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) The ability of the healthcare system to mitigate unit cost and utilization trend increases associated with unnecessary or avoidable hospital admissions/readmissions and unnecessary utilization of the Emergency Department.
2) The practice of exclusive contracts between health systems and health plans limits the expansion of cost effective programs such as One Care and Senior Care Options. When health systems limit their participation to only one plan in a certain region or county in Massachusetts, out-of-network costs rise for the rest of the population not in that exclusive plan. This potentially anti-competitive practice limits the expansion of these programs and leads to increased costs to the Commonwealth of Massachusetts in the long run. As the health care system in Massachusetts experiences more and more mergers between health systems, this practice, if not contained will continue to hamper the Commonwealth's ability to rein in costs for its most expensive and at-risk populations.
3) The continued rise in spending for prescription drugs.

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

1) As MassHealth progresses from Duals 2.0 concept to implementation, CCA believes that the imposition of fixed enrollment periods, applicable to the SCO and One Care programs, would significantly improve long-term cost trends for highly complex patients. CCA has been able to demonstrate the ability to improve the medical cost trend when members stay with the plan for a minimum required number of months. For example, for our highest need members in One Care (those with 7 or more chronic conditions), we have seen a decrease of nearly 21% in per member per month (PMPM) costs over a two-year period from initial enrolment. This longitudinal relationship with our members decreases our costs, and in turn the cost in these government programs. Fixed enrollment is an important tool that will decrease churn in and out of innovative duals programs in the future. Additionally, we are supportive of MassHealth's proposal to expand passive enrollment to the SCO-eligible population. Passive enrollment is the most cost effective way to increase participation in care coordination programs that are saving valuable resources and providing high quality of care.
2) CCA also recommends simplifying eligibility verification procedures enabling more timely responses from members with complex medical conditions who are challenged by the complexity of the current process. We believe that this simplification would reduce churn which has a direct impact on the effectiveness of programs that coordinate longitudinal care for complex residents of Massachusetts.
3) Enhanced flexibility regarding the current "two provider requirement" would help reduce barriers to expanding coverage into underserved regions of the Commonwealth. This

requirement negatively impacts CCA's ability to provide duals programs to those who would be better served in such programs. In addition, this requirement has resulted in CCA being forced to pay providers above market rates to be considered in network simply to fulfill the "two provider requirement" to meet network adequacy.

4) CCA believes that exclusive contracting in public payer programs inhibits patient choice and often forces individuals to choose between a Primary Care Partner relationship and a health plan or care manager relationship. Exclusive contracting has shown to be a compounding process, where the more some plans propagate exclusive contracts, the more competing plans begin to do so defensively, ultimately reducing the options to members throughout the state and increasing costs to the program.
5) CCA believes that full implementation of the statewide Mobile Integrated Health program would reduce avoidable use of the Emergency Department as well as unnecessary hospital admissions. In particular, our pilot mobile integrated health program with EasCare has reduced unnecessary Emergency Department usage.
6) CCA recommends implementing regulated rates of reimbursement for publicly funded programs operated through subcontracted organizations to minimize the impact of outlier patients, limiting rates paid for non-contracted network services, and incentivizing payment and technology innovations that leverage value based payment structures by payers. We believe that these improvements will lead to increased provider participation in One Care and SCO, while at the same time lowering out-of-network costs to the plans, and ultimately to MassHealth.

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) Continued investment in comprehensive primary care based interdisciplinary care teams that support patients in their home and/or community living environment and reduce both the medical and non-medical triggers for unnecessary acute care utilization.
2) Development of innovative disruptions to address acute exacerbations of chronic disease. CCA has multiple programs that are designed to disrupt the reactive medicalized model that often drives acute care utilization.
   A) Overlaying physician level consultation for members in the hospital setting to:
      - Improve the effectiveness of inpatient care;
      - Improve the medical discharge plan;
      - Ensure post-discharge continuity with the patient's providers; and
      - Reduce lengths of admission and limit readmissions.
   B) Employing a robust retrospective review of hospitalizations to drive reductions in inpatient admissions through:
      - Shared learning across the care management and care delivery teams;
      - Leveraging advanced analytics and predictive modeling to drive proactive intervention mitigating unnecessary hospitalization; and
      - Improved care planning and information sharing.
   C) Expansion of Mobile Integrated Health allowing specially trained paramedics to see and treat patients in their homes helping to avoid unnecessary visits to the Emergency Department and unnecessary hospital admissions.
   D) Expansion of programs that leverage predictive analytics and a trauma informed care approach to improve care and reduce spending for our members at high risk of Emergency Department utilization. Through our programs, we provide (1) enhanced engagement and support to those members identified as high risk for Emergency Department utilization and (2) specific care plan interventions including:

- Follow-up within 48 hours after an Emergency Department admission;
- Check-ins from a health outreach worker every other week; and
- Regular inter-professional case discussions.

