Pre-Filed Testimony Questions: Health Policy Commission

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:

Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a. What are your organization's top strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

Atrius Health's top strategic priorities to reduce health care expenditures include the following:

Shifting care to lower cost settings – We continue to encourage utilization of our preferred hospitals, including community hospitals, and other low cost settings such as freestanding Ambulatory Surgical Centers (ASCs), as well as care for patients in their homes when such settings are clinically appropriate. We believe these settings often offer the same or better quality of care at a lower cost, with improved care coordination and convenience for our patients. Atrius Health was the first provider in Massachusetts to move Total Joint Replacement surgery for appropriate patients to an ASC with follow-up home care (a practice that has been done in other parts of the country for a decade). Moving care to lower cost settings is estimated to deliver several million dollars in annual medical expense savings while continuing to achieve excellent clinical outcomes. In addition, feedback from our patients has been extremely positive; patients often find this is also more convenient and lower out-of-pocket costs for them.

Other initiatives include the development of our hospital at home program to provide care in the home rather than in the hospital for select patients. This program permits engaging patients in their homes around other areas critical to improving health, such as nutrition, medication adherence and fall risk reduction. We believe a bundled payment methodology needs to be adopted by payers is needed to support the expansion of this program.

Medical Expense Management –Atrius Health has invested heavily in other initiatives to improve quality and control medical expenses, such as programs to reduce avoidable hospitalizations and re-hospitalizations and to eliminate low value testing.

For example, our "Care in Place" program, which is a partnership between Atrius Health providers and VNA Care nurses, provides urgent care in the home for older patients identified as high risk for hospitalization and who are unable to come in for an office visit because they lack transportation or feel too ill to travel. For older, frailer patients, emergency room visits typically lead to admission, and hospital treatment may cause further complications that result in longer hospital stays and worse health outcomes. Once the determination is made that the patient needs a same day appointment, and does not need to be sent immediately to an emergency room, our nursing staff can contact the Care in Place Referral line to request an urgent home care visit. A designated nurse from VNA Care will then go to the patient's home, provide an assessment (including medication review) and contact the assigned Medical Control Officer (MCO) while in the patient's home to review the patient's condition and develop a treatment plan. The MCO

places any necessary orders, documents the visit as an urgent home care encounter, and sends the encounter to the PCP. The PCP team picks up the follow-up care. From January 2019 through June 2019, there were a total of 400 patients referred to the Care in Place Program that we estimate has resulted in savings of $700,000 in ED/hospital avoidance since the beginning of the year.

In addition, Atrius Health provides telephone access to an Advanced Practice Clinician (APC) 24 hours/day, 7 days/week, as well as same-day appointments and extended weeknight and weekend urgent care hours to reduce unnecessary use of hospital emergency departments. We are also using historical claims data and predictive modeling to identify patients who are at a higher risk of being admitted to the hospital. These patients are flagged internally and are triaged to be seen immediately in the office or are referred to special programs like the one referenced above. We are also able to identify adult and pediatric patients eligible for end-of-life/palliative care using similar modeling.

Finally, under our Medicare Advantage program and pursuant to a "benefit enhancement" available under our CMS Next Generation Model ACO Participation Agreement, we are able to admit qualified patients directly for Skilled Nursing Facility (SNF) care without the otherwise required prior 3-day hospital stay. We continue to work closely with our preferred SNFs which we selected for their high quality care and commitment to patient satisfaction. Many of these SNFs have an Atrius Health affiliated physician or APC on site caring for Atrius Health patients. Medical staff at the SNF has the ability to obtain the patient's current medical record from our EMR, allowing for better communication about the patient's health status and medications between the SNF and the patient's primary care provider. Preferred SNFs are expected to adhere to a list of expectations by Atrius Health to improve care and have agreed to comply with these expectations, which include sending a discharge summary to the PCP, improving care transitions. Home health may be provided after the SNF visit. On average we have reduced the cost of SNF stays by approximately $3,000 per stay for SNFs where we have our own coverage as compared with care that is not directly managed in this way.

Addressing Physician Burnout– A high priority within Atrius Health is addressing physician burnout and turnover, factors which contribute to rising health care expenditures According to a May 2019 article in the Annals of Internal Medicine entitled "Estimating the Attributable Cost of Physician Burnout in the United States": "At an organizational level, the annual economic cost associated with burnout related to turnover and reduced clinical hours is approximately $7600 per employed physician each year." The AMA cites $500-$1 million as the yearly cost of turnover. As an organization with over 700 employed physicians, the associated costs of burnout are significant.

