BOSTON MEDICAL CENTER HealthNet Plan

September 2, 2016

Mr. David Seltz
Executive Director
Health Policy Commission
2 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 July 15, 2016 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 Exhibits B and C and HPC Payer Exhibit 1 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
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 Massachusetts 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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, 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.

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 (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 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 2, 2016**, 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 from HPC-Testimony@state.ma.us. 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, and/or 2015 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 Microsoft Word template, 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@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. 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. 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.

1. Strategies to Address Health Care Cost Growth.

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are the top areas of concern you would identify for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

BMCHP's area of top concern is the increasing costs of prescription drug prices. This concern manifests in two forms: 1) specialty pharmacy trends, specifically hepatitis-C drug treatments, and 2) retail prescription drug price increases.

Specialty pharmacy drugs, including Hepatitis C related drugs

BMCHP continues to observe significant increases in Hepatitis-C related drug costs. For the 12-month period ending June 2016, Hepatitis C drug costs contributed nearly 1% towards BMCHP's medical expense trend.

Beginning August 1, 2016, the MassHealth program (which comprises approximately 70% of BMCHP's total business) is expanding coverage of Hepatitis C drug treatments. Despite projected reductions in the cost per treatment, BMCHP still expects Hepatitis C related drug costs to increase over 50% in calendar year 2016, continuing to drive overall trend upwards by nearly 1%. While these treatments may lead to longer-term cost reduction benefits, we do not expect that those benefits will be realized in the near future.

There are numerous other high-cost specialty drugs (both currently in the market and in the pipeline) that treat less prevalent conditions, but continue to drive cost. Some of these include Gleevec, Evzio and Orkambi.

Retail prescription drugs

BMCHP has also experienced double digit trends for retail prescription drugs (both generic and brand), largely driven by increases in the costs per drug. Recent examples include:

- Epipen, whose price has increased nearly 600% since 2009 and 32% in 2016 alone;
- Benicar, whose price has increased 100% since 2011; and
- Clomipramine, whose price has increased nearly 800% since 2011.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

BMCHP has limited ability to manage growth in prescription drug prices and supports legislation to promote increased competition and transparency within the pharmaceutical industry. In many cases, prescription drug price hikes are directly correlated with monopolies for the affected drugs. The hope is that increased competition will mitigate short-term price increases while still allowing for innovation that helps improve health and healthcare costs over the long term.

2. Strategies to Address Pharmaceutical Spending Trends.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising pharmaceutical prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Do you contract with a pharmacy benefit manager (PBM)? Yes

i. If yes, please identify the name of your PBM.
Envision Rx Options

ii. If yes, please indicate the PBM's primary responsibilities below *(check all that apply)*

- ☐ Negotiating prices and discounts with drug manufacturers
- ☒ Negotiating rebates with drug manufacturers
- ☐ Developing and maintaining the drug formulary
- ☒ Pharmacy contracting
- ☒ Pharmacy claims processing
- ☐ Providing clinical/care management programs to members

b. In the table below, please quantify your projected per-member-per-year (PMPY) rate of growth in pharmaceutical spending for different lines of business and drug types from 2015 to 2016.

Line of Business	Total Rate of Increase (2015-2016)	Rate of Increase for Generic Drugs Only (2015-2016)	Rate of Increase for Branded Drugs Only (2015-2016)	Rate of Increase for Specialty Drugs Only (2015-2016)
Commercial	**4.4%**	**-12.2%**	**11.3%**	**7.3%**
Medicaid	**19.5%**	**13.4%**	**10.3%**	**44.7%**
Medicare	**11.8%-13.6%**	**1.4%-4.3%**	**13%-15%**	**16.5%-17.3%**

c. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including pricing, purchasing, prescribing, and utilization. Using the drop down menu, please specify any strategies your organization is currently implementing, plans to implement in the next 12 months, or does not plan to implement in the next 12 months.

i. Risk-Based or Performance-Based Contracting
Does Not Plan to Implement in the Next 12 Months

ii. Utilizing value-based price benchmarks in establishing a target price for negotiating with drug manufactures on additional discounts
Does Not Plan to Implement in the Next 12 Months

iii. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing).
Does Not Plan to Implement in the Next 12 Months

iv. Monitoring variation in provider prescribing patterns and trends and conducting outreach to providers with outlier trends
Plans to Implement in the Next 12 Months

v. Establishing clinical protocols or guidelines to providers for prescribing of high-cost drugs
Currently Implementing

vi. Implementing programs or strategies to improve medication adherence/compliance
Currently Implementing

vii. Pursuing exclusive contracting with pharmaceutical manufacturers
Currently Implementing

