Response of Beacon Health Strategies LLC

Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

Beacon Health Strategies LLC (Beacon) is pleased to submit to the Attorney General's Office (AGO) of Massachusetts its response to the Health Policy Commission's questionnaire.

Beacon is a managed behavioral health organization (MBHO) that partners with health plans, employers and governments to serve at-risk populations living with mental health and/or substance use conditions. Since 1996, Beacon's collaborative approach to arranging, coordinating and managing behavioral services and social supports has supported improvements in health outcomes for individuals through the delivery of a contracted network of high-quality services across the Commonwealth.

Since its founding, Beacon has developed and innovated a robust continuum of behavioral health services through its contracted network of providers. It has also employed proven clinical management and care coordination techniques to meet the needs of consumers, providers and public and private payers. Currently, Beacon partners with several Medicaid and commercial health plans in Massachusetts and works for the Group Insurance Commission to ensure that individuals living with mental health and substance use conditions have ready access to high quality care in the least restrictive setting to promote and support their pathways to recovery.

Please note that Beacon's responses in this questionnaire are limited to behavioral health benefits that Massachusetts health plans have contracted Beacon to manage on their behalves. As a result, the responses should not be interpreted to be addressing broader health care coverage provided through health plans. Also, some questions are simply not applicable to the services performed by Beacon to its health plan partners in Massachusetts and, for those, Beacon defers to others to provide responses.

Beacon appreciates the Attorney General's attention to the important matter of behavioral health and stands ready to assist with its experience to improve the Commonwealth's standard of care.

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

Timothy Murphy
September 12, 2014

1. Chapter 224 of the Acts of2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY:
   a. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

Beacon's clinical management model is based on the philosophy that individuals living with mental health and substance use conditions can live purposeful lives by receiving timely care from high quality providers in the most appropriate least restrictive setting. This philosophy girds under Beacon's clinical management guidelines and techniques, which encourage well-defined treatment plans with clear objectives for recovery in the community. Examples of Beacon's work include:

- Beacon's licensed clinicians working with providers to ensure that patients receiving care in costly settings (e.g., inpatient psychiatric hospitals) have appropriate discharge plans upon their return to the community and that these individuals are connected with community and outpatient supports with the goal of lowering readmissions to institutional settings;
- Beacon, through the use of informatics and referrals, focuses its clinical efforts to identify individuals whose service utilization patterns suggest failure in treatment (e.g., excessive use of emergency rooms) and unnecessary spending. Upon identification, Beacon's clinicians engage these individuals with their consent in "person-centered" planning to bring about a care plan that emphasizes keys to treatment success (e.g., family involvement and medication management), elimination of social impediments (e.g., housing instability), and coordination amongst providers and proper community supports (e.g., assistance with transportation);
- Beacon's establishment of a "preferred provider program", whereby providers with established track records for quality (e.g., low re-admission rates) are exempted from certain parts of Beacon's clinical management supervision; and,
- Leveraging of community based detoxification for Beacon's members with substance use disorders.

Beacon's confidence in these efforts, along with others, allows us to contract with our Massachusetts payer customers at fixed rates at or below the growth benchmark of 3.6%.

   b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?

Beacon is continually working with health plans, state officials and providers to create innovative and effective programs that focus on the most acute populations. For example, Beacon recently implemented an innovative program for a large Massachusetts health plan to focus on members with high cost and whose behavioral health service utilization suggests treatment failure. Beacon and its health plan partner identified 2,700 members who spent $125 million annually with an annual rate of increase of approximately 30%. The purpose of the program is to identify and engage these members

and activate effective community and treatment supports that are typically only made available to Department of Mental Health clients. The program is designed to provide community-based behavioral health services and supports to adults and children with Serious Mental Illness (SMI) and Serious and Emotional Disturbance (SED). This unique and proactive approach to care delivery promotes resiliency, member self-management skills and, most importantly, creates a pathway for recovery.