Among some of the steps Atrius Health has taken to address this critical issue include the following:

- Strengthening the physician's team within Internal Medicine by conducting competency training and assessment for nurses and medical assistants;
- Implementing enhancements to the EHR that help reduce the number of "clicks" necessary to retrieve information (e.g., introduction of a dashboard summarizing when a physician's patient has been discharged from the hospital)a patient's recent hospital experience);
- Improving efficiency of scheduling and prescription refill processes; ;
- Providing wide screen computer monitors;
- Integrating the state's Prescription Monitoring Program into our EHR, eliminating the need for physicians to log into a web-based platform to access prescription drug history; and

- Focusing on personal resilience training/resources for physicians – designed to improve collegiality, connect PCPs with specialists, and build individual skill

Pharmaceutical Cost Management – Recognizing the critical nature of managing pharmaceutical costs and improved patient outcomes, Atrius Health has a robust clinical pharmacy department that continues to focus on helping our prescribers to do clinically appropriate, evidence-based, cost-effective medication prescribing. A team of 14 clinical pharmacists works directly with our physicians, other health professionals and patients to ensure that the medications prescribed contribute to the best possible health outcomes, are affordable to patients, and are the most cost-effective option.

While we are not able to bill for these clinical pharmacy services, we believe it is essential to invest in this important initiative. Atrius Health's clinical pharmacy team continually monitors for the availability of new generics, blockbuster brand name drugs, and any changes in costs of medications. Once a potential issue is identified and, if appropriate, the clinical pharmacy team develops an initiative to focus on prescriber and staff education with helpful reference material, changes to EMR tools to guide prescribing, and targeted prescribing reports - all of which lead to medication conversions where appropriate. One example of a major initiative where we utilized our clinical pharmacists was a recent effort in educating clinicians to switch to a different preferred glucose meter and test strip for patients with diabetes. This initiative is worth an estimated savings of $900,000 annually, at no extra cost for patients.

Atrius Health's Pharmacy & Therapeutics (P&T) Committee meets quarterly to monitor high volume and high cost medications as well as to make decisions on new or emerging medications and their place on the Atrius Health Formulary. While clinicians are able to prescribe medications that are not on the formulary, they are strongly encouraged to prescribe from our formulary, which is based on efficacy, safety, and cost. Of the medications prescribed at Atrius Health, 89% consist of generic medications.

- Finally, we have implemented Collaborative Drug Therapy Management, and several of our clinical pharmacists see patients in clinic by clinician referral for medication teaching related to uncontrolled hypertension, type 2 diabetes and hyperlipidemia, depression, anxiety and insomnia. These pharmacists modify and adjust medication therapy by protocol with the focus on each individual patient reaching their optimal goal of therapy and healthier outcomes. The education and patient engagement in their own care increases compliance and adherence to therapy. Healthier and adherent patients with improved outcomes have a major impact on reducing total medical expenses (TME). Since pharmacy is a major contributor to overall healthcare costs, dedicating resources to establish a strong clinical pharmacy program to monitor, control, and educate on cost-effective prescribing has helped lower prescription costs and contribute to lowering overall TME. As noted in other sections of this testimony, Atrius Health strongly believes that Clinical Pharmacists should be recognized as billing providers since they provide a valuable resource for chronic disease and TME management.

b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?

1. Increase Health Insurance Products with Risk Arrangements - Despite being a national leader in the implementation of alternative payment methodologies (APMs), Massachusetts has seen a decline in the number of patients enrolled in the traditional health plan products (i.e. HMO) that allow providers like Atrius Health to accept meaningful risk. The Center for Health Information

and Analytics (CHIA), in its Annual Report on the Performance of the Massachusetts Health Care System in its report issued in September of 2018 that adoption of APMs decreased by 1.3% in the commercial market in 2017, driven largely by a decline in HMO members covered under an APM. In addition, even within the traditional HMO and PPO product market, there has been continued movement from fully-insured to self-insured products (where APMs are still evolving), including within the Group Insurance Commission's offerings.

Collectively, these market shifts have been disruptive to providers such as Atrius Health that participate in meaningful risk arrangements and actively work to manage total medical expense (TME). Our ability to sustain the infrastructure, processes, and care management protocols that support the delivery of integrated, high-quality, cost-effective care depends on a reimbursement and incentive system that encourages coordination of care and rewards value and quality. The shift away from risk contracts is a troubling one, and we encourage the HPC to support policies and practices across the Commonwealth to promote the use of robust APMs. We believe that over time this model has the best chance of continuing to bend the cost curve while simultaneously improving the quality of care across our Commonwealth. Additionally, new products such as the full risk contract entered into earlier this year between Atrius Health and Blue Cross, Blue Shield of Massachusetts for PPO members is a product that should be emulated and spread statewide.

2. Address Pharmaceutical Costs - Pharmaceutical costs, including for specialty drugs, biologics and generics, continue to be a major concern for patients, payers and health care providers. As reported by CHIA during the 2018 Annual Cost Trends hearing, prescription drug spending experienced the highest growth among major service categories, with pharmacy spending increasing by 5% in 2017, a slower rate than in past years, but still one that we believe warrants additional oversight by the HPC. The HPC should continue to examine the cost of oncology services by provider and setting as a cost driver related to pharmaceutical costs as some providers are paid twice what others are paid for certain oncology drugs as reported by the HPC.

