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:

COVID-19 has impacted Fallon Health and its employees significantly in terms of where and how we work. Most office based employees moved from being on-site five days a week to working fully remote in about 48 hours. Our clinical employees moved from working primarily at our clinical sites to meeting our participants in the community, either at their homes or a facility. The shift in where and how we work was a large-scale change that, under normal circumstances, would not have occurred without a pandemic as the driver.

COVID-19 caused employees to be fearful about exposure and transmission, and keeping employees safe while continuing operations became paramount. Due to personal challenges related to the pandemic, we saw an increase in leaves of absence and resignations as employees who were sick or taking care of family members needed time away from work. Employee absences led to increased strain on the remaining employee base.

Certain roles changed significantly. For example, HR became a mini public health department focused on tracking positive cases, exposures, and clearance to return to work while making sure employees and the organization took advantages of benefits afforded during the pandemic.

COVID-19 also provided many employees with the flexibility to work effectively from home and have balance in their lives. Fallon surveyed employees to get their input into the future of our work model. As employees adapted effectively to working from home, this new capability resulted in the recognition for a more flexible staffing model and the creation of a long term hybrid workplace model. This model will take time to fully implement, and we will continue to obtain feedback from all employees. As we transition to a hybrid work environment, we are thinking about how we need to operate differently and use it as a future forward design opportunity and not a return-to-work exercise. This will help us to shape our future with our employees by our side to be able to continue to shape our culture and recruit and retain talent.

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):

From the standpoint of claims and medical expense, additional costs were incurred during 2020 due to: 1) the costs of testing and treatment for COVID, 2) the waiver of cost-sharing for all telehealth services, 3) the increase in the utilization of behavioral health services, and 4) the increase in hospital reimbursement rates for COVID-related admissions. However, these additional costs were more than offset by the deferral and elimination of routine and preventative services and elective surgeries, resulting in an overall reduction in incurred medical expense for 2020.

During 2021, we have seen a resurgence of claim costs. This occurred earlier and more significantly in the Commercial population compared to the Medicare and Medicaid populations. The deferral or elimination of elective surgeries and preventive and diagnostic services during the first year of the pandemic has led to increased acuity as members have begun to seek care again.

We observed an increase in deaths among the frail and elderly members in our Medicare and Medicaid populations during the height of the pandemic in 2020.

From a mental health and substance use perspective, through our behavioral health partner (Beacon), we have observed an increase in anxiety, stress and adjustment disorders related to the ongoing pandemic. These increases can be attributable to the impact of social isolation, situational stressors, job loss and caring for family members experienced during the pandemic. We have also observed access issues related to the pandemic, specifically staffing shortages in acute care facilities, resulting in beds being taken offline. The reduction in available beds combined with the increase in patient need has resulted in a significant increase in emergency department boarding. Beacon is a very active participant in the state's Expedited Psychiatric Inpatient Admissions (EPIA) initiative aimed at securing appropriate placements as soon as possible for individuals boarding in the emergency department. On a daily basis, Beacon 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 needed.

Fallon is unique among Massachusetts insurers in having a Program of All-inclusive Care for the Elderly (PACE) plan. During the pandemic, we have observed some challenges that were specific to this population, including disruptions in transportation, which prevented participants from being able to get to medical appointments or to the PACE center, the latter leading to a lack of socialization with others. We have attempted to fill that void by having staff go out to participants. As these issues continue to occur, we are now looking at other options to stay connected, such as group visits through telehealth. More broadly, we did see an exacerbation of behavioral health issues with this population, which led to the deployment of behavioral health staff into the community.

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):

One of the most significant changes involves the availability and use of telehealth services. While telehealth has been available and covered for in-network providers before the pandemic, utilization increased exponentially with the advent of restrictions on in-person visits. The higher rate of use of telehealth, particularly for behavioral health consultation and treatment, has continued. It holds promise for addressing access concerns for behavioral health treatment.

Important considerations remain about ensuring privacy as the technology evolves and becomes more widespread. Quality and safety of care delivered by health professionals is critical to monitor. Evaluation of quality should be built into the process of telehealth including methods of monitoring and reporting to health plans and regulatory bodies. For many, access to telehealth services can be challenging due to the lack of devices and availability of internet services. Addressing this gap with particular attention to issues related to equity will be important to take full advantage of telehealth. Related to telehealth is the increasing availability and supporting evidence of virtual tools, such as mobile and web browser apps to provide digital therapeutics with particular promise again in behavioral health treatment.

