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?

Harvard Pilgrim Health Care (Harvard Pilgrim) understands the importance of reducing health care spending and continues to manage costs aggressively while simultaneously promoting the delivery of high-quality, high value care for consumers. ***As stewards of our customers health care dollars, we maintain a consistent focus on creating value within the health care system for our members.*** We take a multi-prong approach in managing health care expenditures that includes: leveraging value-based contracts and analytics to identify opportunities for cost reduction and care improvement; engaging in innovative pharmacy programs to manage high-cost drugs; and promoting behavioral health integration with primary care. By aggregating resources in these areas, we strive to transform the health care experience of our members. Below are examples of the efforts Harvard Pilgrim is undertaking.

Alternative Payment Models
Insurers and providers must redouble efforts.

As the Commonwealth builds out to capacity its adoption of alternative payment models, it's important that this progress does not stagnate and that we continually look to transform how we deliver and pay for care. Since the adoption of Chapter 224, the reduction of fee-for-service contracts has facilitated new and innovative relationships with payers and providers. Still, there are tangible differences between providers, both contractually and in the depth of the relationship, that have yielded varying results in the efficiency with which care is delivered. Moving forward, we must redouble our efforts to understand, replicate, and expand on those payment models and payer/provider relationships that promote the most effective and efficient means of delivering care to Massachusetts residents.

For our part, Harvard Pilgrim has sought to employ an innovative contracting strategy, improve upon our analytical and care management capacity, strengthen payment integrity programs, and act as a guide to foster patient placement in highly effective and lower cost settings. These efforts include:

- Contracting Strategy: ***Harvard Pilgrim negotiates renewal contracts below the annual growth benchmark set by the state.*** In the last year, we developed and deployed new value-based models to feature more refined care improvement mechanisms, including enhanced contract performance models and menu-based

quality advance (pay-for-performance) programs that give providers the flexibility and support in targeting care improvement that is most meaningful for their patients. ***In addition, we are focusing efforts on pricing rationality with providers to ensure our contracts are not only competitive in aggregate but also at a service category level.*** We continue to see the benefits of value-based contracts with lower risk adjusted medical cost and trends, and better performance on quality metrics (e.g. HEDIS measures) for providers on value-based contracts compared to those on more traditional reimbursement methodologies. TME trend of providers on a value-based contract is lower by 1.4 percentage points than providers not on a value-based contract and providers on value-based contract have a 6.5 - 8% lower risk adjusted TME than those not on value-based contract. From a quality/HEDIS measurement perspective, we have found that members managed by providers on value-based contract have significantly higher compliance rates for chronic (e.g. comprehensive diabetes care) and preventative (e.g. breast and cervical screenings) than members managed by providers not on a value-based contract. For example, screenings for breast and cervical cancer measurements, providers on value-based contract had a 22 - 24% higher compliance rate, resulting in earlier detection and treatment.

- Analytics & Care Improvement: ***We have refined our provider analytics and engagement strategies to help providers better identify and capitalize on opportunities to close gaps in care, apply best practices, monitor drug compliance, and more.*** Specific areas of focus include reducing avoidable emergency room utilization and hospital readmission rates, as well as identifying practice pattern variations among providers. We have also enhanced our strategic insight and decision support, establishing the frameworks to work even more closely with providers to develop goals based on their individualized data, execute a strategic plan, and monitor success.

- Payment Integrity Programs: Harvard Pilgrim maintains a portfolio of payment integrity programs for providers that support accurate coding and compliance with payment and medical policies. ***Collectively, our payment integrity programs delivered a 2.8% cost savings in medical expenses in 2018, which is typical of our experience year over year since 2016 when we strengthened our code editing and audit programs.*** Areas of focus include correct coding initiatives and more robust expectations on appropriate medical record documentation. Our portfolio of payment integrity programs is detailed in our response to question 3B below. In addition to the programs outlined in that response, we also have established a claim-based predictive scoring program that examines claims in real-time, using a variety of analytics to detect and flag coding outliers (for things such as unusual repeat visits, upcoding, incorrect modifier use, unusual frequency of services, etc.). And our coding analysis and education program analyzes provider coding and conducts outreach to outlying providers, providing education and follow up at regular intervals to track progress.

