Commonwealth of Massachusetts
GROUP INSURANCE COMMISSION

VENDOR QUALITY IMPROVEMENT

A Report to the Legislature

For Fiscal Year 2016

September 30, 2016

BACKGROUND

This report is submitted pursuant to Mass. Gen. Laws ch. 32A, § 21, which states as follows:

> The [group insurance] commission is hereby authorized and directed to establish and implement a vendor quality improvement program for purposes including, but not limited to: the evaluation and improvement of all health care services as applied to those contracts and the promotion of customer-oriented quality management techniques. Such program shall include both long- and short-term objectives, quantifiable improvement goals, benchmarks for evaluating vendors and mechanisms to promote collaboration between the commission and health care vendors to improve health care services. The commission shall file an annual report with the clerks of the Senate and House of Representatives and with the governor not later than September 30 concerning such vendor quality improvement program.

Since its formation in 1955, the Group Insurance Commission (GIC) has remained focused on a central purpose: to provide Massachusetts state employees and retirees, and their dependents, with the highest quality health care at the most reasonable cost. With over 436,000 people currently covered under its benefit plans, the GIC has remained focused on that mission, seeking qualitative and quantitative value in each and every vendor relationship.

This report reflects a variety of quality improvement activities undertaken in FY2016 that comprise the oversight and action necessary for the Group Insurance Commission to fulfill its mandate.

GIC STRATEGIC OBJECTIVES FY2016

The GIC's long-term objectives include providing high-quality, affordable benefit options to employees, retirees and dependents; limiting the financial liability to the state and others to sustainable growth rates; and using the GIC's leverage to stabilize, re-balance and otherwise favorably influence the Massachusetts health care market.

To meet these objectives, and ensure that our vendors are aligned with our goals, the GIC takes a comprehensive approach to quality improvement. First, the GIC ensures vendor quality via competitive procurements. Second, the GIC routinely reviews the performance of its vendors via comprehensive performance standards and audits. Finally, the GIC collaborates with its vendors to create quality improvement plans and supports vendor-led initiatives in key strategic areas. In FY2016, these included reducing medical errors; increasing enrollment in Integrated Risk Bearing Organizations; improving the integration of behavioral and medical health care; promoting care coordination; addressing the opioid epidemic; helping members access more appropriate and cost-effective care; using data and analytics to drive quality improvement; increasing transparency; and improving customer service.

PROCUREMENTS

The GIC regularly engages in health plan procurements and rate renewals, providing a systematic opportunity to routinely evaluate and improve our plans and their services. The

procurement process is shaped both by expert consultants and the GIC's senior staff and is designed to ensure the selection of high quality services at competitive prices. As part of this process, the GIC negotiates the plans' rates; implements new plan designs and programs; and reviews and revises its contractual performance guarantees. We also pay particular attention to best practices, policy developments, legislative or regulatory mandates, and, of course, the needs and concerns of our diverse membership.

The GIC conducted the following procurements in FY2016:

Vision Benefit Program

The GIC is authorized to provide dental and vision benefits to a specific subgroup of the active employees eligible for GIC benefits. This group consists primarily of managers, legislators, legislative staff, and certain executive office employees who are not covered by collective bargaining. The GIC also provides a separate retiree Vision benefit to all Commonwealth retirees. The GIC conducted a procurement for a vision vendor in FY2016, resulting in a new three-year contract (with two optional one-year renewals) for Davis Vision, whose bid was over $660,000 lower than the nearest bidder.

Life Insurance

The GIC offers three contributory life insurance plans: a Basic Life Insurance benefit for state agency employees and retirees, a Basic Life benefit for Retired Municipal Teachers (RMTs), and optional Life and Accidental Death and Dismemberment Insurance for all members with Basic Life Insurance coverage. In FY2016, the GIC conducted a procurement for a vendor to provide all three plans, resulting in a new five-year contract for The Hartford. In comparison to the prior contract, The Hartford's new contract will result in a projected savings of $5,500,000 over the course of the contract.

