Commonwealth Care Alliance
Response to the Health Policy Commission's Questions for the 2015 Cost Trends Hearing
Submitted September 11, 2015

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.

    Answer: The One Care and Senior Care Options programs operated by Commonwealth Care Alliance (CCA) are significant components of MassHealth's commitment to alternative payment models. We operate with capitated, monthly payments from both MassHealth and the Centers for Medicare and Medicaid Services and are responsible, and at risk, for all of the health care needs of our members. We do this with personalized individual care plans developed with each member that integrate their Medicare and Medicaid services as well as their behavioral health services with their medical services. We have been serving seniors who are eligble for MassHealth (both dual-eligible and Medicaid-only) in our Senior Care Options (SCO) program since 2004 and currently have over 7000 members in that program. We serve approximately 10,000 individuals who are eligible for both Medicare and Medicaid (dual-eligibles) who are under age 65 and disabled in our One Care program, which opened in October 2013. Because the One Care program is still so new, and saw the majority of new enrollments in 2014, we are not yet able to provide trend data for that program and are therefore submitting cost trend data with this report on the SCO program only.

    Attached please find a slide (attachment 1) showing our cost trend experience for our nursing home certifiable members (75% of membership) for 2008 through 2014, showing our cost growth rate for those members to be -0.6% annually when adjusted for inflation.

    Attached please also find a slide (attachment 2) showing our CAHPS quality case-mix adjusted results for the last 3 years in SCO and for this year in One Care, where we are earning high marks for our high-needs, high-cost members.

    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.

    Answer: In addition to operating as an alternative payment model for MassHealth, we also pay some of the providers we contract with through alternative payment mechanisms. For example, approximately 2000 of our One Care members (1/5 of the

membership) are managed through one of eight sites that operate as behavioral health homes for us. CCA also recently executed contracts with two of our largest, independent primary care practices in the OneCare program to incorporate utilization and quality incentives that align with CCA's global quality withhold incentive and care management/cost management goals. The measures incorporated focus on appropriately managing emergency department and inpatient hospital admissions and readmissions, as well as HEDIS measures related to the management of chronic illness.

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.

Not applicable.

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?

Answer: CCA's integrated care and financing model allows us to innovate in the delivery of care to achieve better health outcomes often at lower costs. There are a number of such initiatives currently in place for our members including:

a) Significant investments in primary care and care coordination. Our care model is centered around individualized care plans developed in partnership with the member, often in their homes. Those care plans often call for significant home and community supports, which has enabled our patients, particularly our seniors to stay healthy, out of the hospital and living in their homes. In our senior program, 10% of our medical expense is for primary care.
b) Crisis stabilization units (CSUs). As discussed in our written and oral testimony for the 2013 cost trends hearing, CCA has been opening its own crisis stabilization units/ community respite facilities to meet the need of our members who require psychiatric stabilization, but do not need (or even want) acute inpatient psychiatric hospitalization. We estimate that 70% of our patients hospitalized for psychiatric reasons before we opened the CSU did not need to be. The opening of these units has allowed us to meet our patients need more effectively and efficiently, closer to home with more connection to their primary care. Please see our

attached slides (attachment 3) showing early indications of the cost effectiveness of this approach.

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.

   Answer: This requirement does not apply to CCA, because CCA is not a carrier as defined in Chapter 176O. Furthermore, all of our members are MassHealth eligible and none of our members share in the cost of their care and therefore are unlikely to inquire about its costs.

   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	☐	No	☐
Outpatient	Yes	☐	No	☐
Diagnostic	Yes	☐	No	☐
Office Visits (medical)	Yes	☐	No	☐
Office Visits (behavioral)	Yes	☐	No	☐

   37T

   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 ☐

   37T

   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.
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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.

