Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts 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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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 Suffolk, 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 (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 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 2, 2016**, 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 from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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, 2014, and/or 2015 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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. 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.

1. Strategies to Address Health Care Cost Growth.

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 has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

Since Ch 224 was enacted, we have been managing to the State's healthcare cost trend benchmark, which has been an aggressive target given our payor mix and labor costs. Areas of concern in continuing to meet this benchmark include:

- Alternative payment contracts, particularly those with risk, require new levels of resources which if not included in the payment mechanisms will continue to slow the rate of success providers will have in lowering the total cost of care. While taking on risk provides incentive to implement provider driven interventions and care coordination, without funding it can only go so far. The funding needs to be included in the model so the efforts can be implemented and new care teams at the primary care practice level can be established. Once established and functioning, the total cost of care will come down, but with limited resources and a push to reduce payment rates down further, there will be little or no advancement in truly reducing the cost of health care. The lower growth rate target will only serve the unintened consequence of reducing and dis-incentivizing funding for these necessary components of building a sustainable valued based care system.
- Health systems that serve a high public payer population are experiencing significant reimbursement cuts in FY17 from Medicare due to continued ACA reductions, Area Wage Index cuts as well as the imposition of penalties for readmissions, hospital acquired conditions, etc. From Medicaid we are experiencing DSH cuts and Managed Care payment rate cuts. Traditionally we have been able to cross subsidize our higher payment rates from private, negotiated contracts to cover shortfalls from the public payers. With a continued decrease in the cost growth benchmark, private payers are able to lower their rates with the cost benchmark as their ceiling. The benchmark should not be lowered giving that advantage to the payers while potentially destabilizing the healthcare providers.
- We have had significant challenges with union wages outpacing general inflation and labor costs being 65% of our total costs. As the state considers payment reform, it needs to also consider labor law reform to ensure that hospitals are not paying more than market competitive wages which are not supported by premium increases. It also should take into consideration that the health plans were approved for premium increases well above the state's GSP target in recognition of the pharmacy trends and severity adjustments which have not been passed through to providers, so to the extent that providers are bearing risk for pharmacy and higher costs associated with

increase acuity, budgets are underfunded and the increased premium is accruing solely to the benefit of the health plans.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)
    - Adequate infrastructure payments need to be built into alternative payment models which address programmatic reimbursement for care coordination and care management resources, data and analytic teams, quality reporting resources
    - Adequate and flexible behavioral health access and reimbursement
    - Regulated standardized, timely and complete claims data including risk factors

2. Strategies to Address Pharmaceutical Spending.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Does NOT Plan to Implement in the Next 12 Months

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Currently Implementing

iv. Establishing internal formularies for prescribing of high-cost drugs

Currently Implementing

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Currently Implementing

vii. Other: UMass Memorial Specialty Pharmacy provides a high touch care model around outpatient prescriptions for our chronically ill patients. Our goal is to create efficiencies for the clinicians and to simplify the pharmacy process for patients on complex medication regimens. Specialty pharmacy "liaisons" are inserted into the specialty clinics to work alongside the care team as patients go on treatment. The pharmacy liaisons oversee all pharmacy needs for each patient enrolled in the program. This includes proactively monitoring refills, handling prior authorizations, discussing how to properly administer and store medications, and identifying opportunities for financial assistance. The liaison(s) will become the direct line of communication between the patient, the pharmacists, and the clinicians to ensure the needs to each patient are identified and delivered on time providing completely integrated delivery of care. Liaison(s) works as an agent of the medical staff to proactively handle all prior authorizations, facilitate bedside delivery, provide medication

education, establish a patient-liaison relationship, and reduce the complexity of the patient discharge process. The UMass Specialty Pharmacy program helps keep our patients' with the highest need adherent to their medications. We have been able to show lower total cost of care, reduced readmission rates, and a virtually 100% patient and doctor satisfaction rates.

viii. Other: Insert Text Here

ix. Other: Insert Text Here

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

First, we'd like to provide some background on behavioral health care services at UMMHC.

UMMHC has been committed to improving the health of the people of our diverse communities of Central New England through culturally sensitive excellence in clinical care, service, teaching and research. Patients come from a variety of socioeconomic, ethnic, and racial backgrounds, with many patients benefitting from the Medicaid program. We have a commitment and a long record of providing care for the most vulnerable residents of the Commonwealth. With our community mental health provider, Community Health Link (CHL), we are the largest provider of outpatient mental health care and substance abuse services in Central Massachusetts, seeing more than 20,000 individuals each year.

Our system provides a comprehensive continuum of care including services to indigent and vulnerable members of our community. UMMHC has services specifically oriented toward persons of different cultural backgrounds and this is supplemented by an active interpreters' service that provides services in over thirty languages as well as providing staff training in cultural competency. In addition to our resources on campus, UMMHC provides substance abuse services at CHL with inpatient and outpatient detoxification and rehabilitation for adults and adolescents, as well as homeless outreach services and dual disorder programs for those suffering from co-morbid mental health disorders and substance abuse. Our collaboration with UMMHC Departments of Family Medicine, Pediatrics, and Internal Medicine supports innovative patient centered medical homes specifically targeted to address the total health care needs of persons with psychiatric illnesses. Finally, our Department of Psychiatry emphasizes family, patient and peer participation in our program development and service delivery.

