



**BlueCross BlueShield  
Association**

An Association of Independent  
Blue Cross and Blue Shield Plans

## **Summary of Testimony by Scott P. Serota President and Chief Executive Officer Regarding “Health Care Payment and Delivery System Innovations”**

*Subcommittee on Health; Energy and Commerce Committee; U.S. House of Representatives  
Hearing on: “Using Innovation to Reform Medicare Physician Payment”  
July 18, 2012*

The Blue Cross and Blue Shield Association (“BCBSA”) – a national federation representing the 38 independent, community-based, and locally operated Blue Cross and Blue Shield companies (“Plans”) that collectively provide health care coverage for 100 million members, one in three Americans in every U.S. ZIP code – is pleased to testify on private sector payment and delivery system innovations that hold lessons for Medicare.

### **Overview of Testimony**

BCBSA believes transforming our health care system involves three interrelated strategies:

- First, change payment incentives, by putting in place innovative payment models that move away from fee-for-service – which rewards volume – and link reimbursement to quality and outcomes.
- Second, partner with clinicians, by giving them individualized support – such as access to data on patients’ full continuum of care, and help improving the processes by which care is delivered – they need to be successful under new payment and care delivery models.
- Third, engage patients, by providing consumers with wellness incentives, transparency tools so they understand the quality and costs of services, and information on how to keep healthy and manage chronic conditions.

In addition to providing an overview of the core principles that Plans believe should underlie any payment and care delivery innovation – such as putting quality and safety first – the testimony provides examples of how Blue Cross and Blue Shield Plans are implementing the three interconnected strategies above to improve quality and reduce costs today.

This includes results from such initiatives as pay-for-performance, patient-centered medical homes, bundled/episode-based payments, and arrangements with accountable care organizations.

### **Lessons Learned**

Sustaining and building on early successes will require a continuously evolving approach, as well as strong alignment between the public and private sectors. Based on Plans’ experience in their local markets, BCBSA believes Medicare should:

- Take a multi-faceted approach using the strategies above.
- Recognize the importance of local flexibility in adapting payment approaches and technical assistance to fit local delivery system conditions.
- Accelerate Medicare’s adoption of private sector innovations, capitalizing on the substantial and growing body of private sector experience, and expand successful initiatives rapidly beyond pilot markets.



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## **Testimony**

Before the

**Subcommittee on Health  
Energy and Commerce Committee  
U.S. House of Representatives**

on

**Health Care Payment and Delivery System Innovations**

Presented by:

**Scott P. Serota  
President and Chief Executive Officer**

July 18, 2012

## **INTRODUCTION**

Thank you Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee for inviting me to testify today on private sector payment and delivery system innovations that hold lessons for Medicare. I am Scott Serota, President and Chief Executive Officer of the Blue Cross and Blue Shield Association (“BCBSA”) – a national federation representing the 38 independent, community-based, and locally operated Blue Cross and Blue Shield companies (“Plans”) that collectively provide health care coverage for 100 million members, one in three Americans in every U.S. ZIP code.

As we all know, the country needs to be more aggressive in getting health costs under control and assuring patients receive the highest quality care. U.S. health care spending exceeds \$2.5 trillion annually. However, with studies estimating that 30 cents of every health care dollar goes to care that is ineffective or redundant (Fisher and Wennberg, 2003), many of those dollars are not well spent.

Blue Plans are leading efforts in communities nationwide to achieve value-based health care, implementing payment, benefit, and delivery reforms that are showing excellent results in improving quality and reining in costs. Because Plans serve members in all 50 states and U.S. territories, yet are community-based and locally operated, they are implementing similar strategies on a broad scale across the country while customizing their approaches to meet local market needs. Plans also are building on their results to expand successful initiatives. BCBSA is working with all Blue Plans to facilitate the sharing of best practices.

We believe Medicare can not only learn from but should align with these private sector initiatives.