GIC Quality Improvement Initiatives

Centered Care Initiative

Increasing enrollment in Integrated Risk-Bearing Organizations

Pursuant to the chapter 224 mandate to move toward alternative payment methodologies, the GIC has required its health plans to restructure their contracts with health care providers to improve health care delivery while managing cost. Since the FY2013 procurement, the GIC's Centered Care initiative has made enrollment in an Integrated Risk-Bearing Organization (IRBO) an integral part of each plan. The hallmarks of IRBOs are financial accountability and contractual commitments to the improvement of care delivery.

The GIC set aggressive goals for member enrollment in IRBOs, with plans required to reach specific benchmarks and milestones. As of FY2016, all six health plans met the FY2016 benchmark of having at least 50% of their members enrolled in an IRBO. The GIC firmly

believes that the increased growth of IRBOs will help our members receive high quality care while holding providers and systems accountable for delivering that care efficiently.

Employer Group Waiver Plan Implementation

Lowering Premiums and Increasing Savings for UniCare State Indemnity Plan/Medicare Extension members

In FY2016 the GIC implemented a new prescription drug program for enrollees in its most popular Medicare plan, the UniCare State Indemnity Plan/Medicare Extension. The Employer Group Waiver Plan (EGWP) and "Wrap" is a standard Medicare Part D plan administered by SilverScript (a division of CVS Health that manages Medicare Part D prescription drug benefits), with a supplemental wraparound plan that offers more comprehensive coverage than a standard Part D plan.

All agency departments were deployed to make the program a success, with two projects serving as particularly notable examples of the demanding nature of the implementation. First, the GIC was required to reconcile over 70,000 member records with those of the Centers for Medicare and Medicaid (CMS). As expected, numerous discrepancies were discovered, and, through file culling and outreach, the GIC ultimately achieved the cleanest files of SilverScript's entire book of business, and the lowest number of errors of its 2016 EGWP implementations.

Second, per CMS regulations, the GIC needed to inform all members of their right to opt out of the SilverScript prescription drug coverage – which would cause them to lose their GIC health, prescription drug and behavioral health benefits. The GIC conducted a comprehensive outreach campaign, with ultimately resulted in ***no members opting out*** of coverage unless they confirmed their desire to do so.

The new EGWP program achieved savings of roughly $30 million in CY2016, enabling the Medicare Extension plan to reduce premiums by 7.2% for FY2017. For retired teachers in the GIC's non-municipal program, the premium went down 10.3%. In addition to premium savings, low-income members can now access prescription drug premium subsidies. Some members prescribed certain drugs are paying lower costs than they did under the CVS Caremark program, as the SilverScript prescription drug formulary is more favorable. Members can also now receive a 90-day supply of prescription drugs at any participating retail pharmacy, and receive their prescriptions at nursing homes and long term care facilities.

Improving the integration of behavioral and physical health care

UniCare, Tufts Health Plan, and Beacon Health Options quality metrics

As part of its ongoing effort to improve care coordination and integration between the medical and behavioral health plans, in FY2016 the GIC developed specific quality metrics to determine the level of integration and areas for improvement. The metrics, which the GIC developed in consultation with leading national and local experts in behavioral health benefit design, are as follows:

- Evidence-Based Practices
    - Initiation and Engagement of Alcohol and other Drug Dependence
    - Screening, brief intervention, and referral for treatment for alcohol misuse
    - Consumer Evaluation of Care: Reporting Positively About Outcomes
- Person-Centered Care
    - Experience of Care and Health Outcomes (or Perceptions of Care Survey) - both inpatient and outpatient
    - Ability to access comprehensive treatment and assessment when needed and desired, in the right setting and geographical area
    - Consumer Evaluation of Care: Family Members Reporting on Participation In Treatment Planning for Themselves and Their Children
- Coordinated/Integrated Care
    - Medication Reconciliation Post-Discharge
    - Referrals to/Communication with Medical Plan
    - Develop processes for the routine screening of persons with increased likelihood of comorbidities. Beacon will work with medical plans to research, operationalize, and build an analysis of the cost of implementation of the following measures in FY 2018:
        - Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications;
        - Diabetes monitoring for people with diabetes and schizophrenia;
        - Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications;
        - Cardiovascular monitoring for people with cardiovascular disease and schizophrenia; and
        - Assistance with Smoking and Tobacco Use Cessation
    - In collaboration with medical plans, develop strategies for the development and deployment of evidence-based guidelines to support the provision of behavioral health services in primary care, including the development of:
        - Strategies to encourage PCPs to provide behavioral health screening, treatment, and referrals.
        - Protocol for psychotropic medication management and review.
        - A referral line for medical/surgical providers to access with behavioral health questions.
    - Work with medical plans to ensure that empaneled clinicians are engaging in collateral communication.
- Data Sharing
    - Medical and pharmacy vendors must share full claims files with behavioral health vendor on a weekly basis, as well as a monthly provider file from the medical plans to ensure greater integration of medical and behavioral health. Medical plans and pharmacy vendors must develop and implement appropriate data sharing procedures, security, and legal releases with Beacon by 9/1/2016.

