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.

The top areas of concern with respect to the state's benchmark include specialty pharmacy, specifically gene therapy, and end-of-life care.

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

Specialty pharmacy continues to be the major driver of total medical expense (TME) trend for Neighborhood Health Plan (NHP). The most expensive of these treatments, gene therapy, can result in dramatic increases in TME for both health plans and self-insured groups. To control these costs, a dedicated multi-stakeholder group is necessary to determine the value of treatments in relation to TME budgets, such as the Institute for Clinical and Economic Review (ICER). We believe that ICER's approach to establishing value in quality-adjusted life years is a good first step. However, it will be necessary to develop a consensus on the ultimate utilization of these therapies given the limited medical and financial resources. To address this issue, NHP is collaborating with two statewide, multi-stakeholder groups to develop approaches to manage gene therapy treatments. These initiatives, coordinated by the Network for Excellence in Health Innovation (NEHI) and the NEW DIGS program at MIT, evaluate potential approaches to maintain the affordability of new gene therapy treatments.

End-of-life care is both a significant public policy issue and a driver of TME, requiring our collective attention to offer new and effective strategies to improve end-of-life care. As the HPC has suggested, there appears to be a defined need for enhanced patient and provider engagement around end of life care, particularly promoting early conversations about preferences and shared decision making. NHP is focused on this issue for our members and their families. We want to facilitate access to effective treatment that seeks to ease symptoms or control pain, improve quality of life, and help create an end-of-life care plan and includes family members, as appropriate. NHP would encourage additional public policy discussion to help create increased marketplace urgency to address end-of life in the near term.

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.

Our top strategic priorities to reduce health care expenditures are aligned with the concerns previously noted. In addition to the direction suggested above, NHP utilizes multiple approaches to manage specialty pharmacy. As a first step, NHP convenes a Pharmacy & Therapeutics (P&T) Committee that consists of network physicians and pharmacists. The P&T Committee is charged with determining the safety and efficacy of new-to-market drugs. Once safety and efficacy are established, an internal Drug Coverage Committee determines formulary placement and, if indicated, management programs. NHP uses formulary tiering, prior authorization and step therapy programs to ensure that the most cost-effective drug is prescribed for members. In addition, NHP has implemented a vendor-based prior authorization program for a defined set of infused medications that are traditionally provided in a medical setting. The prior authorization program mitigates the "buy and bill" approach that generates excessive costs for these medications.

Regarding gene therapy, NHP employs an internal Medical Technology Assessment Committee that reviews the clinical literature and determines the safety and efficacy of new devices or techniques. If the new product or technique is found to be safe and effective, our Medical Policy Committee determines if a utilization management program is required to ensure that the most cost-effective treatment is delivered. In addition, NHP uses a vendor to develop coverage policies for genetic testing to promote efficient use of these tests for evidence-based indications.

As noted above, end-of-life care is both a concerning public policy issue and a significant driver of TME. In this effort, NHP is collaborating with Partners HealthCare clinicians to develop a preferred hospice and palliative care network. While still in the formative stages, we expect this network will be comprised of facilities who perform well on quality measures and achieve the best outcomes to ensure quality of care and affordability for our customers.

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.

CVS Caremark

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.).

CVS Caremark manages all member populations including commercial, Medicaid, Medicare, fully-insured and self-insured. The member populations that CVS Caremark manages for NHP include commercial and Medicaid for both fully-insured and self-insured accounts.

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.

NHP utilizes the "lesser of" logic, meaning that the member will pay the lowest amount. For example, if the cost of the medication is less than the member's copay, then the member will only pay the cost of the medication.

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: **Primary incentive related to the care delivery innovation – (Other; please also see our response to avoidable emergency department visits below)**

☒Avoidable emergency department (ED) visits: **Primary incentive related to the care delivery innovation – (Other)**

NHP has recently engaged a high technology care coordination vendor to track admissions, readmissions, and emergency department (ED) visits in real time. The care coordination software notifies a case manager immediately when a member enters the hospital or emergency room. Equipped with this data in real time, case managers can then provide social support and clinical services to mitigate future unnecessary visits.

