Monday, September 8, 2014

David Seltz, Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116
HPC-Testimony@state.ma.us

RE: Health New England response to HPC

Dear David Seltz:

Attached is Health New England's response to your request for written testimony. The responses are included after each of the questions in the request.

I have been authorized to submit this response on behalf of Health New England, Inc., and I am submitting it under the pains and penalties of perjury.

If you have any questions, please feel free to contact me at any time.

Yours truly,

James M. Kessler
Vice President and General Counsel

cc: Stuart Altman, Ph.D., Chair, Health Policy Commission
cc: Margret Cooke, Acting Chief, Health Care Division, Office of the Attorney General
cc: Áron Boros, Executive Director, Center for Health Information and Analysis

Health New England Inc.

HEALTH POLICY COMMISSION Response to Questionnaire

James Kessler, Esq.
General Counsel
Health New England Inc.

Submitted September 8, 2014

HNE'S Response to Health Policy Commission (HPC)

Summary

Health New England has used a number of strategies to help transform health care in the communities it serves by promoting coordination with providers, care management and transition away from fee-for-service medicine to risk sharing and population health. HNE has invested in new technology for care management and data analysis, and continues to encourage development of patient-centered medical homes, wellness and health education.

As noted in previous testimony, our past efforts have shown some success in providing value: HNE and its provider network have had excellent results for quality over a number of years. At the same time, data included in the Center for Health Information and Analysis (CHIA) 2013 Annual Healthcare Market Report showed that HNE had been one of the lowest cost sources of commercial health care coverage in the Commonwealth. In fact, according to that CHIA report, HNE had the lowest premiums per member per month (PMPM) among the major Massachusetts health plans during the period reported (2009-11). The same report showed that HNE had the second lowest overall medical costs PMPM among the plans mentioned. HNE's strong standing in these indicators is also found the more recent 2014 CHIA report.

Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

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: Achieving the benchmark will not be easy or simple, and there are no apparent shortcuts. HNE will continue to pursue the benchmark goal vigorously, using a combination of many approaches: provider contracting initiatives, care and disease management strategies, heightened attention to data analysis and prevention of fraud, waste and abuse, and a continued search for innovative approaches to attaining the "Triple Aim" of better community health, better patient experiences and better use of resources.

   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?**

      HNE Response: HNE uses a number of strategies to effectively control cost increases. Our primary approach has been to move to alternative payment models (APMs) (mostly global budgets) with primary care groups and other

integrated provider groups. While we believe that this has slowed overall cost trends, there are several challenges to ensure that this model remains successful and sustainable:

- The underlying mechanism for compensating hospitals, specialists and ancillary providers (even under a global capitation agreement) remains fee-for-service. Providers continue to pursue fee schedule increases, many of which are in excess of the Gross State Product cost benchmark.
- After years of modest increases (mostly driven by patent expirations), prescription drug costs (utilization and unit price) have begun to trend at high levels approaching double digits. This is being driven by a slight increase in overall drug utilization trends and significant increases in unit costs, due to the pharmaceutical industries pricing actions. Specialty drugs are the primary driver. While these drugs are already expensive, manufacturers continue to take large price increases (up to 30% for certain drugs). This puts pressure on global budgets as providers who are working to stay within global budgets see those budgets strained by pharmacy price increases beyond their control.
- Because, in many cases, hospitals and specialists do not participate in savings from global budgets, changing their behavior has proven difficult, especially in areas where there are few choices among competing hospitals and specialists.
- Providers continue to seek increases to their global budgets which are often in excess of the cost benchmark.

In light of these pressures, we have focused on our provider contracting activities in efforts to reduce the variability in unit costs across our network. We have attempted to introduce more commonality in both payment methodologies and in fee schedules and have had some success in doing so. We continue to have difficulty in cases where hospitals, specialists and ancillary providers enjoy geographic exclusivity. It has been especially difficult (if not impossible) to reach agreement on reasonable contracts with most Eastern Massachusetts academic medical centers.