viii. Establishing alternative payment contracts with providers that includes accountability for pharmaceutical spending
Does Not Plan to Implement in the Next 12 Months

ix. Strengthening utilization management or prior authorization protocols
Currently Implementing

x. Adjusting pharmacy benefit cost-sharing tiers and/or placement of certain drugs within pre-existing tiers
Currently Implementing

xi. Shifting billing for certain specialty drugs from the medical benefit to the pharmacy benefit
Plans to Implement in the Next 12 Months

xii. Other: Insert Text Here

xiii. Other: Insert Text Here

3. Strategies to Increase the Adoption of Alternative Payment Methodologies.

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 2015 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2017.

a. What are the top strategies your organization is pursuing to increase use of APMs, including efforts to expand APMs to other provider types including hospitals, specialists (including behavioral health providers), and new product types (e.g., PPO)? (Please limit your answer to no more than three strategies)

BMCHP has a shared savings risk model that includes BMCHP Massachusetts MassHealth and QHP products. It is a beat-the-trend model. See our response related to the additional approaches we are taking to address barriers in 3b below.

BMCHP's APM agreements:

- Have limits/caps on the amount of upside and downside potential;
- Require provider groups to be of a credible size and have the appropriate resources and capabilities necessary to take on risk; and
- Include quality incentives and infrastructure payments.

While BMCHP's APM agreements are currently upside risk only, BMCHP continues to work on transitioning providers into agreements that incorporate downside potential with multiple-year arrangements that phase in downside risk.

b. What are the top barriers to increased use of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

BMCHP continues to face several barriers to increased use of APMs, and we have developed alternative approaches to engage providers and promote increased use of APMs.

The barriers include:

- The majority of BMCHP's provider groups do not have a credible population to participate in a shared savings risk model.
- Some providers are reluctant or resistant to enter into such an agreement for reasons that include:
    - Lack of Medicaid membership persistency. BMCHP is optimistic that the upcoming change to require MassHealth members to maintain annual fixed enrollment periods will help address persistency concerns.
    - Difficulty in managing the Medicaid population.
    - Providers not having time or resources to participate. These providers, who participate in commercial plans and/or Medicare, lack time and resources to engage in another program.
    - Providers feel that they cannot obtain access to certain sensitive diagnosis data (including behavioral health information).

To address these issues, BMCHP is developing alternative approaches. These include initiatives that involve working with providers to adjust the nature of the population requirement from total patient population to a smaller subset or targeting particular provider types. In addition, we have created arrangements that maintain shared accountability for all services covered for a select group of members, such as those at high risk, which we are piloting, or pediatrics. These also entail episodes and conditions (bundles) that can also be rolled out to other providers including hospitals. For example, BMCHP developed a bundled payment program for pregnancy and delivery; this is a high-volume episode that involves both physicians and their associated hospitals and is applicable to providers across the network. BMCHP rolled out this bundled payment pilot at the end of 2015 and early 2016 and is working to get providers to agree to participate in it. BMCHP continues to offer the option as appropriate.

While provider hesitancy to take on risk for a Medicaid population that has traditionally been hard to manage remains a challenge, BMCHP has been investigating tools, reporting, and programs that will provide additional information on member costs and utilization trends, aimed at improving providers' ability to manage this challenging population.

To respond to provider concerns about lack of time and resources to engage in a program that differs from the ones in which they currently participate through their commercial plans and/or Medicare, BMCHP has attempted to align aims with providers' other arrangements. For example, BMCHP allows providers to choose quality metrics that leverage initiatives that are part of other APM arrangements they are engaged in to minimize the need to develop additional programs.

BMCHP continues to evaluate options and encourage providers to participate in APMs.

c. Please describe your organization's specific efforts to support smaller providers, including ancillary and community providers, who seek alternatives to fee-for-service payment models.

BMCHP continues to explore other means of engaging providers in APMs, including aligning Home Health, SNFs, LTSS and community providers with APMs. BMCHP is working with its provider partners to learn with whom they work (e.g., which SNF does a particular provider system typically work with) and how we can support their working together in the future in the APM space.

4. Strategies to Align of Technical Aspects of APMs.

In the 2015 Cost Trends Report, the HPC called for an alignment and improvement of APMs in the Massachusetts market.

a. Please describe your organization's efforts to align technical aspects of APMs with Medicare and other plans in the Commonwealth, including specifically on quality measures, patient attribution methodologies, and risk adjustment (e.g. DxCG, HCC scores).

