

## **Exhibit A: Notice of Public Hearing**

---

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

Scheduled hearing dates and location:

**Monday, October 5, 2015, 9:00 AM  
Tuesday, October 6, 2015, 9:00 AM  
Suffolk University Law School  
First Floor Function Room  
120 Tremont Street, Boston, MA 02108**

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to [HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us), or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: [www.mass.gov/hpc](http://www.mass.gov/hpc).

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: <http://www.suffolk.edu/law/explore/6629.php>. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at [Kelly.A.Mercer@state.ma.us](mailto:Kelly.A.Mercer@state.ma.us) a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

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

## **Exhibit B: Instructions and HPC Questions for Written Testimony**

---

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: [HPC-Testimony@state.ma.us](mailto:HPC-Testimony@state.ma.us). **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at [Kelly.A.Mercer@state.ma.us](mailto:Kelly.A.Mercer@state.ma.us) or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

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

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

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

[Remainder of page intentionally left blank]

## Exhibit B: HPC Questions for Written Testimony

---

1. Chapter 224 of the Acts of 2012 (Chapter 224) requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
  - a. Please describe your organization's efforts in the last 12 months to meet this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs) on (i) total medical expenses, (ii) premiums, and (iii) provider quality. Please specifically describe efforts and analyses related to bundled payment and similar payment methods.

Fallon Health continues its work with providers in its commercial networks to move into Alternative Payment Methods (APMs). Our APM models include:

- a) upside only shared savings arrangements;
- b) partial risk up and down arrangements where surpluses/deficits are limited or capped at a mutually agreed target; or
- c) major risk up and down arrangements where providers do not assume 100% risk but are responsible both up and down for whatever portion of risk they assume, typically 20% to 50% with no cap on either surplus or deficit share.

During the past 12 months Fallon Health has improved its commercial risk model(s) by refining the risk acuity calculations, improving the reinsurance options, improving the benefit buy down adjustment, and standardizing our reports. We do not offer bundled payment arrangements for specific procedures. Given the size of our commercial membership and the resources needed to support provider APMs, we have determined that it is more efficient to offer global budget arrangements that engage providers to manage the total medical expenses associated with their Fallon Health member population. This global budget approach incentivizes providers to use evidence based, high quality, efficient and integrated care to improve patient outcomes while lowering total medical costs. With the provider groups that have agreed to these APMs, we have found that there is typically slower growth in total medical expense with no deterioration in quality, patient outcomes, or patient satisfaction.

- b. Please describe specific efforts your organization plans to undertake between now and October 1, 2016 to increase the use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider and product types. Please specifically describe efforts related to bundled payment and similar payment methods.

As mentioned in 1.a above, Fallon Health does not see a demand for bundled payments in the marketplace and does not see bundled payments having a significant effect on slowing or decreasing overall cost trends. During the next 12 months Fallon Health will continue to propose global budget arrangements to those providers who have both sufficient Fallon Health commercial membership and sufficient infrastructure within their own organizations to sustain a shared savings or an up and down risk arrangement.

Fallon Health will continue to offer global budget arrangements as we see this as a) the most effective way for providers to focus on the total continuum of healthcare services available to their patients and b) the model that most incentivizes providers to integrate care (physical and behavioral) across the entire continuum of care. A major constraint for Fallon Health is that our total commercial membership (about 125,000 covered lives) is spread across a very large provider network. Unfortunately, this results in large numbers of provider groups who have very small numbers of Fallon Health commercial members assigned to their patient panels. When this situation exists, it becomes more difficult to engage these provider groups in discussions regarding APM arrangements and in some cases the member numbers are so small that it does not make sense statistically for the provider groups to assume any kind of risk related to their small patient populations.

- c. In its 2014 Cost Trends Report, the HPC stated that major payers and providers should begin introducing APMs for preferred provider organization (PPO) covered lives in 2016, with the goal of reaching at least one-third of their PPO lives that year. Please describe your plans to achieve this goal. Additionally, please describe any specific barriers for moving self-insured business into APM arrangements.

Fallon Health is primarily an HMO. Only 5% of our membership is covered under our PPO product, with 40% of that membership residing out of state. We are not experiencing an increase in PPO membership like other carriers in the state.

