STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Blue Cross and Blue Shield Vermont	)	
3Q 2018 Large Group Rating Program Filing	)	GMCB-03-18-rr
	)	
and	)	
	)	
In re: The Vermont Health Plan, LLC	)	
3rd Q 2018 Large Group Rating Program Filing	)	GMCB-04-18-rr

Blue Cross and Blue Shield of Vermont's Reply Memorandum

While Blue Cross and Blue Shield of Vermont (BCBSVT) disagrees with the arguments put forth by the Health Care Advocate (HCA) in its May 31, 2018 Memorandum and believes that our filing speaks for itself, we address for the record a material inaccuracy in the HCA's characterization of our cost containment efforts for the Large Group insured line of business. We have repeatedly provided information to the Board on our robust cost containment programs within the specific context of rate filings as well as in other contexts, to many of which the HCA has been privy. We are doing excellent, timely, cost effective work and are pleased to reiterate the information in this Reply.

BCBSVT remains a leader in developing and deploying value based reimbursement programs moving providers from the traditional model to comprehensive, and at times risk-based, financial programs. Moreover, BCBSVT's care management programs have a long track record of success in containing costs while supporting our members so that they receive the most cost effective care at the right place, in the right amount and at the right time. We continually assess our value based reimbursement and care management programs and evolve them to improve their impact and maximize the value of our network providers and community resources.

I. Value Based Reimbursement

For years, BCBSVT arrangements with providers have included hospital diagnosis-related groups (DRGs) and per diem payments that provide consistent reimbursements for care and caps to the total cost of care. To ensure such payment limits do not compromise the quality of care, our integrated health and quality departments oversee and ensure that care is not being withheld. Moving from fee-for-service to value based reimbursement, BCBSVT continually collaborates with providers, and often State and Federal administrations, deploying value based programs

challenging BCBSVT and network providers to improve quality and reduce the cost of care for our members. As the Board knows, BCBSVT has led all commercial providers in the state as the only commercial payer for outpatient case rates (e.g. colonoscopy standard rates), and as the first payer reimbursing for Medication Assisted Treatment (Hub) programs.

Our commitment to advancing payment and delivery system reforms through provider collaboration remains focused on a varied set of initiatives from ACO contracts to condition-specific programs. Through a number of value-based programs with providers, we continue to focus on providing better care to our members, improving access if needed, and controlling medical spend. On behalf of our members and groups, BCBSVT has collaborated with network providers to implement the following programs that are currently extended to the Large Group insured line of business.

A. Mental Health/Substance Abuse-Focused Programs (FIT and SBIRT; Hub and Spoke)

- SBIRT
- FIT
- Hub and Spoke
- Other programs

See Appendix A for a high level descriptions of SBIRT, FIT and Hub and Spoke programs; Appendix B for Summary of SBIRT, FIT and Blueprint Participation and Costs; Appendix C for FIT Program Results

B. Accountable Care Organizations, Episode of Care and Case Rate Pilots

Meanwhile, BCBSVT has led all commercial providers in the state being the only commercial payer participating with Vermont's ACOs. While this program does not currently extend to insured Large Groups, we are currently in discussions with OneCare Vermont regarding the potential expansion of the program to include the Large Group insured line of business. We are also looking to expand the episode of care and case rate pilots to insured Large Groups as well. See Appendix D for a Description of ACO Program and Pilots; See Appendix E for Summary of Participation and Costs for ACO and Pilots.

- ACO Shared Savings/Shared Risk Program
- Episode of Care Knee or Hip Replacement Pilot
- Outpatient Case Rate Pilot

II. Care Management

Care Management is the overarching umbrella for all cost containment programs within the clinical departments of BCBSVT. This includes utilization management programs within pharmacy, advanced imaging, medical services, chronic condition disease management (prevalent and rare), and focused case management for complex and catastrophic cases. More detail on the following care management programs (whose results are reflected in our filings) are described in Appendix F.

