MASSACHUSETTS
HEALTH POLICY COMMISSION

2017 Pre-Filed Testimony

Payers

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

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The Hearing will examine 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.

Scheduled Hearing dates and location:

Monday, October 2, 2017, 9:00 AM
Tuesday, October 3, 2017, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 3:30 PM on Monday, October 2. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 2.

Members of the public may also submit written testimony. Written comments will be accepted until October 6, 2017, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 6, 2017, 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: http://www.suffolk.edu/law/explore/6629.php. 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 livestreamed on the HPC's homepage and available on the HPC's YouTube channel following the Hearing.

If you require disability-related accommodations for this Hearing, please contact Andrew Carleen at (617) 757-1621 or by email Andrew.Carleen@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions for Written Testimony

On or before the close of business on **September 8, 2017**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. 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.

We encourage you to refer to and build upon your organization's 2013, 2014, 2015, and/or 2016 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.**

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 Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400.

Exhibit B: HPC Questions

On or before the close of business on **September 8, 2017**, please electronically submit written testimony to: HPC-Testimony@state.ma.us. 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. 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.

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. For 2013-2016, the benchmark was set at 3.6%. Following a public hearing, the Health Policy Commission set the benchmark at 3.1% for 2018. To illustrate how the benchmark could be achieved, the HPC presented at the public hearing several exemplar opportunities for improving care and reducing costs, with savings estimates of between $279 to $794 million annually.

a. From the drop down menus below, please select your organization's top two priorities to reduce health care expenditures.
   i. **Priority 1**: Reduce growth in prescription drug spending
   ii. **Priority 2**: Other
   iii. If you selected "other," please specify: Control over-utilization and unnecessary utilization

b. Please complete the following questions for **Priority 1** (listed above).
   i. What is your organization doing to advance this priority and how have you been successful?

Aetna uses a number of strategies to address the rising trend in pharmacy plan costs and utilization. Aetna's plan design options and total 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 11% savings compared to our broadest formulary.

Plan design selection – Customer plan preferences can vary widely, which is why we offer a variety of benefit plan designs to support cost management strategies. This includes number of tiers, copay spread between tiers, percentage copays, pharmacy plan deductibles, home delivery 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, generic sampling and generic substitution at home delivery. We also recommend our Choose Generics cost-sharing program which on average can save an estimated 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% of plan totals, annually. We offer a focused approach to management of this category, through programs designed to encourage members to use our specialty management program, which includes comprehensive member management, counseling and support, as well as cost effective dispensing. The result is improved adherence and outcomes, along with plan and member savings.

Specifically, we track member adherence to specialty drug regimen for 10 disease states that require the use of specialty drugs. In 2016, Aetna Specialty Pharmacy nurses and pharmacists worked with members to achieve an average compliance level of 97.91 percent calculated using Medication Possession Ratio (MPR). Below are the percentages of members who were compliant with their drug therapy, based on their disease state:

- Asthma – 97.16%
- Crohn's Disease – 98.35%
- Hepatitis C – 98.88%
- HIV – 97.22%
- Multiple Sclerosis – 97.79%
- Osteoporosis – 98.69%
- Psoriasis – 98.22%
- Pulmonary Arterial Hypertension – 97.54%
- Rheumatoid Arthritis – 97.63%
- Transplant – 97.64%

Another program that specifically targets savings while achieving optimal health outcomes is Aetna's Site of Care Optimization program. There, we identify members who could select a more cost effective solution for infusion. We work with each of the identified members and their providers to find ways of reducing the cost of care and, often, to make the infusion more convenient for the member. Depending on the drug, we work with members either prospectively or retrospectively.

ii. What barriers does your organization face in advancing this priority?

Specialty drugs are the trend driver of the future and present the greatest barrier to reducing the growth of prescription drug spending. The United States is projecting a 20% increase in annual growth in specialty drug costs through 2020.* High-cost new drugs and price growth for existing drugs are additional barriers to advancing this priority.