3. Enact Legislation to Remove Regulatory Barriers for Providers and Reduce Health Care Costs

   There are a number of statutory changes that should be considered in the upcoming legislative session including:

   - Legislation that enhances transparency – The legislature should enact legislation addressing both pharmaceutical costs and Pharmacy Benefit Managers (PBMs). It is critical for the state to take decisive action to ensure that prescription drug price increases are warranted and that pharmaceutical manufacturers as well as PBM's, like health plans and providers, are actively engaged in the Commonwealth's effort to make health care more affordable.
   - Elimination of Scope of Practice Barriers - Atrius Health strongly supports the enactment of legislation to eliminate remaining practice barriers for **Nurse Practitioners** (NPs), specifically those related to prescriptive practice. As payers recognize, and providers increasingly rely on, NPs as primary care providers with their own patient panels, it is critical that they be permitted to practice fully within the scope of their knowledge, education and training if we hope to improve access to care, reduce administrative burdens on physicians and contain costs. Finally, **Clinical Pharmacists** should be recognized as billing providers since they provide another lower-cost alternative to physicians. Atrius Health currently utilizes Clinical Pharmacists to support medication titration under physician supervision, but without reimbursement. With the worsening trend of provider shortages at

all levels, we need to expand the availability of all reasonable lower-cost alternatives for care.

- Introduction of Laws and Regulations Promoting Telehealth - Telehealth holds considerable promise in reducing healthcare costs and providing patients with convenient, high quality care for many common conditions. Despite its many innovations in both technology and health system payment reform, Massachusetts remains behind other states in the use of telehealth as statutes here have failed to keep pace with advancing technology and the potential for improved access and convenience for patients. Atrius Health strongly recommends the state enact legislation quickly to reflect this important and evolving change in healthcare. Legislation and/or regulations should be developed to require standard codes and transmittance of coverage information to providers.

Additionally, Atrius Health believes the following should also be considered by policymakers:

- Urgent care centers affiliated with AMC's should be under the purview of the HPC since these have the ability to refer patients to higher cost hospitals when more advanced care is needed.
- The HPC should continue to examine the cost of oncology services by provider and setting. The HPC has already shown that some providers are paid twice what others are paid for certain oncology drugs. It is difficult to move patients away from the higher cost facilities that have very strong brands.
- Following the initial passage of Chapter 224, the Health Planning Council was created; however, the Council has not met for several years due to a lack of resources. Atrius Health believes that the Health Planning Council created a unique opportunity to evaluate the availability of health resources statewide in order to ensure that healthcare services meet the needs of residents without duplicating or adding additional costs and should be re-instituted.
- The state should require hospitals/skilled nursing facilities to consult with the patient's primary care provider for their preferred referral to home health agencies (while continuing to give patients the choices that Medicare requires). Atrius Health tries to use its home health agency, VNA Care, which is an integral partner in providing coordinated and more cost effective home health and hospice services to our patients; however, we frequently find that hospitals/skilled nursing facilities push patients to their own or other home health care providers.
- The state should require that all hospitals allow case managers in their EDs to facilitate care coordination of provider's patients, including directing them to a lower cost option for care. Currently we encounter resistance by some hospitals.
- State legislation, regulations and policies should be fast-tracked where they will foster innovation in the delivery or care to patients.
- Atrius Health supports the principle of "site neutrality" with respect to payment for certain outpatient health care services. Applicable state law should be amended to require notices of material change in advance of AMC's building new outpatient centers in community settings that will add to facility fees or charge AMC rates in the suburbs.

2. STRATEGIES AND POLICIES TO SUPPORT INVESTMENT IN PRIMARY CARE AND BEHAVIORAL HEALTH CARE:

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care, even though evidence suggests that a greater orientation toward primary care and behavioral health may increase health system efficiency and provide superior patient

access and quality of care. Provider organizations, payers, employers, and government alike have important roles in prioritizing primary care and behavioral health *while still restraining the growth in overall health care spending.*

a. Please describe your organization's strategy for supporting and increasing investment in primary care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

   Atrius Health has made significant investments and improvements in the delivery of both pediatric and adult primary care over the past year in order to meet the needs of our patients, and to reduce clinician burnout, which is a high priority of ours. These initiatives include, but are not limited to, the following:

   1) We are working to improve the work and workflow in support of primary care, specifically creating better coordinated teams of people to support care and enabling staff to practice at the top of their license.
   2) Of critical importance to our organization is the creation of a new department of Clinical Affairs that is charged with overseeing improvement in clinician burnout. One of the responsibilities of this new department is to annually measure and track improvement and report to our Board of Trustees.
   3) We are in the process of undergoing a major EMR upgrade with an emphasis on carefully selecting programs to improve workflow.
   4) We have instituted a standardized scheduling template across Internal Medicine at all of our sites and have expanded use of our online scheduling platform by patients to promote improved access and utilization of open appointment slots. We have seen 3000 more appointments accepted by patients since this new initiative was launched, demonstrating increased access to care.
   5) We have automated medication refill requests using software that identifies care gap needs prior to refills of certain medications (e.g., when prior testing is needed in order for a patient to refill a prescription.) Preliminary data from the medication refill initiative suggest improvements in opioid compliance.
   6) We have added nursing staff throughout our sites and have developed an intensive training program that is completed by all nursing and medical assistants in order to strengthen our ability to support our primary care providers.
   7) We have increased the use of APCs as primary care providers to increase capacity and reduce the reliance solely on physicians, particularly in the current environment where it is difficult to recruit and retain PCPs.
   8) As part of Atrius Health's MassHealth ACO work we have added social determinants of health screening for our pediatric patients and are piloting this screening in internal medicine. In addition, we have embedded care facilitators at more of our practices to support connecting patients with organizations and resources in the community that can meet their needs.

b. Please describe your organization's top strategy for supporting and increasing investment in behavioral health care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

   Atrius Health considers behavioral health to be a core clinical service required to care for our patients. With a large ambulatory behavioral health program and an ongoing

commitment to this area, our intention over the next few years is to continue to improve our system of care to streamline access to behavioral health by our patients in order to reduce our "time-to-diagnosis" and "time-to-treatment" for patients with behavioral health conditions.

In order to enhance our care over the past year we have launched several important initiatives including the following:

1. **Focus on Pediatrics** – We have embedded therapists in pediatric departments at three locations that have a large number of pediatric patients and/or referrals from pediatricians to support our patients with behavioral health needs. By embedding a therapist in the department, pediatricians are able to immediately refer patients for therapy and/or medication if appropriate.
2. **Substance Abuse Program –** Earlier this year we launched a comprehensive substance abuse program in Beverly for our patients on the north shore. The program provides therapy, prescribing, shared medical appointments and Suboxone and we have plans to spread the program to Medford.
3. **Increased Availability of Suboxone -** Over the past year the vast majority of our behavioral health prescribers have been trained and certified to prescribe Suboxone, thereby increasing access to this medication.
4. **Telehealth** – We have just launched a behavioral health telehealth program to improve access for our patients, and plan to expand the program in the future.
5. **Clinical Pharmacy** – We added a clinical specialist to do Collaborative Drug Therapy Management under the oversight of a psychiatrist.

c. Payers may also provide incentives or other supports to provider organizations to deliver high-functioning, high-quality, and efficient primary care and to improve behavioral health access and quality. What are the top contract features or payer strategies that are or would be most beneficial to or most effective for your organization in order to strengthen and support primary and behavioral health care?

Atrius Health continues to be a leader in the Massachusetts marketplace in the adoption of APMs, with over 80% of our revenue associated with risk-based contracts. Atrius Health has invested significantly in the provision of primary care and behavioral health.

We find payer approaches that are most beneficial to our ability to strengthen primary care and behavioral health are those that recognize that investments in the infrastructure to support these services will yield improvements in both clinical outcomes and Total Medical Expense. This infrastructure includes, but is not limited to, care managers, clinical pharmacists, integrated behavioral health, sophisticated data analytics and multi-disciplinary roster review. Traditional risk-based, HMO model contracts have been most successful in aligning provider, payer, and patient and rewarding provider groups that can invest in and effectively deploy primary care and behavioral health care. In line with these arrangements, payers willing to work with provider systems to streamline administrative processes or adopt common approaches to utilization review, prior authorization, referral management, and other managed care functions (or delegate these functions to the provider) can allow for greater efficiencies and less costly administrative burden on high-performing groups.

A significant barrier in our ability to support this infrastructure is the unwillingness or inability on the part of many health plans to extend these partnership models to PPO

benefit designs. This is particularly true as these PPO benefit types proliferate in the market. We have had some initial success with one of our larger payers in adopting a PPO patient attribution and risk-sharing arrangement, and are testing the operational features necessary for collective success in such a model. We are hopeful that other payers will follow suit and that employers will recognize the importance of alignment with their providers and employees on these value-based products so that market product shifts do not undermine the gains won over the past several years.

d. What other changes in policy, market behavior, payment, regulation, or statute would best accelerate efforts to reorient a greater proportion of overall health care resources towards investments in primary care and behavioral health care? Specifically, what are the barriers that your organization perceives in supporting investment in primary care and behavioral health and how would these suggested changes in policy, market behavior, payment, regulation, or statute mitigate these barriers?

We believe greater investment in primary care and behavioral health is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality[1]. Despite current high levels of healthcare spending, the proportion spent on both primary care and behavioral health is insufficient. A shift in resources to support greater access to comprehensive, coordinated primary and behavioral health care is imperative to achieving a stronger, higher-performing healthcare system. We believe that underinvestment in both primary and behavioral health care significantly reduces patient access as a result of physicians choosing other areas of specialty as well as workforce issues.