## **OVERVIEW OF TESTIMONY**

Achieving value-based health care ultimately depends on successfully implementing three interrelated strategies:

- First, change payment incentives, by putting in place innovative payment models that move away from fee-for-service – which rewards volume – and link reimbursement to quality and outcomes.
- Second, partner with clinicians, by giving them the individualized support they need to be successful under new payment and care delivery models. This includes real-time information on their practices, their peers, and their patients; hands-on technical assistance and practice coaching on redesigning workflows and adopting best practices; and tools such as embedded nurse care managers and health information technologies (“IT”) that enhance practices’ ability to coordinate care.
- Third, engage patients, by providing consumers with wellness incentives, transparency tools so they understand the quality and costs of services, and information on how to keep healthy and manage chronic conditions.

Changing payments alone will not transform care if clinicians lack the means to identify and implement best practices. Giving clinicians sophisticated information systems and IT tools will not optimize health value if incentives are not realigned to favor outcomes, not volume. Neither changing payments nor partnering with clinicians will achieve its full potential if patients are not engaged in helping to manage their own health and care.

My testimony focuses on:

- 1) The core principles that Plans believe should underlie any payment and care delivery innovation.
- 2) Examples of how Plans are implementing these strategies to improve quality and reduce costs today.
- 3) Some lessons learned from Plans’ experience that can help Medicare.

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## CORE PRINCIPLES FOR PAYMENT AND CARE DELIVERY INNOVATION

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When implementing strategies to achieve value-based health care, Plans adhere to four core principles:

- **First, put quality and safety first.** The health and safety of Plans' members demands that new payment incentives are not premised on cost savings alone. Thus, as Plans move away from fee-for-service reimbursement, they build quality assessment and goals into new payment models.
- **Second, partner with the local provider community.** This means taking a market-specific – not a one-size-fits-all – approach to designing new payment and delivery reforms. Thus, Plans calibrate incentives and individualized support to reflect local provider practices, and they account for providers' readiness to move toward value-based care.
- **Third, measure quality and safety rigorously.** This means using metrics based on nationally accepted quality measures or physician specialty societies' own evidence-based guidelines. Thus, Plans not only achieve credibility with physicians and other providers – because new incentive programs reflect evidence-based care goals that have been carefully vetted by physicians themselves or a multi-stakeholder, consensus-based entity, such as the National Quality Forum – they also minimize the burden on providers that can stem from disparate measures.
- **Fourth, be transparent.** Payment and delivery reforms are far more likely to succeed if they are transparent to providers. Thus, the methodologies and measures that Plans use to assess providers' performance, Plans' scoring approaches, and other mechanics are made available to those affected, not created or administered in a "black box."

Adhering to these principles has helped Plans achieve success, in no small part by minimizing complexity and uncertainty for physicians and other clinicians. Aligning public and private efforts would reduce complexity and uncertainty even further.

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## **EXAMPLES OF BLUE INNOVATIONS**

I would like to share examples of how Plans are implementing the three interrelated strategies I mentioned earlier, showcasing various innovative initiatives to change payment incentives, to partner with clinicians, and to engage patients.

### **Initiatives to Change Payment Incentives**

There is widespread consensus that we need to move away from a fee-for-service payment system – which drives up costs by paying for more services, even if they are unnecessary or redundant – and toward payment models that reward better quality, and move us toward a value-based health care system.

Plans' payment innovations range from pay-for-performance, to patient-centered medical homes ("PCMHs"), to bundled/episode-based payments, to arrangements with accountable care organizations ("ACOs"). These initiatives exist along a continuum and may share features with one another. For example, an ACO might comprise multiple, interconnected PCMHs, and for certain procedures the ACO might receive bundled payments. However, for the sake of clarity, I will focus on these innovations separately.

#### *Pay-for-Performance*

Plans have implemented pay-for-performance initiatives using nationally accepted quality measures so that payment is aligned with what we know works, such as assuring all patients with diabetes receive recommended tests and treatments, or adhering to hospital infection

prevention best practices that can dramatically reduce infections, re-admissions, and other costly complications.

Experience shows that to truly motivate practice change, incentives must be substantial, often in the range of 10 to 15 percent for physicians. This must be coupled with efforts to help providers redesign their practices, examples of which I shall discuss in the next section.

