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) Intensified effort to restrain increases in contractual arrangements despite increased pressure from providers to raise reimbursement levels to match those at the highest levels in the state.
(2) Continuing movement of alternative approaches to provider payment including gain sharing arrangements with large entities, value-based payments with mid-sized practices and bundled arrangements for targeted surgical procedures.
(3) Integration of behavioral health services, i.e., "carve in", to enhance coordinated case management, outreach and data analysis and planning. As part of that integration Anthem is undertaking acquisition of Beacon Health Options before 2020 which will optimize this integration effort.

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

UniCare believes there are a number of policy measures that could be enacted at the federal level that would address the pricing dynamics within the drug industry. In particular, pharmaceutical manufacturers often engage in anticompetitive and other tactics that increase costs in ways that are gaming the system and should be stopped by the federal government. We are supportive of action in the following areas: **REMS reform:** We support the Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act, currently under consideration in the U.S. Congress, which if passed, would curtail abuses of the Risk Evaluation and Mitigation Strategies (REMS) system. We believe this system, which manufacturers have used to block generic and biosimilar development by keeping samples out of the hands of competitors, has been misused for too long, resulting in less competition and increased costs. **Pay-for-delay:** We believe that greater action and transparency is needed when a manufacturer is using financial incentives to induce a generic manufacturer to not produce a drug (i.e. pay-for-delay). We encourage the Federal Trade Commission (FTC) to continue monitoring these arrangements, pursue litigation and file *amicus* briefs when necessary, and advise Congress on a legislative solution prohibiting such agreements; and **"Evergreening" and "Product hopping"** actions should be taken to discourage these two manufacturer tactics that mitigate the market impact of generics by creating new products that are similar to old products. **Manufacturer Copay Assistance Programs:** Copay card prohibitions, which currently exist in government-sponsored programs like Medicare and Medicaid, should extend to the Affordable Care Act (ACA) Exchange market. Copay cards increase required spending by payers, enrollees, and the federal government (in certain

Non-Medicare/Medicaid programs). These third-party payments circumvent health plans deliberate plan design, leading to utilization and cost trends that contribute significantly to premium affordability challenges. Manufacturer coupons can also challenge efforts to improve quality and health outcomes. When a consumer uses a copay card, those claims may not hit a claims system, creating a loss of data that erodes our clinical programs by limiting insight into utilization metrics that confirm clinical appropriateness and flag for safety issues. **Manufacturer List Price Transparency and Accountability:** We believe that creating and maintaining a drug price dashboard tool can improve price transparency in Medicare and Medicaid and promote competition. **Direct-to-Consumer Advertising:** We support efforts that would require manufacturers to include/list prices in their advertisements and improve upon the existing disclosure requirements to ensure there is greater alignment between trial results and advertisements. **Site-Neutral Payments:** We support efforts to implement site-neutral payments for drugs administered in hospital outpatient settings versus those in freestanding outpatient and physician offices. These reimbursement incentives also contribute to provider consolidation strategies that increase costs for consumers, employers, and taxpayers. UniCare along with many academic researchers believes that the consolidation of healthcare providers and hospitals has a direct impact on pricing within a given market. For example, the Robert Wood Johnson Foundation has published research that suggests prices for hospital services can increase 40% or more when merging hospitals are closely located. We believe this continuing national trend requires additional attention from the Federal Trade Commission (FTC). We believe that robust review and action by the FTC on hospital merger applications would have the most impact. The FTC should pay significant attention to hospital mergers and acquisitions to evaluate the impacts that provider consolidation will have on healthcare prices and seek to block those that are anti-competitive.

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.

In Massachusetts, UniCare has introduced its Primary Care Centered (PC2) programs, focused on supporting primary care physicians in their management of our members. These programs attribute plan members to primary care physicians and provide monthly care coordination payments for those members. Financial, quality and utilization performance are evaluated each year of the program and can produce additional gain sharing reimbursement to the practices. Although the numbers are modest, recent analysis has shown downward trends in inpatient admissions and outpatient surgeries and upward trending in PCP utilization. Recent claims data analysis shows a modest increase of about 2% in Primary Care visits per thousand year over year.