The metrics will be used to determine a baseline score for FY2017 and establish targets (with financial penalties and/or rewards) for future years. The GIC will also evaluate applying the quality metrics to all our plans' behavioral health benefits.

Reducing medical errors

Leapfrog's Hospital Survey

The GIC has long been a supporter and participant in the Leapfrog Group, a nationwide coalition of large employers and payers pushing for improvements in the quality and safety of American health care. The GIC strongly believes in the mission of the organization and its valuable efforts to potentially improve patient outcomes.

Leapfrog's Hospital Survey, for which the GIC coordinates Massachusetts survey activities, collects and reports hospital performance data. The results are then shared with purchasers and consumers, providing them both with information to make more informed decisions. Leapfrog's Hospital Safety Score initiative assigns letter grades to hospitals based on their record of patient safety, helping consumers protect themselves and their families from errors, injuries, accidents, and infections.

In spring 2016, Massachusetts hospitals collectively had a safety "GPA" of 3.45, which was consistent with their 2015 score. No Massachusetts hospital scored lower than C, a marked contrast to the rest of the country. Over 62% of Massachusetts hospitals received an "A" score, making Massachusetts fourth in the nation behind Vermont, Maine, and Rhode Island.

As of June 30, the Massachusetts hospital response rate to the 2016 Leapfrog Hospital Survey was 83.1%, third among Leapfrog regions. The Massachusetts response rate declined from 2015, when participation was 88.7% as of June 30. The national rate is 43.9%, which was an increase from 40.3% as of June 30, 2015. 58 of the 59 hospitals responding were put in the running for the "Top Hospital" awards that Leapfrog announces in December. While data from the Leapfrog Hospital Survey is used in calculating the Hospital Safety Score if available a response to the Survey is not required for a Hospital to receive a Safety Score.

The 12 hospitals that declined to respond to the Leapfrog Hospital Survey as of June 30, 2016 are:

Health Alliance Hospital (UMass)
†Clinton Hospital (UMass)
Athol Memorial Hospital (Critical Access Hospital)*
Dana-Farber Cancer Institute
North Shore Medical Center – Salem (Partners)
North Shore Medical Center – Union (Partners)
Massachusetts General Hospital (Partners)
Martha's Vineyard Hospital (Partners; Critical Access Hospital)*
Marlborough Hospital (UMass)
†Nantucket Cottage Hospital (Partners)*
University of Massachusetts Medical Center - Memorial Campus
University of Massachusetts Medical Center - University Campus

*Critical Access Hospitals are excluded from the Leapfrog Hospital Safety Score program.
†Clinton Hospital and Nantucket Cottage Hospital are too small to receive a Leapfrog Safety Score.

MEASURING VENDOR QUALITY

Performance Guarantees

While each of the above quality improvement initiatives has its own specific goals and benchmarks, the Group Insurance Commission also holds its vendors to a set of performance guarantees. The performance guarantees measure plans' claims processing; customer service; implementation; enrollee communication; account management; data, systems and reporting; patient safety; and anti-competitive practices.

Customer service-related measures, with potential penalties of a combined $100,000 per year, include requiring vendors to answer calls within 30 seconds; have a call abandonment rate of less than three percent; respond to customer complaints within 30 or 60 days; and resolve 80% of complaints during the member's first call. The GIC routinely revises these metrics to incorporate feedback from our members and customer service staff.

