aetna®

Aetna
151 Farmington Avenue
Hartford, CT 06156-3124

Barbara Hennessy
Law and Regulatory Affairs
Phone: (860) 273-9559
Fax: (860) 273-3686
Email: HennessyB@aetna.com

Via Email (HPC-Testimony@state.ma.us)

September 15, 2015

David Seltz
Executive Director
Health Policy Commission
2 Boylston Street
Boston, MA 02116

Re: Health Policy Commission Exhibits

Dear Mr. Seltz:

Attached please find Aetna's updated exhibits. As I indicated in my voice mail message to you today there was a typo in HPC Payer Exhibit 1. Per messages, I received from Kate McCann and Kelly Mercer you are allowing Aetna to re-submit the exhibits only.

If you have any questions, please do not hesitate to contact me at (860) 273-9559 or Tracy Shorts, Paralegal at (860) 273-1266 or ShortsT@Aetna.com.

Sincerely,

Barbara Hennessy

Barbara Hennessy
Counsel

cc: Karen Tseng, Chief, Health Care Division, Office of the Attorney General
cc: Aron Boros, Executive Director, Center for Health Information and Analysis

Aetna's responses to Exhibit B: HPC Questions for Written Testimony for 2015

1. Chapter 224 of the Acts of 2012 (Chapter 224) requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
    a. Please describe your organization's efforts in the last 12 months to meet this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs) on (i) total medical expenses, (ii) premiums, and (iii) provider quality. Please specifically describe efforts and analyses related to bundled payment and similar payment methods.

    Aetna's ability to address the impact of growth in prices on medical trend is affected by the rates we pay providers for services rendered to our members (including financial incentives to deliver quality medical and/or other covered services in a cost effective manner) and by our provider payment and other provider relations practices (including whether to include providers in the various provider network options we make available to our customers). In addition, there are factors not associated with our organization that impact these providers and their pricing decisions, including changes in Medicare and/or Medicaid reimbursement levels and increasing revenue and other pressures on providers.

    Aetna strives to contract competitively while developing and maintaining favorable relationships with hospitals, physicians, pharmaceutical benefit service providers, pharmaceutical manufacturers and other health care benefits providers. We seek to enhance our provider networks by entering into collaborative risk-sharing arrangements, including Accountable Care Organizations (ACOs), with health care providers, and are keenly aware of the cost impact of out of network utilization to both our organization and our members. To reduce these costs, we offer products that incent members to use participating providers and have implemented a variety of programs (at both the member and provider level) to reduce the cost impact of out of network utilization.

    Provider collaboration arrangements reduce unnecessary utilization, provide for shared savings through aligned incentives for appropriate care delivered in the best setting, and allow for financially sustainable provider business models. ACOs can enhance patient experience, improve quality of care, and reduce costs to support market share growth and high quality care delivery to larger populations.

    Throughout the country, Aetna collaborates 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.

Today, Aetna's contracted ACOs include some of the most advanced and efficient systems in the country. We currently have 67 ACO arrangements in place, and we are engaged in more than 200 ACO discussions with health systems covering 60 percent of the U.S. population. Nationally, nearly 30 percent of our claim payments are made to providers who deliver value-based care.

Looking forward, we have developed a thoughtful, aggressive approach to continue to increase value-based models. We project that value-based models will account for 47 percent of our national spend in 2017, and at least 50 percent by 2018. By 2020, we hope to reach 75 percent. Of these numbers, just over 30% is or will be tied to our ACOs.

We provide ongoing analytical and care management consulting to our ACO organizations (review of monthly results, metrics, and cost/quality trends) to support continuous improvement in quality and financial outcomes. We also conduct formal quarterly meetings with each ACO to review financial and quality results and trends and assist with action plans to improve outcomes across all facets of care delivery and cost.

Aetna adopts national metrics endorsed by national entities (e.g. National Quality Forum), but since our ACO arrangements are flexible in scope, there is no single approach to defining metrics. We work collaboratively with each organization to outline appropriate measurable and actionable metrics, some of which include, but are not limited to:

- Outpatient surgeries/procedures performed at preferred (ambulatory) 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
- Other preventive care measures

We track utilization to allow each ACO to manage a specific population. In addition, we provide analytic capabilities that allow ACOs to view results and

create actionable reports on a wide range of utilization, quality and financial metrics. These capabilities include both standard monthly/quarterly metrics/results reporting and data sets with user driven drill down capabilities at the physician and member level. We continue to build on our capability to transform raw claims and other administrative data into understandable, actionable and clinically meaningful information.

