BOSTON MEDICAL CENTER HealthNet Plan

September 16, 2013

Mr. David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Re: Boston Medical Center Health Plan - Health Care Cost Trends Written Testimony

Dear Mr. Seltz:

This is in response to your August 16, 2013 letter to Scott O'Gorman as President of Boston Medical Center Health Plan, Inc. (BMCHP) requesting written testimony in connection with the upcoming health care cost trends hearing to be held by the Health Policy Commission, the Office of the Attorney General, and the Center for Health Information and Analysis.

On behalf of BMCHP, please find my written testimony with supporting documentation responding to the questions set forth in Exhibit B, Exhibit C and Exhibit D of your letter.

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

Sincerely,

Laurie Doran

Laurie Doran
Chief Financial Officer

Enclosures

Cc: Scott O'Gorman, President
Susan Coakley, Chief Legal Officer

BOSTON MEDICAL CENTER HealthNet Plan

EXHIBIT B

2013 Health Care Cost Trends Hearing - Written Testimony of Boston Medical Center Health Plan for the Health Policy Commission

Boston Medical Center Health Plan, Inc., d/b/a Boston Medical Center HealthNet Plan (BMCHP), was established and incorporated by Boston Medical Center as a 501(c)(3) not for profit organization on June 12, 1997. We were organized to support and expand BMC's mission to serve the uninsured and to better serve patients through a managed care system. In the same year, BMCHP entered into a contract with the Massachusetts Office of Medicaid, Division of Medical Assistance, to provide managed care services for MassHealth members. We gradually expanded our MassHealth service area beyond Greater Boston, and today serve nearly 192,000 MassHealth members across the state.

In 2006, BMCHP became one of the original managed care organizations offering Commonwealth Care, the health insurance program for certain uninsured adults that was launched by Massachusetts health care reform legislation (Chapter 58). We now serve nearly 88,000 Commonwealth Care members.

In 2008, BMCHP became licensed as a Health Maintenance Organization by the Massachusetts Division of Insurance.

In 2009, BMCHP became accredited by the National Committee for Quality Assurance (NCQA) for our Medicaid product. We have earned the distinction of "Excellent Accreditation," NCQA's highest level of accreditation, and have been ranked in the top 10 for Medicaid health plans each year since 2009.

In 2012, BMCHP entered the Massachusetts small group and individual insurance market in order to be able to continue to serve Commonwealth Care members who become ineligible for that program. We currently serve a modest number of individual and group members through the Health Connector's Commonwealth Choice program and hope to continue to serve this market through the Qualified Health Plan program starting in 2014.

Also in 2012, BMCHP was awarded a contract by the New Hampshire Department of Health and Human Services to provide Medicaid care management services to residents of New Hampshire. This program is scheduled to go live December 1, 2013. BMCHP will operate as Well Sense Health Plan in New Hampshire.

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Question #1:

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 for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.

a) What are the actions your organization has undertaken to ensure the Commonwealth will meet the health care cost growth benchmark?

BMCHP has undertaken several actions relating to network and care management to help the Commonwealth meet the health care cost growth benchmark.

With respect to our provider network, BMCHP annually sets medical cost savings targets for both the unit (provider) cost and utilization management components of medical spend. The organization actively monitors progress against these targets throughout the year. BMCHP has worked aggressively to reduce or limit the growth in provider unit prices. Since at least 2010, BMCHP has been engaged in a focused re-contracting effort with our partner hospitals and physician groups. Although our contract with MassHealth budgets for percentages of the MassHealth fee schedule for hospitals and the MassHealth fee schedule for physicians, there are providers who have been paid higher levels of reimbursements. BCMHP has been engaged in re-contracting efforts and has been successful in negotiating contract rates more in line with the MassHealth MCO benchmarks through a collaborative approach with our provider partners. This is an ongoing process.

In conjunction with these efforts to reduce provider unit costs, BMCHP also continues to actively pursue alternative payment models (APMs) with provider organizations that are willing and able to share in medical cost savings risk. BMCHP currently participates in the Patient Centered Medical Homes Initiative (PCMHI) and maintains several additional alternative payment arrangements, including shared savings and full risk sharing contracts involving ACO models. To date, we have signed APM agreements with several provider organizations. We are continuing discussions with additional provider organizations and healthcare delivery systems to start new APM arrangements.

BMCHP has also developed innovative care management (CM) tools to help address the cost and quality of care. BMCHP's CM program focuses on meeting members' health and treatment needs in a cost effective manner. Our CM program specifically addresses diseases and conditions that are prevalent in the populations we serve. BMCHP's person-centered CM model emphasizes integrated physical and behavioral health (BH) services, pharmacy management and wellness programs. Our programs are also designed to promote the role of the PCP as the primary care coordinator and to facilitate communication between members and their PCPs. BMCHP's CM and Quality and Financial Informatics teams work together to evaluate the effectiveness of CM programs.

One example of our innovative CM approach with members is our Transition to Home (TTH) program. TTH is a telephonic outreach program designed to enhance continuity of care and

reduce 30 day re-admissions after discharge from an acute inpatient setting following medical admissions. BMCHP care managers outreach to members within 48 hours of discharge and follow them for up to 45 days post discharge. BMCHP has calculated the risk adjusted 30 re-admission rate for medical admissions 12 months before and after implementation of the program. Under TTH, there has been a 17% decrease in the re-admission rate from before and after implementation of the program for the period from October 2011 through September 2012. This represents an approximately $1.4 million savings. While seasonal variations have been noted, the trend continues to be favorable under this program under BMCHP continues to monitor re-admission rates on a monthly basis.

BMCHP's care management efforts also involve certain utilization management activities. We use a comprehensive, integrated, and multidisciplinary approach to manage the utilization of healthcare services. BMCHP promotes and maintains a health care delivery model based on PCP coordination of care. While BMCHP does not require referrals for members to access specialty care within our network, we do have authorization requirements for certain services and processes to support care coordination. We collaborate with our providers to ensure that our members receive all medically necessary services in the least restrictive setting. We require authorization or notification of various services and supplies, including select outpatient procedures and services, outpatient physical, speech and occupational therapy, high-end radiology, home health care, certain durable medical equipment and pharmaceuticals. We also review elective and urgent inpatient admissions (medical and behavioral health).

Through this multi-faceted approach of driving rates towards MassHealth MCO benchmarks, increasing our shared accountability for the costs of care with large provider groups, and implementing innovative care management approaches, BMCHP is working to reduce total medical expenses and meet health care cost growth benchmarks consistent with Chapter 224.

b) What are the biggest opportunities you have identified at your organization to improve the quality and efficiency of care? What current factors limit your ability to address these opportunities?

BMCHP has identified several opportunities and related challenges in our ongoing efforts to improve the quality and efficiency of our members' care.

One primary area of opportunity is in the continued development of APMs. As noted above, BMCHP participates in the PCMHI which spans the MassHealth and Commonwealth Care programs, and maintains several additional alternative payment arrangements. We have developed our APM programs collaboratively with provider partners to support high quality care, manage utilization and cost, and ensure sustainable results. Among other things, BMCHP provides data, consultation, and other technical support to participating providers. These arrangements foster a patient-centered, integrated approach to care that helps to increase both the quality and efficiency of care.

However, these APM arrangements can be challenging to initiate and maintain in a Medicaid environment in particular due to the volume of membership required to sustain a reliable and

stable global budget and quality measures. Additional challenges to the effectiveness of APM arrangements in increasing quality and efficiency of care in the Medicaid market include the churning of membership between programs and the governmental capacity to account for alternative payment arrangement costs in Medicaid MCO's revenue streams.

Another opportunity for further improvements in the quality and efficiency of member care is in more closely integrated care management, especially during periods of transition. BMCHP has several programs that focus on care coordination during these periods, which are often the times when members are at greatest risk of experiencing care of diminished quality and efficiency. For example, our Transitions to Home and Re-engineered Discharge (RED) programs apply direct resources to those fragile transitions, and our Sunny Start program guides women through their pregnancies to help avoid fragmented care. In addition, we focus a great deal of attention and effort on ensuring that our members receive all of the preventive and chronic disease care that is appropriate, as measured by HEDIS and NCQA. Our NCQA Excellent accreditation is an important measure of our success in this regard. We achieve these results in partnership with our providers and our members, who receive important information and reminders directly and through care management, and with our providers, who receive extensive reporting on quality and utilization metrics.

