BlueCross BlueShield Association

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STATEMENT

Before the

UNITED STATES SENATE FINANCE COMMITTEE ROUNDTABLE

On

Delivery System Reform

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April 21, 2009

INTRODUCTION

The Blue Cross and Blue Shield Association (BCBSA) commends Chairman Baucus's and Ranking Member Grassley's leadership in holding this important series of roundtable discussions to bring stakeholders together to work toward solutions for improving today's healthcare system.

BCBSA is pleased Congress and the Administration have made healthcare reform a national priority, and we share the commitment to enacting healthcare reform legislation this year that expands coverage to all Americans, reins in costs, and improves the quality and safety of care delivered to patients.

BCBSA strongly believes everyone in our country should be insured. It is unacceptable that 46 million people are uninsured, and we look forward to working with Congress, the Administration and all stakeholders to ensure everyone has coverage.

To attain the goal of having everyone covered, we must address the underlying problems of our current delivery system. Escalating costs are the main reason people are unable to obtain health insurance, and rising health care costs must be addressed through delivery system reforms that increase quality and enhance value. Such a reformed delivery system would ensure patients get the right care at the right time and should focus on four priorities outlined in our comprehensive health care reform proposal, *The Pathway to Covering America*:

- *Providing information on what works best* by comparing the relative clinical effectiveness of new and existing medical procedures, drugs, devices, and biologics – this is a vital first step in addressing the approximately 30 percent of all healthcare spending that goes toward ineffective, redundant, or inappropriate care. (Wennberg, 2003)

- *Changing incentives to advance the best possible care,* instead of paying for more services that may be ineffective, redundant, or even harmful – because providers are generally paid based on the number of services they provide, regardless of quality or outcomes.

- *Empowering consumers and providers* with the information and tools they need to make informed decisions – because too often consumers and providers do not have what they need to encourage the right care done right at the right time for each and every patient.

- *Promoting healthy lifestyles* to prevent chronic illness and work aggressively to help patients with chronic illnesses manage their own health – because one of the greatest challenges facing the healthcare system is managing the care for the growing number of people with chronic illnesses.

A robust private insurance system is critical to reforming the delivery system so that all patients have access to safe, affordable quality care. Private plans in general and Blue Plans in particular have been active innovating in these priority areas. Private health plans' efforts, which depend on thoughtful, coordinated contributions from patients, hospitals, physicians, and policymakers, are already helping to reform the delivery system by changing incentives to advance the best possible care, not just drive the use of more services.

Creating a new government plan that would compete with the private sector would undermine the ability of the health care sector to implement meaningful delivery system reforms. The private sector has led the way in developing innovative programs (e.g., chronic care management, wellness programs, and Centers of Excellence) that would not be possible under a government plan due to enormous political pressure. Private health plans lead innovations to improve quality of care that the government has been historically slow to adopt.

To help the Committee develop its delivery system reform proposals, our statement covers:

(1) The Blue delivery system reforms that we have successfully put into practice to-date; and

(2) Recommendations for what the government should do to reform the delivery system, including recommendations to move Medicare away from a system based on fee-for-service design to one that pays based on quality, coordinated, and outcome-driven care.

PRIVATE SECTOR INNOVATIONS

Today's private insurance companies have been the driver behind numerous innovations in the four priority areas we identified for delivery system reform.

I. Information on what works best

Today, only about half of patients get a full recommended course of evidence-based care. BCBSA and Blue Plans have been working to help doctors and other caregivers deliver better and more consistent clinical care to their patients – the right care done right at the right time for each and every patient – through two leading efforts: (1) BCBSA's Technology Evaluation Center; and (2) Blue Health Intelligence. We also recommend that the government encourage research on what works best and put it into practice – the bedrock of encouraging the right care at the right time for every patient is comparative information on the clinical effectiveness of different treatment approaches.