NHP continues to work closely with network providers to extend clinical availability beyond traditional work hours and promote access to non-emergent care (e.g., urgent care centers). In addition, NHP and Partners HealthCare have recently launched an updated telehealth program staffed by emergency clinicians to provide a timely, all-hours alternative to emergency visits (see Telehealth/telemedicine below).

☒Behavioral health integration into primary care: **Primary incentive related to the care delivery innovation – (Other)**

NHP offers the *Here-For-You*^{SM} and Neighborhood Care Circle (NCC) programs. *Here-For-You*^{SM} identifies NHP members with significant mental illness and provides capitated payments to BH providers to better manage this population. Both care management programs are offered to NHP members with significant behavioral health issues (including substance use) as well as complex, comorbid medical concerns. An integral component of both programs is the involvement of members' primary care providers (PCPs) in treatment planning and the development of care plans.

The more developed of the two programs, NCC primarily addresses the social determinants of health for both its commercial and MassHealth populations. The NCC program focusses on the subset of NHP members with the highest predicted medical risk, including highest risk for admission, re-admission, and emergency room use. These members are often not adequately connected to primary care or behavioral health services in the community. The program proactively identifies this group and supports these members by engaging with them through a "face-to-face" model of care coordination that is delivered in the community.

The NCC program is a holistic and multidisciplinary approach to care management, where care managers visit members in their homes, during hospitalizations, shelters, or other public venues and provide food, nutrition education, cell phones and access to (medical/non-medical) transportation, when these services are central to their care and not otherwise available.
The overall objective of the NCC program is to reduce uncoordinated care and improve quality of life while also reducing ER and inpatient visits/admissions. The NCC program serves both pediatric and adult members and is organized in interdisciplinary teams that work intensively to identify barriers to health. The care managers place a strong emphasis on social determinants of care as drivers of medical and behavioral health costs. A comprehensive assessment is conducted in person to identify multidisciplinary barriers to optimal health with each member. Each interdisciplinary team is comprised of a medical care manager, a behavioral health care manager, a social care manager, and a community health worker. The team works together with the panel of assigned members and actively collaborate with PCPs, community services, and families to deliver an integrated and individualized care plan. Each team also has access to a Flex Team,

which is comprised of a nutritionist, a rehabilitation specialist and a peer recovery coach. The program resources intentionally invest heavily in behavioral health disciplines due to the complex bio-psycho-social health challenges this population faces.

In 2019, NHP will be partnering with Optum to manage the behavioral health benefits for NHP members. Optum provides an integrated care management model that is built on the co-location of BH care managers and coordinators. Optum's Medical Behavioral Integration Care Advocates focus on members with the most severe medical behavioral co-morbidities and high-cost/high-need members with serious mental illness, creating a holistic plan of care that provides follow-up and closes gaps in care.

☒Pharmacologic or other evidence-base therapies for substance use disorder: **Primary incentive related to the care delivery innovation – (Co-Payment Reduction or Elimination)**

On the member side, NHP has eliminated cost-share associated with medication-assisted treatment (MAT) for substance use disorder (SUD). In addition, NHP provides coverage of Naltrexone, an opioid receptor antagonist, without cost share for members who are taking greater than 90 morphine milligram equivalents per day. NHP also employs one recovery coach and is recruiting another to work directly with members who are identified with a SUD diagnosis.

Referring members to effective treatment and level of care is imperative when managing members with SUDs, members who may be inclined to access so-called "destination treatment" that is out of network and not founded on evidence-based practices. MAT is the gold standard for detoxification from opioid use disorders (OUD) and some alcohol use disorders, combining FDA-approved medication with counseling, behavioral therapy, and recovery support to deliver improved clinical and cost outcomes.

Traditional approaches to address SUD, such as detoxification-to-abstinence treatment, do not address ongoing cravings, a major cause of relapse. Instead, MAT employs a "chronic condition approach" through an understanding that there are multiple streams of care needed to address multiple conditions - incorporating the use of medication in addition to counseling, cognitive behavioral therapies, and recovery support, to provide a comprehensive approach. MAT can cost up to 75 percent less than residential treatment and is considered one of the most effective treatments for OUD and other SUDs.

