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?

Boston Medial Center HealthNet Plan (BMCHP) is a non-profit health plan providing health insurance coverage to low income, underserved, disabled and elderly populations. Established in 1997 by Boston Medical Center, the largest safety net hospital in New England, BMCHP has more than 20 years of experience in ensuring quality, accessible care for complex, vulnerable populations. Through four MassHealth ACOs, the MCO program, the SCO program, and Qualified Health Plan (QHP) membership, most of whom are ConnectorCare members, BMCHP serve hundreds of thousands of individuals, most of whom are medically-complex and disabled, with an emphasis on addressing their social determinants of health.

BMCHP is engaged in three major efforts to reduce health care expenditures. Complex Care Management, Reduction in Pharmacy Spend and Behavioral Health.

1. **Complex Care Management** - We are implementing complex care management strategies focused on the top 2% of the highest cost members in our ACOs, who account for more than 20% of our overall cost. This effort is focused on reducing unnecessary use of the emergency department (ED) and inpatient facilities by addressing social, behavioral and medical barriers. Addressing such barriers enables enhanced member engagement with primary care and outpatient specialty care. The BMC Health System has embedded teams, including registered nurses and community health workers, within the majority of its ACO provider sites across the state and, as appropriate, pharmacists and pharmacy technicians as well. These teams utilize a risk algorithm and provider referral data to identify highest risk members. Team members are regarded as key members of the care team at each of the sites in which they are embedded, engaging with patients in the clinic during primary care visits, in the emergency department, in community settings and home settings.

   BMCHP is continuously modifying and improving the program, through the use of data to inform optimal panel size, length of engagement, team composition, and specific interventions. The true goal of the program is to provide the highest quality, coordinated care while reducing the overall cost of care through elimination of unnecessary or inappropriately located encounters. Additionally, we monitor Complex Care Management active and graduated members to judge long-term success of the program by tracking key indicators, including inpatient medical and surgical admissions, BH admissions, ED visits and readmissions.

2. **Reduction in Pharmacy Spend**
   a. **Formulary Change**
      BMCHP regularly conducts a comprehensive clinical and fiscal review of our formulary. A multidisciplinary committee with representation from across the state annually reviews, by drug class, the most recent clinical findings and literature, usage data for our member

population, and market trends to evaluate opportunities to change our preferred formulary agents, augment our prior authorization criteria (for non-preferred drugs) or otherwise reduce our drug utilization and per unit spend.

BMCHP identified two therapeutic classes with rising medication costs, and room for clinical standardization. We made more recently available agents preferred (over previously preferred, branded counterparts), negotiated rebates and lower price agreements for these preferred agents, and established more stringent prior authorization criteria for non-preferred agents. Through these efforts, BMCHP was able to shift the behavior of nearly 300 prescriber sites, 14,000 prescribers and 15,000 members, thereby saving millions of dollars.

b. Pharmacy Network

Among the various categories of rising medical cost, increasing retail pharmacy costs are a major concern across BMCHP's portfolio of products. Over the next year, with the help of our pharmacy benefit manager, we aim to conduct a comprehensive review of our agreements with our statewide network of retail pharmacies and potentially re-bid our entire retail network in an effort to achieve significant total cost of care savings.

3. Behavioral Health

The clinical management model used by BMCHP through our behavioral health vendor, Beacon Health Strategies, LLC (Beacon), is based on the philosophy that individuals living with mental health and substance use conditions can live purposeful lives by receiving timely care from high quality providers in the most appropriate, least restrictive setting. This philosophy informs our clinical management guidelines and techniques, which encourage well-defined treatment plans with clear objectives for recovery in the community.

Below are descriptions of some of the efforts from this past year.

- Licensed clinicians worked with providers to focus on right-sizing spend on new substance use disorder services. We introduced new benefits as part of the Medicaid benefit package, including Recovery Support Navigators and Residential Rehabilitation Services (RRS), which has quickly emerged as one of our 10 top services by paid amount on average. Using informatics and referrals, we work to identify individuals whose service utilization patterns suggest unnecessary spending and work to engage these individuals in a "person-centered" transition of care program to develop a care plan that emphasizes keys to treatment success, elimination of social impediments (e.g. housing instability), and coordination amongst providers and proper community supports. Similar efforts in other states have resulted in significant reductions in the likelihood of repeat acute treatment services or ED usage.

