Neighborhood Health Plan™

SENT VIA EMAIL TO HPC-TESTIMONY@STATE.MA.US

September 2, 2016

David Seltz, Executive Director
Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz:

On behalf of Neighborhood Health Plan (NHP), thank you for the opportunity to provide written testimony in accordance with the Health Policy Commission's (HPC's) request dated July 15, 2016, as provided for in Massachusetts General Law, chapter 6D §8.

NHP is a not-for-profit corporation with operational headquarters located at 253 Summer Street, Boston, Massachusetts. NHP is licensed as a health maintenance organization, under MGL 176G, by the Massachusetts Division of Insurance.

Our testimony is provided in the attached submission templates. I, as a legally authorized and empowered representative of Neighborhood Health Plan, Inc., sign under the pains and penalties of perjury, that the testimony located in Exhibit B, Exhibit 1, and Exhibit C is, to the best of my knowledge, complete and accurate.

Sincerely,

David Segal
President & CEO

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, 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:

Monday, October 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 21, 2016, 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.

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us 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 panelists, testimony and presentations, please check the Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. 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, and/or 2015 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 Microsoft Word template, 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@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. 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. 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.

1. Strategies to Address Health Care Cost Growth.

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are the top areas of concern you would identify for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

Neighborhood Health Plan (NHP) has identified the following areas of concern that will challenge our (and other health plans') ability to meet the Health Care Cost Growth Benchmark set by Chapter 224:

First, prescription drug spending is expected to increase in the near term at or above the pace of the high cost increases seen in the past few years.

For several years now, NHP has seen increased pharmacy claim costs in all of its markets at levels significantly greater than 3.6% growth per year and we expect this trend to continue. These substantial growth trends have been observed and accepted by external sources as well. In its rate development for rating years 2016 & 2017, MassHealth assumes Managed Care Organizations will experience pharmacy trend growth well above 3.6% per year. On the commercial side, reports from actuarial consultants and Pharmacy Benefit Managers all highlight substantial annual pharmacy trends, frequently in the high teens.

Several factors are driving pharmacy cost trends substantially higher than their historical average:

- There is a known "pipeline" of new and high cost specialty pharmacy drugs that are expected to be approved in the coming years.
- Pharmacy Benefit Managers report a shrinking pipeline of generic drugs. When generic drugs come to market and replace a higher cost brand name drug, it reduces overall drug spend. In the past this had the effect of mitigating overall annual cost trends. As the pipeline of new generics slows, the overall cost of drugs increases at a greater rate compared to prior years.
- Policy changes regarding benefit administration can impact drug trends. For example, effective 8/1/2016, MassHealth is requiring MCOs to remove certain medical necessity criteria for Hepatitis C drugs. This loosening of criteria is expected to result in a significant increase in the number of prescriptions authorized for those medications, for which a single course of treatment typically costs between $60,000 and $100,000 per member, depending on the drug prescribed. In order to respond to growing pressure to make access to these lifesaving drugs more available and to ensure equitable treatment among our members, we will be making similar changes to our commercial block of business that are expected to contribute significantly to cost increases in that market as well.

A second area of concern is the impact of the Affordable Care Act (ACA) on commercial premiums.

Below are three ACA initiatives that are expected to impact commercial premiums

- The volatility of several ACA programs in effect since 2014 have caused disproportionate—and to some extent, unpredictable—variation in carrier costs from year to year. We expect this trend to continue into 2017 and beyond. A key contributor to this volatility is the ACA's Risk Adjustment program. Originally designed to compensate carriers who cover sicker members than the market average risk profile, Risk Adjustment has been incredibly complex to implement in practice. In fact, NHP's results from this program illustrate the level of potential volatility: in 2014, the first year this program was implemented, NHP paid over $27 million into the market risk adjustment pool. For 2015 NHP is expected to receive nearly $15 million from the market risk adjustment pool, a variance of $42 million over the prior year. Other carriers saw similar dramatic swings in Massachusetts as well as across the country. Carriers must account for any expected risk adjustment liabilities in pricing; however because of how the program is regulated and implemented, the pricing is done nearly two years before the final risk adjustment liabilities are known. Furthermore, Massachusetts carriers' risk will be evaluated under a new federal model in 2017, about which we have limited predictive knowledge. In fact, CMS (the federal organization that administers the risk adjustment program) has not yet finalized the parameters for the 2017 plan year. This tremendous volatility and uncertainty in pricing contributes to premium rate increases.

