

# Early Retiree Reinsurance Program: Health Management Program Summary

Blue Cross & Blue Shield of Rhode Island (BCBSRI) has strategies in place to address the needs and improve the health for members across the health care continuum. These programs reach both members with complex and high cost conditions, and those with single chronic conditions. The list below identifies conditions addressed by BCBSRI's programs. These programs have either generated or have the potential to generate cost savings with respect to those populations. These chronic conditions typically incur \$15,000 dollars or more in annual medical expense, as identified by evidence based medicine literature, assessments by health management subject matter experts, and claims analysis to determine annual medical expense. BCBSRI's integrated approach uses multiple channels of communication to improve the health outcome of members. We also have established multi-disciplinary teams for those members who require one on one interaction.

## Management of Complex High Cost Members

Four key components of the program include:

1. Member identification and outreach
2. Personal plan development, management and communication
3. Compliance tracking and incentives
4. Measurement

### 1. Member Identification and Outreach

Chronic and complex conditions include but are not limited to the following:

|                                   |                      |
|-----------------------------------|----------------------|
| AIDS/HIV                          | Heart Disease        |
| Alcohol/Drug Abuse                | Hemophilia           |
| Alzheimer's / Dementia            | Hepatitis            |
| Asthma                            | High Blood Pressure  |
| Cancer                            | High Cholesterol     |
| Chronic Pancreatitis              | Kidney Disease       |
| Chronic Thyroid                   | Liver Cirrhosis      |
| Clinical Depression               | Low Back Pain        |
| Cystic Fibrosis                   | Mental Illness       |
| Diabetes                          | Migraine             |
| Emphysema                         | Multiple Sclerosis   |
| End Stage Renal Disease           | Osteoarthritis       |
| Epilepsy                          | Pulmonary Disease    |
| Gaucher's Disease / Fabry Disease | Rheumatoid Arthritis |
| Heart / Liver / Kidney Transplant | Sickle Cell Anemia   |
| Heart Attack                      | Stroke               |

Members with these conditions are identified through:

- Claims data
- Current medical events
- Request for authorization of services
- Personal Health Assessment responses
- Direct referrals from a provider or member

All members are referred to care coordination. Our Care Coordinators, who are also nurses, social workers or dietitians, reach out to the members to engage them to participate in the care coordination program. Our Care Coordination program engages members telephonically and/or face-to-face and develops a plan of care specific to the member's individualized needs, in collaboration with their provider.

## **2. Personal Plan Development, Management and Communication**

Once the member has enrolled, the Care Coordinator then creates a Personal Plan. To do this, he or she:

- Reviews the member's available medical history
- Conducts an initial assessment to determine the members' needs
- Collaborates with the members' providers
- Establishes member goals

The Care Coordinator then manages the plan with the member through robust communications and interventions. The Care Coordinator will utilize available community resources, help the member navigate the healthcare system, work closely with the members' family and advocates for the member.

## **3. Compliance Tracking and Incentives**

A key component of the program is tracking progress toward achievement of goals established in the personal plan, communication with the provider, and for some members, the use of financial incentives to motivate members to achieve the goals established in the personal plan.

## **4. Measurement**

Outcome measurements are specific to the individual member and may include:

- Compliance with a medication regime
- Participating in a smoking cessation program
- Scheduling an appointment with a nutritionist
- Completing recommended preventive screenings

In addition, outcomes are measured at the population level to track inpatient and emergency room trends.

## **Prevention and Disease Management**

With the help of our Disease Management programs, thousands of members each year learn how to maintain and improve their health. BCBSRI provides multi-channel, population-based disease management programs for members with:

- Diabetes
- Asthma
- Congestive heart failure
- Coronary artery disease
- Lower back pain
- Chronic obstructive pulmonary disease

BCBSRI uses preventive health activities to remind members about the importance of regular checkups and well-visits, age appropriate immunizations, and screenings. We also encourage them to schedule these services as appropriate. Preventive health activities include educational mailings and/ or telephonic reminder calls to the home.

The objective of our disease management programs and prevention activities is to close gaps in care and to prevent members from becoming complex patients. We analyze condition specific outcome data to track the member's inpatient and emergency room utilization and close any gaps in care.

### **Pharmacy Programs**

BCBSRI has several pharmacy programs which promote cost effective pharmacy utilization and clinically appropriate drug use, including generic co-pay waiver programs, therapeutic substitution, and half tablet programs.

The Specialty Pharmacy program was established to address the use of biologics, many of which are used to treat chronic or long term diseases that have little or no alternative treatments. Key objectives of the program include appropriate utilization of specialty drugs and enhancing clinical management. These services are provided through a preferred specialty pharmacy network who are specially trained to address the needs of these patients.

BCBSRI also sponsors generic sampling centers in some primary care provider offices. This encourages the use of generic medications when initiating therapies. These programs have been effective in reducing both healthcare costs and out of pocket expenses for our members, while promoting adherence to medication regimes. BCBSRI also sends provider mailings to address polypharmacy issues and appropriate antibiotic, which promote safety and evidence based practice.

### **Prospective Review**

BCBSRI requires notification from providers for admissions to inpatient acute hospitals, inpatient rehabilitation hospitals, inpatient mental health hospitals and Long Term Care facility, unless in an emergency. Registered nurses and medical directors review the request to ensure that it is medically necessary and delivered in the appropriate care setting. In the case of an emergency, notification from the provider is requested, if possible, within 48 hours of when the member is admitted. If the member is outside the service area, the member should contact his or her primary care physician to coordinate care after leaving the facility. Provider notification is also required for some outpatient

services including, but are not limited to, Durable Medical Equipment, high-tech radiology services, and cosmetic procedures.

### **Concurrent Review and Discharge Planning**

BCBSRI's registered nurses and medical directors coordinate efforts with the providers of members in inpatient settings. They do this to maintain the quality and timeliness of healthcare delivery, determine when a transition from the inpatient setting is appropriate, and identify and coordinate the members' needs following discharge.

### **Retrospective Review**

BCBSRI reviews the medical records of members who have received admissions or services which required, but did not receive, prospective reviews. The reviews determine the medical necessity, appropriateness of service, and eligibility for coverage. A member can be held liable for covered services rendered by non-participating providers. The member may also be held liable if his or her provider did not receive the required authorization for a service, but advised the member prior to providing the service that they would not be covered.



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