Our reports include, but are not limited to the following metrics:

Quality of care measures:

- Breast cancer screening
- Colorectal screening
- Cervical cancer screening
- Diabetes Hba1c screening
- Flu vaccination
- Pneumonia vaccination
- Diabetes/Lipid screening
- Pharmacotherapy management of COPD exacerbation
- Use of spirometry testing to assess and diagnose COPD
- Use of appropriate medications for people with asthma
- Follow-up after hospitalization for mental illness
- Medication reconciliation post discharge
- Annual health risk assessment
- Routine medical exams
- Medication adherence (specific drug classes)

Outcomes-based measures:

- Diabetes Hba1c for patients with Type 1 or 2 diabetes
- Diabetes/cholesterol management for people with Type 1 or 2 diabetes and LDL greater than 100
- Cholesterol management for patients with cardiovascular conditions
- Beta blocker therapy for CAD patients with prior myocardial infarction
- Congestive heart failure screening/management
- Medication management for patients with asthma
- Medication adherence/management for newly diagnosed patients with depression; effective acute phase treatment and effective continuation phase treatment
- Adverse event: hospital acquired conditions

Infrastructure/care process measures:

- Outpatient surgeries/procedures performed at preferred/lower cost (ambulatory) facilities
- Hospital readmissions for medical and behavioral health

Care coordination measures:

- Avoidable emergency room utilization
- Ambulatory sensitive condition admissions

Financial/efficiency measures:

- Non-trauma admissions
- 30 Day Readmissions
- Outpatient laboratory tests/services
- Radiology services at preferred (freestanding) facilities
- Generic prescribing rate
- Utilization: ER visits per 1,000
- Utilization: Total Acute hospital days
- Utilization: Total NICU days
- Utilization: Total skilled nursing facility/rehab days

Patient-Centered Medical Homes (PCMH) realign care to focus on maintaining health, and reducing high-intensity, duplicative or medically unnecessary services. Nationally, Aetna has three PCMH models. The PCMH Direct Contract Relationship model allows for care coordination and shared savings by way of a per member per month payment for patients attributed to the practice and a percentage of savings when clinical quality targets are met. The PCMH Recognition Model provides a care coordination fee by way of a per member per month payment for patients attributed to the practice. Aetna monitors providers' clinical performance and efficiency under both the Direct Contract Relationship and the Recognition models. The PCMH Multi-Payor Collaboratives, CMS, and Comprehensive Primary Care Initiative (CPCI) model focuses generally on fully insured commercial business, and allows for variation in clinical performance, efficiency, and data aggregation measures. Aetna is currently participating in CPCI arrangements in Maine, Maryland, New York, Ohio, Pennsylvania and Washington.

Aetna, which has focused on consumer directed plan options and dynamic delivery systems across the country, has maintained a smaller presence in the Massachusetts fully insured markets. However, as the Massachusetts market becomes more consumer-centric and embraces value-based delivery plan options, we believe that competition will increase. To that end, Aetna is implementing two provider collaborative models in Massachusetts: PCMH Recognition and Pay for Performance (P4P) Agreements - both designed to improve the quality and efficiency of care. In 2013, Aetna introduced a PCMH Recognition program to Massachusetts NCQA certified physician practices, encouraging

certain physicians to treat patients while maintaining NCQA PCMH accreditation status. We currently have 2,820 providers and 35,731 members participating in our Massachusetts PCMH recognition programs. As more providers become NCQA PCMH certified, we hope that these programs will serve as the foundation for future programs that will reward recognized PCMH providers for investment in infrastructure, training, health information technology and proactive case management. Aetna also has P4P arrangements in place to reward the continued achievement of specified quality benchmarks with multiple provider groups.

b. Please describe specific efforts your organization plans to undertake between now and October 1, 2016 to increase the use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider and product types. Please specifically describe efforts related to bundled payment and similar payment methods.

Please refer to Aetna's response to Exhibit B, Question 1a, above, for information on Aetna's provider collaboration and ACO arrangements.

c. In its 2014 Cost Trends Report, the HPC stated that major payers and providers should begin introducing APMs for preferred provider organization (PPO) covered lives in 2016, with the goal of reaching at least one-third of their PPO lives that year. Please describe your plans to achieve this goal. Additionally, please describe any specific barriers for moving self-insured business into APM arrangements.

Please refer to Aetna's response to Exhibit B, Question 1a, above, for information on Aetna's provider collaboration and ACO arrangements.

2. Describe your organization's efforts to develop insurance products or plan designs that encourage members to use high-value (high-quality, low-cost) services, settings, and providers, and detail progress made over the past year. Example of such efforts include: phone triage or telehealth services; targeted information about and incentives to reduce avoidable emergency department (ED) use; and reference pricing, or cash-back reward programs for using low-cost providers. Please describe the result of these efforts and attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending. Please describe efforts your organization plans between now and October 1, 2016 to continue progress in encouraging members to use high-value services, settings and providers. What barriers have you identified to introducing insurance products or plan designs that encourage members to use high-value services, settings and providers in Massachusetts?