- Lower Cost Settings & Patient Convenience: Harvard Pilgrim wants to ensure patients receive the right care in the right setting and does so in a variety of ways. Our tiered and limited network products direct members to high-quality, lower cost providers. Our member savings/reward program, Reduce My Cost, enables members to speak with a nurse over the phone to find lower-cost providers for elective, outpatient medical procedures and diagnostic tests, and rewards members for selecting a lower-cost provider. ***In addition, we have established several pilots and***

initiatives that not only drive care to lower cost settings, but also deliver greater patient convenience, including:

- *Outpatient orthopedic program* — Harvard Pilgrim partnered with ambulatory surgery providers and developed reimbursement methods to support the delivery of joint replacement surgeries in outpatient setting at costs that are approximately 20% lower than in the inpatient setting.

- *Hospital at home program* — Our hospital at home program enables members with lower-acuity conditions to be treated in the home rather than the hospital, as appropriate, offering members greater comfort and convenience while lowering costs. These programs have delivered average savings of nearly 15% in comparison to inpatient settings. We are currently looking for additional partners to expand this program.

- Reducing Avoidable ER Use: Additionally, Harvard Pilgrim is placing a heavy emphasis on reducing avoidable emergency room use. Our efforts ensure that there is appropriate collaboration between patients, employers, and physicians to meet the needs of all patients. ***Education on the many non-emergent care options available to patients, as well as alignment of our policies, contracts, and quality grants, foster appropriate emergency room use and are important tools to meet our goals.***

Prescription Drug Costs
Alternative payment arrangements and utilization management help mitigate costs.

Drug companies are making great strides in producing new drugs that can dramatically improve or even save people's lives. However, the cost of these drugs is increasing at an unsustainable rate and insurers are left to grapple with the expense. In addition to utilizing traditional cost savings initiatives led by our pharmacy benefit manager, we aggressively pursue alternative payment arrangements with drug manufacturers and have established a utilization management program to help mitigate costs and ensure our members have access to the drugs they need.

- Innovative Programs to Manage High-Cost Drugs: Harvard Pilgrim has led the way nationally in developing innovative contracts with pharmaceutical companies to control costs. We have negotiated over 15 value-based contracts, including contracts on high priced gene therapy drugs, which are one part of the solution to addressing the high cost of many drugs. ***While value-based contracts have not yet extended to the highly utilized oncology drugs, we are having conversations with clinical leadership at major cancer centers like Dana Farber to discuss how they might support arrangements designed to drive use of high value oncology drugs.*** We have been a long-standing supporter of Dana Farber's Clinical Pathways Program, which creates a virtual roadmap of treatments available for each type and stage of cancer. The Clinical Pathways Program has shown a 30% decrease in costs for participating patients. We are also actively engaged with national multi-stakeholder groups, including MIT-NEWDIGS, the Duke-Margolis Center for Health Policy and ICER, to come up with new approaches to address these issues.

- Utilization Management Program: Harvard Pilgrim has a medical drug utilization management program, administered by our vendor CVS-Novologix, to ensure the

appropriate use of many high-cost drugs. Our medical drug management program and our medical policies require prior authorization for medical necessity and treatment per the FDA labeling guidelines for indication, dosage and frequency for more than 200 medical drugs and is enforced through claim edits. ***Additionally, we have a voluntary site of care program for Remicade and IVIG, offering the option for treatment in the home, a less costly setting, when clinically appropriate.*** Remicade treats conditions like Chron's disease, ulcerative colitis and rheumatoid arthritis, while IVIG is most frequently prescribed for conditions associated with the nervous and immune systems.

Behavioral Health / Primary Care Integration
PCP access and care coordination are critical for patient's overall wellbeing.