Results indicate that aligned incentives drive substantial improvements in care quality while taking avoidable costs out of the system. For example:

- Highmark Blue Cross and Blue Shield's (PA) QualityBLUE incentive program involves 81 local hospitals and two-thirds of Highmark's network primary care providers ("PCPs") in a decade-long effort to align payment with high-quality care and improved outcomes. QualityBLUE also provides technical assistance to PCPs and hospitals to support the use of best-practices in patient safety and care coordination.

In addition to preventing 42 wrong-site surgeries and reducing hospital-acquired infections, during the past four years Highmark has achieved up to \$57 million in savings. 2011 quality results also include breast cancer screening rates nine percentage points above the national average, and practice-based electronic health record ("EHR") adoption rates 11 percentage points higher than the national rate.

Highmark plans to expand the QualityBLUE program to select specialists next year and already is sharing cost and quality performance data with cardiologists in its network to guide improvement.

Other Plans also have worked to expand their pay-for-performance initiatives to specialties including cardiology, obstetrics and gynecology, anesthesia, and orthopedics.

### *Patient-Centered Medical Homes*

Collectively, Blue Plans support the nation's largest network of medical homes with initiatives in 39 states, the District of Columbia, and Puerto Rico, covering millions of members. Plans also are partnering with other payers, including CMS, on multi-payer models that align incentives for providers to transform care delivery.

In a medical home, the patient and primary care practice are at the center of care, and patients have a continuing relationship with a PCP and care team that assures care is comprehensive, proactive, and coordinated. This reinforces primary care's critical role in helping patients get the care they need, when they need it, with greater efficiency, less redundancy, and fewer return trips to the hospital or physician's office – and it encourages teamwork and coordination across all of the clinicians involved in caring for a patient.

Examples range from statewide programs, as in Maryland and Michigan, which are among the nation's largest PCMHs, to targeted pilots as in New Jersey that are undergoing rapid expansion:

- CareFirst BlueCross BlueShield's (Maryland, the District of Columbia, and portions of Northern Virginia) PCMH initiative includes 3,600 primary care providers and nurse practitioners caring for 1 million CareFirst members and is specially tailored so small practices can participate. The Plan helps providers group together into "virtual" panels of five to 15 providers each, which allows for accurate quality and financial measurement, facilitates around-the-clock access for patients, and creates provider "peer-review" of each other's performance. The model includes an immediate double-digit increase in the primary care fee schedule and new payments for "care plans" for chronically ill members. Participating providers also are eligible for additional fee increases based on performance.

Preliminary 2011 results indicate that 60 percent of eligible primary care panels earned Outcome Incentive Awards, which are based on a combination of savings achieved by a particular panel against projected 2011 total care costs for CareFirst members, as well as the attainment of quality points based on care quality measures. Among these panels, costs were 4.2 percent less than expected.

- Blue Cross Blue Shield of Michigan's statewide PCMH program involves 780 practices and 3,000 physicians designated as medical-home PCPs caring for 850,000 patients. PCMH-designated practices work toward implementing key capabilities including using a patient registry, expanding access to after-hours care, and implementing processes for following up on test results. Under the program, PCMHs can earn at least a 10 percent increase in office visit fees for the extra time involved in optimally managing patient health. Physicians also receive additional fee-for-service payments for chronic illness care management services.

Results include a 22 percent lower hospital admission rate for conditions that could have been managed through better primary and outpatient care; a 10 percent lower use of emergency department services; and an eight percent lower use of radiology services. The Plan is also working with CMS, the State of Michigan, and other private payers as part of the Multi-Payer Advanced Primary Care Demonstration, which uses the Plan's PCMH model as a foundation for statewide, multi-payer implementation.

- Horizon Blue Cross and Blue Shield of New Jersey is spearheading a PCMH program – developed collaboratively with the New Jersey Academy of Family Physicians – involving 145 primary care practices and over 500 physicians throughout the state. Horizon provides upfront and ongoing support to redesign primary care, including: an enhanced fee schedule; a monthly per-member fee supporting care coordination, care

plan development, and other patient engagement activities; financial support for a population care coordinator at the practice site who proactively manages patient care; and an opportunity to earn additional incentives based on quality, patient experience, and utilization metrics.

