Health Policy Commission
Public Hearings – Health Care Cost Trends in the Commonwealth
CeltiCare Health Plan of Massachusetts, Inc.
NAIC #13632
September 8, 2014

I am Jay Gonzalez, Plan President and CEO of CeltiCare Health Plan of Massachusetts, Inc (CeltiCare). Thank you for the opportunity to provide testimony regarding health care cost trends in the Commonwealth. The testimony provided serves as CeltiCare's response to the set of questions outlined in Exhibits B and C of the August 1, 2014 letter I received from Mr. Seltz.

I would like to provide a brief overview of our organization followed by responses to the questions.

Introduction

CeltiCare is a health maintenance organization whose home office and principal executive office are located in Waltham, MA. Established in 2009, CeltiCare Health is a subsidiary of Centene Corporation (NYSE:CNC). Centene, with its affiliate subsidiaries and vendor partners, is uniquely structured to address the needs of the populations we serve. Our operating model allows for the right blend of locally-based, high touch services and centralized corporate and subsidiary services that deliver deep expertise, functional specialization, and economies of scale. CeltiCare is a supported by a regional organization and operating structure which also supports Centene's health plan in New Hampshire, Granite State Health. The Company has grown substantially over the last year and has gone from 11,000 members to approximately 35,000 members in Massachusetts and over 90,000 across the northeast region. As of May 2009, CeltiCare was licensed by the Commonwealth of Massachusetts Division of Insurance as an HMO. CeltiCare's business started on 7/1/09 through a benefit plan offering with the Health Connector for the Commonwealth Care Program. As of 10/1/09, CeltiCare expanded our product offering to the Commonwealth Care Bridge program. Starting March 1, 2010, CeltiCare began marketing commercial individual and group products, including offering benefits through the Commonwealth Choice Program. Since January 1, 2014 CeltiCare has been offering health plans through the Connector including ConnectorCare plans. As of January 1, 2014, CeltiCare Health is also participating in MassHealth through the CarePlus program. The CarePlus program serves the Medicaid expansion population which is comprised of low income adults under 138% Federal Poverty Level (FPL).

CeltiCare is committed to providing high quality health care services to all its members. CeltiCare's unique model fosters member-centric care and incorporates the following attributes:

- A locally-based, integrated medical home care model, tailored to meet member needs and improve health outcomes;
- An accessible high quality, community-based provider network;
- The national expertise of its parent company, the best practices of 20 affiliate health plans and the support of 7 specialty companies, 5 of which are affiliates;
- A passionate team of associates with a singular focus to deliver the right care, the right way;
- Member incentives and provider reimbursement methodologies that encourage and reward preventive care utilization;
- Assurance that the right care is received in the most appropriate setting.

Jay M. Gonzalez,
Plan President and CEO
CeltiCare Health Plan of Massachusetts, Inc (CeltiCare

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the 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 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 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 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 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 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

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

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 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%.
   SUMMARY: 6

   a. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

      Utilization management:
      Developed a prior authorization program for high-tech imaging consistent with what many other health plans in the Commonwealth

      The prior authorization strategy is to limit utilization of tertiary and quaternary facilities for services that are appropriately delivered in the community setting with a more efficient and cost effective "work-up" than is practiced in academic teaching centers

      Requires Concurrent Review process:
      - 100% concurrent review of all inpatient acute and extended care admissions
      - Focus is on the right care at the right time in the right setting
      - Emphasis is on discharge planning and care transitions

      Strengthened Care Management Strategy for particular populations in the CarePlus Program:
      - 924 members enrolled in Medical Care Management YTD
        - 34 (3.6%) members in Complex Care Management (high)
        - 560 (60.6%) members in Care Management (moderate)
        - 330 (35.7%) members in Care Coordination (low)
      - 1207 members in Behavioral Health Care Management (YTD)
        - 101(7.9%) members in Intensive Care Management (moderate/high)
        - 153 (12%) members in Care Coordination (low)
      - 21 members currently enrolled in Integrated Care Management
      - 408 Member Connections Home Visits made
      - 15 Behavioral Health Case Manager Home Visits

      Strengthened disease management program in both medical and behavioral in the CarePlus Program.

Provider contracting (Unit Price):
Currently strategically expanding Network:

- to meet access standards for new products
- to assuage member concerns around availability of desired providers
- to offer Primary Care Providers greater access to specialty care providers
- to provide more cost-effective tertiary care

b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?

