



Via email: HPC-Testimony@state.ma.us

September 15, 2015

David Seltz, Executive Director
Commonwealth of Massachusetts
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Mr. Seltz:

Beacon Health Strategies LLC, doing business as Beacon Health Options (Beacon), is pleased to submit our response to the Health Policy Commission's (HPC) questionnaire. We appreciate the HPC's attention to the important matter of behavioral health and stand ready to assist with our experience to improve the standard of care within the Commonwealth of Massachusetts.

As a managed behavioral health organization (MBHO), Beacon has been a long-standing partner within the Commonwealth to serve at-risk populations living with mental health and/or substance use disorders. Through partnerships with local health plans and employers, we currently manage approximately \$800 million in behavioral health reimbursement in Massachusetts through coverage of 1.3 million members. Our collaborative approach to arranging, coordinating, and managing behavioral health services has supported overall improvements in health outcomes for these members through the delivery of a contracted network of high-quality services across the Commonwealth.

The testimony provided on the following pages addresses all lines of business for Beacon Health Strategies LLC. Please note that Beacon's responses to this questionnaire are limited to behavioral health benefits and therefore should not be interpreted to address broader health care coverage. Also, some questions are simply not applicable to the services performed by Beacon. For those questions, Beacon defers to others to provide responses.

I certify that I am legally authorized and empowered to represent Beacon for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury.

Thank you again and please do not hesitate to contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Timothy R. Murphy", written in a cursive style.

Timothy R. Murphy
Chief Executive Officer
Beacon Health Options
Office: 617.747.1111
Cell: 617.447.4583
timothy.murphy@beaconhealthoptions.com

Exhibit B: HPC Questions for Written Testimony

Beacon Health Strategies LLC, doing business as Beacon Health Options (“Beacon”), makes the following responses:

1. Chapter 224 of the Acts of 2012 (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.
 - a. Please describe your organization’s efforts in the last 12 months to meet this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs) on (i) total medical expenses, (ii) premiums, and (iii) provider quality. Please specifically describe efforts and analyses related to bundled payment and similar payment methods.

Over the past 12 months, Beacon did not have any contracts that included alternative payment methods (APMs) in Massachusetts. However, Beacon built data sets to share with providers as a means to educate them about the outcomes based on services they offered through our preferred provider program (known as “Beacon Select”). By doing so, Beacon was able to identify those providers who were equipped and positioned to move from a fee-for-service model to an alternative payment method in the future.

Beacon Select is a calculated and standardized precursor to shifting providers into alternative payment relationships. The overarching goal of the program is to encourage inpatient mental health and substance use providers to meet or exceed quality indicators on behalf of their admitted patients. These quality indicators include:

- Average length of stay
- 7/30-day readmission rates
- Incidence of coordination between the inpatient provider and the member’s primary care provider
- Incidence of coordination between the inpatient provider and the members’ outpatient behavioral health provider
- Aftercare appointments scheduled by facility within seven days of discharge

By meeting these standards, Beacon and inpatient providers are better able to develop bundled payment reimbursement structures that are mutually beneficial.

In terms of active APM relationships, in 2014, Beacon engaged in a contract with a small number of Massachusetts providers for care management of a small population of high-risk and acute members. The compensation is a global fee for a grouping of services. Beacon does not yet have any data to analyze and provide regarding that contract. Given the size and complexity of the population, Beacon expects to have reportable outcomes in 2016.

- b. Please describe specific efforts your organization plans to undertake between now and October 1, 2016 to increase the use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider and product types. Please specifically describe efforts related to bundled payment and similar payment methods.

Beacon worked throughout 2013 and 2014 to build new data sets to share with behavioral health specialty providers to educate them about population management. In addition, Beacon started open-ended discussions with several large-scale behavioral health providers about APMs. Beacon expects to begin small-scale, population-specific pilot programs in 2015 or 2016 to bring APMs into the market in 2016 and 2017.

