MASSACHUSETTS
HEALTH POLICY COMMISSION

2019 Pre-Filed Testimony

PAYERS

As part of the
Annual Health Care Cost Trends Hearing

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

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, 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.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit the Suffolk University website. 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 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 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 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. 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.

HPC Contact Information

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

AGO Contact Information

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

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.

a. 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?

Aetna's chief strategic priorities to reduce health care expenditures concern: (1) prescription drug spending, and (2) overutilization.

1. <u>Prescription Drug Spending</u>

Aetna uses myriad strategies to address the rising trend in pharmacy plan costs and utilization. Aetna's plan design options and member management programs take advantage of our integrated pharmacy and medical data, which helps balance cost savings with member satisfaction and choice. Specifically, Aetna helps control costs through:

Formulary selection – We offer a variety of formulary options that balance member choice with plan savings. We have been leading with the Value and Value Plus formularies for many fully-insured customers because these include better plan cost controls by covering generic drugs with one or two preferred brands per class. The Value formulary offers up to 15% savings compared to our broadest formulary. In 2020, we will be moving to CVS Health formularies. Much like Aetna formularies, CVS Health formularies balance member choice with plan savings. The lead CVS Health formulary will be Advanced Control Formulary, which is designed to control costs of drugs by encouraging use of low-cost generics and lowering the cost of preferred brand drugs. This formulary will offer over 15% savings compared to our broadest formulary.

Plan design selection – With respect to plan design, customers prefer options that offer both variety and savings. Our wide variety of plan designs supports both of those priorities by allowing customers to elect features such as differing tier numbers, copay spreads between tiers, percentage copays, pharmacy plan deductibles, home delivery options, and generic options.

Generic promotion – We increase awareness of generics as safe, effective alternatives to brands through several programs. Examples of our generic promotion strategy include step therapy and generic substitution. Also, our Choose Generics cost-sharing program can save an average of 2.5-3.5% on total pharmacy claim costs, depending on plan design and copays.

Specialty trend management – Specialty drug management challenges are unique and critical, as drug spend on this category often exceeds 20 percent of annual plan totals. We offer a

focused approach to management of this category. We have adopted initiatives designed to encourage members to use our Specialty Management Program, which provides comprehensive management, counseling, and support of members and ensures cost-effective dispensing. The result is improved adherence and outcomes, along with plan and member savings.

Another program that specifically targets savings while achieving optimal health outcomes is Aetna's Site of Care Optimization Program. This program identifies members for whom there is a more cost-effective infusion solution. We work with identified members and their providers to reduce the cost of care and make the infusion more convenient for the member. Depending on the drug, we work with members either prospectively or retrospectively.

2. **Overutilization of Health Care Services**

Spending more for care does not guarantee the quality of that care. Aetna is continually evaluating programs to address inefficient utilization and overutilization by patients and directing our efforts toward the most effective solutions. We continually seek health care management solutions that address both total costs and quality.

Utilization Management and Review

One way in which Aetna contain costs is through thoughtful utilization management processes and reviews. These reviews help make sure our members get the care they need at a reasonable cost.

Precertification – By focusing on high-cost procedures and overutilized and underutilized procedures, our precertification process is an important step in identifying members in need of special services. It is where we learn who needs acute care management or referrals to special programs. From this entry point, we can work with the member to help save costs and improve health. For example, we can refer them to our Institutes of Excellence™ facilities for transplants and highly specialized services, or we can refer them to our Institutes of Quality® facilities that offer quality care for certain bariatric, orthopedic, and cardiac procedures. These facilities will have met a number of industry-recognized standards for cost efficiency and clinical quality.

Since providers do not always realize the cost differences among facilities when referring their patients for tests and other care, we engage *both our members and providers* in this cost-saving process. Our precertification program helps providers give members more care options and refer them to lower-cost facilities that give quality care.

Concurrent review and discharge planning – Our clinical staff review inpatient admissions (except routine maternity care) while the member is in the hospital. We use proven standards of care as guidelines to help make sure treatment rendered is covered and medically necessary.

