Attached please find Tufts Health Plan's written testimony for the 2015 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 eleventh of September, 2015.

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 (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), 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 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 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 both days. 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 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 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 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, 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: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University 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 at Kelly.A.Mercer@state.ma.us a minimum of two (2) 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, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits 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 complete your responses in the provided **Microsoft Word** 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**.

We encourage you to refer to and build upon your organization's 2013 or 2014 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.

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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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (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.
    a. Please describe your organization's efforts in the last 12 months to meet this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs) on (i) total medical expenses, (ii) premiums, and (iii) provider quality. Please specifically describe efforts and analyses related to bundled payment and similar payment methods.

    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 basis, drives behavior change towards high-value care. Value-based contracts provide a key foundation to support the delivery of integrated, efficient, quality care. Tufts Health Plan first began working with value-based providers in its commercial network over 15 years ago and recognizes that successfully moving providers from traditional fee-for-service to value-based payment does not end with the signing of the contract. Tufts Health Plan has developed the Coordinated Care Model (CCM) to assist and support providers as they undertake payment and practice transformation to move towards achieving the triple aim of 1) improving the patient experience of care; 2) improving population health; and 3) reducing the cost of health care.

    Over 85% of our HMO members have a primary care provider that participates in a value-based contract. This is a modest increase of about 5% since we reported APM usage last year. Through these contracts, we have observed three positive trends:

    1) The vast majority of providers experience an increase in the proportion of the care retained within the provider's own system;
    2) The vast majority of the organizations participating in these models shift to lower-cost care settings for the care that is referred outside of the system; and
    3) While practice patterns are delivering lower costs, the quality of care has improved at the same time based upon a review of HEDIS quality measure performance. In addition, our Provider Engagement support has increased physician awareness of our clinical programs and allowed for improved coordination of care management activities. We have also noted increases in physician and member satisfaction during the same period.

    b. Please describe specific efforts your organization plans to undertake between now and October 1, 2016 to increase the use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider and product types. Please specifically describe efforts related to bundled payment and similar payment methods.

    Tufts Health Plan recognizes that that majority of our providers are already at risk for the HMO population. We have recently expanded the use of APMs to include the Group Insurance Commission (GIC) for value-based contracts for POS and PPO membership.

Approximately 40% of our GIC population is in this model. Tufts Health Plan will continue to expand our network of Integrated Risk Bearing Organization (IRBO) providers for our GIC business.

Because providers are not uniform in their level of readiness, engagement of staff and leadership, or infrastructure to take on risk, we do not have a specific timeline for moving providers into value-based models. Additionally, for providers who may 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 quality incentives.

c. In its 2014 Cost Trends Report, the HPC stated that major payers and providers should begin introducing APMs for preferred provider organization (PPO) covered lives in 2016, with the goal of reaching at least one-third of their PPO lives that year. Please describe your plans to achieve this goal. Additionally, please describe any specific barriers for moving self-insured business into APM arrangements.

Tufts Health Plan recently expanded the use of value-based contracts to include the Group Insurance Commission (GIC) for POS and PPO membership.

However, Tufts Health Plan has faced barriers with moving non-HMO membership into value-based contracts. Historically, there has been a portion of our customers that prefer product designs with no gatekeepers. In addition, some providers have expressed concern about taking risk on a product that does not require a gatekeeper or referrals to access care. As we reported last year, Tufts Health Plan has participated in a workgroup to facilitate member attribution for PPO products. Efforts to refine that model have continued over the last year. Our initial contracting efforts in this area will be an important pilot and Tufts Health Plan will carefully monitor the outcomes of the value-based contracts on behalf of the GIC.

2. Describe your organization's efforts to develop insurance products or plan designs that encourage members to use high-value (high-quality, low-cost) services, settings, and providers, and detail progress made over the past year. Example of such efforts include: phone triage or telehealth services; targeted information about and incentives to reduce avoidable emergency department (ED) use; and reference pricing, or cash-back reward programs for using low-cost providers. Please describe the result of these efforts and 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. Please describe efforts your organization plans between now and October 1, 2016 to continue progress in encouraging members to use high-value services, settings and providers. What barriers have you identified to introducing insurance

products or plan designs that encourage members to use high-value services, settings and providers in Massachusetts?

Our goal with product design is to include financial incentives that encourage members to select appropriate and cost-effective providers.

Through our tiered network products, members have access to our full provider network along with financial incentives to seek care from the highest value providers. Your Choice, our tiered network product launched in January 2011, tiers providers based on nationally accepted quality measures and cost efficiency.

