BOSTON MEDICAL CENTER HealthNet Plan

September 8, 2014

Mr. David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Re: Boston Medical Center Health Plan – Health Care Cost Trends Written Testimony

Dear Mr. Seltz:

This is in response to your August 1, 2014 letter to Susan Coakley as Interim President of Boston Medical Center Health Plan, Inc. (BMCHP) requesting written testimony in connection with the upcoming health care cost trends hearing to be held by the Health Policy Commission, the Office of the Attorney General and the Center for Health Information and Analysis.

On behalf of BMCHP, please find my written testimony with supporting documentation responding to the questions set forth in Exhibit B and Exhibit C of your letter.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Laurie Doran

Laurie Doran
Chief Financial Officer

Enclosures

Cc: Susan Coakley, Interim President
Matthew Herndon, Interim Chief Legal Officer

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the 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 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 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 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 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 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school 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 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 Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and 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 other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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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.

1. Chapter 224 of the Acts of 2012 (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: BMCHP has worked on several fronts to help the Commonwealth meet its health care cost growth benchmark. These include provider network relationships and care management. BMCHP is committed to working within our own organization and with our state government partners to achieve healthcare affordability in the Commonwealth.
   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?
      With respect to our provider network, BMCHP annually sets medical cost savings targets for both the unit (provider) cost and utilization management components of medical spend. Throughout the year, BMCHP actively monitors progress against these targets. BMCHP has worked aggressively to reduce or limit the growth in provider unit prices through re-contracting efforts. As a result, we have successfully negotiated contract rates more in line with the MassHeatlh MCO benchmarks
      through a collaborative approach with our provider partners.

      Together with our efforts to reduce provider unit costs, BMCHP also continues to actively pursue alternative payment models (APMs) with provider organizations that are willing and able to share in medical cost savings risk. To date, we have signed APM agreements with several provider organizations. We are continuing discussions with additional provider organizations and healthcare delivery systems to initiate new APM arrangements.

      BMCHP has also developed innovative care management (CM) tools to help address the cost and quality of care. BMCHP's CM program focuses on meeting members' health and treatment needs in a cost effective manner. Our CM program specifically addresses diseases and conditions that are prevalent in the populations we serve. BMCHP's CM and Quality and Financial Informatics teams work together to evaluate the effectiveness of CM programs.

   b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?
      State-set rates for the health plan programs in which BMCHP participates have been lower than the health care cost benchmark for several years. Despite

substantial engagement from providers in accountable care strategies, management of provider payment rates, and utilization management, BMCHP has incurred a significant operating loss.
In preparation for FY15, BMCHP is expanding provider participation in alternative payment arrangements, re-negotiating key provider contracts, and completing the design of an enhanced model of care for our most medically complex members. These actions will contribute toward the Commonwealth's achievement of its benchmark.

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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: BMCHP is working collaboratively with its provider partners in the transition from volume based (fee-for-service) reimbursement to reimbursement that drives quality and cost-effective care. Key objectives include: reducing and stabilizing medical expense trend by improving the health of members through more integrated and coordinated preventive and evidenced-based medicine; improved cost-efficiency; and optimizing members' experience of care through improved access and availability.
    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.
    BMCHP's efforts in this area have included the following:
    •Since 2001, BMCHP has managed a Practice Based Care Management (PBCM) program with our largest health care provider. This PBCM program reimburses providers on a PMPM basis to assume responsibility for care management for high-risk/high-cost cases, post-inpatient or ED follow-up calls and health risk assessments.
    •BMCHP participated in the Patient Centered Medical Home Initiative, a multi-payer program sponsored by the Massachusetts Executive Office of Health and Human Services (EOHHS). The 3-year demonstration program supported fundamental changes in primary care service delivery and payment reform by facilitating comprehensive and coordinated patient-centered care within a medical home environment. Along with several other payers, BMCHP provided financial support for infrastructure development and care management activities, and included a shared savings component.
    •In 2011, BMCHP established a strategic plan for accountable care designed to respond to and support providers in their own transformation to an accountable care environment. The goal of the strategic plan is to develop and implement an approach and infrastructure that supports the delivery of affordable, high quality care to our members.