* PWC Health Research Institute Medical Cost Trend Report, 2014

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

As noted in response to Question 1(b)(ii) above, specialty drugs present the greatest barrier to reducing the growth of prescription drug spending. Some examples of Aetna's solutions specific to advance the priority of a reduction in the expenditures on specialty drugs are:

- **Maximize biosimilar and generic specialty opportunities** – The United States is expecting a $31.8 billion biosimilar savings opportunity through 2020. Aetna is constantly monitoring the specialty drug pipeline and developing strategies for ways to maximize savings while ensuring therapy appropriateness. We anticipate that many of the tools that we have available today 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 for certain specialty drugs to ensure appropriate therapy. We do so using our Clinical Policy Bulletins (CPBs) to determine appropriate therapy.

- **Site of Care Optimization** – Through precertification and claims analysis, Aetna identifies members receiving care at high cost delivery sites and recommends alternate delivery options for the specialty

drug. A nurse contacts the member and recommends the most cost effective site of care for the member (e.g., home infusion). We offer this program at no additional cost and it is voluntary for both the member and the customer. If members agree to the new site of care, we then continue to monitor them closely to ensure a successful transition. This program saves an average of $83,000 per successful conversion.

c. Please complete the following questions for **Priority 2** (listed above).
   i. What is your organization doing to advance this priority and how have you been successful?

Aetna is continually evaluating programs to address inefficient utilization and/or over-utilization by patients and directing our efforts toward the most effective solutions. To curb those trends and rising costs, we use a variety of methods, including:

- Medical cost analysis
- Clear action plans to address emerging cost or quality issues
- Innovative network solutions
- Targeted plan designs
- Differentiated care management programs
- Robust engagement strategies and member tools

Below is some detail on certain of these methods:

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 member 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 tells us that employers who offered AHF plans had an average annual trend that was 1.8 percentage points lower than a comparison group's trend over a five-year period.

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% of referrals to disease management remained active after the referral and 65% 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/nurseline service helps reduce unneeded doctor and emergency room visits by educating the member on their health topic of choice. In addition, our Healthy Lifestyle Coaching program showed an impressive reduction in indirect costs. Participants had the following results (per 2013 Aetna Informatics®):

- 57% improved weight
- 90% reduced or maintained stress
- 86% improved exercise levels
- 73% improved diet
- 58% quit tobacco usage

ii. What barriers is your organization facing in advancing this priority?

Aetna fully supports the mission of the Health Policy Commission to monitor health care spending growth in the Commonwealth and to provide data-driven policy recommendations. To that end, Aetna remains committed to the implementation of thoughtful changes in policy and law that promote an efficient, high quality, healthcare delivery system. That being said, local carriers continue to account for the bulk of members in the Massachusetts marketplace. Aetna, which has focused on consumer-directed plan options and dynamic delivery systems across the country, has maintained a smaller presence in the Commonwealth. However, as the Massachusetts marketplace becomes more consumer-centric and embraces value-based delivery plan options, we believe that competition will increase. Being a national carrier with national standards and metrics presents some difficulty in supporting regional intricacies, such as the Commonwealth's merged individual and small group markets, product mandates, and very high medical loss ratio coupled with increasing state mandated administrative requirements.

iii. What are the top changes in policy, payment, regulation, or statute you would recommend to advance this priority?

Aetna is committed to the pursuit of new and innovative strategies to manage utilization and reduce costs. We continually monitor expenses by working with our partners to identify efficiencies to help Aetna meet cost reduction goals. Like the industry as a whole, our networks have traditionally emphasized network discounts and medical management services. However, through value-based contracting initiatives, we have shifted our emphasis to strategic relationships with the provider community 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.

2. STRATEGIES TO IMPROVE CLINICAL DATA COLLECTION

In each of its four annual reports, the HPC has called for the improvement and alignment of quality measures, particularly for the measures used in APM contracts, and has recognized the burden of reporting different quality measures for different purposes. Please answer the following questions regarding how your organization collects clinical quality data.

a. How does your organization currently collect clinical data from contracted provider organizations for the purposes of outcome quality measures for provider contracts and the NCQA accreditation process? [check all that apply and explain the purpose for which you collect the data for each]

☒Excel document or equivalent

Purpose: Aetna collects this data HEDIS measure processing and/or provider scorecard generation. Aetna also collects medical records in these formats for the purpose of reporting data to NCQA and CMS.

☒Direct data feed

Purpose: Aetna uses direct feeds for the purpose of supplementing administrative data for HEDIS measure processing and/or provider scorecard purposes.