  A second ACA initiative change that will lead to higher rate increases in 2017 is the Reinsurance program. This is a temporary program designed to reimburse carriers for a portion of high cost claims incurred by members purchasing coverage in the individual, or non-group, market. This program will be phased out on 12/31/2016. As a consequence, carriers who cover non-group members will incur higher claim costs in 2017 relative to 2016, all other factors being equal. This will disproportionately impact carriers such as NHP that insure a relatively high concentration of non-group members. As a result, such carriers will experience higher claim trends in 2017 relative to the market average.

  A third impact on rising premium costs is a new, annual Health Insurer Tax levied on insurance carriers. Congress placed a moratorium on the Health Insurer Tax for the 2017 benefit year. While this moratorium had the immediate impact of reducing premium costs for commercial coverage in 2017, if reinstated for 2018 or a future year, it will have the opposite effect, namely to increase premium costs.

Third, a continual area of concern is unit cost and utilization trends and the impact of social determinants on health care cost.

NHP is fully committed to ensure that its members have access to quality, affordable health care. NHP has best-in-class care management programs designed to ensure that members receive appropriate care. Our care management programs work with patients, providers, and care management resources in the greater community to provide appropriate, comprehensive, and fully integrated care management services, without duplicating efforts or works of clinicians.

The need to better engage with complex patient populations has recently received increased attention from the Centers for Disease Control and Prevention (CDC) and the World Health Organization who have both noted that conditions in the places where people live, learn, work, and play increasingly affect a wide range of health risks and outcomes. These conditions are known as social determinants of health which NHP views as being of paramount importance. An important component of this effort is effective provider engagement and integration. NHP's strong provider network includes a deep partnership with community health centers that play a key role in addressing social determinants of health given that

they serve at-risk and underserved communities with broad needs. The growing demand for integrated care as well as Accountable Care Organizations and value-based care presents a strong opportunity for the health care delivery system to address these social determinants of health.

Additionally, NHP has a longstanding view that health needs go beyond the delivery of care. This viewpoint is demonstrated through *Neighborhood Care Circle*, a community-based program designed to provide individualized, coordinated support and care to members who are experiencing a range of biological, psychological, and social health challenges. The program's aim is to identify and address a member's unique health care needs in order to improve that member's overall quality of life. This effort uses trained staff to work with underserved populations by effectively addressing barriers related to social determinants of health (housing, transportation, economic stability, nutrition, and language and literacy challenges) which have shown to reduce health care disparities and promote cost-effective care.

As the Health Policy Commission has recognized, there is growing recognition of the need to address social determinants in health care. The Baker administration's recent Medicaid Section 1115 Demonstration Project Amendment and Extension Request is a prime example of this recognition. We would suggest that our evolving health care system needs to better recognize and address the total cost of care and all its attributes, including social determinants. In addition to impacting health, the failure to address social determinants often leads to health care disparities that have a costly impact on overall quality of care through added expense, productivity loss, and even premature death. Our concern is that the ever-changing health care delivery system, without recognition of the social determinants of health, would lead to a missed opportunity and a public health failure.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

With respect to the areas of concern raised, here are changes in policy or regulation that we believe would support the goal of meeting the Health Care Cost Growth Benchmark:

- We urge the HPC to consider alternative methods when estimating carrier-specific risk-adjusted trends in order to capture the true risk and cost associated with these emerging therapies. In addition, pharmaceutical companies should be held to the same level of scrutiny as health plans and providers in their efforts to control the increasing costs in health care. As noted above, prescription drugs continue to be a main driver of overall claims spend. The Massachusetts Center for Health Information Analysis (CHIA) typically reports carrier-specific trends in Total Medical Expense (TME) on a risk-adjusted basis. However, diagnosis data (the foundation of many risk models) is becoming more removed from the actual cost of drugs as more and more high-cost specialty drugs make up total pharmacy spend. There is the potential for a disconnect in that TME, even on a risk-adjusted basis, may not capture the true risk and cost profile associated with new high-cost drugs if those drugs were not included in the original risk model's calibration algorithms.

