MASSACHUSETTS
HEALTH POLICY COMMISSION

# 2017 Pre-Filed Testimony

## Payers

Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

# Exhibit A: Notice of Public Hearing

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

Scheduled Hearing dates and location:

**Monday, October 2, 2017, 9:00 AM**
**Tuesday, October 3, 2017, 9:00 AM**
**Suffolk University Law School**
**First Floor Function Room**
**120 Tremont Street, Boston, MA 02108**

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 6, 2017, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube channel following the Hearing.

If you require disability-related accommodations for this Hearing, please contact Andrew Carleen at (617) 757-1621 or by email Andrew.Carleen@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

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

# Exhibit B: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, and/or 2016 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

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

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400.

# Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.
**If a question is not applicable to your organization, please indicate so in your response.**

## 1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC presented at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between $279 to $794 million annually.

a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
   i. **Priority 1**: Shift care from high-cost settings (e.g., academic medical centers) to lower-cost settings (e.g., community hospitals)
   ii. **Priority 2**: Reduce growth in prescription drug spending
   iii. If you selected "other," please specify: Click here to enter text.

b. Please complete the following questions for **Priority 1** (listed above).
   i. What is your organization doing to advance this priority and how have you been successful?

BCBSMA has been committed to delivery system reform which will help our members receive the right care in the right setting. As we have detailed in previous testimony, the Alternative Quality Contract (AQC) and our other alternative payment arrangements – which we refer to overall as our Quality Care Advantage -- encourage the use of lower-cost, high quality providers. Our Quality Care Advantage payment approach establishes a platform where primary care physicians are engaged and direct patients to seek care from value-based providers. We regularly share reports and data with our provider organizations on the services their patients receive and identify opportunity to redirect care. We continue to be eager to see MassHealth implement alternative payment arrangements and delivery system reform given the potential impact on how and where care is delivered.

In addition to payment reform efforts, BCBSMA has been implementing different network-based product designs and learning from them. In that vein, BCBSMA has several tiered products which are currently offered. Approximately 240,000 BCBSMA members are in these products. More information on our tiered products was included in our 2016 Pre-Filed Testimony response. In addition, BCBSMA has offered a limited network product, Select Blue, since January 2017. These product designs help incent our members to select high-value providers.

Most recently, BCBSMA has begun to offer the SmartShopper program to our self-funded accounts. Through this incentive and engagement program, members are able to receive cash rewards for choosing an eligible lower-cost provider for a certain set of procedures (e.g., MRIs, mammograms, colonoscopies, etc.). The SmartShopper program provides members with the resources needed to shop for care and make informed decisions.

   ii. What barriers does your organization face in advancing this priority?

Shopping for care, such as within a tiered or limited network, is a new approach for some of our accounts and members. We continue to engage with them and provide them with the tools to make informed decisions about where they will receive their care.

Additionally, under the current laws and environment, some providers are not interested in being included in a narrow network and some employers find that the current offerings do not meet the needs of their employees.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

A critical policy change that will advance this priority are needed reforms for out-of-network billing and costs. The next generation of innovation continues around value-based plan designs, including limited and tiered products, so out-of-network usage and increased costs will continue to be a problem. BCBSMA agrees with the recent Provider Price Variation Commission that in order to address out-of-network billing, there needs to be 1) consumer awareness of surprise billing scenarios, 2) patient protections to prevent balance-billing, and 3) a maximum reasonable provider reimbursements for out-of-network services.

c. Please complete the following questions for **Priority 2** (listed above).

i. What is your organization doing to advance this priority and how have you been successful?

As detailed in our 2016 Pre-Filed Testimony, the increase in pharmacy costs is something we have seen as a cost driver in the last few years. We have taken steps to mitigate the impact including negotiating price and discounts with drug manufacturers, and negotiating rebates with drug manufacturers. More recently, we have begun to pursue value-based contracting with our pharmacy benefit manager (PBM). We plan on sharing these results with the HPC and other policymakers when the data is mature enough on these new contracts.

ii. What barriers is your organization facing in advancing this priority?

