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

Dear Executive Director Seltz,

Thank you for the opportunity to submit testimony to the Health Policy Commission. Since 1996 MBHP has served the Commonwealth by providing a comprehensive behavioral health program for the PCC Plan and partnering extensively with numerous state agencies, including DMH, DCF, and BSAS to coordinate behavioral health care for their clients. In 2012 we were awarded a new contract following a competitive re-procurement. In addition to providing behavioral health programming for 377,000 MassHealth beneficiaries, we provide quality management and behavioral health integration support to PCCs statewide. Our Integrated Care Management Program is unique in the industry for its clinically integrated approach to managing high-risk Membership. We are also partnering with MassHealth to implement the Primary Care Payment Reform Initiative. Attached please find our responses to the Commission's questions, signed under pains and penalties of perjury, by me, Nancy Lane, as the representative legally authorized and empowered to represent MBHP for the purposes of this testimony. We would be happy to provide additional information at the Commission's request.

Sincerely,

Nancy Lane, PhD
Chief Executive Officer
Massachusetts Behavioral Health Partnership
617-790-4081

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: MBHP's medical cost trend for CY2012-2013 is well below the 3.6% benchmark set by the Commonwealth. Between CY2012-2013 MBHP's average membership per month declined 0.5%. Overall cost PMPM declined by 0.4% for the same period. Our weighted penetration rate (the percent of membership consuming services) held steady at 28%, comparatively high for the industry; while average cost per service user increased by only 0.5%. Calendar year 2014 will reflect the impact of rate increases issued in January and July, totalling an average overall increase of 4%. Even with this rate remediation, we expect MBHP overall cost trend for CY2013-2014 will continue to be within range of the State's target. (see Attachment A for more detailed cost and trend information.)
   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?
      MBHP develops a trend management plan annually based on thorough review of utilization and cost data. By focusing on diversionary services, we have reduced reliance on 24 hour levels of care, steadily moderating trend for both youth and adult services since 2011 as shown in Attachment A and described in Question 9 below. In addition, our Inpatient (IP) performance management program continues to emphasize reducing Length of Stay (LOS) and Readmissions. Our network managers review provider profiling data on these performance metrics with inpatient facilities on an ongoing basis. This data compares actual to risk-adjusted expected performance in LOS and readmission rates and informs provider performance improvement activities. Since 2003 IP rate increases (see part b. below) have been linked to improvement in performance on these measures, providing financial incentives for increasing quality and efficiency. These efforts have produced a remarkable improvement in LOS since their inception (see Attachment B.) In addition, MBHP continues to identify specific focus areas for targeted programmatic review. 2014 saw renewed emphasis on reducing Administratively Necessary (AN) days through coordination with multiple agencies to identify placements for individuals who no longer meet medical necessity criteria for inpatient treatment. In addition, improved management of Community Support Program (CSP) services is helping to ensure these critical community support resources continue to focus on individuals recently discharged from 24-hour levels of care who are at greatest risk of readmission.

b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?
MBHP is equally committed to responsible stewardship of the State's Medicaid dollars and to ensuring the adequacy of provider reimbursement for behavioral health services. MBHP does not therefore issue automatic rate increases; however, in January 2014 we targeted specific levels of care for rate relief where the gap between paid rates and the cost of care was substantiated by independent consultants. Inpatient rate increases were linked to quality metrics as has been our practice since 2003. This targeted approach resulted in an average provider rate increase of 2%. MBHP will issue a second round of rate increases in the second half of 2014, again focusing on specific levels of care and tying increases to quality performance, resulting in an average overall increase of 4%.

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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: MBHP has pioneered a number of alternatives to FFS over the years, including case-rate payments for the Community Support Program for People Experiencing Chronic Homelessness (CSPECH) and more recently our CMS Innovation Grant involving Recovery Support Navigators. In addition, we are pleased to support the MassHealth Primary Care Payment Reform Initiative (PCPRI) by administering capitated payments for behavioral health services to a sub-set of the PCPRI participants, and by overseeing all participants' compliance with the clinical milestones in the PCPRI contract. MBHP is also independently pursuing the development of alternative payment models for specialty behavioral health care. We aim to introduce behavioral health APM designs that can work in concert with existing payment reform programs, such as PCPRI, as well as complement potential future models.
    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.
    MBHP pays a case-rate to CSPECH Community Support Program (CSP) providers for chronically homeless individuals who are placed in permanent housing, providing these individuals with the tools and support necessary to retain their housing over time. It is estimated that this intervention has resulted in a net Medicaid savings of more than $3 Million, largely stemming from reduced medical utilization. With the support of CMS Innovation Grant funding, MBHP is also paying a case-rate for Recovery Support Navigators who are assigned to individuals with a history of repeat detox admissions. The program gives providers the flexibility to deliver more intensive, prolonged support for these individuals' recovery. Preliminary analyses project the RSN program will

generate an average savings of more than $50 PMPM, representing a nearly 40% return per enrollment year relative to original up-front investment in the program. In addition, MBHP is a year into the effort to develop two episodic payment designs for specialty behavioral health, one aligning inpatient and outpatient care across an acute episode and a second focused on maintaining chronically ill clients in the community. MBHP has partnered with Brandeis University to conduct analyses and facilitate model development, beginning with the acute episodic model. We are in the process of translating this analysis into payment design options that could afford providers additional incentives for coordinating care across settings, with a particular focus on reducing readmissions where possible. Our external advisory group, representative of both outpatient and inpatient behavioral health providers, will be instrumental in shaping these payment options.

