MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 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 (AGO) and the Center for Health Information and Analysis (CHIA), holds an annual public hearing on health care cost trends. The hearing examines 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.

The 2019 hearing dates and location:

Tuesday, October 22, 2019, 9:00 AM
Wednesday, October 23, 2019, 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 22. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 22.

The HPC also accepts written testimony. Written comments will be accepted until October 25, 2019, 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 25, 2019, 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 the Suffolk University website. 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 available via livestream and video will be 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 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 page on 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 2019 Annual Cost Trends Hearing.

You are receiving two sets of questions – one from the HPC, and one from the AGO. We encourage you to refer to and build upon your organization's 2013, 2014, 2015, 2016, 2017, and/or 2018 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.**

On or before the close of business on **September 20, 2019**, 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.

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 or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC Contact Information

For any inquiries regarding HPC questions, please contact General Counsel Lois H. Johnson at HPC-Testimony@mass.gov or (617) 979-1405.

AGO Contact Information

For any inquiries regarding AGO questions, please contact Assistant Attorney General Amara Azubuike at Amara.Azubuike@mass.gov or (617) 963-2021.

Pre-Filed Testimony Questions: Health Policy Commission

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:

Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced 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 strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

1) Working with providers to promote integrated team-based care that rewards value rather than volume. For members enrolled in certain government products, this can involve the use of community based health workers and Navigators (a unique role that was created by Fallon to serve as a high touch, single point of contact for members with complex health needs). Data Analytics often goes hand in hand with this approach, allowing for more comprehensive provider reporting, and practice pattern variation analysis. The use of health outcome surveys also ties in with this team approach.

2) Encouraging the use of high-performing networks. Fallon has been a pioneer in the use of such networks, and they can be a valuable tool to steer members to providers who have the ability to manage utilization appropriately, resulting in lower rates and high-quality outcomes. We offer high-performing networks extensively in our commercial portfolio, and continue to work towards further refining these products.

3) Strengthening our internal programs to protect against fraud, waste and abuse. We have recently engaged a new vendor to assist our efforts in this space, effective January 1, 2020, featuring an integrated process which combines data analysis, decisions and insights with rules and algorithms to create a dynamic fraud, waste and abuse solution.

4) Updating our pay for performance program to better align program goals with our strategies to reduce health care expenditures, and establishing clear documentation on payment policies, setting expectations on providers.

b. What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?

1) Recognizing that regulation of pharmacy pricing is a complex topic, anything that can be done at either the state or federal levels to put downward pressure on prescription drug price increases would be helpful.

2) Any effort to pass state legislation on provider price variation must address both the top and the bottom of the provider price scale. Health care bills proposed in the state legislature in 2018 contained provisions intended to address provider price variation, but we found the

proposals in both the House and Senate bills to be problematic. The House bill would have created an assessment on insurers, to be used to provide funding for community hospitals. The Senate bill would have imposed a pricing structure to force rates upward for lower-paid hospitals while doing little to rein in increases at the top of the price scale. Both of these proposals would have put pressure on insurance premiums to fund providers at the lower end – thus increasing costs for the system as a whole – while doing little or nothing to control costs at the top end.

3) If provider mergers will be allowed to continue, regulators should hold merged entities to a commitment to keep future cost growth down. Greater efficiency and economies of scale, and therefore the potential for lower costs, are often cited as a possible benefit of provider consolidation. Experience shows this to rarely be true, however. It is far more common for the combined entity to use its market power to extract higher rates from insurers. This is especially problematic for smaller insurers, like Fallon Health, with less leverage due to lower membership and utilization penetration.

4) We would encourage further legislative discussion around the topic of "surprise billing". There are a number of provider types – ambulances; emergency-room physician groups; certain hospital-based services such as pathology, radiology and anesthesiology – which have little incentive to contract with insurers because members with a need for these types of providers are not typically in a position to choose the specific provider they will receive services from. For these providers, it often makes sense economically to refuse to contract with insurers, enabling these providers to bill insurers at higher, non-negotiated rates. This leaves insurers with the choice of paying these higher, non-negotiated rates or allowing their members to be balance billed. We think a sensible solution to this matter is achievable, allowing insurers to pay rates that are reasonable and customary in the overall context of meeting the benchmark, allowing providers to be fairly compensated, and freeing members from needing to worry about being caught in the middle.

