Commonwealth Care Alliance
Response to the Health Policy Commission's Questions for the 2014 Cost Trends Hearing

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY:
   a. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

Answer: Commonwealth Care Alliance serves exclusively MassHealth members, with the vast majority of our members also eligible for Medicare. For 10 years, we have been offering the Senior Care Options (SCO) program for MassHealth members over age 65. We ended 2013 with close to 5600 members in that program. In October 2013, we opened the One Care program, serving dual eligibles under age 65, with 3760 members at year's end. In both programs, we attract and are proud to serve the most medically complex members. In both programs, we integrate the financing and care for our members, within a team-based, consumer centered approach. This approach enhances the effectiveness of care available to our members and creates efficiencies in the reduction of hospital admissions, readmissions and nursing home stays.

   b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?

Answer: Commonwealth Care Alliance has no commercially insured members and no source of revenue other than the capitation payments we receive from MassHealth and the Centers for Medicaid and Medicare(CMS), in rates set by those two agencies. Our pm/pm rate increases year over year in both programs continue to be well below the annual growth benchmarks set by the Commonwealth. However, consistent with our mission and to operate within these very limited rate increases, we are constantly striving to serve our members more effectively and efficiently. For example, on any given day in June, we had 65-70 of our 2000 members with significant mental health needs in a psychiatric inpatient hospital setting at a per diem cost to us (previously Medicare) of about $1100/day, at least half of whom could and should be served in less acute Crisis Stabilization Unit (CSU) settings at a per diem cost of about $550/day. However, because of the decades-long policy anomaly of having hospital in-patient services funded by Medicare and the lower-cost essential community capacity that is better able to serve beneficiaries with serious mental illnesses funded by the state, paired with chronically constrained DMH funding, we find that the CSU capacity and an equally essential step-down supported housing capacity is virtually non-existent in Massachusetts. That, in essence, represents an expensive cost shift to Medicare and now to us. As a consequence, we are compelled to make additional investments to build this essential community capacity ourselves if we are to have any hope of better caring for and reducing the costs of our members with serious mental illness.
These types of infrastructure and clinical development needs required to better serve of our high-need, previously poorly-served population have led us to invest heavily in our One Cared program in 2013 and 2104. We therefore do not expect to meet the benchmark for 2014.

2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high quality, efficient care delivery.

    a. Please describe your organization's efforts to date in meeting this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs)(payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) on your (i) total medical expenses, (ii) premiums and (iii) provider quality.

Answer: Commonwealth Care Alliance exists as an alternative to standard fee-for-service for people who are eligible for Medicaid and Medicare. We not only coordinate the benefits between the two programs, but redesign the way care is delivered to our members. For example, we invest much more in primary care and long-term services and supports than fee-for-service Medicaid, but save significantly on hospital costs, typically reimbursed by Medicare. This saves money overall and greatly enhances the health and satisfaction of our members. In addition, we do not use a typical fee-for-service claims system to provide the majority of our care. 59% of our SCO members are served by our in-house clinicians.

    b. What efforts does your organization plan between now and October 1, 2015 to increase your use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider types?

Answer: Commonwealth Care Alliance is at full risk in its Senior Care Options program, as we must manage membership expenses within the monthly capitation payments we receive from CMS and MassHealth. We have a variety of reimbursement arrangements in place with our primary care sites ranging from a full risk arrangement to fee for service arrangements.

In our One Care program, which began enrollment in October 2013, CCA pays a PMPM payment to selected primary care practices and human service organizations that provide services to Department of Mental Health clients. That payment pays for comprehensive care coordination, care management and care transition services. We are in the process of considering how to tie a portion of the PMPM to selected performance measures for existing providers.

3. Please quantify your organization's experience implementing risk contracts across your provider network using the template below. For purposes of this question, "risk contracts" refers to contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to the provider, including contracts that subject the provider to limited or minimal "downside" risk.

Answer: 59% of Commonwealth Care Alliance's SCO members are served by our own clinical infrastructure of salaried clinicians. (We are essentially a hybrid between an insurer and a provider, which is one of the things that makes our model so unique, but also means that these questions, intended for more traditional insurers, do not capture our model well) In this way, Commonwealth Care Alliance, and our clinical affiliates, are already at risk for the care of the majority of our members. However, below you can see the numbers and percentages of contracted physicians who are under risk-based contracts with us.

SUMMARY:

Year	Number of Physicians in your Network Participating in Risk Contracts*	
CY2012*		224 or 34.09%
CY2013	308	28.65%

* The CY2102, number of physicians cell would not accept data, so we have included that number in the next cell, along with the percentage it represents.