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2. C. 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.
   SUMMARY:
   a. Please describe your organization's efforts to date in meeting this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs)(payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay;-for-performance incentives accompanying fee-for-service payments) on your (i) total medical expenses, (ii) premiums and (iii) provider quality.

For calendar years 2012-13 in Massachusetts, Beacon did not have any contracts that included alternative payment methods. However, Beacon built data sets to share with providers as a means to educate them about the outcomes based on services they offered through the preferred provider program (so-called "Beacon Select"). By doing so, Beacon was able to identify those providers most equipped and best 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;
- Rate of coordination between the inpatient provider and the member's primary care provider;
- Rate or coordination between the inpatient provider and the members' outpatient behavioral health provider; and,
- Aftercare appointment rate scheduled by facility within seven days of discharge.

By meeting these standards, Beacon and the 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 to provide regarding that contract. Given the size and complexity of the population, Beacon expects to have reportable outcomes in 2016.

b. What efforts does your organization plan between now and October 1, 2015 to increase your use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider types?

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 pilots in 2015 or 2016 to bring APMs into the market in 2016 - 2017.

3. Please quantify your organization's experience implementing risk contracts across your provider network using the template below. For purposes of this question, "risk contracts" refers to contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to the provider, including contracts that subject the provider to limited or minimal "downside" risk.

SUMMARY:

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012	0	0
CY2013	0	0

As explained in question #2, Beacon does not have any risk-based contracts in Massachusetts. In 2014, Beacon entered into the APM relationship wherein the small group of providers is compensated on a single monthly fee for a grouping of services to be provided to high-risk and acute members. This payment is not subject to adjustments.

4. Please identify and explain the principal factors considered in formulating risk adjustment measures used in establishing risk contracts or other APM contracts with providers, including how you adjust for changes in population health status over the contract term.

SUMMARY:

a. Does your organization use a common approach to risk adjustment for all providers? If not, what factors support the need for the application of different measures or adjustments for different providers or provider organizations?

b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of risk adjustment measures for use in contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

c. What progress has your organization made to date regarding the development and

implementation of population-based socioeconomic adjustments to risk budgets? What plans does your organization have in this area?

d. How do any such differences interact with other contract elements that materially affect risk budgets and performance-based payments, and what are the results of any analyses conducted by your organization regarding variation in provider performance under different measures and adjustments?

Please see responses to Questions 2 and 3. As Beacon works towards population-based risk contracts in Massachusetts and elsewhere, Beacon intends to incorporate risk adjustments, where appropriate and feasible, using analytically sound methods.

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5. Please identify and explain the principal factors considered in selecting quality metrics used in establishing APM contracts with providers.

   SUMMARY:

   a. Does your organization use a common approach to quality measurement and associated payments for all providers? If not, what factors support the need for the use of different quality measure or performance targets for different providers or provider organizations?

To date, Beacon has piloted payments based on quality metrics in Massachusetts. For example, a large public inpatient mental health provider was eligible to receive an incentive bonus payment based on the ability to increase their HEDIS seven-day follow up percentage rate to the statewide average seven-day follow up average, as calculated by HEDIS specifications. This incentive payment is payable upon Beacon certification that the provider reached this network average for a twelve month period.

As Beacon move towards APMs, it plans to include quality measures in its APM contracts around both traditional behavioral health quality metrics and program-specific measures. For example, Beacon uses HEDIS behavioral health measures to help evaluate quality and expects to use similar metrics when it measures provider quality performance. In addition, Beacon intends to craft program-specific metrics to measure the target activities for a given intervention. Additionally, as described in the response to Question 2, Beacon Select is a program based on quality elements and is Beacon's pathway toward APM with a larger cohort of network providers in Massachusetts and nationally.

   b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of quality measures, such as the measures included in the Standard Quality Measure Set, for use in risk contracts and other APM contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

While Beacon does not yet reimburse Massachusetts providers based on quality metrics, there are drawbacks to statewide standardization of quality measures for several reasons. First, it is difficult to develop a standard quality measure set for multiple populations with varying degrees of acuity for behavioral health conditions. Secondly, standardization would stifle innovation as it would promote providing care specifically around those measures and doing well on only those measures ("teaching to the test"). While prescribing measures may be efficacious in certain areas of medicine, in behavioral health tying APM to a limited set of measures may engender a reluctance to engage in an otherwise successful service if that service is not in some way reflected in the quality measures. This is due

partly to the fact that a diagnosis is only one point of reference of a patient's treatment need.