Plans are evaluated on a quarterly basis, with financial penalties if vendors fail to meet the stipulated targets. The GIC reviews its performance guarantees annually to evaluate their efficacy and to consider new ones as appropriate.

Audit

Each year the GIC audits half of its major vendors, with the other half audited the following year. In FY2016, the GIC, via its vendor Truven Health Analytics, for the first time conducted an audit of 100% of claims. According to Truven, this method "tests all claims for modeled attributes, such as eligibility, plan design features, compliance with an administrator's policies and procedures, and industry practices. This 100-percent claims audit approach identifies hard-to-discover, systemic processing errors and potential overpayment recoveries." The GIC is pleased to report that, while there are areas where each plan can improve upon its performance, this new audit methodology showed that the GIC plans are doing a good job of paying claims accurately.

This change of auditing all claims will afford the GIC a more comprehensive view of our vendors' performance than prior years, and provide a greater ability to recover funds and create broad improvements in quality.

VENDORS' QUALITY IMPROVEMENT INITIATIVES

Using data and analytics to drive quality improvement

Harvard Pilgrim Health Care's targeted reports help IRBOs manage cost and quality

In FY2016, Harvard Pilgrim Health Care (HPHC)'s Medical Informatics team improved its reports to help IRBOs more effectively manage GIC members' care. The new reports, including the three described below, help HPHC's IRBOs reduce costs and improve the quality of care for the GIC's members.

- Quality management report: This report identifies gaps in care by producing a list of members who have not had the recommended preventive care for certain chronic conditions (e.g., diabetic members who have not an eye exam). This information enables IRBOs to conduct proactive outreach to schedule these preventive care visits.
- PAID Dashboard report: This report identifies members who have recently received services at the Emergency Room which would be more appropriate for an ambulatory setting (e.g., asthma management). This information allows IRBOs to educate patients on the most appropriate and cost effective care location and to engage certain members in care/disease management options.
- Inpatient Census/Discharge Notification reports: These reports identify IRBO members who have recently been admitted to or discharged from a hospital. IRBOs can use this information to proactively outreach to patients regarding required follow-up care.

Better coordinating care and increasing care integration

CVS Caremark's Care Team Choice program provides support to members with chronic conditions

Effective July 1, 2015, CVS Caremark initiated the Care Team Choice program to provide comprehensive clinical support for UniCare members with eight conditions: Crohn's Disease, Cystic Fibrosis, Gaucher disease, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis, Systemic lupus Erythematosus, Ulcerative Colitis. In Care Team Choice, a care management nurse is embedded into the Specialty Pharmacy Care Team to help to address all aspects of the member's condition, including symptom management, comorbidities, lifestyle concerns and any non-specialty prescriptions the member uses. By working together as one clinical team, CVS Caremark can better coordinate clinical support and intervene earlier and more effectively – increasing member engagement and helping close gaps in care.

The program generates regular outbound patient phone calls, receives inbound calls, and sends welcome letters and educational materials. In doing so, CVS Caremark aims to provide targeted, eligible patients with whole-patient care management, helping prevent avoidable disease complications, including costly ER visits and hospitalizations.

Neighborhood Health Plan's care coordination helps chronically ill members

To reduce costs associated with the most chronically ill members, Neighborhood Health Plan (NHP) launched a clinical monitoring program to identify and enroll care management members who could potentially benefit from personalized clinical interventions. The program monitored the members over a six-month period by providing guidance and resources to help them better understand and manage their illness, resulting in a higher quality of care and lower costs. To roll out the program, NHP hired two dedicated care managers who adjusted their hours to meet members' needs. Since January 2016, more than 70 GIC members have participated in the program, resulting in about one-third of the care plan's goals met. As the program continues to grow, NHP will allocate more resources to further address the needs of this population.

Helping members access more appropriate and cost-effective care, and reduce unnecessary admissions

Fallon Health's plan to reduce inappropriate emergency department utilization

Based on increasing use of Massachusetts emergency department (ED) for non-emergency treatment, Fallon Health developed a corporate-wide plan to reduce inappropriate ED utilization across all product lines using tactics tailored to the characteristics and specific needs of each population.

