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**: 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: 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?

Boston Medical Center Health Plan, Inc. (BMC HealthNet Plan or BMCHP) is committed to reducing health care costs and improving health outcomes by embracing alternative payment models. BMCHP and the Boston Accountable Care Organization (BACO) were recently selected as a participant in the MassHealth ACO initiative launching early next year. Through the BMC Health System (BMCHS), BMCHP is also in joint ventures/affiliations (JVs) with three other hospital systems under the MassHealth ACO program: Mercy Medical Center, Signature Healthcare and Southcoast Health System. In total, we will be responsible for the health care and outcomes of 180,000 MassHealth members.

Our participation in the new MassHealth ACO model will incorporate collaborative planning and implementation of medical management programs, installation of new case management and analytics systems, and shared financial risk and reward for quality and utilization performance. We have formed workgroups with all of our JV partners, successfully submitted planning year budgets to the Executive Office of Health and Human Services, begun implementation of our new IT systems, and will be ready to go live on March 1st. We have successfully met all of our internal and external milestones for ACO readiness.

The larger BMC Health System is well positioned to succeed in the MassHealth ACO program because of our deep understanding of both the health and social needs of our MassHealth members and the many programs we have to address those. For example, BMCHS has many innovative programs to treat addiction which do not generate any margin in a traditional fee-for-service system, but which help create the best health outcomes for our patients. BMCHS designed an innovative program for babies born with neonatal abstinence syndrome (NAS) where BMCHS replaced the traditional treatment which separated mother and child and relied on significant medication for the infant, with a model that keeps the mother and child together and nearly eliminates the need for

medications. This approach reduced the average length of stay from 19 days to 9, nearly eliminated the need for medications, promoted breastfeeding and reduced the likelihood of readmissions.

BMCHS solidified its leading role in addiction treatment this year with a $25 million donation to create the Grayken Center for Addition Medicine, which is dedicated to combatting the disease of addiction by furthering and disseminating its innovative research and treatment programs.

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

BMCHP has experienced the following barriers in its work to succeed under risk-based contracts:

Addressing social determinants of health and substance abuse: Impacting the total cost of care for our patients/members involves addressing both medical and social determinants of health. Social determinants of health and substance use disorder represent unique challenges in reducing cost and improving quality for our patients and require greater financial investments and time before we can see improved outcomes.

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

In order to succeed under the ACO Model, BMCHP requires sufficient funding for infrastructure and staffing investments in the complex needs of our patients/members. The total costs of care budgets through the various forms of payment need to recognize the unique challenges of care improvement in underserved populations to successfully address all the factors adversely impacting health outcomes for underserved patients.

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 order to reduce unnecessary hospital utilization, BMCHP in its ACO work will be focusing aggressively on high-risk patient case management and, related to this, reducing unnecessary readmissions.

For example, we are establishing a high-risk case management program with BACO. We are focusing on the top 3% of patients who account for 40% of cost and a significant percentage of hospitalizations and Emergency Department (ED) visits. This effort is requiring enhanced support for hospital discharges and transitions of care to outpatient settings for patients at risk of readmissions, and improved case management support in the ED to safely return people home or to other outpatient settings where clinically appropriate.

Readmissions initiatives include a Readmissions Risk Assessment (RRA) tool which was developed by Boston Medical Center and embedded into its electronic health record (EHR) built to allow for a real-time, customized readmission risk assessment. The tool links a static data warehouse with a live, dynamically-calculating EHR tool. The RRA tool is now used for the majority of BMC patients and categorizes patients according to their risk for readmissions. After identifying these high-risk patients, BMC deploys high-value interventions during their inpatient admissions and after discharge. This may include pharmacist admission and discharge medication reconciliation, negotiated follow-up appointment scheduling, enhanced needs assessments and case management involvement, and post-discharge outreach calls. As a result of these efforts, unnecessary hospital readmissions have been reduced.

ii. What barriers is your organization facing in advancing this priority?
In order to succeed in high-risk case management and readmissions reductions, we face specific barriers. For example:

- Engaging patients: It is often very difficult to engage patients who are the highest utilizers of health care services and keep them engaged. This requires repeated follow-up with case managers and boots-on-the-ground. BMCHP and BACO are establishing the framework/staffing for effective patient engagement.