☒Chart reviews by third-party vendor

Purpose: Aetna uses a contracted third party vendor to conduct a portion of chart reviews and related data abstraction. We collect these files for the purpose of supplementing administrative data for HEDIS measure processing and/or provider scorecard generation. Aetna also collects medical records in these formats for the purpose of reporting data to NCQA and CMS.

☒Web-based portal

Purpose: In some instances, providers allow access to EMR (electronic medical record) repositories for retrieval and review of medical records for the purpose of data collection by Aetna HEDIS staff.

☒Other: Chart reviews by nurses

Purpose: For large Medicare provider groups, Aetna assigns nurses to on-site locations. At each of these locations, the Aetna nurses review charts and abstract data based on an Aetna-generated gaps-in-care list. Aetna nurses collect this information for the purpose of supplementing data for HEDIS measure processing and/or provider scorecards.

b. How frequently do you collect clinical quality data from contracted providers? Required Answer.

☒Ongoing
☐Monthly
☐Quarterly
☐Annually
☐Other: Click here to enter text.

c. What is the estimated cost of staff and resources to collect and report on provider clinical quality data each year?

i. Estimated cost (in dollars): Approximately $600,000 on a national basis (i.e., not specific to Massachusetts)
ii. Estimated FTEs: 10 FTEs

3. STRATEGIES TO ADDRESS DRUG SPENDING

The HPC, other state agencies, payers, providers and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. In its 2016 Annual Cost Trends report, the HPC highlighted a range of strategies to reduce drug spending increases, including value-based contracting.

a. Are you pursuing value-based drug contracting?

☒ Yes ☐No

If yes, with whom?

Pharmaceutical manufacturers (*e.g.*, Merck, Boehringer Ingelheim, Eli Lilly, Novo Nordisk, Johnson & Johnson, GSK, etc.)

b. If yes, have you found that your value-based contracts have resulted in meaningful cost savings and/or quality improvement?

☐Yes, cost-savings only
☐Yes, quality improvement only
☐Yes, both
☐No
☒Unknown (insufficient time to measure improvement)

c. If no, what is/are the reason(s) you have not pursued value-based drug contracting? Check all that apply.

☐Lack of appropriate quality measures
☐Administrative and operational implementation costs

☐Inability to negotiate performance incentives with manufacturers
☐Other (please specify): Click here to enter text.

4. STRATEGIES TO SUPPORT INNOVATIVE CARE DELIVERY THROUGH PAYMENT POLICIES

Public payers are implementing new payment policies to support the development and scaling of innovative, high-quality and efficient care delivery, such as, for example, Medicare's readmissions penalty for acute care hospitals, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, and MassHealth's new flexible services spending allocation in its new ACO program to address patients' non-medical needs.

a. Has your organization adopted any new payment policies related to the following areas of care delivery improvement and innovation? [check all that apply]
   ☒Readmissions
   ☒Avoidable ED visits
   ☒Serious reportable events
   ☒Behavioral health integration into primary care (e.g. collaborative care model)
   ☐Care management (e.g., serious or chronic illnesses)
   ☒Telehealth/telemedicine
   ☐Non-medical transportation
   ☐Services to maintain safe and healthy living environment
   ☐Physical activity and nutrition services
   ☐Services to remove/protect patients from violence
   ☐Other: Click here to enter text.

b. For each area identified above, please describe the payment policy in more detail, including whether it is a payment penalty or non-payment, fee-for-service reimbursement for new service codes, per-member-per-month fee, etc.

Readmissions:

Aetna's negotiated agreement with a facility includes a DRG case rate methodology for inpatient stays. We do not recognize and pay for a new inpatient admission when the member is readmitted to the same facility as an inpatient within two days for symptoms related to, or for evaluation and management of, the prior stay's medical condition. This policy extends the member's original stay at the facility when the member is readmitted. This policy applies to any contract with a DRG payment methodology, regardless of product.

Avoidable ED Use:

Aetna's standard hospital contracts typically reimburse outpatient emergency care according to the applicable emergency room negotiated rate. Where possible, we negotiate a case rate for emergency room care. The case rate can be one blended rate for all provided services during a member's visit, or there can be distinct case rates for varying levels of emergency care.

If an emergency room visit results in an admission, we will pay the admission at the applicable inpatient rate and will not include the emergency room rate.

If an emergency room visit results in ambulatory surgery, we will pay the entire episode of care at the applicable outpatient rate and will not include the emergency room rate.