- c. In its 2014 Cost Trends Report, the HPC stated that major payers and providers should begin introducing APMs for preferred provider organization (PPO) covered lives in 2016, with the goal of reaching at least one-third of their PPO lives that year. Please describe your plans to achieve this goal. Additionally, please describe any specific barriers for moving self-insured business into APM arrangements.

In Massachusetts and elsewhere, reimbursement structures will change. The misaligned incentives of a fee-for-service structure are well understood, but consensus regarding alternative structures is more elusive, especially as it pertains to mental health and substance use providers. An informed approach will recognize the heterogeneity of provider capabilities, geography, conditions, and the regulatory environment.

Today, Beacon manages approximately \$800 million in behavioral health reimbursement in Massachusetts through coverage of 1.3 million members across Beacon partners. Beacon's volume brings a number of unique advantages in designing and executing APMs that truly transform patterns of care. Instead of focusing on unit price discounts, Beacon is positioned to design structures that bring members a superior chance for recovery. Guaranteed appointment access, walk-in clinics, same-day/next day access, co-located practice sites, centers of excellence for medication-assisted substance use disorder treatment, autism, eating disorders, and first psychotic breaks are all concrete examples of evidence-based care enabled through payment innovation and market share.

In practice, Beacon's proposed reimbursement changes will be pioneered in collaboration with MassHealth and Medicaid managed care entities. Based on the success and lessons learned from the Medicaid experience, Beacon will then extend those insights to preferred provider organization covered lives.

2. Describe your organization’s efforts to develop insurance products or plan designs that encourage members to use high-value (high-quality, low-cost) services, settings, and providers, and detail progress made over the past year. Example of such efforts include: phone triage or telehealth services; targeted information about and incentives to reduce avoidable emergency department (ED) use; and reference pricing, or cash-back reward programs for using low-cost providers. Please describe the result of these efforts and attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members’ utilization of care, members’ choice of providers, and total medical spending. Please describe efforts your organization plans between now and October 1, 2016 to continue progress in encouraging members to use high-value services, settings and providers. What barriers have you identified to introducing insurance products or plan designs that encourage members to use high-value services, settings and providers in Massachusetts?

As the behavioral health vendor to health plans, Beacon administers the insurance product that our clients have created. At this time, our clients have not elected to move forward with any “tiering” of mental health providers.

3. 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.” Please describe your organization’s progress in meeting this requirement. If you had a tool in place prior to November, 2012, please describe your organization’s prior experience, including how long your tool has been in use and any changes you have made to the tool over time.
 - a. Using **HPC Payer Exhibit 1** attached, please provide available data regarding the number of individuals that seek this information and identify the top ten admissions, procedures and services about which individuals have requested price information for each quarter listed below and the number of inquiries associated with each.

Beacon’s Member Services Department and online tool provides consumers with cost share information. We have not tracked the information in the manner requested above.

- b. Do consumers have the ability to access cost data* for the following types of services (yes/no)? If no, please explain.

Inpatient	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Outpatient	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Diagnostic	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Office Visits (medical)	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
Office Visits (behavioral)	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>

*Beacon provides members share information. For outpatient services, this information is provided through our Member Services Department. Beacon manages only behavioral health services and therefore would not have information regarding medical services.

- c. Does consumer-accessible cost data reflect actual provider contracted rates? If no, please explain.

Yes No

Beacon is reviewing its processes regarding actual provider rates.

- d. Do you provide actual out-of-pocket estimates that reflect a member's specific benefits and deductible status? If no, please explain.

Yes No

- e. Do you provide provider quality and/or patient experience data with your cost data? If no, please explain.

Yes No

Beacon does not package quality and/or patient experience data with cost data.

- f. Please describe any information you have collected regarding how your members use this information and the value of this information to members. Please describe any analyses you have conducted to assess the accuracy of estimates provided and the impact of increased price transparency for members as well as any limitations in the tools you have identified and ways your organization plans to address them.

To date, Beacon has not conducted any analyses.

4. The Massachusetts health care environment has recently undergone significant changes, including multiple hospital and physician group acquisitions and affiliations. Please describe your views on recent market changes, including any impacts these changes have had on costs (e.g., prices and total medical expenses), referral patterns, quality and access to care.