Below are suggested changes we recommend in order to shift a greater proportion of health care resources towards primary care and behavioral health care:

1. **Increase Reimbursements to Primary Care and Behavioral Health -** Rhode Island offers one example where a strategy of shifting fee schedules to favor primary care and behavioral health care appears to have paid off significantly; redirecting funds to PCPs resulted in significant reductions in TME statewide. We believe this strategy should be considered in Massachusetts. There are a number of proposed strategies and potential legislative solutions that are outlined in the Patient-Centered Primary Care Collaborative report (see Table 3.2) that should be considered. Additionally, we believe a similar savings could also be derived by increasing payment rates for behavioral health providers.
2. **Behavioral Health Reimbursement Parity –** Reimbursement for behavioral health is insufficient and as a result, many BH providers refuse to participate with payers. We believe that all payers should be required to reimburse BH providers in a way that supports this critical service and care to patients. BH providers are often out of network so they can collect their actual charges, whereas "in network" providers are often paid after a "carve out" company takes its fees—often at significantly lower rates.
3. **Address Physician Burnout Through Reducing Administrative Complexity** – Addressing physician burnout has been, and continues to be, a priority for Atrius Health. According to the AMA, the cost of physician turnover is at least $500,000 per physician and can add up to more than $1 million. This estimate includes the costs of recruitment, sign-on bonuses, lost billings and onboarding for replacement

[1] *"Investing in Primary Care" released on July 17, 2019 by the Patient-Centered Primary Care Collaborative*

physicians. While we believe there are many factors that contribute to physician burnout, many of which we are attempting to address, it is critical for the state and other stakeholders to recognize the considerable impact administrative complexity has on the number of PCPs and BH providers choosing to stay in these specialties.

Among the areas of most notable concern are prior authorization requirements and processes, quality measurement reporting and documentation/coding and billing requirements, all of which add to physician burnout. While the Commonwealth convened a Quality Measurement Alignment Task Force which Atrius Health participated that developed standardized quality measures, the group's recommendations are not enforceable and we still find that payers establish their own quality measures that providers must adhere to. There are also certain state forms (e.g., D7 Mass RMV forms for bus drivers) that can only be signed by a physician but that could easily be done by an APC. In addition, recently adopted regulations of the Board of Registration in Medicine related to informed consent have the potential to add considerably to the level of administrative complexity for physicians in Massachusetts due to the ambiguity of the regulations at the present time.

Finally, there are several Centers for Medicare and Medicaid Services requirements related to home health that require additional paperwork on the part of PCPs, which we believe APNs could easily perform that need to be revised. It would be helpful if the administration and state policymakers could assist in identifying federal requirements such as this that contribute to physician burnout and help advocate and communicate with federal leaders/agencies on our behalf.

4. **Provide Funding to Promote/Test Innovations in Primary Care and Behavioral Health –** The Legislature should provide funding to the HPC directed specifically to ambulatory care practices statewide to promote and test out innovative programs in internal medicine and behavioral health. To date, the vast majority of funding offered by the HPC has been directed towards hospitals in the state.
5. **Promote Value Based Care** – The state should devote more resources to support payment mechanisms that support and reward value-based primary care.
6. **Require all Insurers to Require Selection of a PCP –** We believe that all insurers should require that patients select a provider of choice, even if the patients have a PPO product. This would not have to require referrals, but could increase the coordination of care such that quality is improved and cost is lowered.
7. **Loan Forgiveness** – Additional consideration should be given to the role loan forgiveness programs could play in increasing the number of primary care and behavioral health providers. In particular graduates of Massachusetts medical schools who agree to practice in Massachusetts for some number of years should be targeted early in their educational careers to go into these fields.
8. **Tuition Free Medical School** – Consideration should be given to providing tuition-free medical school or meaningful grants for anyone willing to serve at least ten years as a practicing at .75 FTE PCP or psychiatrist in the state.
9. **Consumer Education –** The state should embark on a comprehensive campaign to educate consumers about the value of selecting and using a PCP for their health. We additionally support educating consumers about avoiding the Emergency Department for low acuity issues.
10. **Invest and Increase Residency Programs -**–Congress should increase the number of residency slots available to train PCPs and BH providers. Additionally, Congress should allow independent physician practices like Atrius Health to serve as residency training program sites and to receive direct and indirect funding.

11. **Utilize Other Care Providers –** It is vital that the state adopt legislation removing existing regulatory barriers for Nurse Practitioners and recognizing pharmacists as health care providers as noted in our response in Question 3.
12. **Nurse and Physician Compact –** Massachusetts should consider becoming a compact state for both nursing and physicians in order to reduce the amount of time for these clinicians to practice in the state.
13. **Other Areas for Consideration –** We believe there are other areas where the state or federal government should consider incentives geared towards PCPs and BH providers including reduced licensing fees, reduced income taxes for providers who establish practices in underserved areas and subsidized medical malpractice premiums.

3. CHANGES IN RISK SCORE AND PATIENT ACUITY: In recent years, the risk scores of many provider groups' patient populations, as determined by payer risk adjustment tools, have been steadily increasing and a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications. Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your patient population.