4. Please identify and explain the principal factors considered in formulating risk adjustment measures used in establishing risk contracts or other APM contracts with providers, including how you adjust for changes in population health status over the contract term.

SUMMARY:

a. Does your organization use a common approach to risk adjustment for all providers? If not, what factors support the need for the application of different measures or adjustments for different providers or provider organizations?

Answer: Commonwealth Care Alliance itself is paid by the Commonwealth and the Centers for Medicare and Medicaid (CMS) in risk-based contracts for both SCO and One Care. The Medicare portions of our rates, paid by CMS, are risk adjusted by Medicare using the Medicare HCC model, which creates a different rate for each member, based on the diagnostic codes associated with that member. MassHealth assigns each SCO or One Care member to a discrete rating category, based on each member's clinical profile and the region of the Commonwealth in which he or she resides. These processes have many short comings, as discussed in response to question c below, but they do attempt to capture the high costs of our members. Our risk-based contracts with our providers are

built off the per member/ per month rates that we receive for the members served by those providers and therefore are already risk-adjusted.

b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of risk adjustment measures for use in contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

Answer: We assume that this change would not impact how we are paid by MassHealth or require a change in how we subsequently reimburse our providers.

c. What progress has your organization made to date regarding the development and implementation of population-based socioeconomic adjustments to risk budgets? What plans does your organization have in this area?

Answer: Commonwealth Care Alliance is very interested in seeing the Commonwealth and CMS improve its payment methodologies to better reflect the true cost of serving members with socio-economic challenges, including poverty, homelessness and neighborhood risk factors. Medicare does a particularly poor job in compensating plans for the challenges in serving members with socio-economic challenges. They also fail to properly reimburse for patients with behavioral health needs and multiple chronic conditions, all of which exist among our patients in disproportionate numbers. There are active conversations occurring at the federal level, in Congress and at CMS, about how best to adjust for socio-economic challenges. CCA is actively involved with our federal partners in those discussions. Progress in this area is essential if policy makers want to prevent cherry picking among carriers serving the publicly insured and to ensure the financial solvency of those providers and plans, like ours, whose mission it is to serve these populations.

c. How do any such differences interact with other contract elements that materially affect risk budgets and performance-based payments, and what are the results of any analyses conducted by your organization regarding variation in provider performance under different measures and adjustments?

Answer: This question is not relevant to Commonwealth Care Alliance for the reasons stated in response to question a, above.

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5. Please identify and explain the principal factors considered in selecting quality metrics used in establishing APM contracts with providers.
   SUMMARY:
   a. Does your organization use a common approach to quality measurement and associated payments for all providers? If not, what factors support the need for the

use of different quality measures or performance targets for different providers or provider organizations?

Answer: CCA uses a common approach to quality measurement that is largely dictated by the requirements of CMS and MassHealth for our SCO and One Care programs. CCA has not linked performance on quality measures to provider payments. This is something that we are considering for the future.

b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of quality measures, such as the measures included in the Standard Quality Measure Set, for use in risk contracts and other APM contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

Answer: As a Fully Integrated Dual Eligible Special Need Plan (FIDESNP), CCA has extensive experience with national standardization of quality measures across Medicare Advantage plans and across dual eligible demonstrations. Although CCA recognizes the conceptual value in standardizing metrics across provider organizations or health plans, the way such standardization has been implemented has significant drawbacks, largely related to the fact that the characteristics of the populations cared for by different organizations are such that standard measure sets leave critically important areas of performance unmeasured and other relatively unimportant areas of performance over- measured. In addition, the methods for determining targets, in particular if performance is being tied to reimbursement, have led to a very unbalanced playing field and have adversely impacted those organizations that are trying to provide high quality care to the most underserved, severely ill, and frail members of society.

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

Answer: Our SCO contract requires us to ensure that all our members have a primary care provider on day 1 of their enrollment in our plan, or assist them in selecting one so that their coverage with us can begin. The One Care contract requires that this be done within 90 days. We do not attribute a member to a primary care physician, they make the choice themselves. The questions below are therefore not relevant to CCA.

a. Describe your current attribution methodology (or methodologies), identifying the purpose(s) for which it is (or they are) used, and include the following information:
    i. provider types considered for attribution (e.g., primary care physicians, specialist physicians, NPs/PAs)

    ii. units used in counting services (e.g., number of claims, share of allowed expenditures)

    iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)

    iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and v.

    whether patients are attributed retrospectively or prospectively.

b. Please describe your efforts to develop a comprehensive attribution methodology, including the current status of your efforts to validate, pilot and implement a methodology for purposes of implementing risk contracts and other APM contracts for PPO insurance products. What resulting barriers or challenges has your organization faced?

c. What values and/or drawbacks does your organization identify regarding potential standardization of attribution methods, both across providers and across payers? What are the values and/or drawbacks of differentiation?

d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?