We also help members get the care they need after they get out of the hospital. Our proactive discharge planning begins during the hospital stay. We work with doctors and members to develop a transition plan from one level of care to the next.

Case management referrals boost engagement – During our utilization reviews, we look for members who can benefit from a nurse case manager to help prevent more significant health events. We effectively engage more than 95 percent of those members reached. And, our 30-day readmission rate is 5.4 percent, which is well below the national average.

Network Solutions

Aetna offers a variety of network solutions, such as our Aetna Institutes™, that let our members find facilities that offer high levels of clinical care and cost efficiency. When combined with our strong plan-design strategies, our networks help control overall costs. Our Aetna Institutes consist of:

Institutes of Excellence™ (IOE) facilities – Aetna's IOEs offer the highest quality, most cost-effective care available for complex cases. This includes care for organ transplants and infertility services. Because of the complex nature of this care, Aetna coordinates services to achieve better health and cost outcomes.

Institutes of Quality® (IOQ) facilities – Aetna's IOQs offer clinical services for common health procedures – morbid obesity, heart disease, spine surgery, and hip and knee replacement. We measure many factors when selecting our IOQs – everything from the level of care to how often patients return to the hospital after surgery.

Plan Design Strategy

Aetna is continually evaluating ways to improve our plan designs. Adapting to and predicting market changes lets Aetna help members get the right care at the right time. For example, we were the first national insurer to launch a consumer-directed health plan: Aetna HealthFund® (AHF). AHF products are an attractive alternative to traditional plans. They provide coverage by combining a deductible-based medical plan with an employer-sponsored health reimbursement arrangement or a high-deductible health plan with a tax-preferred health savings account. Experience shows that AHF products keep health care costs in check by encouraging members to get preventive care, obtain care for chronic illnesses, and use wellness and education tools to make good health care decisions. By educating members about their health care and involving them financially, they are motivated to use health care services in a more health- and cost-conscious way. In addition, our research has found—on a national basis—that the average annual trend over a five-year period for employers offering AHF plans was 1.8 percentage points lower than a comparison group's trend.

Customers that combine medical with pharmacy, dental, behavioral health, and/or disability plans potentially save even more. In our most integrated model, Aetna One® Premier, 71 percent of referrals to disease management remained active after the referral, and 65 percent had greater participation in case management. We have found that the longer members stay engaged with our programs, the more effectively we can work with them and their providers to help manage acute illness and chronic conditions.

Engagement Strategies

We also engage our members with proven results. Our 24-hour Informed Health® Line service helps reduce unneeded doctor and emergency room visits by educating members on their health topics of choice. In addition, our Healthy Lifestyle Coaching program accomplished an impressive reduction in indirect costs.

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

1. **Prescription Drug Spending**

Specialty drugs are a significant barrier to reducing the growth of prescription-drug spending. Where applicable and permitted by law, Aetna utilizes the solutions listed below to advance the priority of reducing expenditures on specialty drugs. Accordingly, Aetna believes that the most important changes in policy, market behavior, payment, and regulation are those that promote the following cost-saving initiatives.

Maximize biosimilar and generic specialty opportunities

The United States is expecting a $110 billion biosimilar savings opportunity through 2020. Aetna is constantly monitoring the specialty drug pipeline and developing strategies that maximize savings but ensure therapy appropriateness. We anticipate that many of the tools that we already use to encourage the use of cost-effective agents will be useful with biosimilars. These tools include step therapy, precertification, and copay differentials.

Ensure appropriate use through specialty precertification

Aetna's standard is to require precertification—in accordance with our Clinical Policy Bulletins (CPBs)—for certain specialty drugs to ensure appropriate therapy.

Site-of-Care Optimization

During the precertification and claims analysis processes, Aetna engages members receiving care at high-cost delivery sites and mandates or recommends alternate delivery options. An Aetna staff member contacts the member and recommends the most cost-effective and clinically-appropriate site of care (e.g., home infusion). We offer this program at no additional cost, and it is either mandatory or voluntary (depending on the drug). Once a member transitions to the new site of care, we then continue to monitor him or her closely to ensure a successful transition. This program saves an average of $83,000 per successful conversion.