Certain data limitations create an opportunity for improvement with respect to our care management efforts. Inaccurate contact information can create difficulties reaching certain members, and may result in wasteful rework on the part of our staff, and missed opportunities to work with our members. Additionally, there are relatively few standardized metrics for measuring the effectiveness of medical management programs and member-oriented outcomes.

c) What systematic or policy changes would help your organization operate more efficiently without reducing quality?

The following policy changes would help BMCHP operate more efficiently without reducing quality of care:

- *Maintain adequate funding for state programs* – As population changes and shifts occur in the MassHealth program, it is important that the state periodically examine and, if necessary, adjust capitation rates to ensure that they adequately reflect changes in MCOs' risk. For example, a recent April 10, 2013 presentation prepared by Navigant for the Massachusetts Medicaid Delivery Model Advisory Committee noted that between 2010 and 2011 the percentages of high risk and very high risk members in the MCO program has increased. EOHHS and its actuaries should account for this factor in the development of MCO payment rates.

- *Maintain a program structure that supports differentiated rates for providers who care for subsidized members* – The QHP program requires payers to merge the subsidized and commercial markets. It would be beneficial to revisit the Commonwealth Care approach where plans had a greater ability to maintain differential provider payment

rates for the subsidized population. Currently, under the Silver QHP platform, the provider network for both the commercial and ConnectorCare (subsidized) populations must be the same. Providers who have supported lower rates for subsidized populations for many years may not maintain lower terms if significant commercial membership joins "silver" plans. The ultimate concern is that rates will be unsustainable and a lower cost network may not be supported. This could ultimately result in higher program costs and difficulty in maintaining rates. If program costs increase, the state may have to change affordability standards, which will result in higher costs to members.

- *Changes to state laws* - The Massachusetts state laws pertaining to patient confidentiality that limit the sharing of information need to be re-examined. These laws need to evolve to support the secure but more ready exchange of information required for coordination of care, particularly as it pertains to the integration of care between behavioral health and medical health services. This would help reduce and potentially eliminate barriers that currently prevent fuller information sharing and would ultimately lead to the delivery of more efficient, cost effective care to members.

- *Promote MCOs role in integrating care* – As various stakeholders advance efforts to better integrate member care, BMCHP believes that MCOs should play an integral role through both traditional provider arrangements and alternative payment model arrangements, including ACOs. Working in coordination with our provider partners, BMCHP brings experience, expertise and existing infrastructures that make us important parts of care integration efforts.

- *Modification of certain MassHealth payment methods* - BMCHP is encouraged that the MassHealth program plans to move away from the current hospital payment methodology. The SPAD methodology pays hospitals a single rate based on historical case mix. Unless hospitals have the exact same case mix each year, there will be winners and losers in application of the historical weight. The single rate payment approach is a limitation to ACO arrangements as a full SPAD will be attributable to a provider's risk settlement regardless of the actual case mix. The PAPE methodology used for outpatient has similar limitations. Moving to a payment policy that recognizes actual case and service mix is a better policy and provides opportunity and incentive to manage care.

d) What steps have you taken to ensure that any reduction in health care spending is passed along to consumers and businesses?

Consistent with our mission to provide insurance to underserved populations, BMCHP is committed to passing along any reductions in spending to our members and customers. Approximately 85% of BMCHP's members do not pay premiums. This population consists of BMCHP members in the MassHealth managed Medicaid program and in the Commonwealth Care program who are under 100% of the Federal Poverty Level (FPL). For our remaining members, most of whom pay low premiums under the Commonwealth Care program, BMCHP

leverages the most recently available data along with medical expense trend projections and analyses of population and program changes to appropriately reflect expected costs in our premiums.

BMCHP's commercial business, Commonwealth Choice, did not begin until 2012. As the commercial population is still very small, premiums are based on national data, adjusted for regional price and demographic differences. As the line of business matures, BMCHP will continually monitor and incorporate the underlying claim experience as appropriate, consistent with actuarial principles. On a quarterly basis, BMCHP updates premium rates to reflect more current information.

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Question #2:

The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of growth in prices on medical trend and what have been the results of these actions?

BMCHP has undertaken several actions to address the impact of growth in prices on medical trend.

Since 2009, BMCHP has been actively re-contracting with our hospitals and physician groups to reduce the price per unit of delivering medical care. Through close collaboration with these provider partners, we have been largely successful in reducing or limiting growth in prices for medical care.

In addition, BMCHP has been using APMs as an effective mechanism for controlling the total cost of care and improving quality. BMCHP participates in the Patient Centered Medical Home Initiative which spans both our MassHealth and Commonwealth Care programs and maintains several additional alternative payment arrangements in the form of shared savings and full risk contracts. As noted above, BMCHP has developed our current APM arrangements collaboratively with our providers to support high quality care, manage utilization and cost, and ensure sustainable results. To further promote the success of these APM arrangements, BMCHP provides resources and infrastructure assistance in the form of data, consultation, and certain technical support.

While these efforts are not mature enough to reliably measure their cost efficacy, BMCHP's plan-wide unadjusted total medical expense growth for 2012 versus 2011 was lower than the benchmark of 3.6%.

Question #3:

Chapter 224 requires health plans, to the maximum extent feasible, to reduce the use of fee-for-service payment mechanisms in order to promote high quality, efficient care delivery. What actions has your organization undertaken to meet this expectation? What factors limit your ability to execute these strategies or limit their effectiveness?

BMCHP is committed to working collaboratively with our provider partners in the transition from volume rewarded (fee-for-service) reimbursement to quality-driven, cost-effective care. Key objectives include, but are not limited to, reducing and stabilizing medical expense trend through improving the health of our members through more integrated and coordinated preventive and evidenced-based medicine, improved cost-efficiency, and optimizing members' experience of care through improved access and availability. BMCHP's efforts in this area have included the following:

- Since 2001, BMCHP has managed a Practice Based Care Management (PBCM) program with our largest provider. This program reimburses our provider on a per member per month (PMPM) basis to assume responsibility for care management for high-risk, high-cost cases, post-inpatient or ED follow-up calls, health risk assessments and home visits as needed. The program utilizes disease registries and monitors HEDIS measure compliance for members in the program.

- BMCHP currently participates in the Patient Centered Medical Home Initiative, a multi-payer program sponsored by the Massachusetts Executive Office of Health and Human Services (EOHHS). This three year demonstration program supports fundamental changes in primary care service delivery and payment reform, by facilitating comprehensive, coordinated, patient-centered care within a medical home environment. Along with several other payers, BMCHP provides financial support for infrastructure and care management activities, and includes a shared savings component.

- In 2011, BMCHP established a strategic plan for accountable care designed to respond to and support our providers in their own transformation to an accountable care environment. The goal of our strategic plan is to develop and implement an approach and infrastructure that supports the delivery of affordable, high quality care to our members by Accountable Care Organizations (ACOs).

As described earlier, BMCHP's greatest challenges in implementing these models is engaging providers with membership volume levels sufficient to ensure stable and reliable global budgets and quality measures. Further, BMCHP recognizes that varying levels of provider ability and willingness to assume risk for our MassHealth population represents another challenge which may limit the overall effectiveness of the programs. However, BMCHP will continue to collaborate with our providers toward building greater levels of expertise in managing this population and, ultimately, greater willingness to accept risk for these members.

Question #4:

Chapter 224 requires health plans, to the maximum extent feasible, to attribute all members to a primary care provider. Please describe, by product line, how your organization is meeting this expectation, including, as of 7/1/13, the number of members attributed to a PCP, attribution methodologies used, the purpose to which your organization makes such attribution (such as risk payments, care management, etc.) and limitations or barriers you face in meeting this expectation.