Over all, the expansion of risk and surplus sharing arrangements helps us to temper the increases in provider fee schedules and make such increases less relevant to total medical costs. HNE believes that as the percent of providers under these types of arrangements increase, providers will focus on better managing the care of their membership, which will decrease medical expenditures. HNE also makes use of DRG, case rates and Medicare fee based facility payment methodology for continued transition away from percent-of-charge methodologies.

In addition to our contracting efforts, we have invested in data analysis staff and supporting software capabilities to help us with a variety of tasks, such as improving our understanding of provider payments across our network and better understanding of how to benchmark payments for similar provider types. We

have also been thoughtful about the composition of our network in order to negotiate lower rates with our network hospitals and to encourage appropriate, utilization of services susceptible to overuse. We have also limited the provision of certain services in provider offices, such as CT and other diagnostic testing.

In response to increased emphasis on new risk models, and emphasis on quality and pay for performance, HNE and our providers are placing renewed emphasis on management of chronic conditions. Generally this is a collaborative effort between HNE and the practices, since HNE is in the position to identify members with chronic conditions through claims data analysis. The practices with electronic medical records (EMRs) or other appropriate systems are able to maintain their own registries of patients with chronic conditions. HNE has a number of disease management programs, but has generally not dictated to practices how to prioritize their own chronic disease management efforts. We believe that the practices are in the best position to address the needs of their patients. HNE also maintains a staff of nurses who assist with care management and coordination, especially for patients with complex cases or conditions. HNE has also supported development of care management capabilities within medical practices in our network.

In addition, HNE has developed bundled payment programs for certain conditions such as CABGs (coronary artery bypass grafts), cardiac stent placement, joint replacement, bariatric surgery and certain common hospital conditions such as community acquired pneumonia. The hallmark of the management of these episodic conditions revolves around consistent physician ordering, timely provision of appropriate medical services and early discharge planning.

Some other examples of specific approaches that HNE has pursued to control health care costs include procedures and policies to monitor medical utilization and the accuracy and appropriate payment of provider claims, such as:

- Utilization management guidelines, including concurrent review of inpatient admissions based on clinical criteria
- Prior authorization for specific procedures prone to misuse
- Claims editing software
- A new care management system to identify gaps in care, including new predictive modeling capabilities
- Software and staff dedicated to analysis of claims data, including software specifically designed for detection of fraud, waste and abuse
- Dedicated claims audit personnel to review large and/or unusual claims and to detect fraud, waste and abuse
- Use of an external claim reviewer (Nurse Audit) to compare a facility bill to medical records
- Mandatory fraud, waste and abuse training for all HNE associates

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

HNE RESPONSE: There is no obvious magic bullet which will allow the Commonwealth to restrain the growth of health care costs. Continued efforts by government and providers are needed to allow health plans and health insurers any chance to overcome the many cost pressures (such as the increasing drug costs mentioned earlier in this testimony) which are pushing health care costs upward. HNE will continue to work on the many initiatives described in this testimony and still to be developed, which remain our best tools for managing care, but we are also working to find and implement innovative solutions.

To provide some examples, we are planning the development of a so-called "hot spot clinic" or clinics. In this model, Baycare Health Partners (BHP), a physician-hospital organization within our network, willwork with specialists in the hot-spots (or medical neighborhoods) to develop clinics to manage patients with complex diseases such as diabetes or difficult to control hypertension. In these clinics, primary care physicians within Patient Centered Medical Homes (PCMHs) will collaborate with specialists to improve treatment of these difficult cases. Patients will be identified through predictive modeling or through care management referrals. The hot-spot clinics model is inspired by work done in Camden, NJ and reported on in the New Yorker Magazine by Dr. Atul Gawande, and in a similar program in Atlantic City. Within our clinics, we anticipate that decreasing variation and standardizing care for complex diabetics and patients with hard to control hypertension will both improve care and improve costs. Baycare Health Partners has enlisted several specialty groups in cardiology, nephrology, and endocrinology to staff these clinics with the anticipation that they will start operations in 2015.