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?

Both the CSPECH and RSN programs will continue through 2015 and beyond. Following a period of internal development and vetting with our provider advisory group, we anticipate introducing the acute episode-based APM in the first half of 2015. In addition, we will complete analyses related to the chronic care episode in the last quarter of 2014 and will then refine the model and vet it thoroughly with providers before going to market in the second half of 2015.

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: While MBHP does not currently hold risk contracts with any of our BH network providers, we will be careful to consider our providers' capacity to assume risk as we develop APMs for specialty behavioral health. We are presently considering models that involve upside only as well as upside/downside risk options, and are examining programs such as PCPRI and the CMS Shared Savings Program, among others, as precedents.

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

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: While MBHP does not currently hold risk contracts with our BH network, we use risk adjusment in our Inpatient Provider performance program to establish a predicted Length of Stay and a predicted 7 and 30-day readmission rate for each facility. This model factors in age, gender, diagnosis, prior Inpatient, Emergency Services Program (ESP) and detox utilization, MassHealth rating category, agency affiliation, court involvement, and homelessness. We are drawing on this experience to develop a new risk-adjustment model specific to the episode-based alternative payment referenced in Question 2 by testing these factors alongside additional variables in order to produce the model that will be specific to the APM.
   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?

      Our current risk adjustment methodology applies only to the LOS and Readmission measures in our Inpatient Provider performance program. In developing the model, MBHP worked closely with inpatient providers to understand their experience and perspectives with respect to which factors drive the greatest variation in their clients' care and outcomes. While it is likely many of the same factors would come in to play in adjusting either outpatient performance measures or the episodic costs involved in our BH APM, additional analysis and feedback from the network is necessary to develop the most appropriate and precise risk-adjustment models for different uses and providers.

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?
MBHP endorses the inclusion of both behavioral health data as well as socio-economic variables in risk-adjustment models when available and appropriate to the application. Where BH co-morbidty is shown to increase total medical expense, for instance, BH data should be factored in. Guidelines with respect to types of data worth considering for the purposes of risk-adjustment and for different applications could be useful. We would not endorse statewide standardization of adjustment methodology, however, in part because of the difficulty in collecting certain types of data; and in part because the heterogeneity in membership, provider networks, covered services, that exists between payers ought to be reflected in their various risk-adjustment models. Not every factor will be material in every context.

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?
Among the factors listed above, MassHealth rating category is among the principle demographic drivers in our risk adjustment model. The inclusion of rating category serves as a proxy for the incorporation of SES characteristics in the predictive model because the criteria that qualify individuals for specific rating categories - particularly those that qualify individuals as "Disabled" - include socio-economic characteristics. Rating category is also among the variables currently being analyzed to develop the risk adjustment methodology for our episode-based APM.

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?
As noted above we are currently in the process of conducting sensitivity analyses to arrive at the risk-adjustment methodology we will apply to our episodic APM; this model is still in the developmental stages.

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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: In our capacity as both the behavioral health partner to the MassHealth PCC Plan and the State's contractor for the PCC Plan Management Support Services, we follow the State's lead with respect to the measures selected to monitor performance of our BH network and the State's contracted PCCs. Our contract with the State currently encompasses select HEDIS measures (Follow-up after MH Hospitalization, Initiation and Engagement in Treatment for AOD, Diabetes composite measure for DMH clients, and ADHD), as well as measures developed according to the State's specifications for rates of inpatient readmission, appointment scheduling prior to discharge, community tenure, and polypsychopharmacy, among others. Our reporting to providers similarly includes both

HEDIS measures and PCC-Plan specific metrics, but at present we have no APM contracts that encompass these measures.

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?

   MBHP has a diverse portfolio of provider profile reports for communicating performance on both utilization and quality metrics to our network providers. The dashboards we use for routine reporting to Inpatient BH providers, Outpatient BH providers, and Substance Use providers are all distinct, having been specifically tailored to each unique level of care. Simultaneously, we are beginning to report to all providers on measures that are are reflective of continuity of care and integration across providers, including the HEDIS measures for Follow-up after Mental Health Hospitalization, and Initiation and Engagement in Substance Use Treatment. In the context of the PCC-MSS program, we use HEDIS-like specifications as directed by MassHealth to provide member-level lists of individuals eligible for recommended care, including routine cancer screenings, well child visits, and diabetes care. As a means of enlisting BH providers in the effort to engage members in recommended care, we use the same MassHealth specifications to report overall rates of well child visits and diabetic compliance for all those individuals attributed to an outpatient behavioral health provider based on their utilization of BH services with that provider (see Question 6 below for description of this attribution method).

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?