•In 2012, BMCHP entered into APM agreements with a few large primary care provider systems. The agreements are structured to provide a PHO an opportunity to earn financial rewards by managing medical expenses while providing high quality care. Performance is measured against an aggregate risk-adjusted medical expense target (pmpm). The agreements also include quality incentives and infrastructure payments.

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?
BMCHP's intial APM agreements applied only to our MassHealth population and were mostly shared savings models with upside-only earnings potential. For the coming year, BMCHP is in the process of transitioning providers into agreements that incorporate downside potential as well. These upside and downside APM agreements have limits/caps on the amount of upside and downside potential; require provider groups to be of a credible size; and require the providers to meet the ACO checklist criteria to ensure they have appropriate resources and capabilities to competently manage risk. In the past year, BMCHP enhanced the risk model to allow for all BMCHP Massachusetts products to be included and to focus on beating the planwide trend. Over the next year, we plan to transition more large primary care provider systems into APMs. The success of this plan will depend upon the willingness and ability of the providers to make this change and on provider membership size credibility. Finally, BMCHP will also be supporting providers participating in the EOHHS's Primary Care Payment Reform (PCPR) program. The PCPR program will incorporate primary care capitation arrangements as well as shared savings and quality incentives measured across all participating payors.

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: One provider group's agreement for 2012-2013 was structured to provide the PHO an opportunity to earn financial incentives by managing medical expense while providing high quality care. This was the only agreement during this time period with downside risk. We are currently working on moving other providers onto downside risk.

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012	112	1
CY2013	112	1

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: BMCHP strives to administer its risk arrangements in the most appropriate way by utilizing proven risk adjustment tools and applying sound methodologies that account for risk profile differences and changes between populations. The primary consideration is health acuity as measured by patient diagnosis and/or demographics. BMCHP leverages the Verisk DxCG risk adjustment software methodology. This methodology has been evaluated in studies conducted by the Society of Actuaries as one of the top performing risk adjustment methodologies in terms of its ability to explain risk differences in individual patients and populations. BMCHP further enhances its risk adjustment approach by segmenting its diverse population by risk category and product line and subsequently applies risk adjustment within these more homogeneous populations.
   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?
      BMCHP leverages a common risk adjustment tool and methodology for all providers when administering a risk or shared savings contract. However, it is possible that a provider might request a different approach because, for example, the provider serves a unique population or desires to leverage a different methodology for all its other payers. BMCHP would consider these exceptions on a case-by-case basis.
   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?

The advantages of state-wide standardization include administrative simplicity, particularly for providers, but also for insurers who would be able to better streamline APM arrangements with providers. Other advantages include ease of performance measurement across payers and providers and software purchasing power.

However, standard risk adjustment measures and methodologies may not be appropriate for all providers, for example, those with a high concentration of pediatric patients. In addition, there are unique considerations for Medicaid vs. commercial vs. Medicare populations that present drawbacks to standardization.

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?

BMCHP's membership population is generally socioeconomically homogenous - comprised primarily of low income individuals with incomes below 300% of the Federal Poverty Level. We do have a small commercial population for which we separately apply risk adjustment in the context of APMs. BMCHP has found that the risk adjusters on the market currently do not adequately account for socio-economic factors affecting the low income population. BMCHP currently has no plans to adopt or develop a specific socioeconomic adjustment to its risk budget development methodology.

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?

It is important to align the application of risk adjustment with the risk budget development methodology. Depending on how the budget benchmark is set, it may be appropriate to adjust for the change in a provider group's risk from year to year or the change in a provider group's risk from year to year relative to the change in a benchmark population's risk from year to year. BMCHP has not conducted any analyses to measure these differences.

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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: BMCHP has key requirements for selecting quality metrics to include in APM contracts. All selected metrics must be endorsed by the National Quality Forum. (NQF publishes consensus standard for performance measures and ensures that consistent and high-quality performance metrics are publically available.) Selected metrics must have publically available benchmark data for comparative purposes. NCQA publishes an annual Quality Compass database that includes publically reported HEDIS results for over 145 Medicaid plans in the U.S. The database also provides performance thresholds such as the 90^{th}, 75^{th} and 50^{th} percentiles across all plans. BMCHP selects only measures relevant to our enrolled populations and limits them to those where a sufficient volume of

enrollees qualify. BMCHP focuses on metrics for which plan-wide or group level performance is below expected or targeted performance.

