



June 22, 2015

The Honorable Orrin Hatch
The Honorable Ron Wyden
U.S. Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of Blue Cross Blue Shield of Massachusetts (BCBSMA), I appreciate the opportunity to comment on the policy categories that the Senate Finance Committee plans to consider as part of its Medicare chronic care reform efforts.

BCBSMA is a not-for-profit organization that was founded seventy-five years ago by a group of community-minded business leaders. Our history – and our future – is one of collaborating with the community to improve the health and quality of care that our members, and all citizens of the Commonwealth, receive. At BCBSMA, our vision is a transformed health care system that provides safe, timely, effective, affordable, patient-centered care for all.

We are grateful for the chance to comment on the policy options the Committee is considering to help improve the care provided to the Medicare population. We applaud the Senate Finance Committee's efforts to improve the quality and delivery of care that Medicare members with chronic conditions receive throughout the country.

As a nationally-recognized Medicare Advantage health plan, we are proud of our achievements in delivering high quality products and service to our members. This year:

- For the third year in a row, our company's Medicare Advantage plans earned four-and-a-half stars (out of 5) from the Centers for Medicare and Medicaid Service (CMS). Again this year we received 5 stars for Customer Service.
- For the third year in a row, we have the top-ranked Medicare Advantage PPO plan in the country according to NCQA.
- Blue Cross was recently ranked as a Best Medicare plan by US News and World Report for our Medicare Advantage and Medicare Part D plans. We are the only Massachusetts insurer with a Best Medicare Part D plan.

We hope we can be helpful in providing our insight and experience as you confront this challenge on a national level. As set forth below, our comments are focused on: 1) Effective and Innovative BCBSMA Programs; 2) BCBSMA Recommendations to Current Medicare Policies; 3) the need to focus on systemic delivery system reform to effect change.

In general, BCBSMA recommends that the federal government appropriately invest now in successful model-of-care programs and means of engaging with Medicare beneficiaries that will result in savings over the long-term. This investment, including chronic care programs, would allow and encourage health plans to become more engaged in the “full life” of the member in a proactive manner. The chronically-ill are especially in need of this relationship and prospective investment.

I. Effective and Innovative BCBSMA Medicare Programs

Clinical Assessments

BCBSMA would also like to draw the attention of the Finance Committee to the Medicare home clinical assessment program. CMS has recognized the value of these clinical assessments as outlined in the Advance Notice from Feb, 2015:

“We believe that in-home assessments can have significant value as care planning and care coordination tools. In the home setting, the provider has access to more information than is available in a clinical setting. For example, the provider is able to evaluate the enrollee’s home for potential risks, the need for supports to enable an enrollee to continue living in the community, and other relevant aspects of the enrollee’s living situation. We expect plans to take advantage of the opportunities afforded by performance of in-home assessments to obtain and use that full spectrum of information to revise, develop, or implement comprehensive care plans for affected enrollees.”

At BCBSMA, we also believe that in home clinical assessments offer tremendous value and opportunity to gain insight into our members’ health and risks, to close gaps in care, and to enroll members into appropriate clinical management activities. At BCBSMA, we look to identify members who have not seen a Primary Care /Point of Care Provider in past twelve months for an annual wellness visit or a standard Evaluation and management visit. BCBSMA also seeks to identify the members who have chronic conditions that do not appear to be actively managed by their physician based on claims information in data systems.

BCBSMA is seeking to expand and invest in the development of incentive programs to help motivate our members identified during these clinical assessments to complete necessary action items such as self-monitoring, follow up care, and prescription drug adherence. By impacting these members at this point of time and inspiring them to invest in the management of their health, we believe we can make an impact.

Chronic Management Program Development

BCBSMA’s Chronic Condition Management (CCM) Program is a health management initiative designed to target members with common chronic conditions including diabetes, heart failure, coronary artery disease, chronic obstructive pulmonary disease and asthma. This program was developed with a continuum-based approach to health delivery that proactively identifies

populations with, or at risk for, common chronic conditions. It includes identification of members recently discharged from an acute facility to assist members in the transition from the acute care setting to home.

While the Committee will, no doubt, be very familiar with these industry standard programs, BCBSMA is moving forward to enhance them in 2015 by creating a predictive algorithm to identify Members at risk for inpatient admissions.

As we continually seek to improve and expand this program, BCBSMA has identified additional risk factors that our Medicare members face that we will be considering as part of the model. The overall goal of this project would be to identify the population most at risk of admissions within the next six months.

