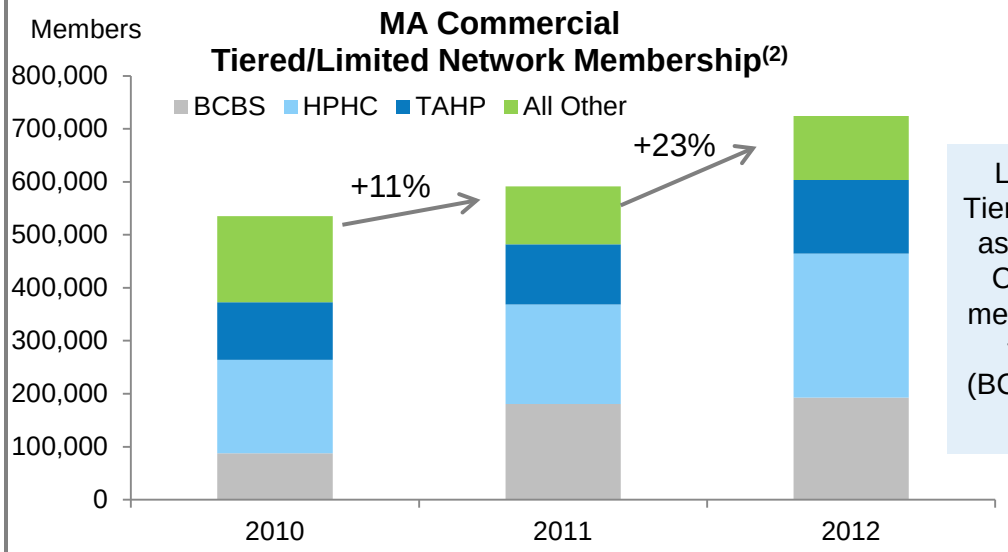


- We are monitoring real time discharges as a proxy for paid claims activity.
- 2014 Med/Surg Discharges/ K are still consistently lower than prior year.

PHS Acute payer mix shift away from commercial; HMO in particular; trend expected to continue

PHS Combined Inpatient & Outpatient by Payer[1]





Limited and Tiered members as % of total 3 Commercial members range from 13% (BCBS) to 44% (HPHC)

- PHS Big 3 HMO has declined -29% across inpatient and outpatient from FY10-FY13
  - Similar degree of Big 3 HMO decline for both inpatient and outpatient, AMC & CHs
  - Decline appears greater than MA HMO membership decline
- Shift may be indicative of increased patient price sensitivity and changes in benefit design
- Increased employer offering and adoption of alternate insurance products; consumer adoption is slower

Increase in transparency will allow patients to shop for "value"

1) PHS Business Planning, AADW Dec 2013
2) PSC Market Data Sharepoint site; compilation of publically reported data (e.g. AG cost hearings)

Exhibit 1 AGO Questions to Providers

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. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services
6. **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.
7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
8. **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.
9. **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.
10. **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.
11. **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 PHS

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$424,587,594		$45,524,517								$376,570,265	$853,613,773	$5,069,549		
Tufts Health Plan	$132,005,692		$10,031,058								$107,092,961	$126,731,169	$587,192		
Harvard Pilgrim Health Care	$160,881,819		$14,346,350								$212,917,102	$131,957,314	$960,341		
Fallon Community Health Plan											$27,816,654				
CIGNA											$90,848,918	$5,067,830			
United Healthcare												$166,625,061			
Aetna											$147,099,956	$27,475,035			
Other Commercial												$379,659,488			
Total Commercial	$717,475,105		$69,901,925								$962,345,856	$1,691,129,670	$6,617,082		
Network Health											$66,400,014				
Neighborhood Health Plan											$74,542,660				
BMC HealthNet, Inc.											$5,644,049				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											$146,586,724				
MassHealth											$222,623,839				
Tufts Medicare Preferred											$77,976,194				
Blue Cross Senior Options											$13,601,229				
Other Comm Medicare											$39,152,937	$20,061,773			
Commercial Medicare Subtotal											$130,730,360	$20,061,773			
Medicare [1]												$1,151,785,973			
Other [1]												$303,650,459			
GRAND TOTAL	$717,475,105		$69,901,925								$1,462,286,779	$3,166,627,875	$6,617,082		

Notes:
Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment
Other Commercial Primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS , One Health, and other smaller payers.
The HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate
Data include MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS
Payer line information for McLean, Spaulding Network, MVH, and NCH is not available. They represent ~8% of total PHS NPSR
1. Medicare and Other Revenue are neither HMO or PPO