BMCHP has established processes to attribute all members to a PCP consistent with Chapter 224. This effort begins with the initial enrollment process. BMCHP assists members in selecting a primary care provider (PCP) within 15 days of their enrollment. Our health care delivery model is based on the PCP as the center of each member's healthcare team. Members have multiple avenues for selecting a PCP. We maintain a comprehensive Provider Directory for members on our web site where they can locate and select a PCP at any time. Upon request, we send members customized hard copy "print-on-demand" versions of the Provider Directory. Members may also call Member Services for assistance in selecting a PCP. For our providers, we make available a PCP Selection Form that allows a PCP change with a member's consent. The identified PCP is then updated in our systems by an enrollment representative within 24 hours of receipt.

During new member welcome calls, Member Services representatives review the role of the PCP and confirm the PCP of record. If a member needs assistance with the selection of a PCP or is dissatisfied with their PCP, the representative assists the member in selecting a new one. This is accomplished by using the Provider Directory and taking into account factors that include: member age and gender; real time travel distance to PCP site(s) from the member's residence; PCP panel size; prior PCP affiliations; any special health care or social needs the member may have, including behavioral health and homelessness; the member's preferred language and capabilities of the PCP to practice in that language; access to skilled medical interpreters; and office accessibility for people with disabilities. The representative will also assist members in scheduling an appointment with the PCP's office, if needed. Finally, BMCHP emphasizes the importance of the PCP and member relationship in the member welcome kit. Our welcome kit also includes a "Babel" card with instructions for getting translation assistance.

In addition to the outreach call, BMCHP has processes in place for assigning PCPs to members who do not select a PCP themselves. On a daily basis, members of the enrollment staff review a report of members who did not select a PCP upon enrollment or during the welcome call (or any other member listed without a PCP). These members are added to a custom PCP assignment application in our system. This application contains a geographic algorithm to calculate a PCP or site within 15 miles of a member's home address. Five PCPs, sorted by distance and panel size, are populated in the application and assignment is made based on: member age and gender; real time travel distance to PCP site(s) from the member's residence; PCP panel size; and prior PCP affiliations.

BMCHP offers only HMO product lines so there is no distinction in the process outlined above based on product type. 100% of BMCHP's MassHealth and Commonwealth Care members are

attributed to a PCP. 37% of BMCHP's Commonwealth Choice members are attributed to a PCP. Our lower rates of PCP attribution under our commercial plan are generally a result of differing member engagement levels. To address this issue, BMCHP will begin to institute auto-assignment of PCPs in this product line in 2014 for those members who do not select a PCP.

Question #5:

Please describe programs you have implemented to engage consumers to use high value (high quality, low cost) providers. How effective have these efforts been? To what percentage of members and to which product lines does each program apply?

As an organization primarily offering managed Medicaid and Commonwealth Care plans, BMCHP's HMO products inherently involve partnerships with high value providers. BMCHP has developed a statewide network of providers who focus on providing high quality care at competitive rates. With a limited commercial product, BMCHP does not steer members to certain products, such as tiered product plans. Instead, BMCHP focuses on member healthcare engagement and network development to achieve this goal.

BMCHP engages members to use our high value provider partners in a number of ways. From a direct engagement perspective, BMCHP's PCP selection process is an important program. Through the identification and selection of an appropriate PCP, we foster patient-centered, integrated delivery of care by our providers. BMCHP has a comprehensive process for conducting outreach, orientation, and education for new members.

Our welcome call is a critical step in engaging the member on how to best utilize their health plan, and how to seek appropriate care, particularly in collaboration with their PCP, using in-network providers. We have extensive experience performing new member welcome calls and pay special attention to cultural sensitivities. We also use the call to identify the individual's healthcare needs while working with the member to eliminate any identified barriers to care. The information shared and gathered during the new member welcome calls is reinforced in our member welcome kits that are also provided to our members. Among other things, the kit includes a letter emphasizing the importance of the PCP relationship and completing the Health Needs Assessment that we use to help partner members with the right providers for their care.

BMCHP also works with our provider partners to engage our members in the delivery of high value care. From a care management perspective, BMCHP works directly with providers by encouraging them to focus on the use of in-network hospitals and specialists when referring members for care. We also give our providers reporting about where care is received so they can better coordinate care with other in-network providers. We have also developed financial arrangements with our provider partners to help ensure the delivery of high value care. BMCHP works closely with providers to achieve efficient payment terms, including APMs, so that our members will have access to high quality, efficient care. Through our providers, we engage our members to participate in their health care treatment decisions, including referrals to specialists and other high value providers.

Question #6:

Please describe the impact on your medical trend over the last 3 years due to changes in provider relationships (including but not limited to mergers, acquisitions, network affiliations, and clinical affiliations). Please include any available documents providing quantitative or qualitative support for your response.

The Massachusetts healthcare market has clearly experienced changes in provider relationships in the form of mergers, acquisitions and affiliations. Depending on the individual circumstances of a provider change, BMCHP may be impacted in a number of ways.

In general, providers who command the highest rates within BMCHP's network are those (a) whose market position is primarily influenced by geography, (b) who are highly specialized, and/or (c) who are publicly recognized as healthcare industry leaders. Provider group and facility acquisitions have generally resulted in greater leverage and contracting complexity as providers seek to integrate all participants under the terms of their most favorable member. Over time, acquisitions may have the benefit of establishing more entities with sufficient population size to accommodate risk arrangements and consolidate resources focused on innovations in care, quality, and population management.

BMCHP's overall total medical expense trend has fluctuated over the past three years due to many factors, including changes in utilization of services, mix of services, mix of providers, and unit cost. The unit cost component of trend includes such factors as provider contracting strategy, introduction of alternative payment models, provider consolidation, and provider network composition.

Please find a chart that illustrates our overall trend split into unit cost versus all other costs at Exhibit B-1 to the Appendix.

Question #7:

Please describe the actions that your organization has undertaken to provide consumers with cost information for health care services, including the allowed amount or charge and any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits as required under Chapter 224. Please describe the actions your organization has undertaken to inform and guide consumers to this cost information.

BMCHP has undertaken several actions to provide consumers with cost information for health care services under Chapter 224, including the specific requirements under sections 206 and 207.

Section 206 of Ch. 224: Two-day Turnaround Time

Pursuant to Section 206 of Chapter 224, health insurers are to respond within two (2) working days to a member's request for certain cost information beginning on October 1, 2013. BMCHP will be using our existing Member Services Department's toll-free numbers to take calls from members requesting cost estimates for covered health care services. Initially, BMCHP will be utilizing our administrative systems to produce a cost estimate relative to the covered health care service(s) for which a member is requesting such cost information – essentially a mock adjudication of claims for the proposed covered healthcare services.

In preparation for this initial roll out, BMCHP will be training Member Services staff to handle these calls and, in conjunction with staff from our Provider Relations Department, process the request to arrive at a cost estimate. We will also be adding messaging to our website (www.bmchp.org) to provide members and their caregivers with a brief description of the information that members can obtain on cost estimates as well as a link to send a request for a cost estimate. We are in the process of developing language for the web site as well as workflows and training for our Member Services staff. In addition, BMCHP's member evidences of coverage will include language instructing members how to obtain cost information for covered healthcare services.

Section 207 of Ch. 224: Real-time Cost Estimator

In response to Section 207 of Chapter 224, health insurers must respond in real time to a member's request for cost information relative to a covered healthcare service beginning on October 1, 2014. To comply with this requirement, BMCHP selected Trizetto's Treatment Cost Navigator ("TCN") which is a configurable solution that delivers key information to consumers before they receive care. TCN uses simple terminology and delivers accurate and personalized information, including:

- Treatment cost information and clinical content;
- Physician and facility cost comparisons; and
- Member out-of-pocket liability estimation.

TCN will be fully integrated with BMCHP's core administrative system and will be accessible through our existing member portal. By utilizing real-time benefit and provider cost information from our core administration system, this solution will give BMCHP members accurate cost information and provide content regarding member eligibility, plan benefits, cost sharing, and pricing information for covered healthcare services. Integration of TCN and our core administration system will enable BMCHP to deliver personalized information to members.