The factors that make a person high risk can include:

1. Diagnosis: Congestive Heart Failure, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease, Diabetes, Parkinson's Disease, Cancer, Dementia, Psychiatric Illnesses such as Depression, End Stage Renal Disease, etc.
2. Risk Score
3. Age
4. Geriatric Conditions such as a history of falls, urinary incontinence, vision problems, hearing problems,
5. Ability to care for oneself:
 - Instrumental Activities of Daily living (IADLS) such as paying bills, shopping, cooking, doing laundry
 - Activities of Daily Living Bathing, Dressing, Walking, Toileting, Eating

As mentioned previously, by identifying these vulnerable members and developing targeted programs, BCBSMA hopes to assist them in maintaining their health and preventing inpatient admissions. BCBSMA strongly encourages the Committee to investigate a revised payment structure which would allow plans to offer such innovative programs to this fragile population of Members. This payment structure could include, but not be limited to, personal assistance, meal plans and Care Management Services.

Behavioral Health

BCBSMA has instituted an innovative program to manage its most at risk Behavioral Health Population which includes a suite of services not usually covered under Medicare. This type of model should be considered, and funded, by CMS. At the head of this care team is a "Health Navigator" assigned to an individual Member who will connect with the Member in the facility or home, and serve as a "quarterback" ensuring appropriate coordinated services by all Members of a synchronized Health team. This team must include Pharmacists, Social Workers and Nurses as well as their Primary Care Physician who should be a geriatric specialist. This prevents the current uncoordinated provision of care which drives higher costs, lower quality care, and worse outcomes for members.

II. BCBSMA Medicare Policy Recommendations to Improve Chronic Care Outcomes

Risk Adjustment

BCBSMA recommends that the Committee encourage CMS to provide insurers with the ability to build benefits that serve specific populations of people not necessarily be captured in the current Medicare risk adjustment model. Given additional flexibility under the risk adjustment model, insurers could potentially provide additional services such as transportation which would allow members to more easily access preventive services or other care providers. Under the current methodology for the risk adjustment model added costs for such ancillary services are not supported. For example, a diabetic member with Congestive Heart Failure (CHF) without access to convenient modes of transportation has a different needs and related costs than a beneficiary that has the ability to get to provider appointments without concern. This added flexibility would allow insurers to help develop innovative ways of assisting Medicare members access the care they need to manage their chronic condition.

Medicare Advantage Part D (MAPD)

CMS recently announced the potential for MAPD plans to allow demonstrations for value-based benefit designs. BCBSMA is supportive of the expansion of such demonstrations. While flexibility in the design of these programs is important, that flexibility should not be limited to providing relief with respect to member cost-sharing. Additional funding to test increased levels of plan engagement should be considered.

For example, a value-based benefit insurers could offer diabetics free eye exams and include free or nominal cost transportation for a member to the visit. Under this scenario, access for the member to such a key preventive service would increase for this population along with the potential to manage this chronic condition more fully.

End of Life (EOL) Issues

End of Life care is an important component of the Medicare program for beneficiaries and their loved ones. Many Medicare members and their families would prefer to prepare a dignified End of Life plan, but as a result of their illness cannot manage to remain at home or afford Hospice Inpatient services. As a result, BCBSMA would advocate that EOL issues should be addressed in a more proactive manner, and funded appropriately, as the majority of Medicare members with multiple chronic conditions would benefit from a detailed End of Life Plan.

This recommendations include appropriate funding for palliative care consultations and discussions of End of Life issues. In addition a payment structure which include room and board funding for "Hospice House" care in the last two weeks of life would avoid expensive, inappropriate, and unnecessary inpatient care and be beneficial to members. While these recommendations are aimed at improving the quality of life in the final days for the beneficiary and their family, the Medicare Program would also produce long term savings for the Medicare program as the last two weeks of life often incur the highest cost claims.

Member Engagement

The most efficient method to reduce the cost of Chronic Care is to develop a strategy of prevention to avoid the long term cost of treating multiple conditions. As mentioned at the beginning of our comments, this strategy, unfortunately will not likely result in immediate

savings, but instead will realize a future of healthier members who spend fewer health care dollars. More robust incentives should be considered for prevention including funding different smart phone apps as well as other devices to track and reward healthy behaviors. Incentives for completion of Health Risk Assessments, and analysis of those results, will also result in detailed opportunities for improvement. This should include monitoring for pre-diabetic markers and payment for proven programs to decrease the movement for pre-diabetic to diabetic. CMS could work with well know senior organizations to develop and fund these programs.