5) Government programs like Medicare and Medicaid must set reasonable reimbursement rates for providers and insurers/ACOs who participate. While doing so may mean increasing costs within these programs, it will reduce the current practice of "squeezing the balloon", which creates pressure for providers to charge higher rates elsewhere to make up for perceived shortfalls in the rates paid by these programs.

6) The state should have a statewide strategy to promote greater access to behavioral health treatment (including substance use disorder treatment), taking into account broader societal solutions, outside of the traditional medical model.

7) The state should take a more active role in workforce development in the health care sector. This would be especially helpful in the case of substance abuse and mental health services. There has been a long-term trend towards greater focus on and access to those services, creating an ongoing need for trained staff on both the clinical and non-clinical sides, especially for products under government programs, including staff such as community based health workers and Navigators. Community based behavioral health providers are particularly valuable in the MassHealth ACO space.

2. STRATEGIES AND POLICIES TO SUPPORT INVESTMENT IN PRIMARY CARE AND BEHAVIORAL HEALTH CARE:

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care, even though evidence suggests that a greater orientation toward primary care and behavioral health may increase health system efficiency and provide superior patient access and quality of care. Health plans, provider organizations, employers, and government alike have important roles in prioritizing primary care and behavioral health *while still restraining the growth in overall health care spending.*

a. Please describe your organization's strategy for supporting and increasing investment in primary care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

Fallon has had success with models of care encouraging the development of an infrastructure to better support primary care and to better integrate primary care with behavioral health care. These include our NaviCare SCO plan and shared risk on commercial contracts. Infrastructure support is an important part of these efforts; if it is working, providers will generally perform well. Primary care capitation and pay for performance also work to encourage population management. A focus on preventive screenings helps to keep populations well, beginning even before a member sets foot in the PCP's office. All of these features create process improvements that focus on and better support primary care.

Fallon Health is studying the further expansion of Navigators beyond the NaviCare SCO program. Navigators can help to promote clinical integration efforts, setting the appropriate level of care, and reducing admissions and complications. We hope to use a predictive modeling tool to identify high risk members in conjunction with Navigators embedded at certain providers and facilities. Navigators could then be used to help remove barriers to discharge and address social determinants. This would support primary care by taking some of the burden off the member's PCP, allowing the PCP to extend their capabilities to attend to other patients.

Fallon Health has recently applied for a grant to support a pilot program for Mobile Integrated Health, in conjunction with other entities including UMass Memorial Health Care and the Boston University School of Public Health. This program would allow treatment of members in the community rather than in an emergency room setting. A pilot program is planned for a limited geographic area across multiple product lines.

b. Please describe your organization's strategy for supporting and increasing investment in behavioral health care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

We have been working with our behavioral health vendor to better support behavioral health care for our members. One specific initiative is to develop a robust telehealth program for behavioral health. Telehealth has the potential to make a significant positive impact on both patient access to services and the cost of services.

c. Provider organizations can take steps to ensure they deliver high-functioning, high-quality, and efficient primary care and improve behavioral health access and quality.

What strategies should provider organizations prioritize to strengthen and support primary and behavioral health care?

Co-locate primary care and behavioral health. This will have a significant impact on integrating the two.

Use crisis stabilization teams to help manage high risk members. One way to accomplish this is by embedding community health workers in emergency room settings.

Work to develop capabilities to treat patients via telehealth. Telehealth has the potential to make a significant positive impact on both patient access to services and the cost of services, but greater development of provider capabilities is needed.

d. What other changes in policy, market behavior, payment, regulation, or statute would best accelerate efforts to reorient a greater proportion of overall health care resources towards investments in primary care and behavioral health care? Specifically, what are the barriers that your organization perceives in supporting investment in primary care and behavioral health and how would these suggested changes in policy, market behavior, payment, regulation, or statute mitigate these barriers?

