Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine 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.

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us 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 panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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 that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and 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 other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY:
   a. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?
      Optum has worked and continues to work to ensure that all negotiations and renegotiations with Hospital, Physician,and Ancillary providers, where appropriate, include inflation (growth) language that maintains spending increases below the above mentioned growth benchmark.
   b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?
      Optum intends to maintain the dilegence that is has demonstrated since the inception of Chapter 224 when negotiating or renegotiating with providers.

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2. C. 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.
   SUMMARY:
   a. Please describe your organization's efforts to date in meeting this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs)(payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) on your (i) total medical expenses, (ii) premiums and (iii) provider quality.
      Most of Optum's book of business in Massachusetts is Administrative Services Only (ASO) where members are part of self-funded plans that have branch offices in Massachusetts and require health care provider reimbursement be consistent across all of the states in which the plan sponsor has members, thus Optum has not, to date, transitioned providers from traditional fee-for-service payment methodologies.
   b. What efforts does your organization plan between now and October 1, 2015 to increase your use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider types?

Optum does not plan any changes to its payment methods between now and October 1, 2015.

3. Please quantify your organization's experience implementing risk contracts across your provider network using the template below. For purposes of this question, "risk contracts" refers to contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to the provider, including contracts that subject the provider to limited or minimal "downside" risk.

   SUMMARY: Optum does not utilize provider risk contracts in Massachusetts

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012	0	0
CY2013	0	0

4. Please identify and explain the principal factors considered in formulating risk adjustment measures used in establishing risk contracts or other APM contracts with providers, including how you adjust for changes in population health status over the contract term.

   SUMMARY: Optum would utilize industry standard Age and Sex factors in formulating risk adjustment factors.

   a. Does your organization use a common approach to risk adjustment for all providers? If not, what factors support the need for the application of different measures or adjustments for different providers or provider organizations?
      Yes
   b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of risk adjustment measures for use in contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?
      Optum continues to utilize industry standard measures and would work to ensure that any Massachusetts specific measures are consistent for implementation on its national book of business.
   c. What progress has your organization made to date regarding the development and implementation of population-based socioeconomic adjustments to risk budgets? What plans does your organization have in this area?
      Optum has not implemented risk budgets in any of its medical provider contracts to date in Massachusetts.
   d. How do any such differences interact with other contract elements that materially affect risk budgets and performance-based payments, and what are the results of any analyses conducted by your organization regarding variation in provider performance under different measures and adjustments?
      N/A---See answer to 'c' above.

5. Please identify and explain the principal factors considered in selecting quality metrics used in establishing APM contracts with providers.
   SUMMARY: Optum utilizes applicable industry standard and nationally recognized qualtiy metrics such as NCQA Patient Centered Medical Home designation, HEDIS measures, and Hospital Compare scores.
   a. Does your organization use a common approach to quality measurement and associated payments for all providers? If not, what factors support the need for the use of different quality measures or performance targets for different providers or provider organizations?
      Optum utilizes a standard set of quality measures available to providers. The measures utlized differ between Hospital and Physician Providers. Targets are determined based upon where a particular provider group or hospital scores against the common benchmarks and the anticipated improvement expected over a particular time period.
   b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of quality measures, such as the measures included in the Standard Quality Measure Set, for use in risk contracts and other APM contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?
      Optum does not anticipate any drawbacks to utilizing a standard set of qualtiy measures as long as those measures comply with industry standards and are transferable to all states.

6. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY: Optum's business does not involve coveage of primary care but would work to ensure its customers, such as its affiliate UnitedHealthcare ("United"), utilize an industry standard methodology for attribution of members to primary care providers for its commercial plans. The methodology utilized by United includes a retrospective review of claims submitted for care on behalf of United members. Providers who have submitted two claims over a twelve month period of deemed to be the principal physician for that member. The responses below relate to our commercial plans.
   a. Describe your current attribution methodology (or methodologies), identifying the purpose(s) for which it is (or they are) used, and include the following information:
      i. provider types considered for attribution (e.g., primary care physicians, specialist physicians, NPs/PAs)
         The methodology is consistent across all of the above mentioned provider types.
      ii. units used in counting services (e.g., number of claims, share of allowed expenditures)
         Number of claims is utilzed.
      iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)
         Both E&M and procedure codes are utilized in the methodology.

iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and Twelve months
v. whether patients are attributed retrospectively or prospectively. The are attributed retrospectively

b. Please describe your efforts to develop a comprehensive attribution methodology, including the current status of your efforts to validate, pilot and implement a methodology for purposes of implementing risk contracts and other APM contracts for PPO insurance products. What resulting barriers or challenges has your organization faced?
Optum, by its affiliate United, supports the methodology described in summary above consistently across all of its product lines, including PPO products.

c. What values and/or drawbacks does your organization identify regarding potential standardization of attribution methods, both across providers and across payers? What are the values and/or drawbacks of differentiation?
Optum does not see any drawbacks to standardizing attribution methodologies as long as they are consistent with industry standard in all states, including Massachusetts.

d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?
Optum will continue to support the current attribution methodology during 2015.

