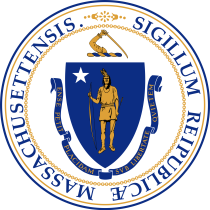
**2019 Pre-Filed Testimony**

PAYERS

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**As part of the**

***Annual Health Care***

***Cost Trends Hearing***

**Notice of Public Hearing**

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), holds an annual public hearing on health care cost trends. The hearing examines health care provider, provider organization, and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth’s health care system.

The 2019 hearing dates and location:

**Tuesday, October 22, 2019, 9:00 AM**

**Wednesday, October 23, 2019, 9:00 AM**

**Suffolk University Law School**

**First Floor Function Room**

**120 Tremont Street, Boston, MA 02108**

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 22. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 22.

The HPC also accepts written testimony. Written comments will be accepted until October 25, 2019, and should be submitted electronically to [HPC-Testimony@mass.gov](mailto:HPC-Testimony@mass.gov), or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 25, 2019, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC’s website: [www.mass.gov/hpc](http://www.mass.gov/hpc).

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit the [Suffolk University website](https://www.suffolk.edu/visit/campus-map-directions/directions). Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided. The event will also be available via livestream and video will be available on the [HPC’s YouTube Channel](https://www.youtube.com/channel/UCGZknspI63TdBuHLf3IrrKQ) following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at [HPC-Info@mass.gov](mailto:HPC-Info@mass.gov) a minimum of two weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant witnesses, testimony, and presentations, please check the [Annual Cost Trends Hearing page](https://www.mass.gov/service-details/annual-health-care-cost-trends-hearing) on the HPC’s website. Materials will be posted regularly as the hearing dates approach.

**Instructions for Written Testimony**

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2019 Annual Cost Trends Hearing.

You are receiving two sets of questions – one from the HPC, and one from the AGO. We encourage you to refer to and build upon your organization’s 2013, 2014, 2015, 2016, 2017, and/or 2018 pre-filed testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

On or before the close of business on **September 20, 2019**, please electronically submit written testimony to: [HPC-Testimony@mass.gov](mailto:HPC-Testimony@mass.gov). Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

**AGO Contact Information**

For any inquiries regarding AGO questions, please contact Assistant Attorney General Amara Azubuike at [Amara.Azubuike@mass.gov](mailto:Amara.Azubuike@mass.gov) or (617) 963-2021.

**HPC Contact Information**

For any inquiries regarding HPC questions, please contact General Counsel Lois H. Johnson at [HPC-Testimony@mass.gov](mailto:HPC-Testimony@mass.gov) or (617) 979-1405.

**Pre-Filed Testimony Questions: Health Policy Commission**

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH:

Since 2013, the Massachusetts Health Policy Commission (HPC) has set an annual statewide target for sustainable growth of total health care spending. Between 2013 and 2017, the benchmark rate was set at 3.6%, and, on average, annual growth in Massachusetts has been below that target. For 2018 and 2019, the benchmark was set at a lower target of 3.1%. Continued success in meeting the reduced growth rate will require enhanced efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

* 1. What are your organization’s top strategic priorities to reduce health care expenditures? What specific initiatives or activities is your organization undertaking to address each of these priorities and how have you been successful?

Click here to enter text.

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

Click here to enter text.

1. STRATEGIES AND POLICIES TO SUPPORT INVESTMENT IN PRIMARY CARE AND BEHAVIORAL HEALTH CARE:

The U.S. health care system has historically underinvested in areas such as primary care and behavioral health care, even though evidence suggests that a greater orientation toward primary care and behavioral health may increase health system efficiency and provide superior patient access and quality of care. Health plans, provider organizations, employers, and government alike have important roles in prioritizing primary care and behavioral health *while still restraining the growth in overall health care spending.*

* 1. Please describe your organization’s strategy for supporting and increasing investment in primary care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

Click here to enter text.

* 1. Please describe your organization’s strategy for supporting and increasing investment in behavioral health care, including any specific initiatives or activities your organization is undertaking to execute on this strategy and any evidence that such activities are increasing access, improving quality, or reducing total cost of care.

Click here to enter text.

* 1. Provider organizations can take steps to ensure they deliver high-functioning, high-quality, and efficient primary care and improve behavioral health access and quality. What strategies should provider organizations prioritize to strengthen and support primary and behavioral health care?

