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)

An area of concern affecting health care costs is the upward trend of the price of drugs. There are many factors that affect this increase, but among them are specialty medications, diabetes and generic drug price increases.

The greatest concern lies with Specialty Pharmacy. These are very high cost medications that have specific indications for the treatment of rare and complex diseases such as cancer. This market has grown tremendously in the past few years with a cost trend rate in the vicinity of 25% and that rate is expected to continue for the next several years. It is expected that by 2018, Specialty drug spend will represent 50% of all drug spend.

In 2015 the FDA approved a record number of new drugs for the year (56). Of those, 33 are considered specialty medications. The FDA has developed policies in order to expedite approval of these types of drugs and with a large pipeline of products, future approvals will have a significant impact on costs.

Because of the complexities of the drugs and of the patients being treated, the setting of delivery of these products is moving away from the provider's office and to hospital outpatient departments. The utilization of that setting greatly increases the cost of administration.

Diabetes is also having a major impact on costs. The incidence of diabetes is rising steadily and it has been estimated that 28% of adults with diabetes are currently undiagnosed. We have seen a trend of about 15% in this area due to increases in both utilization and unit costs. Utilization is up due to new products entering the market. Unit costs have increased steadily due to manufacturers increasing the costs of their medications by substantial margins.

In the last few years generic drug utilization has been increasing but prices have been trending up as well. There are fewer products available for many categories of medications leading to less competition and therefore higher prices. One cause of this is the consolidations and mergers taking place within the generic manufacturing industry. With this consolidation, some manufacturers are ceasing production of product lines that are not deemed profitable. New policies enacted at the FDA have also slowed the approval process of new generic products. These and other factors are driving up costs of very highly utilized medications.

A second area of concern is provider consolidation. As hospital and physician groups consolidate and form ever larger systems it becomes nearly impossible to leave any provider system outside of a commercial network

product. That means that the provider system knows the health plan has to have them in-network in order to have a viable commercial product. Knowing this fact, they demand ever higher reimbursement rates. These large provider systems then use the additional reimbursement monies to promote and advertise their services to the public and more and more people select primary care physicians associated with these large expensive systems, and the cost of care for these members increases even for basic primary care. Unless this cycle of the large systems getting even bigger and increasing their market share is halted- or at least slowed-increased utilization of services in high cost provider settings will negatively affect other initiatives aimed at meeting the Commonwealth's cost growth benchmark.

Finally, the continued passage of mandates that require coverage for specific services by carriers is inconsistent with containing healthcare costs. This is especially true when there is little, if any, clinical evidence that the treatment is effective. One example is the recent enactment of the Lyme disease bill, which requires carriers to cover the costs of long-term antibiotic therapies and off-label uses of other drugs to treat Lyme disease. The legislature passed this bill over the Governor's veto, despite opposition which argued that the mandate was not clinically sound. In a July 14, 2016, letter the Massachusetts Infectious Disease Society stated:

> "However, mandating long-term antibiotic use of the treatment of Lyme disease conflicts with sound, evidence-based patient care, which will ultimately be dangerous for patients and the community."

And Atrius Health stated in a July 14, 2016 letter:

> "Furthermore, this off-label practice is expensive and ill-advised and there is clear evidence of lack of benefit from well-performed clinical trials and a lack of evidence of any benefit."

In addition, mandates only apply to fully-insured plans. This makes the cost of the mandates fall disproportionately on individual and small employers that are unable to self-insure.

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)

The Health Policy Commission (HPC) should convene a panel of stakeholders to review the price of new drugs and any dramatic increases in the price of existing drugs. The panel should determine if there is statistically significant evidence that justifies the price of a new drug or dramatic increase in price of an existing drug. If the panel determines the price is unwarranted the HPC should be required to post a listing on its website of medications that are low-value care options. Pharmaceutical companies should then be required to send representatives to the Cost Trend Hearings to testify as to the justification for the cost or price increases of the drugs on the HPCs low-value list.