Preliminary results comparing 2011 quality and cost trends between 24,000 Horizon members participating in the medical home program and members not in the program indicate that patients within the program are benefiting, and costs are lower. For example, PCMH patients had an eight percent higher rate in improved diabetes control (HbA1c); six percent higher rate in breast cancer screening; and six percent higher rate in cervical cancer screening, as well as a 10 percent lower cost of care (per member per month); 26 percent lower rate in emergency room visits; 25 percent lower rate in hospital readmissions; 21 percent lower rate in hospital inpatient admissions; and five percent higher rate in the use of generic prescriptions.

### *Bundled/Episode-Based Payments*

Another strategy for encouraging teamwork and coordination across all of the clinicians involved in patients' care is to pay for "episodes" or "bundles" of clinically related services. Bundling initiatives are now underway by Plans in 32 states – and growing – for a range of procedures ranging from hip and knee replacements to localized prostate cancer treatment to coronary artery bypass grafting. To implement episode-based/bundled payment arrangements, Plans have worked extensively with local provider partners to define services – down to the code level – that comprise the bundle, as well as the episode duration.

For example, Horizon Blue Cross and Blue Shield of New Jersey is piloting a bundling initiative for hip and knee replacements with eight orthopedic practices. Francois DeBrantes, a pioneer

in promoting new payment incentives, says the pilot “is the broadest one that any health plan has attempted to date. . . the broadest in terms of its scope in the country.”

Because of the complexities involved in paying surgeons a bundled fee for hip or knee replacement, the Plan is taking a phased approach to allow for a transition period before bundled payments take full effect and foster provider involvement in the development and validation of the episode-based approach. Working closely with the practices, the Plan gathered data on hundreds of joint replacement cases, used analytical tools to estimate how much the episode might be expected to cost, and then compared those projections with actual experience. These data will allow the Plan to take into account the severity of the case when it eventually sets the budget for an episode of care.

Horizon is holding monthly meetings with participating surgeons to discuss selecting robust quality measures and setting expectations for transparent Plan-provider data exchange as well as data validity. Next, the Plan will transition to a year-long orthopedics pay-for-performance initiative to incentivize the groups to improve quality and efficiency.

This will culminate in full implementation of bundled payments for total hip and knee replacements – capturing related care up to 30 days pre- and 90 days post-surgery – once the Plan and providers have gained experience with performance measurement and value-based reimbursement. Physicians then will share in any savings, although only if stringent quality benchmarks are met.

Such rigorous quality measurement – chosen with input from provider partners, and built into the payment model as a condition of shareable savings – plays a central role across Plan bundling initiatives. Metrics typically address patient safety, potentially avoidable complications, clinical processes (e.g, adherence to best patient care practices) and outcomes, and patient experience. A number of Plans also use patient-reported functional status measures to assess patient-centered outcomes, such as return to normal activity.

Plans are seeing promising early results. For example, under a bundled payment arrangement between Blue Cross and Blue Shield of North Carolina and Gastonia, N.C.-based CaroMont Health, there has been a reduction in potentially avoidable complications for total knee replacements yielding an average per-episode savings of 10 percent.

While most currently implemented bundled payments are anchored by an inpatient procedure, Plans are exploring strategies for bundling payments for outpatient-oriented services, such as a year's worth of care for a patient with diabetes. This would expand the application of bundling considerably, and help change incentives for high-cost, high-opportunity clinical areas, such as chronic disease management.

#### *Accountable Care Organizations*

ACOs represent another major vehicle for transforming payment to encourage teamwork, coordination, and the move to value-based health care. Often built on a strong foundation of PCMHs that coordinate patient care, ACOs take responsibility for the overall quality and costs of a defined patient population. These arrangements are now underway by Plans and local provider partners in 29 states and the District of Columbia, including several on a statewide basis.

Plans' ACO-type contracts include a variety of models ranging from hospital-centered ACOs to those involving networks of independent physician practices. Reciprocal risk often is an important element of promoting systems change in these arrangements because, although a bonus-only model may yield incremental improvements in quality and cost, it cannot begin to have the power to reshape practice patterns as effectively as a system that also puts providers at risk for losses.