2. **Utilization**

Aetna is committed to developing innovative strategies for managing utilization and reducing costs. We continually monitor expenses by working with our partners to identify efficiencies to help Aetna meet cost-reduction goals. Consistent with industry standards, our networks have traditionally emphasized network discounts and medical-management services. However, through value-based contracting (VBC) initiatives, we have shifted our emphasis to strategic relationships with providers to deliver comprehensive health care management that includes,

and goes beyond, traditional discount improvement programs. In doing so, we strengthen provider performance through collaboration, technology, analytics, and data sharing. Accordingly, Aetna supports changes in policy, market behavior, payment, and regulation that further such VBC initiatives.

2. 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.*

a. 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.

Aetna strongly supports increased promotion of and investment in primary care. We believe that health care systems with robust primary-care foundations deliver health care that is higher quality and more affordable. Primary care providers (PCPs) are in a unique position to coordinate care across the health care system, including specialty care, hospitals, and community services.

At the national level, Aetna has adopted payment models that financially reward PCPs for cost savings and improved health outcomes. Two of these models are Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs).

Our PCMHs and ACOs help redistribute physician compensation to reflect the value of care delivered. Their principal means of accomplishing this are care-coordination payments and shared-savings payments.

PMPM care-coordination payments are distributed by PCHMs and ACOs to physicians with attributed members. The overwhelming majority of care-coordination payments – over 90 percent – go to primary care providers. The care-coordination payments can help offset expenses relating to the implementation of population health management, including information technology upgrades and clinical-integration infrastructure.

Shared-savings payments are made by PCMHs and ACOs to physicians according to protocols for allocating incentive payments. Generally, such payments are contingent on the physician meeting clinical, quality, and cost-of-care performance targets. We expect PCPs to receive a significant share of the shared-savings payments, as PCPs have a tremendous impact on the total cost and quality of care. Indeed, our data shows that members with consistent PCP utilization are more likely to actively engage in their own care, comply with treatment programs, and use emergency rooms less frequently.

Aetna's PCMHs and ACOs have enjoyed success at the national level. With respect to PCMHs, PCPs have proven to have a significant effect on overall cost and quality of care. Specifically, our data indicates the following. PCMH contracted providers ran at a trend that is approximately 1 percent lower than the market. Furthermore, the colorectal cancer screening rate of PCMHs was approximately 2 percent better than the market; their Hba1c testing rate was approximately 1.3 percent better than the market; and their medical attention for nephropathy approximately was 1.5 percent better than the market. Last, PCMHs demonstrated consistent improvement across measured quality measures (from 2014 to 2015).

Our ACOs have enjoyed similar successes at the national level. Our Aetna Whole Health℠ product, for which the provider network consists principally of an ACO, achieved appreciable decreases in service unit costs and utilization. In doing so, it improved costs by $729.30 PMPY, compared to Aetna's broad network plans. Additionally, it reduced annual inpatient admissions by 17 percent, PCP utilization by 9 percent, and specialist utilization by 16 percent. Compared to Aetna's broad network plans, Aetna Whole Health℠ realized average savings of 8 to 15 percent of overall claims. Our Attribution Model ACOs, when constituting a significant part of a product's network, improved costs by $7.74 PMPM, saving a total of $17 million. They furthermore saw improvements in over half of their performance metrics, including decreases in impactable inpatient admissions (–8.1 percent), CAT scans and MRIs (–11.5 percent), and high-tech radiology use (–14.8 percent), and an increase in generic prescribing (+2.1 percent). Compared to broad network plans, typical savings within the attribution model are 1 to 2 percent of overall claims.

b. 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.