- Utilization Management
  - Pharmacy
  - Radiology Appropriate Use Program
  - Integrated Medical and MH/SA Utilization Management Programs
- Chronic Condition Disease Management
  - Prevalent Chronic Condition management
  - Rare condition disease and case management
- Case Management
  - Whole person integrated medical and mental health substance abuse high utilization and high cost case management program
  - Better Beginnings perinatal support and care management program
  - End of Life program

Prescription drug programs alone saved nearly $2 million for Large Group insured customers in 2017. The medical programs contributed an additional $2 million of savings for Large Group insured customers through appropriate utilization. The impact of these programs are implicitly included in both the base claims data and the calculation of utilization trend. Much of the utilization increase is in preventive visits and appropriate care.

Our assessment of the drivers of potentially unnecessary utilization increases have led us to examine treatment patterns in ER and outpatient procedures, specialty pharmacy and more specifically in the areas of musculoskeletal disease, medical specialty pharmacy infusion site of care, cardiovascular disease, GI endoscopy as well as mental health and substance abuse.

As the Board knows, it takes several budget cycles to build and implement new utilization management programs, and for these programs to have an impact on care delivery. Programs are currently in development to mitigate ER use (utilization in Vermont is well above regional benchmarks) and outpatient surgical/facility procedures. We have recently expanded several programs listed below. See Appendix G for more detail on Prior Programs Expansions.

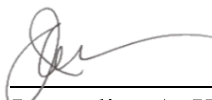
- Specialty pharmacy
- Cardiovascular Disease
- Mental Health and Substance Abuse
- Emergency Room Use including Telehealth
- Case and Disease Management

Far from "paying lip service to cost containment and affordability," as the HCA tries to suggest, BCBSVT continues to pursue our vision of a transformed healthcare system in which every Vermonter has health care coverage, and receives timely, effective, affordable care. We remain a leader in developing and deploying value based reimbursement programs while continually evolving our care management programs to contain costs while supporting our members so that they receive the most cost effective care at the right place, in the right amount and at the right time.

All of these value based reimbursement and care management programs are reflected in our premiums in two ways: they reduce the experience base on which the manual rate, as well as actual group-specific experience, is based; and they limit health care cost and utilization trend. We project trend rates forward using historic experience, so we are effectively assuming that all of these programs will continue to dampen future trend just as they have dampened past experience. Without these programs, current premiums for Large Groups would be significantly higher.

BCBSVT has fully justified and supported the rate factors before the Board as evidenced by the recommendations of the Board's own actuarial consultant and the Commissioner of Department of Financial Regulation's solvency opinion. There is no evidence in the record that would justify reducing the requested rates especially in view of the oversights made by L&E on utilization trend and pharmacy trend. Therefore, BCBSVT asks that the Board approve the filing, without modification.

Dated at Berlin, Vermont, this 5th day of June, 2018.



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APPENDIX A

Mental Health/Substance Abuse-Focused Programs (FIT and SBIRT; Hub and Spoke)