The HPC must continue to diligently monitor provider consolidations, mergers and acquisitions. Proposed provider consolidations involving large provider systems should not be allowed to occur without a full Cost and Market Impact Review (CMIR). All CMIRs should be referred to the Office of the Attorney General. The proposed material change should not be allowed to move forward unless the providers involved are able to provide objective statistical evidence that the material change will provide a truly integrated system with improved quality and lower healthcare costs. If allowed to move forward, the HPC must continue to monitor the transaction after the fact to ensure the proposed benefits are actually realized. If not, the providers involved

in the material change should be prevented from future consolidations, mergers or acquisitions until they attain the improvements stated in their prior notice of material change. In addition, providers that are not in compliance with the HPCs cost growth benchmark should be prohibited from making any material changes.

We recommend a moratorium on mandates until the lower cost growth benchmark for 2017 is met.

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.
   CVS/Caremark

   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	**16.1%**	**2%**	**8.9%**	**30.8%**
Medicaid	**15.0%**	**2.1%**	**10.5%**	**27.7%**
Medicare	**11.6%**	**2.4%**	**15.2%**	**18.3%**

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).
   Currently Implementing

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
Does Not Plan to Implement in the Next 12 Months

viii. Establishing alternative payment contracts with providers that includes accountability for pharmaceutical spending
Currently Implementing

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
Does Not Plan 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)

Fallon Health continues to work with hospital, primary care, specialty, and behavioral health providers in its commercial networks to move them into Alternative Payment Methodologies (APMs). Fallon's three strategic APM models include:

1) Upside only shared savings arrangements;

2) partial risk up and down arrangements where surpluses/deficits are limited or capped at a mutually agreed per member per month target or a mutually agreed percentage of total surplus or deficit; and

3) major risk up and down arrangements where providers do not assume 100% risk but are responsible both up and down for whatever portion of risk they assume, typically 20% to 50% or more with no cap on either surplus or deficit share.

During the past year Fallon Health has continued to improve its commercial risk models by refining risk acuity calculations, improving the reinsurance options for provider organizations, improving the calculation of various adjustment factors, and standardizing our risk reporting package. Fallon does not offer bundled payment arrangements for specific procedures. Given the size of Fallon's commercial membership and the resources needed to support provider APMs, Fallon has determined that it is more efficient to offer global budget arrangements that engage providers to manage the total medical expenses associated with their Fallon Health

member population. This global budget approach incentivizes providers to use evidence based, high quality, efficient and integrated care to improve patient outcomes while lowering total medical costs. With the provider groups that have agreed to an APM arrangement, Fallon has found that there is typically slower growth in total medical expense year over year with no deterioration in quality, patient outcomes, or patient satisfaction.

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)

In Fallon's view, the top three barriers to Fallon's increased use of APMs are:

1) Overall Membership and Panel Size: Fallon's relatively small commercial population is distributed across a very large number of physician and hospital providers located in every county except Barnstable. This means that any given provider has a very small panel of Fallon commercial members. It is very difficult for Fallon to find a Physician Hospital Organization or other provider entity that has a sufficiently large number of Fallon members to use as a risk pool for an Alternative Payment Arrangement. With small panels of Fallon commercial members, most provider organizations are not willing to devote the human and financial resources it takes to develop a successful APM. There is not enough potential money for the Provider Organization to make with a risk arrangement of Fallon commercial members even if the APM was successful. As a result, provider organizations are more interested in putting their time and resources into other opportunities.

2) Reluctance of Providers of Any Size to Assume Downside Risk: Health care insurance, methods of delivering healthcare, new diagnostic testing, new specialty drugs, and other healthcare trends have resulted in more change to healthcare in the past ten years than occurred in the previous thirty years. As a result, many provider organizations are still trying to make sense of all the changes and deciding how to adapt to the demands of a constantly changing healthcare industry. Both in the hospital and physician settings much has changed in patients' expectations, patient needs, and patients' share of the cost of their care. This constantly changing environment has made many provider organizations, of all sizes, very leery of taking on downside risk in any APM arrangement. Hospitals and physician groups have seen large changes in their historical patient volumes for both inpatient and outpatient services over the past five years. With less predictable annual cash flows, both hospital and physician providers are more concerned about their ability to fund potential liabilities associated with a comprehensive up and down risk arrangement.