Our psychiatric clinical services at the medical center include a comprehensive range of services including 53 inpatient psychiatry beds; a large outpatient psychiatry service delivering over 40,000 visits per year; a busy emergency mental health service evaluating almost 7000 patients each year; and a consultation service that sees over 1000 hospitalized medical/surgical patients each year. In addition, UMMHC has fully owned clinical services through CHL at member hospitals throughout Central Massachusetts. The Department of Psychiatry faculty work at all of these sites, in addition to DMH facilities and community agencies.

Clinical faculty of the Division of Addiction Psychiatry have been very active in collaborating with community partners on projects, networking, and continuing education events concerning substance addiction treatment and recovery. Most notably, they have been involved in forming and leading the Central Massachusetts Addiction Consortium (CMAC), through which we have been able to expand our relationships with regional substance addiction providers, recovery advocates, and the Worcester Division of Public Health. These collaborations have facilitated treatment referrals for patients and families and have led to expanded support for families. For example, a continuing education event led by CMAC involved a powerful presentation by the founder of the Learn2Cope family network and led to the implementation of a local support group for families faced with opiate addiction.

It's difficult to list just 3 top strategies to enhance behavioral health integration when our approach is so multi-pronged and far-reaching as described above. However, currently, 3 top approaches are 1) implementing SBIRT (Screening, Brief Intervention, Referral to Treatment) in multiple settings such as the emergency department and inpatient units, 2) expanded pilots/demonstration projects that co-locate behavioral health providers in primary care settings, and 3) expanding primary care access to MAT (Medication Assisted Treatment) for treatment of patients with opioid disorders.

UMass Memorial Medical Center and our Departments of Psychiatry, Family and Community Medicine and Emergency Medicine have a history of developing unique clinical programming that seeks to create integration between behavioral health and physical health in spite of the fact that reimbursement models most often do not support such activities. These are selected examples of previous and present activities:

- Targeted Child Psychiatry Service (TCPS) & MCPAP & MCPAP for Moms
- Psychiatric Treatment and Recovery Center (PTRC)
- Consultation/Liaison Psychiatry (C/L)
- The Department of Emergency Medicine's integrated behavioral health program called the Behavioral Health Service (BHS)
- MyLink - The MyLink program is a collaborative effort between UMass Memorial Medical Center Emergency Department, Community HealthLink, local ambulance emergency medical services, primary care providers of the Family Medicine and Community Health Department of UMass Memorial to address the over utilization of the Emergency Department by high utilizing patients.
- Primary Care Payment Reform (PCPR)
- Adult Primary Care Consultation (APCC)
- Intellectual Disabilities Services (IDS)
- Office Based Opioid Treatment

Additional information about these programs can be provided upon request.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

We queried a number of our behavioral health providers and administrators to get their feedback on this question and the top response from all of them was the lack of adequate financial support for integrated behavioral health models of care. Current fee for service payment rates do not come close to covering the costs of providing outpatient behavioral services, and as a result, there have been many providers of outpatient behavioral health services that have cut services in the region. This has led to a barrier to access for patients needing outpatient behavioral health services, which comes at a time when our goal is to make these services more available to patients that need them. Investment in the system must start with the restructuring of the reimbursement for the present system which would more easily allow for the transformations that will follow as service delivery becomes more integrated. This is clearly the single largest barrier in the integration of behavioral health care.

A second barrier to integrating behavioral health care is the lack of clarity around future payment models. An example of this is the end of MassHealth's PCPR program, coming in December 2016. We have participated in the PCPR program since its beginning in March 2014. Five of our largest primary care sites have been in Tier 3 of the PCPR program, which means they have on-site integrated behavioral health services co-located with their primary care services. In addition to the capitated payments received for these services, we also receive medical home load payments, which help support

the provision of behavioral health services in the primary care setting. Although we know MassHealth is having a Pilot ACO program, which will be followed by a full ACO program, the payment mechanisms for these programs are still not known, leaving much uncertainty around the continuation of the great progress we have made in the integration of behavioral health care in our primary care sites.

Another barrier that impacts the integration of behavioral and medical care is the lack of claims data available to evaluate and enhance clinical interventions. Even in the case of PCPR, claims with susbstance abuse information are not provided. This is a significant barrier that must be overcome in order to allow the patient's providers access to this information to both evaluate the impact of interventions as well as give the full understanding to the provider of the patient's healthcare utilization and status.

4. **Strategies to Recognize and Address Social Determinants of Health.**

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

1. Engaging the community in our Longitudinal Care Management Initiative which seeks to create strategies to care for our community across all aspects of their healthcare and societal needs that influence their wellbeing.
An example of a strategy in place is our recently held Communtiy Summit. A few weeks ago UMass Memorial hosted a community wide session where we invited members of our local community agencies to strategize around how we might together better communicare, care for our community and engage in ongoing discussions, pilot programs and interventions.

