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.

Please note that responses below reflect Tufts Associated Health Maintenance Organization's commercial products only. Tufts Health Public Plans has submitted a separate response.

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?

Three of Tufts Associated Health Maintenance Organization's (TAHMO's) strategic priorities to reduce health care expenditures are 1) Managing unit cost and utilization trends; 2) Expanding value-based reimbursement models and 3) Increasing the effectiveness of value-based reimbursement models.

1) Managing Unit Cost and Utilization Trends

Managing unit cost and utilization trends are increasingly difficult in the current environment, with medical inflation trending higher than it has over the past few years. However, TAHMO has developed and implemented a variety of initiatives to incentivize providers to deliver high value medical care. Those initiatives include but are not limited to the implementation and administration of value-based reimbursement models, which hold providers financially accountable for the cost of the medical care delivered. Value-based reimbursement that rewards providers for the effective management of total cost of care results in providers being less dependent on negotiating unit cost increases.

While maintaining a robust network of providers, we maintain discipline and diligence in structuring reimbursement arrangements. These value-based financial arrangements can take the shape of sharing financial risk with our provider partners on total medical expense or reimbursing providers via an all-inclusive bundled price for select services. These arrangements afford financial opportunity for providers while aligning objectives around the delivery of high quality and cost effective medical care. Depending on the provider's capabilities and infrastructure, we tailor approaches designed to maximize the quality and efficiency of the care delivered. Our efforts have been successful in that the number of providers in our value-based model has more than doubled since 2009. For 2018, more than 87% of our fully insured HMO membership in Massachusetts is covered under value-based arrangements. Additionally, we expanded value-based arrangements to our self-insured clients. As such, we now have select providers that accept financial accountability for self-insured populations that both select a primary care physician (PCP) and, for PPO populations, that are attributed to PCPs.

Finally, TAHMO maintains a medical cost innovation team that is charged with developing and implementing approaches to medical cost management. This team seeks to reduce utilization through minimizing the use of unnecessary health services.

Examples of efforts to reduce unnecessary utilization include but are not limited to: 1) our enhanced initiatives targeting avoidable emergency department utilization through outreaching to patients who access the emergency department for diagnoses that can typically be treated in provider offices and 2) assistance from our care managers to help patients better manage their chronic conditions. Our care managers outreach to patients within 7 to 10 days of an emergency department visit to discuss and promote wellness, clinical interventions and emergency department avoidance strategies.

2) Continued Expansion of Value-Based Reimbursement Models

To support self-insured purchasers and consumers, we are actively expanding the population covered under value-based arrangements with providers who have succeeded in such arrangements with our HMO population. We currently partner with select provider groups to accept financial accountability for both self-insured PCP–based and non PCP-based products. We are also in advanced discussions with other provider groups to expand existing value-based arrangements beyond HMO products. It is our projection that, as of January 2020, we will have approximately 40% of our local non-HMO patients covered under value-based reimbursement arrangements. This expansion in value-based populations not only provides added consumers with the value of aligned provider incentives but also minimizes the effect of providers maintaining different reimbursement structures with misaligned objectives and incentives.

3) Increasing the Effectiveness of Value-Based Reimbursement Models

TAHMO believes that it is essential that we work collaboratively with our providers who are reimbursed under value-based models to reduce health care expenditures. By pairing these types of arrangements with 1) timely, actionable reporting and analytics; 2) patient risk stratification; 3) care management programs and 4) best practices across our network, we can equip provider groups with the tools and data to support cost and quality outcomes. Those outcomes including appropriate cost trends, reduced unnecessary utilization, increased use of high-value providers and appropriate care settings and a reduction in practice pattern variation. Additionally, we are evolving our reporting and data sharing with providers in order to incorporate insights gained from how we interact with members and additional patient demographic information and social determinants of health that will assist providers with the identification of additional areas of opportunity.