The commercial PPO membership is small and is distributed across other states in addition to the Commonwealth of Massachusetts. This small membership is again spread across a very large number of providers with no single provider group having a large commercial PPO panel. This creates a significant barrier to developing APMs with the PPO provider network. Statistically and financially there is too much risk and effort involved for too little potential reward. There is not enough potential for financial surplus on such a small population to engage the interest of provider groups.

With respect to moving self-insured groups into APMs Fallon Health does have a small number of large self-insured groups that have enough members to engage certain large provider groups' interest. During the next 12 months we will attempt to pilot APMs with one or more large provider groups who deliver care to significant numbers of patients from these self-insured groups. We have already designed a proposed APM model for this purpose. Now we have to negotiate this APM with both the targeted employer groups and specific provider group(s) and formalize these arrangements in both the employer group and provider contracts. Having to negotiate with both self-insured employer groups and provider groups to create an APM adds an additional level of complexity that we do not have to surmount when creating an APM for fully insured members. Given the need to obtain agreement from both parties and the limited number of large self-insured groups that work with us, we anticipate that the transition of self-

insured members into APM arrangements will be a slower process than it is for fully insured members.

2. Describe your organization's efforts to develop insurance products or plan designs that encourage members to use high-value (high-quality, low-cost) services, settings, and providers, and detail progress made over the past year. Example of such efforts include: phone triage or telehealth services; targeted information about and incentives to reduce avoidable emergency department (ED) use; and reference pricing, or cash-back reward programs for using low-cost providers. Please describe the result of these efforts and attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending. Please describe efforts your organization plans between now and October 1, 2016 to continue progress in encouraging members to use high-value services, settings and providers. What barriers have you identified to introducing insurance products or plan designs that encourage members to use high-value services, settings and providers in Massachusetts?

Fallon Health has been a leader in developing limited and tiered network products that encourage the use of high-quality, low cost providers. These products have continued to grow and now represent 50% of our commercial membership. These products represent an exceptional value for employers and consumers – for example, our Steward Community Care product is priced 20% below our broad network HMO. Sadly, we have been forced to discontinue offering Steward Community Care in the merged individual and small group market. The introduction of risk-adjustment in the merged market has rendered products like Steward Community Care unsustainable. The Massachusetts risk adjustment methodology – different from the national methodology used in the 49 other states – is gravely flawed. It grossly underpays – by one-half – the cost of caring for members in generally good health. We have even been forced to reduce our wellness benefits in the merged market, because of the perverse incentives created by the Massachusetts methodology.

The Massachusetts legislative framework has also prevented us from expanding our tiered products. Chapter 288, which was intended to stimulate the growth of tiered networks, includes an unfortunate provision that enables providers to opt out of any products in which they are not favorably tiered, regardless of their quality or cost. This has effectively enabled our large and increasingly consolidating provider systems to block expansion of tiered products.

Our SmartShopper tool allows members who choose lower cost providers to earn an additional incentive of up to \$500, depending on the service. In some cases, we actively outreach to members, one example is members receiving infusion, who we encourage to receive infusion in the home setting instead of a hospital or doctor's office. Members save on their cost-sharing and become eligible for a SmartShopper incentive. They also have a better overall experience in the home setting. In the first year of our infusion program we reduced expenses by 8.7% and we have continued to add additional medications to our initiative. We also outreach to members scheduled for high tech radiology services and help redirect them to lower cost providers. We estimate that this has reduced our MRI and CT scan expenses by 3.6%. Members scheduled for joint

replacement surgery are enrolled in our Joint Effort program, which provides services at home to eliminate the need for a post-acute SNF stay. The savings from reduced SNF utilization are 71.6%.

3. Chapter 224 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures and services through a readily available “price transparency tool.” Please describe your organization’s progress in meeting this requirement. If you had a tool in place prior to November, 2012, please describe your organization’s prior experience, including how long your tool has been in use and any changes you have made to the tool over time.

Initially, Chapter 224 created a transparency requirement that required insurers to respond to member inquiries within two working days. To satisfy that requirement, we provided estimates through our customer service toll-free telephone number and our member website. By October 1, 2014 we were required to respond to inquiries in real time. For that purpose we partnered with a vendor to create a web-based solution for consumer use which provides a wide variety of cost data for our members. Unique to our solution is our SmartShopper program, which provides incentive reimbursements to members who choose lower cost providers.