BMCHP's alignment efforts include the following with respect to quality measures, member attribution methodologies and risk adjustment:

- Quality. BMCHP integrates quality measures into its existing APMs to ensure that quality and financial incentives are aligned.
  - Performance in quality measures triggers level-of-surplus sharing.
  - As noted above in BMCHP's response to No. 3.b., to allow providers to deploy resources more efficiently, where possible, BMCHP has attempted to align aims with providers' other arrangements. For example, BMCHP allows providers to choose quality metrics that leverage initiatives that are part of other APM arrangements they are engaged in to minimize the need to develop additional programs.
- Member Attribution. BMCHP has participated in MassHealth workgroups on member attribution (as a health plan, BMCHP refers to "members" versus "patients") and has conducted analytics on different approaches to attribution, such as utilization driven, beyond PCP assignment. These include MassHealth's proposed methodology for attributing members to ACOs as part of the MassHealth redesign initiative.
- Risk Adjustment. While BMCHP currently does not utilize any socio-economic factors in risk adjusting (see barriers in Response to No. 4.b below), BMCHP does utilize DxCG, a model used by other payers in the State. In our beat-the-trend APM model, we use our own plan wide trend, allowing comparison to like populations.

b. What are the top barriers to alignment on these technical aspects and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

The top barriers that BMCHP has encountered related to the alignment of technical aspects of APM implementation include:

- Non-standard quality metrics

- Allowing providers to choose quality metrics that leverage programs used for other APM arrangements so they can use existing resources most efficiently can result in omitting some measures that might be more applicable to the Medicaid population.
- This can be addressed with a standardized set of quality metrics across the providers' entire Medicaid population that would allow for more efficient use of resources and would ensure that measures specific to Medicaid are included in provider care initiatives.

- Lack of risk adjustment for socio-economic disparities
  - Currently we are not aware of risk adjustment models that adequately adjust for socio-economic disparities.
  - To address this issue, BMCHP will continue to assess any new models that might become available for their effectiveness in adjusting for disparities, and we support MassHealth's ongoing efforts to create a risk adjustment methodology that incorporates socio-economic factors.

- Member attribution to providers
  - Member attribution continues to be a challenge given the churn of the Medicaid population and the utilization patterns of the population.
  - When members are newly enrolled in Medicaid, very few self-select a PCP and it may take several months before a member sees a PCP, creating a barrier to attribution during that period.
  - Attribution issues for Medicaid members can continue throughout the time they are enrolled because some members never seek care from a PCP and/or their only contact with the health system is through visits to the emergency room.
  - BMCHP supports providers in their efforts to engage these members so they can develop a relationship with their PCP and establish a medical home.

5. **Strategies to Increase Access to Pharmacologic Treatment for Substance Use Disorder.**
Despite a strong evidence-base, pharmacotherapy is underutilized to treat substance use disorder. Last year, several private payers committed to covering more pharmacologic treatment to address the increasing needs of patients.
    a. What are the top strategies your organization is pursuing to increase access, including affordability and provider availability, of pharmacologic treatment for your members with substance use disorder? Please include in your answer a description of any changes to coverage policies (e.g. cost-sharing, prior authorization, utilization review, duration of treatment limitations) or reimbursement strategies you have implemented or plan to implement with regard to pharmacologic treatment. (Please limit your answer to no more than three strategies)

    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 of our members. With Beacon, BMCHP has a number of early-stage initiatives aimed at supporting increase in access to pharmacological treatment for our membership. These initiatives include the following.

    <u>Alternative payment methodology</u>

    Through Beacon, BMCHP is developing alternative payment models with medication-assisted treatment (MAT) providers as a strategy to increase provider availability. By thinking about the ways in which we can creatively reimburse providers we are better able to align financial incentives with the targeted clinical outcomes associated with a successful pharmacologic treatment regime. In partnership with several providers, Beacon is discussing and developing standard bundled payments for clinic-based models focused on long-term MAT treatment for BMCHP members. These programs will encompass psychotherapy and other wraparound services necessary to promote treatment adherence. The contracts will be structured in such a way to provide the cash flow necessary for providers to expand their services and locations in order to increase access for members.