2. Programatically we are targeting several strategies such as:

- MyLink program – rooted in our emergency department we have put a real time identification system in place to identify high utilizing ED patients who are then surveyed and if acceptable to the patient are placed with community based care coordinators. These care coordinators work with the patient to identify social and economic issues as well as behavioral health needs of the patient and coordinate with community based services to help address those issues.
- Community Health Workers: CHWs are incubated in two pediatric primary care practices, working closely with a provider champion to implement a one year evidence based intervention. Children who have uncontrolled asthma are identified and offered a visit by a specially trained CHW who goes into the home and does an assessment to identify asthma triggers while trying to identify if the child has an Asthma Action Plan, understands the medications and the AAP. The CHW also brings certain supplies to the home such as mattress covers, bins to cut clutter, special mops to clean dust and referrals to other services such as Community Legal Aid to address landlord housing issues, housing, etc
- Meds in School Adherence program: clinical staff in pedi-pulmonology provides advice and coordinates control medications given by Worcester Public School and the Head Start program nurses for high risk patients. They also provide referrals to the home visiting/community health worker and provide trainings to school nursing staff.

- Inpatient/ED intervention: under the pedi pulmonology leadership and with communication with the ED and medical residents, upon discharge, a community health worker is connected to the child's family for the home visiting component (see above).
- Partnership with Community Legal Aid: through a partnership with Community Legal Aid, UMass Memorial Legal Department and the Office of Clinical Integration and Population Health, patients who encounter issues primarily with housing, education, guardianship, employment, disability, insurance/benefits enrollment are having their problems addressed through legal services.

3. Hotspotting: patients who have been identified as having difficulties with chronic condition and/or high no show rate get a home visit to assess how the patient can be assisted to better manage their health. This is a smaller program that is still in the developmental phase.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

The entire health care system needs to see Social Determinants of Health (SDOH) as an "Health in All Policies" approach (Wilkinson and Sir Marmot 2003) where we go beyond/outside the traditional health care system and beyond public health to community stakeholders where we collaborate, recognizing that cross sectors need to come together to improve the health of the community. For example, we need to advocate for certain policies that impact the health of our patients. We need to improvev the health literacy of our patients so that they are knowledgeable and empowered to participate in the strategy. Currently, there is a lack of "Collective Impact" approach in the state government (i.e. Medicaid) and clinical systems to address SDOH. In addition to these underlying issues, the top barriers to understanding and addressing the SDOH are –

- A lack of information about available resources in the community – we need to establish bidirectional communication with community stakeholders and get knowledgeable about existing assets. There is a need for real-time connections to community based resources and services provided near the patient's home. We need better data- where are the greatest needs; can we get neighborhood data? And how can we link community resources to where our patients live? Also, a major problem is the lack of financial resources available to multiservice community organizations, limiting their capacity This is an issue that must be taken up by state and federal policy makers. The clinical system cannot create the Housing needed, the State and Federal Food (SNAP) Benefits/Resources, the Transportation, etc. – the larger community and state and federal policy makers must take thi on much more upstream than at the clinical intersect when the community comes for acute healthcare.
- There is a need to have an IT system/platform that integrates socioeconomic information into the electronic medical record so that it keeps front and center the patients' SDOH needs documented and the outcome of the intervention. For example, was the diabetic patient able to successfully secure food?
- Competing Demands – challenge is to focus and select goals – there are many worthy efforts but they cannot all be dealt with immediately

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

UMass Memorial Health Care includes three community hospitals (Clinton Hospital, Health Alliance Hospitals and Marlborough Hospital) in addition to UMass Memorial Medical Center. We have been actively encouraging optimal use of our community hospitals to provide lower cost options for patients whose clinical needs can be met at these lower acuity hospitals. In addition, as we have expanded our population health infrastructure and have moved into more alternative payment arrangements, we have stepped up our work to make sure we see patients in the most appropriate setting based upon their clinical needs. The Medical Director of our ACO has regular meetings with our providers to continue to educate them on the concept of value based care – the right care at the right time at the right place.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

i. If yes, please describe what information is included.
n/a

ii. If no, why not?
Quality and cost of care are key factors in identifying value-based care. Current UMass Memorial ambulatory systems provide feedback to primary care providers about the quality of care for the primary care provider and practice. Current state challenges with interoperability of disparate IT and EHR systems limit the ability to put the acute and ambulatory care system information together within the EHR. As an interim solution, the Office of Clinical Integration has developed Population Health dashboards that incorporate clinical data, claims data and high level information on cost of care.