3) Lack of Staff and Technical Infrastructure at Provider Group Level to Organize and Deliver Healthcare from a Population Management Perspective. To be successful in an APM arrangement, a provider entity has to understand population management. They must own or have access to strong analytics and predictive tools to identify patients who have, or at risk for, developing chronic diseases that are likely to require expensive treatments and/or hospitalizations. The provider organization also has to have trained support staff and clinical staff who can effectively use these software tools on both the population level and the individual case management level. Most of the large provider systems in the Commonwealth have some or all of this infrastructure in place. However, most of the small and mid-size provider organizations have not had the time or money to develop these human and technical capabilities. As a result, few of the relatively small or mid-size hospital and provider organizations feel capable of taking on an Alternative Payment Arrangement and its accompanying financial responsibilities.

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.

As noted in Fallon's previous answer, many smaller providers, including ancillary providers and community providers of many types, do not come to Fallon seeking alternatives to fee-for-service payment models. If they did, Fallon would have the same major problem with establishing APMs with small and ancillary providers as it has with larger providers, i.e. lack of member volume with any particular provider. Our commercial membership is spread over so many of these providers that it is very difficult to find a provider who has enough annual volume of Fallon commercial business to make an alternative payment arrangement feasible. That said, Fallon has tried, with some success, to implement either commercial shared savings arrangements, commercial up and down risk arrangements, or Pay for Performance quality improvement relationships with several of the smaller hospital, physician, and ancillary providers. Typically, our core service areas of Worcester and Middlesex counties are the only areas where smaller providers would have enough Fallon membership volume to allow for a statistically significant program, which would typically be a portion of total reimbursement rather than a total replacement for fee-for service reimbursement.

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).

During the past year Fallon Health has worked diligently to align the technical aspects of its commercial APM arrangements so that providers can use the same quality measures, population management strategies, risk model design, risk adjustment methodologies, and reporting mechanisms that the provider uses with other commercial payers. Fallon invites the provider organizations to help in the design of any APM arrangement and to make any suggestions to Fallon Health that would assist the provider entity to establish an APM that can be successful.

An example of how Fallon strives to use the same quality measures as other payers in the state is our participation in the recent collaborative effort between MAHP, MHA and the health plans to identify a suite of metrics for use in hospital tiering; Fallon uses these metrics for our hospital quality pay for performance efforts. Additionally, Fallon does not use internally developed quality metrics, but rather uses validated, population based reliable, national metrics which are built upon evidenced based medicine such as HEDIS metrics. This allows a comparison across health plans. HEDIS was conceived as a way to streamline measurement efforts and promote accountability in managed care and is used by a vast majority of all managed care organizations to evaluate performance.

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)

Lack of Agreement on Risk Adjustment Methodologies: There is no "optimal" choice or industry standard for risk adjustment. The various systems (DxCG, ETG, etc.) each have their own strengths and weaknesses. Also, different provider groups also have strong opinions as to how to handle risk adjustment calculations and overall design of the risk model.

Reporting capabilities vary greatly amongst the different health plans depending on their choice of claims systems, population management analytic capability, Utilization Management systems, use of carve out vendors for specific functions, and large database management technology. These differences all contribute to the difficulty in aligning risk reporting packages across multiple health plans.

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)

We have made Vivitrol, a drug used to treat alcohol dependence and also used to prevent relapse of opioid dependence, available to our members. We removed authorization requirements in 2014.

We have made available two naloxone products on each of our Pharmacy Formularies without restriction so that they will be readily available to our members. We have covered the naloxone injection since October 2014 and we have covered Narcan Nasal Spray® since its market introduction in January 2016.

We have made Suboxone Film and buprenorphine/naloxone SL tabs available to our members provided the prescriber is enrolled with the Substance Abuse and Mental Health Services Administration (SAMSHA).

Through our behavioral health vendor, Beacon Health Strategies (Beacon), a major strategy to increase provider availability is to develop alternative payment models with Medically Assisted Therapies (MAT) providers in order to align financial incentives with the targeted clinical outcomes associated with a successful pharmacologic treatment regime. In partnership with Column Health, Adcare and other similar providers, we are developing standard bundled payments for clinic-based models focused on long-term MAT treatment for members. These programs also encompass psychotherapy and other wraparound services necessary to promote treatment adherence. The contracts are 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.

Our second strategy through Beacon is a focus 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. Beacon's goal is to reverse this trend by ensuring that all members leaving inpatient detox are offered MAT. To do so, we piloted an effort with one large provider that has a comprehensive continuum of care. Together, we developed mechanisms for internal transfers within that care continuum, as well as for external transfers/direct admissions to an outside methadone provider. This approach addressed 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 program extends the duration of MAT treatment from Acute Treatment Services (ATS) 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.