There is a fundamental connection between physical and mental health with mental health playing a critical role in all aspects of a patient's overall well-being. Physical health can exacerbate mental health just as mental health can exacerbate physical health. And primary care providers, who have the most consistent contact with our members, are especially important in the coordination of treatment for the whole person. We encourage primary care providers to screen for behavioral health conditions and work with them to ensure our members are receiving the appropriate care.

- Supporting PCP Access Points to Behavioral Health Care: We encourage and expect our in network primary care providers to screen, treat and/or refer members who have depression or substance use issues. ***Contracts for our pay for performance program for primary care physician groups include behavioral health measures for initiation and engagement in alcohol and other substance use treatment and anti-depressant medication management.*** We have a robust behavioral health network and regularly monitor performance of the network regarding member access to care. We encourage use of Doctor on Demand, a telehealth service that includes behavioral health services, and Virtual Visits, a telehealth service maintained by our behavioral health vendor Optum Behavioral Health (Optum), to increase access. Optum has express access appointments to aid in facilitating quick access to outpatient behavioral health treatment and a psychiatric consult service that can be accessed by primary care.

- Expanded Care Coordination: At Harvard Pilgrim, we make a concerted effort to identify, outreach and engage members when they are at risk for increased cost expenditures and health instability. ***Utilizing algorithms that not only identify members with current conditions, high utilization, and frequent acute care (i.e. emergency room, inpatient), we also identify those with rising risk – where impactability on the outcome is at its greatest.*** Earlier this year we started sharing medical and pharmacy claims information with Optum to improve identification of members with medical behavioral comorbidities. By integrating our platforms and workflows, we are better able to broaden our reach within the membership population and identify addressable clinical intervention opportunities for members with well-managed, but complex, clinical conditions. This integration allows our medical and behavioral health care managers to collaborate to ensure members are receiving the right care at the right time in the right setting.

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

- **Evaluate Urgent Care, Ambulatory Surgery Centers, and Alternative Sites of Care:** A trend in the market is the growing number of provider and hospital organizations opening urgent care and/or ambulatory surgery centers as a means to offer patients lower-cost, more convenient settings for care. While this appears to be a positive development that may reduce health care costs, we believe it would be worthwhile for health policy organizations to evaluate the expected and actual results of this occurrence, with a lens on whether the long-term effect will be one of reducing health care costs or potentially increasing overall demand for and consumption of health care services.

- **Adopt Surprise Billing Protections for Patients:** Certain provider specialties — such as emergency room physicians, radiologists, anesthesiologists, pathologists, and ambulance providers — choose to provide services without participating in health plan networks. Patients are adversely affected when they unknowingly see one of these out-of-network providers and receive a large "surprise" medical bill. Harvard Pilgrim has noted that some other New England states have adopted legislation that prevents surprise bills and reimburses these providers more consistently with contracted providers, and we would advocate for Massachusetts to enact similar legislation.

- **Address Prescription Drug Costs:** FDA approval of a drug for an unmet need, particularly for life-threatening conditions, gives drug manufacturers a blank check to set ultrahigh prices, some more than $2 million. These high costs are ultimately borne by all via higher premiums. The prices of these life changing prescription drugs that we need to cover for the sake of our members need to be tied to a benchmark or some other objective measure of value as determined by an organization like ICER.

- **Allow Flexibility For Prescription Drug Alternative Payment Arrangements:** We need new financing mechanisms that allow health plans to pay a fair price for drugs. For drugs that promise a lifetime cure, we need to be able to pay over a number of years and only continue to pay if the drug continues to work. This would require changes in the Medicaid best price rules, as they do not account for alternative payment arrangements that are tied to efficacy rather than those based solely on negotiating leverage. The Duke-Margolis Center for Health Policy recently issued a policy brief, *Clarifying Medicaid Best Practice Regulations In the Context of Value-Based Payment Arrangements*, that makes two suggested edits to the bundled sales policy that would accommodate alternative payment arrangements: (1) clarify that "performance requirement" extends to the performance of the product itself; and (2) clarify that "a bundled sale does not require more than one product as long as the sale contains a performance requirement, which…could include the performance of the product itself in achieving specified outcomes."

