The Commonwealth of Massachusetts
Executive Offices of Health and Human Services
Health Policy Commission

HPC Written Testimony

Submitted September 16, 2013

1. **C.224 sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012- CY2013 and CY2013-CY2014 is 3.6%.**

   a. **What are the actions your organization has undertaken to ensure the Commonwealth will meet the benchmark?**

   Fallon Community Health Plan (FCHP) aggressively negotiates contracts with providers and offers limited and tiered network products in an effort to help the Commonwealth meet the benchmark.

   In accordance with Chapter 224, FCHP has conducted all provider rate negotiations since 2012 with the goal of having Total Medical Expense (TME) increases not exceed 3.6% on an annual basis. Since TME is driven by three factors--unit cost, utilization, and intensity--FCHP makes every attempt to persuade providers to keep their unit costs flat or (if needed) to increase their unit costs at a percentage considerably less than 3%. This assures that even if there are increases in utilization and/or intensity in addition to unit cost, the overall goal of not more than a 3.6% increase in TME is met. In addition to standard fee-for-service arrangements, FCHP has moved providers, whenever feasible, to surplus sharing or full up and down risk arrangements. In these alternative payment arrangements, the targeted provider group would have a global budget that focuses on the per member per month cost of each type of medical service and where those services are being delivered to the patients. Frequently, just assisting the patient to access more care in non-teaching hospital settings can significantly lower the cost trend for the selected member population.

   FCHP has been developing high-performing limited networks since 2002 when FCHP Direct Care was established. Direct Care has been thoughtfully built around carefully selected, community-based, multi-specialty physician groups who are dedicated to providing care locally, comprehensively and efficiently. Direct Care features more than 22,000 providers carefully chosen for their medical excellence, patient access and ability to manage the most appropriate utilization in their provision of care. Direct Care premiums are priced approximately 12% less than FCHP's full network HMO offering.

   FCHP Steward Community Care is an additional limited network option, built out of FCHP's and Steward Health Care's shared commitment towards the provision of high quality, affordable health care within our communities. FCHP Steward Community Care is a particularly favorable offering to those members who live and work within the Steward Network coverage area in Eastern Massachusetts. Members generally use providers who are in the Steward Health Care system, which is comprised of a network of community-based doctors and hospitals, keeping the member's care conveniently close to home. FCHP Steward Community Care is priced approximately 20% less than FCHP's full network HMO product.

FCHP Tiered Choice, which has been offered in the marketplace since 2012, is a fully-insured tiered network plan that allows members to decide how much they pay for care they receive at the point of service. Doctors, hospitals, and other providers in this plan are tiered based on their overall risk adjusted TME. If members choose to obtain services from a Tier 1 provider – those providers with relatively low TME and high quality – their copayments and deductibles are significantly lower. FCHP Tiered Choice members have a broad network of providers from which to access care. FCHP's largest client, the Massachusetts Group Insurance Commission (GIC), has used a tiered plan design for many years to encourage members to choose high quality, low cost providers.

Since 2010, FCHP has provided tiered network plan designs to our self-insured clients. These "Advantage Plans" are designed with provider tiering based on an individual employer's claims experience and the geographic location of their employees, as well as data on the quality, cost and utilization efficiency of the providers in the network. Advantage Plans include distinct programs to keep members healthy while reducing overall costs, such as integrated care management and value-added features such as our "It Fits" fitness reimbursement program.

b. What are the biggest opportunities you have identified at your organization to improve the quality and efficiency of care? What current factors limit your ability to address these opportunities?

A significant opportunity to improve the quality and efficiency of care involves the use of outcomes metrics to better manage patients with chronic diseases, like diabetes, depression and asthma.

Identifying, measuring, and utilizing outcome metrics to better manage patients with chronic diseases can be challenging. It involves ensuring providers adhere to evidence-based protocols to improve quality of care. It requires that all the physicians (primary care and specialty) involved in the care of a patient coordinate and communicate with each other, and follow-up with the patient, to ensure that the patient is complying with the appropriate protocols for their particular chronic illness. And it may involve persuading patients to engage in healthier lifestyles. When care is not effectively coordinated between providers, patients may not receive all the appropriate screenings, medications or follow up indicated for their chronic illness. Electronic medical records (EMRs) can facilitate effective coordination, however, many providers lack sophisticated EMR capabilities. Further, small, independent physician practices may not maintain the type of systems to enable them to effectively identify their patients with chronic conditions, or to track and monitor their outcomes.

Another significant opportunity to improve the quality and efficiency of care involves more effectively ensuring that the right services are provided in the right setting for

those services. However, the historical dependence on hospital-based care, the significant variability on cost based among provider settings, and the challenge of changing consumer perceptions, can be an obstacle to achieving these improvements.

FCHP has found that there can be significant variation in the types of services provided for a particular condition, the setting those services are provided in, and as a result, the cost of those services. For example, there are delivery systems that may perform the majority of ambulatory surgeries in less costly freestanding out-patient facilities, while others perform a majority of similar ambulatory surgeries in more expensive hospital settings, with little or no difference in quality or outcomes, but significant differences in cost. However, health care consumers and their providers remain strongly influenced by perceptions of quality that may not be supported by actual outcomes. Changing those perceptions so that the right care is provided at the most appropriate – and in many cases the more cost-effective and high-quality – setting, can be a challenge.

c. What systematic or policy changes would help your organization operate more efficiently without reducing quality?

State-wide efforts to promote administrative simplification, increased care coordination between providers and health plans, and increased use of electronic medical records are all systematic changes that would allow us to operate more efficiently without reducing quality.

d. What steps have you taken to ensure that any reduction in health care spending is passed along to consumers and businesses?

FCHP, as a mission-driven, not-for-profit organization, is committed to providing the most affordable quality health care to our communities, and to passing along savings to our customers – both employers and individual subscribers – that may result from reductions in health care spending. FCHP operates in a very competitive marketplace where we price our health insurance products to cover anticipated medical costs and administrative expenses, with very little contribution to reserves. While building reserves is very important to any insurance company, FCHP endeavors to pass along its savings to its customers to the extent possible. FCHP has also been a pioneer in rewarding our members for engaging in healthy lifestyles – FCHP was the first health plan to eliminate any member cost-sharing for well-patient visits to their physician, and in providing members with the "It Fits" benefit, which reimburses members for expenses they incur for fitness centers, weight control programs, and sports programs.

2. **The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of growth in prices on medical trend and what have been the results of these actions?**

   FCHP constantly monitors the three main drivers of healthcare cost increases. These drivers are provider unit cost, utilization of healthcare services, and intensity of services.

   FCHP agrees with the Attorney General that of these three major factors, provider unit cost increases have had the largest influence on increasing TME. FCHP has consistently employed strategies to reduce the growth in the prices of medical care, with good results. However, challenges remain.

   As detailed in the response to Question #1 above, FCHP has: (a) in negotiations with providers, targeted increases that are significantly less than the 3.6% benchmark, and has negotiated these smaller increases successfully with many providers in both 2012 and 2013; (b) whenever possible has moved provider groups to alternative payment arrangements where the providers' incentives are changed to decrease cost while maintaining quality care and promoting wellness in their assigned patient population; and (c) established limited and tiered networks that provide incentives for members to utilize the most cost-effective and high-quality providers, and therefore providing incentives to providers to reduce their costs in order to participate in these popular lower-priced insurance products. Furthermore, FCHP operates a formal cost of care program that seeks to reduce the cost of care utilizing a broad variety of tools to address not just price, but also the most appropriate utilization of services in the most appropriate settings.