- **SBIRT**: BCBSVT is the only commercial payer collaborating with the Vermont Department of Health to expand the number of providers trained and utilizing SBIRT, a federally funded treatment method. We support the required training of these providers and reimburse for such services, which is increasing access to evaluation by our members. Additionally, we track the outcome of the program in collaboration with the State. Today, these practices impact the lives of 5,000 members.
- **FIT**: The FIT program is a SAMHSA-recognized best practice using real-time feedback from clients to better inform the process of therapy. FIT is proven to reduce drop-out rates and improve client satisfaction and outcomes while reducing unnecessary treatment. We provided training to 110 clinicians who took part in the two-day workshop. From this group, 70 clinicians were recruited into the first phase of implementation. The implementation phase included consultation groups, data collection on outcomes, and participation in a learning collaborative to reinforce accomplishments. Currently, these 70 clinicians care for 1,114 of our members. Following the initial phase of data collection, we continue to evaluate new reimbursement mechanisms that can support and expand the program. Providers who participated in our FIT program have three to four fewer visits per patient and significantly reduced patient emergency room usage. See Appendix C for Summary Chart.
- **Hub and Spoke**: We are the first health plan to fully engage with the State of Vermont's Hub and Spoke system of care treating opioid addiction. The program reimburses providers a monthly bundled rate—requiring only one co-payment from members—reducing previous barriers to care. The programs allow the VCC and us to integrate mental health, social, and medical services into one program. Clinicians and our care coordinators focus on the connections between detoxification, initiation of treatment with Suboxone, and referral to primary care for ongoing treatment. The results are positive for members regarding readmission rates and use of non-planned emergency department services.
- **Other programs**: Not resting on our successes, BCBSVT is currently collaborating with network providers on a number of other programs that will be assessed during their pilot stage for rollout to the Large Group insured line of business. These take time to do right.

APPENDIX B – SBIRT, FIT, Blueprint Summary Chart.

Program	Year	BCBSVT Members	Impacted Providers	Overall cost of care associated the program	% of Total BCBSVT Medical Cost	% of Membership (BCBSVT Members)
FIT	2016	1336	61	$913,811	0.09%	0.76%
	2017	1665	71	$1,122,488	0.10%	0.93%
SBIRT	2016	46	45	$2,318	0.00%	0.03%
	2017	31	45	$949	0.00%	0.02%
Blueprint	2016	118785	1033	$8,617,296	0.82%	67.27%
	2017	115908	923	$8,618,644	0.79%	64.95%

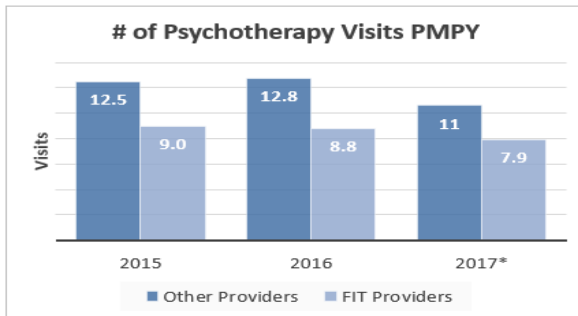
APPENDIX C Feedback Informed Treatment (FIT) Program Results

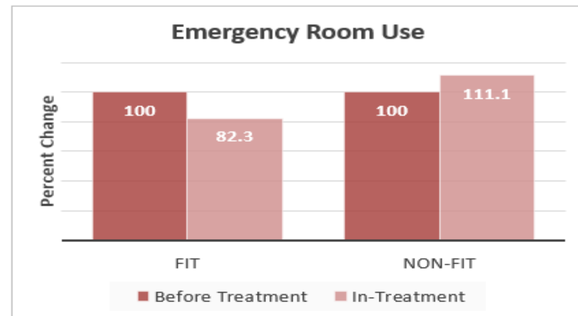
Blue Cross and Blue Shield Programs Are Designed to Reduce Barriers to Routine Evidence-Based Practice

Feedback Informed Treatment (FIT)

OBSERVATIONS

- Providers using the FIT program have 3-4 fewer visits per patient
- Providers using the FIT program show impact on reducing emergency room use





2017* - January-September

BlueCross BlueShield of Vermont

Appendix D ACO Program and Pilot Descriptions

1. ACO Shared Savings/Shared Risk Program

BCBSVT continues to be a key stakeholder in Vermont's healthcare reform initiatives. As the only commercial payer participating in Vermont's ACO shared savings pilot, we work closely with the ACOs and Green Mountain Care Board, establishing the framework necessary to move providers to risk-based contracts. In 2018, we implemented the state's first commercial ACO shared risk contract with OneCare Vermont covering approximately 21,000 BCBSVT lives.

