celticare health

200 West Street
Suite 250
Waltham, MA 02451

September 2, 2016

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street 8th Floor
Boston, MA 01209

Dear David:

Attached please find CeltiCare Health's written testimony in support of the upcoming 2016 Cost Trends Hearing. I confirm that I am legally authorized to submit this testimony and it is signed under the pains and penalties of perjury.

Please don't hesitate to contact me if you have any questions regarding this response.

Respectfully,

Jay Gonzalez
President and CEO

Exhibit A: Notice of Public Hearing

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

Scheduled Hearing dates and location:

Monday, October 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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

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

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

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

Exhibit B: Instructions and HPC Questions for Written Testimony

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

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

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

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

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

If a question is not applicable to your organization, please indicate so in your response.

1. Strategies to Address Health Care Cost Growth.

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

a. What are the top areas of concern you would identify for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)
   i. Provider consolidation
   ii. Provider price variation
   iii. Increases in drug cost

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)
   1. Continue to limit provider consolidation and study the impact on costs prior to allowing mergers/acquisitions and affiliations between providers to happen.

      The leverage of large, consolidated provider systems does influence both our network strategy and adversely impacts our ability to negotiate sustainable reimbursement rates with providers. As a small scale plan focused almost entirely on providing coverage to members of the MassHealth program, CeltiCare Health is already constrained in its ability to negotiate sustainable contracts with providers while maintaining adequate network access for its members. This challenge is compounded by provider consolidations. This is particularly true when a provider system achieves significant market share in a particular geographic area of the state and CeltiCare Health is effectively required to contract with them in order to maintain network adequacy in that region. This may be compounded by the Medicaid redesign as providers are trying to partner with larger systems to be ACO models A and B. The true challenge faced in the Massachusetts health care market is how to achieve the benefits of providers participating in comprehensive systems or networks capable of coordinating and managing care that enable them to assume accountability for cost and quality outcomes, while at the same time not creating a market that consists of a handful of large provider systems that leverage significant market power to obtain higher reimbursement rates that result in higher health care costs.

   2. Government intervention to address provider pricing to limit unwanted price disparities among providers.

      The Commonwealth is continuing to see price disparities that are not warranted by quality outcomes. The move toward alternative payments and away from FFS could help to address the price disparities between providers in the market but in many instances these alternative payment and total costs of care arrangements with providers are based on underlying FFS rates that are inflated and based in part on market dominance and

brand name. The Commonwealth should consider ways in which it can intervene to prevent price disparities that drive up overall health care costs from occurring.

3. Require pharmaceutical companies to report on profits and administrative expenses

   Pharmaceutical costs went up by double digits last year and should be examined more closely by public officials. Health plans and providers are required to report on financial results quarterly. There are some legitimate reasons why pharmaceutical spending may increase in certain years but it is not reported or analyzed on a regular basis by government. There should be some specific reporting requirements for the entire pharmaceutical industry in Massachusetts to get a better understanding of what is driving up drug costs and whether there are opportunities for better managing drug costs.

2. Strategies to Address Pharmaceutical Spending Trends.

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

a. Do you contract with a pharmacy benefit manager (PBM)? Yes
   i. If yes, please identify the name of your PBM.
   US Script

   ii. If yes, please indicate the PBM's primary responsibilities below *(check all that apply)*
   - ☒ Negotiating prices and discounts with drug manufacturers
   - ☒ Negotiating rebates with drug manufacturers
   - ☒ Developing and maintaining the drug formulary
   - ☒ Pharmacy contracting
   - ☒ Pharmacy claims processing
   - ☐ Providing clinical/care management programs to members

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

Line of Business	Total Rate of Increase (2015-2016)	Rate of Increase for Generic Drugs Only (2015-2016)	Rate of Increase for Branded Drugs Only (2015-2016)	Rate of Increase for Specialty Drugs Only (2015-2016)
Commercial	7.30%	**3.10%**	**9.00%**	**11.40%**
Medicaid	**7.10%**	**3.97%**	**9.08%**	**8.73%**
Medicare				

c. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including pricing, purchasing, prescribing, and utilization. Using the drop down menu, please specify any strategies your organization is currently implementing, plans to implement in the next 12 months, or does not plan to implement in the next 12 months.
   i. Risk-Based or Performance-Based Contracting
   Plans to Implement in the Next 12 Months
   ii. Utilizing value-based price benchmarks in establishing a target price for negotiating with drug manufactures on additional discounts
   Currently Implementing

iii. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing).
Plans to Implement in the Next 12 Months

