Part VI: TCCI: Eighteen Supporting Programs
Preface

As first noted early in these Program Guidelines, all TCCI Programs are intended to wrap around, enable and support the core PCMH model. They provide needed capabilities that are often called upon in helping Members achieve the highest level of recovery and stabilization possible. They are also critical to helping Panels achieve their goals of improving quality and restraining the rise in health care spending.

Figure 1 below presents all 18 Program Elements of TCCI.

Part VI, Figure 1: TCCI Program Elements

Some Elements – such as the HTC Program – serve CareFirst Members whether or not they are in the PCMH Program. For example, the HTC Program monitors hospitalizations of CareFirst Members throughout the country. Yet, the HTC Program is integrally connected to the PCMH Program as described more fully below.

TCCI Programs are intended to bring needed capabilities to bear at the right time, at the right level for the Member, through the right provider in the right setting. An example of this is the CCC Program through which Care Plans are developed and maintained for Members in the PCMH Program with multiple chronic conditions that create instability and have an Illness Burden Score of at least six times greater than average. A Member in such a plan may receive services such as HBS, EMP and any TCCI Program as part of their Care Plan.

The TCCI Continuum shown in Figure 2 on the following page captures this idea. The TCCI Program starts with a Health Assessment and detection of early health risks (for which telephonic and online coaching/information is available). A lifestyle and behavioral coach - for those at risk for one of 10 chronic disease or disease clusters - is available while Disease Management is available for those with active disease in one of these 10 clusters. Other more intense Care Coordination Programs (CCC and CCM) are available, when these are needed, for the sickest Members.
Some Program Elements – like Urgent Care Access – are arranged as a backup to aid Members and Panels in seeking less costly alternatives to hospital ER services. Community Based Programs are intended to provide specific courses of treatment and therapy for certain diseases and conditions as part of a coordinated course of action set forth in a Care Plan. A wide range of such Community Based Programs is available.

Part VI, Figure 2: TCCI Continuum: Wellness Through Acute Illness And Recovery

Members who need particular supports or services, under the direction of the PCP or NP and in coordination with appropriate specialists are placed in Care Plans as part of the CCC or CCM Programs. Then, any TCCI Program or combination of Programs can be brought to bear within the context of the Care Plan as appropriate and needed by the Member.
Service Request Hub – The Access Channel to TCCI Programs

To facilitate the introduction and coordination of TCCI Programs, CareFirst operates a Service Request Hub as part of the iCentric System. The Service Request Hub is the essential means by which LCCs and CCMs connect Members to the specific TCCI Programs and services they need. An LCC or CCM need only make an online referral to the Service Request Hub to assure a needed TCCI Element is brought to bear for the Member they are caring for. The Service Request Hub takes it from there – assuring that the right connection is made to the requested Program and confirming that the service request for the Program Element sought has actually been arranged and delivered as intended.

This is shown in Figure 3 below.

Part VI, Figure 3: Depiction Of Service Request Hub
Cost Share Waiver For Members In Care Plans And Certain TCCI Programs

CareFirst takes the point of view that improvement in quality is essential to long term cost savings and this goal can be greatly aided when there is coordination of services – across provider type, setting and time – for Members at high risk or with multiple chronic conditions. Further, quality outcomes can best be improved by the attentive guidance of a motivated PCP who is rewarded for differentially attending to these Members with the aid of a specific Care Coordinator dedicated to the Member.

The vehicle for all Care Coordination efforts in the TCCI Program is the Care Plan. There are three TCCI Program Elements that employ Care Plans: Chronic Care Coordination (CCC), Complex Case Management (CCM) and Behavioral Health and Substance Abuse Case Management (BSACM).

Essential to Care Coordination and case management is the creation, maintenance and faithful adherence to a Care Plan by the Member. The duration of a Member’s Care Plan averages two to four months for Complex Case Management, six to nine months for Chronic Care Coordination, and six to nine months for Behavioral Health and Substance Abuse Case Management.

During this time it is crucial that Members frequently communicate with their Care Coordinator and follow the tasks agreed to in their Care Plan. Examples of these tasks could include taking medications as prescribed, following a recommended diet, attending appointments with specialists as ordered, exercising as directed, meeting milestones in physical therapy, or any number of other things ordered by their physician.

In the early years of the PCMH/TCCI Programs, CareFirst observed that cost-sharing (i.e., copays, coinsurance and deductibles) was a barrier for Members managing chronic and acute conditions. The burden of cost-sharing thwarted use of the very services Members in Care Plans needed most and hindered the efforts of the Program. Thus, in 2015, CareFirst began to waive certain cost-sharing responsibility for Members in active Care Plans (the “Cost Share Waiver” or “CSW”).

Generally, Member cost-sharing for services rendered outside of a hospital setting can be waived while cost-sharing for services rendered in a hospital or for drugs is not waived. The central idea is to remove a key barrier to compliance while the Member is home and seeking to stabilize or manage chronic illnesses or recover from an acute phase of illness. **Figure 4** below shows the categories of services covered under the Cost Share Waiver:

**Part VI, Figure 4: Categories Of Services Covered Under The Cost Share Waiver**

<table>
<thead>
<tr>
<th>Cost Share for Certain Services</th>
<th>Compliant Member in Active Care Plan¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td>Waived</td>
</tr>
<tr>
<td>In-Network Professional Services in Office Setting</td>
<td>Waived</td>
</tr>
<tr>
<td>Laboratory (Not in a Hospital)</td>
<td>Waived</td>
</tr>
<tr>
<td>Physical Therapy (Not in a Hospital)</td>
<td>Waived</td>
</tr>
<tr>
<td>Radiology (Not in a Hospital)</td>
<td>Waived</td>
</tr>
<tr>
<td>Drugs in the Medical Benefit</td>
<td>Not Waived</td>
</tr>
<tr>
<td>Drugs in the Pharmacy Benefit</td>
<td>Not Waived</td>
</tr>
<tr>
<td>Inpatient Hospital Facility Costs</td>
<td>Not Waived</td>
</tr>
<tr>
<td>Outpatient Hospital Facility Costs</td>
<td>Not Waived</td>
</tr>
<tr>
<td>Professional Services in Hospital Setting</td>
<td>Not Waived</td>
</tr>
</tbody>
</table>

¹ Cost-Sharing rules vary for Members with a Health Savings Account (HAS).

Copyright © 2016
All rights reserved
CareFirst also offers the following TCCI Program Elements without cost-sharing responsibility for all Members referred by a Care Coordinator:

- Chronic Care Coordination
- Complex Case Management
- Behavioral Health and Substance Abuse
- Comprehensive Medication Review
- Enhanced Monitoring
- Expert Consults
- Home Based Services
- Home Hospice/Palliative Care
- Wellness and Disease Management Services

Once a Member successfully attains their Care Plan goals and the Care Plan is closed, cost-sharing in the form of copays, deductibles and coinsurance will apply. Members who do not engage with their Care Coordinator in a meaningful way or fail to comply with the action steps required to reach their Care Plan goals will lose the benefit of the Cost Share Waiver.
Dedicated Customer Service Support For TCCI Program Elements

Before, during and after a Member engages in a TCCI Program, it is critical that the Member and those in their Care Coordination Team understand how their Care Coordination activities are covered under the Member’s benefits.

To assure that all involved parties – and the Member most importantly - understand what and how TCCI Care Coordination services are covered, dedicated customer service support is arranged to assure that a prompt and accurate explanation of a Member’s benefits are provided whenever an Element of the TCCI Program is involved.

To enable this, each Strategic Business Unit (SBU) at CareFirst maintains a team of Customer Service Representatives (CSRs) specifically dedicated to answering all Member questions relating to the coverage of all TCCI Program Elements. These dedicated CSR Teams support proper benefit administration for Members who are participating in or being evaluated for participation in one or more of the TCCI Program Elements. Benefit questions may come directly from Members or from LCCs, Case Managers, BSA Case Managers (collectively referred to in this section as “Care Coordinators”) and other TCCI Partners (i.e., Enhanced Monitoring Staff, Disease Management Coaches etc.).

Activation Calls

Activation of a TCCI Program Element – especially a Care Plan – is accompanied by a check of the Member’s current medical and pharmacy benefits by a Care Coordinator or TCCI Partner. A three-way conference call that includes the Member, Care Coordinator/TCCI Partner, and a dedicated CSR is always the starting point for Care Plan activities.

Once this initial “activation call” is completed, the call-routing system will direct any future inquiry to the appropriate dedicated CSR for resolution.

The activation call process is as follows:

- TCCI Partners and Care Coordinators dial the toll-free number provided with the Member already on the call or with the Care Coordinator in person.

- The caller is prompted to enter the Member’s ID number, date of birth and zip code (or last name of the policyholder).

- The Member’s eligibility is confirmed, the correct SBU is determined, and the Member is routed directly to the appropriate team of dedicated CSRs.

- A CSR receives the call and engages with the TCCI Partner/Care Coordinator and Member, with full reference to the iCentric Member Health and Service Request Records. This CSR will become the “dedicated” CSR for any future needs of the Member while they are in a Care Plan or participating in a TCCI Program.

Maintenance Calls to the Member’s Designated CSR

When benefit questions arise after a Member’s activation in a Care Plan, calls are routed to the same CSR that addressed benefit coverage at the outset. This assures a greater likelihood that the CSR is familiar with the Member’s Care Plan and better informed of the Member’s circumstances. This CSR becomes the Member’s “Designated CSR” and all calls to CareFirst regarding the Member will be routed to this designated CSR. If the Designated CSR is not available, the dedicated team of CSRs who support the TCCI Program will serve as back up.

To access the Member’s Designated CSR, Care Coordinators dial a toll-free number and enter in the three data Elements listed above that are necessary to identify the Member. Once the Member is engaged in a Care Plan or a TCCI Program Element, the Care Coordinator is directed to that particular Member’s Designated CSR for any subsequent questions. If the dedicated CSR is available, a call back can be arranged or, if necessary, another CSR can serve as back up.

Similarly, calls directly from Members who are active or were recently active in a TCCI Program Care Plan are directed the same way.
Care Coordination Card

Member Engagement and understanding of the Care Plan process is critical to the success of the TCCI Program. To facilitate this Engagement and understanding, CareFirst provides every Member in a Care Plan with a Care Coordination Card. This card specifies the TCCI Program Elements in which the Member participates and lists contact information for key Members of the Care Coordination Team such as the Member’s Care Coordinator and Designated CSR.