Aetna offers several programs to its Massachusetts self-insured plan sponsors to promote use of high value providers and service settings. In addition to the PCMH and P4P programs

described above, Aetna also offers these plan sponsors "Aexcel" (high performance tiered physician network) and the Aetna Performance Network (high performance tiered hospital network).

Aetna is currently developing a tiered network product for its fully insured Massachusetts customers, and we hope that product will be available for plans effective January 1, 2016. This tiered performance network, known as the Savings Plus plan, aims to reduce health care costs for employers and create cost savings opportunities for employees by directing members to a designated network of quality, cost-effective doctors and hospitals.

In addition to the programs described above, we also offer other programs that help members access high quality, low cost services. We offer the Institute of Excellence (transplants) and Institutes of Quality (bariatric surgery, cardiac surgery, and orthopedic spine and joint replacement) on a fully insured and self-insured basis. As of July 2015, we offer Teledoc (the program offering members access to quality, affordable care for routine illnesses via telephonic and video consultation) to all fully insured members in Massachusetts. Teledoc is automatically included for most self-funded plan sponsors unless they opt out. Lastly, the iTriage app is also available to Aetna members in Massachusetts. In addition to the basic iTriage features, plan sponsors may purchase additional features that enable members to view membership, claim and provider network status.

3. Chapter 224 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures and services through a readily available "price transparency tool." Please describe your organization's progress in meeting this requirement. If you had a tool in place prior to November 2012, please describe your organization's prior experience, including how long your tool has been in use and any changes you have made to the tool over time.

   Aetna's general response on our Member Payment Estimator Tool (MPE) is incorporated into its response for subsection *f.*, below.

   a. Using **HPC Payer Exhibit 1** attached**,** please provide available data regarding the number of individuals that seek this information and identify the top ten admissions, procedures and services about which individuals have requested price information for each quarter listed below and the number of inquiries associated with each.

      Please see HPC Payer Exhibit 1 for Aetna's response.

   b. Do consumers have the ability to access cost data for the following types of services (yes/no)? If no, please explain.

Inpatient	Yes	☒	No	☐
Outpatient	Yes	☒	No	☐
Diagnostic	Yes	☒	No	☐
Office Visits (medical)	Yes	☒	No	☐

Office Visits (behavioral) Yes ☐ No ☒

We do not include behavioral health in our transparency tools at this time. As always, we continue to evaluate ways to add new types of care to our tools.

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

Yes ☒ No ☐

38T

d. Do you provide actual out-of-pocket estimates that reflect a member's specific benefits and deductible status? If no, please explain.

Yes ☒ No ☐

38T

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

Yes ☒ No ☐

38T

f. Please describe any information you have collected regarding how your members use this information and the value of this information to members. Please describe any analyses you have conducted to assess the accuracy of estimates provided and the impact of increased price transparency for members as well as any limitations in the tools you have identified and ways your organization plans to address them.

Aetna's MPE is available via Aetna's secure member website, Aetna Navigator. It is an interactive tool that members use to estimate and compare out-of-pocket costs for over 650 medical services for up to 10 in-network providers at once. MPE provides point-in-time estimates using Aetna's claim adjudication system and real-time data - provider's negotiated rates and the member's plan information (eg. deductible balances, benefit limits and coinsurance amounts). MPE is free of charge and available to over 98% of Aetna's commercial medical membership. Additionally, beginning in the first quarter of 2015, Aetna members can now access MPE through the Aetna Mobile app.

"Ask Ann," our virtual assistant, is available to walk members step-by step through the estimation process, and to answer questions about MPE. Members of our plans not supported by MPE (e.g. Student Health, Affordable Health Choices and Fixed Indemnity plans) can receive similar information by calling a dedicated customer service line.

MPE includes non-emergency services that are commonly used by our members including physician office visits, surgical procedures (including maternity and cataract/lens surgeries), and diagnostic tests and procedures (including upper GI endoscopies and colonoscopies). Members can generate estimates for themselves and their covered dependents. The tool displays the appropriate services based on

age and gender. It provides both in-network (doctor and hospital) and out-of-network charges (doctor only). MPE displays icons to indicate high-performing doctors and hospitals that have met clinical performance and efficiency standards, so members can review quality along with costs. In 2014, we added direct links for 13 of the most frequently searched services on MPE. MPE also provides estimates in the form of service bundles where appropriate. Service bundles represent the most likely combination of services that may be performed together in a doctor's office or in a facility setting. Estimates include all related costs from admission to discharge (e.g. the number of units of anesthesia included with a particular procedure in addition to the physician and facility charges.) There are approximately 450 physician service bundles and approximately 220 facility bundles included in MPE today.