   Answer: We believe that hospital and health system consolidation and market power have had a significant negative effect on our small organization. We are unable to secure contracts with all the hospitals we would like to because some hospitals refuse to contract with us at 100% of the Medicare rate. (Even 100% of Medicare is 10% above what we should pay for our dual eligible members because MassHealth does not cover the patient cost sharing portion of the admission because 90% of the Medicare rate already exceeds the MassHealth rate.) This difficulty in contracting with providers with significant market power not only limits options for our patients and threatens continuity of care, but prevents us from expanding to all areas we would like to, because we need certain hospitals to meet the federal network adequacy requirements in each area in which we operate.

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?

      Answer: There are some legitimate regional differences in wages and staff availability that could account for some price differences. But, in our experience, most price variation seems to be because of market power and the ability to demand a certain price, rather than any legitimate difference in underlying costs.

   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.

      Answer: Our policy is to pay providers on the basis of the prevailing public payer fee schedule for the service being provided. Medicare covered services are paid at the level of Medicare reimbursement, and Medicaid covered services are paid on the basis of the prevailing Medicaid fee schedule. We will pay above the fee schedule for primary care for complex patients in keeping with our commitment to invest in primary care to create savings in acute care utilization.

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.

   Answer: All of our members are MassHealth members. Per our contracts with MassHealth and the Centers for Medicare and Medicaid Services, and our own commitment to the health of our low income members, we do not charge our members a fee for seeing out of network providers, or any other form of cost sharing. In cases when a member receives services from an out of network provider, CCA works actively with providers to negotiate appropriate payment for covered services on a case by case basis. In instances in which CCA identifies that members have received bills directly from providers, we outreach to and work directly with providers to ensure they are following appropriate billing guidelines and make sure they are aware that members are not financially responsible for covered services. In addition, we reimburse members who pay out of pocket for an authorized service.

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.

   Answer: An informal analysis of our available data suggests that there has been a noticeable shift in patients seeking services in an outpatient hospital setting rather than an office setting and that there has been a corresponding increase in cost per service as well.

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 attaching analyses you have conducted.

   Answer: From its inception in 2003, CCA has integrated behavioral health into its primary care delivery model. Three decades of experience with high needs patients before even opening CCA has taught us the close relationship between mental health needs, overall health outcomes, and medical expense. Also, as has been repeatedly documented, the life expectancy for an individual with serious and persistent mental illness is twenty-five years less than the general population largely because of cardiac related death. Thus the need for primary care and behavioral health integrations has been quite clear.

In the past twelve months CCA has taken the following educational and operational actions to enhance its integrated medical and behavioral health practice:

a. Initiated training seminars for non-behavioral health clinicians to enhance awareness of behavioral health conditions and to educate clinicians about appropriate management approaches;
b. Hired behavioral health specialists and psychiatric nurse practitioners to provide consultation to the primary care teams and for direct behavioral health care;
c. Implementing a range of integration-related initiatives led by our quality department at our behavioral health homes with the goal of improving performance on HEDIS quality measures, such as improving compliance with medications for hypertension and diabetes;
d. Opened two crisis Stabilization units, allowing for enhanced integration because at least 15% of patients admitted to the CSUs did not have completed in-person assessments. Completing the assessments at our crisis stabilization units has allowed for integration with their primary care clinicians. In addition, all patients admitted to our crisis stabilization units are assessed for their current medical needs to identify opportunities for better integration.
e. Implemented addiction and pain management consultation services for the primary care teams; and
f. Developed a crisis plan for members with exceedingly high behavioral health utilization that includes addressing the medical needs, such as for those with diabetes who need to carefully manage their diabetes along with their mental health.

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.

Answer: The next twelve months will include further implementation of the initiatives described above. In addition, we are planning the following:

a. Opening a third crisis stabilization unit in the western part of the state;
b. Enhancing addiction consultation to clinical teams; and
c. Developing program for outlier medical utilizer program driven by behavioral health diagnosis.