The solution will also enable BMCHP to educate members about service costs that can be expected to arise with particular treatments. TCN includes provider and facility cost-comparison capabilities with which the member can search and select physicians and/or facilities that offer the selected treatment. In addition, the member can view comparative provider/facility costs and related information, view average cost for each provider/facility, and locate and map providers near the member's address or any other selected address. The solution estimates out-of-pocket liability and shows what the member can expect to owe for the selected service. TCN also delivers information about out-of-pocket costs, fully reconciled in real time with the member's current accumulated deductible and/or out-of-pocket maximums. It also provides user-friendly explanations of how these out-of-pocket liability estimates were determined. In addition, TCN provides functionality that allows the member to save cost estimates for future viewing.

BMCHP has developed a comprehensive work plan on the requirements, installation, configuration, testing and training of the TCN solution. We will also be working on communication and training plans that will include staff, providers and members as appropriate. Our current plan is to open the web solution for internal use as a pilot by January 1, 2014, and make it available to consumers later in the year.

Question #8:

After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.

Comments on the CHIA Report on the Massachusetts Health Care Market:

The focus of the CHIA report is on the commercial market. BMCHP's main lines of business include MassHealth Medicaid and Commonwealth Care. Our commercial product has minimal membership at this time. BMCHP comments on the report are as follows:

Health insurance coverage and costs in Massachusetts:

The report shows some increase in coverage through Medicare and Medicaid in 2011. We believe this is a reflection of the state of the economy in 2011 and the recession that impacted Massachusetts and the nation during that time period. We believe the increase in Medicare membership is largely a result of the aging baby boomer population. As a result of population changes and some shifts to government programs, BMCHP recommends that the state continue to evaluate capitation rates and adjust them accordingly to ensure that they adequately reflect the changes to the risk covered by MCOs.

Health payer use of health care funds:

The report indicates that between 2010 and 2011, half of the retention dollars for the reporting payers went to the category of administrative expenses. Although BMCHP is not represented in the report, our administrative expense ratio, 6.9% as of June 30, 2013, is in the topmost quartile amongst Medicaid plans nationally. The administrative ratio demonstrates that we are among the most efficient plans in the country. However, as we implement new federal and state regulations over the next several years to comply with ACA and Chapter 224 requirements, there will be additional pressures on maintaining our historically low administrative expenses.

With respect to increases in total medical expenses (TME), BMCHP has observed significant variations in TME across provider groups. Although provider rates are a key driver of variation there are differences in service use that may not be adequately risk adjusted. For example, risk adjustment methodologies may be insufficient for populations with a low mean age or with higher prevalence of homelessness and behavioral health conditions.

Consistent with the report's findings on payer performance on selected quality measures, BMCHP has been recognized by the industry as providing quality services to its members. NCQA has ranked BMCHP's MassHealth plan as one of the top 10 Medicaid plans nationally for the past four years according to its Medicaid Health Insurance Plan Rankings 2009-2012. Additionally, NCQA ranked our performance in the top 10% of all Medicaid HMO plans on more than a dozen measures included in the Healthcare Effectiveness Data and Information Set (HEDIS®) and we have achieved Excellent Accreditation status as a Medicaid HMO.

Health Care Payments to Providers and Systems:

BMCHP's experience with our provider network supports the findings in the report. Providers that command the highest rates within BMCHP's network are those (a) whose market position is

primarily influenced by geography, (b) who are highly specialized, and/or (c) who are publicly recognized as health care industry leaders. Provider group and facility acquisitions have generally resulted in greater leverage and contracting complexity as providers seek to integrate all participants under the terms of their most favorable members.

Comments on the Attorney General's Report on Health Care Cost Trends and Cost Drivers in the Commercial Market:

BMCHP comments on the report are as follows:

Consistent with the report findings, BMCHP has experienced variation in the payments made to providers, although not as significant as the ones experienced by the commercial payers represented in the report. As the industry moves away from fee-for-service to alternative payment models, there will be a need to level additional services performed by providers. Alternative payment relationships often require providers to develop clinical infrastructure and provide services that are not "billable." These services should result in savings but without some mechanism for valuing them, they will be challenging to fund, which impacts their sustainability. Therefore, it will be important to recognize and accurately reflect these costs in MCOs' capitation payments. To help ensure the long-term success of these alternative payment model arrangements, capitation rates need to include an adjustment for the costs associated with these provider services.

The report also points out the increased performance risk that providers are undertaking without consistent mitigation by health plans. BMCHP's approach has been to set conservative limits on both upside and downside risk, in order to mitigate potential losses by the Plan and providers, and to ensure the evolution of sound and rational financial and quality infrastructures on both sides. For those providers with whom BMCHP has risk arrangements, BMCHP monitors changes in the acuity of the populations served by such organizations and the related impact on the PMPM cost of care. BMCHP adjusts PMPM targets for such organizations flexibly to reflect any such changes. In addition, BMCHP designs such financial risk-mitigation components to comprise risk sharing as well as minimum and maximum gain/loss thresholds. Minimum thresholds are intended to reduce the random fluctuation risk around the global budget target. Maximum thresholds are intended to limit the maximum savings or losses a provider may achieve. Within these thresholds, BMCHP shares a percentage of risk with the provider. Through these mechanisms, BMCHP designs such financial risk-sharing arrangements with a cap/limit on the amount of risk to such organizations.

BOSTON MEDICAL CENTER HealthNet Plan

EXHIBIT C

2013 Health Care Cost Trends Hearing - Written Testimony of Boston Medical Center Health Plan for the Office of the Attorney General

Question #1:
Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2010 to 2012, YE Q1 2012, and YE Q1 2013 according to the format and parameters provided and attached as AGO Exhibit C1 with all applicable fields completed. Please explain for each year 2010 to 2012 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g. utilization trend, payer mix trend).

For all years 2010-2012, the impact of benefit buy down is negligible. The member cost sharing associated with the benefit plans that BMCHP offers in our MassHealth Medicaid and Commonwealth Care programs (which comprise 100% of membership in 2010 and 2011 and nearly 100% of membership in 2012) is both minimal and stable from year to year. The demographic and health status components of trend are reflected in the utilization component of trend. We estimate 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 actions. Please see Exhibit C-1 to the Appendix.

Question #2:

Please submit a summary table showing your total membership for members living in Massachusetts as of December 31 of each year 2009 to 2012, broken out by:

a) Market segment (Hereafter "market segment" shall mean Medicare, Medicaid, other government, commercial large group, commercial small group, and commercial individual)

Please see attached Summary Table illustrating market segments for the above period at Exhibit C-2 to the Appendix.

b) Membership whose care is reimbursed through a risk contract, by market segment (contracts that incorporate a PMPM 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 do not subject the provider to any "downside" risk)

Please see attached Risk Contract Table illustrating BMCHP's population whose care is reimbursed through risk contracts for the above period at Exhibit C-3 to the Appendix.

c) Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity)

Please see attached Summary Table illustrating commercial membership information for the above period at Exhibit C-2 to the Appendix.

d) Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for inpatient and outpatient services (e.g. lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective).

Based on its current commercial market membership, BMCHP does not offer a tiered network product.

e) Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services)

Based on its current commercial membership, BMCHP does not offer a limited network product.

f) Membership in a high deductible health plan by market segment ("high deductible health plans" are defined by IRS regulations)

Please see attached Summary Table illustrating membership in high deductible health plans for the above period at Exhibit C-2 to the Appendix.

BOSTON MEDICAL CENTER HealthNet Plan

Question #3:

To the extent membership in any of the categories reported in response to Question has changed from 2009 to 2012, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership.

BMCHP Commonwealth Care membership fluctuated between 2011 and 2012. Under the Commonwealth Care program, the state requires participating MCOs to bid, each fiscal year, a monthly fixed capitation rate for members. This population is cost sensitive and large membership shifts between MCOs is common from year to year. In 2011, BMCHP's bid was relatively higher than most of the other MCOs and the result was a decline in membership. In 2012, BMCHP was able to submit the lowest bid among the five MCOs in the program, which resulted in a large membership increase. The bid position of the different Commonwealth Care MCOs in 2011 and 2012 is reflected in the attached summaries issued by the Connector at Exhibit C-4 to the Appendix.