   The Standard Quality Measure Set recommended by the SQAC provides a useful menu of measures that have been endorsed for their measure validity, reliability, and feasibility by organizations such as NQF, CMS, and The Joint Commission. Nationally endorsed measures are suitable for use in risk contracts and other APM designs, and can help to ensure payers and programs reinforce a coherent set of quality objectives, that are measurable in a consistent, scientifically valid, and comparable way. That said, adoption of the Standard Measure Set should not preclude the use of endorsed measures that have not yet been incorporated into the Standard Set, including many measures pertaining to mental health and substance abuse treatment quality and outcomes that have been endorsed nationally, but are not reflected on the list. Nor should it preclude the introduction of additional measures by State agencies or other measure developers to capture aspects of clinical processes, outcomes, or patient experience that are not yet addressed by existing measures or which pertain to unique sub-populations of members or providers, including individuals with severe and persistent mental illness or developmental disabilities. This kind of work, which the State has always had a role in sponsoring and MBHP has been pleased to support, is also instrumental to a vibrant and ongoing measure development and

endorsement process. In this way new or non-standard measures may co-exist with standardized ones in APMs or other risk contracts, particularly when their inclusion is not only specific to the contract but also helpful to accelerate the development or adoption of additional measures in areas where they are needed, including behavioral health.

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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: MBHP is not involved in the attribution of PCC Plan members to primary care providers. For the purposes of administering BH capitation for PCPRI, we utilize the PCC assignment provided to us by the State. For the purposes of performance reporting to our Outpatient Behavioral Health providers we utilize a claims-based attribution methodology which is described in part a. below. This type of BH attribution model could contribute to the assignment methodology used for Behavioral Health Homes, pending submission of MA's State Plan Amendment, or to ACO attribution. Part b. comments on attribution as it pertains to the development of our APM for specialty behavioral health.
   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)
      MBHP's Outpatient BH Attribution model assigns members to a primary behavioral health provider
      ii. units used in counting services (e.g., number of claims, share of allowed expenditures)
      The primary provider is identified using claims for behavioral health units.
      iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)
      The primary BH provider is the provider who has delivered the most units of individual counseling to the member, or, in cases that do not involve individual counseling, the provider delivering the most units overall.
      iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and
      Attribitution is performed every 6 months to be coincident with the reporting period.
      v. whether patients are attributed retrospectively or prospectively.
      Members are attributed retrospectively and for reporting purposes only.
   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?
      Although MBHP is not an insurance company, we are nevertheless concerned with questions of member assignment to providers. MassHealth members are not required to select a single behavioral health provider for ongoing outpatient care; which, very similar to the PPO product, creates a natural tension between the

benefits of member choice and the virtues of assignment for the purposes of provider accountability, measurement, and payment. For the purposes of our acute episode APM, "attribution" will be tied to episode initiation at an inpatient facility. Nevertheless, our goal is to use the episode "bundle" as a means of constructing incentive opportunities that may be equally beneficial to IP and OP providers who partner together to better manage episodes of care for the population within a region.

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?
Because there are distinctions between different types of alternative payment models there may be necessary distinctions between the attribution models and contractual arrangements appropriate to each. Moreover, based on the Four Quadrant Model, different members may be more appropriately attributed to providers other than a PCC for their overall care coordination needs, or "Health Home." Therefore there could be advantages to fostering a variety of payment and attribution models, including some that are agnostic to insurance product, in order to observe the relative impact of different designs on a common set of trend and quality indicators. This could facilitate the evolution of an evidence-base for the efficacy of different provider accountability models for different populations.

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

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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: N/A
ANSWER:

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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: N/A

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			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER:

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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: At present 80% of MBHP Inpatient Hospital expenditure is associated with community-based or private psychiatric hospitals, while only 20% of IP expenditure is associated with academic medical centers. In addition, diversionary strategies are a cornerstone of MBHP's quality-focused medical management approach. The impact of our Emergency Services Program (ESP) and CBHI programs at diverting cases from 24-hour levels of care to less-intensive community-based treatment is described below.
ANSWER: Over the years, MBHPs focus on delivering the most appropriate level of services to members - "the right care, at the right time, in the right place" - has led to fewer services being delivered in acute settings, even for the most complex, disabled members; and, according to studies conducted by Milliman and cited in our 2013 testimony to the Commission this approach has produced financial returns to the Commonwealth. The CBHI program, in particular, continues to illustrate the relationship between increased utilization of community-based diversionary services and decreased utilization of 24-hour levels of care. With the maturation of the CBHI program, and the advent of innovative diversionary tactics such as Youth Mobile Crisis Intervention, the rate of medical inflation for Youth services has experienced a steady YoY decline since 2011 (see Attachment A). The overall performance of our Emergency Services Program (ESP) also suggests that community-based intervention is correlated with lower-intensity treatment. ESP interventions for MBHP members increased by 3,071 encounters between FY10 to FY13, a 9.5% increase in member volume. During this time community based interventions increased by 5.5 percentage points from 30.35% of

encounters in FY10 to 35.85% in FY13. If a person is seen in the community instead of the emergency department the rate of inpatient disposition drops significantly. In FY13, if a person was seen in an emergency department they were 20.16% more likely to receive an inpatient disposition.

