BOSTON MEDICAL CENTER HealthNet Plan

September 11, 2015

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 6, 2015 letter to Susan Coakley as 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 HPC Payer Exhibits 1 and 2 of your letter. I am legally authorized and empowered to represent Boston Medical Center Health Plan, Inc. for purposes of the written testimony herein, and I sign this testimony under the pains and penalties of perjury.

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

Sincerely,

Laurie Doran

Laurie Doran
Chief Financial Officer

Enclosures

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

## Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), 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 5, 2015, 9:00 AM**
**Tuesday, October 6, 2015, 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 both days. 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 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 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 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, 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: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at 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 at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

## Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment 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 complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement 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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## Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
    a. Please describe your organization's efforts in the last 12 months to meet this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs) on (i) total medical expenses, (ii) premiums, and (iii) provider quality. Please specifically describe efforts and analyses related to bundled payment and similar payment methods.

    *In the past year, BMCHP enhanced its shared savings risk model to allow for all of its Massachusetts products to be included and to focus on beating the plan-wide trend. As with the initial shared savings model, BMCHP's APM agreements have limits and caps on the amount of upside and downside potential and require provider groups to be of a credible size and have the appropriate resources and capabilities necessary to take on risk. The agreements also include quality incentives and infrastructure* payments. *While its agreements currently in effect remain upside only, BMCHP continues to work on transitioning providers into agreements that incorporate downside potential.*

    *The majority of BMCHP's provider groups do not have a credible population to participate in a shared savings risk model and some are reluctant or resistant to entering into such an APM agreement for various reasons including: lack of Medicaid membership persistency; insufficient time to engage in shared savings discussions; and concerns over requesting data for sensitive diagnoses and other provider contract terms for their members. To address these issues, BMCHP is developing approaches that reduce the scope of the population requirement and maintain shared accountability for all services covered but for a select group of members (i.e., high risk, which is being piloted) or for episodes and conditions (bundles). BMCHP is also developing a bundled payment pilot that it intends to roll out within the next 12 months.*

    *BMCHP continues to evaluate options and encourage providers to participate in APMs. As part of its commitment to APMs, BMCHP has created a permanent position/role to develop, contract, and oversee APMs and other provide-based initiatives designed to promote high quality efficient care delivery.*

    *During the past year BMCHP also prepared for participating in the EOHHS's Primary Care Payment Reform (PCPR) program which would include many of the groups with whom BMCHP previously had APM arrangements, but ultimately the program was not rolled out for the MCO populations.*

    b. Please describe specific efforts your organization plans to undertake between now and October 1, 2016 to increase the use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health

providers), and other provider and product types. Please specifically describe efforts related to bundled payment and similar payment methods.

*As noted in 1.a above, BMCHP faces several barriers in implementing total medical expense shared risk arrangements with its Medicaid network. As a result, BMCHP is focusing on developing approaches that can be offered to a wider group of providers as well as hospitals, including, but not limited to, bundled payments. As part of its bundled payment development efforts, BMCHP participated in the ACAP (Association for Community Affiliated Plans) Bundled Payment Collaborative and funded research on potential episodes or conditions suitable for a Medicaid bundled payment model with one of our larger network hospitals. As noted above, BMCHP intends to implement a bundled payment pilot in the next 12 months, will continue efforts to engage providers in APM discussions, and will roll out shared savings arrangements with remaining eligible providers over the next year.*

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

*BMCHP does not currently offer PPO products and does not intend to do so for 2016.*

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

*As noted in last year's testimony, BMCHP primarily serves Medicaid and ConnectorCare members. As a result, BMCHP HMO-based products necessarily involve partnerships with high value providers. BMCHP's statewide provider network is designed to provide high quality care at competitive rates. BMCHP has not offered tiered products in any of its benefit plans, including the commercial plans.*

*As previously explained, BMCHP focuses on member engagement and network development as the means to support and promote delivery of high value care as detailed below.*

*Member Engagement: BMCHP engages members to use high value providers in several ways. This begins with the PCP selection process where BMCHP works with the member to select an appropriate PCP. BMCHP has a comprehensive process for conducting new member outreach, orientation and education. The 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. These calls enable BMCHP to identify special healthcare needs and to address identified barriers to care, including cultural issues. The new member Welcome Kits reinforce information provided during these calls. Additionally, BMCHP's Health Needs Assessment process enables it to coordinate member healthcare needs and ensure access to appropriate high value network providers. In this way, BMCHP fosters patient-centered integrated care delivery.*

*Network Development: BMCHP also works with its provider network to promote delivery of high-value care. Providers are oriented to refer members to in-network hospitals and specialists. BMCHP also gives providers reports that show where care is received so that it can be better coordinated with in-network providers. BMCHP's financial arrangements with providers help to ensure appropriate coordination of care with other in-network high value providers. BMCHP focuses its efforts on ensuring that members receive services at the most appropriate site of care.*