For our MassHealth Medicaid product, membership shifts are generally a result of some action taken by the state or the economy. In March 2011, MassHealth discontinued the practice of auto assignment of eligible members to the MCO program. Instead, MassHealth enrolled all eligible Medicaid members who did not make an active health plan election into the MassHealth Primary Care Clinician (PCC) program, causing BMCHP's MassHealth membership to flatten for that year. With the reinstatement of partial auto assignment to the MCOs effective October 1, 2012, BMCHP began to experience slight membership growth in our MassHealth population, though not at the levels when full auto assignment was used by MassHealth. BMCHP strongly supports the reinstatement of the original auto assignment formula.

BMCHP entered the commercial (Commonwealth Choice) market in 2012 and as such has no membership fluctuation to report.

Question #4:

Please describe your models for risk contracting since 2009. Include, for example, the structure and elements of such contracts, the role of any non-claims based payments, the role of any trend factors or growth caps, the role of any adjustments to risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, and insurance product populations to which your risk contracts apply (e.g. HMO, PPO, self-insured, fully insured).

BMCHP has developed risk contracting arrangements that are targeted towards providers who deliver services to MassHealth and Commonwealth Care members. Key elements of these arrangements include:

- Global per member per month (PMPM) budget targets, based on historical cost, with utilization trended forward. Other adjustments to the global budget account for variances in unit price and benefits.
- Some subcontracted services may be carved out of the budget.
- High cost (outlier) cases are truncated in the data (claims costs greater than a certain dollar amount per member are excluded from the risk performance calculation).
- Risk budgets are re-calculated at the end of the measurement period to accommodate changes in health risk status.
- All providers engage in upside risk sharing (shared savings achieved through improved performance against budget), while some providers may engage in downside risk sharing (share losses associated with poor performance against budget targets).
- BMCHP and participating providers work collaboratively to identify areas of quality improvement, and establish specific quality measures and improvement targets. Areas for quality improvement typically include HEDIS measures, as well as other areas of improvement considered relevant to both BMCHP and the provider.
- BMCHP provides a comprehensive cadre of reports and patient information to assist providers in a number of areas including (a) financial reports – monthly summaries of provider performance against medical expense budget by medical expense category (e.g., inpatient, outpatient, lab & radiology, pharmacy and physician services, (b) primary care profile reports – member demographics medical-surgical admissions, re-admissions, ED utilization, pharmacy and chronic disease cost/utilization, (c) quality reports – monthly membership registries identifying members who fall into chronic disease categories, and clinical compliance, and (d) raw claims extracts provided on a monthly basis.
- BMCHP also provides financial support for improvements in infrastructure that will enhance the provider's ability to engage in the work required to successfully manage cost, utilization, quality and clinical strategies throughout the program period and into the future. These investments in infrastructure may include enhancements in personnel, care management programs, financial analysis and reporting.
- BMCHP's clinical and administrative departments are available to work directly with the provider to interpret reports, identify improvement opportunities and strategies for

setting and attaining improvement objectives.
- BMCHP only administers HMO products and does not administer self–insured business.

Question #5:

Please explain and submit supporting documents that show how you quantify, and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully-insured members. Include in your response any adjustments for changes in health status, individual or aggregate stop loss insurance, claims truncation thresholds, distinction you make between performance and insurance risk, adjustments for risk due to socioeconomic factors, and any other ways in which you mitigate the transfer of insurance risk to providers.

For those providers (including, but not limited to Community Health Centers, Independent Physician Associations, Physician Hospital Organizations and large group practices) with whom BMCHP has risk arrangements:

- BMCHP generates and provides monthly reports to the organizations with estimated liability/gain based on performance to date.
- BMCHP monitors changes in the acuity of the populations served by such organizations and the related impact on the PMPM cost of care. BMCHP adjusts PMPM targets for such organizations flexibly to reflect any change in the acuity of the populations being served. BMCHP truncates aggregate member claims above a certain dollar amount from PMPM targets and assessment of organization's performance. We do not make specific adjustments for individual or aggregate stop loss insurance other than the above process for truncating claims at a certain dollar level.
- BMCHP designs such financial risk mitigation components to comprise risk sharing as well as minimum and maximum gain/loss thresholds. Minimum thresholds are intended to reduce the random fluctuation risk around the global budget target. Maximum thresholds are intended to limit the maximum savings or losses a provider may achieve. Within these thresholds, BMCHP shares a percentage of risk with the provider. Through these mechanisms, BMCHP designs such financial risk-sharing arrangements with a cap/limit on the amount of risk to such organizations.
- BMCHP does not currently make adjustments based on socio-economic factors at this time.

BMCHP does not maintain self-insured arrangements. We have attached our template monthly report to illustrate the information that we share with our providers under risk contracts at Exhibit C-5 to the Appendix.

BOSTON MEDICAL CENTER HealthNet Plan

Question #6:

Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider's size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.

BMCHP evaluates each participating provider's existing ability to enter into a risk contract in the form of an ACO arrangement based on such factors as whether the provider is recognized as a Patient Centered Medical Home (PCMH) by NCQA, and/or participates in other initiatives, such as the PCMHI, or other payer-sponsored programs (e.g., Blue Cross Blue Shield AQC). In addition, we use several criteria to assess a provider's readiness and capacity to enter into partial or full-risk sharing arrangements and to function as an ACO.

BMCHP has developed and uses an ACO checklist to determine providers' readiness to engage in risk-based contracting. This checklist includes specific factors that BMCHP considers in evaluating the capacity of a provider to participate in a risk contract. Please see attached our ACO checklist at Exhibit C-6 to the Appendix.

BOSTON MEDICAL CENTER HealthNet Plan

Question #7:

Please explain and submit supporting documents that show for each year from 2009 to 2013 the average difference in prices for (1) tiered network products as compared to non-tiered network products; and (2) limited network products as compared to non-limited network products. Include an explanation of assumptions around these price differences, such as, (a) for tiered network products, expected utilization shift to tier 1 providers, unit price differences between tier 1 and tier 2 providers, and benefit differences between tiered network and non-tiered network products, and (b) for limited network products, unit price differences between limited network and non-limited network providers, and differences in benefit and member health status between limited network and full network products. In addition, please summarize any analysis performed on these products that validates or disproves the assumptions used.

BMCHP entered the commercial market in 2012 with our Commonwealth Choice and Employer Choice products. As reflected in our response to Question # 2, we have very modest commercial membership. As of August 2013, BMCHP has only 500 commercial members, all in our Commonwealth Choice product offered through the Connector. As such, BMCHP does not have nor is it required to have tiered or limited network products at this time. BMCHP's existing commercial products all leverage a narrow, regional network which serves as our broadest network offering.

Question #8:

Please describe and submit supporting documents regarding any programs you offer purchasers and/or members (including your employees) that promote health and wellness. Include in your response any analysis you have performed regarding the cost benefit of such wellness programs.

BMCHP is dedicated to helping our members maintain healthy lifestyles and prevent disease. We promote health and wellness to all our members through a variety of programs. BMCHP's wellness program provides members materials and tools to support them in maintaining healthy lives. BMCHP's website contains a *Guide to Wellness* that provides members with helpful tips and resources to keep them healthy. It includes information on preventive care and prevalent chronic conditions. It contains details on the tests and immunizations they should have, tips on eating right and exercising, signs and symptoms of health problems, and more.

To assist members in learning about their health and management of chronic conditions, BMCHP offers tools, including individualized and educational materials provided through *Krames Online*, which has more than 4,000 topics related to health and medications with printable information materials available, as well as McKesson's Audio Library and Nurse Advice line, with thousands of educational messages on staying healthy and a wellness guide developed using evidence based recommendations.

BMCHP also has several disease management programs that cover such items as medical nutritional therapy for members with diabetes and many other conditions, including weight management/obesity, heart failure, eating disorders, and HIV/AIDS, cancer. We also cover smoking cessation therapy which includes individual and group counseling sessions and nicotine replacement therapy. Members are encouraged to use these benefits by our care management team and through our wellness newsletters.

BMCHP further promotes annual well visits for children from birth to age 21 and sends annual reports to providers identifying members due for well visits. Members are sent an annual wellness guide (based on endorsed clinical guidelines) with a schedule of age based recommended screenings. Parents/guardians of children approaching their first birthday receive a colorful, educational card which includes recommended screenings for up to age two.

