MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Payers

As part of the
Annual Health Care Cost Trends Hearing

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), 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:

Tuesday, October 16, 2018, 9:00 AM
Wednesday, October 17, 2018, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from individuals of the public beginning at approximately 3:30 PM on Tuesday, October 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Individuals of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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 Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov 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 witnesses, 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.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. Please complete relevant responses in the provided 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, 2014, 2015, 2016, and/or 2017 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the templates, did not receive the email, or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC staff at HPC-Testimony@mass.gov or (617) 979-1400.

Pre-Filed Testimony Questions

1) STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.

Key Concern 1: Continued rise in costs associated with the opioid epidemic

As the prevalence of opioid use disorder (OUD) continues to increase, so too do the medical costs. The Commonwealth must continue to focus on education and prevention efforts, while at the same time ensuring optimal care pathways are in place for those in need of care today. Beacon's experience has been that too often individuals and families are unaware of the array of evidence-based addiction care options available and instead, rely on detoxification (detox) programs as the primary avenue for opioid treatment.

The limitation of a detox-first approach lies in the missed opportunity to make community-based medication assisted treatment (MAT) services more readily available. The evidence shows that relapse rates for individuals on MAT are significantly lower than those using detox as primary intervention. Until such a time that we can increase member and family education surrounding the clinical evidence in opioid addiction treatment, Beacon will remain concerned about a high rate of relapse in those struggling with opioid use. Inherent in high rates of relapse is an increased risk of overdose. Even after a brief period of abstinence, tolerance is reduced when a relapse occurs.

In addition to negative clinical outcomes and compromised quality of life associated with relapse, is increased health care spending. To help mitigate these risks, Beacon recommends that individuals in need of addiction treatment receive care delivered by providers who are adherent to the American Society of Addiction Medicine (ASAM) standards. ASAM criteria is the clinical standard in addiction treatment, matching the specific and unique needs of each individual, including physical and social determinants of health factors, to tailored clinical models and interventions. (https://www.asam.org/resources/the-asam-criteria/about)

MA Chapter 258 law is a step in the right direction in helping addiction resources become more attainable for individuals and families. Our experience to date suggests that a high proportion of individuals continue to seek treatment that is not congruent with ASAM standards. Massachusetts could consider enhancing Chapter 258 to try to mitigate this risk. One example of a change might be to create a triage resource for individuals or families seeking addiction treatment, whereby helping to make available an array of therapeutic options based on the unique needs of each individual presenting for services.

Doing this would ensure access to critical addiction treatment while reinforcing ASAM decision criteria. The result of this enhancement would drive a reduction in relapses as well as faster attainment of sustained recovery.

To measure the legislation's impact on cost, Beacon conducted an analysis of individuals' utilization pre- and post- Chapter 258 legislation. That analysis revealed, a post-legislation increase in detox episodes, a greater proportion of individuals with opioid addiction who relapsed, and an increase in the number of total readmissions.

