

**Health Policy Commission
Public Hearings – Health Care Cost Trends in the Commonwealth**

**CeltiCare Health Plan of Massachusetts, Inc.
NAIC #13632**

September 16, 2013

I am Dr. Robert LoNigro, Interim President and CEO of CeltiCare Health Plan of Massachusetts, Inc (CeltiCare). Thank you for the opportunity to provide testimony regarding health care cost trends in the Commonwealth. The testimony provided serves as CeltiCare's response to the set of questions outlined in Exhibits B, C and D of the 8/16/2013 letter I received from Mr. Seltz.

I would like to provide a brief overview of our organization followed by responses to the questions.

Introduction

CeltiCare is a health maintenance organization whose home office and principal executive office are located in Brighton, MA. CeltiCare is a wholly-owned subsidiary of Celtic Group, Inc, which is a wholly-owned subsidiary of Centene Corporation, located in St. Louis, MO. Centene Corp. is a multi-line healthcare enterprise operating primarily in the Medicaid Managed Care and Specialty Services segments. As of May 2009, CeltiCare was licensed by the Commonwealth of Massachusetts Division of Insurance as an HMO. CeltiCare's business started on 7/1/09 through a benefit plan offering with the Connector Authority for the Commonwealth Care Program. As of 10/1/09, CeltiCare expanded our product offering to the Commonwealth Care Bridge program. Starting March 1, 2010, CeltiCare began marketing commercial individual and group products, including offering benefits through the Commonwealth Choice Program. CeltiCare has been accredited as a Qualified Health Plan with the Health Insurance Connector Authority. Our qualified health plans have been chosen as ConnectorCare plans and will be offered in six regions. We are waiting to hear of our participation in EOHHS' CarePlus Medicaid expansion program.

CeltiCare's unique model fosters member-centric care and incorporates the following attributes:

- A locally-based, integrated medical home care model, tailored to meet member needs and improve health outcomes;
- An accessible high quality, community-based provider network;
- The national expertise of its parent company, the best practices of 18 affiliate health plans and the support of 7 specialty companies, 5 of which are affiliates;
- A passionate team of associates with a singular focus to deliver the right care, the right way;
- Member incentives and provider reimbursement methodologies that encourage and reward preventive care utilization;
- Assurance that the right care is received in the most appropriate setting.

Exhibit B: HPC Questions For Written Testimony

1. C.224 sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012- CY2013 and CY2013-CY2014 is 3.6%.
 - a. What are the actions your organization has undertaken to ensure the Commonwealth will meet the benchmark?

CeltiCare Response: The actions CeltiCare has taken fall into four categories: Unit Cost, Utilization, Payment Reform and Care Management.

Unit Cost

- i. Network
 - a Initially a very limited network strategy
 - b Currently strategically expanding Network
 - to meet access standards for new products
 - to assuage member concerns around availability of desired providers
 - to offer Primary Care Providers greater access to specialty care providers
 - To provide more cost-effective tertiary care options
- ii. Place of service
 - a Prior authorization strategy to limit utilization of tertiary and quaternary facilities for services that are appropriately delivered in the community setting (at a lower unit cost)

Utilization

- i. Co-location and integration of physical health care managers, behavioral health care managers, and disease management staff to support the best opportunity for whole patient care by our health plan clinical teams
- ii. Participation in the Patient Centered Medical Home Initiative to support and foster improved clinical outcomes at the primary care practice level
- iii. Developed a prior authorization program for high-tech imaging consistent with what many other health plans in the Commonwealth already have in place
- iv. Prior authorization strategy to limit utilization of tertiary and quaternary facilities for services that are appropriately delivered in the community setting with a more efficient and cost effective "work-up" than is practiced in academic teaching centers

Payment reform

- i. Contracting with a subset of Providers to encourage greater focus on cost and quality, with opportunities for shared savings
- ii. Developing financial incentive programs to encourage the integration of physical and behavioral health care within and among a variety of different provider entities throughout the state, based upon the assumption

that such collaboration will lead to decreased resource utilization and improved clinical outcomes

- iii. Supporting the EOHHS primary care payment reform initiative by mirroring the program structure such that we are offering providers consistency in their overall approach, rather than asking providers to meet differing requirements from differing plan specific programs
- iv. Enhancing our IT support systems to provide data and management support to effectively manage insurance risk within a medical home or ACO model

Care Management

- i. Integrating Care Management efforts around whole patient care that emphasizes the intricate relationship between physical health, behavioral health, and socioeconomic needs.
 - ii. Risk stratifying our membership to identify members at risk, offering targeted outreach and support to members and families through innovative face-to-face programs such as Member Connections
 - iii. Leveraging our corporate structure that includes Behavioral Health Benefit Manager, Pharmacy Benefit Manager, Specialty Pharmacy Benefit Manager, Disease Management and Vision Benefit Manager to support our local plan, with an integrated solution that eliminates silos that lead to financially fragmented care
- b. What are the biggest opportunities you have identified at your organization to improve the quality and efficiency of care? What current factors limit your ability to address these opportunities?