The second innovative program is for transitions of care. HNE is working with a medical group which employs physicians called "SNFists" within the group. These SNFists are the medical directors for at least five skilled nursing facilities (SNFs) in HNE's service area. Based on the practice's past experience, the attention of the SNFists to patients within the facilities can significantly reduce patient lengths of stay.

Finally, HNE has for some time been engaged in a program of "Business Improvement" to increase quality and reduce costs within our administrative functions. This has included an idea generation program that implements literrally thousands of improvement ideas each year, as well as numerous focused projects that have used LEAN techniques and other methodologies to improve many aspects of HNE's operations. HNE's business improvement staff will use LEAN and other techniques to identify cost saving and quality improvement ideas which can be put in place in cooperation with our providers, and to offer business improvement consulting to provider practices. We anticipate that in those

projects HNE will help the practices identify care bottlenecks and reduce rework and waste to improve patient flow, patient access and patient satisfaction.

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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.**

   SUMMARY: Changing the payment model is inherently difficult. HNE has been working to increase risk sharing and other methods of reducing the impact of fee-for-service payment models through the creation of budgets and other standard payment methods. This phased approach to the recontracting process has been met with some success, as it allows for flexibility to meet the diverse needs and characteristics of providers in our network.

   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.**

      HNE Response: The central difficulty in evolving away from fee-for-service model is that it is a significant change which affects both the mechanism and logic of financing health care delivery. It cannot be done instantaneously or easily. HNE's contracting strategy has included the following components:

      Global and Other Risk Sharing Models: Approximately 50,000 HNE members in all of our products are in PCMH arrangements with global risk components. Our oldest global risk contract is over ten years old, and we are continuing to develop our approach to this model. These contracts may involve shared savings, or shared savings evolving toward shared risk, infrastructure or a payment based on historical costs with built in decreased premium contributions over the next several years. A "global" contract may include features such as fee-for-service payments for certain services such as laboratory, a monthly capitation for primary care services, or structures limiting fee-for-service prices for services within the overall financial model. HNE has supported the development of PCMHs and has supported development of infrastructure and expertise needed for developing these models as core components of an integrated, risk sharing care delivery model. Several of the provider entities we deal with are exploring new models for internal compensation better suited to new approaches emphasizing population health management. We are also refining our provider contracting to reflect the IRBO initiative of the Group Insurance Commission (GIC).

Our risk contracting strategy has also included other components, such as:

Quality bonuses: HNE has had pay for performance (P4P) quality bonus incentives in place for key Physician Health Organizations (PHOs) for many years. We have begun to enter into global risk contracts with PCMHs involving a more expansive quality program and more dollars are at risk on a per-member basis, and which may include HEDIS-like measures involving care processes and outcomes as well as initiatives around access and patient satisfaction or incentives around access and emergency room use related to ambulatory-sensitive ER visits. We believe that these initiatives are equally quality and utilization measures.

Bundles: HNE has implemented bundled payment initiatives involving total joint replacement, bariatric surgery, cardiac stent placement and CABGS. Additional information is provided under HNE Response question 1 a.

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?

HNE RESPONSE: HNE is continuing to work on strengthening provider relationships and increasing use of APMs by understanding providers' issues and concerns and working to move toward increased risk sharing in a thoughtful way. These approaches have been referenced in earlier commentaries – global risk, capitation, quality performance bonuses and bundles. While this approach requires additional time and communication, its flexibility is a strength in developing durable changes.

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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.**

SUMMARY: HNE has worked to engage primary care providers through establishing PMPM budgets tied to a Health Services Fund. These financial reports are used to educate providers in medical and pharmacy costs as well as efficient facilities and specialists.

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012	465	6%
CY2013	754	9%

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: HNE has been developing risk sharing relationships and/or APMs with a relatively small community of providers through provider organizations and has done so through a process specific to each provider grouping and based on ongoing dialogue. Due to variation in the size and sophistication of practices and provider organizations, there is no "one size fits all" formula for these conversations. Collaboration based on the provider's size, capabilities and willingness to evolve to each more challenging step of risk sharing has generated a phased approach of implementing risk in our network.