*As noted last year, the 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 28% of BMCHP 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 vital to achieving lower cost, higher quality care for BMCHP members. Going forward, much of BMCHP's efforts in ensuring its members seek out high value providers and services remains focused on network development. By implementing value based reimbursement arrangement, BMCHP aims to incentivize providers to deliver high quality, efficient care to its members.*

*For the low income and disabled population that BMCHP primarily serves, plan design efforts and limited/tiered network products do not offer a feasible mechanism to encourage use of high value services, settings, and providers. BMCHP members typically use products with either no member cost sharing or very low member cost sharing which limits BMCHP's ability to change member behavior through plan design. In addition, access to care is of primary importance for BMCHP members as transportation to and from a medical facility is more challenging for a low income and disabled population. This creates additional barriers around implementing narrow networks as well as instituting plan design elements that require members to seek care at lower cost sites of service, such as free standing labs versus hospital labs. On the commercial product platform, BMCHP does offer a narrow network product centered on high value hospitals in and around the Boston region.*

3. Chapter 224 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures and services through a readily

available "price transparency tool." Please describe your organization's progress in meeting this requirement. If you had a tool in place prior to November, 2012, please describe your organization's prior experience, including how long your tool has been in use and any changes you have made to the tool over time.

*Notwithstanding BMCHP's historic and ongoing focus on the Medicaid population, it has made significant progress in the development and implementation of its price transparency tool for its limited commercial plan membership. This progress has included moving from an initial call-in process to a web-based tool. This web-based tool generates benefit design and cost sharing information specific to individual members. After an initial phase with more limited condition information, the tool now covers a significant number of conditions, including those frequently the subject of member inquiries. BMCHP will continue to enhance the price transparency tool in support of its members and consistent with applicable requirements.*

a. Using **HPC Payer Exhibit 1** attached**,** please provide available data regarding the number of individuals that seek this information and identify the top ten admissions, procedures and services about which individuals have requested price information for each quarter listed below and the number of inquiries associated with each.

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

| | | | | |
|---|---|---|---|---|
| Inpatient | Yes | ☒ | No | ☐ |
| Outpatient | Yes | ☒ | No | ☐ |
| Diagnostic | Yes | ☒ | No | ☐ |
| Office Visits (medical) | Yes | ☒ | No | ☐ |
| Office Visits (behavioral) | Yes | ☒ | No | ☐ |

*BMCHP members are redirected to our behavioral health partner, Beacon Health Options, for cost information on behavioral health services.*

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

Yes ☒ No ☐

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

Yes ☒ No ☐

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

Yes ☐ No ☒

*At this time, this is not a capability of BMCHP's transparency software.*

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

*The utilization of the transparency tool by BMCHP's membership has been limited mainly due to the small size of our commercial membership. As a result, a meaningful analysis of the impact this tool is not feasible. No material limitations to the tool's capabilities have yet been identified.*

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

*BMCHP's view of market changes is challenged by their recentness and their variability. Some provider groups change systems multiple times resulting in insufficient data to evaluate the impact of a single migration. Consolidation is generally accompanied by pressure to adjust contract terms to the most favorable position of the numerous participants, which would increase total medical expense. In some cases, the changes result in entities being better able to partner with BMCHP on population health initiatives because of their size and scope. BMCHP expects these initiatives to lower costs and improve quality and access to care.*

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

    *BMCHP recognizes several understandable variations in global budgets and rates. These include risk of the population served, geographic cost adjustments, and disproportionate care status. There are other factors that drive variation in price without clear value. The most significant factor is market leverage due to actual or perceived specialization and geographic isolation.*

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

    *BMCHP has worked with the provider network to establish rate levels that are more sustainable to the programs we serve. We advocate for program funding that recognizes these rates also need to be sustainable to the organizations serving our members.*

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

   *BMCHP has an Access & Availability to Non-Network Providers Policy. The purpose of the policy is to address access for members who may need services outside of BMCHP's network under certain circumstances. In general, non-network options are available when the member's in-network provider(s) determine that the member requires a service not available within BMCHP's provider network and/or without which the member would be subjected to unnecessary risk by using a network provider who cannot provide a comparable service. If services with a non-network provider are approved, BMCHP will coordinate payment to the provider and the cost to the member will be no greater than it would be if the services were furnished through the in-network provider. BMCHP's provider contracts contain a requirement that network providers seek prior authorization from BMCHP when they want to refer members to a non-network provider. This process provides for communication to the member.*

