Commonwealth of Massachusetts
Group Insurance Commission

VENDOR QUALITY IMPROVEMENT

A Report to the Legislature

For Fiscal Year 2018

September 28, 2018

INTRODUCTION

This report is submitted pursuant to Massachusetts General Laws c. 32A, § 21, which states:

> 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 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 provided the Commonwealth's employees and retirees and their dependents with the highest quality benefits at the most reasonable cost. With 430,000 people currently covered under its 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 Fiscal Year (FY) 2018 that comprise the oversight and action necessary for the Group Insurance Commission to fulfill its mandate.

GIC STRATEGIC OBJECTIVES FISCAL YEAR 2018

The GIC's long-term objectives are four-fold:

- Provide access to high-quality, affordable benefit options to employees, retirees and dependents;
- Limit the financial liability to the state and others (of fulfilling benefit obligations) to sustainable growth rates;
- Use the GIC's leverage to innovate and otherwise favorably influence the Massachusetts health care market; and
- Evolve GIC's existing business and operational environment to meet business demands and security standards.

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 FY2018, these initiatives included improving the integration of behavioral and medical health care; promoting care coordination; helping members access more appropriate and cost-effective care; and improving customer service. One example is in the Commonwealth's effort to allow more access to the evidence-based Medication Assisted Treatment (MAT) program, as all GIC vendors have eliminated the prior authorization requirements and member copayments for generic buprenorphine-naloxone and naloxone products, effective July 1, 2017. By eliminating the prior authorization requirements and member cost share for generic MAT medications, we are able to reduce the barriers of access to MAT and encourage members to use generics. Not only does this reduce the out-of-pocket cost for the member, it decreases cost for the GIC and makes it easier for members to access MAT.

PROCUREMENTS

To fulfill its mission of providing members with high-value care at the most reasonable cost, the GIC regularly engages in competitive procurements and annual rate reviews, providing a systematic opportunity to routinely evaluate and improve our plans and our vendors' services. All procurements executed by the GIC are subject to Massachusetts public bidding laws and regulations and are designed to ensure the fair selection of high quality services at competitive prices. Section 4 of Chapter 32A of the Mass General Laws limits GIC benefit contracts to a maximum of five years.

Additionally, 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's contracts with its six health insurance carriers ended on June 30, 2018, after having been under contract since GIC's last medical and behavioral health procurement in 2012 (for Fiscal Years 2013-2018). During that time, the GIC's active and non-Medicare medical and behavioral health benefits offered by all six health insurance carriers featured a variety of products and funding arrangements (fully insured vs. self-insured). For example, some GIC

members received behavioral health and pharmacy benefits through a “carve-in” relationship with their health carrier, whereby members accessed such benefits directly through their health carrier, while others obtained benefits through a separate “carve-out” relationship between the GIC and behavioral health and pharmacy benefit manager (PBM) vendors. With the “carve-out” model, members access their behavioral health and pharmacy benefits through Optum and Express Scripts respectively.

In the spring of 2017, the GIC evaluated the benefit structures of the medical, behavioral health, and prescription drug benefits offered to GIC members. As a result of this process, the GIC moved forward with several key strategic decisions that formed the basis for the FY2018 procurement recommendations: (i) move to self-insured funding arrangements for all products (except the Medicare Advantage product); (ii) carve out prescription drugs to a Pharmacy Benefit Manager; (iii) carve in behavioral health services; (iv) include wellness within health insurance carrier offerings; (v) offer product designs similar to the FY2018 offerings; and (vi) develop a stand-alone Employee Assistance Program.

These decisions necessitated three separate procurements. The GIC conducted procurements in FY2018 for pharmacy benefit manager vendor(s); medical and behavioral health insurance vendors; and an Employee Assistance Program vendor.

1. **Pharmacy Benefits Managers**
   With the high cost of prescription drugs adversely impacting our members’ ability to pay for them, GIC conducted an extensive and competitive procurement process for a new Pharmacy Benefit Manager (PBM). This process led to the selection of Express Scripts (ESI) as the new Pharmacy Benefit Manager (PBM) for GIC’s non-Medicare population. The GIC will continue to utilize the services of CVS Caremark for GIC Medicare members.

   By contracting with one pharmacy benefit manager for the non-Medicare population, the GIC standardized its prescription drug access, ensuring all members have access to the same drugs at the same prices. In addition to achieving benefit consistency, this approach leverages the GIC’s purchasing power and is projected to save the Commonwealth $500-$750 M in averted cost increases over three years, and was instrumental in achieving a zero aggregate premium increase for many members in FY2019.