- a. Using **HPC Payer Exhibit 1** attached, please provide available data regarding the number of individuals that seek this information and identify the top ten admissions, procedures and services about which individuals have requested price information for each quarter listed below and the number of inquiries associated with each.
- b. Do consumers have the ability to access cost data for the following types of services (yes/no)? If no, please explain.

Inpatient	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Outpatient	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Diagnostic	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Office Visits (medical)	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
Office Visits (behavioral)	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>

We provide information for office visits via our customer service department. This data is not yet available via the online tool.

- c. Does consumer-accessible cost data reflect actual provider contracted rates? If no, please explain.  
 Yes  No

37T

- d. Do you provide actual out-of-pocket estimates that reflect a member's specific benefits and deductible status? If no, please explain.

Yes  No

37T

- e. Do you provide provider quality and/or patient experience data with your cost data? If no, please explain.

Yes  No

We do provide access to Healthcare Compass, the consumer quality tool created and maintained by the MHQP, directly on the Fallon Health website.

- f. Please describe any information you have collected regarding how your members use this information and the value of this information to members. Please describe any analyses you have conducted to assess the accuracy of estimates provided and the impact of increased price transparency for members as well as any limitations in the tools you have identified and ways your organization plans to address them.

Fallon Health has taken the unique step to offer members an incentive reimbursement for utilizing low cost providers identified via our transparency tool, which is known as our SmartShopper program. Our SmartShopper program is one way in which to reward members for taking an active role in their health care and encourage the use of the tool. Feedback from the market continues to be positive regarding the incentive component. We continue to review the list of procedures and services available via the tool and monitor opportunities to add additional services based upon feedback from our members. The volume of users remains very small despite numerous marketing and outreach campaigns.

Member feedback around the tool remains positive, however, some have raised concerns that navigating the health care marketplace has been a challenge. Obstacles exist when providers are resistant to redirection efforts and moving referrals from one provider to another provider outside of their referral circle can be difficult. Additionally, provider groups and hospitals do not have a common technology platform to easily exchange test results to those outside of their organization. Fallon Health remains committed to assisting our members in removing roadblocks to obtaining care at alternate locations.

We have worked closely with our vendor to validate the accuracy of the estimates and have spent considerable time reviewing the cost outputs from the tool and reviewing these estimates based on our contracted rates with the providers.

4. The Massachusetts health care environment has recently undergone significant changes, including multiple hospital and physician group acquisitions and affiliations. Please describe your views on recent market changes, including any impacts these changes have had on costs (e.g., prices and total medical expenses), referral patterns, quality and access to care.

In Fallon Health's view, the changes that have not happened during the past year have been more important than the changes that have happened. In Fallon Health's view none of the first or second tier systems significantly increased their marketing or pricing clout during the past 12 months. Instead, most large systems and even the standalone community providers appeared to be focused on developing their service lines, managing cost, and preparing their organizations to be more competitive in a health care environment where revenue increases are smaller and new growth opportunities are more difficult to find.

With respect to quality, Massachusetts providers, both physicians and hospitals typically perform at the 90<sup>th</sup> percentile or higher in relation to national benchmarks and the various affiliations, mergers, and the most recent consolidations do not seem to have impaired their quality rankings. Although past consolidations did lead to increased market power and higher physician and facility prices these newer consolidations and acquisitions appear to be different. Often, these newer deals seem designed to maximize efficiencies by allowing community hospitals to focus on what they do best and centralizing more complex services at a core tertiary partner.

In terms of overall increases in TME, Fallon Health has actually observed that the provider consolidations, mergers, and affiliations that have occurred in the past 12-24 months do not seem to have affected prices in a negative way. Two years ago we would have expected TME to increase at an annual rate of approximately 8.5%. However, with increased scrutiny by the Commonwealth, the efforts of the Attorney General's Office, the passage of Chapter 224 and its various requirements, and the oversight of the Health Policy Commission, we have actually seen an overall trend in TME that is closer to 5.8% on an annual basis. The one exception to this trend is the rising cost of specialty pharmacy but that cost push factor is much more tied to the power and marketing clout of national drug manufacturers than any provider consolidations happening in the local market.