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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: MBHP's Integrated Care Management Program addresses the totality of needs confronting the highest cost, highest risk members in the PCC Plan, including those non-clinical barriers to care for both medical and behavioral health conditions that can result in frequent ED and IP utilization. The PCC Plan population is risk-stratified using a predictive model that applies a multivariate regression analysis to assign risk scores to members. High-risk members who have chronic medical, behavioral health, and/or substance use diagnoses, high utilization and cost, gaps in care, or polypharmacy, among other risk factors are assigned an RN or Behavioral Health care manager depending on their primary condition. In 2013 ICMP care managers engaged more than 6000 members in intensive care management over the phone, in their homes, at doctor's offices, and even, when necessary on the street.
    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.
    ICMP Care managers work with members and their providers both telephonically and in person to ensure integrated treatment plans are in place, set goals that support the treatment plan, monitor progress, coordinate with the care team, and facilitate access to social supports. These interventions are having a measurable impact on the quality and efficiency of care for these members. Specifically, in 2013 the program resulted in an 8% combined reduction in preventable physical health admissions and overall behavioral health admissions (7.7% BH only and 8.1% PH only), exceeding the program goal of a 5% reduction. In addition, integrated care management interventions in combination with ongoing MBHP clinical review and pharmacy management efforts, resulted in a 33.7% reduction in polypsychopharmocology among members engaged in the program, exceeding the target set for the program by 94%.
    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.
    In delivering the ICMP program to MassHealth we are addressing medical and behavioral health co-morbidities with a single program that assigns one care manager to coordinate with the member and all his/her providers. This is different from carve-out models in which separate BH and Medical CM programs may co-exist side-by-side but not be fully integrated. In addition to ICMP, MBHP has integrated aspects of our core behavioral health management operation with the Integrated Care Management Program. In this way we are working to

ensure that our core analytic and medical management competencies as a MBHCO are being leveraged to identify the population most in need of integrated care management. For instance, our monthly report of behavioral health high-utilizers is compared to the ICMP stratification list and any members not already identified by the predictive model are added to the list of members eligible for ICMP intervention. In addition we utilize the daily census of members boarding in EDs and Inpatient BH units to assign members to ICMP for outreach and care coordination. We also generate a list of members whose providers receive Alerts for polypsychopharmacy through our Pharmacy program to identify these individuals for ICMP and begin working more closely with both the member and their prescribers to reduce medication risks. Finally, in 2014 we initiated a pilot to deliver the ICMP intervention through Practice-Based Care Management at four Community Health Centers. These providers will be responsible for managing the identified population of high-risk members in the same integrated fashion, with face- to-face interventions, and meeting the same performance measurement expectations as the plan-based program.

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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.
    SUMMARY: MBHP does not provide incentives for PCMH transformation or accreditation; however we are serving as the State's partner in overseeing PCPRI participants' compliance with contract milestones involving implementation of PCMH capabilities.
    ANSWER:

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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:
    ANSWER:

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

   MBHP operates as a behavioral health managed care company for MassHealth and Health New England and is not an insurance company or a provider as defined by Massachusetts state law. Please see Attachment A in which we have reported information for our MassHealth business that is analogous to the type of information requested of provider and insurers in Exhibit 1 & 2.

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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).

N/A.

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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

N/A

Massachusetts Behavioral Health Partnership
Health Policy Commission Testimony - Attachment A

MBHP PCC Plan Cost and Utilization Data

AGGREGATE COST & UTILIZATION METRICS	All Members, All Ages		
	2011	2012	2013
Total Medical Expenditures	$443,164,347	$472,832,225	$468,872,613
Annual % Change in Total Spend	*5.2%*	*6.7%*	*-0.8%*
Average Monthly Membership	388,209	429,841	427,819
Annual % Change in Ave. Monthly Membership	*2.9%*	*10.7%*	*-0.5%*
Weighted Penetration Rate	30.76%	28.41%	28.16%
Annual % Change in Weighted Penetration Rate	*-4.4%*	*-7.6%*	*-0.9%*
Cost PMPM	$95.13	$91.67	$91.33
Annual % Change in Cost PMPM	*2.3%*	*-3.6%*	*-0.4%*
Cost Per Service User	$3,712	$3,872	$3,892
Annual % Change in Cost Per Service User	*7.0%*	*4.3%*	*0.5%*
Units Per Service User	101.9	112.6	118.1
Annual % Change in Units Per Service User	*16.7%*	*10.5%*	*4.9%*

Massachusetts Behavioral Health Partnership
Health Policy Commission Testimony - Attachment A

Break-out By Age and Level of Care

Categories of Spend	Total Medical Expenditure						Average Monthly Membership					
	0-20			21+			0-20			21+		
	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
24-Hour Level of Care	$63,919,705	$64,161,944	$59,218,089	$97,988,171	$103,861,179	$98,824,792						
Non-24-Hour Level of Care	$150,066,754	$170,235,169	$180,161,842	$129,986,001	$133,309,396	$129,970,475						
P4P	$277,588	$259,522	$120,493	$926,128	$1,005,015	$576,921						
Total	$214,264,047	$234,656,635	$239,500,425	$228,900,300	$238,175,590	$229,372,188	198,607	226,331	235,817	215,980	257,981	243,508