- With respect to the volatility of ACA programs, in the short-term, more frequent (e.g. monthly) risk adjustment simulations should be made available to health plans by the Connector which would better enable plans to predict costs. And as Massachusetts plans its movement to the Federal Risk Adjustment program, Massachusetts officials should encourage CMS to continue to refine its Risk Adjustment methodology, inclusive of increasing the induced demand factor for ConnectorCare plans; and seeking a partial enrollment credit.

- As noted above, effective engagement of complex patient populations requires recognition of the social determinants of health to be part of any effective solution. NHP would strongly support a public policy effort that includes this vital data as an important part of the overall effort to bring health care spending growth in line with growth in the state's overall economy. The Health Policy Commission's (HPC) stated mission is to advance a more transparent, accountable, and innovative health care system through independent policy leadership and investment programs. We support this mission and applaud the HPC's recent targeted investment in programs that address social determinants among the Health Care Innovation Investment Program awardees. The evolving health care system needs to better recognize and address the total cost of care and all its attributes, including social determinants, and our health policy should reflect and/or incent this goal. We are hopeful that the HPC will build on these recent investments as well as other successful programs, through policy development that encourages the local health care delivery system to initiate broad strategies that address the social determinants of health, including the development of best practices related to screening and program criteria. NHP firmly believes that continued investment in care that recognizes the underlying drivers of health, like social determinants, provides a more complete picture of cost and will serve the Commonwealth well with regard to overall cost as measured by the Health Care Cost Growth Benchmark.

2. Strategies to Address Pharmaceutical Spending Trends.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising pharmaceutical prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Do you contract with a pharmacy benefit manager (PBM)? Yes

   i. If yes, please identify the name of your PBM.
   CVS Caremark

   ii. If yes, 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

b. In the table below, please quantify your projected per-member-per-year (PMPY) rate of growth in pharmaceutical spending for different lines of business and drug types from 2015 to 2016.

Line of Business	Total Rate of Increase (2015-2016)	Rate of Increase for Generic Drugs Only (2015-2016)	Rate of Increase for Branded Drugs Only (2015-2016)	Rate of Increase for Specialty Drugs Only (2015-2016)
Commercial	**6.8%**	**-37.1%**	**21.1%**	**27.7%**
Medicaid	**-1.9%**	**-33.6%**	**17.1%**	**10.1%**
Medicare	**n/a**	**n/a**	**n/a**	**n/a**

Note: NHP changed our Pharmacy Benefit Manager (PBM) on 1/1/2016 which led to significant reductions in pricing for higher use generic drugs.

c. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including pricing, purchasing, prescribing, and utilization. Using the drop down menu, please specify any strategies your organization is currently implementing, plans to implement in the next 12 months, or does not plan to implement in the next 12 months.

i. Risk-Based or Performance-Based Contracting
Plans to Implement in the Next 12 Months

ii. Utilizing value-based price benchmarks in establishing a target price for negotiating with drug manufactures on additional discounts
Does Not Plan to Implement in the Next 12 Months

iii. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing).
Currently Implementing

iv. Monitoring variation in provider prescribing patterns and trends and conducting outreach to providers with outlier trends
Currently Implementing

v. Establishing clinical protocols or guidelines to providers for prescribing of high-cost drugs
Currently Implementing

vi. Implementing programs or strategies to improve medication adherence/compliance
Currently Implementing

vii. Pursuing exclusive contracting with pharmaceutical manufacturers
Does Not Plan to Implement in the Next 12 Months

viii. Establishing alternative payment contracts with providers that includes accountability for pharmaceutical spending
Currently Implementing

ix. Strengthening utilization management or prior authorization protocols
Currently Implementing

x. Adjusting pharmacy benefit cost-sharing tiers and/or placement of certain drugs within pre-existing tiers
Currently Implementing

xi. Shifting billing for certain specialty drugs from the medical benefit to the pharmacy benefit
Does Not Plan to Implement in the Next 12 Months

xii. Other: Insert Text Here

xiii. Other: Insert Text Here

3. Strategies to Increase the Adoption of Alternative Payment Methodologies.

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 2015 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2017.

