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June 22, 2015

The Honorable Orrin Hatch, Chairman
US Senate Committee on Finance
United States Senate
Committee on Finance
Washington, DC 20510-6200

The Honorable Ron Wyden, Ranking Member
US Senate Committee on Finance
United States Senate
Committee on Finance
Washington, DC 20510-6200

The Honorable Johnny Isakson
US Senate Committee on Finance
United States Senate
Committee on Finance
Washington, DC 20510-6200

The Honorable Mark Warner
US Senate Committee on Finance
United States Senate
Committee on Finance
Washington, DC 20510-6200

Dear Senators:

CareFirst BlueCross BlueShield appreciates the opportunity to share our insights gained from successfully operating the largest patient-centered medical home (PCMH) program of its kind in the country for the past five years and to comment on the limitations of current Medicare payment policy preventing promising innovations from benefitting Medicare beneficiaries and the program itself.

Background

CareFirst BlueCross BlueShield is the largest insurer in the Mid-Atlantic region, serving 3.4 million members. We have the largest provider network in the region, with approximately 90 percent of the region's health care providers participating in one or more of our networks. CareFirst also serves more than 577,000 members in the Federal Employees Health Benefits Program (FEHBP) – the largest FEP enrollment in the nation – and the majority of Members of Congress and designated Congressional staff through our plans offered on the DC SHOP Exchange.

The CareFirst PCMH program is designed to empower and support primary care providers (PCPs) with financial incentives, data, tools and technical assistance to provide high quality, cost effective care to CareFirst members. Understanding that 12 percent of CareFirst members account for almost 63 percent of the costs that CareFirst pays for health care services (for its under age 65 commercial population), and that nearly well over 80 percent of these members suffer from multiple chronic conditions, the PCMH program is designed to enable physicians to closely coordinate care for the chronically ill and help these patients better manage their diseases and improve their overall health.

Launched in January 2011, CareFirst's PCMH is among the nation's first truly uniform region-wide programs with robust physician participation and patient reach within Maryland, Washington, D.C. and Northern Virginia. Over 4,000 PCPs – both physicians and nurse practitioners – representing 90 percent of PCPs in CareFirst's network participate on a voluntary basis. Approximately 1.1 million CareFirst members are covered by the program.

By providing incentives to primary care providers based on patient outcomes, promoting collaboration and integration between health care providers, and emphasizing coordinated care for the chronically ill, the PCMH program is truly patient-centered. This high-quality, patient-centered care has not only improved health outcomes on a sustained basis, it has experienced 1% overall medical cost growth for the 1.1 million members involved, 2014 over 2013.

Based on our experience, we believe the following top six issues need to be addressed in Medicare payment policy:

1. **Medicare payment rules do not fully cover the cost of developing and maintaining a full, detailed care plan addressing all of the medical, pharmacy, and behavioral health needs of people with multiple chronic conditions.** Though the new code for non-face-to-face care coordination services (CPT99490) is a step in the right direction, it is insufficient and may even impede care plan development. We have found it takes intense follow-up and comprehensive planning between members, their primary care physician, and needed specialists. However, there is no current mechanism to charge Medicare if more than 20 minutes is required (e.g., the existing, non-reimbursable CPT codes for complex care management). This could cause physician practices to bill for CCM for a large number of patients that do not actually receive the intense coordination they need. Given that nearly 70% of Medicare beneficiaries have two or more chronic conditions, Medicare could wind up paying for a significant amount of inefficient, ineffective care coordination services. Further, the CCM Scope of Service elements and electronic technology requirements that must be met in order to bill the service are overly exhaustive, difficult for physicians to meet, and overly process oriented, which will ultimately discourage physicians who truly wish to provide meaningful care coordination from participating. We have had successful experience with a simple fee structure for care coordination rendered to beneficiaries who are actually in (and complying with) a care plan prepared by a qualified and trained nurse who closely coordinates with the patient's primary care provider. This year we will do 50,000 such care plans across our PCMH and Total Care & Cost Improvement programs.