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

One acceptable reason for different prices for the same services is the actual cost difference among providers operating in very different areas of the state. For example, a hospital operating in eastern Massachusetts and a hospital operating in western Massachusetts may offer many of the same services but the costs to hire staff and maintain a hospital operation in western Massachusetts is very different from running a

similar operation in the metro Boston area. The eastern Massachusetts hospital has to pay its staff more because the cost of living in greater Boston is much higher than the cost of living in western Massachusetts. Also, many of the services purchased from local vendors in eastern Massachusetts are more costly than the same services purchased from vendors in western Massachusetts. In Fallon Health's view, differences in regional cost must be taken into consideration for both fee for service reimbursement and when developing global budgets for Alternative Payment Methodologies (APMs). Another valid situation can occur when comparable services are offered at two different hospitals but one of the hospitals is a teaching hospital or academic medical center and the other is a standard community hospital. Both hospitals offer many of the same services on both an inpatient and outpatient basis, however, the academic medical center is also a major trauma provider, a transplant provider, and a tertiary level of care provider, and has to maintain services, staff and technology investment 24-7 that a community hospital does not have to provide. These greater infrastructure and ongoing maintenance expenses are a part of the reason that academic medical centers have higher rates than community hospitals.

The primary valid reason for global budgets to vary across different providers is the risk acuity of the patients/members assigned to the primary care providers in a specific global risk arrangement. The characteristics of member populations can vary widely from one provider group to another. For example, if a provider group is primarily composed of physicians 50 or older, then we frequently find that their patient panels are older as well. These patients have often been with their primary provider for a long time and have aged along with their PCP. These older commercial populations typically have more chronic health problems and are using more ongoing pharmacology than younger commercial members. So, a provider group assuming risk for an older, sicker population would receive a larger global budget on a per member per month funding basis than a similar or identical size provider group with a younger, healthier population. This represents one of the clear differences between the commercial global risk budgets of the 80's and 90's versus the global budgets developed in 2015. In that earlier period the global budgets were typically a flat percentage of the commercial premium with no significant adjustments for member population other than age and gender. Now, global budgets are more likely to be built from the "ground up" using a year or more of history of actual utilization and cost associated with specific members that the physician group already has been treating under the fee for service model. That actual data is evaluated for risk acuity to determine whether the provider group is managing the population efficiently, i.e. the total medical expense on a pmpm basis is at or below what would be expected given the overall risk acuity of the population or inefficiently, i.e. the total medical expense for the member population is above what the benchmark expectation would be for a population with that overall risk acuity.

Unacceptable reasons for different pricing or a higher global budget can occur when the provider(s) ask for higher fee for service rates or higher global budgets in a geographic area where the costs of doing business do not support higher rates and/or where the acuity

level of the member population does not support the global budget requested by the provider. This frequently happens when a hospital provider reviews the publicly available data online and decides that their rates should be “brought up” to other hospitals in the state, often without considering the differences in regional costs or the services available at their facility versus the services available at the facility being used for comparison.

Unacceptable reasons for different, i.e. excessive pricing also occur when a single provider group or hospital has a “geographic lock” on an area by virtue of being the only provider in that area. Instead of basing rates on a proposal that covers costs plus a reasonable surplus/profit for growth some providers with a geographic “moat” try to charge whatever the market will accept. Finally, there are providers who are so well known for both their standard and tertiary services that it is nearly impossible to sell a commercial network product in Massachusetts without having these providers participate. These providers understand that fact and take advantage of their “irreplaceability” to insist on rates that would be unacceptable coming from any other provider.

- b. What steps are you taking to address this variation in prices and budgets? Please include any approaches you have considered implementing to reduce the role that past or current fee-for-service price disparities play in global budgets.

Fallon Health is using several different strategies to address the historical variations in unit pricing and budgets among different facilities. These include but are not limited to:

- Negotiating smaller annual increases with higher priced providers than with other providers so that the less expensive providers can “catch up” with pricing over time.
- Negotiating risk arrangements with the higher priced providers if possible so that these providers will focus on the costs associated with receiving care within their group or facility and will move to decrease costs, eliminate unnecessary utilization, and/or offer Fallon less expensive rates for members who choose one of the group’s physicians as their primary care provider. Any or all of these reactions by the high priced provider tend to reduce Total Medical Expense (TME) with their patient population.
- In conjunction with the Chapter 224 requirement to provide a real time transparency tool, we partnered with a vendor to design a market differentiator that provides incentive payments to members that decide to visit a more cost efficient provider. Our SmartShopper program allows members to shop for a specific set of medical procedures and returns a result of the most cost efficient network providers within a defined radius of the member’s home address. There are three levels of reimbursement; a visit to the most cost efficient provider will

result in the highest incentive reimbursement to the member with lower incentive reimbursements given at the lower levels.