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 measures or performance targets for different providers or provider organizations?
   While BMCHP uses a common approach to quality measurement and associated payments to providers, the quality metrics selected for inclusion in a new APM contract or a contract renewal may differ by provider group. BMCHP maintains a list of relevant metrics, primarily HEDIS measures, for potential inclusion in an APM. Selection of the appropriate metrics to include in a contract is based on a review of a provider group's past performance on each of the metrics of interest. Final metrics selected for the group include those for which the provider group is performing below plan targets and where there is a sufficient volume of eligible enrollees for which to generate a precise rate of performance. Performance targets are set for each metric based on the provider group's baseline performance and what the plan assesses to be an achievable target in a one year period.
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?
   To a large extent, a great deal of standardization currently exists in the quality measures chosen for APM contracts across plans in Massachusetts. This is demonstrated by the fact that many plans include many HEDIS quality metrics in their APM contracts. The MA statewide Quality Measure Set for physician groups/practices includes primary HEDIS, CAHPS and PQI measures. BMCHP believes that having a standardized set of quality metrics from which plans can choose for their APM quality metrics would be primarily consistent with current practice. That said, we highly recommend that the standardized set of measures represent the book of measures from which to choose, but the number of measures and specific measures chosen should be at the discretion of the plan and be based on existing physician group performance. Measures selected for an APM contract must be tailored to the number and type of enrollees the plan has at each specific group that is considering an APM contract. However, specific quality measures selected for each APM contract with a provider group may differ based on the provider group's past performance on the various metrics under consideration.

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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: Nearly 100% of BMCHP members are attributed to PCPs. For certain members, our Member Services representatives make outreach calls to help with PCP selection. For members who do not select a PCP, our attribution methodology includes the following: a daily internal report identifies members who have not selected a PCP. Our custom PCP assignment application uses a geographic algorithm to calculate a PCP

within 15 miles of a member's home address. Five PCPs, sorted by distance and panel size, are populated in the application and assignments are made based on - member age and gender; travel distance; PCP panel size; provider speciality; and prior PCP affiliations. Enrollment representatives review every PCP assignment. When a PCP is assigned, a new member ID card is sent to the member. Members are advised that they may call to request a different PCP at any time.

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)
    Primary care physicians, NPs and PAs. Specialists may be selected on a case by case basis. Our attribution method is set forth above.
    ii. units used in counting services (e.g., number of claims, share of allowed expenditures)
    N/A
    iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)
    N/A
    iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and
    N/A
    v. whether patients are attributed retrospectively or prospectively.
    Both
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?
    N/A - BMCHP does not offer PPO insurance products.
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?
    Standardization of attribution methods promotes administrative simplicity and ease of measurement across payers and providers. Differentiation, however, may be more appropriate in cases where population types (e.g., low income/Medicaid; commercial; and Medicare) access the healthcare system in different ways.
d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?
    BMCHP consistently achieves nearly 100% attribution. Therefore, we will continue to use current methods for maintaining this successful attribution level.

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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 an organization primarily serving Medicaid and Commonwealth Care members, our HMO-structured products inherently involve partnerships with high value providers. We have developed a statewide provider network which focuses on providing high quality care at competitive rates. Our approach to achieving high value care for all our members has focused on member healthcare engagement and network development. We have not, to date, offered tiered products in any of our benefit plans, including our commercial plans.

ANSWER: We focus on both member engagement and network development as the means to support and promote delivery of high value care, as further set forth below.

Member Engagement: We engage members to use our high value providers in a number of ways. Our PCP selection process ensures selection of appropriate PCPs. In this way, we foster patient-centered integrated care delivery. We also have a comprehensive process for conducting new member outreach, orientation and education. Our welcome call is a critical step in engaging members to understand how to best utilize their health plan and how to seek appropriate care through their PCP and other network providers. We have extensive experience making these welcome calls and attending to cultural sensitivities that can create barriers to care. These calls enable us to identify special healthcare needs and to address identified barriers to care. Our new member welcome kits reinforce information provided during these calls. Further, our Health Needs Assessment process enables us to coordinate member health care needs with access to appropriate high value network providers.