BMCHP finally offers members several supports for health and wellness, such as free dental care kits, car seats, bike helmets, reimbursement programs for Weight Watchers® and fitness memberships, and vision care discounts.

To date, BMCHP has not conducted analyses to evaluate the cost benefit of our health and wellness programs.

Please find attached copies of our *Guide to Wellness* from our web site on disease and care management at Exhibit C-7 to the Appendix.

BOSTON MEDICAL CENTER HealthNet Plan

EXHIBIT D

2013 Health Care Cost Trends Hearing - Written Testimony of Boston Medical Center Health Plan for the Center for Health Information and Analysis

Question #1:

Do you analyze information on spending trends (e.g. TME) and clinical quality performance of the MA Medicare Pioneer ACOs and the providers that participate in the Patient Centered Medical Homes Initiative?

a) If so, please provide such information on the performance of these entities compared to other MA provider entities. If available, please provide the information with and without health status adjustment, and the number of member months associated wit the identified and comparative providers.

BMCHP does not participate in the MA Medicare Pioneer ACO program. To date, BMCHP has not performed any studies aimed at measuring the spending trend performance of providers that participate in the Patient Centered Medical Home Initiative.

BOSTON MEDICAL CENTER HealthNet Plan

The below signatory is legally authorized and empowered to represent Boston Medical Center Health Plan, Inc. for purposes of the written testimony herein, and signs this testimony under the pains and penalties of perjury.

Boston Medical Center Health Plan, Inc.

Laurie Doran

By: Laurie Doran
Its: Chief Financial Officer

APPENDIX
BOSTON MEDICAL CENTER HEALTH PLAN
WRITTEN TESTIMONY
HEALTH POLICY COMMISSION
September 16, 2013

EXHIBIT B-1

BMCHP TOTAL ALLOWED MEDICAL EXPENDITURE TRENDS (QUESTION #6)

HPC Q6

Actual Observed Total Allowed Medical Expenditure Trend by Year
All product lines

	Unit Cost	**Utilization/Mix**	**Total**
CY 2010	0.6%	-1.5%	-0.9%
CY 2011	0.6%	4.2%	4.8%
CY 2012	1.6%	1.3%	2.9%

EXHIBIT C-1

BMCHP COST TRENDS TABLE (QUESTION #1)

Exhibit C1 AGO Questions to Payers

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 2010	0.6%	-1.7%	0.2%	-0.1%	-0.9%
CY 2011	0.6%	4.0%	0.2%	0.0%	4.8%
CY 2012	1.6%	1.0%	0.2%	0.1%	2.9%
YE Q1 2012 (April 1, 2011 - March 31, 2012)					6.2%
YE Q1 2013 (April 1, 2012 - March 31, 2013)					-1.0%

Notes:

1. **ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual**
2. **PROVIDER MIX is defined as the impact on trend due to the change in the types of providers. 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,**

EXHIBIT C-2

BMCHP MEMBERSHIP TABLE (QUESTION # 2)

Boston Medical Center Healthnet Plan Insurance Membership

BMCHP Participates in three Massachusetts health insurance programs

Market Segment	12/31/2009	12/31/2010	12/31/2011	12/31/2012
COMMERCIAL (Commonwealth Choice)				417
OTHER GOVERNMENT (Commonwealth Care)	59,868	55,990	39,794	71,535
Medicaid (Mass Health)	183,460	200,580	188,508	191,860
Grand Total	**243,328**	**256,570**	**228,302**	**263,812**

BMCHP Commercial (Individual and Small Group) Business

All BMCHP commercial small group and individual business is fully-insured HMO/POS business

BMCHP does not have Commercial Large Group Business

	12/31/2009	12/31/2010	12/31/2011	12/31/2012
Commercial Small Group				
Fully Insured HMO/POS	0	0	0	69
Self Insured HMO/POS	0	0	0	0
Fully Insured PPO/Indemnity	0	0	0	0
Self Insured PPO/Indemnity	0	0	0	0
Commercial Individual				
Fully Insured HMO/POS	0	0	0	348
Self Insured HMO/POS	0	0	0	0
Fully Insured PPO/Indemnity	0	0	0	0
Self Insured PPO/Indemnity	0	0	0	0
Total				
Fully Insured HMO/POS	0	0	0	417
Self Insured HMO/POS	0	0	0	0
Fully Insured PPO/Indemnity	0	0	0	0
Self Insured PPO/Indemnity	0	0	0	0

BMCHP High Deductible Summary by Market Segment

3 products within the Commercial (Commonwealth Choice) program qualify as high deductible which BMCHP defines as $1000+ individual deductible.

BMCHP does not have Commercial Large Group Business

	12/31/2009	12/31/2010	12/31/2011	12/31/2012
Commercial Small Group	0	0	0	37
Commercial Individual	0	0	0	183
Total	0	0	0	220

EXHIBIT C-3

BMCHP RISK CONTRACT ARRANGEMENTS TABLE (QUESTION #2)

BMCHP Estimated Membership under Risk Arrangements 2009 - 2013*

	2009			2010			2011			2012		
Provider	**MH**	**CommCare**	**Total**	**MH**	**CommCare**	**Total**	**MH**	**CommCare**	**Total**	**MH**	**CommCare**	**Total**
Health System #1	5,456 *	-	5,456 *	4,924 *	-	4,924 *	2,807 *	-	2,807 *	1,824 *	-	1,824 *
Health System #2	-	-	-	-	-	-	4,306	-	4,306	4,173	-	4,173
Health System #3	-	-	-	-	-	-	4,709	-	4,709	4,703	-	4,703
Health System #4	-	-	-	-	-	-	-	-	-	6,310	-	6,310
Total	**5,456**	**-**	**5,456**	**4,924**	**-**	**4,924**	**11,822**	**-**	**11,822**	**17,010**	**-**	**17,010**
PCMHI	**-**	**-**	**-**	**-**	**-**	**-**	**23,943**	**10,377**	**34,320**	**23,943**	**10,377**	**34,320**
GRAND TOTAL	**5,456**	**-**	**5,456**	**4,924**	**-**	**4,924**	**35,765**	**10,377**	**46,142**	**40,953**	**10,377**	**51,330**

* membership based on period during year program was in place

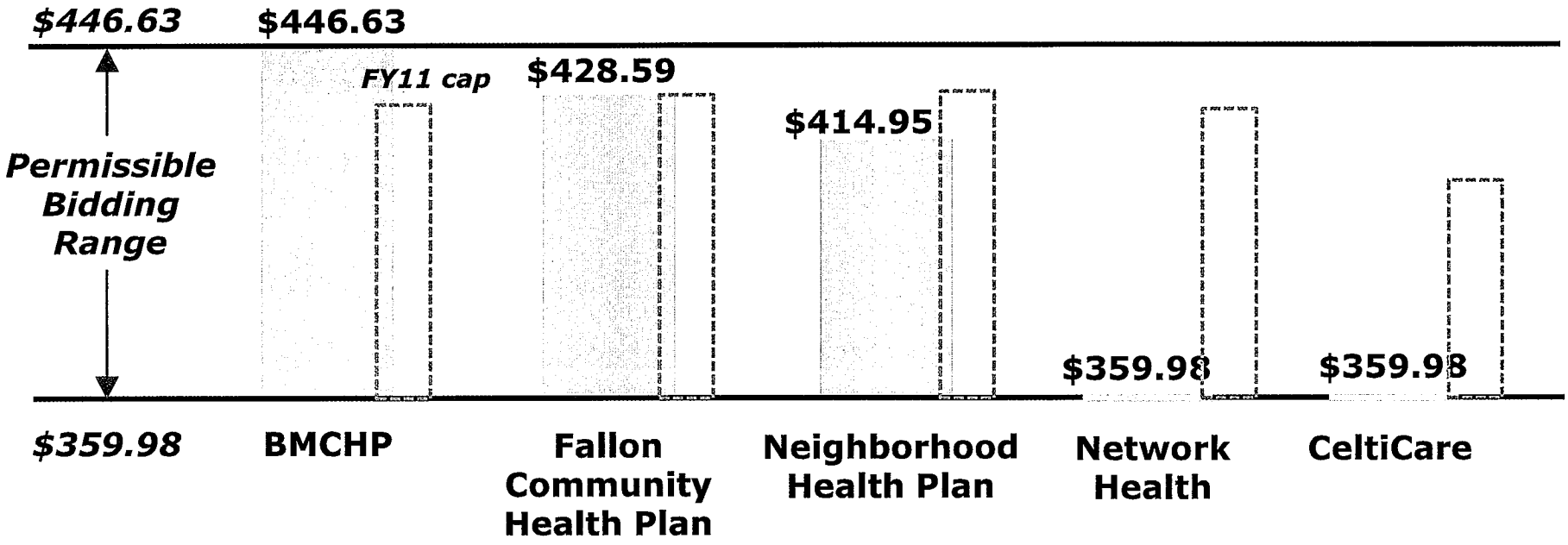
EXHIBIT C-4

CONNECTOR MCO CAPITATION BID RATES FY 11 AND FY 12 (QUESTION #3)

