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 particular 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?

Blue Cross Blue Shield of Massachusetts (BCBSMA) takes seriously our role in controlling health care costs for our members, employer customers and the community. We have numerous strategic priorities to reduce health care expenditures, and refer to our Pre-Filed Testimony from 2016, 2017, and 2018 which details ongoing work on numerous fronts, including innovative plan designs and prescription drug costs. We would like to highlight our work on shifting care from high-cost settings and working with our accounts and members to access high value care.

BCBSMA believes that changing the way we pay for health care is vital to addressing the cost burden felt by consumers and employers, so we continue to prioritize alternative payment methodologies (APMs) – not only the adoption, but working closely with providers to make sure they excel under these models for the benefit of our members. We have seen significant success on the Alternative Quality Contract (AQC) which we will detail in later responses. In addition to promoting APMs, BCBSMA considers the statewide benchmark in negotiating all of our contracts so that we are helping the Commonwealth achieve that goal.

BCBSMA has invested in Telehealth to improve access and affordability for both medical and behavioral health services. Our Telehealth benefit is included in all of our fully-insured accounts and is available to our self-insured accounts. We also continue to offer varied products so that employers can select products that work best for their business and employees, including tiered and limited network products. Shopping for care within a tiered or limited network is still a somewhat new approach for some of our accounts and members, so we continue to engage with them and provide them with the tools to make informed decisions about where they will receive their care. BCBSMA has invested and updated our member portal so that members can easily access information on their benefits, Find-A-Doctor, and the cost estimator tools.

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

BCBSMA strongly supports renewed efforts to further spur multi-stakeholder cost containment, as first codified within Chapter 224 of the Acts of 2012. Now that we have several years of experience, there are several steps Massachusetts should take now that would assist in these efforts: (1) with hospital costs being a significant factor in total health care expenditure (THCE) growth, the state should add reasonable statutory or administrative tools

to directly test hospital systems via a cost benchmark analysis specific to these hospitals and systems – unlike provider group analyses, this does not exist currently; (2) for another major THCE growth driver, pharmaceutical costs, we should enact strong transparency tools very similar to those already employed for health plans and providers. Comparable to the public reporting requirements of payers and providers, pharmaceutical companies should be required to submit data to the state and participate in the Annual Cost Trends Hearing with the HPC. This additional information will help policymakers make more informed decisions. Moreover, similar to the market mechanisms in place for providers and plans, the HPC's performance improvement process should be employed as an additional set of tools for the pharmaceutical industry adding value without being overly burdensome; (3) we remain concerned about efforts that could stifle innovation and have the potential to add needless costs to the system. While much attention has been paid to alignment and uniformity, some of the ideas under consideration could hurt the system's ability to address high costs and potentially leave stakeholders in stagnating systems; (4) lastly, some providers remain uninterested in narrow networks even though some employers find that current offerings do not meet the needs of their employees. As we have noted previously, a critical policy change that will advance this priority are reforms for out-of-network billing and costs. As the next generation of innovation continues around value-based plan designs, we must advance a solution to this critical area. Like commissions and multiple stakeholders, BCBSMA believes that this solution should include: (1) consumer awareness of surprise billing scenarios, (2) patient protections to prevent balance-billing, and (3) reasonably set and transparent provider reimbursements for out-of-network services.

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.

Our Alternative Payment Models, which have been in place for over 10 years, are anchored in primary care and include twin goals of reducing medical spending growth while simultaneously improving quality and outcomes of care. The focus of these models is supporting and investing in primary care through these value based contracts. Our landmark Alternative Quality Contract (AQC), a global budget-based payment model with a robust quality program, now covers nearly 85% of our HMO members and over 80% of our primary care providers (PCPs). In significant studies conducted by Harvard Medical School faculty and published in leading scientific journals, the AQC has been shown to both improve quality and slow cost growth. The most recent findings released in 2019 show continued gains in both quality and cost savings.

In 2016, we expanded the concepts of the AQC to our PPO contracts and, as of January 1, 2019, have approximately two thirds of our provider network taking risk for the management of their PPO population. This alignment of provider incentives across our HMO and PPO

products has led providers to invest meaningfully in population-based health management resources, including new staffing models, new uses of information technology, new ways of engaging their patients, and new means of integrating care across settings, positioning them for continued success under their value-based contracts.

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.
Over the last 10 years, BCBSMA has made numerous changes to better support and invest in behavioral health care. We took significant steps to in-source behavioral health management and to include behavioral health care in our physician-based risk-arrangements.

