Attached please find Tufts Health Plan's written testimony for the 2014 Cost Trends Hearing. I am legally authorized and empowered to represent Tufts Health Plan and this testimony is signed under the pains and penalties of perjury.

Subscribed and sworn to, this eighth of September, 2014.

James Roosevelt, Jr.
President and Chief Executive Officer

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: Tufts Health Plan has numerous approaches to meet the health care growth benchmark. Our primary approach to mitigating the growth in total medical expense (TME) continues to be our Coordinated Care Model (CCM), which incorporates three elements that are necessary to encourage the delivery of cost-effective care. These three elements include 1) value-based, global budget contract models that pay providers for their ability to manage the overall cost and quality of care; 2) product designs that create aligned incentives for members and providers as they seek and direct care; and 3) clinical management programs that support providers who increasingly share employers' and government's goals of reducing health care cost trends.
   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?
      Tufts Health Plan has developed contracting strategies for provider negotiations with targets that have resulted in historically low unit cost levels in the past several years. Our contract negotiations take into account a number of factors, including; a provider's reimbursement relative to the network and peer group; their ability to manage TME through alternative payment methods; the margins generated from Tufts Health Plan's reimbursement; and a provider's overall quality relative to the network and peer groups. The aggregate unit cost targets plus expected utilization trends are benchmarked against the Commonwealth's health care cost growth target of 3.6%. Tufts Health Plan also has an internal Medical Trend Management (MTM), a multi-disciplinary team which conducts in-depth analyses of topics such as hospital readmissions, preventable initial admissions, emergency department overuse, and high cost services such as specialty pharmacy and oncology. As a way to address potential MTM opportunities, Tufts Health Plan regularly assesses existing, or develops new interventions in the areas of complex case management, disease management, health and wellness, utilization and level of care management, and payment and medical policies. Lastly, Tufts Health Plan continues to focus on engaging consumers in health care decisions through product design and transparency. Product design includes a portfolio of high-deductible plans and tiered/limited network products.
   b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?

Tufts Health Plan expects to continue the progress it has made using the efforts highlighted in its response to Question 1.a to help the Commonwealth meet its benchmark. We strongly believe that our CCM approach provides the appropriate alignment of reimbursement, product design, and care management to move towards controlling health care costs in a prudent and sustainable manner. To that end, we are continuously refining and updating our processes to adapt to new medical/ pharmacological usage trends and market dynamics that emerge in the Massachusetts marketplace, so that we can maximize our ability to work collaboratively with providers to achieve the benchmark set by the Commonwealth.

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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: Tufts Health Plan believes that paying providers based on their ability to manage overall cost and quality of care delivered to its members, instead of a fee-for-service bases, drives behavior change towards high-value care. Value-based contracts provide a key foundation to support the delivery of integrated, efficient, quality care.

    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.
    Tufts Health Plan first began working with providers for value in its commercial network over 15 years ago and has expanded value-based, global budget contract models to over 80% of its HMO membership. Tufts Health Plan is in the process of evaluating our risk arrangements overall and the impact on total medical expense and premium.

    Additionally, Tufts Health Plan's clinical management programs and performance reporting efforts support providers in global payment contracts by helping practices determine opportunities to deliver that right care to the right people at the right time. Results from individual provider group meetings indicate changes in referral patterns, redirecting care to lower cost providers or retaining the care in their own system.

    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?
    Tufts Health Plan has a variety of providers on alternative payment models, including physician only groups, integrated delivery systems, and specialty

groups. Because not every provider is at the same level of readiness, engagement of staff and leadership, or infrastructure to take on risk, we do not have a specific timeline for moving providers onto value-based models. Additionally, for providers who would not be good candidates for value-based contracts, Tufts Health Plan is exploring other alternative payment models, such as bundled payments, as a way to better align cost and care provided.

