

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)

CCA Response: The One Care and Senior Care Options (SCO) programs operated by Commonwealth Care Alliance (CCA) are significant components of MassHealth's commitment to alternative payment models. We operate as a fully integrated payer and provider with capitated, monthly payments from both MassHealth and the Centers for Medicare and Medicaid Services and are responsible, and at full insurance risk, for all of the health care needs of our members including traditional medical services, behavioral health, and long term services and supports (LTSS). CCA has been serving seniors who are eligible for MassHealth (both dual-eligible and Medicaid-only) in the SCO program since 2004 and currently have over 7,000 enrollees. We serve more than 10,000 individuals who are eligible for both Medicare and Medicaid (dual-eligibles) who are aged 21-65. One Care members are characterized by being low income and having significant disabilities. The cost profile of these members is significant. By way of benchmark, the average per-member, per-month premium for a One Care member is more than \$3,800. Through CCA's lens of caring for more than 17,000 individuals who disproportionately utilize health care services in the Commonwealth, we identify the following three primary concerns for meeting the Health Care Cost Growth Benchmark in Massachusetts.

1. **Pharmaceutical costs, particularly those relating to hepatitis C treatment and other specialty medications.** As detailed in 1.b., pharmaceutical spending is and has been since 2013 CCA's single largest cost category when disaggregating total medical spending – and the area in which we continue to see significant positive growth trends. Further, given access challenges that One Care members have previously faced, when joining CCA we see profound unmet need. This has resulted in skyrocketing spending on pharmaceuticals, which not only risks the viability of the One Care program, but also limits our ability to push risk down to network providers. CCA is hopeful of aggressive policy actions to help drive reforms in particular on pricing controls for Hepatitis C medications.
2. **Lack of meaningful information sharing across care settings to reduce preventable acute care utilization.** After pharmaceutical spending, acute care utilization continues to be CCA's largest category of medical spending. As with many in Massachusetts, we are substantially limited in our ability to know when our members access acute care settings. When members are admitted to an inpatient setting, CCA is notified via prior authorization requests (required for inpatient admission). But when members are in an emergency department or observation status, CCA lacks the ability to ensure consistent, near-real time information on our members (e.g., admission/discharge/transfer (ADT) feeds). Having rapid and consistent access to such information would allow CCA to deploy our staff who are skilled in ensuring members are cared for in the optimal care setting to engage early in the course of acute care. This approach would effectively bolster our already significant pre-hospital engagement through programs such as mobile integrated health/community paramedicine, which has successfully diverted more than 80% of our members who receive this service away from emergency departments for their urgent care needs.

- 3. Lack of sufficient alignment of financial incentives for acute care settings to maximize high value care for our members.** Largely, the acute care delivery system continues to be incentivized through volume-based payment methodologies. These arrangements create significant risk for CCA and our members as such incentives are often contradictory to the goals of care for our members. In particular, for example, the model of reimbursement of emergency medical services providers whereby EMS is only paid for transporting individuals to an acute care setting creates a consistent and strong pull towards acute care utilization. For the general population this is counterproductive, but in a population with complex needs, becomes almost insurmountable. Where we are able to reach our members first (for example when they leverage our after-hours urgent care services), we find significant opportunity to prevent acute care utilization. Shifting pre-hospital acute care incentives (and subsequently culture of care) to align around optimal and not just emergent care would have significant benefit – and conversely threatens the cost growth benchmark through high acute care utilization. Similarly, hospitals themselves continue to be incentivized on volume and not value. CCA is actively exploring opportunities to reimburse hospitals on value, for example through episode-based payment, but broader policy reforms to re-incentivize hospitals to drive volume to less acute, outpatient care settings would have significant value.
- 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)

CCA recommends the following top changes in policy to support the goal of meeting the Health Care Cost Growth Benchmark.