Moreover, a standardized measure set would limit the expertise of MCOs to manage care that aligns with the most important managed care principle, namely, to provide the right care at the right time for the right duration and in the right setting. As with providers, the administrative time devoted to measuring these metrics would diminish resources available to engage in pilots and other similar programs that could promote innovative solutions for improving individuals' quality of life as well as the healthcare delivery system at large.

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6. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.

   SUMMARY:

   a. Describe your current attribution methodology (or methodologies), identifying the purpose(s) for which it is (or they are) used, and include the following information:

      i. provider types considered for attribution (e.g., primary care physicians, specialist physicians, NPs/PAs)

      ii. units used in counting services (e.g., number of claims, share of allowed expenditures)

      iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)

      iv. Time period for evaluation of attribution (e.g., 12 months, 18 months) and v. whether patients are attributed retrospectively or prospectively.

   b. Please describe your efforts to develop a comprehensive attribution methodology, including the current status of your efforts to validate, pilot and implement a methodology for purposes of implementing risk contracts and other APM contracts for PPO insurance products. What resulting barriers or challenges has your organization faced?

   c. What values and/or drawbacks does your organization identify regarding potential standardization of attribution methods, both across providers and across payers? What are the values and/or drawbacks of differentiation?

   d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?

As a managed behavioral health organization, Beacon does not attribute members to primary care providers. In 2014, Beacon started to attribute its behavioral health members to behavioral health outpatient practices for reporting purposes only. Beacon does, however, ensure integrated mental health competency at PCP sites of plan partners.

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7. Describe your organization's efforts and results in developing insurance products that encourage members to use high-value (high-quality, low-cost) care and providers, including but not limited to tiered network and limited network products. Please 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.

SUMMARY:

As the behavioral health vendor to health plans, Beacon administers the insurance product that clients have created, and therefore its services/products do not have the differentiations described above.

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8. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

SUMMARY:

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Ql			
	Q2			
	Q3			
	TOTAL:			

**Please indicate the unit of time reported.*

As Beacon is not a provider, it does not currently track inquiries regarding the price of admissions, procedures and services, and therefore does not have any corresponding analysis. However, Beacon tracks and reports for health plan clients the following types of member and provider inquiries from its call center: appointment access, benefits, claims issues, referrals and more. Beacon has the capacity to collect the information described above if required to do so.

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9. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than national average utilization of inpatient care and its heavy reliance on academic medical centers. Describe your organization's efforts to address these trends, including efforts to redirect appropriate care to lower cost community settings. Please attach any analyses you have conducted on such "outmigration," including specific estimates of cost savings that may be accrued through redirection of care.

SUMMARY:

ANSWER:

As the behavioral health vendor to health plan clients, Beacon supports and partners with safety net facilities, which includes certain academic medical centers. As such, one of Beacon's core competencies is partnering with and expanding access to community based services. As described in response to Question 1, Beacon has engaged with a key Massachusetts partner to target members and

expand access to appropriate community support services. From its very inception, Beacon understood that community-based agencies, such as mental health, substance use treatment, and family service organizations, were the predominant source of behavioral health treatment for health plan partners' members. Beacon recognized the importance of these safety net providers. As a result, from the development of first provider network in Massachusetts to the present time, Beacon holds provider service agreements with the vast majority of community-based agencies in every region in which it operates.

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10. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

    SUMMARY:

    a. Please describe any efforts your organization has made to effectively address the needs of these high-cost, high-risk patients in an integrated manner.