- Our vendor's clinicians collaborated with ACOs to understand cost drivers in both unit price and volume of service delivered, working to optimize services driving the strongest clinical outcomes. Since the introduction of the ACO model, average unit cost has increased by more than 3% across all levels of care, and combined with increased penetration of unique utilizers, achieving the sustainable growth benchmark of only 3.6% annually requires close partnership between ACOs and MCOs to ensure effective deployment of all health care dollars.

- Best-practice ABA service delivery emphasizes the use of home-based services to support members and their families in achieving a high-functioning lifestyle. Home-based services are both clinically and financially superior based on delivering improved treatment outcomes at a lower total cost. In 2018, the portion of center-based ABA services for BMC increased to 35.4% of total paid services, and 36.1% of units of service. We then worked to utilize home-based services if possible, resulting in a reduction in center-based ABA

service delivery down to 29.9% of total paid services in 2019, and 30.4% of units of service.

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

- Legal requirements and coverage mandates arounds substance use disorder combined with the shift to the ACO model of care delivery have driven a significant increase in BH utilization and spend without an appropriately calibrated risk-adjustment methodology reflecting the anticipated service utilization. A more accurate risk-adjustment model, which more appropriately accounts for SUD-related services would help ensure the appropriateness and effectiveness of dollars spent on BH.

- As the ability to manage SUD services through traditional utilization review has decreased, BMCHP has actively implemented initiatives targeted toward both members and providers with the goal of assuring high-quality care and decreasing the likelihood of relapse following a detoxification. Addressing the opioid crisis requires supporting individuals' informed knowledge of treatment options. Efforts to eliminate utilization management have hindered our ability to educate members about the full range of evidence-based treatments and the best approach for each individual patient on a timely basis. For example, Medication Assisted Treatment (MAT) is proven to reduce rates of relapse, but it remains underutilized compared to detox. Revising Chapter 258 or the regulations promulgated under Chapter 258 would allow us to guide members towards evidence-based care pathways on a more timely basis. BH clinical staff engages providers to assist with assessments, ensure effective discharge-planning, and connect members with care managers, but restriction of this ability has resulted in greater utilization of detox without improving utilization of proven treatment pathways such as MAT. MAT should be more available in emergency departments and the number of providers with authority to prescribe MAT should be increased to reduce a significant barrier to individuals accessing MAT.

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.

Since inception, BMCHP has primarily driven models of care and risk share methodologies from the perspective of the PCP as the care manager. The current MassHealth Accountable Care Partnership Program is also predicated on the concept of shared risk for enrollees attributed to the ACO PCPs. The Plan and PCPs have shared goals to increase access, and improve quality of care. Through the ACO program, we have seen improvements in ensuring access to care, better communication between the PCP and other members of the health care team, including behavioral health coordination.

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.