a. What are the top strategies your organization is pursuing to increase use of APMs, including efforts to expand APMs to other provider types including hospitals, specialists (including behavioral health providers), and new product types (e.g., PPO)? (Please limit your answer to no more than three strategies)

During the past several years, NHP has implemented Alternative Payment Methodologies that include primary care-focused shared savings programs, capitated risk arrangements, and budgeted and percent-of-premium arrangements. Many of these arrangements include the expansion of hospital and specialty services. NHP continues to explore opportunities to incorporate bundled-payment arrangements (and other risk arrangements) with specialty and ancillary providers—including behavioral

health services.

- NHP continually evaluates its current network of providers to identify expansion of APM. Through analysis of membership, performance, and organizational structure of the provider group, NHP engages the provider around opportunities to move to APM arrangements. In creating an APM with a provider group, it is important to understand the provider's readiness and ability to be in an APM.

- NHP views the development of ACOs as a top strategy in expanding APMs across our provider network. Under an ACO model, an APM can support new and innovative models of care delivery that are patient-centered, highly reliant on primary care, quality-focused, and data driven. This creates financial incentives for all providers who are appropriately aligned in the patient-care value chain.

- Another key strategy to expanding APMs is through focused work with behavioral health providers through our behavioral health partner, Beacon Health Options (Beacon). One notable example is our "Here-for-you" program. It features a care coordination model that outlines an innovative and integrated approach to the delivery of care coordination services. It is reimbursed via a monthly case rate for service provision. Beacon and NHP pay for provider participation in a different way than in the past; we propose a mix of FFS and case rates to pay for day-to-day care in addition to a share of total medical savings including pharmacy, behavioral health, and physical health costs.

- As NHP looks at opportunities under PPO products, we continue to monitor membership and while membership remains low (currently less than 500 individuals), PPO members are required to select a PCP, and in doing so may select a PCP that is under an APM contract with NHP. Given this small membership, NHP has not directed any analysis/action to date that is specific to the PPO membership. As membership in this product grows, NHP will examine whether specific analysis/action is needed.

b. What are the top barriers to increased use of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

Many providers are vocal about the need to standardize performance measurements across payers and programs. Substantial IT, reporting, and other administrative work is required to monitor and track financial and clinical outcomes against contract requirements. It is discouraging to providers that want to focus on delivering quality care to have to divert attention and resources to design and implement processes to capture and review different performance measurements to satisfy each payer's demands.

Standardizing these measures—such as limiting them to metrics that are part of the Standard Quality Measure Set (SQMS)—will help ease that burden and allow more focus to go towards service delivery.

While many providers have expressed a desire to enter into APM contracts, many are not prepared to support the new type of contract. There are significant clinical, operational and financial changes that impact a provider's business model when implementing an alternative payment contract. Providers need to be able to understand data and effectively use it to drive decision making. These providers

need training, consultation, and technical assistance over a period of time in order to successfully transition into this new model.

c. Please describe your organization's specific efforts to support smaller providers, including ancillary and community providers, who seek alternatives to fee-for-service payment models.

Over the past several years, NHP has partnered with over 20 community health centers and provider groups to participate in a Medical Shared Savings program. This program, in its fourth year, has allowed providers to become more comfortable with some components of risk under an upside risk-based program. These arrangements include selected cost and utilization metrics, as well as HEDIS quality metrics. The goal over time is to move these providers on the risk continuum as they continue to develop and enhance practice capabilities in:

- Care management and coordination
- Payment innovation and finance administration
- Population health management
- Outcome-focused quality measurement and management

NHP looks to include additional providers under this model as well as explore new models that support other smaller providers and ancillary and community providers.

