MASSACHUSETTS
HEALTH POLICY COMMISSION

2017 Pre-Filed Testimony

Payers

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

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The Hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled Hearing dates and location:

Monday, October 2, 2017, 9:00 AM
Tuesday, October 3, 2017, 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 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, 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 6, 2017, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube channel following the Hearing.

If you require disability-related accommodations for this Hearing, please contact Andrew Carleen at (617) 757-1621 or by email Andrew.Carleen@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

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

Exhibit B: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, and/or 2016 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

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

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400.

Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.
If a question is not applicable to your organization, please indicate so in your response.

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

Comment [JK1]: Alida, can we get section 1 completed now, or is this response dependent on the data your team is working on?

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC presented at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between $279 to $794 million annually.

a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
   i. **Priority 1**: Reduce unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions)
   ii. **Priority 2**: Increase the use of alternative payment methods (APMs)
   iii. If you selected "other," please specify: Click here to enter text.

b. Please complete the following questions for **Priority 1** (listed above).
   i. What is your organization doing to advance this priority and how have you been successful?
   Implemented an integrated approach to care management in January 2015 which resulted in a 7% decrease in PMPM cost and 5.3% decrease in ED visits per 1000 from 2015 to 2016. Post hospital outreach after discharge calls have resulted in a 2% readmission reduction in Q1 2017.
   ii. What barriers does your organization face in advancing this priority?
   Difficulty reaching members due to bad phone numbers and/or addresses
   iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
   Improve State's process for updating and communicating reliable phone numbers and addresses to the health plan.

c. Please complete the following questions for **Priority 2** (listed above).
   i. What is your organization doing to advance this priority and how have you been successful?

   Since 2014, CeltiCare's main line of business is the Medicaid Expansion product through MassHealth and has no significant membership in Commercial insurance. For our Medicaid Expansion product, CeltiCare has implemented value based programs for two large provider systems in Massachusetts. Minimum membership thresholds are required for these payment arrangements to be successful. As we look past 2017, CeltiCare is designing programs to meet the provider community "where they are" on the continuum of APM sophistication. We are able to administer shared savings programs, upside/downside risk models, percent of premium models, and programs that incorporate quality as a "gate" to risk sharing as well as quality incentives on a PMPM basis. As CeltiCare's membership grows, we look to implement these models with providers across the state. APMs that include total cost of care management aimed at lowering overall costs, and quality targets promoting member engagement, improved performance on recognized quality measures, and patient outcomes

are all options. CeltiCare is able to leverage a robust APM infrastructure with various options and approaches developed by its corporate parent that are geared not only to large integrated provider systems but also to community and ancillary providers. CeltiCare realizes sharing data with providers regarding the cost, diagnoses and care gaps is key to value based contracting success and is placing much emphasis on these resources.

ii. What barriers is your organization facing in advancing this priority?
CeltiCare believes that the most significant partnerships can be achieved through allowing providers to share in risk, both upside and downside. To do so, there must be sufficient membership to make measuring provider performance in a total cost of care APM model reliable/statistically significant. CeltiCare's main barrier to implementing APMs is the Plan's membership size and distribution of membership being spread widely across the state.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?
MassHealth premiums are risk adjusted on a regional basis. Thus, risk scores included in the premium cannot be aligned to individual medical groups or healthcare systems within a region. The methodology creates a dynamic whereby the financial risk in the program cannot be shared with providers on a similar foundation. Medical Expense budgeting and risk adjustment at the regional average level present challenges to implementing APM models. Budgets based on actual member medical expense and risk adjustment would facilitate implementation of total cost of care models. .

2. STRATEGIES TO IMPROVE CLINICAL DATA COLLECTION

In each of its four annual reports, the HPC has called for the improvement and alignment of quality measures, particularly for the measures used in APM contracts, and has recognized the burden of reporting different quality measures for different purposes. Please answer the following questions regarding how your organization collects clinical quality data.

a. How does your organization currently collect clinical data from contracted provider organizations for the purposes of outcome quality measures for provider contracts and the NCQA accreditation process? [check all that apply and explain the purpose for which you collect the data for each] Required Answer.