Successful Blue ACO-type arrangements include:

- Blue Cross and Blue Shield of Massachusetts's ("BCBSMA") Alternative Quality Contract ("AQC") – launched in 2009 – is an innovative global payment model that is on track to reduce medical expense trend by half in five years while substantially improving care quality. The AQC gives providers a population-based global budget that is adjusted annually for health status and inflation, combined with substantial performance incentives tied to nationally accepted quality measures. To help providers improve, the Plan shares efficiency and quality data monthly and partners with providers on performance improvement. The Plan now covers 79 percent of its HMO members under AQC agreements, up from 39 percent in 2008.

According to an independent analysis by Harvard Medical School researchers appearing in the August 2012 edition of *Health Affairs*, providers' participation in the contract over two years led to cost savings and quality improvement that steepened in the AQC's second year. For example, AQC groups achieved overall savings of 2.8 percent over two years (1.9 percent in year 1 and 3.3 percent in year 2) compared to spending in nonparticipating groups, driven by shifting procedures, imaging, and tests to facilities with lower fees, as well as reducing utilization among some groups. Quality of care also improved compared to nonparticipants, with chronic care management, adult preventive care, and pediatric care within AQC groups improving more in year 2 than in year 1.

- Blue Shield of California in 2010 partnered with Dignity Health (formerly Catholic Healthcare West) – which operates four Sacramento-area hospitals – and Hill Physicians Medical Group to launch an ACO serving 41,500 CalPERS members. The ACO promised to hold costs flat, with the Plan, physicians, and hospital system sharing in potential savings of exceeding that goal, as well as absorbing the difference if the target was not met. Blue Shield played a major role in assuring providers' success by

sharing timely clinical and case management information and identifying members going outside the ACO for care.

Results include a 15 percent decrease in hospital readmissions; a 15 percent decrease in inpatient hospital stays; a 50 percent decrease in inpatient stays of 20 days or more; a half-day reduction in the average patient length of stay; and an estimated \$15.5 million in overall health care cost savings. The Plan has replicated the ACO model in several additional counties and now covers more than 100,000 members under ACO arrangements.

- Blue Cross and Blue Shield of Illinois (“BCBSIL”) in January 2011 entered a three-year agreement with the 10-hospital Advocate Health Care system under which Advocate significantly limited annual rate increases in return for Advocate having the opportunity to share in savings resulting from care improvements. The contract applies to 420,000 BCBSIL PPO and HMO members who receive care from Advocate and its 2,700 affiliated physicians, who predominately are in small, independent practices. The Plan supports Advocate’s care improvement efforts through monthly performance feedback on quality, costs, and utilization. The Plan also shares updated lists of the BCBSIL attributed members and their care patterns, including concurrent (daily) communication of attributed members who have been hospitalized, enabling Advocate to proactively manage patients’ care. Shareable savings are measured by Advocate’s performance compared with other BCBSIL network providers. In order to receive payments for savings created, Advocate needs to meet a series of specified quality, service, and safety parameters, which must show continuous improvement. Additionally, Advocate faces downside risk if costs are higher than the average network medical cost trend, as well as penalties if there are declines in the quality, service, and safety parameters.

In the first three quarters, the ACO has seen a 4.6 percent decrease in costs versus the market benchmark, with improved clinical outcomes such as lower admission rates.

### **Initiatives to Partner with Clinicians**

To realize value-based health care, realigning incentives is necessary but not sufficient without Plans giving clinicians the individualized support they need to be successful. Plans partner with physicians and other providers by (1) sharing data about a patient's full continuum of care; (2) helping to improve the processes by which care is delivered; (3) enhancing care coordination; and (4) providing powerful health IT capabilities. I have already alluded to some of these efforts, and I would now like to give you more specific examples.

#### *(1) Sharing Data*

Experience has proven the importance of robust, actionable data-sharing between Plans and providers, especially since provider organizations are likely to vary widely in their ability to capture and analyze data independently.

For example, as part of its AQC contracts discussed earlier, BCBSMA distributes practice pattern variation analyses ("PPVA") to physician groups emphasizing unexplained variations in practice patterns that are clinically and financially important. In 2009 and 2010, BCBSMA provided PPVA reports twice a year on more than a dozen conditions across multiple specialties and subspecialties noting physician-specific information on practice tendencies, and allowing comparison to all other physicians within that specialty. The reports allow medical groups and individual clinicians to drill down to patient-level detail in order to truly engage with the information and attempt to understand the underlying reasons for differences in practice patterns.

