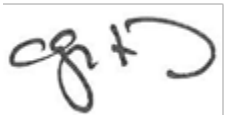
Attached please find Tufts Health Public Plans, Inc.'s written testimony for the 2015 Cost Trends Hearing. I am legally authorized and empowered to represent Tufts Health Public Plans, Inc. and this testimony is signed under the pains and penalties of perjury.

Subscribed and sworn to, this tenth of September, 2015.



Christopher Gorton
President
Tufts Health Public Plans, Inc.

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.

    Over the past twelve months, Tufts Health Public Plans (THPP) has diligently pursued Alternative Payment Methodology (APM) arrangements with its provider network. During this past year, we have agreed to APM terms with three of our provider partners, one of which is a large healthcare system. This is in addition to one other large network provider that continues on an APM agreement.

    Prior to 2014, THPP had consistently increased its membership under risk contracts. In 2014, the Patient Centered Medical Home Initiative (PCMHI) ended resulting in a decrease in APM membership. We expected the successor program, Primary Care Payment Reform Initiative (PCPRI), to result in a continued increase in APM membership. However, what we found is membership went down because it was not financially or operationally viable for us to implement the PCPRI model within our network. As a result, after many months of pursuing this with several FQHCs, the model was deemed not feasible for us to implement, in part due to the underfunding of the MCO program.

    THPP also experienced a decrease in APM membership when one of the large health care systems referenced above reverted back to a transactional (fee for service) arrangement due to the amount of transition occurring in the Medicaid program and the delay in the implementation of the subsidized qualified health plan market. In 2015, as the marketplaces have begun to normalize, THPP has been able to negotiate a new APM successor agreement with that provider.

    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.

    THPP has begun a process to reengage its provider network by supporting the providers' ACO development and transitioning the fee for service model to one based on APMs. THPP is developing a pathway to APMs with several provider systems. As mentioned above, we have a new APM agreement with a large healthcare system in effect beginning October 1, 2015 and are engaged in discussions with several other large providers to

arrive at sustainable APM terms. The continued challenge remains in creating APMs that are financially sustainable for both the provider and the plan.

We continue to highlight THPP's strong clinical programs. Our ability to demonstrate to providers key design principles of our care management programs will support our collective success under APMs. We strongly believe successful APM agreements must align financial incentives and clinical outcomes.

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 Public Plans does not offer PPO products.

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?

   Tufts Health Public Plans does not offer tiered-network products or products with networks more restrictive than our full network. However, as described further in Question 5, we feel that developing a high-value network that offers quality services at reasonable prices is the best way to achieve value for our members and the state. As described in our testimony last year, we have recently made decisions to non-renew or not contract with providers that do not satisfy this value proposition. As described more in Question 8, we offer a number of care management programs and disease management that target members who are susceptible to high ED use.

   For our MassHealth members, we offer extra incentives for certain healthy behaviors. These include gift cards for receiving yearly pediatric and child check-ups as well as for completing all the recommended childhood immunizations before age 2. For our ConnectorCare members, we have similar incentives for adult PCP visits and diabetes check-ups.

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 **THPP_HPC Payer Exhibit 1.xlsx**

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	☐

37T

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

   Yes ☒ No ☐

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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 ☒

Commercial enrollment did not begin to grow until January 2015. Previously, members were not typically subject to out-of-pocket expenses.

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

   Yes ☐ No ☒

No, we do not fully provide quality/patient experience information at this time; however we do currently provide cost data in the online treatment cost estimator. There's a separate effort to include quality indicators in the online provider directory, which is in early stages of development and which we expect to offer in the future.

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.

Most members of Tufts Health Public Plans have limited cost sharing and are not subject to out of pocket expenses. As such, they are unlikely to use the cost comparison tool or to shop for services.

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.

   Provider acquisitions and affiliations continue to put pressure on increasing unit costs as negotiations on rates become more complex. There is still little evidence that these changes have reduced unit costs in total medical expenses or improved quality of care. It is unclear to THPP if these market changes have had an impact on access to care as the evidence thus far is non-discernable. Additionally, the size of the provider organizations post acquisition and affiliation has made the path to APMs more difficult.

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?

      There are several reasons for which prices may vary across providers for the same services rendered. 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.*

      Price variation may also reflect the severity of the population being served, including members of the government-sponsored programs that THPP serves. Economically

disadvantaged individuals tend to have higher-risk scores and to be more vulnerable. As such, payments to providers must be tailored to account for these needs and to account for serving these needs at the appropriate level of care. This population also often faces significant challenges related to access to services. Payments must account for providing member access to certain essential providers and, in some cases, will reflect the value that a strategic partner brings to a carrier's network, particularly if there are limited alternative providers in a geographic area. As one of the six Medicaid managed care organizations, THPP considers itself a steward of public tax dollars. We feel that creating high-value networks that provide vulnerable members with access and quality care at reasonable prices is one of the best ways to achieve value for the state.

There are also a host of reasons why carriers would invest in provider partners, particularly those of strategic importance, which would lead to price variation. For example, investments might be made to drive or incentive quality in a particular clinical area. Significant work has been done to create care delivery systems that integrate both physical and behavioral health. Investing in these systems or creating centers of excellence can affect price variation. Similarly, supporting provider transitions to Alternative Payment Methods can affect price variation. With many providers, there needs to be a ramp up to such models, and investments may be needed to offset the volume versus unit-cost tradeoff that providers face.

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.

In order to minimize variation in prices and budgets, Tufts Health Public Plans has focused on three target areas. First, we are managing network configuration to achieve a lower aggregate price point. Second, we are electing to non-renew or not contract with providers that are operating outside of our target rate ranges. This shift further emphasizes a need to constantly monitor and review our relationships with providers and ensure that providers with whom we contract share our goal of providing quality care at a reasonable price. Furthermore, it incentivizes providers to control costs so that they are not at risk of non-renewal.