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)

- Provider access: Providers have historically been highly restricted on the number of patients they can treat with buprenorphine yearly (100 maximum). Legislation recently changed, but providers will only react with a corresponding increase of patient populations if they are incentivized to do so. Beacon will continue to expand its standardized bundled payment for buprenorphine treatment across more providers in order to align provider financial incentives with clinical outcomes. Even with the recent changes, there is still a disconnect between the widely unchecked prescribing of prescription painkillers and the highly limited prescription of the pharmacologic treatment, and the public discourse around the opioid epidemic 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 to the other. The current pathways of care within our substance use provider network delivery system evolved in the context of alcohol being the primary substance of choice and abstinence from substances being the preferred outcome. This creates the barrier in substance use disorder treatment that members relapse following acute care while 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, including expanding our previously mentioned initiatives to offer members access to buprenorphine or vivitrol in addition to methadone.
- 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. This means they fail to 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, actions are 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.)?

Fallon is currently in the process of choosing a telemedicine network vendor. The contract will be operational by 1/1/2017. This initiative is part of Fallon's commitment to provide urgent care in the most appropriate setting at the most affordable cost. We believe telemedicine has an important role for uncomplicated common medical conditions where there is resolution at a fraction of the cost of an emergency room visit and at half the cost of urgent care.

The plan currently covers telemedicine as outlined below.
1. Services must be equivalent or similar to in-person services with a patient in order to be eligible for telemedicine reimbursement.

2. Services are limited to telemedicine that involves secure electronic communication which typically involves both audio and video components. These consultations are typically for the purpose of evaluations, follow-up care, or treatment of a specific condition. Telephone (audio) only services are not applicable under this policy.
3. In order for telemedicine services to be eligible for reimbursement, the provider's services must be rendered in one of the following medical/behavioral health locations:

- Hospital;
- Critical access hospital (CAH);
- Rural health clinic (RHC);
- Federally qualified health center (FQHC);
- Hospital-based or critical access hospital-based renal dialysis center (including satellites)
- Skilled nursing facility (SNF)
- Community mental health center (CMHC)
- Provider's office

4. The following providers are eligible to submit for telemedicine services:

- Physician;
- Nurse practitioner;
- Physician assistant;
- Nurse midwife;
- Clinical nurse specialist;
- Clinical psychologist;
- Clinical social worker; and
- Registered dietitian or nutrition professional

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.)?

The codes below are currently in use and are generally reimbursed FFS. This may change when our new telemedicine program, discussed in the initial paragraph of our response is implemented.

G0406 Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
G0407 Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408 Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0425 Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426 Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427 Telehealth consultation, emergency department or initial inpatient, typically 70 minutes communicating with the patient via telehealth
G0459 Inpatient telehealth pharmacologicmanagement, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

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? Yes
    i. If yes, please describe the types of cash-back incentives offered.

Fallon Health has been a leader in building products that reward members for taking an active role in their health care. We pioneered a direct cash back incentive program that is integrated with our transparency tool, as well as introduced programs that result in lower cost sharing for members when they seek care from high value providers.

Direct Cash Back Incentives

1. SmartShopper

Our SmartShopper tool allows members to not only compare the cost of procedures across alternative providers, but also earn an additional incentive of up to $500 when they choose high value providers. Members use an online tool to search the service they are preparing to utilize. The tool returns several options of providers to choose from in the selected geography. If the member receives the service from one of the high value providers listed they will benefit from potentially lower cost sharing and they will automatically be issued the cash incentive from the program. Currently the SmartShopper tool includes 60 Inpatient and Outpatient Services and Procedures, including surgery, radiology, infusion therapy, and diagnostic testing. SmartShopper is web-enabled for smartphones. In some cases, we actively outreach to members when they may have the option of making a choice to receive services at a site that provides higher value and lower cost. One example is members receiving infusion. We communicate directly with these members and encourage them to receive their infusion in the home setting, instead of a hospital or doctor's office. Members save on their cost-sharing and become eligible for a SmartShopper incentive if they choose this option. They also have a better overall experience in the home setting. In the first year of this infusion program we reduced expenses by 8.7%.