Annual Percentage Change

Categories of Spend	Total Medical Expenditure						Average Monthly Membership					
	0-20			21+			0-20			21+		
	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
24-Hour	-1.6%	0.4%	-7.7%	0.6%	6.0%	-4.8%						
Non-24-Hour	15.1%	13.4%	5.8%	1.3%	2.6%	-2.5%						
P4P	#DIV/0!	-6.5%	-53.6%	#DIV/0!	8.5%	-42.6%						
Total	9.7%	9.5%	2.1%	1.4%	4.1%	-3.7%	6.4%	14.0%	4.2%	2.1%	19.4%	-5.6%

Categories of Spend	WeightedPenetrationRate						Cost PMPM					
	0-20			21+			0-20			21+		
	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
24-Hour Level of Care	2.1%	2.0%	1.9%	7.0%	6.7%	6.9%	$ 26.26	$ 23.01	$ 20.28	$ 42.17	$ 41.43	$ 41.54
Non-24-Hour Level of Care	22.7%	20.9%	20.3%	37.6%	34.9%	35.6%	$ 61.65	$ 61.06	$ 61.70	$ 55.94	$ 53.18	$ 54.62
P4P	0.5%	0.4%	0.3%	2.1%	2.3%	2.4%	$ 0.11	$ 0.09	$ 0.04	$ 0.40	$ 0.40	$ 0.24
Total	22.8%	21.0%	20.4%	38.3%	35.5%	36.1%	$ 88.03	$ 84.17	$ 82.02	$ 98.50	$ 95.01	$ 96.41

Annual Percentage Change

Categories of Spend	WeightedPenetrationRate						Cost PMPM					
	0-20			21+			0-20			21+		
	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
24-Hour	-9.3%	-4.9%	-6.8%	-6.5%	-5.4%	2.9%	-7.4%	-12.4%	-11.9%	1.4%	-1.7%	0.3%
Non-24-Hour	-3.8%	-7.7%	-3.1%	-2.7%	-7.1%	1.9%	8.4%	-1.0%	1.0%	2.0%	-4.9%	2.7%
P4P	#DIV/0!	-13.4%	-39.1%	#DIV/0!	7.5%	4.6%	#DIV/0!	-18.4%	-55.7%	#DIV/0!	0.6%	-39.5%
Total	-3.9%	-7.7%	-3.1%	-3.2%	-7.2%	1.8%	3.3%	-4.4%	-2.5%	2.2%	-3.5%	1.5%

*P4P category reflects additional reimbursement paid since 2011 to OP and CSP providers for delivering recommended follow-up care to members within 7 and 30 days of discharge from an acute hospital. 2011-2012 also includes expenditure associated with the Rapid Admission Incentive program which was phased out in 2013.

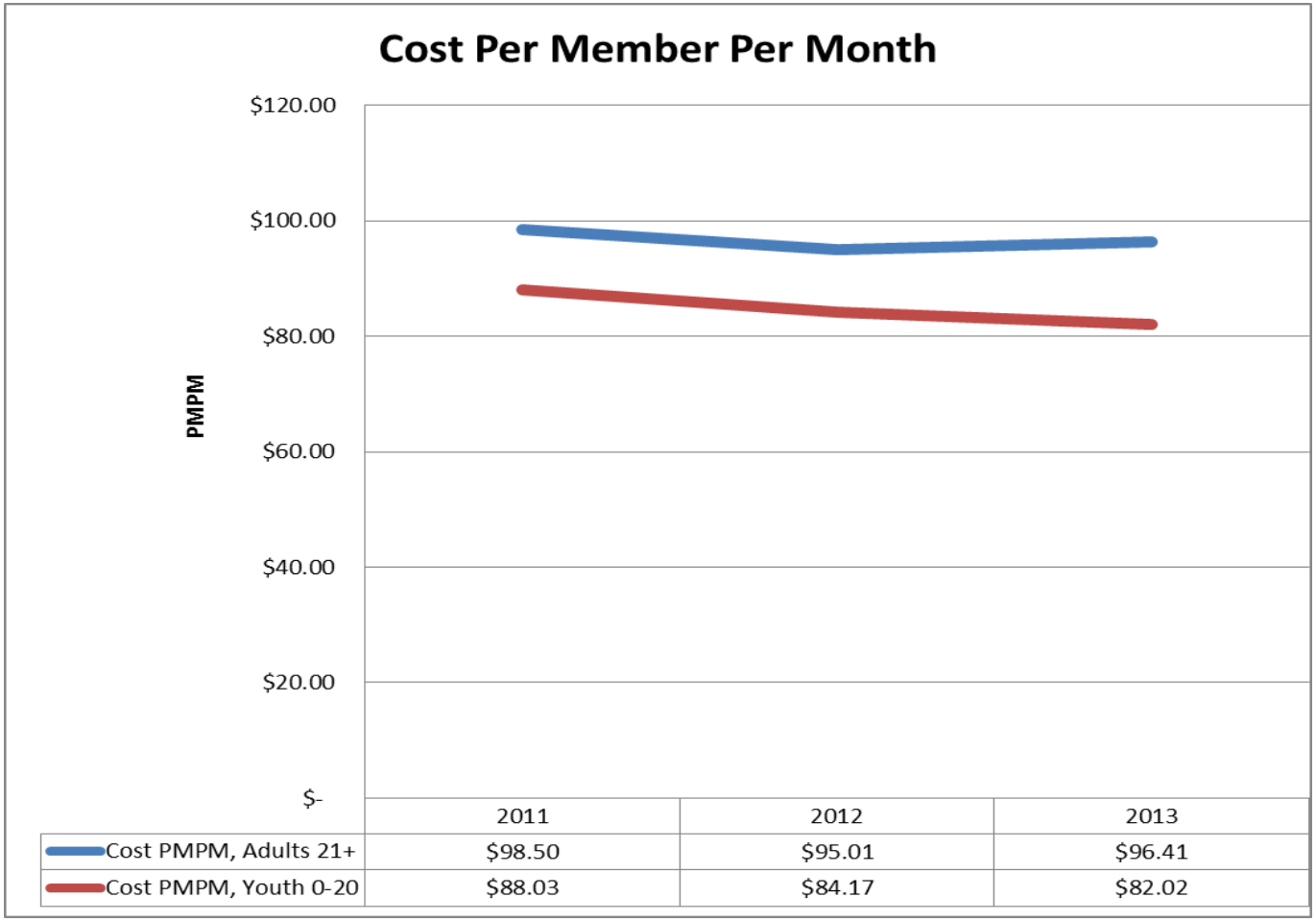
Massachusetts Behavioral Health Partnership
Health Policy Commission Testimony - Attachment A