3. **C.224 requires health plans, to the maximum extent feasible, to reduce the use of fee-for-service payment mechanisms in order to promote high quality, efficient care delivery. What actions has your organization undertaken to meet this expectation? What factors limit your ability to execute these strategies or limit their effectiveness?**

   Since the passage of Chapter 224, FCHP has put an even greater emphasis on creating surplus sharing (upside only), partial capitation, and full up and down risk budget arrangements for provider groups whenever possible.

   In situations where these arrangements exist providers tend to focus on two major cost drivers: (a) coordination of care, i.e. avoiding unnecessary treatments, overuse of appropriate treatments, or use of the wrong intensity of care, and; (b) site of service, i.e. where the patient receives needed services -- in a doctor's office, community hospital, or teaching hospital. FCHP has found that provider groups with both up and down risk have been able to reduce overall TME by as much as 30% simply by wisely coordinating care for their patients and managing delivery of services in the lowest cost setting possible. More importantly, this has been accomplished with no decrease in quality of service and typically with improved patient outcomes.

The factors that limit FCHP's ability to execute these strategies generally involve the ability of providers to adopt these alternative payment arrangements. Because FCHP is a relatively small health plan in Massachusetts, there are providers who do not have a sufficient number of FCHP members as patients to allow for a statistically valid surplus sharing or full risk sharing budget model. In addition, for even some of those providers who do have sufficient FCHP patient volume, they are nevertheless slow to adopt alternative payment or risk arrangements for various reasons. A large number of provider groups are still loosely organized and have not built the infrastructure needed to coordinate care and eliminate waste and overuse in the healthcare delivery system. That infrastructure may include referral coordinators, case managers, analysts and staff who understand how to work with patients who may have one or more chronic conditions.

4. **C.224 requires health plans, to the maximum extent feasible, to attribute all members to a primary care provider. Please describe, by product line, how your organization is meeting this expectation, including, as of July 1, 2013, the number of members attributed to PCPs, attribution methodologies used, the purpose to which your organization makes such attribution (such as risk payments, care management, etc.), and limitations or barriers you face in meeting this expectation.**

   FCHP's history as a health maintenance organization (HMO) incorporates the fundamental principle that members choose a PCP to coordinate their care if they choose the HMO product. Approximately 94.4% of FCHP HMO members have a PCP at any one point in time; 100% assignment is not a practical goal due to the dynamic nature of health insurance enrollment.

   FCHP tracks on a daily basis the member's choice of PCP and can attribute services received by the member, no matter who provides the services or where they are provided, back to the PCP as of the date of service. In turn, PCP's are assigned and tracked to the larger care delivery systems to which they have chosen to affiliate. The combined membership of the PCPs with the larger delivery systems represents the population of members under management by that delivery system. FCHP's contract with the delivery system and its underlying claims experience and risk profile drive the development of global medical expense budgets, performance management and risk arrangements.

   About 4% of FCHP's commercial membership has chosen to join a PPO product which does not require the choice of a PCP. Many of these members are out of state. Due to this low membership, FCHP does not maintain a formal PCP attribution method for this membership. Should this product line expand to be a major membership contributor, FCHP will develop a formal process for attributing each PPO member to a PCP.

5. **Please describe programs you have implemented to engage consumers to use high value (high quality, low cost) providers. How effective have these efforts been? To what percentage of members and to which product lines does each program apply?**

   FCHP has significant experience with strategies to steer and/or incentivize members and employers towards high-value providers in its limited and tiered network products.

   The most common is the pricing differential between FCHP's limited and tiered network products and FCHP's full network or un-tiered counterparts. FCHP has also in the past collaborated with our largest commercial client, the GIC, to offer a "premium holiday" to those members who opt to choose enrollment into a limited network, rather than the broad network HMO. FCHP also engages in significant education of, and outreach to, its customers, brokers, and providers about the value of its limited and tiered network products.

   Currently FCHP has approximately 27,000 members in commercial tiered products and 30,000 in limited network products. Together this represents 46% of FCHP's commercial membership; up from 33% in 2009.

6. **Please describe the impact on your medical trend over the last 3 years due to changes in provider relationships (including but not limited to mergers, acquisitions, network affiliations, and clinical affiliations). Please include any available documents providing quantitative or qualitative support for your response.**

   With the increase in mergers, acquisitions, and affiliations among large hospitals and provider groups it has become more difficult to reduce the annual rate increases at large integrated provider organizations to a minimal level. At the same time it is almost impossible to not include these large integrated provider organizations in most commercial network products. In some geographic areas FCHP could not meet access and availability criteria unless these major provider systems are included. Even network affiliations become an impediment when they lead the newly affiliated provider organization to state that all their contracting decisions have to go through the larger provider system or that the smaller organization will only participate in those network products where the larger provider organization has also agreed to participate. These trends have hindered FCHP's ability to create cost-effective limited or tiered networks or to expand existing provider networks.

7. **Please describe the actions that your organization has undertaken to provide consumers with cost information for health care services, including the allowed amount or charge and any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits as required under Chapter 224. Please describe the actions your organization has undertaken to inform and guide consumers to this cost information.**

   FCHP supports providing cost sharing information to its members. FCHP is working on implementing the transparency provisions of Chapter 224 as part of a larger Federal and State Health Care Reform project. We are taking a two tiered approach to addressing these provisions.

   For October 1, 2013, we plan to provide cost information through our customer service toll-free telephone number and our member web site. Based upon our experience, members have a strong interest in cost and cost share information for radiology and lab services, some elective outpatient procedures, and routine acute services such as office visits. We will provide some general information on health care costs and member cost share obligations for the most common services members have inquired about in the past. If the request is for other service types, or if further information is requested on these common service types, members must obtain codes and other detailed information from their providers to facilitate a more detailed analysis. We will post a form on the member web site for this purpose. Upon receipt of this information from the member, we will provide a detailed summary of the member cost for the requested services by the providers they have selected. We anticipate having this capability in place on or shortly before October 1.

   By October 1, 2014, we intend to have a web-based process in place which will make a much broader range of data readily available to members in real time.

8. **After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.**

<u>AG Report</u>

Purchasers/Consumers

In the past two decades, the percent of family income dedicated to health insurance more than doubled. Employers have increasingly shifted the costs of care to their employees in the form of premiums, copayments, co-insurance and deductibles. Employers are consistently "buying down," or opting for a lower-cost plan. Over the past two years FCHP's most popular plan designs have had a $500 deductible. In 2011 these plan designs had 17,200 members representing nearly 16% of FCHP's membership. In 2013 these plan designs have 21,000+ members representing just over 19% of FCHP's membership. Total members in all deductible plans as of June of 2013 totaled 75.7%.

In addition, FCHP has experienced significant growth in both Limited and Tiered networks. With health care costs increasing faster than general inflation, or wages, it has been important for purchasers and consumers of health care to find additional ways to save money. By choosing to move to a limited or tiered network plan, employers and employees have had the ability to save premium dollars without necessarily giving up the comprehensive rich benefits package they have become accustomed to. In order to do this, employees sometimes need to be flexible with their choice of providers. Currently FCHP has 46% of our commercial membership in limited and tiered networks; up from 33% in 2009.

Unlike some of our competitors, FCHP has not seen a dramatic increase in the amount of PPO enrollment over the past several years. We attribute this to the limited network models we have developed and our clients' early adoption of this philosophy and these plan designs. Many of FCHP's customers are those that have come to realize the value of our limited network products in preserving benefits while maintaining reasonable costs for them and their employees. As such, although FCHP does offer a PPO network as an option along-side other networks in many accounts – we have seen little overall growth in that product.