- Through our partnership with Beacon, BMCHP is seeking to expand the use of collaborative models that improve integrated care, including expanding the Massachusetts Child Psychiatry Access Project (MCPAP) to offer substance use consultations to PCPs under the MCPAP program.
- BMCHP is using population-based analytics to identify individuals at risk of acute behavioral health need. Beginning in July 2018, we introduced enhanced analytic capability, which employs machine learning and natural language processing to identify members most at risk of an imminent inpatient admission. These predictions enable care managers to focus on proactively outreaching to at risk members to refer them into case management before their condition escalates requiring inpatient care. BMCHP is confident that this advanced analytics model is capable of saving us more than $500,000 through avoiding preventable services.
- BMCHP is also committed to **improving the quality** of SUD care in several ways:
  - *Integration of new substance use disorder levels of care* (including RRS, recovery coaches, and recovery support navigators). BMCHP, along with our BH vendor collaborates with state partners and other key stakeholders, including actively participating in the development, including performance specifications and medical necessity criteria, of Recovery Coaches and Recovery Support Navigators, which were implemented on July 1, 2018. BMCHP has also worked together with our vendor to advocate for policy changes to implement evidence-based approaches to address the opioid crisis and SUD generally.
  - *Expansion of SUD provider quality initiatives, including ATLAS and ASAM training.* Starting in March of 2018, Beacon on behalf of BMCHP, engaged with 100 percent of our higher level of care substance use provider network through face-to-face visits, conversations with leadership, and review of treatment records to assess for and promote quality improvement. Based upon the data and analysis, guidance was offered to providers on best practice models, feedback via individualized provider data, and technical assistance with identified challenges or barriers.
  - *MAT micro-grants.* BMCHP's vendor is also conducting a MAT micro-grant program, targeting applications from providers with innovative ideas on how to increase access and adherence to evidence-based MAT within the Massachusetts community.
- BMCHP has expanded the use of telehealth for mild to moderate behavioral health needs as a viable means of expanding access to ABA services. Arising from a severe shortage of Board Certified Behavioral Analyst (BCBA) providers, the use of a HIPAA-compliant, synchronous video app allows for increased access to ABA services by allowing BCBA supervision and parent training to occur. Telehealth is now being used for members in rural areas with no access to a BCBA provider and in urban areas where transportation is limited for the member or traffic, road hazards, excessive tolls or safety concerns prevent the BCBA from meeting in the member's home. ABA therapy continues to be provided directly in the home by a behavioral technician.

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?

- **Screening** - Provider should regularly use evidence-based screening tools and SBIRT (Screening, Brief Intervention, Referral to Treatment) methods to help identify and triage specialty needs as early as possible. In 2017, BMCHP and our BH vendor collaborated on a grant-funded program to provide SBIRT training to 6 PCP sites in MA and help connect PCPs to behavioral health providers within our BH network. The initiative was targeted toward screening of adolescents and promoting more timely identification and referral to treatment when substance misuse indicators were present.
- **Coordination** - Providers should strive to match patient acuity to the right healthcare "quarterback" – i.e. individuals with mild BH needs managed by PCP with appropriate wraparound supports, while those with serious mental illness should be managed by a behavioral health specialist.
- **Collaboration** - Providers should collaborate on implementing a single integrated care plan that follows an individual longitudinally throughout their care pathway.
- **Consultation** - Providers should be encouraged to access expert consultation and resource hubs as needed. Proven models that support this effort include Project ECHO, the Vermont Hub-and-Spoke model, and other collaborative care initiatives.

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?

BMCHP would like to see **improvement in ACO rates** especially the rates for the most complex members – e.g. members with housing insecurity, SUD and serious mental illness.

- We would also appreciate better alignment of incentives to improve quality and patient experience with ACO efforts to decrease unnecessary utilization and reduce total costs of care across the care continuum. Incentives should:
  - Ensure ACO per-member per-month (PMPM) payment adequately funds BH acuity;
  - Expand efforts for ED diversion and increase outpatient urgent care access; and
  - Hold inpatient psychiatry providers accountable for readmissions and appropriate post-discharge planning.

Invest in crisis services for behavioral health. Massachusetts has been a pioneer in developing crisis services for those with behavioral health needs. The ESP has been a critical component of the Commonwealth's crisis system, but there is opportunity for improvement. For example:

- *Improve the capabilities of Emergency Service Programs (ESPs) to deal with SUD-related crises.* The opioid epidemic has increased the need for ESPs, who are traditionally trained to deal with mental health conditions and to triage those individuals who present with co-morbid SUD conditions. ESPs would benefit from dedicated training on dealing with individuals with SUD-related crises.
- *Continue to improve on the quality and accessibility of mobile crisis units.* While many ESPs have the capability to deploy mobile teams, improving psychiatric support to these units will potentially increase their utilization. The scarcity of MD-level supports has limited the ability of mobile teams to engage members where they are.
- *Expand new models of crisis care, such as the Certified Community Behavioral Health Clinics model.* Massachusetts can benefit from funding a more robust crisis provider network. Best-in-class crisis systems include a comprehensive array of crisis providers including peer-operated alternatives like those operated by META Services in Phoenix,

AZ. Alternative service providers in other markets and have seen a significant decrease in ED utilization and short-term incarceration resulting from coordination across a system of mobile crisis teams and crisis respite centers.

