Pre-Filed Testimony Questions

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

A) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.

1. Maintaining cost effective, high quality care.
2. Provider charge increases.
3. Rising specialty medications costs.

B) What are the top changes in policy, market behavior, payment, regulation or statute would your organization recommend to address these concerns?

1. Require provider charge increases to be in line with the Total Medical Cost cap.

C) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

1. Provide information and tools to engage individuals to improve their health.
2. Manage chronic conditions and refer customers with these conditions to high quality, cost effective services.
3. Early identification of high risk individuals and provide them with programs to address catastrophic illness and their associated expenses.

2. INFORMATION ON PHARMACY BENEFIT MANAGERS

The HPC, other state agencies, payers, providers, and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. Pharmacy benefit managers (PBMs) play a major role in the market, significantly impacting drug pricing and access. Furthermore, PBM policies that restrict the ability of pharmacies and pharmacists to share certain information with patients have been an increasing area of focus.

a) Please identify the name of your organization's contracted PBM(s) as applicable:

<u>Answer</u>: Our organization's PBM is our Cigna Pharmacy Management business division. We subcontract the pharmacy claim processing function to a third party

vendor (DST Systems), and subcontract the retail pharmacy network contracting function to another third party vendor (OptumRx).

b) Please indicate the PBM's primary responsibilities below (check all that apply).

Answer:

√ ***Negotiating prices and discounts with drug manufacturers***

√ ***Developing and maintaining the formulary***

√ ***Negotiating rebates with drug manufacturers***

√ ***Pharmacy contracting***

√ ***Pharmacy claims processing***

√ ***Providing clinical/care management programs to members***

√ ***Other / As noted in response to (a), Cigna Pharmacy Management subcontracts the pharmacy contracting and pharmacy claims processing functions to other entities.***

c) Briefly describe the Massachusetts member populations managed by your PBM (commercial, Medicaid, fully-insured, self-insured, etc.)

Answer: The Massachusetts member populations managed by our PBM division are commercial, fully-insured, self-funded, and Medicare. We do not manage a Massachusetts Medicaid population.

d) Does your organization or any PBM with which you contract have policies that restrict the information a pharmacy or pharmacist can share with a covered person on the amount of the covered person's cost share for the prescription drug compared to self-pay (so-called "gag clause")? If yes, briefly describe the policy.

Answer: Cigna Pharmacy Management does not have any such policies and is not aware of any such policies between OptumRx and its retail pharmacy network available to Cigna's covered persons.

e) Does your organization or any PBM with which you contract have policies requiring a pharmacy to charge or collect a copayment from a covered person even if that amount exceeds the total charges submitted by the network pharmacy? If yes, briefly describe the policy.

Answer: The network pharmacy submits their "U&C" (usual and customary charge) within the claim for the prescription they dispensed to the covered person. Pursuant to the terms of the covered person's plan, our claims processing system ensures that the covered person's copayment will not exceed the pharmacy's submitted usual and customary charge. This charge is also known as the "retail price" or the price the covered person would pay for the medication without using a health benefit plan and paying cash.

f) Does your organization or any PBM with which you contract have policies requiring a pharmacy to proactively disclose to a covered person if the total charges submitted by the network pharmacy are less than the required copayment?

Answer: ***The network pharmacy submits their "U&C" (usual and customary charge) within the claim for the prescription they dispensed to the covered person. Pursuant to the terms of the covered person's plan, our claims processing system ensures that the covered person's copayment will not exceed the pharmacy's usual and customary charge. This charge is also known as the "retail price" or the price the covered person would pay for the medication without using a health benefit plan and paying cash. There is no policy requiring the pharmacy to proactively disclose the relative value of their usual and customary charge as compared to the required copayment.***

3) STRATEGIES TO PROMOTE INNOVATIVE CARE DELIVERY THAT INTEGRATES BEHAVIORAL, SOCIAL, AND MEDICAL CARE

Public and private payers alike are implementing new policies to support the development and scaling of innovative, high-quality, and efficient care delivery, such as, for example, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, reimbursement for services rendered by peers and community health workers, and incentives for patients and providers to engage in evidence-based treatment for substance use disorder.

Has your organization adopted policies related to any the following areas of care delivery improvement and innovation? (check all that apply), and describe your primary incentive related to the care delivery innovation in the fields below]

- √ ***Readmissions***
- √ ***Avoidable emergency department (ED) visits***
- √ ***Behavioral health integration into primary care (e.g., collaborative care model)***
- √ ***Pharmacologic or other evidence-base therapies for substance use disorder***
- √ ***Peers and/or community health workers***
- √ ***Telehealth/telemedicine***
- √ ***Non-medical transportation***
- ***Supportive temporary or permanent housing***
- ***Other:***

Readmissions

Cigna has a robust internal program to engage our customers preadmission or during the admission to help assist with transition of care and prevent readmissions. Similarly, we provide value-based incentives (for high quality, more cost effective

care) to over 500 large physician groups that are both large primary care groups and specialty groups. As a part of these relationships, we flag out for these groups when one of their patients is admitted to the hospital and provide best practices for them to effectively facilitate transition of care from the hospital.