CeltiCare plans to continue to participate in the MassHealth PCPRI initiative. The hope is that our membership would grow and therefore we would have more eligible providers that will have the ability to share and upside and downside risk for total costs of care for our members.

In addition, CeltiCare is working with its corporate parent to move toward innovative payments in 2015. The focus of the models is to enhance quality, focus on primary care and reduce costs through P4P programs, shared savings and HBR/fund based initiatives.

CeltiCare is also piloting a program with Pine Street Inn to serve homeless members. The goal of the pilot is for CeltiCare to deliver Medical and Behavioral services to members while Pine Street will help with housing and other social service supports. Studies have shown that housing and other social service reports reduces emergency room visits and inpatient stays which will reduce costs for these members.

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2. C. 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. SUMMARY:
   a. Please describe your organization's efforts to date in meeting this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs)(payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) on your (i) total medical expenses, (ii) premiums and (iii) provider quality.

CeltiCare has maintained an ongoing contract featuring APMs with our largest provider which represents approximately 25% of our network for Commonwealth Care. In this arrangement we provide upside-only shared savings to the Provider who achieves budget targets on the total cost of Member care in addition to meeting quality benchmarks. The agreement's quality and performance measures

include diabetes, asthma, and prenatal care indicators as well as prescribing rates of generic medications when appropriate. Providers must meet or exceed agreed upon targets to receive shared savings and quality bonuses. We are working on the same arrangement for our CarePlus product.

CeltiCare is commited to assisting the Commonwealth in achieving its goals as expressed in the Primary Care Payment Reform Initiative as evidenced in the fact that all of our deemed contracts for CarePlus contain language that requires providers to negotiate agreements that meet the requirements outlined in the PCPRI should they become participants.

CeltiCare has initiated numerous meetings with key acute care hospital and physician group stakeholders across the Commonwealth during 2014 about creating new contractual relationships and modifying existing arrangements to employ alternative payment arrangements including gain-share, upside/downside risk arrangements as well as bundled payments that have reduced fee-for-service payments in Centene plans across the county. Celticare looks forward to finalizing these arrangements during the later stages of 2014.

b. What efforts does your organization plan between now and October 1, 2015 to increase your use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider types?

In 2015 CeltiCare hopes to gain membership so that it can more directly engage providers in contracting for alternative payment arrangements through PCPRI and others. CeltiCare is working with its corporate parent to move toward innovative payments in 2015. The focus of the models is to enhance quality, focus on primary care and reduce costs through P4P programs, shared savings and HBR/fund based initiatives.

3. Please quantify your organization's experience implementing risk contracts across your provider network using the template below. For purposes of this question, "risk contracts" refers to contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to the provider, including contracts that subject the provider to limited or minimal "downside" risk.
   SUMMARY: To date, CeltiCare's approach to alternative payments to incentivize better cost and quality outcomes has not included global payments or other alternative payments that shift downside risk to providers. Consequently, we do not have any relevant experience that is responsive to this question. CeltiCare has a new population with limited claims experience. As we grow we plan to integrate innovative payment to support costs and quality measures. Our parent, Centene has a portfolio of product offerings that include P4P, shared savings and HBR initiatives.

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012		
CY2013		

4. Please identify and explain the principal factors considered in formulating risk adjustment measures used in establishing risk contracts or other APM contracts with providers, including how you adjust for changes in population health status over the contract term.
   SUMMARY: As noted above, CeltiCare has not yet entered into a contract with a provider that shifts downside risk to them. In order to make further progress in implementing alternative payment arrangements consistent with state objectives and with our goal of achieving better health outcomes at lower costs, we are currently in the process of developing a standard approach for evaluating the capacity of providers to enter into a risk-based contract and, more broadly, to determine what types of alternative payment arrangements would be most appropriate for a particular provider. Factors that we plan to take into account as part of any such evaluation include, but are not limited to, the provider's location, panel size, financial ability to sustain risk, performance management capabilities and degree of system integration.
   a. Does your organization use a common approach to risk adjustment for all providers? If not, what factors support the need for the application of different measures or adjustments for different providers or provider organizations?
      N/A
   b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of risk adjustment measures for use in contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?
      N/A

c. What progress has your organization made to date regarding the development and implementation of population-based socioeconomic adjustments to risk budgets? What plans does your organization have in this area?
N/A

d. How do any such differences interact with other contract elements that materially affect risk budgets and performance-based payments, and what are the results of any analyses conducted by your organization regarding variation in provider performance under different measures and adjustments?
N/A

