MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 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

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization, and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Tuesday, October 16, 2018, 9:00 AM
Wednesday, October 17, 2018, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

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 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses 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 2013, 2014, 2015, 2016, and/or 2017 pre-filed testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so 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.

If you have any difficulty with the templates, did not receive the email, or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC staff at HPC-Testimony@mass.gov or (617) 979-1400.

Pre-Filed Testimony Questions

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.

1. Pharmaceutical spending

Growth in pharmaceutical spending has consistently far exceeded the benchmark. According to the Health Policy Commission's (HPC) 2017 Cost Trends Report, pharmaceutical spending grew at a rate of 7.2% and 6.1% in 2015 and 2016, respectively – the highest rates of any spending category. In 2017, BMCHP observed retail pharmacy trend of 9% and specialty pharmacy trend of 50% (largely driven by Hepatitis-C treatments) in our MassHealth program which comprises 2/3 of BMCHP's business. As a result of continued double digit pharmacy trend, BMCHP's pharmacy expense now comprises approximately 25% of total health care spend, and on its own contributes about 2% to total healthcare spend growth.

2. Opioid crisis

Massachusetts continues to be one of the states hardest hit by the opioid crisis. While the state's opioid-related death rate decreased (by 4%) in 2017 for the first time since 2010, the effects of the opioid crisis on patient care and healthcare costs going forward remains of grave concern. BMCHP data for its New Hampshire Medicaid population shows that from July 2017 through June 2018 total medical expense for patients with opioid use disorder (OUD) was 300% higher as compared to similar patients without OUD. BMCHP also understands that of particular importance to provider costs is the increasing burden placed on resource intensive emergency services to care for overdose victims, which comes at a significantly higher cost to the system than prevention or outpatient treatment, and puts a strain on already limited resources.

3. Mandated nurse staffing ratios ballot question (Question #1)

BMCHP has concerns regarding ballot Question #1, which, if passed, would mandate all Massachusetts acute care hospitals meet strict minimum nurse-to-patient staffing ratios beginning January 1, 2019. As written, the one-size-fits-all approach to staffing would result in dramatically increased costs to consumers, providers, and the state, estimated in the first year alone to add $1.3 billion to the state's overall healthcare spending. Increased cost pressure on providers may lead to payers having to increase provider rates. In effect, Question #1 would significantly impede the state's efforts to promote cost containment and meet the 3.1% benchmark in future years.

b) What are the top changes in policy, market behavior, payment, regulation, or statute would your organization recommend to address these concerns?

1. Pharmaceutical spending. Significant changes are needed in order to control skyrocketing drug prices and prevent pharmaceutical spending from crowding out other important healthcare services. BMCHP supports legislation to promote increased competition and transparency within the pharmaceutical industry. In many cases, prescription drug price hikes are directly correlated with monopolies for the affected drugs. The hope is that increased competition will mitigate short-term price increases while still allowing for innovation that helps improve health and healthcare costs over the long term. BMCHP would also support legislation that promotes greater availability of generic specialty drugs (biosimilars), because branded specialty drugs account for significant portions of drug spend.

2.. Opioid crisis Despite the recent turnaround in the state's opioid-related mortality rate, there remains much to be done in order to reach more vulnerable patients with opioid use disorder and effectively stop the epidemic. We commend the Governor and state Legislature for their recent efforts in passing the Opioid 2.0 bill, which includes many provisions that will advance treatment for opioid use disorder (OUD) across the Commonwealth. We are particularly encouraged by the measures that seek to make Medication for Addiction Treatment (MAT) more available in emergency departments and correctional facilities, as well as the language authorizing an HPC grant program to support programs studying and treating the long-term effects of neonatal abstinence syndrome (NAS) on children as they grow. An area that remains a concern across the Commonwealth is the low number of providers with waiver authority to prescribe MAT. More can and should be done to incentivize greater provider participation and address the low number of prescribers that poses a significant barrier to individuals with OUD accessing MAT. BMCHP's affiliate Boston Medical Center (BMC), through its Grayken Center for Addiction, has long served as a testing ground for many pioneering initiatives in addiction treatment, prevention, training, and research, and will continue its work of spreading best practices.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

The BMC Health System partners with four hospital system-led ACOs across the state – Signature, Southcoast, Mercy, and the Boston Accountable Care Organization (BACO). BMCHP's affiliate Boston Medical Center (BMC) is the anchor institution of BACO. As part of their Total Cost of Care management strategy, each of the ACOs is considering strategies to direct volume to high-quality, low-cost sites of care, where applicable. Directing clinical services to lower-cost providers will play a role in driving down overall healthcare costs. BMCHP also minimizes costs by maintaining a low administrative rate and by leveraging the plan's multi-product, multi-state (Massachusetts and New Hampshire) operations to generate economies of scale.