This value-added data-sharing is augmented with hands-on technical assistance discussed below. Plan-generated data and analytics, for instance, often are foundational to guiding Plan-provider discussions – via e-mail, phone, and at monthly in-person meetings – regarding actionable strategies for improving performance.

## *(2) Improving Health Care Processes*

Making data available in the context of realigned incentives encourages clinicians to identify best practices. However, constraints on time, staffing, and expertise may hold some back without additional coaching and management support that Plans can provide.

For example, as part of its QualityBLUE incentive program, Highmark provides forums for providers to obtain feedback and share best practices, and dedicates consultative resources that provide on-site program guidance. To support QualityBLUE hospital partners, Highmark has formed teams of professionals that include medical technology experts, registered nurses, Certified Infection Control Professionals, speech pathologists, Registered Health Information Administrators, and Certified Professional Healthcare Quality experts, including medical directors, who provide consultative support to hospitals' quality teams and lead an annual "Best Practice Forum."

To support physicians, Highmark has formed the Clinical Quality Consultants (CQCs), a dedicated staff that includes a medical director and clinical pharmacy consultants to provide consultative quality improvement support, education, and training to participating practices. CQC teams evaluate physicians' operations to determine process improvement opportunities, provide feedback and recommendations to improve clinical quality and office operations, and help create and execute work plans; they also provide methods for conducting patient outreach and assistance for identifying opportunities for electronic reminders and alerts.

In 2011, CQCs supported 993 primary care practices, 62 percent of those participating in QualityBLUE. As a result of CQC coaching and support, QualityBLUE participating practices continually improve quality scores. Additionally, CQC-supported practices achieved statistically significant clinical outcomes compared to non-CQC-supported practices on metrics including acute pharyngitis testing, adolescent well care, well child care (3-6 years of age), cervical cancer screening, annual cholesterol screening, and diabetes management.

### *(3) Enhancing Care Coordination*

Plans have learned that a powerful way to improve the quality of care for members with chronic illnesses is to enhance practices' care coordination capabilities. For example, CareFirst contracts with registered nurse Local Care Coordinators that partner with PCMH practices to help assure patient follow-through on the provider-directed care plan.

Nurse-led teams can include privately practicing allied professionals such as home care agencies, hospital affiliated care coordinators, and other community-based providers (e.g., pharmacists, therapists, and mental health professionals) specifically assigned and available to work with each PCMH to aid in the completion and implementation of care plans for chronically ill members.

The Local Care Coordinator helps coordinate patients' care transitions – such as following up on specialist referrals, assuring coordination after hospital discharge or an ER visit, and conducting medication reconciliation with the appropriate pharmacist. In addition, the Local Care Coordinator works closely with the PCP, including making office visits to discuss patients' care plans, and provides regular web-based updates to a record available to the entire care team.

Recognizing the potential impediments to a PCMH-based approach caused by personnel shortages, Horizon Blue Cross and Blue Shield of New Jersey has gone to the next level by partnering with Duke and Rutgers Universities to train at least 200 nurses over the next two

years to be practice-based population care coordinators in PCMHs and other settings. The first-of-its-kind nurse training curriculum recognizes the workforce enhancement necessary to enable a state-wide expansion of PCMHs and includes modules on complex patient management, care coordination, patient communication strategies, and disease registry and EHR use.

*(4) Providing Health IT*

Plans are helping providers adopt and make powerful use of health IT tools such as electronic prescribing and EHRs.

For example, since 2005, Blue Cross and Blue Shield of Rhode Island (“BCBSRI”) has been implementing programs to assist and encourage PCPs to adopt multifunctional EHR systems in their offices. The Plan currently offers two EHR Incentive Programs, including enhanced reimbursement to providers who have met Stage 1 criteria under CMS’s Medicare and Medicaid EHR Incentive Program for the “meaningful use” of certified EHRs.