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

   *To date, BMCHP has not experienced an increased prevalence of encounters with same-day facility and physician components. However, BMCHP acknowledges that the shift of patient visits from physician's offices toward outpatient based practices would likely result in higher health care costs, presumably without significant changes in the quality of care delivered to members. In terms of access, BMCHP has concerns that efforts to mitigate the impact on healthcare costs, by creating payment parity between a physician office setting and an outpatient-based practice setting for appropriate services, may result in significant reductions in revenue for hospitals serving a disproportionate share of the low-income population, thereby potentially reducing patient access for this population.*

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

   *Every year, BMCHP reviews its care management registry which is designed to use predictive modeling software to identify members who are 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 facilitates identification of more high risk members, for either behavioral health, medical or co-care management. In addition, identifying those members with frequent ED use has demonstrated higher levels of co-morbid diagnoses and homelessness.*

*BMCHP continues to work with the Institute for Healthcare Improvement (IHI), and has established a multi-disciplinary subgroup (including behavioral health) to develop and evaluate the most effective tools and interventions. BMCHP has continued to incorporate several of these interventions into the broader care management population's interventions. Tools such as ED assessment, and pro-active "crisis" plans that aim to avoid emergency and inpatient admissions and give patients alternative treatment options are key to these interventions. BMCHP's work with IHI has expanded and efforts have been made to reach out to members in additional parts of BMCHP's Massachusetts coverage area.*

*As noted last year, BMCHP contracts with Beacon Health Strategies (Beacon), an NCQA accredited managed behavioral health organization (MBHO), to manage and coordinate behavioral health (BH) services for all its members. Beacon works with BMCHP, BMCHP's participating medical providers, and Beacon's BH provider network to ensure that integrated services are provided for all high-cost, high-risk members. BMCHP's work with Beacon has been designed to ensure that there is no "wrong door" in accessing integrated services, as providers and members who require BH consultation are encouraged to call either BMCHP or Beacon - either approach prompts the caller to the proper queue. BMCHP Care Managers (CMs) and Beacon's CMs are co-located in each of BMCHP's regional offices. This allows them to holistically meet the needs of a specific population in a regional area, or identify resources available to alleviate barriers to treatment. 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 Grand teaching Rounds. Medical directors (medical and BH) attend the co-managed care rounds, and are available for consultation. In terms of managing the direct care of members, Beacon also 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. BMCHP medical staff completes a similar process when BH issues are identified by a medical CM. The two CMs will review each other's documentation and communicate about the case both formally (in the system), in person or by phone to coordinate next steps, a process that may also include the member's provider.*

*As stated above, members with co-morbid conditions may be assigned both a medical and behavioral health CM. The primary CM is selected based on the severity of each condition and the quality of the alliance each CM has with the member. On occasion, both CMs may make a joint face-to-face visit to the member's home, a provider's office or a shelter. Beyond the daily discussions and rounds that take place about member care, CM staff use a variety of tools to ensure integrated treatment is being appropriately provided and monitored. BMCHP's high cost claims report ensures that all members needing care management*

*services have been properly identified, triaged and outreached. Beacon's regular reporting to BMCHP serves to monitor the number of co-managed cases, and the number and appropriateness of referrals. Beacon provides BMCHP regular reporting on members who are having care coordinated either directly via Beacon, or via other Beacon managed providers in the community, such as psychiatric visiting nurses or community service providers. Monitoring the number and scope of these "community services" allows BMCHP to consider the needs of the population and the focus of CM resources directly provided by Beacon.*

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

*BMCHP currently has a number of early-stage initiatives aimed at supporting integrated care. For example, BMCHP has contracted with a new primary care practice in the Southeast region, operated by a known substance use provider. The practice, which is located next to a methadone clinic, aims to provide high quality integrated primary care to a very difficult-to-reach population. Additionally, BMCHP is exploring several potential alternative payment arrangements, including bundled payments, to support substance use treatment integration into primary care. These initiatives are too early in their development to establish success metrics.*

*Finally, in the past year, BMCHP made improvement grants to community health centers across the state to support, among other things, behavioral health integration into primary care and expansion of primary care-based medication-assisted treatment for substance use disorders. The first progress reports from grantees are expected later this summer, and BMCHP anticipates offering another round of grants in early CY 2016.*

9. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2012 to CY2014 according to the format and parameters provided and attached as **HPC Payer Exhibit 2** with all applicable fields completed. Please explain for each year 2012 to 2014, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).