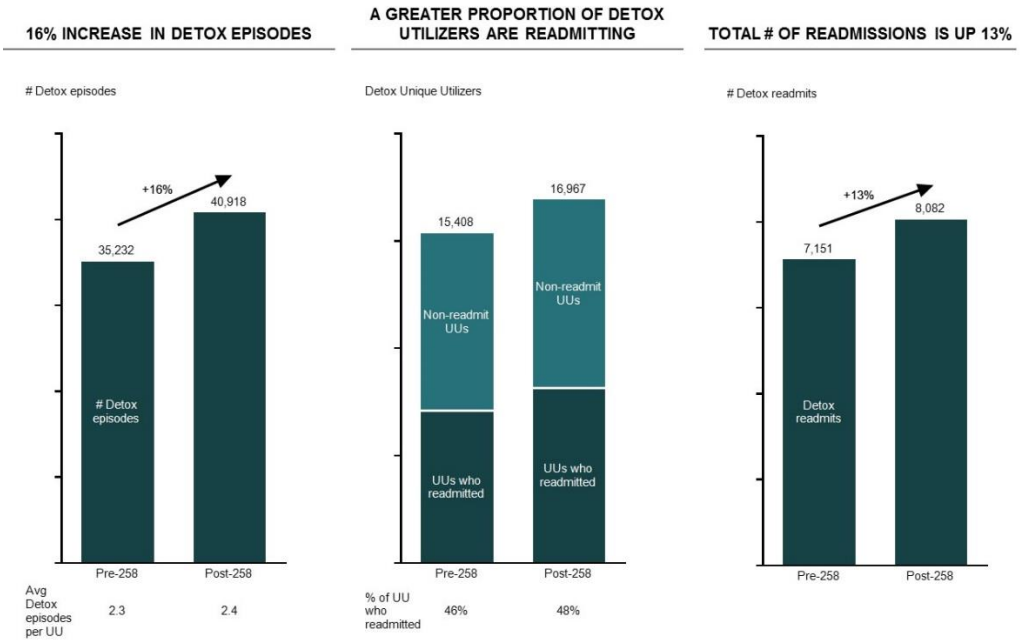

Figure 1: Beacon Detox Utilization Pre- and Post- Chapter 258 Legislation[1]

Despite the increased utilization, there is no clear evidence in our data that shows a commensurate improvement in clinical outcomes. On the contrary, there is good reason to think that the increased utilization of detox is counter-productive. As discussed previously and in our white paper "Confronting the Crisis of Opioid Addiction[2]," addressing the opioid crisis requires supporting individuals' informed knowledge of treatment options and connecting those in need of care with the most effective care models. Beacon believes that Governor Baker's new opioid bill passage will help increase access to evidence-based options, through the establishment of new care pathways, could help to reduce the rate of relapse, and increase sustained recovery.

[1] Source: Beacon internal claims data, 2016 – 2017

[2] http://beaconlens.com/wp-content/uploads/2015/11/Confronting-the-Crisis-of-Opioid-Addiction.pdf

Key Concern 2: Increased costs driven by suboptimal utilization

2a: Chronic emergency department (ED) utilization[3]
There continues to be high ED usage among a group of individuals with behavioral health needs, particularly those with serious mental illness (SMI) or substance use disorders (SUD). This scenario is concerning from both a cost and quality of life perspective. The ED is usually not the optimal location for individuals to receive the best possible care as ED staff often lack the behavioral health training to address complex issues that affect people with SMI and/or SUD. For example, the "highest utilizer" cohort of individuals[3] contribute disproportionate cost to the system because the acute care received in the ED is not the ideal intervention generally needed. Often the root cause of ED utilization includes social determinants of health considerations such as lack of housing, food, and natural supports. Addressing social determinant needs could be cost effective while at the same time improving overall quality of life for individuals stuck in a pattern of sustained and frequent ED use.

2b: High inpatient/detox utilization due to limited step-down options and challenges successfully transitioning to lower levels of care
Beacon has implemented several initiatives focused on discharge planning and follow-up after hospitalization/detox recognizing the importance of successful transitions of care and the enhanced risk for relapse if transitions are not well managed,. These interventions have included:

- Increasing inpatient/detox provider engagement through onsite discussion and performance evaluation in the area of comprehensive discharge planning
- Establishing advanced discharge planning data-reporting to routinely share with providers
- Partnering with strategic inpatient and outpatient providers to improve communication, referral pathways, and data-sharing
- Providing targeted appointment assistance services as a stop gap measure for comprehensive discharge planning and transition of care appointments with outpatient providers

Sustainable improvements in these areas remain a key priority for Beacon going forward, and we look for support from all stakeholders to make continued advancement a reality.

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3 National Institute on Drug Abuse. "Part 2: Co-occurring Substance Use Disorder and Physical Comorbidities." *National Institute on Drug Abuse (NIDA)* |, 2018, www.drugabuse.gov/publications/common-comorbidities-substance-use-disorders/part-2-co-occurring-substance-use-disorder-physical-comorbidities

What are the top changes in policy, market behavior, payment, regulation, or statute would your organization recommend to address these concerns?

