MASSACHUSETTS
HEALTH POLICY COMMISSION

# 2018 Pre-Filed Testimony

## Payers

## As part of the *Annual Health Care Cost Trends Hearing*

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

# Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), 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:

**Tuesday, October 16, 2018, 9:00 AM**
**Wednesday, October 17, 2018, 9:00 AM**
**Suffolk University Law School**
**First Floor Function Room**
**120 Tremont Street, Boston, MA 02108**

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, 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 HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov 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 witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

# Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. 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, 2016, and/or 2017 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 templates, 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@mass.gov or (617) 979-1400.

# Pre-Filed Testimony Questions

## 1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.

1) Rising prescription drug costs remain a major concern, as in past years. Fallon Health has taken a number of steps over time to address this issue, including the use of various medical management tools like prior authorization, step therapy and quantity limits; case management and disease management; reviews of specialty drugs and drugs new to the market; contracting strategy; site of care initiatives, including home infusion where medically appropriate; promotion of transparency through the use of copayments and tiering in plan designs (we recently made more than 200 changes to our formulary); and, member and physician education. While we believe these efforts have made a difference, high-cost drugs that lack generic equivalents limit our ability to use the above tools to place restraints on price growth, therefore cancelling out progress made elsewhere, and making it more difficult to meet the benchmark.

2) Provider consolidation also continues to be a major concern. The pace of consolidation has picked up in recent years, and shows no sign of slowing down. Fewer providers with greater market power make it increasingly difficult for insurers to use contracting strategy as a tool to help keep cost growth within the benchmark. This is especially problematic for smaller insurers like Fallon Health. Our relatively small population of fully insured commercial members gives Fallon limited leverage with large providers outside of our core area of Central Massachusetts. As provider organizations grow larger and have fewer serious competitors, our leverage deceases further.

3) Provider price variation has emerged as significant topic of policy discussion in recent years. In addition to the market dysfunction brought about by the gap between lower-paid and higher-paid providers, many proposals to address this issue have been flawed in that they have focused much more on increasing payments to providers at the bottom of the scale than reining in cost increases at the top of the scale. While efforts to aid community hospitals are in general a worthy initiative, increasing costs on the low end while at the same time allowing the top end to grow unabated will only result in increased costs for the system as a whole. This will make it harder for the state to meet the benchmark.

b) What are the top changes in policy, market behavior, payment, regulation, or statute would your organization recommend to address these concerns?

While recognizing that regulation of pharmacy pricing is a complex topic, anything that can be done at the state level to put downward pressure on prescription drug price increases would be helpful. Prior to the end of the most recent legislative session on July 31, both chambers of the state legislature were working on their own versions of a proposed health care bill, each of which included provisions addressing this matter. We were in support of the provisions in the final Senate bill, which gave increased roles in this area to the Health Policy Commission (HPC), Center for Health Information and Analysis (CHIA), and the Attorney General's Office. We would encourage further legislative discussion around this topic.

The proposed health care bills discussed above also contained provisions intended to address provider price variation. Unfortunately, we found the proposals in both bills to be problematic. The House bill would have created an assessment on insurers, to be used to provide funding for community hospitals. The Senate bill, meanwhile, would have imposed a pricing structure to force rates upward for lower-paid hospitals while doing little to rein in increases at the top of the price scale. Both of these proposals would put pressure on insurance premiums to fund providers at the lower end – thus increasing costs for the system as a whole – while doing little or nothing to control costs at the top end. While we were disappointed that some aspects of these bills did not move forward, not passing either of the price variation proposals was, frankly, the best outcome. The Senate proposal was a good start in attempting to address one end of the scale, but any future legislative discussion around this topic must address both the top and the bottom of the price scale.

If provider mergers will be allowed to continue, regulators should hold merged entities to a commitment to keep future cost growth down. Greater efficiency and economies of scale, and therefore the potential for lower costs, are often cited as a possible benefit of provider consolidation. Experience shows this to rarely be true, however. It is far more common for the combined entity to use its market power to extract higher rates from insurers. This is especially problematic for smaller insurers, like Fallon Health, with less leverage due to lower membership and utilization penetration.