Capitation Bids

Most MCOs bid flat or lower rates relative to FY11

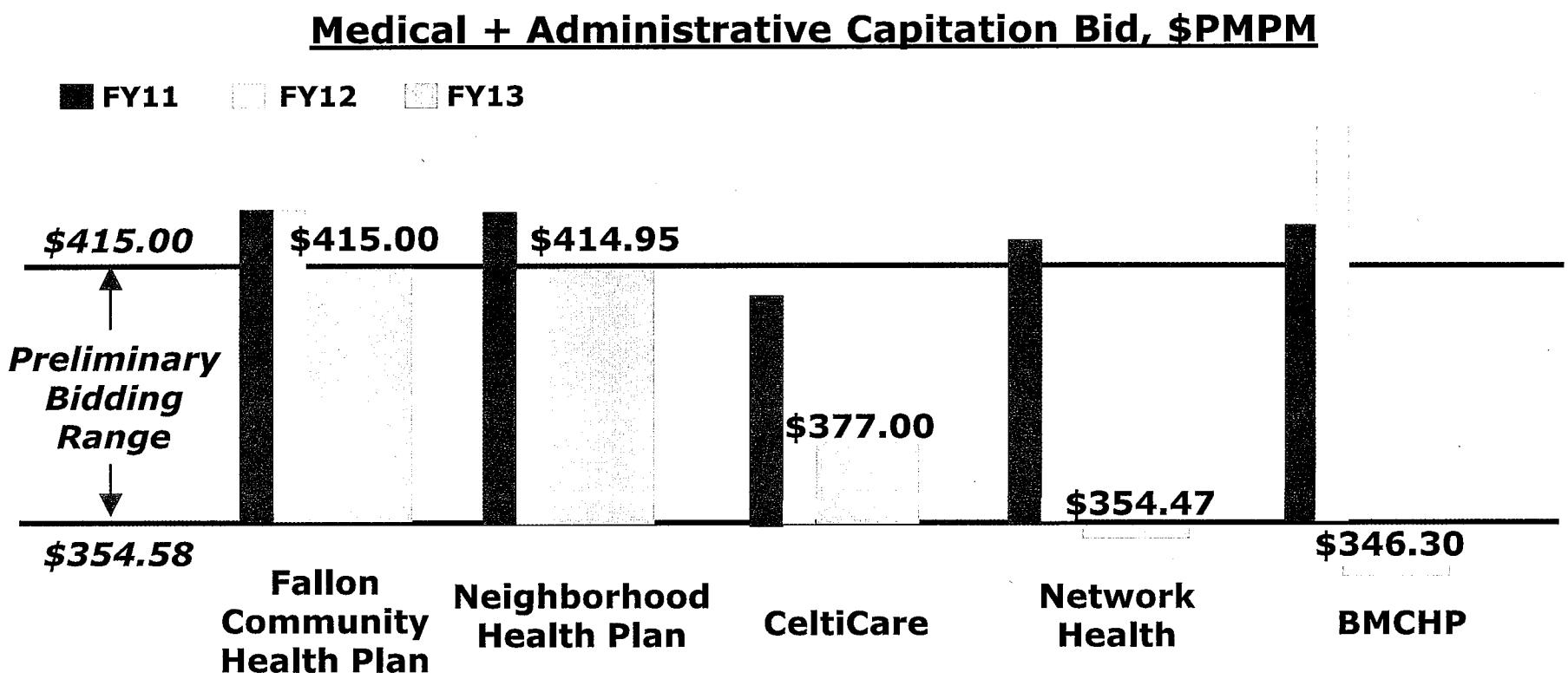
Medical + Administrative Capitation Bid, $PMPM



A single PMPM capitation bid was requested for all plan types and regions; actual capitation rates are subject to program-wide adjustment factors/methodologies (plan type, region, demographics, acuity) defined by the Connector.

Capitation Bids

Most MCOs bid flat or lower rates relative to FY12.



All five capitation rate bids have been determined by an independent actuary to be actuarially sound and are within the final actuarially sound rate range.

EXHIBIT C-5

BMCHP TEMPLATE FOR "PERFORMANCE TO DATE RISK ARRANGEMENT MONTHLY REPORT TO PROVIDERS" (QUESTION #5)

BOSTON MEDICAL CENTER HealthNet Plan

Provider Group 2013 Risk Arrangement Performance to Date v. Budg

MassHealth

Incurred X to Y paid thru Z; includes IBNR

Member Months: XXXXX

		Budget	Measurement Period to Date	Variance
1	Total PMPM	$ -	$ -	
2	Adjustment for Outliers	$ -	$ -	
3	PMPM Excluding Outliers	$ -	$ -	
4	Adjustment for Change in Risk		1.00	
5	Net PMPM	$ -	$ -	0.0%
6	PMPM Under (+) / Over (-) Budget		$ -	
7	50% of PMPM Under (+) / Over (-) Budget			
8	Estimated Amount Due to Provider Group			

Notes:

1 Total PMPM cost for MH members with PHO's PCPs; excludes BH
2 PMPM cost of outlier claims
3 [Line 1] - [Line 2]
4 Change in DxCG score; not available until measurement period is complete
5 [Line 3] x [Line 4] measurement period only
6 Measurement Period PMPM - Budget PMPM
7 [Line 6] * 0.5 if 2% or more under or over budget with cap applied per agreement
8 [Line 7] * member months in measurement period

Performance by Service Category

Includes All Claimants

	Budget	Measurement Period to Date	Variance
Facility Inpatient			
Facility Outpatient			
Lab and Radiology			
Other Medical			
Pharmacy			
Physician Services			
Total	$ -	$ -	

Outliers

Outlier Claims Threshold: $ 150,000

Claimants	Total Claims	Outlier Claims	Outlier PMPM
0	$ -	$ -	

EXHIBIT C-6

BMCHP ACO CHECKLIST (QUESTION #6)

BOSTON MEDICAL CENTER
HealthNet Plan

ACCOUNTABLE CARE ORGANIZATION (ACO) CHECKLIST

☐ Must have at least 5,000 Boston Medical Center HealthNet Plan (BMCHP) members assigned to the practice at the time of contract execution.

☐ Must have at least 1 adult PCP with an open panel and 1 pediatric PCP with an open panel as applicable. Having 1 Family Practice physician with an open panel would also meet the criteria.

☐ Site must have 90% of their BMCHP credentialed PCPs and BMCHP credentialed Nurse Practitioners complete a Culturally Linguistic and Appropriate Services (CLAS) program by the end of the program year. Attestation of completion must be submitted.

☐ Practice must designate an MD and administrative point person.

☐ Practice agrees to partner with BMCHP on quality initiatives.

☐ Practice must have expanded on site after hours availability including, at a minimum, 1 weekday evening or 1 weekend day. (BMCHP reserves the right to audit)

☐ Practice must provide laboratory data electronically to BMCHP if applicable or support BMCHP's efforts to work with their laboratory vendor to exchange data electronically. Laboratory data must include at a minimum LDL-C, HbA1c, HDL, Total Cholesterol and Triglycerides.

☐ Practice must use certified Electronic Health Record (EHR) technology or have made substantial progress toward meaningful use of certified EHR technology by the end of the contract term.

☐ Practice must be accessible for routine and urgent care needs in timeframes outlined in the BMCHP Provider Manual.