CeltiCare Response:

Opportunities: In the subsidized population on which CeltiCare focuses, the integration of physical health and behavioral health care has provided a great opportunity to improve outcomes for members in both the physical and behavioral health domains. This is a multipronged effort which includes:

- i. The co-location of the clinical staff of our sister company, Cenpatico Behavioral Health with our own physical health focused clinical staff here in Brighton;
- ii. Incentivizing providers to develop care integration at the practice level, especially focusing on the communication between primary care and behavioral health providers;
- iii. Supporting the Patient Centered Medical Home Initiative that also encourages provider integration.

Barriers to above:

- i. Insufficient access to non-inpatient Behavioral Health services is at the forefront of conversation within the care delivery community

- ii. An equally important issue that has severely limited our ability to support an information sharing infrastructure between physical and behavioral health providers is the limitation on sharing certain behavioral health specific information among providers without evidence of a member-signed consent form on file. It is currently cost and resource prohibitive to selectively make behavioral health clinical information available to primary care, emergency department, and ESP providers through an electronic portal for only those members for whom we can determine have a signed consent on file. It is estimated that 50% to 70% of all primary care visits for which an individual has a specific complaint is associated with an underlying behavioral health component, either diagnosed or undiagnosed. We believe it is mission critical to make behavioral health information available to support urgent and emergent care efforts, but this limitation has created cost prohibitive barriers to developing such a system. The inability to share diagnoses, medication lists, and crises intervention to avoid hospitalization puts an unnecessary cost burden on the entire care delivery system and creates an inordinate gap in the ability to deliver just in time care for those most in need of it. We strongly encourage the state develop a dialogue with appropriate parties in the hope of developing a framework that can address this barrier.
 - iii. Additional barriers to effectiveness include our small plan size and lack of leverage that results from this.
- c. What systematic or policy changes would help your organization operate more efficiently without reducing quality?

CeltiCare Response: The increased state engagement pursuant to Chapter 224 in monitoring and reporting on market trends is extremely helpful, particularly to a smaller plan like ours. We encourage the state to continue and build on these efforts.

- d. What steps have you taken to ensure that any reduction in health care spending is passed along to consumers and businesses?

CeltiCare Response: Because our primary focus is on the subsidized population, cost savings that we have been able to achieve translate directly to savings to the Commonwealth of Massachusetts. To date, through the Commonwealth Care program, we have helped the state achieve significant savings through competitive rate reduction pressure that was not present prior to our arrival in the marketplace. We look forward to expanding our opportunities in this regard through participation in other state subsidized health care programs.

2. The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of growth in prices on medical trend and what have been the results of

these actions?

CeltiCare Response: This is an area that we have little to no control over given our current market footprint, and we look to the state for relief in this area. We support all efforts around cost transparency to support this issue. In order to optimize our unit cost of care, we attempt to adjust the place of service mix for services that are available in a community setting at a significantly lower cost than when delivered at a tertiary care center. To accomplish this, we have implemented policies requiring prior authorization for all services requested to be delivered in conjunction with a tertiary center. This has led to a more appropriate place of service mix, helping reduce overall cost. One particularly glaring challenge is the fact that in heavily concentrated urban centers, especially Boston, there are few if any non-tertiary-based options for care delivery outside of a practitioner's office. Additionally we have taken a disciplined approach to network development, favoring a partnership with those providers who are willing to participate in creative contracts that help foster payment reform and assume more responsibility for cost and quality.

3. C.224 requires health plans, to the maximum extent feasible, to reduce the use of fee-for-service payment mechanisms in order to promote high quality, efficient care delivery. What actions has your organization undertaken to meet this expectation? What factors limit your ability to execute these strategies or limit their effectiveness?

CeltiCare Response: CeltiCare began developing and implementing alternate payment methodologies (APMs) at the earliest stages of building our Massachusetts network.

- a. CeltiCare has maintained an ongoing contract featuring APMs with our largest provider which represents approximately 25% of our network. In this arrangement we provide upside-only shared savings to the Provider who achieves budget targets on the total cost of Member care in addition to meeting quality benchmarks. The agreement's quality and performance measures include diabetes, asthma, and prenatal care indicators as well as prescribing rates of generic medications when appropriate. Providers must meet or exceed agreed upon targets to receive shared savings and quality bonuses.
- b. CeltiCare has been an active participant in EOHHS' patient-centered medical home initiative (PCMHI). A shared savings component of the initiative ties payments to a Provider's ability to generate cost savings or trend reduction relative to a control group.
- c. CeltiCare is committed to assisting the Commonwealth in achieving its goals as expressed in the Primary Care Payment Reform Initiative as evidenced in the fact that all of our deemed contracts for CarePlus contain language that requires providers to negotiate agreements that meet the requirements outlined in the PCPRI should they become participants.
- d. CeltiCare is collaborating with 7 CHCs (2 in the Boston region and 5 in the Western region) to achieve greater integration of physical and behavioral health services. CeltiCare is rewarding PCP and BH Providers for documented communication between Providers as evidenced in the Enrollees' medical record.

Other program components include requirements for screening BH needs, and utilizing outcomes measures in developing and modifying BH care plans. CeltiCare will audit for evidence of signed records release documentation. Incentives will be based on financial outcome measures, promoting an APM strategy.