The state can further access to medication assisted treatment (MAT) for opioid addiction by removing the cap on the number of physicians who are able to receive a MAT waiver.

The state can play a role in encouraging workforce development, including the development of a more robust non-clinical workforce, and the strategic use of state dollars to this end (e.g., paying a living wage to members of the workforce funded through state programs; debt payoff or forgiveness for individuals who agree to serve in underserved communities).

As the role of social determinants has become increasingly apparent, a clear need for supportive housing has emerged. MassHealth funds cannot be used for this purpose, but a separate source of state (or federal) funding for this purpose would be helpful.

At the federal level, revisions to 42 CFR 2 are needed, to increase the ability to share behavioral health information between behavioral health providers and PCPs. While proposed federal regulatory changes would take a step in this direction, we believe the proposals do not go far enough in allowing the sharing of information between behavioral health providers and PCPs. Legislative changes may be required for reform in this space to truly have an impact.

As much of the current reimbursement system is built using Medicare rules as its basis, changes in those rules to encourage primary care reimbursement would help to place a greater focus on primary care well beyond the confines of Medicare itself. Examples could include the development of new codes and reimbursements for services such as new member assessments and annual visits. Encouragement of these services will allow PCPs to better understand and manage care for their patients.

3. CHANGES IN RISK SCORES AND PATIENT ACUITY:

The HPC has observed that member risk scores have been steadily increasing for many payers and that a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications.

a. Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your members.

Factors	Level of Contribution
Increased prevalence of chronic disease among your members	Not a Significant Factor
Aging of your members	Major Contributing Factor
New or improved EHRs that have increased providers' ability to document diagnostic information	Not a Significant Factor
Coding integrity initiatives (e.g., hiring consultants or working with providers to assist with capturing diagnostic information)	Not a Significant Factor
New, relatively less healthy patients entering your patient pool	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Major Contributing Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Not a Significant Factor
Other, please describe: Increase in completed retrospective chart reviews	Minor Contributing Factor

☐ Not applicable; neither risk scores nor acuity have increased for my members in recent years.

b. Please describe any payment integrity initiatives your organization is undertaking to ensure that increased risk scores and/or acuity for your members reflects increased need for medical services rather than a change in coding practices.

Fallon Health has partnered with vendors to target several different aspects of payment integrity, including the following:

- Implementation of an integrated platform for pre-payment code editing and the identification of suspicious activities that could be potential fraud, waste and abuse. The vendor will also provide data reports and trending of claims for further internal review to help identify potential outliers and solutions for preventive measures (e.g., payment polices)
- Expanding our partnership with a vendor who performs hospital bill audits (a line-by-line audit of individual charges on final itemized billing statements to supporting documentation for accuracy of billed services), and DRG Validation Audits (an audit of coding and DRG assignments for accuracy).
- Partnering with a vendor to conduct reviews of high dollar claims.

Other activities in this space include:

- Use of a claim check editing tool – includes but is not limited to edits to review for potential of duplication of claim, member matching criteria and CPT code and NPI edits
- Working with our pharmacy benefit manager, who provides us with several reports to assist with identifying potential and suspected unusual trends, utilization patterns, and provider billing practices
- Other internal activities, including quarterly overall claims audits, monthly letters to a selected population of members to verify billed and paid services

4. REDUCING ADMINISTRATIVE COMPLEXITY:

Administrative complexity is endemic in the U.S. health care system. It is associated with negative impacts, both financial and non-financial, and is one of the principal reasons that U.S. health care spending exceeds that of other high-income countries.

a. For each of the areas listed below, please indicate whether achieving greater alignment and simplification is a **high priority**, a **medium priority**, or a **low priority** for your organization. Please indicate **no more than three high priority areas**. If you have already submitted these responses to the HPC via the June 2019 *HPC Advisory Council Survey on Reducing Administrative Complexity*, do not resubmit unless your responses have changed.