While not directly related to the top three areas of concern identified in Part a, we also have the following additional recommendations:

In addition to the items noted above, the proposed health care bills from the last legislative session contained provisions intended to address payments for certain out-of-network services. We would encourage further legislative discussion around this topic. There are a number of provider types – ambulances; emergency-room physician groups; certain hospital-based services such as pathology, radiology and anesthesiology – which have little incentive to contract with insurers because members with a need for these types of providers are not typically in a position to choose the specific provider they will receive services from. For these providers, it often makes sense economically to refuse to contract with insurers, enabling these providers to bill insurers at higher, non-negotiated rates. This leaves insurers with the choice of paying these higher, non-negotiated rates or allowing their members to be balance billed. While this issue is just one piece of the larger cost

puzzle, we think a sensible solution to close this gap is achievable, allowing insurers to pay rates that are reasonable and customary in the overall context of meeting the benchmark, allowing providers to be fairly compensated, and freeing members from needing to worry about being caught in the middle by "surprise billing".

The Commonwealth should take a more active role in workforce development in the health care sector. This would be especially helpful in the case of substance abuse and mental health services. There has been a long-term trend towards greater focus on and access to those services, creating an ongoing need for trained staff on both the clinical and non-clinical sides, especially for products under government programs, including staff such as community based health workers and Navigators. Community based behavioral health providers are particularly valuable in the MassHealth ACO space.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

1) Working collaboratively with providers to build value-based contracts with shared risk arrangements. We are especially excited about the opportunity presented in this regard by the introduction of the MassHealth ACO program, in which Fallon Health is a participant. The ACO arrangement allows us to invest in addressing social determinants, which are often a major underlying cost driver, much more than would be possible in a traditional insurance arrangement. We hope to ultimately leverage some of the capabilities we are building through the ACOs to our other product lines, both government and commercial.

2) Working with providers to promote integrated team-based care that rewards value rather than volume. For members enrolled in certain government products, this can involve the use of community based health workers and Navigators, i.e., a unique role that was created by Fallon to serve as a high touch, single point of contact for members with complex health needs. Data Analytics often goes hand in hand with this approach, allowing for more comprehensive provider reporting, and practice pattern variation analysis. The use of health outcome surveys ties in with this team approach.

3) Encouraging the use of high-performing networks. Fallon has been a pioneer in the use of such networks, and they can be a valuable tool to steer members to providers who have the ability to manage utilization appropriately, resulting in lower rates and high-quality outcomes. We offer high-performing networks extensively in our commercial portfolio, and continue to work towards further refining these products. Our MassHealth ACO networks also represent a variation on this concept.

## 2. INFORMATION ON PHARMACY BENEFIT MANAGERS

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. Pharmacy benefit managers (PBMs) play a major role in the market, significantly impacting drug pricing and access. Furthermore, PBM policies that restrict the ability of pharmacies and pharmacists to share certain information with patients have been an increasing area of focus.

a) Please identify the name of your organization's contracted PBM(s), as applicable.
CVS/Caremark

b) 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
- ☐Other: Click here to enter text.

c) Briefly describe the Massachusetts member populations managed by your PBM (commercial, Medicaid, fully-insured, self-insured, etc.).
All product lines use CVS/Caremark (including fully-insured commercial, self-funded commercial, Medicare Advantage and Medicaid ACO) except for those commercial clients who have carved out their pharmacy benefit and do not obtain pharmacy coverage through Fallon.

d) Does your organization or any PBM with which you contract have policies that restrict the information a pharmacy or pharmacist can share with a covered person on the amount of the covered person's cost share for the prescription drug compared to self-pay (so-called "gag clause")? If yes, briefly describe this policy.
No

e) Does your organization or any PBM with which you contract have policies requiring a pharmacy to charge or collect a copayment from a covered person even if that amount exceeds the total charges submitted by the network pharmacy? If yes, briefly describe this policy.
No

f) Does your organization or any PBM with which you contract have policies requiring a pharmacy to proactively disclose to a covered person if the total charges submitted by the network pharmacy are less than the required copayment? If yes, briefly describe this policy.
Yes. Members are charged the lowest of the following: 1) their normally required copayment; 2) the pharmacy usual and customary charge; 3) the contracted rate negotiated by CVS/Caremark.

## 3) STRATEGIES TO PROMOTE INNOVATIVE CARE DELIVERY THAT INTEGRATES BEHAVIORAL, SOCIAL, AND MEDICAL CARE

Public and private payers alike are implementing new policies to support the development and scaling of innovative, high-quality, and efficient care delivery, such as, for example, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, reimbursement for services rendered by peers and community health workers, and incentives for patients and providers to engage in evidence-based treatment for substance use disorder.