Health Plans

As noted in the AG's report, FCHP and other health plans continue to pay providers widely different rates for patients of comparable health. The market clout of certain providers and the increasing consolidation of provider groups and hospitals have contributed to this trend. Large provider systems that dominate one or more geographies can still command premium prices because a health plan cannot have a viable network without them. FCHP, like other health plans, also sees variation in provider rates within separate geographic areas of the state. Growth in unit prices of medical services, not increased utilization, is still the primary cost driver for Total Medical Expense (TME). FCHP agrees with the AG's conclusion that the design of health plan products does affect which types of consumers tend to purchase which types of products with a resulting impact on both administrative cost and TME.

Providers

FCHP has not experienced the variety and complexity of risk arrangements noted in the AG's report. FCHP has established a standardized commercial risk model that is straightforward and provider friendly. The parameters of the model are clear and can only vary within a limited range. FCHP assists at-risk providers with reports and consultation regarding care management, referral management, chronic disease management, risk management, and maintaining the quality of patient outcomes. FCHP's risk model and model of care philosophy incents providers to coordinate care, manage cost, and manage risk successfully. When FCHP enters into a risk arrangement with a provider organization FCHP develops a budget which is appropriately risk adjusted both for that provider

organization's patient population and for the historical levels of utilization that the provider organization has experienced. This approach plus having the provider organization maintain reinsurance coverage mitigates the financial risk that the provider organization assumes when entering a full risk arrangement.

CHIA Report

Health Care Coverage and Premiums:
FCHP in general agrees with the major observations in the report concerning health care coverage and premiums. There are several observations that should be monitored and discussed in the future:

1) Higher percentage of Medicare and Medicaid.
   The dramatic shift in the number of individuals in Medicare and Medicaid – from 30.3% in 2009 to 35.1% in 2011 is significant. It is well known that Medicare and Medicaid reimbursement is below commercial reimbursement and some would argue that the reimbursement for Medicare and Medicaid is inadequate to cover the true underlying costs of services administered by providers for those products. As such, providers – who typically budget an aggregated level of reimbursement – may feel the need to make up for the lower government program reimbursement levels by increasing their commercial reimbursement. This creates upward pressure on provider rates for commercial business.

2) Increase in self-insurance future outlook.
   The increase in self-insurance by employer groups can also create upward pressure on the remaining fully insured rates. This is caused by the fact that healthier employer groups may see self-insurance as a more cost-effective alternative to purchasing from the pooled insurance market. If the healthier employer groups move to self-insurance, the remaining groups are slightly less healthy on average and the relative TME in the insured market increases. As a result, overall health insurance premium rates for these groups are likely to also increase.

3) The average deductible increased over 40% between 2009 and 2011, approaching the national average.
   Deductibles are increasing which may lead to additional consumerism and subscribers/members seeking more efficient care. Price transparency and engaged consumers are an important tool in working to reduce long term costs.

4) Premium growth and inflation – "According to the Bureau of Labor Statistics' Consumer Price Index Inflation was approximately 1.6% from 2009 to 2010 and 3.1% from 2010 to 2011 (4.9% over the two year period). In comparison, the overall increase in Massachusetts premiums from 2009-2011 was 9.7%."

It is important to note that this is not an "apples to apples" comparison:

(a) It is unclear whether the Price Index Inflation was specific to healthcare or all services. Healthcare inflation has historically been higher then general inflation.

(b) Consumer Price Index Inflation is a fixed market basket of services measured over time, so this comparison fails to take into consideration the utilization and intensity of medical services that impact the price of health insurance. For example, as the Commonwealth's population ages, re there is greater utilization of health care services. Also, as technology improves and more expensive procedures/drugs are developed, they replace older, less expensive services. These increases in utilization and intensity of services are not necessarily accounted for in the CPI, yet have a significant impact on health insurance premiums.

Payment Arrangements

FCHP agrees with the CHIA findings that the shift from fee-for-service payment methodologies to alternative payment methods has been mostly limited to fully-insured commercial HMO products.

Health plans and providers have not developed alternative payment methodologies as yet that would support alternative payment arrangements or risk based contracting for ASO populations of any type (HMO, POS or PPO) or for fully-insured PPO and POS populations. As an increasing number of employer groups move to ASO arrangements this presents a significant conundrum for health plans when faced with the requirement to move providers into non fee-for-service payment arrangements.

FCHP also agrees with CHIA's findings that the majority of its commercial members' care continues to be paid using fee-for-service payment methods. As noted previously, FCHP faces many of the same issues in this area as other health plans plus it has the additional challenge of finding provider groups with a sufficient panel of FCHP members to support an alternative payment arrangement. At this time FCHP does not make significant use of bundled payment methodologies or partial capitation payment methodologies.

Health Care Payments

FCHP notes that some of the CHIA-reported information with regard to health care payments may imply that fewer resources are being put into patient care when compared to direct care claims expenses. For example, CHIA reported that statewide commercial TME increased 3.8%, whereas non-claims payments to providers for quality performance, global budget financial settlements, and other purposes grew by 24%. In our experience, managing health care expenses effectively at the provider level requires significant investment by providers in infrastructure, time (outside of direct "billable" patient face time) and reward (incentives) for focusing on quality and cost effective care management. There are expenses tied to hiring on-site medical directors, operating a referral management process and utilization management committees, and gathering, analyzing

and reporting information on quality and utilization. These are activities that contribute directly to the process of cost effective high quality care management. As public policy continues to encourage the move from fee-for-service to global payment arrangements, it is likely that the proportion of medical expense allocated to these types of activities will increase.

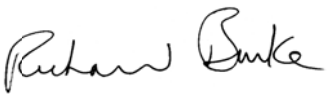
Provider Payments

The provider payment pattern of large amounts of care being concentrated into some of the highest cost providers is consistent with FCHP's experience. These patterns reflect the choices of Massachusetts citizens on where they want to receive care. However, FCHP has also found that with the right incentives consumers will also choose lower cost networks. About 46% of FCHP commercially insured members are in its limited or tiered network products. It is important for public policy to have as few burdens as possible on insurers' ability to develop and implement networks and products that encourage the use of cost efficient providers.

CERTICIATION OF WRITTEN TESTIMONY FOR THE 2013 COST TREND HEARINGS FOR THE HEALTH POLICY COMMISSION AS AREQUIRED BY M.G.L. c. 6D, SECTION 8.

I, Richard Burke, am the President of Senior Care Services and Government Programs for Fallon Community Health Plan, Inc. (FCHP). I am legally authorized and empowered to represent FCHP for the purposes of this testimony. The responses contained in this submission were prepared by employees of FCHP who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest that the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury:

AUTHORIZED SIGNATORY: 

Print Name: Richard Burke

Title: President of Senior Care Services and Government Programs

Date: September 16, 2013

The Commonwealth of Massachusetts
Executive Offices of Health and Human Services
Center for Health Information and Analysis

AGO Written Testimony

Submitted September 16, 2013

1. **Please submit a summary table (see attached) showing actual observed allowed medical expenditure trends in Massachusetts for CY 2010 to 2012, YE Q1 2012, and YE Q1 2013 according to the format and parameters provided and attached as AGO Exhibit C1 with all applicable fields completed. Please explain for each year 2010 to 2012 what portion of actual observed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g. utilization trends, payer mix trend).**

   Below is the summary table showing Fallon Community Health Plan's (FCHP) actual observed allowed medical trends. For the time frames requested FCHP did not have specific studies to break out the mix between provider and service, so provider and service have been combined in the Service Mix column. FCHP believes that this "allowed" trend understates the true allowed trend if there were no benefit buy-downs. This is true even though the data includes allowed trends of both the payer and member share of the expense, because as the member's share of the cost rises it has an impact on reducing the underlying utilization. This understates the utilization and therefore the total trend in the table below. The trends in the table below indicate that the slow economy had a significant effect of lowering utilization in 2010, which then rose in 2011 and 2012 as the economy improved.