Since MPE uses real-time claim adjudicating logic (the logic used to process a claim for a particular provider), it consistently uses the most current provider rates and member benefit plan information to give Aetna members a point-in-time estimate.

We believe that transparency of both cost and quality information will improve significantly as the delivery system progresses away from fee-for-service to a value based payment model. Perhaps the most important example will be seen in the context of hospital-based providers (radiologists, anesthesiologists, and pathologists), which often don't contract with health plans, even when the hospital(s) at which they perform services do. In a value based model, these services will be included in the overall value payments, and will be available for use in transparency tools.

In 2011, members who used MPE and had a claim for the same procedure experienced average savings of $612 on allowed expenses and $170 on their out of pocket costs for the 34 procedures included in our 2012 study.* Members who used MPE displayed increased use of lower cost providers and lower rates of using higher cost providers – 60% chose to receive care at a low or medium cost in-network provider after getting an estimate.

**Member Payment Estimator Study, Informatics and Product Strategy, August 2012*

4. The Massachusetts health care environment has recently undergone significant changes, including multiple hospital and physician group acquisitions and affiliations. Please describe your views on recent market changes, including any impacts these changes have had on costs (e.g., prices and total medical expenses), referral patterns, quality and access to care.

   The Massachusetts marketplace continues to be dominated by local payers. Aetna, which has focused on consumer directed plan options and dynamic delivery systems across the country, has maintained a smaller presence in the Massachusetts fully insured markets. However, as the Massachusetts market becomes more consumer-centric and embraces value-based delivery plan options, we believe that competition will increase. To that end, we remain committed to providing our members with transparency tools to make informed healthcare purchasing

decisions, launching new accountable care organizations where appropriate, and giving providers the data analytic capabilities they need to be successful partners with us in the delivery of value-based care.

5. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Health Policy Commission in 2014; and by the Center for Health Information and Analysis in 2012, 2013, and 2015, prices paid to different Massachusetts providers for the same services as well as global budgets vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value.
    a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

       Provider collaboration arrangements (including ACOs), P4P arrangements, and PCMHs) reduce unnecessary utilization, provide for shared savings through aligned incentives for appropriate care delivered in the best setting, and allow for financially sustainable provider business models. By focusing on value-based delivery, improved efficiency, and overall improved patient satisfaction, ACO arrangements can enhance patient experience, improve quality of care, and reduce costs to support market share growth and high quality care delivery to larger populations.

       Please refer to Aetna's response to Exhibit B, Question 1a, above, for information on Aetna's provider collaboration and ACO arrangements.

    b. What steps are you taking to address this variation in prices and budgets? Please include any approaches you have considered implementing to reduce the role that past or current fee-for-service price disparities play in global budgets.

       Aetna reviews variations in pricing and budgets in its discussions with providers. As stated in response to Exhibit B Question 1 above, Aetna believes that developing relationships with providers that are not based in fee-for-service (value based contracts, ACOs, PCMHs) but rather establish joint collaboration to pay for quality and efficiency, are the most promising way to control overall costs.

6. Please describe your policies and procedures, including notice policies and protections from out-of-network charges, for members referred to out-of-network providers and cases in which services at in-network facilities are provided by out-of- network providers. Please describe any policies you have in place to ensure that a referring provider informs a patient if a provider to whom they are referring the patient is not in the patient's insurance network.

   Aetna's provider networks bring great value to our members and plan sponsors. While we encourage members to use our networks whenever possible to reduce out of pocket costs, we recognize that not all members choose to or can always get all their care from network providers. We therefore continue to evolve our out-of-network benefits and policies to best align them with the value our networks deliver, our customers' benefit preferences, state and federal law obligations, and the need to protect members in emergency and certain other situations.

Not all out-of-network claims are the same. Sometimes members choose to go out of network and sometimes they need care when an in-network provider is not available. When members knowingly choose to obtain services from outside our network (voluntary; second opinion consult with an out-of-network specialist), we pay for that care pursuant to the terms of each member's benefit plan. When members are unable to select a participating provider and get care outside of our network (involuntary; an emergency situation or when members receive care rendered at an in-network facility by an out-of-network specialist like a radiologist or anesthesiologist), we hold our members harmless from incurring more costs than if they received the care in-network.