- e. There is 1 CHC in the Boston area with which CeltiCare is collaborating in a CMS grant program in which Enrollees will receive a tiered level of individual care management and support services, with a focus on care transitions and comprehensive CHC visits intended to address all physical and behavioral health (BH) needs in one visit (a departure from historically siloed visits). The CHC will receive a comprehensive primary care/BH capitation payment from CeltiCare for each Enrollee who participates in the program.
- f. CeltiCare is currently negotiating contracts with additional providers that include commitments to develop APMs that reward cost and quality.
- g. Celticare's broader strategy is to develop a comprehensive APM approach that aligns the right payment methodologies with the right providers to achieve the best outcomes.

Generally speaking, the biggest limitation to our ability to execute more robust APMs in which there is down-side risk as well as up-side, has been our size. Often larger membership numbers are needed in order to establish reliable baselines around which goals can be set and risk confidently assumed. Our small size can also make it more challenging to get provider engagement.

- 4. C.224 requires health plans, to the maximum extent feasible, to attribute all members to a primary care provider. Please describe, by product line, how your organization is meeting this expectation, including, as of July 1, 2013, the number of members attributed to PCPs, attribution methodologies used, the purpose to which your organization makes such attribution (such as risk payments, care management, etc.), and limitations or barriers you face in meeting this expectation.

CeltiCare Response: As of July 2013 all of CeltiCare's members had an assigned PCP. There are 3 key processes that CeltiCare utilizes for the purpose of assigning a PCP:

- a. Receipt of an Enrollee's personal PCP selection via a data file sent by the state (Commonwealth Care and Commonwealth Choice products)
- b. Post enrollment welcome call outreach during which the member is queried regarding PCP selection and assisted by a CeltiCare associate to select a PCP. Note that welcome calls to members who have not selected a PCP are prioritized in order to encourage self-selection.
- c. Use of an auto assignment algorithm if CeltiCare is unable to obtain a selection from a member.

Additionally, if/when a member wants to change a PCP, CeltiCare seeks to make this process as easy as possible. Toward that end, PCP changes may be made through multiple channels (web, call center, fax, on-line) that means a member can make a change 24/7. Changes are effective immediately.

To date, none of these processes are integral to a risk payment process.

5. Please describe programs you have implemented to engage consumers to use high value (high quality, low cost) providers. How effective have these efforts been? To what percentage of members and to which product lines does each program apply?

CeltiCare Response: Celticare was the first in the market to introduce a financial reward for members who participate in certain healthy behaviors. The CeltiCare CentAccount card offers members the opportunity to earn monetary rewards for completing a health risk screening upon enrollment and visiting a primary care provider on an annual basis. These funds can be utilized for purchase of healthcare related goods and services. This program has since been copied by market competitors. Our own internal data shows an increased engagement rate between member and provider, and enhanced identification of at-risk members. This program applies to all of our Commonwealth Care membership.

Additionally, please see descriptions above for our tertiary management program and provider network strategy.

6. Please describe the impact on your medical trend over the last 3 years due to changes in provider relationships (including but not limited to mergers, acquisitions, network affiliations, and clinical affiliations). Please include any available documents providing quantitative or qualitative support for your response.

CeltiCare Response: For the contract year 2012, Network Health Plan removed Partners hospital system and their PCPs from their covered network. As a result, the CeltiCare membership with a Partners PCP increased 57.9%. CeltiCare's members with a Partner's PCP were a higher acuity population and sought treatment at high cost facilities. Medical expenses reflected this change in contract years 2012-2013. A mutual decision was made to terminate the relationship with BWH and MGH PCPs as of July 1, 2013.

7. Please describe the actions that your organization has undertaken to provide consumers with cost information for health care services, including the allowed amount or charge and any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits as required under Chapter 224. Please describe the actions your organization has undertaken to inform and guide consumers to this cost information.

CeltiCare Response: CeltiCare takes every opportunity possible to ensure our consumers understand their benefits, how to access those benefits and cost information for health care services. To date, this information is provided to consumers via multiple different channels. CeltiCare's call center educates members during inbound calls, as well as outbound calls welcoming consumers to the Health Plan. Cost information is also made readily available through our secure web portal, where a member can easily ascertain current accumulation, cost sharing information such as copays, deductibles and co-insurance, as well as information regarding their claims history.

Additionally we are complying with an initial version of the Ch 224 Consumer Data Transparency tool requirement for a toll-free number and website that allows consumers to obtain cost information for admissions, procedures and services.

8. After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.

CeltiCare Response: The Attorney General's report dated April 24, 2013 and the Center for Health Information and Analysis's report dated August 2013 both focused on the commercial health insurance market. While CeltiCare has participated in the commercial market through Commonwealth Choice and its Direct products, our primary focus has been serving government subsidized programs, including Commonwealth Care and Commonwealth Care Bridge. Our total unsubsidized commercial membership over the last few years has never exceeded 500 members, and we were not one of the health plans reviewed by the Attorney General or CHIA for purposes of their reports. Nevertheless, based on our experience, we do offer the following comments on certain of the key findings in those reports.

Both the Attorney General's report and the CHIA report found that there continues to be significant variation in payment rates to providers. We have experienced this price variation in our provider contracts for our Commonwealth Care products, and we recently made changes to our network and are in the process of making additional changes to our network to mitigate the cost impact of the higher priced providers going forward. For our Commonwealth Care Bridge product and our commercial products over the last few years, we developed a narrow network in order to avoid higher priced providers and offer lower cost products.

