Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), 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 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 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 both days. 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 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 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 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, 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: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at 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 at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

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

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment 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 complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

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

The testimony must contain a statement 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.

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

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

09/09/2015

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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

    Although all health plan settlements are not final for 2014 we experienced a decline in surplus largely due to contractual changes in our health plan contracts. We anticipate this decline to continue.

    Based on early 2015 trends we are experiencing a large increase in the number of high cost patients (expenses >$50K in first quarter 2015) which is resulting in increased medical expenses. We are seeing this trend in both our Commercial and Medicare Advantage population. In addition we are experiencing an increase in pharmacy expenses in our risk contracts. Some drivers of rising pharmacy expenses include Hepatitis C treatments, compound drugs and cancer treatment drugs.

    MACIPA's operating costs have continued to increase over the past few years as a result of the additional infrastructure needed to support meeting the goals of our extensive and expanding risk contracts. We anticipate this trend to continue while we work with health plans on PPO risk contracts which will add a significant number of patients for quality and utilization management.

    The cost of patient care is rising faster than our contractual budgets/trends, which is limiting our surplus. This surplus is used to fund the infrastructure at MACIPA, supporting quality, utilization and care management. We are unable to expand programs to manage care and decrease costs given these financial constraints.

    In addition the cost of managing care to improve population health is increasing for our primary care practices. The surplus distributed by MACIPA supplements primary care practices fee-for-service revenue to support their internal infrastructures supporting quality contracts and patient care. We are concerned about our future ability to support our PCP's. Given the higher salaries of PCP's at the downtown tertiary facilities, the limited financial resources in the future, the viability of our PCP's in private practice is in question.

    b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

    We continue to provide programs to reduce the cost of patient services including complex care management provided by nurse care managers and social workers who deal with behavioral health issues, disease management, social work, pharmacy management, quality improvement, utilization management and referral management. We continue to manage, train and support the Electronic Health Record (EHR) for over 300 physicians. These programs will continue to contribute to controlling health care costs while improving quality of care and patient outcomes.

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

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

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

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

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

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

In April of 2014 we entered into an agreement with Inspiris Services Company-Optum to provide the following services to our Pioneer ACO Medicare Beneficiaries:

- The Transitions- Skilled Nursing Program provides direct patient care for patients accessing their 100 day skilled benefit in skilled nursing (SNF) settings from admission to discharge. The primary goal of this program is the avoidance of acute re-admissions, reduction of the length of stay and quality of clinical care.
- The Home Program provides in-home care and care coordination to participants who have multiple chronic conditions that increase avoidable inpatient admissions and emergency department use. Employed Nurse Practitioners make house calls to provide direct care to enrolled patients, and coordinate care with their family caregivers, PCP's, and other healthcare providers.

- The 30 Day Transitions Program provides continuity of care after an acute or skilled nursing facility admission. The Nurse Practitioner visits the patient in the residence to bring care during this critical move and reduce re-admission. The primary objective of the Transitions Program is the avoidance of acute re-admissions when a patient has returned to a home-based setting.

Beginning in June of 2015 we entered into an arrangement with Patient Ping which currently expands our knowledge of ACO SNF admissions. Patient Ping works with a network of SNF's that allows ACO's to be notified when an ACO aligned beneficiary is admitted to their facility. Prior to this implementation we only learned of SNF's admissions when a patient was discharged from Mount Auburn Hospital. This expansion allows for us to get real-time information when SNF admissions occur at a large number of facilities, allowing us to manage patient length of stay.

Social Work Department – We continue to have an established social work department. We have a team of a director, three social workers and four health coaches. A consultative model is used, and the social worker is the point of contact with the nurse case manager, who works with each of our primary physician Pods.

The social work team is knowledgeable on the various community support programs available which would benefit our patients. By aligning our efforts with the state-wide network of Aging Services Access Points (ASAPs), the patients benefit from various services at no cost to them. The philosophy of the program is to provide consumer directed care which supports providing the patient with options, helping the patient understand their options, all while respecting patient choice.