Beacon developed an integrated care management strategy and program with its health plan partners in Massachusetts to address the needs of members affected by co-occurring chronic medical and BH conditions. This program was first initiated in 2005 when Beacon placed its entire staff of independently licensed BH care managers and program staffs on-site within a partner health plan's Medical Management Department. The elements of the program have subsequently been expanded to Beacon's other Massachusetts based plans and include the following:

- Use of multiple sources to identify members with co-morbid Behavioral Health and medical conditions, including use of algorithms to incorporate claims and encounter data analyses; Health Risk Assessments; referrals from Primary Care Physicians, family members, Behavioral Health providers, and Plan internal departments such as utilization management;
- Use of multi-disciplinary, clinical rounds to determine most effective plan for outreach and engagement of the member. Beacon clinicians and plan nurse care managers work in teams to conduct the outreach and engagement of the member by the primary contact person determined by the primary needs of the member (behavioral health or medical). In all cases, clinicians from all disciplines remain as either lead clinicians or consultants to their colleagues throughout both the outreach and actual care management processes;
- Once members are contacted and consent to integrated care management, an assessment of the members needs is completed. The member and their family or other supports are then engaged in a member-centered care planning process. The member's behavioral health and medical needs are addressed in one comprehensive plan, and the integrated team from Beacon and the Plan collaborate to ensure each element of the care plan is implemented. The lead care manager serves as the care coordinator, ensuring medical and behavioral health providers provide services in synch with each other and in such a way as to produce optimal outcomes.

Beacon's health plan partners conducted an analysis of the integrated care management program for each year since program inception. This analysis compared the costs of members' utilization of medical and behavioral health inpatient, diversionary, emergency room and outpatient services during the 12 months prior to program involvement and the 12 months following program participation. On average, a 13% reduction in behavioral health costs of care and an average of a 40% reduction in medical costs was observed when the pre and post periods were compared. The source of costs reductions were related to significant reductions in inpatient and Emergency Department usage with a

concomitant increase in diversionary behavioral health services and outpatient medical services. Beacon integrated care management model is a staple in its product offering to new and existing health plan partners, especially throughout the Massachusetts market.

b. If you contract with or otherwise use a behavioral health managed care organization or "carveout," please describe how you ensure that integrated treatment is provided for these high-cost, high-risk patients.

Beacon is a managed behavioral health organization. As described above, it achieves integration of services for members with high cost, high risk co-morbid conditions through the integration of behavioral health and medical data, care management staffs and services, and through the co-management of the care of each member prospectively identified with these conditions.

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11. Please describe whether and how your organization provides financial support or incentives for a provider to achieve recognition or accreditation from a national organization as a patient-centered medical home (PCMH) or improve performance as a PCMH. Attach any analyses your organization has conducted on the impact of PCMH implementation in your provider network on outcomes, quality, and costs of care.

Beacon does not provide financial support or incentives for providers to achieve recognition or accreditation from a national organization as a patient-centered medical home. While Beacon does not currently provide financial incentives for PCMHs, it supports and engages in training to ensure Primary Care Physicians have adequate resources and wherewithal to manage a patient's behavioral health needs. While the majority of psychosocial prescriptions and many referrals for behavioral services are initiated by a Primary Care Physicians, many unfortunately are not adequately trained in this arena. As such, Beacon consistently develops provider training materials, which in turn supports PCMHs and ultimately improves performance.

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12. After reviewing the Commission's 2013 Cost Trends Report and July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

SUMMARY:

Beacon supports the Commission's view that behavioral health conditions are a major factor in overall health and a significant driver of health care costs. Additionally, addressing the complexity of behavioral health conditions and treatment (as highlighted around schizophrenia and alcohol dependence in the report) is a key issue warranting attention.