In addition, the Attorney General's report recommends various steps by the Health Policy Commission, CHIA and other state agencies to work with stakeholders to promote a value-based health care market and to support efforts to improve health care delivery systems. Improved transparency around market dynamics like price variation and transitions to global payments and other alternative payment methods will make a significant difference in assisting – and driving – market changes toward a more value-based system. The role of Commonwealth agencies in supporting and promoting these market changes is particularly important for a smaller health plan like CeltiCare which faces more challenges in influencing and driving change in the market due to its relatively small size.

Exhibit C: OAG Questions For Written Testimony

1. Please submit a summary table (see attached) showing actual observed allowed medical expenditure trends in Massachusetts for CY 2010 to 2012, YE Q1 2012, and YE Q1 2013 according to the format and parameters provided and attached as AGO Exhibit C1 with all applicable fields completed. Please explain for each year 2010 to 2012 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).

CeltiCare Response: Please see Attachment A

2. Please submit a summary table showing your total membership for members living in Massachusetts as of December 31 of each year 2009 to 2012, broken out by:
 - a. Market segment (Hereafter “market segment” shall mean Medicare, Medicaid, other government, commercial large group, commercial small group, and commercial individual)
 - b. Membership whose care is reimbursed through a risk contract, by market segment (contracts that incorporate a per member per month 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 do not subject the provider to any “downside” risk; hereafter “risk contracts”)
 - c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity)
 - d. Membership in a tiered network product by market segment (Hereafter “tiered network products” are those that include financial incentives for inpatient and outpatient services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)
 - e. Membership in a limited network product by market segment (Hereafter “limited network products” are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)
 - f. Membership in a high deductible health plan by market segment (“high deductible health plans” as defined by IRS regulations)

CeltiCare Response:

The table below gives the membership for CeltiCare on December 31st of each year. The breakout of our membership includes –

- a) Three distinct market segments: the Commonwealth Care, the Commonwealth Care Bridge and the Commonwealth Choice/Commercial segments;
- b) Membership whose care is reimbursed through a risk contract occurs in the Commonwealth Care market segment.
- c) All of our Commercial products providing fully-insured individual or small-group coverage;
- d) The same network of providers within each segment with members facing the same cost-sharing requirements regardless of the provider as long as they are in-network;

- e) A smaller, lower-cost network of providers for our Commercial product relative to our Commonwealth Care product.
- f) CeltiCare does not offer a high-deductible health plan as defined by IRS regulations.

	2009	2010	2011	2012
<u>Commonwealth Care</u>				
Plan Type I	651	3,103	7,248	10,733
Plan Type II	868	8,668	10,373	6,420
Plan Type III	<u>137</u>	<u>2,537</u>	<u>4,011</u>	<u>2,659</u>
Total	1,656	14,308	21,632	19,802
Total Risk	26.1%	21.4%	29.3%	35.7%
<u>Commonwealth Care Bridge</u>	26,127	21,609	13,411	0
<u>Commercial*</u>				
Gold	0	9	42	47
Silver High	0	15	103	133
Silver Medium	0	2	128	169
Silver Low	0	3	12	16
Bronze High	0	73	12	11
Bronze Medium	0	47	2	1
Bronze Low	<u>0</u>	<u>36</u>	<u>15</u>	<u>16</u>
Total	0	185	314	393
Grand Total	27,783	36,102	35,357	20,195
* Commercial membership combines the CeltiCare Direct and Commonwealth Choice member counts.				

3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2009 to 2012, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership.

CeltiCare Response: When CeltiCare started accepting members in 2009, the largest product line was Commonwealth Care Bridge (we were the sole provider of this coverage in Massachusetts). This program was open to legal immigrants in Massachusetts that were not eligible for the Commonwealth Care program and offered similar but reduced coverage.

Enrollment in Commonwealth Care Bridge was frozen in December 2009 and no new members were allowed. As a result, our membership in this segment steadily eroded over time as members “timed out” of this program or became eligible for the Care program.

Based on a ruling by the Massachusetts State Supreme Judicial Court that deemed this insurance product unconstitutional, the program was terminated as of February 29, 2012 and

all Bridge members were integrated into the Commonwealth Care program on March 1, 2012.

4. Please describe your models for risk contracting since 2009. Include, for example, the structure and elements of such contracts, the role of any non-claims based payments, the role of any trend factors or growth caps, the role of any adjustments to risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, and insurance product populations to which your risk contracts apply (e.g., HMO, PPO, self-insured, fully insured).

CeltiCare Response: Please see the response to question #3 of the HPC question set.

5. Please explain and submit supporting documents that show how you quantify, and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully-insured members. Include in your response any adjustments for changes in health status, individual or aggregate stop loss insurance, claims truncation thresholds, distinction you make between performance and insurance risk, adjustments for risk due to socioeconomic factors, and any other ways in which you mitigate the transfer of insurance risk to providers.

CeltiCare Response: To date, CeltiCare's approach to alternative payments to incentivize better cost and quality outcomes has not included global payments or other alternative payments that shift downside risk to providers. Consequently, we do not have any relevant experience that is responsive to this question. See our response to question #3 of the HPC question set for a description of the types of alternative payments we have used and are in the process of developing.

6. Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider's size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.