While BCBSMA actively manages pharmacy costs, more transparency is needed with regard to these costs and the pharmaceutical industry. Similar to the public reporting requirements of payers and providers, pharmaceutical companies should be required to submit data to the state and participate in the Annual Cost Trends Hearing with the HPC. This additional information will help policymakers reviewing the landscape to make informed decisions about pressing concerns since pharmaceutical costs will continue to be a large portion of health care cost growth.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

As we noted in our 2016 Pre-Filed Testimony, the larger health care community has to tackle some difficult questions around pharmacy costs: What is the right price for new drugs and therapies? What is their appropriate use and who decides? How can we achieve a better balance between medical advancements and affordability? Data transparency from the pharmaceutical industry is necessary and the HPC should provide analysis to aid policymakers in this discussion. Given the impact pharmaceutical costs have on the state's ability to meet the statewide benchmark, the pharmaceutical industry should be included in the Annual Cost Trends Hearing.

## 2. STRATEGIES TO IMPROVE CLINICAL DATA COLLECTION

In each of its four annual reports, the HPC has called for the improvement and alignment of quality measures, particularly for the measures used in APM contracts, and has recognized the burden of reporting different quality measures for different purposes. Please answer the following questions regarding how your organization collects clinical quality data.

a. How does your organization currently collect clinical data from contracted provider organizations for the purposes of outcome quality measures for provider contracts and the NCQA accreditation process? [check all that apply and explain the purpose for which you collect the data for each] Required Answer.

☒Excel document or equivalent
*Purpose*: For AQC provider contract
☐Direct data feed
*Purpose*:
☐Chart reviews by third-party vendor
*Purpose*:
☐Web-based portal
*Purpose*: Click here to enter text.
☐Other:
*Purpose*:

b. How frequently do you collect clinical quality data from contracted providers? Required Answer.

☐Ongoing
☐Monthly
☐Quarterly
☒Annually
☐Other: Click here to enter text.

c. What is the estimated cost of staff and resources to collect and report on provider clinical quality data each year?

i. Estimated cost (in dollars): $4 K (including FTEs and operational cost)
ii. Estimated FTEs: 0.04 FTEs (approximately two weeks of time from 1 FTE)

## 3. STRATEGIES TO ADDRESS DRUG SPENDING

The HPC, other state agencies, payers, providers and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. In its 2016 Annual Cost Trends report, the HPC highlighted a range of strategies to reduce drug spending increases, including value-based contracting.

a. Are you pursuing value-based drug contracting? Required Answer.

☒ Yes ☐No

If yes, with whom?

In partnership with our PBM, Express Scripts, we have implemented or will be implementing value-based contracts for the inflammatory conditions biologic products as well as Trulicity, a diabetes medication. These contracts are relatively new and we do not have results to prove value yet.

b. If yes, have you found that your value-based contracts have resulted in meaningful cost savings and/or quality improvement? Required Answer

☐Yes, cost-savings only
☐Yes, quality improvement only
☐Yes, both
☐No
☒Unknown (insufficient time to measure improvement)

c. If no, what is/are the reason(s) you have not pursued value-based drug contracting? Check all that apply. Required Answer.

☐Lack of appropriate quality measures
☐Administrative and operational implementation costs

☐Inability to negotiate performance incentives with manufacturers
☐Other (please specify):

## 4. STRATEGIES TO SUPPORT INNOVATIVE CARE DELIVERY THROUGH PAYMENT POLICIES

Public payers are implementing new payment policies to support the development and scaling of innovative, high-quality and efficient care delivery, such as, for example, Medicare's readmissions penalty for acute care hospitals, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, and MassHealth's new flexible services spending allocation in its new ACO program to address patients' non-medical needs.

a. Has your organization adopted any new payment policies related to the following areas of care delivery improvement and innovation? [check all that apply] Required Answer.
   ☒Readmissions
   ☒Avoidable ED visits
   ☒Serious reportable events
   ☒Behavioral health integration into primary care (e.g. collaborative care model)
   ☒Care management (e.g., serious or chronic illnesses)
   ☒Telehealth/telemedicine
   ☒Non-medical transportation
   ☐Services to maintain safe and healthy living environment
   ☒Physical activity and nutrition services
   ☒Services to remove/protect patients from violence
   ☐Other: Click here to enter text.

b. For each area identified above, please describe the payment policy in more detail, including whether it is a payment penalty or non-payment, fee-for-service reimbursement for new service codes, per-member-per-month fee, etc.