Our members have access to a wide range of behavioral health services. In Massachusetts, Aetna's behavioral health provider network comprises over 7,000 individual providers, including psychiatrists, psychologists, therapists, and behavior analysts. In addition, our network includes behavioral health facilities providing inpatient, residential, partial hospitalization, and intensive outpatient services. Across those levels of care, we have 65 in-network facilities in Massachusetts. These numbers met or exceeded all of Aetna's enterprise-wide access standards for 2019.

Alongside our behavioral health specialists, we are committed to increasing mental health and wellness through primary care integration and collaborative care initiatives. To that end, our national approach to behavioral health includes the Aetna Integrated Primary Care Behavioral Health Program. One of the Integrated Program's principal goals is to place a co-located behavioral health clinician in the primary care setting to address behavioral health alongside and in conjunction with physical wellness. We are currently working to facilitate increased participation by Massachusetts providers in the Integrated Program.

Pursuant to our Integrated Program, a primary care physician refers patients, as clinically indicated, to a behavioral health clinician. The behavioral health clinician maintains a problem-solution focus and sees patients for up to three sessions within the primary care setting. If

additional behavioral health services are required beyond the three initial visits, the patient is referred to a network community provider or continues to see the integrated behavioral health clinician outside the primary care setting. In so doing, the behavioral health clinician communicates on a regular basis with the primary care physician and provides written reports about interventions and patient progress.

In addition to the Integrated Program, our national approach includes other initiatives to facilitate the coordination and integration of primary and behavioral care. The Aetna Depression in Primary Care Program assists primary care providers address behavioral health during routine visits. The Depression Program provides primary care providers with a time-saving tool that helps screen patients for depression and monitor progress during treatment. The tool includes a patient health questionnaire, available in English and Spanish languages, that is specifically developed for use in primary-care depression screening. We also have developed a similar tool that assists primary care providers with screening for alcohol-abuse issues.

Along with our coordination and integration initiatives, Aetna facilities access to behavioral health services through robust disease-management and case-management programs. Those programs are staffed by Aetna nurses with behavioral-health expertise and licensed clinical social workers.

c. 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?

As explained in our answers to questions 2a and 2b, Aetna believes that improving primary care and behavioral health lies chiefly in adopting value-based payment models (PCMHs and ACOs) and initiatives that integrate primary and behavioral care. To that end, we believe that provider organizations would strengthen and support primary care and behavioral health by increasing their participation in such models and initiatives. See answers to question 2a and 2b above for more details.

d. 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?

We believe that the main barriers to supporting investment in primary and behavioral care are the Commonwealth's high cost of living and scarcity of providers of primary care and behavioral health. Encouraging pay for performance and increasing the number of primary care and behavioral health providers would assist in mitigating the barriers to increased investment in primary care and behavioral health.

3. 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.

a. 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.

Aetna does not have any risk adjustment covered plans in Massachusetts. Accordingly, we are not in possession of data that specifically addresses how the identified drivers contribute to increased risk scores.

b. 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.

Aetna employs resources from its clinical, actuarial, financial, statistical, systems, programming, and data-analysis areas to monitor the integrity of coding and payment practices. There numerous processes that are used as a part of such monitoring, but here are few illustrative examples. First, actuarial collaborates with medical and clinical leaders to develop claim-policy controls and to evaluate the effectiveness thereof. Second, our network, operations, and actuarial teams coordinate to perform root-cause analyses of contract set-up issues (both provider and plan sponsor) and resolve such issues through payment-accuracy validation. Third, we leverage uniquely-designed reporting that identifies significant changes in billing and reimbursement trends, which may indicate errors, waste, fraud, or abuse. Fourth, our Special Investigations Unit is a business area dedicated solely to detecting, investigating, preventing, and recovering payments procured through fraud. One particularly egregious and prevalent form of provider fraud is billing a more complicated service than was actually rendered in order

to increase reimbursement ("upcoding"). We have special controls across our business areas that constantly and regularly monitor suspected upcoding cases.