Inappropriate, avoidable use of the emergency department (ED) is an expensive indication of the opportunity to deliver better-coordinated, more comprehensive care. Inappropriate use has significant impact on both cost and quality of care. Waiting rooms can become overcrowded, and when patients repeatedly visit the ED rather than a primary care physician and they may see different providers each time, which affects continuity of care. A recent CDC study showed that approximately 31% of ED visits in the US are non-emergent. Drivers of ED overuse include lack of access to timely primary care services, referral to the ED by primary care physicians themselves, and financial and legal obligations by hospitals to treat all patients who arrive in the ED.

Fallon Health ED reduction strategies include:

- Broadening access to primary care services
- Developing reporting capabilities to differentiate emergency and non-emergency use of the ED and providing this data to PCPs
- Improving management of chronic disease patients
- Focusing on high utilizers
- Targeting needs of people with behavioral health conditions

Through reporting and measurement, Fallon Health will track the success of the goals to:

- Reduce the number of ED visits for non-urgent ER visits by 5%
- Reduce the number of members having 6 or more ER visits per year by 5%
- Reduce ED encounters/1000 by 5%

To complement these efforts, Fallon Health also expanded its network of urgent care centers and mini clinics by nearly 30 percent. These facilities provide increased and immediate accessibility for GIC members when their PCPs are not available, serving as cost-effective and time-saving alternatives to a hospital emergency department.

Neighborhood Health Plan's program to improve health outcomes and reduce emergency/acute admissions for persons with serious and persistent mental illness

In FY2016, Neighborhood Health Plan and its behavioral health partner, Beacon Health Options, developed the Here for You program, which aims to reach as many as 10,000 members with psychotic or bipolar disorders. The primary goal is to improve health outcomes and reduce emergency room and acute hospital admissions. Here for You provides coordinators at hospitals and in community mental health centers, where many patients receive most of their care. The

program improves communication and coordination between behavioral and physical health care providers to help ensure that patients do not fall through the cracks as they transition between different levels and kinds of care.

Health New England's medication reconciliation program

Medication management is one of the most significant factors contributing to unnecessary hospital readmissions. The majority of medication errors occur during times of transitions, approximately half of hospital-related medication errors and 20 percent of adverse drug events are due to poor communication at transitions. Approximately half of adults experience a medical error after hospital discharge, and 19 percent to 23 percent experience an adverse event, which is most commonly related to medications. Medication reconciliation, which includes an evaluation of the patient's current health status, affects all patients as they move between health care settings. The medication reconciliation process reduces medication errors and patient harm by comparing a patient's current medication regimen against the physician's admission, transfer, and or discharge orders to identify discrepancies.

Due to the importance of the topic, Health New England implemented a Transition of Care Medication Therapy Management Program through its pharmacy benefits manager (PBM). The goal of the program is to reduce readmissions while improving quality-of-care and decreasing overall spend. The PBM pharmacists reach out to members within 72-hours of discharge from selected facilities following hospitalization discharge for Atrial Fibrillation, Myocardial Infarction / Acute Coronary Syndrome, Heart Failure, COPD, Asthma, Pulmonary Embolism, and General Depression.

Addressing the Opioid Epidemic

The opioid epidemic remains a priority for all of the GIC's vendors, each of which continue to shape and implement programs to identify, prevent, and treat opioid use disorder.

Beacon Health Options, UniCare, and CVS Caremark pilot project to identify opioid misuse

Beacon Health Options, UniCare State Indemnity Plan, and CVS Caremark worked together to try to prevent and intervene in cases of opiate misuse. As the pharmacy benefit manager, CVS Caremark monitors prescription data for signs of overuse or uncoordinated care, intervening and educating prescribers as appropriate. CVS Caremark then shares these reports with UniCare and Beacon, which add their utilization data to provide a comprehensive profile of members' clinical information. At that time, the plans work together to identify and engage with persons who may benefit from behavioral health or medical case management.