Technology Evaluation Center

Since it was founded by BCBSA more than 20 years ago, the Technology Evaluation Center (TEC) has helped physicians and other caregivers across the country improve quality. TEC has led the development of scientific criteria for assessing the effectiveness of medical technologies through comprehensive reviews of clinical and scientific evidence. TEC is one of only 14 evidence-based practice centers for the Agency for Healthcare Research and Quality, publishing an average of 15-20 clinical assessments annually. Recently, for example, TEC assessed whether computer-assisted navigation improved alignment of the implant during knee replacement surgery. TEC's study found that there was little existing evidence that computer-assisted navigation technology helped improve patient outcomes compared to conventional knee replacements.

Blue Health Intelligence

To further support evidence-based medicine, we created Blue Health Intelligence (BHI) – the nation's largest, most comprehensive healthcare data repository – which has patient-protected health claims information on more than 54 million BCBS subscribers. BHI will be a powerful research tool that can inform decisions that will ultimately improve care. It can benefit employers

by providing them with information on trends and utilization that they can use to develop state-of-the-art wellness programs. It can also provide information on breakthrough treatments and potential problems in care delivery. For example, if BHI had existed a few years ago, we would have known sooner about Vioxx's link to increased heart attack and stroke risk.

Comparative Effectiveness Research

We applaud the comparative effectiveness provisions included in the American Recovery and Reinvestment Act of 2009, but urge further steps to strengthen delivery system reform:

- Create an independent, federally chartered, not-for-profit Institute to prioritize and fund a variety of research – including clinical trials, cohort studies, literature reviews, and other studies – evaluating the comparative clinical effectiveness of different procedures, drugs, devices, and biologics.

- The Institute should ensure that new comparative information is disseminated timely to providers, patients, and others in easy-to-use formats. Electronic medical records should be required to incorporate these guidelines into their clinical decision support systems.

- Finally, the resulting evidence-based standards should inform medical malpractice, for example by creating rebuttable presumptions and safe harbors concerning the standards of care that providers are expected to meet in medical malpractice cases.

II. Changing Incentives

Most physicians and hospital staff are well-trained and well-intentioned, but need to spend more time improving the processes by which care is delivered, and using systems to support decision-making that adheres to the scientific evidence that is available. This requires realigning financial incentives, as well as training in process improvement techniques. We must change processes and incentives in our current health care system to advance the best possible care, not just drive the use of more services. We believe that by helping providers implement best patient care practices, health plans can deliver better value and efficiency to members, ensuring access to affordable and high quality health coverage.

Blue Distinction

One major way that BCBSA has been realigning incentives and helping providers is our national program of nearly 800 Blue Distinction Centers (BDC) across 43 states. This program designates facilities that have demonstrated expertise in delivering quality healthcare in the challenging specialty areas of Transplantation, Bariatric Surgery, Cardiac Care, and Complex and Rare Cancers.

To receive this designation, facilities must meet stringent quality criteria, as established by experts in the specialty field. Centers must demonstrate better outcomes and consistency of care, which provide greater value for Blue Plan members. Facilities that have the BDC designation are subject to periodic evaluations as criteria continue to evolve; facilities that do not receive the BDC designation receive assessments and advice on doing better the next time.

The early results for the Cardiac Care BDCs are especially encouraging. Currently there are more than 410 Blue Distinction Centers for Cardiac Care. The stringent clinical criteria that designated

facilities met were developed in collaboration with the American College of Cardiology (ACC), the Society of Thoracic Surgeons (STS), and with the input from a panel of leading clinicians.

A study by HealthCore, Inc., found that readmission rates for certain procedures performed at Blue Distinction Centers for Cardiac Care® were lower than at other hospitals. The study found:

- 26 percent lower readmission rates for bypass surgery and 37 percent lower for outpatient angioplasty, based on 30-day cardiac-related readmission rates.

- 21 percent lower readmission rates for bypass surgery and 32 percent lower for outpatient angioplasty based on 90-day cardiac-related readmission rates.