2. **Medical and Behavioral Health Insurance Carriers**
   The GIC initiated a procurement seeking health insurance vendors to provide medical and behavioral health services to the GIC’s population. In August 2017, the GIC

released a Request for Responses (RFR). The bidders included all incumbents and two new bidders, who were scored for the products bid and for the overall value to members and to the Commonwealth. While originally recommending consolidation, after considering public and member feedback, the Commission ultimately approved re-contracting with all of the existing carriers: UniCare, Tufts Health Plan, Harvard Pilgrim Health Care, Fallon Health, Health New England and Neighborhood Health Plan.

The financial benefits of this procurement allowed the GIC to implement a series of member-friendly benefit design changes for members, including reducing deductibles and co-pays on certain products. For FY2019, the overall premium aggregate increase was zero, and 84 percent of GIC enrollees saw premium increases of 2 percent or less.

3. **Employee Assistance Program**

With a desire to promote employee wellness and well-being, the Group Insurance Commission, in partnership with the Human Resources Division (HRD), released a Request for Responses (RFR) on September 27, 2017 seeking a new Employee Assistance Program (EAP) vendor. This resulted in a competitive procurement with a total of seven bidders. All submissions were scored for competitive price and overall value. Optum was selected as the new vendor, and the EAP initiative has since been rebranded as *Mass4You* in order to increase brand recognition.

As of July 1, 2018, *Mass4You* EAP is available to 344,000 active, benefits-eligible GIC employees and their dependents. Now, as a result of the *Mass4You* EAP, all active, state and municipal employees and their families who are eligible for GIC benefits have access to a comprehensive suite of resources and the confidential support needed to achieve better work/life balance, including in-person or tele-EAP counseling sessions as well as help with financial or legal concerns, child and elder care.

Additionally, as a public service, Optum is offering use of its substance abuse helpline to support anyone coping with opioid and other substance abuse issues. This is the first time the Commonwealth of Massachusetts has offered an EAP of this magnitude to all benefits-eligible employees and their dependents. Optum is expected to provide seamless integration with the GIC's selected health insurance carriers. The belief is that *Mass4You* EAP will be well-received and well-utilized.

GIC QUALITY IMPROVEMENT INITIATIVES

Audit Findings

In FY2018 the GIC, through its vendor Truven Health Analytics (IBM Watson Health), conducted an audit of 100 percent of FY2017 and FY2016 claims of Neighborhood Health Plan, Tufts Health Plan, Harvard Pilgrim Health Care and CVS/Caremark. The audits also covered FY2017 and FY2016 for the Medicare prescription drug plan offered to members enrolled in Tufts Health Plan's Medicare Complement, UniCare's Medicare Extension, and Health New England's MedPlus products.

The audit method tests all claims, such as for eligibility, plan design features, compliance with an administrator's policies and procedures, and industry practices. This approach facilitates identifying hard-to-discover, systemic processing errors and potential overpayment recoveries. It also provides GIC with a more comprehensive view of vendor performance and a greater ability to recover funds and create broad improvements in quality.

The GIC is pleased to report that while there are areas where each vendor can improve upon its performance in claims processing and operations, the audit showed that the GIC vendors are well within industry standards for claims processing and doing a good job paying claims accurately. The overall results for this audit cycle were consistent with the results from prior audits, which were also positive.

Measuring Vendor Quality, Performance Guarantees

The Group Insurance Commission holds its health care and behavioral health 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 include requiring vendors to answer calls within 30 seconds; have a call abandonment rate of less than 3 percent; respond to customer complaints within 30 or 60 days; and resolve 80 percent 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 (potential penalties of a combined $100,000 per year). The GIC reviews its performance guarantees annually to evaluate their efficacy and to consider new ones as appropriate; the results of these annual reviews will be available in October 2018.

VENDORS IMPROVING QUALITY, CUSTOMER SERVICE AND ADMINISTRATION

HEALTH INSURANCE VENDORS

UniCare
UniCare implemented a diabetes prevention program for non-Medicare members at various locations throughout Massachusetts. It is an evidence-based program designed to help members make lifestyle changes to greatly reduce their risk for, or delay the onset of, diabetes. Additionally, UniCare revised its website to streamline annual enrollment information, making it easier for members to access key information to help them select the right plan for them. The website now includes a "What's New" column on the member home page to call out the latest member news.

Tufts Health Plan
As part of GIC's ongoing effort to align incentives between Tufts Health Plan, providers and members to provide coverage for cost-effective, high-quality care, Tufts Health Plan also implemented a new performance based methodology tiering structure. Tiering was completed at the physician group level, and was based on a provider's participation in GIC risk arrangements known as IRBOs (IRBO = Integrated Risk Bearing Organization) and total medical expense, effective July 1, 2017.