First, we recommend a policy change to ensure that an appropriate risk adjustment methodology for the complex populations includes a primary focus on social determinants. CCA's capitated premium based on MassHealth rating categories and Medicare risk scores does not keep pace with expenses for members who have significant social determinants-driven complexity. For example, many of our homeless or marginally-housed members have elevated rates of inpatient admissions and emergency department utilization, and corollary elevated medical expenses. Further, as such members are often challenging to find and engage, our care teams often expend significantly more resources trying to provide outpatient services to them. It is widely known that most conventional risk adjustment methodologies by design do not have high fidelity at the upper margins of complexity and cost. Where the vast majority of dually-eligible individuals (and other populations with complex needs) are in fact reflective of those margins in any distribution, the insufficiency of these tools has profound impacts on our ability to provide financially viable care to complex populations. We recommend establishment of a system to adjust payments based on social determinants to ensure more appropriate premium allocation. We are eager to support the state in development of such methodologies, leveraging our experience caring for a highly complex population that "breaks" most risk adjustment methodologies.

Second, we recommend more aggressive pharmaceutical price controls and, potentially, state-facilitated bulk purchasing arrangements, in particular for Hepatitis C drugs and naloxone. We note that the exorbitant cost of hepatitis C drugs such as Harvoni/Sovaldi present a major barrier to cost control for payers/at-risk providers such as CCA as there is little we can do to mitigate costs if the treatment is needed. We recommend that Massachusetts pursue pricing control policies to ensure reasonably-priced hepatitis C drug access. Specifically with regard to naloxone, Massachusetts has an opportunity to quickly stem the rise of fatal opioid overdoses via widespread prescription of naloxone to people who are prescribed opioids as well as broadly equipping clinicians with naloxone, facilitating speedy response to overdoses. CCA and our members continue to face significant financial barriers to

accessing naloxone. Bulk purchasing arrangements and/or continued efforts to drive price down will rapidly increase the spread of naloxone, including through such initiatives as co-prescribing.

Third, we recommend the expansion of reimbursement for alternative sites of care, including mobile integrated health (MIH) and telehealth. MIH is a high value and cost-effective component of integrated care delivery. Partnering with EasCare, LLC, CCA's MIH program, Acute Community Care, has allowed CCA to send specially-trained paramedics to homes of members with urgent care needs, averting more than 80% of emergency department visits for those members seen by a paramedic. The Department of Public Health is currently considering regulations to formalize and expand MIH programs in the state, and CCA strongly supports and encourages these efforts. In particular, CCA encourages the Commonwealth to adopt a program framework that encourages and promotes higher complexity home and community-based services as an alternative to acute care. We further recommend that as such programs emerge, MassHealth and other insurers actively pursue EMS reimbursement reforms to appropriately incentivize MIH and to shift incentives away from the current 'pay-to-transport' model. Similarly, shifting reimbursement structures for telehealth will promote enhanced community access and reduce acute care utilization. Although CCA is able to cover these services currently, we strongly encourage expansion of payment mechanisms to allow reimbursement for telehealth.

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.
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ii. If yes, please indicate the PBM's primary responsibilities below (*check all that apply*)

- ☐ Negotiating prices and discounts with drug manufacturers
This responsibility is contracted to different partner vendor, Health Delegates
- ☐ Negotiating rebates with drug manufacturers
This responsibility is contracted to different partner vendor, Health Delegates
- ☒ 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.

Provided below is our pharmaceutical trend data for our Senior Care Options (SCO) product (Medicare-Medicaid duals). We do not have this information readily available for our One Care product.

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
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				(2015-2016)
Commercial				
Medicaid				
Medicare				
Dual Medicaid-Medicare	4%	-12%	9%	0%

- c. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including pricing, purchasing, prescribing, and utilization. Using the drop down menu, please specify any strategies your organization is currently implementing, plans to implement in the next 12 months, or does not plan to implement in the next 12 months.
- i. Risk-Based or Performance-Based Contracting
Does Not Plan to Implement in the Next 12 Months
 - ii. Utilizing value-based price benchmarks in establishing a target price for negotiating with drug manufactures on additional discounts
Does Not Plan to Implement in the Next 12 Months
 - iii. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing).
Currently Implementing
 - iv. Monitoring variation in provider prescribing patterns and trends and conducting outreach to providers with outlier trends
Currently Implementing
 - v. Establishing clinical protocols or guidelines to providers for prescribing of high-cost drugs
Plans to Implement in the Next 12 Months
 - vi. Implementing programs or strategies to improve medication adherence/compliance
Currently Implementing
 - vii. Pursuing exclusive contracting with pharmaceutical manufacturers
Plans to Implement in the Next 12 Months
 - 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
Currently Implementing
 - xi. Shifting billing for certain specialty drugs from the medical benefit to the pharmacy benefit
Plans 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)