Additionally we have opened our behavioral health provider network to any willing provider, so we will contract with any qualified provider who is interested in being part of our network. We also added additional behavioral health provider types to our network, including Licensed Drug and Alcohol Counselors and Applied Behavioral Analysis, and contracted with four new behavioral health hospitals. In our provider network, 40% of behavioral health providers are part of large physician organizations, up from 2% in 2013. Having more behavioral health providers aligned with large physician organizations enables behavioral health services to integrate more effectively with the primary care side. It also holds the behavioral health providers more accountable for the cost and quality priorities of these large physician organizations. Our behavioral health network has grown by 20% in the last five years. From a payment perspective, we have standardized our behavioral health payment methodology to align with other professional providers.

Moreover, we have removed prior authorization requirements for Psychotherapy services and prioritized behavioral health as part of our Telehealth benefit so that members can obtain services locally, which has improved access to needed care. Through our Telehealth benefit, members have access to more than 1,000 behavioral health providers nationally and 240 behavioral health providers locally, averaging a combined 1,000 Telehealth visits per month.

BCBSMA also contributed $550,000 to the Blue Cross Blue Shield Foundation to build and launch an online tool, called Network of Care Massachusetts, which will allow Massachusetts residents to search for behavioral health services in their area. Network of Care Massachusetts will allow residents, family members, primary care providers and care managers to search for organizations based on specific need – such as depression, alcoholism, food or housing – or by the services they are looking for, such as emergency mental health services, alcohol detox, food pantries or rental assistance. BCBSMA is one contributor to this project, and we look forward to seeing how this collaboration evolves.

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?

While provider organizations differ, we have seen success in utilizing and expanding the use of Telehealth services to improve access to care. Focusing on areas where there is need for specialized care, such child psychiatry, could potentially increase the access for this needed service.

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?
We believe that changing the way we pay for health care is vital to allow for investments in primary care and behavioral health. We continue to prioritize alternative payment methodologies that will allow for this, and we urge other stakeholders to support and expand these efforts.

From a policy perspective, BCBSMA supports the expansion of the Massachusetts Child Psychiatry Access Program (MCPAP) to include consultations for adults. We would support consideration of a carefully crafted and responsive Child Psychiatry Loan Forgiveness program to address the shortage of clinicians in this specialty.

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.

Unfortunately, it is impossible to quantitatively break apart drivers of risk score in this way. Notwithstanding this caution we have made best efforts at the qualitative statements below. It is worth noting that a recent study on the effectiveness of our AQC published in the New England Journal of Medicine concluded that risk scores have actually been increasing faster in a control population of other Northeastern states than in BCBSMA's own HMO population.

Factors	Level of Contribution
Increased prevalence of chronic disease among your members	Major Contributing Factor
Aging of your members	Major Contributing Factor
New or improved EHRs that have increased providers' ability to document diagnostic information	Major Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with providers to assist with capturing diagnostic information)	Minor Contributing Factor
New, relatively less healthy patients entering your patient pool	Minor Contributing Factor

Factors	Level of Contribution
Relatively healthier patients leaving your patient pool	Minor Contributing Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Major Contributing Factor
Other, please describe: Changes in clinical definitions and treatment protocols for conditions in an effort to diagnose and treat earlier (e.g., sepsis/septicemia)	Major Contributing Factor

☐ 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.
BCBSMA has undertaken numerous initiatives to ensure payment integrity, including claims editing, claims review, and partnering with a payment integrity vendor. Additionally, we routinely audit our claims to conduct comprehensive reviews to validate claim payment accuracy. BCBSMA has made considerable investments in a dedicated team of resources to perform post-payment audits of diagnosis-related group (DRG), outpatient, and professional claims. Threshold limits are defined, and for DRG claims, a software program is used to identify claims that appear to be abnormal for DRG payment. Expert clinical staff perform the reviews and works with the servicing providers to identify and acknowledge documentation, billing and coding issues.

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.

BCBSMA is a member of the Advisory Council and previously submitted the *Survey on Reducing Administrative Complexity*. Our responses have not changed since this submission.

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	Priority Level

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	Priority Level
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Priority Level
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Priority Level
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	Priority Level
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Priority Level
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Priority Level
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	Priority Level
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	Priority Level
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Priority Level
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Priority Level
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	Priority Level
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.