Network Development: BMCHP works with our provider network to promote delivery of high-value care. Providers are oriented to refer members to in-network hospitals and specialists; and BMCHP gives providers reports about where care is received so that it can be better coordinated with in-network providers. Certain financial arrangements with our providers help ensure appropriate coordination of care with other in-network high value providers.

As noted in the response to Q. 9 below, we focus our efforts on ensuring that members receive services at the most appropriate site of care. Our Community Health Center (CHC) relationships play a pivotal role in high value care delivery. CHCs provide high quality care and culturally sensitive health and social services in a community setting with an affordable cost structure. Approximately 29% of our members receive their care at CHCs. Many of the CHCs were participants in the Patient Centered Medical Home Initiative and have achieved NCQA recognition as Level 2 or 3 Patient Centered Medical Homes. The ability to arrange for person-centered care is key to achieving lower cost, higher quality care for BMCHP members.

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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: In October of 2013, BMCHP implemented a system that allows BMCHP's members to call our toll-free Member Services number to obtain cost estimates. We received one call in October, 2013 and zero calls in CY 2014 to date. We have been working to implement the Treatment Cost Navigator which will provide a web-based solution to provide cost estimates by utilizing benefit and provider information and content regarding member eligibility, benefits, deductibles and service pricing information. By October 1, 2014, we will have in place the first procedures available online for consumers to access cost estimate information. We will continue to add to that online procedure set in order to provide even more real-time estimates. While the full procedure set is being implemented, the telephonic capability for cost estimates will be maintained.

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	**Q1**		0	
	Q2		0	
	Q3		0	
	TOTAL:		0	

** Please indicate the unit of time reported.*

ANSWER: Please see summary above. Observation about the value of increased price transparentcy for BMCHP members: BMCHP is primarily a Medicaid and Commonwealth Care managed care organization. Cost sharing for Medicaid members is minimal and exclusively in the form of fixed copayments. Cost sharing in the Commonwealth Care benefit plans is, with one small exception, exclusively in the form of fixed copayments. Therefore, because member out- of- pocket costs are known up front, there would appear to be little incentive for members in these products to seek further cost transparency.

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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: Since its inception, BMCHP has increasingly focused its efforts on ensuring that members receive services at the most appropriate site of care. BMCHP maintains a comprehensive provider network without including all academic medical centers. In our network, Massachusetts Community Health Centers (CHCs) play a key role in providing

our members with access and availability to all covered physical and behavioral health care services. Approximately 29% of BMCHP members receive their care at CHCs.
ANSWER: We contribute to addressing these trends through our inpatient care management activities and our coordinated relationships with CHCs, as further described below:
Managing Inpatient Care: BMCHP's Acute Care Coordination (ACC) department manages all inpatient stays. The ACC team determines the medical necessity of acute inpatient, skilled nursing, and acute rehabilitation stays according to established criteria. It also coordinates discharges to home and transfers to participating facilities according to established factors, such as patient condition and network resources. Examples of areas for cost savings include: approving, where appropriate, administratively necessary days (rather than the more expensive acute care days); conversion of a request for a short stay inpatient admission to an (often less expensive) observation room admission based on medical necessity criteria; and reviewing continued stays at skilled nursing facilities to determine and ensure that members are receiving services at the most appropriate level of care.

Reducing Reliance on Academic Medical Centers: BMCHP's relationships with CHCs, and its approach to provider network management, are catalysts for reducing reliance on academic medical centers. BMCHP strategically does not contract with all academic medical centers in Massachusetts. The CHC practice environment offers quality primary care and coordinated, culturally sensitive health and social services in a community setting with an affordable cost structure. In fact, BMCHP has developed its clinical programs and specialized interventions to be complementary in structure to those found in the CHCs. BMCHP and our CHC network share a comprehensive approach to caring for the whole person through a focus on preventive health and integrated care management. In all of our collective programs, emphasis is placed on health screening, sharing of data, and collaborative member outreach and monitoring. Based on an ongoing review of data, BMCHP has seen significant success within the CHC primary care network achieving certain quality and access benchmarks.

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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: BMCHP and its managed behavioral health partner Beacon Health Strategies, LLC (Beacon) have put policies and processes in place to better manage and coordinate services for members with comorbid conditions, including the use of predictive modeling software, collaboration with the Institute for Healthcare Improvement (IHI) to develop and evalute more effective management tools, and the assignment of medical and behavioral health care managers to improve care integration.
    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.

