MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 Pre-Filed Testimony

PAYERS

As part of the
Annual Health Care Cost Trends Hearing

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), holds an annual public hearing on health care cost trends. The hearing examines health care provider, provider organization, and private and public health care payer costs, prices, and cost trends, with attention to factors that contribute to cost growth within the Commonwealth's health care system.

The 2019 hearing dates and location:

Tuesday, October 22, 2019, 9:00 AM
Wednesday, October 23, 2019, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 22. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 22.

The HPC also accepts written testimony. Written comments will be accepted until October 25, 2019, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 25, 2019, 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 the Suffolk University website. 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 available via livestream and video will be available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing page on the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2019 Annual Cost Trends Hearing.

You are receiving two sets of questions – one from the HPC, and one from the AGO. We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, 2017, and/or 2018 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.**

On or before the close of business on **September 20, 2019**, please electronically submit written testimony to: HPC-Testimony@mass.gov. 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.

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 templates or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC Contact Information

For any inquiries regarding HPC questions, please contact General Counsel Lois H. Johnson at HPC-Testimony@mass.gov or (617) 979-1405.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Amara Azubuike at Amara.Azubuike@mass.gov or (617) 963-2021.

Pre-Filed Testimony Questions: Health Policy Commission

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:

Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a. What are your organization's top strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

AllWays Health Partners' strategic focus is customer-centric value-based care. Our strategic priorities to reduce health care expenditures have taken a combined approach to:

1. **Control of prescription drug cost through transparent management that increases access to effective customer-focused alternatives (e.g., generics, home infusion);**
2. **Remove barriers (financial or access-related) to effective chronic disease management through increased access to evidence-based interventions and an emphasis on prevention and adherence;**
3. **Increase provider engagement and expansion through the removal of administrative complexity and an increased adoption of alternative payment methodologies (APMs); and**
4. **Advancing customer-centric product innovation.**

<u>Pharmacy cost controls</u>

AllWays Health Partners understands that we have a responsibility to provide access to the right care at the right time in the right setting. In addition to standard prescription drug formulary management, we use pharmacy claims and analytics to improve several aspects of our members' care. For example, we address gaps in care and identify members who may need care management. Moreover, our data analysis is employed to identify children who may be receiving multiple psychotropic medications. These efforts not only improve clinical outcomes but also prevent avoidable downstream costs. In addition to standard formulary management tools, AllWays Health Partners identifies the right setting for infused drug utilization at the lowest net cost option. For example, clinically indicated members will be incented to receive infused medications via home infusion therapy as compared to physician-administered sites. This home infusion program is expected to save approximately $1.6m in annual infused drug costs.

AllWays Health Partners also seeks to contract with providers to standardize drug pricing across the pharmacy and medical benefits. This approach will minimize any additional costs that can be associated with prescription drugs billed through the

medical benefit. These combined efforts resulted in a -13.4% pharmacy trend in the first quarter of 2019 when compared to the same period in 2018. Moreover, we appreciate that pharmacy pricing is complex and we continue to work with our pharmacy benefit manager, CVS/Caremark, to improve transparency on "spread" and rebate arrangements with the pharmaceutical industry. While formulary management continues to demonstrate its value, we believe that these additional management measures will serve as a transparent and effective complement to more efficiently deliver pharmacy services.

Chronic Disease management

AllWays Health Partners is focused on increasing access to evidence-based interventions through an emphasis on prevention and adherence. The key is to efficiently identify those that would benefit from these interventions. AllWays Health Partners uses several data sources to identify members for case management. In addition to standard predictive analytics, we have employed Patient Ping to access a digital alert system that identifies admission, discharge and emergency department utilization in real time. This information enables care managers to intervene and more effectively manage transitions of care and eliminate future preventable visits.

Applying system-based contracting arrangements, AllWays Health Partners was able to apply our MassHealth experience in the Merrimack Valley to improve care management for our commercial business. For example, our Your Care Circle (YCC) program (described below) addresses social determinants of health and has been successful in addressing transportation, nutrition and other factors that contribute to health. Additionally, AllWays Health Partners directly employs recovery coaches who have had a significant impact on members with substance use disorder.