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

TAHMO would appreciate the Commonwealth's focus on 1) continued monitoring of provider consolidation; 2) management of pharmaceutical cost trends; and 3) monitoring the expansion of high cost ambulatory surgical centers.

1) **Continued monitoring of provider consolidation.** As health systems and provider organizations continue to grow through expansion, a focus on improved population health and lower cost trends should remain a principle concern. This type of expansion can

increase healthcare costs through both enhanced bargaining leverage and steerage of utilization into higher priced facilities and provider groups. Additionally, expansion of this nature can also increase costs when professional office-based services are billed with the addition of facility payments solely due to affiliation. While provider expansion and growth may create better communication and coordinated patient care eventually, it is our experience that these benefits take significant time and investment to be realized while increased costs materialize at a much faster pace. As such, as provider growth and expansion continues, it is critical that ensuring adherence to improved quality and lower cost trends is fulfilled as opposed to the achievement of higher costs.

2) **Management of Pharmaceutical Cost Trends.** The rising cost trend in pharmaceutical prices poses a challenge to our ability to moderate health care expenditures. Providers and health plans work diligently to control many areas of medical cost and utilization, but have difficulty controlling pharmacy trends that are due to both unwarranted increases in price for existing drugs and high prices for new drugs. Many providers who have long been comfortable with value-based arrangements are increasingly concerned with taking responsibility for pharmacy expenses because of pricing control by pharmaceutical manufacturers 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 market reform in this area, this trend will derail cost control efforts.

3) Expansion of Ambulatory Surgical Centers. Recently, TAHMO has seen a targeted effort by health systems to expand their market reach through the building and acquisition of ambulatory surgical centers (ASCs). As health systems invest in these facilities, they often seek levels of reimbursement that are only slightly beneath the rate structure that these health systems receive for care delivered within one of their acute care facilities; in spite of the ASCs being able to operate at a much lower cost. It is not uncommon that the initial reimbursement expectations of certain health systems, specific to their ASCs, would not benefit the costs of the local community.

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.

TAHMO supports primary care through 1) direct financial support; 2) the opportunity to earn additional reimbursement through value-based contracts and 3) care management for patients.

1) Direct Financial Support

TAHMO provides higher reimbursement on a subset of codes that are commonly billed by PCPs, as well as, management fees that help further high quality care and evidence-based medicine in order to promote good patient outcomes and cost efficient care.

2) Value-Based Arrangements

TAHMO believes value-based arrangements are crucial to incentivizing provider systems to invest in primary care and behavioral health in a way that best supports the needs of patients. These arrangements provide financial incentive to providers by affording providers the opportunity to share in the value of the delivery of high-value care.

Within many of our value-based arrangements, providers are able to earn additional funding through performing well on quality measures that are based on providing high quality primary care; e.g., adult and childhood immunizations, cervical cancer screening, breast cancer screening, etc.

3) Care Management

TAHMO recognizes that provider groups vary in their capacity to provide coordinated care management to their patients. TAHMO's care management team supports our provider network through the coordination of care and the motivation and education of patients within the care plan as developed by PCPs and their teams. Our care management team works in conjunction with providers and care teams to provide a seamless approach to patient support.

Additionally, TAHMO works closely with high-performing providers to maximize the efficiency of care delivered. For providers that have the infrastructure in place to efficiently and effectively manage patients, we allow those providers to manage utilization requests, thereby reducing the administrative burden for PCPs.

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.

TAHMO continues to focus on its ongoing efforts to better integrate behavioral health into primary care through collaboration with our provider partners. We collectively work together to identify opportunities to address and resolve any barriers to access issues. TAHMO's internally managed behavioral health care managers assist providers and patients with accessing care, referral assistance, and consultation to direct care to the most appropriate behavioral health care setting. Our behavioral health and medical care managers work closely to allow for smooth integration of both medical and behavioral health needs of our patients.