With respect to NHP network expertise, NHP recognizes the value of expanding Suboxone expertise and has created an innovative approach to drive provider engagement. NHP is now promoting a financial incentive program to reward clinicians upon completion of Suboxone training as well as additional incentive once they have prescribed Suboxone to more than 10 patients. NHP employs behavioral health clinicians, community health workers and recovery coaches with substance expertise on care coordination teams that outreach to members (by phone and in person) for both the commercial and MassHealth populations. These are small teams that engage the most complex, and costly patients.

☒Peers and/or community health workers: **Primary incentive related to the care delivery innovation – (Other)**

Recovery Coach:

The Recovery Coach (RC) provides peer recovery support services to members of NHP that have SUDs and have expressed an interest in recovery. The RC meets with members in their homes, in public locations, or at treatment settings to support them in moving toward sustained recovery. The RC assesses a member's readiness for behavioral change, identifies recovery needs, and offers suggestions for the appropriate level of care for members with substance use and co-occurring conditions. The RC identifies and addresses barriers to successful recovery and engages members in the development of a wellness plan to achieve the goals of harm reduction and/or abstinence. The RC works both independently and collaboratively with an interdisciplinary team of mobile case managers.

Community Health Workers:

The Community Health Worker (CHW) in NHP's NCC program provides a key role within an integrated, multidisciplinary care management team responsible for contacting and engaging high risk members - the overall goal is increased coordinated care in the community, decreased acute care, a reduction in social determinants, and overall improvement in health and quality of life.

The CHW works primarily in the community, meeting members in their homes or public spaces. The CHW role focusses on engaging and building trust and assessing needs from the member's cultural perspective and experience in their own community. The main role of the CHW is to find, engage and build trust with complex members. The CHW acts as a bridge between the care management team and appropriate treating providers in the community. The CHW accompanies members to healthcare and social appointments and helps with resource applications. In addition, the CHW will evaluate social determinants and barriers that may impact coordinated care and overall positive health outcomes.

☒Telehealth/telemedicine: **Primary incentive related to the care delivery innovation** – (**Accounted for in Global Budget Payment)**

NHP recently launched *Partners HealthCare on Demand*, a telemedicine service for urgent care and visits offered by network PCPs and specialists for the same or less member cost share as an in-person visit, depending on the plan. *Partners HealthCare on Demand* features access to quality providers staffed by Partners HealthCare providers for care within Massachusetts and Teladoc physicians for care within the other 49 states. *Partners HealthCare on Demand* replaced our Teladoc-branded offering in June 2018.

***The Partners HealthCare on Demand* telemedicine initiative is being managed by Partners Connected Health, in collaboration with Partners Community Physicians Organization and NHP. Partners Connected Health is leveraging digital health technologies to deliver quality patient care outside of traditional medical settings, including programs for medication adherence, care coordination, chronic disease management, prevention and wellness.**

This latest benefit expands our current telemedicine offering providing further access to convenient, high-quality urgent care anytime, anywhere from their tablet, smart phone, or computer. Member cost share for the telemedicine visit is the same or less than a PCP visit, depending upon the plan. The combination of low cost, convenient access and wide geographic availability provides our members with an alternative to emergency rooms and urgent care centers for appropriate care. The *Partners HealthCare on Demand* telemedicine initiative is an example of the integrated approach to health care we can offer through our affiliation with the Partners HealthCare system and is part of our ongoing effort to improve health outcomes for our members by providing the right care, at the right time and place.

As mentioned above, NHP will be partnering with Optum to manage behavioral health for NHP members. Optum's Telemental Health (TMH) option provides real-time, audio-video, and HIPAA-secure transmission access to behavioral health providers. Currently, Optum has 183 TMH providers in Massachusetts that consist of:

- **three provider groups**
- **15 MDs**
- **83 MSWs**
- **76 PhDs**
- **six RNs with prescriptive ability**

☒ Non-medical transportation: **Primary incentive related to the care delivery innovation – (Other)**

The NCC program also provides access to transportation for medical and certain non-medical appointments to address underlying social determinants and to improve overall access to care.