- Identifying the real cause of readmissions: Additionally, for the at-risk population that our affiliate BMC serves, the seeming causes of readmissions may not reflect the actual factors that bring patients unnecessarily back to the hospital, which may include: lack of a support system and behavioral health issues which influence patient compliance.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
Here again, in order to succeed in effective high risk patient management, BMCHP and BACO require sufficient funding to address the total cost of care for our socially complex patients. Please see our response to Question 1.b.iii.

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: Click here to enter text.
☐Direct data feed
Purpose: Click here to enter text.
☐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: With respect to data needed for HEDIS measurements, BMCHP collects medical record data from servicing providers. BMCHP employs clinical reviewers and support staff to collect and review medical record documents for specific services rendered that meet the HEDIS specifications. BMCHP sends related medical record requests to provider systems. The data is sent to us by providers via mail or fax, or records are individually downloaded by BMCHP at provider site visits or through remote EMR system access. It is used for NCQA accreditation and rating purposes.

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

☐Ongoing
☐Monthly
☐Quarterly
☐Annually
☒Other: As needed for HEDIS purposes, which is almost ongoing.

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): No response
   ii. Estimated FTEs: No response

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?
   N/A

b. 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)

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) - *BMCHP does not have a payment policy for care management services but we cover chronic and transitional care management at fee-for-service rates for SCO members only.
   ☐Telehealth/telemedicine - *BMCHP does not have a payment policy for telehealth/telemedicine services but we do cover and pay fee-for-service rates for these services.
   ☒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:

Inpatient readmissions to the same facility for the same or related condition to the initial inpatient stay are subject to review and payment may be retracted under certain circumstances, including but not limited to, premature discharge, nosocomial infections, medical necessity and complications related to serious reportable events.

Avoidable ED Use:

Click here to enter text.

Serious reportable events:

Providers are required to report all Serious Reportable Events (SREs) within 7 calendar days of the event. Additionally, in accordance with state requirements, providers are to file a report with the Department of Public Health, with a copy to BMCHP and the patient, no later than 30 days after the date of the event. BMCHP requires the provider to submit two claims: one for services related to the SRE and another for any services unrelated to the SRE. Services related to an SRE and follow-up care billed by the same provider that is related to the event is not paid.

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

Click here to enter text.

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

We do not have a payment policy for care management for providers but we cover chronic and transitional care management at fee-for-service rates for SCO members only.

Telehealth/telemedicine:

We do not have a payment policy for telehealth/telemedicine services for providers but we do cover and pay fee-for-service rates for all products for these services.

Non-medical transportation:

For SCO members only, BMCHP pays for non-medical transportation to allow the member to continue to function in the community. Transportation is arranged by the member's Aging Service Access Point (ASAP) or personal care attendant. Services are paid fee-for-service reimbursement. These services are managed by MassHealth for Medicaid-only products.

Services to maintain safe and healthy living environment:

In order to improve and/or maintain safe and independent living, the following services are covered and paid on a fee-for-service basis for SCO members only:
- Home/environmental accessibility adaptations, such as ramps and grab bars;
- Assistive/adaptive technology;
- Personal emergency response systems; and
- Personal care assistance with Activities of Daily Living (i.e., mobility/transfers bathing) and Instrumental Activities of Daily Living (i.e., laundry and meal preparation).

MassHealth manages these services for Medicaid-only products.

Physical activity and nutrition services:

For SCO members only, BMCHP pays for one 13-week weight watchers program and members receive a $150 annual allowance to a health/fitness club. The members are required to submit receipts to BMCHP for reimbursement.

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**	*	Less than 5
	Q2	*	Less than 5
	Q3	2	Less than 5
	Q4	4	None
CY2017	**Q1**	21	4
	Q2	7	2
	TOTAL:	*BMCHP had technical challenges with its web tool in Q1 and Q2 of 2016, (reported in BMCHP's 2016 HPC testimony) which have been resolved. During Q1 and Q2, members could still obtain cost information by phone. BMCHP members typically use products with either no member cost sharing or very low member cost sharing, so utilization of the tool is extremely low.	