Over recent years, our system has increased use of alternative payment methodologies – assuming full risk in the aforementioned Medicaid ACOs – and decreased unnecessary hospital utilization. Going forward, these areas remain high-level system priorities, which drive system-wide strategies aimed at reducing health care expenditures. These strategies, which in many ways are complementary and not mutually exclusive, include: high risk care management, strengthening the care continuum, and addressing social determinants of health (or root causes) of high health care utilization.

i.) *High risk care management – i.e., management of the top 2-3% of highest cost patients who account for a disproportionate share of overall cost. Our overarching goal for our high risk care management program is to decrease unnecessary healthcare utilization and improve the relationship patients have with the healthcare system, which together, ultimately aim to improve the health of the population. Specifically, the program aims to reduce costly inpatient and emergency department (ED) visits and increase engagement with outpatient primary and specialty care. As part of these efforts, we are monitoring important clinical indicators, such as readmission rates, low acuity ED visit rates, and medication adherence rates – the latter of which also happens to be an area where our system has a strong track record of success through our Specialty Pharmacy Program.*

Readmissions initiatives include a Readmissions Risk Assessment (RRA) tool which was developed by BMC and embedded into its electronic health record (EHR) built to allow for a real-time, customized readmission risk assessment. The tool links a static data warehouse with a live, dynamically-calculating EHR tool. The RRA tool is now used for the majority of BMC patients and categorizes patients according to their risk for readmissions. After identifying these high-risk patients, BMC deploys high-value interventions during their inpatient admissions and after discharge. This may include pharmacist admission and discharge medication reconciliation, negotiated follow-up appointment scheduling, enhanced needs assessments and case management involvement, and post-discharge outreach calls. As a result of these efforts, unnecessary hospital readmissions have been reduced.

ii.) *Care continuum – Maintaining a robust continuum of care across the system, including primary care provider (PCP) sites and community health centers (CHC), has long been a strategic priority. BMCHP's affiliate BMC is a founder of Boston HealthNet, a network affiliation of BMC, Boston University School of Medicine and fourteen community health centers across the Boston area. Our efforts to strengthen the care continuum dovetail with the state's Community Partner (CP) integration through the Medicaid ACO, bolstering capacity for community-based care. In order to achieve desired cost savings, improving transitions of care between sites of care is a key system goal.*

iii.) *Pathways to address root causes – Social determinants of health are a key driver of high cost and are targeted through numerous system interventions. As an example, we have identified lack of stable and affordable housing as a major strategic area for our system to address in order to positively impact patient and community health. Our system has increased investment in affordable housing and community housing organizations through our $6.5 million Determination of Need initiative, and increased our partnerships with Boston Health Care for the Homeless Program (BHCHP), and the Housing Prescription (Rx) Project, among other initiatives. Please see Boston Medical Center's response to Question 3b (2018 Pre-Filed Testimony - Hospital and Provider Organizations) for further details.*

2. INFORMATION ON PHARMACY BENEFIT MANAGERS

The HPC, other state agencies, payers, providers, and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. Pharmacy benefit managers (PBMs) play a major role in the market, significantly impacting drug pricing and access. Furthermore, PBM policies that restrict the ability of pharmacies and pharmacists to share certain information with patients have been an increasing area of focus.

a) Please identify the name of your organization's contracted PBM(s), as applicable.

Envision Rx Options

b) Please indicate the PBM's primary responsibilities below [check all that apply]
- ☒ Negotiating prices and discounts with drug manufacturers
- ☒ Negotiating rebates with drug manufacturers
- ☐ Developing and maintaining the drug formulary
- ☒ Pharmacy contracting
- ☒ Pharmacy claims processing
- ☐ Providing clinical/care management programs to members
- ☐Other: Click here to enter text.

c) Briefly describe the Massachusetts member populations managed by your PBM (commercial, Medicaid, fully-insured, self-insured, etc.).
Envision Rx Options provides support for BMCHP's Massachusetts Medicaid, Qualified Health Plans, and Senior Care Options products.

d) Does your organization or any PBM with which you contract have policies that restrict the information a pharmacy or pharmacist can share with a covered person on the amount of the covered person's cost share for the prescription drug compared to self-pay (so-called "gag clause")? If yes, briefly describe this policy.
No

e) Does your organization or any PBM with which you contract have policies requiring a pharmacy to charge or collect a copayment from a covered person even if that amount exceeds the total charges submitted by the network pharmacy? If yes, briefly describe this policy.
No

f) Does your organization or any PBM with which you contract have policies requiring a pharmacy to proactively disclose to a covered person if the total charges submitted by the network pharmacy are less than the required copayment? If yes, briefly describe this policy.
BMCHP requires that Envision not allow its participating pharmacies to charge members a copayment that is in excess of the cost of the drug.

