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**: Reduce growth in prescription drug spending
   ii. **Priority 2**: Reduce provider price variation
   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?

Fallon Health has historically employed a number of different strategies to help reduce growth in prescription drug spending, including prior authorization; step therapy; quantity limits; case management and disease management; reviews of specialty drugs and drugs new to the market; contracting strategy; site of care initiatives (for example, for oral drugs and injectable); promotion of transparency through the use of copays and tiering in plan designs; member education; and physician education.

More recently, Fallon Health has conducted two major initiatives to reduce drug spending. First, Fallon has renegotiated its contract with Caremark, our PBM, to produce unit cost savings for 2017 and 2018. Second, Fallon Health has created an internal unit of pharmacists who reach out to high pharmacy utilizers, make appointments to visit them in their homes, assess and assist the members with their medication compliance, provide the members with additional tools and strategies to better manage their medications and the (typically) chronic conditions for which the member is taking medicines. This program has led to: a) better medication adherence 2) elimination of conflicting or unneeded medications, 3) less medication reactions and adverse medication events, 4) lower rate of hospital readmissions related to medication issues. Through these initiatives, Fallon Health has decreased unit cost through its negotiating with Caremark, and has decreased inappropriate utilization of medications, while at the same time improving overall patient health status and patient satisfaction with their pharmacy regimen and satisfaction with their health plan.

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

Many factors influence the growth in prescription drug spending, but among them are specialty medications, diabetes and generic drug price increases.

The greatest concern lies with Specialty Pharmacy. These are very high cost medications that have specific indications for the treatment of rare and complex diseases such as cancer.

In recent years the FDA approved a record number of new drugs. Of those, many are considered specialty medications. The FDA has developed policies in order to expedite approval of these types of drugs and with a large pipeline of products, future approvals will have a significant impact on costs.

Because of the complexities of the drugs and of the patients being treated, the setting of delivery of these products is moving away from the provider's office and to hospital outpatient departments. The utilization of that setting greatly increases the cost of administration.

Diabetes is also having a major impact on costs. The incidence of diabetes is rising steadily and it has been estimated that 28% of adults with diabetes are currently undiagnosed. We have seen a trend of about 15% in this area due to increases in both utilization and unit costs. Utilization is up due to new products entering the market. Unit costs have increased steadily due to manufacturers increasing the costs of their medications by substantial margins.

In the last few years generic drug utilization has been increasing but prices have been trending up as well. There are fewer products available for many categories of medications leading to less competition and therefore higher prices. One cause of this is the consolidations and mergers taking place within the generic manufacturing industry. With this consolidation, some manufacturers are ceasing production of product lines that are not deemed profitable. New policies enacted at the FDA have also slowed the approval process of new generic products. These and other factors are driving up costs of very highly utilized medications.

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

1) If federal policy were to change so that traditional Medicare could negotiate for drug costs, then overall costs for many drugs would probably come down for Fallon and other health plans. The Medicaid program can negotiate drug prices; Medicare needs to be able to do so as well.

2) The Health Policy Commission (HPC) should convene a panel of stakeholders to review the price of new drugs and any dramatic increases in the price of existing drugs. The panel should determine if there is statistically significant evidence that justifies the price of a new drug or dramatic increase in price of an existing drug. If the panel determines the price is unwarranted the HPC should be required to post a listing on its website of medications that are low-value care options. Pharmaceutical companies should then be required to send representatives to the Cost Trend Hearings to testify as to the justification for the cost or price increases of the drugs on the HPCs low-value list.

3) Massachusetts should enact legislation that requires drug manufacturers to apply to the HPC for a DON for any price increase of greater than 2% in any given year for any existing medication that has been FDA approved and sold on the regular market for 3 years or more. Controlling the rate of unwarranted price increases on existing drugs would be a significant help in controlling ever rising drug costs.

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?

Fallon Health has conducted extensive analysis to determine which providers are outliers in unit cost. This analysis includes physician, hospital, and all ancillary provider types. Fallon then deploys a contracting strategy depending on whether targeted providers are non-participating or already participating for commercial products. If the cost outlier status is due to non-participating status, then Fallon Health attempts to contract those non-participating providers and to convince them to execute a contract for fixed pricing that is less than their charges.

With participating providers, Fallon Health analyzes its entire book of business with that provider, i.e. commercial, Medicare, and Medicaid to determine which type of business is important to the provider and then see if a renegotiation of their contract for all lines of business can produce overall savings to the health plan.

While it does not directly address the issue of provider price variation, Fallon has also historically been a proponent of limited networks, which steer members to providers who have the ability to manage utilization appropriately, resulting in lower rates and high-quality outcomes.

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

Fallon Health's small population of fully insured commercial members gives Fallon very little leverage when trying to negotiate lower rates with large hospitals (both community and tertiary) and large physician groups. The problem of low membership is made worse because the membership we do have is dispersed over such broad commercial networks. That means that Fallon fully insured commercial business is fairly small at most providers outside of those provider groups and hospitals primarily based in Worcester County.