Telehealth

BCBSMA also believes members with chronic conditions would benefit from a more comprehensive suite of at home services. These could include engaging Members remotely through telemedicine as well as more inclusive tele-monitoring strategies. Payment for at home visits by advanced practitioners, nurse practitioners and physician assistants, should also be considered for this vulnerable population if office visits are not appropriate.

III. The Importance of Fundamental Delivery System Reform

At BCBSMA, we have had five years of experience with delivery system reform and we have learned when you integrate care, change the financial incentives and increase accountability – good things happen. Quality gets better and costs come down. An independent study in the New England Journal of Medicine (NEJM) shows that the BCBSMA Alternative Quality Contract (AQC) has improved the quality of patient care and lowered costs in the four years since it was first implemented. The impact of these results on a Medicare population that experiences multiple chronic conditions cannot be overstated.

AQC Background

Introduced in 2008, the AQC now includes 85 percent of the physicians and hospitals in the Blue Cross HMO network and includes over 18,000 physicians and nearly \$4 billion in spending. It is an innovative way to pay for care that focuses on promoting quality and rewards positive health outcomes. It is a crucial component of BCBSMA’s agenda to make quality health care affordable for its members and employer customers and is the predominant contract model between Blue Cross and its network physicians and hospitals. The alternative payment model fosters shared responsibility for both improving care and moderating the unsustainable rate of increase in health care costs. The AQC is currently one of the largest private payment reform initiatives in the United States.

AQC and Chronic Care

Better Care for Chronic Illnesses - Among all AQC groups, 4 out of 5 BCBSMA members with diabetes have blood sugars under good control. Some AQC practices have 9 out of 10 under good control. This compares to the HEDIS national average, in which 70 percent of patients have blood sugars under good control.

For hypertension and cardiovascular conditions, all AQC groups have at least 66 percent of our members under good control, with most having 75 percent under control—as compared to about 50 percent in the HEDIS national benchmark.

What do these improved quality scores mean? For our diabetic members, they mean a reduced risk of the serious complications associated with uncontrolled diabetes over time including: damage to the lens of the eye that can lead to blindness, kidney disease, and a combination of problems that result in amputations. For our members with other chronic conditions, they mean better management of cholesterol levels and blood pressures, reducing the risk of heart disease and stroke.

Key Study Findings

The study –by researchers at Harvard Medical School and funded by the Commonwealth Fund and the National Institute on Aging – compares Blue Cross members with a Primary Care Physician (PCP) in an AQC contract with a control group comprised of commercially-insured individuals across eight northeastern states (Connecticut, Maine, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont).

The study’s authors concluded that when compared with similar populations in other states, Massachusetts AQC enrollees had lower spending growth and greater quality improvements after four years. The findings relative to the control group are important because they account for more general trends locally and nationally – showing that the AQC achieved savings over and above what was happening in the general environment

The study found the savings achieved by the AQC groups accelerated year by year. In the initial year, savings were approximately two percent compared to the control group, while by year four, the AQC groups saved 10 percent compared to control group. Savings were concentrated in the outpatient setting and explained by providers increasingly using lower cost settings and by reduced utilization, including discretionary procedures, imaging and testing.

The study also demonstrates significant quality improvements achieved under the AQC. While quality scores for BCBSMA members were on par with local and national averages prior to the AQC contract, the dramatic improvements in quality over the course of the contract show that members now receive quality of care that is significantly higher than national averages. These improvements include preventive care for healthy children and adults as well as improvements in the management of serious chronic illnesses.

One of the pioneering features of the AQC was providers’ willingness to accept accountability for the outcomes of care, and not just for the quality of what occurs in the office setting. To be successful in managing outcomes, providers have to engage differently with patients and understand the things in their day-to-day lives that could get in the way of successfully managing their diabetes, hypertension or heart disease, and help patients develop ways to overcome those barriers. The results led to remarkable gains for individual patients and in population health – with thousands of patients with serious chronic illness now under good control, thereby avoiding the terrible and even deadly consequences that can occur when these conditions are not well controlled.

I want to thank the Senate Finance Committee for its leadership and true commitment to improving the health care system and, importantly, the people it serves. With a senior population that is growing, it is imperative that we invest in models that focus on chronic care not only to improve the health of our nation's seniors but to also make the entire health care system more affordable.

Very Truly Yours,

A handwritten signature in cursive script, appearing to read "DWSavage".

Deirdre W. Savage
Government and Regulatory Affairs
Blue Cross Blue Shield of Massachusetts