   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?**

      HNE Response: While not exactly standard, HNE does work within a common framework for risk adjustment. Depending on the specific contract, HNE uses risk adjustment methods such as the following:

      - Medical budgets on which the risk is based are set using factors such as product mix, demographics, known high-cost cases and case mix adjustment;
      - Member-specific reinsurance thresholds are set and costs for any member beyond the threshold are allocated across risk pools;
      - Providers are assigned to risk pools, and positive and negative experience within the risk pools offset to limit exposure based on random variation in patient experience;
      - Upper and lower risk corridors are used to mitigate overall risk exposure.

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?**

HNE Response: Conceptually, standards offer a sense of administrative simplification for both Providers and Plan; however the variation between provider organizations and provider groups in the state is so great that this may not be feasible. Even looking at the variability within HNE's service area demonstrates this point. There may be an opportunity for guidance or guardrails in developing risk arrangements which could prepare a provider group for taking on risk, but identifying standard measures may be too rigid.

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?**

HNE Response: Currently HNE establishes medical budgets using factors such as product mix, demographics, known high-cost cases and case mix adjustment.

d. **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?**

HNE Response: These factors, product mix, demographics, known high-cost cases and case mix adjustments, all work to accurately reflect the population under the budgeted Health Services Fund. These adjustments allow for a more accurate reflection of the population covered under the appropriate budget.

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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: The focus behind the quality metrics used for providers with pay-for-performance is based in HEDIS, CAHPS, MA-CAHPS and MA Stars. This allows the Plan to accomplish its goals in partnership with providers as these same measures impact the providers with government payors.

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?**

HNE Response: HNE applies the same principles to setting quality metrics and associated payments for all providers. However, performance targets may differ and are based on prior year's performance compared to benchmarks (generally NCQA Quality Compass 90th percentile national). Additionally, associated payments may differ if a large gap between actual performance and benchmark exists; this helps emphasize the importance of the measure.

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?

HNE Response: The value is that consistency across payors stresses the importance of certain measures makes it easier for provider to focus attention on those measures. One drawback is the chosen statewide quality measure might not represent an issue for some physicians. Also, a statewide measure does not take into account other differences among practices or among different geographic areas. Finally, in some cases, quality measures may stifle innovation or prevent evolution to newer, possibly improved approaches to certain disease states.

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

SUMMARY: Approximately 96% of HNE members are enrolled in an HMO or POS product and have a Primary Care Physician (PCP) assignment. As a result, attribution of almost all patients to a primary care physician is clear and prospective. HNE has not yet implemented an attribution model for PPO members, however HNE has participated with the other GIC health plans that do have GIC PPOs on how attribution would occur. HNE might adopt that methodology in the event we had a larger PPO product penetration. In the meantime we would use the methodology of an anchor record described in a. ii below.

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:

HNE Response: HNE attributes members to primary care physician in one of several ways. The first is member selection. We also attribute members to PCPs based on claims. When a provider leaves the practice, we attribute members to a new PCP based on the disenrolling doctor's instructions, which are confirmed with the new provider office. For our Medicaid line of business only, we attribute members to PCP by member age, geographic area, and the provider's status for accepting new patients.

i. **provider types considered for attribution (e.g., primary care physicians, specialist physicians, NPs/PAs)**

HNE Response: The principal provider type for attribution is primary care physicians. There are also some Nurse Practitioners or Physician Assistants that are set up to be considered for attribution. For our Medicaid line of business only, OB-GYN providers may also be attributed as a primary care physician.

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

HNE Response: HNE uses a methodology which identifies an episode of care in which we establish an anchor record between a PCP and member. We then look for follow-up associated services attributed to the primary care physician. These services can be any type of claim, including lab or x-rays. When a patient has had at least two visits to a PCP within one year attribution becomes much easier.

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

HNE Response: Members who visit a primary care physician for a primary care physician type office visit are attributed to that doctor as of the date of service, unless the physician is in the same physician group or if the provider is seeing the member in an on-call or urgent care setting.

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

HNE Response: Attribution due to claims is effective as of the date of service, regardless of the service date.

v. **whether patients are attributed retrospectively or prospectively**.