The cumulative goals for these interventions include:

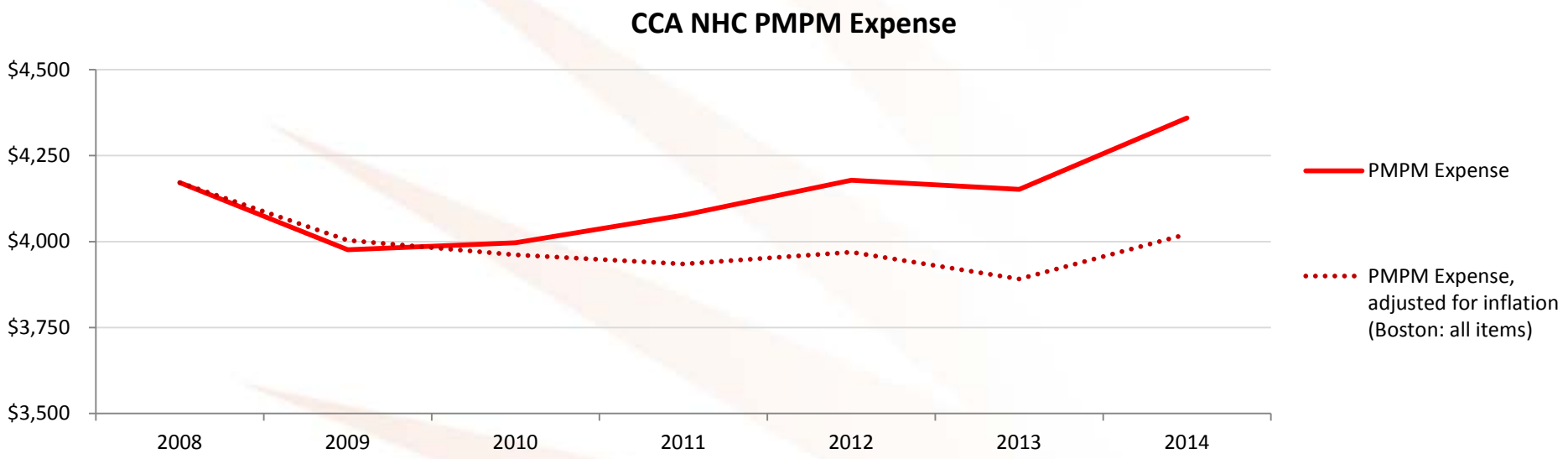
1) Improving per member per month costs for our patients with behavioral health diagnoses; and

2) Improving performance on the HEDIS quality measures for hypertension and diabetes management, beyond the Medicaid benchmark.

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).

   Please see CCA attachment 4/ exhibit 2.

CCA'S COST TREND EXPERIENCE IN SCO
PMPM EXPENSE BY YEAR



CCA's overall expense per member per month for NHC members has increased by 5.4% from 2008 to 2014. When adjusted for inflation, the change is -3.6%, representing a compounded annual growth rate of -0.6%.

NHC – CCA's members who are deemed nursing home certifiable, about 75% of our membership in 2014.