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

The Social Work Team has recently been involved with managing chronic disease patient outcomes. They are part of the "Systematic Case Review" team described below under Pharmacy Management. The Social Work Team has been tracking high risk patient's patient outcomes and is able to see the direct impact their services are having on patients.

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

Coordination of Data – MACIPA has worked hard to improve the quality of care provided to all patients by standardizing specific clinical care processes across our members' practices. We use both data systems and human resources to drive standardization. Recognizing the continued need to improve quality through population health management we use an interdisciplinary team including case managers, physicians, nurses and a pharmacist to review areas ripe for quality improvement.

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

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

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

We extract data from the EHR and combine it with claims data and other clinical data to produce reports that help to support the clinical work done by our physicians.

Pharmacy management – The IPA also has a pharmacy management program that combines three components: 1) education conducted by a pharmacist and a physician advisor to help doctors choose the most appropriate drugs for treating particular conditions; 2) polypharmacy review by the pharmacist to identify potentially unsafe drug combinations among patients taking eight or more drugs, as well as opportunities for generic substitution to reduce pharmacy costs and patient copayments; 3) a multidisciplinary team including an Endocrinologist, a Psychiatrist and a Pharmacist makes recommendations to our primary care physicians for management of patients with blood sugar, blood pressure and cholesterol levels out of control. MACIPA also utilizes a team of four health coaches, an endocrinologist, a pharmacist, and two alternating psychiatrists for its Systematic Case Review of patients with depression comorbid with diabetes, hypertension and CAD. This team employs creativity, critical thinking, problem solving, and team collaboration to develop the best solutions for this patient population.

The clinical pharmacist provides a MACIPA formulary annually to physicians and tracks the use of generic vs. brand name drugs. The result is lower cost of medications for MACIPA patients, their employers and health plans. Physicians are free to reject the recommendation of the clinical pharmacist in the exercise of their independent medical judgment.

c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

We plan on continuing the actions and efforts as outlined in Section B above and will continue to monitor our performance and identify additional areas of opportunity, as necessary.

Unfortunately, as noted in Section 1.A above the cost of patient care is rising faster than our contractual budgets/trends, which is limiting our surplus. This surplus is used to fund the infrastructure at MACIPA, supporting quality, utilization management and care management programs. We are unable to expand programs to manage care and decrease costs given these financial constraints. In addition the cost of managing care to improve the population health is increasing for our primary care practices. The surplus distributed by MACIPA supplements primary care practices fee-for-service revenue to support their internal infrastructures supporting quality contracts and patient care. We are concerned about our future abilities to support our PCP's. Given the higher salaries of PCP's at the downtown tertiary facilities, the limited financial resources in the future, the viability of our PCP's in private practice is in question.

We plan to continue working on additional alternative payment methods at the local and Federal level. We remain committed to Medicare alternative payment methodologies. We are currently a Pioneer ACO and have been since 2012. For the 2015 performance year, the Pioneer financial model has changed; early results show MACIPA going from being one of the top ACO providers to being in a potential deficit for the 2015 performance year. Despite this methodology change and potentially having to leave the Pioneer program in 2015 we are committed to Medicare alternative payment methods. We have applied to participate in the Next Generation Model which we feel will offer a more reasonable, stable financial model and are hopeful to begin participation in this model beginning in 2016.

On the commercial market, we continue to engage with health plans and expand our risk portfolio which will help the Commonwealth meet the benchmark. Beginning 2014 we entered into Integrated Risk Bearing Organization (IRBO) arrangements managing the Group Insurance Commission patient population and plan on continuing with GIC arrangements. Beginning in 2015 we have taken on an additional ~5,000 risk lives by expanding one of our risk deals to include self-insured patients and began managing expenses and quality for a PPO population.

We have also begun discussions with Blue Cross Blue Shield of Massachusetts to expand a model similar to the AQC for the PPO population. We anticipate reaching an agreement with BCBS no later than late September with a contract effective date of January 1, 2016. We look forward to being one of the first organizations' to engage in this PPO model with Blue Cross Blue Shield of Massachusetts.

