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?

Response: Health New England's top strategic priorities to reduce health care expenditures are:
Priority 1: Reduce growth in prescription drug spending
Priority 2: Reduce over-utilization of unnecessary emergency room care
Priority 3: Move provider mindset toward value-based care

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

Response:
1. 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 are one of the largest drivers of total health care expenditures. Therefore, Health New England supports

a. Regulations to promote transparency of drug prices. Many states are considering enacting such regulations. The proposed regulations would require drug manufacturers to give notice to health plans and state purchasers several months in advance of a major price hike or release of a new drug. The regulations would also require manufacturers to specify the rationale for a price increase or for the price of a newly-approved specialty drug. The pricing rationale for a new drug must include documentation of any improvement in clinical efficacy that the new drug offers over alternative treatments.

b. Independent evaluation of the cost effectiveness of new high-cost prescription drugs and value-based pricing for high cost drugs. This objective can be met through the efforts of Institute for Clinical and Economic Review (ICER), an independent non-partisan organization that objectively evaluates the clinical and economic value of prescription drugs, medical tests, and other health care delivery innovations. ICER's drug assessment reports include full analyses of how well each new drug works and the economic value each treatment represents. ICER uses this research to establish a "value-based price benchmark reflecting how each drug should be priced to appropriately reflect long term improved patient outcomes."

2. We also support improved patient protection against surprise billing. Surprise billing occurs when an insured consumer unknowingly receives care or services from an out-of-network provider, such as an emergency room or ambulance provider. It can also occur if a consumer receives care at an in-network facility, such as a hospital, from a provider within that facility who is not contracted with the health plan. Typically, when an out-of-network claim is filed, the health plan either pays the full charged amount or negotiates a lesser rate with the provider. In the latter case, the provider often bills the consumer for the amount not paid by the health plan. The most frequent sources of surprise billing situations are emergency room physicians, radiologists, anesthesiologists and pathologists, often referred to as "ERAP providers". In Massachusetts, an overwhelming 85% of all out of network physician claims originate from ERAP providers, These claims increase the cost of care to health plans, employers, and consumers, both directly and indirectly.

Finally, we support the benchmark approach included in both S. 1895, the "Lower Health Care Costs Act" recently approved by the Senate HELP Committee, and H.R. 3630, the "No Surprises Act." These bills would require that health plans pay out of network providers, at a minimum, the median contracted rate for services in the geographic area where the services were delivered. The establishment of a default reimbursement methodology based on the in-network contracted rates between health plans and providers will lead to a more accurate reflection of the cost of services, because rates that are the result of contractual negotiations under true market conditions account for the provider's specialty and geographic variation. Further, this straightforward approach will insulate members financially and result in cost savings to the Commonwealth's health care system. The establishment of non-contracted commercial rates for emergency and nonemergency out of network services will encourage providers to charge more reasonable rates and participate in health plan networks, resulting in lower costs for members.

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.

Response: Health New England long has supported care coordinated through primary care clinicians. This support is evident in initiatives within all lines of business, such as our serving as a MassHealth Accountable Care Partnership Plan for five primary care health centers. In partnership with the health centers, we have deployed community health workers to evaluate the Accountable Care Organization (ACO) population through the use of care needs screening tools; established multi-disciplinary care teams to manage our ACO population; and created comprehensive care plans for the highest risk patients.

Early results show a modest decline in emergency department utilization and slower growth for inpatient admissions. We have also committed to a benefit design to keep primary care copays low for both our Medicare and Commercial membership. All of our commercial plans offer a $0 PCP copay for preventive visits.

Health New England has invested in primary care providers by making supplemental support payments to PCPs who are committed to improving access to care. This investment has resulted in improved performance in HEDIS measures for adolescent well care visits, well child visits, and adult access to preventive/ambulatory healthcare visits.

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.