3) STRATEGIES TO PROMOTE INNOVATIVE CARE DELIVERY THAT INTEGRATES BEHAVIORAL, SOCIAL, AND MEDICAL CARE

Public and private payers alike are implementing new policies to support the development and scaling of innovative, high-quality, and efficient care delivery, such as, for example, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, reimbursement for services rendered by peers and community health workers, and incentives for patients and providers to engage in evidence-based treatment for substance use disorder.

Has your organization adopted policies related to any the following areas of care delivery improvement and innovation? [check all that apply, and describe your primary incentive related to the care delivery innovation in the fields below]

☒Readmissions Other (please describe in a text box)
BMCHP understands the importance of increasing the community tenure of our members and is operating several programs to intervene with those who are at risk. Inpatient readmissions to the same facility for the same or related condition to the initial inpatient stay are subject to review and payment may be retracted under certain circumstances, including but not limited to, premature discharge, nosocomial infections, medical necessity and complications related to serious reportable events.

Specific to the behavioral healthcare of our members, we offer through programs with Beacon Health Options:

- *Precision case management* – Beacon is investing in machine learning to create predictive algorithms that identify members with high risk of admission or readmission. This will allow the incorporation of thousands of variables to assess each member's risk. Through this process, members can be prioritized and offered a preventative intervention to reduce the likelihood of hospitalization or emergency services.
- *High utilizer support* – On behalf of BMCHP, Beacon is completing comprehensive reviews of members who are frequently readmitting to higher levels of care. These members are connected to community and outpatient supports, who work with Beacon to identify patterns of utilization and collaborate with Emergency Service Providers (ESPs), inpatient providers,

and state agencies to break ineffective cycles in treatment. Care managers create individualized treatment plans for each member enrolled in the program, and maintain increased levels of engagement until the member has reached six months in their community. As a result, we have seen annualized outpatient spend increase while utilization of other levels of care decreased over the course of the members' intervention.

- *Provider quality management* – On behalf of BMCHP, Beacon generates quarterly follow-up after hospitalization profile reports comparing Massachusetts providers to other regional providers and national HEDIS benchmarks. Reports are used to engage providers and collaboratively work to improve performance. Technical support includes training providers on discharge planning and improving compliance with arranging aftercare prior to discharge, monitoring community tenure and readmissions for the network, evaluating utilization of community support programs (CSPs) and care management involvement in preventing readmissions, and notifying primary care clinicians upon discharge.

☒Avoidable emergency department (ED) visits Other (please describe in a text box)
For the behavioral healthcare of our members, BMCHP works with Beacon to utilize many of the programs highlighted above in the Readmissions response to reduce the number of avoidable emergency department visits. In addition, care managers engage in proactive care planning with at-risk members that are designed to ensure that processes are in place to utilize alternatives to the ED in the event of a crisis. Care managers work with the member's therapist, PCP, family and other stakeholders to create a crisis plan that is well communicated among the care team so that the intervention is effective at keeping the member in the community.

☒Behavioral health integration into primary care (e.g., collaborative care model)
Other (please describe in a text box)
BMCHP works with Beacon to offer quarterly initiation and engagement in treatment (IET) profile reports comparing behavioral health providers to other regional behavioral health providers and national HEDIS benchmarks to measure and improve behavioral health integration. These reports are supplemented by quality improvement activities such as:

- Sharing and training an IET toolkit for primary care clinicians (PCCs) to inform them about the importance of integration and screening and referral to treatment;
- Monitoring inpatient records for evidence of communication between behavioral health and primary care, including release of information;
- Encouraging the use of two-way communication form; and
- Providing member level detail to behavioral health providers who index members in the IET measure to assist in supporting members along care pathway.