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.
Navitus Health Solutions

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 (Navitus provides point-of-sale coordination drug utilization review edits and retrospective drug utilization review interventions, which are considered clinical programs)
☒Other: Delegated coverage determinations, preferred specialty pharmacy

c) Briefly describe the Massachusetts member populations managed by your PBM (commercial, Medicaid, fully-insured, self-insured, etc.).
Navitus manages CCA's Dual Eligible – Medicare/Medicaid populations for both SCO and One Care. Navitus also manages our smaller population of MassHealth-only SCO members.

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.
No

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 Other (please describe in a text box)

1) CCA requires that each member who is hospitalized receive close follow-up post hospitalization by a member of our clinical team. For optimal results, CCA's population often requires an in person visit by a member of the CCA care team. CCA ensures that members have adequate supply of the appropriate medications, necessary assistive devices, long-term support services, and are scheduled for appropriate follow-up with a provider. CCA also continues to follow the member closely after hospitalization and adjust the care plan as necessary in order to decrease the risk of readmission.

2) CCA recently launched a pilot program regarding complex transition of care service at Boston Medical Center in which CCA physicians follow patients during a hospitalization. Through this service, CCA makes recommendations for the inpatient plan of care, which are tailored to the unique needs of the member. CCA also collaborates on appropriate discharge planning, and then engages in telephonic follow-up for 72 hours post discharge, in addition to the standard CCA post-discharge protocol. CCA will leverage lessons learned from the pilot to improve transitions of care and contemplate additional pilot programs that could reduce readmissions.

3) Set to launch in 2019, CCA will begin routine Root Cause Analysis on all inpatient hospitalizations. This improvement project will help determine how best to leverage the skills of the Advanced Practice Clinicians while providing the highest quality care for our most vulnerable members. CCA will evaluate all readmissions with the aim of preventing future admissions based on those learnings. Our analysis will enable CCA clinicians to better leverage the tools and resources available to them and allow CCA's Advanced Practice Clinicians, to earlier assess, diagnose, and treat members and avoid unnecessary inpatient admissions.

☒Avoidable emergency department (ED) visits Other (please describe in a text box)
CCA's "We Care" pilot, launched in 2018. This pilot provides structured and enhanced Health Outreach Worker support to members who have been identified as frequent ED users, or based upon a predictive model, have been determined to be at a high-risk for ED utilization. These members are assigned to a Health Outreach Worker who maintains regular contact with the member, either in person or telephonically. Through such regular contact, CCA's goal is to establish a lasting therapeutic, trusting relationship between the Health Outreach Worker and the member. Although the sample is small, CCA has seen improved relationships and will be expanding the "We Care" program to the other clinical sites with a goal of enrolling 400 members into the program over the next 12-18 months.

☒Behavioral health integration into primary care (e.g., collaborative care model)
Other (please describe in a text box)
Each CCA member has an assigned care partner whose role includes coordination of care. In CCA's role as payer, the assigned care partner has access to all the utilized services along the continuum of

care and plays a key role in facilitating communication. CCA's behavioral health specialists provide consultation, education, and support on behavioral health issues as well as substance use disorder treatment and management. These specialists engage in significant care coordination for beneficiaries, including:

- Coordinating behavioral health treatment and addiction treatment at the request of the primary care provider and Long-term Supports and Services coordinator (LTS coordinator);
- Coordinating care and treatment interventions in collaboration with the LTS coordinator upon request;
- Offering ongoing support regarding symptoms, medication, resources, and intervention for the LTS coordinator; and
- Collaborating on necessary adjustments to the individualized care plan to ensure a successful transfer for members who are behaviorally and socially complex.