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2010	5.40%	-2.70%	N/A*	-1.10%	1.50%
CY 2011	3.90%	0.20%	N/A*	-0.90%	3.20%
CY 2012	3.80%	1.30%	N/A*	0.80%	5.90%
YE Q1 2012 (April 1, 2011 - March 31, 2012)					3.90%
YE Q1 2013 (April 1, 2012 - March 31, 2013)					3.60%

2. **Please submit a summary table showing your total membership as of December 31of each year 2009 to 2012, broken out by:**

   **Please see attached Excel spreadsheet in folder titled "AG Question 2 – Membership Totals" for answers to the following membership questions.

   a. **Market segment (Hereafter "market segment" shall mean Medicare, Medicaid, other government, commercial large group, commercial small group, and commercial individual)**

   b. **Membership whose care is reimbursed through a risk contract, by market segment (contracts that incorporate a per member per month 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 do not subject the provider to any "downside" risk; hereafter "risk contracts")**

   c. **Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity)**

d. **Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for inpatient and outpatient services (e.g. lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)**

e. **Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)**

f. **Membership in a high deductible health plan by market segment ("high deductible health plans" as defined by IRS regulations).**

3. **To the extent your membership in any of the categories in your response to the above Question 2 has changed from 2009 to 2012, please explain and submit supporting documents that show your understanding of the reasons underlying this growth.**

   There have been minor changes to FCHP's overall membership from 2009 to 2012 (question 2a). FCHP does not attribute the minor changes to any particular factor, rather these small changes are due to the expected "ebbs and flows" that exist in the insurance marketplace.

   While the overall membership has seen little change, there has been a significant increase in membership in FCHP's tiered network plans from 2009 to 2012 (question 2d). We attribute this increase to the development and sale of our "Advantage Plans", which are tiered network plan designs FCHP has offered to certain of our self-insured clients since 2010. To date, FCHP has built Advantage Plans for 6 large employer groups.

4. **Please describe your models for risk contracting since 2009. Include, for example, the structure and elements of such contracts, the role of any non-claims based payments, the role of any trend factors or growth caps, the role of any adjustments to risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, and insurance product populations to which your risk contracts apply (e.g. HMO, PPO, self-insured, fully-insured).**

   FCHP currently has risk arrangements in place for various Commercial, Medicare, and Medicaid HMO provider groups.

   Items such as interim cash flow (capitation payments or fee for service equivalents), unit cost assumptions, utilization trend assumptions, intensity of services assumptions, as well as risk sharing parameters, risk caps, and reinsurance attachment points are all negotiated between the provider group and the health plan.

   At-risk providers will attempt to meet or beat the annual budget. The provider group will be supported in this effort by FCHP reporting on a monthly, quarterly, and annual basis as well as by any internal infrastructure that the provider group has established on its own or in collaboration with FCHP. If the provider group also services members who are not part

of the provider group's risk pool, they would typically be reimbursed at fee for service rates for services provided to non-risk members. If the provider group wants infrastructure payments, PCP management fees, and/or pay for performance incentives for certain quality measures, these amounts will also be negotiated between the parties and included as part of the total at-risk PMPM annual budget. Upside only risk is typically a shared savings model. Models with both up and down side risk can be either low risk, moderate risk, or high risk.

FCHP's models for risk contracting in general use a global medical expense budget approach, inclusive of almost all medical expenses, including pharmacy. Mental health and substance abuse expenses are generally not included in delivery system (DS) risk arrangements. FCHP starts with the population-based claims experience of the DS. A minimum membership threshold is required. Actuarial techniques are applied to the claims expenses to finalize an expense budget for a specific risk budget period: incurred but not reported (IBNR) completion factors; medical trend; member liability adjustments, and adjustments to normalize for the effect of high cost cases on the baseline experience. Specific localized adjustments are made to the claims expense, such as adjustments for known local hospital payment changes. Expenses are translated into a cost per member per month ($PMPM) expense so that the budget varies based on total membership enrollment. In addition, each budget is given a baseline age/gender factor, a product adjustment factor and a benefit adjustment factor. These factors are used to adjust budgets during the contract year to account for changes to the baseline assumptions. By example, increased purchase of high deductible products could trigger a downward adjustment in the benefit adjustment factor and thus a reduction in the global medical expense budget. Non-claims based payments such as for quality goals, infrastructure fees and medical director fees are incorporated into the budget. Within the global medical budget, various sub capitation arrangements may be arranged on a service specific basis. Stop loss reinsurance premiums are included in medical expense budgets. Risk contracting is limited to insured HMO populations.

5. **Please explain and submit supporting documents that show how you quantify, and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully-insured plans. Include in your response any adjustments for changes in health status, individual or aggregate stop loss insurance, claims truncation thresholds, distinction you make between performance and insurance risk, adjustments for risk due to socioeconomic factors, and any other ways in which you mitigate the transfer of insurance risk to providers.**

   FCHP's models for risk contracting use a global medical expense budget approach, inclusive of all almost all medical expenses tied to the delivery system through the member's PCP, including pharmacy. Mental health and substance abuse expenses are generally not included in delivery system (DS) risk arrangements. In building risk budgets, FCHP starts with the population-based claims experience of the DS. A minimum

membership threshold is required. Actuarial techniques are applied to claims expenses to finalize an expense budget for a specific risk budget period: incurred but not reported (IBNR) completion factors; medical trend; member liability adjustments, and adjustments to normalize for the effect of high cost cases on the baseline experience.

Standard adjustments to risk budgets include age/gender, product mix, and benefit change. These adjustments are made during the course of the contract year as a result of a change between baseline assumptions and actual contract year experience. By example, a 1% change in the age/gender factor would trigger an adjustment to the global budget. Health status adjustment, as measured by predictive modeling techniques, is generally not included. FCHP does not believe these models are stable enough to use in general application. By using a delivery system's own experience, the health status of its members as well as their socioeconomic conditions are built into its expense base. (This does not preclude use of predictive modeling from analyzing the performance of a delivery system.) Also, as reported above, baseline budgets are adjusted both upward and downward to account for under- or overrepresentation of catastrophic cases.

To protect for insurance risk, and depending on the size of the population at risk, delivery systems typically purchase individual member stop loss insurance that covers 90% of all member expenses (inpatient, outpatient and pharmacy) beyond the stop loss level. Aggregate risk management is typically accomplished through the use of risk corridor gain and loss sharing on the global medical budget. The goal of risk arrangements should be to have delivery systems focus on standard "every day" management of care rather than to be concerned over risk of catastrophic cases.

FCHP has several risk model variants that are made available to health care providers who are interested in risk and have the necessary infrastructure to manage member populations at risk. The common denominator for any risk model is that at-risk providers attempt to perform at or below a targeted per member per month (PMPM) medical cost budget for their assigned member population.

FCHP risk models are only applicable to fully insured members. FCHP does not assume any risk associated with self-insured groups. Providers do not assume any risk associated with self-insured groups. Each self-insured employer, health and welfare fund, or state approved collaborative retains any and all risk associated with their members. Typically, the self-insured entity will purchase reinsurance on their own behalf to mitigate the risk associated with their member population's health expenses.