Area of Administrative Complexity	Priority Level
Billing and Claims Processing – processing of provider requests for payment and insurer adjudication of claims, including claims submission, status inquiry, and payment	High
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Medium
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Medium
Eligibility/Benefit Verification and Coordination of Benefits – determining whether a patient is eligible to receive medical services from a certain provider under the patient's insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment	High
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Medium
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Low
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	High
Quality Measurement and Reporting – evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results	Medium

Area of Administrative Complexity	Priority Level
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Medium
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	Low
Variations in Payer-Provider Contract Terms – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts	Medium
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level
Other, please describe: Click here to enter text.	Priority Level

b. CAQH estimates that the health care industry could save nearly $10 billion if all organizations were to perform six transaction types entirely electronically.[1] Please report your organization's calendar year 2018 volume for the following transaction types in the table below. Please also describe any barriers to performing all of the listed transactions entirely electronically.

Transaction	Manual or Partially Electronic	Fully Electronic, in Accordance with ASC X12N
Eligibility and Benefit Verification (270)	30,199	9,850,751
Prior Authorization (278)	*91,000	*35,824
Claim Submission (837)	792,861	3,836,764
Claim Status Inquiry (276)	50,858	1,112,602
Claim Payment/Remittance Advice (835)	N/A	4,737,333

*The manual/partially electronic prior authorizations number is approximate. Both the manual/partially electronic and fully electronic prior authorizations numbers reflect primarily prior authorization requests processed by Fallon Health, not by delegated vendors; these numbers exclude prior authorization requests processed by most delegated vendors.

Barriers to performing all of the listed transactions entirely electronically include:

[1] CAQH. 2018 CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings. https://www.caqh.org/sites/default/files/explorations/index/report/2018-index-report.pdf

- For prior authorization, a current lack of automated functionality; the time, cost, and complexity of extracting necessary information (from the clinical to the required data elements) from various electronic health record systems for import into our electronic processing system, and the time and expense required to train external users, to hire and onboard dedicated support staff, licensing, etc.
- Differing levels of service and technological needs of providers. While Fallon Health offers automated claims submissions, enrollment inquiries and claim status checks, we have found it necessary for alternative inquiry and submission options to remain in place, including paper and phone inquiries.

5. PROGRESS ON ALTERNATIVE PAYMENT METHODS:

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. The Center for Health Information and Analysis reports that the majority of care for commercial members continues to be paid using fee for service; with 59% of HMO patients and 18.7% of PPO patients covered under alternative payment contracts in 2017. In the 2018 Cost Trends Report, the HPC found that payers and providers have not made sufficient progress to meet the HPC's targets for expanded use of alternative payment methods (APMs).

a. Please describe what your organization has done to make progress in 2018 on expanding the use of APMs in both HMO and PPO products and the use of APMs with new providers and provider types.

Fallon Health is focused on the HMO model of care, and has minimal PPO membership. As such, we have relatively little to gain on the PPO side, and our efforts around APMs have been almost entirely on the HMO side.

The most notable development around APMs in 2018 was the rollout of the MassHealth ACO program. Fallon Health is a participant in three ACOs, which have served to significantly increase the number of members we have under APM models. We hope to ultimately leverage some of the capabilities we are building through the ACOs to expand APM-based provider partnerships to other lines of business.

b. Please identify which of the following strategies you believe would most encourage further adoption and expansion of APMs. **Please select no more than three.**

☐ Support and/or technical assistance for developing APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payment
☐ Identifying strategies and/or creating tools to better manage the total cost of care for PPO populations
☒ Identifying strategies and/or creating tools for overcoming problems related to small patient volume
☒ Enhancing EHR connectivity between payers and providers
☐ Aligning payment models across providers
☒ Enhancing provider technological infrastructure
☐ Other, please describe: Click here to enter text.

6. 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 Calendar Years (CY) 2018-2019			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2018	**Q1**	735	254
	Q2	350	693
	Q3	237	425
	Q4	282	204
CY2019	**Q1**	166	35
	Q2	146	45
	TOTAL:	1916	1656

7. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS:

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2016 to 2018 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2016 to 2018, 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.