We have seen some upward trend in limited network products, but this has primarily been contained to our self-insured business. These two lines represent approximately 29% of our total commercial business.

Although telehealth may have potential to benefit members in terms of convenience of and access to care and will encourage them to utilize lower-cost care settings, there is the also the potential for increased costs and fragmentation of care as the providers for such telehealth services are not the traditional providers, and often out of state entities. This could limit information sharing and population management.

Tufts Health Plan recently engaged in limited pilots with two hospital systems in telehealth initiatives which cover virtual visits between providers and members. These telehealth services are currently limited to specific programs at each hospital, such as dysphagia and behavioral health services.

The goal of the pilots is to determine the efficacy, efficiency and patient satisfaction of these programs. Tufts Health Plan will closely monitor the benefit/success of these pilot programs and determine if there are any modifications needed for improvement. As part of this analysis, Tufts Health Plan will collect information on member demographics and risk scores, shifts in utilization, and total medical expense.

3. Chapter 224 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." Please describe your organization's progress in meeting this requirement. If you had a tool in place prior to November, 2012, please describe your organization's prior experience, including how long your tool has been in use and any changes you have made to the tool over time.
    a. Using **HPC Payer Exhibit 1** attached**,** please provide available data regarding the number of individuals that seek this information and identify the top ten admissions, procedures and services about which individuals have requested price information for each quarter listed below and the number of inquiries associated with each.

See attached exhibit THP_HPC Payer Exhibit 1.xlxs

b. Do consumers have the ability to access cost data for the following types of services (yes/no)? If no, please explain.

Inpatient	Yes	☐	No	☒
Outpatient	Yes	☒	No	☐
Diagnostic	Yes	☒	No	☐
Office Visits (medical)	Yes	☒	No	☐
Office Visits (behavioral)	Yes	☒	No	☐

The tool uses 2 years of historical claims data to calculate estimates. Unfortunately, due to the complexity of IP services, the only service with enough volume to accurately predict costs is Pregnancy/Delivery.

c. Does consumer-accessible cost data reflect actual provider contracted rates? If no, please explain.

Yes ☒ No ☐

37T

d. Do you provide actual out-of-pocket estimates that reflect a member's specific benefits and deductible status? If no, please explain.

Yes ☒ No ☐

37T

e. Do you provide provider quality and/or patient experience data with your cost data? If no, please explain.

Yes ☒ No ☐

37T

f. Please describe any information you have collected regarding how your members use this information and the value of this information to members. Please describe any analyses you have conducted to assess the accuracy of estimates provided and the impact of increased price transparency for members as well as any limitations in the tools you have identified and ways your organization plans to address them.

We have not conducted any study to date to better understand how members use the newly available cost information. Furthermore, since relatively few members are currently taking advantage of the new consumer pricing tools, the overall impact on member behavior is estimated to be small.

4. The Massachusetts health care environment has recently undergone significant changes, including multiple hospital and physician group acquisitions and affiliations. Please describe your views on recent market changes, including any impacts these changes have had on costs (e.g., prices and total medical expenses), referral patterns, quality and access to care.

There is ample evidence that consolidation through mergers and acquisitions has generally resulted in higher prices. Given the predominance of risk in the market, there is now a structure that has the potential to mute the benefits to a provider of higher prices that often result from a consolidation. Such risk-based models encourage providers to render high-quality services at a lower cost.

While we acknowledge that the HPC reviews these requests prior to their approval, Tufts Health Plan believes there is merit in periodic reviews to ensure that the organizations involved in these consolidations remain accountable for fulfilling their stated purpose and vision. As such, retrospective reviews of market transactions would provide a means to ensure that the promises made to justify market transactions are realized after they have occurred.

5. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Health Policy Commission in 2014; and by the Center for Health Information and Analysis in 2012, 2013, and 2015, prices paid to different Massachusetts providers for the same services as well as global budgets vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value.
    a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

    Tufts Health Plan seeks a rate of reimbursement with each provider that is as low as possible. This is especially relevant given that the majority of employer premium dollars are paid to providers in the form of medical costs.

    Despite this goal, Tufts Health Plan recognizes that similarly situated providers may receive different rates of reimbursement. These differences are driven by a variety of factors, including market pressure as a result of uneven distribution of provider leverage, as reflected in the following areas:

    • Geographic location. Providers that are located in regions with limited alternatives may be in a position to receive higher rates, or we may risk having significant access disruption in a given region.

    • Service uniqueness. Similar to the issue with geographic importance, providers that provide critical and unique services (e.g., pediatrics, cardiac care, cancer care, transplant, NICU) may leverage their position to exact higher rates, or we may risk having significant service disruption.

