NEW ENGLAND DRAFT RESPONSES to MHP QUESTIONS:
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?
   (1) Provider reimbursement increases.
   (2) Rising specialty medication costs.
   (3) Maintaining cost effective, high quality of care

b) What changes in policy, market behavior, payment, regulation, or statute would most support your efforts to reduce health care expenditures?
   (1) Require provider charge increases to be in line with the Total Medical Cost cap in Massachusetts.

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.

   i) Expanding our collaborative care agreements to involve more provider organizations in activities that increase patient quality and reduce cost.
   ii) Working with local integrated delivery systems to have them invest more in primary care by sharing savings directly with primary care providers for improving patient outcomes.

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.

1) Cigna has recognized the importance of the interaction of mind and body and has taken steps to integrate behavioral health into primary care and offer programs to patients to improve their mental health.

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?

1. **Providers need to provide resources for integrated medical and behavioral health (space, mental health professionals, and appropriate sharing of health care information) between medical and behavioral health providers.**

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?

i. **Reimburse mental health professionals for seeing patients in a primary care setting.**
ii. **Barriers to implementation of embedding behavioral health in primary care in provider organizations included: limitations in provider operational capabilities.**

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	Minor Contributing Factor
Aging of your members	Minor Contributing Factor
New or improved EHRs that have increased providers' ability to document diagnostic information	Minor Contributing Factor
Coding integrity initiatives (e.g., hiring consultants or working with providers to assist with capturing diagnostic information)	Minor Contributing Factor
New, relatively less healthy patients entering your patient pool	Not a Significant Factor
Relatively healthier patients leaving your patient pool	Not a Significant Factor
Coding changes (e.g., shifting from ICD-9 to ICD-10)	Minor Contributing Factor
Other, please describe:	Not a Significant Factor

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

a. 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.
   i. **Cigna continuously monitors claims to assure adherence to appropriate billing and coding practices.**

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.

b) For each of the areas listed below, please indicate whether achieving greater alignment and simplification as 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 unless your responses have changed. **Previously submitted**

c)

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

Area of Administrative Complexity	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

d) 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. **Previously submitted.**

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		

2.
3.

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, 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] 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

Cigna has a number of APM offerings and continues to deploy those with provider partners who are aligned to moving to value based reimbursement and where we have statistically meaningful patient population. We've expanded our APM programs to include total medical cost management ACO type arrangements, episode of care for high volume specialty care, bundled payment arrangements and hospital care collaboratives.

a. 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: Hold providers responsible for expenditures over the annual health care cost growth benchmark.

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."

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**	2,424,338	9,710
	Q2	1,935,143	6,869
	Q3	1,986,070	5,982
	Q4	1,957,240	5,295
CY2019	**Q1**	2,707,197	7,412
	Q2	2,092,311	4,271
	TOTAL:	13,102,299	39,539

5. 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.

See attached document, for 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: **Cigna consistently updates its payment policies to insure providers are in compliance with national standards of reimbursement.**

    b. Payment structure (e.g., use of DRGs, per diem, fee schedules, service categories, observation structure, etc.): **We strive to move all provider reimbursement to fixed payments terms primarily using DRGs for inpatient and APCs for outpatient services.**

    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.):
    Cigna continually updates risk scores using nationally accepted ERG software.
    ☒ Risk structure (e.g., risk exposure, the allowed budget, exclusions, bonuses, quality performance, etc.):
    Cigna has developed standard risk structure models which are deployed in the market. These models involve metrics for measuring quality along with methods for excluding groups from inappropriate risk exposure.
    ☐ 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.

    d. Please describe any ways in which your unique payment approach brings value to patients, plan sponsors, or payers: **Given our standardization across our entire enterprise plan sponsors and their employees can feel confident that their experience will be consistent throughout our broad national network.**

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?
Most providers are not prepared to take global lump sum payment and lack the capabilities to redistribute dollars to utilized providers so rather than replicate capabilities that already exist with payors have focused more around value based contracts that keep FFS payments in place but measure performance on set cost and quality targets.

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?
100%

HPC Payer Exhibit 1

All cells should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insured and self-insured product lines

Year	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2016	3.8%	2.9%	*	-2.9%	3.6%
CY 2017	5.1%	0.1%	*	-1.3%	3.8%
CY 2018	2.9%	2.3%	*	2.8%	8.4%

*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 and to a lesser extent service mix.

1. Actual Observed Medical Expenditure Trend Cigna OAP membership. Pharmacy is excluded.
   a. For 2016 through 2018, demographics of the population impacted observed trend for MA residents by -0.7% in 2016, -0.3%% in 2017, and -0.4% in 2018.
   b. Benefit buy downs decreased observed trend for MA residents by -0.2%, -1.4%, and -0.3% for the years 2016-2018 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 +1.5% in 2016, +0.2% in 2017 and -1.6% in 2018.

Notes:

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

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

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

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