4. 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.

a. 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	Low
Clinical Documentation and Coding – translating information contained in a patient's medical record into procedure and diagnosis codes for billing or reporting purposes	Medium
Clinician Licensure – seeking and obtaining state determination that an individual meets the criteria to self-identify and practice as a licensed clinician	Low
Electronic Health Record Interoperability – connecting and sharing patient health information from electronic health record systems within and across organizations	Medium
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	Low
Prior Authorization – requesting health plan authorization to cover certain prescribed procedures, services, or medications for a plan member	Low
Provider Credentialing – obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization	Medium
Provider Directory Management – creating and maintaining tools that help health plan members identify active providers in their network	High
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	High
Referral Management – processing provider and/or patient requests for medical services (e.g., specialist services) including provider and health plan documentation and communication	Low
Variations in Benefit Design – understanding and navigating differences between insurance products, including covered services, formularies, and provider networks	High

Area of Administrative Complexity	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	Low
Other, please describe: N/A	Priority Level
Other, please describe: N/A	Priority Level
Other, please describe: N/A	Priority Level

b. CAQH estimates that the health care industry could save nearly $10 billion if all organizations were to perform six transaction types entirely electronically.[1] 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.

We believe that performing the identified transactions electronically is hampered by the following three barriers. First, many provider still lack the ability or desire to convert their administrative transactions to electronic processing. Second, many of the mandated administrative transactions have not kept up with ever-changing business needs. Third, there are significant financial costs associated with implementing the technology necessary to perform transactions electronically.

Transaction	Manual or Partially Electronic[1]	Fully Electronic, in Accordance with ASC X12N [1]
Eligibility and Benefit Verification	103,864,469	626,482,374
Prior Authorization	1,831,388	841,262
Claim Submission	12,386,324	237,151,641
Claim Status Inquiry	25,529,238	63,187,782
Claim Payment	7,993,169	32,454,007
Remittance Advice	10,595,829	34,128,471

Note: *The figures reported above reflect Aetna's Medical and Dental transactions on a national basis. Massachusetts-specific transaction data are not available. "Manual or Partially Electronic" includes call volume. "Prior Authorization" includes only submissions and not inquiries.*

5. 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

[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

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, 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).

a. 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.

Aetna promotes high quality, cost-effective care through value-based contracting (VBC) strategies. By changing the reimbursement paradigm from volume-driven to value-based, our VBC models help members receive the right services at the right time in the right setting. We take a national, regional, and local market approach to developing value-based collaborations. With over 1,900 value-based contracts nationally, 60 percent of our claim payments go to providers who deliver value-based care. We're committed to having 75 percent of all medical spend in VBC models by 2020, which is well above the national average for commercial payors.

The success of our VBC strategy is also the result of the depth and intensity of our provider collaborations. We understand that no two health systems are alike. Each has unique characteristics, attributes, and strengths. While a standardized VBC model is preferable at the early stages of development, transformational reform requires more intensive, resource-sharing partnerships. We engage providers at whatever stage they happen to be in their VBC development. Ongoing, collaborative support enables progression further up the VBC continuum. The types of models on our VBC continuum include: Joint Ventures, Accountable Care Organizations, Patient-Centered Medical Homes, Pay-for-Performance, and Bundled Payments. All types of our VBC models include clinical and/or quality performance targets and require the management of medical costs.

b. 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: We strive for consistency across all of our programs, but providers are in various stages of development as they transform from volume-driven to value-based care. Our goal is to partner with provider organizations that can increase their level of clinical and financial accountability. By rewarding providers for clinical and cost-of-care performance, we're encouraging accountability for healthy outcomes. For providers, that typically translates into implementing the resources necessary to drive population health management and enhanced clinical coordination. Technology-driven population health management

empowers providers to deliver more proactive care not just for the acute and high-risk population, but for the entire population across the continuum of care.

6. 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.

Note: The number of inquiries reported below is based on Massachusetts fully-insured and self-funded Commercial business.

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**	39,169	188
	Q2	32,550	185
	Q3	29,185	170
	Q4	30,840	180
CY2019	**Q1**	30,554	282
	Q2	18,596	292
	TOTAL:	180,894	846

7. 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.