    <u>Improved access to MAT</u>

    To enhance access to needed MAT services for BMCHP membership, Beacon has also focused on seamlessly transitioning members from inpatient withdrawal management/detox programs to outpatient methadone maintenance. As it currently stands, outpatient methadone treatment programs report that most of their patients are self-referred and rarely receive referrals from inpatient withdrawal management programs. Our goal is to reverse this trend by ensuring that all members leaving inpatient detox are offered MAT. To do so, Beacon has piloted an effort with one large provider that has a comprehensive continuum of care. Together, Beacon and the provider have developed mechanisms for internal transfers within that care continuum, as well as for external transfers/direct admissions to an outside methadone provider. This approach addresses the issue that many episodes of treatment are cut short when members relapse in the high-risk period of abstinence between inpatient withdrawal management and outpatient MAT. Instead, this direct admission into a MAT program extends the duration of MAT treatment from Acute Treatment Services (ATS, or "detox")) through long-term outpatient care by eliminating the need to "detox to zero" before discharging from ATS. With dozens of successfully transferred members, this program has shown strong member adherence to treatment, a key to recovery from opioid use disorder. Furthermore, all members admitted to this provider for acute treatment of opioid use disorder have received a MAT consultation, a critical effort in expanding member awareness of MAT.

BMCHP intends to go live with these initiatives for its members in 2017.

b. What are the top barriers to increasing access to pharmacologic treatment for your members and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

The top barriers that BMCHP has encountered related to increase access to pharmacologic treatment for our members include:

- Provider access. Providers have historically been highly restricted on the number of patients they can treat with buprenorphine yearly (100 maximum). Legislation recently changed this, but providers will only react with a corresponding increase of patients populations if they are incentivized to do so. Even with the recent changes, there is still a disconnect between the widely unchecked prescribing of prescription painkillers, the highly limited prescription of the pharmacologic treatment, and the public discourse around the opioid epidemic, which needs to continue to focus on removing barriers to treatment.

- Care pathways. Care pathways are discontinuous and are inadvertently designed to not promote continuity of MAT from one level of care (LOC) care to the other. The current pathways of care within our substance use disorder (SUD) provider network delivery system originated from the days of alcohol being the primary substance of choice and the then prevailing treatment model and preferred outcome being full abstinence from substance use. Subsequently, the current opioid use disorder treatment system is ill equipped to support members after discharge from acute care, when many members relapse awaiting access to MAT. This barrier should be addressed by focusing provider reimbursement on full episodes of care for those facilities that offer services across the care continuum. We also must continue to work to foster partnerships for direct admission into outpatient MAT programs from inpatient withdrawal management services.

- Provider bias toward abstinence. Some providers do not fully embrace the evidence-based practice of long-term MAT as the treatment for opioid addiction and other addictions. As a result, these providers may not educate members around the MAT treatments available, and even refuse to treat members who are not willing to adhere to an abstinence-based treatment model. In order to address this barrier, systems must be committed to engaging in peer education, payment incentives, and outcomes-based feedback to providers regarding relapse rates for MAT vs non MAT treatments.

6. Strategies to Support Telehealth.

In its 2015 Cost Trends Report, the HPC recommended that the Commonwealth be a national leader in the use of enabling technologies to advance care delivery transformation.

a. Does your organization offer or pay for telehealth services? Yes
   i. If yes, in which scenarios or for which categories of care or specific populations do you pay for telehealth services (e.g. primary care, behavioral health, elderly, rural, etc.)?

BMCHP currently covers telehealth services for behavioral health services.

In addition, in September, 2016, BMCHP will begin participating in a pilot program in Tele-dermatology. We are embarking on a program with seven Community Health Centers who will have imaging technology available through 3Derm. This imaging technology will allow the PCPs to forward images to one of three contracted dermatologists who will review the images and report on their findings to the PCPs. Based on the findings, the dermatologists may recommend that the member be seen by a dermatologist on an urgent, medium or low basis, or

not at all. They may also provide the PCP with a diagnosis and possible treatment options for rashes, acne, and other skin conditions.

ii. If yes, how do you pay for these services (e.g. equivalent FFS rates as office visits, partial FFS rates, as part of a global budget, etc.)?

For behavioral health services, the rates are equivalent FFS rates as office visits.

There will be a flat fee paid to the dermatologists who review images for the tele-dermatology pilot program. For PCPs and specialists, the rates are equivalent FFS rates as office visits.

iii. If no, why not?
36T

7. Strategies to Encourage High-Value Consumer Choices.

In the 2015 Cost Trends Report, the HPC recommended that payers continue to innovate and provide new mechanisms that reward consumers for making high-value choices. The HPC highlighted strategies such as providing cash-back incentives for choosing high-value providers and offering members incentives at the time of primary care provider selection.

a. Do you currently offer cash-back incentives to encourage members to seek care at high-value providers? No
   i. If yes, please describe the types of cash-back incentives offered.
   36T

   ii. If no, why not?

BMCHP primarily serves MassHealth and ConnectorCare members. As a result, BMCHP's 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 does not currently offer tiered products in any of its benefit plans, including our commercial plans.