With fully insured commercial members FCHP may use any of the following models with a provider group interested in risk:

- A full capitation arrangement where the provider group has close to 100% upside and downside performance risk for a designated set of medical services with a specific

PMPM annual budget. FCHP remains at risk for services excluded from the target budget.

- A limited risk capitation arrangement where the provider group still wants upside and downside performance risk but wants to limit its risk on both the upside and downside to designated PMPM thresholds.
- A transitional risk model that uses fee for service (FFS) payment combined with a withhold percentage. In this model the provider group typically has never had a risk arrangement with any payer. The provider group wants to have a trial run at managing to a PMPM budget but with very little downside. So, the provider group negotiates FFS rates but agrees to a small withhold such as 5%.
- A final transitional model to help a provider group become accustomed to the idea of risk is a shared savings program. In this model there is FFS payment but the group is again trying to meet or beat the PMPM annual budget that has been set as the appropriate risk adjusted goal for the target member population. If the provider group can beat the budget by coming in at a lower PMPM, FCHP will share the savings, typically up to an agreed upon PMPM limit, with the provider group.

6. **Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider's size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.**

FCHP's assessment as to whether a provider group can assume risk is determined on a case by case basis after extensive discussions between the provider group and FCHP. During these meetings the following variables are typically examined:

- Membership. Does the provider group have enough members in the particular product(s) to have an actuarially sound risk pool? If not, is the membership pool at least large enough that the provider group should not experience the significant random variations often seen with very small patient populations?
- Provider Group Infrastructure. Does the provider group have or is it willing to develop the infrastructure needed to manage member population health and the associated financial risk? Does the provider have an electronic medical record system, a referral coordination program, a formal CQI plan, and a Medical Director or Assistant Medical Director to focus efforts on a risk venture? What management reports and support are needed from FCHP and is the provider group willing to work with clinical staff resources at FCHP? Does the group have embedded case management staff or are they willing to embed FCHP case management staff at their site?
- Managing Clinical Care. What subpopulations does the provider group know best? What does the provider group see as its mission and which type of members (Commercial,

Medicaid, and Medicare) tend to seek out the provider group for services? Is the group comfortable treating a population with a high number of chronic conditions? What tools does the provider group use or is willing to use to reduce inappropriate hospital readmissions or unnecessary skilled nursing admissions? Is the provider group's model for integrated care consistent with FCHP's expectations for integrated care? What has been the provider group's experience with risk arrangements with other health plans?

- Structure, Governance, and Leadership. How is the provider group organized? Are they employed, independent, or a mixture of both? How are decisions made and funded? If, as is typical, the risk contract is made at a contracting entity level, how are individual providers within the physician organization bound by the risk contract? Do the physicians have to opt in individually to a risk deal or can they all be bound by one signatory? If there is downside risk how will that downside risk be funded and accrued for by the provider group? How will the physician leadership communicate the risk deal initially to rank- and -file providers within the group and how will the physician leadership work to make sure that performance feedback is given on a regular basis to their individual providers?
- Proposed Budget. Does the provider group understand the budget by service type? Do they see the potential areas where changes in utilization, choice of provider setting for services and reduction of unnecessary hospital admissions/readmissions could result in better quality care at a lower total cost? Do they have a targeted focus with priorities for managing types of care that has historically been an outlier from state and national norms with respect to episode frequency and total cost?

To proceed with a risk venture between FCHP and a provider group, the majority of answers to the above topics would have to indicate that the provider group is able to manage care from a population perspective, has the appropriate infrastructure to manage care and assure high quality cost effective outcomes, is adequately organized and financed to accept risk on a health plan population, and is willing to be an active business partner with FCHP to appropriately care for and manage the target member population.

7. **Please explain and submit supporting documents that show for each year from 2009 to 2013 the average difference in prices for (1) tiered network products as compared to non-tiered network products; and (2) limited network products as compared to non-limited network products. Include an explanation of assumptions around these price differences, such as, (a) for tiered network products, expected utilization shift to tier 1 providers, unit price differences between tier 1 and tier 2 providers, and benefit differences between tiered network and non-tiered network products, and (b) for limited network products, unit price differences between limited and non-limited network providers, and differences in benefit and member health status between limited network and full network products. In addition, please summarize any analysis performed on these products that validates or disproves the assumptions used.**

   FCHP believes that limited networks are a more effective way to manage costs than tiered products. We introduced the first limited network product in Massachusetts, FCHP Direct Care, over 10 years ago. In 2012, we added a second limited network, FCHP Steward Community Care, built around Steward Health Care.

   FCHP has successfully utilized a multi-network option strategy to employer groups of all sizes. This allows employers to offer the same benefits to all employees, and then lets each employee choose a network at point of enrollment. FCHP offers all benefit designs available with our broad network through both Direct Care and FCHP Steward Community Care.

   In 2009, FCHP used a 13% differential between its Direct Care and Select Care products within the merged market. This decrement was reduced to 10% in 2010, but expanded to 12% starting in 2011. It has remained at that differential throughout 2013.

   Since there are no benefit differences between products offered through FCHP's non-limited Select Care network and FCHP Direct Care, the 12% pricing differential is a combination of unit cost and better than average state-wide utilization, which reduces the total medical expenditure. We do attempt to negotiate savings close to the pricing differential in these contracts compared to similar contracts with the same providers in our broad network, but it is the criteria for selecting the providers in Direct Care which drives most of the overall reduction in price. There are also differences in member health status; however, these do not drive the standard pricing difference between the two networks.

   FCHP utilized its experience with limited networks to develop the pricing for FCHP Steward Community Care. FCHP Steward Community Care has been priced 20% below Select Care since its introduction. Unit cost differences from our broad HMO contracts and anticipated efficiency improvements due to the contracting arrangements and collaborative efforts with FCHP's Care Management team were reflected, as well as a small incremental amount for member health status was also included in the 20% differential. Experience with this network is still developing, but early indicators show that the difference in costs are in line or better than expected.

In the fully insured market, FCHP did not begin offering a tiered network product until March 1, 2012. Depending on the specific plan design, this product is priced about 7-9% below a broad-based Select Care HMO network product with a plan design similar to the Tier 1 benefits.

Our pricing assumes the total cost for Tier 1 providers is 10-20% less than Tier 2 and that the Tier 3 providers are about 30-50% more expensive. Although we believe there will be shift in utilization towards more efficient providers, we have assumed less than 5% steerage towards tier 1 providers on a total cost basis due to limited differences in the benefits between the three tiers which may not effectively deter the trend for sickest patients to seek care in the more expensive facilities throughout the state. Membership for this product is not credible at this point to draw meaningful conclusions regarding the assumptions used.

8. **Please describe and submit supporting documents regarding any programs you offer purchasers and/or members (including your employees) that promote health and wellness (hereinafter "wellness programs"). Include in your response any analyses you have performed regarding the cost benefit of such wellness programs.**

FCHP believes it is a "healthier" health plan. FCHP focuses on preventive care, as reflected by the many programs and initiatives we offer our members. These include tobacco cessation programs, multi-faceted wellness programs, a fitness reimbursement program, and preventive screenings. In addition, FCHP is the first health plan in Massachusetts to introduce a wellness program to all members that rewards them for being—and becoming—healthy. The "Healthy Health Plan" is a robust solution for members looking to engage in a comprehensive wellness solution.

The Healthy Health Plan provides members financial incentives for (1) taking an online health assessment and, based on the results, (2) completing a customized action plan that may involve workshops and health coaching. This program also provides FCHP with the ability to aggregate important member health information that will help craft appropriate health and wellness programs customized towards our entire membership base.