CeltiCare Response: As noted above, CeltiCare has not yet entered into a contract with a provider that shifts downside risk to them. In order to make further progress in implementing alternative payment arrangements consistent with state objectives and with our goal of achieving better health outcomes at lower costs, we are currently in the process of developing a standard approach for evaluating the capacity of providers to enter into a risk-based contract and, more broadly, to determine what types of alternative payment arrangements would be most appropriate for a particular provider. Factors that we plan to take into account as part of any such evaluation include, but are not limited to, the provider's location, panel size, financial ability to sustain risk, performance management capabilities and degree of system integration.

7. Please explain and submit supporting documents that show for each year from 2009 to 2013 the average difference in prices for (1) tiered network products as compared to non-tiered network products; and (2) limited network products as compared to non-limited network

products. Include an explanation of assumptions around these price differences, such as, (a) for tiered network products, expected utilization shift to tier 1 providers, unit price differences between tier 1 and tier 2 providers, and benefit differences between tiered network and non-tiered network products, and (b) for limited network products, unit price differences between limited network and non-limited network providers, and differences in benefit and member health status between limited network and full network products. In addition, please summarize any analysis performed on these products that validates or disproves the assumptions used.

CeltiCare Response: Not applicable

8. Please describe and submit supporting documents regarding any programs you offer purchasers and/or members (including your employees) that promote health and wellness (hereinafter “wellness programs”). Include in your response any analyses you have performed regarding the cost benefit of such wellness programs.

CeltiCare Response:

Care Management

CeltiCare believes that an integrated whole-person approach to care management enhances health outcomes, reduces health care costs and improves access to health care. Care management services are provided for members with complex medical, social and behavioral conditions. Care management serves as a means for achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The goals of care management are to identify and mitigate barriers to care, decrease fragmentation of care across settings, enhance the member’s quality of life and promote efficient utilization of health care resources. CeltiCare’s medical and behavioral health care management staff are co-located and supported by a shared care management data platform.

CeltiCare assigns a risk score to Members based on analysis of claims paid, using Centene’s Centelligence Foresight predictive modeling tools. This software identifies opportunities for increased use of preventive services, stratifies members according to risk, and provides member profiles showing historical diagnoses, care episodes and service utilization. It also provides patterns of utilization by members with specified conditions at risk of over- or under-utilization, such as asthma, cardiovascular disease and chronic neuromuscular conditions. CeltiCare Care Management staff proactively contact members and enroll them in disease or case management before their condition worsens. The focused Centelligence reporting and analytical capabilities allow CeltiCare to better serve our Members through quicker identification of intervention opportunities – all of which are electronically fed back into EDW for import into our clinical management system, triggering subsequent action by our case managers.

Disease Management

CeltiCare's disease management programs are disease specific and evaluated for relevance to the health plan's membership demographics and utilization patterns. Our DM programs are accredited by NCQA and URAC. The major components of each program include:

- Identification of members with specified diagnosis
- Stratification or classification of these members according to the severity of their disease, the appropriateness of their treatment and the risk for complications and high resource utilization
- Provision of proven interventions that will improve the clinical status of the member and reduce the risk for complications and long-term problems
- Involvement of the member, family, and physician to promote appropriate use of resources
- Education of patient and family to promote better understanding of disease and improved self-management

CeltiCare's current disease management programs include the following:

- Asthma
- Diabetes
- Back Pain
- Coronary Artery Disease
- Chronic Obstructive Pulmonary
- Heart Failure
- Hypertension
- Hyperlipidemia
- Tobacco Cessation

MemberConnections® Program

MemberConnections is CeltiCare outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. This program promotes health, connects members with quality health care and community social services, and provides home visits for the most at-risk members. By connecting MemberConnections Representatives (MCRs) to individual members, the program creates a vital link between members and their Primary Care Providers, and other healthcare providers and community services. MCRs contact members by phone, mail and home visits to provide education on navigating the healthcare system. MCRs may also be a valuable source of information on health benefits, access to services and physicians. MCRs also use assessment tools, such as home safety or environmental risk assessments to identify "high risk" members and assist them in accessing care and services. The program recruits bilingual/multilingual staff from the local community to establish a grassroots support and awareness of CeltiCare among members of the community being served. MCRs are familiar with the community, knowledgeable about Plan benefits, and familiar with local agencies and services. The program is an integral part of our integrated care management program and has multiple components that can be provided depending on the need of the member.

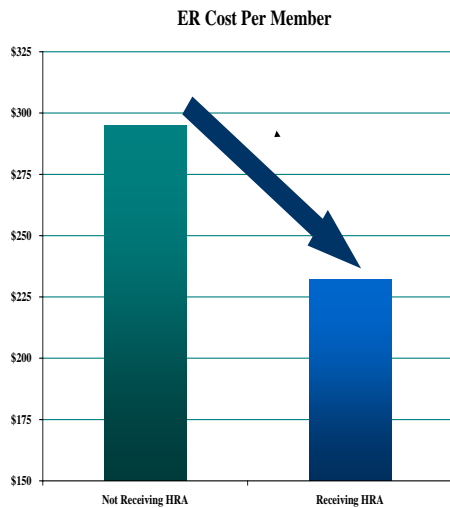
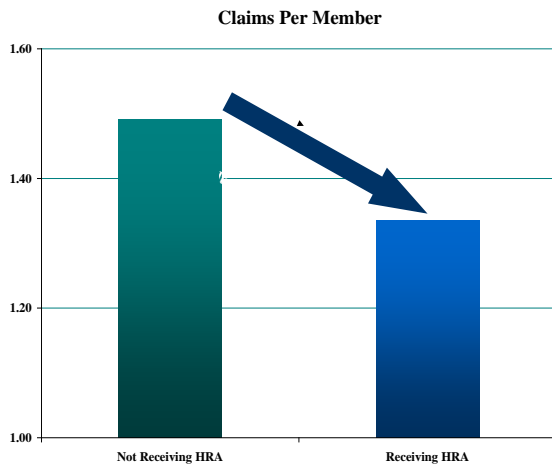
ConnectionsPLUS