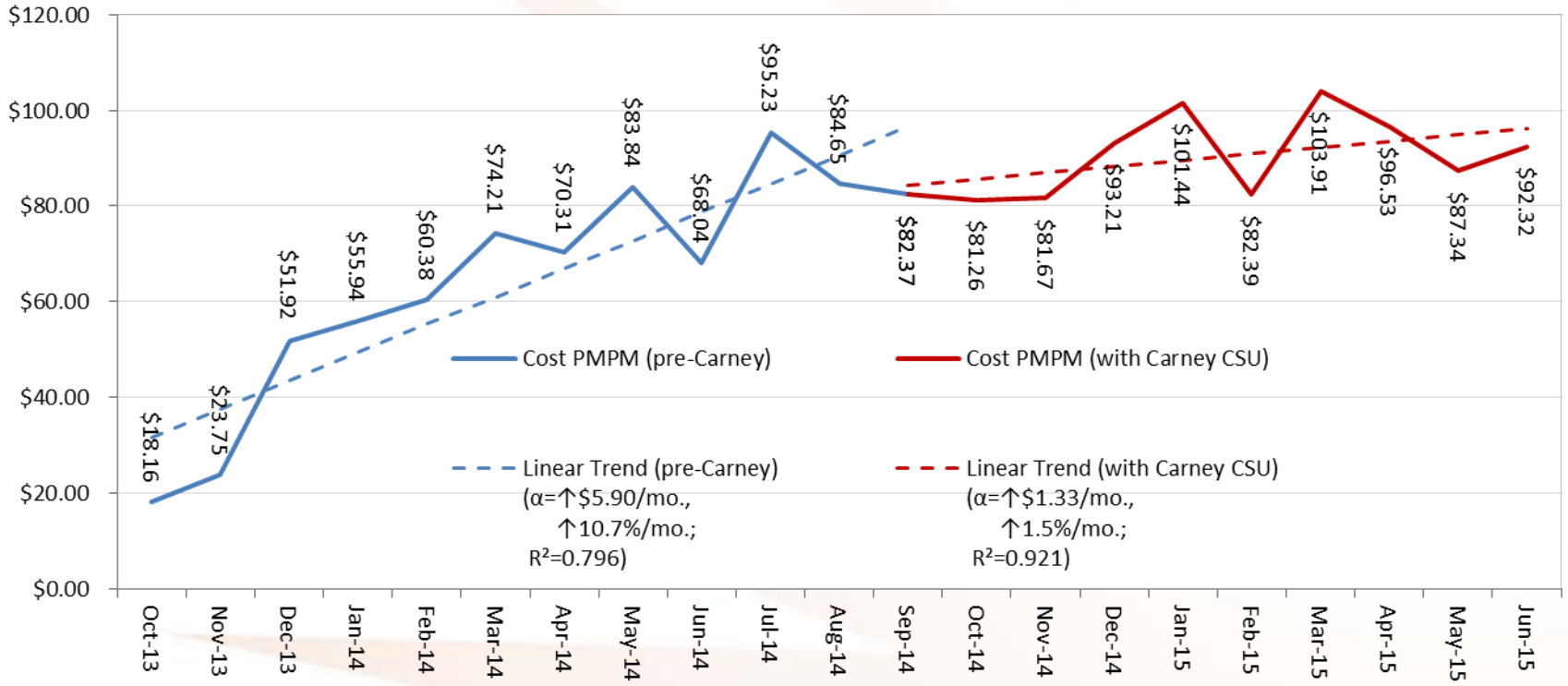
QUALITY: 2015 CAHPS RESULTS (CASE MIX ADJUSTED)

- The 2015 CAHPS results for our One Care population show results at least as high as those in our senior duals program (SCO), which have earned us 4 and 5 stars in prior years

	2013	2014	2015	2015	2013	2014	2015
Measure	**SCO Score**			**OC Score**	**SCO Star Rating**		
Getting Needed Care	87%	87%	84%	86%	4	4	tbd
Getting Appointments and Care Quickly	77%	76%	75%	81%	4	4	tbd
Customer Service	90%	89%	88%	89%	4	4	tbd
Rating of Health Care Quality	87%	89%	87%	89%	4	5	tbd
Rating of Health Plan	89%	92%	90%	90%	5	5	tbd
Care Coordination	87%	89%	85%	88%	4	5	tbd
Rating of Drug Plan	88%	89%	88%	92%	5	5	tbd
Getting Needed Prescriptions	93%	94%	91%	95%	4	5	tbd