Hence, the Care Coordination Card is an informational card given to Members who, along with their PCP and Care Coordinator, consent to participate in one or more of the TCCI Care Plan Programs (i.e., CCM, CCC, and BSA). Once a Member’s Care Plan is activated, a Care Coordination Card and a welcome letter are sent to the Member within three to five business days. The card is valid for the duration of the Member’s Care Plan.

The welcome letter that accompanies the card, encourages the Member to engage with their Care Coordinator and explains Care Plan compliance requirements. An image of the card is shown in Figure 5 below.

Part VI, Figure 5: Care Coordination Card

The messaging on the Care Coordination Card alerts providers that a Member is eligible for a Cost Share Waiver (CSW) and prompts providers to log on to the CareFirst provider Portal to check the Member’s eligibility for a CSW to accurately determine the Member’s out-of-pocket expense owed at the time of an office visit and to avoid erroneous charges. The Care Coordination Card is not an insurance card, but is meant to be provided to the physician’s office in conjunction with the Member’s CareFirst ID card to verify eligibility and benefits.

Maintenance of the Cost Share Waiver Benefit

As already noted, for the duration of their Care Plan, CareFirst will waive a Member’s cost-sharing - deductible, copay, and coinsurance – for many professional services, such as doctor's visits on the condition that the Member actively cooperates and complies with the actions and steps called for in the Care Plan and makes progress toward more stable health.

A Member must be actively engaged with their Care Plan to receive CSW benefits by complying with three ongoing steps:

- Telephone or in-person discussion with their Care Coordinator weekly to discuss progress;
- Completion of the tasks that the Member, their physician and Care Coordinator have agreed are necessary as documented to stabilize the Member and improve their health; and
- Active and cooperative progress toward a desired “State of Being” and Care Plan “graduation” date.

Failure to meet these requirements will result in the closing of the Member’s Care Plan and the Member will no longer have access to CSW benefits or the Care Coordination services a Care Plan brings. Hence:

Copyright © 2016
All rights reserved
• The Member’s Care Coordinator will no longer support the Member in making progress toward their health goals;

• The Member will no longer have access to other supportive TCCI Program Elements which require participation in a Care Plan; and

• CareFirst will no longer waive cost-sharing on professional services and the Member will be responsible for paying their deductible, copays and coinsurance for all covered services.

See Appendix C for a full description of the Care Planning process and standards and processes that underlie it.
Closing A Care Plan For Various Reasons

Closing a Care Plan at Graduation

Members in Care Plans are guided by their physician and Care Coordinator toward an intended “State of Being” which is stabilization of the Member’s health and a sufficient ability on the part of the Member to self-manage their chronic conditions. Arrival at this “State of Being” triggers graduation from a Care Plan. Graduation from a Care Plan is a mutual decision made by the Member’s treating physician, Care Coordinator and the Member.

When Members are ready to graduate from their Care Plan Program, their Care Coordinator changes the status of their Care Plan within iCentric to “Closed” with a closure reason of “Graduation – Goals Met”. The Member’s consent to this action is documented in their Care Plan. This action triggers mailing of a Graduation Letter to the Member thanking them for their participation and reminding them of their need to stay vigilant regarding their health care needs and the maintenance of their achieved targeted “state of being”. The letter also explains the value of their CSW benefits and that CareFirst will no longer waive Member cost-sharing.

Closing a Care Plan for Non-Compliance

30-Day Warning Letter

While in a Care Plan, any Member that fails to fully engage with their Care Coordinator is deemed non-compliant. If this occurs, the Care Coordinator initiates a process for closing the Care Plan due to non-compliance. Before doing so, Care Coordinators make multiple calls and attempts to re-engage the Member in their Care Plan resulting in a higher frequency of contact to obtain their willingness to complete the steps outlined in the Care Plan.

If this does not occur, the Care Coordinator issues a warning message to the Member advising them of their non-compliant status as is necessary in the CSW benefit. The letter notifies the Member that unless the Member re-engages with their Care Coordinator and makes progress on their Care Plan goals within the next 30 days, the Member’s Care Plan will be closed and the CSW benefit will end.

The warning letter is accompanied by a personal email from the Member’s Care Coordinator. During the 30-day notice period, the Care Coordinator attempts to re-engage the Member in their Care Plan and Members are urged to contact their Care Coordinator to discuss a path to becoming compliant and remaining in the Program.

Termination Letter

If, after 30 days, the Member has not re-engaged with their Care Coordinator, the Care Coordinator will recommend to the Member’s PCP that the Care Plan be closed. If the PCP agrees with the recommendation, a final notice of Care Plan closure and termination is mailed to the Member from CareFirst. The termination letter explains that the Member’s Care Plan has been closed due to failure to comply with the actions called for in the Care Plan and the Member’s CSW benefit is immediately revoked. Enclosed with each termination letter is a description of the Member’s appeal rights should the Member choose to appeal the revocation.

Members Participating in Two or More TCCI Programs

Since Members may participate in more than one TCCI Program at the same time, a responsible lead Care Coordinator is assigned – either a CCM or LCC. Under the direction of the lead Care Coordinator, both Care Coordinators are expected to discuss the Member’s progress weekly and work together to keep the Member engaged and successful in both Care Plans.

Care Plan benefits remain active and the CSW benefit continues to apply if the Member is engaged and compliant in both of their Care Plan Programs. The decision to deem a Member non-compliant or recommend termination of a Care Plan is made at the discretion of the responsible lead Care Coordinator after discussion with the other Care Coordinator for the Program in which the Member is also involved. Only the Member’s PCP or NP may decide to close one or both Care Plans.
Finding And Focusing On Those Most In Need – Fulfilling Population Health Through TCCI Programs

CareFirst uses a population health approach to identify Members for each TCCI Program Element. As noted throughout the Guidelines, within any sizable population of people there is a small percentage who account for the majority of medical spending. The challenge is to identify those who would most benefit from programs such as those offered within the TCCI Program. No one illness measure or score captures the entire picture for an individual Member or for a cohort of Members. Therefore, CareFirst uses multiple measures to capture various health factors or statuses to determine which Members to focus on for greater support, Care Coordination or specialized programs.

Typically, a three-pronged process is used to target the Members most in need:

- a flag or indication from data mining;
- a clinical review and recommendation from a nurse; and
- a review/initiation by the Member’s physician.

Members flagged for greater attention are tracked in the iCentric System with their status regarding Care Coordination activity shown in Searchlight and displayed in the Account HealthCheck section of the Account Searchlight Report. CareFirst classifies the level of Care Coordination activity into four categories:

- “Reviewed” – The Member has been evaluated for a TCCI Program Element;
- “Approached” – Direct outreach to a Member is made by a Care Coordinator or TCCI Partner;
- “Engaged” – The Member agrees to participate in the TCCI Program Element and receives services; and
- “Completed” – The Member no longer receives services provided under the TCCI Program Element.

Top 50 Lists and Index Scores

As a starting point for the flagging and review process, CareFirst provides “Top 50 Lists” for each Panel, and updates these lists monthly. SearchLight Reports present views of the 50 Members who have the highest costs, highest utilization, or show other patterns of progressive disease or instability that places them at greatest risk within a Panel’s membership.

These Members typically experience far higher than average unplanned hospital events related to chronic conditions, multiple gaps in care, repeat admissions and ER visits or are taking a large number of prescription medications. An intense focus on these sensitive Member populations is a vital component in a Panel’s approach toward finding and attending to the needs of high risk/high cost Members’ outcomes. Top 50 Lists typically represent the upper two to three percent of medically complex or fragile Members in the Panel. There are 10 Top 50 Lists including those Members with the highest:

- Overall PMPM Costs
- Pharmacy PMPM Costs
- Drug Volatility Score
- Specialty Drug PMPM Costs
- Drug Utilization
- Hospital Use (Admissions, ER Visits)
- Multiple Comorbidities
- Gaps in Care
- Disease Instability
- Health Assessment Risk Indicators

Index Scores

In addition to the Top 50 Lists, there are 10 Index Scores that are applied to all Members where and when appropriate. All Top 50 Lists and Index Scores are applied to all Members, on a monthly basis. All scores are displayed in the Member Health Record as they become available or updated. This provides each Panel with a clear view of the Members within its own population who are in need of increased attention and possible Care Coordination activities. The 10 Index Scores are explained on the following pages.
Overall Health Profile Score

A “confluence score” that captures the Overall Health Profile of each Member is also generated reflecting the fact that Members who appear on multiple lists or score high on multiple indices are most likely to need Care Coordination or other targeted TCCI Programs. This ‘Confluence Score” is known as the Overall Health Profile Score of each Member. This is shown in the Figure 6 below.

Part VI, Figure 6: Overall Health Profile Score For Each Panel

Description of Index Scores

Illness Burden Score (IBS) - The IBS is calculated for each Member every month based on the Member’s unique claims history, using trailing 12 months of claims experience. This score is based on the Diagnostic Cost Grouper (DxCG) classification model which has been researched and refined over 20 years. The DxCG model relies on diagnosis and demographic information to assess the level of illness of a Member. ICD-9-CM diagnostic codes in claims are grouped into Condition Categories that have a hierarchy and a numerical weight for relative importance. DxCG groupings are based on diagnosis codes, not procedure codes.

Thus, these groupings describe morbidity or illness level, not treatment or cost patterns. This has the benefit of limiting the potential impact of provider ‘up’ coding or ‘under’ coding of claims since the DxCG groupings are not affected by the type or intensity of health care services delivered. An added benefit is that the groupings are less sensitive to variations in local practice styles or health delivery system configuration.