The One Care and Senior Care Options (SCO) programs operated by Commonwealth Care Alliance (CCA) are significant components of MassHealth's commitment to alternative payment methodologies (APMs). As an integrated payer/provider, CCA operates with capitated, monthly payments from both MassHealth and the Centers for Medicare and Medicaid Services and are responsible, and at risk, for all of the health care needs of our members. As a fully integrated payer/provider, in many ways CCA itself is the recipient of APMs from the state and federal governments, and see significant value to the financial and clinical alignment that results from this approach. To highlight that value, CCA's expense per member per month for SCO Nursing Home Certifiable members (75% of SCO membership) has increased by only 4.2% from 2008 through May 2016. When adjusted for inflation, the change is -5.4%, representing a compounded annual growth rate of -0.74%.

In One Care overall, we have seen a (risk-adjusted) 39% increase in per member per month expenses from 2013 to 2015, with the major cost drivers being pharmacy and long-term services and supports, reflecting the significant unmet need in this population prior to enrollment. However, for One Care members with at least 21 months of continuous enrollment we have seen a leveling off of the rate of increase in total medical expense after 12-18 months of continuous enrollment, as pent-up demand for services were addressed.

In addition to receiving APMs from MassHealth and CMS, CCA pays many of the providers we contract with through alternative arrangements. For example, approximately 1,800 of our One Care members (18% of the membership) are managed through one of seven sites that operate as One Care delegated care management sites ("Health Homes") for us, receiving per-member per-month (PMPM) care management fees. In addition to the premium-based, risk stratified care management fee, Health Homes have the opportunity to earn additional revenue based on performance on operational and utilization metrics aligning with CCA's global quality withhold incentive and care management/cost management goals. Measures target inpatient hospital admissions, post-discharge follow-up with members, and timeliness of annual assessments.

Likewise, approximately 2,500 of our SCO members (38% of the membership) are managed through one of five sites that operate as SCO delegated care management sites. For SCO delegated sites, CCA has further aligned incentives by establishing a range of shared-savings and risk-share contracts that ensure these community partners' incentives are aligned with those of CCA. Various levels of risk are established with the delegated primary care sites including upside bonus, shared savings, and full risk arrangements. All are based on performance compared to agreed-upon targets. Some delegated sites are paid a PMPM capitation, while others are paid fee-for-service with periodic settlement.

CCA also has developed contracts with two of our largest independent primary care practices in the One Care program to incorporate utilization and quality incentives aligning with CCA's goals. These practices account for approximately 14% of our One Care members. The measures incorporate focus on appropriately managing emergency department and inpatient hospital admissions and readmissions, as well as HEDIS measures related to the management of chronic illness.

Across our partner network we are working to identify opportunities for enhanced financial alignment through the adoption of APMs, as we view this as a critical component to appropriately aligning incentives in the care of our members. Our provider partners are situated in a variety of positions relative to their ability to manage APM (small scale, ability to manage clinical and financial aspects of risk), and we are working to position provider partners on a trajectory from targeted performance-based incentives, to one-sided risk arrangements (shared savings), to, where appropriate, two-sided risk arrangements (shared risk, including downside). This is a core and growing component of our contracting strategy.

- 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 challenges that CCA faces as barriers to expansion of APMs are similar to those that we observe across the Massachusetts and complex care markets, namely: 1) sample size and population volatility, 2) lack of sufficient risk adjustment methodologies, and 3) lack of community-based capacity for management of financial risk.

