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.
Response: 1) Pharmacy spend continues to be the #1 concern. There are no price caps or controls. Fewer branded drugs are coming off patent. 2) New lines of treatments and technologies related to cancer treatment such as CAR-T (chimeric antigen receptor) cell therapy, which uses transformed cells for cancer therapy. 3) The ability to meet the 3.1% benchmark could also be impacted by the result of the upcoming November ballot question (Question 1) regarding Mandated Nurse Staffing Ratio as well as future legislative activities aimed at dealing with Provider Price Variation and funding for Community Hospitals.

b) What are the top changes in policy, market behavior, payment, regulation, or statute would your organization recommend to address these concerns?
Response: Prescription drug costs have risen considerably in the last few years, and broad demand for high-priced drugs has led to significant increases in pharmacy costs for health plans, impacting member premiums. Pharmaceutical costs as one of the largest drivers of total health care expenditures. We therefore would like to see regulations to promote transparency of drug prices. Many states are considering enacting such regulations. This would require drug manufacturers to give notice to health plans and state purchasers several months in advance of a major price hike. It would also require manufacturers to lay out rationale for such price increases and for the prices of newly approved specialty drugs along with documentation of any improvement in clinical efficacy that their drugs offer over alternative treatments. We also would like to see a default rate established for emergency and nonemergency out-of-network services at the greater of 115% of the average rate the carrier pays for that service, or 125% of Medicare. In its 2017 report, the HPC found that the average spending on out-of-network claims far exceeded the average spending on in-network claims across a range of identical services. Average out-of-network payment rates for common emergency department visits were 70% higher than in-network rates. In almost 2/3 of the cases, the health plan paid the full charge amount of the out-of-network claim. In addition to the cost to members, out-of-network bills are costly for the health care system as a whole. Out-of-network issues can impact bargaining dynamics between payers and providers, and any statutory setting of a rate must be set low enough so as to incent providers to participate in carrier networks. An out-of-network reimbursement set too high will cause providers to leave networks and opt for the out-of-network rate, as is seen with emergency, radiology, anesthesiology, and pathology which account for over 90% of out-of-network claims. Additionally, we recommend establishing an out-of-netowrk default rate for reimbursement rates for payments to ambulance service companies. The majority of licensed ambulance providers in the state do not contract for emergency services because they are able to obtain higher rates by remaining outside of a health plan's network. Results of the HPC's most recent study on out-of-network billing in commercial health insurance found that the average spending on out-of-

network ambulance service claims far exceeds the average spending on in-network claims, by 22% to 227%. For non-emergency ambulance transportation services, average out-of-network payment rates exceeded $1,100, compared to an in-network average payment rate of approximately $340. The establishment of default rates for ambulance services will have a significant impact on keeping costs down and will remove the disincentive for ambulance service providers to avoid negotiating a reasonable rate with health plans.

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.
Response: Priority 1: Reduce growth in prescription drug spending.
Priority 2: Reduce over-utilization of unnecessary emergency room care.
Priority 3: Move provider mindset towards value based care.

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.
Response: Health New England has vendor relationships with two PBMs. We use OptumRx for our Commercial and Medicaid lines of business and CastiaRx for our Medicare line of business.

b) Please indicate the PBM's primary responsibilities below [check all that apply]
- ☒ Negotiating prices and discounts with drug manufacturers
- ☒ Negotiating rebates with drug manufacturers
- ☒ Developing and maintaining the drug formulary
- ☒ Pharmacy contracting
- ☒ Pharmacy claims processing
- ☒ Providing clinical/care management programs to members
- ☐Other: Click here to enter text.

c) Briefly describe the Massachusetts member populations managed by your PBM (commercial, Medicaid, fully-insured, self-insured, etc.).
Response: Health New England has vendor relationships with two PBMs. We use OptumRx for our Commercial and Medicaid lines of business and CastiaRx for our Medicare line of business.

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.
Response: No. Health New England members' cost share is always available.

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.

Response: No. Our contracts require the covered person to pay the lesser of their copay or usual and customary.

