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.

Please note: All responses below refer to Tufts Associated Health Maintenance Organization (TAHMO) and its commercial line of business

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**: Increase the use of alternative payment methods (APMs)
   ii. **Priority 2**: Reduce unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions)
   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?
   Tufts Associated Health Maintenance Organization (TAHMO) believes that it is essential to engage providers in managing cost, and the best way to do so is through global risk arrangements. Through risk arrangements, innovative cost management and quality programs can occur on the front line of patient care. By pairing risk arrangements with timely, actionable reporting through our Provider Engagement team, we can equip provider groups with the information necessary to address cost management goals, such as moving care to lower cost providers and reducing variation in practice patterns.

   Over the past several years, TAHMO has expanded the number of provider organizations with alternative payment methodologies (APMs) in their contracts. Historically, these risk arrangements have covered members in fully-insured HMO products. Because membership has trended away from fully-insured HMO products to self-insured POS and PPOs products, we have experienced limited growth of total membership covered under APMs.

   Beginning July 2013, TAHMO expanded APMs beyond HMO to include self-insured PPO and POS members in the Group Insurance Commission (GIC). This was our first step into APMs for non-HMO products, and throughout 2016, we have worked to expand our capabilities to administer risk contracts for the rest of our self-insured clients. We have built the contract structure, payment, and data and reporting systems required to administer this model, and we are beginning to pilot this type of risk with select providers in 2017 with the intention of continuing to add more providers in coming years.

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

One of the top barriers to increasing the prevalence of APMs is related to the size and readiness of providers. Most of the providers remaining, who are not in a value-based model, are smaller and lack the infrastructure required to support APMs. There are considerable technical and administrative capabilities required to enter into an APM for both plans and providers.

On the other hand, provider consolidation and changing affiliation of provider groups can also hinder the effectiveness in APMs. Consolidation often causes administrative slowdowns, and it can take years to align physicians to meet an organization's cost and quality targets. Additionally, we see that consolidations can increase the prevalence of facility fees on professional services and drive more care into in-system Academic Medical Centers that could have been provided in the community. The impact is increased cost to the health care system, plan sponsors, and members.

In addition, the rising trend in pharmaceutical prices posed challenges to APM arrangements. Providers can control many areas of cost and utilization, but they have difficulty controlling pharmacy trends that are due to unwarranted increases in price. Some providers who have long been comfortable with APMs are now more reluctant to manage global risk due to pharmacy trends and manufacturer's pricing. TAHMO believes that providers still play an important role in managing pharmacy trend through prescription choices, care management for members receiving specialty pharmaceuticals, and pharmacy reconciliation.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
Regarding consolidation, we support policies that provide the Health Policy Commission with greater oversight of provider transactions. This would include the authority to conduct deeper, more longitudinal evaluations on cost, quality and value. We would support a regular, ongoing process by which the HPC could evaluate and assess completed transactions to determine if providers are meeting their stated goals for pursuing consolidation, which often include increasing efficiency, reducing health care costs, and assuming greater risk in APM contracts. It is important to note that providers' efforts to reduce their own administrative costs as a result of transactions do not necessarily reduce the cost borne by employers and members. This reduced employer/member cost only results if providers lower their total medical expense.

We believe that neither health plans nor providers can effectively control pharmaceutical pricing decisions. Unless pharmaceutical manufacturers are also held accountable in controlling healthcare costs, it will remain challenging to keep providers engaged in managing total medical expense, including pharmacy costs.

Finally, it would be helpful to understand how much risk providers are assuming as a percent of their total revenue across all contracts. If the state has this data, it should be reported publicly, similar to other provider information. If not, the state should coordinate with CHIA and the Division of Insurance (through the Risk Bearing Provider Organization certification) to collect it. We believe it is important to measure not just the presence or absence of a risk contract, but the degree to which providers are taking meaningful, or non-meaningful, risk. Transparency into provider's commitment to risk would be a useful metric for health plans, regulators and provider groups themselves.

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?
   In 2016 TAHMO saw utilization trends for inpatient and outpatient services increase at a rate that we haven't experienced in recent years.

   Emergency Department (ED) utilization, in particular, was a cost driver in 2016. In response, our care management team is leading an initiative to directly reach out to members who access the ED for diagnoses that can typically be treated in provider offices. We are working to understand why

members choose the ED, and provide education about alternatives such as PCP offices or urgent care centers. We are also collaborating with providers to get more timely feeds of ED encounters rather than having to wait for claims submission to outreach to members. In addition, for members who are high utilizers of the ED, care managers will outreach directly to the provider to offer assistance with management and coordination of the member's care.