Since neither utilization of service nor the unit costs of services affect this score, the score becomes a more “pure” indicator of a Member’s clinical complexity and health status. The IBS demonstrates the relative recent illness level of the Member that is a useful factor in determining which Members are most likely to have high future needs or costs. The IBS is normalized for the CareFirst population to an average of 1.0. The Illness Burden Pyramid stratifies Members, based on their normalized IBS, into five bands to focus PCPs’ attention on which Members may be most clinically appropriate for PCMH Care Plans and other TCCI Programs.
LACE Index Score (LACE) - A LACE Index Score is determined for all hospital inpatients by the Hospital Transition Coordinator (HTC) responsible for the hospital into which a Member has been admitted. This index is calculated from four metrics, which include length of stay (“L”), acuity (planned/unplanned) of admission (“A”), the Charlson Co-morbidity Index (“C”) and the number of emergency visits (“E”) in the six months prior to admission. It is used to estimate the likelihood of inpatient readmission or death within 30 days, with higher scores being highly correlated with readmission events. LACE scores are calculated at the time of discharge from the hospital, while an ACE Index Score is calculated on admission (since length of stay is unknown at that time). Higher values for either index indicate the need for more intensive post-hospitalization Care Coordination and prioritize the Member for TCCI interventions.

Charlson Comorbidity Index Score (CCI) - The CCI is calculated on weights assigned to over 20 conditions, including both common chronic conditions and advanced illness, and is based on likely clinical risk. Examples include moderate to severe Liver, Renal, Heart and Pulmonary Disease as well as Acquired Immunodeficiency Disease (AIDS), Leukemia, Lymphoma and Diabetes. Higher scores indicate more serious conditions and/or greater number of conditions. The CCI serves as an independent measure of clinical complexity as well as an essential Element in the LACE and ACE indices.

Consumer Health Inventory Score (CHI) - The CHI is a structured health assessment that measures and tracks changes in mental well-being and physical functioning for individuals aged 14 years and older. For Members under age 14, the CHI-C is the corresponding scoring tool. Behavioral and Substance Abuse Case Managers administer the CHI/CHI-C at the time of Case Management Program enrollment, then periodically throughout participation in the Program, and finally at Program graduation to assess Member progress and Program outcomes.

Patient Health Questionnaire Score (PHQ-2) - PHQ-2 is a brief depression screening tool administered by all Care Coordinators to Members with chronic illnesses, serious and acute catastrophic illnesses and/or behavioral health issues. A positive score indicates the need for further evaluation using more detailed survey instruments and/or prompt evaluation and intervention by behavioral health specialists.

Framingham Heart Disease Score (FHD) - The FHD score is a gender-specific analysis of information supplied as part of a self-reported health assessment (supplemented with biometric data when available), which is used to estimate the 10 year cardiovascular risk of an individual. It predicts not only heart-related events, but also vascular risk such as stroke and peripheral artery disease. The score is useful in identifying Members who would benefit from using medication to prevent or delay cardiovascular disease and for referral to specific TCCI Programs.

Well-Being Score (WBS) - WBS is provided to all Members who complete a Health Assessment as part of an individualized report that identifies specific health risks. The Well-Being Score, developed by Healthways and Gallup, includes five Elements of well-being, each scored on a 0 to 10 point scale. The report provides data to the Member about their health and well-being for each of the five Elements as follows:

1. Purpose (having motivation to achieve goals),
2. Social (having supportive relationships),
3. Financial (managing economic life and financial security),
4. Community (living in a safe, positive environment), and
5. Physical (having good health and energy for daily activities).

For each of these topics, the Member is informed of any identified risks for the development of a preventable chronic condition. The Well-Being Score is correlated with future health care costs, utilization of hospital services and worker productivity measures.

Drug Volatility Score (DVS) - DVS is calculated monthly for every Member with CareFirst pharmacy benefits. The DVS model provides a way to stratify Members into different levels of potential instability, due to the drug(s) they are on. These are manifested by adverse or unpleasant physical symptoms, or mental/behavioral symptoms including confusion, depression or psychosis. These symptoms may lead to serious consequences as well as non-adherence. The DVS ranges from 0 to 10, with higher scores associated with higher risk of instability or breakdown. The DVS allows the pharmacist and physician to prioritize efforts, focusing on those Members who appear to require intervention on a timelier basis because of their potential to rapidly decompensate into a lesser state of health. These Members are far more likely to break down and be admitted/readmitted or use emergency room services frequently. The DVS score is derived from prescription drug claims data and Member demographic information.
Pharmacy Risk Groups (PRG) - PRG uses a Member’s pharmacy claims and demographics to assess future health risk. PRG is measured using Optum’s proprietary drug hierarchy, with an assigned Drug Class Code, that is further categorized into one of over 100 initial pharmacy risk groups. The PRG is refined using Member age and various combinations of initial PRGs, which are weighted and summed to develop a single risk score that reflects both clinical risk and likelihood of exceeding a cost threshold. The PRG Score is used to assess a Member’s pharmacy “load” or use of drugs that when taken in combination indicate the level of risk a Member may have.

Metabolic Index Score (MIS) - MIS indicates the risk of future medical breakdowns and poor health, based on both certain lab results and available key biometric parameters. The MIS encompasses five categories of a Member’s health:

- Cardiac Health,
- Glucose Metabolism,
- Kidney Health,
- Liver Health, and
- A Biometric Factor (derived from Body Mass Index and blood pressure) when available.

The score incorporates an age adjustment factor. As a predictor of potential future disease, its primary use is to identify Members for targeted coaching programs or specific TCCI Programs, such as the Chronic Kidney Disease Program.

In Sum

It is obviously the case that not all Members generate scores in all categories each month, so the scores that are available are used when they become available. Since so much disease is chronic in nature, those Members with multiple chronic conditions and those who are experiencing breakdowns or exacerbations of chronic disease are also those who most often evoke high scores, which naturally draws attention to them.

It is when there is a confluence of high scores on multiple indices that attention peaks. This is at the heart of what it means to be focused on “Population Health”. There is much to be gained by seeing patterns of disease progression in an individual or in a whole population. This concept is best applied at a Panel level where motivated, attentive and engaged PCPs search through their population of attributed Members with the help of LCCs and Program Consultants to find and focus on those Members who need them the most and for whom a TCCI Program Element may be just what is needed.
Selection and Engagement of Members by Clinical Professionals

With all that is said above, it is nevertheless, the judgement of clinicians that is vital to selecting the most appropriate Members for TCCI Programs. In a very real sense, flagging Members through Indices and Top 50 Lists is only the first level of review in discerning which Members will benefit from participating in one or more TCCI Program Elements. Each Member identified is reviewed by the Member’s physician.

Those Members who have high scores on multiple index scores and/or are on multiple lists constitute a population health “bull’s eye” to be very seriously pursued for one or more focused TCCI Programs once confirmed by the PCP.

Typically, Members enter a TCCI Program in one of six ways:

1. Hospital Transition of Care Program (HTC);
2. Complex Case Management Program (CCM);
3. Chronic Care Coordination Program (CCC);
4. Behavioral Health and Substance Abuse Program (BSA);
5. Wellness and Disease Management Program (WDM) or
6. Automatic Data-triggered Referrals.

Figure 7 below defines the four reporting categories for each TCCI Program Element.

<table>
<thead>
<tr>
<th>Program</th>
<th>Reviewed</th>
<th>Approached</th>
<th>Engaged</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTC Program</td>
<td>An HTC nurse reviews admissions to acute care hospitals to determine whether the nature of the Member’s illness/condition is likely to require post-discharge services. Each admission is categorized:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Category 1 indicates the Member will likely need post-discharge services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Category 2 indicates that post-discharge services are not required.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An HTC nurse approaches Category 1 Members and their family to ask questions and make a more refined judgment as to whether the Member could benefit from post-discharge Care Coordination.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An HTC nurse refers the Member to another TCCI Program based on an active discussion with the Member and family and makes a referral to this Program with the Member’s consent.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Member has completed the HTC Program when:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The Member has an accepted referral to the CCM Program;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The Member has an accepted referral to the CCC Program;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The Member has an accepted referral to the BSA Program; or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An HTC nurse confirms that the referral to one of these Programs has been completed and the receiving Program has accepted the Member.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program</td>
<td>Reviewed</td>
<td>Approached</td>
<td>Engaged</td>
<td>Completed</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CCM Program</td>
<td>The Complex Case Management Program receives referrals primarily from the HTC and CCC Programs or from data-triggered flags. Once a referral is received: ● A nurse triages the Member based on their diagnosis and assigns the Member to a specialty CCM; and ● A CCM assesses the information provided in the referral, consults with the Member’s physician and reviews the information in the Member Health Record.</td>
<td>The CCM calls the Member to: ● Conduct a more in-depth assessment; ● Describe the CCM Program to the Member; and ● Obtain consent to be placed in a CCM Care Plan. A Member is still considered “Approached” if they are unable to be reached or declines to participate.</td>
<td>Following the Member’s consent to participate in the CCM Program, a CCM works closely with the Member, their family and other clinicians in developing and carrying out the Member’s Care Plan. The Member remains “Engaged” as long as they are in an active CCM Care Plan.</td>
<td>The Member has completed the CCM Program when: ● The Member successfully meets the Care Plan goals; ● The Member has an accepted referral to the CCC Program; ● The Member voluntarily or involuntarily terminates from the Program; or ● The Member is no longer covered by CareFirst.</td>
</tr>
<tr>
<td>CCC Program</td>
<td>In the Chronic Care Coordination Program, a Member is “Reviewed” through the following approaches: ● The Local Care Coordinator (LCC) assesses Members who are flagged on Top 50 Lists; ● The LCC accepts the referral of a Member from the HTC or CCC Programs; or ● A PCP directly identifies a Care Plan candidate.</td>
<td>The LCC and PCP work to schedule an appointment with the Member in order to: ● Conduct a more in-depth assessment; ● Describe the CCC Program to the Member; and ● Obtain written consent to be placed in a CCC Care Plan. A Member is still considered Approached” if they are unable to be reached or declines to participate.</td>
<td>Following the Member’s consent to participate in the CCC Program, the LCC works closely with the Member and their PCP in developing and carrying out the Care Plan. The Member remains “Engaged” as long as they are in an active CCC Care Plan.</td>
<td>The Member has completed the CCC Program when: ● The Member successfully meets the Care Plan goals; ● The Member has an accepted referral to the CCM Program; ● The Member voluntarily or involuntarily terminates from the Program; or ● The Member is no longer covered by CareFirst.</td>
</tr>
</tbody>
</table>
### BSA Program

A referral for the Behavioral Health and Substance Abuse Program is accepted from BHTCs, LCCs or CCMs.

Behavioral Health and Substance Abuse Case Managers (BSACM) review the behavioral and medical history of all Members referred to determine if the Member is appropriate for the Program.