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).

- For years 2014-2016, the impact of benefit buy down is negligible. The member cost sharing associated with the benefit plans that BMCHP offers in its MassHealth Medicaid program, which comprised 85% of BMCHP's membership in years 2014-2016, is both minimal and stable from year to year. The remaining 15% of membership primarily resided in the former Commonwealth Care program or the current ConnectorCare programs through the State's Exchange, and both of these programs had or have minimal members cost sharing.

- As previously reported, the demographic and health status components of trend are reflected in the utilization component of trend. BMCHP's MassHealth product experienced significant changes from 2015 to 2016, including provider network changes in 2014 and 2015 and changes related to MassHealth eligibility redeterminations. This resulted in a change in demographics and health status in the MassHealth population which resulted in much higher utilization in 2016 relative to 2015. In addition, our QHP product grew from 23K member to 37K members in 2016. The change in demographic and health status for the QHP business has also resulted in higher utilization in 2016. Please see HPC Payer Exhibit 1 of the Appendix.

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	100%
PPO/Indemnity Business	0%

   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	21%
PPO/Indemnity Business	N/A

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)?

   In 2017, BMCHP entered into JV agreements to administer four separate ACO Partnership Plans. These JV agreements are risk contracts incorporating both upside and downside risk with an integrated quality component. We estimate these ACOs will account for over 80% of our MassHealth lives and over 60% of total covered lives in Massachusetts when they go into effect in 2018.

   BMCHP continues to evaluate APM options for its other lines of business and is evaluating opportunities to expand APMs to providers other than PCPs, including skilled nursing facilities (SNFs), hospitals, specialists and community providers. BMCHP is collaborating with its provider partners to learn with whom they work (e.g., which SNF does a particular provider system typically use) and how we can support their working together in the future in the APM space.

   ii. What are the top barriers you are facing and what are you doing to address such barriers?
   BMCHP continues to face several barriers to increased use of APMs outside of MassHealth, and we have developed alternative approaches to engage providers and promote increased use of APMs.

These barriers include:

- The majority of BMCHP's provider groups do not have a credible population size to participate in a shared savings risk model.
- Some providers are reluctant or resistant to enter into such an agreement for reasons that include:
    - Potential changes in the Qualified Health Plan (QHP) program around membership.
    - Providers not having time or resources to participate. Providers who participate in commercial plans and/or Medicare lack time and resources to engage in another program.

To address these issues, BMCHP is developing alternative approaches. These include initiatives that involve working with providers to adjust the nature of the population requirement from total patient population to a smaller subset or targeting particular provider types. In addition, we have created arrangements that maintain shared accountability for all services covered for a select group of members, such as those at high risk, which we are piloting, or pediatrics. These also entail episodes and conditions (bundles) that can also be rolled out to other providers, including hospitals.

In response to potential changes in the QHP program and movement across the programs, BMCHP is investigating options to align APMs for the QHP population with the new MassHealth ACOs.

To respond to provider concerns about lack of time and resources to engage in a program that differs from the ones in which they currently participate through their commercial plans and/or Medicare, BMCHP has attempted to align aims with providers' other arrangements. For example, BMCHP allows providers to choose quality metrics that leverage initiatives that are part of other APM arrangements they are already engaged in to minimize the need to develop additional programs.

BMCHP continues to evaluate options and encourage providers to participate in APMs.

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? We are interested in evaluating changes in methodology away from FFS and reconciliation. Currently, the majority of our APM contracts are for the Medicaid population under which revenue capitation is not consistent across a period given quarterly adjustments for changes in risk and is subject to other changes made by EOHHS, such as changes in benefits or provider payment rates. With such variability, it is difficult to establish a consistent monthly capitation payment. In addition, there is a great deal of administrative complexity for our provider partners to intake capitation and make in-network and out-of-network payments to providers, thereby making it more administratively efficient for BMCHP to assume those capabilities.