UMass Memorial has embarked on a journey to a system level EHR, EPIC by FY2018. The EHR transformation work is a lynchpin to link workflows and business data across UMass Memorial as an organization and with our community provider partners. This transformation will enable UMass Memorial to move upward in the HIMSS Analytics Continuity of Care Maturity Model. Some Epic users have achieved Stage 7 which is defined as "Knowledge drive engagement for a dynamic, multi-vendor, multi-organizational interconnected health care delivery model.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

i. If yes, please describe what information is included.
n/a

ii. If no, why not?
UMass Memorial's future EHR system, EPIC, which goes live on October 1, 2017, has the ability to insert "Best Practice Advisories" that can include information on quality and cost around referral orders. These advisories can also provide information around unnecessary treatments as a vehicle to wisely inform care decisions and reduce overall costs of care.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
No

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.
n/a

ii. If no, why not?
UMass Memorial's future EHR system, EPIC, will provide interfaces to other provider systems who utilize the Epic EHR as well as with those that are using non Epic EHRs although access and information sharing will be somewhat different. UMass Memorial providers will have access at the patient level, to clinical information to inform and avoid replication of care provided in other settings. The patient information must match at multiple data points for the access to be permitted via the electronic interface. There are 2 modes of interaction through 2 separate interfaces. One is view only with the ability for the provider to incorporate the data into their instance of the patient's Epic record. The second capability permits a provider external to Epic to contribute to or request certain types of care.

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

We have been undergoing a major transition over the past few years at UMMHC in creating the infrastructure and capabilities to move from the traditional fee-for-service environment into new alternative payment mechanisms and we would like to give some background around this transition.

Providing patient-centered, data-driven quality care across the care continuum is a system-wide commitment. With the advent of alternative payment models and the shift from volume to value, UMMHC recognized the need to shift as well as direct our focus from simply providing quality health care to actively identifying and managing the health needs of the population it serves. Demonstrating our understanding and commitment to this shift, UMMHC established the Office of Clinical Integration (OCI) and charged it with development and implementation of strategies to identify, stratify, manage and improve the health of the patients we serve. It is with this directive that the leadership and staff of OCI created the UMass Memorial Accountable Care Organization (UMMACO) for our Medicare Shared Savings Program (MSSP) and endeavors to lead the industry in effective population health management strategies and practices.

UMass Memorial Health Care (UMMHC), its partner providers and community organizations recognize that researching, building and implementing innovative care management models and reimbursement strategies are the next steps in supporting the provision of high value care. There is no single solution to improving the quality and safety of care while also making it affordable. Rather, a comprehensive, collaborative, coordinated whole-patient approach is necessary to transform health care delivery and the health of the population. All of our initiatives are designed

with the goal of transitioning the health care system along the continuum from fee-for-service reimbursement towards increasing models of clinical accountability and risk in ways that are thoughtful, well researched, evidenced based and designed to meet stakeholder needs for successful transformation.

Although we participate in Blue Cross's AQC and risk based contracts with our other private payers, most of our movement into significant alternative payment arrangements has been with Medicare and MassHealth. For Medicare, we have been in the MSSP (ACO) since January 2015, and have expanded our ACO in 2016 with another expansion coming in 2017. We also participate in Medicare's BPCI (Bundle) program, having started with one bundle in April 2015 (Total Joints), adding another in July 2015 (CABG), and two more in October 2015 (Cervical Spine and Non-Cervical Spine). For MassHealth, we have participated in their PCPR program at 7 of our primary care sites since March 2014. We have applied for the MassHealth ACO Pilot Program starting later this fall and have received initial acceptance into this program. We plan to participate in MassHealth's ACO which will follow their Pilot ACO program. We have also worked to integrate care in our primary care sites and now have 8 primary care practices that are NCQA certified as medical homes.

Our three top strategies for expanding our adoption of alternative payment mechanisms are:

1. **Expansion of Population Health Analytical Capabilities**

   Essential to transformation of the health care system is strong data collection and analysis capabilities. Early in our accountable care development, we recognized the critical function data collection and analysis plays in identifying trends and opportunities for intervention and improvement through our participation in the Blue Cross Blue Shield Alternative Quality Contract (AQC) as well as the MSSP program. The OCI Data Analytics Team provides data aggregation, reporting and analysis to support clinical innovations, provider performance improvement, quality improvement, and financial model development.

   Reporting Capabilities
   The Data Analytics Team utilizes claims and electronic health record (EHR) data, as well as patient experience data, to provide regular reports and analysis to OCI and providers to evaluate performance and identify opportunities for improvement. The following are examples of the types of regular reports utilized by the team:
   High-Risk Lists – Through predictive modeling, the Data Analytics Team is able to identify patients who are at high-risk for increased utilization based on severity scores. These lists are shared with OCI's Care Management Team and providers to identify opportunities for intervention and inform longitudinal care planning.
   Patient Attribution Lists: Enable groups within the Medicare ACO to see which patients have been attributed to them based on CMS attribution methodology. Patients' claims data is used to determine which provider has performed the majority of services. OCI's Performance Improvement Team shares this data with physicians, care managers and office staff on a quarterly basis through a web link program called Tableau allowing direct access to secure patient level information.
   Performance Reports: Provide OCI leadership, physicians and office staff year-to-date progress information on quality measures at the practice level for ACO patients, allowing ongoing visibility to gauge advancement towards year end goals. Monthly Tableau report provides bar graphs in three categories:
   - Quality Measures: updated monthly from claims data and available EHR data.

- Claims Based Measures: updated annually with claims data
- Patient Experience Measures: CAHPS survey provides patient experience rates annually through an outside vendor, Press Ganey

Total Medical Expense Analysis: Monthly claims data allows the Data Analytics Team to evaluate and trend medical expense and provide meaningful and actionable information to our care managers and clinical practices.