Fallon Health, Beacon Health Options, and the Gloucester Police Department: Improving access to treatment for Substance Use Disorder

In FY2016, Fallon Health, its behavioral health subcontractor Beacon Health Strategies, and the Gloucester Police Department's Police Assisted Addiction and Recovery Initiative (PAARI)

program agreed to work collaboratively on a pilot program that builds off of the success of PAARI in providing individuals in need of addiction services a pathway for obtaining treatment. The Gloucester Police Department has had success in assisting individuals with obtaining services, primarily Acute Treatment Services or detox services. A combination of persistent outreach to locate a detox bed and a warm handoff has been a large part of the success. Gloucester Police Department's PAARI program has identified that there are additional opportunities to support individuals once they leave the police station, leveraging the health plans' ability to support similar warm handoffs to provide support services focused on guiding people in need substance use services through the system. Fallon Health and Beacon Health Strategies are committed to working collaboratively with the Gloucester Police Department on a pilot program aimed at improving care coordination and discharge planning, providing education to members regarding the services available to them for support, and by collecting data on admissions targeting the reduction of overall recidivism rates.

Increasing transparency

UniCare State Indemnity Plan's SmartShopper program

In FY2016, UniCare implemented the SmartShopper program to address often-significant price disparities for common tests and procedures. The program helps to engage members by providing comparative costs of 37 commonly performed tests and procedures across providers. If members then elect to use the more cost-effective facilities, they become eligible for cash rewards ranging from $50 to $500.

The program has been implemented with a comprehensive promotional campaign including an introduction letter, a roadmap outlining how to use the program and monthly postcards reminding members of the program. Experience with similar programs has shown that significant savings can be achieved as the program becomes popular with members. For example, State of New Hampshire employees have saved over $17 million since the program's implementation in 2011.

Improving customer service

All of the GIC's vendors focused on improving customer service in FY2016. Some examples include:

CVS Caremark: Cross-training customer service representatives

CVS Caremark trained its non-Medicare Care Team in the Pittsburgh call center on Medicare protocols. This enables the same team of customer service representatives to take both non-Medicare and Medicare calls, rather than having Medicare calls taken in a totally separate call center. CVS also assigned one supervisor to oversee both programs for continuity, quality and root cause analysis. Having a designated supervisor and a designed team managing all GIC calls provides enhanced efficiency and user experience for GIC members.

Fallon Health: Helping members more easily obtain affordable Durable Medical Equipment

Fallon enhanced its Customer Service workflows to help members more easily obtain Durable Medical Equipment (DME). Fallon developed a DME network, designating a subgroup of vendors across the service area as "preferred" if they agreed to provide equipment at a lower rate. Fallon added this listing to the Fallon Health website to better enable members to identify high-quality DME providers at a lower member cost-share.

UniCare: Improving Member Communication

UniCare re-wrote its Member Handbooks for the Basic, PLUS and Community Choice plan options to improve understanding and access on information about their benefits. Outdated or overly complex language was eliminated wherever possible, resulting in significantly shorter, more easily-read documents. According to UniCare, "Initial responses from members have been positive."

Beacon Health Options' website redesign

Beacon Health Options overhauled its website to enhance the user experience by providing a more intuitive interface. The website improvements have given members and providers increased access to health improvement tools and information about their behavioral health benefits.

Harvard Pilgrim's Member Services enhancements

Harvard Pilgrim significantly enhanced its Member Services department by hiring additional Member Services Representatives and trainers; promoting five representatives to a new role, Performance Improvement Specialist, to mentor staff and help improve performance; and creating a dedicated Correspondence Team to respond to email and social media inquiries. Harvard Pilgrim states that the changes "have already had a significant positive impact on key call answer metrics, and are enabling us to deliver more prompt member service for the GIC's Harvard Pilgrim members throughout the year."

CONCLUSION

The GIC looks forward to our ongoing collaboration with our vendors to provide high-quality, cost-efficient care to our members. We engage in these processes with an eye towards our long-term objectives: providing high quality, affordable benefit options to employees, retirees and dependents; limiting the financial liability to the state and others to sustainable growth rates; and using the GIC's leverage to stabilize, re-balance and otherwise favorably influence the Massachusetts health care market.

Of course, the GIC does not operate in a vacuum but rather as one of many entities in the Commonwealth, a state rich with thought leadership in transformative health care. We hope that this report serves to inform and complement the work of our elected leaders and other health care stakeholders in Massachusetts.