Attached is the summary table showing actual observed allowed medical trends (note that figures for CY 2017 have been restated). For the time frames requested we did not have specific studies to break mix between provider and service mix so the mix has all been put into the Service Mix column. We do believe that this "Allowed" trend understates the true allowed trend if there were no benefit buy-downs. This is true even though we are looking at allowed trends that include both the payer and member share of the expense because as the member's share of the cost rises it has an impact on the underlying utilization. This understates the utilization and therefore the total trend in the attached table.

1. In the 2018 AGO Cost Trends Report, the AGO examined the complex and varied methods used to determine health care payment rates. Please describe the strategies that your organization is pursuing to reduce complexity and increased standardization where appropriate in each of the following areas:

    a. Payment policies and procedures: Fallon Health utilizes payment policies to both support contractual payment terms and clarify situations where the provider's contract is silent on specific reimbursement. Payment policies support appropriate payments utilizing industry standard coding and billing guidance to reduce payments when appropriate, deny incidental services, or deny excessively billed services. Fallon continually monitors industry standards, regulatory guidance (e.g. CMS), and other resources to update policies and vet potential ideas for new payment methodologies. Fallon reviews these policies via the Payment Policy Committee whose representation consists of multiple department subject matter experts. Where feasible, we attempt to align policies across all product lines (for example, using CMS guidelines for all products, even those not regulated in any way by CMS) and with other payers (by following industry standards).

    b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.): We have worked to standardize our payment structure as much as possible, establishing internal standards and employing them across all arrangements. We prefer to use DRGs whenever possible, but this is not always feasible. Within the categories of DRG and per diems, we have worked to use standard fee schedules.

    c. Alternative Payment Models ("APMs"): Please select any of the subcategories that apply and explain your selection.

        ☐ Health status adjustment methods (e.g., types of claims used to determine health status score, such as medical or Rx, etc.):
        Click here to enter text.

        ☒ Risk structure (e.g., risk exposure, the allowed budget, exclusions, bonuses, quality performance, etc.):
        Adoption of pay for performance provisions, and upside only contracts with budgets.

        ☐ Use of pre-paid lump sum payments (rather than volume-based, fee-for-service interim basis payments):
        Click here to enter text.

        ☐ Other, please describe:
        Click here to enter text.

    d. Please describe any ways in which your unique payment approach brings value to patients, plan sponsors, or payers: We believe that our approach in this space is consistent with that of other carriers.

2. Please answer the following questions regarding your organization's APM contracts with providers in our marketplace:

a. What are the main barriers to shifting away from using a volume-based, fee-for-service interim basis payment approach (i.e. prior to settlement) to using pre-paid lump sum payments?

Lack of infrastructure on the provider side, especially for smaller providers.

Lack of patient volume between specific providers and insurers, especially with smaller or regional carriers like Fallon Health.

Adoption of APMs can cause problems with coding initiatives reliant on claims submission – adoption of APMs tends to divert attention away from coding.

b. In 2018 (or in the most recent year for which you have complete data), what percent of your medical payments for commercial products were paid for on an interim basis under volume-based, fee-for-service claims adjudication?

The most recent year available is 2017, in which 52% of Fallon's medical payments for commercial products were paid for on an interim basis under volume-based, fee-for-service claims adjudication. We do not expect that the figure for 2018 would have changed much from 2017.

I, Richard Burke, am the President and CEO of Fallon Community Health Plan, Inc. (Fallon Health). I am legally authorized and empowered to represent Fallon Health for

the purposes of this testimony. The responses contained in this submission were prepared by employees of Fallon Health who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury on this 20th day of September 2019:

Richard Burke
President and CEO
Fallon Community Health Plan, Inc.

HPC Payer Exhibit 1

All cells should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

Year	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2016	3.2%	4.2%	n/a	1.9%	9.6%
CY 2017	3.6%	3.3%	n/a	2.0%	9.1%
CY 2018	4.0%	1.3%	n/a	2.7%	8.1%

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

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.