AllWays Health Partners has successful chronic disease management programs with plans to expand. Our iHeart Champion program is an excellent example of the opportunities that exist for improving health outcomes when providers and health plans combine their resources to develop industry-leading innovations. Developed in association with Partners HealthCare, iHeart Champion uses data tools and specific algorithms to titrate medications used to treat hypertension and high cholesterol. Clinical navigators use the data - under physician or pharmacist supervision - to communicate with patients digitally. The results have been positive, resulting in rapid control of high blood pressure and high cholesterol (usually within 8-12 weeks) without repeated doctor visits. Early control of these conditions will result in significant savings to the health care system by reducing the risk of stroke and heart disease. In 2020, AllWays Health Partners plans to extend this approach to both depression and diabetes, two conditions that contribute to significant morbidity and mortality. Lastly, we are working with Partners HealthCare to develop new products and digital tools to reduce member out-of-pocket costs and improve access to both preventive and chronic disease management services.

Increasing APMs

AllWays Health Partners is keenly interested in increased provider engagement which we feel is critical to creating provider agreements that promote effective care for our members. In support of this effort, AllWays Health Partners contracts with providers at the delivery system and/or Physician-Hospital Organization (PHO) level. Using a system-focused, PHO-level contracting mechanism that brings all primary care providers (PCPs), specialists and hospital(s) under one agreement serves to aggregate AllWays Health Partners members. This cohesive approach increases the number of members participating under an APM and leverages infrastructure at the delivery system/PHO to help create targeted and innovative programs, provide data sharing, and measure outcomes in support of managing total medical expense (TME). In 2018, approximately 25% of total commercial membership and 40% of fully insured commercial HMO membership were covered under APMs. Our goal is to increase this to 50% of members by the end of 2020.

Product Innovation

AllWays Health Partners is focused on developing innovative products that provide care for our members at the right time and in the right place and that do not place unnecessary financial barriers in the way of accessing care. In addition, we seek to leverage our relationship with Partners Healthcare to develop unique, high value offerings for the Massachusetts market. Some examples of our product innovation are:

- **Our Care Complement plan designs that remove financial barriers to various care options by removing cost sharing for certain services like chiropractic, acupuncture and physical therapy (first six visits at no cost sharing). Care Complement also has no cost sharing on eleven common prescription drugs that treat chronic conditions like depression, diabetes, high cholesterol and high blood pressure.**
- **Working in conjunction with Partners HealthCare, AllWays Health Partners introduced a program called iHeart Champion (described more fully above) and will continue to work with providers to introduce a pre-diabetes program designed to prevent or delay the onset of diabetes through lifestyle changes that increase activity and support weight reduction.**

Additionally, AllWays Health Partners products are focused on increasing access to care and offering choices in how care is obtained. Some examples include:

- **Partners HealthCare on Demand: we have introduced a virtual urgent care option offering convenient, high quality care from Partners HealthCare providers. We are currently working on expanding our virtual care capabilities for future product solutions.**
- **In 2020, we will be removing cost sharing on many of our plan designs for three pediatric sick visits (medical and behavioral health visits – three each) so**

that parents are not forced to make a financial decision about whether to seek care for their child.

b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?

Initiatives that promote transparency in drug pricing will assist efforts to control health care inflation. Recent approaches that primarily tie drug costs to efficacy are useful but fail to address the core issue - retail drug cost. Many drug manufacturers continue to price a drug based on known effectiveness to maximize revenue. We would suggest that an objective, multidisciplinary, third-party is essential to evaluate the value of new biological medications that may cost anywhere from hundreds of thousands to millions of dollars. A key component of any objective evaluation would require that medications which do not meet an established threshold are only available if the manufacturer adjusted the price to match an objective value calculation.

As an additional policy issue, there is a current shortage of behavioral health (BH) providers in Massachusetts who accept commercial insurance. One cause of the shortage of BH providers is the undersupply of practitioners to meet patient demand. For 2019, AllWays Health Partners has increased BH reimbursement and suggests a broader market approach, mindful of budget neutrality. BH conditions are a common comorbidity of chronic disease and are shown to exponentially increase medical expense. In 2018, AllWays Health Partners sought to address this shortage in a modest manner by underwriting training costs to obtain the Drug Enforcement Agency (DEA) waiver necessary to prescribe medication-assisted treatment (MAT). In total, an additional 53 network providers in Massachusetts attained the waiver and are now treating substance use disorder (SUD). This model is helpful and can be expanded with additional academic and government support.