Shared Savings: Annual evaluation of practice performance on patient care measures and distribution of monetary reward, if applicable, based upon final determination of shared savings.

2. Managing Total Cost of Care (TCOC)

As the largest system in Central Massachusetts, we are acutely aware of the impact on the Total Cost of Care our system has on the Commonwealth. It is our understanding of this impact and our goal to provide the right care at the right time at the right cost that drives us to explore options to reduce the TCOC we provide to the patients we serve and to manage our cost trends to be at or below the Commonwealth's aggressive benchmark of 3.6%.

Recent initiatives and activities to reduce the TCOC include:

- Negotiate payer contract renewals at or below the benchmark;
- Open urgent care centers and ambulatory surgical centers to provide lower-cost options to the emergency department and inpatient settings;
- Develop telemedicine capabilities like eICU to provide clinical oversight of critical care patients in our community hospitals to prevent transfer to a higher-cost tertiary setting;
- Explore bundled payment and accountable care models to more effectively manage acute events and avoidable high-cost utilization;
- Develop targeted initiatives based on cost and utilization data; and,
- Create preferred provider networks to leverage accountability and performance improvement in post-acute settings such as Skilled Nursing Facilities.

We are committed to providing high-quality cost-effective healthcare to all we serve and will continue to explore models, initiatives and pilots such as this to advance our understanding of how to meet the goals of the Triple Aim, to simultaneously improve the health of the population, enhance the experience and outcomes of the patient, and reduce per capita cost of care for the benefit of communities.

3. Patient-Centered Care Management

Patient and Family Centered Care is core to the Mission, Vision and Values of the UMass Memorial Health Care system. Through engagement with our patients, providers and community partners, we identified the need for infrastructure to support collaboration across the care continuum. Transitions of care is a critical time for a patient and developing a cross-setting collaborative approach to managing transitions results in improved communication, better health outcomes, and greater patient engagement in their care and overall satisfaction with their health care experience. In addition, we identified the critical role non-medical social support plays in the overall health and well-being of our patients, especially those in the disadvantaged and underserved populations and those with chronic complex diseases and/or unmet behavioral health and substance use disorder needs. Consequently, we developed a longitudinal care management team and several programs and initiatives targeting high risk patients whom would likely benefit from more intensive cross-setting care coordination and intervention.

Longitudinal Care Management Team

The current Care Management Team is staffed by RN-level Nurse Case Managers, Social Workers, and Care Coordinators. The Care Management Team members are in part co-located in the primary care offices where they collaborate with the primary care team to identify patients at risk and develop longitudinal care plans. The standard scope of work of the team includes:

- Patient identification, assessment, and engagement;
- Lead multidisciplinary care team to develop and manage longitudinal care plans;
- Conduct ongoing case finding activities including registry reviews, real-time admission, discharge and transfer data, and provider schedule reviews;
- Conduct monthly care planning meetings with patients, providers and community partners
- Provide ongoing patient assistance and follow-up to identify and access clinical and social service needs;
- Maintain case notes, care plans, progress reports, and care management dashboard; and,
- Manage active and inactive status, scheduling and follow-up.

All of the strategies described above rely on technology to be able to make them work. UMMHC has been investing in data systems over the past few years that are specifically geared towards population health management. This will be enhanced as we implement the EPIC system in the fall of 2017.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

As we stated in last year's testimony, the top barriers in the adoption of new APM's are –

- The infrastructure investment required to manage alternative payment arrangements is significant and the payments available for this investment do not cover these costs. Additional infrastructure payments would allow us to build the care management and analytical capacity needed as we expand into more or more heavily risk based APM's. Another way for payers to provide infrastructure payments would be to return a much greater percentage of the shared savings to the provider to reinvest into the programs. Often payers are looking to take 50% or more of the savings which should be reinvested in the providers efforts to redesign particularly in the early years of the contract.
- Access to real-time data from the payors has always been a challenge and often does not allow us to do the required analyses. And even if we do have some data, the addition of analytical staff is necessary to work the claims data but with limited resources and the push to reduce costs, this is a significant challenge. Payers need to work with the providers to determine how to improve the data that is currently being made available. Without good and timely data, it is difficult to know where to focus our care management efforts.
- Some programs mandate assumption of risk too soon - sometimes before data is available to analyze initial results. A more thoughtful transition to risk would make it more tenable to adopt alternative payment mechanisms. Many different programs and models exist among a number of payors. This increases the level of work involved in implementing and analyzing these new programs and payment models.

c. Are behavioral health services included in your APM contracts with payers?