Has your organization adopted policies related to any the following areas of care delivery improvement and innovation? [check all that apply, and describe your primary incentive related to the care delivery innovation in the fields below]

☒Readmissions Required Answer: Click Here
☒Avoidable emergency department (ED) visits Other (please describe in a text box)

☐Behavioral health integration into primary care (e.g., collaborative care model)
Required Answer: Click Here
☐Pharmacologic or other evidence-base therapies for substance use disorder
Required Answer: Click Here
☒Peers and/or community health workers Required Answer: Click Here
☒Telehealth/telemedicine Other (please describe in a text box)
☒Non-medical transportation Other (please describe in a text box)
☒Supportive temporary or permanent housing Required Answer: Click Here
☒Other: Click here to enter text. Other (please describe in a text box)

Readmissions:
For providers who are reimbursed by Fallon Health according to a DRG or similar case-rated methodology for Commercial plan and MassHealth enrolled members, we will deny reimbursement for readmission for inpatient services occurring within 7 days of discharge from the same facility for the same or related condition for which the member was treated at the time of the original discharge. For providers that are reimbursed by Fallon Health according to a DRG or similar case-rated methodology for Medicare plan members, we will deny reimbursement for readmission for inpatient services occurring within 30 days of discharge from the same facility for the same or related condition for which the member was treated at the time of the original discharge.

Avoidable Emergency Department (ED) visits:
Fallon Health has an agreement with Teledoc. This relationship is stated on our Telemedicine policy. Teledoc provides 24/7/365 access to quality medical care through telephone and video communication. This service is for sick members and aims to allow a consultation with a physician at all times rather than utilizing the ED.

Peers and/community health workers:
There is a community health worker component to our MassHealth ACO plans.

Telehealth/telemedicine:
Fallon Health has an agreement with Teledoc. This relationship is stated on our Telemedicine policy. Teledoc provides 24/7/365 access to quality medical care through telephone and video communication. This service is for sick members and aims to allow a consultation with a physician at all times rather than utilizing the ED.

Non-Medical Transport:
For Fallon Health's NaviCare SCO product only, social transportation is covered. (Note that this is unique to the NaviCare SCO product and does not apply to Fallon commercial plans.) NaviCare will cover up to 90 roundtrip transports per year via van/chairvan, taxi, or ambulance (when required), with no more than one roundtrip transport daily. Transports are limited to a 30-mile radius and must be coordinated and arranged during NaviCare business hours. Services covered under this benefit may include transportation to qualified fitness center locations (e.g., Silver Sneakers), or transportation to assist with activities of daily living, nutritional and dietary services, counseling services, and social activities.

Supportive temporary or permanent housing:
There is a temporary housing component to our MassHealth ACO plans.

Other: Opioids:

Opioid painkillers provide needed relief to those with acute or chronic pain. But given their potential for harm, and the very real – and pervasive – problem of misuse and abuse, ensuring appropriate use is more critical now than ever before. Effective February 1, 2018 Fallon Health implemented our standard opioid management program which will be aligned with the "Guideline for Prescribing Opioids for Chronic Pain" issued by the Centers for Disease Control and Prevention (CDC) in March 2016.

The enhanced programs will:

- **Limit days' supply**
  The length of the first fill (when appropriate) will be limited to seven days for immediate release, new, acute prescriptions for plan members who do not have a history of prior opioid use, based on their prescription claims. A physician can submit a prior authorization (PA) request if it is important to exceed the seven-day limit.
- **Limit quantity of opioids**
  The quantity of opioid products prescribed (including those that are combined with acetaminophen, ibuprofen or aspirin) will be limited up to 90 Morphine Milligram Equivalent (MME) per day (based on a 30-day supply). Prescribers who believe their patient should exceed CDC Guideline recommendations can submit a PA request for up to 200 MME per day unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME per day. Quantities higher than that would require an appeal. Opioid products containing acetaminophen, aspirin, or ibuprofen will be limited to 4 grams of acetaminophen or aspirin, and 3.2 grams of ibuprofen per day.
- **Require step therapy**
  Use of an immediate-release (IR) formulation will be required before moving to an extended-release (ER) formulation, unless the member has a previous claim for an IR or ER product, or the prescriber submits a PA.

## 4) STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

Chapter 224 of the Acts of 2012 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) In the table below, please provide available data regarding the number of individuals that sought this information:

| Health Care Service Price Inquiries CY2017-2018 | | | |
|---|---|---|---|
| Year | | Aggregate Number of Inquiries via Website | Aggregate Number of Inquiries via Telephone or In-Person |
| **CY2017** | **Q1** | 856 | 127 |
| | **Q2** | 720 | 155 |
| | **Q3** | 813 | 121 |

| | | | |
|---|---|---|---|
| | **Q4** | 676 | 148 |
| **CY2018** | **Q1** | 735 | 254 |
| | **Q2** | 350 | 693 |
| | **TOTAL:** | 4150 | 1498 |

Note: the data for the second quarter of 2018 are significantly different from previous quarters. We believe this was due to the launch of a revised web site which took place during this time frame. The revised web site required existing members to re-register, and presented the telephone option much more prominently. This may have had the effect of reducing the number of web inquiries while increasing the number of telephone inquiries.

b) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?

