MASSACHUSETTS
HEALTH POLICY COMMISSION

2022 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 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 2022 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Monday, October 24, 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 2021, if applicable. If a question is not applicable to your organization, please indicate that in your response.

Your submission 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.

INTRODUCTION

This year marks a milestone anniversary in the Commonwealth's ambitious journey of health care reform. Ten years ago, through the advocacy of a broad coalition of stakeholders, Massachusetts adopted an innovative approach to slowing the rate of health care cost growth by establishing an annual cost growth benchmark and providing oversight authority to the newly established HPC.

In the first several years of benchmark oversight, the Commonwealth made notable progress in driving down health care spending growth. In recent years, however, spending growth has exceeded the benchmark (with the exception of 2020) and appears likely to continue that upward trajectory.

This trend is driven largely by persistent challenges and market failures that have not been adequately addressed in the past ten years. These challenges, which have been consistently identified by the HPC and others, include:

- Excessive provider price growth and unwarranted variation,
- Increased market consolidation and expansion of high-cost sites of care,
- High, rising, and non-transparent pharmaceutical prices, which may not reflect value,
- Steadily increasing health insurance premiums, deductibles, and cost-sharing, resulting in increased costs to businesses and consumers,
- Stalled uptake of value-based payment models and innovative plan offerings, and
- Systemic and persistent disparities in health care access, affordability, and outcomes.

The ongoing impact of the COVID-19 pandemic has only exacerbated many of these dynamics, contributing to greater health disparities, while adding to inflationary headwinds in the form of increasing labor and supply costs.

These challenges are not unique to Massachusetts, and many other states are evolving their cost containment strategies accordingly to respond to them. In order for Massachusetts to continue to be the national leader on health care cost containment, it must similarly adapt. Unless the state's health care cost containment approach is strengthened and expanded by policymakers, the result will be a health care system that is increasingly unaffordable for Massachusetts residents and businesses with growing health inequities.

ASSESSING EFFORTS TO REDUCE HEALTH CARE COST GROWTH, PROMOTE AFFORDABLE, HIGH-QUALITY CARE, AND ADVANCE EQUITY

a. Reflecting on the past ten years of the Massachusetts health care cost containment effort, and the additional context of ongoing COVID-19 impacts, please identify and briefly describe the top (2-3) concerns of your organization in reducing health care cost growth, promoting affordability, and advancing health equity in future years.

WellSense (WS) is a non-profit health plan plan providing health insurance coverage to low income, underserved, disabled and elderly populations. Established in 1997 by Boston Medical Center, the largest safety net hospital in New England, WS has 25 years of experience in ensuring quality, accessible care for complex, vulnerable populations. Through four MassHealth ACOs, the MCO program, the SCO program, and Qualified Health Plan (QHP) membership, most of whom are ConnectorCare members, WS serves hundreds of thousands of individuals, most of whom are medically-complex and disabled, with an emphasis on addressing their social determinants of health.

In reflecting on the past ten years of health care cost containment efforts in Massachusetts, WellSense's top three concerns are:

- Continuously increasing cost of pharmaceuticals
- Insufficient access to appropriate behavioral healthcare, along with cost increases, which do not correlate to quality improvement
- Continuing health equity disparities

Pharmacy Spending

Over the past ten years, WS has observed significant growth in pharmacy spending. Based on mid-year data from 2022, this trend has continued across all of our lines of business. The spending increase is a result of increased drug and dispensing costs as well as increased utilization, While we expect that MassHealth's shift to a Unified Pharmacy Product List (UPPL) will help to blunt the impact of cost increases at the system level, these cost control measures could have inequitable impact on our members by restricting or limiting access to necessary medications for some Medicaid members.

Behavioral Health

WS continues to observe troubling trends related to Behavioral Health. These include increased prevalence and acuity among our members, as well as increases in the cost of services and reductions in ready access to providers.

Across all of our lines of business, 80% of our total TCOC is associated with members that have some behavioral health complexity, and almost half is driven by members that are homeless and/or are suffering from substance use disorder or severe mental illness. Given access challenges, it can be difficult to ensure that members receive the care that they need. To give one example, we have seen ongoing 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.

The challenge presented by the behavioral health landscape has a strong equity component, too. We recognize that this disease burden is tied to the health-related social needs that most of our members are experiencing, and that access challenges are most acute for underserved populations.