The problem of provider price variation is also further exacerbated by provider consolidation. As hospital and physician groups consolidate and form ever larger systems it becomes nearly impossible to leave any provider system outside of a commercial network product. That means that the provider system knows the health plan has to have them in-network in order to have a viable commercial product. Knowing this fact, they demand ever higher reimbursement rates. These large provider systems then use the additional reimbursement monies to promote and advertise their services to the public. More and more people select primary care physicians associated with these large expensive systems, and the cost of care for these members increases even for basic primary care. Unless this cycle of the large systems getting even bigger and increasing their market share is halted - or at least slowed - increased utilization of services in high cost provider settings will negatively affect other initiatives aimed at meeting the Commonwealth's cost growth benchmark.

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

1) The state legislature should consider taking steps to discourage high annual rate increases for high cost providers until those providers are no longer unit cost outliers. The HPC and Attorney General's Office should consider using their existing power under M.G.L. Chapter 6D, Section 10 to take steps to do the same.

2) The HPC must continue to diligently monitor provider consolidations, mergers and acquisitions. Proposed provider consolidations involving large provider systems should not be allowed to occur without a full Cost and Market Impact Review (CMIR). All CMIRs should be referred to the Office of the Attorney General. The proposed material change should not be allowed to move forward unless the providers involved are able to provide objective statistical evidence that the material change will provide a truly integrated system with improved quality and lower healthcare costs. If allowed to move forward, the HPC must continue to monitor the transaction after the fact to ensure the proposed benefits are actually realized. If not, the providers involved in the material change should be prevented from future consolidations, mergers or acquisitions until they attain the improvements stated in their prior notice of material change. In addition, providers that are not in compliance with the HPCs cost growth benchmark should be prohibited from making any material changes.

3) Regulation for HPC to require something like a Determination of Need (DON) filing for any hospital, physician, or ancillary provider that has >$500,000 in commercial health plan revenue per year and plans to request more than a 2% increase in any given year from any health plan that is licensed to sell health insurance in the Massachusetts commercial market. Before pursuing a negotiation for >2% with any commercial health plan the provider would have to go through this DON process with the HPC and prove why they need more than 2%. For 2% or less the provider can negotiate with the health plan without doing a DON with the HPC.

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: To supplement claims data for the purpose of measuring HEDIS and Pay for Performance.

☒Direct data feed

Purpose: Fallon Health receives a direct feed from two of our large providers for the purpose of measuring HEDIS and Pay for performance.

☐Chart reviews by third-party vendor

Purpose: Click here to enter text.

☐Web-based portal

Purpose: Click here to enter text.

☒Other: Click here to enter text.

Purpose: 1. Medical record review onsite at the provider's office by Fallon staff; 2. Lab results from Quest and Labcorp, 3. Record retrieval from companies such as CIOX with whom our providers contract to meet Fallon requests for medical record data.

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): $669,000
ii. Estimated FTEs: 8 FTE including data analysts, nurse reviewers and administrative support

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?
Required Answer: Click here to enter text.

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): Click here to enter text.

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:

For providers who are reimbursed by Fallon Health according to a DRG or similar case-rated methodology for Commercial plan and MassHealth enrolled members, we will deny reimbursement for readmission for inpatient services occurring within 7 days of discharge from the same facility for the same or related condition for which the member was treated at the time of the original discharge. For providers that are reimbursed by Fallon Health according to a DRG or similar case-rated methodology for Medicare plan members, we will deny reimbursement for readmission for inpatient services occurring within 30 days of discharge from the same facility for the same or related condition for which the member was treated at the time of the original discharge.

Avoidable ED Use:

Fallon Health has entered an agreement with Teledoc. This relationship is stated on our Telemedicine policy. Teledoc provides 24/7/365 access to quality medical care through telephone and video communication. This service is for sick members and aims to allow a consultation with a physician at all times rather than utilizing the ED.

Serious reportable events:

Fallon Health will not reimburse for the SREs as categorized by the National Quality Forum. Providers will not be reimbursed for services provided as a result of an SRE occurring on premises covered by the provider's license if the hospital determines that the SRE was:
a) Preventable, and
b) Within the hospital's control, and
c) Unambiguously the result of a system failure.

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

Click here to enter text.

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

Fallon Health has two policies that pertain to this question: Diabetes Self-Management and Training (DSME/T), and Palliative Care.

DSME/T:

Fallon Health's payment for all services provided by non-physician professionals is 85 percent of the applicable physician fee schedule amount, or as per contract. We will reimburse for an initial visit of up to one hour and up to nine hours of follow up visits during the first year that DSME/T is provided to a Plan member. For subsequent years, we will reimburse up to a maximum of two hours of follow up visits.

