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

Please note that the responses below are for Tufts Associated Health Maintenance Organization's (TAHMO) commercial line of business only.

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) Pharmaceutical Cost Trends

The rising cost trend in pharmaceutical prices poses a significant challenge to meeting the cost growth benchmark. Providers and health plans have worked diligently to control many areas of medical cost and utilization, but we believe that neither has control over pharmaceutical pricing decisions. Both unwarranted increases in prices for existing drugs and high prices for new drugs on the market have caused pharmaceutical trend to increase at a rate nearly double the cost growth benchmark. Many providers who have long been comfortable with value-based arrangements are increasingly concerned with taking responsibility for pharmacy expenses because of manufacturer pricing control and the growth of new-to-market high cost specialty drugs. Although TAHMO believes that providers and health plans still play an important role in managing pharmacy trend through prescription choices, care management and pharmacy reconciliation, we also believe that, without systemic change in this area, this trend has the potential to derail cost control efforts.

2) Value-Based Reimbursement Effectiveness

TAHMO believes that a health system's or a provider group's effectiveness in managing the total medical expense of its patients is a prerequisite to the Commonwealth's ability to meet the cost growth benchmark. As TAHMO has increased the depth and breadth of value-based reimbursement among its contracted network of providers, we have seen improvements in both medical trends and quality of care. Value-based reimbursement has had the effect of: 1) reduced utilization; 2) introduction of financial incentives for lowering total medical expense trend; and 3) provider accountability with the introduction of both upside and downside financial risk. We expect to continue to see the effectiveness of these arrangements, albeit with a degree of moderation due to expected unit cost inflationary demands.

To continue to drive towards achievement of the cost growth benchmark, it will be critical to expand the adoption and implementation of value-based reimbursement. Recently, TAHMO expanded its value-based arrangements with selected providers to include self-funded clients and

non-primary care physician products. The future growth of this expansion will support adherence to the benchmark.

Finally, there are other provider groups that are limited in their ability to accept value-based contracts due to low volume that would not support provider financial accountability. Since these provider groups do not have the same incentives to manage total medical expense, this limitation poses a risk to achieving the benchmark.

3) Provider Consolidation

Provider consolidation and changing affiliation of health systems and provider groups is one of TAHMO's principle concerns with the ability to meet the cost growth benchmark. Provider consolidation can increase health care costs through both enhanced bargaining leverage and steerage of utilization into higher-priced facilities and provider groups. Provider consolidation can also increase costs when professional office-based services are billed with the addition of facility fees solely due to affiliation. While provider consolidation may theoretically create better communication and coordinated patient care among a provider ecosystem, realizing these benefits is uncertain and requires significant time and investment in technology, infrastructure and organizational processes for this to occur after an affiliation.

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

1. Pharmaceutical Cost Trends

While a federal policy response is likely needed to address pharmaceutical pricing, we support state-based transparency initiatives to gather more information on how pharmaceutical prices are set and how they impact the state's ability to meet the cost growth benchmark. This should include participation in the annual Cost Trends Hearings and the ability for the Attorney General to require pharmaceutical manufacturers to produce data and testify under oath. There needs to be shared accountability among health plans, providers and pharmaceutical manufacturers for meeting the benchmark.

2. **Value-Based Reimbursement Effectiveness**

It would be helpful to understand the degree and timing for which health systems and provider groups have accepted value-based arrangements across the full spectrum of public and private volume. This information would provide insight into the investments, infrastructure and funding of providers as they build population health capabilities. Specifically, it would be helpful to understand the degree of liability within each value-based arrangement in order to understand the level of risk that a provider is assuming. Finally, it would be helpful to measure the change in a provider's total medical expense as it relates to the timing of when a provider enters into a value-based contract, which would allow measurement of the effectiveness of such arrangements. For provider groups and facilities to engage fully with cost control efforts, there needs to be a commitment throughout the organization to focus on input cost structure. We support efforts to bring greater transparency to providers' underlying cost structure, which would help to determine which providers are efficient with respect to their input costs. Facilities should continue their efforts to monitor and improve upon existing cost structures, and provider groups would benefit from modifications to compensation structures that currently promote volume and productivity rather than population health and wellness.