- Similar to our SmartShopper program, our SmartChoice program targets high-tech radiology, specifically MRIs and CAT Scans, for “soft steerage” by encouraging providers to direct members to lower cost and often more convenient facilities. If a provider selects a higher cost facility, SmartChoice representatives will recommend a lower cost option to the provider. Depending on the provider’s choice, SmartChoice will also outreach to the member to inform them of their options. Since this is a voluntary program members still retain the decision as to where they are most comfortable receiving their care. This strategy encourages care to occur at lower cost, more efficient providers and encourages high cost outlier providers to reconsider pricing their services closer to the rest of the provider market.
  - Working more closely with high quality, low cost providers to grow their Fallon membership via longer term network contracts, joint marketing efforts, and investments in infrastructure that will increase quality, reduce ongoing costs, and improve patient/member satisfaction.
6. Please describe your policies and procedures, including notice policies and protections from out-of-network charges, for members referred to out-of-network providers and cases in which services at in-network facilities are provided by out-of-network providers. Please describe any policies you have in place to ensure that a referring provider informs a patient if a provider to whom they are referring the patient is not in the patient’s insurance network.

Fallon Health has standard language in its commercial provider network contracts that requires participating physicians and participating facilities to use and refer to other in-network participating providers whenever possible. Both hospitals and physicians are required to make best efforts to make this happen. Our HMO Evidences of Coverage state: “Your PCP is responsible to ensure that the provider he refers you to is within the network.”

In situations where the in-network commercial network provider refers the commercial product member to an out-of-network provider, Fallon Health will only hold the member responsible for the same cost sharing amount that he/she would have experienced if they had been treated by an in-network provider.

For commercial HMO members, whenever a location is part of the plan’s commercial HMO network, we will cover medically necessary covered benefits delivered at that location and the member will not be responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by out-of-network providers unless the member has a reasonable opportunity to choose to have the service performed by a network provider. This statement is also included in the member’s Evidence of Coverage as required by Chapter 224 of the Acts of 2012. This policy primarily protects members being seen in hospital settings where the hospital is participating for a commercial network product, but some

or all of the Emergency Department physicians, anesthesiologists, radiologists and pathologists at that hospital are non-participating for the member's specific commercial network product.

7. The Medicare Payment Advisory Commission and others have noted that patient visits to outpatient-based practices, which can bill a "facility fee," are increasing faster than visits to freestanding practices. Please describe any shift you have observed toward increased use of outpatient-based practices and the impact of facility fees and any such shift toward the use of outpatient-based practices on health care costs, quality and access.

Fallon Health has not observed any notable increase in outpatient physician practices billing a "facility fee" in addition to standard professional billing. When contracting with physician groups, either employed or independent, for commercial networks, we contract for direct professional services only. These Fallon Health physician contracts do not include separate reimbursement for "facility fees" or "clinic fees". It would not be appropriate to pay a contracted physician a separate facility fee since the contracted physician fee reimbursement already contains two components: a professional portion, i.e. for the evaluation and treatment the physician performs and a technical component, i. e. to cover the costs of the office, materials, and support staff needed to run the physician practice. The only type of Fallon Health contract that includes facility fees or clinic fees are hospital contracts.

In hospital contracts, facility/clinic fees exist to reimburse the hospital on those occasions when a specialty physician needs to treat a patient in the outpatient department of the hospital rather than treating the patient in the specialist's own office. There are various reasons for this to occur, typically involving the safety of the patient. However, we have a mechanism in place to ensure that a specialty physician does not receive the same payment when he/she treats a patient in a hospital outpatient setting instead of treating the patient in the physician's own office. We program into our claims payment system an adjustment known as the Site of Service adjustment. Every claim submitted by a physician has to have a site of service field indicating whether the services were provided in an office setting or in a hospital outpatient setting. If the site of service field indicates that the services were performed in the physician's office, the physician receives full payment including both the professional and technical components of the contracted reimbursement amount. However, if the site of service field indicates the services were performed in a hospital setting, the payment that the physician would normally have received (for office based services) is instead reduced. The technical component portion is eliminated. We do this as part of our normal operating policies because we know that in addition to the physician claim there will also be a facility or clinic claim coming from the hospital for the physician's use of its outpatient facility. So, there is no overpayment involved. A physician claim reimbursement will only include a technical component when the physician performs services in an office setting. So, a contracted physician has an actual disincentive to submit a claim using an outpatient facility setting as the site of service since they will receive less reimbursement rather than more reimbursement.