☒Excel document or equivalent
Purpose: Click here to enter text.
☐Direct data feed
Purpose: Click here to enter text.
☐Chart reviews by third-party vendor
Purpose: Click here to enter text.
☒Web-based portal
Purpose: Click here to enter text.
☒Other: Click here to enter text.
Purpose: Direct access to provider EMR for HEDIS reviews

b. How frequently do you collect clinical quality data from contracted providers? Required Answer.

☒Ongoing
☐Monthly
☐Quarterly
☐Annually
☐Other: Click here to enter text.

c. What is the estimated cost of staff and resources to collect and report on provider clinical quality data each year?
   i. Estimated cost (in dollars): $60,000
   ii. Estimated FTEs: 3 FTEs (2 Registered Nurses and one HEDIS Coordinator)

3. STRATEGIES TO ADDRESS DRUG SPENDING

The HPC, other state agencies, payers, providers and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. In its 2016 Annual Cost Trends report, the HPC highlighted a range of strategies to reduce drug spending increases, including value-based contracting.

a. Are you pursuing value-based drug contracting? Required Answer.
   ☐ Yes ☒No

   If yes, with whom?
   N/A

b. If yes, have you found that your value-based contracts have resulted in meaningful cost savings and/or quality improvement? Required Answer
   ☐Yes, cost-savings only
   ☐Yes, quality improvement only
   ☐Yes, both
   ☐No
   ☐Unknown (insufficient time to measure improvement)

c. If no, what is/are the reason(s) you have not pursued value-based drug contracting? Check all that apply. Required Answer.
   ☒Lack of appropriate quality measures
   ☒Administrative and operational implementation costs
   ☐Inability to negotiate performance incentives with manufacturers
   ☐Other (please specify): Systematic implementation limitations and availability of necessary metrics to report back on these contracts.

4. STRATEGIES TO SUPPORT INNOVATIVE CARE DELIVERY THROUGH PAYMENT POLICIES

Public payers are implementing new payment policies to support the development and scaling of innovative, high-quality and efficient care delivery, such as, for example, Medicare's readmissions penalty for acute care hospitals, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, and MassHealth's new flexible services spending allocation in its new ACO program to address patients' non-medical needs.

a. Has your organization adopted any new payment policies related to the following areas of care delivery improvement and innovation? [check all that apply] Required Answer.
   ☒Readmissions
   ☐Avoidable ED visits
   ☒Serious reportable events
   ☐Behavioral health integration into primary care (e.g. collaborative care model)
   ☐Care management (e.g., serious or chronic illnesses)
   ☒Telehealth/telemedicine
   ☐Non-medical transportation
   ☐Services to maintain safe and healthy living environment
   ☐Physical activity and nutrition services
   ☐Services to remove/protect patients from violence
   ☐Other: Click here to enter text.

b. For each area identified above, please describe the payment policy in more detail, including whether it is a payment penalty or non-payment, fee-for-service reimbursement for new service codes, per-member-per-month fee, etc.

Readmissions:
This policy implements non-payment for avoidable readmissions.

Avoidable ED Use:
Click here to enter text.

Serious reportable events:
This policy implements non-payment for avoidable never events.

Behavioral health integration into primary care (e.g. collaborative care model):
Click here to enter text.

Care management (e.g. serious or chronic illnesses):
Click here to enter text.

Telehealth/telemedicine:
This policy provided guidance with billing these services.

Non-medical transportation:
Click here to enter text.

Services to maintain safe and healthy living environment:
Click here to enter text.

Physical activity and nutrition services:
Click here to enter text.

Services to remove/protect patients from violence:
Click here to enter text.

Other:
Click here to enter text.

5. STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

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

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

Health Care Service Price Inquiries CY2016-2017			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2016	**Q1**	19	1
	Q2	4	1
	Q3	9	2
	Q4	15	4

CY2017	**Q1**	11	1
	Q2	6	0
	TOTAL:	64	9

6. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2014 to CY2016 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2014 to 2016, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).

CarePlus:

- Unit Cost is the contracting change blended with the actual unit cost increases on pharmacy.
- Provider Mix is the actual experience annual unit cost increase backed down by the contracting change from above.
- Service mix is the change is risk score year-over-year. We believe risk score is reflective of acuity and represents a reasonable estimate of mix differences.
- Utilization is the actual experience annual utilization change backed down by the service mix estimate from above.
- Since publishing last year's report, the CY 2015 total trend changed slightly from -1.2% to -0.8%. The CY 2016 was driven primarily by a very high Rx trend (34.9%) and a high other trend (17.4%.) OP and Professional were relatively low at 3.0% and 1.1% respectively. Much of the Rx trend appears to be due to an increase in Hep C and specialty. MassHealth loosened prior authorization criteria August 1, 2016 allowing members who have been diagnosed with Hep C to receive the treatments regardless of fibrosis scores. Previously, a fibrosis score of 3 or higher was the criteria.