- Lower costs, five percent less for bypass procedures and 12 percent less for outpatient angioplasty, with a 90-day episode of care.

Similarly, there is a significant difference in the inpatient mortality of patients admitted to BDC facilities as opposed to those facilities that were denied the designation. And in a striking confirmation that improved quality leads to better affordability, allowed charges for bypass surgeries were $45,215 in BDCs – $2,260 less than in non-BDC hospitals. Economic criteria were not used to designate facilities as BDCs; it just turned out that facilities that offered better care were associated with better clinical outcomes and generated more affordable care, an important insight for national policy.

Pay-for-Quality

A critical strategy for BCBS Plans to drive delivery system reform is to continue to raise the bar on quality through the use of pay-for-quality or pay-for-performance (P4P) programs that begin to align incentives – improving quality and affordability by facilitating the adoption of best patient care practices for hospitals, physicians, and members. Plans focus on measuring quality indicators that have been identified by national quality improvement organizations as areas of opportunity, and tie significant financial incentives to improvements in these quality measures.

For example, Highmark BCBS's hospital P4P program has focused on reducing the incidence of central line bloodstream infections in ICUs. During 2008, hospitals in the program reported a significantly lower rate of central line infections compared to the national average, (1 infection per 1000 line days compared to 2.7 infections per 1000 line days), translating to an imputed savings of more than $21 million and between 69 and 142 lives saved compared to the national norm. Highmark's P4P program for primary care physicians has greatly increased the rate of generic prescribing, resulting not only in financial savings to members and employers, but also increasing the likelihood that patients will adhere to treatment plans.

III. Empowering Consumers and Providers

With timely information and well-designed electronic tools, BCBS Plans have been working to encourage the right care done right at the right time for each and every patient. Blue Plans across the U.S. are leading efforts to promote widespread adoption of electronic medical records, e-prescribing, personal health records, and consumer decision-support tools. We are very pleased the American Recovery and Reinvestment Act will play a decisive role in furthering adoption of health information technology.

- *Claims-based Electronic Records:* Many Blue Plans are giving providers access to comprehensive information on a patient's health and medical history through payer-based electronic health records. These records are populated with pertinent claims data such as recent health encounters, diagnoses, medication histories, prescription refill status from pharmacies, and test results from laboratories. This information enables providers to better coordinate care.

- *Personal Health Records:* Blue Plans are providing personal health records (PHRs) for their members, which are auto-populated with key claims data, including medications, immunizations, and provider information, and can be self populated with other important information such as family history and over-the-counter drugs. A PHR can help consumers be better informed and more actively involved in their healthcare – and lead to better coordination among caregivers.

- *Electronic Prescribing:* Blue Plans have been leaders in facilitating e-prescribing. For example, in 2006 BCBS of North Carolina launched an e-prescribing program that provided more than 1,000 high-volume prescribing physicians with a handheld personal digital assistant (PDA), software licenses, and wireless network hardware free-of-charge. Since the program's launch, the improvements to patient safety have been impressive: more than four million electronic prescriptions have been submitted, 59 percent received drug-to-drug interaction warnings, 32 percent of the orders were flagged as formulary warnings, and 2 percent were halted altogether because of patient allergy alerts.

IV. Promoting Healthy Lifestyles

Chronic illnesses such as heart disease, hypertension, diabetes, and stroke account for 70 percent of deaths and 75 percent of total healthcare costs. Delivery system reforms that encourage patients and caregivers to aggressively tackle these diseases can go a long way to improving patient care.

Disease Management

One such reform is the aggressive use of disease management programs. BCBS Plans nationwide have led the way in implementing disease management programs for members with complex chronic conditions. For example, BC of Idaho launched a disease management program in 2001 designed to reduce hospital admissions and improve medication compliance for members with congestive heart failure (CHF). The program used educational materials and one-on-one physician coaching and outreach to improve self-management techniques, as well as offered biometric monitoring equipment to high-risk CHF members that allowed them to report on their conditions from home. The coordinated efforts led to a five percent reduction in hospital readmission rates among members with CHF.