Behavioral health expenses are often included in value-based arrangements. Therefore, appropriate incentives are in place for providers to proactively manage opportunities for interventions. Further, organizations under value-based arrangements receive claims data

to support population health management across the care continuum, inclusive of both medical and behavioral opportunities. Additionally, TAHMO partners with one provider under a pilot program arrangement whereby the provider is reimbursed for the integration of an innovative primary care and behavioral health model. Under the pilot, the provider is reimbursed when a PCP engages with a behavioral health specialist to assess the need for behavioral health services.

Specific to one of our large clients, TAHMO also maintains an arrangement with a high-value provider designed to provide funding outside of standard billing models to promote flexibility in the delivery of care. Additionally, we are also 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 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.

Access is a critical factor in behavioral health services, and TAHMO is focused on expanding our network to bring in qualified, skilled providers for both mental health and substance abuse disorder treatment. The expansion includes both facilities and individual providers, allowing for growth across the continuum of care. We also are invested in understanding best practices and innovation within our network. We are currently exploring best-in-class providers for substance abuse disorder management, and it is our intent to identify one or more high-value providers that can be utilized as a steerable option for all of our members.

Additionally, we established robust emergency department boarding protocols that engage our clinicians in understanding barriers and identifying solutions for faster access to treatment.

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?

TAHMO has identified two key areas that will help strengthen the coordination between primary care and behavioral health care.

1) **Reducing Stigma Associated with Behavioral Health**

Provider organizations that are able to integrate the assessment of behavioral health into their daily practice routines will be better able to reduce the stigma associated with behavioral health through this "normalization" process. As assessing patients in this holistic manner becomes standard, patients will become more accepting of behavioral health assessments and will be more willing to engage sooner in a behavioral health discussion, when early intervention has the potential to make a greater impact. This holistic approach would allow for earlier identification and intervention at a less intensive

need.

2) Oversight of Behavioral Health Quality Standards

Provider organizations should prioritize development and oversight of quality standards for behavioral health. Within behavioral health care, there is known variation in the type of care provided. By instituting quality standards at a practice or organizational level, the standards can Prioritize areas of focus, establish guidelines, specifications and use of assessment tools and implement how to measure progress. These standards can ensure that services are being consistently delivered. While development of quality standards is the first step, oversight and monitoring of adherence is also a necessary step.

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?
TAHMO has identified the following three areas to improve investment to primary care and behavioral health.

1) Monitoring Accountable Care Organization funds flow
As provider organizations grow in size and scope, many health care services have been consolidated under a single Accountable Care Organization. While we try to structure our value-based reimbursement arrangements with ACOs to achieve the best value for our employer clients, we have little to no control over how ACOs flow funding through their organizations. Nor do we have significant visibility into this dynamic. Requiring ACOs to report publicly how much of their revenue is being spent on primary care and behavioral health services would provide important data into the service areas that ACOs are prioritizing. It would also allow health care purchasers to better rationalize spending for certain ACOs.

2) Improve Patient Education
It is critical that the importance of the primary care be reinforced to both the purchasers and consumers of health care services. Patients often do not engage with PCPs until they are either in crisis or have developed a chronic condition. A public health campaign to encourage and educate the general population regarding the need to identify and engage with a PCP would reinforce the importance of preventive care.

2) Improve Existing Privacy Regulations
Due to privacy regulations (e.g. 42 CFR Part 2), coordination of behavioral health care and substance use disorder treatment with PCPs can be challenging. Often, treating providers are unable to communicate critical needs to PCPs because of the heightened requirement of permission to share information on mental health or addiction. This leads to segmented treatment with providers operating independently instead of within a coordinated fashion with common goals of patient wellness and the delivery of high-value coordinated care.

3) Supporting Integration

Supporting integration at the primary care level is critical. For patients suffering with mental health and/or substance use disorders, integration of skilled behavioral health professionals with medical providers should be the gold-standard in treatment. This is easiest to achieve when those specialties work in a coordinated fashion. Provider organizations that commit to investing in integration pilots, medical home models, high touch behavioral health services and early intervention and screening will be critical for future success.

