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January 26, 2016

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
Chronic Care Working Group, Co-Chair
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
Chronic Care Working Group, Co-Chair
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Submitted electronically to chronic_care@finance.senate.gov

Re: Comments on the Chronic Care Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the Bipartisan Chronic Care Working Group's Policy Options Document.

BCBSA is the national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for almost 105 million members, including almost three million members through Medicare Advantage (MA) plans and 4 million through Medicaid managed care. Blue Plans are leading innovations in these government programs that focus on keeping beneficiaries healthy and ensuring high quality, coordinated care for those with chronic and acute conditions.

We support your bipartisan efforts to improve care for Medicare beneficiaries with chronic conditions. Our comments and questions are informed largely by the experiences and successes of Blue Plans in MA, Medicaid managed care, Medigap, and in the commercial market.

I. Medicare Advantage Benefit Plans Should Include Hospice Benefits

BCBSA supports allowing MA plans to offer hospice benefits to enrollees. Currently, Medicare hospice benefits are "carved out" of MA and paid for by traditional Medicare. MA enrollees are consequently forced by hospice eligibility criteria to either leave their MA plan and enroll in traditional Medicare, or remain in their MA plan but receive hospice care through traditional Medicare. These policies lead to disruptions in care and result in difficult decisions for members

and their families. The current carve out also results in fragmented care delivery and confusion at the pharmacy counter over which prescription drugs are properly paid for by Medicare Part B and which are properly paid for under an MA-Part D plan. Allowing MA plans to offer hospice benefits would allow for seamless medication coverage and continuity of care.

MedPAC has supported the inclusion of hospice benefits in MA contracts. We agree with both MedPAC and the Working Group that this reform will lead to more seamless service delivery and improve end of life care. MA is a mature program, and plans are prepared to expand into this area of care and cover the full scope of the hospice benefit and contract with hospice providers in their community.

If this policy shift were to occur, payment to MA plans would need to be adjusted to adequately account for this additional benefit.

II. Enrollment of End-Stage Renal Disease Patients in Medicare Advantage Needs Further Study

The Working Group is also considering a policy to require MA plans to enroll patients with end-stage renal disease (ESRD). Currently, ESRD patients are a special patient category and, once in traditional Medicare, are not permitted to enroll in MA after they are diagnosed with ESRD. MA plans do provide coverage to ESRD patients through other mechanisms, however, such as for those who are diagnosed after enrollment in an MA plan.

BCBSA has concerns about the incentives that could be created by this policy proposal. If the Working Group were to pursue this policy, it would be critical that payment to MA plans appropriately account for the cost of ESRD members and be sufficient to adequately compensate providers, at private insurance rates. It is important to note that in some areas it has been difficult for health plans to negotiate with dialysis providers, leading to significant differences in reimbursement by traditional Medicare and private plans. This dynamic introduces the potential for certain providers to steer patients from traditional Medicare to private plans, which increases the need to assure that payment to MA plans for the care of ESRD patients is sufficient.

Considering these variables, we suggest that further study and an impact analysis be done before moving forward.

III. Allow Medicare Advantage Plans to Tailor Benefits and Cost-Sharing to Meet the Needs of the Chronically III

Added flexibility to create network and benefit designs tailored to those with chronic conditions is the key to continuing and expanding the work of MA plans in providing coordinated care for individuals with chronic illness. BCBSA applauds the Working Group's draft policy to give MA plans the flexibility to establish a benefit structure that varies based on chronic conditions by employing value-based insurance design (VBID), just as plans do for private sector patients, to thoughtfully manage chronic conditions, improve patient health, and contain costs.

Currently, MA plans are statutorily prohibited from providing unique benefits to certain subgroups or charging different cost sharing amounts to different populations based on various factors. This restriction effectively prevents MA plans from using evidence-based, innovative benefit design strategies to offer reduced cost-sharing arrangements tailored to those with

chronic conditions, or to provide rewards and incentives to people with chronic conditions to take advantage of wellness programs and opportunities available to enrollees.

The Center for Medicare & Medicaid Innovation (CMMI) is in the process of launching a VBID demonstration, which we support, but the demonstration is narrow in scope and geographically limited to only MA plans in seven states. Additional flexibility and geographic expansion is needed.

Blue Plans are successfully using VBID in Medicaid and the commercial market to tailor benefits to focus on proven care interventions that better addresses chronic conditions and keep patients healthier, reducing the need for expensive procedures or hospitalizations. BCBSA believes Plans can likewise harness VBID to reduce overall health care costs for beneficiaries with chronic conditions in MA.

Beneficiaries would be better served if MA plans could offer reward and incentive programs to targeted populations, such as members with a specific chronic condition or combination of conditions. Well-tailored benefit designs increase patient adherence, improve disease management, and give individuals incentives to make high-quality, cost-effective choices. They are thus far more effective at achieving positive health outcomes.

The use of a broad range of network options in MA should also be encouraged. Tiered physician networks with appropriate cost sharing in each tier provide affordable options for patients, incent patients to use efficient and high quality providers, and help contain costs in the healthcare system and achieve better outcomes.