☐ A clinician returns calls or responds to email in a timely manner to meet the clinical needs of the member. Timeframe to be determined by practice.

☐ Practice must have a documented process for laboratory and imaging test tracking and follow-up. Practice must notify member of normal and abnormal results. (BMCHP reserves the right to audit)

☐ Practice must have an ACO Program Plan approved by the governing body or develop an ACO Program Plan within six months of the contract effective date.

☐ During the measurement period Practice must adopt the use of Current Procedural Terminology (CPT), Category II codes, which are supplemental tracking codes used for performance measurement, where appropriate. Plan and Practice will work together to identify mutually agreed-upon use of CPT II code categories.

☐ Practice agrees that Plan may from time to time make modifications in its ACO program, including this ACO checklist, to ensure compliance with specific Payment Reform requirements as determined by key stakeholders, including regulatory and accrediting entities.

EXHIBIT C-7

BMCHP WELLNESS GUIDE (QUESTION #8)

Your Guide to Wellness

The best health care happens before you get sick. It's called preventive care. To help you and your family stay healthy, BMC HealthNet Plan has put together this special guide to wellness. You'll find information on all of the tests and shots you should have, tips on eating right and exercising, signs and symptoms of health problems, and more. Keep this with you and refer to it often. Here's to your health!

BOSTON MEDICAL CENTER
HealthNet Plan
Get more.℠

BIRTH to 23 MONTHS

- Well Visits: age 1, 2, 4, 6, 9, 12, 15, and 18 months
- Lead Screening: 9-12 months
- Infant vaccines and immunizations should be almost complete by 23 months
- Developmental Milestones are important (visit www.cdc.org)
- Keep your child safe! Talk to your doctor about:
  - Car seats
  - Child locks
  - SIDS – Sudden Infant Death Syndrome
  - Poison prevention and control
  - Sleeping safety
  - Sun protection
  - Breast or bottle feeding

2 YEARS OLD to 10 YEARS OLD

- Annual Well Visits
- Be aware of developmental milestones
- Make sure all immunizations and vaccinations are up to date*
- Lead Screening 2 and 3 years old
- Keep your child safe! Talk to your doctor about:
  - Car safety
  - Bike safety
  - Sun protection
  - Poison prevention and control
  - Home safety
  - Healthy foods/eating and activities

11 YEARS OLD to 17 YEARS OLD

- Annual Well Visits
- HPV (Gardasil) and other vaccines
- Talk to your child's doctor about:
  - Sexual development
  - Sexual activity
  - Sexual identity
  - Substance abuse prevention
  - Self image
  - Peer pressure
  - Bullying
  - Eating disorders
  - Depression
- Keep your child safe! Talk to your doctor about:
  - Sports safety
  - Seat belts
  - Guns
  - Smoking
  - Helmets
  - Sun protection

18 YEARS OLD to 49 YEARS OLD

- Annual Well Visits
- Make sure you are up to date on immunizations and vaccinations*
- It is important to be screened for cervical cancer, breast cancer, skin cancer
- Talk to your doctor about:
  - Safe sex
  - Family planning
  - Substance and/or alcohol abuse
  - Depression
  - Nutrition
  - Smoking
- Safety is important to your wellness, make sure to stay safe by learning more about:
  - Using seat belts
  - Using sun protection
  - Sport safety
  - Home safety
  - Poison control

50 YEARS OLD +

- Annual Well Visits
- Screen for colon cancer, breast cancer, prostate cancer risk*
- Screen for diabetes, high blood pressure and cholesterol*
- Safety is important! Talk to your doctor about:
  - Using seat belts
  - Sun protection
  - Home safety
  - Poison control
  - Vision tests

** Immunization guidelines are available at bmchp.org. On the MassHealth member page, click on "Publications".*

SMALL CHANGES CAN MAKE A BIG DIFFERENCE

Eat Healthy

You may be eligible for nutritional counseling. Talk to your doctor about this. The following are a few changes you can make to your diet to help stay healthy:

Changing eating and exercise habits is easier with family and friends.

- Learn to analyze your plate www.fruitsandveggiesmatter.gov/activities/analyze_my_plate.html
  - It's important to include fruits, vegetables, grains, and dairy into your every day diet. See www.mypyramid.gov for more information about the food pyramid.
- Portion Control: It's important to eat in moderation. Here are some small changes you can make to limit your portions:
  - Don't supersize your meal
  - Stop at one serving, don't get seconds
  - Eat only when you're hungry
  - A serving size is about the size of a fist
- Make time for meal time
  - Breakfast is still the most important meal of the day
  - Establish a regular time and place for meals
  - Avoid eating in the car
- Fast food is cheaper and faster sometimes; make healthier choices from the menu
  - Try to limit the number of times you eat at fast food restaurants per week
  - Consider healthier choices on fast food menus such as salads, grilled or baked meats, fruits, vegetables and water instead of soda.

Stay Active

- You don't need to belong to a gym to be fit. Here are some ways you can work exercise into your day.
  - You can get a full workout at home. Visit the Wellness Center at www.bmchp.org or Mass in Motion at www.mass.gov/massinmotion for workout ideas
  - Take the stairs, not the elevator
  - If you drive, park further away and walk to your destination
  - If you take public transportation, get off one stop earlier and walk to your destination.
  - Walk your kids to school
- Get involved with sports
- Walk or run your way to fitness. Map routes around your where you live with www.mapmywalk.com or www.mapmyrun.com.
- Be a role model and set a good example for your family and friends.

It's important to consult your doctor prior to starting any new exercise or nutrition program.

If you or someone in your family isn't at a healthy weight, your overall health is at risk. That includes your risk for diabetes, heart disease, depression, eating disorders, and more.

SIGNS AND SYMPTOMS

It's important to stay active and healthy. It's also important to be aware of signs and symptoms of conditions such as the following:

Depression Warning Signs

If you answer yes to these questions, talk to your health care provider about depression.
Depression is treatable and there is help.

- Over the past two weeks have you noticed that you have little interest or lost pleasure in doing things?
- Over the past two weeks have you been feeling down, depressed or hopeless?

Heart Attack Warning Signs

- If you or someone else is experiencing these symptoms, call 911 immediately
- Pressure, squeezing or pain in center of chest lasting more than a few minutes
- Pain spreading to shoulder, neck or arms
- Chest discomfort with lightheadedness, fainting, sweating, nausea or shortness of breath
- Anxiety, nervousness and/or cold, sweaty skin
- Fast or irregular heart rate

Stroke Warning Signs

If you think someone may be having a stroke, act F.A.S.T. and do this simple test:

- **F = Face** – ask the person to smile. If one side of the face appears crooked or drooping this person may be having a stroke
- **A = Arms** – ask the person to lift both of his or her arms in the air–if he or she has difficulty with one arm this too might be a sign that this person is having a stroke
- **S = Speech** – ask the person to speak. If his or her words are slurred or they are unable to speak, they might be having a stroke
- **T = Time** – if any of the above symptoms are present you must call 911 immediately in order to make sure that this person reaches the hospital FAST.

Signs and Symptoms of Diabetes

- Talk to your doctor if you're experiencing these symptoms
- Frequent trips to the bathroom
- Unquenchable thirst
- Losing weight without trying

COMMUNITY RESOURCES:

Here's a sampling of resources in your community that might be able to help you with things like clothing, housing, food stamps and more:

- www.massresources.org
- www.mass.gov/dta
- www.gettingfoodstamps.org/apply.htm
- www.mass211.org
- www.housingworks.net

For more resource listings, go to bmchp.org.

CARE MANAGEMENT

BMC HealthNet Plan is committed to giving you, our members, the information and tools you need to build and maintain a healthy lifestyle. Our Care Management program is free for members (adults and children) and their families and is just a phone call away.

Our Care Management program includes you, your health care providers, and us, working together for you to be healthy. BMC HealthNet Plan staff, including registered nurses, licensed social workers, and trained Care Management Specialists, will be in touch with you to check on your progress and help coordinate care with all necessary health care providers.

We also help you learn what benefits and community resources are available because we want to help you with more than just health care.

Check and see if you are eligible for this program by calling BMC HealthNet Plan's Care Management department at 1-866-853-5241.