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	Major Contributing Factor
Aging of your members	Major Contributing Factor
New or improved EHRs that have increased providers' ability to document diagnostic information	Minor Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with providers to assist with capturing diagnostic information)	Minor Contributing Factor
New, relatively less healthy patients entering your patient pool	Minor Contributing Factor
Relatively healthier patients leaving your patient pool	Minor Contributing 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.

Tufts Health Plan employs a team of certified medical coders with specific expertise in diagnosis coding accuracy. This quality assurance team within Tufts Health Plan performs coding and documentation audits to identify and remediate provider coding errors. The team also performs coding and documentation trainings and education to providers and their staff.

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	Medium
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	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	Low

Area of Administrative Complexity	Priority Level
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.

TAHMO has the electronic systems and the functionality in place for providers to perform all of these transactions electronically. The primary barrier to performing these transactions entirely electronically is provider ability and willingness to comply and adopt electronic methods for performing transactions. Additionally, for some providers, a lack of existing infrastructure poses a barrier to performing transactions fully electronically. For example, some segments of the provider community, such as behavioral health providers, may not have the electronic resources and tools that allow them to work or comply with electronic methods of performing some of these transactions.

Also, while TAHMO does not charge providers for submitting claims electronically, some providers may submit through a clearing house which charges them for their services. This may impose a financial barrier for some providers.

Transaction	Manual[1]	Partially Electronic[2]	Fully Electronic, in Accordance with ASC X12N
Eligibility and Benefit Verification	Benefits – 70,082 Eligibility – 52,232	Web portal – 1,012,358 IVR - 212,994	30,394,813[3]
Prior Authorization		100,564[4]	1,334[5]
Claim Submission[6]	445,064	n/a	6,806,260
Claim Status Inquiry	135,137	Web portal – 1,653,801 IVR – 292,584	216,465[7]
Claim Payment	100,874	n/a	750,312
Remittance Advice[8]	n/a	n/a	1,565,498

1. CY2018 call volume transactions are reported for *Eligibility and Benefit Verification*, and *Claims Status Inquiry* transactions. CY 2018 paper payment and paper submission transaction volumes are reported for *Claim Payment* and *Claim Submission* transactions.

[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

2. CY 2018 Provider web portal and IVR transaction volumes are reported for *Eligibility and Benefit Verification*, and *Claims Status Inquiry* transactions. Transaction volumes reported include both TAHMO commercial products and senior products operated by Tufts Medicare Preferred.
3. CY 2018 *Eligibility and Benefit Verification* EDI transaction volume reported includes all products in all lines of business: TAHMO commercial, TMP senior products and Tufts Health Public Plans.
4. Includes medical, behavioral health and pharmacy claims. Although some submissions are electronic and approved without manual intervention, we believe the entire process is not compliant with ASC X12N.
5. Pharmacy claims only.
6. *Claims Submission* and *Claims Payment* manual and fully electronic (EDI) transaction volumes reported include TAHMO employer-sponsored products only.
7. CY2018 *Claims Status Inquiry* EDI transaction volumes includes both TAHMO commercial products and senior products operated by Tufts Medicare Preferred.
8 CY2018 *Remittance Advice* transaction volume represents all Explanation of Payments documentation generated in 2018 for all TAHMO Commercial products. All EOPs must be accessed online via the vendor portal. A very small number (less than 1%) of EOPs are delivered by mail.
n/a = data not exist for transaction type

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.

As TAHMO continues to increase the depth and breadth of value-based reimbursement among its contracted network of providers, we note positive changes in both cost trends and the quality of delivered medical care.