If an emergency room visit results in observation services, we will pay the claims at the applicable emergency room payment rate and will not include the observation rate.

Serious reportable events:

Aetna's policy requires facilities to report all National Quality Forum (NQF) "serious reportable events" (SREs) to us, but reimbursement only affects a subset of these events. Consistent with the NQF, we consider the following SREs as never events. We will not pay facility charges for these events:

- Procedures performed on the wrong person
- Wrong side or body part
- Wrong service is rendered

We will also not reimburse any provider for his or her services while in attendance at surgery during these never events.

Of the remaining SREs, we have identified the following events as "SRE-reimbursement review." When these events occur, we will not pay for charges directly and solely related to them, including an extended length of stay due to the event or an admission that is the sole result of the event. When these SRE-reimbursement review events occur, we will work with the facility to identify the directly and solely related charges and recover applicable funds. The facility should submit claims to us for SRE-reimbursement review events, but should waive all costs directly and solely related to these events. Additionally, the facility may not seek payment from the patient for these charges:

- Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- Intraoperative or immediately postoperative/post procedure death in an ASA Class I patient
- Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the health care setting
- Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a health care setting
- Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- Patient death or serious injury associated with unsafe administration of blood products
- Patient death or serious injury associated with a fall while being cared for in a health care setting
- Any stage 3, stage 4 and unstageable pressure ulcers acquired after admission/presentation to a health care setting
- Patient death or serious injury associated with an electric shock in the course of a patient care process in a health care setting
- Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or is contaminated by toxic substances
- Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a health care setting
- Manifestations of poor glycemic control (i.e., diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidocis, secondary diabetes with hyperosmolarity) while the patient is being cared for in a health care setting
- Deep vein thrombosis and/or pulmonary embolism following certain orthopedic procedures: total knee replacement or hip replacement
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Surgical site infection following coronary artery bypass graft (CABG)-mediastinitis, bariatric surgery (i.e., laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery), orthopedic procedures (i.e., spine, neck, shoulder, elbow)

The remaining SRE events are identified as "SRE-reporting only." The facility should submit claims for these events and reimbursement is not affected.

Facilities must contact us to report all never events and SREs. If we learn about a potential never event or SRE–Reimbursement Review event by a source other than the facility, we will notify the facility and the never event and SRE reimbursement policy will apply. If the claim has been reimbursed, we maintain the right to seek recovery of the overpaid charges as applicable.

Our intent is to make equitable decisions that appropriately protect the member and our customers. Facilities will continue to have access to all applicable appeals processes.

Behavioral health integration into primary care (e.g. collaborative care model):

Our members have access to a range of behavioral health services. In Massachusetts, Aetna's behavioral health provider network includes 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 67 in-network facilities in Massachusetts. These numbers met or exceeded all of Aetna's enterprise-wide access standards for 2017.

Alongside our behavioral health specialists, however, Aetna is committed to increasing mental health and wellness through primary care integration and collaborative care initiatives. To that end, Aetna has developed the "Aetna Integrated Primary Care Behavioral Health Program." One of the primary goals of our Integrated Program is to place a co-located behavioral health clinician in the primary care setting to address behavioral health alongside and in conjunction with physical well as health and wellness. We are committed to developing and growing our Integrated Program throughout our network, including in Massachusetts. 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. Aetna provides details about this program, including information for providers on how to bill us for these services, at the following website: http://www.aetna.com/healthcare-professionals/documents-forms/integrated-details.pdf

Through and along with our Integrated Program initiatives, Aetna strives to ensure facilitated access to behavioral health services. In part, this goal is achieved through disease management and case management programs, which are staffed by Aetna nurses and licensed clinical social workers.

To help primary care providers address behavioral health during routine visits, Aetna has developed the Aetna Depression in Primary Care Program. Our Depression Program provides primary care providers with a time-saving tool to help 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. In providing this tool to primary care providers, we again include resources concerning how to bill for the emotional/behavioral assessment and screening for depression as part of a primary care visit. More information is published for providers at the following website: http://www.aetna.com/healthcare-professionals/documents-forms/depression-program.pdf

Finally, we have created and offer a comparable tool to assist primary care providers in screening for alcohol abuse issues. Information on this four-step program, including how providers can bill us for alcohol abuse screenings, is published here: http://www.aetna.com/healthcare-professionals/documents-forms/alcohol-program.pdf

Care management (e.g. serious or chronic illnesses):

Click here to enter text.