MA can be a space for innovation and a real-world laboratory for changes that can be folded into traditional, fee-for-service Medicare. MA plans offered by BCBS companies outperform traditional Medicare on a variety of quality measures while protecting patients from high out-of-pocket costs, providing strong consumer protections and maintaining high levels of consumer satisfaction. The more flexibility provided to MA plans, the more they can test new approaches for managing chronic illness.

IV. Remove Barriers to Telehealth and Remote Monitoring Technology for Medicare Advantage

The expanded use of telehealth and other remote monitoring technologies has the capacity to improve access and quality of care for individuals with chronic conditions as well as reduce cost. BCBSA supports the direction of the Working Group to maximize the benefit of telehealth in the MA space by permitting MA plans to include telehealth services as a basic benefit, not a supplemental benefit, in their annual bids.

Telehealth includes a broad range of technologies with the potential to enhance patient care by meeting patients where they are and providing necessary and appropriate services outside of costly clinical settings. Its use is currently hobbled by a patchwork of state and federal licensure laws and inflexible Medicare restrictions, such as “originating site” rules that limit its use to rural areas. All MA beneficiaries should have access to appropriate telehealth, not only those in isolated rural areas.

We strongly recommend that the Working Group pursue a policy to eliminate these access barriers and cover a wide variety of telehealth services, not only those permitted in traditional Medicare.

V. Ensure a Level Playing Field and Foster Partnerships between Accountable Care Organizations and Medicare Advantage Plans

As the Working Group considers granting flexibility to both MA plans and Accountable Care Organizations (ACOs) to provide coverage beyond Medicare's current rules—for instance, expanded use of telehealth and supplemental services as described in the Options Paper— it is critical to ensure a level playing field for both entities. A level playing field for MA plans and ACOs that bear risk for the cost and quality of care is needed to protect beneficiaries and prevent adverse selection among different types of risk-bearing entities.

Additionally, if ACOs were to become full risk-bearing entities, the same quality standards, regulatory requirements, capital reserve rules, licensure requirements, and other standards that apply to MA plans should be applied consistently to ACOs.

BCBSA also encourages the Working Group to foster partnerships between ACOs and MA plans in order to promote coordinated care and protect beneficiaries, rather than seeing these entities as distinct, non-overlapping payment models

MA plans have a long history of managing and coordinating care for members, via a long-standing infrastructure that is required to support risk-based arrangements. In these arrangements, MA plans bear the risk of caring for their members through receipt of capitation payments from CMS. In addition, MA plans have led the creation of multiple innovative partnerships with providers, such as ACO relationships, allowing providers to share in the benefits and risk of providing high quality care to members. MA organizations have already established the infrastructure necessary to promote care coordination and risk sharing relationships with providers, including development of robust networks, health information technology systems, and reliable data and data sharing mechanisms.

As care integration and risk-sharing models in the fee for service system are considered, a strong role for managed care should remain. New models should rely on and use the infrastructure that MA organizations have built and sustained, rather than using limited resources to reinvent the system in a potentially unsustainable way.

The government should explore opportunities to create partnerships between MA organizations and ACOs, relying on this managed care infrastructure, particularly in areas where there has not been high uptake or success in ACO participation. Relying on this existing infrastructure will allow new partnerships to evolve by building upon best-practices and minimizing the administrative hurdles that impede beneficiary care.

VI. Ensure Adequate Payment for the Chronically Ill

We applaud the Working Group for looking into the MA risk adjustment methodology to ensure that plans participating in the Medicare program are appropriately paid and evaluated on the care that they provide to chronically ill Medicare beneficiaries.

Each MA plan enrolls a unique mix of individuals with different demographic features, diagnoses, and healthcare needs, which corresponds to different healthcare costs. The Centers for Medicare & Medicaid Services (CMS) consequently risk adjusts plan payments based on beneficiary demographics and health status. It is vital that the risk adjustment model is an accurate predictor of cost, otherwise it will create payment distortions and fail to properly reimburse high-quality MA plans that are providing high-quality care to chronically ill patients.

Any changes to the risk adjustment model should be consistent with national health policy goals to promote early identification and treatment of chronic diseases, and should not be designed to reduce program funding. Specifically, BCBSA urges Congress to recognize the value of early identification and treatment of chronic illness and act to fully restore payment codes for the early stages of chronic kidney disease, as well as add codes for Alzheimer's disease and related dementia. CMS recently changed their risk adjustment methodology to eliminate payment codes for early chronic kidney disease—stages 1, 2, 3—which reduced program funding by 2.5% and directly affected plan programs that detect conditions at their earliest stages and help to prevent progression.

More than 15 percent of all Medicare beneficiaries have been diagnosed with chronic kidney disease, and early intervention and treatment during the early stages of the disease is critical to managing care for patients with this condition. MA plans aim to identify their enrollees' health conditions early on so they get the treatment they need and to mitigate serious, complicated health issues that may arise in the future. Removing payment codes for diseases directly impacts MA plans serving the most vulnerable and chronically ill Medicare beneficiaries and limits the ability of those plans to provide expanded care and extra benefits.