This does not necessarily mean that we pay whatever a provider bills for out-of-network care. Unless state law requires a different result, upon receipt of an involuntary out-of-network claim, we pay a fair amount for the services rendered. At the same time, we tell our members that we have paid the provider equitably and ask that they forward any additional bills (balance bills) to us for handling.

Aetna seeks to have its participating providers refer to other participating providers so members receive the maximum value from our network. Aetna requires participating providers to refer/admit members to other participating providers for services covered by the member's benefit plan. In addition, our new contract templates require providers to obtain written consent when referring/admitting a member to a non-participating provider and an acknowledgement of the additional financial responsibility associated with the use of an out-of-network provider. When we learn of a provider who routinely refers/admits members to an out-of-network provider, we educate that provider on the value of the network. If the referring/admitting patterns do not change, we will consider removing that provider from our network. Members who are unknowingly referred to an out-of-network provider may appeal to Aetna and ask that Aetna hold them harmless from amounts incurred beyond the in-network financial responsibility.

Across the country, Aetna is taking important steps to address the cost of out-of-network care. First, we are building Accountable Care Organizations and pursuing other network strategies to provide the most robust network options for our members and customers. Second, we continue to support customer preference and offer choices in out-of-network plan design. Third, we are taking legal action, and lobbying for sensible legislative changes, to curb the abusive billing practices of a small number of providers who refuse to join networks and unnecessarily raise medical costs and premiums by charging egregious amounts for their services. Sensible legislative changes include eliminating the ability of providers to balance bill members who receive out-of-network care involuntarily, and establishing an equitable process for resolving disputes between providers and insurers about the fair value of services rendered. Finally, we are increasing transparency and helping members better understand their in-network choices through our online provider directory, our Member Payment Estimator tool, and our product names and plan documents.

7. The Medicare Payment Advisory Commission and others have noted that patient visits to outpatient-based practices, which can bill a "facility fee," are increasing faster than visits to freestanding practices. Please describe any shift you have observed toward increased use of outpatient-based practices and the impact of facility fees and any such shift toward the use of outpatient-based practices on health care costs, quality and access.

Nationally, Aetna has seen a shift away from inpatient facilities toward outpatient, or ambulatory, facilities. Beginning in 2009, in Massachusetts, we began to see a shift away from a physician office service to a split billed physician outpatient clinic visit and facility service fee. Aetna's contracts with providers contemplate both the professional and technical components of the services provided. Therefore, Aetna's claim payment logic excludes payment for a separate facility fee for outpatient-based practices. However, when a hospital system negotiates an exemption from that logic, facility fees can be paid at a percentage of billed charges and those costs are ultimately passed along in the form of higher premium rates for insured groups and higher costs for self-funded groups.

8. The Commission has identified that spending for patients with co-morbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health conditions. As reported in the July 2014 Cost Trends Report, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    a. Please describe your efforts in the past 12 months to effectively address the needs of these patients in an integrated manner, clearly identifying areas of progress, attaching any attaching analyses you have conducted.

    Aetna understands that spending for patients with comorbid behavioral health and chronic medical conditions can be higher than spending for those patients with a chronic medical condition alone. We strongly believe in an integrated approach to managing medical and behavioral health services. As such, Aetna does not carve out the management of behavioral health services to an external vendor. In addition, to help achieve better outcomes and reduce costs, Aetna offers several different case management services and activities that address both behavioral health and medical conditions in an integrated way.

    In 2011, Aetna launched efforts to more fully integrate case management for its members with medical and behavioral health conditions. As part of this integration, and until January 1, 2016 (please see response to Exhibit B, question 9 below) members with serious behavioral health issues have been referred to Aetna’s behavioral health/medical psychiatric case management program – the Med-Psych Case Management Program (the “Med-Psych Program”.) The Med-Psych Program addresses significant behavioral health issues that may impede treatment progress for medical conditions and facilitates communication and coordination of care between treating physicians and behavioral health professionals. The Med-Psych Program can help members improve/resolve behavioral issues before they have a serious effect on medical conditions, which in turn can help to reduce high-cost medical procedures. Through internal program development, we have found the Med-Psych program to have reduced emergency room visits by 5% and medical admissions by 37%.

    In addition, Aetna provides access and referrals to telemedicine programs provided by AbilTo, LLC which assist members with chronic health conditions, such as diabetes and cardiac conditions. AbilTo provides video-based counseling and coaching services, which help Aetna members address from their homes the emotional challenges that may accompany medical diagnoses (e.g. depression, anxiety, and stress). As reported in the Aetna Analytics AbilTo 2013 Study, the program has a 97% satisfaction rate and has resulted in significant

health improvements, including a significant reduction in depression among participants.* Additional information is contained in Aetna's AbilTo Program Description, a copy of which can be found as **HPC Payer Exhibit 3**.

b. Please describe your specific plans for the next 12 months to ensure that integrated treatment is provided for these patients, including specific goals and metrics you will use to measure performance whether you use a behavioral health managed care organization ("a carve-out") or manage behavioral health care within your organization.