In the past decade, there has been ample proof that behavioral health conditions have a profound influence on quality of life and overall healthcare costs. These effects range from overutilization of primary care services for individuals with anxiety and depression to significant utilization of emergency rooms and specialist care for individuals with serious mental illness and a co-morbid chronic medical condition. The present fragmented medical and behavioral health service delivery system contributes to an increase in cost and compromises quality of care. Increasingly, there is a call for public sector medical and behavioral health service integration, leading to improved care coordination.

In 2006, the National Association of State Mental Health Program Directors issued a position paper that called the health status of the population with serious mental illness (SMI) a new health disparity

in America. The paper reported that individuals with SMI die, on average, 25 years earlier than the general population. This is due, in part, to the fact that many individuals with SMI have co-morbid chronic medical conditions brought on by a variety of modifiable risk factors such as smoking, obesity, substance abuse, prescription drug misuse, and inadequate access to healthcare services. In fact, the medical utilization of the SMI population is quite staggering:

- 3x more likely to have 5 or more physical health inpatient stays
- 4x more likely to have 5 or more emergency department visits
- 2.5x more specialist utilization (excluding behavioral health)
- 3x more pharmacy cost (excluding behavioral health)

The profound influence of mental health conditions on health status can be found across populations, behavioral health diagnoses, and age groups. Additionally, for individuals with SMI and chronic health conditions, healthcare costs are as much as 75% higher than for those with chronic health conditions and no mental health concerns. These costs are a product of not only increased usage of mental health services, but also significantly greater medical services associated with the treatment of chronic medical disorders.

Beacon concurs with the Commission's statement that "Integration of behavioral and physical care delivery is an opportunity to improve coordination of care for patients with multiple conditions". Beacon is working as a strategic partner and advocate for integrated care models across all of its health plan partners in Massachusetts and nationally. Beacon's goal is to enhance continuity and coordination between behavioral healthcare and physical healthcare providers. Beacon's "carve-in" model of co-locating behavioral health care managers with medical care managers manages costs and outcomes for members with both behavioral and medical diagnoses through care management access to information for both behavioral health and medical care plans. Nothing short of this level of integration can work to deliver the best outcomes for members and the plans. Not only is integration key for better service delivery, Beacon finds that primary care physicians, behavioral health clinicians and patients alike in primary care sites support this system integration model. Specifically, Beacon's surveys show that:

- Overall patient satisfaction was 91% higher than for similar individuals served in traditional behavioral health site;
- There were fewer "failure to keep appointment" rates than in behavioral health-only sites
- 81% of primary care physicians reported referring patients to the co-located behavioral health service; and,
- 72% of primary care physicians reported that the clinical behavioral health services their patients received were "good to excellent".

Beacon supports the Commission's concerted effort to support the provision of behavioral health services in primary care settings and supporting community hospitals through the CHART program to provide care to members with complex behavioral health needs. It also supports the Commission's efforts to improve behavioral health awareness from a clinical, financial, and quality perspective and is open to working collaboratively to contribute to this effort.

Exhibit C: Instructions and AGO Questions for Written Testimony

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2011 to 2013 according to the format and parameters provided and attached as AGO Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2011 to 2013 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).

   Completed in Attachment AGO Payer Exhibit 1

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2. Please submit a summary table according to the format and parameters provided and attached as AGO Payer Exhibit 2 with all applicable fields completed showing your total membership for members living in Massachusetts as of December 31 of each year 2010 to 2013, broken out by:
   a. Market segment (Hereafter "market segment" shall mean commercial individual, commercial small group, commercial large group, Medicare, Medicaid MCO, MassHealth, Commonwealth Care, other government. "Commercial" includes fully-insured and self-insured.)
   b. Membership whose care is reimbursed through a risk contract by market segment (Hereafter "risk contracts" shall mean contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold retumed, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)
   c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity).
   d. Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for hospital services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)
   e. Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)
   f. Membership in a high cost sharing plan by market segment (Hereafter "high cost sharing plan" is any plan in which an individual deductible or copayment of$1,000 or more may apply to any in-network benefit at any tier level.)

   Completed in Attachment AGO Payer Exhibit 2

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3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2010 to 2013, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership (e.g., why membership in PPO is growing).