As part of the Member Connections Program, ConnectionsPLUS provides free cell phones to high risk members who do not have safe, reliable access to a telephone. When a member qualifies, a MCR visits the member's home and gives them a free cell phone with critical healthcare phone numbers preprogrammed in the phone. Members may use this cell phone to call their health plan case manager, PCP, specialist, other significant providers, NurseWise (our 24/7 nurse advice line), the National Domestic Violence Hotline, and 911. These free cell phones include a "walkie-talkie" feature that allows a case manager to call the member if they miss an appointment or need to contact the member for some other reason. This is accomplished by having the case managers keep a ConnectionsPlus phone in the office to text members.

CentAccount® Enrollee Incentive Program

This program offers valued, financial incentives to members for achieving healthy behaviors such as annual well-visits with PCPs and completion of the health risk assessment. This innovative program reflects CeltiCare's continuous efforts to design new programs that lead to healthier outcomes for our members. The program was designed to strengthen the relationships between our members and their primary care providers and increase utilization of preventive care services. New rewards will be added to the CentAccount card after completion of each healthy behavior. The CeltiCare CentAccount program utilizes industry leading technology to restrict card purchases to healthcare related products at stores and pharmacies that accept MasterCard® debit cards or for health-related services at healthcare provider offices that accept MasterCard® debit card. The CentAccount card not only strengthens the relationship between members and their Medical Home, but also promotes personal healthcare responsibility and ownership. Since the inception of the program, over 40,000 CeltiCare members across all programs have earned a CentAccount card by completing a healthy behavior eligible for reward. This innovative program – which was featured as a best practice in the Medicaid Health Plans of America Best Practice Compendium 2012 and was the winner of a Case in Point Platinum Award for Case Management in 2012 – reflects CeltiCare's efforts to design programs that lead to healthier outcomes for our Enrollees.

CentAccount outcomes for Centene relative to reduction in claims per member and ER cost reductions are demonstrated in the tables below:



Start Smart for Your Baby®.

Start Smart for Your Baby (Start Smart) promotes education and communication between pregnant members and their case managers to ensure a healthy pregnancy and first year of life for their babies. Start Smart offers a range of care management techniques, including health screenings, educational literature and MP3 players with educational podcasts designed to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease which can result from high-risk pregnancies. The program provides educational materials as well as incentives for going to prenatal and postpartum visits. (See Start Smart 2012 trended data in the table below)



Puff Free Pregnancy

This program targets pregnant members who are identified smokers through health assessments or pregnancy notification processes. A Tobacco Cessation Specialist provides outreach to the member that includes an initial assessment call to establish smoking history and interest in the program. Once enrolled, members receive a welcome letter, tool kit, and counseling calls at 1-3 week intervals during the pregnancy. A call will be made within one month after the baby is delivered to see if the mother is still not smoking. Information will be provided on drug therapies as an option after she's done breast feeding and refer her to support services if appropriate.

Balance Program

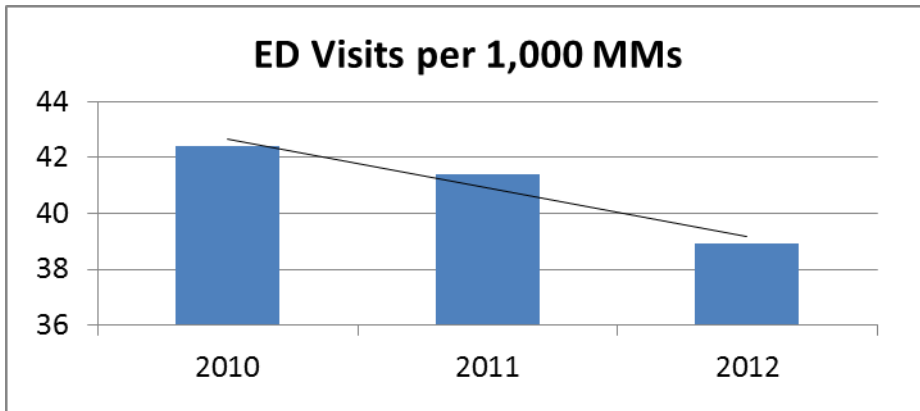
This program is offered through CeltiCare's affiliated health management company, Nurtur Health, Inc. Balance brings together work-life support and health management services in one program. Balance is designed to help people at all life stages address the barriers that get in the way of health as well as the health issues that complicate life. This program provides comprehensive online support and resources, unlimited telephonic consultation and referrals (Life Stage Support) and telephonic health coaching (Disease Management) that, together, seamlessly supports all aspects of work, life, and health.