Third, we are developing multi-year frameworks that transition provider relationships into more collaborative risk-sharing models. By strengthening our commitments beyond a calendar year, we can work together to ensure a mutually beneficial pathway to shared financial accountability for member care.

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 Public Plans' primary policy preventing charges from out-of-network providers is the Specialty Services Referral Requirement Payment Policy. It requires a primary care provider (PCP) referral for specialty services with some exceptions such as OB/GYN or behavioral health services rendered by in-network providers. All prior authorization requests are initially reviewed by staff. Those requesting either out-of-network providers or out-of-network facilities without any attached clinical information explaining medical necessity for an out-of-network request are denied administratively as not a covered benefit. Those requests containing clinical information for a medically necessary out-of-network request are forwarded to a physician for medical necessity review.

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.

   Although we have not noted a specific trend towards outpatient-based practices versus freestanding practices, we have become aware of the impact of the significant total price difference between the two. Our Medicaid contract defines medically necessary services as those provided at a site where there is no other comparable site of service that is less acute or less costly. However, in-network services cannot be denied solely based on cost, even though the site of service could have a substantial impact on total medical expense.

   We are attempting another method to encourage increased utilization of freestanding physical therapy practices by offering 12 visits per incident without the usual required prior authorization. However, this isn't practical with all services as it mitigates our ability to manage utilization in general. We are still working our way through this issue to discover other methods and best practices to address this problem.

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.

      Members with comorbid medical and behavioral conditions are stratified as high risk and targeted for Care Management outreach. Care managers utilize motivational interviewing techniques to help members address all of their medical and behavioral health needs. THPP has an Integrated Care Management Program that is comprised of medical and behavioral health care managers, disease care managers, social care managers, clinical community outreach support staff, and population health and wellness staff. The goal of the Integrated Care Management Program is to reduce avoidable ED

admissions and facilitate the removal of barriers that are impacting members' ability to care for their health, homelessness, lack of food, heat, clothing, housing etc. Certain targeted populations, such as High ED utilizers, and predictive modeling identifying the top 15% of the population are used to identify members for Care Management/Care Coordination, in addition to referral sources from other internal departments such as medical management, specialty pharmacy such as Hepatitis C and MS, physicians, members, and care givers.

There are four Disease Management Programs that focus on Asthma, Diabetes, Heart Failure and COPD. The purpose of the DM programs is to improve the health of individuals with specific chronic conditions and to reduce health care service use and costs associated with avoidable complications, such as ED and hospitalizations. Members in DM programs have access to member educational material, and the option to receive targeted text messages with general health information. Members enrolled in disease management also have access to other disciplines on the team.

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.
THPP manages behavioral health care in house and does not carve out these services.

In addition to the efforts described above, THPP has undertaken or will undertake a number of new initiatives to address this population with the overall goal of lowering ED utilization. Provider relations in collaboration with medical management has identified five Federally Qualified Health Centers with patients who have high ED utilization for ambulatory diagnoses. The purpose of this collaboration with FQHC's is to provide data on patients who are high utilizers of the ED, and to work collaboratively to develop care management strategies to engage member and provider to mitigate risk of ED utilization and to improve quality of care through care coordination activities.

Doula By My Side is a program for high-risk pregnant women. Tufts Health Public Plans, in conjunction with Pettaway Pursuit Foundation, is proposing to open this program as a pilot to members residing in the Worcester area beginning in the fourth quarter 2015. Women participating in the program will receive visits from local doulas throughout their pregnancies and during their postpartum periods. The goal of the program is to improve birth outcomes in at-risk populations and increase postpartum visits and assessment for postpartum depression.

Tufts Health Public Plans is also in the early phases of developing a Substance Abuse Chronic Care Management program to help address the medical and behavioral needs of members with substance use and abuse. This includes exploring opportunities to partner with local law enforcement and judicial system to assist members in obtaining treatment.

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; **THPP_HPC Payer Exhibit 2.xlsx**

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	0	2	10 minutes
	Q2	0	2	15 minutes
	Q3	0	0	N/A
	Q4	0	7	16 minutes
CY2015	Q1	0	7	13.4 minutes
	Q2	0	9	10.4 minutes
	TOTAL:	0	25	

** Please indicate the unit of time reported.*

******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 Q1	**1**	Computed Tomography scan (high cost imaging) 70486
	2	MRI (high cost imaging)
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
CY2014 Q2	**1**	Colonoscopy
	2	Out-Patient surgery CPT code 44394
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
CY2014 Q3	**1**	N/A
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
CY2014 Q4	**1**	Computed Tomography scan (high cost imaging) CPT 70486
	2	Ultrasound (Diagnositc Services)
	3	CPT code 93270- "Actived ECG Record Monitor
	4	Out-Patient surgery
	5	
	6	
	7	
	8	
	9	
	10	

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

CY2015 Q1	**1**	MRI
	2	Colonoscopy
	3	DME
	4	Labwork
	5	
	6	
	7	
	8	
	9	
	10	
CY2015 Q2	**1**	colonoscopy
	2	out-Patient surgery
	3	CT scan
	4	Office Visit
	5	Diabetic supply
	6	
	7	
	8	
	9	
	10	

HPC Payer Exhibit 2

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 2012	-5.3%	3.6%	Unable to Determine	Unable to Determine	-1.9%
CY 2013	4.1%	3.4%	Unable to Determine	Unable to Determine	7.6%
CY 2014	-3.0%	2.4%	Unable to Determine	Unable to Determine	-0.7%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.