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

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

One policy change we encourage is the Commonwealth reviewing the for-profit tax status of physician groups. In order for us to expand our book of alternative payment contracts we need to maintain strong reserves. As a for-profit organization we are currently required to pay Federal and State taxes on reserves. We would prefer to put this this money into helping the Commonwealth meet the cost benchmark.

Making the commitment to the Commonwealth for lowering medical expenses has had a significant impact on our surplus. This surplus is used to manage patient care, we fear that with lowering surpluses we will be unable to support the infrastructure that is resulting in significant savings to the Commonwealth.

We believe that the Commonwealth agencies could help us save on administrative costs. We currently receive overlapping requests from multiple agencies within the Commonwealth. Our analytic resources could be better spent identifying cost trends and using data to manage quality. A policy change that allows agencies share their data internally before issuing requests would save a lot of time and administrative dollars on the Organization's receiving such requests.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

The ability to have a full data set to manage patients is a barrier we face. With patients changing health plans and limited data available to Provider Organizations through the APCD we struggle to get the full patient picture. In addition data limitations impact risk scores with health plans and the ability for us to have a full patient risk profile for disease management.

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

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
    a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

        We have continued to focus on the four areas outlined above. We continually monitor appropriate LTAC usage shifting these services to Skilled Nursing Facilities when appropriate that are lower cost. As mentioned in Section B above we have Nurse Care Managers and Optum Nurse Practitioners at Skilled Nursing Facilities that focus on reducing average length of stay, when appropriate and post discharge planning. This post discharge planning includes organizing home visits from both SNF and acute discharges with the goal of preventing readmissions. We have experienced a decrease in our ACO SNF average length of stay and readmission rates since implementation of these programs.

        We continue to work with our PCP's and Specialists on patient access that assists in lower emergency department usage. Our PCP's and Specialists do an annual quality projects, many of these projects are focused on patient access.

        Also described in Section B above our Case Managers, Social Workers and Health Coaches provide services to high risk/high cost patients. Patients are identified through use of predictive modeling software, PCP referral and health plan recommendations.

    b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

        We plan on continuing the actions and efforts outlined in sections above and will continue to explore additional areas of opportunity, as necessary.

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
    a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

        Being an independent physician organization associated with a community hospital within an area surrounded by high cost Academic Medical Centers doesn't allow us to have sufficient market leverage to unduly influence its

commercial prices. We believe that there will always be price differentials in the Commonwealth due to market leverage. Price variability based on geography, teaching status within perspective and quality seem reasonable. For global budgets, variation based on severity of illness makes most sense.

b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

As we expand our risk portfolio the price variation within the Commonwealth is problematic. When we analyze our Commercial and Medicare services being provided outside of Mount Auburn Hospital and Cambridge Health Alliance, a large number of these services are being provided at local Academic Medical Centers. Since we are in close proximity to 2 of the major Partners facilities, they receive the majority of this business. In the current PPO model, although we can encourage staying within the local community we have little to no control of patients receiving services at these high cost facilities. We are very much committed to expanding our risk portfolio however price differential are a major concern being taken into consideration as we engage with local health plans on this venture.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 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.
   a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

   We have developed an internal behavior health and social work program (described in Section 1.B) and have incorporated these services within our PCP practices. Unfortunately due to poor access of behavioral health services in the community we have been unable to make an impact on the use of emergency room and psychiatric inpatient care services.

   MACIPA was one of eight partner organizations across the country who participated in the CMS CMMI funded COMPASS grant, administered by the Institute for Clinical Systems Improvement (ICSI), to create a collaborative team-based model in primary care. The goal of COMPASS is to help patients who struggle with the chronic diseases of diabetes and/or cardiovascular disease and the frequently accompanying depression. This program was insurance blind. MACIPA hired social work Health Coaches to work directly with patients to bring their disease values under control and reduce depression. Patient progress is reviewed in a team-based model (Systematic Case Review (SCR))

with an endocrinologist, a pharmacist and consulting psychiatrists who meet weekly for this purpose. This project has allowed MACIPA to take a meaningful step towards integration of behavioral health within primary care.

b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

As noted above we plan on continuing our internal physical and behavioral health care services made available in the PCP practices. Given the current behavioral health needs of the community, limiting access to services and growing operating expenses we are unable to invest more than we already have in these services.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