2. **It essential to appropriately target the right patients for care coordination.** The decision to place a person in a care plan must be based on more than the presence of two diagnosis codes, and must take into account the vulnerability and volatility of the patient within the totality of circumstances that could predict an inclination of the patient to break down**.** We have successfully used 10 different indices to focus in on those who can most benefit. Without this ability to find the right care plan candidates, efforts on care coordination become diffused, ineffective and may actually add unnecessary care coordination costs to the system. Medicare does not require this focus or any disciplined patient selection process. We believe that this, combined with the flawed payment approach described above, will lead to ineffective, wasteful and spotty attempts at care coordination that will yield little in benefits to either the program or the beneficiary.

3. **Prescription medications are the primary means of treating beneficiaries with multiple chronic conditions, yet Medicare Parts A & B remain separated from Part D**. Medicare prescription drug claims are a critical source of information about a patient's adherence to their care plan, yet these data are not available on a timely basis for any meaningful care coordination by primary care teams to improve care. Further, Medicare currently pays only for a limited suite of medication therapy management services that

are paid only to Part D plans as an administrative cost included in the plan bid with little accountability for Part D plans to improve pharmacy management. There is no mechanism to pay other entities to improve medication use in fee-for-service Medicare in spite of CBO estimates that improvement in medication adherence would cause Medicare spending on medical services to fall. In combination, Medicare rules work against effective drug management within the context of overall care coordination. We have found, based on our own experience, that management of drug therapies is one of the most essential elements of effective care coordination without which, most attempts at getting better cost and care outcomes are greatly diminished.

4. **Similarly, Medicare payment rules generally do not cover a number of services or innovations that could identify and prevent a worsening of chronic disease**. Under CMS's current payment innovation portfolio, home-based monitoring and assessments, behavioral health assessments and follow-up, and other similar care coordination services are not directly reimbursed and participants must cover these costs through shared savings. Shared savings are too unpredictable and unreliable to allow for the effective development and use of these services.

5. **There is no robust gain-sharing opportunity for primary care physicians while ACO formation seems to favor high-cost integrated hospital systems.** Primary care providers account for less than 5% of Medicare spending, yet the hospitals they choose, the drugs they prescribe and the specialists to whom they refer account for the majority of Medicare spending. Medicare should more directly consider a way to reward primary care physicians who make cost-effective referrals and manage their patients against total quality and budget targets beyond the opportunities provided by Medicare's ACO programs and the Innovation Center's Comprehensive Primary Care Initiative. We have extensive, successful experience with primary care provider incentives that have worked effectively to reduce overall spending during the 5 years our PCMH Program has been in large scale operation. The form, degree and methods of shared savings we use are significantly different than the models being piloted today by the CMMI, and we believe provide much greater incentives to improve quality and reduce the total cost of care.

6. **Medicare payment rules currently require beneficiary cost sharing for any care coordination services they receive, and prevent the use of financial incentives to reward care plan compliance.** Since 2013, we have waived cost sharing for care coordination services for our commercial members who are in a care plan in order to encourage engagement and compliance. We have found that even small amounts of patient cost sharing often deter patient engagement thereby limiting effective care coordination. This year, we expanded this cost sharing waiver to all professional medical services for commercial members who are adhering to their care plan. We believe Medicare should more earnestly consider ways to reduce cost sharing to reward patient engagement and adherence to their care plan in order to reduce the likelihood of expensive breakdowns.

Conclusion

We greatly appreciate the opportunity to submit this response to your call for information and appreciate your leadership in exploring solutions that will improve outcomes for Medicare beneficiaries requiring chronic care. We have achieved substantial success in our commercial population at considerable scale and are keenly interested in improvements to Medicare payment rules that would permit Medicare fee for service beneficiaries to benefit from insights we have gained. We deeply believe the changes we have identified above would help slow the growth of Medicare spending on beneficiaries with chronic conditions while improving the quality of their care through enhanced coordination.

Our comments above are necessarily brief and do not capture the full extent of our leanings based on the extensive experience we have gained over the past five years.

We, therefore, would be pleased to provide a staff briefing on our experience if you so desire. In particular, we note that we are currently in the third year of operating a “common model” for Medicare and CareFirst members built on our PMCH model design - thanks to an initiative by CMMI. We believe our emerging experience here is very illuminating regarding payment reform needs.

Hence, if we may provide any additional information, please know that we stand ready to do so and that we are very willing to help in any way that we can on this important topic.

Sincerely,

Chet Burrell
President and CEO