Moving from a shared savings contract to a risk-based ACO contract for the first time provides the financial alignment between premiums paid by BCSBVT members and employers and medical care reimbursement. Our contract with OneCare requires shared risk for any medical cost in excess of the expected cost of the care for its population. Sharing of risk provides a new forum for BCSBVT and OneCare to work together, focusing not only on ensuring high-quality care but on the core components driving increased cost of medical care.

As providers accept risk and share in savings, they engage more in managing the risk, resulting in new community-based care coordination programs, continuous review of utilization of services, and deployment of condition-specific pilots. In our collaboration with OneCare, we remain the subject matter expert in data exchange, actuarial modeling, and group-level analytics. In exchange, we receive clinical data enhancing reporting and analytics capability. More importantly we expand our ability to provide community-level care coordination leveraging the expertise of our care coordinators and provider-based care coordinators.

2. Episode of Care Knee or Hip Replacement Pilot

In the third year of our episode of care knee or hip replacement pilot with UVMMC, self-insured groups experienced savings averaging $2,000 per case. With demonstrated savings and continued increase in orthopedic spend, we are approaching other facilities besides UVMMC to expand the pilot model. We expect to link future bundle rates to outcomes performance and outreach/care coordination with community providers.

3. Outpatient Case Rate Pilot

BCBSVT and Northwestern Medical Center collaborated to develop the first outpatient procedure case rate focusing on colonoscopies. Together, we modeled and developed the first colonoscopy case rate program in Vermont, directly addressing the need for consistent pricing for high-volume services and linkage to outcome results. In addition to being a standard rate for facility services, our organizations agreed to a lower cost for the procedure and redirect a portion of the money to preventive and wellness services. Assuming the pilot meets expectations, we will deploy this program to additional facilities in 2019 and 2020 and expand the number of case rate services.

APPENDIX E Summary of Participation and Costs for ACO Program and Pilots

Program	Year	BCBS VT Mem bers	Impacted Providers	Overall cost of care associated the program	% of Total BCBSVT Medical Cost	% of Membership (BCBSVT Members)
ACO	2017	37871	1057	$141,526,379	13.02%	21.22%
	2018 projected	21000	603	$98,643,081	9.08%	11.77%
Episode of Care Pilot	2017	13	3	$513,316	0.05%	0.01%
Northwestern Case Rate (projected 2018)	2018 projected	568	4	$710,000.00	0.07%	0.32%

APPENDIX F Care Management Programs

a. Utilization Management

Pharmacy:

i. Step therapy encouraging appropriate use of generics and formulary therapies.
ii. Quantity limits encouraging regular follow-up with prescribing providers and adherence with care.
iii. Prior authorizations using industry standard appropriate use criteria guiding members towards more well proven therapies before the use of emerging and potentially less effective and not well proven therapies.
iv. RationalMed pharmacy safety program which makes use of integrated medical and pharmacy claim data to provide drug-drug and drug-condition interaction warning to pharmacists prior to a drug being dispensed.
v. Specialty Pharmacy Care Value programs which provide reimbursement for failed starts and indication based pricing models to help to contain the cost of specialty medications.
vi. Opportunities exist for clients to “lock in” to one specialty pharmacy to reduce cost and/or elect a “home infusion” program to move the site of care from outpatient facility to home based therapy for a portion of patients receiving specialty medication infusions.

Radiology Appropriate Use Program:

i. Prior Approval utilization management program for advanced and cardiology imaging which directs care to the most appropriate technologies for a given patient using industry standard appropriate use criteria.