- **Remove Barriers to Expanded Care Coordination:** We believe that integrating behavioral health and primary care is essential not only to lower costs, but more importantly to ensure our members are receiving the right care at the right time in the right setting. We have integrated our medical, behavioral health, and pharmacy

claims information so we are better able to broaden our reach within the membership population and identify addressable clinical intervention opportunities for members with well-managed, but complex, clinical conditions. However, federal regulation 42 CFR Part 2 continues to be a barrier to sharing information and collaborating between behavioral health and primary care providers. We encourage the HPC to work with the federal government to achieve full alignment with HIPAA as it is an appropriate model for sharing information for care management purposes.

- **Refinement of Cost Trend Targets:** The state medical cost trend targets have served a valuable role in sensitizing and aligning providers, payers and purchasers around controlling costs in the marketplace. In our current contract renewal cycle, we are observing possible shifts in consideration of the target by some providers. While we understand that the targets are not intended to specifically guide negotiated unit cost increases, we have observed:

    - More highly leveraged providers position the cost trend target as an expected rate increase – irrespective of their relative cost position
    - Some providers requesting increases 2 – 3 times the cost trend target
    - Challenges by providers of the relevance of the target - particularly as it relates to commercial payers - citing lower government payer reimbursement

  We suggest the HPC consider a study of future refinements of the cost trend targets to ensure that it may continue to support overall management of health care spending.

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.

   Harvard Pilgrim understands the importance of primary care and behavioral health access and prioritizes these services in a number of ways — including through our value-based contracts that reward the delivery of well-coordinated, cost effective care; products and plan designs that require coordination of care through a primary care provider and ensure access to behavioral health care; and our quality grant programs that support providers in improving care delivery and reducing costs.

   Harvard Pilgrim's Quality Grants Program, which is in its 19th year, supports physician practices throughout our service area by funding clinical initiatives aimed at improving care delivery and reducing costs, including those focused on primary care and behavioral health. To date, we have awarded more than $2 million to roughly 200

providers, with nearly 20% of our grant dollars awarded since 2016 focused on substance abuse initiatives. Examples of recent grants include: collaborative care models for depression in diverse primary care practices; pain management and opioid addiction; behavioral health integration in primary care; substance abuse avoidance and intervention; care coordination for complex and chronic care; improving the health of patients with COPD through primary care and specialty partnerships; and discussions about serious illnesses in the primary care setting.

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 Optum, contracted behavioral health providers are rewarded for achieving key quality and cost metrics. Through value-based contracts, cost, quality and outcome metrics are tied to provider incentives and are used to tier the provider network. We incentivize providers using a combination of member improvement metrics, measured through a member-reported wellness assessment, case-mix adjusted average number of visits and cost of the outpatient episode. ***We align our incentives with our providers to strengthen the provider partnership and promote positive member outcomes.*** Inpatient providers with a value-based contract have decreased readmission rates by 15 – 20%.

Value-based contracts also help drive whole-person care approaches by incentivizing coordinated, collocated and fully integrated models of integration. In turn, these incentives can improve member outcomes and the overall system of care. As mentioned in question 1A above, our behavioral health and medical care managers are an integrated care team that focus on relapse prevention planning, minimization of disease progression, medication reconciliation and provider education. The clinical model of care has support from an integrated care coordination platform, which leverages intelligent automation to remove administrative burdens and enables the integrated care management team to spend more time with members. It builds an integrated plan of care that enables prioritization and flagging of both member and care team goals.

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?

We would encourage provider organizations to work collaboratively with us to ensure that members are receiving the care they need and that early signs of member deterioration are not missed. ***We utilize emerging risk algorithms that allow us to identify members in outpatient treatment who are showing signs of heightened risk or are not progressing in treatment.*** Our care advocates intervene in these situations by reaching out to the member's treating provider to discuss treatment plans and/or unique needs. When appropriate, our psychiatrists will hold peer-level discussions to enhance treatment planning for improved outcomes.

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?