Member Cost Share Savings

2. Joint Effort Program™

Members scheduled for total joint replacement surgery are enrolled in our Joint Effort program, which provides services at home to eliminate the need for a post-acute Skilled Nursing Facility (SNF) stay. The incentive is the member's cost share savings e.g., a lower amount applied to the member's deductible, plus the member's ability to recover in the comfort of their own home.

Fallon Health works closely with the member and a team of medical professionals, including a nurse case manager who works with the orthopedic surgeon's staff, the hospital, skilled nursing facilities if needed, and the home care agency.

Once the member is home, a staff member from one of our network home care agencies will visit and help with whatever is needed to make a full recovery, including:

- help with the therapies the doctor ordered
- advice about exercises and healing body movements the member can do on their own
- referrals to local organizations that can help with the recovery

In collaboration with surgeons, skilled nursing facilities, home health care organizations and hospitals, Fallon Health works closely with our members so they may recover comfortably at home. This program reduced SNF utilization by 71.6% for joint surgery with a Total Medical Expense (TME) impact of minus .02%.

3. SmartChoice Program

Fallon Health's SmartChoice program targets high-tech radiology, specifically MRIs and CAT Scans, for "soft steerage" by encouraging providers to direct members to lower cost and often more convenient facilities. If a provider selects a higher cost facility, SmartChoice representatives will recommend a lower cost option to the provider. Depending on the provider's choice, SmartChoice will also outreach to the member to inform them of their options. Since this is a voluntary program, members still retain the decision as to where they are most comfortable receiving their care. This strategy encourages care to occur at lower cost, more efficient providers and encourages high cost outlier providers to reconsider pricing their services closer to the rest of the provider market. The incentive is the member's cost share savings e.g., a lower amount applied to the member's deductible. We have seen a reduction in the High Tech imaging cost by 3.6%, with a TME reduction of .07%.

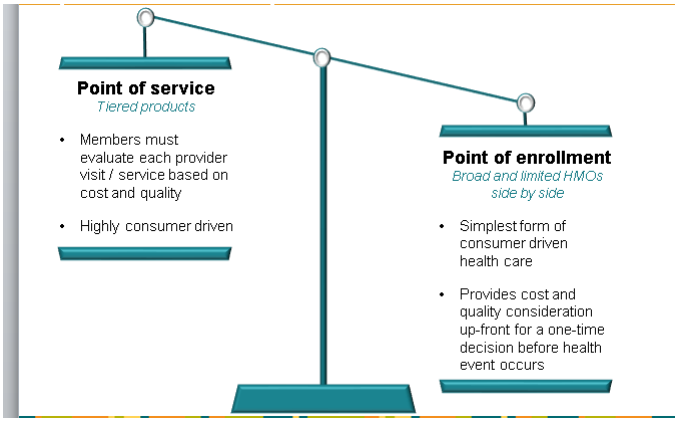
ii. If no, why not?
36T

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? Yes
   i. If yes, please describe the types of incentives offered.

Fallon Health has been a leader in developing limited and tiered network products that encourage the use of high-quality, low cost providers through financial incentives. This includes both:

- A Point of Enrollment incentive – Payroll premium differential in limited networks.
- A Point of Service incentive – Cost of care price differentials in tiered products

These products have continued to grow and represent 50% of Fallon's commercial membership. They represent an exceptional value for employers and consumers.

