MASSACHUSETTS
HEALTH POLICY COMMISSION

2021 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

INSTRUCTIONS FOR 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 2021 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, November 5, 2021**, please electronically submit testimony to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed 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.

We encourage you to refer to and build upon your organization's pre-filed testimony responses from 2013 to 2019, if applicable. If a question is not applicable to your organization, please indicate that in your response.

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.

You are receiving questions from both the HPC and the Attorney General's Office (AGO). 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 Johnson at HPC-Testimony@mass.gov or lois.johnson@mass.gov.

AGO Contact Information

For any inquiries regarding AGO questions, please contact:
Assistant Attorney General Sandra Wolitzky at sandra.wolitzky@mass.gov or (617) 963-2021.

HPC QUESTIONS

1. UNDERSTANDING THE IMPACT OF COVID-19:

Please briefly describe how you believe COVID-19 has impacted each of the following:

a. Your organization and its employees:

Recognizing the devastating and lasting impact of COVID-19, one of BMCHP's top priorities has been the vaccination of our members and employees. BMCHP was among the first employers in the state to impose a COVID-19 vaccine mandate, believing that universal vaccination would help ensure the health and safety of our employees as well as the members we serve. BMCHP supported state efforts to make coverage of the vaccine mandatory, without any cost-sharing, and BMCHP continues to work diligently to promote the vaccine and help our employees and members actually receive shots.

COVID-19 significantly impacted our work environment and employees, just like it did for businesses across the country. By March 13, 2020 BMCHP had moved to a virtual work environment. Over the course of 2020, BMCHP recognized the technological advances facilitating remote work, the ability of remote employees to remain highly productive as well as the opportunities created through enabling employees to work remotely. Consequently, BMCHP has now decided to remain in a virtual work environment going forward. Although BMCHP will retain some office space for various purposes, as a lasting impact of COVID-19, BMCHP employees will indefinitely work remotely.

b. Your members, including but not limited to the direct health effects of COVID-19 as well as indirect health effects, such as the effects of deferred or cancelled care, exacerbation of behavioral health and substance use conditions, and effects from economic disruption and social distancing (e.g., evictions, food security):

During COVID-19, BMCHP member visits initially decreased along with overall claims. This was associated with members avoiding preventative care and services, ranging from mammograms and colonoscopies to care of chronic disease like diabetes and hypertension. The co-occurring behavioral health conditions created further care issues and deteriorating physical health.

More recently, BMCHP member utilization has increased across all categories to pre-COVID levels. The hospitalization rate has remained steady for our members who are dually eligible, initially driven by COVID hospitalizations but now driven by rebound hospitalizations for chronic disease superimposed with behavioral health and social issues.

Initially BMCHP member's pharmacy use decreased as members stopped refilling their medications, but within the last quarter BMCHP has seen an overall increase in pharmacy costs. Medication adherence rates, especially in the dually eligible population has dipped and BMCHP has instituted focused attention within care management and primary care practices accordingly. BMCHP remains concerned that the true burden of smoldering chronic behavioral and physical health conditions superimposed with broader social policies like the expiration of the eviction moratorium will lead to poorer health quality in our community. BMCHP is returning to field based assessments, per the state's guidance in November, and expects to find higher levels of undiagnosed behavioral health issues, medication adherence issues as well as self-care deficiencies in chronic disease.

During the pandemic our ability to connect with members was often limited to phone contact as many members either lack the appropriate internet to support video calls and or cannot navigate the requisite set-up. Telehealth for our members was further complicated by the varied capabilities of physician practices across the state. In many cases, physician practice constraints prevented thorough evaluation and assessment of the member. Some members essentially went without needed telehealth and in-person care and services. Extensive telehealth would have facilitated appropriate triage and subsequent redirection to in-persons visits.

Behavioral Health

BMCHP, through our BH provider Beacon, continues to observe an increase in anxiety, stress and adjustment disorders related to the ongoing pandemic. These increases can be attributable to the impact of certain experiences during the pandemic such as: social isolation, situational stressors, job loss and caring for family members.