Additionally, the Plan provides incentives for EHR adoption through its current PCMH initiative, which also includes bonus payments based on mutually agreed-upon quality measures ranging from immunization rates to blood pressure control. To date, nearly 500 PCPs have participated in the BCBSRI EHR Incentive Programs. All of these providers have fully implemented EHRs in their practices.

Blue Cross and Blue Shield of North Dakota has created a statewide health information and care coordination technology platform with embedded decision support that is available to the 80 percent of primary care providers in the state who are in the Plan’s PCMH initiative (MediQhome).

Providers send their electronic patient data, such as progress notes, procedure reports, lab test results, and discharge summaries, to the Plan’s technology platform (run by MDdatacor) on a daily or weekly basis through a secure Internet connection. MDdatacor quantifies the data and

creates reports for physician practices that identify potential gaps in care and opportunities to improve adherence to best practices.

### **Initiatives to Engage Patients**

Because none of these innovations would succeed without patient engagement, Plans are prioritizing new transparency tools that help patients make informed decisions about the relative quality and efficiency of network providers; creating tiered benefit designs that encourage patients to seek care from high-quality providers; and providing members with tools and resources to improve their health and wellness.

#### *Transparency Tools*

The Blue System engages consumers with actionable data and tools that enable them to make the most informed decisions for their health care needs.

- BCBSA's online National Consumer Cost Tool, available to all Plans, lets members obtain information on total estimated costs – and soon an estimate of out-of-pocket liability – for 100+ of the most commonly billed elective procedures for hospitals, ambulatory surgery centers, and free-standing radiology centers in nearly every U.S. ZIP code.
- The Physician Quality Measurement program displays physician performance measures to assist members in selecting a provider. Through the Blue National Doctor and Hospital Finder, members view physicians' performance and local comparison scores for a core set of National Quality Forum-endorsed HEDIS<sup>®</sup> Physician Quality of Care measures.
- The Blue Physician Recognition Program identifies physicians, groups, or practices who have demonstrated their commitment to delivering quality and patient-centered care by

currently participating in national, regional, or local quality improvement or recognition programs such as the National Committee for Quality Assurance PCMH recognition program.

- BCBSA's Patient Review of Physicians is a member tool for reading and writing reviews of physicians and professional providers nationwide based on a standard methodology.
- Plans offer personal health records ("PHRs") to their members. BCBSA recently collaborated with several professional specialty societies to roll out an informational tool showing consumers how they can use PHRs to store vital health information in one convenient and secure place, empowering them to take a more active role in coordinating their own care.

### *Tiered Benefit Designs*

Plans are working to tier physicians and facilities based on a transparent, statistically rigorous methodology incorporating *both* quality and cost metrics so members have incentives to seek out those providing the best care.

Tiering is a key driver of consumer engagement – especially when paired with robust transparency tools – because this gives consumers tools and incentives for seeking high-quality, affordable care while sensitizing them to the cost of care.

In a typical benefit arrangement, Plans place providers into two or three benefit tiers based on how they score on nationally accepted quality benchmarks and costs. Members' cost sharing is based on the tier status of the provider they see, which encourages members to consider the quality and cost of their provider each time they get care.

This also harnesses consumer behavior to encourage providers to move toward greater value. For example, some Plans' tiered networks evaluate providers' rates of potentially avoidable complications; achieving higher performance can qualify providers for a more favorable tier.

Good data is essential to tiering. Plans are able to take advantage of industry-leading health informatics from Blue Health Intelligence ("BHI"), which accesses a database of claims data from more than 110 million individuals nationwide, collected over seven years.

For example, BHI collaborated with Independence Blue Cross (PA) to determine the best-performing facilities in bariatric surgery. Looking at three years of data, BHI analyzed potentially avoidable complications at 214 facilities, identifying the rate, cost, and type of complications associated with the bariatric surgery episodes of care. BHI identified that southeastern Pennsylvania's Crozer-Chester Medical Center has a truly extraordinarily low complication rate for bariatric surgery – just 0.04 percent compared to a nationwide average of 6.7 percent – designating Crozer as a best-in-class provider in this specialty.

The analytics enabled by resources like BHI help to transform the health care system by delivering data-driven information about health care trends and best practices, resulting in healthier lives and affordable access to safe and effective care.