In addition, Tufts Health Plan has alternative payment programs in place with specialty providers of laboratory and behavioral health services. Our Laboratory Capitation Program pre-pays participating hospital, physician office, and freestanding laboratories a per member per month amount for providing certain lab tests, including clinical lab testing, genetic testing, cytopathology, and surgical pathology. Tufts Health Plan's Designated Facility Program (which is a key component of our longstanding, in-house behavioral health department) pre-pays participating providers on a capitated basis to provide care for mental health and substance abuse care, including emergency, inpatient, and partial hospitalizations, for HMO members. Our Designated Facilities are chosen for their ability to provide quality services, and we match the level and intensity of treatment to patients' clinical needs. These capitated arrangements included have been shown to be consistently cost-effective and clinically preferred to comparable fee-for-service arrangements.

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: In CY2012, over 45% of physicians in Tufts Health Plan's commercial network were participating in value-based contracts. In CY2013, the percentage of physicians in Tufts Health Plan's commercial network increased to 51%, representing an over 5% growth in the span of one year. The growth in the number of physicians providing care under value-based contracts highlights the strength of Tufts Health Plan's CCM in supporting providers who are new to alternative payment methods.

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012	13945	47
CY2013	14556	51

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: Tufts Health Plan uses DxCG Software licensed from Verisk Health to adjust for the severity of illness experienced by members associated with each provider. This software has been studied and refined for decades by academics and medical experts, and we believe that this well-tested method accounts for population-based morbidity differences, including those related to socioeconomic factors, that may affect risk budgets.
   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?
      Tufts Health Plan uses the industry standard approach to risk adjustment for all providers. Tufts Health Plan does incorporate risk adjustment as a component of the provider's budget to account for changes in the severity of illness of their members. The adjustment allows for Tufts Health Plan to incentive provider's performance improvement and not reward or penalize providers from changes in their mix of members.
   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?
      Tufts Health Plan has generally refrained from taking a prescriptive approach to standardizing risk adjustment measures. We recognize that each provider's

capacity to take on risk varies significantly, and therefore, it is important to have flexibility when structuring contracts to allow for the provider to successfully transition to value-based payment.

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?
Tufts Health Plan does not have any immediate plans to expand socioeconomic adjustments beyond population-based morbidity differences already captured in the DxCG risk adjustment methodology.

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?
Tufts Health Plan's Coordinated Care Model (CCM), aims to support providers on value-based contracts long after the contract is signed. Through our Provider Engagement Program, comprehensive data analysis is shared with providers on a quarterly basis encompassing cost and utilization data, referral pattern analysis, practice pattern analysis, quality performance measures and medical management data. Additional custom analyses are also routinely designed for individual providers based on analytical findings and provider areas of interest. Information is presented to the provider in a consultative fashion to identify areas of opportunity and providers are expected to collaboratively agree on action steps to improve performance in targeted areas.

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5. Please identify and explain the principal factors considered in selecting quality metrics used in establishing APM contracts with providers.
SUMMARY: Quality metrics are crucial to Tufts Health Plan's APM contracts with providers. We are committed to selecting specific metrics for provider groups and setting reasonable and achievable goals and targets.
    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?
    Yes, Tufts Health Plan uses a common approach to quality measurement and associated payments for all contracts. We have standard quality measures that we use in our contracts (e.g., HEDIS, CMS Process of Care Measures, Leapfrog, HCAHPS). After reviewing the measures, we select specific metrics for each provider group based on the areas where the group can make the most quality improvement. To empower and engage providers to strive for improvement, we work to set reasonable and achievable improvement goals and targets. We also consider which metrics Tufts Health Plan has as priority for improvement in any given year.

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?
The potential value of statewide standardization would be familiarity and understanding of the metrics across providers and payers. However, the drawback is the lack of flexibility, especially when a new measure is particularly important to a group, or a specialized group is working toward a specific project. The lack of flexibility could hinder provider engagement and improvement in the process.