Avoidable ED

Cigna has worked with our value-based partners to focus on engaging our customers in the community so that they have a close relationship with their primary care providers and their staff, who are working to optimize their health in the community. This helps address ED utilization for ED avoidable visits, ED high utilizers, and ED and inpatient admissions for chronic conditions. These physician groups provide services including nurse and back-up physician call lines, extended office hours, and follow up after an ED visit or inpatient admission to stabilize our customers, educate them on their conditions, and discuss site of service options. With these partnerships, we have seen a continued decrease in ED and inpatient utilization. Most of our clients also have plans with benefit differentials for urgent care vs. ED utilization to encourage customers to utilize more cost-effective service locations.

Behavioral Health Integration

Cigna is keen to address the behavioral health needs of our customers and has educated our value-based partners to help them facilitate integrated behavioral health services in the physician's office. Cigna is facilitating a pilot using the Center for Medicare & Medicaid Services (CMS) Psychiatric Collaborative Care Model (CoCM) reimbursement codes. With this pilot, we are looking for groups to identify customers who would benefit from integrated behavioral health for intervention around conditions like depression, anxiety, and substance use disorder. We are also flagging customers with chronic medical conditions so that the providers can screen for associated behavioral health conditions.

Substance Use Disorder

Cigna is an active thought leader addressing substance use disorder (SUD) and the opioid epidemic. In 2015, our CEO, David Cordani, challenged us to reduce opiate utilization by 25% in three years; we achieved that goal in less than 18 months. This was done through discussions with the White House, Veterans Administration, Centers for Disease Control (CDC), and national and local stakeholders to understand and collate best practices around SUD, which we have shared with our network providers. Cigna is also exploring other innovations focused around substances use disorder including: (1) sharing blinded behavioral health claims with the American Society of Addiction Medicine (ASAM) to identify SUD treatment trends and best practices; and (2) asking the provider community to sign the Surgeon General's "Turn the Tide" Pledge. We have also identified at-risk customers for case management programs. We share our opioid prescriber patterns with the leadership teams of our value-based partners so that they can address these prescribing patterns as needed.

Community Support Programs

Cigna is providing a community support program to address social determinants of health such as food, medications, and transportation that can have a negative

impact on a customer's ability to take care of themselves and their medical conditions. More broadly, the Cigna Foundation has invested in a number of programs around the country and globally that help to address social determinants of health.

<u>Telehealth</u>
Cigna has made video and telehealth resources available 24/7/365 for our medical and behavioral health customers. The medical services are available for more urgent, lower acuity services by board-certified internal medicine, family practice and pediatric physicians. The behavioral health telehealth services are provided by psychiatrists, psychologists and licensed social workers. Cigna understands that increasing consumerism requires us to make telehealth services more readily available, so some of the new innovations that we have targeted include identifying providers in our directory who provide telepsychiatry. This is an area that we are continuing to innovate in to meet the needs of our customers.

<u>Nonmedical Transportation</u> (see Community Support Programs)

4) 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."

a) In the table below, please provide available data regarding the number of individuals that sought this information:

Cigna Health Care Service Price Inquiries CY2017-2018			
Year		**Aggregate Number of Inquiries via Website**	**Aggregate Number of Inquiries via Telephone or In Person**
CY2017	**Q1**	4,409,501	13,573
	Q2	3,294,312	9,451
	Q3	3,520,893	7,437
	Q4	3,386,804	7,800
CY2018	**Q1**	4,885,562	11,035
	Q2	3,901,129	7,994
	TOTAL:	23, 398,201	57,290

Note—the above quarterly information on website and telephone inquiries includes both member/consumer and provider inquiries, based on Cigna national numbers.

b) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information on admissions, procedures and service?

Customer's missing information:

- ***Procedural codes/Tax ID Number - When our customers call in to receive an estimate, they do not always readily have all the information needed.***
- ***CPT provided may not reflect complete account of services to be rendered.***

Out of Network Providers:

- ***Without a contractual agreement in place, Cigna cannot determine what the provider will charge the customer.***

Third Party Vendors/Alliances:

- ***Cigna does not maintain the provider contracts and has limited access to contracted rates***

Facilities:

- ***Facilities may be allowed a percentage discount or bundled pricing on some services***
- ***Customers need complete charges from the facility and then apply the percentage in order to get estimate.***
- ***Additional services rendered that go beyond what was initially provided due to circumstances encountered while being services.***

Contracted provider billing practices:

- ***Contract Disputes***

How have you sought to address each of these barriers?