In terms of increasing APMs, we continue to support the state legislature, the Health Policy Commission (HPC) and other state agencies to explore opportunities to create incentives for providers to participate in an APM arrangement. Possible options include either competitive grants, technical assistance, and other incentives for collaboration among small providers. Setting the proper incentive to participate, in concert with ongoing health plan efforts to increase the use of APMs, will advance this priority and lead to more efficient care delivery.

2. STRATEGIES AND POLICIES TO SUPPORT INVESTMENT IN PRIMARY CARE AND BEHAVIORAL HEALTH CARE:

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care, even though evidence suggests that a greater orientation toward primary care and behavioral health may increase health system efficiency and provide superior patient access and quality of care. Health plans, provider organizations, employers, and government alike have important roles in prioritizing primary care and behavioral health *while still restraining the growth in overall health care spending.*

a. Please describe your organization's strategy for supporting and increasing investment in primary care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

AllWays Health Partners believes strongly in the integration of medical and BH care and is invested in developing strategies to support this core belief. Countless studies have demonstrated that early access to BH services improves patient outcomes, particularly for those with chronic disease. The effort to increase access to primary care is a natural extension of our belief system and our related strategies. In fact, AllWays Health Partners has been engaged in a successful campaign to increase our members' access to PCPs – having added over 600 new PCPs in the past year.

Also, AllWays Health Partners has had risk arrangements with two of the largest delivery systems in the Commonwealth, Atrius Health and Partners HealthCare. Through these risk arrangements, AllWays Health Partners was able to invest in a new incentive structure that supports primary care through the removal of many prior authorization requirements, resulting in less administrative burden on PCPs and improved access to care for members. Under these risk arrangements, providers in the impacted systems are no longer required to submit clinical information and wait for an authorization. Referrals and other services can be scheduled directly allowing for a better administrative process and improved access to care.

Another initiative underway at AllWays Health Partners that supports our strategy to expand access to both primary and BH care is through the development of a virtual provider network. The goal of this pilot program is to increase access services by offering video visits and algorithmic-based digital management tools. In addition, AllWays Health Partners utilizes quality improvement metrics that serve to incent PCPs to deliver high-quality care such as immunization rates, annual screening rates, and follow-up post hospital discharge.

AllWays Health Partners' internal care management program, YCC, is an excellent team-based platform that serves members with complex medical and/or BH conditions (including SUD). See response to Question 2b for a detailed description of the YCC program. For some accounts, this program has resulted in up to a 35% decrease in inpatient admissions and a 37% decrease in emergency department utilization. For the total book of business, the YCC program has demonstrated a reduction in overall expenditures of $2.8M in 2018.

b. Please describe your organization's strategy for supporting and increasing investment in behavioral health care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

AllWays Health Partners does not view either the role of the PCP or our BH investments in isolation and we support the integration of medical and BH care.

Overall, we take a holistic approach in the care of our members and our investments reflect that approach.

As noted, YCC connects members with the highest predicted medical risk, (including highest risk for admission, re-admission, and emergency room use) directly with PCPs, BH providers, care managers and community care. Addressing the social determinants of health for these members, the interdisciplinary YCC team is comprised of a medical care manager, a BH care manager, a social care manager, and a community health worker. The YCC team provides home visits, food, nutritional education, cell phones, and access to medical transportation when these services are not otherwise available.

In addition, AllWays Health Partners works with its BH vendor, Optum, to manage the BH benefits for AllWays Health Partners' members. AllWays Health Partners provides access to an integrated care management model that is built on the co-location of BH care managers and coordinators. Medical Behavioral Integration Care Advocates focus on members with the most severe medical behavioral comorbidities and high-cost/high-need members with serious mental illness, creating a holistic plan of care that provides follow-up and closes gaps in care.

AllWays Health Partners' customers can also access a Provider Integration Resource Specialist (PIRS). The PIRS is responsible for collaborating with PCPs and BH providers to:

- **Assess BH integration capabilities;**
- **Provide training on BH and medical behavioral integration topics (including but not limited to Best Practices, self-management tools, a PCP Toolkit, screening tools, Motivational Interviewing, Trauma Informed Care, and Dealing with Suicidal Patients);**
- **Increase the capacity to manage BH within a primary care setting**
- **Provide access to BH resources;**
- **Establish or enhance access to BH providers as well as processes (e.g., facilitate psychiatric consultations, connect with care management services, and enhance/establish provider relationships); and**
- **Provide relevant reporting to PCPs as indicated.**

Allways Health Partners has expanded the BH provider network and successfully improved reimbursement rates for BH providers in 2019.