The Member, if appropriate, is called by a BSACM, who:

- Conducts a more in-depth assessment;
- Describes the BSA Program to the Member; and
- Obtains consent to be placed in a BSA Care Plan.

A Member is still considered “Approached” if they are unable to be reached or declines to participate.

Following the Member’s consent to participate in the BSA Program, the BSACM works closely with the Member, their family and other clinicians in carrying out the Care Plan.

The Member remains “Engaged” as long as they are in an active BSA Care Plan.

The Member has completed the BSA Program when:

- The Member successfully meets the Care Plan goals;
- The Member voluntarily or involuntarily terminates from the Program; or
- The Member is no longer covered by CareFirst.

### WDM Program

The Member's Well-Being Score and Health Condition Track are reviewed to determine the Member’s current health status.

If the Member has a health status of “High Risk” or “Full Expression” a referral is made to the WDM Program.

The Member, if High Risk or at Full Expression, is called by a WDM nurse, who attempts to:

- Introduce and describe the WDM Program to the Member; and
- Obtain consent to participate in coaching sessions.

A Member is still considered “Approached” if they are unable to be reached or declines to participate.

The Member sets goals and is participating in Lifestyle Management or Disease Management Coaching sessions.

The Member has completed the WDM Program when:

- The Member successfully meets their goals;
- The Member has a confirmed referral into the CCM or CCC Programs;
- The Member voluntarily or involuntarily terminates from the Program; or
- The Member is no longer covered by CareFirst.
## Part VI, Figure 7: Methods/Rules For Reporting Status In Each TCCI Program Element (continued)

<table>
<thead>
<tr>
<th>Program</th>
<th>Reviewed</th>
<th>Approached</th>
<th>Engaged</th>
<th>Completed</th>
</tr>
</thead>
</table>
| **HBS Program** | A CCM / LCC along with the Member’s physician review the Member’s case to determine if the Member is an appropriate candidate for the Home-Based Services Program. If the Member is an appropriate candidate, a referral is sent to a preferred home health agency in the region where the Member lives. | A selected home health agency contacts the Member to:  
- Obtain consent in order to receive home-based services, and  
- Schedule a visit to complete a home care assessment.  
A Member is still considered “Approached” if they are unable to be reached or declines to participate. | Following the Member’s consent to a HBS Plan, a Member is "Engaged" as long as they remain in compliance with the HBS Plan. | The Member has completed the HBS Program when:  
- The Member successfully meets the HBS Plan goals;  
- The Member voluntary or involuntary terminates from the Program; or  
- The Member is no longer covered by CareFirst. |
| **EMP Program** | A CCM / LCC along with the Member’s physician review the Member’s case to determine whether enhanced home-based monitoring is needed. If the Member is an appropriate candidate, a referral is sent to the EMP Program. | The Member is contacted by a CCM / LLC who:  
- Describes the EMP Program to the Member; and  
- Obtains consent to be placed in the EMP Program  
A Member is still considered “Approached” if they are unable to be reached or declines to participate. | Following the Member’s consent to enhanced monitoring services, a monitoring device is delivered and activated at the Member’s home.  
The Member remains “Engaged as long as they remain in compliance with the enhanced monitoring plan. | The Member has completed the EMP Program when:  
- The Member reaches a sufficiently improved state of stability;  
- The Member voluntary or involuntary terminates from the Program; or  
- The Member is no longer covered by CareFirst. |
| **CMR Program** | A CCM / LCC reviews the Member’s health record to determine whether the Member could benefit from a Comprehensive Medication Review by a pharmacist.  
If appropriate, a referral is sent to the CMR Program. | N/A | A CMR Program pharmacist contacts one or more parties (the Member or prescribing physicians) involved in the CMR to complete the review and make recommendations. | The Member has completed the CMR Program when:  
- Recommendations have been made to prescribers, and  
- The Member is notified of their recommendations. |
### Reporting on TCCI Program Elements

In the TCCI reporting sections of the Healthcheck Report, the volumes of Members in each TCCI Program during a performance year in each status category is displayed on a Year to Date basis. Taken as a whole across all TCCI Programs, this affords a complete picture of how many Members are – or have been – in a TCCI Program out of a Panel’s total population of attributed Members, or who have been reviewed and approached for these programs. This gives an overview of the degree to which TCCI Programs are being used to coordinate the care of a Panel’s attributed membership.

<table>
<thead>
<tr>
<th>Program</th>
<th>Reviewed</th>
<th>Approached</th>
<th>Engaged</th>
<th>Completed</th>
</tr>
</thead>
</table>
| ECP Program | A CCM / LCC and Medical Director review the Member’s case, along with the Member’s PCP. If the Member would benefit from an expert consultation on a complex medical situation, a referral is sent to the ECP Program. | The Member is contacted by the CCM/LLC who introduces and describes the ECP Program and prepares the Member for contact by ECP Program partner, Best Doctors. | Best Doctors contacts the Member and the Member’s treating physicians to seek their assessment of the Member’s medical situation. | The Member has completed the ECP Program when:  
  - Best Doctors provides an Expert Consult Report to both the Member and their treating physicians. |
Summary And Overview Of TCCI Program Elements

Once an assessment of a Member’s need is established that indicates the Member could benefit from Care Coordination through one or more TCCI Programs, a request is made by an LCC, CCM or BSACM through the Service Request Hub. This triggers entry into one or more of 18 different Programs that comprise the larger TCCI Program so that needed capabilities and services can be brought to bear in meeting Member needs. Each TCCI Program is briefly summarized below:

1. **Health Promotion, Wellness and Disease Management Services Program (WDM)** consists of Lifestyle and Disease Management coaching by licensed professional coaches who are expert in motivating people toward healthier lifestyles and reducing risk if they are headed towards or already have certain common chronic diseases. Also included in this program is a Health Assessment – with and without biometric screening - that reveals one’s overall health and wellbeing as well as the changes in this over time – not only for each individual, but for an employer group as a whole. A broad array of supporting program Elements on fitness, smoking cessation and other health promotion activities is available as is a rich online set of resources and information to Members that support their wellness and Disease Management efforts.

2. **Hospital Transition of Care Program (HTC)** monitors admissions of CareFirst Members to hospitals anywhere in the country. Locally, it relies on specially trained nurses who are stationed in hospitals throughout the CareFirst region. The HTC Program assesses Member need upon admission and during a hospital stay with a focus on post discharge needs. It begins the Care Plan process for Members who will be placed in the CCM or CCC Program. The HTC process also categorizes Members based on the level of their severity of need and the nature of their illness or condition so that they can be placed in the best possible "track" for follow-up Care Coordination services and flags cases that will likely result in high cost to ensure they receive the attention they need.

3. **Complex Case Management Program (CCM)** offers Care Plans for Members with advanced or critical illnesses. These Members are typically being cared for by specialists. CareFirst Specialty Case Managers provide Care Coordination services in concert with the various specialists involved. Case management services most often follow a hospitalization. The HTC is typically the entry point for Members into Case Management prior to discharge. All Specialty Case Managers are registered nurses with substantial experience in their respective specialties.

4. **Chronic Care Coordination Program (CCC)** offers Care Plans to targeted Members that are developed under the direction of the PCP or NP. This Program provides coordination of care for Members with multiple chronic illnesses. While Care Plans often result from a case management episode, they can also result from a review of the trailing 12 months of healthcare use by an attributed Member who is identified as likely to benefit from a Care Plan. Care Coordination for these Members is carried out through the Local Care Coordinator (LCC), a registered nurse who is assigned to each provider/practice within a Panel. The LCC assists the PCP or NP in coordinating all Elements of the Member's healthcare and ensures all action steps in the plan are followed up and carried out.

5. **Behavioral Health and Substance Abuse Program (BSA)** includes a range of services that deal with the behavioral health needs of Members (such as depression and various forms of psychosis and other disorders) that often accompany physical illnesses or that may stand alone. Included in this TCCI Program Category are substance abuse services as well as psycho-social services.

6. **Home Based Services Program (HBS)** serves Members in CCM or CCC who often need considerable support at home, sometimes on a prolonged basis. These services can include home health aide, psycho-social services and other behavioral health services as well as medication management and support in activities of daily living. If such services are needed, they are provided following an assessment of the home situation by an RN Home Care Coordinator (HCC) and become part of the overall plan of care maintained by the LCC or Case Manager responsible for the Member. HBS are often critical to avoiding the cycle of breakdown (admission, readmission) that commonly occurs with Members who have multiple chronic diseases. Only Members specifically referred to the Home Based Care Coordination Program through the CCM and CCC Programs are eligible for full assessment and integrated home-based services pursuant to a Care Plan. A preferred list of home care agencies is used in the provision of services within the HBS Program.
7. **Enhanced Monitoring Program (EMP)** focuses on those Members at high risk for disease progression to more advanced or serious illness. The EMP uses prescription drug and other data to identify Members that have patterns of illness that suggest incipient high risk for progression or have chronic conditions already that need active monitoring to ensure Member stability. EMP services are provided at home or in the work setting using mobile and digital capabilities that send a stream of data to a central monitoring station staffed by specially qualified nurses. The EMP Program issues alerts to PCPs or NPs as necessary.

8. **Comprehensive Medication Review Program (CMR)** is offered to Members where there are indications of high potential for drug interaction, overdosing, side effects, etc. Each CMR review is performed by a specially trained pharmacist who consults with a Member’s physician prescribers. Certain criteria such as high drug use, high cost and high likelihood of drug-induced instability is used to flag Members for a CMR. The objective is to assure a Member's drug profile is optimal and to resolve any issues with it in order to assure an enhanced therapeutic result as well as improve overall Member compliance.

9. **Community-Based Programs (CBP)** is a compendium of local Programs that have been reviewed and selected in advance by CareFirst to be made available to Members with identified needs who could benefit from such Programs. These selected programs are created in collaboration with specifically contracted Providers on an ongoing basis and typically reflect improvements in organization of care within existing benefits that are linked to other TCCI Elements to enable Care Coordination and reporting. Examples include, but are not limited to, programs to better manage diabetes and congestive heart failure, as well as improved processes for supporting Members in need of skilled nursing facility care or palliative care/hospice care.