Break-out By Age and Level of Care

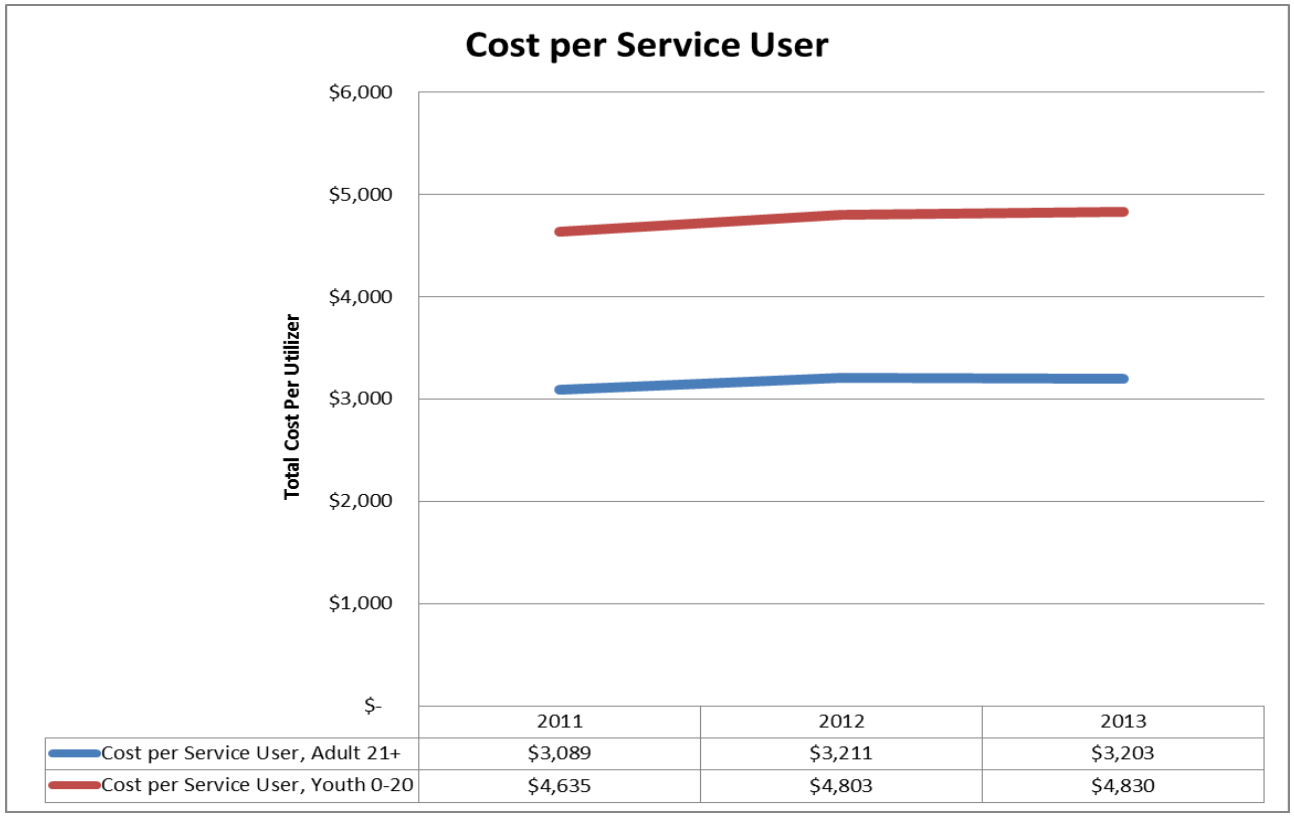
Categories of Spend	Cost/Service User						Units/Service User					
	0-20			21+			0-20			21+		
	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
24-Hour Level of Care	$ 15,090	$ 13,906	$ 13,142	$ 7,190	$ 7,469	$ 7,279	27.7	26.3	24.9	16.2	16.3	16.0
Non-24-Hour Level of Care	$ 3,260	$ 3,499	$ 3,648	$ 1,787	$ 1,829	$ 1,845	150.8	166.6	173.9	66.9	72.3	75.2
P4P	$ 282	$ 265	$ 193	$ 223	$ 208	$ 121	4.1	4.0	3.5	5.3	5.4	3.0
Total	$ 4,635	$ 4,803	$ 4,830	$ 3,089	$ 3,211	$ 3,203	152.8	168.5	175.5	68.9	74.4	77.2