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7. Describe your organization's efforts and results in developing insurance products that encourage members to use high-value (high-quality, low-cost) care and providers, including but not limited to tiered network and limited network products. Please 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.

Answer: Commonwealth Care Alliance does not use tiered or limited networks. We cannot use financial incentives to steer our members to use certain providers because, under our contract and consistent with our mission, our members do not share in the monetary cost of their care. There are no co-pays, co-insurance or deductibles in SCO or One Care. In contrast to narrowing our network, we are required to meet certain network adequacy requirements under our SCO and One Care contracts to ensure the availability of care for our members within certain geographic parameters.

8. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1	0	0	N/A
	Q2	0	0	N/A
	Q3	0	0	NA
	TOTAL:	0	0	

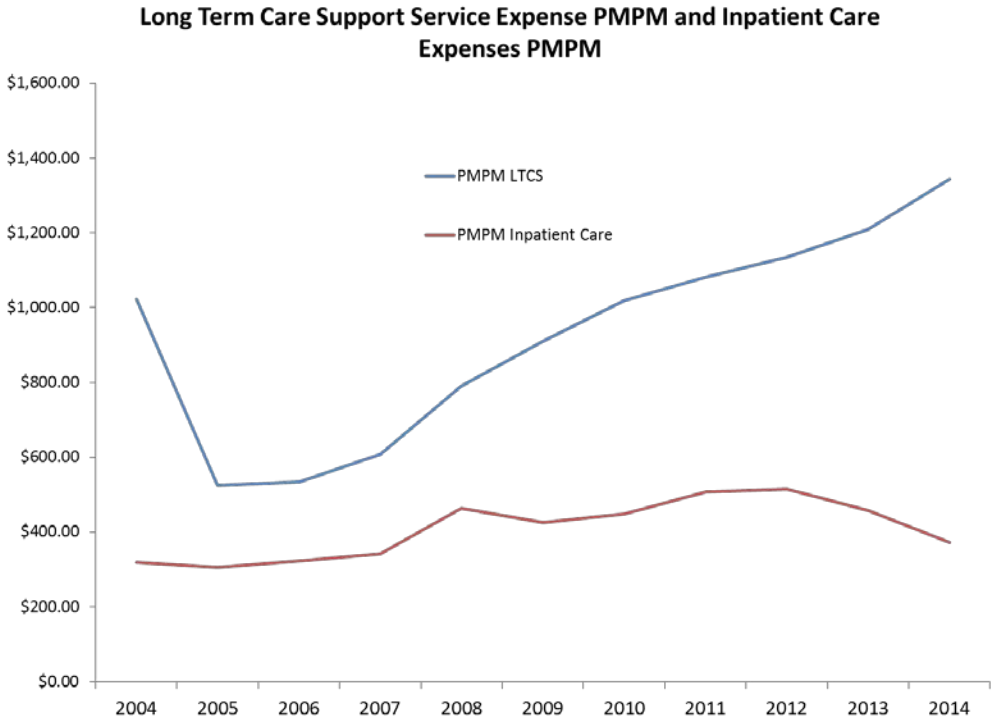
** Please indicate the unit of time reported.*