HNE Response: Patients are attributed retrospectively to date of service if the attribution is due to claims-based methodology, and in some cases when attribution is based on provider leaving the practice. Patients are generally attributed prospectively if the PCP assignment is based on member request, but may be assigned retrospectively if a member specifically requests it.

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?**

HNE Response: Health New England has used standard methodologies for attribution as described above for the GIC PPO plans, however most of HNE's membership is in HMO plans, in which a member is required to designate a PCP. Therefore, in a risk contract, for the bulk or our membership, there is no ambiguity about attribution since HNE can provide panel reports and adjust premium by age and sex. If HNE had a significant PPO membership, we would use the GIC attribution methodology which establishes a so-called anchor record to a provider and requires at least two contacts with the provider based on claims. Since we use our HMO product for risk contracting our challenge is around the 5% of members who initially do not identify a PCP.

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?**

HNE Response: HNE would welcome a standardized methodology for PPO members. We think the methodology developed for the GIC has general applicability. We do not think health plans should develop different methodologies, which would lead to confusion in the provider community and make management of risk more difficult for those providers.

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

HNE Response: At this time HNE will continue its work with Mercer and the GIC to refine attribution methodology. We will consider applying this methodology to PPO members if our PPO membership warrants it.

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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.**

SUMMARY: HNE's has increased development of new health care delivery models involving collaboration, coordination and shared risk, which requires new attention to population management and access to primary care. Because of the unique challenges of operating almost entirely in Western Massachusetts, such as the relatively smaller

size of both our plan and our provider network, HNE does not offer a tiered or limited network (aside from one plan created for the GIC). By the nature of its size and geography, however, HNE already has many of the positive aspects of a selective network plan. For the same reasons, there are fewer providers in HNE's network, less diversity of providers, and in some geographic areas, less competition among providers that would be true in Eastern Massachusetts. These factors make it difficult to create a limited-network product that achieves significant premium savings while providing full geographic coverage.

The health care delivery environment in Western Massachusetts is significantly different than in some other parts of the Commonwealth. A single hospital or physician specialty group may serve a fairly large geographic area. As a result, consumer engagement may require tactics other than tiered or selective provider networks. As noted elsewhere in these responses, HNE's focus has been on efforts to increase development of new health care delivery models involving collaboration, coordination and shared risk, which in return requires new attention to population management and access to primary care.

Population Management: HNE has actively promoted the development of PCMHs. Approximately 50,000 HNE members currently receive care in PCMHs in over 20 practices. A number of PCMH practices are involved in population management as part of the mission and vision of a new ACO, Pioneer Valley Accountable Care. These initiatives include embedded care management in the practices, plans for so-called development of hot spots to treat certain kinds of complex medical conditions in one location and continuing the development of practice guidelines to decrease care variation.

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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.**

SUMMARY: HNE established a web portal in our HNE Direct website effective 10/1/2013 to serve as a communication platform in which a member can request an estimate of "out of pocket" expense prior to seeing the provider. Experience to date with the portal has been limited.

HNE RESPONSE: Since its inception HNE has received an approximate combined total of 47 cost of care requests. No two requests were alike regarding the coding, none were replicated. All requests to date were to gain prior knowledge of deductible/ coinsurance/ copay information for members enrolled in the HDHP health plans.

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	Not Available	Not Available	Not Available
	Q2	Not Available	Not Available	Not Available
	Q3	Not Available	Not Available	Not Available
	TOTAL:	26	21	1 Business Day

** Please indicate the unit of time reported.*

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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.

SUMMARY: HNE uses several methods which include provider education, risk contracting and care management to encourage care in the most appropriate setting.

HNE Response: HNE is well aware that Massachusetts physicians hospitalize patients more frequently than the national average and that academic medical centers care for a disproportionate share of hospitalized patients, many of whom have uncomplicated problems better suited for care in less expensive community hospitals. HNE believes that providers in risk contracts understand and will look for less expensive alternatives sites of care which include community hospitals, skilled nursing facilities and home care. Often, patients choose academic medical centers because of reputation, or physicians do not direct their patients to community hospitals. This trend has been reinforced over the past 10-15 years because PCPs rarely care for their own hospitalized patients, but rely on hospitalists. In addition, many patients and providers perceive, though not always accurately, that community hospitals do not have specialists available in the event a patient needs a more complex management plan.