While the vast majority of BCBSMA transactions are already electronic, we continually look for opportunities for improvement. For example, we are exploring moving more of the eligibility and benefit verifications to an electronic format. We also regularly consider the extent and scope of the prior authorization process to assess continued need on an evaluative basis and whether the process can be simplified. While BCBSMA seeks to fully utilize electronic transactions in accordance with ASC X12N, some limited manual processes remain necessary, especially in cases that demand additional human scrutiny. Additionally, we interact with providers with a wide range of technological sophistication, and so we take multiple approaches to encourage the adoption of efficient and compliant processes.

Please note that some of the transaction counts below are estimates since we do not have processes in place to capture some of this data.

Transaction	Manual or Partially Electronic	Fully Electronic, in Accordance with ASC X12N
Eligibility and Benefit Verification	41,305	93,877,641
Prior Authorization	243,361	1,280,622
Claim Submission	1,755,453	47,311,835
Claim Status Inquiry	20,808	6,774,388
Claim Payment	815,939	1,168,877
Remittance Advice	286,847	818,786

*Electronic Remittance Advice (ERAs) are created for BCBSMA by our vendor. BCBSMA does not separately capture this data.

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.

BCBSMA remains committed to APMs and is focused on meeting the goals set by the Health Policy Commission. To date, we have nearly 85% HMO members and 47% PPO members in APMs. In addition to the AQC and our expansion to PPO, BCBSMA continues our work on payment model innovation. In 2018, we introduced a model that aims to bring hospital payment incentives more fully into alignment with those of our global budget models. The new hospital payment model, launched in January 2018 with

South Shore Hospital, rewards the hospital based on its success at managing the cost and quality of patients in its catchment area—regardless if those patients are affiliated with a South Shore system primary care physician. In other words, the hospital now has financial incentives to support physician organizations in its community who, themselves, have risk-based contracts with BCBSMA—and to help those organizations succeed at managing total cost of care and improving quality and outcomes. This means helping to avoid unnecessary uses of the emergency room, unnecessary admissions and readmissions, unnecessary tests and procedures, and importantly, working with providers in their community to manage the health of the population in that local market.

Also in 2018, Blue Cross introduced a novel reimbursement model for groups previously too small to take on risk independent of a larger provider system. This option allows providers interested in remaining independent to take accountability for the population they serve, be rewarded financially in a way that is sustainable, and to refer for health care services that they don't themselves provide without a bias toward the traditional facility-based providers. With the right incentives, these small accountable provider groups will be more likely to refer patients to the most-efficient care settings, often free-standing, and will more likely identify other innovative ways of delivering high quality, more affordable care.

Finally, since the launch of AQC 10 years ago, Blue Cross has embraced a different way of working with our network providers—given our shared risk and reward for achieving better cost, quality, and outcomes for our members. Since 2009, through our Network Performance Improvement Support Program (formerly known as AQC Support), Blue Cross has supported provider success in our risk-based contracts through a multi-faceted approach that includes deep and actionable analytics and reporting, onsite collaboration with clinical leadership on performance improvement goals and convening to share best practices and learn from industry experts on a wide range of topics that are critical to population health management success.

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: Not all providers are ready or interested in APMs, which needs to be considered.

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**	10,767	76
	Q2	9,026	83
	Q3	9,119	79
	Q4	10,352	102
CY2019	**Q1**	17,718	102
	Q2	14,486	103
	TOTAL:	71,468	545

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.

Please see HPC Payer Exhibit 1 attached

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: To increase claim payment consistency and transparency, BCBSMA set a course to revise several payment policies in support of an updated Outpatient Fee Schedule (OPFS) methodology. Examples of this include the following: (1) pricing certain services that have historically been delivered exclusively in an inpatient setting but there is now clinical evidence to support delivery in an outpatient setting; (2) aligning with CMS for the bundling of certain items (e.g. implantable devices, durable medical equipment, add on codes) into payment of "global" services such as surgical procedures, cardiac procedures, etc.; and (3) revised payment policy and billing guidelines to support proper adjudication of claims for routine and investigational services associated with approved clinical trials.

    b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.): BCBSMA understands the need to simplify our payment structures and have taken steps with this in mind. In 2018 we made the investment in the upgrade of our Diagnosis Related Grouping (DRG) software to accurately reflect current resource consumption, accounting for clinical severity, natively process industry standard coding conventions (ICD-10 diagnosis and procedure coding) and properly recognize advancements in clinical care over time. We also began the process to significantly reduce the level of intricacy in calculating reimbursement for hospital outpatient services. We are in the process of making changes that in base-level reimbursement to facilities that directly reflects the cost of the services, and that is consistent across our contracted provider network. We are also taking steps to consolidate the existing variable factors across the fee schedule. We have made significant progress in the normalization of fees within our fee schedule, utilizing the CMS resource consumption weight values as our primary source when available.