The SmartShopper feature on Fallon's web site provides price information on the most common services used by Fallon Members. Some of these services are MRIs, CT Scans, bone density screening, and bariatric surgery. Consumers have access to our cost transparency tool 24 hours a day 7 days a week. Within this tool they can search various services on their own, chat on line, or call and receive help from a personal assistant. Fallon has made every effort with our vendor to ensure that members have access and receive a response timely.

Maintaining up to date data which will accurately reflect a member's prospective service is obviously a challenge. Fallon actively works with our vendor to verify the data multiple times a year. We want to be sure that each member has options when it comes to choosing a low cost provider, so it is important that we review this data with our vendor frequently. We have weekly claims files transmitted in order to update the services offered with the most up to date information.

Member engagement has also been a challenge for this process. The percentage of members who use this process has historically been low despite attempts to ensure that members are aware of its availability.

c) What barriers do you encounter in accurately/timely responding to provider inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?

Contracted providers have access to verify eligibility, and have the option to contact our Customer Service department to verify a particular member's benefits. If the provider needs more information on pricing for the procedures and services they are offering, they can refer to their contract, or reach out to their Provider Relations Representative or Contract Manager for assistance.

## 5) INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2015 to CY2017 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2015 to

2017, the portion of actual observed allowed claims trends that is due to (a) changing demographics of your population; (b) benefit buy down; (c) and/or change in health status/risk scores of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

Attached is the summary table showing actual observed allowed medical trends. For the time frames requested we did not have specific studies to break mix between provider and service mix so the mix has all been put into the Service Mix column. We do believe that this "Allowed" trend understates the true allowed trend if there were no benefit buy-downs. This is true even though we are looking at allowed trends that include both the payer and member share of the expense because as the member's share of the cost rises it has an impact on the underlying utilization. This understates the utilization and therefore the total trend in the attached table.

6) INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND AND ALIGN 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 2017 Cost Trends Report, the HPC recommended the Commonwealth continue to promote the increased adoption of alternative payment methodologies (APMs) from present levels of 59% of HMO patients and 15% of PPO patients in 2016. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a) Please answer the following questions related to risk contract spending for the 2017 calendar year, or, if not available for 2017, for the most recently available calendar year, specifying which year is being reported. (Hereafter, a "risk contract" shall mean a contract that incorporates a budget against which claims costs are settled for purposes of determining the surplus paid or deficit charged to a provider organization.)
   i) What percentage of your organization's covered lives, determined as a percentage of total member months, is HMO/POS business? What percentage of your covered lives is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)
      1. HMO/POS 96%
      2. PPO/Indemnity Business 4%
   ii) What percentage of your HMO/POS lives is covered under a risk contract? What percentage of your organization's PPO/indemnity lives is under a risk contract?
      1. HMO/POS 32%
      2. PPO/Indemnity Business 0%
   iii) What percentage of your organization's HMO/POS lives is covered under a risk contract with downside risk? What percentage of your PPO/indemnity lives is under a risk contract with downside risk?
      1. HMO/POS 28%
      2. PPO/Indemnity Business 0%

b) Please answer the following questions regarding quality measurement in APMs.
   i) Does your organization plan to implement the core and menu quality measure set in all of your future global-budget based APM contracts, as applicable, with Accountable Care Organizations (ACOs) as defined by the Executive Office of Health and Human Services' Quality Alignment Taskforce (see Appendix A)?
      (a) If yes, what is your timeline for implementing the measures in contracts? If no, why not?

(b) Fallon currently uses the measures found in Appendix A as a menu from which providers can select components of their P4P program. Providers do not select all of the measures in Appendix A. As providers develop the membership volume required for a P4P program, these are the measures that are offered to them.

ii) What are your organization's priority areas, if any, for new quality measures for ACOs?

(a) Each year Fallon analyzes quality metrics to identify priorities. We are particularly interested in measures related to behavioral health, asthma and comprehensive diabetes care.

I, Richard Burke, am the President and CEO of Fallon Community Health Plan, Inc. (Fallon Health). I am legally authorized and empowered to represent Fallon Health for the purposes of this testimony. The responses contained in this submission were prepared

by employees of Fallon Health who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury on this 14th day of September 2018:

Richard Burke
President and CEO
Fallon Community Health Plan, Inc.