We are unable to complete the chart below as we are cannot determine to what extent any of these factors have contributed to increased risk scores and/or increased acuity. We do not routinely assess our population churn in this manner. These measures are relatively new and algorithms vary across payers, making it difficult to trust the metrics. In theory, risk scores will increase with patient age and acuity; however, we do not analyze population churn/trends in this manner. Logically though, age, and chronic disease, of patients entering or leaving a provider's patient pool would affect risk scores, however we don't feel like we can attribute a level of contribution to each of these factors.

It should be noted that most of the risk adjustment algorithms used by payers were developed decades ago when ICD-9 was used for diagnosis coding. While these algorithms were updated to accommodate the transition to ICD-10, we have little understanding how these updates may have led to any increases in risk scores. Except for the commonly used CMS algorithms that are in the public domain, risk adjustment methodologies used by commercial payers rely on proprietary algorithms to which neither Atrius Health nor our payer partners have full access. In our experience, regardless of which algorithm is used, demographics and patient churn in the form of employer shifts from one payer to another have also been important factors beyond our control that have affected our population risk scores.

Factors	Level of Contribution
Increased prevalence of chronic disease among your patients	Level of Contribution
Aging of your patients	Level of Contribution
New or improved EHRs that have increased your ability to document diagnostic information	Level of Contribution
Coding integrity initiatives (e.g., hiring consultants or working with payers to assist with capturing diagnostic information)	Level of Contribution
New, relatively less healthy patients entering your patient pool	Level of Contribution

Factors	Level of Contribution
Relatively healthier patients leaving your patient pool	Level of Contribution
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Level of Contribution
Other, please describe: Click here to enter text.	Level of Contribution

☐ Not applicable; neither risk scores nor acuity have increased for my patients in recent years.

4. REDUCING ADMINISTRATIVE COMPLEXITY:

Administrative complexity is endemic in the U.S. health care system. It is associated with negative impacts, both financial and non-financial, and is one of the principal reasons that U.S. health care spending exceeds that of other high-income countries. For each of the areas listed below, please indicate whether achieving greater alignment and simplification is a **high priority**, a **medium priority**, or a **low priority** for your organization. Please indicate **no more than three high priority areas**. If you have already submitted these responses to the HPC via the June 2019 *HPC Advisory Council Survey on Reducing Administrative Complexity*, do not resubmit unless your responses have changed.

Previously submitted to the HPC

Area of Administrative Complexity	Priority Level
Billing and Claims Processing – processing of provider requests for payment and insurer adjudication of claims, including claims submission, status inquiry, and payment	Priority Level
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Priority Level
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Priority Level
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Priority Level
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	Priority Level
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Priority Level
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Priority Level
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Priority Level

Area of Administrative Complexity	Priority Level
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	Priority Level
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Priority Level
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Priority Level
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level

5. STRATEGIES TO SUPPORT ADOPTION AND EXPANSION OF ALTERNATIVE PAYMENT METHODS:

For over a decade, Massachusetts has been a leader in promoting and adopting alternative payment methods (APMs) for health care services. However, as noted in HPC's 2018 Cost Trends Report, recently there has been slower than expected growth in the adoption of APMs in commercial insurance products in the state, particularly driven by low rates of global payment usage by national insurers operating in the Commonwealth, low global payment usage in preferred provider organization (PPO) products, and low adoption of APMs other than global payment. Please identify which of the following strategies you believe would most help your organization continue to adopt and expand participation in APMs. **Please select no more than three.**

- ☐ Expanding APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payments
- ☒ Identifying strategies and/or creating tools to better manage the total cost of care for PPO populations
- ☒ Encouraging non-Massachusetts based payers to expand APMs in Massachusetts
- ☒ Identifying strategies and/or creating tools for overcoming problems related to small patient volume
- Enhancing data sharing to support APMs (e.g., improving access to timely claims data to support population health management, including data for carve-out vendors)
- Aligning payment models across payers and products
- Enhancing provider technological infrastructure
- Other, please describe: Click here to enter text.

Pre-Filed Testimony Questions: Attorney General's Office

1. For provider organizations: please submit a summary table showing for each year 2015 to 2018 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.

2. Chapter 224 requires providers to make price information on admissions, procedures, and services available to patients and prospective patients upon request.

    a. Please use the following table to provide available information on the number of individuals that seek this information.

Health Care Service Price Inquiries Calendar Years (CY) 2017-2019			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	**Q1**		833
	Q2		787
	Q3		837
	Q4		874
CY2018	**Q1**		1027
	Q2		986
	Q3		906
	Q4		825
CY2019	**Q1**		825
	Q2		809
	TOTAL:		8709

    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 analysis.

    Atrius Health monitors customer service related metrics such as average speed of call answer, call abandon rate and length of time speaking with patients and reports are generated monthly. Performance is consistently within Atrius Health's customer service standards, with over 90% of calls from patients answered within 30 seconds and call abandon rate less than 2%. The average amount of time spent on these inquiries is approximately 3-4 minutes. Although we do not have formal process for monitoring the

accuracy of responses to requests for price information, complaints by our patients regarding incorrect pricing information are rare.

