

**Testimony of Chet Burrell**

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**Chronic Illness: Addressing Patients' Unmet Needs**

**Senate Committee on Finance**

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Good morning Chairman Wyden, Ranking Member Hatch, and members of the Committee. I am pleased to be here to offer a payer's perspective on strategies to address the unmet needs of patients with multiple chronic conditions.

I would start by saying that chronic conditions are conditions that last a year or more and require ongoing attention. They often limit activities of daily living. They include both physical conditions such as arthritis, cancer, and HIV infection, as well as mental and cognitive disorders, such as ongoing depression, substance addiction, and dementia – often mingled together.

One in four Americans – including one in 15 children and two of three people covered by Medicare – have more than one chronic condition. Chronic conditions often occur in clusters – obesity mixed with hypertension, cardiovascular disease, diabetes, osteoarthritis – compounding the risk of costly breakdowns in health.

These diseases are progressive, typically lifelong and involve multiple specialists with a primary care physician often playing a supporting role. Many people with multiple chronic diseases take 10 or more prescription drugs. It is not uncommon to see people in the under 65 population that we principally serve with 20 or more prescriptions. In the Medicare population, this is even more pronounced.

Since this population also exhibits higher rates of depression and other behavioral health challenges than the rest of the population, we often see non-compliance with medications and other requirements of good care, worsening the chronic diseases involved and deepening the inclination toward depression. This leads, in turn, to a cycle of admission, readmissions and repeated emergency room visits.

A key challenge is that the specialists who treat chronic conditions typically operate in unrelated practices with little or no communication among them. This fragmentation often leads to breakdowns even when each specialist is effectively diagnosing and treating his/her portion of the patient's needs.

Thus, even if each of the specialists is providing outstanding care, the net effect is an uncoordinated jumble of medications and confusing instructions with no one to sort it out. No longitudinal view of the patient's care across settings and over time is ever created and a guide or navigator through the complex health care system is often lacking. If the patient has a primary care physician, they are generally not aware when their patients are hospitalized or when and which specialists see them, making it impossible for them to intervene in a timely way and break the cycle.

The question before us - a great societal problem of our time - is how can we correct the fractured, uncoordinated system I have just described. We have extensive experience with this given that we are now in the fourth year of one of the largest patient centered medical home programs in the country, serving over one million people through over 4,000 primary care providers – all in accordance with one common financial and quality model. After three years of experience, our program has accounted for \$267 million in avoided costs, a 6.4% reduction in hospital admissions, an 8.1% reduction in all-cause readmissions, and improvements in other quality measures. Given national trends downward over the last few years, it would be unfair to attribute these shifts solely to our program, but we believe the PCMH program has had a significantly contributory effect. Here's what we think is working.

Our central focus in this program is to deal more effectively with those who have multiple chronic diseases, who constitute about 10 percent of our subscriber membership and who consume more than a third of all the health care spending we carry out each year. If one were to include those with acute exacerbations of chronic disease and those at high risk for future breakdown, one could safely say that about one quarter of the total number of the 3.4 million people we serve in the greater DC, Maryland and Northern Virginia region consume the clear majority of the nearly \$8 billion in health care spending we incur every year.

The first step toward an effective approach is to accurately identify the people with multiple chronic diseases. We do this based on the comprehensive, detailed claims data we have on each service rendered to each of our members across all care settings over time. To this extensive data, we apply advanced analytical software that can reliably profile those with chronic diseases and conditions. So, this identification process is a critical first step.

Second, we work with an identified chronic care member's primary care physician in our PCMH Program (over 80 percent of PCPs are in the program) to determine if a formal, detailed care plan is called for. If so, a plan is developed by a qualified Registered Nurse who works closely with the PCP and the various specialists involved. The care plan addresses all the pharmacy, behavioral health and medical services needed. The care plan creates a holistic picture of the patient's needs. It is finalized in consultation with and under the direction of the member's PCP. This year, we will complete over 10,000 such plans for people with multiple chronic conditions. We will do 30,000 additional care plans where the conditions involved have reached a more extreme or acute expression. As a result, through the stabilization these plans and their support

provides, we are seeing double digit declines in admission, readmission and ER visit rates for this population.

Third, all care plans are maintained daily and are contained in a single, online system that tracks the care delivered over time and that shows the progress of the patient – or lack thereof. All treating providers, including those providing behavioral health, pharmacy or social services, can see this longitudinal member health record with a few clicks over the web. It also includes a complete pharmacy reconciliation.

Fourth, we have found we had to create a more on-demand capability to offer a majority of the services needed in the home or the community – not in a hospital. The goal is to keep the patient stable at home, using community-based services that are often, themselves, fragmented and under-resourced and un-coordinated.

Fifth, we provided strong financial incentives and rewards to PCPs to allow them to differentially focus on the care of the multi-chronic patient and to encourage them to actively follow these patients carefully through all the care settings and services they receive at the direction of specialists.

At every turn, we have found that we are confronted by the limits in law, rule, policy and custom that thwart the doing of these common sense things, which limit access to needed ongoing services and lead to new levels of noncompliance. For example, Medicare payment rules often do not cover the cost of developing and maintaining care plans. There are limits placed on the circumstances and duration of home based services and so on. We are undertaking a listing of all in current law, rule and policy that thwarts the ability to effectuate the five common sense programmatic elements above.

Historically, Medicare has provided no incentives or additional compensation to PCPs to do the very things that most lead to better outcomes, and we are now participating in a pilot program with Medicare to see if these can be overcome. And, it's not just Medicare. The parts of the tax code governing Health Savings Accounts – the use of which is growing rapidly – do not allow private insurers to provide first-dollar coverage for things to prevent the worsening of chronic disease. We can waive cost-sharing for your ACE inhibitor after you have a heart attack, but not when your doctor is trying to prevent a heart attack.

We have found that primary care providers are eager to take on more of a role in the management of the chronic patient when they fairly compensated for it. We have also found that they respond to financial incentives for achieving better overall outcomes. We have found that they are very focused on understanding gaps in the care of their chronic patients and, in general, are extremely interested in how they are doing on a variety of quality measures. But, we have also found they need extensive supports in data systems, nursing, access to ancillary services such as behavioral health services that we have provided for them. And, they need help in seeing

and assessing with a chronic patient's specialty care givers, the sheer array of drugs their patients are on.

Getting this right based on the experience emerging from models such as ours is critical if we wish to achieve better outcomes and sustained cost restraint.

What I have described is the essence of the CareFirst model. We restructure the care coordination paradigm by setting up the PCP as the quarterback of a patient care team. We equip them with tools to deliver patient-centered care coordination including nursing support and 24/7 access to data, reward them and incentivize patients to further encourage behaviors that promote enhanced quality and a more disciplined stewardship of referrals and other medical services. This is the basis upon which we believe our program has seen its early success. For the third year in a row we have seen costs substantially lower than projected with improvements on key quality measures. And while it is early still in our implementation, we have high expectations for greater, continued quality improvements and savings in the future.

Over the long term, a greater focus on wellness as a sustained, lifelong practice for all Americans is sorely needed and we have placing great emphasis on this with the subscribers we serve. In the meantime, there is much to be done to achieve better cost and quality outcomes for those with chronic diseases or conditions and for those who are at elevated risk of contracting them.

I would be pleased to take any questions you may have or to expand on any aspect of my testimony if you wish me to do so.