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.

Fallon collects race, ethnicity and language (REL) data for all of our products. The majority of our data comes directly from the member, either from enrollment forms or from interactions with Fallon staff, e.g. when engaging with various care management programs. At one point, we imputed race and ethnicity data from census tracts for commercial reporting, but we now feel that our focus should be on building capacity for acquisition of this data directly.

We are an active participant with the Massachusetts Health Data Consortium (MDHC), a group of payors and providers working together to create and socialize a common file layout for electronic medical record file feeds. This layout

includes a member file, which includes REL data. We are working with our provider community to adopt this layout when they send monthly EMR files to Fallon Health.

We are focused on expanding the collection, reporting and analysis of standardized data, using the data to evaluate disparities and impacts and to integrate equity solutions, improving communication and language access for individuals with limited English proficiency and persons with disabilities, and increasing the ability of our workforce to meet the needs of these populations through education and resources.

Fallon selects large population based metrics (e.g. cancer screenings, diabetes screenings) and stratifies results by race, ethnicity, language (REL), age and gender to identify disparities and potential improvement activities. Some examples of current improvement projects recently completed or underway include diabetes eye exams, adolescent immunizations, flu shots and utilization of telehealth. We also annually measure race, ethnicity and language diversity in our membership to help us to make sure that our outreach materials are culturally and linguistically appropriate.

We support the NCQA proposal to add race and ethnicity stratifications to select HEDIS measures beginning in measurement year 2022 because we see this as a way to advance health equity by leveraging HEDIS to hold health plans accountable for disparities in care among their member populations. This approach along with public reporting and national benchmarks (Quality Compass) will highlight plans that are successful in implementing strategies that lead to a reduction in disparities in care and outcomes. This will allow for plans to learn from each other via best practices.

Collecting REL data is not without challenges. The first challenge is data accuracy. While self-reporting of data on race and ethnicity is the collection method of choice, it is most often done on a voluntary basis, leading to problems of missing data. Another challenge is a concern for privacy. Low participation by health plan members in reporting REL data could be related to their mistrust about how the information will be used.

To help address these barriers, we have previously suggested to the Connector that they could support the health plans by making this data a mandatory field on enrollment forms. The Connector could convene a workgroup to discuss challenges such as: how to train staff to elicit this information in a respectful and efficient manner; how to address potential enrollee pushback respectfully; how to address the discomfort of health plan call center staff about requesting this information; and how to address system-level issues, such as data flow, standardization of categories, HIT limitations (number of fields, comparability of categories among systems), and space on collection forms both paper and electronic.

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.

Attached is the summary table showing actual observed allowed medical trends. For the time frames requested we did not have specific studies to break mix between provider and service mix, so the mix has all been put into the Service Mix Column. Note that ASO data was not readily available in a format that could be combined with the fully insured data without distorting the analysis, so it is not reflected in these results. We do believe that this "Allowed" trend understates the true allowed trend because it reflects the effect of benefit buy-downs. This is true even though we are looking at allowed trends that include both the payer and member share of the expense because as the member's share of the cost rises it tends to decrease utilization.

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?

Going into 2021, we have already observed a significant increase in utilization and acuity. This is the result of care that was deferred during the height of the pandemic and the increased availability and use of telehealth services. There still remains a good deal of uncertainty with respect to future experience because: (1) the rate of resurgence has varied by product and population segment and (2) there is still a risk of resurgence of COVID cases should a variant emerge that is resistant to already acquired immunity or vaccines.

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**	166	35
	Q2	146	45
	Q3	430	30
	Q4	337	27
CY2020	**Q1**	276	31
	Q2	143	13
	Q3	267	41
	Q4	242	18
CY2021	**Q1**	284	33
	Q2	79	5
	TOTAL:	3229	369

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 2017	3.7%	1.7%	n/a	-1.5%	3.9%
CY 2018	3.3%	3.1%	n/a	-3.9%	2.4%
CY 2019	-2.1%	7.8%	n/a	-3.7%	1.7%
CY 2020	-2.7%	-3.5%	n/a	-3.9%	-9.8%

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.