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 unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions)
   iii. If you selected "other," please specify: N/A

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?

      Harvard Pilgrim has several initiatives aimed at reducing growth in prescription drug spending:

      - **Utilization management programs:** We have established comprehensive utilization management programs, including prior authorizations, quantity limits, and step edits. In July 2017, we partnered with CVS Health - NovoLogix to oversee and expand our utilization management program for medical drugs. Our strategic partnership has allowed us to develop a process to continuously evaluate medical drug spend and implement programs to address areas of concern. We are better able to ensure that utilization is safe and evidence-based as well as reduce cost by promoting an automated workflow and reporting process to reduce paperwork and administrative costs.

      - **Direct negotiations with specialty pharmacies:** We negotiate directly with a small network of specialty pharmacies for specialty and infertility medications. In July 2017, we successfully implemented CVS Specialty as our new specialty pharmacy vendor which will produce pricing improvements while maintaining high member service. In addition to specialty medications, CVS Specialty provides personalized specialty pharmacy services, such as access to pharmacists and nurses, and a 24-hour-a-day on-call pharmacist, thus reducing the number of unnecessary office visits and Harvard Pilgrim's administrative burden.

      - **Rebate and alternative contracts:** We are aggressively pursuing rebate contracts for preferred and non-preferred formulary access as well as creative, alternative contracts with pharmaceutical manufacturers. The alternative contracts include outcomes based contracts and price protection (inflation cap) components. We currently have 12 value based contracts with 7 manufacturers.

      - **Improved vendor management:** We are actively pursuing improved PBM and vendor management which allows for annual market checks for pharmacy pricing. Improved PBM

pricing was implemented in 2017. In October 2017, we will implement MedImpact Direct as our new mail order pharmacy for our commercial and Medicare Advantage plans which will provide additional savings.

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

Harvard Pilgrim faces several challenges in reducing the growth of prescription drug spending. While the strategies listed above are effective tools, they may not be applicable to all types and classes of drugs. Traditional utilization management techniques, for instance, cannot be applied to generic drugs since substitution of brand names is done at the point of dispensing and cannot be influenced by health plans.

Furthermore, outcomes based contracts with pharmaceutical manufacturers are most appropriate for high cost drugs for which there is robust efficacy data and metrics suitable for measuring performance. However, many new high cost drugs, particularly those treating a disease or condition of low prevalence (e.g. Exondys 51, Spinraza, and Kalydeco) are being approved by the FDA with very limited efficacy data. Furthermore, it can be difficult to engage manufacturers of drugs that provide limited value or to the degree that there is efficacy data it does not indicate high performance. Containing the cost of those drugs requires different strategies, such as price transparency as indicated below in response to question iii. Finally, managing outcomes based contracts can be time and resource intensive, certainly more so than traditional contracts based primarily on price.

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

There are a number of policies that could be adopted at the federal level to help reduce growth in prescription drug spending. These include: prohibiting drug companies from delaying access to generic drugs (pay-for-delay), reforming the patent system to shorten product exclusivity, and restricting direct to consumer advertising. However, fewer solutions are available to the states. One solution would be for the state to consider prescription drug price transparency legislation. Legislation was introduced this session that would require pharmaceutical manufacturers to report to the Massachusetts Department of Public Health drugs that had a wholesale acquisition cost increase of 15% or more over a 12-month period. Other states have already passed price transparency legislation. In 2016, Vermont passed legislation that requires state officials to identify 15 drugs for which "significant health care dollars" are spent, and list where prices rose by 50 percent or more over the previous five-year period. Earlier this year, Maryland passed legislation that would allow the State Attorney General and Circuit Courts authority to penalize generic drug manufacturers for excessive price increases.

One traditional and effective tool for managing prescription drug spending is benefit design that includes cost sharing variations that encourage the use of less expensive therapeutic alternatives. Prescription drug manufacturers have had significant success undermining this tool through the issuance of drug "coupons" that cover the consumer's copayment. What may seem on its face to be a consumer-friendly aid to ease the cost burden ends up driving overutilization of expensive drugs when a much less expensive therapeutic equivalent is available and perfectly appropriate. Until recently, Massachusetts was a national leader in banning this cost inflating industry practice but that ban has since been repealed, and its sunset provision has been delayed numerous times. Bringing back the prohibition on prescription drug coupons would restore this mechanism that health plans can use to ensure appropriate utilization of costly drugs.