Telehealth/telemedicine:

We cover physician e-visits through arrangements with Teladoc, Inc.* We pay for these services on either a PMPM or PEPM basis or with a set consult fee, depending on whether the member is covered under a self-insured or fully-insured health plan. Depending on plan design and funding, a member's responsibility is either a PCP or Specialist copay or the consult fee.

*Please see Aetna's response to Question 6 in its 2016 testimony for a description of the Teladoc program.

Non-medical transportation:
Click here to enter text.
Services to maintain safe and healthy living environment:

Physical activity and nutrition services:
Click here to enter text.
Services to remove/protect patients from violence:

Other:
Click here to enter text.

5. STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

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."

a. Please provide available data regarding the number of individuals that seek this information in the following table:

Health Care Service Price Inquiries CY2016-2017			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2016	**Q1**	10,545	124
	Q2	6,787	58
	Q3	6,831	74
	Q4	7,652	63
CY2017	**Q1**	16,585	75
	Q2	52,894	65
	TOTAL:	**101,294**	**459**

6. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2014 to CY2016 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2014 to 2016, 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 the attached HPC Exhibit 1 for Aetna's Response

7. INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND APMS

Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. In the 2016 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2018. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a. Please answer the following questions related to risk contracts spending for the 2016 calendar year, or, if not available for 2016, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)

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

HMO/POS	2%
PPO/Indemnity Business	98%

   ii. What percentage of your HMO/POS business is under a risk contract? What percentage of your PPO/indemnity business is under a risk contract?

HMO/POS	0%
PPO/Indemnity Business	0%

b. Please answer the following questions regarding APM expansion.

   i. How is your organization increasing the use of APMs? Are you expanding the participation in risk contracts to providers other than primary care providers (e.g., hospitals, specialists, behavioral health providers) or into new product types (e.g., PPO)?

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 efforts have focused on accountable care organizations (ACOs), Patient-Centered Medical Homes (PCMH), and other provider collaborative models known as PCMH Recognition and Pay for Performance (P4P) Agreements.

First, Aetna's contracted ACOs include some of the most advanced and efficient systems in the country. We currently have around 200 ACOs and joint ventures (JVs), and we expect that number to grow in 2018. We are engaged in discussions with health systems across the country to identify additional ACOs that focus on delivering high quality, efficient care. Nationally, 50% of our claim payments go to providers who deliver value-based care, with 53% of those payments aligned with our commercial ACOs and joint ventures. In addition, 14% of value-based contracting (VBC) spend is aligned with our PCMH models and 11% is aligned with P4P arrangements. Having already achieved our 2018 goal of 50%, we are committed to having 75% of all medical spend in VBC arrangements by 2020.

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.

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 the following:

- Outpatient surgeries/procedures performed at preferred (ambulatory) facilities
- Hospital readmissions for medical and behavioral health
- Avoidable emergency room utilizations
- 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 to 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.

Second, 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 Ohio, New York (Hudson Valley) and Colorado.

Finally, Aetna, which has focused on consumer-directed plan options and dynamic delivery systems across the country, has maintained a smaller presence in Massachusetts fully-insured products. However, as the Massachusetts marketplace becomes more consumer-centric and embraces value-based delivery plan options, we believe that competition will increase. Our VBC initiatives currently include physician P4P and PCMH arrangements. We offer three P4P arrangements with Baycare Health Partners, Lowell PHO, and Atrius Health, the largest independent physician group in Massachusetts. 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. 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.

ii. What are the top barriers you are facing and what are you doing to address such barriers?

Aetna continues to work toward expanded value-based payment methodologies. Being a national carrier with national standards and metrics presents some difficulty in supporting regional intricacies. However, Aetna expects to have continued success in implementing these programs as we grow.

iii. Currently, most APM contracts pay providers on a FFS basis with reconciliation at the end of the year. Is your organization taking steps to move payment toward population-based models (e.g. capitation) and away from FFS as the basis for the APM contracts?
☒ Yes ☐No
If no, why not? Click here to enter text.

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 signed under the pains and penalties of perjury.

Mark Santos
President, New England Market
Aetna