As HNE develops risk contracts with provider groups we make providers aware of this relative difference in cost between in-network community hospitals and in-network teaching institutions. Our care managers also provide information to members and providers about options for care in community settings.

We also make providers aware of the cost of care when patients go out of network since that out migration is almost exclusively to large academic centers. To address concerns about specialty services, HNE has supported our parent's (Baystate Health)

telemedicine program, and have supported efforts to have specialists from Baystate Medical Center seeing patients onsite at Baystate's three small (and inexpensive) community hospitals in Greenfield, Ware and Palmer. In addition HNE staff are involved in an innovative "hospital at home" pilot with Baystate staff. In that program, patients with certain conditions won't be hospitalized, but will have service provided through the Baystate VNA.

The need to optimize appropriate care in the community is an ongoing balancing act, because the large institutions are often too busy caring for patients who do not need the massive and costly infrastructure of the academic medical center. HNE has analyzed hospitalizations in the eastern region of our network. For every 100 hospitalizations we find that 25% go to Baystate Medical Center, 25% to UMass Memorial, 25% to Wing in Palmer and 25% go to Mary Lane in Ware. We believe at least 40% of the patients hospitalized at the tertiary hospitals, Baystate and UMMHC, could have been hospitalized at the community hospitals. Based on case mix adjusted discharge payment, savings would have been at least $150,000.

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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: HNE uses an integrated, bio-psycho-social model care management system and a new care management software tool to manage patients with high-cost and high risk patients, including those with comorbid behavioral health and chronic medical conditions. HNE does not, in general, carve out behavioral health management, but does have a contract with the Massachusetts Behavioral Health Partnership (MBHP) to provide certain management services for Medicaid enrollees. HNE coordinates its own care management closely with MBHP for those members.

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.**

HNE Response: HNE uses several methods to address the needs of high-cost, high risk members, including integrated care. First, HNE encourages the use of Emergency Screening Programs (ESPs) to assess for the appropriate level of behavioral health care for our members. This evaluation can be performed in the community, in the ESP's office or in the emergency room. This service is not mandatory. HNE does not require prior authorization for behavioral health admissions. The admitting facility forwards a notification after the admission has occurred. These practices allow the member to avoid the emergency room or will facilitate the admission and avoid being "stuck" in the emergency room. This has

helped in controlling higher costs and higher wait times from Emergency Room visits.

HNE performs concurrent review for all inpatient care to ensure that the setting is most appropriate for the member's condition as well as the least restrictive. HNE uses licensed criteria sets that reflect national standards of care as a guide to make these determinations. Both medical and Behavioral Health reviewers work in an integrated department that uses one medical management system. This practice fosters collaboration internally and externally and facilitates decision making in a timely manner.

Ensuring that the member has an adequate discharge plan is part of the concurrent review process. HNE encourages continuity and coordination of care with the member's medical and behavioral health providers. HNE has contracted for transitional visits with its largest behavioral health inpatient psychiatric (IP) provider, and continues to work with community behavioral health providers as well. The purpose of the visit is to connect with the member and review the discharge plan, the importance of follow-up care and to assist the member with any gaps in this care. This practice helps to minimize the risk of the member returning to an emergency room for services that may not be clinically indicated.

HNE has also been working closely with hospital providers who demonstrated poor follow-up rates for discharged members. Rates are reviewed and shared quarterly both internally at HNE as well as with the BH providers. Corrective action plans are required for those providers with less than satisfactory results.