Horizon BCBS of New Jersey is using critical health IT tools while also offering primary care physicians financial incentives to provide comprehensive, coordinated patient care and management of chronic diseases. Under this pilot, Horizon shares pertinent claims data with providers that can tell the physician which of his or her patients have diabetes and which have not had important tests or screenings as part of their recommended care, such as a blood glucose test within the last year. With this information now readily available, physicians are able to reach out to the patient to make sure they are getting the care they need. This program is yielding impressive results: in just one year, compliance rates for HbA1c blood tests (a key health status indicator for patients with diabetes) jumped from 40 percent to over 90 percent.

INNOVATIONS TO REFORM MEDICARE

We urge Congress to follow the lead of the private sector and, instead of creating a new government plan, begin moving Medicare away from a system based on fee-for-service design to one that pays based on quality, coordinated, and outcome-driven care.

We recommend Congress enact a three-tiered strategy for Medicare that phases in a range of innovative reforms:

- Tier I – Reforms that could be started immediately and would lay the groundwork for major changes in the structure of the healthcare delivery system by moving away from fee-for-service care to reward quality and outcomes. This includes expanding successful pay-for-performance programs based on Plan experience to all of Medicare.

- Tier II – Reforms that could be planned now and implemented within the next two years to build on Tier I reforms and further advance quality and outcomes. These include promoting wellness through benefit design changes, and creating an environment of professional accountability for providers.

- Tier III – Major reforms in the structure of the healthcare delivery system that could be planned now, tested through public-private demonstrations over the next couple years, and implemented thereafter. This includes piloting approaches that move the entire system away from fee-for-service and into new payment models that will more closely align outcomes with reimbursement.

Tier I Reforms

We recommend that Medicare start these reforms now, but phase them into completion at different rates.

1) Pay-for-quality

Medicare should follow the lead of the private sector by expanding its pay-for-quality incentive programs and eventually require participation by all Medicare providers. Medicare should start with primary care physicians and hospitals in 2010 because extensive performance measures are available, and accelerate efforts to develop performance measures for specialists in order to expand to specialists by 2011.

We urge incorporating lessons learned from successful Blue program: for example, incentives must be in the range of 10 percent to 15 percent to motivate practice changes. CMS should also:

- Explore the potential for incorporating med-mal insurance discounts for high-performers into incentive programs.

- Streamline quality reporting requirements to reduce providers' administrative burden.

We note that BCBS of Massachusetts has launched a major new program in collaboration with all provider communities in the state, basing reimbursement on clinical outcomes and efficiency. Although recently launched, such innovation is only possible in an environment within which decisions can be made and revisited by all participants without political or social pressure from myriad interested parties.

2) Increase reporting and transparency

We urge CMS to continue to partner with the private sector to provide quality information on individual physicians and hospitals.

3) Build up the Primary Care Workforce

Increasing payments to primary care physicians, while at the same time strengthening the foundation of the overall primary care workforce, are critical delivery system reforms to ensure a high performing health care system.

- To increase payments, we recommend adjusting payments through the Resource Based Relative Value Scale (RBRVS) to give primary care providers a 5 percent relative increase in 2010; 10 percent in 2011; and 15 percent thereafter. Paying for this could be done primarily by reducing payments for imaging services to providers who rely heavily on costly imaging machines. At the same time, we would change the membership of the RVS Update Committee – which is sponsored by the AMA and makes recommendations that CMS uses to set payment rates. Currently only five of the Committee's 29 members represent primary care specialties as defined by the AAFP. We would increase the proportion of primary care physicians to at least 35 percent of the medical professionals on the Committee, and add private payers as non-voting members.