Similarly, our behavioral health partner Beacon actively engages with providers of all different sizes to find a viable solution that is tailored to their unique circumstances. As an example, Beacon is about to enter into an APM relationship with a community health center in the Northeast region of the state to pilot an ambulatory detox program that will expand access to services in an area where there is a shortage of inpatient beds. Payment will be based on a daily rate for a bundle of services.

4. Strategies to Align of Technical Aspects of APMs.

In the 2015 Cost Trends Report, the HPC called for an alignment and improvement of APMs in the Massachusetts market.

a. Please describe your organization's efforts to align technical aspects of APMs with Medicare and other plans in the Commonwealth, including specifically on quality measures, patient attribution methodologies, and risk adjustment (e.g. DxCG, HCC scores).

NHP strives to use industry-standard technical aspects in APMs that align with non-Medicare plans. HEDIS quality measures provide standardized measures and are used as a basis for NHP's APM quality measures. Further, NHP's Medicare APM model uses methodologies for patient attribution and risk adjustment that are consistent across all APMs.

b. What are the top barriers to alignment on these technical aspects and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

The presence of many options of methodologies available can create barriers for a provider and plan to reach agreement on best suited technical aspects (based on populations and other programmatic issues). From the plan perspective, NHP's standardized model seeks to be consistent across APMs for ease of reporting and to limit customization. It is critical that all methodologies are documented and agreed upon at the start of an APM arrangement. A Provider's preference of certain methodologies that best support their models can create barriers to alignment and require the plan to customize APMs and

not use standardized reporting. Limiting methodologies available for APMs may help streamline agreement and lessen the need for customization across APMs.

5. **Strategies to Increase Access to Pharmacologic Treatment for Substance Use Disorder.**
Despite a strong evidence-base, pharmacotherapy is underutilized to treat substance use disorder. Last year, several private payers committed to covering more pharmacologic treatment to address the increasing needs of patients.
    a. What are the top strategies your organization is pursuing to increase access, including affordability and provider availability, of pharmacologic treatment for your members with substance use disorder? Please include in your answer a description of any changes to coverage policies (e.g. cost-sharing, prior authorization, utilization review, duration of treatment limitations) or reimbursement strategies you have implemented or plan to implement with regard to pharmacologic treatment. (Please limit your answer to no more than three strategies)

NHP utilizes two main strategies to increase access to and affordability of pharmacotherapy to treat substance use disorder.

First, we are collaborating with our behavioral health partner, Beacon, to develop alternative payment models with providers of Medication-Assisted Treatment (MAT) in order to align financial incentives with the targeted clinical outcomes associated with a successful pharmacologic treatment regime.

In partnership with MAT providers, Beacon is developing standard bundled payments for clinic-based models focused on long-term MAT. In addition to MAT, services include psychotherapy and other wraparound services necessary to promote treatment adherence. The contracts are structured in such a way as to provide the cash flow necessary for providers to expand their services and locations in order to increase access for members.

Our second strategy is a focus on seamlessly transitioning members from inpatient withdrawal management/detoxification programs to outpatient methadone maintenance. As it currently stands, outpatient methadone treatment programs report that most of their patients are self-referred and rarely receive referrals from inpatient withdrawal management programs. Our goal is to reverse this trend by ensuring that all members leaving inpatient detox are offered MAT. To do so, Beacon piloted an effort with one large provider that has a comprehensive continuum of care. Together, they developed mechanisms for internal transfers, as well as for external transfers/direct admissions to an outside methadone provider. This approach addressed the issue that many episodes of treatment are cut short when members relapse in the high-risk period of abstinence between inpatient withdrawal management and outpatient MAT and has demonstrated strong member adherence to treatment.