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7. Describe your organization's efforts and results in developing insurance products that encourage members to use high-value (high-quality, low-cost) care and providers, including but not limited to tiered network and limited network products. Please attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending.
SUMMARY:
ANSWER: Optum does not currently offer limited or tiered network products in Massachusetts but is considering offering such products in the future. In the meantime, Optum provides communications to its members on the beneficial cost differentials of accessing services from network providers versus accessing services from non-network providers. Optum also provides members with tools to better understand their provider choices and costs associated with those choices. As an example, Optum has implemented a healthcare cost estimator tool on its member website. The application is known as MyHealthcare Cost Estimator and is accessible at liveandworkwell.com or through United's site myuhc.com. Members are also able to obtain cost estimates by calling the customer service telephone number provided on their ID cards. A customer service representative will assist the member in obtaining the requested information. Optum has sent communications to its members to educate them on the availability of the tool and how to obtain information through the web portal and customer service. The cost estimator tool covers members and providers in all parts of the state.

8. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY:

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1	0	0	
	Q2	0	0	
	Q3	0	0	
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER: Optum has no very minimal active membership in the Commonwealth and has no recorded inquiries currently. Response times would be immediate for members who access our cost estimator tool on our website and for calls received from members that are made to our Customer Service teams.

9. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than national average utilization of inpatient care and its heavy reliance on academic medical centers. Describe your organization's efforts to address these trends, including efforts to redirect appropriate care to lower cost community settings. Please attach any analyses you have conducted on such "outmigration," including specific estimates of cost savings that may be accrued through redirection of care.
SUMMARY:
ANSWER: At this time, there have not been any efforts made to shift utilization out of the academic medical centers to community settings. There has not been any analysis performed to quantify the value of such an "outmigration."

10. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with

a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
SUMMARY:

a. Please describe any efforts your organization has made to effectively address the needs of these high-cost, high-risk patients in an integrated manner.
Optum works to identify patients who have particularly complex needs due to behavioral health conditions and co-morbid medical conditions which drive increased costs. These patients are identified through a variety of means such as care coordination, claims analysis and self-identification by the patient. There are significant costs driven by utilization of emergency services and acute inpatient services which Optum attempts to address by use of timely intervention to ensure the individuals obtain services at the proper place in a timely fashion with a coordinated plan that aims to ensure the individual is able to receive the appropriate level of care to treat and manage their condition.
b. If you contract with or otherwise use a behavioral health managed care organization or "carveout," please describe how you ensure that integrated treatment is provided for these high-cost, high-risk patients.
Optum is itself such a contractor/vendor for its affiliate United and other health plans and cooridnate with those plans as described above.

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11. Please describe whether and how your organization provides financial support or incentives for a provider to achieve recognition or accreditation from a national organization as a patient-centered medical home (PCMH) or improve performance as a PCMH. Attach any analyses your organization has conducted on the impact of PCMH implementation in your provider network on outcomes, quality, and costs of care.
SUMMARY:
ANSWER: Optum does not currently financially support patient-centered medical home designation in Massachusetts.

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12. After reviewing the Commission's 2013 Cost Trends Report and July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
SUMMARY:
ANSWER: We agree with the findings stated in the reports.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2011 to 2013 according to the format and parameters provided and attached as AGO Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2011 to 2013 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).

   Completed in Attachment AGO Payer Exhibit 1

   See Exhibit C-1 Attached showing data for Optum's affiliate Unite, Optum does not have direct data

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2. Please submit a summary table according to the format and parameters provided and attached as AGO Payer Exhibit 2 with all applicable fields completed showing your total membership for members living in Massachusetts as of December 31 of each year 2010 to 2013, broken out by:
   a. Market segment (Hereafter "market segment" shall mean commercial individual, commercial small group, commercial large group, Medicare, Medicaid MCO, MassHealth, Commonwealth Care, other government. "Commercial" includes fully-insured and self-insured.)
   b. Membership whose care is reimbursed through a risk contract by market segment (Hereafter "risk contracts" shall mean contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)
   c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity).
   d. Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for hospital services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)
   e. Membership in a limited network product by market segment

(Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)

f. Membership in a high cost sharing plan by market segment
(Hereafter "high cost sharing plan" is any plan in which an individual deductible or copayment of $1,000 or more may apply to any in-network benefit at any tier level.)