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

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

vi. Implementing programs or strategies to improve medication adherence/compliance
Plans to Implement in the Next 12 Months

vii. Pursuing exclusive contracting with pharmaceutical manufacturers
Currently Implementing

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

ix. Strengthening utilization management or prior authorization protocols
Currently Implementing

x. Adjusting pharmacy benefit cost-sharing tiers and/or placement of certain drugs within pre-existing tiers
Does Not Plan to Implement in the Next 12 Months

xi. Shifting billing for certain specialty drugs from the medical benefit to the pharmacy benefit
Does Not Plan to Implement in the Next 12 Months

xii. Other: Insert Text Here

xiii. Other: Insert Text Here

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

Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. In the 2015 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2017.

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

Given the membership volume that CeltiCare has had for the products that the Plan has offered it has been difficult to implement APMs since there are minimum membership thresholds for these payment arrangements to be successful. As the Plan's membership grows we look to implement additional APMs that aim to improve quality and lower costs for the Plan's members. We have been and continue to be primarily 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. We have, however, entered into new APM arrangements over the past year with provider partners that serve a larger share of our membership.

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

The main barrier that we have had to implement APMs is the Plan's membership size and the lack of sufficient membership with most of our providers to date to make APMs workable.

c. Please describe your organization's specific efforts to support smaller providers, including ancillary and community providers, who seek alternatives to fee-for-service payment models.
CeltiCare is able to leverage a robust APM infrastructure with various options and approaches developed by its corporate parent that is geared not only to large integrated provider systems but also to community and ancillary providers.

4. Strategies to Align of Technical Aspects of APMs.

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

a. Please describe your organization's efforts to align technical aspects of APMs with Medicare and other plans in the Commonwealth, including specifically on quality measures, patient attribution methodologies, and risk adjustment (e.g. DxCG, HCC scores).
In the APM arrangements we have entered into to date, CeltiCare Health has worked with providers to align the technical aspects of the APM with providers' requests for standardization purposes when possible. For example, we have worked with providers to negotiate quality measures used to calculate payment that are consistent with quality initiatives the providers' already have in place and with CeltiCare Health's quality objectives. Since virtually all of our membership is in the MassHealth program, we will be working with MassHealth to align our APM approach with their requirements, goals and objectives in connection with their program redesign.

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

The top barrier to aligning technical APM requirements is the fact that these requirements are currently being driven by multiple payers in different ways and without coordination or common standards. There is a role for government to play in developing common standards to align APMs to ease the burden on providers and increase the likelihood of success in achieving improved cost and quality outcomes. MassHealth has indicated, for example, that they intend to develop some common standards and parameters for MCOs to follow in developing APMs with Model C ACOs in the context of their program redesign.

5. Strategies to Increase Access to Pharmacologic Treatment for Substance Use Disorder.

Despite a strong evidence-base, pharmacotherapy is underutilized to treat substance use disorder. Last year, several private payers committed to covering more pharmacologic treatment to address the increasing needs of patients.

a. What are the top strategies your organization is pursuing to increase access, including affordability and provider availability, of pharmacologic treatment for your members with substance use disorder? Please include in your answer a description of any changes to coverage policies (e.g. cost-sharing, prior authorization, utilization review, duration of treatment limitations) or reimbursement strategies you have implemented or plan to implement with regard to pharmacologic treatment. (Please limit your answer to no more than three strategies)

CeltiCare Health has been a leader in implementing a number of initiatives to get better outcomes for members suffering from substance use disorders and to address the opioid epidemic, including initiatives to limit the flow of prescribed opioids, identify and engage members who are addicted or at risk of addiction and increase access to treatment for substance use disorder, including medication assisted treatments. Specifically, we took the following steps to lift barriers to medication assisted treatments and

other services for our members in the MassHealth program before any such steps were required by MassHealth:

1. Removed all prior authorization requirements for access to Suboxone
2. Removed all prior authorization requirements for access to Vivitrol
3. Removed all prior authorization requirements for access to any outpatient behavioral health services for substance use disorders, which in turn should help ensure members get access to any medication assisted treatments their provider believes is appropriate

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

Cost is the primary barrier to making it easier to access these treatments. For example, since we lifted our prior authorization requirements for Vivitrol for our MassHealth members, we have seen utilization of Vivitrol increase by three times and a corresponding increase in our costs for this expensive drug. We believe, however, that increasing access to this treatment will help people overcome their addiction, improve their health, and reduce their overall health care costs. We are tracking the impact of our steps to remove barriers to determine whether we achieve these expected results.