As mentioned above in question 1B, federal regulation 42 CFR Part 2 is a barrier to better case management because it prohibits information sharing and collaboration across settings. ***Changes to 42 CFR Part 2 would allow behavioral health and primary care providers to share information and treat the whole person by collaboratively creating the best treatment plan for the patient.*** Further, additional funding is needed for stop stigma campaigns surrounding mental health and its treatment. The stigma associated with mental health disorders stops individuals from getting appropriate treatment. Continued communication and understanding around mental health conditions will eliminate misconceptions and get people the help they need.

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	Minor 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	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Minor 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.

Harvard Pilgrim maintains a portfolio of payment integrity programs to ensure that providers code correctly and that risk scores accurately reflect the need for medical services. This includes our ACA risk adjustment data validation program, in which Harvard Pilgrim, through a vendor partner, reviews a sample of medical charts for audit and to identify gaps in care. In addition, our payment integrity and auditing programs include:

- **Coding advisor program** — In collaboration with a vendor partner, Harvard Pilgrim reviews the use of evaluation/management, psychotherapy, and inpatient and subsequent observation codes and identifies providers whose billing patterns vary from their peers. The claims are returned to providers for confirmation and provider education is conducted as needed.
- **Data-mining based audits** — These audits identify and validate atypical provider billing patterns, contract and payment policy noncompliance, Medicare coordination of benefits (COB) issues, etc.
- **DRG validation and chart reviews** — On-site diagnostic related groups (DRG) validation and chart reviews to ensure that paid claims are supported by the appropriate clinical documentation.
- **In-line Quality Review** —A Harvard Pilgrim quality analyst reviews daily a randomly selected sample of manually processed claims and reviews them for accuracy.
- **Random Post-payment Audit** — A random sample of claims, stratified by dollars paid, is reviewed with a focus on system configuration, contract compliance, member eligibility, and benefit accumulations.
- **High Dollar Audit** — For this pre-payment review, quality analysts review all qualifying high dollar claims.
- **High-cost injectable drug audits** — These audits review high-cost injectable drug claims to validate code description, dosage, accurate and complete physician orders, and dispensed and administered quantity.

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.

The relative rankings below reflect Harvard Pilgrim's assessment of where the greatest opportunities for closer alignment and simplification exist. While a rating of "high" reflects that we see strong prospects for alignment and simplification, a low priority level

may reflect that we have made great strides in achieving more effective, efficient processes and the prospects for further refinement or alignment are not as robust.

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

We have promoted the use of electronic tools for common transactions with great success. As the chart below illustrates, there is widespread adoption of electronic transaction tools in our network. For example, 99% of our eligibility and benefit verification is performed fully electronically, and 97% of our claims submissions are fully electronic. Factors that prevent full adoption include the fact that some small physician practices don't have the infrastructure needed to administer electronic transactions and the lack of national standards for sharing clinical data means vendors, providers, payers and intermediaries all make independent decisions on what should be submitted and how, making fully electronic submission and exchange difficult.

Transaction	Manual or Partially Electronic	Fully Electronic, in Accordance with ASC X12N
Eligibility and Benefit Verification*	293,852	33,294,757
Prior Authorization*	81,258	69,735
Claim Submission	515,278	13,623,508
Claim Status Inquiry*	2,239,523	1,792,836
Claim Payment	1,993,688	11,687,120
Remittance Advice	1,269,527	11,938,176

*Includes medical/surgical data only

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.

We have a longstanding commitment to alternative payment arrangements and utilize value-based contracts as the primary reimbursement method for our network, with more than 80% of our total (fully and self-insured) HMO/POS membership managed

[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

under some form of APM. In the remaining cases, our physician compensation includes a quality program that rewards high performance on key HEDIS and efficiency measures.

While we also have the capability to support PPO APMs, our experienced provider groups are more cautious about embracing PPO risk than they have been with HMO/POS risk due to the product's inherent design, which allows patient freedom to seek health care from providers and specialists of their choice. This greater movement among and between provider practices makes referral management and cost- and quality-focused managed care efforts more challenging. An additional challenge is that our PPO risk populations at the practice level may not always be of sufficient size to support a viable risk unit. Even for those with suitable membership, we need to be cautious as providers expect and demand certain protections due to the nature of this product, which may lead to unintended consequences in driving up costs vs. being paid on a fee-for-service basis.