Response: Health New England understands that access for behavioral health treatment continues to be a challenge both in our region and our network, especially for certain behavioral health treatment types. As part of our commitment to remove barriers to access, Health New England has contracted with Teladoc to provide behavioral health services for all of our fully funded members. Some of our self-funded accounts provide Teladoc benefits as well. Teladoc can provide immediate access to a network of Massachusetts-licensed clinicians and psychiatrists who can provide both initial and ongoing behavioral health sessions for our members. The current turnaround time for members who request a consultation from a Teladoc behavioral health clinician/psychiatrist is approximately 5.5 hours. Members can schedule a consultation around their schedule for convenience. Health New England has also been engaged in an initiative to provide follow-up behavioral health care for members who have had an admission into a 24-hour level of care. In a pilot program, Health New England has been offering Community Support Program (CSP) services to commercial and Medicare members. Historically, CSP has only been covered for Medicaid beneficiaries. CSP providers work to ensure that members are engaged in follow-up behavioral health services post discharge from 24-hour levels of care. In 2018, Health New England also started a program to increase initiation and engagement in Substance Use Disorder treatment by providing an incentive program for members who meet certain engagement activities. Incentives for the member increase based on the member's continuing participation in follow up activities during their course of recovery.

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?

Response:
1. Provider organizations should prioritize the following strategies to support primary and behavioral health care:

- Investment in team based care
- Assistance with electronic medical record (EMR) documentation
- Alternative payment models that focus on managing the health of a panel of patients rather than maximizing RVUs
- Access to specialists through the EMR or e-consults

- Utilization of care guidelines for chronic disease patients to support managing most patients with chronic disease in a primary care practice and referring only more acute patients to specialists

2. Provider organizations who are looking to deliver high quality, efficient primary care and improve behavioral health access and quality should invest in offering co-located behavioral health clinicians and access to psychiatric consultations within their practices. As part of its annual PCP survey, Health New England collects data on this issue and received insightful feedback from PCPs on the barriers to coordination and communication with their patients' behavioral health providers. PCPs themselves have highlighted the need for behavioral health resources to be located in their practices. If that were the case, behavioral health brief encounters and assessments of members could be provided on-site, often in the presence of the PCP. Further, use of a single EMR by the PCP and onsite co-located integrated behavioral health resource has been identified as a vital step to achieve the goal of providing higher quality, efficient primary care with improved access to behavioral health treatment.

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?

Response: Barriers to integrating behavioral health into primary care include, but are not limited to, reimbursement issues, limited access and capacity, resistance to change, information technology issues, cultural competency issues, and confidentiality rules for behavioral health. Best practices going forward should 1) allow global capitation payments for vulnerable populations to include payment for social determinants of health; 2) encourage the use of data-driven practices and increased interoperable and/or shared EHRs; 3) establish a team approach to care that includes the patient and family or caregivers; and 4) utilize telehealth services for behavioral health. Health New England would support legislation that creates funding to facilitate the integration of behavioral health providers into medical practices of three or more primary care clinicians. Legislation would provide: 1) training for both behavioral health providers and primary care providers regarding assessment and referral of patients for behavioral health intervention and care; and 2) interim funding to partially offset the costs of adding a behavioral health FTE to a primary care practice; for example, subsidizing 80% of cost in year one, 60% in year two, 40% in year three, and 20% in year four, with the practice covering full cost of the behavioral health provider in year five and afterwards.

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	Minor Contributing Factor
Aging of your members	Minor Contributing Factor
New or improved EHRs that have increased providers' ability to document diagnostic information	Major Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with providers to assist with capturing diagnostic information)	Major Contributing Factor
New, relatively less healthy patients entering your patient pool	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe: Click here to enter text.	Level of Contribution

☐ 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.

Response: Health New England annually performs medical record reviews to ensure that all submitted diagnosis data for selected medical records is valid and substantiated by the documentation within the record. This initiative ensures that any increases in overall risk score performance are due to an increases in medical services and/or acuity and not to up-coding or fraudulent billing. In cases where diagnosis data is identified as not being supported, the applicable providers receive formal feedback and coaching. Providers who require repeat coaching due to coding and documentation inaccuracies are referred by the risk adjustment department to the appropriate department for further review.

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	Low
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Low
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	High
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	Low
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Low
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	High
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
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Low
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,	Low

Area of Administrative Complexity	Priority Level
quality measurement, and other terms between different payer-provider contracts	
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.

Response: The two main barriers to performing all listed transactions electronically are provider willingness to submit electronically and limited capability to provide a self-service method to make a status inquiry. Health New England is in the development stages of an enhanced portal for providers to address these barriers.