    • Affiliation with large systems. Providers that are part of large systems may leverage their position to exact higher rates as a result of bundled negotiation by the systems.

b. What steps are you taking to address this variation in prices and budgets? Please include any approaches you have considered implementing to reduce the role that past or current fee-for-service price disparities play in global budgets.

Tufts Health Plan seeks a rate of reimbursement with each provider that is as low as possible. This is especially relevant given that the majority of employer premium dollars are paid to providers in the form of medical costs.

Tufts Health Plan strives to balance access to providers within the network with the lowest possible costs for our customers. Global budgets are structured in such a way to reward providers for performance against peers for successful management of medical expense.

It is important to point out that we have limited flexibility to exclude providers if they are not willing to accept lower rates. While there is increasing demand from certain employers and customers for limited network products, the majority of our customers continue to exert significant pressure on Tufts Health Plan to include all providers in the network.

6. Please describe your policies and procedures, including notice policies and protections from out-of-network charges, for members referred to out-of-network providers and cases in which services at in-network facilities are provided by out-of- network providers. Please describe any policies you have in place to ensure that a referring provider informs a patient if a provider to whom they are referring the patient is not in the patient's insurance network.

Tufts Health Plan remains greatly concerned that in-network hospitals staff services with providers that refuse to contract with commercial payers. The most significant concern is with emergency, radiology, anesthesiology, and pathology (ERAP) providers. Members typically receive services from these providers in an emergency setting when they are likely in duress, and unaware that they are receiving services from non-contracted physicians. Balance billing by these out-of-network providers can pose a great difficulty for our members, and Tufts Health Plan has not pursued members to recoup these costs.

Tufts Health Plan continues to discourage hospitals from engaging in these practices. In the event that this occurs, Tufts Health Plan works with our members to provide education on the risks of receiving services from out-of-network providers and help them to understand their benefits. We also work with risk providers to highlight potential referral partners that engage in this practice and encourage them to refer care within the member's benefit whenever possible.

7. The Medicare Payment Advisory Commission and others have noted that patient visits to outpatient-based practices, which can bill a "facility fee," are increasing faster than visits to freestanding practices. Please describe any shift you have observed toward increased use of

outpatient-based practices and the impact of facility fees and any such shift toward the use of outpatient-based practices on health care costs, quality and access.

In recent years, Tufts Health Plan has observed a slight increase in physician claims performed in the facility setting. If the focus is narrowed to the small set of codes identified by MedPAC, we have observed a greater increase, but not to the same extent as the impact that MedPAC observed.

Tufts Health Plan has found difficulty in incentivizing providers to steer care away from outpatient-based practices as providers perform services in multiple practice settings. We have attempted to mitigate the impacts of this billing practice on our members' cost share.

This shift toward the use of outpatient-based practices could raise cost; however the absolute cost varies by provider. It is important to note that many providers in our network look to Medicare for a standard for how services are reimbursed.

8. The Commission has identified that spending for patients with co-morbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health conditions. As reported in the July 2014 Cost Trends Report, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    a. Please describe your efforts in the past 12 months to effectively address the needs of these patients in an integrated manner, clearly identifying areas of progress, attaching any attaching analyses you have conducted.

Our telephonic care management programs include assessment of both medical and behavioral health needs. Members identified for care management programs routinely receive depression screening using the PHQ-2 patient questionnaire, as well as mental health and substance abuse screenings. If a member screens positive for behavioral health needs, the nurse care manager, with the member's permission, will inform the PCP of the positive screening, and of any immediate steps taken, such as a referral for behavioral health services, consultation with clinicians on the Tufts Health Plan behavioral health team, or recommendation of behavioral health case management services through the THP behavioral health team. The medical care managers partner with care managers and social workers within the Tufts Health Plan behavioral health department to integrate the plan of care, work together to manage and coordinate the needs of the member, and ensure whole-person care, engaging the correct combination of resources.

Our care managers follow a schedule for re-screening for depression for multiple circumstances specific to the populations and conditions such as pregnancy and postpartum; life changing events (divorce, loss of job, etc.); recent 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 throughout the programs.