Please refer to attached HPC Payer Exhibit 1.

Pre-Filed Testimony Questions: Attorney General's Office

1. In the 2018 AGO Cost Trends Report, 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:

a. Payment policies and procedures:

Payment policies and procedures are designed to ensure providers are reimbursed based on the code that correctly describes the procedure performed. In developing such policies and procedures, industry-standard payment logic, regulatory requirements, and benefit designs are considered. Furthermore, the policies and procedures incorporate industry-accepted coding methodologies, including CPT, HCPC, and CMS. Generally, payment policies and procedures apply across all provider types.

b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.):

Throughout the country, Aetna continues its efforts to collaborate with providers to help them transition from fee-for-service models to value-based care delivery models. We give providers strategic financial incentives to improve quality and control costs and information to help them and their patients make more informed health care decisions. Aetna's national efforts have focused primarily on accountable care organizations (ACOs), Patient-Centered Medical Homes (PCMHs), and other provider-collaborative models known as PCMH Recognition and Pay for Performance (P4P) Agreements.

c. 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.):

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

☒ Other, please describe:

On a national basis, the three principal Alternative Payment Models that Aetna has adopted are the Pay-for-Performance Arrangement (P4P), Patient-Centered Medical Home (PCMH), and Accountable Care Organization (ACO).

P4P

Aetna uses P4P arrangements to introduce providers to APMs and to set the foundation for their transition to more complex value-based models. P4P providers agree to tie a portion of their usual fee-for-service increases to performance on quality and efficiency measures. The measures are intended to increase members' quality of life, decrease unnecessary utilization, and contain costs. For P4P providers that are physicians, the performance measures include: formulary compliance; generic substitution; therapy for children with upper respiratory infections; asthmatics receiving inhaled corticosteroids; ACE inhibitor or ARB therapy for members with congestive heart failure; beta blocker use for ischemic heart disease and history of acute myocardial infarction; lipid-lowering drugs for prevention of ischemic heart disease; breast cancer screening; cervical cancer screening; colorectal cancer screening; HbA1c measurement for diabetics; lipid measurement for diabetics; retinal exams for diabetics; NCQA heart and stroke recognition; and NCQA physician practice connections.

For P4P providers that are facilities, the performance measures include: use of network anesthesiologists, emergency physicians, pathologists, radiologists; 30-day readmission rates; average lengths of stay; adverse event rates; risk-adjusted C-section rates; timeliness and effectiveness of care for heart attack, chest pain, and strokes; blood clot prevention and treatment; pregnancy and delivery care; emergency care; preventive care; rate of hospital acquired infections; HCAHPS patient experience survey measures; Leapfrog hospital safety score; Leapfrog hospital survey participation; and elective delivery infant safety.

P4P providers who meet their performance targets are rewarded with a value-based payout. Each customer pays a proportionate share of the payout based on their share of claims (aligned with P4P doctors and hospitals) during the period that the value-based payment was earned. The value-based payment is made as either a one-time lump sum or an increase in rates. Depending on the P4P provider's overall score on the applicable performance measures, the one-time lump sum payment can range from 50 to 100 percent of the negotiated payment.

PCMHs

Our PCMH models promote patient-centered care through the primary care doctor-patient relationship. PCPs are uniquely positioned to coordinate care across the health care system, including specialty care, hospitals, and community services. As such, PCPs can have a tremendous effect on overall cost and quality of care. Members with consistent PCP utilization are more likely to actively engage in their own care and comply with treatment programs and use emergency rooms less often.