Aetna does not contract with, otherwise use a behavioral health managed care organization, or "carve-out" for fully insured plans in Massachusetts. Some of our self-funded national account customers, which may have members residing in Massachusetts, do carve-out behavioral health services.

As part of our continuous quality improvement monitoring, Aetna has identified several opportunities for enhanced care management for members with both behavioral and medical conditions. Recognizing that many behavioral health conditions often overlap one another, in 2016, Aetna Behavioral Health will be offering a new program known as Condition Management. The Aetna Behavioral Health Condition Management Program offers an innovative approach to managing behavioral health. Our transformed product offering treats the range of behavioral health conditions, from mild to severe, all within the same clinical model and reporting structure. The Condition Management Program employs an integrated approach to care, which is based on an evidence-based, bio-psychosocial model.

The Condition Management Program will replace Aetna's current case management and disease management programs, including the Med Psych program described above. Through the Condition Management Program, Aetna will be better able to engage our members and their families struggling with acute, costly and chronic behavioral health conditions.

When a person experiences a behavioral health condition, the very essence of this struggle is a unique set of challenges:

- Difficulty coping with everyday life activities
- Stressful impacts on family and support systems
- Difficulty accessing and navigating an environment of complex treatment and service delivery
- Motivational issues due to the condition, its stigma and the hard work needed to succeed at treatment

These members and their families will benefit from active support to overcome these challenges. To accomplish this, Aetna Behavioral Health Condition Management Program offers:

- Early identification through sophisticated triggers
- Improved engagement through intensive outreach strategies

- Health advocacy for members to coordinate and work through co-existing medical and behavioral health conditions
- A unified approach to help members get the right treatment, services and resources
- Opportunities to measure and analyze efficacy and value

Objectives

The Condition Management Program identifies and engages Aetna members diagnosed with high-risk acute and chronic behavioral health conditions. Enrolled members get support to keep them involved in and compliant with treatment. They also get support with behavior change to improve overall functioning and wellness.

One condition can affect the successful treatment of another. For this reason, the Condition Management Program promotes active collaboration and coordination of everyone involved in the member's medical and behavioral health care, including providers, the member's family and support system, and other Aetna clinical programs.

Behavioral Health Product Offering

The new Condition Management Program will replace our current BH Disease Management/Case Management programs as of January 1, 2016 for new and renewing customers. This includes members suffering from any of the following: depression, alcohol and other substance use problems, anxiety, bipolar conditions or eating disorders, and more.

The program will be available to all National Accounts, Middle Market, Small Group, Individual and Medicare segments.

Care Coordination

BH Condition Management coordinates member care through the combined efforts of our BH clinical team. This includes nurses, social workers, medical directors, and psychologists. They work with other partners across Aetna, with providers and facilities, and with family and community support systems. Coordination among treating providers is central to improving outcomes.

Coordination among treating providers is central to improving clinical outcomes. Core components include:

- Motivational interviewing throughout the continuum of engagement
- Holistic assessment informing the case formulation
- Member-centric care plan development, including focused goals and activities
- Focused follow-up to track progress and condition/wellness improvement
- Coordinated integration or co-management *internally* with Medical, Disability, Behavioral Health, Employee Assistance Programs, and Pharmacy
- Active provider collaboration

Process

The new Behavioral Health Condition Management Program follows the ***Identify/Engage and Assess/Plan/Help*** Care Management model. We will:

- Identify: the Aetna member who needs help
- Engage and Assess: the member to introduce the program, evaluate the member's condition, needs and goals
- Plan: with the member to develop an effective care plan addressing the member's main concerns and critical needs
- Help: coordinate care, follow up as appropriate and monitor outcomes; integrate with other health provider partners; and modify plan as needed.

9. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2012 to CY2014 according to the format and parameters provided and attached as **HPC Payer Exhibit 2** with all applicable fields completed. Please explain for each year 2012 to 2014, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).

   Please see HPC Payer Exhibit 2 for Aetna's response.

I, Mark Santos, 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.

_____

Mark Santos
President, New England Market
Aetna

AETNA
HPC Payer Exhibit 1

Health Care Service Price Inquiries CY2014-2015				
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person	Aggregate Average Time to Resolve Inquiries*
CY2014	Q1	4,126	252	15 minutes
	Q2	3,881	201	17 minutes
	Q3	14,971	200	15 minutes
	Q4	63,050	325	15 minutes
CY2015	Q1	19,780	259	16 minutes
	Q2	14,513	298	16 minutes
	TOTAL:	120,321	1535	

** Please indicate the unit of time reported.*

***Estimate due to reporting contraints.*

******In addition, payers MUST identify the Top 10 admissions, procedures and services in the next two (2) tabs ("Top 10 CY2014" and "Top 10 CY2015")******

All 3 tabs must be completed.