10. **Pharmacy Coordination Program (RxP)** is a program available for Members with pharmacy benefits as part of their coverage plan. This includes management of retail and wholesale pharmacy benefits, including formulary management as well as specialty pharmacy benefits for certain disease states (such as hepatitis C, rheumatoid arthritis, and multiple sclerosis) that require high-cost pharmaceuticals that must be administered according to rigorous treatment plans. The RxP program consists of five key Elements including obtaining the best possible ingredient cost pricing for generic and brand drugs, optimum formulary design and administration, specialty pharmacy preauthorization and case management, analysis of drug therapy problems and identification of Members taking drugs for behavioral health purposes.

11. **Expert Consult Program (ECP)** allows network physicians or CareFirst to seek an outside expert opinion from leading, recognized medical experts when this is needed for highly complex cases. Through this Program, CareFirst has access to the top physicians in the nation in every specialty and sub-specialty category, organized by disease state. Cases referred to this program from CCM and CCC after CareFirst Medical Director review are complex, expensive and have the characteristic that diagnosis and treatment have not been complete, accurate or effective up to the point of referral. Recommendations are made in each case by the expert reviewers that are almost always followed by treating providers resulting in lower overall cost due to fewer Member breakdowns or inappropriate treatments.

12. **Urgent and Convenience Care Access Program (UCA)** offers organized back up for PCPs to support Members with urgent care needs that might otherwise go to a hospital based emergency department or outpatient facility. Generally the costs are one-third of what they would otherwise have been had these services been provided in a hospital emergency room.

13. **Centers of Distinction Program (CDP)** is a TCCI Program focused on highly specialized, high cost categories of hospital care. Hospitals that demonstrate expertise in delivering quality specialty care in these high volume/impact specialty areas are designated by the Blue Cross Blue Shield Association as Blue Distinction Centers.

14. **Preauthorization Program (PRE)** obtains a review of certain proposed services to Members that are usually infrequent but that are high cost and where evidence of medical need must be established before approval for payment is given. Examples include high cost specialty drugs and certain durable medical equipment.

15. **Telemedicine Program (TMP)** offers the integration of voice, data and image to create a “Video Visit” to a provider for a Member. Through “Video Visit”, the Program also enables a specialty consult for a Member or PCP.
in certain cases where this is more responsive than an in-person visit. TMP also applies in cases where an off hours visit to a Member’s PCP is not readily available.

16. **Dental-Medical Health Program (DMH)** recognizes dental care is an important part of overall health. This Program Element is designed to enable and encourage appropriate dental care as determined by the Member’s treating dentist and to integrate the Member’s dental health into their overall health profile.

17. **Detecting And Resolving fraud, Waste And Abuse (FWA)** is a TCCI Program that detects – based on claim patterns – areas of abuse or outright fraudulent billing. There is an underlying heavy reliance on data mining and analytics to identify these patterns, which is derived from the same data warehouse that is used for SearchLight Reporting. This data warehouse is extremely comprehensive including all claims for all services ever rendered by any provider to any Member over a multi-year period. Once fraud or abuse is shown, this Program initiates recoupment yielding an 8:1 savings for every dollar spent.

18. **Automating And Improving The Accuracy Of Provider Practice Data For Use In Directories (APD)**

**Continuous Tracking of TCCI Programs**

All Programs used in support of a specific Member are tracked and shown in the PCMH and Account SearchLight Reports. Included in this tracking is a pre and post view of the Member’s claims experience in order to assess the degree to which the Program Element(s) are working to improve care to the Member and reduce breakdowns that may involve expensive hospital based services.

It should be noted that Care Coordination fees are charged to each Panel’s Patient Care Account (PCA) for TCCI Program Elements as “Debits”. However, these Programs are only relevant for those Members who need the services provided in the TCCI Program portfolio. The reduction in care costs resulting from these Programs far outweighs any Debits. See **Appendix M** for a more complete understanding of how these fees are included as Debits in the PCAs of Panels.

In the pages that follow in this **Part VI**, each of the 18 TCCI Programs is more fully described and relevant data applicable is presented.
Detailed Program Descriptions

Of

TCCI Program Elements
Program #1: Health Promotion, Wellness and Disease Management Services Program (WDM)

Preface

The burden imposed by chronic disease on society is driven by a relatively small set of conditions and often preventable risk factors. The 15 most costly chronic conditions account for more than 80 percent of the total cost of all chronic illnesses. These are shown in Figure 8 below:

Part VI, Figure 8: Top 15 Costly Chronic Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Asthma</td>
</tr>
<tr>
<td>Obesity</td>
<td>Coronary Artery Disease (CAD)</td>
<td>Cancer</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>Heart Failure</td>
<td>Sinusitis</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Hypertension</td>
<td>Allergies</td>
</tr>
<tr>
<td>Back Pain</td>
<td>Chronic Kidney Disease</td>
<td>Depression</td>
</tr>
</tbody>
</table>

Many of these conditions are preventable, and are typically related to sedentary lifestyle, poor diet and smoking. Others are not preventable, but can be effectively managed to the benefit of both the Member and the employer. In either case, the early detection of these conditions is part of the integrated CareFirst Total Cost and Care Improvement Program (TCCI) Continuum (shown in Figure 9 below) that is intended to bring the right intervention/Program Element to bear at the right time for the right Member in order to get the best possible outcome at the lowest possible cost.

The TCCI WDM Program plays a key role at the beginning of the continuum by identifying those whose health can be enhanced or stabilized. It begins a process of heightened awareness and vigilance on the part of the Member, as well as provides coaching to help their attentiveness to behaviors that can improve their well-being.

Part VI, Figure 9: TCCI Continuum: Wellness Through Acute Illness And Recovery

---

2 The New Discipline of Workplace Wellness, Enhancing Corporate Performance by Tackling Chronic Disease; World Economic Forum, 2010.

Copyright © 2016
All rights reserved
The thrust of the CareFirst Model Program is two-fold: to differentially focus on the minority of Members who are either at high risk for illness or who are experiencing illness, and raise the awareness and vigilance of those who are healthy to stay that way through healthier lifestyle habits and behaviors. The Program works with the other Elements that are part of the TCCI Program as an integrated whole to achieve these results. The gateway to the entire TCCI Program spectrum is the identification of Members’ through the Health Assessment process.

The initial Health Assessment process is designed to identify and triage Members into the most appropriate TCCI Program Element. With the Wellness Program as a gateway and initial directional guide, the integrated whole operates with maximum benefit for the Member and, therefore, for the employer group of which they are a part.

**Early Intervention**

Chronic conditions often occur in combination with one another and create a cause and effect pattern that systematically undermines health, while contributing to the high cost of health care through demand for prescription drugs, emergency room visits and hospital stays.

Research shows that without a change in behavior, a significant percentage of patients in the early stages of chronic disease will proceed toward full manifestation down the line. For example, the Centers of Disease Control and Prevention indicate that without lifestyle changes to improve their health, 15–30 percent of people with pre-diabetes will develop Type 2 diabetes within five years. This percentage grows over time. CareFirst has examined claims data over each decade of life for its Members. The analysis shows that there are often predictive signs of chronic conditions that occur early in life and well before full manifestation is obvious.

A central aim of the WDM Program is to identify these Members as soon as possible – when the path can still be mitigated by behavior change and before breakdown occurs.

This is further reinforced by CareFirst data that shows such individuals incur significantly more cost once they reach the full manifestation of one or more chronic conditions. This is reflected in the data below comparing the PMPM cost of someone in the early stages of disease versus someone who has the full diagnosis for the disease. The increased costs are generated as the patient begins to need more and more clinical intervention to prevent critical breakdowns or to deal with the manifestation of their condition. This is shown in Figure 10 below.

<table>
<thead>
<tr>
<th>HEALTH CONDITION</th>
<th>Average Condition Cost Per Member</th>
<th>Average Total Cost Per Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial Year Cost</td>
<td>3-Year Cumulative Cost</td>
</tr>
<tr>
<td>OVERWEIGHT AND OBESITY</td>
<td>$2,489</td>
<td>$8,322</td>
</tr>
<tr>
<td>CARDIOVASCULAR DISEASE</td>
<td>$5,518</td>
<td>$10,341</td>
</tr>
<tr>
<td>COPD</td>
<td>$2,560</td>
<td>$7,991</td>
</tr>
<tr>
<td>DIABETES</td>
<td>$823</td>
<td>$4,273</td>
</tr>
<tr>
<td>HYPERTENSION</td>
<td>$1,034</td>
<td>$1,943</td>
</tr>
<tr>
<td>CANCERS</td>
<td>$17,401</td>
<td>$27,636</td>
</tr>
<tr>
<td>RENAL FUNCTION FAILURE</td>
<td>$10,709</td>
<td>$82,779</td>
</tr>
<tr>
<td>OSTEOARTHRITIS</td>
<td>$3,970</td>
<td>$11,656</td>
</tr>
<tr>
<td>DEPRESSION</td>
<td>$1,413</td>
<td>$3,659</td>
</tr>
</tbody>
</table>

While many of CareFirst’s TCCI Programs are designed to support those with multiple chronic conditions after they experience breakdowns in their health, the Wellness portion of the TCCI Program is targeted to those Members who are currently healthy, in the early stages of illness or at-risk for developing chronic illness. Where lifestyle or other preventable causes can be determined, the Program seeks to intervene in order to reduce the risk of a further decline in health status and to improve overall Member health and well-being.

**Annual Health Assessments**

Awareness of health status and risks is one of the strongest factors affecting the likelihood of behavioral and lifestyle change. Studies show that those who complete a Health Assessment are more likely to improve their overall health status. A 2009 study from the American College of Occupational and Environmental Medicine showed that over a three year period, those who completed a Health Assessment improved their overall health status and experienced both a decrease in high-risk health factors as well as an increased proportion of low risk factors. In fact, those who completed more than one assessment over the three year period showed an even greater degree of favorable change.

Hence, the Program emphasizes initial and ongoing assessment – best done on a repeating annual cycle – to promote Member awareness and to identify appropriate intervention. The Program calls for an annual two part assessment process for all Members aged 18 and older, which includes a Health Assessment questionnaire and Biometric Screening. When these two parts are combined with CareFirst’s extensive claims and utilization data, a reasonably accurate picture of health status emerges for individuals and, in the aggregate, for employer accounts. This includes both the current health of the Member as well as data on the future health and conditions that might develop or worsen without effective intervention.