In addition, Beacon reimburses the providers in the behavioral health network for case consultation codes to ensure that therapists and psychiatrists are compensated for the time spent collaborating with PCPs. This action supports the tenets of the collaborative care model and focuses on finding ways to improve integration through better data-sharing (e.g., patient disease registries), outcomes measurement (e.g., improvement in PHQ-9 scores over time) and alternative payment arrangements (e.g., shared savings based on total cost of care for attributed members).

☒Pharmacologic or other evidence-base therapies for substance use disorder
Other (please describe in a text box)
Specific to working with providers, in 2017, Beacon and Column Health developed a bundled payment program with the goal of providing access to and encouraging the use of medication-assisted treatment (MAT) to treat opioid use disorder (OUD).

Reimbursement for the bundle is designed based on a suggested visit frequency threshold for the covered services; patients may require more or fewer visits based on their individual circumstance. The bundle is billed on a weekly to monthly basis, depending on phase of treatment and frequency of medication management appointments. Encounter claims are collected to reconcile bundle payment against the full set of services delivered.

The payment bundle also incorporates outcomes metrics and bonus payments to effectively align financial incentives with high-quality treatment. Column Health is at risk if it falls below targets on certain measures, while Beacon pays a quarterly bonus for exceptional outcomes performance. Outcomes measures include:

- Admission rates to 24-hour substance use levels of care
- MAT adherence
- Treatment engagement and progression
- Quality of life
- Population health metrics (e.g., participation in Hepatitis C Virus and HIV screenings)

☒Peers and/or community health workers Other (please describe in a text box)
Within the behavioral health space, Beacon on behalf of BMCHP has been guiding the development of peer-run recovery initiatives and the integration of peers in service delivery statewide. This has resulted in a number of efforts to integrate peers and recovery into service systems. Over the years, Beacon has partnered with organizations such as Consumer Quality Initiatives, as well as noteworthy experts working on peer-led initiatives. Beacon currently holds two contracts with local peer-run organizations:

Dual Recovery Anonymous
Beacon has provided funds to support the Massachusetts Clubhouse Coalition (MCC) in providing Dual Recovery Anonymous (DRA) services since FY 1999. DRA is an anonymous 12-step meeting specifically to support those with both a mental health and an addiction condition. DRA offers peers the opportunity to develop leadership skills by facilitating self-help meetings. The program provides mutual support and cross-training through monthly leadership meetings and an annual leadership development conference. This innovative dual recovery model has become internationally recognized by the International Center for Clubhouse Development network.

The MCC DRA Contract:

- Has expanded from ~12 meetings in 1999 to ~50 meetings in 2018;
- Provides funding for DRA support in clubhouses and the larger community;
- Provides leadership support to help meeting leaders bring DRA meetings to hospitals, detoxes, and other facilities;
- Funds the annual DRA Retreat, which offers workshops, training, and networking for DRA members and leaders throughout the state; and
- Helps fund important meeting starter supplies, such as books, coins, workbooks, etc.

The Transformation Center
Since 1999, Beacon has held a contract with The Transformation Center, a state-wide, peer-run technical assistance and training center. The Transformation Center has historically consulted with Beacon on a variety of topics and offered training to Beacon staff. Currently, the contract held with the Transformation Center focuses on the Massachusetts Leadership Academy (MLA). The MLA is a peer-run, in-depth training program that recruits and trains consumers in good citizenship, self-empowerment, and systems knowledge.

The Massachusetts Leadership Academy:

- Is a peer-run leadership and empowerment retreat that trains consumers in self-empowerment and advocacy;
- Accepts ~25 students each year for the weekend-long retreat;
- Enables graduates to go on to be strong advocates in their own communities; and
- Has focused on timely topics such as Back to Work, Health and Connection, Connecting Communities, and the Power of Culture and Language.

☒Telehealth/telemedicine Fee-for-Service Reimbursement
Massachusetts has some of the most restrictive limitations on the use of telehealth nationally. Though Beacon reimburses contracted behavioral health providers for services today, we have not seen the modality used to its fullest potential. Beacon would advocate for telehealth care delivery to be widely adopted and promoted. Telehealth can be promoted to assist with access and speed of appointments, and has done so with great success in many other states nationally without negative clinical impact of the use of a virtual visit as compared to those one at a "brick and mortar" office.

☒Non-medical transportation Fee-for-Service Reimbursement
For Senior Care Options (SCO) members only, BMCHP pays for non-medical transportation to allow the member to continue to function in the community. Transportation is arranged by the member's SCO Care Manager, SCO Concierge Team, Aging Service Access Point (ASAP) or personal care attendant. Services are paid fee-for-service reimbursement.