Over the last two years, MACIPA has undertaken a large initiative with a goal of having all of our primary care practices become recognized by NCQA as Patient-Centered Medical Homes (PCMH). MACIPA hired a full time PCMH facilitator in 2013 to help MACIPA practices undergo the PCMH transformation. The core principles of PCMH provide for a focus on patient and caregiver engagement, and shared decision making between patients and their physicians. Through this initiative, MACIPA physicians and support staff receive training which enhances their ability to work with patients and their families. The goal is to ensure patients and caregivers understand how to best care for themselves and take responsibility for their own care in conjunction with their physicians. MACIPA provides educational tools and training to both office staff and clinicians focusing on patient motivational training and improving the patient experience. MACIPA has developed patient educational materials which are incorporated into our EMR that offices can use to help patients manage their care. At this writing, eight of our primary care practices have current recognition from NCQA as Patient Centered Medical Homes, five are currently in the process of becoming recognized and four more practices are set to undergo recognition. Our goal is to have all of our primary care practices recognized by NCQA. MACIPA puts a high emphasis on coordination of care and care transitions. Many of MACIPA's physicians and practices share an EMR which enables coordination of care and care transitions between primary care and specialist physicians. Furthermore, MACIPA has partnered with Mount Auburn Hospital in care transitions work. Collaborating together, we redesigned discharge processes to use our integrated technology for improved accuracy of discharge medications. We have also standardized and coordinated the consistency and quality of discharge information used for transfers between hospital and home, and hospital to other provider sites. Key information such as medications and test results are available in real time to all providers at the time of transition. Ambulatory and inpatient electronic health records are linked through shared

access and a shared community record. MACIPA's physicians use the Care Plan module, an EHR functionality, which allows inclusion of a care plan at the point of care for patients identified as high-risk patients.

The PCMH initiative ensures that our physicians are trained to realize the importance of seamless transitions of care that is afforded by sharing access to our EMR. Beneficiaries have access to their medical records through an electronic patient portal within our EMR and to clinical knowledge from personalized patient care plans and materials given to them at the office visit from the EMR. MACIPA patients currently receive patient experience/satisfaction surveys from multiple sources including Massachusetts Health Quality Partners (MHQP) and from their individual physician offices.

MACIPA's goal is to become a certified Accountable Care Organization; we plan on meeting this goal by 2017. We believe that the work highlighted above will help us reach this goal.

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 provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1	0	0	N/A	N/A
	Q2	0	0	N/A	N/A
	Q3	0	0	N/A	N/A
	Q4	0	0	N/A	N/A
CY2015	Q1	0	0	N/A	N/A
	Q2	0	0	N/A	N/A

At the IPA we have received no patient inquires to provide this information. Patients direct these inquires to their PCP, Specialist or hospital that would be performing procedures. We have no data on any of those inquires.

2. Please submit a summary table showing for each year 2011 to 2014 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. 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.

AGO Provider Exhibit 1 includes claims based revenue, surplus/quality revenue and other revenue (e.g., management fees) for health plans that share data with MACIPA. As described in the notes section of each worksheet, claims-based revenue is not received by MACIPA, this is received by MACIPA physician practices. The figures included are those available at the time of this submission, we have not settled final 2014 year performance for some of the health plans noted. All figures are for Contract Year 2014, settlements occur in the following year.

3. Please explain and submit supporting documents that describe (a) the process by which your physicians make and receive patient referrals to/from providers within your provider organization and outside of your provider organization; (b) how you use your electronic health record and care management systems to make or receive referrals, including a description of 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; (c) how, if at all, you make cost and quality information available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care; and (d) whether your organization, in referring patients for services, ascertains the status in the patient's insurance network of the provider to whom you are referring the patient, and informs the patient if that provider is not in the patient's insurance network.

   We handle referral management by educating of our physicians about specialist expertise in our system. We monitor leakage on a quarterly basis with our PCPs. We have also monitored access to specialists and have worked with our specialist to improve access. We believe integration of nurse and social work case management as well as population health efforts have also helped to decrease leakage and has had the effect of directing more patients to Mount Auburn Hospital verses other hospitals. Due to these efforts we have seen an increase in the number of patients staying within MACIPA and Mount Auburn Hospital for specialty services.