It should also be noted that NHP's pharmacy benefit strategy encourages the appropriate use of MAT medications that are based on appropriate clinical use and allows prescribers and members wide choice of MAT therapies.

    b. What are the top barriers to increasing access to pharmacologic treatment for your members and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

The top barriers to increasing access to pharmacologic treatment for NHP members and how they should be

addressed are the following:

- Provider access: Providers have historically been restricted on the number of patients they can treat with buprenorphine yearly (100 maximum). While recent legislation increased that number to 275, providers are unlikely to increase the number of patients treated in the absence of incentives. NHP, via Beacon, will continue to expand their standardized bundled payment for buprenorphine treatment across more providers in order to provide such financial incentives.
- Care pathways: Care pathways are discontinuous and are inadvertently designed to not promote continuity of MAT from one level of care (LOC) to another. The current pathways of care within our substance use provider network evolved in the context of alcohol being the primary substance of choice and abstinence being the preferred outcome. This creates a barrier in opioid use disorder treatment that allows members to relapse following acute care while awaiting access to MAT. This barrier should be addressed by focusing provider reimbursement on full episodes of care where possible. Efforts also need to continue to encourage direct admission into outpatient MAT programs from inpatient withdrawal management services.
- Provider bias toward abstinence: Some providers do not fully embrace the evidence-based practice of long-term MAT as a legitimate treatment for substance use disorders. Consequently they fail to educate members around the availability of MAT treatments, and, in some cases, refuse to treat members who are not willing to adhere to an abstinence-based treatment model. A multi-pronged approach that includes peer education, payment incentives, and outcomes-based feedback to providers is needed to address this barrier.

6. Strategies to Support Telehealth.

In its 2015 Cost Trends Report, the HPC recommended that the Commonwealth be a national leader in the use of enabling technologies to advance care delivery transformation.

a. Does your organization offer or pay for telehealth services? Yes
   i. If yes, in which scenarios or for which categories of care or specific populations do you pay for telehealth services (e.g. primary care, behavioral health, elderly, rural, etc.)?

NHP, through our Managed Behavioral Health Organization, Beacon, has begun to reimburse some behavioral health providers for appropriate and medically necessary telehealth services. Telehealth services are specific services that can be provided to members who are unable to receive outpatient psychopharmacology and/or psychotherapy treatment locally due to a lack of available resources in their geographic area, due to clinical reasons, or due to other preferences. Individuals who can benefit from receiving telehealth services include those with mental illnesses, chronic and acute medical illnesses, substance use disorders, family problems, and a vast array of personal and interpersonal challenges. The goal of telehealth services is to improve access to and delivery of psychopharmacology and/or psychotherapy services to ensure that all members receive the best possible care regardless of geographic location.

By the fall of 2016, Neighborhood Health Plan (NHP) will launch a dermatology telehealth pilot with seven Community Health Centers under the Partnership for Community Health Grant Program. The pilot program will be available to all NHP Medicaid and Commercial members at the seven health centers. Referral to the service is made through the member's primary care provider. The pilot involves new innovative high resolution photo technology in which the PCP takes pictures and submits the photos and observations to one of the participating dermatologists through a proprietary tool. The dermatologist reviews the image and recommends next steps to the PCP.

   ii. If yes, how do you pay for these services (e.g. equivalent FFS rates as office visits, partial FFS rates, as part of a global budget, etc.)?

Beacon's reimbursement for Telehealth is equivalent to the negotiated FFS rates for the equivalent face-to-face encounters.

For the dermatology telehealth pilot, NHP has established a FFS rate which is a fractional rate as compared to the reimbursement for traditional in-office dermatology consult visits.

iii. If no, why not?
37T

7. Strategies to Encourage High-Value Consumer Choices.

In the 2015 Cost Trends Report, the HPC recommended that payers continue to innovate and provide new mechanisms that reward consumers for making high-value choices. The HPC highlighted strategies such as providing cash-back incentives for choosing high-value providers and offering members incentives at the time of primary care provider selection.

a. Do you currently offer cash-back incentives to encourage members to seek care at high-value providers? No
    i. If yes, please describe the types of cash-back incentives offered.
    37T

    ii. If no, why not?

NHP does not currently employ cash back incentives to encourage members to seek care at high-value providers.