☒Supportive temporary or permanent housing Other (please describe in a text box)

BMCHP, in conjunction with Beacon, has adopted several programs to address the needs of its homeless population. These include the Community Support Program for People Experiencing Chronic Homelessness (CSPECH), Pay for Success, and the Hospital to Housing program.

CSPECH began in 2005 as a partnership between not-for-profit policy advocacy organizations the Massachusetts Housing and Shelter Alliance (MHSA) and the Massachusetts Behavioral Health Partnership, now a division of Beacon. In 2016, CSPECH was expanded to serve MassHealth members that are enrolled in health plans that collaborate with Beacon, including BMC HealthNet Plan. CSPECH was developed under the authority of the 1115 waiver. It provides supportive services to individuals who meet the U.S. Department of Housing and Urban Development (HUD) definition of chronic homelessness and who have been placed in permanent supportive, low-threshold housing. These services are meant to help members attain life skills and accesses to community resources to remain housed and improve health. Services provided include help with daily living skills, transportation, connection to health care and other services, and case management services.

The Pay for Success (PFS) initiative, also known as Social Innovation Financing (SIF), is another program that benefits homeless BMCHP/Beacon members. Since 2015, PFS/SIF has successfully engaged health plans in efforts to expand permanent supportive housing opportunities for their members. Administered by MHSA, PFS/SIF uses a mix of philanthropic funding and private investor capital from United Way, Santander Bank and the Corporation for Supportive Housing to provide upfront funding to underwrite housing efforts for 500 to 800 chronically homeless individuals over six years. It also uses public resources, including Massachusetts Rental Voucher Program subsidies from the Department of Housing and Community Development, and relies heavily on CSPECH to cover the services necessary to keep chronically homeless individuals stably housed.

CSPECH and PFS/SIF show the power of collaboration among the health care and housing sectors. Organizations that secure housing for chronically homeless individuals need dollars to pay for the intensive services needed by this population and managed care plans need housing resources for their homeless members to allow members to focus on their health care needs. With programs like CSPECH and PFS/SIF, both housing and health care entities are coming together to provide a more comprehensive level of care for members that will bring profound success. Generally, members are referred into CSPECH and PFS/SIF by providers of housing to the homeless, and Beacon keeps track of these members through claims. While Beacon and BMCHP are not typically involved in referrals, there may be instances where case managers at the plan may refer individuals into the programs. One element of CSPECH that has proven to be a challenge is that chronically homeless Medicaid members who are also Medicare recipients are not eligible for the program. Many CSPECH providers have willingly served this population anyway. Yet this may be a disincentive for these providers going forward, as they need to pay for both housing and services for these individuals without the additional resource of CSPECH, which may prove to be unsustainable in the end.

Hospital to Housing

A third initiative that serves chronically homeless BMCHP/Beacon members is the Hospital to Housing (H2H) program. H2H is a three-year grant program funded by the United Health Foundation. It aims to identify 250 chronically homeless members and house at least 100 of them over the course of three years. The program is a partnership between MHSA (the grantee), and Beacon Health Options. It targets homeless adults with serious mental illness and a history of behavioral health inpatient admissions. The goal of the program is to reduce hospitalization and emergency service usage of this population by connecting them to permanent supportive housing.

In H2H, MHSA collaborates with Beacon to hire, train, and deploy five community health workers (CHWs) to "embed" at homeless service providers in three different geographic locations in Massachusetts. The CHWs are employees of Beacon and their role is to find chronically homeless members eligible for the program and connect them to housing and supportive services. CHWs act as system navigators, guiding and supporting members through the often complex and overlapping worlds of housing and health care. CHWs help members through the housing application process and with necessary tasks such as clearing up credit issues and criminal record reviews that often make the difference between securing housing and remaining homeless.

☐Other: Click here to enter text. Required Answer: Click Here

4) STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

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."

a) In the table below, please provide available data regarding the number of individuals that sought this information:

Health Care Service Price Inquiries CY2017-2018			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	**Q1**	21	4
	Q2	7	2
	Q3	1	11
	Q4	19	3
CY2018	**Q1**	44	7
	Q2	42	3
	TOTAL:	134	30

b) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?
BMCHP has not identified any barriers to responding to inquiries in a timely manner.

c) What barriers do you encounter in accurately/timely responding to provider inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?
BMCHP has not identified any barriers to responding to inquiries in a timely manner.

5) INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2015 to CY2017 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2015 to 2017, 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., utilization trend, payer 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.