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6. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
SUMMARY: Tufts Health Plan is committed to attributing all members to a primary care provider as required by Chapter 224.
    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)
        All provider types are considered.
        ii. units used in counting services (e.g., number of claims, share of allowed expenditures)
        We use the number of claims.
        iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)
        We use well visits, E&M, and Rx.
        iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and
        We currently use 18 months but are looking to move to 24 months.
        v. whether patients are attributed retrospectively or prospectively.
        We attribute patients prospectively in our contracts, but we also look back retrospectively for specific projects, such as quality improvement efforts.
    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?
    We have participated in EOHHS's Patient Centered Medical Home Initiative, with MHQP on the attribution validation project, and with one of our larger employer groups to pilot our attribution methodology. In addition, our system allows for members to self-select their PCP. Our largest barrier is that, although we encourage self selection for our members, we are not seeing large increases in PPO members willing to choose a PCP. In addition, providers in this state have been changing health care group affiliations at a greater rate recently, which can skew the methodology.

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?
Standardization of the methodology that leads to more provider investment in the management of PPO members for both cost efficiency and quality improvement would help to control costs and improve quality. The drawback to a set methodology is that for different attribution purposes, different methodologies may make more sense. We want providers and members to understand and agree with the attribution. Easy-to-understand, standard methodology is helpful in gaining understanding and acceptance, however specific groups and projects may warrant different approaches.

d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?
As we standardize the PPO attribution methodology, we intend to further engage more providers in the process. We believe once the providers more fully understand, contribute, and agree with the methodology, the more committed they will be to managing member's care.

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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: Tufts Health Plan has developed a portfolio of products that encourage members to seek care in more cost-effective settings to reduce medical costs.

ANSWER: Tufts Health Plan's Choice Copay options include differential copayments for physician and inpatient services. Available on most product platforms, this option provides a financial incentive for members to seek care from primary care physicians and community hospitals rather than specialists and tertiary hospitals, where appropriate.

Additionally, Tufts Health Plan offers limited network products that provide members and employer groups with a quality, cost effective alternative to products with a broader provider base. These Select Network plans allow members to obtain medical care in many cost effective settings at a reduced premium when compared to equivalent full-network plans.

Tufts Health Plan also offers a suite of two and three-tier network plan designs that group hospitals and affiliated physicians into tiers based on a comprehensive cost and quality analysis. By tiering providers, members have cost-sharing incentives to select efficient and high-quality providers that provide the best value.

Finally, Tufts Health Plan continually evaluates new initiatives for managing medical costs. Product changes aimed at managing utilization, promoting wellness and reducing unit costs are regularly assessed to ensure that Tufts Health Plan does all that it can to effectively manage the costs of health care delivery for our members. Please see Attachment 1 for membership information.

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: Since October 2013, Tufts Health Plan has provided cost estimate information to members for procedures and conditions across plan designs and geographic areas via our Member Services Call Center. Beginning October 2014, Tufts Health Plan will also offer an on-line Treatment Cost Estimator to help members gain a better understanding of the total medical costs associated with a service or procedure, including out-of-pocket expenses.

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**	1	80	16
	Q2	1	122	16
	Q3	0	47	16
	TOTAL:	2	249	

** Please indicate the unit of time reported.*

ANSWER: Currently, members can contact our Member Services center to request estimates of medical costs for various treatments and locations. Emailed requests are also accepted. Within 16 business hours, the member is contacted by a representative to review the results of the estimate and expected medical costs. Providers can also request estimates on behalf of members.

Beginning October 2014, an automated Treatment Cost Estimator will be available to registered members on www.mytuftshealthplan.com, our customized member portal. This tool, called "EmpowerMe", will provide real-time estimates of both total medical cost and expected out-of-pocket expenses for hundreds of common health care services and procedures.

The top 10 services about which individuals have requested price information are as follows:
MRI - 11%
Bone Density - 6%
EKG - 5%
Physical Therapy - 5%

Labs - 5%
Ultrasound - 4%
Cat Scan - 4%
Colonoscopy - 4%
X-Ray - 3%
Diagnostic Mammogram - 3%
Knee Arthroplasty - 3%

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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: Tufts Health Plan is concerned about the state's higher than national average utilization on impatient care and its reliance on academic medical centers. We are committed to having members receive the appropriate care at the appropriate setting.
   ANSWER: A key component of Tufts Health Plan's Coordinated Care Model (CCM) focuses on the provision of care in the most appropriate setting. Through our Provider Engagement Program Tufts Health Plan shares comprehensive cost and utilization data, referral pattern, practice pattern analysis on a regular basis with providers who are reimbursed through risk-based contracts. The robust analytics paired with face-to-face meetings with individual provider units encourages and supports provider's efforts to direct care to the most appropriate setting and the more cost-effective providers.