All Health Assessment and Biometric Screening criteria in the WDM Program have been scientifically validated based on decades of research and experience by independent researchers through CareFirst’s partnership with Healthways – the leading provider of WDM services in the country, with one of the largest data libraries on the factors that impact wellbeing and health status. Through years of experience, we have shaped the process for conducting assessments and developed specific questions and biometric data points that are highly predictive at determining the current and future onset of chronic and preventable conditions.

The two parts of the Health Assessment are as follows:

- **An online Health Assessment Questionnaire** that is accessed through the CareFirst Member Portal that generally asks a Member about the five interrelated Elements that research has shown to have the greatest impact on an individual’s well-being: purpose, social, financial, community and physical. The results of which can identify the Member’s health risk factors and suggest changes the Member can make to improve and maintain the Member’s health. This Assessment takes a holistic approach to the measurement of each Member’s total well-being and includes health related questions as well as questions relating to four other key areas scientifically shown to influence health: purpose, social, financial and community. The assessment also includes Member consent for sharing the information gathered with the Member’s PCP through the secure Member Health Record.

- **Biometric Screening** that is either provided at the employer worksite or through a visit to the Member’s PCP. Generally, the participation rate is higher if worksite screening is made available. The screening includes basic measurements including weight, BMI, cholesterol, blood pressure, nicotine and blood glucose levels. Data from screenings done at a Member’s worksite are automatically loaded into the Member Health Record in CareFirst’s iCentric System. If the screening occurs in the physician’s office, the information is recorded on a form which the Member can then submit via the CareFirst Member Portal.

---

The additional step of professionally collected Biometric Screening data is critical to the Assessment Process. We know from years of experience in examining the data that self-reported and biometric values differ. Depending on the measure, the accuracy level of self-reported data can be as low as 50 to 65 percent. Without an accurate starting point, tracking is less effective and the Member often does not engage in the behavior change needed to improve their health.

The data from the biometric measures above is highly correlated and predictive of multiple chronic conditions, including obesity, heart disease, high blood pressure and musculoskeletal problems. Having these critical data points discussed between the Member and their PCP raises the awareness further still, and creates a call to action leading to change.

**Well-Being Score**

All Members who complete the Health Assessment receive an individualized report that includes their identified risks and an overall Well-Being Score. The report provides data to the Member about their health and well-being in each of the proven areas of purpose, social, financial, community and physical health. In each of these areas, the Member is informed of any identified risks for the development of a preventable chronic condition.

The Member Well-Being Score has been developed based on extensive research by Healthways and the Gallup organization. Each data point has been evaluated for validity, accuracy and precision, based on analyzing nearly one million surveys. When combined, they produce a comprehensive score that is valid, predictive and actionable within a population.

**Part VI, Figure 11: Member Well-Being Score**

<table>
<thead>
<tr>
<th>90-100</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>75-89</td>
<td>Good</td>
</tr>
<tr>
<td>66-74</td>
<td>Fair</td>
</tr>
<tr>
<td>50-65</td>
<td>Poor</td>
</tr>
<tr>
<td>&lt;50</td>
<td>Very Poor</td>
</tr>
</tbody>
</table>

*Overall Population Average = 70*

The Well-Being Score is grounded in the concept that many factors affect the health and productivity of an individual. As stated above, the Health Assessment questions the Member in traditional areas of health status as well as those pertaining to other aspects correlated to health and well-being:

- **Physical** – Having good health and enough energy to get things done
- **Purpose** – Liking what you do and being motivated to achieve goals
- **Social** – Having supportive and loving relationships
- **Financial** – Managing economics to reduce stress and increase security
- **Community** – Feeling of safety, liking where you live and feeling pride in your community

In addition to being validated as predictive of health care costs and hospital and emergency room utilization, the Well-Being Score has been proven to correlate to measures relating to employer productivity such as:

1. Unscheduled Absences
2. Short-Term Disability Days
3. Supervisory Rating of Performance
4. Employee Self-rating of Performance
5. Turnover Intentions

A growing body of peer reviewed science indicates that traditional HRA’s that focus only on health measures provide an incomplete picture of risk and future cost. When the Well-Being Score is combined with other claims based scored maintained by CareFirst, a far more holistic understanding of the current health of a Member emerges that more clearly identifies their likely path without intervention or behavior change.
Hence, the Well-Being Score provides Members with an awareness of their current health status and likely future health track while informing them of related risks that they have. The process also allows CareFirst to know what support, services and interventions should be made available to Members to improve their health or prevent further deterioration.

At an employer account level, the data enables a longitudinal profile of the group over time showing changes to the overall Well-Being Score for the group as a whole, including the improvement or worsening of chronic and preventable conditions. This allows CareFirst to work with the employer on effective wellness and care management strategies for employees and dependents as an integral part of the Total Cost and Quality Improvement Program. Figure 12 below shows the profile of an employer group in two time periods based on the distribution of Well-Being Scores.

**Part VI, Figure 12: Two Year View**

![Graph showing Well-Being Score distribution](image)

The movement in the distribution to the right indicates an improvement in employee well-being. Experience shows that even a one point improvement in an employer group’s Well-Being Score can equate to 0.4-1.0 percent reduction in overall health care costs. For example, an account with 30,000 Members with an average PMPM of $400 could realize $1.5 million in savings annually for each one point shift to the right in the overall Well-Being Score for the group.

**Figures 13 and 14** on the next page show Well-Being Scores specifically correlated to both hospital utilization and health care costs.5

---

Another view is shown in Figure 15 below which reveals the importance of the predictive power of adding the non-health factors to the traditional HRA that are contained in the Well-Being Assessment and Score.

Incenting Member Participation

It is essential to obtain strong Member participation in the annual Health Assessment process in order to produce meaningful results. A central goal is to attain greater than 50 percent participation for all Members (employees and dependents) in an employer group.

The use of incentives is essential to raising participation levels in the Health Assessment process. Employer groups with higher participation are more likely to have their Members targeted for appropriate intervention early, before the Member
fully manifests a chronic disease or when the condition still has the opportunity for improvement. Independent studies show that participation can regularly reach 80 to 90 percent when the right incentives are introduced.  

Incentives can come in many forms based on the employer’s needs and culture and can include direct dollars toward an employee’s benefit premium, gift cards or other non-monetary rewards such as points earned towards prizes or additional vacation hours. There are two important things to consider when designing an effective incentive Program:

1. **Incentive strategies should evolve over time as an employer’s culture of wellness evolves and goals become more ambitious.** In the first year or two, an employer may primarily reward participation in the Program to get employees comfortable and trusting of the assessment process. Once a credible number of employees participate – generally 50 percent or more – data is sufficiently complete to enable the employer to determine the priorities for their population. Rewards can then be tailored to focus more on achievement of goals that are the most impactful on the needs identified. It is important to consider how the incentive Program will evolve over time, so that communications and reward strategies can anticipate and effectively reinforce the changes.

   Generally speaking, rewards should rise over time, but should be increasingly tied to the actual attainment of healthy outcomes as shown in Figure 16 below. That is, a higher reward is achieved by actually improving one’s Well-Being Score while a lower portion of the overall reward is tied to simple participation.

   **Part VI, Figure 16: Wellness Incentive Strategies Evolve**

![Chart Title]

   - Outcomes/Results-Based
   - Participation-Based
   - HRA/Screening
   - Base Contribution

2. **Incentives need not cause the employer to spend more money.** Most employers already provide some contribution or subsidy to their employees toward the cost of their health benefits. In Figure 16 above, the employer provided a base contribution of $1,000 to each employee in the initial year. In a subsequent year, the employer contributed more, but began to condition the increase on participation in the Wellness Program. In other words, the Wellness Participation Credit became available only if the employee participated in the two part

---


assessment process. In this example — modeled after an existing CareFirst account — the group experienced a greater than 70 percent participation rate in the assessment process with this strategy.

As time went on, a larger portion of the higher potential incentive became conditioned on achieving healthy outcomes. That is, each time a new goal was introduced, employees could earn more subsidy in total than they had previously while the base employer reward for participating declined. It may appear that employer costs increased, but, since a percentage of employees will always decline to participate or will not achieve the outcome needed for a reward, costs tend to remain stable. With this strategy, the account shown maintained a 70-83 percent participation rate throughout the period, but did not increase the overall dollars spent on incentives.

A recent study of 151 mid to large employers showed that 95 percent of employers now offer a screening process and 74 percent offer wellness related incentives. The same study showed that the median incentive offered by these employers is $500 in 2014, up from $338 in 2010. CareFirst’s experience with its own Wellness Program showed 70-75 percent participation in 2010, with an incentive to participate in the screening process of $300. When the overall incentive increased in 2012 to include incentives for outcomes, the participation rate increased to over 80 percent CareFirst currently provides $1,000 in wellness incentives for each associate if all goals and participation are met.

Because such a large percentage of overall health care costs are generated by the dependents of employees, accounts should provide wellness incentives for spouses and adult dependent children as well. The same study showed that more than one-third of employers now provide incentives to spouses and domestic partners. Providing direct incentives to spouses and dependents can be complicated by laws pertaining to income tax withholding, wellness Programs and even those pertaining to the collection of genetic information through family history. Even with these obstacles, more and more employers are considering this option.

CareFirst works closely with each employer to design an incentive Program that fits the employer’s needs while maximizing participation and threading through the maze of tax and legal requirements.

Once data has been collected through the assessment process, the employer’s results are compared nationally, regionally or within a targeted industry. Results can also be compared across an account’s operating divisions or locations. The results are presented in account specific SearchLight Reports. CareFirst works with the employer to implement targeted Programs through plan design changes, employer communications and workplace wellness initiatives to foster a more impactful culture of wellness.

Plan Design

In addition to direct incentives for participation, the employer’s health benefit plan design should be aligned to provide additional incentives to reward a healthy lifestyle, a strong PCP relationship and reinforcement to use the most cost effective site for services. These include:

1. A Medical Expense Debit Card or a vanishing deductible concept for the Member and each of their adult dependents to participate in the assessment process. Once the Member’s results are collected through the screening they can increase their rewards by maintaining a healthy weight, blood pressure and glucose levels, being tobacco free and receiving an annual flu shot. For self-insured employers, these measures and the reward vehicle can be customized.