Post Discharge Member Outreach

CeltiCare members who are discharged from non-contracted facilities are contacted by a medical management staff person within 48 hours of discharge. The purpose of the contact is to assess for case management opportunities, identify any knowledge gaps and redirect the members to a plan provider.

Emergency Department Member Outreach Initiative

Members with frequent emergency department utilization are contacted by CeltiCare medical management staff to identify and address barriers to care; increase the member's ability to self-manage symptoms and encourage preventative and non-emergent acute care services at the appropriate primary care physician level of care. As a result of these efforts, CeltiCare has noted a year over year decline in emergency room utilization as noted in the table below:



Healthy Pathways

Healthy Pathways is a voluntary health and wellness program offered by Centene to its employees designed to help employees get healthy – and stay that way. Healthy Pathways does this by:

- Offering health coaches who can help employees lose weight, get more physically active, lower blood pressure or cholesterol, manage chronic conditions and even quit smoking.
- Promoting the *Healthy Pathways* website, which features interactive tools and trackers, videos, podcasts and other resources to help employees live a healthier life.
- Offering preferred health plan options and contributions toward tax-deferred health spending accounts for employees who participate.

Successful completion of program requirements qualifies eligible employees to receive incentive rewards, including preferred health plan options.

All Centene employees who are **benefit-eligible** are able to participate in the program. Benefit-eligible employees who are not enrolled in Centene’s health insurance are eligible to earn incentive rewards, but they are not eligible for preferred health plan options. To earn incentive rewards, employees must complete a combination of the following:

- Health Risk Assessment (HRA)
- Biometric screening
- Health advising
- Tobacco Cessation Program (Required for employees with a positive nicotine test)
- Disease Management coaching (Required for employees with a chronic condition)
- Lifestyle Management coaching
- Verifiable activities (such as age appropriate health, dental, vision preventive screenings, sessions at a gym or fitness studio, timed road race or weight management program participation)

In 2012, the estimated savings resulting from the reduction in health risk from health coaching was \$798,486 and the claims-based ROI for this program was 1.51:1.

Exhibit D: CHIA Questions For Written Testimony

1. Do you analyze information on spending trends (e.g. TME) and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative?
 - a. If so, please provide such information on the performance of these entities compared to other Massachusetts provider entities. If available, please provide the information with and without health status adjustment, and the number of member months associated with the identified and comparative providers.

CeltiCare Response: CeltiCare has no membership that is participating in a Pioneer ACO. We do have membership in the PCMHI, and have been participants in this program from its beginning. We have had approximately 20% of our membership participating in PCMH practices, though this has never resulted in more than 400-500 CeltiCare members in any given practice, so our ability to analyze activity at the practice level has been quite limited. On an aggregated basis, however, CeltiCare has relied upon its participation in the PCMHI Shared Savings Steering Team to develop the appropriate statistically valid measurement strategies to evaluate TME and whether or not true savings are likely to have occurred as a result of the pilot.

We have done some ad-hoc reporting to understand differences in Emergency department utilization as a proxy for overall success in activating the member/ provider relationship, and in decreasing resource utilization. Attachment B is one such evaluation which looks at members with multiple ED admissions over a fixed time period. We have not risk adjusted this data, but have used the entire membership in PCMHI as compared to the remainder of our book of business in the Commonwealth Care Program. There is a significant reduction among PCMHI members as compared to non-PCMHI members.

This concludes CeliCare's testimony. Thank you for the opportunity to respond to your questions regarding health care provider and payer costs and cost trends.

Statement:

I, Robert LoNigro, Interim President and CEO of CeliCare Health Plan of Massachusetts, Inc., am legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury.

A handwritten signature in black ink, appearing to read "Robert LoNigro", with a long horizontal line extending to the right from the end of the signature.

Robert LoNigro, M.D.
Interim President & CEO

ATTACHMENT A

Exhibit C1 AGO Questions to Payers

****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 2010	17.6%	-13.5%	0.0%	0.1%	1.8%
CY 2011	5.5%	34.9%	0.0%	1.3%	44.2%
CY 2012	14.3%	8.5%	0.0%	-4.8%	18.1%
YE Q1 2012 (April 1, 2011 - March 31, 2012)					38.5%
YE Q1 2013 (April 1, 2012 - March 31, 2013)					7.5%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix changes. 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 change in the types of providers. 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.