In summary, Fallon Health has not observed any issues associated with facility fees being charged in conjunction with physician office visits. We do not see this occurring within our commercial

product networks and since it is not occurring we do not see this as having any effect on cost of care, access to care, or quality of care

8. The Commission has identified that spending for patients with co-morbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health conditions. As reported in the July 2014 Cost Trends Report, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
  - a. Please describe your efforts in the past 12 months to effectively address the needs of these patients in an integrated manner, clearly identifying areas of progress, attaching any analyses you have conducted.
    - Weekly integrated rounds to discuss members from a biopsychosocial perspective attended by a Medical Director and medical and physical health utilization management and case management staff. Annually conduct staff surveys about integration efforts and the integrated rounds and utilize survey results to initiate programmatic changes.
    - Monthly integrated meeting with health plan Senior Medical Director, Director of Case Management, Director of Utilization Management, Behavioral Health Director, Case Management Managers, Disease Management Director, Clinical Manager and Beacon Health Strategies (Beacon Health Strategies is Fallon Health's vendor for behavioral health managed care, i.e. "carve out") Program Director to discuss integration issues, training needs and training curriculum. Weekly integrated meeting between Beacon Manager and Case Managers and Behavioral Health Director to discuss training needs and policy development. Periodic trainings for Nurse Case Managers about diagnoses and periodic trainings for behavioral health staff about medical conditions.
    - Fallon Health Nurse Case Managers and Beacon social workers co-manage members with medical and behavioral health comorbidities. Beacon staff is located on site at Fallon Health to promote staff-to-staff discussions about members. Modification of Fallon Health Social Worker's role to triage members with behavioral health needs and refer to Beacon as appropriate.
    - Fallon Health's Behavioral Health Oversight Committee and Beacon representatives meet up to eight times per year to discuss regulatory changes, policy issues and updates on clinical programs Beacon is conducting on our behalf and quality initiatives that address behavioral and medical concerns.
  - b. Please describe your specific plans for the next 12 months to ensure that integrated treatment is provided for these patients, including specific goals and metrics you will use to measure performance whether you use a behavioral health managed care organization ("a carve-out") or manage behavioral health care within your organization.

Fallon Health will continue with the techniques and strategies described above. In addition, we will work on initiatives with Beacon to have individuals with lived experience attempt to engage members to decrease emergency department (ED) visits,

decrease inpatient psych admits, increase community-based services and increase adherence to treatment plans. We also plan to collaborate with Beacon and a community-behavioral health provider on an ED wraparound project where the community provider engages with members to decrease ED visits, decrease inpatient psych admits, increase community-based services and increase adherence to treatment plans. This project will focus on high ED users who have medical conditions that are exacerbated by a substance use disorder with goal to engage in behavioral health case management or engage in community based treatment and decrease unnecessary ED use.

9. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2012 to CY2014 according to the format and parameters provided and attached as **HPC Payer Exhibit 2** with all applicable fields completed. Please explain for each year 2012 to 2014, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).

Attached is the summary table showing actual observed allowed medical trends. For the time frames requested we did not have specific studies to break mix between provider and service mix so the all the mix has been put into the Service Mix column. We do believe that this “Allowed” trend understates the true allowed trend if there were no benefit buy-downs. This is true even though we are looking at allowed trends that include both the payer and member share of the expense because as the member’s share of the cost rises it has an impact on the underlying utilization. This understates the utilization and therefore the total trend in the table below.