As described more in **question 4**, we have implemented payment policies such that payment for a readmission to the same acute facility within a set period of time may be denied if TAHMO determines that the admission was due to a premature discharge of the prior admission, or that the readmission was for services that should have been rendered during the previous admission.

At the request of the provider community, we are also evaluating expanding the scope of surgical codes that could be performed at ambulatory surgery centers (ASCs). By continuing to expand the scope of contracted services with ASCs, providers have more options for offering appropriate surgeries in lower acuity and lower cost settings.

Finally, through our medical trend management program, we are identifying and implementing solutions that address hospital utilization. We carefully monitor hospital claims to ensure appropriateness of services and accuracy of billing.

ii. What barriers is your organization facing in advancing this priority?
Timeliness of notification that a member is accessing hospital services is a barrier to our ability to take action in real time. In addition, the lack of access to many providers' electronic health records presents a barrier. We are trying to address this challenge through working directly with hospitals for more real-time information.

Another barrier to controlling trend due to unnecessary utilization is balancing provider and member interests. New programs that more heavily manage service utilization at hospitals may be burdensome for hospitals and providers because they risk slowing down approval for necessary care, or result in a negative member experience in which a member may not be able to receive the care they are expecting. For all of our cost management initiatives we must consider the impact to our provider network and members. Therefore, we generally target programs in areas in which there is large, unwarranted variation in practice and where risk group interventions have not been effective. Programs are aligned with nationally accepted standards, making it more likely that the standards will be similar across health plans, reducing complexity for providers.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
The state should collect the data necessary to report on the appropriateness of ED visits by hospital, similar to other data sets that are publicly reported (e.g. readmission rates, C-section rates, etc.).

There is evidence that increased capacity in hospitals leads to increased utilization, which is one reason for the Determination of Need (DoN) requirements that DPH oversees. We support ongoing DON review and strengthening of requirements, as it relates to both new capacity and mergers and re-affiliations. To the extent possible, HPC should have a role in informing cost implications for DoN requests.

The state could also launch a public education campaign to educate the public about appropriate use of emergency rooms and other options that may be available such as urgent care centers.

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]

☒Excel document or equivalent

Purpose: To supplement our claims data in reporting quality measurement to NCQA and our provider contracts we accept many Excel files during the year.

☒Direct data feed

Purpose: We accept direct data feeds to supplement our claims information; however, we do not have many of these at this time because providers have expressed a reluctance to grant us direct access to their systems due to data use and privacy concerns. Increasing this option would be optimal to our efficient reporting.

☒Chart reviews by third-party vendor

Purpose: We usually train and lead our own Health Plan Chart Audit but on occasion provider groups hire third-party vendors to copy medical record documentation for HEDIS data collection. This is not our preferred approach because third-party vendors often do not correctly and completely gather the data needed for HEDIS.

☒Web-based portal

Purpose: We have a few provider groups and lab companies that allow direct access into their web portals. This is our preferred approach, and we find this very efficient.

☐Other: Click here to enter text.

Purpose: Click here to enter text.

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

☒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): $200,000 non-HEDIS /$300,000 HEDIS
ii. Estimated FTEs: 2 FTE non-HEDIS/3 FTE HEDIS

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?
b. ☐ Yes ☒No

If yes, with whom?
N/A

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

☐Yes, cost-savings only
☐Yes, quality improvement only
☐Yes, both

☐No
☐Unknown (insufficient time to measure improvement)

d. If no, what is/are the reason(s) you have not pursued value-based drug contracting? Check all that apply.
☒Lack of appropriate quality measures
☒Administrative and operational implementation costs
☐Inability to negotiate performance incentives with manufacturers
☒Other (please specify): While the concept of value based contracts is appealing, practically they present multiple challenges: a) They require administratively burdensome process to gain access to clinical metrics (pre and post drug administration) to determine drug effectiveness and b) explicit correlation and attribution of drug value is difficult to substantiate. Value-based purchasing also does not address the underlying issue of manufacturer pricing; therefore, we do not see it as a solution. To date, the value based rebate opportunities we have evaluated would yield less value than what we currently achieve through traditional rebate contracts. We continue to evaluate new rebate opportunities via multiple channels (i.e, through our PBM relationship and direct discussions with manufacturers) as value based drug contract methodologies evolve.

