Exhibit B: Notice of Public Hearing

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)

      Response (required):
      1. Pharmaceutical costs, including medical injectable drugs
      2. Unit costs for hospital based services with continued expectations of annual fee increases that exceed the benchmark.
      3. Increase in the number of independent for-profit urgent care centers that offer convenient care that (a) is dis-integrated from the primary care practice without access to patient medical records, (b) can be duplicative for services, (c) has a need for follow up, and (d) may over-utilize labs and medications.

   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)

      Response (required): The first policy that Health New England would advocate is a moratorium on any new mandated benefits, including in the area of treatment for substance use disorder. Legislation is not, in Health New England's opinion, the appropriate avenue for making coverage determinations. These determinations should be evidence-based. During the 2015-16 legislative session, there were numerous proposed new mandates that were subject to a cost study by CHIA. Two of those,

long-term antibiotic treatment for Lyme disease and coverage for lipodystrophy syndrome, were enacted at the end of the formal session. In addition, there continue to be calls for increasing mandated coverage for substance use disorder by requiring 30 days of ATS/CSS coverage and/or expanding the levels of care that issuers must cover. Though some of the mandates may have a small financial impact on their own, the cumulative effect of continuing to add to the list of mandated services is to increase the cost of coverage for small employers and individuals, the only market segments that are affected by these state mandates. The push to increase the length of mandated coverage for ATS/CSS comes at a time when we have not yet been able to determine the effectiveness of the 14 days of coverage mandated by Chapter 258.

The second policy Health New England would advocate for is transparency requirements to be placed on pharmaceutical companies with respect to pricing decisions. All payers across the country, not just here in the Commonwealth, are experiencing the growth of prescription drugs as a percentage of total medical spend. This growth is driven by escalating prices in all segments of the pharmaceutical industry – generic, name brand and specialty. Health New England believes that requiring pharmaceutical manufacturers to explain the rationale for drug prices will bring additional accountability and lead to smaller price increases.

The third policy Health New England would advocate is a corollary of the second policy. Pharmaceutical companies, as significant players in the overall cost of health care, ought to be subject to the requirements of Chapter 224 to participate in these hearings for all of the reasons stated in the prior paragraph.

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)?

Response (required): Yes. One for Medicaid and Commercial and one for our Medicare line of business.

i. If yes, please identify the name of your PBM.

Response (required): OptumRx for Medicaid and Commercial lines and PTI/NPS for our Medicare line of business.

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	8.7%	0.1%	6.9%	14.2%
Medicaid	10.8%	11.4%	4.6%	18.0%
Medicare	13.6%	9.3%	12.5%	41.7%

*Commercial and Medicaid rates obtained from OptumRx quarterly review of key performance indicators. Medicare rates from our NPS performance summaries.

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).
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
Currently Implementing

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
Plans to Implement in the Next 12 Months

viii. Establishing alternative payment contracts with providers that includes accountability for pharmaceutical spending
Currently Implementing

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
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)

Response (required):

i. Risk sharing and shared savings contracts with local PHOs.
ii. Bundled payments for specialty services modeled like CMS bundles.
iii. Capitation arrangements with primary care provider groups.

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)

Response (required):

i. Physician buy-in.
ii. Practices cannot change model of care delivery for just one payer.
iii. Payment models for medical care do not support need for addressing social determinants of health for high cost patients.

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.

Response (required): Most of the smaller providers have the option to join a PHO for contracting and administrative support purposes and many are doing so.

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).

Response (required): We are closely following the development of APMs in the Commonwealth and specifically the technical aspects around quality measures, patient attribution and risk adjustment. Examples of models in use or soon to be adopted in the Commonwealth include the BCBS AQC program, Medicare Shared Savings Program (MSSP), Medicare NextGen, and the MassHealth ACO payment reform effort.

We have a long-standing history of working with providers around APMs. The models typically were designed as total cost of care approaches where all medical and pharmacy related expenses were evaluated against a budget. The budget has standardly been developed as a percentage of premium, age/gender and product mix adjusted. Incentives for quality are distinct, sitting outside and not influenced by the financial performance of the APM. As a predominantly HMO product design health plan, the APM programs use the primary care provider selection/assignment as the driver for patient attribution.

As we have been following the new models under development, we are evaluating a series of changes to our current APMs to align several key common elements with the

other plan or governmental driven APMs. We have engaged the consulting firm Milliman to assist in evaluating a variety of key concepts including a move to a risk adjusted budget using a methodology such as HCCs, connecting the financial component with the quality goals and adding initial corridors for savings to be achieved.

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)

Response (required): There are a variety of barriers to alignment around the technical aspects mentioned in the previous question. Barriers include differences in the underlying population, programs defined uniquely by different governmental entities and general provider acceptance.