- To strengthen the overall primary care workforce, we would recommend increasing educational subsidies for primary care providers (not only physicians, but also physician assistants and nurse practitioners). This could involve (1) modifying current Graduate Medical Education (GME) payments to provide greater subsidies for primary care training (hospitals currently receive only slightly higher payments for training primary care residents versus specialists); (2) Augmenting current loan forgiveness programs by forgiving loans for primary care providers who work in medically underserved areas and who are not part of the National Health Service Corps; (3) For primary care positions only, lifting the cap introduced under the Balanced Budget Act of 1997 so that additional primary care residency programs could be funded; and (4) Removing the Medicare limitation on supporting allied (non-physician) health practitioner clinical training not directly operated by a hospital so that more professionals can receive training.

4) Create clinical pathways to help physicians provide compassionate and cost-effective end-of-life care.

Medicare spends more than a quarter of its annual budget on care for those in their last year of life. Among patients who died of cancer, a major contributor to cost and quality-of-life issues is the

widespread use of chemotherapy in the last three months of life. Studies show that 15 to 20 percent of patients with incurable, end-stage cancer receive chemotherapy within 14 days of their death, a time when chemotherapy has no benefit.

- Therefore, we recommend funding a pilot starting in 2009 to identify the extent of overuse errors in treatment of cancer patients, for example by measuring non-palliative chemotherapy use in the last two weeks of life, and to establish best use of palliative care. CMS would develop pathways based on the pilot and incorporate those pathways into future pay-for-quality programs for specialists treating cancer patients.

Tier II Reforms

We recommend that Medicare start planning for these reforms now, and implement them within the next two years.

1) Create an environment of "professional accountability" that empowers provider organizations to drive quality care.

In order to empower providers to take a role in ensuring quality care, we recommend that CMS engage and fund medical specialty boards to determine standards for appropriateness of care that would be used by all practicing providers. To ensure full representation, and to ensure that reforms also affect rural or underserved communities, mechanisms to reach out to non-board-certified physicians also must be funded and developed. The standards for appropriateness that are developed and then used by Medicare should be vetted and endorsed by the National Quality Forum or another nationally-recognized, consensus organization.

2) Modernize benefit design to promote prevention, wellness, and management of chronic conditions.

Medicare beneficiaries should be incentivized to participate in wellness activities, such as through programs that provide financial incentives for participating in a personalized online health promotion program and meeting targeted health goals. As one example of how to do this, BS of California offers its members a program called Healthy Lifestyle Rewards. The customized, online program attacks the root causes of chronic illness by offering financial incentives to motivate individual efforts to reduce modifiable risk factors. Cash rewards are offered, and the amount is determined based on the member's duration of participation completion of online modules that drive behavioral change and provide practical support.

Medicare should also identify and test relevant value-based insurance designs – where the more clinically beneficial the service is to a beneficiary, the lower that beneficiary's cost sharing for the service. Demonstration programs could begin in 2010, with full implementation in 2011.

3) Advance administrative efficiencies that can lower costs and free up provider time for patient care.

Medicare should require providers (with rare exceptions) to use the standard HIPAA electronic transactions for submitting claims, getting eligibility and benefits information, etc. Currently, while close to 70% of overall claims in general are submitted by providers electronically, the rates for other electronic transactions are much lower – most eligibility and benefits checks are done by phone calls or paper.

Tier III Reforms

We recommend that Medicare start planning for these fundamental delivery system reforms now, test them in demonstrations in 2010, and implement lessons learned thereafter.

These recommendations would fundamentally change the delivery system to pay for quality, integration, and coordination of care (among primary care practitioners, specialists, and hospitals). Since they would largely be entirely new approaches, we recommend each first be pilot tested to fully understand their impact before broader implementation. Medicare could partner with the private sector on these pilots to ensure that eventual implementation is sustainable in an all-payer environment.

1) Expand the scope of care coordination in the medical home model.