2011 PHS

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$448,222,202		$47,484,701								$324,274,556	$904,357,168	$4,666,282		
Tufts Health Plan	$137,265,405		$12,654,603								$95,841,251	$157,028,743	$494,044		
Harvard Pilgrim Health Care	$166,641,127		$16,406,473								$209,722,136	$172,658,417	$829,071		
Fallon Community Health Plan											$28,871,969				
CIGNA											$100,447,066	$5,599,138			
United Healthcare												$198,209,821			
Aetna											$162,537,571	$26,080,761			
Other Commercial												$391,240,739			
Total Commercial	$752,128,734		$76,545,777								$921,694,548	$1,855,174,788	$5,989,397		
Network Health											$81,656,996				
Neighborhood Health Plan											85858079.48				
BMC HealthNet, Inc.											$7,968,874				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											$175,483,950				
MassHealth											$199,845,348				
Tufts Medicare Preferred											$72,681,425				
Blue Cross Senior Options											$13,810,081				
Other Comm Medicare											$18,656,837	$28,252,545			
Commercial Medicare Subtotal											$105,148,343	$28,252,545			
Medicare [1]												$1,249,747,510			
Other [1]												$306,176,033			
GRAND TOTAL	$752,128,734		$76,545,777								$1,402,172,190	$3,439,350,876	$5,989,397		

Notes:
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2012 PHS

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$112,234,564		$11,692,162		$271,941,278		$2,628,689		2012 not yet settled		$293,675,254	$1,105,698,770	$2,877,349		
Tufts Health Plan	$34,219,763		$3,260,239		$72,482,229		($282,009)		2012 not yet settled		$123,614,701	$196,279,371	$433,286		
Harvard Pilgrim Health Care	$41,581,138		$4,180,762		$81,938,348		$793,187		2012 not yet settled		$281,712,620	$208,038,009	$762,045		
Fallon Community Health Plan											$31,242,463				
CIGNA											$129,114,275	$3,787,321			
United Healthcare												$211,465,271			
Aetna											$182,104,609	$27,371,434			
Other Commercial												$398,111,271			
Total Commercial	$188,035,465		$19,133,163		$426,361,856		$3,139,867				$1,041,463,922	$2,150,751,446	$4,072,681		
Network Health											$57,770,940				
Neighborhood Health Plan											$78,559,128				
BMC HealthNet, Inc.											$5,502,614				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											$141,832,681				
MassHealth											$213,448,418				
Tufts Medicare Preferred											$79,455,133				
Blue Cross Senior Options											$16,371,342				
Other Comm Medicare											$11,364,546	$32,282,718			
Commercial Medicare Subtotal											$107,191,021	$32,282,718			
Medicare[1]						$184,943,252		$5,151,516				$1,178,117,914			
Other[1]												$343,698,882			
GRAND TOTAL	$188,035,465		$19,133,163		$426,361,856	$184,943,252	$3,139,867	$5,151,516			$1,503,936,042	$3,704,850,960	$4,072,681		

Notes:
Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment
Other Commercial Primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS , One Health, and other smaller payers.
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1. Medicare and Other Revenue are neither HMO or PPO

2013 PHS

	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue Arrangements		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					$314,782,238		2013 not yet settled		2013 not yet settled		$279,245,036	$1,198,443,341	$2,829,580		
Tufts Health Plan					$96,361,714		2013 not yet settled		2013 not yet settled		$143,816,708	$208,349,409	$420,418		
Harvard Pilgrim Health Care					$112,474,039		($674,482)		2013 not yet settled		$285,465,483	$227,804,378	$762,310		
Fallon Community Health Plan											$35,616,770				
CIGNA											$139,820,539	$5,349,354			
United Healthcare												$208,193,230			
Aetna											$195,703,317	$29,478,565			
Other Commercial												$411,871,573			
Total Commercial					$523,617,991		($674,482)				$1,079,667,854	$2,289,489,851	$4,012,308		
Network Health											$70,343,636				
Neighborhood Health Plan											$82,708,529				
BMC HealthNet, Inc											$11,000,595				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											$164,052,761				
MassHealth											$221,889,587				
Tufts Medicare Preferred											$77,146,761				
Blue Cross Senior Options											$18,921,067				
Other Comm Medicare											$15,416,472	$39,212,981			
Commercial Medicare Subtotal											$111,484,300	$39,212,981			
Medicare [1]						$274,084,307						$1,128,295,998			
Other [1]												$354,479,325			
GRAND TOTAL					$523,617,991	$274,084,307	($674,482)				$1,577,094,502	$3,811,478,154	$4,012,308		

Notes:
Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment
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Data include MGH, BWH, NSMC, NWH, BWFH, MGPO, BWPO, NSPG, NWAS, and PHS
Payer line information for McLean, Spaulding Network, MVH, and NCH is not available. They represent ~8% of total PHS NPSR
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