Completed in Attachment AGO Payer Exhibit 2

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3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2010 to 2013, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership (e.g., why membership in PPO is growing).

The competitive climate has changed significantly in MA and because of that we have experienced significant membership declines from 2010 to 2012 for our commercial products. This applies to both the merged small group and large group markets. Furthermore, we have introduced a new small group business strategy that drives our overall focus on certain geographic areas where we remain more competitive. There were no material changes in commercial membership in 2013. For our Senior Care Option plans, we have seen substantial growth since 2010. We attribute this growth to a grass roots community outreach campaign that educates potential members to the benefits of these plans which far outweigh those of traditional Medicare or Medicaid on their own.

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4. Please explain and submit supporting documents that show for each year 2009 to 2013, (i) your total number of employer accounts and the total annual claim payments made for those employers; and (ii) the total number of such employers for whom you do not have arrangements to provide behavioral health network or management services and the total annual claim payments for such employers

(i) See Exhibit C-4 attached.
(ii) All employer accounts have arrangements to provide behavioral health network or management services.

Exhibit # 1 AGO Questions to Payers

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 2011	1.8%	18.8%	N/A	N/A	21.0%
CY 2012	-4.9%	5.6%	N/A	N/A	0.5%
CY 2013	-2.3%	5.3%	N/A	N/A	2.8%

UHC does not separate observed trends by provider or service mix

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, 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 change in provider. 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.

Exhibit C - AGO Questions for Payers

2. Please submit a summary table showing your total membership as of December 31 of each year 2010 to 2013, broken out by:

a) Market Segment (Medicare, Medicaid, other government, commercial large group, commercial small group, and commercial individual)

	December 31, 2010	December 31, 2011	December 31, 2012	December 31, 2013
Medicare	11,541	18,518	21,881	22,916
Medicaid	5,309	6,968	9,488	11,851
Other Government	0	0	0	0
Commercial Large Group	134,690	135,057	142,141	143,107
Commercial Small Group	15,508	14,582	12,493	10,879
Commercial Individual	0	0	0	0
Total	167,048	175,125	186,003	188,753

b) Membership whose care is reimbursed through a risk contract……..

NONE

c) Within your commercial large group, commercial small group, and commercial individual membership, by Product line (fully insured HMO/POS, self-insured HMO/POS, fully insured PPO/Indemnity, self-insured PPO/indemnity)

			December 31, 2010	December 31, 2011	December 31, 2012	December 31, 2013
Commercial Large Group	Fully Insured	HMO/POS	14,729	15,458	14,754	14,616
Commercial Large Group	Self Insured	HMO/POS	98,948	97,588	105,141	105,948
Commercial Large Group	Fully Insured	PPO/Indemnity	11,213	11,515	11,957	12,450
Commercial Large Group	Self Insured	PPO/Indemnity	9,800	10,496	10,289	10,093
Commercial Small Group	Fully Insured	HMO/POS	15,392	14,519	12,475	10,812
Commercial Small Group	Self Insured	HMO/POS	55	45	7	57
Commercial Small Group	Fully Insured	PPO/Indemnity	61	18	11	10
Commercial Small Group	Self Insured	PPO/Indemnity	0	0	0	0
Commercial Individual	Fully Insured	HMO/POS	0	0	0	0
Commercial Individual	Self Insured	HMO/POS	0	0	0	0
Commercial Individual	Fully Insured	PPO/Indemnity	0	0	0	0
Commercial Individual	Self Insured	PPO/Indemnity	0	0	0	0
Total			150,198	149,639	154,634	153,986

Exhibit C-4

MA FI & ASO Employer Group Information

-For MA Cost Containment 201409

	Total # of Employer Accounts	Total Annual Claim Payments
2010	4,965	176,972,976
2011	5,124	214,053,847
2012	4,953	215,022,881
2013	4,877	221,041,459

All UHC policies include coverage for behaviorial health

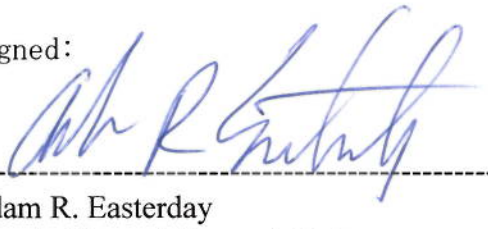
The foregoing statements, opinions and data were compiled from responses provided to me by employees of Optum and its affiliates, UnitedHealthcare, and are true and correct to the best of my knowledge and belief.

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

Dated this 8th day of September, 2014

OPTUM

Signed:



Adam R. Easterday
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