Annual Percentage Change

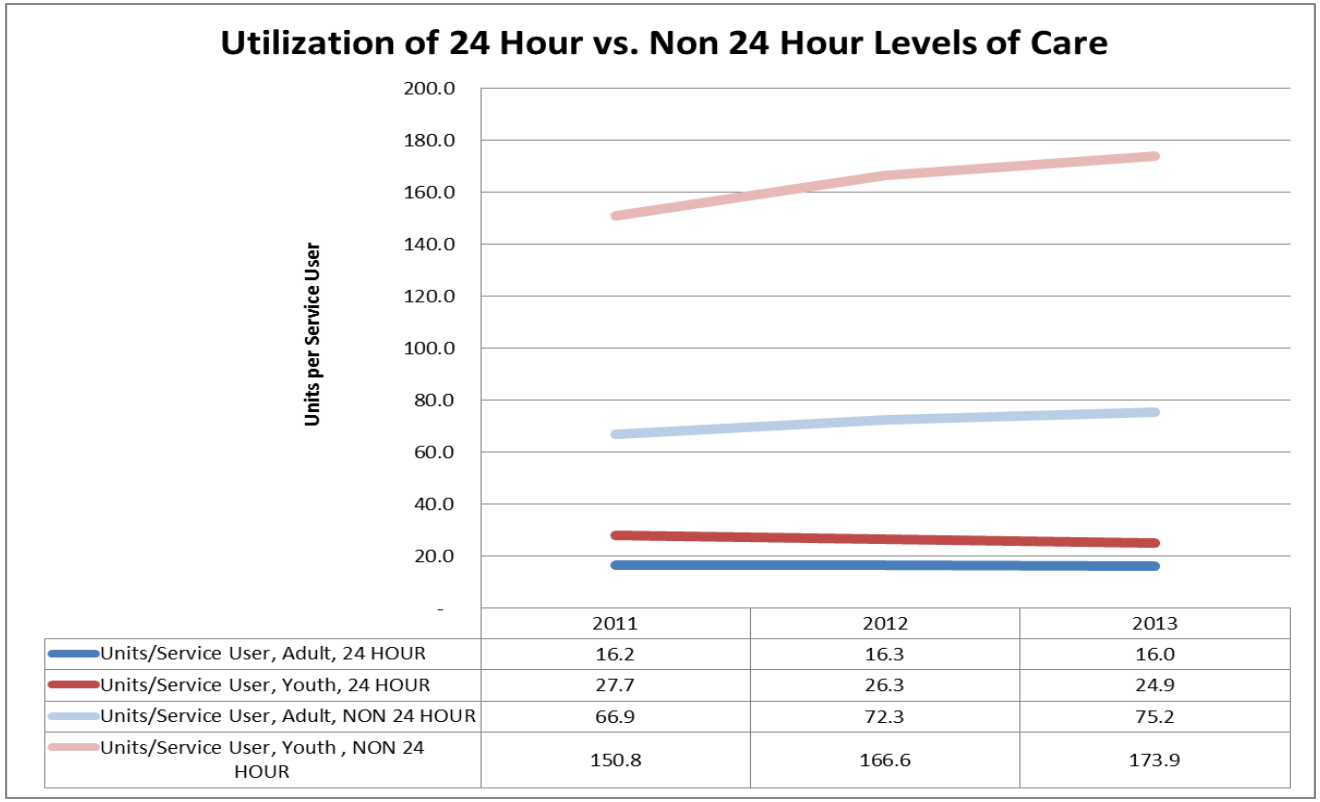
Categories of Spend	Cost/Service User						Units/Service User					
	0-20			21+			0-20			21+		
	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
24-Hour	2.1%	-7.8%	-5.5%	8.4%	3.9%	-2.5%	0.1%	-5.2%	-5.4%	5.4%	0.5%	-1.8%
Non-24-Hour	12.7%	7.3%	4.3%	4.9%	2.4%	0.9%	20.5%	10.5%	4.4%	9.0%	8.1%	4.0%
P4P	#VALUE!	-5.7%	-27.2%	#VALUE!	-6.4%	-42.1%	#VALUE!	-2.5%	-12.5%	#VALUE!	0.8%	-45.1%
Total	7.5%	3.6%	0.6%	5.5%	4.0%	-0.3%	20.2%	10.2%	4.2%	9.6%	8.0%	3.7%