Palliative Care:

Fallon Health covers palliative care consultations for plan members with acute or chronic, life-threatening or life-limiting conditions, for whom the palliative care specialist has been asked to:

- Provide education for the patient and family regarding disease progression, pain/symptom management, and treatment options;
- Identify and address the physical, psychological, spiritual, and social issues during treatment;
- Guide and support the patient and family toward developing realistic goals; and/or
    - Encourage patient and family to consider social, financial and legal issues including advance directives.

Telehealth/telemedicine:

In addition to Teledoc (see discussion above under Avoidable ED use), Fallon Health covers Telemedicine for consults for in-patient and emergency room related services. These codes are typically used when a specialist consult is needed and that specialist is at another hospital/facility. The consult being done via telemedicine rather than waiting for the specialist can often lead to an earlier discharge.

Non-medical transportation:

For Fallon Health's NaviCare SCO product only, social transportation is covered. (Note that this is unique to the NaviCare SCO product and does not apply to Fallon commercial plans.) NaviCare will cover up to 80 roundtrip transports per year via van/chairvan, taxi, or ambulance (when required), with no more than one roundtrip transport daily. Transports are limited to a 30-mile radius and must be coordinated and arranged during NaviCare business hours. Services covered under this benefit may include transportation to qualified fitness center locations (e.g., Silver Sneakers), or transportation to assist with activities of daily living, nutritional and dietary services, counseling services, and social activities.

Services to maintain safe and healthy living environment:

Fallon Health has several policies that address these areas such as Preventative Services, Vaccines, and Aging Services Access Points (ASAP).

Preventative Services: Our policy outlines how Fallon Health determines if a service is preventative and that it will be zero cost-sharing to the member. Additionally it outlines how, if a provider also discusses a problem-focused issue at a routine physical, they can bill for additional payment yet still allow for the member to have zero cost-share for a routine annual physical.

Vaccines: Our policy outlines Fallon's coverage of preventative vaccines. Additionally providers are instructed, when available, to obtain the vaccine free from the state as they will not be reimbursed by Fallon when it is available for free.

ASAP: For Fallon's NaviCare SCO only (note that this is unique to the NaviCare SCO product and does not apply to Fallon commercial plans): ASAPs provide a variety of coordinated home-care &

community services to qualified seniors, individuals with disabilities, their families, and caregivers. Some examples of services include: Home delivered meals, adult foster care, personal care, respite, Home-care, adult day health, laundry. Our policy details how these agencies should submit claims for reimbursement for the vast array of services they coordinate.

Physical activity and nutrition services:

Fallon Health's Medical Nutrition policy outlines licensing requirements for providers rendering this service and establishes that non-physicians will be reimbursed at 85% of the fee schedule. Medical Nutritional Therapy (MNT) is nutritional therapy and counseling services for the purpose of management of a medical condition.

Services to remove/protect patients from violence:

Click here to enter text.

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**	898	105
	Q2	732	67
	Q3	539	96
	Q4	663	80
CY2017	**Q1**	856	127
	Q2	720	155
	TOTAL:	4,408	630

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).

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

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	96%
PPO/Indemnity Business	4%

   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	37%
PPO/Indemnity Business	0%

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)?

Fallon Health has had behavioral health providers under risk for many years by capitating our behavioral health partner, Beacon Health Options, for Commercial and Medicaid products which have a large membership. For commercial and other government products with smaller membership, Fallon still reimburses behavioral care for those members on a FFS basis.

With respect to the commercial PPO product, Fallon Health's PPO membership is very small and is distributed over a large number of unrelated providers. These two key factors prevent us from creating a reasonable risk model for our commercial PPO population.

When Fallon Health does have a concentration of commercial members with one provider organization that is large enough to support an APM arrangement, Fallon always attempts to include PCPs, specialists, and their affiliated hospital in the risk arrangement whenever possible. This aligns the interests, financial incentives, and population management approach of all three parties and is more likely to produce the desired outcomes of better integrated care at the most efficient cost.

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

Our barriers remain the same as in previous years. In particular, 1) Our overall fully insured commercial membership is small (< 100,000 members) and spread out over the entire state, and 2) Due to the small overall fully insured membership, very few provider groups in the state have a large enough panel of Fallon Health members to make it reasonable to take on a risk based APM. If Fallon did create a risk arraignment with these provider groups a very small number of cases could swing the provider group into a deficit and undo an entire year's work of careful care coordination by the provider

group. Finally, on a small panel of members the potential for surplus is such small money relatively speaking, that many provider groups do not want to put significant effort into a risk deal with Fallon Health because the possible payout, even if they are successful, is not seen as worth the effort it takes on behalf of the provider organization.

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? Click here to enter text.

I, Richard Burke, am the President and CEO of Fallon Community Health Plan, Inc. (Fallon Health). I am legally authorized and empowered to represent Fallon Health for the purposes of this testimony. The responses contained in this submission were prepared by employees of Fallon Health who are subject

matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury on this 12th day of September 2017:

Richard Burke
President and CEO
Fallon Community Health Plan, Inc.