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5. Please identify and explain the principal factors considered in selecting quality metrics used in establishing APM contracts with providers.
SUMMARY: CeltiCare Health's approach to payments associated with quality measure achievement is developed very much as a collaborative effort. We have learned that we cannot force a square peg into a round hole, and that providers are at many different levels of development and structural maturity. Creating a shared vision of success begins with a mutual understanding of each other's needs. When that has been successfully created, that vision is translated into calculable measures that serve as proxies for overall success.

   a. Does your organization use a common approach to quality measurement and associated payments for all providers? If not, what factors support the need for the use of different quality measures or performance targets for different providers or provider organizations?
   As a relatively new market entrant, we are attempting to broaden our market presence in this area, balancing pre-existing mature relationships between plans and providers with our corporate approach at offering a broad array of alternative payment strategies along a continuum that includes P4P at one end and assumption of significant downside risk at the other.
   We utilize standard quality measures that have previously been defined and accepted in the marketplace (e.g., HEDIS, LEAPFROG, CMS, NQF, JCAHO measures), and attempt to apply them discriminately based upon the variable provider and member populations with which CeltiCare Health operates.
   We find regional variation in provider performance, sophistication, and bandwidth, especially as relates to attainment of cost and quality targets. These and other related parameters are assessed collaboratively, and the "right" combination of quality measures is selected to serve as a quality improvement incentive.
   The above notwithstanding, CeltiCare Health is a collaborator with the state's efforts to develop Alternative Payment Models, and to the extent feasible, we follow the guidance of the state in regards to such model development. CeltiCare Health is participating in the PCPRI, and is approaching the quality incentive component of the PCPRI exactly as has been designed by the program developers within EOHHS. In this way we are supporting the specific efforts as defined by the state while achieving the intended outcome improvement that will benefit members, providers and the plan.

b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of quality measures, such as the measures included in the Standard Quality Measure Set, for use in risk contracts and other APM contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

Standardization: Value

• Ease of use by providers across all payers
• Consistent focus by providers without having to develop multiple processes
• Ease of use for payers; one data set for all providers
• Consistent focus for payers across all providers

Standardization: Drawbacks

• Tends to lead to performance at the least common denominator rather than customizing incentives to assure improvement across all providers AND payers, across measures that NEED improvement
• Difficulty applying to a variety of different demographic populations and those with differing Case Mix Indices
• Differing levels of EMR connectivity may diminish the value of standardization across providers

Differentiation: Value

• Allows for payers to develop provider relationships that support provider efforts and their self-identified areas of needed improvement
• Allows for payers to achieve a broad range of improvements across multiple provider types and geographies
• Allows for greater flexibility if broader multi-plan data is available for decision making

Differentiation: Drawbacks

• Creates many varying workflows and data reporting needs for both plans and providers

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6. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.

SUMMARY:

We encourage selection prior to enrollment and through our welcome call process which includes identification of a primary care provider, assignment as well assistance with scheduling an appointment if needed. If a primary care provider is not selected, we will work with the Member to auto-assign a provider. If we auto-assign a Provider to a Member, we utilize available data elements including:

- Prior claims history
- Match of Member's age, gender, language (to extent they are known), and geographic (zip code) proximity (mileage radius) to provider panel requirements.
- Previous primary care assignments

Previous family member assignments.

a. Describe your current attribution methodology (or methodologies), identifying the purpose(s) for which it is (or they are) used, and include the following information:
    i. provider types considered for attribution (e.g., primary care physicians, specialist physicians, NPs/PAs)
    We review PCP historical data.
    ii. units used in counting services (e.g., number of claims, share of allowed expenditures)
    We utilize historical claims usage
    iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)
    We utilize historical claims usage.
    iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and 12 months
    v. whether patients are attributed retrospectively or prospectively.
    Prospectively
b. Please describe your efforts to develop a comprehensive attribution methodology, including the current status of your efforts to validate, pilot and implement a methodology for purposes of implementing risk contracts and other APM contracts for PPO insurance products. What resulting barriers or challenges has your organization faced?
    N/A. CeltiCare does not have PPO products in the market.
c. What values and/or drawbacks does your organization identify regarding potential standardization of attribution methods, both across providers and across payers? What are the values and/or drawbacks of differentiation?
    We utilize GEOs that show PCP coverage by area and we then reach out to those not contracted
d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?
    We utilize GEOs that show PCP coverage by area and we then reach out to those not contracted