BMCHP annually evaluates its care management registry which utilizes predictive modeling software to identify members most in need of care management. The registry is a large source of incoming referrals that the care management staff triages for appropriateness.

The addition of members with Serious and Persistent Mental Illness (SPMI) and who are homeless to the registry criteria has facilitated identification of more high risk members, for either behavioral health, medical or co-care management. Additionally, identifying those members with frequent ED use has demonstrated higher levels of co-morbid diagnoses and homelessness.

Through BMCHP's work with IHI, a multi-disciplinary subgroup (including behavioral health) has been formed to develop and evaluate the most effective tools and interventions. Several of these interventions have been incorporated into the broader care management population's interventions. ED assessment tools, and pro-active "crisis" plans that seek to avoid emergency and inpatient admissions and give patients alternative treatment options are key to these interventions.

Members with co-morbid conditions may be assigned both a medical and behavioral health care manager. The primary care manager is selected based on the severity of each condition and with the quality of the alliance each care manager has with the member. On occasion, both care managers may make a joint face-to-face visit to the member's home, a provider's office or a shelter.

Furthermore, the Care Management staff use BMCHP's high cost claims report as an additional tool to ensure that all members needing care management services have been properly identified, triaged and outreached.

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.

BMCHP contracts with Beacon, an NCQA accredited managed behavioral health organization (MBHO), to manage and coordinate behavioral health (BH) services for all our members. Beacon works with BMCHP, BMCHP's participating medical providers, and Beacon's BH provider network to ensure that integrated services are provided for these high-cost, high-risk members. Providers and members who require BH consultation can call either BMCHP or Beacon - either approach prompts the caller to the proper queue.

Beacon identifies a subset of high risk, high-cost members using an algorithm. When medical issues are identified, Beacon uses the daily bi-directional referral file to BMCHP's Care Management department. Similarly BMCHP staff do the same when BH issues are identified by a medical care manager. The two care managers will review each other's documentation and communicate about the case both formally (in the system), in person or by phone to plan next steps. This may include the member's provider. The Plan CMs and Beacon's CMs are co-located in each of BMCHPs regional offices. Members may be co-managed when they have both medical and behavioral health needs. There is a joint care plan for each of the co-managed members. There are co-managed care rounds and collaboration meetings in addition to teaching rounds. Medical directors (medical and BH) attend the co-managed care rounds, and are available for consultation.

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.
SUMMARY: BMCHP supports providers in their development to be a PCMH. We categorize provider groups along a clinical and financial primary care model continuum based on their level of sophistication, ability to manage financial risk and readiness to accept independence in managing the needs of BMCHP members. Providers' categorization on the continuum depends on a number of factors, including provider groups' current experience in evolving into a PCMH, as evidenced by (a) NCQA recognition as a PCMH, (b) previous participation in EOHHS' multi-payor Patient Centered Medical Home Initiatives (PCMHI), and (c) participation in various payors' programs intended to promote Accountable Care and PCMH. BMCHP also reviews an internal PCMH readiness checklist (attached as Exhibit B-1) to assist in assessing providers' readiness and capacity to accept more care management responsibility and financial risk.
ANSWER: BMCHP participated in the Patient Centered Medical Home Initiative, a multi-payer program sponsored by the Massachusetts Executive Office of Health and Human Services (EOHHS). This three-year demonstration program supported fundamental changes in primary care service delivery and payment reform, by facilitating comprehensive, coordinated, patient-centered care within a medical home environment. Along with several other payers, BMCHP provided financial support for infrastructure and care management activities, and included a shared savings component. Providers who participated in the EOHHS PCMHI program were eligible to receive reports to help them manage their population.

Other providers who demonstrate PCMH capabilities are eligible for delegated care management PMPM fees, upside and downside risk and quality incentives, along with infrastructure payments from BMCHP. BMCHP supplies technical support, in the form of quality reports, claims data extracts and chronic disease member registries, to providers with upside and upside/downside risk. Providers who are working to enhance their PCMH capabilities are also eligible for infrastructure payments and a more gradual entry into risk starting with upside only, in addition to technical support in the form of reports.

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: Please see BMCHP's comments immediately below.