Prior authorization is not required for emergency services including, but not limited to, inpatient mental health and crisis evaluations – this is in addition to the SUD services (such as detoxification) which do not require prior authorization under Chapter 258.

Lastly, members can use a cost estimator tool on the member portal called Live and Work Well under the Benefits and Claims tab for members https://www.liveandworkwell.com**. This tool allows members to estimate cost-sharing and access other information prior to beginning a service for a BH condition.**

c. Provider organizations can take steps to ensure they deliver high-functioning, high-quality, and efficient primary care and improve behavioral health access and quality. What strategies should provider organizations prioritize to strengthen and support primary and behavioral health care?

There are a variety of ways that provider organizations can ensure they are delivering high quality and efficient primary care while improving access to quality BH care. One of the most effective strategies to integrate quality BH care into primary care is to embed BH providers in the primary care practices. These embedded providers can be used on a consultative, emergent/urgent, or therapeutic basis. They can also assist in securing longer-term BH services for members. Importantly, this embedded model supports coordinated BH and medical services.

d. What other changes in policy, market behavior, payment, regulation, or statute would best accelerate efforts to reorient a greater proportion of overall health care resources towards investments in primary care and behavioral health care? Specifically, what are the barriers that your organization perceives in supporting investment in primary care and behavioral health and how would these suggested changes in policy, market behavior, payment, regulation, or statute mitigate these barriers?

The discrepancies within the federal Relative Value Units (RVUs) reimbursement formula is a primary barrier to improving primary care and BH reimbursement. RVUs are a key component of the resource-based relative value scale (RBRVS) used to measure value in the Medicare reimbursement formula for physician services and serves as a foundation for physician reimbursement.

As the delivery of health care continues to grow in cost over time, businesses and health plans struggle to control health care cost as the pool of available reimbursement funds is not limitless. In addition, given the current level of reimbursement for BH services, many providers have opted out of accepting health insurance and have moved toward private pay, decreasing affordable access to BH in the Commonwealth.

To invest in primary care as well as BH, the corresponding RVUs should be addressed to make gradual adjustments in a budget neutral manner.

3. CHANGES IN RISK SCORES AND PATIENT ACUITY:

The HPC has observed that member risk scores have been steadily increasing for many payers and that a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications.

a. Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your members.

Factors	Level of Contribution
Increased prevalence of chronic disease among your members	Major Contributing Factor

Factors	Level of Contribution
Aging of your members	Minor Contributing Factor
New or improved EHRs that have increased providers' ability to document diagnostic information	Minor Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with providers to assist with capturing diagnostic information)	Not a Significant Factor
New, relatively less healthy patients entering your patient pool	Major Contributing Factor
Relatively healthier patients leaving your patient pool	Major Contributing Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe: Click here to enter text.	Level of Contribution

☐ Not applicable; neither risk scores nor acuity have increased for my members in recent years.

b. Please describe any payment integrity initiatives your organization is undertaking to ensure that increased risk scores and/or acuity for your members reflects increased need for medical services rather than a change in coding practices.

Required participation in Risk Adjustment Data Validation (RADV) allows AllWays Health Partners to sample test the risk scores to assess if they accurately reflect the acuity of our commercial membership. While the results can be mixed, in general it appears the coding accurately reflects the acuity of our membership. Although RADV only covers the merged market, we believe it is representative of coding by providers.

4. REDUCING ADMINISTRATIVE COMPLEXITY:

Administrative complexity is endemic in the U.S. health care system. It is associated with negative impacts, both financial and non-financial, and is one of the principal reasons that U.S. health care spending exceeds that of other high-income countries.

a. For each of the areas listed below, please indicate whether achieving greater alignment and simplification is a **high priority**, a **medium priority**, or a **low priority** for your organization. Please indicate **no more than three high priority areas**. If you have already submitted these responses to the HPC via the June 2019 *HPC Advisory Council Survey on Reducing Administrative Complexity*, do not resubmit unless your responses have changed.