Marketplace:

- We consider the base of membership to not be credible for any of the presented periods. Thus, large swings in trends can be noted due to small membership and lack of a consistent membership (eligibility swings - members terming and being added). In both 2015 and 2016, our average membership was only 1,300 members.
- Unit Cost Trend is mostly due to higher Outpatient cost per unit
- Utilization trend is mostly due to higher-acuity membership
- Provider Mix Trend is mostly due to utilization of lower cost Inpatient, Outpatient, and Specialist providers
- Service Mix Trend is primarily due to reduced use of high-cost injectable drugs and reduced likelihood of surgery in Outpatient settings
- Pharmacy Utilization: By far the biggest contributor to utilization was a larger proportion of members receiving scripts within certain expensive drug classes. This was especially true for the following specialty drugs within drug classes where there are few alternatives:
  - Hepatitis Agents
    HARVONI TAB 90-400MG
  - Multiple Sclerosis Agents
    GILENYA CAP 0.5MG
    TECFIDERA CAP 120MG
    TECFIDERA CAP 240MG
  - Soluble Tumor Necrosis Factor Receptor Agents
    ENBREL SRCLK INJ 50MG/ML
  - Anti-TNF-alpha - Monoclonoal Antibodies

HUMIRA PEN INJ 40MG/0.8
HUMIRA PEN INJ PSORIASI

Only one of these drug classes (Soluble Tumor Necrosis Factor Receptor Agents) had any spend at all in 2015.

Pharmacy unit cost and Brand/Generic Mix:

- Cost Per Unit was up for Rx mostly due to higher cost per unit of drug, there was a slight tendency toward more units per day as well.
- Service Mix helped drive PMPMs down due to generally favorable trends in Brand/Generic mix. The mix of drugs within categories (category here means things like Branded Smoking Deterrents or Generic Smoking Deterrents) worsened slightly, offsetting some of the favorability. So basically, utilization shifted from brands to generics, but the mix of branded drugs was more expensive than it was before).

7. INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND APMS

Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. In the 2016 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2018. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a. Please answer the following questions related to risk contracts spending for the 2016 calendar year, or, if not available for 2016, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)

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

HMO/POS	100%
PPO/Indemnity Business	0%

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

HMO/POS	18.5%
PPO/Indemnity Business	0%

b. Please answer the following questions regarding APM expansion.

   i. How is your organization increasing the use of APMs? Are you expanding the participation in risk contracts to providers other than primary care providers (e.g., hospitals, specialists, behavioral health providers) or into new product types (e.g., PPO)?

   We have historically engaged in APM arrangements with provider partners that serve a larger share of our membership. Given the membership volume that CeltiCare has had for the products that the Plan has offered, it has been challenging to implement additional APMs. Minimum membership thresholds are required for these payment arrangements to be successful. As the Plan's membership grows we look to implement additional APMs that include total cost of care management and quality targets aimed at lowering overall costs, promoting member engagement, and improving performance on accepted quality measures. We have been and continue to be focused on working with MassHealth to align our APMs with MassHealth's requirements, goals and objectives in the context of their program redesign and our upcoming opportunities for membership growth in the MassHealth program.

   ii. What are the top barriers you are facing and what are you doing to address such barriers?

The main barrier that we have had to implement APMs is the Plan's membership size and distribution of membership being spread widely across the state. CeltiCare has experienced a lack of sufficient membership with most of our contracted provider organizations to date to make APMs workable.

iii. Currently, most APM contracts pay providers on a FFS basis with reconciliation at the end of the year. Is your organization taking steps to move payment toward population-based models (e.g. capitation) and away from FFS as the basis for the APM contracts?

☐ Yes ☒No

If no, why not? If no, why not? CeltiCare is able to leverage a robust APM infrastructure with various options and approaches developed by its corporate parent that are geared not only to large integrated provider systems but also to community and ancillary providers. With the appropriate volume of membership, we will seek to deploy APM models.