Recommendation 1: Increased collaboration between managed care and public policy to address the opioid epidemic
We believe there is an opportunity to better align efforts between managed care and public policy, as both entities are striving toward common goals. Possible initiatives include:

- *Revisiting Chapter 258 legislation.* We strongly believe that a revision to Chapter 258 could improve health outcomes while preserving the original and laudable goal of improving access. Revising the regulations, such that the Commonwealth can pivot from what has become a detox-first approach, would allow access to greater evidence-based care options on

a timelier basis. Alternatively, a revision would allow insurers to engage in discharge planning with detox facilities. Beacon's clinical staff would welcome the ability to engage providers to assist with ensuring effective discharge planning, and to connect individuals with needed care managers or other community supports. Such revision would work to ameliorate the restriction of insurer participation that has resulted in greater utilization of detox, relapse, and readmission without improving utilization of proven treatment pathways such as MAT.

- *Ensuring a no wrong door approach to treatment, furthering the capability of the Emergency Services Program (ESP) teams.* Beacon's Massachusetts Behavioral Health Partnership (MBHP), as the ESP administrator, will work with ESP provider teams to add licensure requirements for SUD assessment and to create stronger referral pathways to MAT providers.

- *Developing MAT ED/facility licensure requirements on SUD.* In conjunction with the newly empowered DMH/BSAS oversight body, Massachusetts can ensure all facilities applying for operating licensure in the Commonwealth have an outlined plan as to how they will meet the SUD assessment and MAT referral requirements.

Additionally, in order to improve patient access to preventative care and reduce need for treatment, the market should expand its efforts to leverage peer support systems and telehealth capabilities. Payers and providers should also seek to establish value-based payments where appropriate to improve outcomes for their patients.

Recommendation 2: Invest in crisis services for behavioral health. Massachusetts has been a pioneer in developing crisis services for those with behavioral health needs. The ESP has been a critical component of the Commonwealth's crisis system, but we believe there is opportunity for improvement. Examples include:

- *Expand ESP competencies to address the needs of individuals with SUD-related crises.* The opioid epidemic has increased the need for ESPs capability to serve not only those with primary mental health presenting conditions, but to increase access to addiction licensed clinicians for more comprehensive and effective assessment capabilities.
- *Continue to improve on the capabilities of mobile crisis units.* While many ESPs have the capability to deploy mobile teams, improving psychiatric support to these units will potentially increase their utilization. The scarcity of MD-level support limits the mobile team's ability to engage individuals where they are. Telehealth is an option to augment this unmet need.
- *Exploring new models of crisis care, such as the Living Room model.* Massachusetts can benefit from funding a more robust crisis provider network. Best-in-class crisis systems include a comprehensive array of crisis providers including peer-operated alternatives, like those operated by META Services in Phoenix, AZ or urgent care crisis centers.
- *Continued investment in statewide, payer-agnostic infrastructure (e.g., MABHA website).* Massachusetts should further invest in its crisis services to expand the Commonwealth's ability to respond to mental health crises. That investment should focus on a more robust contact center that allows different modalities of engagement, as well as a mobile response team that can act in both rural and urban areas.
- *Conducting a thorough end-to-end review of the Massachusetts crisis system*: seek to identify gaps in the MA Crisis system against the national *Crisis Now* framework (http://crisisnow.com/) to further identify investment priorities.

b) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

Strategic Priority 1:
Continue to address the opioid epidemic through an optimized delivery system.
Beacon has undertaken a review of the current SUD care system to strengthen documented treatment interventions, promote coordination of care, and ensure appropriate transition of care planning for members with SUD. In Q1 2018, Beacon audited member records of our volume acute SUD providers.

Beacon shared the results of the member record review with participating providers. We will continue offering guidance on best practice models, feedback via individualized provider data, and technical assistance with identified challenges or barriers. We will develop performance improvement goals with providers, and will conduct supplemental chart reviews to monitor quality improvement and ultimately the care delivered to individuals receiving treatment.

By doing so, individuals are more likely to recover, less likely to readmit to the hospital and ultimately, more likely to experience improved health status.

Strategic Priority 2:
Address unnecessary ED and inpatient visits.
We continue to focus on 1) promoting alternative forms of care to the ED/IP, and 2) connecting members to care after discharge. We work with crisis providers, inpatient facilities, community partners, and state agencies to improve the crisis system of care. Through our MBHP contract, as the ESP administrator, we have been working with MassHealth to continue to improve the crisis system. We continue to monitor the quality of the ESP system and have implemented infrastructure enhancements, such as the MABHA website, to help ensure members are not stuck in the ED. Additionally, Beacon continues to focus on ensuring our members get connected to care after discharge. Our Care Managers help connect members to community resources while successfully transitioning members to outpatient supports.