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 process of answering calls, researching requests, and providing a response is labor intensive. To make the process more efficient, Atrius Health developed a pricing template for the most commonly requested pricing information (e.g., colonoscopy with biopsy, endoscopy with polypectomy and mammogram screening with tomosynthesis). The development of this pricing template has allowed Atrius Health to provide immediate pricing response which we call "one-touch" service during business hours for 98% of pricing requests. Any requests for pricing information that requires additional research is provided within 2 business days.

3. For hospitals and provider organizations corporately affiliated with hospitals:

Not applicable.

a. For each year **2016 to present**, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing the hospital's operating margin for each of the following four categories, and the percentage each category represents of your total business: (a) commercial, (b) Medicare, (c) Medicaid, and (d) all other business. Include in your response a list of the carriers or programs included in each of these margins, and explain whether and how your revenue and margins may be different for your HMO business, PPO business, and/or your business reimbursed through contracts that incorporate a per member per month budget against which claims costs are settled.

b. For **2018 only**, please submit a summary table for your hospital or for the two largest hospitals (by Net Patient Service Revenue) corporately affiliated with your organization showing for each line of business (commercial, Medicare, Medicaid, other, total) the hospital's inpatient and outpatient revenue and margin for each major service category according to the format and parameters provided and attached as **AGO Provider Exhibit 2** with all applicable fields completed. Please submit separate sheets for pediatric and adult populations, if necessary. If you are unable to provide complete answers, please provide the greatest level of detail possible and explain why your answers are not complete.

2015

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Net Cap Revenue		Incentive-Based Revenue		Net Cap Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					$ 95,808,638		$ 9,594,587						
BCBSMA PPO										$ 123,387,515			
Tufts FI					$ 23,220,938		$ 1,372,391						
Tufts SI	$ 11,580,139		$ 719,502										
Tufts PPO (incl. CareLink)										$ 30,713,016			
HPHC FI					$ 39,964,330		$ 471,232						
HPHC SI					$ 71,595,067		$ 2,071,886						
HPHC PPO (incl. Passport & Independence)										$ 53,462,881			
NHP Comm			$ 517,000		$ 12,001,990				$ 3,112,348				
Fallon	$ 3,319,424			$ 135,975									
Aetna	$ 18,922,602			$ 150,000									
Other Commercial (Any remaining payors not listed above - lump together)										$ 29,442,067			
Total Commercial	$ 33,822,165		$ 1,236,502	$ 285,975	$ 242,590,963		$ 13,510,096			$ 237,005,479			
NHP Medicaid					$ 24,916,824		$ 1,000,000		$ 5,919,288		$ 298,432		
Total Managed Medicaid					$ 24,916,824		$ 1,000,000				$ 298,432		
Medicaid FFS										$ 2,392,156			
Tufts Medicare Preferred					$ 51,889,142		$ 505,314			$ 1,447,360			
Commercial Medicare Subtotal													
Medicare FFS										$ 60,825,350			
GRAND TOTAL	$ 33,822,165		$ 1,236,502	$ 285,975	$ 319,396,929		$ 15,015,410		$ 9,031,636	$ 301,670,345	$ 298,432		

$ 680,757,394

(1) Represents Net Capitation Revenue which is the total revenue earned for each of our Risk Contracts. This is consistent with last year's filing.
(2) Represents estimates since final calculations/settlement do not occur until October/November
(3) As of January 1, 2015, Atrius Health, Inc. includes only HVMA, DMA and GMG. These entities merged to a single entity of Atrius Health, Inc. as of July 1, 2015.

2016

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Net Cap Revenue		Incentive-Based Revenue		Net Cap Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					$ 88,020,886		$ 9,061,866						
BCBSMA PPO										$ 126,523,361			
Tufts FI					$ 29,583,901		$ 1,260,852						
Tufts SI	$ 19,952,282		$ 1,281,387										
Tufts PPO (incl. CareLink)										$ 27,445,907			
HPHC FI					$ 37,100,381		$ 697,758						
HPHC SI					$ 95,261,280		$ 3,173,390						
HPHC PPO (incl. Passport & Independence)										$ 41,281,672			
NHP Comm					$ 23,960,187		$ 800,000		$ 1,812,932				
Fallon	$ 3,308,596			$ 129,640									
Aetna	$ 19,406,362			$ 149,779									
Other Commercial (Any remaining payors not listed above - lump together)										$ 24,440,335			
Total Commercial	$ 42,667,240		$ 1,281,387	$ 279,419	$ 273,926,635		$ 14,993,866		$ 1,812,932	$ 219,691,275			
NHP Medicaid					$ 28,356,572		$ 1,300,000		$ 246,147				
Total Managed Medicaid					$ 28,356,572		$ 1,300,000		$ 246,147				
Medicaid FFS										$ 1,582,154			
Tufts Medicare Preferred					$ 73,965,404		$ 503,662			$ 651,709			
Commercial Medicare Subtotal					$ 73,965,404		$ 503,662			$ 651,709			
Medicare FFS										$ 62,262,719			
GRAND TOTAL	$ 42,667,240		$ 1,281,387	$ 279,419	$ 376,248,611		$ 16,797,528		$ 2,059,079	$ 284,187,857			