   Our current electronic health records does not allow for our physicians to send or receive referrals. We look forward to integrating a new medical record beginning in 2017 that allows those capabilities. Our current medical record does allow for easy access to our partner hospital, Mount Auburn Hospital's health record and has physician to physician functionality that encourages MACIPA physicians to refer within our community of providers.

   MACIPA is not directly involved with managing practices use of cost information availability and insurance network patient education. We assume that patients are always referred within the network of their health plan.

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 reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
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.

2011

	P4P Contracts				Risk Contracts**						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue **(A)**		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	X	X	X	X	$14.45M	X	$10.26M	X	$5.35M	X	X	X	$2.62M	X	X
Tufts Health Plan	X	X	X	X	$4.63M	X	$3.65M	X	X	X	X	X	$0.74M	X	X
Harvard Pilgrim Health Care	X	X	X	X	$11.72M	X	$4.36M	X	X	X	X	X	$0.59M	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	$0.02M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$30.80M	X	$18.27M	X	$5.35M	X	X	X	$3.97M	X	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred **(B)**	X	X	X	X	$6.31M	X	$2.58M	X	$0.02M	X	X	X	$1.45M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	$0.04M	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$6.31M	X	$2.58M	X	$0.02M	X	X	X	$1.49M	X	X
Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$37.11M	X	$20.85M	X	$5.37M	X	X	X	$5.46M	X	X

Notes:

(a) Claims-Based Revenue: MACIPA does not bill or receive physician claims payments. Claims-based revenue are received by physicians/practices directly. The numbers provided are per claims data files received by MACIPA.
BCBS includes HMO and POS claims data
Tufts provides claims payment data for HMO products only
HPHC provided claims data for HMO and POS claims

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

**Surplus received by MACIPA is shared with Mount Auburn Hospital. The numbers reported in this section reflect only the MACIPA portion of the surplus. Some of the surplus received is used to fund the MACIPA infrastructure.

2012

	P4P Contracts				Risk Contracts**						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue **(A)**		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	X	X	X	X	$11.60M	X	$9.66M	X	$4.59M	X	X	X	$2.51M	X	X
Tufts Health Plan	X	X	X	X	$4.88M	X	$3.47M	X	X	X	X	X	$0.70M	$0.03M	X
Harvard Pilgrim Health Care	X	X	X	X	$15.34M	X	$4.33M	X	X	X	X	X	$0.59M	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	$0.01M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$31.82M	X	$17.46M	X	$4.59M	X	X	X	$3.81M	$0.03M	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred **(B)**	X	X	X	X	$5.96M	X	$2.67M	X	$0.06M	X	X	X	$1.55M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	$0.04M	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$5.96M	X	$2.67M	X	$0.06M	X	X	X	$1.59M	X	X
Medicare (C)	X	X	X	X	X	X	$1.01M	X	X	X	X	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$37.78M	X	$21.14M	X	$4.65M	X	X	X	$5.40M	$0.03M	X

Notes:

(a) Claims-Based Revenue: MACIPA does not bill or receive physician claims payments. Claims-based revenue are received by physicians/practices directly. The numbers provided are per
BCBS includes HMO and POS claims data
Tufts provides claims payment data for HMO products only
HPHC provided claims data for HMO and POS claims
Pioneer ACO Medicare claims are not inclusive of all claims data due to CMS data issues

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

(c) Represents surplus received from Pioneer ACO Agreement with the Center for Medicare and Medicaid Innovation

**Surplus received by MACIPA is shared with Mount Auburn Hospital. The numbers reported in this section reflect only the MACIPA portion of the surplus. Some of the surplus received is used to fund the MACIPA infrastructure.