For the GIC Navigator tier design, all commercial providers and hospitals were placed in one of three tiers. The Spirit tier design is different from the Navigator tier design and applies only to providers and hospitals who participate in the Spirit product. Hospitals/PCPs and specialists within the same system are in the same tier.

Members of Tufts Health Plan's GIC Navigator and Spirit plans save on their out-of-pocket health care costs by paying lower copays when they receive non-emergency covered services from Tier 1 hospitals and providers. To help GIC plan members manage their out-of-pocket costs, we encourage participating providers to refer their GIC plan members to Tier 1 providers, when appropriate.

Neighborhood Health Plan
Neighborhood Health Plan created GIC-specific communication pieces designed to make it easier for members and those assisting them to better understand their insurance product. These include a comprehensive reference guide with information on benefits, perks, savings options, network, and other key features. The booklet was provided to GIC Agency Coordinators to facilitate their communication with members.

A Transition of Care flyer for members considering moving to Neighborhood Health Plan from another carrier addressed some of the key questions and concerns members may have on the transition.

Neighborhood Health Plan's GIC-designated Customer Service staff received training on all materials to ensure they were prepared to answer questions from both current and prospective members, in advance of this year's Annual Enrollment. To make it easier for members to look up doctors at GIC's

Annual Enrollment health fairs, Neighborhood Health Plan provided training on how to use its provider search tool, and provided computer monitors with keyboards that enabled members to look up providers on their own in real-time. Neighborhood Health Plan staff was on hand to assist as needed and handed out phone wallets that included an insert with directions on conducting provider searches.

Harvard Pilgrim Health Care

Harvard Pilgrim Health Care has revamped its population health strategy to deliver access to healthcare in a more convenient setting, with on-demand access to services. Harvard Pilgrim now takes in daily feeds from Emergency Departments throughout Massachusetts and uses that information to follow-up with members to ensure optimal care at the earliest opportunity. Also, it uses Wellframe, a technology solution that allows Harvard Pilgrim's Care Management department to reach out to members on a HIPAA-compliant platform. This has greatly increased the ability to engage members at times and locations that are convenient to those individuals.

Harvard Pilgrim has increased the coordination and outreach of its behavioral health partner, Optum, to members. Optum now does direct outreach to its members with specific diagnoses and has rounds weekly with Harvard Pilgrim to identify and reach out to at-risk/need members with both medical and behavioral health diagnoses. These higher-touch models are conducted in near real-time, at settings that are convenient to its members.

Harvard Pilgrim also has made consistent improvements to the member's experience in the digital space. In February 2018, it implemented and installed a conditional content engine to allow customized content, presented to members when they log into the Harvard Pilgrim portal. This improves the ability to customize information specifically to each member, based on their own plan design. It also improved the provider and drug lookup experience, making the process simpler for the member. Members are no longer required to enter their specific plan into the engines; instead, the member is recognized and routed to the information specific to their plan design or network, eliminating any confusion.

Fallon Health

Fallon Health implemented a member preference tool to enhance and improve member communications and member experience. The tool allows members to select the means by which they receive communications from Fallon - text, email or mail – enhancing customer service and administrative efficiencies.

Fallon's Medical Economics and Care Services teams continued to improve the reporting suite available to clients, including the GIC, to more effectively manage and monitor members' care and utilization. Fallon implemented a solution designed to strengthen its ability to report data relative to managing populations, current and future cost trends and the quality of services provided to our members.

Fallon's in-house Oncology Management program was expanded to add esophageal, pancreatic and ovarian cancers to the list of cancers managed. The purpose of the Oncology Management program is to improve the coordination and case management for members with cancer leading to decreased inpatient admissions and, when appropriate, increased and earlier admissions into hospice care. In addition to the three newly added cancers, case managers in the program manage colorectal, lung,

breast, and uterine cancer. Program outcomes for 2017 include increased number of referrals to palliative care/hospice by 6.1% and increased average length of stay in hospice to 30 days. Fallon's goals are to maintain focus on fostering care coordination, ensuring continuity of care and continuing to support hospice initiatives.

Health New England

To better position Health New England for population health management, value-based payment models, and clinical transformation activities, Health New England began development of an organization-wide Operational Data Store in September 2017 as a new data asset that supports advanced analytics and reporting. In 2018, the initiative focused on the integration of claims and clinical data into a single data model/architecture and the implementation of a data quality solution to ensure reliable and valid data for analytics and reporting. The first phase is expected to be completed by December 31, 2018 and will produce a fully functioning Operational Data Store comprising 15 independent data sources integrated into one data model, which is capable of producing clinical, quality, and financial reporting.