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.
Response: 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 Payment Penalty or Non-Payment
☐Avoidable emergency department (ED) visits Payment Penalty or Non-Payment
☒Behavioral health integration into primary care (e.g., collaborative care model)
Other (please describe in a text box)
☒Pharmacologic or other evidence-base therapies for substance use disorder
Fee-for-Service Reimbursement
☒Peers and/or community health workers Accounted for in Global Budget Payment
☒Telehealth/telemedicine Fee-for-Service Reimbursement
☐Non-medical transportation Payment Penalty or Non-Payment
☐Supportive temporary or permanent housing Required Answer: Click Here
☒Other: Claims editing, Audit Program and Fraud, Waste and Abuse Policies

4) STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

Chapter 224 of the Acts of 2012 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures, and services through a readily available "price transparency tool."

a) In the table below, please provide available data regarding the number of individuals that sought this information:

Health Care Service Price Inquiries CY2017-2018			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person *
CY2017	**Q1**	569	1
	Q2	404	0
	Q3	535	2
	Q4	405	0
CY2018	**Q1**	424	1
	Q2	498	4
	TOTAL:	2835	9

* We do not receive price inquires in person. Numbers represent telephone inquiries only.

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?
Response: We do not receive many cost of care inquiries, but for the few that we do receive, the biggest challenge we face is that members don't always know the name of the procedure/service/item that they are inquiring about. They will use generic terms such as "back surgery", "knee brace", or "CT scan of the head". There are multiple listings for these surgeries and identifying and quoting the cost of the correct procedure is challenging. We now offer to call the member's provider to try to confirm the specifics, but that can be challenging as providers aren't always available to provide this to us timely, thus causing a delay in quoting the estimated cost of care.

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?
Response: When a provider is initiating the cost of care request, we rarely have issues as the provider is able to give the specific CPT and/or HCPC code needed for us to provide the cost estimate.

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.

Response: Please see attachment HNE HPC Payer Exhibit 1-2018. Please note, Provider Mix and Service Mix are marked as N/A because Health New England's data sets do not accurately separate this data at this time.

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 80%
      2. PPO/Indemnity Business 20%

   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 71%
      2. PPO/Indemnity Business **Response:** Due to the identification of primary care affiliations and therefore connection to contracts, at this time Health New England cannot report this data.

   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 53%
      2. PPO/Indemnity Business **Response:** Due to the identification of primary care affiliations and therefore connection to contracts, at this time Health New England cannot report this data.

b) Please answer the following questions regarding quality measurement in APMs.
    i) Does your organization plan to implement the core and menu quality measure set in all of your future global-budget based APM contracts, as applicable, with Accountable Care Organizations (ACOs) as defined by the Executive Office of Health and Human Services' Quality Alignment Taskforce (see Appendix A)?
        (a) If yes, what is your timeline for implementing the measures in contracts? If no, why not?
        (b) **Response:** Health New England is currently evaluating the impact of the core and menu quality measure set as defined by the Executive Office of Health and Human Services' Quality Alignment Taskforce to ensure the chosen measures meet the current and future quality operations and improvement needs of Health New England and our provider network. Health New England updates its current core quality measure set utilized for APM contracts on an annual basis in the third and fourth quarter of the calendar year. If Health New England were to adopt the new core and menu quality measure set then the earliest this could be adopted in APM contracts would be for January 1, 2020.
    ii) What are your organization's priority areas, if any, for new quality measures for ACOs?
        (a) **Response:** Health New England is part of the BeHealthy Partnership. The Partnership is still measuring the current performance of the ACO and are awaiting a finalized slate of quality measures, given that updates were just made by EOHHS in August 2018. Priority areas will be identified and interventions will be created for the 2019 performance year.

HPC Payer Exhibit 1

All cells shaded in BLUE should be completed by carrier*

Response: Please note, Provider Mix and Service Mix are marked as N/A because Health New England's data sets do not accurately separate this data at this time.

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 2015	3.4%	1.8%	n/a	n/a	5.2%
CY 2016	1.5%	1.1%	n/a	n/a	2.6%
CY 2017	4.6%	0.7%	n/a	n/a	5.3%

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.