*The trends in the attachment (HPC Payer Exhibit 2) reflect BMCHP's entire Massachusetts business which includes the MassHealth Medicaid Program, the Commonwealth Care program, and BMCHP's commercial products. For years 2012-2014, the impact of benefit buy down is negligible. The member cost sharing associated with the benefit plans that BMCHP offers in its MassHealth Medicaid and Commonwealth Care programs (which comprise more than 99% of BMCHP's membership in all 3 years) is both minimal and stable from year to year. As previously reported, the demographic and health status components of trend are reflected in the*

*utilization component of trend. BMCHP estimates 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 HPC Payer Exhibit 2 of the Appendix.*

**HPC Pre-Filed Testimony - Payer Questions**
**HPC Payer Exhibit 1**

| Health Care Service Price Inquiries CY2014-2015 | | | | |
|---|---|---|---|---|
| **Year** | | **Aggregate Number of Inquiries via Website** | **Aggregate Number of Inquiries via Telephone or In Person** | **Aggregate Average Time to Resolve Inquiries*** |
| **CY2014** | **Q1** | 0 | 0 | 0 |
| | **Q2** | 0 | 0 | 0 |
| | **Q3** | 1 | 0 | 0 |
| | **Q4** | 28 | 2 | 0 |
| **CY2015** | **Q1** | 206 | 31 | 0 |
| | **Q2** | 139 | 32 | 0 |
| | **TOTAL:** | 374 | 65 | |

** Please indicate the unit of time reported.*

******In addition, payers <u>MUST</u> identify the Top 10 admissions, procedures and services in the next two (2) tabs ("Top 10 CY2014" and "Top 10 CY2015")******
***All 3 tabs must be completed.***

**Identify the Top 10 Admissions, Procedures and Services for CY2014 by Quarter:**

| | | |
|---|---|---|
| **CY2014 Q1** | **1** | |
| | **2** | |
| | **3** | |
| | **4** | |
| | **5** | |
| | **6** | |
| | **7** | |
| | **8** | |
| | **9** | |
| | **10** | |
| **CY2014 Q2** | **1** | |
| | **2** | |
| | **3** | |
| | **4** | |
| | **5** | |
| | **6** | |
| | **7** | |
| | **8** | |
| | **9** | |
| | **10** | |
| **CY2014 Q3** | **1** | MRI - Brain; without Contrast |
| | **2** | |
| | **3** | |
| | **4** | |
| | **5** | |
| | **6** | |
| | **7** | |
| | **8** | |
| | **9** | |
| | **10** | |
| **CY2014 Q4** | **1** | MRI - Abdomen; without Contrast |
| | **2** | MRI - Brain; without Contrast |
| | **3** | MRI - Brain; without Contrast, followed by with Contrast |
| | **4** | MRI - Abdomen; without Contrast, followed by with Contrast |
| | **5** | MRI - Cervical Spine; without Contrast |
| | **6** | MRI - Thoracic Spine; without Contrast |
| | **7** | MRI - Thoracic Spine; without Contrast, followed by with Contrast |
| | **8** | MRI - Cervical Spine; without Contrast, followed by with Contrast |
| | **9** | |
| | **10** | |

**Identify the Top 10 Admissions, Procedures and Services for CY2015 by Quarter:**

| | | |
|---|---|---|
| **CY2015 Q1** | **1** | MRI - Abdomen; without Contrast |
| | **2** | MRI - Abdomen; without Contrast, followed by with Contrast |
| | **3** | MRI - Brain; without Contrast, followed by with Contrast |
| | **4** | Eye Exam - New Patient Ophthalmologist Visit |
| | **5** | Eye Exam - New Patient Optometrist Visit |
| | **6** | MRI - Brain; without Contrast |
| | **7** | MRI - Cervical Spine; without Contrast |
| | **8** | MRI - Cervical Spine; without Contrast, followed by with Contrast |
| | **9** | Eye Exam - Established Patient Optometrist Visit |
| | **10** | Physical Therapy - 2 modalities |
| **CY2015 Q2** | **1** | Eye Exam - New Patient Ophthalmologist Visit |
| | **2** | Wellness visit - established patient, age 18-39 years |
| | **3** | Chiropractic Care - Manipulation of 5 Spinal Regions |
| | **4** | Eye Exam - New Patient Optometrist Visit |
| | **5** | Podiatry Services- office visit, new patient |
| | **6** | Physical Therapy - 2 modalities |
| | **7** | Eye Exam - Established Patient Ophthalmologist Visit |
| | **8** | Eye Exam - New Patient Optometrist Visit, with an Eye Refraction Test |
| | **9** | Chiropractic Care - New Patient Visit |
| | **10** | Asthma - Office visit for a new patient |

## HPC Payer Exhibit 2

***All cells shaded in BLUE should be completed by carrier****

**Actual Observed Total Allowed Medical Expenditure Trend by Year**
***Fully-insured and self-insured product lines***

| | Unit Cost | Utilization | Provider Mix | Service Mix | Total |
|---|---|---|---|---|---|
| **CY 2012** | -0.41% | 2.03% | 0.24% | 0.06% | 1.93% |
| **CY 2013** | 1.75% | 0.21% | 0.08% | -0.47% | 1.57% |
| **CY 2014** | 2.81% | -2.05% | 0.68% | -0.31% | 1.13% |

**Notes:**

**1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.**

**2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.**

**3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.**

**4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.**