2013

	P4P Contracts				Risk Contracts**						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue **(A)**		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	X	X	X	X	$12.17M	X	$4.23M	X	$2.85M	X	X	X	$1.42M	X	X
Tufts Health Plan	X	X	X	X	$4.63M	X	$3.44M	X	X	X	X	X	$0.70M	$0.06M	X
Harvard Pilgrim Health Care	X	X	X	X	15.03M	X	$4.56M	X	X	X	X	X	$0.62M	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	$0.01M	X	X
CIGNA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
United Healthcare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Aetna	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Commercial	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Commercial	X	X	X	X	$31.83M	X	$12.23M	X	$2.85M	X	X	X	$2.75M	$0.06M	X
Network Health	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Neighborhood Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BMC HealthNet, Inc.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health New England	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fallon Community Health Plan	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Other Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Total Managed Medicaid	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MassHealth	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tufts Medicare Preferred **(B)**	X	X	X	X	$6.13M	X	$2.09M	X	X	X	X	X	$1.48M	X	X
Blue Cross Senior Options	X	X	X	X	X	X	X	X	X	X	X	X	$0.03M	X	X
Other Comm Medicare	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Commercial Medicare Subtotal	X	X	X	X	$6.13M	X	$2.09M	X	X	X	X	X	$1.51M	X	X
Medicare (C)	X	X	X	X	X	X	$1.13M	X	X	X	X	X	X	X	X
Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GRAND TOTAL	X	X	X	X	$37.96M	X	$15.45	X	$2.85M	X	X	X	$4.26M	$0.06M	X

Notes:

(a) Claims-Based Revenue: MACIPA does not bill or receive physician claims payments. Claims-based revenue are received by physicians/practices directly. The numbers provided are per
BCBS includes HMO and POS claims data
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Pioneer ACO Medicare claims are not inclusive of all claims data due to CMS data issues

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

(c) Represents surplus received from Pioneer ACO Agreement with the Center for Medicare and Medicaid Innovation

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2014

	P4P Contracts				Risk Contracts **						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue **(A)**		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield **(B)**	x	x	x	x	$12.2M	x	$2.92M	x	TBD	x	x	x	$0.99M	x	x
Tufts Health Plan	x	x	x	x	$4.0M	x	$2.71M	x	x	x	x	x	x	x	$0.72M
Harvard Pilgrim Health Care	x	x	x	x	$16.0M	x	$4.0M	x	x	x	x	x	$0.60M	x	x
Fallon Community Health Plan	x	x	x	x	x	x	x	x	x	x	x	x	$0.01M	x	x
CIGNA	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
United Healthcare	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Aetna	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Other Commercial	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Total Commercial	x	x	x	x	$32.2M	x	$9.63M	x	TBD	x	x	x	$1.6M	x	$0.72M
Network Health	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Neighborhood Health Plan	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BMC HealthNet, Inc.	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Health New England	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Fallon Community Health Plan	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Other Managed Medicaid	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Total Managed Medicaid	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
MassHealth	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Tufts Medicare Preferred **(C)**	x	x	x	x	$6.2M	x	$2.0M	x	$.06M	x	x	x	$1.42M	x	x
Blue Cross Senior Options	x	x	x	x	x	x	x	x	x	x	x	x	x	x	$0.03M
Other Comm Medicare	x	x	x		x	x	x	x	x	x	x	x	x	x	x
Commercial Medicare Subtotal	x	x	x		$6.2M	x	$2.0M	x	$.06M	x	x	x	$1.42M	x	$0.03M
Medicare (D)	x	x	x	x	x	x	$1.9M	x	x	x	x	x	x	x	x
Other	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
GRAND TOTAL	x	x	x	x	$38.4M	x	$13.5M	x	$.06M	x	x	x	$3.0M	x	$0.75M

Notes:

(a) Claims-Based Revenue: MACIPA does not bill or receive physician claims payments. Claims-based revenue are received by physicians/practices directly. The numbers provided are per
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Tufts provides claims payment data for HMO products only
HPHC provided claims data for HMO and POS claims
Pioneer ACO Medicare claims are not inclusive of all claims data due to CMS data issues

(b) BCBS Quality settlement has not accured, this figure is being set at TBD

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

(D) Represents surplus received from Pioneer ACO Agreement with the Center for Medicare and Medicaid Innovation

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