BCBSA also asks the Working Group to look into ways the 5-Star Rating Program can be improved to ensure appropriate quality incentives. MA plan performance is evaluated by CMS using Star Ratings, which are intended to incentivize plans and provide Medicare beneficiaries with a clear standard for evaluating plan quality and service. The process, measures, and methodologies used to determine Star Ratings must be correct and transparent to ensure that they properly reflect the care provided and meaningfully address concerns about vulnerable populations. It is especially important that beneficiaries requiring specialized chronic care management can rely on Star Ratings as a useful and meaningful tool in selecting the right plan for their specific needs.

We recommend that the Working Group consider policies to improve the Star Rating Program by adjusting MA plans, either in their payments or Star measures, for low-income and dual-eligible beneficiaries, lifting the benchmark caps affecting the highest quality plans (4, 4.5, and 5-star contracts), and requiring CMS to make changes to measures and methodologies on a prospective (rather than retrospective) basis.

VII. Other Issues for the Working Group to Consider: Constraining Rising Drug Costs and Limiting Provider Consolidation

BCBSA also encourages the Working Group to study other policies that would improve and enhance care for chronically ill Medicare beneficiaries by lowering costs and increasing innovation; specifically, constraints on high drug costs, limits on provider consolidation, and Medigap product demonstrations.

A. Constrain Rising Drug Costs

Spending on many of the newest high-priced and specialty prescription drug therapies is growing rapidly. CMS announced the Part D benefit parameters will grow by 11.76% in 2016, a significant increase from 4.07% in 2015. An increase of this factor means out-of-pocket costs for Part D beneficiaries will increase under the defined standard Part D benefit. The agency has noted the recent introduction of high-cost drugs is the primary reason for the growth in this

factor, and a recent Avalere study found the appearance of just ten of these products in the market is estimated to increase Medicare spending by \$31.3 billion over the next decade.

Addressing this cost trend is critically important to maintaining a workable healthcare system and safeguarding access and affordability for patients, including those patients with chronic conditions. Substantial reforms are needed to ensure that prescription drug costs over the long run are fair and sustainable.

It is therefore crucial that Part D sponsors have flexibility to use clinically-based tools and techniques to promote greater affordability in the program in response to the threat provided by the influx of high-cost drugs into Part D. Congress should allow Part D plans increased flexibility in formulary design, specifically in their ability to establish coverage policies and to determine which drugs and drug classes are included in their formularies. Health plans negotiate prices with pharmaceutical manufacturers to bring the most affordable treatment options to patients and use these tools to inform individuals about treatment alternatives that may be more clinically safe and effective, often at lower cost.

Congress should also give MA-Part D plans and stand-alone Part D plan sponsors the authority to limit access to certain frequently abused drugs (e.g., opioids) for enrollees with documented patterns of overusing prescription drugs to one authorized prescriber and to one pre-designated pharmacy.

Finally, BCBSA recommends that Congress ensure greater transparency into drug valuation and fund more studies on the clinical effectiveness and safety of drugs. Greater availability and use of comparative effectiveness data is necessary for developing innovative new payment arrangements and incentive structures for drugs. Work from the NIH and PCORI can be leveraged to make more clinical data available to researchers, policymakers, and payers.

B. Limit Provider Consolidation

Payment differentials across sites of service encourage the acquisition of office-based physician practices by hospitals, which results in provider consolidation. This, in turn, leads to community clinic closures, less competition, more expensive physician networks, increased costs for beneficiaries, and reduced patient options. A Northwestern University study found a substantial amount of vertical integration since 2007, with the share of spending by physicians whose practices are owned by hospitals increasing by more than 50 percent. These acquisitions lead to substantial price increases for the acquired physician groups, with average price increases reaching nearly 14 percent.

We commend Congress for the inclusion of the site-neutral payment provision for newly acquired off-campus providers in the Bipartisan Budget Act of 2015, and we urge lawmakers to stand by the budget deal and resist pressure to rollback reforms. Furthermore, we ask the Working Group to adopt expansive new site-neutral payment policies as a complementary component of efforts to improve care for the chronically ill, increase system efficiencies, and reduce unnecessary healthcare spending.

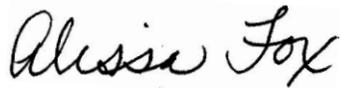
We specifically ask that Congress evaluate the impact of provider consolidation on access to high-quality primary and other care for patients with chronic conditions. Additionally, Congress should ensure that government policies do not further anticompetitive arrangements or consolidation among physician practices and hospitals.

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BCBS companies have a growing body of experience in improving care and constraining costs for vulnerable populations, and we welcome opportunities to partner with the government to leverage these experiences and help them gain momentum.

Thank you for your bipartisan efforts to enhance the care provided to Medicare beneficiaries living with chronic illness, and for allowing us the opportunity to comment on the Options Paper. BCBSA and its member Plans look forward to working with you to make MA and Medicaid managed care even more valuable to this vulnerable population.

Sincerely,

A handwritten signature in black ink that reads "Alissa Fox". The signature is written in a cursive, flowing style.

Alissa Fox
Senior Vice President, Office of Policy and Representation
Blue Cross Blue Shield Association