Over the last several years, we have continued to invest resources to optimize the use of payment models that deliver the appropriate value and quality for our members. Some recent initiatives in support of value-based contracts include:

- **Enhancing our VBC models:** In the last year, we revamped our value-based contracting models to feature more refined care improvement mechanisms that give providers the flexibility and support in targeting care improvement that's most meaningful for their patients.
- **Provider engagement and analytics:** We have also enhanced our provider engagement efforts with improved support tools and analytics. Our refined analytics give our provider partners the actionable information they need to identify and capitalize on opportunities to close gaps in care, apply best practices, monitor drug compliance, and more. Additionally, through regular, focused meetings with provider partners we strengthen existing collaborations and develop strategic plans for new payment model opportunities.

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**	3,131	491
	Q2	2,328	487
	Q3	1,379	426
	Q4	1,259	455
CY2019	**Q1**	2,539	613
	Q2	2,255	547
	TOTAL:	10,636	3,019

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 find Harvard Pilgrim Payer Exhibit 1 attached, which demonstrates the total allowed medical expenditure for CY2016 to CY2018.

(a) The impact of demographics on actual observed allowed trend is 0.6% for 2016, 0.9% for 2017, and 0.6% for 2018.

(b) The impact of benefit buy down on actual observed trend are 0.8% for 2016, -0.1% for 2017, and -0.5% for 2018.

(c) The impact of health status on actual observed trends are 5.9% for 2016, 4.9% for 2017, and 4.1% for 2018.

Health status excludes the impact of demographics.

The buy down factors have been revised to reflect the impact on allowed dollars, rather than paid.

The demographic, benefit and health status trends would mostly impact service mix and utilization trend.

In addition to the above, please also note:

- Historic annual trends are provided on an observed allowed basis for both fully insured and self-insured commercial business in the rating state of Massachusetts. Medicare products were excluded.

- Trends include non-claim based expenditures and are based upon actual observed claims and non-claim base trend.

- Valuation Date: 7/31/2019, with IBNR completion factors for Medical only.

- Provider mix is not separately tracked at this time.

- Utilization represents admits per thousand for Inpatient Facility, services per thousand for all other Medical categories and 30-day supply count for all Prescription Drug categories.

- Unit cost trend has assumed that the trend for self-insured Pharmacy was the same as fully insured.

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:

    Our payment policies and procedures are based on nationally recognized guidelines, such as those from the Centers for Medicare and Medicaid Services, assessments of industry standards established by national and local competitors, and evidence-based clinical literature.

    b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.):

    We have adopted standard reimbursement methods for hospital and professional services. In Massachusetts, more than 80% of our physicians are reimbursed under APM contracts. When fee schedules are used as the underlying reimbursement structure, they apply for 99% of our contracted providers for professional services. In addition, approximately 75% of our contracted hospitals are reimbursed for inpatient services using a DRG payment methodology and for outpatient services using a fee schedule.

    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 rely on DxCG methodology, specifically Verscend's (now Cotiviti) risk adjustment and predictive software, to apply health status adjustments under our APMs. Our methodology utilizes both medical and pharmacy claims.

    ☐ Risk structure (e.g., risk exposure, the allowed budget, exclusions, bonuses, quality performance, etc.):

    Harvard Pilgrim has developed standard risk models. However due to variation among providers – size of the practice and patient panels, volatility of membership, and other factors – we negotiate variations, such as the level of risk exposure and adjustments to trend targets, as necessary.

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

    Assuming that pre-paid lump sum payments refers to direct capitation (prospective payment risk model), we have such arrangements in place with certain large multi-specialty practices in Massachusetts.