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.

This year we "carved in" behavioral health benefits and management for our plans. This integration approach for behavioral health with the medical plan enabled more comprehensive medical management. Care management integration activities included data sharing, weekly rounds, routine referrals from medical case managers to behavioral health case managers and vice versa, and reporting. Additionally, as part of this integration effort, we worked with our behavioral health partner to increase reimbursement to a large number of providers with focus on independent behavioral health providers. It is too early to be able to assess the impact on quality, utilization or cost.

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?

We would recommend several approaches that provider organizations consider to improve primary care and behavioral health services. 1. Support efforts to increase the PCP base and expand access in numbers of providers and hours. 2. Increase gain sharing arrangements with PCPs to encourage their participation in value based payments. 3. Support efforts to incorporate behavioral health providers within PCP group practices. 4. Support the introduction of medication assisted treatment for substance use disorder within primary care practices.

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?

Reimbursement levels represent a critical factor relative to investment in both primary care and behavioral health Reimbursement to these providers lags behind that to procedural based providers. Movement to a more equitable payment methodology across all providers would help address this issue. Additionally, the disparity of reimbursement levels, driven by market power alone, reduces the availability of resources to increase investment in primary care and behavioral health. Efforts to restrain market power should consider linkage to efforts to improve investment in primary care and behavioral health services.

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	Major 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.

At the present time we have not introduced any initiatives of this nature.

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

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

[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

Transaction	Manual or Partially Electronic	Fully Electronic, in Accordance with ASC X12N
Eligibility and Benefit Verification	Not available on an account basis	N/A
Prior Authorization	36,936	None
Claim Submission	24,910	4,229,513
Claim Status Inquiry	This data is not available at the local level	
Claim Payment	40% checks	60% EFTs
Remittance Advice	40%	60%

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.

In the last year we have introduced a program to engage smaller primary are practices in gain sharing arrangements. These arrangements include monthly reimbursement on a PMPM basis for care coordination activities and potential reimbursement at the end of the performance year related to performance on quality and utilization measures.

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**	2250	690
	Q2	1894	898
	Q3	1092	883
	Q4	756	871
CY2019	**Q1**	391	888
	Q2	368	858
	TOTAL:	6751	5088

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.

Please see HPC Payer Exhibit 1 for summary table.

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: Payment policies and procedures are intended to be in line with prevailing industry practices across the country and in Massachusetts.

    b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.): We utilize prevailing approaches to payments structure including DRGs for inpatient stays and fee schedules that reference existing Medicare fee schedules for consistency and standardization across provider contract periods and across providers in general.

    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.):

        For our larger providers in APMS, we allow them to develop several aspects of our program to be consistent with other programs in which they participate including level of bonuses and risk, quality measures, and exclusions.

        ☐ 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:

        Our approach is consistent with other approaches in the market to shared savings arrangements. Our shared savings arrangements in Massachusetts are based upon members in an indemnity plan. Given the nature of the indemnity plan, with no requirement for PCP selection, our approach provides leeway for customization at the provider level to deal with concerns around smaller panel sizes and lack of affirmative assignment of members to specific providers.

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?

The major barrier to changing from a fee for service, transaction based payment approach to a pre-paid lump sum is the volume of members with a given provider organization. As numbers fall below certain levels, the predictability of expected use of resources becomes less reliable.

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?

All medical payments are made using fee for service adjudication. Value based contracts retrospectively look at the claims and then terms of the APMs are applied for the ultimate payment.

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	3.6%	2.1%	1.0%	-3.9%	2.6%
CY 2017	2.2%	-4.3%	-0.2%	1.1%	-1.4%
CY 2018	1.2%	1.4%	1.4%	-0.8%	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.

Question 7	CY 2016	CY 2017	CY 2018
(a) Change in Demographics	included in (c) below		
(b) Benefit Buy-down Effect:	-0.6%	-0.5%	-0.4%
(c) Change in Health Status / Risk Score	-2.0%	1.1%	0.0%

The health status of the UniCare GIC population has been fairly stable over time.