Coordinated Focus on Addressing Health Equity

WS is deeply committed to eliminating health equity gaps in healthcare along racial and ethnic lines. Health equity is not a new challenge, but we believe that during this period of

increased focus on the issue, it is important to ensure that stakeholders across our healthcare system are coordinating around data collection, specific disparities, investment, incentives, and accountability. A splintered and siloed approach runs the risk of hampering progress and dividing efforts.

b. Please identify and briefly describe the top strategies your organization is pursuing to address those concerns.

Behavioral Health

WS has worked diligently to ensure that members with complex behavioral health conditions receive the care that they need. Several different WS programs and strategies are designed to address this challenge.

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

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

- BH-specific programs - The clinical management model used by WS is based on the philosophy that individuals living with mental health and substance use conditions can live purposeful lives by receiving timely care from high quality providers in the most appropriate, least restrictive setting. This philosophy informs our clinical management guidelines and techniques, which encourage well-defined treatment plans with clear objectives for recovery in the community. Specific programs that we have worked on together include:

- Rapidly Readmitting Members - our behavioral health partner identifies members with readmission patterns and assigns them to either CCM, a BH Community Partner (CP) or WS' BH Care Management team. These teams engage each member and provide

weekly updates, while monitoring utilization data and trends for these members and engaging inpatient and outpatient providers, as needed.

- Value-Based contracts - WS utilizes value-based contracts with some outpatient behavioral health providers in order to incentivize access for WS members and encourage positive outcomes. In part, this is accomplished through enhanced rates for serving certain members with more intense needs (*e.g.* increased rates for SNFs that serve members with SUD diagnoses).
- Best-practice ABA service delivery emphasizes the use of home-based services to support members and their families in achieving a high-functioning lifestyle. Home-based services are both clinically and financially superior based on delivering improved treatment outcomes at a lower total cost. In 2018, the portion of center-based ABA services for BMC increased to 35.4% of total paid services, and 36.1% of units of service. We then worked to utilize home-based services if possible, resulting in a reduction in center-based ABA service delivery down to 29.9% of total paid services in 2019, and 30.4% of units of service.

Health Equity

As referenced above, health equity is engrained in WS' history and mission. WS benefits from working closely with the Health Equity Accelerator at BMC Health System, and is pursuing a number of broad next steps in the near term, including the following.

- Promoting a culture of equity, respect, fairness, and inclusion across our system through training and other staff-focused efforts
- Specific initiatives and evidence-based interventions directed at the greatest inequities in quality, clinical services delivery, and access
    - Potential focus areas here include: Maternal and child health, Cancer, End-stage renal disease, Chronic conditions (e.g. diabetes, hypertension), Infectious disease (e.g. COVID, sexually transmitted illnesses, flu), and Behavioral health.
- Improving collection of complete and accurate social risk factor data
- Ensuring major health plan policy and procedures are designed to promote health equity
- Programs and efforts to address health related social needs
- Soliciting feedback directly from our members through Health Equity Committees
- Developing a health equity strategy plan and roadmap for WS

c. Please describe your progress in the past year on efforts to collect data to advance health equity (i.e., data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity, see 2021 Cost Trends Testimony), including specific metrics and results. Please also describe other specific activities your organization has undertaken to advance health equity.

During the past year, WellSense has devoted significant resources to assessing and creating a baseline for data collection and reporting practices on health equity data, including race, ethnicity, written and spoken language, disability, and sexual orientation and gender information. As a first step, WellSense has been actively working with state-level committees to provide input informing the data standards that EOHHS is proposing to utilize

during the new Medicaid 1115 Waiver (e.g., utilizing OMB data standards for race and ethnicity). WellSense has formed a governance committee on Health Equity data including representatives from WellSense, Boston Medical Center, and our partner Accountable Care Organizations. WellSense has successfully documented a single standard for how to collect race, ethnicity, and spoken and written language data. Although we have not yet finalized it, we continue to collaborate with EOHHS as well as our patient and provider communities to developing a single standard for tracking disability and SOGI data as well.

From a data collection standpoint, WellSense has documented the sources by which it collects race, ethnicity and language (REL) data today, which includes state 834 enrollment files, call center interactions, care management, and provider encounters. Currently, disability data is received through state files however WellSense is evaluating our data collection efforts for disability due to changes to the state's definition of "disability". Wellsense utilizes a data integration platform, Arcadia, which integrates REL data for members incorporating both Plan and provider electronic medical record data. WellSense is currently documenting the data standards and rules which govern the taxonomy and treatment of that data from multiple sources, and rules by which WellSensewill map legacy data to the new EOHHS standards.