ATTACHMENT B

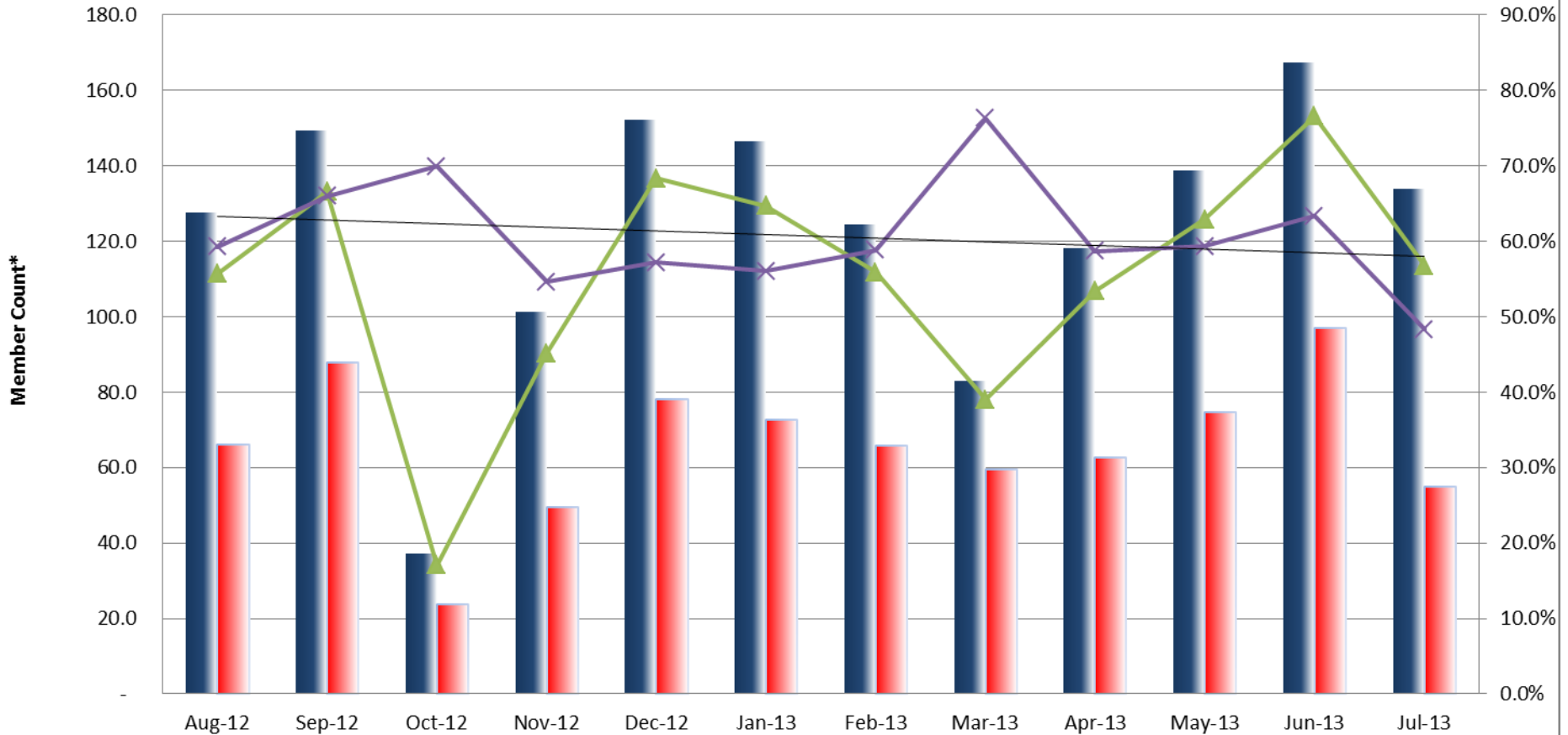
**Emergency Department Utilization by enrollment in PCMHI vs not enrolled in PCMHI.
Member Count = Members with multiple ED visits in the preceding 3 months**

Member/1000	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	12 Mos Avg
Non-PCMHI	127.5	149.3	37.1	101.3	152.2	146.4	124.5	83.0	118.1	138.9	167.4	134.0	123.3
PCMHI	66.1	87.9	23.8	49.3	78.2	72.6	65.8	59.6	62.6	74.6	97.0	54.9	66.0
Grand Total	111.4	133.1	34.1	90.4	136.7	129.5	111.8	78.1	106.7	125.8	153.1	113.5	110.3
PCMHI %	59.3%	66.0%	69.9%	54.6%	57.2%	56.1%	58.8%	76.3%	58.7%	59.3%	63.4%	48.3%	59.8%

CommCare Membership	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	12 Mos Avg
Non-PCMHI	21,453	19,131	17,149	16,474	15,612	13,848	13,306	12,863	12,595	11,922	11,108	8,147	14,467
PCMH	7,629	6,827	5,037	4,377	4,143	4,134	3,650	3,425	3,257	3,056	2,845	2,844	4,269
Total	29,082	25,958	22,186	20,851	19,755	17,982	16,956	16,288	15,852	14,978	13,953	10,991	18,736

Member Freq Flier Count	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	12 Mos Avg
Non-PCMHI	228	238	53	139	198	169	138	89	124	138	155	91	147
PCMHI	42	50	10	18	27	25	20	17	17	19	23	13	23
Grand Total	270	288	63	157	225	194	158	106	141	157	178	104	170
PCMHI %	15.6%	17.4%	15.9%	11.5%	12.0%	12.9%	12.7%	16.0%	12.1%	12.1%	12.9%	12.5%	13.8%

ED Frequent Flier - Member Count Trend



	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13
Non-PCMHI	127.5	149.3	37.1	101.3	152.2	146.4	124.5	83.0	118.1	138.9	167.4	134.0
PCMHI	66.1	87.9	23.8	49.3	78.2	72.6	65.8	59.6	62.6	74.6	97.0	54.9
Grand Total	111.4	133.1	34.1	90.4	136.7	129.5	111.8	78.1	106.7	125.8	153.1	113.5
PCMHI %	59.3%	66.0%	69.9%	54.6%	57.2%	56.1%	58.8%	76.3%	58.7%	59.3%	63.4%	48.3%