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7. Describe your organization's efforts and results in developing insurance products that encourage members to use high-value (high-quality, low-cost) care and providers, including but not limited to tiered network and limited network products. Please attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending.
    SUMMARY:
    ANSWER: CeltiCare does not offer tiered or limited products to its members. The main reason for that is that CeltiCare's population is primarily subsidized. The subsidized products include Commonwealth Care and CarePlus through the Health Connector and

MassHealth. The contracts with MassHealth and the Connector have requirements around access to providers within certain milage or timeframe requirements.
Celticare was the first in the market to introduce a financial reward for members who participate in certain healthy behaviors. The CeltiCare CentAccount card offers members the opportunity to earn monetary rewards for completing a health risk screening upon enrollment and visiting a primary care provider on an annual basis. These funds can be utilized for purchase of healthcare related goods and services. This program has since been copied by market competitors. Our own internal data shows an increased engagement rate between member and provider, and enhanced identification of at-risk members. This program applies to all of our Commonwealth Care membership.

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8. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY: CeltiCare takes every opportunity possible to ensure our consumers understand their benefits, how to access those benefits and cost information for health care services. To date, this information is provided to consumers via multiple different channels. CeltiCare's call center educates members during inbound calls, as well as outbound calls welcoming consumers to the Health Plan. Cost information is also made readily available through our secure web portal, where a member can easily ascertain current accumulation, cost sharing information such as copays, deductibles and co-insurance, as well as information regarding their claims history.

Additionally we are complying with an initial version of the Ch 224 Consumer Data Transparency tool requirement for a toll-free number and website that allows consumers to obtain cost information for admissions, procedures and services

Health Care Service Price Inquiries				
Year		**Number of Inquiries via Website**	**Number of Inquiries via Telephone/In Person**	**Average (approximate) Response Time to Inquiries***
CY2014	**Q1**			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER: We have not had any price information requested to date.

9. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than national average utilization of inpatient care and its heavy reliance on academic medical centers. Describe your organization's efforts to address these trends, including efforts to redirect appropriate care to lower cost community settings. Please attach any analyses you have conducted on such "outmigration," including specific estimates of cost savings that may be accrued through redirection of care.
   SUMMARY:
   ANSWER: CeltiCare Health supports member care delivery at the most appropriate place of service through our clinical management program. Access to contracted tertiary/quaternary/academic centers can be made by a community based specialist knowledable in the disease or condition of which the member has concern, after that specialist has determined that the nature of the condition, or the complexity of care requried, is such that appropriate care is not able to be accomplished in the community setting. In this way, members recieve care at the right place of service as determined by the providers themselves. Prior to the implementation of this program in mid 2012, approximately 40% of all medical admissions were provided in a tertiary or higher level facility. 12 months after implementation of this program, the percent of admissions to tertiary facilities had been reduced to 27%.

10. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    SUMMARY:
    a. Please describe any efforts your organization has made to effectively address the needs of these high-cost, high-risk patients in an integrated manner.
       As noted above, CeltiCare and Cenpatico, the behavioral health material subcontractor, meet daily to discuss high-cost, high-risk members who are identified through the various reports discussed above. Staff are co-located which helps to facilitate the daily discussions. In addition to being co-located, behavioral health and physical health case managers develop an integrated medical record using the same software technology which provides the staff to access the patient's record. Interventions and resources are identified to meet the member's physical health and behavioral health needs, including connecting the member to a primary care clinician, behavioral health provider, and community supports. Focus also includes identifying the member's natural supports to assist in supporting the members who are identified as high-risk, high-cost members.
    b. If you contract with or otherwise use a behavioral health managed care organization or "carveout," please describe how you ensure that integrated treatment is provided for these high-cost, high-risk patients.
       As noted above, CeltiCare and Cenpatico, the behavioral health material subcontractor, meet daily to discuss high-cost, high-risk members who are identified through the various reports discussed above. Staff are co-located which helps to facilitate the daily discussions. In addition to being co-located,

behavioral health and physical health case managers develop an integrated medical record using the same software technology which provides the staff to access the patient's record. Interventions and resources are identified to meet the member's physical health and behavioral health needs, including connecting the member to a primary care clinician, behavioral health provider, and community supports. Focus also includes identifying the member's natural supports to assist in supporting the members who are identified as high-risk, high-cost members.