Integrated Medical and MH/SA Utilization Management Programs:

i. Using >200 industry standard appropriate use medical policies to guide medical management to the most effective care plan for an individual through prior approval program (includes advanced and emerging procedures, outpatient surgery, sleep medicine, DME, out-of-network access and others
ii. Working with medial facilities help to guide patients through transitions in care from inpatient to outpatient settings, as well as alternate sites of care for mental health and substance abuse such as partial hospitalizations, to ensure appropriate and safe discharge plans and to avoid readmissions
iii. Manage medical pharmacy utilization within outpatient offices and facilities using industry standard pharmacy policies.

b. Chronic Condition Disease Management
- Prevalent Chronic Condition management program – disease education, self-management and care plan adherence support for members with common chronic diseases such as diabetes and asthma.
- Rare condition disease and case management working with Accordant Health Care a national case management vendor with subject matter expertise in rare disease.

c. Case Management
- Whole person integrated medical and mental health substance abuse high utilization and high cost case management program using retrospective and predictive identification working closely with our providers and community support systems.

i. Includes complex and catastrophic conditions such as cancer care, multiple chronic diseases with complications, advanced and complex musculoskeletal care and recovery s/p catastrophic events such as trauma.
ii. Focuses specifically on addressing social determinants of health and removing barriers to patient/member adherence to treatment plans, such as financial, social, psychosocial and health system related barriers

- Better Beginnings perinatal support and care management program.
- End of Life program – care management for patients receiving palliative or hospice care.

APPENDIX G Prior Programs Expansions

a) Specialty pharmacy
- We are focused, with our PBM, on the best price points available in the market and reduction of the impact of price inflation of specialty drugs
- We have instituted innovative indication based pricing for certain classes of specialty drugs, again with our PBM ESI, to leverage pricing by clinical utility with the pharmaceutical companies
- We obtain credits for "failed starts" or specialty medications which members dis-continue due to side effects or complications. For example 50% of members starting a multiple sclerosis medication discontinue it within the first few months of use.

- We have a full time pharmacist who travels the state and “details” our network providers on new programs, adverse prescribing trends and clinically appropriate alternatives to higher cost pharmaceuticals. This detailing initiative has been well received by our network providers.

b) Cardiovascular Disease
- We are working with our members to improve engagement with our disease management programs and our cardiac rehab program which have proven value to modulate adverse utilization.

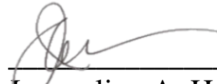
c) Mental Health and Substance Abuse
- Through our partnership with Brattleboro Retreat, Vermont Collaborative Care, we have integrated a whole person approach to our case and utilization management programs through integrated resources which include focused clinical expertise in the areas of mental health and substance abuse. Through this and components of the program, we have significantly driven down inpatient and ER utilization and increased outpatient ongoing care with a mental health and substance abuse provider. As noted above, we support the state Hub and Spoke program through innovative care management and payment programs as well as eliminating benefit based barriers to care for our members. We will continue to expand this work.

d) Emergency Room Use
- Member education through our “Know Before You Go” campaign providing examples of alternative sites of care for less complex acute conditions such as primary care urgent visits, urgent care visits and telemedicine.
- Roll out of our Telehealth for minor acute care issues through the American Well program filling the access gaps that many of our members face in seeing their primary care providers when they need care for urgent issues.
- 2019 Implementation of new technologies providing real time notification of admission, transfers and discharge information enabling timely care management support for members who either frequently utilize the ER or utilize it for potentially avoidable visits where an alternate site of care may be more appropriate.

e) Case and Disease Management
- Implementation of a new mobile care management app which extends the opportunity for communication and engagement with our members meeting their needs through multiple channels.
- After one-on-one engagement, this provides the capability for asynchronous communication such as texting as well as broad disease education resources and customized materials to our members whenever and wherever they need it.
- This will expand the efficiency and reach of our staff without the need to expand personnel while improving the effectiveness of our care management interventions.

CERTIFICATE OF SERVICE

I hereby certify that a copy of this Reply Memorandum of Law has been duly served upon Judith Henkin, General Counsel to the Green Mountain Care Board, and Kaili Kuiper and Eric Schultheis, Office of Vermont Health Advocate, by electronic mail, return receipt requested, this 5th day of June, 2018.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