3. Provider Consolidation

TAHMO supports policies that provide greater oversight of provider consolidation transactions.

This would include authority for the Health Policy Commission to conduct deeper, more longitudinal evaluations on cost, quality and value. TAHMO supports a regular, ongoing process by which regulators could evaluate and assess completed transactions to determine if providers are meeting their stated goals for pursuing consolidation, which often include increasing efficiency and quality, reducing health care unit costs for insurers and customers, and assuming greater accountability under value-based reimbursement.

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.
Three of TAHMO's primary strategic priorities to reduce health care expenditures are to: 1) increase the effectiveness of value-based reimbursement models; 2) reduce unnecessary hospital utilization; and 3) increase use of high value providers.

1) Increase the Effectiveness of Value-Based Reimbursement Models

TAHMO believes that it is essential that we work collaboratively with our providers that are reimbursed under value-based models to reduce health care expenditures. By pairing these types of arrangements with timely, actionable reporting and analytics and care management programs, we can equip provider groups with the information necessary to achieve cost management goals, which include the reduction of unnecessary utilization, the shifting of care to lower-cost providers, and the reduction of variation in practice patterns. We are evolving our reporting and data sharing with providers in order to incorporate additional patient demographic information that would help providers identify areas of opportunity in population subsets.

Additionally, as our membership migrates to self-funded clients and non-primary care physician products, we see opportunity to expand the population covered under value-based arrangements with providers who have succeeded in such arrangements with our HMO population. We have select provider groups that have accepted financial accountability for both self-insured and non-primary care physician products. We are in serious discussions with other provider groups to determine whether they are ready to expand financial accountability to these patients as well. This expansion in risk population will allow us to share and report data on a new pool of patients with providers, allowing them to better manage health and cost.

Finally, TAHMO believes that provider groups need to make material and substantial changes to the compensation structure of its employed providers to appropriately provide incentives to such employees to manage total medical expense and drive improvements in wellness. Such compensation changes should encourage the provider organization to implement population health based components while removing incentives for productivity and volume.

2) Reduce Unnecessary Hospital Utilization

TAHMO is consistently focused on reducing unnecessary hospital utilization from a variety of sources. We recently enhanced our initiatives on reducing avoidable emergency department utilization by reaching out to patients who access the emergency department for diagnoses that can typically be treated in provider offices. Through this initiative, we provide educational materials about alternatives to emergency care and assistance with the management of chronic conditions.

TAHMO reports rates of avoidable emergency department use to providers under value-based arrangements. TAHMO reviews these findings with providers on a regular basis, and both entities collaborate on action plans to address and reduce unnecessary ED use.

Additionally, we collaborate with providers to get real-time data exchanges of emergency department encounters, which provides TAHMO with opportunities for expedited patient outreach. TAHMO implemented a care management program that outreaches to patients within 7-10 days of an ED visit to discuss and promote wellness, clinical interventions and ED avoidance strategies.

Hospitals readmissions are reviewed concurrently and payment for any readmission is denied if the readmission was due to incomplete discharge planning or the same or similar condition. Although some readmissions are unavoidable, a readmission may also be the result of quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care. Therefore, TAHMO will be expanding its window of time between the admission and the readmission to14 days.

3) Increase Use of High Value Providers

TAHMO recently finalized an arrangement with a high-value provider designed to provide a bundled payment for substance use disorders which would allow the provider to have flexibility in the type of treatment. Further, we commenced discussions to implement a bundled payment with a high value provider for orthopedic services. This arrangement would also provide patient incentives to seek orthopedic services within the bundled payment arrangement. It is the intent of these programs to provide the delivery of high quality care that will result in cost savings through the use of high value providers, the effective management of post-acute care, and the avoidance of avoidable emergent care. Further, we are having additional discussions with providers on additional, similar programs.