- *Continue to invest in statewide, payer-agnostic infrastructure (e.g., MABHA website).* Massachusetts should further invest in its crisis services to expand the Commonwealth's ability to respond to mental health crises. That investment should focus on a more robust contact center that allows different modalities of engagement, as well as a mobile response team prepared to respond in rural and urban areas. Payers could also be mandated to pay for BH crisis services, commensurate with emergency treatment payment requirements.

Expand models supporting use of alternative settings for the delivery of behavioral healthcare, including: telehealth, home-based care for Applied Behavioral Analysis services, and ambulatory detox.

- *Emergency Triage, Treat, and Transport (ET3) model for alternative locations for EMS transportation*. We support CMS' proposed usage of the ET3 model, which encourages integration of behavioral health clinicians into the EMS care team and subsequent transport to alternative behavioral health settings as destinations for care. Opportunity for transport to alternative settings offers an important opportunity to reduce utilization and burden on high-cost ED settings.
- *Telehealth services*. Massachusetts has historically had restrictive telehealth requirements, but has been more permissive of expanded use of telehealth more recently. We support further expansion of telehealth, especially to reach members in rural and underserved communities.

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	Minor Contributing Factor
Aging of your members	Not a Significant 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)	Major Contributing Factor
New, relatively less healthy patients entering your patient pool	Major Contributing Factor
Relatively healthier patients leaving your patient pool	Major Contributing Factor

Factors	Level of Contribution
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Not a Significant 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.

- **Screening** - BMCHP uses analytics is to ensure accuracy in the coordination between funding and acuity of members, which has historically been underreported on medical claims. We work with ACO partners to ensure that, at the point of care, members are being screened for various chronic conditions and social determinants of health, such as obesity and homelessness. While we are not directly responsible for creating and administering this program, we work in tandem with ACO partners to provide the necessary analytics to target these screening interventions for investment. Specifically, we leverage claims and enrollment data to determine whether particular chronic diseases are likely to be underrepresented in our population, to evaluate the changing prevalence of these chronic conditions, to assess the potential impact on risk scores, and to track against what we believe the population prevalence to be.

- **Coding Accuracy** - Additionally, BMCHP works with nurse coders to periodically review member charts to ensure that the diagnoses submitted on claims are consistent with the doctor's notes. Some of the consistent themes we have identified in charts that needed adjustment were members being under diagnosed or missing follow up on lifelong chronic conditions, improper or incorrect coding of diagnoses within the charts, and improper or inadequate coding of co-morbidities such as obesity, smoking, and hypertension. Failure to include these diagnosis codes results in a lower risk score, underrepresenting the actual acuity of the member. Like our work with our ACO partners, the goal of retro- coding reviews is to ensure accuracy and coordination between actual acuity of members and risk score calculation. Accuracy in coding ensures greater accuracy of funding determinations and ensures our ability to provide the care and resources that the member needs.

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. Note that BMCHP is part of the Boston Medical Center Health System, but this chart reflects the priorities of BMCHP.

Area of Administrative Complexity	Priority Level

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
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	Low
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	Low
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	Low
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	Low
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Low
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

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

[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

your organization's calendar year 2018 volume for the following transaction types in the table below. Please also describe any barriers to performing all of the listed transactions entirely electronically.

Provider adoption continues to be a barrier, but BMCHP is constantly working with providers to educate and train them on opportunities for simplification.

Transaction	Manual or Partially Electronic	Fully Electronic, in Accordance with ASC X12N
Eligibility and Benefit Verification	70,822	46,968,339
Prior Authorization	104,320	98,100
Claim Submission	261,441	5,804,455
Claim Status Inquiry	179,776	893,720
Claim Payment	129,005	106,542
Remittance Advice	1,811	233,736

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.