Similarly, as prescription drug costs continue to rise and insurers are left to grapple with the expense, it is important that policymakers preserve the breadth of tools available to insurers to manage costs and utilization. Recent efforts in the Legislature, almost entirely funded and promoted by the prescription drug industry, to limit the use of step therapy, mandate coverage for specific drugs, or set

maximum cost sharing for specific prescriptions handcuff the ability of health plans to manage these costs and only serve to drive up premiums. These proposals must be resisted.

Finally, the ability of plans to negotiate outcomes based contracts is predicated on the flexibility to contract directly with manufacturers, so it is important that this flexibility be preserved as the system transitions from fee-for-service models to frameworks that reward outcomes.

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?

Harvard Pilgrim regularly reviews trend data to identify opportunities for cost savings that keep premiums affordable. Among the more notable trends in recent years is a steady increase in hospital admissions. Beginning in September 2017, in an effort to ensure appropriate utilization of inpatient care while also providing quality care for our members, Harvard Pilgrim nurse care managers will review inpatient surgical/medical admissions against InterQual criteria – a nationally accepted standard medical necessity criteria set from McKesson/Change Healthcare - to ensure that the appropriate level of care (inpatient vs. observational admission) is being applied. In addition, Harvard Pilgrim will end the practice of reimbursing for observational services that exceed 48 hours.

Another trend that we observe, one that is also widely documented, is the persistence of unnecessary use of emergency departments for routine or follow up care that can and should be provided in a physician's office or urgent care center. Harvard Pilgrim recently engaged a group called Cotiviti to conduct an audit of coding patterns by providers offering emergency department services to members across Massachusetts, New Hampshire, Maine and Connecticut. Based on an 8-month sample of physician ED claims and 7 months of facility ED claims, the audit showed that more than 28% of physician ED claims and almost 20% of facility ED claims should not have been reimbursed as ED visits and as emergency, but as office visits. Inaccurate coding of this sort costs Harvard Pilgrim more than $6 million annually. These findings are not surprising. In May 2014, a report from the Office of Inspector General found that 55% of claims for E&M services were coded incorrectly and/or lacked documentation, which resulted in $6.7 billion in improper payments. We continue to assess how best to address these findings.

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

The care management techniques described above are not necessarily novel ideas, but were commonly used by HMOs previous decades before growing out of favor in the late 1990s. They represent some of the most effective tools available to ensure appropriate utilization of services but they require investments of human and technical resources to manage them effectively.

As we take these steps, we are keenly aware that the introduction (reintroduction, in some cases) of these types of initiatives has the potential to generate discomfort and confusion among providers and others. Minimizing this discomfort and confusion will require significant provider and member education which also requires time, attention and resources.

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

Similar to our response to question b(iii) above relative to prescription drug costs, it is important for policymakers to resist calls that may come to halt or roll back care management initiatives such as those described in c(ii). Instead, we recommend reliance on the consumer protections that exist in state law and regulation today (e.g. requirements that care management programs be evidence based, internal and external appeals processes, etc.) that guard against arbitrary decisions by plans that are not in the best interest of the patient/member. Health plans must be allowed to perform the function

envisioned for them in the state's managed care law, to ensure that members have coverage for an access to appropriate, evidence-based care that is medically necessary.

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 collect outcomes data.
☒Direct data feed
Purpose: Harvard Pilgrim obtains some lab data feeds.
☐Chart reviews by third-party vendor
Purpose: Click here to enter text.
☐Web-based portal
Purpose: Click here to enter text.
☒Other: Harvard Pilgrim staff
Purpose: Harvard Pilgrim staff is deployed to collect data at the provider site.

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): Minimal cost for APM contracts and approximately $750,000 to collect and report on HEDIS measures.
ii. Estimated FTEs: Minimal FTE usage for APM contracts and 6 FTEs responsible for analytics and chart collection and review for HEDIS measures.

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?

Novartis, Amgen, Eli Lilly, Astra Zeneca, Biogen, Bristol-Myers Squibb, Johnson and Johnson

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:

Harvard Pilgrim has an existing policy for readmissions that currently does not allow separate reimbursement for readmissions to the same facility within 7 days for the for the same or related condition. Effective December 2017, we are increasing the review timeframe from the current 7 days to 30 days for readmissions in the same facility and for the same or a related condition.