2. INFORMATION ON PHARMACY BENEFIT MANAGERS

The HPC, other state agencies, payers, providers, and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. Pharmacy benefit managers (PBMs) play a major role in the market, significantly impacting drug pricing and access. Furthermore, PBM policies that restrict the ability of pharmacies and pharmacists to share certain information with patients have been an increasing area of focus.

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

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.).

CVS Health is the PBM for the entire Tufts Health Plan enterprise. For TAHMO, this includes both fully-insured and self-insured commercial business. CVS Health is also the PBM for our Medicare Advantage product and our Senior Care Options Product, both offered through TAHMO's Tufts Medicare Preferred. Please also see the Tufts Health Public Plans response to this question.

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. However, the member is automatically charged the lower amount if the pharmacy charges are less than the required copayment.

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 Other (please describe in a text box)
☒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
Other (please describe in a text box)
☐Peers and/or community health workers Required Answer: Click Here
☒Telehealth/telemedicine Other (please describe in a text box)
☐Non-medical transportation Required Answer: Click Here
☐Supportive temporary or permanent housing Required Answer: Click Here
☒Other: Click here to enter text. Other (please describe in a text box)

Avoidable ED
Rates of avoidable ED are reported to providers under value-based arrangements. TAHMO reviews these findings with providers on a regular basis, and both entities collaborate on action plans to address and reduce unnecessary ED use.

TAHMO also has a care management program that outreaches to patients within 7-10 days of an ED visit to discuss and promote wellness, clinical interventions and ED avoidance strategies. This program is supported by providers who share clinical data with TAHMO on patients receiving services in the ED. These outreach efforts often include: the provision of educational materials on the appropriate use of ED; information on how to reach physicians during off hours; information on the availability of urgent care services; and the offer to assist with finding a primary care physician if needed. Although some providers have partnered with TAHMO on providing this data in support of this outreach, other providers have not shown a willingness to collaborate on this initiative. Thus far, this program has shown effectiveness and TAHMO will continue to seek expansion with additional providers.

Behavioral Health Integration into Primary Care
The integration of behavioral health into primary care is an ongoing focus of our efforts as we continually collaborate with our provider partners. Behavioral health expenses are often included in provider risk contracts, and primary care physicians receive holistic claims information to manage across the medical and behavioral risk spectrum.

TAHMO has partnered with one provider under a pilot program arrangement whereby the provider is reimbursed for the integration of a primary care and behavioral health model. Under the pilot, the provider is reimbursed when a primary care physician engages with a behavioral health specialist to assess the need for behavioral health services.

Pharmacologic or other Evidence-Based Therapies for Substance Use Disorder
TAHMO recently finalized an arrangement with a high-value provider to offer a bundled payment for substance use disorders which would allow the provider to have flexibility in the type of treatment.

Additionally, TAHMO is currently working with other health systems to establish centers of excellence for community-based care for substance use disorder. These efforts include medication assisted treatment as well as other therapies. TAHMO maintains a substance use disorder navigator that assists patients and families with obtaining community-based resources. Further, TAHMO implemented and maintains a clinical program, staffed by nurse care managers, that helps patients who are dealing with chronic pain to obtain non-opiate treatments when appropriate. Finally, TAHMO has recently partnered with Delta Dental to help dentists improve safe prescribing practices and to promote opioid alternatives.

Telehealth/Telemedicine
TAHMO approaches telehealth via a two-pronged approach. First, TAHMO is working with multiple providers in the evaluation of models that would incorporate high-quality virtual visits into integrated care models. To date, these initiatives have focused on a diverse range of conditions, including after-hours primary care, behavioral health and specialty care, such as neurological conditions and pediatric specialties. TAMHO has also worked collaboratively with providers that have developed telehealth-based capabilities to begin adapting our system capabilities to this new technology. However, since many local practices are still developing telehealth capabilities, TAHMO also offers a second approach through a vendor, TelaDoc. TelaDoc is made available to the purchasers of health care coverage, providing subscribers and dependents with access to virtual visits.