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 that aims to engage 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 us 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 members are receiving their care 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.

Our Community Health Centers (CHCs) 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. As of July 2016, 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 our members seek out high-value providers and services remains focused on network development, specifically, network composition, value-based payment arrangements, and promoting an efficient, high quality group of providers with whom we work. By implementing value-based reimbursement arrangements, BMCHP aims to incentivize providers to deliver even more high quality, efficient care to our 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. This 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 challenging for the low income and disabled population. This creates additional barriers around implementing narrow networks as well as instituting plan design elements that would 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.

b. Do you currently offer incentives (e.g. premium differential) at the point of enrollment or the point of primary care provider (PCP) selection to encourage members to select high-value PCPs? No
    i. If yes, please describe the types of incentives offered.
    36T

    ii. If no, why not?

As noted in the response to No. 7.a above, 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. This limits BMCHP's ability to change member behavior through plan design.

8. Strategies to Increase Health Care Transparency.

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."

a. Please provide available data regarding the number of individuals that seek this information in the following table:

Health Care Service Price Inquiries CY2015-2016			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2015	**Q1**	238	Less than 5
	Q2	172	Less than 5
	Q3	87	Less than 5
	Q4	47	Less than 5
CY2016	**Q1**	*	Less than 5
	Q2	*	Less than 5
	TOTAL:	544 *BMCHP had technical challenges with its web tool in 2016 and is working diligently to resolve them. During Q1 and Q2, members could still obtain cost information by phone. As noted above, BMCHP members typically use products with either no member cost sharing or very low member cost sharing, so utilization of the tool is extremely low.	

9. Information to Understand Medical Expenditure Trends.

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2013 to CY2015 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2013 to 2015, 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 products for the MassHealth Medicaid Program and the Commonwealth Care program, which is now closed, as well as our commercial products.

- For years 2013-2015, the impact of benefit buy down is negligible. The member cost sharing associated with the benefit plans that BMCHP offers in its MassHealth Medicaid program and its prior Commonwealth Care program, which comprised more than 99% of BMCHP's membership in years 2013 and 2014 and 94% in 2015, 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. In 2015, the health status component of trend was influenced by the partial closure of the Commonwealth Care program and the growth of the commercial QHP products, resulting in a significant drop in utilization trends and an increase in service mix trends simply due to the large population changes. Please see HPC Payer Exhibit 1 of the Appendix.

10. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) increase the adoption of APMs; c.) support alignment of APMs; d.) increase access to pharmacologic treatment; e.) support the adoption of telehealth; f.) encourage high-value consumer choices; and, g.) enhance consumer price transparency and utilization of transparency tools.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please answer the following questions related to risk contracts and pharmaceutical spending for the 2015 calendar year, or, if not available for 2015, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a 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.)

    a. What percentage of your business, determined as a percentage of total member months, is HMO/POS business? What percentage of your business is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)

HMO/POS	100%
PPO/Indemnity Business	0%

    b. What percentage of your HMO/POS business is under a risk contract? What percentage of your PPO/indemnity business is under a risk contract?

HMO/POS	For BMCHP's Massachusetts business 23% of its HMO/POS business is under a risk or shared savings contract.
PPO/Indemnity Business	N/A

    c. What percentage of your HMO/POS business that is under a risk contract has carved out the pharmaceutical benefit? What percentage of your PPO/indemnity business that is under a risk contract has carved out the pharmaceutical benefit?

HMO/POS	0%
PPO/Indemnity Business	N/A

    d. For your risk contracts that include the pharmaceutical benefit, how is the provider's pharmacy budget set? How is the budget trended each year?

    BMCHP does not explicitly create a separate pharmacy budget; budgets are set on a total, combined medical and pharmacy expense basis. Implicitly, the underlying subset of the aggregate budget attributable to pharmacy related expenses is trended in the same manner as the aggregate budget. The provider's budget trend is based on the BMCHP network trend. This protects the provider against environmental trends that they cannot control. Hepatitis-C drugs are currently carved out of the budget.

e. For your risk contracts that include the pharmaceutical benefit, how, if at all, are pharmaceutical discounts and/or rebates (e.g., from the manufacturer) incorporated into the provider's pharmacy budget?
Pharmacy discounts are included in the provider's total, combined budget; however, supplemental rebates are excluded as they occur outside of the claims system.

HPC Payer Exhibit 1

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 2013	1.75%	0.05%	0.08%	-0.47%	1.42%
CY 2014	2.59%	-2.11%	0.68%	-0.28%	0.88%
CY 2015	1.30%	-10.78%	0.43%	7.22%	-1.83%

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.