6. Strategies to Support Telehealth.

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

a. Does your organization offer or pay for telehealth services? Yes

i. If yes, in which scenarios or for which categories of care or specific populations do you pay for telehealth services (e.g. primary care, behavioral health, elderly, rural, etc.)?
We cover all the telehealth services recommended by Medicare in its CY 2016 recommendations.

ii. If yes, how do you pay for these services (e.g. equivalent FFS rates as office visits, partial FFS rates, as part of a global budget, etc.)?
We pay the same amount for a telehealth visit as we would for an office visit. Specifically, we pay the provider's contracted rate when billed with the telehealth GT modifier.

iii. If no, why not?
Not Applicable

7. Strategies to Encourage High-Value Consumer Choices.

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

a. Do you currently offer cash-back incentives to encourage members to seek care at high-value providers? No

i. If yes, please describe the types of cash-back incentives offered.
36T

ii. If no, why not?
Virtually all of our membership is in MassHealth, so there is not the same cost-sharing that exists in commercial products and our Medicaid contract restricts the incentives we can offer members for any reason. We do, however, offer members cash incentives for healthy behaviors.

b. Do you currently offer incentives (e.g. premium differential) at the point of enrollment or the point of primary care provider (PCP) selection to encourage members to select high-value PCPs? No

i. If yes, please describe the types of incentives offered.
36T

ii. If no, why not?
Virtually all of our membership is in MassHealth, so there is not the same cost-sharing that exists in commercial products and our Medicaid contract restricts the incentives we can offer members for any reason. We do, however, offer members cash incentives for healthy behaviors.

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

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

Health Care Service Price Inquiries CY2015-2016			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2015	**Q1**	16	0
	Q2	16	2
	Q3	17	2
	Q4	12	0
CY2016	**Q1**	19	1
	Q2	4	1
	TOTAL:	84	6

9. **Information to Understand Medical Expenditure Trends.**
Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2013 to CY2015 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2013 to 2015, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).
Please see attached HPC Payer Exhibit 1

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

Exhibit C: AGO Questions for Written Testimony

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

1. Please answer the following questions related to risk contracts and pharmaceutical spending for the 2015 calendar year, or, if not available for 2015, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)

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

HMO/POS	100%
PPO/Indemnity Business	0%

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

HMO/POS	0%
PPO/Indemnity Business	0%

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

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

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

    e. For your risk contracts that include the pharmaceutical benefit, how, if at all, are pharmaceutical discounts and/or rebates (e.g., from the manufacturer) incorporated into the provider's pharmacy budget?
    N/A

HPC Payer Exhibit 1 - CONNECTOR MARKETPLACE

All cells shaded in BLUE should be completed by carrier*

CELTICARE HEALTH PLAN OF MASSACHUSSETS, INC.

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2013	7.4%	2.6%	0.0%	-4.3%	5.4%
CY 2014	4.1%	-27.7%	0.0%	-7.4%	-30.4%
CY 2015	17.2%	-16.3%	0.0%	-8.3%	-10.1%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

Our trend value reflects changes in Unit cost (reimbursement contracting changes as well as increases to Medicare fee schedule), Utilization (frequency of services), Provider Mix, and Service Mix(severity of claims due to types of services rendered). The favorable shift in the health status/morbidity of our members leads to decreases in the utilization and service mix categories. Our Unit Cost trend is in line with expectations and driven primarily by increases in Rx costs and lower rebates.

HPC Payer Exhibit 1 - MEDICAID EXPANSION

All cells shaded in BLUE should be completed by carrier*

CELTICARE HEALTH PLAN OF MASSACHUSSETS, INC.

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2013					
CY 2014					
CY 2015	3.5%	1.9%	-5.2%	-1.3%	-1.2%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

Note: The Careplus program began in January 2014, thus prior year data is not applicable.

Unit cost increase is primarily due to a 10.3% increase in the cost of pharmacy.