    ☐ Other, please describe:

d. Please describe any ways in which your unique payment approach brings value to patients, plan sponsors, or payers:

Harvard Pilgrim's payment strategy is founded on flexible value-based frameworks that advance population health management, foster provider engagement, drive care improvement, and yield high value for employers and members. We have invested in a value-based care approach that pays physician groups to take care of populations of patients, rather than paying for volume of services, based on our belief and experience that this approach delivers not only greater value but also better health outcomes. By employing a standard reimbursement method broadly, we also support greater transparency by providing a means for members, employers, and other constituents to compare the relative cost and quality of providers and make more informed health care choices.

By its nature, the fee for service model — in which complex tests, medications and procedures are rewarded the most, and care management and patient education are reimbursed far less —offers few incentives to prevent delivery of unnecessary care or invest time in care coordination and patient education. It skews toward more complexity (e.g. high cost drugs, complex procedures), more utilization, and less patient accountability.

In contrast, risk-based contracts are constructed to reward care coordination and prevention, promote the use of lower-cost sites of care when appropriate, and invest in patient-centered care and efforts to understand social determinants of health. It skews toward more patient education, fewer unnecessary procedures, and greater focus on managing complex chronic conditions.

For these reasons, value-based contracting is at the core of our payment approach, and we have maximized adoption of alternative payment models in Massachusetts with more than 80% of our total HMO/POS membership managed under these types of contracts. We have achieved these results by ensuring that our payment approach is founded on certain guiding principles:

- **Flexibility** to enable physician groups with various levels of sophistication with value-based payment models to participate
- **Focus on PCP & total medical expense** to support care coordination and medical cost management across health delivery sites
- **Data-driven** goal setting to ensure that provider groups are focused on the greatest opportunities for care and cost improvement
- **Innovation and clinical transformation** by rewarding the development of programs that emphasize adoption of new technology and processes that improve the delivery of care, such as medical home or automated prevention and wellness programs
- **Collaboration** with our provider partners in setting goals, measuring progress, and refining objectives
- **Patient-centered approach** that promotes patient engagement and education, access to care, coordination and care management for patients with complex care needs, and transitional care management

- **Quality at the forefront** by incorporating nationally recognized, evidence-based quality and efficiency standards into incentive payments

As outlined in our response to question 5a, we continually strive to improve our value-based contract approach and have made a number of key advancements in the last year: refining our APMs; enhancing provider analytics to better identify and capitalize on quality and cost opportunities; and emphasizing provider engagement. Some of the innovations that our value-based contracts have supported include:

- Shifting care to low-cost settings — In a partnership with ambulatory surgery providers, we have developed reimbursement methods to support the delivery of joint replacement surgeries in outpatient settings at 20% below the inpatient rate.
- Dermatology access — A pilot with a Massachusetts provider that enables better access for members who need to see a dermatologist.
- Home-based hospital payment system — A program that enables members with lower-acuity conditions to be treated in the home rather than the hospital, when appropriate.
- Practice pattern variations — Projects are aimed at pinpointing opportunities for lowering cost and improving quality of care by identifying practice pattern variations among providers.

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?

    In our reading of this question, we believe you are asking for our perspective on barriers to shifting from a budgeted capitation model (in which total medical expense targets are set, claims are paid on a FFS basis, and reconciliation later occurs) to a direct capitation model (in which a prospective payment for all covered services is determined and made to a physician organization). We believe there are several barriers, the most important of which is that direct capitation models are best suited to large physician practices where the profile of the patient risk pool is closely aligned with the health plan's overall risk pool. Our experience has shown that this payment distinction — whether lump-sum payment or interim basis payment — is less of a determinant of provider success in managing cost and quality under value-based contracts than other factors, such as practice size and structure and physician leadership. The level of engagement of physicians, where physicians are deeply engaged in the principles of population health management, plays a more direct and critical role in meeting quality and cost goals. In addition, direct capitation does not necessarily preclude the need for settlements and reconciliation.

    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?

    In 2018, approximately 70% of our medical payment for fully and self-insured commercial products were paid on an interim basis under capitation.

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	2.2%	2.4%	N.A.	0.0%	4.6%
CY 2017	2.6%	0.1%	N.A.	1.4%	4.1%
CY 2018	2.8%	-2.4%	N.A.	2.8%	3.1%

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.