Identify the Top 10 Admissions, Procedures and Services for CY2014 by Quarter:

		Via Web	Via Customer Service
CY2014 Q1	1	New Patient Office Visit	Colonoscopy - For Diagnosis or Follow-up
	2	Vaginal Delivery Uncomplicated	MRI of the Lower Extremity Joint without Contrast (Dye)
	3	Colonoscopy - For Diagnosis or Follow-up	CT Scan of the Abdomen/Pelvis withouth Contrast (Dye)
	4	Colonoscopy - For Preventive Care	Cataract/Lens Procedures Sleep Studies MRI-General (1 Body Part) with Contrast (Dye)
	5	Cesarean Section Uncomplicated	Vaginal Delivery Uncomplicated Shoulder x-ray; complete, minimum of two views
	6	MRI Abdomen without Dye	MRI of the Lower Extremity Joint without Contrast (Dye)
	7	Upper GI Endoscopy	Upper GI Endoscopy MRI of the Lower Back without Contrast (Dye)
	8	New Patient Office Visit	MRI of the Brain with Contrast (Dye)
	9	MRI of the Lower Extremity Joint without	Knee x-rays; both knees, standing, anteroposterior
	10	Initial Gynecologic Well Visit for New Patient Ages 18-39	CT Scan of the Face and Jaw without Contrast (Dye) Mammogram (diagnostic) MRI Chest without Dye
CY2014 Q2	1	Colonoscopy - For Preventive Care	Ultrasound (Transvaginal)
	2	Vaginal Delivery Uncomplicated	MRI of the Lower Back without Contrast (Dye)
	3	Colonoscopy - For Diagnosis or Follow-up	MRI of the Lower Extremity Joint without Contrast (Dye)
	4	New Patient Office Visit	MRI Brian without Dye
	5	Cesarean Section Uncomplicated	MRI of the Brain with Contrast (Dye) Mammogram (diagnostic)
	6	MRI of the Lower Extremity Joint without	Colonoscopy - For Diagnosis or Follow-up
	7	Typical Established Patient Office Visit	Upper GI Endoscopy Sleep Studies
	8	MRI Pelvis without Dye	Total Knee Replacement (1 knee) MRI Thoracic (spinal canal) without Dye Office Consultation ONLY for new or established patients, no testing (Orthopedics)
	9	MRI Brain without Dye	Cataract/Lens Procedures
	10	Established Patient Preventive Care Visit Ages 18 - 39	Fibroid Removal via Hysteroscopy Vaginal Delivery Uncomplicated CT Scan of the Chest with Contrast (Dye)
CY2014 Q3	1	Vaginal Delivery Uncomplicated	Knee Arthroscopy
	2	New Patient Office Visit	Cataract/Lens Procedures
	3	Colonoscopy - For Diagnosis or Follow-up	Vaginal Hysterectomy
	4	Colonoscopy - For Preventive Care	MRI of the Neck without Contrast (Dye)
	5	Cesarean Section Uncomplicated	Office Consultation ONLY for new or established patients, no testing (Orthopedics
	6	New Patient Office Visit with EKG	MRI of the Lower Back without Contrast (Dye)
	7	Upper GI Endoscopy	MRI of the Brain with Contrast (Dye)
	8	Established Patient Office Visit for Low to	Vaginal Delivery Uncomplicated
	9	Asthma	MRI of the Lower Extremity Joint without Contrast (Dye)
	10	New Patient Office Visit - Dermatology	Colonoscopy - For Diagnosis or Follow-up
CY2014	1	Vaginal Delivery Uncomplicated	Colonoscopy - For Diagnosis or Follow-up
	2	Colonoscopy - For Diagnosis or Follow-up	Cesarean Section Uncomplicated
	3	New Patient Office Visit	Vaginal Delivery Uncomplicated
	4	Cesarean Section Uncomplicated	Mammogram (diagnostic)
	5	Upper GI Endoscopy	MRI of the Lower Extremity Joint without Contrast (Dye)

Q4	**6**	New Patient Office Visit - Dermatology	MRI -General (1 Body Part) with Contrast (Dye)
	7	Colonoscopy - For Preventive Care	Upper GI Endoscopy
	8	Ear Wax Removal	Ultrasound, Pelvic (Non-Obstetric)
	9	Sore Throat	MRI of the Lower Back without Contrast (Dye)
	10	Asthma	MRI Brain without Dye