I, W. Patrick Hughes, am the President and CEO of Fallon Community Health Plan, Inc. (Fallon Health). I am legally authorized and empowered to represent Fallon Health for the purposes of this testimony. The responses contained in this submission were prepared by employees of Fallon Health who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury on this 11<sup>th</sup> day of September 2015:



W. Patrick Hughes  
President and CEO  
Fallon Community Health Plan, Inc.

HPC Pre-Filed Testimony - Payer Questions  
HPC Payer Exhibit 1

Health Care Service Price Inquiries CY2014-2015				
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person	Aggregate Average Time to Resolve Inquiries*
CY2014	Q1		6	2.17 days
	Q2		8	3 days
	Q3		6	2.5 days
	Q4	1813	9	3.75 m/3.5 d
CY2015	Q1	881	5	3.82 m/2.4 d
	Q2	684	8	3.37 m/6.25 d
<b>TOTAL:</b>		3378	42	

- Note: 1. Inquires via the website are resolved in real time and are tracked in minutes.  
2. In-person and telephone inquires are timed from date of receipt of request to resolution. However, many requests are incomplete and require additional informatinon. Once all of the information necessary to fulfill a request is gathered, inquires are resolved in 2 working days or less.

**Identify the Top 10 Admissions, Procedures and Services for CY2014 by Quarter:**

<b>CY2014 Q1</b>	<b>1</b>	Dermatologist Office Visit
	<b>2</b>	Diagnostic Prenatal Ultrasound
	<b>3</b>	Medical Eye Exam
	<b>4</b>	Diagnostic Lab Tests (e.g. Microalbumin, Lipid Panel, etc.)
	<b>5</b>	Urgent Care Visit
	<b>6</b>	
	<b>7</b>	
	<b>8</b>	
	<b>9</b>	
	<b>10</b>	
<b>CY2014 Q2</b>	<b>1</b>	MRI
	<b>2</b>	Allergy Testing
	<b>3</b>	CPAP
	<b>4</b>	Micrographic Surgery
	<b>5</b>	Diagnostic Lab Tests (e.g. Microalbumin, Lipid Panel, etc.)
	<b>6</b>	Tomosynthesis Mammogram
	<b>7</b>	
	<b>8</b>	
	<b>9</b>	
	<b>10</b>	
<b>CY2014 Q3</b>	<b>1</b>	MRI
	<b>2</b>	Physical Therapy
	<b>3</b>	Anesthesia
	<b>4</b>	Genetic Testing
	<b>5</b>	Botox Injections
	<b>6</b>	
	<b>7</b>	
	<b>8</b>	
	<b>9</b>	
	<b>10</b>	
<b>CY2014 Q4</b>	<b>1</b>	Colonoscopy
	<b>2</b>	Lab/Blood Work
	<b>3</b>	Mammogram
	<b>4</b>	Knee Replacement
	<b>5</b>	MRI-Arm (Non-Joint)
	<b>6</b>	MRI-Head
	<b>7</b>	Cataract Removal
	<b>8</b>	Bone Density Study
	<b>9</b>	MRI-Shoulder or Elbow
	<b>10</b>	Upper GI endoscopy

Note: Fallon Health did not receive enough inquiries prior to the development of the on-line tool to have a Top 10.

**Identify the Top 10 Admissions, Procedures and Services for CY2015 by Quarter:**

<b>CY2015 Q1</b>	<b>1</b>	Lab/Blood Work
	<b>2</b>	Colonoscopy
	<b>3</b>	Mammogram
	<b>4</b>	MRI-Hip or Knee
	<b>5</b>	Bone Imaging
	<b>6</b>	Ultrasounds (non-maternity)
	<b>7</b>	MRI-Brain
	<b>8</b>	CT Scan- Chest
	<b>9</b>	Cataract Removal
	<b>10</b>	MRI Abdomen
<b>CY2015 Q2</b>	<b>1</b>	Lab/Blood Work
	<b>2</b>	Colonoscopy
	<b>3</b>	MRI-Hip or Knee
	<b>4</b>	Mammogram
	<b>5</b>	Ultrasounds (non-maternity)
	<b>6</b>	Bone Imaging
	<b>7</b>	CT Scan- Maxillofacial
	<b>8</b>	CT Scan- Abdomen & Pelvis
	<b>9</b>	MRI-Brain
	<b>10</b>	MRI-Shoulder or Elbow

## HPC Payer Exhibit 2

**\*\*All cells shaded in BLUE should be completed by carrier\*\***

Actual Observed **Total Allowed Medical Expenditure** Trend by Year  
Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2012	3.4%	0.9%	n/a	0.5%	4.83%
CY 2013	1.9%	2.1%	n/a	1.1%	5.16%
CY 2014	2.1%	0.6%	n/a	1.5%	4.28%

### Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. **These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.**
2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.
3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.
4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.