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4. Please explain and submit supporting documents that show for each year 2009 to 2013, (i) your total number of employer accounts and the total annual claim payments made for those employers; and (ii) the total number of such employers for whom you do not have arrangements to provide behavioral health network or management services and the total annual claim payments for such employers

Exhibit # 1 AGO Questions to Payers

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

Total

	Unit Cost	Utilization (Units Per 1,000)	Provider Mix	Service Mix	Allowed Per Member Cost
CY 2010-2011	-5%	28%	*	*	21%
CY 2011-2012	-6%	16%	*	*	9%
CY 2012-2013**	4%	-12%	*	*	-8%

Inpatient

	Unit Cost (Cost per Day)	Utilization (Days Per 1,000)	Provider Mix	Service Mix	Allowed Per Member Cost
CY 2010-2011	-2%	25%	*	*	22%
CY 2011-2012	1%	3%	*	*	4%
CY 2012-2013**	7%	-10%	*	*	-4%

Outpatient

	Unit Cost	Utilization (Units Per 1,000)	Provider Mix	Service Mix	Allowed Per Member Cost
CY 2010-2011	-3%	17%	*	*	14%
CY 2011-2012	-3%	9%	*	*	6%
CY 2012-2013**	2%	-11%	*	*	-9%

Diversionary

	Unit Cost	Utilization (Units Per 1,000)	Provider Mix	Service Mix	Allowed Per Member Cost
CY 2010-2011	-4%	41%	*	*	35%
CY 2011-2012	-3%	24%	*	*	20%
CY 2012-2013**	2%	-14%	*	*	-12%

*** Beacon was currently unable to produce the provider mix and service mix data, however, the analysis of our data did not show a meaningful change in volume based on the provider or**

**** CY 2012-2013 trends in Allowed Per Member Cost and Utilization are impacted by a meaningfull shift in membership mix. In 2012-2013 Beacon added over 270,000 commercial membe**

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, 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 change in provider. 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.

Beacon Health Strategies AGO Payer Exhibit # 2, Question #2
Total In-State Membership (for members living in Massachusetts)

a. In-State Membership by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual*				
Commercial Small Group*				
Commercial Large Group*	485,534	207,615	198,749	195,064
Medicare	29,531	31,265	31,152	32,681
Medicaid MCO	387,982	374,022	359,492	370,078
MassHealth				
Commonwealth Care	134,428	109,281	82,614	101,870
Other Government**	13,128	1,693	1,005	674
Total	1,050,603	723,876	673,012	700,367

b. In-State Membership Whose Care Is Reimbursed Through a Risk Contract by Market Segment***

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Medicare				
Medicaid MCO				
MassHealth				
Commonwealth Care				
Other Government				
Total	NA	NA	NA	NA

c. In-State Membership by Commercial Market Segment and Product Line****

Market Segment	Product Line		Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	HMO/POS	Fully-Insured				
		Self-Insured				
	PPO/Indemnity	Fully-Insured				
		Self-Insured				
Commercial Small Group	HMO/POS	Fully-Insured				
		Self-Insured				
	PPO/Indemnity	Fully-Insured				
		Self-Insured				
Commercial Large Group	HMO/POS	Fully-Insured	355,290	180,596	169,978	174,648
		Self-Insured	130,244	27,020	28,771	20,416
	PPO/Indemnity	Fully-Insured				
		Self-Insured				

d.In-State Membership in Tiered Network Product by Market Segment*****

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Total	NA	NA	NA	NA

e.In-State Membership in Limited Network Product by Market Segment******

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Total	NA	NA	NA	NA

f.In-State Membership in High Cost Sharing Plan by Market Segment*******

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Total	NA	NA	NA	NA

* Beacon does not report membership at the Large, Small and Individual levels. All commercial membership has been rolled up and reported at the Large Group level for the purposes of this report
**Other Government is defined as Dual Eligible Senior Care Option (SCO) Programs where the members have both a Medicare and Medicaid Benefit
***Beacon did not have any Provider Risk contracts during the timeframes indicated
****Beacon does not report to the PPO/Indemnity vs HMO/POS level. All data has been aggregated up to the Commercial Large Group category.
*****Beacon does not have any Tiered Network Products for its behavioral health network
****** Beacon does not have any limited network products for its behavioral health network
*******Beacon does not able to report based on High Cost Sharing plans