	2011	2012	2013
Cost PMPM, Adults 21+	$98.50	$95.01	$96.41
Cost PMPM, Youth 0-20	$88.03	$84.17	$82.02



	2011	2012	2013
Cost per Service User, Adult 21+	$3,089	$3,211	$3,203
Cost per Service User, Youth 0-20	$4,635	$4,803	$4,830



	2011	2012	2013
Units/Service User, Adult, 24 HOUR	16.2	16.3	16.0
Units/Service User, Youth, 24 HOUR	27.7	26.3	24.9
Units/Service User, Adult, NON 24 HOUR	66.9	72.3	75.2
Units/Service User, Youth , NON 24 HOUR	150.8	166.6	173.9

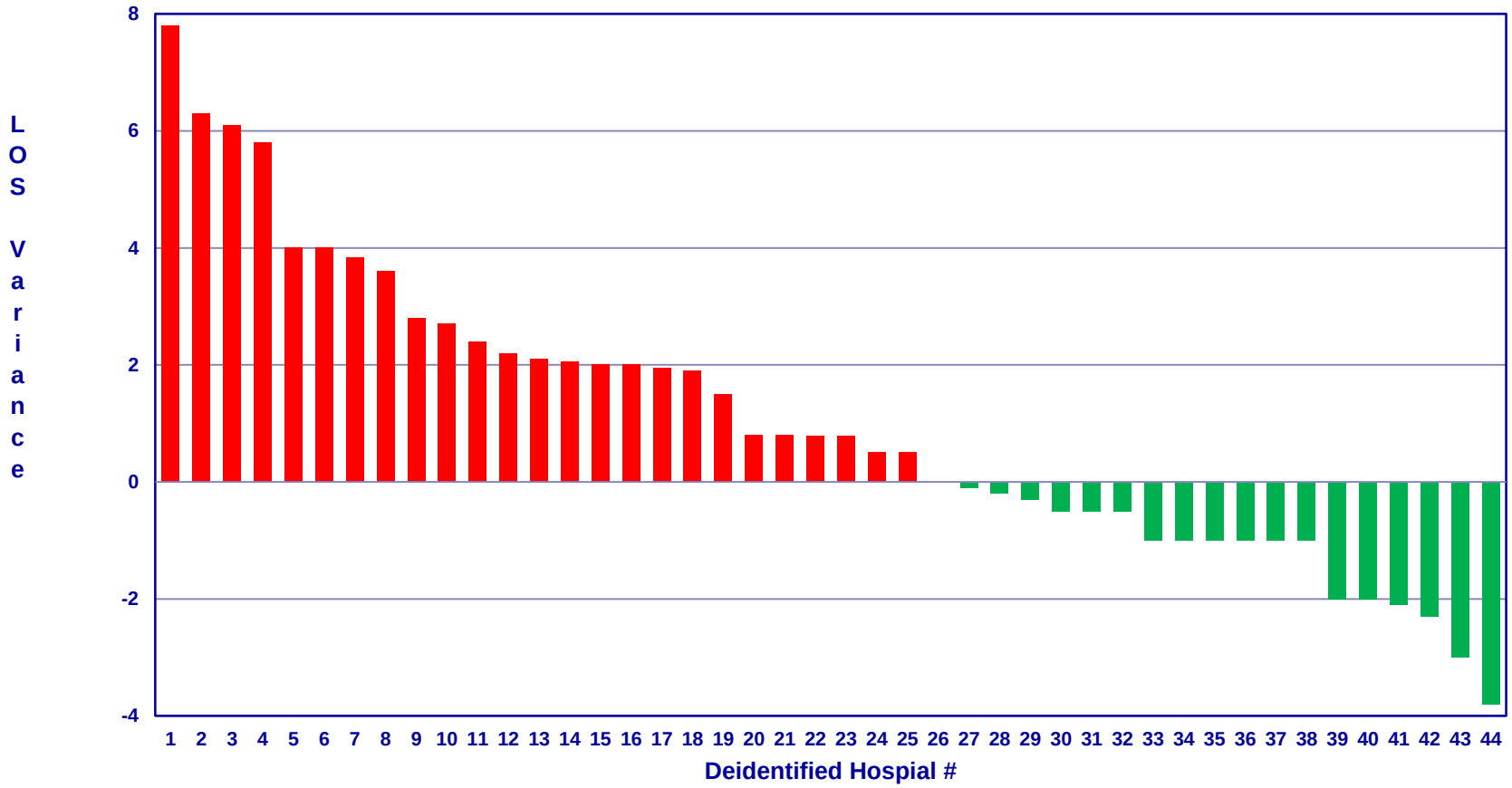
Massachusetts Behavioral Health Partnership

MBHP Inpatient Hospital Performance Management:

Improvement in Predicted vs. Actual Length of Stay

2003-2014

MBHP Network Hospitals:
Predicted vs. Actual Length of Stay Variance In Days Per Admission
March 2003



MBHP Network Hospitals:
Predicted vs Actual Length of Stay Variance In Days Per Admission
March 2014