PCMHs receive care coordination payments (CCPs) to help fund enhanced clinical coordination and investment in health information technology. Nationwide, Aetna generally uses two types of PCMH models. Under the Recognition PCMH model, the PCMH receives a CCP based on its NCQA recognition level: $2 PMPM for Level 1 and Level 2, and $3 PMPM for the Level 3. Under the Direct PCMH Model, the PCMH not only receive CCPs (typically $1.50 to $3.00 PMPM), but it is also eligible for shared-savings payments. To qualify for shared-savings payments, the PCMH must generate cost savings though improvements in seven efficiency measures: non-Trauma Bed days per thousand; 30-day readmission rate; potentially avoidable emergency room visits per thousand; percentage of outpatient laboratory services performed at independent labs; percentage of outpatient radiology performed at free-standing facilities; percentage of outpatient

surgeries/procedures performed at preferred sites; and generic prescribing rate. The value of the PCMH's CCPs is deducted when calculating shared-savings payments. Half of the PCMH's share of savings that exceeds the CCP is subject to its performance on the efficiency measures.

ACOs

Nationally, Aetna uses two principal types of ACOs—Attribution ACOs and Product ACOs. Both types of ACOs receive a PMPM accountable care payment (ACP) that typically ranges from $3 to $6. For an Attribution ACO, ACPs are made only for members that access care through providers that are part of the ACO. For a product ACO, the ACPs are made for each member actively enrolled in the ACO product. Offset by lower fee-for-service schedules, the ACP helps fund implementation of value-based strategies, including improved clinical coordination and population-health management. For most ACOs, the ACP is fully at risk. All or a portion of the ACP may be refunded to self-funded customers if the ACO does not meet clinical and/or cost-of-care performance targets.

In addition to ACPs, certain ACOs are eligible to earn another payment—shared savings payments. Generally, an eligible ACO will receive a shared savings payment if it meets both a financial-performance target and specific quality and efficiency benchmarks. For product ACOs, financial performance is measured against a PMPM medical cost target, which is calculated using historical claims data and standard underwriting and actuarial guidelines. For attribution ACOs, financial performance is measured relative to the geography's average trend. If an ACO meets its financial-performance target, its shared savings payment is calculated according to its performance on quality and efficiency measures. Aetna and the ACO mutually agree to the quality and efficiency measures, the relative weight for each measure, and the performance thresholds. The ACO's performance on each of the quality and efficiency measures is compared to the target. A composite quality and efficiency score is calculated, and the shared savings payment is adjusted proportionally. Typical quality and efficiency measures include: outpatient surgeries/procedures performed at preferred facilities; hospital readmissions for medical and behavioral health; avoidable emergency room utilization; ambulatory sensitive condition admissions; non-trauma admissions; 30-day readmissions; outpatient laboratory tests/services; radiology services at preferred (freestanding) facilities; generic prescribing rate; breast cancer screening; colorectal screening; cervical cancer screening; diabetes Hba1c screening; flu vaccination; pneumonia vaccination; diabetes/lipid screening; various preventive care measures; and total cost of care.

d. Please describe any ways in which your unique payment approach brings value to patients, plan sponsors, or payers:

We believe that shifting provider reimbursement to value-based payments is necessary to drive healthier outcomes, contain costs, and improve the efficiency and quality of care. If providers are not held accountable for the cost and quality of care, costs will continue to rise, and quality will continue to stagnate. Across the nation, we are using the following value-based contracting (VBC) models to deliver cost, quality, and efficiency improvements.

Aetna Whole Health℠ is our product-based accountable care organization (ACO). Aetna Whole Health is a member-focused and doctor-driven product that rewards health systems for improving health outcomes and costs. Both members and plan sponsors realize great value through the

strong improvements and transformative savings that Aetna Whole Health achieves. We collaborate with our ACO partners to identify additional savings by redesigning processes, directing members to more cost-effective providers, and continuing to improve proactive identification and management of members that have rising risk factors. Indeed, our data indicates that Aetna Whole Health achieved the following national successes: (1) improved costs by $29.25 PMPM, compared to Aetna broad-network plans; (2) resolved 97.8 percent of member inquiries in the first call (February 2016); and (3) reduced unit costs for physician visits by $4.51 PMPM and unit costs for lab services by $4.54 PMPM over a 12-month period (2016–2017).