As part of Harvard Pilgrim's physician group pay-for-performance program, Quality Advance, we have implemented two elements where local physician groups are incentivized to implement interventions to reduce readmission rates and ER use rates. Physician groups are expected to develop and share their business plan on the topic, give midyear results, and present final results in early 2018. Physician leaders will share lessons learned during the statewide medical directors meeting.

Since 2000, Harvard Pilgrim has funded Quality Grants, where local leaders submit a proposal on topics outlined by Harvard Pilgrim in the Annual Quality Program Description. In 2017, we funded projects aimed at reducing hospital readmission rates for ambulatory care sensitive conditions.

Avoidable ED Use:

As mentioned above, as part of Harvard Pilgrim's physician group pay-for-performance program, Quality Advance, we have implemented two elements where local physician groups are incentivized to implement interventions to reduce readmission rates and ER use rates.

Serious reportable events:

https://www.harvardpilgrim.org/pls/portal/url/item/F25B6915D95846498B4BBF1B3FFACCA1

Harvard Pilgrim updated its serious reportable events policy in November 2016. We do not reimburse for services associated with serious preventable conditions and/or "never events". Providers are also not permitted to bill members for serious preventable conditions and/or never events.

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

In 2017, Harvard Pilgrim has provided Quality Grants to fund projects on: psychiatry eConsults; supporting behavioral health and substance use management in the primary care medical home; care transitions; behavioral health integration of primary care practices; and deepening behavioral health integration in order to address opioid use disorder in primary care.

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

In 2017, Harvard Pilgrim has provided Quality Grants to fund projects on: managing care of COPD through innovative partnerships between primary and specialty care; expansion of pilot population health program to additional chronic diseases; redesigning care delivery in diabetes management; cancer survivorship navigation program; discussions about serious illnesses in the primary care setting; tele-management of children with asthma and their caregivers; National Diabetes Prevention Program; and bolstering ovarian cancer patients care transitions to improve outcomes.

Telehealth/telemedicine:

https://www.harvardpilgrim.org/pls/portal/url/item/D804C7DAF7714F9FB9919B3E1F904DF8

Harvard Pilgrim updated its Telehealth/Telemedicine policy in June 2017. The updated policy allows for a percentage reduction in payment for Telehealth/Telemedicine services.

In 2017, Harvard Pilgrim has provided Quality Grants to fund projects on psychiatry eConsults supporting behavioral health and substance abuse in the primary care medical home and tele-management of children with asthma and their caregivers.

Non-medical transportation:

https://www.harvardpilgrim.org/portal/page?_pageid=253,10368074&_dad=portal&_schema=PORTAL

Beginning in January 2017 for Medicare and in May 2017 for commercial members, prior authorization is required for all non-emergent transportation, including air (fixed wing) and ground transportation (i.e. ambulance, wheelchair van). Prior authorization is not required for emergency transportation that is reasonable and medically necessary to ensure the member's safe transport to the nearest medical provider capable of furnishing covered services.

Services to maintain safe and healthy living environment:

Click here to enter text.

Physical activity and nutrition services:

Click here to enter text.

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**	13,722	356
	Q2	10,504	467
	Q3	6,866	431
	Q4	7,626	355
CY2017	**Q1**	6,306	460
	Q2	559*	556
	TOTAL:	45,583	2,625

*Due to technical problems with our online cost transparency tool, utilization of the tool substantially decreased in the second quarter of 2017. During this time, Harvard Pilgrim's website redirected members to call our Member Services unit to ensure the continued availability of cost estimate information. Access to the online tool has been restored. In 2018, Harvard Pilgrim will be launching a new transparency tool that will provide improved features, simpler functionality and mobile friendly capabilities.

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 find Harvard Pilgrim Payer Exhibit 1 attached, which demonstrates the total allowed medical expenditure for CY2014 to CY2016.

(a) The impact of demographics on actual observed allowed trend is 1.1% for 2014, 2.1% for 2015, and 1.4% for 2016.

(b) The impact of benefit buy down on actual observed trend are -0.5% for 2014, -0.9% for 2015, and -0.8% for 2016. The buy down factors indicate that groups have changed their benefit plans from smaller member cost-share in each year.

(c) We do not measure health status as a separate factor at this time. The effect of the change in health status is primarily incorporated in the demographic factors.