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11. Please describe whether and how your organization provides financial support or incentives for a provider to achieve recognition or accreditation from a national organization as a patient-centered medical home (PCMH) or improve performance as a PCMH. Attach any analyses your organization has conducted on the impact of PCMH implementation in your provider network on outcomes, quality, and costs of care.
SUMMARY:
ANSWER: CeltiCare Health has been an ardent supporter of the EOHHS sponsored PCMH Pilot since its inception over three years ago. As part of this effort, CeltiCare Health participated in the data sharing, education, and collaborative processes as developed and required by the program originators. CeltiCare Health provided funds to participating provider organizations to help support infrastructure development, leading to accreditation as a PCMH by NCQA, a PCMH program participation requirement. To date, CeltiCare Health has depended upon the efforts of the UMMC analytics team that has been supporting the PCMH effort for EOHHS, primarily due to our small membership size and effective lack of statistical significance we could place on CeltiCare Health specific member outcomes. While we await the final results from the state regarding the overall outcome of the program, we believe that the advancement of provider integration that this program fostered is invaluable for the Commonwealth.
With the discontinuation of the EOHHS PCMH program, CeltiCare Health has turned to supporting the PCPRI, and will again be participating in the distribution of financial incentives for providers to continue in their efforts to build accreditable medical homes for members.

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12. After reviewing the Commission's 2013 Cost Trends Report and July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
SUMMARY: CeltiCare believes that Massachusetts should be a leader in providing high quality health care that is affordable to its residents. It commends the commissions work on the 2013 Cost trends report and the 2014 supplement to help monitor the rising costs of health care in the Commonwealth. CeltiCare is particularly interested in a few of the topics that have been covered by the Health Policy Commission.
ANSWER:
Celtic are predominately serves subsidized populations and is therefore interested in monitoring:
1. Promoting an efficient, high quality health care delivery system in particular for behavioral health members. Our experience in the CarePlus MassHealth program has shown us that our members with behavioral health and substance abuse problems have much higher costs than an average member. We have been working with our sister company Cenpatico to coordinate the physical and behavioral care for these members. We had an example out in the Western region of the state where a man had been in and out of the ER 25 times between January and June for being intoxicated. A case manager finally tracked him down at the hospitals and got him into treatment. The person has not been back to the ER in the last couple months saving us significant inpatient

dollars. Cenpatico and CeltiCare work extremely closely on better outcomes for these high costs individuals. CeltiCare support the findings of the HPC to increase behavioral health in primary care settings as those are the least restrictive.

2. Advancing Alternative Payment methods findings are important to be monitoring in the market. CeltiCare is extremely focused on moving to Innovative alternative payment models that will provide incentives for providers to coordinate care and lower costs. CeltiCare did participate in MasssHealth's PCMHI and will be participating in the PCPRI program. These programs are aimed at lower costs with a focus on primary care. It will be interesting for the HPC to monitor how primary care impacts total cost of care given that the costs of primary care is so low compared to other spending in the system. CeltiCare also looks forward to reviewing best practices set by the Health Policy Commission because there appears to be a lot of models out there. To the extent the Massachusetts market can be consistent and use practices that are simple and we know work the better it will be for the member, the provider and the plan.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2011 to 2013 according to the format and parameters provided and attached as AGO Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2011 to 2013 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).

   Completed in Attachment AGO Payer Exhibit 1

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2. Please submit a summary table according to the format and parameters provided and attached as AGO Payer Exhibit 2 with all applicable fields completed showing your total membership for members living in Massachusetts as of December 31 of each year 2010 to 2013, broken out by:
   a. Market segment (Hereafter "market segment" shall mean commercial individual, commercial small group, commercial large group, Medicare, Medicaid MCO, MassHealth, Commonwealth Care, other government. "Commercial" includes fully-insured and self-insured.)
   b. Membership whose care is reimbursed through a risk contract by market segment (Hereafter "risk contracts" shall mean contracts that incorporate a per member per month 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.)
   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).
   d. Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for hospital services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)
   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.)
   f. Membership in a high cost sharing plan by market segment

(Hereafter “high cost sharing plan” is any plan in which an individual deductible or copayment of $1,000 or more may apply to any in-network benefit at any tier level.)