2. The receipt of a debit card or vanishing deductible conditioned on the completion of the Health Assessment which requires a PCP visit if the screenings are not done at the employer’s worksite. In addition, the CareFirst

Model Plan Design provides office visits with the PCP at a “zero” copay – eliminating financial barriers to receiving care.

3. **Differential copays based on site of service**, through lower copays for Members to access their care in the most appropriate and cost effective setting. For example, the copay for a visit to a freestanding urgent care center is lower than that for an emergency room visit in the hospital.

Thus, the overall “Model Strategy” is one of stacked incentives through both the health plan and the Wellness Program to reinforce the importance of the annual assessment and maintaining a healthy lifestyle. More detail on Benefit Design can be found in **Part X** of these Guidelines.

**Condition Tracks**

Once Health Assessment and Biometric Screening data is combined with CareFirst’s historical claims data, each Member’s current and potential risk for one or more Health Condition Tracks is identified. For Members that are not yet at a full expression stage, it is important to identify early what track they are on in order to address the underlying risk factors and behaviors. With the right intervention, the progression toward disease can be slowed or stopped. **Figure 17** below lists the top 10 targeted Health Condition Tracks in the CareFirst Model.

**Part VI, Figure 17: Chronic Health Condition Tracks**

<table>
<thead>
<tr>
<th>Condition Track</th>
<th>Condition Track</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Preventable Cancers</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>Metabolic Cluster</td>
</tr>
<tr>
<td>Musculoskeletal Cluster</td>
<td>Mental Health Cluster</td>
</tr>
</tbody>
</table>

CareFirst derived these health tracks from the 15 costly chronic conditions referenced in **Part VI, Figure 5**. These 10 Health Condition Tracks are chronic diseases that are preventable or can be managed effectively. The tracks were identified through a process that considered, among other factors, the following:

- Chronic illnesses that are caused or worsened through unhealthy lifestyle choices and behavior such as lack of exercise, smoking or poor nutrition.
- Conditions that result in a significant incremental cost that can be avoided if managed appropriately.
- Chronic illnesses that account for a significant percentage of overall health care spending.
- Illnesses that manifest themselves across genders and throughout life as evidenced by Decade of Life analysis.
- Conditions with risk factors that can be addressed successfully through scientifically proven Programs of coaching, behavior modification and clinical management.
The goal is to identify what track(s) the Member is on, based on their identified risks, and get them into the right Program to better manage their course to full health. After receiving data from the Member’s Health Assessment and Biometric Screening and combining this with available claims data, it is possible to determine if a Member is at-risk or has already manifested one or more of the 10 Health Condition Tracks. CareFirst then assigns the Member to one of the three categories below in order to determine the most appropriate and cost effective method of intervention:

- **Full Expression** (Well-Being Score range of 0-49) – These Members already have the full expression of one or more chronic conditions and, therefore, are assigned to either a more intensive TCCI Program such as CCC or CCM, or telephonic Disease Management coaching. If the Member is already participating in a CareFirst TCCI Program, the Health Assessment and Biometric Screening results will be provided to the Member’s provider and Care Coordinator (if applicable) through CareFirst’s electronic Member Health Record.

- **High Risk** (Well-Being Score range of 50-74) – These Members have a high risk for developing a preventable disease related to one or more of the Health Condition Tracks, but do not yet have the disease or condition. They are targeted for Lifestyle Coaching, which focuses on improving their risk by addressing unhealthy behaviors that can lead to serious illness.

- **Low Risk** (Well-Being Score range of 75-100) – These Members are generally healthy and exhibit a low risk for developing a preventable chronic condition. These Members are not automatically referred for Disease Management or Lifestyle Coaching, but can self-refer themselves into online and telephonic coaching at any time.

**Wellness and Disease Management Coaching Program Services**

Once CareFirst identifies a Member’s risk level and Health Condition Track(s), every Member in the “High Risk” or “Full Expression” categories is contacted to gain their willingness and consent to participate in coaching services. A running record of successful and unsuccessful contacts is kept.

Members are contacted by a qualified coach within two weeks of CareFirst identifying them. During the initial interactive phone-based contact with the identified Member, an attempt is made to obtain the Member’s consent to participate in coaching services, establish a defined goal(s) for Wellness and/or Disease Management coaching, and establish the frequency and duration of future coaching sessions to best meet the established goal(s). More serious conditions require more frequent contact according to clinical guidelines.

Unless services are refused or the employer requests less intervention, a minimum of three attempts at contact made are via phone and twice via mail/email over six weeks to initially engage the Member in identified coaching. A “no call list” is maintained for Members that have refused all WDM Services and/or other CareFirst TCCI Programs. This refusal remains in effect for the individual Member unless revoked.

Two types of coaching are offered:

1. **Lifestyle Management Coaching** is targeted to those Members who are at risk, but have not yet experienced the full onset of chronic disease. The coaching seeks to mitigate risk progression through the management of underlying behavioral factors associated with the condition and is conducted telephonically by trained behavioral health coaches who work with the Member to make incremental lifestyle modifications in order to reduce the chance of developing preventable disease. This type of coaching can also be delivered through an online format that engages the Member via electronic tools such as goal setting, monitoring, and specific strategies for success.

   Lifestyle Management coaches have, on average, two to five years coaching experience. Many of these coaches hold licenses and certifications including Certified Health Education Specialist and Registered Dietician.
2. **Disease Management Coaching** is targeted for those Members that already manifest one or more of the identified chronic conditions or diseases, and focuses on the clinical management of these disease condition(s). The coaching is conducted telephonically by specially trained and licensed registered nurses. The coach works with the Member to mitigate the progression of the disease and lessen the impact of their condition(s) on their quality-of-life. The Program emphasizes monitoring and adherence to recommended treatment plans as well as self-care strategies.

Disease Management coaches are required to hold licensure/certification as a registered nurse, with a bachelor’s degree in nursing preferred, three to five years of related experience in a clinical health care setting and appropriate licensure and certification depending upon position (respiratory therapist, etc.). The credentialing process, which recurs every two years, includes primary source verification of licenses and/or registrations, national practitioner database querying, and a peer-review process.

If a Member is identified for both Disease Management and Lifestyle coaching due to the presence of multiple conditions, the Disease Management coach is trained to provide both categories of service to the Member to avoid confusion for the Member that might arise from multiple points of outreach. Similarly, if a Member is already engaged with a Care Coordinator as part of an active Care Plan within TCCI, Wellness/Disease Management coaches will not outreach to the Member unless requested by the Care Coordinator.

Although the primary way in which a CareFirst Member is referred to Disease Management or Lifestyle Management coaching is through the review of Health Assessment and available claims data as described, a Member may also be referred into coaching as part of a Care Plan under the CCC or CCM Programs within TCCI. In this case, the CCC or CCM Nurse involved indicates that the Member would benefit specifically from Disease and/or Lifestyle Management coaching. This is documented in the Member’s Care Plan and a referral to the WDM Coaching Program is automatically processed through iCentric’s Service Request Hub. The coach then contacts the Member and provides the designated coaching services within the context of the Member’s CCC or CCM Core Plan.

All coaching is offered Monday through Friday 8:30 a.m. to 8:30 p.m. Eastern Standard Time and Saturday 7:30 a.m. to 5:30 p.m. Eastern Standard Time.

**Updating the Member Health Record in iCentric**

Within the iCentric System, the Member Health Record, shown in Figure 18 on the next page has a section dedicated to Wellness and Disease Management. Data from the Health Assessment process and claims are automatically loaded into the iCentric System. Members are highlighted for outreach if they fall within the Full Expression or High Risk categories. Key data from the Health Assessment, and all subsequent Lifestyle Management or Disease Management activity is stored in the Member Health Record along with daily updates from coaching Programs including Member outreach, interaction and Engagement, clinical notes and outcome data related to the coaching services.

Year over year historical data is kept within the Member Health Record so that the Member’s PCP has access to all assessment data, claims and coaching Program activity and results. Disease and Lifestyle Management coaches have full access to the Member Health Records for CareFirst Members through iCentric. This access enables the coach to view all longitudinal and detailed claims information, which may be useful in providing timely and appropriate services to the Member.
Part VI, Figure 18: Member Health Record

Carefirst

New Window Print Close

View Care Plan Version Working Draft

VI - 34

Member Health Record - Timeline


Member Since: October 2012

Diabetes
Percent of Total

Episode Duration

Click on the episode to see health details

Prescription Drugs

Drug Name

Antihypertensive
Alprazolam
Terbinafine Inc.

Antifungal Antimicrobial

Dermatological Agents

Dermatological - Anti-Infective Combinations

Dermatological - Anti-Infectives

Dermatological - Keratolytic-Antibiotic Singe Agent

NOTE: Products are grouped by therapeutic class. List is not a complete list.

Disclaimer:

You are viewing information disclosed to you from records protected by state and federal confidentiality rules.

- The state and federal rules prevent you from making any further disclosure of alcohol abuse records or drug abuse records unless further disclosure is expressly permitted by the written consent of the person to whom it applies or is otherwise permitted by law.

- A general authorization for the release of medical or other information is NOT sufficient for further disclosure of alcohol abuse records or drug abuse records.

- The federal rules restrict any use of the information to ordinary investigation or prosecution any alcohol or drug abuse patient.

- Any person who willfully and knowingly discloses or uses confidential information in violation of the law may be liable to the individual for actual and punitive damages, attorney’s fees, and litigation costs, and may also be subject to criminal penalties.

- Disclosures of mental health information may only be made pursuant to a valid authorization by the member or as provided in Title III of the DHHS or other applicable laws.
Member And Employer Reporting

Member Reporting – All Members who participate in the Health Assessment process can access their personalized information and reporting through the CareFirst Member Portal. This includes the Member’s overall assessment and screening results, personalized Well-Being Score, risk factors, Programs available and strategies for improvement.

The online Member Well Being report is tailored to the individual based on their self-reported and biometric screening results. As noted earlier, it paints a personalized picture of the participant’s current health along with numerous calls to action to initiate a well-being plan. Additional resources are also highlighted for the Member’s use and exploration, including:

- Nutrition, exercise, and calorie tracking, including healthy meal planning and recipes.
- Specialized resources and Programs for tobacco cessation.
- A comprehensive health library.
- Progress trackers and monitoring for multiple personalized goals.
- Online coaching Programs with access to a virtual coach.
- Daily challenges.
- Social media interaction including the ability to invite friends and family to join the Member in their activity and goal attainment.