Our **Attribution ACOs** encourage quality, efficiency, and member satisfaction. Based on recent claims history, members are automatically assigned to providers where they already seek care today. Unlike with our product-based ACO (Aetna Whole Health), members do not have to change primary care doctors, and there is no benefit plan change. Our data indicates that Aetna's Attribution ACOs have achieved the following positive outcomes at the national level: (1) improved costs by $7.74 PMPM, compared to Aetna broad-network plans; (2) improved more than half of their performance metrics over a 12-month period (2014–2015); (3) decreased impactable inpatient admissions (–8.1%); (4) decreased utilization of CAT scans and MRIs (–11.5%); (5) decreased utilization of high-tech radiology (–14.8%); and (5) increased generic prescribing (+2.1%).

Our **Patient-Centered Medical Homes (PCMHs)** coordinate care for members through a team-based approach that leverages the electronic health record and Aetna care management programs. Our data indicates that PCMHs—on a national basis—reduced costs by $0.81 PMPM and achieved an overall 2.5 percent reduction in inpatient readmissions per 1,000 members.

Our **Pay-for-Performance Arrangements (P4P)** rewards physicians and hospitals that meet incremental goals for targeted metrics. Our data indicates that our Hospital P4Ps realized national savings of $171 million (2.3 percent) over a 3-year period (2012–2014), as compared to expected costs. Savings were concentrated in the Northeast, where 31 of our 43 P4P Hospital Arrangements are located.

We are encouraged by these early indicators of success, and we are confident in our vision. Nationally, 60 percent of our claim payments go to providers who deliver value-based care, with 61 percent of those payments aligned with our commercial ACOs and joint ventures. In addition, 10 percent of national value-based spend is aligned with our PCMH models, and 12 percent is aligned with P4P arrangements. We have developed an aggressive roadmap to increase value-based models in our contracts and are working systematically to achieve our goals. Our nationwide target for 2019 is to have 68 percent of claim payments going to providers of value-based care. We are committed to having 75 percent of all national medical spend in VBC arrangements by 2020.

2. Please answer the following questions regarding your organization's APM contracts with providers in our marketplace:

a. 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?

We believe that the following barriers limit our ability to shift from FFS payment models to APMs. First, the majority of Aetna's Massachusetts membership is covered under plans sponsored by self-funded employers, who generally do not support non-FFS models. Second, Aetna has various internal administrative limitations (e.g., operational, technical, etc.) that complicate its replacement of FFS models with APMs. Third, and most importantly, health systems in Massachusetts have been reluctant to participate in Aetna's APMs because our membership is smaller than that of many local plans.

b. 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?

In 2018, 100 percent of our Massachusetts claims were adjudicated on a fee-for-service basis. Approximately 34 percent of the dollars of those claims were impacted by a value-based arrangement.

***

I, Duncan Stuart, President of the New England Market for Aetna, am legally authorized and empowered to represent Aetna for the purposes of this testimony, which is signed under the pains and penalties of perjury.

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Duncan Stuart
President, New England Market
Aetna

HPC Payer Exhibit 1

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Actual Observed Total Allowed Medical Expenditure Trend by Year

- Includes both fully-insured and self-insured Commercial product lines

Time Period	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2016	1.7%	1.5%	2.3%	0.8%	5.6%
CY 2017	3.9%	-0.8%	1.4%	0.2%	4.8%
CY 2018	3.4%	2.0%	1.4%	-0.5%	6.4%

A. The effect of changes in demographics on trend is contained within Utilization and Service Mix. As members age, utilization and intensity of services vary according to gender, age, and other demographic factors.

B. The effect of benefit buy downs on trend is contained within Unit Cost and Utilization. Benefit buy downs impact Unit Cost trends because members are incented to see lower-cost providers and sites of service. Benefit buy downs also impact Utilization because as members pay an increased share of total spend, unnecessary utilization decreases.

C. The effect of changes in health status on trend is similar to and difficult to differentiate from changes in demographics. As health status for the population changes, so will all of the categories of trend. In a block of declining health status, Costs and Utilization increase and drive increases in Provider Mix and Service Mix