Area of Administrative Complexity	Priority Level
Billing and Claims Processing – processing of provider requests for payment and insurer adjudication of claims, including claims submission, status inquiry, and payment	High

Area of Administrative Complexity	Priority Level
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Medium
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Medium
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	Medium
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	High
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Medium
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	High
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	Medium
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Medium
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Medium
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	Medium
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level

b. CAQH estimates that the health care industry could save nearly $10 billion if all organizations were to perform six transaction types entirely electronically.[1] Please report your organization's calendar year 2018 volume for the following transaction types in the

[1] CAQH. 2018 CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings. https://www.caqh.org/sites/default/files/explorations/index/report/2018-index-report.pdf

table below. Please also describe any barriers to performing all of the listed transactions entirely electronically.

Below, please find the AllWays Health Partners data for our calendar year 2018 volume related to the transaction types listed in the table below. In general, we would add the following context:

Eligibility and Benefit Verification - Fully electronic includes the transactions performed through our portals.

Prior Authorization - Manual or Partially Electronic includes the OCR (Optical Character Recognition) based claim entry processes.

Claims Status Inquiry - 779 of the manual inquiries were from Non-Par providers. Non-Par providers who do not have access to NHPnet (Provider Online Portal) cannot check claim status electronically.

Claim Payment - Fully electronic means the Electronic Fund Transfer went through ACH (Automated Clearing House).

In terms of potential barriers related to performing the listed transactions electronically, we would only add that it is important that providers collaborate. For example, we can work together to change processes to add electronic payment options.

Transaction	Manual or Partially Electronic	Fully Electronic, in Accordance with ASC X12N
Eligibility and Benefit Verification	115,819	14,949,996
Prior Authorization	5,298	210,548
Claim Submission	105,019	2,403,482
Claim Status Inquiry	6,774	1,004,515
Claim Payment	119,341	51,263
Remittance Advice	77,405	93,199

5. PROGRESS ON ALTERNATIVE PAYMENT METHODS:

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. The Center for Health Information and Analysis reports that the majority of care for commercial members continues to be paid using fee for service; with 59% of HMO patients and 18.7% of PPO patients covered under alternative payment contracts in 2017. In the 2018 Cost Trends Report, the HPC found that payers and providers have not made sufficient progress to meet the HPC's targets for expanded use of alternative payment methods (APMs).

a. Please describe what your organization has done to make progress in 2018 on expanding the use of APMs in both HMO and PPO products and the use of APMs with new providers and provider types.

Several of AllWays Health Partners' large system contracts include a risk sharing element for the HMO products, and in some instances, for the PPO product. In 2018, AllWays Health Partners added quality measures to several of its provider contracts, impacting both HMO and PPO products. Additionally, AllWays Health Partners utilizes a case rate methodology in many of its provider contracts, including outpatient services such as urgent and emergent care. New provider contracts contain withhold arrangements wherein providers must reach specific quality and utilization targets to qualify for additional payment (e.g., pay for performance). As contracts renew this coming Fall, AllWays Health Partners will explore additional APM opportunities, including reference pricing and bundling of commoditized treatments (e.g., hip and knee replacements).

b. Please identify which of the following strategies you believe would most encourage further adoption and expansion of APMs. **Please select no more than three.**

- ☒ Support and/or technical assistance for developing APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payment
- ☒ Identifying strategies and/or creating tools to better manage the total cost of care for PPO populations
- ☐ Identifying strategies and/or creating tools for overcoming problems related to small patient volume
- ☐ Enhancing EHR connectivity between payers and providers
- ☒ Aligning payment models across providers
- ☐ Enhancing provider technological infrastructure
- ☐ Other, please describe: Click here to enter text.

6. STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY:

Chapter 224 of the Acts of 2012 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. In the table below, please provide available data regarding the number of individuals that sought this information.

Health Care Service Price Inquiries Calendar Years (CY) 2018-2019			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2018	**Q1**	1913	91
	Q2	1655	116
	Q3	1757	107
	Q4	1452	113
CY2019	**Q1**	2334	115
	Q2	1497	104
	TOTAL:	**10608**	**646**

7. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS:

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2016 to 2018 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2016 to 2018, the portion of actual observed allowed claims trends that is due to (a) changing demographics of your population; (b) benefit buy down; (c) and/or change in health status/risk scores of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

CY 2016 trends were driven by unit cost, the beginning of a three-year transition as AllWays Health Partners, formerly Neighborhood Health Plan, began moving from being viewed as a Medicaid health plan to a commercial health plan. This transition has led to higher unit cost trends than market average in 2017.