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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: Tufts Health Plan Commercial Care Management offers an array of RN supported care management programs for members with complex, catastrophic, multiple co-morbid or high-cost , high-risk medical conditions.
    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.
       Members supported in the care management programs typically have both complex physical and behavioral health needs. The telephonic care management programs include comprehensive assessment of medical and behavioral health needs. Care management programs include depression screening (PHQ-2), mental health, and substance abuse screenings. Should a member screen positive for depression or other behavioral health needs, the nurse care manager, with the members permission, will inform the PCP of the positive screening, and of any immediate steps taken such as identifying a behavioral health provider or referral

for collaboration with Tufts Health Plan behavioral health team. The medical care managers partner with care managers and social workers within Tufts Health Plan behavioral health department. Tufts Health Plan's goal is to integrate the plan of care and ensure whole person care for these members.
Our model supports integration of behavioral and medical needs as consults or co-managers to best support the member. We continue to maximize the effectiveness of our integration of medical and behavioral care management for optimal member care management.
Our care managers follow a schedule for re-assessing for depression for multiple circumstances specific to the populations and conditions such as pregnancy and postpartum; following life changing events (divorce, loss of job, etc.), after hospitalization; and/or based on the care manager's clinical judgment. The standardized Caregiver Strain survey is administered to assess the status and needs of the member's care giver and to develop an effective care plan and intervention. Care managers interface with the PCP or specialists through out the programs.

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.
N/A

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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: Tufts Health Plan supports PCMH efforts throughout the Commonwealth.
ANSWER: As of September 2013, MACIPA has 1,900 members participating in the GIC Medical Home, and another 331 participating in the pilot through EOHHS. MACIPA has 7 sites with Level 3 and 7 additional sites in the process of receiving approval. THP has seen improvement in the MACIPA GIC HEDIS measures for 2013 compared to 2012.

HEDIS Measure	Improvement
Breast Cancer Screening	3%
Diabetes HbA1c Screening	1%
Diabetes LDL Screening	8%
Diabetes Nephropathy Test	5%

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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: The findings and recommendations from the 2013 Cost Trends report and July 2014 Supplement are in line with the Tufts Health Plan experience and programs implemented to increase health care value for our members.

ANSWER: In terms of the report's conclusions and recommendations for fostering a value-based market, Tufts Health Plan continues to place increasing focus on limiting the growth in prices paid to providers and we are in agreement with the Commission's conclusion that unit cost, significantly more so than utilization, continues to drive overall trend. Obviously, our ability to control unit cost growth is limited by the provider market, particularly providers with significant leverage and of critical importance to our purchasers. We also continue to observe the impact of market concentration with a small number of systems accounting for the majority of admissions. In an effort to provide incentives for care to take place at the highest-value setting, Tufts Health Plan works with providers under Alternative Payment Methods (APM) to share "leakage" reports that highlight opportunities to steer care to lower cost, equal or better quality, settings such as community-based hospitals for deliveries. In line with the report's recommendation to promote efficient, high-quality health care delivery systems, Tufts Health Plan continues to evolve its programs. Of note, we have made significant progress in moving away from fee-for-service to APMs across all populations, including, most recently, the PPO self-insured population through the implementation of APM for the Group Insurance Commission. As more providers transition to APMs, we continue to expand our care coordination collaborative through Provider Engagement analytics and consultative support. Lastly, we believe members also play a key role in managing their health and in selecting high-value care. To this end, we continue to evolve our tiered-network product solutions that provide cost-share incentives to members who select high-value providers. We are also enhancing member support tools to provide cost and quality transparency information for our members. Our treatment cost estimator tool will allow members to compare cost of procedures at various providers along with a calculation of out-of-pocket member expenses. In addition we will enhance our provider search tool to show cost and quality indicators for members selecting a provider within a practice or a hospital. Both of these tools are in line with legislation to promote high-value care.