BMCHP continues to observe access issues related to the pandemic. Specifically, we have seen the impact of staffing shortages in acute care facilities, which has resulted in beds being taken offline. The reduction in available beds combined with the increase in patient need has resulted in a significant increase in ED boarding. BMCHP actively participates in the state's EPIA initiative aimed at securing appropriate placements as soon as possible for individuals boarding in the ED. On a daily basis, clinicians outreach to Emergency Services Programs/Mobile Crisis Intervention teams (ESP/MCI), community supports, natural supports, state agencies and group care facilities to assess for potential diversion and to collaborate on arranging for the services and supports our members need. Additionally, work at the health plan has focused on members who are the highest risk for behavioral health readmissions (in great part due to pandemic related issues). One positive observation related to access is that, for outpatient services, telehealth mental health visits have compensated for the decrease in in-person visits during the pandemic, and continued to increase through the end of 2020.

Throughout the pandemic, we have also observed an increase in members experiencing food and housing security issues. At the outset of the pandemic, Beacon pivoted field-based peers and UM staff to focus on member outreach and assistance. Staff have worked with members to assess their shelter and food needs and to educate them on accessing housing and obtaining food. On behalf of BMCHP members, Beacon has continuously updated the information on community resources available on the website, and all members can use the access line to obtain support from a clinician.

c. The health care system as a whole, including but not limited to how you think the health care system will change going forward, and any policies or innovations undertaken during the pandemic that your organization believes should continue (e.g., telehealth, licensure and scope of practice changes):

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The pandemic expedited the involvement of remote care and remote care coordination on providers and health plans, but simultaneously created the potential for higher levels of efficiencies throughout health care entities. Remote work helped employees recapture commuting time and opened up the possibility of new and more meaningful, more human centered ways of communicating and engaging with patients and members. With many providers, plans and members all homebound, phones and computers became the only avenue by which BMCHP could help members understand their

medications, and often just listen with what should have been, new found time. Providers began treating symptoms and answering questions remotely. But suddenly, payers and providers began literally meeting members where they were.

With the assistance of new web-based applications, informed with artificial intelligence we were able to ensure that care was provided throughout the pandemic. As behavioral economics emerged, behavioral telehealth expanded, and new sources of data landed on our computers, we were able to utilize the information to re-imagine the way that behavioral health care was provided.
But the pandemic exacerbated existing problems as well. BMCHP, like many other employers, had to furlough staff, while some of our provider practices closed. The result of the diminishing health care resources was that long-existing health inequities became more urgent and apparent. The pandemic created the perfect storm, a public health emergency and rapid fire, new innovative, technical, remote approaches to health care.

Patients/members and providers have discovered a few areas of success along the way, but, for the most part, there is much work to be done in order to successfully meld the new technically enabled remote capabilities with the human needs. At its core, health care is a human endeavor in which payers, providers, members, patients and policy makers, must collaborate to pay for and deploy the new technologies which enhance and work with – not replace, our human-centered and community bound relationships.

The expansion of telehealth usage during the pandemic is an excellent example of the health care system's ability to be flexible and adapt to the needs of the residents of Massachusetts. As a payer, BMCHP is continuously looking for ways to reduce the cost of health care to our members, but also to ensure that the delivery system is safe and protects against actually causing harm. Telehealth presented an excellent way for our members to received needed health care without subjecting them to potentially harmful exposure to COVID-19.

Technological advances have demonstrated numerous benefits in health care and our system must remain flexible in order to fully leverage evolving technologies in the future.

2. EFFORTS TO COLLECT DATA TO ADVANCE HEALTH EQUITY:

a. Comprehensive data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity is foundational to advancing health equity in the Commonwealth. Please describe your current efforts to collect these data on your members. Please also describe specific barriers your organization faces in collecting such data and what policy changes or support has your organization identified as necessary to overcome such barriers.

BMCHP collects race, ethnicity, written language, and spoken language from all members using a hierarchy process to ensure that this information comes directly from the member. BMCHP currently has Race, Ethnicity, & Language ("REL") data from approximately 30-40% of the

membership for most products. However, BMCHP has REL information for about 84% of our SCO population.

BMCHP's access to information differs by product. MassHealth will send gender, race, and language information, as available. The Massachusetts Health Connector only sends race information when related to the AIAN (American Indian/Alaskan Native) population. BMCHP generally does not receive sexual orientation, ethnicity or gender identity information. BMCHP does have the ability to capture both ethnicity and gender identity, if that information is provided. Disability status may be ascertained for Medicaid members by reviewing the member's plan type (e.g. "BO" indicates that a member is disabled) but does not provide the nature of the disability.