2) INFORMATION ON PHARMACY BENEFIT MANAGERS

The HPC, other state agencies, payers, providers, and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. Pharmacy benefit managers (PBMs) play a major role in the market, significantly impacting drug pricing and access. Furthermore, PBM policies that restrict the ability of pharmacies and pharmacists to share certain information with patients have been an increasing area of focus.

a) Please identify the name of your organization's contracted PBM(s), as applicable.

N/A

b) Please indicate the PBM's primary responsibilities below [check all that apply]

c) Briefly describe the Massachusetts member populations managed by your PBM (commercial, Medicaid, fully-insured, self-insured, etc.).

N/A

d) Does your organization or any PBM with which you contract have policies that restrict the information a pharmacy or pharmacist can share with a covered person on the amount of the covered person's cost share for the prescription drug compared to self-pay (so-called "gag clause")? If yes, briefly describe this policy.

N/A

e) Does your organization or any PBM with which you contract have policies requiring a pharmacy to charge or collect a copayment from a covered person even if that amount exceeds the total charges submitted by the network pharmacy? If yes, briefly describe this policy.

N/A

f) Does your organization or any PBM with which you contract have policies requiring a pharmacy to proactively disclose to a covered person if the total charges submitted by the network pharmacy are less than the required copayment? If yes, briefly describe this policy.

N/A

3) STRATEGIES TO PROMOTE INNOVATIVE CARE DELIVERY THAT INTEGRATES BEHAVIORAL, SOCIAL, AND MEDICAL CARE

Public and private payers alike are implementing new policies to support the development and scaling of innovative, high-quality, and efficient care delivery, such as, for example, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, reimbursement for services rendered by peers and community health workers, and incentives for patients and providers to engage in evidence-based treatment for substance use disorder.

Has your organization adopted policies related to any the following areas of care delivery improvement and innovation? [check all that apply, and describe your primary incentive related to the care delivery innovation in the fields below]

☒Readmissions Other (please describe in a text box)

Reducing unnecessary readmissions is one of Beacon's top priorities. To that end, understanding the importance of increasing our individuals' community tenure, we are operating several programs to intervene with those who are at risk:

- *Precision case management*. We are investing in machine learning to create predictive algorithms that identify individuals at high risk of admission or readmission. While traditional analytics focus on simple metrics, such as recent medical costs, machine learning allows us to incorporate thousands of variables to assess each member's risk. Beacon can then better prioritize individuals who would benefit from a preventative intervention to reduce the likelihood of a crisis and therefore hospitalization or emergency services.
- *High utilizer support.* Beacon is completing comprehensive reviews of individuals who are frequently readmitting to higher levels of care. Focusing on connecting these individuals to community and outpatient supports, we identify patterns of utilization and work with ESP providers, inpatient providers, and state agencies to break ineffective treatment cycles. Our

Care Managers create individualized treatment plans for each member enrolled in the high utilizer program, and maintain increased levels of engagement until the member has reached six months in his/her community. As a result, we have seen annualized outpatient spend increase while utilization of other levels of care decrease over the course of the member's intervention and an improvement in community tenure.

- *Provider quality management.* Beacon generates quarterly Follow-Up after Hospitalization profile reports comparing Massachusetts providers to their peers and national HEDIS benchmarks. Using these reports to collaborate with providers on improving performance, Beacon technical support includes the following activities:

    - Training providers on discharge planning and improving compliance with arranging aftercare prior to discharge
    - Monitoring community tenure and readmission rates of our individuals in a provider's care
    - Evaluating utilization of community service providers and care management involvement in preventing readmissions
    - Notifying primary care physicians of a member's discharge

We stand behind these programs' effectiveness by agreeing to performance incentives in our contracts. Specifically, they are measured against reducing readmission rates, as well as against other metrics that indirectly impact readmissions.

