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?

UnitedHealthcare's ("UHC") top strategic priorities include a continued focus on value based contracting while deemphasizing payment based on the volume of care provided; review of exclusive provider arrangements and the impact such arrangements have on members and providers; and review of hospital and physician consolidations and ensuring that rate caps remain in place. Activities taken to address these priorities include contracting strategies that employ alternative payment methodologies and efforts to shift the delivery of care from high-cost settings, e.g., academic medical centers, to community hospitals, with the aim of reducing unnecessary hospital utilization (e.g., avoidable emergency department use, admissions and readmissions). These initiatives are relatively new, and data is not yet available to definitively determine whether such activities increase access, improve quality or reduce the total cost of care.

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

The following changes would most support our efforts to reduce health care expenditures: (1) increased regulatory oversight of provider practices resulting in surprise billing, possibly including: (a) requirements fostering improved transparency in regard to hospitals that employ providers that bill under an FTIN different from the facility; (b) stricter limitations on non-contracted provider reimbursements for surprise billing situations; (2) efforts to minimize negative cost impacts associated with provider consolidation, possibly including: (a) requiring that health systems disclose increased MCO reimbursement rates resulting from provider consolidation (acquired provider contract rates revert to more expensive health system contract rates); (b) improved transparency when providers change billing FTIN as a result of provider consolidation; (c) requiring maintenance of in force MCO rates for a period of time following provider consolidation; (3) Increased oversight of health system use of facility site billing (resulting in significantly higher medical cost) for office visit procedures.

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.

UHC continues to support and invest in primary care, through initiatives to (1) introduce tools to the marketplace to incent members to use ACOs, which perform better in terms of care delivery and member cost, (2) provide primary care offices with access to tools that can help reduce paperwork, streamline administrative task management, monitor patient needs and improve member outcomes, (3) increase utilization of telemedicine, (4) expand the number of contracts with Federally Qualified Health Centers, and (5) implement incentives to encourage the use of Ambulatory Care Centers when appropriate, rather than hospitals, through the development of a preferred list of procedures that can be performed in such centers, thereby reducing costs.

These initiatives are relatively new and data is not yet available to definitively state whether such activities increase access, improve quality or reduce the total cost of care.

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.

Through our partnership with our UnitedHealth Group affiliate, Optum Behavioral Health ("Optum"), UHC has invested in behavioral healthcare with a focus on meeting the increased demand for access to treatment while simultaneously working to ensure the treatment provided meets standards for quality and is evidence-based, cost effective care.

Currently this partnership provides material benefits to our membership in support of their behavioral health through the following initiatives:

- Large performance-tiered behavioral health network: UHC has over 14,000 participating behavioral providers in Massachusetts, including 2,400 prescribers (psychiatrists and physician extenders with prescribing privileges) along with access to the nation's largest performance-tiered behavioral health network with 195,000 providers.
- Care access support: UHC has made substantial investments in capabilities to help members access the care they need quickly and efficiently. This includes Virtual Visits (telehealth) and the Express Access Network (a subset of the Optum behavioral provider network that has committed to seeing UHC members within 5 business days), which both reduce appointment wait times by 50%.
- Dedicated regional clinical teams: UHC's fully-dedicated, Northeast-based team of behavioral clinician care advocates partner with UHC to clinically manage complex members.
- Advanced clinical algorithms: Our sophisticated clinical algorithms developed with over 35 million lives of longitudinal data, helps to uncover latent behavioral health gaps in care, and pinpoint opportunities for clinical intervention.

- Market-leading clinical programs: Guiding members and their families into the highest quality evidence-based treatments for substance use disorders, and providing longitudinal clinical support, helps create the best opportunity for member recovery.

In addition, UHC has partnered with Optum to help ensure quality care is delivered in an integrated way, to improve outcomes at reduced costs. Optum's model is built around 3 major pillars:

1. Connecting people to quality care
2. Guiding high-impact, integrated care
3. Engaging and supporting individuals.

Connecting people to quality care

Access to services is vital, so Optum makes it easier for individuals to get evidence-based treatment from top-performing providers.

- Our large network includes providers and specialists at all levels of mental health care and substance use disorder treatment.
- Optum performs clinical vetting of its provider network, ensuring safe, high-quality member care.
- Innovative approaches to member access and availability include our Express Access Network providers, who guarantee that they will see UHC members within 5 business days. This is important, because medical research suggests that due to the stigma associated with mental health and substance use disorders, if a newly referred patient does not see their behavioral provider within 7 days, their likelihood of following through plummets.
- Optum has an integrated tele-mental health network which enables us to provide a secure, HIPAA / 42 CFR Part 2 compliant portal to all of our providers and members at no extra cost to either.