For example, NHP has contracted with Community Servings, a food and nutrition program providing medically-tailored home delivered meals to members living with chronic illness. Members who meet criteria are referred to Community Servings for nutrition education and meals for a defined period. The NCC clinical nutritionist develops care plan goals to achieve enhanced understanding of nutrition and its relation to disease prevention and management, improved diet compliance, increased access to healthy foods and overall improved health conditions. Through this intervention members have successfully met these goals. In addition, the NCC program incorporates other unique interventions to support coordinated care and improved health including, distribution of smart phones to members when needed to improve communication with their providers and care team. Anecdotal reports from providers have indicated these interventions have greatly improved communication with their patients and with members keeping appointments.

☐Supportive temporary or permanent housing Required Answer: Click Here
☐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**	3412	126
	Q2	2101	106
	Q3	785	101
	Q4	1048	89
CY2018	**Q1**	1970	91
	Q2	1719	116
	TOTAL:	**11,305**	**629**

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?

Instances of being unable to respond to a request within the required window are quite rare. On the occasion that a request is delayed due to unanticipated dependencies on other areas, the urgency is proactively conveyed at the time the information is requested and escalated for response.

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?

Cost estimate requests have been initiated by consumers/members only.

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.

Attached is summary table "HPC Payer Exhibit 1-2018-NHP" showing medical expenditure trends in Massachusetts for CY2015 to CY2017.

In 2015, NHP experienced significant growth in subsidized non-group membership. On average, these members incur significantly higher claims than NHP's other commercial markets. This influx of subsidized non-group membership resulted in a change in average health status of NHP's population and drove the majority of overall 2015 trend.

In 2016, NHP continued its commercial membership growth. However, on average, the additional membership's risk profile associated with this growth was consistent with existing membership.

2017 trends are driven by changes in provider contracts resulting from provider pressure as NHP began moving from being viewed as a Medicaid health plan to a commercial health plan. Also, changes in the ConnectorCare premium subsidies and premium increases resulted in significant adverse selection within our individual subsidized and unsubsidized business, as members seeking access to NHP's broad network, which includes Partners providers, the Dana Farber Cancer Institute, and Children's Boston hospital were disproportionately enrolled with NHP. NHP is the only carrier to offer ConnectorCare members access to these providers and we remained the least expensive option for members to access these providers in the non-subsidized individual market. This adverse selection raised our overall risk scores by approximately 4% across NHP's commercial lines and is reflected in the higher than average utilization figures for 2017. On a risk-adjusted basis, our utilization trend for CY 2017 is –0.5%.

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 **99%**
      2. PPO/Indemnity Business **1%**

   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 **51%**
2. PPO/Indemnity Business **0%**

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 **51%**
2. PPO/Indemnity Business **0%**

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)? **Yes.**

(a) If yes, what is your timeline for implementing the measures in contracts? If no, why not? **While NHP has not contractually implemented every measure listed in the Massachusetts Aligned Measure Set, NHP does currently use the National Committee for Quality Assurance (NCQA) standards as our foundation for measurement and the required HEDIS and CAHPS measures, many of which align with the state measure set. In the future, NHP will continue to evaluate and expand the use of published measures that appropriately align with our goal to provide access to quality care.**

(b) **N/A.**

ii) What are your organization's priority areas, if any, for new quality measures for ACOs?

(a) **NHP's priority areas regarding quality measures have been around chronic disease management such as asthma and diabetes and the behavioral health measures.**

HPC Payer Exhibit 1

All cells shaded in BLUE should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2015	6.6%	1.5%	0.0%	6.9%	15.0%
CY 2016	6.2%	1.1%	0.0%	1.4%	8.7%
CY 2017	7.3%	3.7%	0.0%	3.6%	14.6%

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.