In conclusion, we believe our efforts are in line with the Commission's recommendations and will continue to monitor the performance of these efforts to further enhance the value of care provided to our members.

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

   Please seee Attachment 1

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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).

   Overall, from 2010 - 2013 Tufts Health Plan Medicare and other government business membership has been gradually increasing, while the Commercial membership has been gradually decreasing. Key trends to note during this period include:

   • A growing proportion of self-insured members within the Large Group segment.

   • Noticeable growth in the proportion of Commercial members falling under risk contracts, which is consistent with Tufts Health Plan's contracting strategy during that time, and the increasing willingness of providers to take on risk.

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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

	Annual claim payments1	Employer Groups1
2009	$ 2,091,183,917	16,448
2010	$ 2,174,755,953	15,186
2011	$ 2,218,891,213	14,704
2012	$ 2,241,494,499	14,038
2013	$ 2,278,276,970	13,065

Tufts Health Plan does not provide behavioral health coverage to three of these employer groups. All three of them are self-insured. Claims information is not available for these three employer groups.

1 Excludes Carelink Shared Admin and Supporting Party

THP membership information

Year	Tiered	Limited	Total
2011	124,384	9,235	133,619
2012	163,612	8,838	172,450
2013	176,200	8,323	184,523

Exhibit # 1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

Summary: Below is Tufts Health Plan's summary table showing actual observed allowed medical expenditure trends in Massachusetts for the specified time periods.

Response: On average, the aging of the population adds about 1% to trend annually, while the health status of the population increased by slightly more than 2% per year. The impact of these changes (which are not normally exclusive) is seen primarily in the utilization trend. Other factors such as a slow economy, greater employee cost sharing and provider contracts encouraging quality over volume may have been factors in suppressing utilization trends during that time. Tufts Health Plan has observed a slight deceleration in the rate of benefit buy down over that period.

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured product lines

	Unit Cost	Utilization	Mix	Total
CY 2011	4.8%	0.1%	-1.7%	3.1%
CY 2012	2.8%	1.9%	-1.3%	3.4%
CY 2013	3.3%	1.2%	-0.1%	4.4%

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 # 1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

Summary: Below is Tufts Health Plan's summary table showing actual observed allowed medical expenditure trends in Massachusetts for the specified time periods.

Response: On average, the aging of the population adds about 1% to trend annually, while the health status of the population increased by slightly more than 2% per year. The impact of these changes (which are not normally exclusive) is seen primarily in the utilization trend. Other factors such as a slow economy, greater employee cost sharing and provider contracts encouraging quality over volume may have been factors in suppressing utilization trends during that time. Tufts Health Plan has observed a slight deceleration in the rate of benefit buy down over that period.

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured product lines

	Unit Cost	Utilization	Mix	Total
CY 2011	4.8%	0.1%	-1.7%	3.1%
CY 2012	2.8%	1.9%	-1.3%	3.4%
CY 2013	3.3%	1.2%	-0.1%	4.4%

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.

AGO Payer Exhibit # 2, Question #2
Total In-State Membership (for members living in Massachusetts)

a. In-State Membership by Market Segment[1]

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	8,069	7,463	6,321	6,108
Commercial Small Group	78,653	85,963	93,239	96,780
Commercial Large Group	250,665	266,468	280,059	290,630
Medicare[2,3]	114,741	111,822	105,212	94,060
Medicaid MCO	-	-	-	-
MassHealth	-	-	-	-
Commonwealth Care	-	-	-	-
Other Government	107,903	106,131	91,299	93,336
Total	560,031	577,847	576,130	580,914

[1] Membership recorded at year end. Excludes Carelink Shared Admin and Supporting Party membership.

[2] Includes membership in Medicare and Medicare-related products (e.g. Medicare Supplement and Medicare Complement plans).