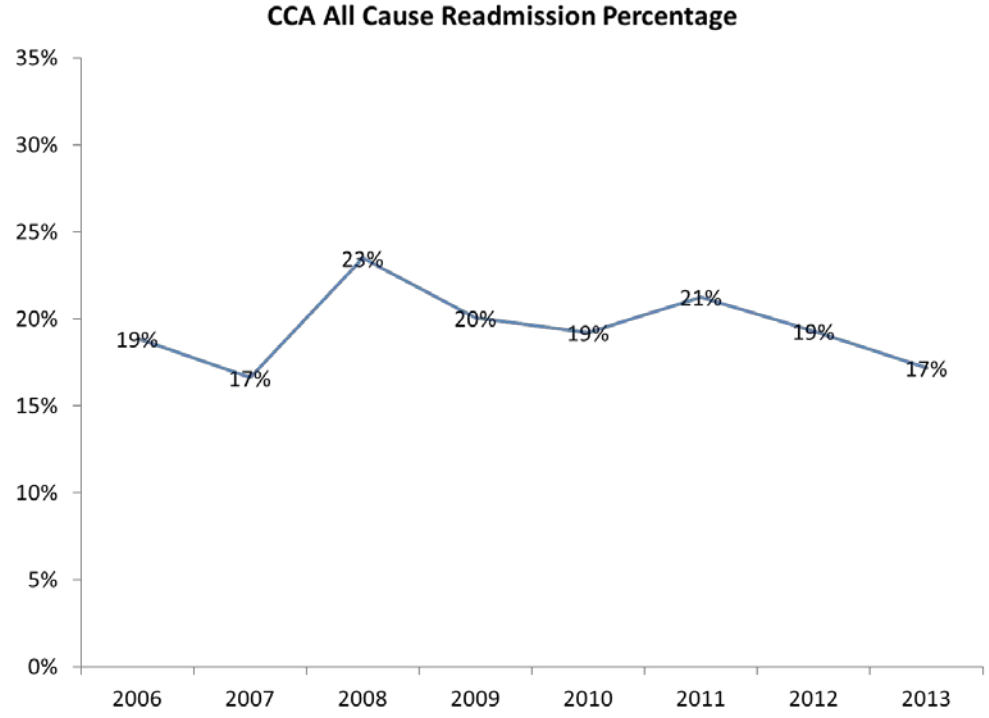
Answer: Commonwealth Care Alliance serves only people who are eligible for Medicaid or both Medicaid and Medicare. Consistent with our contract requirements in both SCO and One Care and our mission, our members do not share in the monetary cost of their care. There are no co-pays, co-insurance or deductibles in either SCO or One Care. Therefore, we do not get questions about the costs of specific procedures or services.

9. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than national average utilization of inpatient care and its heavy reliance on academic medical centers. Describe your organization's efforts to address these trends, including efforts to redirect appropriate care to lower cost community settings. Please attach any analyses you have conducted on such "outmigration," including specific estimates of cost savings that may be accrued through redirection of care.

Answer: Commonwealth Care Alliance's enhanced primary care model effectively uses community-based care support services aimed at serving a member's care needs in such a way to avoid the need for expensive and avoidable inpatient stays. The member's care management team works to balance these services depending on the member's individual needs and within the community that the member resides. The result of this balancing of community-based care support services against the inpatient care has been effective. Our data show an increase in community-based care services expenses PMPM, at the same time that inpatient care expenses PMPM are reduced. Moreover, of those members admitted to hospitals, we have achieved a steadily decreasing readmission rate that can be in part attributed to the member returning home with these community-based care supports in

place.


Long Term Care Support Service Expense PMPM and Inpatient Care Expenses PMPM
$1,600.00
$1,400.00
$1,200.00
$1,000.00
$800.00
$600.00
$400.00
$200.00
$0.00
PMPM LTCS
PMPM Inpatient Care
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014


CCA All Cause Readmission Percentage
35%
30%
25%
20%
15%
10%
5%
0%
19%
17%
23%
20%
19%
21%
19%
17%
2006
2007
2008
2009
2010
2011
2012
2013

10. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    SUMMARY:
    a. Please describe any efforts your organization has made to effectively address the needs of these high-cost, high-risk patients in an integrated manner.

Answer: From our inception, Commonwealth Care Alliance has been integrating behavioral health into our primary care delivery model. We operate under a completely integrated financing and care model, so that we can provide all Medicaid covered services and Medicare services to our members seamlessly. Rather than simply being an insurer bridging Medicare and Medicaid, we either augment the primary care traditionally provided to Medicare and Medicaid beneficiaries or replace it with a greatly enhanced model of primary care, care coordination and mental/behavioral health clinical care that we provide ourselves. Our model reimagines primary care, not as a building, but as a concept. We provide care to our members in their homes, meeting them where they are, mentally and physically. We see patients in supported housing arrangements, adult day health centers, substance-abuse treatment centers, in homeless shelters and under bridges.

Each member, whether receiving primary care directly from us or from one of our partner clinicians, has a care team coordinating and integrating his or her care. Our behavioral health staff helps support our nurse practitioners who are seeing the patients in their homes. For example, some patients initially do not want to be touched by a nurse practitioner, much less seen by a physician in a clinic. We get to know the patient, address his or her fears and earn his/her trust to enable appropriate medical care. We conduct weekly team meetings with the medical staff to make sure the care is coordinated. We have outreach workers to connect members with the social service supports that they need.

    b. If you contract with or otherwise use a behavioral health managed care organization or "carveout," please describe how you ensure that integrated treatment is provided for these high-cost, high-risk patients.