**Readmissions:**

BCBSMA includes readmission measures in our incentive program for hospitals and in our quality scores within our HMO and PPO risk arrangements, as well reporting to hospitals and physician groups. In certain circumstances, when a readmission occurs, BCBSMA will combine both claims into one for payment purposes.

**Avoidable ED Use:**

BCBSMA includes avoidable ED use in our HMO and PPO risk arrangements. These measures are used for reporting only.

**Serious reportable events:**

BCBS regularly reviews and tracks SREs reported by facilities in accordance with DPH regulations to identify potential, persistent quality issues.

**Behavioral health integration into primary care (e.g. collaborative care model):**

BCBSMA risk models for ACOs on both HMO and PPO include behavioral health services. In addition, beginning in 2017 we added the new collaborative care management codes to our fee schedule.

**Care management (e.g. serious or chronic illnesses):**

BCBSMA regularly reviews prospective authorizations and claims experience to identify members for case management based on critical events, diagnoses, or the potential to require extensive use of services. These members receive outreach and are encouraged to enroll in a program to help coordinate their care and services while improving their self-management skills. For Medicare Advantage members, Landmark Health provides home-based care to target population as part of our Serious Illness Management (SIM) program. The Landmark in-home visits are designed to support complex patients but do not replace normal office-based visits with patient's PCP.

**Telehealth/telemedicine:**

Beginning in 2016, BCBSMA created a new policy to cover telemedicine for our members. We added a national telemedicine vendor and enabled our existing local clinicians to be reimbursed for telemedicine services to members.

**Non-medical transportation:**

BCBSMA regularly monitors the use of non-participating ambulances for non-emergent transportation. Our contracts give BCBSMA the right to offset hospital payments if there is excessive use of non-participating ambulances.

**Services to maintain safe and healthy living environment:**

N/A

**Physical activity and nutrition services:**

BCBSMA offers a variety of Prevention and Wellness services including discounts at various non-tradition wellness providers (e.g., Massage Therapists, Acupuncture) and reimbursement for gym membership fees.

**Services to remove/protect patients from violence:**

The BCBSMA Behavioral Health Incentive Program includes hospital-based inpatient psychiatric measures. These measures used to calculate incentives track hours of seclusion and hours of restraint to keep patients safe from self-harm.

**Other:**

Click here to enter text.

## 5. STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

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."

a. Please provide available data regarding the number of individuals that seek this information in the following table:

| Health Care Service Price Inquiries CY2016-2017 | | | |
|---|---|---|---|
| Year | | Aggregate Number of Inquiries via Website | Aggregate Number of Inquiries via Telephone or In Person |
| **CY2016** | **Q1** | 7,949 | 100 |
| | **Q2** | 7,012 | 52 |
| | **Q3** | 7,925 | 51 |
| | **Q4** | 10,335 | 53 |
| **CY2017** | **Q1** | 11,547 | 78 |
| | **Q2** | 8,371 | 52 |
| | **TOTAL:** | 53,139 | 386 |

## 6. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2014 to CY2016 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2014 to 2016, 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 attached Exhibit 1

## 7. INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND APMS

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. In the 2016 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2018. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a. Please answer the following questions related to risk contracts spending for the 2016 calendar year, or, if not available for 2016, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a 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.)
   i. What percentage of your business, determined as a percentage of total member months, is HMO/POS business? What percentage of your business is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)

| | |
|---|---|
| HMO/POS | 48% |
| PPO/Indemnity Business | 52% |

   ii. What percentage of your HMO/POS business is under a risk contract? What percentage of your PPO/indemnity business is under a risk contract?

| | |
|---|---|
| HMO/POS | 88% |
| PPO/Indemnity Business | 25% |

b. Please answer the following questions regarding APM expansion.
   i. How is your organization increasing the use of APMs? Are you expanding the participation in risk contracts to providers other than primary care providers (e.g., hospitals, specialists, behavioral health providers) or into new product types (e.g., PPO)?