Yes

i. If no, why not?
n/a

7. **Strategies to Improve Quality Reporting.**
At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

We are monitoring performance for the quality measures for 6 different programs. As seen on the attached quality grid, there are 73 quality measures. Some of these measures are very similar yet we are required to report for each. For example, there is a metric for Diabetes A1c Good Control and another payer wants Diabetes A1c Poor Control. Reporting results to these payers as well as reporting performance to our own organization and provider groups is very resource intensive. Our group includes 3 Senior Data Analysts, 2 Data Analysts, 1 Project Coordinator, and a Manager of Reporting and Analysis. Further, in our attempt to do Population Health Quality reporting within our organization we are constantly posed with the challenge of creating payer-blind reporting across all of these measures with varying data feeds. While we do believe that quality measures lead to improved patient outcomes, we would like to see more alignment of measures across programs. Lastly, it is a particular challenge to report the quality data for providers who do not use our system-wide EMR. Our Managed Care network is comprised of 60% employed providers and 40% independent providers. Our ACO is comprised of a similar distribution. For the non-employed providers, the data collection for quality reporting is a very manual, arduous process that involves the entire team as well as part-time staff hired during our busy data collection season.

See attached Quality Measure matrix.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

To the extent that we can be heard, we are trying to make recommendations early in our contracting processes with the commercial payers to select measures that are already "on our list". Regarding a few payers for whom we provide HEDIS data from our EMR, we have been able to move the frequency of this reporting from monthly to quarterly. We continue to face the challenge of payers who need the results in their custom format and file delivery processes. Reducing the frequency of required reporting to payers and more standardized reporting formats will allow us to redirect more of our resources to providing more current performance reports and practice improvement support to our patient care teams.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.

We have some additional comments below which are specific to certain topics, as noted below. However, we need to comment on some major concerns at a higher level. All of the good work to move to value is seriously jeopardized by some of the recent haphazard and seemingly arbitrary cuts by government that is causing severe disruption to the market. Between the rural floor cut by Medicare and the state's recent MCO cap in Medicaid (with virtually no advanced warning), it is resulting in drastic and draconian cuts that are causing us to reconsider our involvement in all of the initiatives. When such drastic change is proposed, the system simply cannot move fast enough and is therefore forced to make the kind of decisions that set us back from transformation and are not best for patients. More deliberate, thoughtful and gradual changes are the only path to success.

a) We feel strongly about being able to dispense medications to our patients treated at the medical center rather than being forced to accept medications from outside pharmacies. We can control the cost (and quality) of these through our 340B program and manage patient care better. There is waste in the current system. We support legislation to prevent this practice or place a moratorium on it that has been proposed in the state.

b) MassHealth began to address behavioral health integration via the move to Tier 3 PCPR where rates were capitated for such services and providers were held to certain deliverables associated with that integrated care. This was a good step forward only to have the program close in December with no successor program in place. Payers must be held to a standard which creates sustainability, consistency and predictability. The program and funding for it should continue until a successor program is implemented which does not dismantle the progress and investment that were put into building the capacity at these practices. Too often interventions like this are started and stopped before true analysis can be done to study the effectiveness and before the return on investment can be realized. Policy needs to address gaps in program implementation with some accountability at the payer level. Additionally, payers should be mandated to provide analysis to study the effectiveness of integrating behavioral health in various settings.

c) Policy to address social determinants of health should include a statewide solution to collecting the information that is currently in the state information systems. The state is in the unique position of having large sets of data from a number of agencies that gather information about the low income individuals in the state. Medicaid collects certain data in its enrollment applications and claims data, department of revenue holds additional information on income and family size, departments of public health, mental health, housing hold information about public program eligibility, SNAP benefits, housing etc. The state could harness all of the data from all of its agencies to be able to report and provide information to healthcare providers and community agencies that come together in ACOs to better coordinate care for their communities.

f) Regulation should mandate quality reporting be standardized among all payers.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **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.

   See attached Exhibit 1

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

UMass Memorial Medical Center has been helping patients understand their financial responsibility related to their medical bills for a number of years. This includes patients who are insured, but may have some out of pocket costs, as well as patients who are uninsured. With the implementation of the provisions in Chapter 224, we have reviewed and updated our procedures to ensure that we are in compliance with all aspects of the law.

Chapter 224 requires that prior to an admission, procedure or service and upon request by a patient or prospective patient, a healthcare provider shall within two (2) working days, disclose the allowed amount or charge of the admission, procedure or service. The UMass Memorial Patient Financial Counseling Department coordinates all patient pricing requests for UMass Memorial Hospital, the UMass Memorial Medical Group and Clinton Hospital. The Financial Counselors work with the health care provider to obtain the appropriate CPT/Procedure codes in order to obtain a more accurate estimate of charges. Many of the requests are from patients who are primarily concerned with their out of pocket responsibility. The patient financial counselors also work with patients by providing them with their insurers toll free telephone number and web site to obtain the estimate of any patient liability such as co-insurance and or deductibles. All requests are tracked in a database to determine the number, type and nature of the request and to monitor the turnaround time. An oral and a written estimate is provided to the patient for each request. This process has remained the same over the past few years.

Requests are received via email, telephone and in person. The contact information is as follows: Telephone: 508-334-9300; Internal e-mail: Financial Counseling; External e-mail: NeedInsurance@UMassmemorial.org.

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.

