

Quality & Utilization Management

Blue Cross & Blue Shield of Rhode Island's quality management program is designed to help ensure optimal physical and behavioral health outcomes for our members. Our program focuses on maximizing member health and safety, and improving member and provider service and satisfaction.

Goals of our Quality Management Program

- Monitor and improve the quality of clinical care delivered to members.
- Monitor and improve the quality and efficiency of service delivered to members and providers.
- Appreciate and address the cultural and linguistic requirements of our members.
- Promote member safety whenever and wherever possible, including safe medical and behavioral health practices in the provider network delivery system.
- Help members make healthy lifestyle choices and manage chronic diseases.

Measuring the effectiveness of our Quality Management Program

- **The Healthcare Effectiveness Data and Information Set (HEDIS)** – A tool used by more than 90 percent of America's health plans to measure performance in many areas of care and service. HEDIS is maintained by the National Committee for Quality Assurance.
- **The Health Outcomes Survey (HOS)** – A survey conducted each spring by the Centers for Medicare & Medicaid Services (CMS) to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health. All managed care plans with Medicare Advantage (MA) contracts must participate.
- **The Consumer Assessment of Healthcare Providers and Systems (CAHPS)** – A survey conducted annually by CMS to assess the experiences of beneficiaries in Medicare Advantage plans. CMS administers this survey and sends results to Plans each fall.

Utilization Management Programs

Our utilization management programs include prospective review, concurrent review, discharging planning, and retrospective review.

Prospective Review

We require notification from our providers before admission to an inpatient acute hospital, inpatient rehabilitation hospital, inpatient mental health hospital, and long-term care facility, unless in an emergency. Registered nurses and medical directors will review the upcoming services to ensure medical necessity and appropriateness of care in the settings indicated above.

In the case of an emergency, notification from the provider is requested, if possible, within 48 hours of admission.

If a member receives services outside the service area, he or she should contact their primary care physician (PCP) to coordinate care after he or she has left the hospital. We also require notification from providers for some services that occur in the outpatient setting. These include, but are not limited to some durable medical equipment, high-tech radiology services, and cosmetic procedures. Refer to your Evidence of Coverage for information on services which require prior authorization.

Concurrent Review and Discharge Planning

For members in an inpatient setting, registered nurses and medical directors coordinate efforts with providers to maintain the quality and timeliness of healthcare delivery, determine when transition from the inpatient setting is appropriate, and identify and coordinate the members' needs following discharge.

Retrospective Review

For admissions or services in which prospective review was required, and not obtained, we review medical records after discharge, to determine the medical necessity, appropriateness of service, and eligibility for coverage. A member would be held liable if a covered service was rendered by a non-participating provider. The member would also be held liable when a provider has not received the required authorization for the service and had advised the member prior to providing the service that they would not be covered.

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Medicare Part D Prescription Drug Utilization Management Programs

For BlueCHiP for Medicare Value (HMO-POS), BlueCHiP for Medicare Standard with Drugs (HMO), BlueCHiP for Medicare Plus (HMO), and BlueCHiP for Medicare Preferred (HMO-POS) plan members

BlueCHiP for Medicare Formulary

A formulary is a list of covered drugs selected by BlueCHiP for Medicare in consultation with a team of healthcare providers. The formulary represents the prescription therapies believed to be a necessary part of a quality treatment program.

Utilization Management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult a copy of the formulary or use the formulary look up tool on our Web site at www.BCBSRI.com for more information about these requirements and limits. These requirements for coverage or limits on certain drugs include:

Prior Authorization: We require you to get prior authorization (prior approval) for certain drugs. This means that your provider will need to contact us before you fill your prescription. If we do not get the necessary information to satisfy the prior authorization, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/or provide you the generic version, unless your doctor has told us that you must take the brand-name drug and we have approved this request.

Step Therapy: In some cases, BlueCHiP for Medicare requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, BlueCHiP for Medicare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, BlueCHiP for Medicare will then cover Drug B.

If your drug is subject to one of these additional restrictions or limits and your physician determines that you are not able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception.

Drug Utilization Review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.


Medication Therapy Management Programs

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. If you are selected to join a medication therapy management program, you will receive information about the specific program, including information about how to access the program. Remember, you do not need to pay anything extra to participate. These programs were developed by a team of pharmacists and doctors. We use these medication therapy management programs to help provide better coverage for you.

Questions?

Please call Customer Service at **1-800-267-0439** or TYY **1-877-232-8432**. Our Customer Service hours are: **October 15, 2011 – February 14, 2012:** Seven days a week, 8:00 a.m. to 8:00 p.m.; **February 15, 2012** until the following annual enrollment period, Monday – Friday, 8:00 a.m. to 8:00 p.m.

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BlueCHIP for Medicare is a program of Blue Cross & Blue Shield of Rhode Island—a Medicare Advantage organization with a Medicare contract. The Medicare contract between Blue Cross & Blue Shield of Rhode Island and the Federal Government is valid for one year. The availability of coverage beyond the end of the current year is not guaranteed. The benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change on January 1, 2013. Members may enroll in the plan only during specific times of the year. Contact Blue Cross & Blue Shield of Rhode Island for more information. Anyone with Medicare may apply, including those under the age of 65 entitled to Medicare on the basis of disability. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.



**Blue Cross
Blue Shield**
of Rhode Island

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