To date, we have found these changes in the market to be inconsequential to the behavioral health system. However, Beacon urges the Commission to continue to monitor this activity moving forward.

5. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Health Policy Commission in 2014; and by the Center for Health Information and Analysis in 2012, 2013, and 2015, prices paid to different Massachusetts providers for the same services as well as global budgets vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value.

- a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

Beacon recognizes that the value of a service is contingent upon many more factors than just the agreed-upon definition of said service. There are meaningful regional distinctions between services within the Commonwealth, and for this reason, providers have varied cost structures. Beacon's prices reflect those cost structure and regional differences.

- b. What steps are you taking to address this variation in prices and budgets? Please include any approaches you have considered implementing to reduce the role that past or current fee-for-service price disparities play in global budgets.

We engage in conversations around pricing and value with our providers on a daily basis with the goal of ensuring our customers receive access to timely and high-quality care.

6. Please describe your policies and procedures, including notice policies and protections from out-of-network charges, for members referred to out-of-network providers and cases in which services at in-network facilities are provided by out-of-network providers. Please describe any policies you have in place to ensure that a referring provider informs a patient if a provider to whom they are referring the patient is not in the patient's insurance network.

Beacon's combined networks include more than 6,000 providers in Massachusetts to support the diverse clinical specialties needed to care for members. When making referrals, we encourage our network providers to use our online provider directory to identify in-network providers or to ask members to contact Beacon directly for referrals. To protect members from out-of-network costs, we will execute Single Case Agreements (SCAs) with out-of-network providers when one or more of the following criteria are met:

1. There are no network resources for medically necessary care within access standards of a member's residence (Note: these distances may be altered to client specifications)
2. Beacon's network facilities are full/Beacon's network practitioners cannot accommodate new patients/clients
3. Clinical/service needs (e.g., clinical specialty, language, cultural sensitivity, gender) cannot be met by available network resources
4. Member preferences cannot be met by available network resources and are deemed relevant to treatment outcome
5. An SCA supports necessary continuity of care for a member with a history of treatment with an out-of-network provider
6. Transportation available to a member only enables the member to access an out-of-network resource
7. The available network resource believes it cannot meet the member's treatment needs
8. A network facility is not contracted for a specific, required modality
9. Emergency treatment/admission requires an SCA
10. The facility/practitioner terminated network status during the member's course of treatment and either the disenrolled provider, if not disenrolled for a professional review action, or his/her patient in active treatment requested that the disenrolled provider continue treating the patient through the current period of active treatment or for up to 90 calendar days, whichever is shorter
11. Medically necessary psychiatric consultations are required on a medical unit and a participating psychiatrist is not available
12. New client transition as part of client implementation plan
13. When the member is a full-time student and consequently outside of the geographic area of the network

14. Confidentiality issues are present whereby a member who is a provider or a member who is an employee (or an employee family member) of Beacon or one of the plans Beacon manages is in need of behavioral health treatment
15. An administrative decision has been made by the client or Beacon to approve an SCA

We use Fair Health calculations for out-of-network referrals. Our mental health and substance use provisions align with our clients' physical health benefit structures in compliance with Mental Health Parity Act regulations.

7. The Medicare Payment Advisory Commission and others have noted that patient visits to outpatient-based practices, which can bill a "facility fee," are increasing faster than visits to freestanding practices. Please describe any shift you have observed toward increased use of outpatient-based practices and the impact of facility fees and any such shift toward the use of outpatient-based practices on health care costs, quality and access.

This question is not applicable to Beacon's line of business.

8. The Commission has identified that spending for patients with co-morbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health conditions. As reported in the July 2014 Cost Trends Report, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
 - a. Please describe your efforts in the past 12 months to effectively address the needs of these patients in an integrated manner, clearly identifying areas of progress, attaching any attaching analyses you have conducted.