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:

TAHMO attempts to decrease avoidable readmissions through payment policies and utilization review activity. We carefully review hospital admission criteria to judge whether an admission would count under preventable readmission status and be ineligible for payment. Payment for a readmission to the same acute facility within seven days may be denied if we determine that the admission was due to a premature discharge of the prior admission, or that the readmission was for services that should have been rendered during the previous admission. Beyond payment, we support hospitals with transition care managers to help prevent readmissions.

Avoidable ED Use:

Serious reportable events:

TAHMO's longstanding policy has been to deny or retract payment for care related to procedures which meet the definition of a serious reportable event or "never event." After such events are reported, our Clinical Quality Improvement (CQI) Department works directly with the involved provider to review the clinical event and opportunities for improvement.

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

For pediatric providers with established programs integrating behavioral health and primary care, TAHMO pays for consults between primary care physicians and BH specialists, in which PCPs can reach out directly to BH specialists for a consult or, if necessary, a referral for follow-up care. The goal of this program is to provide resources to PCPs that allow them to feel more comfortable treating patients with behavioral health symptoms. In our shared risk model, we also encourage practices to develop integrated models that extend into adult practices.

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

Telehealth/telemedicine:

Tufts Health Plan has several provider-specific pilots in place that fund telemedicine services for various specialties, including telestroke, specialty and acute pediatric care, and behavioral health care. Additionally, we will be introducing a telemedicine platform for office visits, behavioral health visits, and urgent care visits for our network providers.

Non-medical transportation:

Click here to enter text.

Services to maintain safe and healthy living environment:

Click here to enter text.

Physical activity and nutrition services:

TAHMO covers medically necessary nutritional counseling services based on the member's benefits. For most products, members can receive financial reimbursement for fitness activities, and employer groups can leverage wellness programs.

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: Please note that the numbers below represent the number of inquiries received not the number of unique individuals

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**	12021	69
	Q2	10516	89
	Q3	5624	89
	Q4	3183	51
CY2017	**Q1**	10847	116
	Q2	11720	115

	TOTAL:	**53911**	**529**

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 file THP_HPC Payer Exhibit 1.xlsx

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	86%
PPO/Indemnity Business	14%

   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	54.2%
PPO/Indemnity Business	6.7%

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)?
   See the answer to **question 1.B.i.** for how TAHMO is expanding the use of APMs into new product types. Our APM take up rate for 2016 fell slightly due to the product shift of the Group Insurance Commission from PPO to POS, and the termination of one HMO risk arrangement with an organization that is going through a merger and was not able to manage risk through the reorganization. We are working on a 2018 risk arrangement with this organization.

   TAHMO has an integrated behavioral health offering and most behavioral health services are included under risk contracts for fully-insured members and employer groups who offer behavioral health coverage through TAHMO. As many behavioral health providers align with larger systems, there is a more direct relationship between the risk-bearing organization and behavioral health care.

   Additionally, we are enhancing pilot programs to directly incentivize specialists in focused APM arrangements that may be beyond the scope of the primary care physician's purview.

ii. What are the top barriers you are facing and what are you doing to address such barriers?
See the answers to **question 1.B.i** for TAHMO's top barriers to expanding APMs. To address these barriers, we are engaging in the following initiatives:
To address provider readiness for risk and consolidation confusion, we offer a customized provider engagement approach to work with providers who have accepted meaningful risk in their contracts. Over time, we have observed that while some providers greatly mature in their own analytic capabilities, others still require in depth analysis and reporting.

To address concerns about performance volatility (e.g., pharmaceutical pricing changes), we have offered providers reinsurance-link mechanisms in their risk agreements that control for such concerns in a reciprocal manner. This protects providers who, through randomness, experience volatility driven by things like patients who need high cost pharmaceuticals. It distributes the risk more evenly across providers in our network.

To address proof of risk, we are constantly evaluating success metrics for risk contracts. From what we have seen in our experience in both fully-insured and self-insured risk, providers have been able to successfully move care to lower cost settings, which has led to TAHMO spending less at higher relative priced providers than other health plans in the market. Additionally, we see that providers specifically manage to improve quality metrics in contracts, emphasizing the ongoing importance of choosing meaningful quality metrics for providers.

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.