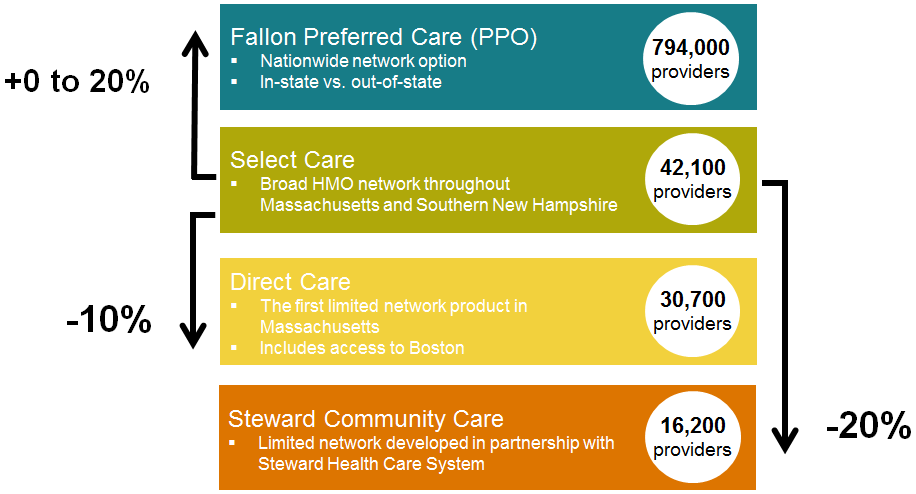


Point of Enrollment – Limited Network and Defined Contribution Strategy

A Defined Contribution strategy allows Fallon Health's clients and their employees to control cost through the choice of networks at different price points. Fallon's limited network products include only the most efficient high quality providers in Massachusetts while continuing to provide significant choice to employees and their dependents.

There is a cost difference of as much as 20% for the same benefit designs between Fallon's broad Select Care HMO network and our limited HMO networks - Direct Care and Steward Community Care. When the employer sets a fixed dollar contribution, the difference in cost between networks is fully transparent to the employee and creates a powerful incentive to choose the high value limited network. Defined contribution offerings help drive our clients' employees into high-performing limited network plans, while keeping options available for all employees. Fallon Health customers who have utilized these strategies have experienced year over year health care costs below trend.

Fallon Health Network Premium Differentials compared to Fallon's Broad Select Care HMO Network



Point of Service – Tiered Advantage Plans

In addition to our Limited Network Plans, Fallon has developed several self-insured custom tiered network products designed to meet employer specific objectives. Fallon Health currently works closely with hospital systems administering custom benefits plans that drive utilization to their domestic facilities as well as keep tertiary care local. Other clients have been able to utilize a similarly designed custom tiered program to direct care to high value providers and focus on population health.

Fallon designs each unique Advantage plan to:

- Develop health plan solutions that offer a broad range of specialty care
- Provide the cost savings of a local, closely managed, high value health organization
- Allow employers to benefit from lower claim costs
- Allow employees to benefit from lower premiums and lower copayments when they use high value providers.

ii. If no, why not?

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**	881	5
	Q2	684	8
	Q3	721	59
	Q4	632	67
CY2016	**Q1**	913	104
	Q2	732	67
	TOTAL:	4563	310

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).

Attached is the summary table showing actual observed allowed medical trends. For the time frames requested we did not have specific studies to break mix between provider and service mix so the all the mix has been put into the Service Mix column. We do believe that this "Allowed" trend understates the true allowed trend if there were no benefit buy-downs. This is true even though we are looking at allowed trends that include both the payer and member share of the expense because as the member's share of the cost rises it has an impact on the underlying utilization. This understates the utilization and therefore the total trend in the table below.

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.

Unfortunately, Chapter 288 has created a significant obstacle to developing a marketable fully insured tiered product available to all market segments. Chapter 288 includes a provision that enables providers to opt out of any products in which they are not favorably tiered, regardless of their quality or cost (see M.G.L. Chapter

176O, section 9A (a)(i) added by Section 39 of Chapter 224). This has enabled our large and increasingly consolidated provider systems to block expansion of tiered products.

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	95%
PPO/Indemnity Business	5%

    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	34%
PPO/Indemnity Business	0%

    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	2%
PPO/Indemnity Business	0%

    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?

    For risk contracts that are based:

    Using historical experience (expense based budgets): Pharmacy budget = Baseline PMPM times actuarial trend factor

    As a percent of premium:

    Part of the total budget: There are no specific adjustments to the pharmacy portion of the overall 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?

    When applicable, the rebates are included as an offset to the provider's pharmacy budget.

I, Richard Burke, am the President and CEO of Fallon Community Health Plan, Inc. (Fallon Health). I am legally authorized and empowered to represent Fallon Health for the purposes of this testimony. The responses contained in this submission were prepared by employees of Fallon Health who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury on this 1st day of September 2016:

Richard Burke
President and CEO
Fallon Community Health Plan, Inc.

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	1.9%	2.1%	n/a	1.1%	5.16%
CY 2014	2.1%	0.6%	n/a	1.5%	4.28%
CY 2015	4.2%	1.7%	n/a	2.0%	8.10%

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.