Beacon has long acknowledged the positive impact of collaborative treatment for co-morbid physical and behavioral health conditions, and for this reason, integration is a key tenant of our care philosophy and operational approach. We define integration broadly, along a continuum, and support it at all levels from integrated care management to practice consultation and support. Since our inception, we have collaborated with the Commonwealth and health plans that serve Massachusetts citizens to develop seamlessly integrated systems of care that reduce costs, increase care coordination, and improve outcomes for individuals with comorbid behavioral health and chronic medical conditions. Examples of our ongoing efforts include:

- **Massachusetts Child Psychiatry Access Project (MCPAP):** We continue to expand the use of this psychiatric consultation service to support PCPs in Massachusetts who see children. As of August, 2015, MCPAP has served more than 42,000 unique patients, enrolled 447 practices with nearly 3,000 providers, taken more than 61,000 calls from PCPs, and provided more than 23,000 face-to-face psychiatric evaluations.
- **Intensive Community Care and Support (ICCS):** We continue to collaborate with Neighborhood Health Plan (NHP) and participating community-based provider agencies to support the medical, behavioral health and social support needs of individuals who are suffering with comorbid serious mental illness (SMI) and complex medical conditions. Through an individualized, comprehensive and person-centered care plan, the program provides linkages to medical, community-based, and

behavioral health service as well as addressing daily living needs such as housing, food, and transportation.

- **Wrap-around Programs for Commercial Health Plans:** We continue to partner with Blue Cross Blue Shield of Massachusetts (BCBSMA) to bring wrap-around support services to commercial health plan members who have a substantial behavioral health impairment. The Recovery, Education and Access to Community Health (REACH) program brings effective care models developed under public behavioral health programs to the commercial health plan space. The program focuses on care plan development and management along with coordinated behavioral health and medical services to address members' comprehensive needs, and uses a co-located model of care to ensure a high level of service coordination.

Building upon the structure of REACH, this year we collaborated with one of our health plan clients to launch our first total cost of care sharing for members with SMI. This program establishes a completely new way of organizing care and payment with provider partners and includes a focus on wrap around service support.

- b. Please describe your specific plans for the next 12 months to ensure that integrated treatment is provided for these patients, including specific goals and metrics you will use to measure performance whether you use a behavioral health managed care organization ("a carve-out") or manage behavioral health care within your organization.

In the coming year, we will build upon the successes and lessons learned from the integrated care models detailed above. Our goals for 2016 and beyond include:

Promoting wrap-around services for individuals with SMI and comorbid physical and behavioral health conditions:

- We will continue to partner with state-funded and commercial health plans to expand the ICCS and REACH programs.
- We will explore opportunities to increase total cost of care sharing SMI initiatives with MassHealth and our commercial health plan clients.

Supporting PCPs as the primary entry point for behavioral health care:

- We will continue to partner with the Commonwealth to expand the reach of MCPAP to improve access to child psychiatry services.
- We will work with the Commonwealth to increase the availability of same day, next day and walk-in appointments to improve access to care following a PCP's diagnosis of mild to moderate mental illness.
- We will continue to work within the law to expand the use of and training for medication-assisted treatment as a resource for PCPs, as well as the appropriate therapy and wrap-around support to sustain this treatment.

Assessing medical and behavioral health teams' capability and readiness for coordination and integration activities:

- We will share our Integrated Practice Assessment Tool (IPAT) with health care organizations to help them more accurately assess their level of integration and

support them as they move towards more fully integrated behavioral and physical health care models. Data collected will also be analyzed and shared to enable providers, researchers and payers to better measure integration both within and across health care settings. Our IPAT is available on our website at <http://www.valueoptions.com/company/Integrated.htm>.

9. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2012 to CY2014 according to the format and parameters provided and attached as **HPC Payer Exhibit 2** with all applicable fields completed. Please explain for each year 2012 to 2014, 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).

Beacon's response is included in HPC Payer Exhibit 2 2015 Submission.

HPC Payer Exhibit 2

****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 2012	-5.7%	12.90%	0.00%	2.85%	9.58%
CY 2013	-0.1%	-9.00%	3.58%	-0.74%	-9.11%
CY 2014	5.8%	-5.35%	0.00%	-3.09%	-0.34%

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.