Health New England has developed a strong "keepage" program since 2015. The goal is to identify tertiary care being referred unnecessarily to Boston providers that could be provided in network closer to home and in coordination with the member's primary care team – ideally affordable, convenient, coordinated care. Starting as a pilot in 2015 with outpatient neurology and cardiology services in partnership with Baystate Health, the program has since expanded, with Health New England's Member Service Team educating members and providers who called in to check benefits and offering education and assistance to members to find care in-network.

ANCILLARY INSURANCE VENDORS

Dental

MetLife

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 and their staff, and certain executive office employees who are not covered by collective bargaining. The GIC also provides a separate retiree dental benefit to all Commonwealth retirees as well as certain municipal retirees whose municipality elects to join the plan. The GIC's dental vendor is Met Life.

For the Active Dental programs, MetLife implemented the following enhancements in FY2018:

- Members' Type I services (preventative and diagnostic) do not accumulate against the members' annual calendar year maximum.
- Periodontal Maintenance was enhanced to a Type I service (reimbursed at 100%) from a Type II service (reimbursed at 80%).
- The Ortho Lifetime maximum for both Active plans was increased from $1,250 to $1,500.
- The annual calendar year maximum for both Active plans was increased to $1,500 for In-Network claims and to $1,250 for Out-of-Network claims.

- The rates for both Active plans were reduced by 6.5% effective 7/1/17.

For the Retiree program MetLife implemented an Enhanced Table of Allowance, and continued maintain the plan's rates, which were unchanged effective 7/1/17.

Additionally, MetLife expanded its Dental network access points in Massachusetts by approximately 8% between FY2017 and FY2018, providing enhanced network access for GIC members. And, it upgraded the *MyBenefits* online member portal providing an enhanced experience for members by making it easier for them to access their Dental plan information.

Vision

Davis Vision
During FY2018, Davis Vision improved accessibility for all GIC members. Specifically, it expanded its Massachusetts provider panel to include a new Visionworks location in Shrewsbury, Massachusetts, and also added Massachusetts Eye and Ear to its provider panel in Boston. It also invested in improvements to its mobile application for members on both iOS and Android to review benefit eligibility, find providers, and submit out of network claims.

Davis Vision has also migrated its Interactive Voice Response to a new platform called INcontact by NICE which will give it a dynamic interface designed for the streamlined handling of all contact center interactions, regardless of channel. Analysis shows this will improve its call center average speed of answer by 18% and its call handling time by 29% making it more efficient in handling both member and provider calls.

Flexible Spending Account

ASIFlex
During FY2018, ASIFlex implemented member-centric improvements to its system and mobile capabilities. Its online self-service now offers immediate email/text alert confirmation of claim information received, allows participants to manage personal account settings for electronic email/text alerts and direct deposit reimbursements, and includes debit card educational material included on its website. Also, ASIFlex has installed upgraded computer systems for handling core processing functions that are expected to provide significant performance improvements, such as increased storage capacity and increased capacity for growth.

Life Insurance

The Hartford
In November of 2017, the Hartford acquired Aetna Group Benefits. This acquisition moves the Hartford to the #2 Life and Disability Carrier spot in the industry with approximately $5 billion in assets. As a result of this acquisition, the Hartford now has access to Aetna's first-in-class systems and technology, which will substantially add to its high level service model and improve the employer and employee claims experience.

Long-Term Disability

Unum

For FY2018, Unum, in partnership with the GIC, implemented a fully telephonic claims-filing process for GIC's Long Term Disability plan. By removing the paper claim form and allowing employees to initiate their claim telephonically, the claim filing process was simplified for GIC members, their care providers and Agency Coordinators. Employees simply call Unum to report their absence and Unum reaches out directly to care providers and Agency Coordinators for any necessary medical and employment information specific to that claim situation. This eliminates the need for GIC Agency Coordinators and employees to gather and provide information that may not be relevant to the particular absence. Although Unum is still in the early stages of this change, it is expected to minimize late-filed claims as employees gather information before contacting Unum, with the goal of reducing decision times and facilitating the gathering of the appropriate claim materials.

CONCLUSION

This was an important year for the GIC during which a rational and more consistent footprint was established for our medical, behavioral health and pharmacy product lines. New products were introduced, prices were controlled and our vendors continued to engage in market leading innovations. Amid a rapidly changing health care market, GIC is committed to supporting health care innovation to benefit our members across the Commonwealth. This effort is driven through our ongoing collaboration with our vendors to continue to provide high-quality, affordable care to our members. Going forward, GIC will be focusing efforts on modernizing its communication channels, shifting toward the use of digital communications as a way to better respond to and engage with our diverse membership and key stakeholders. Additionally, we are strengthening our collaboration with our carrier partners to align messaging and support member education and engagement. This includes working with our partners to promote greater use of digital tools, i.e. new mobile applications to facilitate enrollment in and access to health and other insurance benefits.