ANSWER: BMCHP primarily covers the MassHealth (Medicaid) and Commonwealth Care populations. Our experience is consistent with the trends reported in Table 1.5. The Report acknowledges that Massachusetts costs for government programs are influenced

by policy choices that may reduce comparability to other states. However, the low trends observed in Massachusetts were reported nationally.

Recent changes in the service requirements of our populations have increased trend due to differences in the populations eligible for Medicaid in a post- ACA environment, and new high cost therapies (including Hepatitis C drugs), among other drivers.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

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

   The trends in the attachment (Exhibit C-1) reflect our entire business including Medicaid and Commonwealth Care. For all years 2011-2013, the impact of benefit buy down is negligible. The member cost sharing associated with the benefit plans that BMCHP offers in our MassHealth Medicaid and Commonwealth Care programs (which comprise 100% of membership in 2011 and nearly 100% of membership in 2012 and 2013) is both minimal and stable from year to year. The demographic and health status components of trend are reflected in the utilization component of trend. We estimate that on average, one-third of the utilization trend is driven by demographic changes and two-thirds of the utilization trend is driven by health status changes, changes in managed care practices, and environmental issues such as economic conditions and legislative/regulatory actions. Please see Exhibit C-1 to the Appendix.

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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 returned, 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).

BMCHP Commonwealth Care membership fluctuated between 2011 and 2013. Under the Commonwealth Care program, the state requires participating MCOs to bid, each fiscal year, a monthly fixed capitation rate for members. This population is cost sensitive and large membership shifts between MCOs is common from year to year. In 2011, BMCHP's bid was relatively higher than most of the other MCOs and the result was a decline in membership. In 2012, BMCHP was able to submit the lowest bid among the five MCOs in the program, which resulted in a large membership increase. The membership growth continued into 2013 as the Commownwealth Care program was extended along with the original 2012 bid positions. The bid position of the different Commonwealth Care MCOs in 2011 and 2012/2013 is reflected in the attached summaries issued by the Connector at Exhibit C-3 to the Appendix.

For our MassHealth Medicaid product, membership shifts are generally a result of the economy or some action taken by the state. In March 2011, MassHealth discontinued the practice of auto assignment of eligible members to the MCO program. Instead, MassHealth enrolled all eligible Medicaid members who did not make an active health plan election into the MassHealth Primary Care Clinician (PCC) program, causing BMCHP's MassHealth membership to flatten for that year. With the reinstatement of partial auto assignment to the MCOs effective October 1, 2012, BMCHP began to experience slight membership growth in our MassHealth population, though not at the levels when full auto assignment was used by MassHealth. BMCHP strongly supports the reinstatement of the original auto assignment formula.

BMCHP entered the commercial (Commonwealth Choice) market in 2012 and as such has no membership fluctuation to report.

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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

   BMCHP entered the commercial (Commonwealth Choice) market in 2012 and has minimal employer group data. Please see the attached Exhibit C-4 for BMCHP's employer account membership and claims from 2012 and 2013. BMCHP provides all employer groups its behavioral health network and related management services.

BOSTON MEDICAL CENTER HealthNet Plan

PATIENT CENTERED MEDICAL HOME (PCMH) QUESTIONNAIRE & REQUIREMENTS

Administrative and Clinical Questions

☐ Identify the number of Medicaid Members currently served in the last calendar year

☐ Total number of patients served in the last calendar year?

☐ Number/license of clinical and administrative staff

☐ Estimated wait time to get an appointment for primary care? and specialty care?

☐ Do you use telemedicine?

☐ Do you offer tele-health assessment/services?

☐ What is the range of services offered?

☐ What disease management programs do you offer?

☐ Are you (or your affiliated FQHC or CHC/Provider Group NCQA) recognized as a PCMH?

Case Management Questions

☐ Are Case Management services offered? How are members selected to receive Case Management (any specific algorithm?) Do you provide coverage 24 hours?

☐ How is staff assigned to provide CM/Care Coordination? Average case load?

☐ Are there different levels of care management/care coordination?

Behavioral Health Questions

☐ How would you describe your behavioral health/medical integration?

☐ Medical Providers what assessment tool/s do you use for screening BH/SA?

☐ BH Providers what assessment tool/s do you use as part of your practice?

☐ BH Providers what process do you use for obtaining/release of medical history?