Within the past 12 months we also developed a new clinical program, the Emergency Department Initiative, designed to identify and assist members who make frequent use of the emergency room. We've begun by identifying a group of specific medical diagnoses that do not typically require emergency services. We reach out to members to identify the factors that led to the use of emergency services, and when alternatives might have been appropriate, develop options and plans with the member for the next time they experience difficulties. Our medical team worked directly with our behavioral health team to develop behavioral health screening and assessment items to identify BH elements that may have contributed to the crisis, or the member's response to it, and to develop protocols for working with the member in these areas. When issues are identified that suggest that more specialized initiatives with the member would be productive, consultation between the medical case manager and a behavioral health case manager occurs, and when indicated, the behavioral health case manager co-manages the case with their medical counterpart. When the medical situation is stable and behavioral health issues remain, the BH case manager takes over the case. We will continue to monitor the impact of the program to determine its effectiveness in reducing cost and improving quality.

b. Please describe your specific plans for the next 12 months to ensure that integrated treatment is provided for these patients, including specific goals and metrics you will use to measure performance whether you use a behavioral health managed care organization ("a carve-out") or manage behavioral health care within your organization.

Behavioral health is managed within Tufts Health Plan.

Over the next 12 months we hope to continue and expand the Emergency Department Initiative. We also are in the process of developing a specialized substance abuse case management program. We believe this initiative has the potential to identify, and improve the clinical and cost outcomes of, members with complex medical conditions and previously unrecognized or unaddressed substance abuse issues. Once that program is launched we also have plans to develop additional behavioral health case management services that target members with unmet behavioral health needs.

9. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2012 to CY2014 according to the format and parameters provided and attached as **HPC Payer Exhibit 2** with all applicable fields completed. Please explain for each year 2012 to 2014, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).
See attached exhibit THP_HPC Payer Exhibit 2.xlxs

HPC Pre-Filed Testimony - Payer Questions
HPC Payer Exhibit 1

Health Care Service Price Inquiries CY2014-2015				
Year		**Aggregate Number of Inquiries via Website**	**Aggregate Number of Inquiries via Telephone or In Person**	**Aggregate Average Time to Resolve Inquiries***
CY2014	**Q1**		81	**
	Q2		122	
	Q3	1201	118	
	Q4	10604	61	
CY2015	**Q1**	6302	69	
	Q2	4169	89	
	TOTAL:	22276	540	

** Please indicate the unit of time reported.*

** Tufts Health Plan does not track aggregate time to resolve inquiries via telephone. Rather, we can confirm that all inquiries were repsonsed to within two business day

******In addition, payers MUST identify the Top 10 admissions, procedures and services in the next two (2) tabs ("Top 10 CY2014" and "Top 10 CY2015")******
All 3 tabs must be completed.

Identify the Top 10 Admissions, Procedures and Services for CY2014 by Quarter:

CY2014 Q3	1	MRI	89	
	2	Colonoscopy	63	
	3	Primary care for adults	46	
	4	Lab test	41	
	5	Mammogram	33	
	6	Pregnancy	31	
	7	mri	28	
	8	Ob/Gyn	28	
	9	Obstetrics and gynecologic	27	
	10	Dermatologist	24	
CY2014 Q4	1	Primary care for adults	730	
	2	MRI	668	
	3	Colonoscopy	585	
	4	Lab test	379	
	5	X-ray	202	
	6	Ob/Gyn	195	
	7	Obstetrics and gynecologic	178	
	8	colonoscopy	158	
	9	Pregnancy	150	
	10	Physical therapy	146	

Number of Searches	Number of unique Searchers
1,201	141

Number of Searches	Number of unique Searcher
10,604	1,164

Identify the Top 10 Admissions, Procedures and Services for CY2015 by Quarter:

CY2015 Q1	1	MRI	471	
	2	Primary care for adults	443	
	3	Pregnancy	332	
	4	Lab test	283	
	5	Colonoscopy	224	
	6	Obstetrics and gynecologic care	163	
	7	Mammogram	161	
	8	Physical therapy	147	
	9	X-ray	125	
	10	Ob/Gyn	111	
CY2015 Q2	1	Primary care for adults	296	
	2	MRI	177	
	3	Psychological and Psychiatric care	164	
	4	Colonoscopy	131	
	5	Pregnancy	119	
	6	Ob/Gyn	110	
	7	Obstetrics and gynecologic care	86	
	8	Lab test	83	
	9	Mammogram	79	
	10	X-ray	77	

Number of Searches	Number of unique Searcher
7,302	967

Number of Searches	Number of unique Searchers
4,169	583

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 1% to 2% per year. The impact of these changes (which are not normally exclusive) is seen primarily in the utilization trend. Other factors such as 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 2012	2.8%	2.0%	-1.4%	3.3%
CY 2013	3.3%	1.2%	0.0%	4.5%
CY 2014	3.0%	0.8%	2.4%	6.3%

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.