BMCHP's efforts to collect more of this information is done primarily in 3 ways:

1. When speaking with a member, Member Services staff ask if a member will share their REL information with the plan if BMCHP does not yet know;
2. The Health Needs Assessment which members are asked to complete and return to the plan, may indicate a disability status; and
3. Care Management staff works with members who are, or may be, disabled or have special needs and can document disability information.

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3. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS:

a. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2017 to 2020 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2017 to 2020, 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., unit cost, utilization provider mix, service 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.

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To supplement to HPC Payer Exhibit 1(summarizing allowed trends for 2017 through 2020 split by Utilization, Unit Cost, Provider Mix and Service Mix), the following table demonstrates Health Status Adjusted (HSA) Trends, since risk adjustment explains the high trends in 2018 and 2019:

	Unadjusted TME Trend	Risk Score Trend	HSA TME Trend
CY 2017	1.1%	-1.6%	1.9%
CY 2018	12.0%	13.8%	-1.2%
CY 2019	10.1%	13.2%	-2.3%
CY 2020	-1.4%	2.4%	-3.5%

The average risk score for our MassHealth and QHP commercial members increased significantly from 2017 through 2019, so on an adjusted basis our emerging trends have been negative for all years after 2017. The reason for the high risk score trends in 2018 and 2019 varies by product line.

For the BMCHP commercial QHP line of business, risk score trends are tied to large increases in our population base. Enrollment grew by more than 100% from 2016 to 2017 due to BMCHP being one of the lowest cost options on the Connector exchange. New members were generally lower risk individuals shopping for the lowest premium product on the market, as shown by the negative risk score and TME trends. From 2017 to 2018 QHP enrollment grew by 24% and BMCHP's average medical costs and risk score trends were higher due to regressing to the market mean. This trend of regressing to the market mean was similarly observed from 2018 to 2019.

For the MassHealth products, the risk score trends are also related to large population changes. This impact was most acute with the start of the ACO program in March 2018 when members shifted from MCO affiliation to ACO affiliation. The shift increased our average enrollment by 40% and significantly concentrated the risk profile of members associated with BMCHP. Additionally, delays in member affiliation with the appropriate ACO complicated risk scores, which ultimately took two years to level off. That is driving the large average risk score trends for MassHealth members of 14.5% from 2017 into 2018 and 14.1% from 2018 to 2019.

BMCHP now believes that demographic changes are appropriately being captured through the health status adjustment trend.

BMCHP does not consider benefit buy down to be a material driver of trend due to MassHealth and SCO members already being in $0 premium products, and the vast majority (85%) of our QHP members being in significantly subsidized premium products.

b. Reflecting on current medical expenditure trends your organization is observing in 2021 to date, which trend or contributing factor is most concerning or challenging?
Click or tap here to enter text.

Trends for 2021 appear to be returning to pre-COVID levels across most product lines on a health status adjusted basis. BMCHP remains concerned that acuity for inpatient and outpatient services is increasing due to a combination of reduced access to routine services during the

pandemic and members choosing to defer needed care during the pandemic due to the danger of catching COVID during a medical visit. BMCHP has also observed a recent demographic shift in our MassHealth population related to the mix of adult vs children. The BMCHP membership has shifted approximately 4% toward adult populations since the start of the COVID-19 pandemic.

AGO QUESTION

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." 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) 2019-2021			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In- Person
CY2019	**Q1**		0
	Q2		4
	Q3		0
	Q4	85	1
CY2020	**Q1**	193	0
	Q2	95	0
	Q3	165	0
	Q4	271	0
CY2021	**Q1**	392	0
	Q2	339	0
	TOTAL:	1,540	5

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 2017	6.0%	-7.1%	0.2%	2.5%	1.1%
CY 2018	0.1%	17.4%	0.8%	-5.5%	12.0%
CY 2019	2.0%	9.6%	0.0%	-1.6%	10.1%
CY 2020	1.4%	-2.6%	0.0%	-0.2%	-1.4%

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

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.