The differences in populations between commercial, Medicare and Medicaid are a barrier to alignment with APMs. For example, certain risk adjustment methodologies don't account for pediatric conditions, so the use of a common risk methodology or mechanism model is hindered. Greater collaboration and consistency around the use of risk adjustment methodologies between government agencies may help overcome this barrier.

Each APM program rolled out by government is using different approaches. For example, Medicare, Medicaid and the GIC each use different risk adjustment tools, each handle quality uniquely and each develop a budget or target in a distinct manner. Greater collaboration between government agencies may help overcome this barrier.

Provider acceptance of APMs is varied depending on the underlying payment structures and levels of reimbursement. Providers are wary to share risk on a Medicaid population due to payment structures that don't distinguish the risk of the service and inadequate payment levels. Providers have thin margins, limited capital and limited risk management capabilities. Providers entering into APMs need to be vetted for both capabilities and financial resources.

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)

Response (required): We have instituted a comprehensive, proactive approach to supporting members in need of treatment for substance use disorder. In the spring of 2015 we formed a Substance Abuse Work Group, headed by a Medical Director and including representatives from all relevant departments including Pharmacy, Care Management, Utilization Management, Behavioral Health, Payment Integrity, Provider Contracting and others. Steps taken to increase access to pharmacologic treatment have included adding methadone maintenance treatment coverage for commercial members (already covered for Medicaid) with no copay, removing prior authorization for Suboxone, and having our social case managers assist members in finding sites for delivery of Vivitrol injections.

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)

Response (required):

1. Lack of access to the Prescription Monitoring program for the state. Access to this by health plan medical directors and pharmacists would allow more timely identification of members at risk for or with substance use disorder so that our care management team could provide outreach and help in linking these members to services and prescribers.
   Address this by giving access to health plan professionals.

2. Legislation focused on requiring coverage for longer and longer inpatient and residential care is pulling resources from outpatient pharmacologic treatment to less successful inpatient care.
   Address this by strong education efforts for legislators to understand best practices in substance use disorder treatment.

3. Lack of interest by primary care providers in adding suboxone treatment to their general primary care practice.
   Address this by development of an Addiction Specialist resource for primary care providers modeled on MCPAP.

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?

Response (required): We offer telehealth services through Teladoc, a national company that offers access to a board certified physician 24/7 for low acuity medical conditions.

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.)?

Response: We currently offer support for several telehealth pilots focused on access to specialists for its commercial members. It is also supporting telehealth services for behavioral health services with a local provider group to improve access.

i. 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.)?

Response: For pilot projects – equivalent. For national telehealth service, less than an office visit with equivalent copay.

ii. If no, why not?

Response: N/A

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.

Response:

ii. If no, why not?

Response: While we have evaluated cash-back incentives to encourage members to seek care at high-value providers in the past, we have not done so. We believe that we do not currently have complete tools to allow our members to make a provider choice that includes all aspects of high value, such as quality measures, as opposed to simply cost. With that said, we are still in the process of fully implementing all of the tools available with our cost transparency tool. As we continue to develop the product we plan to build in more information around quality of care. At that time, we may reevaluate this option.

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.

      Response:

   ii. If no, why not?

      Response: As mentioned in the previous response, we are still in the process of fully implementing all of the tools available with our cost transparency tool around quality of care which may allow us to fully evaluate quality of primary care physicians. Currently our tool is focused on cost of services by provider.

8. Strategies to Increase Health Care Transparency.

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

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**		0
	Q2	243*	1
	Q3	344*	3
	Q4	405*	1
CY2016	**Q1**	481*	2
	Q2	456*	0
	TOTAL:	1929*	7

*Total number of visits to the Health New England Treatment Cost Calculator Homepage

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).

Response (required): Health New England does not break trends out to include change in provider mix. Summary table is included in Attachment AGO Payer Exhibit 1. Exhibit 1 is attached

HPC Payer Exhibit 1 081116.xlsx

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.

Response:

Exhibit C: AGO Questions for Written Testimony

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	**Response (required):** 85%
PPO/Indemnity Business	**Response (required):** 15%

    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	**Response (required):** 58.4%
PPO/Indemnity Business	**Response (required):** 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	**Response (required):** FF=0% SF=16%
PPO/Indemnity Business	**Response (required):** FF=0% SF=16%

    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?

Response (required): Most of our risk contracts are based on a budget tied to a percent of premium for the membership assigned to that contract. Pharmacy is included in that premium base. The one exception utilizes a budget based on a set year's experience and applies a trend for future years under that agreement. However, this budget includes pharmacy in the base as well.

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?

Response (required): Pharmacy discounts and rebates are incorporated into the experience of the overall budget by contract. Discount and rebate credits are allocated to the various contracts based on membership.

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	Provider Mix	Service Mix	Total
CY 2013	5.0%	-2.7%			2.1%
CY 2014	4.7%	-1.7%			3.0%
CY 2015	4.7%	5.4%			10.4%

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.