☒Avoidable emergency department (ED) visits Other (please describe in a text box)

Beacon uses many of the programs highlighted above in the readmissions response to reduce the number of avoidable emergency department visits. In addition, our Care Managers engage in proactive care planning with at-risk individuals to ensure that processes exist to access ED alternatives in the event of a crisis. Care Managers work with the member's therapist, PCPs, family and other stakeholders to create a crisis plan that is well-communicated among the care team so that the intervention is effective at keeping the member in the community.

☒Behavioral health integration into primary care (e.g., collaborative care model)
Other (please describe in a text box)

Beacon is an established thought leader in the area of integration. As stated in our 2016 white paper, "Integration," we are strong proponents of the University of Washington collaborative care model[3] and promote its adoption within our network. For example, Beacon supports one of the model's five principles--patient-centered team care—by reimbursing behavioral health providers for case consultation, thus promoting PCP collaboration. Additionally, we support integration through better data sharing (e.g., patient disease registries); outcomes measurement (e.g., improvement in PHQ-9 scores; and alternative payment arrangements (e.g., shared savings based on total cost of care for attributed individuals).

We also leverage Project ECHO, a tele-monitoring model designed to improve care for OUD, by linking Beacon-led behavioral health specialists with PCPs through interactive videoconferencing. Although PCPs are frequently the first point of contact for individuals with OUD, they often lack the training or support necessary to treat OUD and consequently refer to specialty care. When given the

[3] http://beaconlens.com/integration/

proper training, PCPs can be instrumental in caring for those battling OUD. Through Project ECHO, Beacon will achieve three target outcomes:

1. Expanding access to ambulatory substance use treatment with a focus on MAT
2. Educating PCPs on skills and processes needed to treat OUD with MAT
3. Improving integration of behavioral health support for addiction care in primary care settings

Beacon's Medical Director (a licensed psychiatrist and addictionologist) leads our Project ECHO hub. The hub team includes interdisciplinary Beacon specialists, such as a pharmacist, peer, nurse, and a behavioral health counselor.

In summary, this "hub-and-spoke" learning model enables primary care providers and other clinicians to develop the skills needed to treat patients with complex, chronic conditions, such as OUD, within their own communities.

☒Pharmacologic or other evidence-base therapies for substance use disorder
Other (please describe in a text box)

In 2017, Beacon and Column Health developed a bundled payment program with the goal of providing access to, and encouraging the use of, MAT to treat OUD. We base the bundled payment structure on two treatment phases for patients on MAT:

- **Intake and induction:** Includes a full psychosocial assessment, MAT induction and stabilization, and full treatment planning
- **Maintenance:** Ongoing MAT dosing, psychotherapeutic programming, and wraparound supports, including care coordination for physical health comorbidities. The bundle includes three maintenance phases with decreasing service levels that the member progresses through by achieving recovery plan goals.

We base reimbursement for the bundle on a suggested visit-frequency threshold for the covered services; patients may require more or fewer visits based on individual circumstance. The bundle is billed on a weekly to monthly basis, depending on the phase of treatment and frequency of medication management appointments. Encounter claims are collected to reconcile the bundle payment against the full set of services delivered.

The bundled payment also incorporates outcomes metrics and bonus payments to align financial incentives with high-quality treatment. Column Health will miss the opportunity to earn reimbursement if it falls below targets on certain measures, while Beacon pays a quarterly bonus for exceptional outcomes performance. Outcomes measures include:

- Admission rates to 24-hour substance use levels of care
- MAT adherence
- Treatment engagement and progression
- Quality of life
- Population health metrics (e.g., participation in HCV, HIV screenings)

☒Peers and/or community health workers Fee-for-Service Reimbursement

Beacon has taken a leadership role in envisioning, planning, and guiding the development of peer-run recovery initiatives and the integration of peers in service delivery statewide. Beacon contracts for

Parent Partners (Peers) within the Children's behavioral Health (CBHI) suite of Mass Health covered services for youth. We contract with specialized Community Support Program (CSPs) who offer Peer teams in the field of mental health and have recently added the Recovery Coach, a Peer, as a benefit under Mass Health.

Over the years, Beacon has collaborated with organizations such as Consumer Quality Initiatives, as well as other organizations with peer expertise. Beacon currently holds two contracts with local peer-run organizations:

Dual Recovery Anonymous
Beacon has financially supported the Massachusetts Clubhouse Coalition (MCC) in providing Dual Recovery Anonymous (DRA) services since FY 1999. DRA is an anonymous 12-step meeting that supports only those people with both a mental health and SUD condition. More specifically, DRA offers peers the opportunity to develop leadership skills by facilitating self-help meetings. This innovative dual recovery model has become internationally recognized by the International Center for Clubhouse Development network.