Exhibit # 1 AGO Questions to Payers: Response of Beacon Health Strategies LLC

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

Total

	Unit Cost	Utilization (Units Per 1,000)	Provider Mix	Service Mix	Allowed Per Member Cost
CY 2010-2011	-5%	28%	*	*	21%
CY 2011-2012	-6%	16%	*	*	9%
CY 2012-2013**	4%	-12%	*	*	-8%

Inpatient

	Unit Cost (Cost per Day)	Utilization (Days Per 1,000)	Provider Mix	Service Mix	Allowed Per Member Cost
CY 2010-2011	-2%	25%	*	*	22%
CY 2011-2012	1%	3%	*	*	4%
CY 2012-2013**	7%	-10%	*	*	-4%

Outpatient

	Unit Cost	Utilization (Units Per 1,000)	Provider Mix	Service Mix	Allowed Per Member Cost
CY 2010-2011	-3%	17%	*	*	14%
CY 2011-2012	-3%	9%	*	*	6%
CY 2012-2013**	2%	-11%	*	*	-9%

Diversionary

	Unit Cost	Utilization (Units Per 1,000)	Provider Mix	Service Mix	Allowed Per Member Cost
CY 2010-2011	-4%	41%	*	*	35%
CY 2011-2012	-3%	24%	*	*	20%
CY 2012-2013**	2%	-14%	*	*	-12%

* Beacon was currently unable to produce the provider mix and service mix data, however, the analysis of our data did not show a meaningful change in volume based on the provider c

** CY 2012-2013 trends in Allowed Per Member Cost and Utilization are impacted by a meaningfull shift in membership mix. In 2012-2013 Beacon added over 270,000 commercial meml

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, 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 change in provider. 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.

AGO Payer Exhibit # 2, Question #2: Response of Beacon Health Strategies LLC
Total In-State Membership (for members living in Massachusetts)

a. In-State Membership by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual*				
Commercial Small Group*				
Commercial Large Group*	485,534	207,615	198,749	195,064
Medicare	29,531	31,265	31,152	32,681
Medicaid MCO	387,982	374,022	359,492	370,078
MassHealth				
Commonwealth Care	134,428	109,281	82,614	101,870
Other Government**	13,128	1,693	1,005	674
Total	1,050,603	723,876	673,012	700,367

b. In-State Membership Whose Care Is Reimbursed Through a Risk Contract by Market Segment***

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Medicare				
Medicaid MCO				
MassHealth				
Commonwealth Care				
Other Government				
Total	NA	NA	NA	NA

c. In-State Membership by Commercial Market Segment and Product Line****

Market Segment	Product Line		Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	HMO/POS	Fully-Insured				
		Self-Insured				
	PPO/Indemnity	Fully-Insured				
		Self-Insured				
Commercial Small Group	HMO/POS	Fully-Insured				
		Self-Insured				
	PPO/Indemnity	Fully-Insured				
		Self-Insured				
Commercial Large Group	HMO/POS	Fully-Insured	355,290	180,596	169,978	174,648
		Self-Insured	130,244	27,020	28,771	20,416
	PPO/Indemnity	Fully-Insured				
		Self-Insured				

d. In-State Membership in Tiered Network Product by Market Segment*****

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Total	NA	NA	NA	NA

e. In-State Membership in Limited Network Product by Market Segment******

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Total	NA	NA	NA	NA

f. In-State Membership in High Cost Sharing Plan by Market Segment*******

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual				
Commercial Small Group				
Commercial Large Group				
Total	NA	NA	NA	NA

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