Processes are in place to obtain pricing when utilizing third parties to obtain an accurate portrayal based on information provided. Frontline advocates are trained that the expectation is to contact the providers directly to obtain all necessary information when a price estimate is requested. Provider Services Unit helps resolve contractual disputes to ensure accuracy for initial estimates provided. We've also added a cost estimator tool based on claim data to our customer facing websites.

c) What barriers do you encounter in accurately/timely responding to provider inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?

When contracted providers can't get a cost estimate from the website, because they have entered incorrect coding information, or don't have the necessary information to complete the quote, they receive a message directing them to call a toll-free Cigna phone number. In response to a provider call, the Customer Service Associates (CSAs) use a Standard Operating Procedure (SOP) that tells them how to address the various issues, in order to resolve the provider's request.

5) INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2015 to CY2017 according to the format and parameters provided and attached as HPC Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2015 to 2017, 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.

6) INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND AND ALIGN APMS

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. In the 2017 Cost Trends Report, the HPC recommended the Commonwealth continue to promote the increased adoption of alternative payment methodologies (APMs) from present levels of 59% of HMO patients and 15% of PPO patients in 2016. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a) Please answer the following questions related to risk contract spending for the 2017 calendar year, or, if not available for 2017, for the most recently available calendar year, specifying which year is being reported. (Hereafter, a "risk contract" shall mean a contract that incorporates a budget against which claims costs are settled for purposes of determining the surplus paid or deficit charged to a provider organization.)

i) What percentage of your organization's covered lives, determined as a percentage of total member months, is HMO/POS business? What percentage of your covered lives is FPO/indemnity business? (Together, HMO/POS and FPO/indemnity should cover your entire book of business.)

1. **HMO/POS** **0.7%**
2. **PPO/Indemnity Business** **99.3%**

ii) What percentage of your HMO/POS lives is covered under a risk contract? What percentage of your organization's FPO/indemnity lives is under a risk

contract?

1. **HMO/POS** **12.5%**
2. **FPO/Indemnity Business** **19.1%**

iii) What percentage of your organization's HMO/POS lives is covered under a risk contract with downside risk? What percentage of your PPO/indemnity lives is under a risk contract with downside risk?

1. **HMO/POS: N/A-- We do not have downside risk**
2. **PPO/Indemnity Business: N/A—We do not have downside risk**

Cigna has led national and regional efforts to advance population attribution incentive-based financing programs to support alternative payment models (APM) and financial arrangements for PPO health plans. Cigna is committed to the robust deployment of these capabilities in Massachusetts in keeping with our overall value proposition, which has been well received by our customers and their agents throughout the region. The majority of customers served by Cigna are covered under self-funded benefit plans. Accordingly, Cigna has and will continue to include such beneficiaries in APM arrangements.

b) Please answer the following questions regarding quality measurement in APMs

i) Does your organization plan to implement the core and menu quality measurement set in all of your future global-budget based APM contracts, as applicable, with Accountable Care Organizations (ACOs) as defined by the Executive Office of Health and Human Services Quality Alignment Taskforce (See Appendix A)

a) If yes, what is your timeline for implementing the measures in contracts? If no, why not?

ii) What are your organization's priority areas, if any, for new quality measures for ACOs?

b.i. (a) No, Cigna sees quality as one of the core component of its APM contracts and includes quality performance criteria in all of its APM arrangements. As Cigna operates throughout the country, it became impractical to try and adopt quality criteria for each state in which we operate. As a result Cigna developed a national core measure set using nationally vetted and accepted measures. Many of these measures overlap with the core and menu quality measures as defined by the Executive Office of Health and Human Services.

b.ii. (a) Although Cigna has no immediate plans to change our core measure set, the organization is constantly evaluating quality measures, criteria for inclusion and exclusion, and numerator and denominator specifications to ensure what we are using in our APMs consistent with current evidence-based standards and criteria.

HPC Payer Exhibit 1

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 2015	2.7%	1.5%	*	-1.5%	2.7%
CY 2016	3.8%	2.9%	*	-2.9%	3.6%
CY 2017	5.1%	0.1%	*	-1.3%	3.8%

*We did not think we could accurately normalize the impact of provider mix and report a distinct trend figure. The impact of provider mix is captured in unit cost an

1. Actual Observed Medical Expenditure Trend Cigna OAP membership. Pharmacy is excluded.
   a. For 2015 through 2017, demographics of the population impacted observed trend for MA residents by 0.9% in 2015, -0.7% in 2016, and -0.3%% in 2017.
   b. Benefit buy downs decreased observed trend for MA residents by -1.0%, -0.2% and -1.4% for the years 2015-2017 respectively.
   c. We are defining change in health status as changes in risk. Year over year metrics imply the average impact of risk on trend is approximately +0.7% in 2015, +

Notes:

1. **ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each**
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 trend**
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,**