Beacon's MCC DRA contract:

- Has expanded from ~12 meetings in 1999 to ~50 meetings in 2018
- Provides funding for DRA support in clubhouses and the larger community
- Provides leadership support to help meeting leaders bring DRA meetings to hospitals, detoxes, and other facilities
- Funds the annual DRA Retreat, which offers workshops, training, and networking for DRA individuals and leaders throughout the state
- Helps fund important meeting starter supplies, such as books, coins, workbooks, etc.

The Transformation Center
Since 1999, Beacon has held a contract with The Transformation Center, a statewide, peer-run technical assistance and training center. Currently, the contract held with the Transformation Center focuses on the Massachusetts Leadership Academy (MLA). The MLA is a peer-run, in-depth training program that recruits and trains consumers in good citizenship, self-empowerment, and systems knowledge.

☒Telehealth/telemedicine Fee-for-Service Reimbursement

Massachusetts has some of the most restrictive limitations on the use of telehealth nationally. According to a survey[4] by Manatt, the Commonwealth's telemedicine policies received an overall grade of "Restrictive" – one of only 12 states to receive that evaluation. Though we reimburse for services today, we have not seen the modality used to its fullest potential. Beacon advocates for telehealth care delivery to be widely adopted and promoted. We use telehealth to improve access and speed of appointments in many other states and have found there to be no negative clinical impact compared to visits at a "brick-and-mortar" office. Indeed, a recent Yale University study[5] comparing web-based therapy to in-person treatment for SUD found that online treatment was not only as effective as in-person treatment but possibly more so.

[4] https://www.manatt.com/Insights/Newsletters/Manatt-on-Health/State-Policy-Levers-for-Telehealth-50-State-Surve?utm_source=manattonhealthnewsletter&utm_medium=email&utm_campaign=manattonhealth_6.28.18
[5] https://news.yale.edu/2018/05/29/online-program-outperforms-standard-addiction-treatment

☐Non-medical transportation Required Answer: Click Here

☒Supportive temporary or permanent housing Other (please describe in a text box)

Beacon is proud to collaborate with the Massachusetts Housing and Shelter Alliance (MHSA) on the Hospital to Housing (H2H) program. It is a three-year, private-foundation, grant-funded initiative that began in late 2016. Its goal is to reduce hospitalizations and emergency service utilization for the chronically homeless with serious mental illness. Beacon has employed five community health workers (CHWs) who work at permanent supportive housing providers. These Beacon CHWs must identify and reach Beacon individuals eligible for the program and connect them to housing and services. CHWs also provide supportive services and care coordination to help individual's access permanent housing, primary care, behavioral health care, and other resources.

In addition, the Community Support Program for People Experiencing Chronic Homelessness (CSPECH) began in 2005 as a partnership between not-for-profit policy advocacy organizations, the Massachusetts Housing and Shelter Alliance (MHSA), and the Massachusetts Behavioral Health Partnership, now a division of Beacon. In 2016, CSPECH we expanded to serve MassHealth individuals enrolled in health plans that collaborate with Beacon. Developed under the authority of the 1115 waiver, CSPECH provides supportive services to individuals who meet the U.S. Department of Housing and Urban Development (HUD) definition of chronic homelessness and who have been placed in permanent supportive, low-threshold housing. These services aim to help individuals attain life-skills and to access community resources to remain housed and improve health. Services provided include help with daily living skills, transportation, connection to health care and other services, and case management.

☐Other: Other (please describe in a text box)

4) STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

Chapter 224 of the Acts of 2012 requires payers to provide individuals with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures, and services through a readily available "price transparency tool."

a) In the table below, please provide available data regarding the number of individuals that sought this information:

Health Care Service Price Inquiries CY2017-2018			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person[6]
CY2017	**Q1**	23	2348
	Q2	51	3178
	Q3	48	3006
	Q4	26	2472
CY2018	**Q1**	44	2812
	Q2	43	2315
	TOTAL:	235	16131

b) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?