Click here to enter text.

* 1. What other changes in policy, market behavior, payment, regulation, or statute would best accelerate efforts to reorient a greater proportion of overall health care resources towards investments in primary care and behavioral health care? Specifically, what are the barriers that your organization perceives in supporting investment in primary care and behavioral health and how would these suggested changes in policy, market behavior, payment, regulation, or statute mitigate these barriers?

Click here to enter text.

1. CHANGES IN RISK SCORES AND PATIENT ACUITY:

The HPC has observed that member risk scores have been steadily increasing for many payers and that a greater share of services and diagnoses are being coded as higher acuity or as including complications or major complications.

* 1. Please indicate the extent to which you believe each of the following factors has contributed to increased risk scores and/or increased acuity for your members.

| **Factors** | **Level of Contribution** |
| --- | --- |
| Increased prevalence of chronic disease among your members | Level of Contribution |
| Aging of your members | Level of Contribution |
| New or improved EHRs that have increased providers’ ability to document diagnostic information | Level of Contribution |
| Coding integrity initiatives (e.g., hiring consultants or working with providers to assist with capturing diagnostic information) | Level of Contribution |
| New, relatively less healthy patients entering your patient pool | Level of Contribution |
| Relatively healthier patients leaving your patient pool | Level of Contribution |
| Coding changes (e.g., shifting from ICD-9 to ICD-10) | Level of Contribution |
| Other, please describe:  Click here to enter text. | Level of Contribution |

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

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

Click here to enter text.

1. REDUCING ADMINISTRATIVE COMPLEXITY:

Administrative complexity is endemic in the U.S. health care system. It is associated with negative impacts, both financial and non-financial, and is one of the principal reasons that U.S. health care spending exceeds that of other high-income countries.

* 1. For each of the areas listed below, please indicate whether achieving greater alignment and simplification is a **high priority**, a **medium priority**, or a **low priority** for your organization. Please indicate **no more than three high priority areas**. If you have already submitted these responses to the HPC via the June 2019 *HPC Advisory Council Survey on Reducing Administrative Complexity*, do not resubmit unless your responses have changed.

| **Area of Administrative Complexity** | **Priority Level** |
| --- | --- |
| **Billing and Claims Processing** – processing of provider requests for payment and insurer adjudication of claims, including claims submission, status inquiry, and payment | Priority Level |
| **Clinical Documentation and Coding** – translating information contained in a patient’s medical record into procedure and diagnosis codes for billing or reporting purposes | Priority Level |
| **Clinician Licensure –** seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician | Priority Level |
| **Electronic Health Record Interoperability –** connecting and sharing patient health information from electronic health record systems within and across organizations | Priority Level |
| **Eligibility/Benefit Verification and Coordination of Benefits –** determining whether a patient is eligible to receive medical services from a certain provider under the patient’s insurance plan(s) and coordination regarding which plan is responsible for primary and secondary payment | Priority Level |
| **Prior Authorization** – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member | Priority Level |
| **Provider Credentialing –** obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization | Priority Level |
| **Provider Directory Management** – creating and maintaining tools that help health plan members identify active providers in their network | Priority Level |
| **Quality Measurement and Reporting –** evaluating the quality of clinical care provided by an individual, group, or system, including defining and selecting measures specifications, collecting and reporting data, and analyzing results | Priority Level |
| **Referral Management –** processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication | Priority Level |
| **Variations in Benefit Design** – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks | Priority Level |
| **Variations in Payer-Provider Contract Terms** – understanding and navigating differences in payment methods, spending and efficiency targets, quality measurement, and other terms between different payer-provider contracts | Priority Level |
| **Other, please describe:**  Click here to enter text. | Priority Level |
| **Other, please describe:**  Click here to enter text. | Priority Level |
| **Other, please describe:**  Click here to enter text. | Priority Level |

* 1. CAQH estimates that the health care industry could save nearly $10 billion if all organizations were to perform six transaction types entirely electronically.[[1]](#footnote-2) Please report your organization’s calendar year 2018 volume for the following transaction types in the table below. Please also describe any barriers to performing all of the listed transactions entirely electronically.