Guiding high-impact, integrated care

With groundbreaking data analytics and clinical insights, Optum offers a more intelligent approach to integrating care for greatest impact through the following:

- Population health approach to Behavioral Health, which expands beyond the industry's historical focus on outlier management, enabling Optum to proactively engage members and address their clinical issues. This broadens and deepens reach within a member population
- Advanced data-driven analytics that pinpoint clinical opportunities for member intervention. Most industry analytics attempt to predict population outlier costs. However, there is a significant swath of members who are complex and require a lot of care, but if their conditions are well-managed, without gaps in care, there is little opportunity for clinical intervention. Optum's analytics are built to identify addressable clinical intervention opportunities, to create the greatest clinical impact on the population.
- Integrated platforms and workflows with UHC's clinical staff, to provide a seamless holistic member experience, and to support members with the most clinically-appropriate degree of touch.
- Holistic clinical management approach to the opioid epidemic and substance use disorders, which provides end-to-end support for the member and their family throughout the recovery journey. This includes Medication Assisted Treatment ("MAT"), behavioral therapy (to address underlying drivers for substance use), and longitudinal peer recovery coaching support.

- Large network of MAT providers (with over 500 providers contracted in Massachusetts) which is the strongest evidence-based treatment for substance use disorder, with recovery rates of 5-6x that of standard detoxification.

Engaging and supporting individuals

Individuals get the most out of their care when they are actively involved. Optum offers tools and support that inspire people to become invested in their own wellness, helping to ensure improved outcomes.

- Clinical member support resources, including both inbound call centers and online portal-based tools, guide members to the right care, at the right time, in the right setting.
- Substance Use Disorder recovery experts help individuals remain engaged and adherent with their recovery plans. This includes an SUD Helpline, which is staffed 24 hours a day, 7 days a week, and provides members with clinical guidance, education, and steerage to evidence based providers.
- An entire portfolio of education resources and self-care tools to promote a positive way of life, enabling members to take charge of their conditions. These are accessed through our member portal: www.liveandworkwell.com.
- Continual investment with innovative partners to support greater member engagement with their overall health and well-being.

Regarding whether such initiatives are increasing access, improving quality or reducing total cost of care, we do not yet have available data to reach definitive conclusions.

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?

The following have been identified as actionable strategies that provider organizations ("POs") can implement to strengthen and support primary and behavioral health care: (1) better integrate primary and behavioral healthcare: enhance the integration of primary care and behavioral health through the (a) creation of incentives that would, for example, encourage small behavioral health practices to integrate with larger multi-group practices so that reimbursement and care for primary care and behavioral health are aligned and integrated), (b) inclusion of behavioral health providers into large organized health systems and multi-specialty practices; (2) enhance access to behavioral care: include behavioral health services at urgent care and emergency care facilities where appropriate; (3) implement alternative payment models: apply alternative payment models in behavioral health, such as bundled payment approaches for substance use disorder treatment and recovery or inpatient admissions, to lower costs and improve care; (4) develop behavioral health evidence based guidelines: develop guidelines and best practices as well as behavioral health quality measures that are supported by data and not defer to subjective treatment approaches that may be unsupported by meaningful data and analysis; and (5) promote utilization of behavioral health evidence based guidelines once developed: incentivize and promote provider adherence to evidence based practice and minimize variations in practice; (6) improve care access: POs can help improve care access through (a) application of afterhours appointment scheduling, (b) implementation of a 24 hour service delivery model at a minimum of three days per week, and (c) greater use of physician assistants or nurse practitioners; (7) simplify scheduling: POs could

establish easier pathways to schedule medical appointments by leveraging various IT appointment scheduling technologies, thereby encouraging greater and more prompt access to care; (8) improve care management: POs could improve care management through (a) adoption of more triage, and better utilization of care management nurses allowed to take on appointments themselves, such as routine diabetic care, flu shot clinics, nutritional education and high risk care management programs. This would create more free time in physician schedules, helping to improve overall quality of care and patient satisfaction; (b) expanded use of house calls by nurses and physicians, providing the opportunity to better address social determinants of health, and integration of case management and social work support to high risk members.

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?
We have outlined key aspects of improving the system in our responses above. In addition we encourage HPC to evaluate the importance of maintaining the independence of primary care and behavioral health practices, and supporting that independence through policy. We believe these suggestions create a framework for discussion, study, analysis and ultimately legislative/regulatory action if appropriate. However, consideration, further study and ultimately piloting the concepts above should precede any legislative effort to codify mandates for changes in the system that may result in unintended or harmful consequences.