For CY2015 to CY2017, the impact of benefit buy down was negligible. The majority of BMCHP's membership in years 2015-2017 was in the MassHealth Medicaid program. The member cost sharing in the MassHealth program is minimal and has remained stable from year to year. The other significant portion of our Massachusetts membership came from the ConnectorCare program through

the State Exchange. This offering, which is a Qualified Health Plan (QHP), also has minimal member cost sharing. In CY2017, membership in the Connector Care increased significantly but since member cost sharing is minimal, there was no significant benefit buy down impact in the overall Massachusetts claims trend.

As reported in previous years, the demographic and health status components of trend are reflected in the utilization component. Our membership doubled in the QHP product from 34,000 in CY2016 to 70,000 in CY2017. This new membership has resulted in lower utilization due to a change in demographics and health status of the total Massachusetts population. The lower utilization was also influenced by the fact that new members enrolled throughout the year and utilized the medical services gradually.

6) INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND AND ALIGN APMS

Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. In the 2017 Cost Trends Report, the HPC recommended the Commonwealth continue to promote the increased adoption of alternative payment methodologies (APMs) from present levels of 59% of HMO patients and 15% of PPO patients in 2016. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a) Please answer the following questions related to risk contract spending for the 2017 calendar year, or, if not available for 2017, for the most recently available calendar year, specifying which year is being reported. (Hereafter, a "risk contract" shall mean a contract that incorporates a budget against which claims costs are settled for purposes of determining the surplus paid or deficit charged to a provider organization.)

   i) What percentage of your organization's covered lives, determined as a percentage of total member months, is HMO/POS business? What percentage of your covered lives is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)

      1. HMO/POS 100%
      2. PPO/Indemnity Business 0%

   ii) What percentage of your HMO/POS lives is covered under a risk contract? What percentage of your organization's PPO/indemnity lives is under a risk contract?

      1. HMO/POS 14% - In 2017, our risk partners who were moving to the MassHealth ACO program in 2018 transitioned out of our risk arrangements when the measurement periods ended resulting in a decrease from 2016. In 2018 we expect over 50% of our members to be covered under a risk contract.
      2. PPO/Indemnity Business N/A

   iii) What percentage of your organization's HMO/POS lives is covered under a risk contract with downside risk? What percentage of your PPO/indemnity lives is under a risk contract with downside risk?

      1. HMO/POS 4% - In 2017, our risk partners who were moving to the MassHealth ACO program in 2018 transitioned out of our risk arrangements when the measurement periods ended resulting in a decrease from 2016. In 2018 we expect over 50% of our members to be covered under a risk contract with downside risk.
      2. PPO/Indemnity Business N/A

b) Please answer the following questions regarding quality measurement in APMs.
    i) Does your organization plan to implement the core and menu quality measure set in all of your future global-budget based APM contracts, as applicable, with Accountable Care Organizations (ACOs) as defined by the Executive Office of Health and Human Services' Quality Alignment Taskforce (see Appendix A)?
        (a) If yes, what is your timeline for implementing the measures in contracts? If no, why not?
        (b) BMCHP entered into Joint Venture (JV) agreements to administer four separate ACO Partnership Plans which were launched in March 2018 and is participating in one MCO-Administered ACO. The ACO agreements are risk contracts incorporating both upside and downside risk with an integrated quality component currently comprised of twenty measures defined by EOHHS, many of which are included in the core and menu measure sets. BMCHP integrates a quality component into all plan-administered risk sharing arrangements. The parties mutually agree to a set of 4-5 HEDIS quality measures chosen based on previous performance with the intent to align with initiatives our partners have with their other payers. This supports the payer-agnostic approach to quality taken by most providers and reduces their administrative burden. The suite of measures evaluated for potential inclusion includes the majority of measures on the Aligned Measure Set.
    ii) What are your organization's priority areas, if any, for new quality measures for ACOs?
        (a) In the MassHealth ACO line of business, BMCHP intends to align with the state in measures that most impact this population. For our other populations where BMCHP has risk-sharing arrangements with providers, BMCHP will continue the approach of mutually selecting measures with our provider partners that support ongoing initiatives impacting our members without adding administrative burden.

HPC Payer Exhibit 1 - Question #5

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 2015	1.30%	-10.78%	0.43%	7.22%	-1.83%
CY 2016	4.02%	6.79%	-2.58%	0.83%	9.05%
CY 2017	3.74%	-4.28%	2.78%	0.33%	2.39%

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.