As of 2018, we have more than 87% of our fully insured HMO membership in Massachusetts covered under value-based arrangements and have expanded value-based reimbursement to include the non-HMO population (inclusive of self-insured products that require a PCP, and fully and self-insured products where PCPs are attributed) to three large provider organizations. Additionally, we are in active discussions with numerous large provider organizations that will potentially result in further expansion of value-based terms for the non-HMO population effective for calendar year 2020. It is our projection that, as of January 2020, we will have approximately 40% of our local non-HMO patients covered under value-based reimbursement arrangements.

We work closely with all providers in our network that accept financial accountability for the total cost of care to monitor and evaluate their performance and opportunities for improvements in cost and quality. We provide comprehensive patient data, actionable reporting and tailored consulting to at-risk providers to support the management of care as efficiently and effectively as possible. Additionally, we support providers in the following areas of focus: cost and utilization management, the prospective identification of high cost patients, referral pattern opportunities, practice pattern variation, quality performance and care management effectiveness. This data sharing, reporting and

collaboration promote the development of provider-specific roadmaps for maximizing quality and efficiency. We also believe that, based on our existing value-based efforts in the commercial population, and our efforts with Accountable Care Organizations through MassHealth (Tufts Health Public Plans), there will be opportunities to develop learnings and better understand best practices. It is our expectation that we will deploy those learnings and best practice behaviors across our network of providers to continue to improve performance.

Finally, it is important to note that 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 will limit full adoption of value-based arrangements across our provider network.

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**	4523	156
	Q2	4155	140
	Q3	3841	144
	Q4	4521	118
CY2019	**Q1**	5481	178
	Q2	4755	178
	TOTAL:	27,276	914

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.

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. Tufts Health Plan has observed a similar rate of benefit buy down over that period.

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: TAHMO reviews payment policies and procedures for consistency across business lines (to the extent possible), and when differences are required, documents those differences in a consistent manner that is clear for our provider networks. Additionally, we often develop and implement payment policies and procedures that align with nationally accepted standards.

    b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.): Based on feedback from external stakeholders, TAHMO has shifted a significant portion of its inpatient reimbursement from per diem to diagnosis-related grouper (DRG) based reimbursement, in an effort to align with more standard reimbursement methodologies. This change was implemented in collaboration with each affected provider. For outpatient and professional health services, TAHMO develops and, where deemed appropriate, aligns its fee schedules with those of the Centers for Medicare and Medicaid Services (CMS). These fee schedules are reviewed annually with consideration given to any changes that CMS has proposed for the upcoming year.

    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.): TAHMO adjusts for health status using industry-standard models. This approach aligns with other health plans and reduces the administrative burden on providers.

        ☒ Risk structure (e.g., risk exposure, the allowed budget, exclusions, bonuses, quality performance, etc.): TAHMO understands that each provider group is unique and works closely with providers to develop a mutually agreeable value-based structure that appropriately incentivizes providers to provide high-quality, cost-effective care and aligns with the provider's capabilities and infrastructure. This approach provides opportunities to develop a value-based structure that aligns priorities, minimizes complexity and increases standardization for both providers and TAHMO.

        ☒ Use of pre-paid lump sum payments (rather than volume-based, fee-for-service interim basis payments):
        For providers that are able to effectively manage reimbursement through pre-paid lump sum payments, TAHMO collaborates with these providers to develop a mutually agreeable structure that appropriately incentivizes providers to provide high-quality, cost-effective care. This approach provides opportunities to develop a reimbursement arrangement that aligns with the provider's priorities, minimizes complexity and increases standardization for both providers and TAHMO.