☐ BH Providers how do you communicate with the PCP?

☐ How is BH/Medical care coordinated? Is care provided on site? (if so – what services?)

☐ How are crisis plans set up for members? Who do they call when in crisis? Where/how are they evaluated?

☐ Do you have "specialty" areas, or do you work with other local agencies to share areas of expertise?

☐ Do you provide any acute or diversionary levels of care? If not – what acute providers do you work with?

☐ Mobile abilities (as it applies to assessment, particularly emergency)?

Requirements

☐ Must have at least 1 adult PCP with an open panel and 1 pediatric PCP with an open panel as applicable. Having 1 Family Practice physician with an open panel would also meet the criteria.

☐ Site must have 90% of their Well Sense Health Plan credentialed PCPs and Nurse Practitioners complete a Cultural Competency Program annually. This program will be available on line. Attestation of completion must be submitted.

☐ Practice must designate an MD and administrative point person.

☐ Practice agrees to partner with Well Sense Health Plan on quality initiatives.

☐ Practice must have expanded on site after hours availability including, at a minimum, 1 weekday evening or 1 weekend day. (Well Sense Health Plan reserves the right to audit)

☐ Practice must provide laboratory data electronically to Well Sense Health Plan if applicable or support Well Sense Health Plan's efforts to work with their laboratory vendor to exchange data electronically. Laboratory data must include at a minimum LDL-C, HbA1c, HDL, Total Cholesterol and Triglycerides.

☐ Practice must use certified Electronic Health Record (EHR) technology or have made substantial progress toward meaningful use of certified EHR technology by the end of the contract term.

☐ Practice must be accessible for routine and urgent care needs in timeframes outlined in the Well Sense Health Plan Provider Manual.

☐ A clinician returns calls or responds to an email from the Well Sense Health Plan ICT within 24 hours to meet the clinical needs of the member

☐ Practice must have a documented process for laboratory and imaging test tracking and follow-up. Practice must notify member of normal and abnormal results. (Well Sense Health Plan reserves the right to audit)

☐ Practice must have Accessible Equipment including but not limited to Accessible and Bariatric Scales and Accessible and Bariatric Examination Tables.

Items to be reviewed annually.
Any change will be updated in the provider manual.

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

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2011	2.88%	1.77%	0.16%	0.01%	4.83%
CY 2012	0.59%	1.99%	0.24%	0.12%	2.94%
CY 2013	1.57%	0.42%	0.08%	-0.48%	1.59%

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
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	341	344	0	0
Commercial Small Group	89	67	0	0
Commercial Large Group				
Medicare				
Medicaid MCO	195276	192385	189319	198964
MassHealth				
Commonwealth Care	94780	71548	39796	55991
Other Government				
Total	290486	264344	229115	254955

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	5005	4890	4771	0
MassHealth				
Commonwealth Care				
Other Government				
Total				

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	341	344	0	0
		Self-Insured				
	PPO/Indemnity	Fully-Insured				
		Self-Insured				
Commercial Small Group	HMO/POS	Fully-Insured	89	67	0	0
		Self-Insured				
	PPO/Indemnity	Fully-Insured				
		Self-Insured				
Commercial Large Group	HMO/POS	Fully-Insured				
		Self-Insured				
	PPO/Indemnity	Fully-Insured				
		Self-Insured				

d. In-State Membership in Tiered Network Product by Market Segment **N/A- BMCHP does not offer these plans**

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

e. In-State Membership in Limited Network Product by Market Segment **N/A- BMCHP does not offer these plans**

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

Total				

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

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	226	183	N/A	N/A
Commercial Small Group	30	34	N/A	N/A
Commercial Large Group	N/A	N/A	N/A	N/A
Total	256	217	N/A	N/A

	# Employer accounts	Annual claims
CY2009	0	$ -
CY2010	0	$ -
CY2011	0	$ -
CY2012	23	$ 38,911.37
CY2013	47	$ 147,656.53

BOSTON MEDICAL CENTER HealthNet Plan

The below signatory is legally authorized and empowered to represent Boston Medical Center Health Plan, Inc. for purposes of the written testimony herein, and signs this testimony under the pains and penalties of perjury.

Boston Medical Center Health Plan, Inc.

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By: Laurie Doran
Its: Chief Financial Officer