Medicare should establish public-private pilots that integrate specialists and hospitals into the medical home model. The current medical home model incentivizes the primary care provider to better coordinate care, but lacks a mechanism to encourage hospitals and specialists to respond to, or participate in, these coordination efforts. Therefore, we recommend that the pilots establish and include incentives (such as expanded fee schedules or other additional payments) for specialists and hospitals to share information and improve coordination.

2) Encourage greater integration of providers through "virtual" arrangements.

Medicare should establish public-private pilot programs that give providers incentives to participate in what are known as "Accountable Care Organizations" (ACOs), which emulate fully-integrated delivery systems. These models are expected to greatly improve care coordination, as well as lower costs, by allowing participating providers a share of savings gained through efficiency.

Coordination by providers should be incentivized through group-level quality reporting and payments that tie a provider's performance rating to that of all other providers involved in the patient's care. Medicare should also:

- Set spending targets for care with opportunities for providers to receive a share of any savings, as long as quality benchmarks also are met.

- Pilots should be structured to determine who best to serve as the primary recipient of shared savings (e.g. hospitals or individual providers) and under what method those savings should be allocated to the other providers involved in the patient's care. This would address a key challenge in such delivery system reforms: how to equitably distribute resources [shared savings] across physicians, hospitals, and other providers – and, ultimately, taxpayers.[1]

3) Encourage greater integration of providers through bundled episodic payments for a targeted patient population.

[1] Mechanic, RE, and Altman, SH. (2009). Payment reform options: Episode payment is a good place to start. *Health Affairs, 28, no. 2.*

We also recommend that CMS establish public-private pilot programs where Medicare and private payers use bundled payment arrangements for certain conditions. Rather than separate payments for the hospital, post-acute providers, and physicians involved in treatment of a patient hospitalized for a procedure, only a single payment would be made by the payer for a defined episode of care.

Because the predetermined payment will be split among the hospital, post-acute providers, and physicians, it is hoped they will collaborate more closely to avoid complications and unnecessary procedures and re-admissions, thus preserving more of the payment for them. We recommend initially focusing on congestive heart failure/coronary disease, since this condition results in some of the highest rates of hospital readmissions under our current system, and would likely benefit most from the improved care coordination that episodic payments are expected to produce.

- As in the recommendation above, pilots should be structured to determine who best to serve as primary recipient of the payment, and under what method it should be allocated to the rest of the providers involved in the patient's care.

- Reduced hospital readmission rates should be established as one overall performance objective to which payments are tied, to encourage better care and follow-up of patients after discharge from acute care.

CONCLUSION

BCBSA appreciates this opportunity to share our recommendations for delivery system reforms to increase quality and enhance the value of our healthcare system. Delivery system reforms are critical as we work toward the goal of assuring all Americans have access to affordable, high quality care. The Blue System has several successful initiatives already underway that are making a difference in advancing the best possible care for patients. Our vision for a reformed delivery system would ensure patients get the right care at the right time by focusing on four priorities:

- *Providing information on what works best* by comparing the relative clinical effectiveness of new and existing medical procedures, drugs, devices, and biologics.

- *Changing incentives to advance the best possible care,* instead of paying for more services that may be ineffective, redundant, or even harmful.

- *Empowering consumers and providers* with the information and tools they need to make informed decisions.

- *Promoting healthy lifestyles* to prevent chronic illness and work aggressively to help patients with chronic illnesses manage their own health.

We believe a robust private insurance system is critical to achieving these needed delivery system reforms. Creating a new government plan would undermine the ability of the healthcare sector to implement the meaningful delivery system reforms needed to improve our healthcare system. Instead, Congress should follow the lead of the private sector and begin moving Medicare away from a system based on fee-for-service design to one that pays based on quality, coordinated and outcome-driven care. We look forward to continuing to work closely with Congress, the Administration and all stakeholders to enact comprehensive healthcare reform legislation this year.