        ☒ Other, please describe:
        TAHMO developed, implemented and maintains additional innovative and flexible reimbursement structures beyond those highlighted above that are deployed among

high-value providers. These additional models include a substance use disorder pilot predicated on a reimbursement arrangement that provides for flexibility in the use of resources and a bundled payment specific to hip and knee replacements. These arrangements are designed to align objectives between the provider, the purchaser and the health plan and to promote the delivery of high-value care

d. Please describe any ways in which your unique payment approach brings value to patients, plan sponsors, or payers: TAHMO developed and implemented a variety of initiatives to establish provider incentives for the delivery of high-value medical care. Those initiatives include the implementation and maintenance of value-based reimbursement models, which hold providers financially accountable for the cost of the medical care delivered. These accountable care arrangements offer financial incentives to providers to maximize population health and wellness and focus on cost efficiency and remove the incentive for increased usage. We believe that structuring reimbursement arrangements that incentivize providers to focus on population health and cost efficiency will have the effect of maximizing quality and patient experience while controlling expense trend. We strive for aligned incentives through these models because we believe that fee for service utilization driven models are unlikely to achieve similar high value outcomes. While maintaining a robust network of providers, we maintain discipline and diligence in structuring value-based reimbursement arrangements. These value-based financial arrangements can take the shape of sharing financial risk with our provider partners on total medical expense or reimbursing providers via an all-inclusive bundled price for select services. Depending on the provider's capabilities and infrastructure, we employ a number of approaches designed to maximize the quality and efficiency of the care delivered. Our contracting efforts have been successful in that the number of providers in our value-based model has more than doubled since 2009. Finally, we recently expanded value-based arrangements to our self-insured clients; as such, we now have select providers that accept financial accountability for self-insured populations that both select a primary care physician and, for PPO populations, that are attributed to primary care physicians.

   Additionally, we drive value to patients and the purchasers of health care services through unique arrangements with our network providers. Such initiatives include: 1)The implementation of an orthopedic bundled payment arrangement with a premier center of excellence in the field designed to steer volume to the high-value provider that willingly accepts financial accountability for cost and quality outcomes and 2) The establishment of a substance use disorder payment arrangement with a center of excellence designed to maximize long-term adherence to treatment through a focus on community care and provider coordination and a minimization of inpatient and emergent costs.

   Finally, we continue to drive value to patients and the purchasers of health care coverage by the manner in which we partner with providers under value-based arrangements. For providers accepting financial accountability for the total cost of care, we provide comprehensive patient data, actionable reporting and tailored consulting to manage care as efficiently and effectively as possible. The areas of focus include but are not limited to cost and utilization management, the prospective identification of high cost patients, referral pattern opportunities, practice pattern variation, quality performance and care management effectiveness. This data sharing, reporting and collaboration promote the development of provider-specific roadmaps for maximizing quality and efficiency.

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?
    TAHMO believes there are two main barriers to shifting to pre-paid lump sum payments. **1) Lack of Technical Infrastructure.** Most providers seem to lack the technical infrastructure and willingness to manage pre-paid lump sum payments. Current billing and revenue systems are maintained to disseminate revenue under a fee-for-service paradigm and are incapable of distributing revenue on a prospective basis to primary care, specialty physicians, and advance practice clinicians. Provider organizations would likely need to invest in significant infrastructure changes to implement a pre-paid lump sum payment model.

    2) Provider Compensation Misalignment. TAHMO believes that provider groups would need to make material and substantial changes to the employed provider compensation structure to appropriately incentivize employed providers to manage total medical expense and drive improvements in wellness. Current compensation models are likely heavily predicated on volume and therefore would not well align with a pre-paid payment system. Additionally, it would be worthwhile to study the implications of deploying a pre-paid lump sum payment approach on non-employed providers practicing through a provider organization or health system.

    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?
    As indicated above, although the majority of our provider network maintains a value-based reimbursement structure, the payment methodology is largely still predicated on a fee-for-service paradigm. As such, the percentage of our medical payments for commercial products that are paid on an interim basis under a fee-for-service claims adjudication is 98.7%.

HPC Payer Exhibit 1

All cells should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured product lines

	Unit Cost	Utilization	Mix	Total
CY 2016	2.7%	2.0%	0.4%	5.1%
CY 2017	3.4%	0.7%	-1.7%	2.4%
CY 2018	2.7%	0.8%	-0.1%	3.4%

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.