As mentioned above, most pricing requests from patients are related to the patient's expected financial responsibility, in the form of copayments, deductibles and coinsurance. As of this time, we have not performed any analysis to compare the estimates provided to patients against the actual final payment amounts.

c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

The largest barrier is to obtain an accurate service description or appropriate CPT codes. Many times a patient does not have this information at the time of the initial request. The patient and/or Financial Counselor must reach out to the ordering Physician to obtain and verify the information on the prospective service.

Exhibit 1 AGO Questions to Providers and Hospitals

Please email HPC-Testimony@state.ma.us to request an Excel version of this spreadsheet.

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. For hospitals, please include professional and technical/facility revenue components.
3. Please include POS payments under HMO.
4. Please include Indemnity payments under PPO.
5. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
6. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that do not subject you to any "downside" risk.
7. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
8. **Other Revenue Arrangements** are arrangements for revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as managements fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
9. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
10. **Incentive-Based Revenue** is the total revenue a provider received under a P4P contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
11. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
12. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

UMass Memorial Medical Center - 2012 (Reported in Millions)

	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/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO	Both
BCBSMA	$ 113.7	$ 103.2	$ 2.6	$ 2.5											
Tufts	$ 40.2	$ 21.0	$ 0.3	$ 0.1											
HPHC	$ 42.9	$ 26.7	$ 0.3	$ 0.1											
Fallon											77.7	0.5			
CIGNA											13.7	10.3			
United											19.2	0.3			
Aetna											5.5	14.5			
Other Commercial											45.4	22.5			
Total Commercial	196.8	150.9	3.2	2.7	-	-	-	-	-	-	161.5	48.2	-	-	-
Network Health											47.9				
NHP											16.3				
BMC Healthnet											15.8				
Fallon											7.3				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	87.3	-	-	-	-
Mass Health		86.1		3.0											
Tufts Medicare Preferred											10.0				
Blue Cross Senior Options											26.7				
Other Comm Medicare											41.8				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	78.5	-	-	-	-
Medicare												329.3			
All other payers											29.7	42.4			
GRAND TOTAL	$ 196.8	$ 237.0	$ 3.2	$ 5.7	X	X	X	X	X	X	$ 357.0	$ 419.9	X	X	X

UMass Memorial Medical Center - 2013 (Reported in Millions)

	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/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO	Both
BCBSMA	$ 47.9	$ 90.8	$ 2.6	$ 2.5	57.0		(2.6)								
Tufts	$ 48.2	$ 16.1	$ 0.3	$ 0.1											
HPHC	$ 51.6	$ 22.1	$ 0.3	$ 0.1											
Fallon											75.6	0.8			
CIGNA											13.7	3.7			
United											13.0	3.5			
Aetna											5.4	18.1			
Other Commercial											44.8	22.0			
Total Commercial	147.8	128.9	3.2	2.7	57.0	-	(2.6)	-	-	-	152.6	48.0	-	-	-
Network Health											48.3				
NHP											16.0				
BMC Healthnet											16.2				
HealthNE											0.2				
Fallon											7.9				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	88.6	-	-	-	-
Mass Health		79.7		2.0										5.7	
Tufts Medicare Preferred											10.6				
Blue Cross Senior Options											26.7				
Other Comm Medicare											45.9				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	83.2	-	-	-	-
Medicare												313.1			
All other payers											29.0	41.1			
GRAND TOTAL	$ 147.8	$ 208.6	$ 3.2	$ 4.7	$ 57.0	X	$ (2.6)	X	X	X	$ 353.4	$ 402.2	X	$ 5.7	X

UMass Memorial Medical Center - 2014 (Reported in Millions)

	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/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO	Both
BCBSMA	$ 45.9	$ 88.7	$ 2.1	$ 1.8	60.6		(6.5)								
Tufts	$ 43.2	$ 14.4	$ -	$ -											
HPHC	$ 51.3	$ 22.0	$ 0.1	$ 0.0											
Fallon											79.2	0.9			
CIGNA											14.9	4.0			
United											13.3	5.0			
Aetna											5.2	18.6			
Other Commercial											55.7	27.5			
Total Commercial	140.4	125.1	2.2	1.8	60.6	-	(6.5)	-	-	-	168.3	56.0	-	-	-
Network Health											59.4				
NHP											22.7				
BMC Healthnet											13.8				
HealthNE											0.2				
Fallon											10.3				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	106.4	-	-	-	-
Mass Health		100.9		1.3										5.7	
Tufts Medicare Preferred											16.4				
Blue Cross Senior Options											27.0				
Other Comm Medicare											47.1				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	90.5	-	-	-	-
Medicare												323.1			
All other payers											29.8	44.6			
GRAND TOTAL	$ 140.4	$ 226.0	$ 2.2	$ 3.1	$ 60.6	X	$ (6.5)	X	X	X	$ 395.0	$ 423.7	X	$ 5.7	X

UMass Memorial Medical Center - 2015 (Reported in Millions)