    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.):
        We use medical claims in the concurrent version of DxCG. This model has been tested and has demonstrated its value in terms of its comparative design structure and its ability to be understood.

        ☒ Risk structure (e.g., risk exposure, the allowed budget, exclusions, bonuses, quality performance, etc.):
        Our risk models cover the total cost of care. The models and incentives for the providers are highly aligned across HMO and PPO so that providers can manage in a consistent way. In both models, providers can earn a higher portion of a surplus (or owe less of a deficit) through quality performance, and exclusively on HMO providers can earn an additional bonus for strong quality performance.

        ☐ Use of pre-paid lump sum payments (rather than volume-based, fee-for-service interim basis payments):

Click here to enter text.

☐ 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 contracting strategy is based on quality and/or efficiency performance. BCBSMA's strategy around network contracting is anchored in a desire to maintain the affordability of care while creating provider incentives that work to reward improvements in the quality, safety and effectiveness of the health care our members receive. The underlying intent is to shift to a payment system that rewards providers for the quality, not quantity, of care our members receive. In support of this strategy, our payment reform contracts include both our HMO and PPO membership. Our PPO model, along with our AQC for HMO, promotes affordable care through paying doctors and hospitals based on the quality and outcome of the care they provide to our members. Our alternative payment methodologies for physicians and hospitals includes our AQC, PPO Payment Reform, and our Hospital Performance Incentive Program (HPIP). The significant benefits of the APM impact our members, providers, and accounts.

Members. This contract approach provides members with higher-quality, more-effective care that is more affordable. With increased transparency about health care quality and costs and through incentives we develop, our members become better educated health care consumers and are empowered to make the best decisions about their care.

Providers. This contract option supports providers who can deliver high-quality care, who can manage services efficiently, and who demonstrate improved patient health. The AQC gives these providers a competitive advantage in the marketplace. We share a reporting package of quality and efficiency data with providers.

Accounts. Employers benefit from this arrangement, as this system lowers costs through higher-quality care and results in more affordable premiums. With higher-quality care, our accounts also realize a healthier and more productive workforce. The PPO contract strategy has unparalleled advantages for large national accounts, enabling them to benefit from local innovation on a national platform.

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?

We have found that self-insured accounts prefer to see the majority of claims coming through the fee-for-service platform instead of a settlement approach. Additionally, member cost sharing still requires a fee-for-service billing platform so that copays/coinsurance/deductibles can be accurately recorded. Finally, it's unclear to what extent all provider organizations would be able to manage paying secondary providers for services not provided by the organization.

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?

95% on HMO and 99.8% on PPO

---- End of BCBSMA Responses ----

I affirm that the facts contained in the preceding responses are true to the best of my knowledge. This document is signed under the pains and penalties of perjury. I have relied on others in the company for information on matters not within my personal knowledge and believe that the facts stated with respect to such matters are true.

Sincerely,

Richard Lynch
Chief Operating Officer

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	1.8%	0.8%	0.3%	0.3%	3.2%
CY 2017	1.2%	0.5%	0.2%	0.2%	2.2%
CY 2018	2.2%	1.0%	0.4%	0.4%	4.0%

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 include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

5. Estimated changes in benefit buydown and demographics have stayed fairly constant over the past couple of years.

6. Changes in health status were estimated using DxCG risk scores.

7. Overall health status deteriorated every year from 2016-2018. Change in health status can potentially impact all components of trend except unit cost

8. Note that the data and trends above are limited to claim experience for Massachusetts residents in Commercial plans whose primary coverage is with BCBSMA

9. There is volatility in the components of trend due to macro and micro factors impacting health care trends including but not limited to economy, advances in medical tech and treatment including new drugs, increased consumer engagement resulting from new product designs and transparency tools

NOTE: The Health Policy Commission trend methodology set forth in this question reflects benefit buy downs. In order to respond reliably for each year requested, in its response BCBSMA has used a consistent methodology to allocate all components of trend. It should further be noted that any stated unit cost component of trend is not an accurate reflection of BCBSMA's actual contracts. The reported information should instead be used as directional information only and not as an absolute measurement. Moreover, in light of the fact that preliminary data was used, it is noted that these numbers will likely change.