In addition to The Healthy Health Plan program, FCHP provides a wide variety of wellness programming that helps to ensure members receive the information, skills and care they need to maintain optimal health. This includes:

Wellness Works

- FCHP works directly with employers and their Wellness Committees to build population specific wellness programs to promote a healthy lifestyle for employees. These programs can include personal health assessments, preventive screenings, individual and group wellness challenges, and educational workshops.

Quit to Win!

- FCHP's tobacco cessation program has one of the best quit rates of all health plans in the nation. Participants can receive discounted nicotine replacement therapy while attending weekly group sessions. Members may opt to choose individual telephonic counseling and receive patches in the mail.

Oh Baby!

- Expectant parents receive information, resources and literature, plus complimentary items such as prenatal vitamins, a toddler car seat, breast pump, and home safety kits.

It Fits!

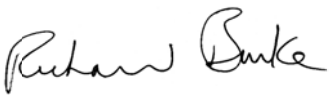
- FCHP offers one of the richest fitness reimbursement programs in the state. "It Fits" reimburses eligible families up to $400 and individuals $200 for participating in a variety of healthy activities: membership at local fitness centers, home fitness equipment, aerobics, Pilates and yoga classes when taught by a certified instructor, Weight Watchers® programs, and local town and school sports programs for all ages when they include an aerobic and instructional component.

For members who want to meet with health and wellness professionals, FCHP has opened a walk-in information center. The FCHP Information Center is a place where members can come to learn about many of the healthy offerings that are available, receive handouts and attend seminars, and sign up for a large number of wellness initiatives.

CERTICIATION OF WRITTEN TESTIMONY FOR THE 2013 COST TREND HEARINGS FOR THE HEALTH POLICY COMMISSION AS AREQUIRED BY M.G.L. c. 6D, SECTION 8.

I, Richard Burke, am the President of Senior Care Services and Government Programs for Fallon Community Health Plan, Inc. (FCHP). I am legally authorized and empowered to represent FCHP for the purposes of this testimony. The responses contained in this submission were prepared by employees of FCHP who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest that the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury:

AUTHORIZED SIGNATORY: 

Print Name: Richard Burke

Title: President of Senior Care Services and Government Programs

Date: September 16, 2013

The Commonwealth of Massachusetts
Executive Offices of Health and Human Services
Center for Health Information and Analysis

CHIA Written Testimony

Submitted September 16, 2013

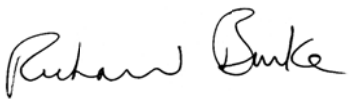
1. **Do you analyze information on spending trends (e.g. TME) and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative?**
   a. **If so, please provide such information on the performance of these entities compared to other Massachusetts provider entities. If available, please provide the information with and without health status adjustment, and the number of member months associated with the identified and comparative providers.**

FCHP does not analyze the information on spending trends and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative.

CERTICIATION OF WRITTEN TESTIMONY FOR THE 2013 COST TREND HEARINGS FOR THE HEALTH POLICY COMMISSION AS AREQUIRED BY M.G.L. c. 6D, SECTION 8.

I, Richard Burke, am the President of Senior Care Services and Government Programs for Fallon Community Health Plan, Inc. (FCHP). I am legally authorized and empowered to represent FCHP for the purposes of this testimony. The responses contained in this submission were prepared by employees of FCHP who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest that the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury:

AUTHORIZED SIGNATORY: 

Print Name: Richard Burke

Title: President of Senior Care Services and Government Programs

Date: September 16, 2013

The Commonwealth of Massachusetts
Executive Offices of Health and Human Services
Center for Health Information and Analysis

CHIA Written Testimony

Submitted September 16, 2013

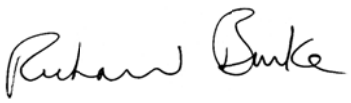
1. **Do you analyze information on spending trends (e.g. TME) and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative?**
   a. **If so, please provide such information on the performance of these entities compared to other Massachusetts provider entities. If available, please provide the information with and without health status adjustment, and the number of member months associated with the identified and comparative providers.**

FCHP does not analyze the information on spending trends and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative.

CERTICIATION OF WRITTEN TESTIMONY FOR THE 2013 COST TREND HEARINGS FOR THE HEALTH POLICY COMMISSION AS AREQUIRED BY M.G.L. c. 6D, SECTION 8.

I, Richard Burke, am the President of Senior Care Services and Government Programs for Fallon Community Health Plan, Inc. (FCHP). I am legally authorized and empowered to represent FCHP for the purposes of this testimony. The responses contained in this submission were prepared by employees of FCHP who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest that the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury:

AUTHORIZED SIGNATORY: 

Print Name: Richard Burke

Title: President of Senior Care Services and Government Programs

Date: September 16, 2013

The Commonwealth of Massachusetts
Executive Offices of Health and Human Services
Center for Health Information and Analysis

AGO Written Testimony

Submitted September 16, 2013

1. **Please submit a summary table (see attached) showing actual observed allowed medical expenditure trends in Massachusetts for CY 2010 to 2012, YE Q1 2012, and YE Q1 2013 according to the format and parameters provided and attached as AGO Exhibit C1 with all applicable fields completed. Please explain for each year 2010 to 2012 what portion of actual observed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g. utilization trends, payer mix trend).**

   Below is the summary table showing Fallon Community Health Plan's (FCHP) actual observed allowed medical trends. For the time frames requested FCHP did not have specific studies to break out the mix between provider and service, so provider and service have been combined in the Service Mix column. FCHP believes that this "allowed" trend understates the true allowed trend if there were no benefit buy-downs. This is true even though the data includes allowed trends of both the payer and member share of the expense, because as the member's share of the cost rises it has an impact on reducing the underlying utilization. This understates the utilization and therefore the total trend in the table below. The trends in the table below indicate that the slow economy had a significant effect of lowering utilization in 2010, which then rose in 2011 and 2012 as the economy improved.

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2010	5.40%	-2.70%	N/A*	-1.10%	1.50%
CY 2011	3.90%	0.20%	N/A*	-0.90%	3.20%
CY 2012	3.80%	1.30%	N/A*	0.80%	5.90%
YE Q1 2012 (April 1, 2011 - March 31, 2012)					3.90%
YE Q1 2013 (April 1, 2012 - March 31, 2013)					3.60%

2. **Please submit a summary table showing your total membership as of December 31of each year 2009 to 2012, broken out by:**

   **Please see attached Excel spreadsheet in folder titled "AG Question 2 – Membership Totals" for answers to the following membership questions.

   a. **Market segment (Hereafter "market segment" shall mean Medicare, Medicaid, other government, commercial large group, commercial small group, and commercial individual)**

   b. **Membership whose care is reimbursed through a risk contract, by market segment (contracts that incorporate a per member per month 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 do not subject the provider to any "downside" risk; hereafter "risk contracts")**

   c. **Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity)**

d. **Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for inpatient and outpatient services (e.g. lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)**

e. **Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)**

f. **Membership in a high deductible health plan by market segment ("high deductible health plans" as defined by IRS regulations).**

3. **To the extent your membership in any of the categories in your response to the above Question 2 has changed from 2009 to 2012, please explain and submit supporting documents that show your understanding of the reasons underlying this growth.**

   There have been minor changes to FCHP's overall membership from 2009 to 2012 (question 2a). FCHP does not attribute the minor changes to any particular factor, rather these small changes are due to the expected "ebbs and flows" that exist in the insurance marketplace.

   While the overall membership has seen little change, there has been a significant increase in membership in FCHP's tiered network plans from 2009 to 2012 (question 2d). We attribute this increase to the development and sale of our "Advantage Plans", which are tiered network plan designs FCHP has offered to certain of our self-insured clients since 2010. To date, FCHP has built Advantage Plans for 6 large employer groups.