BMCHP primarily serves the state Medicaid programs and does not offer a PPO product.

The BMC Health System partners with four hospital system-led ACOs across the state: Signature; Southcoast; Mercy; and the Boston Accountable Care Organization (BACO). BMCHP's affiliate Boston Medical Center (BMC) is the anchor institution of BACO. As part of the Total Cost of Care management strategy, each of the ACOs has implemented strategies to direct volume to high-quality, lower-cost sites of care. Directing clinical services to cost efficient, collaborative providers contributes to lower cost of care and improved continuity of care for members. BMCHP also minimizes costs by maintaining a low administrative rate and leveraging the plan's multi-product, multi-state (Massachusetts and New Hampshire) operations to generate economies of scale.

We have increased use of alternative payment methodologies (*i.e.* assuming full risk in the four ACOs) and we have worked with our ACO partners to develop strategies that reduce unnecessary utilization, such as low-acuity emergency department utilization.

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**	44	7
	Q2	42	3
	Q3	24	2
	Q4	39	12
CY2019	**Q1**	68	14
	Q2	63	4
	TOTAL:	280	42

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.

For years 2016-2018, the impact of benefit buy-down is negligible. The majority of BMCHP's membership in years 2015-2017 came from the MassHealth program, in which membership cost sharing is minimal and stable from year to year. The remaining membership came from the

Connector Care program, which also has minimal member cost sharing. In 2018, BMCHP's membership through Connector Care increased significantly, but because member cost sharing remains minimal, the benefit buy-down does not significantly impact the overall MA claims trend.

The demographic and health status components of trend are reflected in the utilization component of trend. BMCHP's QHP membership doubled from 2016 to 2017 and continued to grow in 2018. This increased membership also led to a change in demographic and health status, which resulted in lower utilization in 2017 but stabilized in 2018 for the total MA population. The higher cost trend for 2018 is driven by Rx and Behavioral Health, which comprised about 40% of the total medical claims. The higher overall trend is also driven by change in health status of the total MA population. The combination of newer BMCHP members exhibiting relatively less healthy status combined with relatively healthier members leaving the BMCHP risk pool has resulted in increased medical expenditure trend in 2018.

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: BMC HealthNet Plan utilizes payment policies and procedures in accordance with MassHealth, CMS, and industry standard coding, billing and reimbursement practices.

    b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.): BMCHP primarily uses Medicare and Medicaid rate and reimbursement methodologies including: All Patients Refined Diagnosis Related Groups; Medicare Severity Diagnosis Related Groups; Enhanced Ambulatory Patient Grouping; Fee Schedules; and case rates. BMCHP has made a conscious effort to limit charge based reimbursement methodologies.

    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.):

        ☐ 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: As a Medicaid plan, BMCHP remains vigilant about the use of taxpayer dollars. Through our four ACOs we have implemented a total cost of care management strategy designed to direct volume to high-quality, lower-cost sites of care. BMCHP has increased use of alternative payment methodologies (*i.e.* assuming full risk in the four ACOs) and we have worked with our ACO partners to develop strategies that reduce unnecessary utilization, such as low-acuity emergency department utilization.

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?
    Provider risk tolerance for participating in a pre-paid lump sum or capitated reimbursement methodology is one of the primary barriers to transitioning from FFS. Providers often require a period of "upside only" shared savings initiatives as a means to

determine readiness to enter into a risk model. For a plan whose predominant population is MassHealth members, providers are more likely to consider capitated or bundled reimbursement if they participate in risk programs with their MA and/or commercial relationships.

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?
Effectively, 100% of our reimbursement for medical services is fee-for-service. Our current shared savings programs are paid FFS and settled on trended performance improvement.

HPC Payer Exhibit 1

All cells shaded in BLUE should be completed by carrier*

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 2016	4.02%	6.79%	-2.58%	0.83%	9.05%
CY 2017	3.74%	-4.28%	2.78%	0.33%	2.39%
CY 2018	5.25%	4.50%	-0.25%	0.62%	10.40%

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.