Answer: CCA does not contract with behavioral health managed care organizations or carve-outs. We do, however, contract with selected behavioral health providers to provide care management services, described below.

11. Please describe whether and how your organization provides financial support or incentives for a provider to achieve recognition or accreditation from a national organization as a patient-centered medical home (PCMH) or improve performance as a PCMH. Attach any analyses your organization has conducted on the impact of PCMH implementation in your provider network on outcomes, quality, and costs of care.
    SUMMARY:

Answer: CCA provides financial support in the form of a PMPM for assessment, care planning, care

coordination and management, care transitions, outreach and engagement efforts, and service referrals and authorizations to nine organizations that provide these services to our One Care members on our behalf. These payments are stratified based of member complexity. Four of the organizations are primary care clinics that have robust behavioral health services; four of the organizations are human service providers that serve DMH clients and are committed to coordinating services with primary care providers; and one organization provides both primary care and DMH-funded services. Two of the organizations have NCQA certified clinics, and are seeking additional certifications. All are working to improve performance as PCMHs or Behavioral Health Homes. This program is not yet one year old; therefore we are just beginning to collect the data that will allow us to analyze the impact of these programs on outcomes, quality and cost of care.

12. After reviewing the Commission's 2013 Cost Trends Report and July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

Answer: Both the 2013 Cost Trends Report and the July 2014 supplement reported facts about our health care environment in Massachusetts that we have known to be true, many only from anecdotal experience in serving our members every day. Most striking and most familiar to us is the 2013 Report's finding that patients who have both a behavioral health diagnosis and a chronic condition were 4.2 times more expensive in the commercial market and 7 times more expensive in Medicare in 2010, and the Supplement's finding that these increased costs are concentrated in ED and inpatient care. We appreciate the Heath Policy Commission shining a light on these challenges in particular, and are proud to be working to improve the care for these challenging, high-need, high-cost patients, particularly through the introduction of the One Care program. But, being deep in the business of caring for these publicly insured residents, whose needs have been under or poorly served for decades, we need to caution the Health Policy Commission and other policy makers that these deeply entrenched problems are not simply or quickly solved. Take for example, the need to build sufficient sub-acute behavioral health capacity to serve many of these members in a way that is both most effective for them and most cost efficient, discussed in response to question 1. Changes like these take time and the investment of significant resources. However, we believe the in the capacity of these changes to begin to reverse the troubling trends you have identified and are proud to be a part of the solution that the Health Policy Commission is calling for.

Commonwealth Care Alliance AGO Payer Exhibit # 2, Question #2
Total In-State Membership (for members living in Massachusetts)

a. In-State Membership by Market Segment

Market Segment	12/31/2013*	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Medicare**	9011	4398	3467	2776
Medicaid MCO				
MassHealth	9357	4681	3666	2948
Commonwealth Care				
Other Government				
Total				

** About 6-7% of our SCO members are MassHealth only, ie, without Medicare coverage. All our One Care members are duals.

* The 2013 totals reflect SCO and One Care Enrollment. 3760 of both the Medicaid and Medicare totals were One Care members.

b. In-State Membership Whose Care Is Reimbursed Through a Risk Contract by Market Segment***

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Medicare	9011	4398	3467	2776
Medicaid MCO				
MassHealth	9357	4681	3666	2948
Commonwealth Care				
Other Government				
Total				

*** Commonwealth Care Alliance is at risk for all its members' care. Please see our response to HPC question 3.

c. In-State Membership by Commercial Market Segment and Product Line

Market Segment	Product Line		Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	HMO/POS	Fully-Insured				
		Self-Insured				
	PPO/Indemnity	Fully-Insured				
		Self-Insured				
Commercial Small Group	HMO/POS	Fully-Insured				
		Self-Insured				
	PPO/Indemnity	Fully-Insured				
		Self-Insured				
Commercial Large Group	HMO/POS	Fully-Insured				
		Self-Insured				
	PPO/Indemnity	Fully-Insured				
		Self-Insured				

d. In-State Membership in Tiered Network Product by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Total				

e. In-State Membership in Limited Network Product by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Total				

f. In-State Membership in High Cost Sharing Plan by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Total				

Exhibit # 1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

Commonwealth Care Alliance Senior Care Options

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

	Unit Cost*	Utilization *	Provider Mix**	Service Mix**	Total PMPM
CY 2011					$3,628.28
CY 2012					$3,708.87
CY 2013					$3,728.09

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, 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 change in provider. 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.