☒Pharmacologic or other evidence-base therapies for substance use disorder
Other (please describe in a text box)
CCA makes evidenced-based treatments for opioid use disorder available through CCA's network and clinical staff. Because the combination of medication assisted treatment and nonpharmacological based treatment, such as counseling, has proven to be the most effective treatment for opioid use disorder, CCA actively recruits providers able to provide both and provides non-emergency transportation to medication assisted treatment. However, CCA remains concerned about the availability of properly trained providers able to fulfill demand.

While overcoming the provider limitations can be addressed by increasing the amount of required education and training of providers, there is also a need to reduce administrative barriers such as rigid prior authorization requirements. The recently signed law, *An Act For Prevention and Access to Appropriate Care and Treatment of Addiction*, has helped reduce such barriers by requiring emergency departments to offer medication assisted treatment and requiring that facilities providing care and treatment to individuals with alcohol or substance use disorder maintain the capacity to treat such disorders with all FDA-approved medication assisted treatment modalities. However, CCA will continue to experience limitations for our members until there is wider participation by the health community in public programs serving the poor and disabled.

☒Peers and/or community health workers Other (please describe in a text box)
CCA Health Outreach Workers engage with members to provide concrete social service referral and support for benefits such as Supplemental Nutrition Assistance Program benefits and housing assistance. In addition, CCA leads members through a variety of Stanford evidence-based chronic disease self-management programs, including diabetes and depression. Finally, our Health Outreach workers deeply engage with our members to resolve housing issues, which are inextricably linked to an individual's healthcare costs. Housing assistance includes securing emergency housing, housing preservation and assistance with negotiating the Commonwealth's public housing court system.

☒Telehealth/telemedicine Other (please describe in a text box)
Tele-Psychiatry: CCA utilizes tele-psychiatry to improve access to psychiatric care and offer on-demand support to members in the community. Our field-based care managers can leverage tele-psychiatry to conduct joint consultations over the telephone with an off-site CCA psychiatrist while the care manager is in the home with the member. This technological innovation has improved efficiency and availability of psychiatric resources for members in need.

Life Pod: LifePod™ is a "voice-first" caregiver device, designed to improve the quality of life for CCA members and increase the reach of their care teams. Expanding on the capabilities of popular

smart speakers, LifePod™ proactively assists members, and their care teams, managing a day-to-day schedule, medications, appointments, activities, and entertainment. Voice-first technology supports adherence with a member's care plan, supports therapeutic life changes, and enables social connection, all correlative to decreased social isolation and improved overall health outcomes.

☒Non-medical transportation Other (please describe in a text box)
All CCA members are eligible for non-medical transportation. This includes taxi and car, or chair car service. Rides are typically curb-to-curb. Companion or escort for supervision is available as well. Rides are meant to help support member's ability to meet a wide variety of their needs, including grocery shopping, pharmacy visits, and periodic social visits.

☐Supportive temporary or permanent housing Required Answer: Click Here
☐Other: Click here to enter text. Other (please describe in a text box)

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." This requirement does not apply to CCA because CCA is not a carrier as defined in Chapter 176*O*. Furthermore, all of CCA's member are MassHealth eligible and none of CCA's members share in the cost of their care. Therefore, CCA members are unlikely to inquire about cost of their care.

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**		
	Q2		
	Q3		
	Q4		
CY2018	**Q1**		
	Q2		
	TOTAL:		

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?
NA

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?
NA

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.

Required Answer: CCA's member population, within our two product offerings: (1) Senior Care Options; and (2) One Care, increased from 14,430 members in 2014 to 22,628 members in 2017. During this period, the most significant portion of growth was in our under 65 duals demonstration product, One Care. The increase of members enrolled in One Care as a percentage of overall membership causes the overall service utilization of the product portfolio to be more reflective of the needs of the One Care members. Thus, for each of the years 2015 to 2017, a significant portion of the allowed claims trend is due to changing demographics of the population and the associated change in health profile.

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2015	-1%	6%	0%	4%	9%
CY 2016	-4%	0%	0%	5%	1%
CY 2017	0%	-2%	0%	0%	-2%

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 100%
2. PPO/Indemnity Business 0%

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 36%
2. PPO/Indemnity Business N/A

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 10%
2. PPO/Indemnity Business N/A

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)? Yes

(a) If yes, what is your timeline for implementing the measures in contracts? If no, why not?

(b) CCA has begun implementing this requirement in contracts for CY 2019

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

(a) N/A