#### *Blue Distinction Centers for Specialty Care<sup>®</sup>*

BCBSA's Blue Distinction Centers ("BDCs") for Specialty Care<sup>®</sup> is a national initiative that empowers and encourages consumers to seek out the best providers for their needs. BDCs are facilities recognized by Plans for distinguished care in bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery, or transplants. The designation process considers total value measures (quality metrics established in collaboration with expert clinicians and leading professional organizations, cost, and access). Plans may use benefit differentials to incent members' use of BDCs. Research shows that BDCs outperform their

peers on quality (e.g., 21 percent lower readmission rate for cardiac bypass procedures for a BDC vs. non-BDC).

### *Health and Wellness*

Plans are committed to helping members lead healthier lives. To do this, they are using a dual strategy: keep people healthy to prevent the onset of disease, and effectively coordinate care for those with chronic conditions.

Both of these approaches rely on empowering patients with information and tools to support healthier lifestyles, which is crucial to curbing health care cost growth. Both also involve helping people understand that they play a vital role in their own health care.

Examples include:

- Blue Cross and Blue Shield of Hawaii supports self-monitoring of blood glucose (SMBG) to help address gaps in diabetes care. It launched an educational program to promote regular monitoring that increased SMBG compliance 58.1 percent to 67.8 percent among Medicare members, and 67.5 percent to 75.6 percent among commercial members.
- Louisiana 2 Step is Blue Cross and Blue Shield of Louisiana's flagship free health and wellness program available to both members and non-members. Participants have access to an interactive website featuring healthy food recommendations, activity and walking logs, weight tracker, calorie counter, and personal virtual coach.
- Blue Cross and Blue Shield of Kansas City's A Healthier You is emblematic of many Plan workplace wellness programs that engage employees in positive behavior change to improve their health status and avoid the impact of chronic disease. A mix of

incentive programs, lifestyle coaching, and webinar and onsite health education classes have reduced the medical trend by more than 30 percent.

- Blue Cross of Idaho Health Service provides one-on-one nurse health coaching and outreach to members who visit the ER or receive inpatient services due to congestive heart failure. By using a team-based and patient-centered approach, the program helps ensure that members take the correct medications and receive the necessary screenings and follow-up care. The Plan gives biometric monitoring equipment to high-risk members with congestive heart failure, enabling them to report their conditions from home. The program collectively achieved more than \$1 million in medical claims cost savings in a single year while empowering patients to take a more active role in managing their own health.

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## **LESSONS LEARNED**

I would like to conclude with some lessons learned from Plans' experience that can inform efforts to transform Medicare. BCBSA believes there is a compelling opportunity to accelerate Medicare's adoption of private-sector innovations, which would not only help transform Medicare's payment approach, but also align public and private initiatives so providers have a clear set of incentives for providing high-quality, affordable care.

Chief among our lessons learned is that no single reform will, by itself, transform the health care system. Achieving tomorrow's value-based health care system will require a multi-faceted approach using all of the strategies I've outlined: changing payment incentives, partnering with clinicians to transform care, and engaging patients.

Second, while wide-scale implementation is imperative, we must not lose sight of the importance of local flexibility – built on a foundation of core, cross-cutting principles such as

being collaborative and transparent with providers. Provider configurations and readiness to transform vary widely across the country, and require that payment approaches and technical assistance be adapted to fit local delivery system conditions. This assures that payers can meet practices “where they are,” rather than attempting to overlay a one-size-fits-all solution that may not be workable locally.

Finally, the time is ripe to accelerate the pace of reform for Medicare. We now have a substantial and growing body of private-sector experience with innovations such as PCMHs that support wide-scale implementation in both public and private programs. We are pleased that Plans are participating in CMS pilots to test varying approaches to fostering PCMH-like care delivery models and urge that successful approaches be expanded rapidly beyond pilot markets.

As you can see, Plans have a full slate of initiatives underway that have lessons for Medicare. However, sustaining and building on these early successes will require a continuously evolving approach of fine-tuning existing strategies while implementing new ones. We cannot do it alone. A collaborative approach is imperative, and we need the government aligning with what works in the private sector to really move the needle.

I appreciate the opportunity to share Blue Plans’ innovations today and look forward to your questions.