NHP is in the process of evaluating new capabilities that marry provider selection with cost, and will enable a consumer to choose providers based on the values that s/he prioritizes. NHP is targeting 2017 for these new capabilities, and it will include optimal ways to encourage members to seek care at high-value providers.

b. Do you currently offer incentives (e.g. premium differential) at the point of enrollment or the point of primary care provider (PCP) selection to encourage members to select high-value PCPs? No
    i. If yes, please describe the types of incentives offered.
    37T

    ii. If no, why not?

NHP does not currently employ premium differential incentives at the point of enrollment or PCP selection. However, NHP leverages two distinct programs to enable members to have tools that guide the best selection based on their individual needs.

First, a program that we have launched, in partnership with a large employer account, encourages utilization of providers that have been identified as high value. While there is no monetary incentive attached to the program, there is a robust member education plan that includes outreach calls, as well as written and online communications that reinforce the benefits of selecting primary care providers that participate in the program.

Second, NHP has member education and outreach programs in place, in English, Spanish, and in the mode preferred by members, to guide members to understand their out-of-pocket costs and the

importance of primary care provider selection. We monitor member feedback around this program, and we continue to have over 80% of our members finding this program valuable.

We have taken these approaches to be extremely mindful of adding administrative costs, under a deliberate strategy to ensure the highest quality plan at an affordable premium. In parallel, we continue to monitor provider performance and have action plans in place, when necessary, to ensure our network is made up of high-value, high-quality, efficient providers.

8. Strategies to Increase Health Care Transparency.

Chapter 224 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. Please provide available data regarding the number of individuals that seek this information in the following table:

Health Care Service Price Inquiries CY2015-2016			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2015	**Q1**	244	55
	Q2	299	73
	Q3	371	69
	Q4	463	62
CY2016	**Q1**	689	82
	Q2	533	93
	TOTAL:	2599	434

9. Information to Understand Medical Expenditure Trends.

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2013 to CY2015 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2013 to 2015, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).

In each of 2013 and 2014, approximately 25% of the actual observed allowed claims trend is due to benefit changes. This impact is reflected in the utilization and service mix categories of "HPC Payer Exhibit 1". Changes in the health status or population demographics are minimal for these years.

However, in 2015 NHP experienced significant growth in subsidized non-group membership. On average these members incurred 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 is driving 2/3 of the overall 2015 trends. This impact is reflected in each of the unit cost, utilization, and service mix categories of "HPC Payer Exhibit 1". Aside from this population mix impact in 2015, changes to benefits or demographics had minimal impact on 2015 trend.

10. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) increase the adoption of APMs; c.) support alignment of APMs; d.) increase access to pharmacologic treatment; e.) support the adoption of telehealth; f.) encourage high-value consumer choices; and, g.) enhance consumer price transparency and utilization of transparency tools.
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Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please answer the following questions related to risk contracts and pharmaceutical spending for the 2015 calendar year, or, if not available for 2015, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)

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

HMO/POS	99.94%
PPO/Indemnity Business	0.06%

    b. What percentage of your HMO/POS business is under a risk contract? What percentage of your PPO/indemnity business is under a risk contract?

HMO/POS	23%
PPO/Indemnity Business	0%

    c. What percentage of your HMO/POS business that is under a risk contract has carved out the pharmaceutical benefit? What percentage of your PPO/indemnity business that is under a risk contract has carved out the pharmaceutical benefit?

HMO/POS	0%
PPO/Indemnity Business	0%

    d. For your risk contracts that include the pharmaceutical benefit, how is the provider's pharmacy budget set? How is the budget trended each year?

    Provider's budget is based on internal NHP projected increases in pharmacy expenses. NHP's projected increases are based on actuarially forecasted expense trends combined with the expected release of specialty drugs that will enter the market in the performance year.

    e. For your risk contracts that include the pharmaceutical benefit, how, if at all, are pharmaceutical discounts and/or rebates (e.g., from the manufacturer) incorporated into the provider's pharmacy budget?

    Rebates are excluded from risk contracts as they are not part of the baseline used to develop the provider's pharmacy budget.

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 2013	3.8%	1.1%	0.0%	1.3%	6.2%
CY 2014	4.2%	0.3%	0.0%	2.4%	6.9%
CY 2015	6.6%	1.5%	0.0%	6.9%	15.0%

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.