The demographic, benefit and health status trends would mostly impact utilization trend but would also have some effect on mix.

Calendar Year	Demographics	Benefit Buy-Down
2014	1.1%	-0.5%
2015	2.1%	-0.9%
2016	1.4%	-0.8%

In addition to the above, please also note the following comments and explanations that should accompany the above information:

- Historic annual trends are provided on an observed allowed basis for both fully insured and self-insured commercial business in the rating state of Massachusetts. Medicare products were excluded.
- Trends include non-claim based expenditures and are based upon actual observed claims and non-claim base trend.
- The impact of demographics and benefit buy down on actual observed trend is available for fully insured business only. Self-insured demographics and benefit buy downs are not separately tracked.
- Provider mix is not separately tracked at this time.

Utilization represents admits per thousand for Inpatient Facility, services per thousand for all other Medical categories and 30-day supply count for all Prescription Drug categories.

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	56%
PPO/Indemnity Business	44%

   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	84%*
PPO/Indemnity Business	1%

   *The 84% for HMO/POS reflects Harvard Pilgrim's fully insured membership in risk contracts; 48% of Harvard Pilgrim's self-insured HMO membership is covered under risk contracts.

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)?

Since 2012, Harvard Pilgrim has nearly doubled its network participation in Value Based Contract ("VBC"). We feel we have maximized our footprint based on our Fully Insured and Self Insured HMO/POS products (please refer to barriers below).

Harvard Pilgrim has fully developed capabilities to support PPO alternative payment models and in 2014, implemented PPO alternative payment models with 6 key provider entities under the Massachusetts Group Insurance Commission's (GIC) Integrated Risk Bearing Organization (IRBO) program. Together, these alternative payment models covered more than 50,000 GIC PPO members. In July 2015, Harvard Pilgrim's PPO GIC plan converted to a new POS plan, and this membership then migrated to HMO/POS APMs.

In January of 2017, we adopted and implemented a singular, consensus PPO Attribution model. Harvard Pilgrim continues to work to integrate PPO data across all our technical platforms to support PPO APMs with viable membership at the practice level, and pursuing additional PPO APM contracts across our provider network, where feasible. There are challenges to be addressed to support PPO risk expansion (refer to next question for barriers/challenges).

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

<u>Membership Saturation</u>

Harvard Pilgrim has successfully reached a saturation point in FI market in MA network. Small groups (with less than 1,000 members) and individual/independent providers, contributing about 16% FI HMO/POS population, are more exposed and, therefore, adverse to risk volatility. With these providers, we engage in participation in quality performance based earnable rates increase (i.e., inflationary adjustment plus quality earnable).

<u>PPO Products</u>

While we have the capabilities to support PPO attribution, it has been our experience more recently that provider groups are more cautious about embracing PPO risk than they have been with HMO/POS risk, due to the product's inherent design, which allows patients freedom to seek health care from providers and specialists of their choice. This greater movement among and between provider practices makes referral management and cost- and quality-focused managed care efforts more challenging. An additional challenge to Harvard Pilgrim is that our PPO risk populations at the practice level may not always be of sufficient size to support a viable risk unit. Even those with suitable membership Harvard Pilgrim needs to be cautious as providers expect and demand certain protections due to the nature of this product which may lead to unintended consequences in driving up costs vs. being paid on Fee-For-Service.

<u>Market Volatility</u>

As provider consolidation and movement is ever present, it has created additional complexity in our existing VBC contracts that is not unique to Harvard Pilgrim. For instance, physician migration from one to group to another group has resulted in multiple discussions regarding modifications to certain components in VBC risk models. This has been an additional burden to both Harvard Pilgrim and providers under these models to find the right balance in applying appropriate adjustments as a result. Harvard Pilgrim will continue to review and monitor how best to capture such changes in 2017.

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, we have two groups on full-risk capitation models in MA, which represents ~24% of FI HMO/POS membership. Capitation requires for the provider certain operational and financial structure to be in place. Full Capitation model is not feasible for all providers, and could potentially be a costly way to change physician behavior, and exceeding relative cost compared to other VBC mechanism in our effort of containing medical expense trend. ASO accounts prevalence of preference and reliance on fee-for-service payments and year-over-year trend based on claims payments is another major market force that challenges a full adoption of capitation model.