WellSense has performed baseline analyses of our data completeness on all members for race and ethnicity. We currently have 57% data completeness on race across all Massachusetts lines of business (in part due to EOHHS' use of Office of Management and Budget (OMB) 1997 standards for race and ethnicity collection, which do not include Hispanic/Latino as a race option which differs from historical data collection practices), 47% completeness on ethnicity, and 67% on language.

d. Please identify and briefly describe the top state health policy changes your organization would recommend to support your efforts to address those concerns.

Pharmacy

WS is in favor of limits on pharmaceutical manufacturer cost growth. WS supports expanded authority for the HPC to track and report excessive price increases, based upon reasonable factors.

Behavioral Health

WS would like to see **improvement in ACO rates, especially the rates for the most complex members** (i.e. SUD and serious mental illness).

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

Health Equity

WS feels strongly that coordinated guidance from the Commonwealth is necessary for making substantial progress on Health Equity. Data collection efforts should be coordinated and standardized to ensure uniform information, which account for all races and ethnicities, and understanding of disparities,

A common baseline and understanding will appropriately lay the groundwork for tracking improvements, while accounting for progress that has already been made. Lastly, common data and understanding will clearly indicate what types of activities should be incentivized, which interventions are within the control of payers, providers or other stakeholders in the health care space and how best to achieve desired outcomes.

UNDERSTANDING TRENDS IN MEDICAL EXPENDITURES

a. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2018 to 2021 according to the format and parameters provided and attached as HPC Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2018 to 2021, 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.

HPC Payer Exhibit 1 is attached, summarizing allowed trends from 2018 to 2021 by Utilization, Unit Cost, Provider Mix, and Service Mix for WellSense's Massachusetts product lines.

This supplemental chart shows our Health Status Adjusted (HSA) trends for Massachusetts combined:

Time Period	Unadjusted TME Trend	Risk Score Trend	HSA TME Trend
CY 2018	12.0%	13.8%	-1.2%
CY 2019	10.0%	13.2%	-2.4%
CY 2020	-1.4%	2.4%	-3.5%
CY 2021	-0.2%	-4.0%	3.7%

As illustrated above, our high trend in 2018 and 2019 was driven by higher risk scores. After HSA, our trend is negative through 2020. The increasing risk scores in this time period were driven by large population changes in our MassHealth and QHP products. The growth of the WellSense growth in MassHealth was driven by the ACO implementation in 2018, while the QHP's membership increase was a direct result of WellSense's position as one of the lowest premium options on the Connector Exchange.

In 2020, WellSense risk scores increased less than prior years while TME decreased due to COVID-19. During this time period, the WellSense QHP membership decreased as the Connector Exchange population decreased. Meanwhile, the WellSense MassHealth membership increased, largely due to MassHealth pausing redeterminations due to the Federal Public Health Emergency (PHE). The newer MassHealth members have artificially lower risk scores due to a lack of claims and PCP visits, which is why the WellSense risk score trend is artificially low from 2020 to 2021, while unadjusted TME has remained relatively flat.

This HSA view explains our demographic changes. WellSense does not believe benefit buy down to be a driver of trend due to our product design. MassHealth and SCO are zero premium products, while the majority of QHP members have highly subsidized premiums.

b. Reflecting on current medical expenditure trends your organization is observing in 2022 to date, which trend or contributing factor is most concerning or challenging?

Emerging 2022 trends are driven by Unit Cost, with the majority of the increase from Pharmacy claims. BH claims have also progressively increased since COVID. We are also seeing an increase in average risk scores as new members gain claims experience. As a result our HSA trend is emerging relatively flat. There remains uncertainty around the end of the Public Health Emergency (PHE). When the PHE ends, eligibility redeterminations will resume and we expect trends to increase when that happens. That remains our most concerning impending trend factor.

QUESTION FROM THE OFFICE OF THE ATTORNEY GENERAL

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) 2020-2022			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2020	Q1	1	6
	Q2	1	1
	Q3	0	1
	Q4	0	1
CY2021	Q1	1	0
	Q2	0	0
	Q3	0	0
	Q4	3	3
CY2022	Q1	0	9
	Q2	1	15
	TOTAL:	7	36

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 2018	0.3%	16.9%	0.8%	-5.3%	12.0%
CY 2019	-1.0%	13.5%	0.0%	-2.0%	10.0%
CY 2020	1.5%	-2.7%	0.0%	-0.1%	-1.4%
CY 2021	-2.5%	3.0%	1.0%	-1.6%	-0.2%

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.