Completed in Attachment AGO Payer Exhibit 2

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3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2010 to 2013, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership (e.g., why membership in PPO is growing).

   The membership in Commonwealth Care declined in the period from 2010 to 2013 for two reason: 1) the Commonwealth Care Bridge program which CeltiCare was the sole source plan was discontinued because the court ordered it unconstitutional, 2) CeltiCare was not longer the lowest costs plan and therefore the lowest premium plan so was less appealing to members that had to pay premiums.

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4. Please explain and submit supporting documents that show for each year 2009 to 2013, (i) your total number of employer accounts and the total annual claim payments made for those employers; and (ii) the total number of such employers for whom you do not have arrangements to provide behavioral health network or management services and the total annual claim payments for such employers

   N/A. Employer count is very low for the CommChoice products during this time period.

CeltiCare Health Plan Membership

As of December 31 of Each Year

	December 2010			December 2011			December 2012			December 20	
	All	With Risk Contract	W/O Risk Contract	All	With Risk Contract	W/O Risk Contract	All	With Risk Contract	W/O Risk Contract	All	With Risk Contract
Commonwealth Care											
Plan Type I	3,071	629	2,442	7,244	1,244	6,000	10,790	1,671	9,119	3,663	621
Plan Type II	8,610	1,534	7,076	10,414	1,671	8,743	6,539	916	5,623	5,759	1,208
Plan Type III	2,524	439	2,085	3,909	610	3,299	2,709	429	2,280	1,995	402
Total	**14,205**	**2,602**	**11,603**	**21,567**	**3,525**	**18,042**	**20,038**	**3,016**	**17,022**	**11,417**	**2,231**
Comm Care Bridge	**21,567**		**21,567**	**13,414**		**13,414**	**-**		**-**	**-**	
Commercial, Individual											
Gold	8		8	42		42	10		10	10	
Silver High	11		11	96		96	12		12	12	
Silver Medium	2		2	128		128	1		1	-	
Silver Low	3		3	12		12	6		6	9	
Bronze High	72		72	11		11	150		150	171	
Bronze Medium	41		41	-		-	128		128	139	
Bronze Low	35		35	8		8	47		47	42	
Total Individual Comm	**172**		**172**	**297**		**297**	**354**		**354**	**383**	
Commercial, Small Group											
Gold	1		1	-		-	4		4	3	
Silver High	4		4	7		7	3		3	3	
Silver Medium	-		-	-		-	-		-	-	
Silver Low	-		-	-		-	5		5	-	
Bronze High	1		1	1		1	13		13	13	
Bronze Medium	6		6	2		2	2		2	5	
Bronze Low	1		1	7		7	2		2	2	
Total Small Grp Comm	**13**		**13**	**17**		**17**	**29**		**29**	**26**	
Total Commercial	**185**		**185**	**314**		**314**	**383**		**383**	**409**	

Grand Total	**35,957**	**2,602**	**33,355**	**35,295**	**3,525**	**31,770**	**20,421**	**3,016**	**17,405**	**11,826**	**2,231**

)13 W/O Risk Contract
3,042
4,551
1,593
9,186
-
10
12
-
9
171
139
42
383
3
3
-
-
13
5
2
26
409

9,595

Total Commercial Membership

Commercial, Individual	Dec 2010	Dec 2011	Dec 2012	Dec 2013
Gold	9	42	14	13
Silver High	15	103	15	15
Silver Medium	2	128	1	-
Silver Low	3	12	11	9
Bronze High	73	12	163	184
Bronze Medium	47	2	130	144
Bronze Low	36	15	49	44
Total	**185**	**314**	**383**	**409**

Small Group Commercial Membership

Commercial	Dec 2010	Dec 2011	Dec 2012	Dec 2013
Gold	1	-	4	3
Silver High	4	7	3	3
Silver Medium	-	-	-	-
Silver Low	-	-	5	-
Bronze High	1	1	13	13
Bronze Medium	6	2	2	5
Bronze Low	1	7	2	2
Total	13	17	27	26

Source: H:\BBERSZONER\Program Code\DOI Quarterly Membership Report.SQL

Exhibit # 1 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 2011	5.5%	34.9%	0.0%	1.3%	44.2%
CY 2012	14.3%	8.5%	0.0%	-4.8%	18.1%
CY 2013	9.6%	0.5%	0.0%	-4.3%	5.4%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, 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 change in provider. 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.