1. Sample size and volatility: A challenge CCA encounters in furthering financial alignment and expanding risk arrangements to some of our delegated community partner sites is that the total size of membership for many community partners is quite small (for example, many of our One Care delegated care management partners have less than 200 One Care members each). Volatility in utilization and cost make it difficult to reliably measure performance and to enter into risk arrangements with such partners. Tight alignment of APM methodologies across health care programs may allow providers to more effectively balance risk across different payers. CCA is committed to aligning our APM methodologies with other leading market participants caring for complex populations as additional risk arrangements emerge.

2. Lack of sufficient risk adjustment methodologies for individuals with most complex needs: While all members enrolled in One Care and SCO have complex needs, a subset of our members have such complex and expensive care needs that the cost impact of related expenses is not addressed by current risk adjustment methodologies. As noted in our Section 1 testimony above, establishment of a system to adjust risk based on social determinants would help to address this barrier. Further, in populations with significant pent up demand, APMs must be able to accommodate atypical cost profiles and longer range returns.

3. Lack of community-based capacity: A significant barrier to APM spread is also the technical capacity of community based providers to manage the operational and financial aspects of risk arrangements. Lack of care management technologies, financial management strategies that incorporate risk planning, and sufficient financial reserves that allow providers to bear risk continue to be barriers to entry.

- 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.

Please see 3A, above.

4. Strategies to Align 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).

CCA utilizes Medicare and Medicaid risk adjustment methodologies in our revenue structures with the Commonwealth/CMS and works to ensure alignment by flowing some of the same risks and incentives down through our risk-based contracts, including in targeted pay-for-performance quality metrics. Please see Section 3 for further testimony on how our community/provider partnerships support financial alignment and how CCA continues to move these relationships on a trajectory toward greater alignment.

- 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)

1. **Lack of meaningful sociodemographic risk adjustment:** As described in our testimony in Section 1, we recommend adoption of a common methodology to adjust risk based on social determinants of health and stand ready to support the Commonwealth in development of such an approach.
2. **Lack of meaningful quality measures for long-term services and supports (LTSS):** There is very little high fidelity performance information on LTSS providers in the Commonwealth. We recommend that the Commonwealth aggressively pursue an approach to performance measurement of LTSS, including measurement and reporting on the interaction effects of LTSS with the traditional medical delivery system, thereby capturing the full value of these services.
3. **Current models for risk adjustment and quality measures do not accurately capture the situation for our most complex patients:** As noted in our Section 1 and Section 3 of our testimony, there is a significant subset of CCA members who have such complex and expensive care needs that the cost impact of related expenses is not addressed by current approaches to risk adjustment. Similarly, conventional quality measurement approaches focused on traditional Medicare and Medicaid populations do not effectively capture the unique needs and care goals of dually-eligible individuals. There is significant need for development of quality measures that in particular effectively capture the nuanced profile of individuals with significant disability.

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)

CCA covers all pharmacologic treatments for substance use disorder (SUD) without prior authorization, member cost sharing, or other treatment limitations. CCA covers buprenorphine, naltrexone, and methadone, including transportation to the opioid treatment program. CCA's primary strategies for enhancing SUD treatment are as follows.

1. **Improve identification of patients in need of care through proactive case review**

A core challenge to expansion of access to pharmacological therapy for SUD is early identification of members who would benefit from these services. CCA is actively developing a comprehensive pain management program as well as analytic tools to better serve members who would benefit from pharmacotherapy for SUD. CCA routinely conducts comprehensive case reviews of members who are on high doses of morphine-equivalent opioids, those who are frequently in emergency departments, or those who are known to have had an overdose. All such members are considered for initiation of pharmacological therapies for SUD.

2. Reduce stigma and expand discussion of SUD as a medical disease

CCA is implementing system-wide co-prescribing of naloxone to all members receiving opioid medications. All providers are being trained to discuss naloxone as an intervention to prevent overdose with every prescription for opioids. Although patients receiving appropriate short-term opioid therapy for acute conditions are unlikely to need this medication, the conversation about substance use disorder as a legitimate medical condition as well as about the risks of opioid use is expected to enhance provider-member communication, strengthen provider status as a non-judgmental support for our members, and encourage patients to self-identify problems with substance use, even as it makes a life-saving intervention more available within the community.