Between 2016 and 2018, we have seen significant shifts in our membership mix, with declines in individual lines and growth in large group. The decline in individual and ConnectorCare membership has been associated with significant adverse selection, probably due to the ease of access to academic medical centers and Dana-Farber Cancer Institute, as compared to other carriers in these segments. We estimate that our overall book of business risk score increased by 4% in 2017 over 2016, and by an additional 6% in 2018 compared to 2017. The impact of the increased risk is reflected in the utilization and service mix trends, as higher risk members use higher cost services, such as expensive chemotherapies. Benefit buydown does not seem to be a significant contributor to our overall allowed trends.

Please see attached HPC Payer Exhibit 1.

Pre-Filed Testimony Questions: Attorney General's Office

1. In the 2018 AGO Cost Trends Report, the AGO examined the complex and varied methods used to determine health care payment rates. Please describe the strategies that your organization is pursuing to reduce complexity and increased standardization where appropriate in each of the following areas:

    a. Payment policies and procedures: **AllWays Health Partners utilizes and publishes payment policies that align with industry standards.**

    b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.): **AllWays Health Partners has introduced standardized payment methodologies (DRG, Enhanced Ambulatory Patient Grouping or EAPG, and streamlined fee schedules) and is slipstreaming these methodologies into provider contracts as they turn over.**

    c. Alternative Payment Models ("APMs"): Please select any of the subcategories that apply and explain your selection.

    ☐ Health status adjustment methods (e.g., types of claims used to determine health status score, such as medical or Rx, etc.):
    Click here to enter text.

    ☒ Risk structure (e.g., risk exposure, the allowed budget, exclusions, bonuses, quality performance, etc.):
    AllWays Health Partners utilizes shared risk in its provider contracts that is tied to performance metrics like quality, attainment of certain clinical measures, and timeliness of reporting. AllWays Health Partners also utilizes managed care contract mechanisms, such as withholds, to enable our physician organizations to incentivize quality measures and other pay-for-performance programs.

    ☒ Use of pre-paid lump sum payments (rather than volume-based, fee-for-service interim basis payments):
    AllWays Health Partners utilizes case rates where they are accepted by providers. They provide cost predictability, smoothing of spending, and predictability for members with respect to cost sharing amounts. We are also rapidly introducing DRG and EAPG payment methodologies into our provider contracts, which improve acuity reporting, smooth spending, and allow for more transparency around cost for like services from one system to the next.

    ☐ Other, please describe:
    Click here to enter text.

    d. Please describe any ways in which your unique payment approach brings value to patients, plan sponsors, or payers: **Our payment approach is multi-faceted: Case rates insulate members from surprise billing; bundled payment similarly insulates members and rate payers from overages driven by ancillary service categories. EAPG methodology provides cleaner metrics for reporting and insulates members from payment surprises. Using quality metrics drives compliance by members, which drives better patient outcomes which drives down costs for plan sponsors.**

2. Please answer the following questions regarding your organization's APM contracts with providers in our marketplace:

    a. What are the main barriers to shifting away from using a volume-based, fee-for-service interim basis payment approach (i.e. prior to settlement) to using pre-paid lump sum payments?
    A major barrier includes contracts that are currently not negotiable (e.g., contracts that are in year two of a three-year contract). Additionally, some providers resist these contractual arrangements for a variety of reasons. These include provider readiness for making the system changes necessary to implement alternative payment methods. Another reason is that providers often become dissatisfied over time with bundled payments, because bundled payments tend to be fixed where payments tied to fee-for-service methodologies (e.g. RVU) tend to fluctuate in response to input from specialty Relative Value Scale Update Committee (RUC) and other stakeholders.

    b. In 2018 (or in the most recent year for which you have complete data), what percent of your medical payments for commercial products were paid for on an interim basis under volume-based, fee-for-service claims adjudication?
    40%

HPC Payer Exhibit 1

All cells should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

Year	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2016	6.2%	1.1%	N/A	1.4%	8.7%
CY 2017	7.3%	3.7%	N/A	3.6%	14.6%
CY 2018	5.1%	0.4%	N/A	1.1%	6.7%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will