$ 723,521,121

(1) Represents Net Capitation Revenue which is the total revenue earned for each of our Risk Contracts. This is consistent with last year's filing.
(2) Represents estimates since final calculations/settlement do not occur until October/November
(3) As of January 1, 2015, Atrius Health, Inc. includes only HVMA, DMA and GMG. These entities merged to a single entity of Atrius Health, Inc. as of July 1, 2015.

2017

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Net Cap Revenue		Incentive-Based Revenue		Net Cap Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					$ 115,716,188		$ 7,699,142						
BCBSMA PPO										$ 136,831,423			
Tufts FI					$ 30,670,666		$ 1,336,572						
Tufts SI	$ 20,860,936		$ 804,703										
Tufts PPO (incl. CareLink)										$ 26,786,148			
HPHC FI					$ 43,865,991		$ 620,543						
HPHC SI					$ 113,796,869		$ 3,428,234						
HPHC PPO (incl. Passport & Independence)										$ 41,227,943			
NHP Comm					$ 24,745,653		$ 831,589		$ 1,338,376				
Fallon	$ 3,573,875			$ 149,570									
Aetna	$ 20,889,677			$ 149,779									
Other Commercial (Any remaining payors not listed above - lump together)										$ 14,498,130			
Total Commercial	$ 45,324,488		$ 804,703	$ 299,349	$ 328,795,367		$ 13,916,080		$ 1,338,376	$ 219,343,644			
NHP Medicaid					$ 27,237,696		$ 1,158,299						
Total Managed Medicaid					$ 27,237,696		$ 1,158,299		$ -				
Medicaid FFS										$ 2,114,360			
Tufts Medicare Preferred					$ 72,362,629		$ 517,038			$ 1,275,568			
Commercial Medicare Subtotal					$ 72,362,629		$ 517,038			$ 1,275,568			
Medicare FFS										$ 85,309,476			
GRAND TOTAL	$ 45,324,488		$ 804,703	$ 299,349	$ 428,395,692		$ 15,591,417		$ 1,338,376	$ 308,043,048			

$ 799,797,073

(1) Represents Net Capitation Revenue which is the total revenue earned for each of our Risk Contracts. This is consistent with last year's filing.
(2) Represents estimates since final calculations/settlement do not occur until October/November
(3) As of January 1, 2015, Atrius Health, Inc. includes only HVMA, DMA and GMG. These entities merged to a single entity of Atrius Health, Inc. as of July 1, 2015.

2018

	P4P Contracts				Risk Contracts				FFS Arrangements		Other Revenue Arrangements		
	Net Cap Revenue		Incentive-Based Revenue		Net Cap Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
BCBSMA FI & SI					$ 104,848,095		$ 7,865,628						
BCBSMA PPO										$ 140,078,411			
Tufts FI					$ 28,851,970		$ 2,489,397						
Tufts SI	$ 19,495,942		$ 743,700										
Tufts PPO (incl. CareLink)										$ 25,836,435			
HPHC FI					$ 41,464,098		$ 762,620						
HPHC SI					$ 108,408,101		$ 3,949,703						
HPHC PPO (incl. Passport & Independence)										$ 43,894,745			
NHP Comm					$ 20,618,893		$ 728,163		$ 2,308,955				
CIGNA										$ 12,905,305			
United HealthCare										$ 13,676,747			
Fallon	$ 3,525,503			$ 137,795									
Aetna	$ 23,546,099			$ 144,000									
Other Commercial (Any remaining payors not listed above - lump together)										$ 30,283,962			
Total Commercial	$ 46,567,544		$ 743,700	$ 281,795	$ 304,191,157		$ 15,795,511		$ 2,308,955	$ 266,675,605			
NHP Medicaid					$ 22,262,889								
Total Managed Medicaid					$ 22,262,889		$ -		$ -				
Medicaid FFS										$ 1,423,616			
Tufts Medicare Preferred					$ 54,633,405		$ 512,416						
Commercial Medicare Subtotal					$ 54,633,405		$ 512,416			$ -			
Medicare FFS										$ 94,844,293			
GRAND TOTAL	$ 46,567,544		$ 743,700	$ 281,795	$ 381,087,451		$ 16,307,927		$ 2,308,955	$ 362,943,514			

$ 810,240,886

(1) Represents Net Capitation Revenue which is the total revenue earned for each of our Risk Contracts. This is consistent with last year's filing.
(2) Represents estimates since final calculations/settlement do not occur until October/November
(3) As of January 1, 2015, Atrius Health, Inc. includes only HVMA, DMA and GMG. These entities merged to a single entity of Atrius Health, Inc. as of July 1, 2015.