3. Enhance access to the particular method of pharmacologic treatment most likely to work for a particular member

CCA is conducting utilization review of all members enrolled in methadone maintenance programs to identify loss from programs and offer re-entry or alternative pharmacologic interventions. Methadone maintenance is provided in specialized treatment facilities which are not included in any of the physician monitoring programs, and are not immediately apparent from pharmacy data. Our utilization review demonstrates significant transitions in and out of Opioid Treatment Programs (methadone clinics) with many patients leaving treatment to resume unsupervised opioid prescriptions from providers. Using claims data, we are able to follow members and offer appropriate interventions including both naltrexone and buprenorphine if the patient does not choose to remain on methadone but wishes to continue treatment.

- 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)

1. Wide geographic discrepancies in service availability

Western Massachusetts has significantly fewer resources at each and every American Society of Addiction Medicine (ASAM) level of care for SUD. While CCA provides transportation for any member needing SUD treatment service, a state-wide coordinated system which provided current information about all available service slots would enhance access and provide significantly greater likelihood of success when members could be placed in services nearer their homes.

2. Identification of patients with SUD

More than 75% of Massachusetts patients with the most severe SUD (patients who die from disease) experience fatal overdose from heroin and fentanyl, not from prescription opioids. These members often have no prescriptions for opioids and are not identifiable utilizing tools like a prescription monitoring program. While previous non-fatal overdose is the most likely indicator of future fatal overdose, and is frequently the first indicator of a substance use disorder, the only data available on emergency department resuscitation is from claims submitted and paid – with a lag of about three months and with limited reliability, since the billing codes from the emergency department visit may nest resuscitation into other claims from the visit. There is currently no information available to providers about patients

with out-of-hospital resuscitation. A registry of patients who have experienced non-fatal overdose, while complicated to implement while maintaining privacy rights, would be one way to allow providers to identify patients in need of treatment and to offer it to them.

3. Inability to link pharmacologic treatment of SUD with treatment of co-morbid mental or somatic health conditions

For many individuals with SUD, co-morbid psychiatric conditions create insurmountable barriers to regular attendance at clinics or programs that provide on-going pharmacologic management of opioid or alcohol use disorders. Adequate counseling and adjuvant pharmacotherapy are hard to access, but without managing underlying behavioral health concerns, it is impossible for many people suffering SUD to stay in care and meet conditions determined by the caregiver. Likewise, for people who experience exacerbation of an underlying physical complaint (particularly those in chronic pain) it is extremely difficult to remain in care. Here again, coordination and a meaningful registry (as noted above) would increase the likelihood of accessing the integrated care that is crucial to connecting people with needed SUD treatment and ensuring they stay in treatment.

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.)?

Electronic medication dispensing system

CCA pays for and coordinates use of an electronic medication dispensing system that allows for remote Internet-based monitoring of medication adherence. We deploy this system for seniors and other adults that have trouble remembering to take their medications; the programmable system emits a visual and audio signal at the designated time and is lockable; it comes with an optional built-in Lifeline response system, and tracks activity to a web-based platform such that nurses/care managers/family members can remotely monitor patient med compliance and receive notices if a dose is missed. We have found this system to be a cost-effective, high-value strategy for increasing member independence and reducing utilization of home-based skilled nursing for medication management. We have demonstrated success and very high return on investment when using the automated system as a direct substitute for skilled nursing for medication administration.

We plan on expanding use of this medication system, for example employing it for palliative care; the system can be used to remind patients to take their symptom-controlling medications, averting issues such as uncontrolled pain and dehydration from nausea.