      BCBSMA has been a leader in the state in developing APM programs and working with our provider delivery systems to support implementation of these programs. In 2016, we expanded our APM suite to include both our PPO population as well as our Medicare Advantage population. Because our model relies on global budgets, primary care AND specialists are included in our APMs by design. Behavioral Health is also explicitly included in almost all arrangements so that provider organizations are accountable for the total cost of care and are able to redesign and integrate Behavioral Health and medical care at once.

   ii. What are the top barriers you are facing and what are you doing to address such barriers?

      We continue to face many of the same challenges we articulated in our 2016 Pre-Filed Testimony.

      One critical challenge is that nearly all organizations who have accepted APM models continue to have a blend of traditional FFS incentives alongside their APM incentives. As we described last year – this is the "two horses" problem – riding two horses at once – continuing to ride the FFS revenue horse while also riding the global budget/population accountability horse. Referral business is often part of the continued FFS revenue – where an organization's specialty physicians and/or hospital(s) are treating patients who are not part of their own APM population (and might be part of someone else's). In this case, the organization has FFS incentives, rather than APM incentives involving accountability for the total cost of care, quality and outcomes for those patients. In addition, the "FFS horse" is still in play for the part of the provider's population that is covered by a payer with whom the provider still has a traditional FFS contract.

      An additional challenge relates to the payment models in place with physicians on the front lines vs. the incentives that organizations have under APMs. Like many APMs, BCBSMA population based payment models establish accountability and incentives at the organizational level for total cost of care, quality and outcomes. Each organization then chooses how to set incentives for its clinicians and staff. Available and emerging evidence on the topic of physician compensation reveals that, nationally,

physician payment still largely emphasizes volume over value. While many organizations have begun implementing models to create incentives for PCPs and occasionally for specialists that are more inclusive of quality and total cost of care, to be truly successful, the salary/bonus structure of both PCPs and specialists needs to be fundamentally altered to align significantly with the objectives of APMs.

A third challenge is the need for delivery systems to invest in population health management infrastructure (technology, process changes and personnel) often in advance of receiving earned incentives from APMs. As such the system needs to ensure that their board/executive leadership understand that this is a long term investment. As we were implementing the AQC, we found that the supplemental AQC support model, in addition to the change in payment, was invaluable. The support model has four key aspects: the availability of actionable data, consulting team that meets with organizational leadership and helps meld their population health strategy, educational sessions that train leaders and key personnel such as care managers and finally forums that allow for spread of best practice. We recommend that these type of support models be implemented along with APMs to ensure they have the necessary data, information and guidance to prioritize the strategies most appropriate to their population and their organizational transformation needs.

A fourth challenge relates directly to the third challenge above. As many of our delivery systems have invested significantly in population health and now are asking increases in guaranteed payments to support this infrastructure. They have also performed well for the first few years of the contracts by bringing more in system (to fill their beds) and are now adding services/subspecialists to increase these in system services often with a large financial investment. Thus fixed costs are rising and groups under APMs are becoming increasingly worried about how they will cover these costs.

Given that we are facing increasing headwinds on APMs and seeing less care innovation than we would like we are working on several new analytic and alignment opportunities which we believe will assist our providers with continuing to advance APMs and the clinical care transformation which we believe will result from these payment models.

iii. Currently, most APM contracts pay providers on a FFS basis with reconciliation at the end of the year. Is your organization taking steps to move payment toward population-based models (e.g. capitation) and away from FFS as the basis for the APM contracts?

☐ Yes ☒No

If no, why not? Currently, more than 5% of our HMO TME is paid in "non-claims" payments. In addition, we have recently upgraded our IT/technical systems to allow for even more flexibility about directing funds to ACOs vs the individual providers. These tools foster ACO functions and innovations, as well as diminish some of the negative incentives of FFS. However, fully capitated models pose several IT/technical/financial challenges for both payer and providers, so we are not currently pursuing those. Even in a capitated model, claims data is required to assist in risk adjustment, attribution and quality measurement.

---- End of BCBSMA Responses ----

I affirm that the facts contained in the preceding responses are true to the best of my knowledge. This document is signed under the pains and penalties of perjury. I have relied on others in the company for information on matters not within my personal knowledge and believe that the facts stated with respect to such matters are true.

Sincerely,

Deborah Devaux
Chief Operating Officer