	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/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO/Ind	HMO	PPO	Both
BCBSMA	$ 35.5	$ 87.7	$ 1.7	$ 1.6	58.2		(2.4)								
Tufts	$ 47.4	$ 17.3	$ -	$ -											
HPHC	$ 48.6	$ 25.5	$ 0.1	$ 0.0											
Fallon											74.2	0.8			
CIGNA											11.5	3.7			
United											10.9	3.7			
Aetna											3.7	14.1			
Other Commercial											71.6	35.2			
Total Commercial	131.5	130.5	1.8	1.6	58.2	-	(2.4)	-	-	-	171.9	57.5	-	-	-
Network Health											60.1				
NHP											17.1				
BMC Healthnet											22.9				
HealthNE											0.6				
Fallon											12.3				
Other Managed Medicaid											5.4				
Total Managed Medicaid	-	-	-	-	-	-	-	-	-	-	118.4	-	-	-	-
Mass Health		103.6		1.7										3.1	
Tufts Medicare Preferred											16.3				
Blue Cross Senior Options											29.6				
Other Comm Medicare											46.1				
Commercial Medicare Subtotal	-	-	-	-	-	-	-	-	-	-	92.0	-	-	-	-
Medicare												365.0			
All other payers											34.8	52.3			
GRAND TOTAL	$ 131.5	$ 234.1	$ 1.8	$ 3.3	$ 58.2	X	$ (2.4)	X	X	X	$ 417.1	$ 474.8	X	$ 3.1	X

OCI Quality Measures Reporting Grid by Program

Focus on Ambulatory Quality & Utilization Measures for Primary Care

Measures	Program 1	Program 2	Program 3	Program 4	Program 5	Program 6
ACSC admissions: COPD	Yes					
ACSC admissions: HF	Yes					
ACSC ED Visits					Yes	
Acute Bronchitis		Yes				
ADHD				Not selected	Yes	
Adult BMI Assessment						Yes
Asthma Medication Ratio		Yes				
Asthma Meds			Yes	Not selected	Yes	
Back Pain Imaging		Yes		Yes: Stage 1		
BMI Screening	Yes			Not selected	Yes	
BP Testing	Yes					
Breast Cancer Screening	Yes	Yes	Yes	Not selected	Yes	
CAD Meds	Yes					
Cervical Cancer Screening		Yes	Yes	Not selected	Yes	
Childhood Immunizations				Yes: Stage 1&2	Yes	
Chlamydia Screening		Yes		Not selected	Yes	
Colorectal Cancer Screening	Yes	Yes		Not selected		Yes
Current Meds List	Yes			Yes: Stage 2		
Depression Meds Acute		Yes		Not selected		
Depression Meds Continuous		Yes	Yes	Not selected		
Depression Remission	Yes					
Depression Screening	Yes			Not selected	Yes	
Developmental Screening					Yes	
Diabetes A1c Good Control			Yes	Not selected	Yes	Yes
Diabetes A1c Poor Control	Yes	Yes		Yes: Stage 1	Yes	
Diabetes A1c Testing		Yes		CDS		
Diabetes BP Control		Yes	Yes	Not selected	Yes	Yes

OCI Quality Measures Reporting Grid by Program

Focus on Ambulatory Quality & Utilization Measures for Primary Care

Measures	Program 1	Program 2	Program 3	Program 4	Program 5	Program 6
Diabetes Eye Exam	Yes	Yes		Not selected		Yes
Diabetes LDL Control				Yes: Stage 1	Yes	
Diabetes LDL Testing				CDS		
Diabetes Nephropathy		Yes	Yes	Not selected		Yes
Diabetes Statin Adherence		Yes				
Fall Risk Screening	Yes					
Flu Shot	Yes			Yes: Stage 1		
Follow-up After Discharge: Mental Illness					Yes	
HF Beta-Blockers	Yes			Not selected		
HTN BP Control	Yes	Yes	YES	Yes: Stage 1&2	Yes	Yes
HTN BP Testing				CDS		
IVD LDL Control				Not selected		
IVD LDL Testing						
IVD Meds	Yes			Not selected		
IVD Statin Adherence		Yes				
Medication reconciliation					Yes	
MU Qualification	Yes					
PCMH Recognition					Yes	
Pediatric BMI Screening				Not selected	Yes	
Pediatric Nutrition Counseling				Not selected	Yes	
Pediatric Physical Activity Counseling				Not selected	Yes	
Pharyngitis		Yes		Yes: Stage 1&2, CDS		

OCI Quality Measures Reporting Grid by Program

Focus on Ambulatory Quality & Utilization Measures for Primary Care

Measures	Program 1	Program 2	Program 3	Program 4	Program 5	Program 6
Pneumonia Vaccine	Yes			Yes: Stage 1, CDS		
Readmissions	Yes					
Statin Therapy	Yes					
SNF Readmissions	Yes					
Substance Abuse Treatment				Not selected	Yes	
Survey: Access to care		Yes				
Survey: Communication	Yes	Yes				
Survey: Decision Making	Yes					
Survey: Health Promotion	Yes					
Survey: Health Status	Yes					
Survey: Integration		Yes				
Survey: Patient Knowledge		Yes				
Survey: Patient Rating	Yes					
Survey: Specialist Access	Yes					
Survey: Stewardship	Yes					
Survey: Timely Care	Yes					
Tobacco Use Screening	Yes			Yes: Stage 2	Yes	