Telehealth technology for chronic disease management

Via a Centers for Medicare and Medicaid Innovation (CMMI) grant, CCA, together with community and research partners, has improved the health of individuals with severe mental illness by increasing their access to health services and teaching them self-management behavior to improve health and reduce the impact of their disorders. The intervention included use of a telehealth system for chronic disease management; the telehealth unit was placed in members' homes and used by nurse practitioners (NPs) to increase their efficiency in prioritizing and intervening with individuals who need urgent attention. The system provides in-home monitoring of several key biometric measures, which were fed by intranet to a software system which uses data-based algorithms to assess immediate health risks and recommend interventions. Using this system, an NP can monitor the daily health data of 20-40 individuals. The system allows the NP to customize threshold values for symptom, behavior and

knowledge risk for each individual, ensuring that appropriate alerts are stratified to identify individuals needing immediate attention.

CCA is also actively developing further telehealth pilots for behavioral health, medication therapy management and palliative care that we anticipate implementing in the coming 12 months, including those funded by the Health Policy Commission's Health Care Innovation Investment Program.

- 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 for the electronic medication system via a monthly service fee. The vendor has also recently developed an in-house pharmacy which is utilized to greatly decrease the time and effort expended on filling and managing the system.

The telehealth technology system for chronic disease management was paid for by our community partner under the CMMI grant; CCA did not directly contract the vendor for this project. To date, CCA has had limited uptake in telehealth among network providers, but remains very open to reimbursing equivalent FFS rates as office visits via telehealth, or creating alternative fee schedules for alternative service uses (e.g., partial FFS rates for abbreviated visits).

- iii. If no, why not?

The primary barrier to entry to date has been limited uptake among network providers. In CCA's wholly-owned primary care delivery system, telehealth development is well underway.

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?

CCA intends to pilot a strategy to reward consumers for making high-value choices in the coming year. We were recently awarded a grant to evaluate whether we can increase meaningful, sustained engagement among One Care enrollees using financial incentives. Through this pilot, CCA will provide modest direct financial incentives to members who have been difficult to engage for annual assessment, to encourage them to meet with our clinicians and meaningfully engage in care planning and care coordination activities. CCA has found significant evidence that completion of the initial assessment is a critical first step in providing members with enhanced access to high-value services, resulting, over time, in a reduction in total cost of care.

- 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?

Not applicable to our population and the incentives created by CMS/MassHealth in One Care and SCO.

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		
	Q2		
	Q3		
	Q4		
CY2016	Q1		
	Q2		
	TOTAL:		

This requirement does not apply to CCA, because CCA is not a carrier as defined in Chapter 176O. Furthermore, all of our members are MassHealth eligible and none of our members share in the cost of their care and therefore are unlikely to inquire about its costs.

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 Exhibit 1 which shows the overall CCA average cost per claim, claims per member per month, and average cost per member per month, and the breakdown by product. The decreasing PMPM cost and claims per member month overall can be explained by the increasing enrollment of One Care members, who have an average lower cost and lower utilization than SCO members, as can be seen in the subsequent summaries by CCA product.

It is difficult to summarize changes in service mix and provider mix from year to year based on average cost per claim or claims per member because billing changes may have more impact than service or provider mix

in the average cost per claim. Elsewhere in this testimony we provide more detailed information on specific efforts to control costs.

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	Approximately 33% of members are in a 1- or 2-sided risk arrangement
PPO/Indemnity Business	n/a

- 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	0%
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?

Directly included in overall total cost of care (TCOC) budget and not segregated.

- 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?

These are built into CCA’s routine annual reconciliation with providers at-risk for TCOC.

HPC Payer Exhibit 1

****All cells shaded in BLUE should be completed by carrier****

Actual Observed **Total Allowed Medical Expenditure** Trend by Year

Fully-insured and self-insured product lines

	Unit Cost	Utilization Claims Per Member per Month	Provider Mix	Service Mix	Total
All CCA	Cost per Claim				Cost PMPM
CY 2013	135.01	26.18			3,534.45
CY 2014	129.71	22.09			2,864.70
CY 2015	133.39	24.32			3,244.02

Actual Observed **Total Allowed Medical Expenditure** Trend by Year

Fully-insured and self-insured product lines

	Unit Cost	Utilization Claims Per Member per Month	Provider Mix	Service Mix	Total
SCO	Cost per Claim				Cost PMPM