Beacon is unaware of any barriers that hinder accurate and timely response to consumer inquiries. As Beacon's contracts with providers change based on plan design, fee schedules or other factors, updates are reflected in our system and on our website on a timely basis.

c) What barriers do you encounter in accurately/timely responding to provider inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?

Beacon is unaware of any barriers that hinder accurate and timely response to provider inquiries. As Beacon's contracts with providers change based on plan design, fee schedules or other factors, updates are reflected in our system and on our website on a timely basis.

5) INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2015 to CY2017 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2015 to 2017, the portion of actual observed allowed claims trends that is due to (a) changing demographics of your population; (b) benefit buy down; (c) and/or change in health status/risk scores of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

[6] Note: Beacon is not tracking inquiries separately for price information from overall benefit or eligibility questions. The numbers displayed here are the aggregate call volume for a category of inquiries called "Benefit and Eligibility" that includes benefit definition and member eligibility inquiries as well as pricing information.

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 2015	3.0%	-7.4%	-0.9%	0.2%	-5.29%
CY 2016	1.0%	4.1%	3.4%	-0.5%	7.79%
CY 2017	1.9%	8.9%	0.03%	-1.9%	8.93%

Drivers of trend:

1) Utilization trend in 2015 impacted by membership growth and the overall number of services
2) SU mandates in 2016 and 2017 have contributed to the upward movement in IP/Detox utilization and downward trend to IP within service mix, i.e. the service mix trend is the impact on total unit cost of the higher inpatient/Detox utilization
3) 2016 and 2017 outpatient unit cost trends are impacted by rate increases
4) Provider mix in 2017 driven by large increase in usage at higher unit cost hospitals
5) Increase in 2017 utilization steered by overall more services in OP; true count of visit increase

6) INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND AND ALIGN APMS

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. In the 2017 Cost Trends Report, the HPC recommended the Commonwealth continue to promote the increased adoption of alternative payment methodologies (APMs) from present levels of 59% of HMO patients and 15% of PPO patients in 2016. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a) Please answer the following questions related to risk contract spending for the 2017 calendar year, or, if not available for 2017, for the most recently available calendar year, specifying which year is being reported. (Hereafter, a "risk contract" shall mean a contract that incorporates a budget against which claims costs are settled for purposes of determining the surplus paid or deficit charged to a provider organization.)
   i) What percentage of your organization's covered lives, determined as a percentage of total member months, is HMO/POS business? What percentage of your covered lives is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)
      1. HMO/POS N/A
      2. PPO/Indemnity Business N/A
   ii) What percentage of your HMO/POS lives is covered under a risk contract? What percentage of your organization's PPO/indemnity lives is under a risk contract?
      1. HMO/POS N/A
      2. PPO/Indemnity Business N/A
   iii) What percentage of your organization's HMO/POS lives is covered under a risk contract with downside risk? What percentage of your PPO/indemnity lives is under a risk contract with downside risk?
      1. HMO/POS N/A
      2. PPO/Indemnity Business N/A

b) Please answer the following questions regarding quality measurement in APMs.
   i) Does your organization plan to implement the core and menu quality measure set in all of your future global-budget based APM contracts, as applicable, with Accountable Care Organizations (ACOs) as defined by the Executive Office of Health and Human Services' Quality Alignment Taskforce (see Appendix A)?
      (a) If yes, what is your timeline for implementing the measures in contracts? If no, why not?

Beacon currently does not have any global-budget based APM contracts. However, we are experienced with implementing quality measures to support value-based payments. For example, our contract with Column Health includes performance incentives related to achievement of HEDIS measures such as 7- and 30-day rates of initiation and engagement in treatment (IET).

As it is an important part of Beacon's clinical and operational philosophy, quality measurement will be a key component of any alternative payment contract we undertake going forward.

   ii) What are your organization's priority areas, if any, for new quality measures for ACOs?

Beacon believes that behavioral health is well represented in the quality measure set. However, our priority area to improve these measures include measures that focus on MAT adherence for individuals with substance use disorder. For example, we would like to measure 60-, 120- and 180-day rates tracked against a target rate. These measures are essential for ensuring individuals are engaging in evidence-based care.