4. **Please describe your models for risk contracting since 2009. Include, for example, the structure and elements of such contracts, the role of any non-claims based payments, the role of any trend factors or growth caps, the role of any adjustments to risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, and insurance product populations to which your risk contracts apply (e.g. HMO, PPO, self-insured, fully-insured).**

   FCHP currently has risk arrangements in place for various Commercial, Medicare, and Medicaid HMO provider groups.

   Items such as interim cash flow (capitation payments or fee for service equivalents), unit cost assumptions, utilization trend assumptions, intensity of services assumptions, as well as risk sharing parameters, risk caps, and reinsurance attachment points are all negotiated between the provider group and the health plan.

   At-risk providers will attempt to meet or beat the annual budget. The provider group will be supported in this effort by FCHP reporting on a monthly, quarterly, and annual basis as well as by any internal infrastructure that the provider group has established on its own or in collaboration with FCHP. If the provider group also services members who are not part

of the provider group's risk pool, they would typically be reimbursed at fee for service rates for services provided to non-risk members. If the provider group wants infrastructure payments, PCP management fees, and/or pay for performance incentives for certain quality measures, these amounts will also be negotiated between the parties and included as part of the total at-risk PMPM annual budget. Upside only risk is typically a shared savings model. Models with both up and down side risk can be either low risk, moderate risk, or high risk.

FCHP's models for risk contracting in general use a global medical expense budget approach, inclusive of almost all medical expenses, including pharmacy. Mental health and substance abuse expenses are generally not included in delivery system (DS) risk arrangements. FCHP starts with the population-based claims experience of the DS. A minimum membership threshold is required. Actuarial techniques are applied to the claims expenses to finalize an expense budget for a specific risk budget period: incurred but not reported (IBNR) completion factors; medical trend; member liability adjustments, and adjustments to normalize for the effect of high cost cases on the baseline experience. Specific localized adjustments are made to the claims expense, such as adjustments for known local hospital payment changes. Expenses are translated into a cost per member per month ($PMPM) expense so that the budget varies based on total membership enrollment. In addition, each budget is given a baseline age/gender factor, a product adjustment factor and a benefit adjustment factor. These factors are used to adjust budgets during the contract year to account for changes to the baseline assumptions. By example, increased purchase of high deductible products could trigger a downward adjustment in the benefit adjustment factor and thus a reduction in the global medical expense budget. Non-claims based payments such as for quality goals, infrastructure fees and medical director fees are incorporated into the budget. Within the global medical budget, various sub capitation arrangements may be arranged on a service specific basis. Stop loss reinsurance premiums are included in medical expense budgets. Risk contracting is limited to insured HMO populations.

5. **Please explain and submit supporting documents that show how you quantify, and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully-insured plans. Include in your response any adjustments for changes in health status, individual or aggregate stop loss insurance, claims truncation thresholds, distinction you make between performance and insurance risk, adjustments for risk due to socioeconomic factors, and any other ways in which you mitigate the transfer of insurance risk to providers.**

   FCHP's models for risk contracting use a global medical expense budget approach, inclusive of all almost all medical expenses tied to the delivery system through the member's PCP, including pharmacy. Mental health and substance abuse expenses are generally not included in delivery system (DS) risk arrangements. In building risk budgets, FCHP starts with the population-based claims experience of the DS. A minimum

membership threshold is required. Actuarial techniques are applied to claims expenses to finalize an expense budget for a specific risk budget period: incurred but not reported (IBNR) completion factors; medical trend; member liability adjustments, and adjustments to normalize for the effect of high cost cases on the baseline experience.

Standard adjustments to risk budgets include age/gender, product mix, and benefit change. These adjustments are made during the course of the contract year as a result of a change between baseline assumptions and actual contract year experience. By example, a 1% change in the age/gender factor would trigger an adjustment to the global budget. Health status adjustment, as measured by predictive modeling techniques, is generally not included. FCHP does not believe these models are stable enough to use in general application. By using a delivery system's own experience, the health status of its members as well as their socioeconomic conditions are built into its expense base. (This does not preclude use of predictive modeling from analyzing the performance of a delivery system.) Also, as reported above, baseline budgets are adjusted both upward and downward to account for under- or overrepresentation of catastrophic cases.

To protect for insurance risk, and depending on the size of the population at risk, delivery systems typically purchase individual member stop loss insurance that covers 90% of all member expenses (inpatient, outpatient and pharmacy) beyond the stop loss level. Aggregate risk management is typically accomplished through the use of risk corridor gain and loss sharing on the global medical budget. The goal of risk arrangements should be to have delivery systems focus on standard "every day" management of care rather than to be concerned over risk of catastrophic cases.

FCHP has several risk model variants that are made available to health care providers who are interested in risk and have the necessary infrastructure to manage member populations at risk. The common denominator for any risk model is that at-risk providers attempt to perform at or below a targeted per member per month (PMPM) medical cost budget for their assigned member population.

FCHP risk models are only applicable to fully insured members. FCHP does not assume any risk associated with self-insured groups. Providers do not assume any risk associated with self-insured groups. Each self-insured employer, health and welfare fund, or state approved collaborative retains any and all risk associated with their members. Typically, the self-insured entity will purchase reinsurance on their own behalf to mitigate the risk associated with their member population's health expenses.

With fully insured commercial members FCHP may use any of the following models with a provider group interested in risk:

- A full capitation arrangement where the provider group has close to 100% upside and downside performance risk for a designated set of medical services with a specific

PMPM annual budget. FCHP remains at risk for services excluded from the target budget.

- A limited risk capitation arrangement where the provider group still wants upside and downside performance risk but wants to limit its risk on both the upside and downside to designated PMPM thresholds.
- A transitional risk model that uses fee for service (FFS) payment combined with a withhold percentage. In this model the provider group typically has never had a risk arrangement with any payer. The provider group wants to have a trial run at managing to a PMPM budget but with very little downside. So, the provider group negotiates FFS rates but agrees to a small withhold such as 5%.
- A final transitional model to help a provider group become accustomed to the idea of risk is a shared savings program. In this model there is FFS payment but the group is again trying to meet or beat the PMPM annual budget that has been set as the appropriate risk adjusted goal for the target member population. If the provider group can beat the budget by coming in at a lower PMPM, FCHP will share the savings, typically up to an agreed upon PMPM limit, with the provider group.

6. **Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider's size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.**

FCHP's assessment as to whether a provider group can assume risk is determined on a case by case basis after extensive discussions between the provider group and FCHP. During these meetings the following variables are typically examined:

- Membership. Does the provider group have enough members in the particular product(s) to have an actuarially sound risk pool? If not, is the membership pool at least large enough that the provider group should not experience the significant random variations often seen with very small patient populations?
- Provider Group Infrastructure. Does the provider group have or is it willing to develop the infrastructure needed to manage member population health and the associated financial risk? Does the provider have an electronic medical record system, a referral coordination program, a formal CQI plan, and a Medical Director or Assistant Medical Director to focus efforts on a risk venture? What management reports and support are needed from FCHP and is the provider group willing to work with clinical staff resources at FCHP? Does the group have embedded case management staff or are they willing to embed FCHP case management staff at their site?
- Managing Clinical Care. What subpopulations does the provider group know best? What does the provider group see as its mission and which type of members (Commercial,

Medicaid, and Medicare) tend to seek out the provider group for services? Is the group comfortable treating a population with a high number of chronic conditions? What tools does the provider group use or is willing to use to reduce inappropriate hospital readmissions or unnecessary skilled nursing admissions? Is the provider group's model for integrated care consistent with FCHP's expectations for integrated care? What has been the provider group's experience with risk arrangements with other health plans?