AETNA
HPC Payer Exhibit 1

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

		Via Web	Via Customer Service
CY2015 Q1	1	Vaginal Delivery Uncomplicated	Cesarean Section Uncomplicated
	2	New Patient Office Visit	Vaginal Delivery Uncomplicated
	3	Colonoscopy - For Diagnosis or Follow-up	Sleep Studies
	4	Cesarean Section Uncomplicated	MRI of the Lower Extremity Joint without Contrast (Dye)
	5	Colonoscopy - For Preventative Care	MRI of the Lower Back without Contrast (Dye)
	6	Sore Throat	Chest x-ray, two views, frontal and lateral
	7	New Patient Office Visit - Dermatology	Ultrasound (complete) during Pregnancy
	8	Ear Wax Removal	MRI Upper Extremity Joint without Dye
	9	Asthma	MRI of the Brain with Contrast (Dye)
	10	Office Consultation ONLY for new or established patients, no testing	Colonoscopy - For Diagnosis or Follow-up
CY2015 Q2	1	New Patient Office Visit	MRI of the Lower Extremity Joint without Contrast (Dye)
	2	Vaginal Delivery Uncomplicated	Echocardiogram
	3	Colonoscopy - For Diagnosis or Follow-up	MRI of the Lower Back without Contrast (Dye)
	4	Cesarean Section Uncomplicated	Sleep Studies
	5	Office Consultation ONLY for new or established	Mammogram (diagnostic)
	6	Sore Throat	CT Scan of the Abdomen/Pelvis & Chest with Contrast (Dye)
	7	Office Consultation ONLY for new or established	Vaginal Delivery Uncomplicated
	8	Tonsillectomy	MRI Brain without Dye
	9	Ear Wax Removal	CT Scan of the Face and Jaw without Contrast (Dye)
	10	Colonoscopy - For Preventative Care	Colonoscopy - For Diagnosis or Follow-up

AETNA
HPC Payer Exhibit 2

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

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2012	2.7%	4.4%	0.1%	-1.6%	5.6%
CY 2013	1.6%	0.3%	-0.3%	0.1%	1.6%
CY 2014	1.60%	-0.90%	0.50%	0.80%	2.10%

a. The effect of demographics on trend is contained within the changes due to Utilization and Service Mix as the age/gender and other demographic factors vary the utilization and intensity of services people receive as they age.

b. Benefit buy downs affect utilization as they impact of members paying increased cost share of the total spend lowers unnecessary utilization. Benefit buy downs also impact unit cost trends as members are incented to see lower cost providers and sites of service.

c. The change in the health status is similar to, and measurement would be difficult to differentiated from, (a) above. As health status for the population changes, aso will all of the categories of trend. In a block of declinging health status, cost and utilization increase and drive increases in Provider and Service mix.

AETNA
HPC Payer Exhibit 3

Aetna and AbilTo - A dynamic new approach to providing behavioral health support

Individuals with certain health care conditions and life changes can have a hard time managing the emotional impact of their diagnosis or situation. When this happens, medical costs can spiral out of control. For this reason, Aetna and AbilTo have designed an innovative approach to help members better engage in their own health, while helping employers better manage medical costs.

Convenient and confidential

This program aims to remove the hurdles that can prevent members from taking advantage of traditional behavioral health support. Participants connect with their therapist and behavior coach through secure online video-chat or telephone (if online is not available or preferred), providing unparalleled convenience. Members can "meet" their therapist and behavior coach for scheduled appointments at convenient times, during the day, evening or on weekends.

Defined program combines counseling with coaching

We make it easier for members to get the help they need. The program is a defined 8 weeks, with 1 therapist session and 1 coach session each week. 16 sessions total. All for 1 copay per week. Participants benefit from a:

- **Therapist** to address the emotional challenges that can come with their diagnosis, like depression, anxiety or stress
- **Behavior coach** to partner with the member to identify personal health goals and develop an activity plan to follow through and stay on track

Aetna and AbilTo collaboration

The Aetna and AbilTo partnership began in 2011 to address the behavioral health needs of cardiac patients. Today, the program has been expanded to address these health conditions:

- Cardiac
- Diabetes
- Thrive – breast cancer recovery
- Thrive – prostate cancer recovery
- Renew – pain management
- Digestive Health
- Respiratory

And these life changes:

- Resilience – depression/anxiety and depression/substance use
- Momentum - postpartum depression
- Anxiety & Panic
- Bereavement
- Caregiver – support for those giving care to adults
- Caregiver – support for those giving care to children
- Caregiver – support for those giving care to children with autism spectrum disorder