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	Minor Contributing Factor
New or improved EHRs that have increased providers' ability to document diagnostic information	Not a Significant Factor
Coding integrity initiatives (e.g., hiring consultants or working with providers to assist with capturing diagnostic information)	Not a Significant Factor
New, relatively less healthy patients entering your patient pool	Minor Contributing Factor
Relatively healthier patients leaving your patient pool	Minor Contributing Factor

Factors	Level of Contribution
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Not a Significant Factor
Other, please describe: Click here to enter text.	Minor Contributing Factor

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

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

The following payment integrity programs help ensure that increased risk scores reflect increased medical needs.

Our Fraud, Waste, Abuse & Error initiative is designed to identify intentional and unintentional billing and coding inaccuracies in provider and facility claims, not identifiable through standard claim review processes.

We also apply automated claim edits to ensure accurate claim payment, as well as a consistent member and provider experience, based on correct coding and industry standards for HIPPA, state and federal regulations, etc.

We routinely develop and implement facility audits designed to identify billing and coding inaccuracies.

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	Medium
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

Area of Administrative Complexity	Priority Level
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, 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.
UHC does not have barriers to performing the transactions listed entirely electronically. Please note that the numbers listed below are national numbers for our commercial and Medicaid business. UHC does not track these numbers on a state by state basis.

[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	329,490,442	1,215,797,996
Prior Authorization	7,088,212	1,099,854
Claim Submission	23,314,205	513,260,763
Claim Status Inquiry	218,079,272	170,978,248
Claim Payment	82,387,049	528,162,370
Remittance Advice	N/A	65,583,839

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.
UHC continues its drive towards the development and implementation of alternative payment, value based agreements, and works closely with providers to further this objective.

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**	3,345	
	Q2	2,812	
	Q3	2,739	
	Q4	2,813	
CY2019	**Q1**	3,841	
	Q2	3,152	
	TOTAL:	18,702	

*The UHC online cost estimator tool provides non-binding cost estimates, and directs members desiring the estimate described in Chapter 224 of the Acts of 2012, to call customer service. The numbers shown above reflect Massachusetts members seeking a non-binding cost estimate on myUHC.com.

**UHC does not separately track phone inquiries for the cost estimates described in Chapter 224 of the Acts of 2012. UHC tracks overall benefit and coverage related calls, which could include cost estimate inquiries.

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.

HPC Payer Exhibit 1 is attached. With respect to 2016 to 2018 and portions of actual observed allowed claims trends, we were able to determine that due to changing demographics, our age/gender risk scores increased by 0.45% between 2016 to 2017, and by 1.44% between 2017 to 2018. We were not able to parse available information to determine the impact of benefit buy down or changes in population health status. We have, however, consistently observed changes in provider coding practices that result in increased risk scores.

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 standardized.

    b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.): Payment structures are standardized across provider types.

    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.):
        Claims coding and scoring are standardized for all providers in alternative payment programs.
        ☒ Risk structure (e.g., risk exposure, the allowed budget, exclusions, bonuses, quality performance, etc.):
        Risk baseline is standardized for all providers in alternative payment programs
        ☐ 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: Standardized coding payment policies are critical as they directly impact provider payment levels and member payment obligations by supporting consistent and accurate claim adjudication, assist members in understanding services received across all provider types, and may affect medical care received if services are coded incorrectly.

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 88% MLR in Massachusetts limits the flexibility of the payer community, by leaving it with little margin to formulate and implement pre-paid lump sum payment models that remain within the MLR parameters. Additionally, many providers have low patient volume, making it difficult to craft a prepayment model that is statistically credible. Without the volume to be successful in these complex reimbursement models, payers are required to enter into a complex and administratively burdensome reconciliation process, so neither simplicity nor value is achieved.

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?
Approximately 75% fee for service and 25% value based.

CERTIFICATION

The foregoing statements, opinions and data were compiled from responses provided to me by employees of UnitedHealthcare and are true and correct to the best of my knowledge and belief.

I affirm that I am legally authorized and empowered to represent UnitedHealthcare Insurance Company for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury.

Dated this 20th day of September, 2019

UNITEDHEALTHCARE INSURANCE COMPANY

Signed:

Stephen J. Farrell
Health Plan CEO

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	-5.50%	15.30%	N/A	N/A	8.90%
CY 2017	5.90%	10.20%	N/A	N/A	16.70%
CY 2018	-1.97%	11.71%	N/A	N/A	9.52%

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.