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."

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**	10,847	116
	Q2	11,720	115
	Q3	8,826	168
	Q4	11,127	174
CY2018	**Q1**	4,035	156
	Q2	3,650	140
	TOTAL:	**50,205**	**869**

a) 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?

Barriers for accurate/timely responses to members are most often due to the need for more information from the provider to confirm the exact services being requested or to obtain more details to provide an accurate estimate. Member services representatives reach out to providers to obtain CPT codes, when needed, and additional information to process the request. Timeliness in response time is sometimes impacted by the date of services being rendered, and the member's initial outreach, while contacting the provider to obtain more information, if needed. (e.g., the member may reach out on the same day with limited information.)

Educating members at first contact regarding the information needed to provide accurate estimates and explaining the process can help address this barrier. We have also updated our search tool so that it provides estimates for a much greater number of episodes of care. In this respect, it should be easier for members to gauge what their entire care might cost from start to finish, even without specific codes.

b) 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?

Provider inquiries related to price information for the specified services are infrequent, but, when a provider requests such information, we work to respond to providers in a timely and accurate manner. For providers that use the online price tool, the wide range of prices provided via the

tool (due to contractual rates being masked) can cause some confusion. Providers who require additional price information may call TAHMO directly with their specific inquiry.

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.

On average, the aging of the population adds about 1% to trend annually, while the health status of the population increased by 1% to 2% per year. The impact of these changes (which are not normally exclusive) is seen primarily in the utilization trend. Other factors such as greater employee cost sharing and provider contracts encouraging quality over volume may have been factors in suppressing utilization trends during that time. TAHMO has observed a slight acceleration in the rate of benefit buy down over that period.

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 87%
      2. PPO/Indemnity Business 13%

   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 55%
      2. PPO/Indemnity Business 9%

   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 50%
      2. PPO/Indemnity Business 7%

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?

            For the Core measures, we often use the controlling high blood pressure and the diabetes Hba1c good control (<8) measures, as it is a more stringent and meaningful measure than what is specified in the Core measure set. We do not require use of the patient experience information from Massachusetts Health Quality Partners (MHQP), as these metrics are created outside of TAHMO, and MHQP's process and timing does not align well with our contractual cycle. We do not use the behavioral health metrics in most of our value-based contracts, as the denominator for TAHMO members in these measures is too small for meaningful improvement and measurement. In addition, many of the behavioral health measures require data that TAHMO does not have access to at this time. We include many of the Menu Aligned Measure set metrics in most of our contracts (colorectal cancer screenings, immunization for adolescents, cervical cancer screening rates, etc.).

            TAHMO has been actively engaged in the Executive Office of Health and Human Services' Quality Alignment Taskforce. Most of our current value-based arrangements already include one or more quality measures. In addition, almost all of the measures that TAHMO uses in our contracts are included in the Massachusetts Aligned Combined Measure Set. TAHMO's approach is to work with our provider partners to focus on a few of the most relevant and appropriate measures for each provider, as we believe a focused approach on a few metrics will more effectively improve quality for patients. The selection of metrics is informed by areas where TAHMO believes the provider can improve and areas where the provider's leadership has chosen to focus.

    ii) What are your organization's priority areas, if any, for new quality measures for ACOs?
        (a) We are working with provider groups to increase their use of appropriate outcome billing codes (CPTII, ICD10, HCPCS) and sending increased electronic medical record files in order for TAHMO to more accurately run, analyze and improve outcome measurement.

Exhibit C1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

TUFTS HEALTH PUBLIC PLANS

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2015	-3.4%	-1.1%	Unable to Determine	Unable to Determine	-4.6%
CY 2016	6.2%	-0.6%	Unable to Determine	Unable to Determine	5.5%
CY 2017	1.8%	2.6%	Unable to Determine	Unable to Determine	4.5%

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.