HNE's complex case management and disease management programs aim to proactively manage members who are likely to become hospitalized or require multiple health care services. The programs have a bio-psycho-social focus, incorporating all needs of the member into one plan of care by a single care manager. On a regular basis, the Clinical Service Initiative (CSI) team meets for case discussion during which team members present challenging cases for clinical feedback and management or treatment plan suggestions. HNE conducts bi-monthly clinical meetings with each of the Enhanced Primary Care Practices, and monthly Grand Rounds in which case discussions and brainstorming around complex cases is the forefront. Grand Rounds are attended by an integrated team consisting of case managers, pharmacists, a medical director, and on occasion a case manager from a PCMH practice. The Integrated Care Managers (ICM) provide members with one direct contact at HNE for medical concerns; this design allows the ICM to build trusting relationships with HNE members and treating providers.

HNE recently retired its home grown medical management system and purchased the Medecision – Aerial Clinical Programs (ACP) medical management application. This system is used by the utilization management and case management staff. This system is also used by the case managers in the Patient Center Medical Home offices, helping to facilitate professional collaboration aimed at optimizing health outcomes for the members. By using the same system,

we ensure that members receive fully integrated medical and behavioral healthcare, gaps in care are more easily identified, and duplication of care is more easily prevented.

HNE clinical staff works with both a Behavioral Health Advisory Committee (BHAC) and a Clinical Care Assessment Committee (CCAC) throughout the year to discuss best practice models. These committees serve as an audience of network providers that offer recommendations and guidance for both utilization management and case management processes.

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.

HNE Response: HNE does not "carve out" behavioral health services, with the exception of our Medicaid product. For HNE's Medicaid product, HNE contracts with the Massachusetts Behavioral Health Partnership (MBHP). Serving as our delegate for certain behavioral health management services, MBHP closely coordinates care with Health New England to assure integrated treatment for our members. HNE has a Medicaid behavioral health manager who provides delegation oversight to ensure that systems are in place between the two organizations that result in improved outcomes and best practice standards for case management. As part of this process, MBHP has assigned a dedicated BH case manager for HNE members. This case manager routinely communicates with the health service case managers at HNE and attends monthly team meetings at HNE, where referrals for case management, clinical cases and best practice models are discussed. In addition to this, HNE and MBHP hold monthly care management team meetings, which allows for a discussion that is inclusive of supervisors, directors and other clinical staff at MBHP in addition to case manger representation. Additionally, HNE and MBHP discuss issues such as barriers, trends and utilization of our membership in these meetings. This allows for discussion on how to better serve high-cost and high-risk members, and interventions that can be employed as part of integrated services.

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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: HNE has made extensive efforts to promote the adoption of patient centered medical homes. HNE has worked with 20 medical practices to assist them in becoming PCMHs. Over 35% of HNE's members are treated by PCMH practices.

HNE Response: In furtherance of the "Triple Aim" of improved community health, improved patient experience and improved use of resources, HNE assists primary care physician practices to establish PCMHs, in which patients have a direct relationship with a provider who coordinates a team of healthcare professionals, takes collective responsibility for the care provided to the patient, and arranges for appropriate care with other qualified providers as needed. Care is facilitated by patient registries, information technology, health information exchange and other means to assure that patients receive the indicated care when and where they need and want it and in a culturally and linguistically appropriate manner. In all, approximately 50,000 HNE enrollees (35%) are treated by these PCMH practices.

HNE has worked with 20 medical practices to assist them in becoming PCMHs and attaining certification as such by NCQA. HNE assists in the development of registries and provides the practices with funding to implement the necessary information technology, including electronic medical records. HNE has provided approximately $200,000 in grants to health systems operating in Holyoke and Berkshire County, Massachusetts, to establish the infrastructure and systems necessary to develop PCMH practices. HNE also works with physician groups to educate them on best practices for improving the management of patient populations.

Since PCMH certification requires the PCMH approach to be applied practice-wide, not just to HNE enrollees, acquisition of PCMH certification benefits all patients of the practices. Full-time Pioneer Valley Accountable Care (PVAC) nurse managers work on site at the PCMHs and coordinate care, encourage patient engagement and involvement with their own health, and provide information and assistance to individuals with chronic disease or multiple ailments, to all PCMH patients. As a result, the PCMH practices benefit a large portion of the community beyond HNE's enrollees.[1]

HNE has implemented a care management software system that will be shared, at cost, with the Baycare Health Partners PHO within our network to support Baycare-affiliated practices and benefit all patients of those practices.