Transaction	Manual or Partially Electronic	Fully Electronic, in Accordance with ASC X12N
Eligibility and Benefit Verification	53,945	N/A
Prior Authorization	3,790	52,131
Claim Submission	9%	91%
Claim Status Inquiry	14,561	N/A
Claim Payment	241,331	2,681,457
Remittance Advice	87	33

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.

[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

Response: Health New England continues to offer value based arrangements, including shared savings, downside risk, and PCP capitation payments, and encourages providers to move toward participating in such arrangements. Though we have achieved some success in this, there remain barriers, primarily the willingness of provider organizations to understand and take risk. To help providers to manage cost and quality of care, Health New England offers new quality incentives and is providing more actionable provider data and. Despite this, Health New England has found that the challenges for provider groups remain: 1) the many different and constantly changing payment and incentive models used by Medicaid, Medicare and Commercial Payers; 2) the cost of development of care management programs; 3) the lack of comprehensive data and analytics infrastructure; 4) the challenges to sharing timely and actionable data; and 5) clinical interoperability between providers. To be successful, an APM arrangement must have a significant number of members so that risk can be moderated over a large patient population. Since Health New England is a smaller, regional health plan, there are a limited number of provider groups which are large enough to have a significant concentration of Health New England commercially insured members. Thus, there are practical limits to the number of provider groups that can enter into an APM arrangement with Health New England.

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**	424	1
	Q2	498	3
	Q3	566	1
	Q4	512	3
CY2019	**Q1**	649	5
	Q2	576	16
	TOTAL:	3,225	29

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

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.

Response: Please refer to HNE-HPC Payer Exhibit 1, accompanying this document.

Pre-Filed Testimony Questions: Attorney General's Office

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:

    Response: When appropriate, Health New England is working to utilize Medicare policies and procedures as a standard across all populations. Providers typically have a large portion of their business with Medicare, so using Medicare as the basis for policies and procedures brings a level of standardization and simplicity that can benefit the system as a whole.

    b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.):

    Response: Health New England is working to transition in-network providers from percent of charge reimbursement to fixed payment methodologies. For individual providers, Health New England uses fee schedules whenever possible. For facility providers Health New England primarily uses DRGs, per diems, ASC case rates, and fee schedules to reimburse.

    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.):

    Response: Health New England works continuously with provider claims and provider EMR systems to determine risk scores for our Commercial, Medicare Advantage, and MassHealth populations. These risk scores in turn impact the financial budgets for the various APMs Health New England maintains with providers for the Commercial, Medicare Advantage, and ACO MassHealth populations. Guaranteeing that risk adjustment works properly and impacts APM budgets correctly increases the probability that providers will stay engaged in APMs with Health New England and moderates cost increases year over year. This leads to improving the overall quality of care and targeting the subpopulations that require increased provider focus.

    ☒ Risk structure (e.g., risk exposure, the allowed budget, exclusions, bonuses, quality performance, etc.):

    Response: Health New England has worked with providers using both percent-of-premium and budget-based risk models. Health New England has also used upside and downside risk caps to limit providers' risk and attract more providers to participate in risk arrangements. Quality programs that work in conjunction with the risk arrangement and impact the surplus/deficit sharing are also an important feature of Health New England's risk arrangements with providers.

☐ Use of pre-paid lump sum payments (rather than volume-based, fee-for-service interim basis payments):
Response:

☐ Other, please describe:
Response:

d. Please describe any ways in which your unique payment approach brings value to patients, plan sponsors, or payers: Click here to enter text.

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?

Response: Provider sophistication and tolerance for risk will continue to be Health New England's largest barriers to increasing risk arrangements. Another significant barrier to having additional member lives under APM arrangements is that approximately 50% of Health New England membership is spread over many different providers, each of whom may have only a few Health New England members on their panels. These small groupings of members do not lend themselves to an APM arrangement. The remaining 50% of commercial membership are with large provider groups, where Health New England is able to maintain various types of APMs. Health New England will continue to partner with our contracted providers to understand their needs regarding data, reporting, care management coordination and support to assist them in developing a level of sophistication that would allow steps towards risk.

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?

Response: Only a small percent of Health New England's provider payments are made through a capitated arrangement.

HPC Payer Exhibit 1

All cells shaded in BLUE should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2016	2.2%	0.9%			3.1%
CY 2017	5.3%	0.8%			6.1%
CY 2018	0.3%	-3.4%			-3.1%

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 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.