Click here to enter text.

|  |  |  |
| --- | --- | --- |
| **Transaction** | **Manual or Partially Electronic** | **Fully Electronic, in Accordance with ASC X12N** |
| Eligibility and Benefit Verification |  |  |
| Prior Authorization |  |  |
| Claim Submission |  |  |
| Claim Status Inquiry |  |  |
| Claim Payment |  |  |
| Remittance Advice |  |  |

1. PROGRESS ON ALTERNATIVE PAYMENT METHODS:

Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. The Center for Health Information and Analysis reports that the majority of care for commercial members continues to be paid using fee for service; with 59% of HMO patients and 18.7% of PPO patients covered under alternative payment contracts in 2017. In the [2018 Cost Trends Report](https://www.mass.gov/doc/2018-report-on-health-care-cost-trends), the HPC found that payers and providers have not made sufficient progress to meet the HPC’s targets for expanded use of alternative payment methods (APMs).

* 1. Please describe what your organization has done to make progress in 2018 on expanding the use of APMs in both HMO and PPO products and the use of APMs with new providers and provider types.

Click here to enter text.

* 1. Please identify which of the following strategies you believe would most encourage further adoption and expansion of APMs. **Please select no more than three.**

Support and/or technical assistance for developing APMs other than global payment predominantly tied to the care of a primary care population, such as bundled payment

Identifying strategies and/or creating tools to better manage the total cost of care for PPO populations

 Identifying strategies and/or creating tools for overcoming problems related to small patient volume

 Enhancing EHR connectivity between payers and providers

 Aligning payment models across providers

 Enhancing provider technological infrastructure

Other, please describe: Click here to enter text.

1. STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY:

Chapter 224 of the Acts of 2012 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures, and services through a readily available “price transparency tool.”

1. In the table below, please provide available data regarding the number of individuals that sought this information.

| **Health Care Service Price Inquiries**  **Calendar Years (CY) 2018-2019** | | | |
| --- | --- | --- | --- |
| Year | | Aggregate Number of Inquiries via Website | Aggregate Number of Inquiries via Telephone or In- Person |
| **CY2018** | **Q1** |  |  |
| **Q2** |  |  |
| **Q3** |  |  |
| **Q4** |  |  |
| **CY2019** | **Q1** |  |  |
| **Q2** |  |  |
|  | **TOTAL:** |  |  |

1. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS:

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2016 to 2018 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2016 to 2018, the portion of actual observed allowed claims trends that is due to (a) changing demographics of your population; (b) benefit buy down; (c) and/or change in health status/risk scores of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

Click here to enter text.

**Pre-Filed Testimony Questions: Attorney General’s Office**

1. In the [2018 AGO Cost Trends Report](https://www.mass.gov/files/documents/2018/10/11/AGO%20Cost%20Trends%20Report%202018.pdf), the AGO examined the complex and varied methods used to determine health care payment rates. Please describe the strategies that your organization is pursuing to reduce complexity and increased standardization where appropriate in each of the following areas:
2. Payment policies and procedures: Click here to enter text.
3. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.): Click here to enter text.
4. Alternative Payment Models (“APMs”): Please select any of the subcategories that apply and explain your selection.

Health status adjustment methods (e.g., types of claims used to determine health status score, such as medical or Rx, etc.):

Click here to enter text.

Risk structure (e.g., risk exposure, the allowed budget, exclusions, bonuses, quality performance, etc.):

Click here to enter text.

Use of pre-paid lump sum payments (rather than volume-based, fee-for-service interim basis payments):

Click here to enter text.

Other, please describe:

Click here to enter text.

1. Please describe any ways in which your unique payment approach brings value to patients, plan sponsors, or payers: Click here to enter text.
2. Please answer the following questions regarding your organization’s APM contracts with providers in our marketplace:
3. What are the main barriers to shifting away from using a volume-based, fee-for-service interim basis payment approach (i.e. prior to settlement) to using pre-paid lump sum payments?

Click here to enter text.

1. In 2018 (or in the most recent year for which you have complete data), what percent of your medical payments for commercial products were paid for on an interim basis under volume-based, fee-for-service claims adjudication?

Click here to enter text.

1. CAQH. 2018 CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings. <https://www.caqh.org/sites/default/files/explorations/index/report/2018-index-report.pdf> [↑](#footnote-ref-2)