[3] Medicare Segment includes government members in Medicare products.

b. In-State Membership Whose Care Is Reimbursed Through a Risk Contract by Market Segment[1]

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	4,319	4,147	1,918	1,000
Commercial Small Group	54,460	61,240	42,760	32,165
Commercial Large Group	126,724	139,801	100,947	73,543
Medicare[2,3]	90,992	83,787	76,568	75,269
Medicaid MCO	-	-	-	-
MassHealth	-	-	-	-
Commonwealth Care	-	-	-	-
Other Government	-	-	-	-
Total	276,495	288,975	222,193	181,977

[1] Membership recorded at year end. Excludes Carelink Shared Admin and Supporting Party membership.

[2] Includes membership in Medicare and Medicare-related products (e.g. Medicare Supplement and Medicare Complement plans).

[3] Medicare Segment includes government members in Medicare products.

c. In-State Membership by Commercial Market Segment and Product Line[1]

Market Segment	Product Line		Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	HMO/POS	Fully-Insured	7,805	7,185	6,134	5,919
		Self-Insured	-	-	-	-
	PPO/Indemnity	Fully-Insured	264	278	187	189
		Self-Insured	-	-	-	-
Commercial Small Group	HMO/POS	Fully-Insured	76,612	83,690	90,564	93,396
		Self-Insured	-	-	-	-
	PPO/Indemnity	Fully-Insured	2,041	2,273	2,675	3,384
		Self-Insured	-	-	-	-
Commercial Large Group	HMO/POS	Fully-Insured	125,194	138,352	142,346	143,489
		Self-Insured	82,949	71,179	84,211	97,716
	PPO/Indemnity	Fully-Insured	15,313	15,878	15,102	14,400
		Self-Insured	27,209	41,059	38,400	35,025

[1] Membership recorded at year end. Excludes Carelink Shared Admin and Supporting Party membership.

d. In-State Membership in Tiered Network Product by Market Segment[1,4,5]

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	-	-	-	-
Commercial Small Group	847	793	370	-
Commercial Large Group	45,733	45,944	30,123	21,931

Total	46,580	46,737	30,493	21,931

[1] Membership recorded at year end. Excludes Carelink Shared Admin and Supporting Party membership.

[4] Designated Provider Organization (DPO) members are included in the Tiered Network Product member counts.

[5] Members in a product with a limited and tiered provider network are reflected in both Tables 2d and 2e.

e. In-State Membership in Limited Network Product by Market Segment [1,5]

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	1,344	1,353	1,890	3,045
Commercial Small Group	835	1,072	1,061	962
Commercial Large Group	9,064	50	-	-
Total	11,243	2,475	2,951	4,007

[1] Membership recorded at year end. Excludes Carelink Shared Admin and Supporting Party membership.

[5] Members in a product with a limited and tiered provider network are reflected in both Tables 2d and 2e.

f. In-State Membership in High Cost Sharing Plan by Market Segment [1]

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	6,041	5,138	4,191	3,708
Commercial Small Group	39,920	40,345	41,683	35,159
Commercial Large Group	61,866	69,519	71,200	59,849
Total	107,827	115,002	117,074	98,716

[1] Membership recorded at year end. Excludes Carelink Shared Admin and Supporting Party membership.

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

Summary: Overall, from 2010 - 2013 Tufts Health Plan Medicare and other government business memb
been gradually increasing, while the Commercial membership has been gradually decreasing.

Response:

Overall, from 2010 - 2013 Tufts Health Plan Medicare and other government business membership has
gradually increasing, while the Commercial membership has been gradually decreasing. Key trends to r
this period include:

- A growing proportion of self-insured members within the Large Group segment.
- Noticeable growth in the proportion of Commercial members falling under risk contracts, consistent with Tufts Health Plan's contracting strategy during that time, and the increasing willingness of providers to take on risk.

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.

	Annual claim payments[1]	Employer Groups[1]
2009	$ 2,091,183,917	16,448
2010	$ 2,174,755,953	15,186
2011	$ 2,218,891,213	14,704
2012	$ 2,241,494,499	14,038
2013	$ 2,278,276,970	13,065

Tufts Health Plan doesn't provide behavioral health coverage to three of these employer groups. All three of them are self-insured. Claims information is not available for these three employer groups.

[1] Excludes Carelink Shared Admin and Supporting Party