- Structure, Governance, and Leadership. How is the provider group organized? Are they employed, independent, or a mixture of both? How are decisions made and funded? If, as is typical, the risk contract is made at a contracting entity level, how are individual providers within the physician organization bound by the risk contract? Do the physicians have to opt in individually to a risk deal or can they all be bound by one signatory? If there is downside risk how will that downside risk be funded and accrued for by the provider group? How will the physician leadership communicate the risk deal initially to rank- and -file providers within the group and how will the physician leadership work to make sure that performance feedback is given on a regular basis to their individual providers?
- Proposed Budget. Does the provider group understand the budget by service type? Do they see the potential areas where changes in utilization, choice of provider setting for services and reduction of unnecessary hospital admissions/readmissions could result in better quality care at a lower total cost? Do they have a targeted focus with priorities for managing types of care that has historically been an outlier from state and national norms with respect to episode frequency and total cost?

To proceed with a risk venture between FCHP and a provider group, the majority of answers to the above topics would have to indicate that the provider group is able to manage care from a population perspective, has the appropriate infrastructure to manage care and assure high quality cost effective outcomes, is adequately organized and financed to accept risk on a health plan population, and is willing to be an active business partner with FCHP to appropriately care for and manage the target member population.

7. **Please explain and submit supporting documents that show for each year from 2009 to 2013 the average difference in prices for (1) tiered network products as compared to non-tiered network products; and (2) limited network products as compared to non-limited network products. Include an explanation of assumptions around these price differences, such as, (a) for tiered network products, expected utilization shift to tier 1 providers, unit price differences between tier 1 and tier 2 providers, and benefit differences between tiered network and non-tiered network products, and (b) for limited network products, unit price differences between limited and non-limited network providers, and differences in benefit and member health status between limited network and full network products. In addition, please summarize any analysis performed on these products that validates or disproves the assumptions used.**

   FCHP believes that limited networks are a more effective way to manage costs than tiered products. We introduced the first limited network product in Massachusetts, FCHP Direct Care, over 10 years ago. In 2012, we added a second limited network, FCHP Steward Community Care, built around Steward Health Care.

   FCHP has successfully utilized a multi-network option strategy to employer groups of all sizes. This allows employers to offer the same benefits to all employees, and then lets each employee choose a network at point of enrollment. FCHP offers all benefit designs available with our broad network through both Direct Care and FCHP Steward Community Care.

   In 2009, FCHP used a 13% differential between its Direct Care and Select Care products within the merged market. This decrement was reduced to 10% in 2010, but expanded to 12% starting in 2011. It has remained at that differential throughout 2013.

   Since there are no benefit differences between products offered through FCHP's non-limited Select Care network and FCHP Direct Care, the 12% pricing differential is a combination of unit cost and better than average state-wide utilization, which reduces the total medical expenditure. We do attempt to negotiate savings close to the pricing differential in these contracts compared to similar contracts with the same providers in our broad network, but it is the criteria for selecting the providers in Direct Care which drives most of the overall reduction in price. There are also differences in member health status; however, these do not drive the standard pricing difference between the two networks.

   FCHP utilized its experience with limited networks to develop the pricing for FCHP Steward Community Care. FCHP Steward Community Care has been priced 20% below Select Care since its introduction. Unit cost differences from our broad HMO contracts and anticipated efficiency improvements due to the contracting arrangements and collaborative efforts with FCHP's Care Management team were reflected, as well as a small incremental amount for member health status was also included in the 20% differential. Experience with this network is still developing, but early indicators show that the difference in costs are in line or better than expected.

In the fully insured market, FCHP did not begin offering a tiered network product until March 1, 2012. Depending on the specific plan design, this product is priced about 7-9% below a broad-based Select Care HMO network product with a plan design similar to the Tier 1 benefits.

Our pricing assumes the total cost for Tier 1 providers is 10-20% less than Tier 2 and that the Tier 3 providers are about 30-50% more expensive. Although we believe there will be shift in utilization towards more efficient providers, we have assumed less than 5% steerage towards tier 1 providers on a total cost basis due to limited differences in the benefits between the three tiers which may not effectively deter the trend for sickest patients to seek care in the more expensive facilities throughout the state. Membership for this product is not credible at this point to draw meaningful conclusions regarding the assumptions used.

8. **Please describe and submit supporting documents regarding any programs you offer purchasers and/or members (including your employees) that promote health and wellness (hereinafter "wellness programs"). Include in your response any analyses you have performed regarding the cost benefit of such wellness programs.**

FCHP believes it is a "healthier" health plan. FCHP focuses on preventive care, as reflected by the many programs and initiatives we offer our members. These include tobacco cessation programs, multi-faceted wellness programs, a fitness reimbursement program, and preventive screenings. In addition, FCHP is the first health plan in Massachusetts to introduce a wellness program to all members that rewards them for being—and becoming—healthy. The "Healthy Health Plan" is a robust solution for members looking to engage in a comprehensive wellness solution.

The Healthy Health Plan provides members financial incentives for (1) taking an online health assessment and, based on the results, (2) completing a customized action plan that may involve workshops and health coaching. This program also provides FCHP with the ability to aggregate important member health information that will help craft appropriate health and wellness programs customized towards our entire membership base.

In addition to The Healthy Health Plan program, FCHP provides a wide variety of wellness programming that helps to ensure members receive the information, skills and care they need to maintain optimal health. This includes:

Wellness Works

- FCHP works directly with employers and their Wellness Committees to build population specific wellness programs to promote a healthy lifestyle for employees. These programs can include personal health assessments, preventive screenings, individual and group wellness challenges, and educational workshops.

Quit to Win!

- FCHP's tobacco cessation program has one of the best quit rates of all health plans in the nation. Participants can receive discounted nicotine replacement therapy while attending weekly group sessions. Members may opt to choose individual telephonic counseling and receive patches in the mail.

Oh Baby!

- Expectant parents receive information, resources and literature, plus complimentary items such as prenatal vitamins, a toddler car seat, breast pump, and home safety kits.

It Fits!

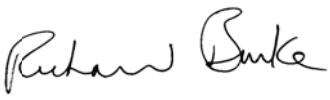
- FCHP offers one of the richest fitness reimbursement programs in the state. "It Fits" reimburses eligible families up to $400 and individuals $200 for participating in a variety of healthy activities: membership at local fitness centers, home fitness equipment, aerobics, Pilates and yoga classes when taught by a certified instructor, Weight Watchers® programs, and local town and school sports programs for all ages when they include an aerobic and instructional component.

For members who want to meet with health and wellness professionals, FCHP has opened a walk-in information center. The FCHP Information Center is a place where members can come to learn about many of the healthy offerings that are available, receive handouts and attend seminars, and sign up for a large number of wellness initiatives.

CERTICIATION OF WRITTEN TESTIMONY FOR THE 2013 COST TREND HEARINGS FOR THE HEALTH POLICY COMMISSION AS AREQUIRED BY M.G.L. c. 6D, SECTION 8.

I, Richard Burke, am the President of Senior Care Services and Government Programs for Fallon Community Health Plan, Inc. (FCHP). I am legally authorized and empowered to represent FCHP for the purposes of this testimony. The responses contained in this submission were prepared by employees of FCHP who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest that the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury:

AUTHORIZED SIGNATORY: 

Print Name: Richard Burke

Title: President of Senior Care Services and Government Programs

Date: September 16, 2013