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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.

SUMMARY AND HNE RESPONSE: Significantly altering the curve of health care cost growth in Western Massachusetts will require continued progress in developing new

1 See Nielsen, Langner, Zema, Hacker, and Grundy, *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012* Patient Centered Primary Care Collaborative 2012 ("Data demonstrates that the PCMH improves health outcomes, enhances the patient and provider experience of care, and reduces expensive, unnecessary hospital and emergency department utilization"), available at http://www.pcpcc.net/files/benefits_of_implementing_the_primary_care_pcmh_0.pdf

models for integrating the delivery and financing of health care, including further progress in development of patient centered medical homes and appropriate cooperation between providers and payors.

Western Massachusetts faces challenges that differ significantly from the challenges faced by health plans in other portions of the Commonwealth. It is less populous, and its distinctive demographics, geography and culture change the character of the provider community and the health care coverage market. As a result, the growth in PPO plans and in tiered and limited network plans reported in the Attorney General's report is not necessarily representative of Western Massachusetts. Creating a limited network offering limited to the four westernmost counties is difficult, if not impossible. PPO offerings are possible, but must reflect the significantly higher costs charged by providers in Eastern Massachusetts. Significantly altering the curve of health care cost growth in Western Massachusetts will require continued progress in developing new models for integrating the delivery and financing of health care, including further progress in development of patient centered medical homes and appropriate cooperation between providers and payors. It will also require willingness on the part of Boston area tertiary and quaternary referral providers to provide care for patients referred from Western Massachusetts at affordable rates.

Exhibit C: Instructions and AGO Questions for Written Testimony

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2011 to 2013 according to the format and parameters provided and attached as AGO Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2011 to 2013 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).

HNE Response: Health New England does not break trends out to include change in provider mix. Summary table is included in Attachment AGO Payer Exhibit 1.

FINAL C-1-AGO Payer Ex 1Trend.xlsx

2. Please submit a summary table according to the format and parameters provided and attached as AGO Payer Exhibit 2 with all applicable fields completed showing your total membership for members living in Massachusetts as of December 31 of each year 2010 to 2013, broken out by:

a. Market segment (Hereafter "market segment" shall mean commercial individual, commercial small group, commercial large group, Medicare, Medicaid MCO,

MassHealth, Commonwealth Care, other government. "Commercial" includes fully-insured and self-insured.)

b. Membership whose care is reimbursed through a risk contract by market segment (Hereafter "risk contracts" shall mean 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 a provider, including contracts that subject the provider to limited or minimal "downside" risk.)
c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity).
d. Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for hospital services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)
e. Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)
f. Membership in a high cost sharing plan by market segment (Hereafter "high cost sharing plan" is any plan in which an individual deductible or copayment of $1,000 or more may apply to any in-network benefit at any tier level.)

HNE Response: The summary table is completed in Attachment AGO Payer Exhibit 2.

FINAL C-2-AGO Payer Ex 2 Membersh

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3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2010 to 2013, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership (e.g., why membership in PPO is growing).

HNE Response: Changes reflect normal loss and growth of membership over time.

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4. Please explain and submit supporting documents that show for each year 2009 to 2013, (i) your total number of employer accounts and the total annual claim payments made for those employers; and (ii) the total number of such employers for whom you do not have arrangements to provide behavioral health network or management services and the total annual claim payments for such employers

HNE Response:

- The jump in groups from 2011 to 2012 is due to an administrative decision at HNE to break out small groups from within a global group number which covered many of these groups; the increase in the number of groups reflected that decision, but did not reflect a true change in the number of small groups.

- Health New England provides a behavioral health network to all employer groups.

Year	Number of Groups	Amount Paid
2009	1,163	$209,650,915.82
2010	1,267	$226,767,971.64
2011	1,343	$238,831,883.07
2012*	3,526	$256,092,246.37
2013	3,474	$254,845,798.63