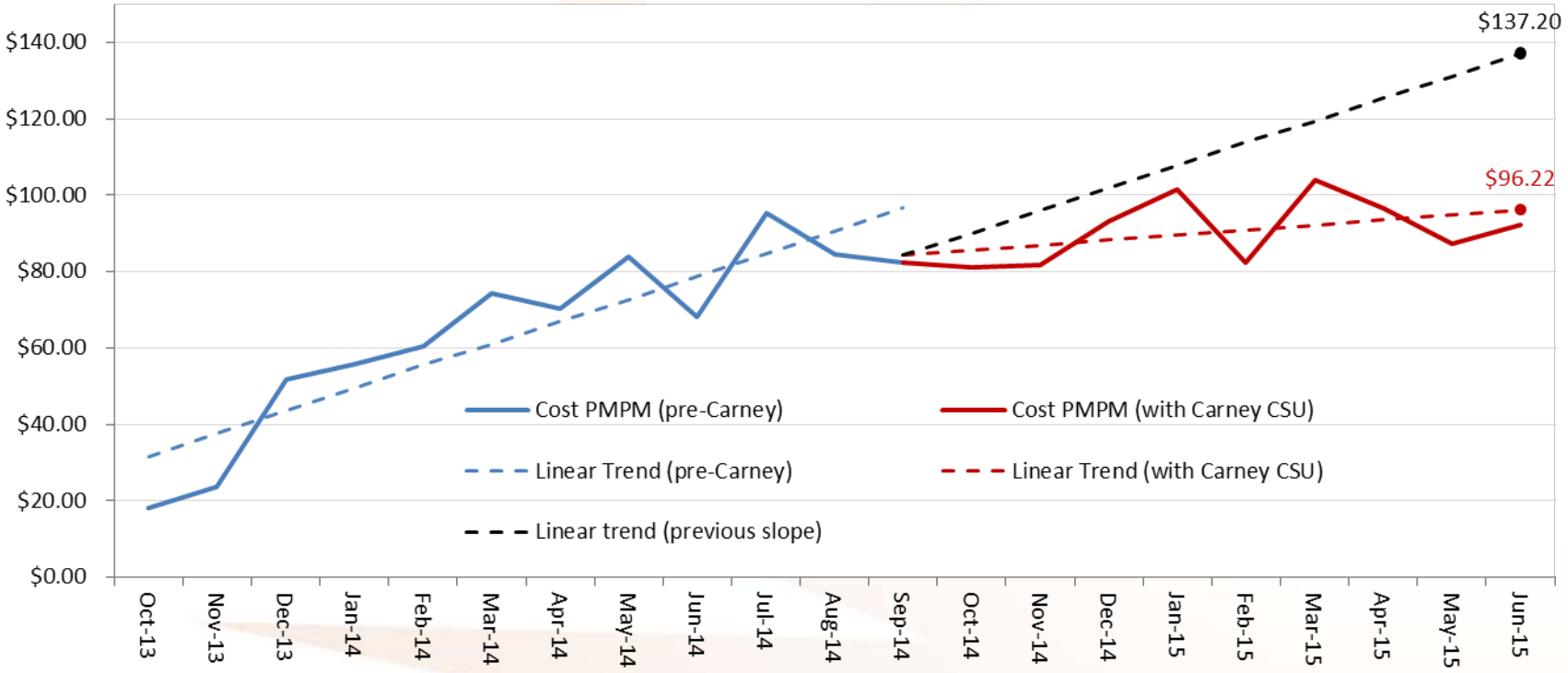
BEHAVIORAL HEALTH PMPM COST TREND

At the start of the One Care program, behavioral health costs PM/PM were increasing by 10.7% per month. Since opening the first CSU in 10/14, BH costs PM/PM increased by only 1.5% /month.



IMPACT OF MEDICAL INTERVENTION

Engaging One Care members into Care Plans and opening CSUs helps to divert medical expenses. If the previous cost trend had extended past the creation of the Carney CSU, behavioral health costs PMPM would have been $137.20 in June 2015 instead of $96.22. A comparison of the lower rate represents potential medical expense diversion of $593,001 at June 2015.



ProductDual	SCO
Source Cat	All
Source Key	(Multiple Items)

Row Labels	PMPM	Enroll Pct
2012	3,729.60	50479
2013	3,753.65	62340
2014	3,894.42	72647
Grand Total	**3,802.25**	**185466**