The online Member Portal is designed to maximize the participation and Engagement of the participant. As such, all facets are tracked including Program enrollment, Well-Being Assessment and Screening completion, enrollment in self-management tools, establishment of a plan and the tracking of activity and progress related to the plan – including activity related to coaching Programs.

Employer Reporting – Self-insured employers that participate in the TCCI WDM Program are provided aggregate reporting through CareFirst’s Account SearchLight Reporting package. Information is provided in the following areas:

- Overall Wellness Program participation including demographic breakdowns for Members participating (and not participating) in Health Assessments and Biometric Screenings.
- Member costs and Illness Burden Scores for those participating (and not participating) in Health Assessments and Biometric Screenings.
- The overall Well-Being Score distribution for the group comparing results year over year.
- The number of Members identified as either “Full Expression” or “High Risk”, total PMPM and average Illness Burden Scores of those in each of the 10 Health Condition Tracks. This is also compared against the PMPM cost for those more fully advanced in the Condition Track, showing the potential exposure without intervention.
- The total number of Members identified as either Full Expression or High Risk that have been contacted, engaged in coaching and those achieving improved outcomes. The reporting also highlights the number of Members that have refused coaching services.

CareFirst also makes available certain standard and ad hoc employer reports as needed to supplement the SearchLight Reporting package.

Workplace Wellness Services

CareFirst provides additional workplace wellness services as requested by the employer account. These are generally discussed as part of the strategy for addressing the health of the employer account population. It is important to note that some employers want to provide wellness services to their entire population of employees regardless of their health insurance carrier involved. This is because of the strong correlation between productivity and overall health and wellbeing.
This enables the employer to provide services to those employees who waive health coverage, have coverage through another carrier, or are not eligible for health coverage due to their status under the employer’s policy. CareFirst is able to provide coverage to both Members and non-CareFirst Members in an integrated and seamless fashion.

To support an overall culture of wellness in the workplace, CareFirst provides Supplemental Workplace Wellness Programs and services which can be purchased separately by the employer. These include:

- Additional Disease Management categories.
- Additional Biometric Screening categories.
- On-site inoculation services.
- Targeted wellness educational sessions which can be provided on site or via webinar.
- On-site professional services such as personal training, dietician, and personal massage.
- Professional fitness class instruction.
- Support and tracking for workplace wellness contests and Program activities.
- Customized incentive tracking.

Program Costs And Financing

The WDM Program outlined in this section of the TCCI Program is integral to the overall CareFirst approach, and is the “gateway” to greater health for many. Program costs are divided into two categories:

- Administrative charges for the administration of the TCCI WDM are included in the overall CareFirst PMPM Administrative Charge for self-insured employer accounts. This includes costs such as those for communications, reporting, and the web Portal. No separate, itemized administrative costs are charged to the group for the Program.

- Direct services related to the care of the Member such as Biometric Screenings, Lifestyle or Disease Management Coaching Services are processed as a claim and attributed to the Member receiving the service. In order to encourage maximum Engagement and participation, these claims have a zero Member cost share (copay) under the CareFirst Model Benefit Design unless required by federal law regarding the administration of certain high deductible health plans. The advantage of this approach is obvious: Claim charges are limited to only those Members who actually use the services – not to the entire employee group whether or not the services are utilized.

Supplemental Wellness or services may be purchased as well and they may be charged separately based on a schedule of fees for the services selected. These include workplace wellness activities or additional Disease Management support for targeted conditions requested by the employer.

The overall cost of the TCCI WDM Program depends on the account, but is generally around 0.5 percent of overall health care premium or premium equivalent, not including the cost for annual Biometric and/or Health Screening with a PCP. Actual return on these dollars is calculated in terms of reduced claims costs, utilization and absenteeism along with higher productivity.

While the amount of return varies by account and by participation level, studies show that every dollar spent on these types of services will generally yield $3-5 in savings in return. As noted earlier, even a small change in a Member’s Well-Being Score can make a difference. The elimination of only a few hospital admissions or Emergency Room visits per year can easily create a positive Return on Investment for an account.

---

**High Deductible Health Plan Administration**

CareFirst seeks to maximize the Member’s access to preventative and care management services such as those provided in the WDM and throughout the various TCCI Programs. Where allowed by law and the employer’s health benefit contract, services will have a zero copay and cost share. For the health benefits outlined in this section:

- All wellness/biometric screening, health risk assessment and wellness/lifestyle coaching are provided to the Member at a zero copay and cost share.

- Similarly, Disease Management coaching is generally provided at a zero copay and cost share, with the exception of federally qualified High Deductible Health Plans that include a funded Health Savings Account (HSA). Current Federal Law requires that these services can only be provided with a zero cost share once the Member’s annual deductible is met.

CareFirst through its partnership with Healthways will notify Members of High Deductible Health Plans whether they will incur a copay or cost share prior to receiving any coaching benefits under this Program.

- Prior to the receipt of services, the Disease Management coach will ask the Member if they participate in a High Deductible Health Plan with an HSA. If the Member says no, the coach will document this response, and there will be no copay or cost share applied to the benefit.

- If the Member does have a High Deductible Health Plan with HSA, or is unsure of their plan, the coach will email (or mail if required) the Member a three question email to determine and communicate the Member’s status.
  
  a. Does the Member have health benefits through a High Deductible Health Plan with HSA?
  
  b. If yes, does the Member fund or plan to fund the HSA during the year?
  
  c. If yes to both, the Member will be told that they will be responsible for the Disease Management coaching copay/cost share until the IRS required deductible is met. Once the deductible is met, there will be zero copay or cost share to the Member. The Member will also be reminded that they can pay for any required copays with their funded HSA balance.

- Once the Member replies to the email – checking the appropriate boxes – then the Disease Management coach will reach out to the Member to begin coaching services.
Program #2: Hospital Transition Of Care Program (HTC)

Of all the transitions of care that occur, the most significant is from hospital to home or to another setting. A Member left to navigate this transition alone – particularly one with multiple ongoing chronic conditions - has a higher likelihood of readmission in the 30 day period following discharge. This risk often remains elevated for a considerable period of time – up to 90 days or more.

As pointed out in Part I, CareFirst operates in a region with among the highest admission and re-admission rates in the country. This is shown more specifically in Figure 19 below.

<table>
<thead>
<tr>
<th>AVERAGE</th>
<th>Inpatient Admissions per 1,000</th>
<th>30 day Hospital Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>Rank</td>
</tr>
<tr>
<td>US Average</td>
<td>295</td>
<td>N/A</td>
</tr>
<tr>
<td>Maryland</td>
<td>309</td>
<td>35th</td>
</tr>
<tr>
<td>DC</td>
<td>358</td>
<td>51st</td>
</tr>
</tbody>
</table>

Part VI, Figure 20: CareFirst Illness Burden Pyramid, 2014

\[9\] Source: CMS State/County Table All Beneficiaries Data, December 2013.

\[10\] Source: CareFirst HealthCare Analytics – Incurred in 2014 and paid through March 2015 – CareFirst Book of Business, excluding Medicare Primary Members.
In total, CareFirst’s membership produces about 8,300 admissions per month or approximately 100,000 per year. This is down markedly from 2012 levels when CareFirst Members were admitted to a hospital over 130,000 times. Each admission is a signal event since nothing so predicts the likelihood of future health care expenditures as a hospital admission. Indeed, an admission is followed by a readmission within 30 days in approximately 12 percent of cases. This readmission rate rises to 27 percent within 90 days of admission.

The key goal of the Hospital Transition of Care Program is to quickly assess each admission as it occurs and decide which ones will likely need follow-up attention post discharge to best assure recovery to the extent possible with an eye toward avoiding the breakdowns that lead to readmissions and further complications.

This capability is critical to Medical Care Panels because most admissions and their aftermath occur out of sight of PCPs or NPs and without their knowledge or awareness. Yet, so many consequences flow from these admissions for the Members involved as well as for the Panels who inherit all the costs (“Debits”) for the care involved.

To provide this much needed support capability, CareFirst employs approximately 70 HTC registered nurses, all of whom have extensive experience in working in a hospital setting on Care Coordination and discharge planning. These HTC nurses monitor all hospital admissions every day throughout the CareFirst service region and more broadly, throughout the United States. Under cooperative arrangements with regional hospitals, the majority of the nurses are physically stationed in the hospitals that account for 75 percent of all CareFirst regional admissions. Other HTC nurses remotely monitor daily admissions in smaller hospitals and in hospitals around the country.

For out of area admissions, which constitute approximately 20 percent of all admissions, CareFirst is notified by a call from the admissions staff of the admitting hospital. This typically occurs within the first 24 hours following admission. Information on the admission is gathered telephonically and is then loaded into the iCentric System by the CareFirst representative who took the call. Full time, dedicated representatives are assigned to this function.

Once an admission notification occurs, the responsible HTC nurse reviews the case to determine whether the nature of the illness/condition of the Member is likely to require post discharge services. This results in the assignment of one of two designations in the iCentric System:

**Category 1 Admission.** If the Member is likely to need post discharge services, they are designated as a Category 1 admission. Members in this category have acute or critical illness or the acute manifestation of one or more chronic illnesses.

**Category 2 Admission.** If the Member is not likely to need follow-up care post discharge, they are designated a Category 2 admission. Members in this category are likely to quickly recover. Examples include childbirth and routine surgeries in otherwise generally healthy people.

These designations are entered into the iCentric System and made part of each Member’s Health Record by the HTC nurse. Roughly 60 percent of all admissions fall into Category 1, and this percentage appears to be rising. All subsequent claim information on each admission is entered into the Member Health Record as are any HTC notes.

For those in Category 1, a further, more refined categorization is made by the HTC nurse after gaining a better understanding of the Member’s condition(s) and illness(s). This more refined judgment is based on direct interaction by the HTC nurse with the treating providers in the hospital, the Member and family as well as a review of the clinical records available on the Member during their hospital stay. These further categorizations are as follows:

**Level 1A: Advanced Illness/Palliative** – End stage disease, end of life care, end stage organ failure, palliative care and/or hospice care. This distinction may apply to any terminal condition or illness such as metastatic cancer (even if newly diagnosed), as well as advanced COPD and CHF (NYHA Stage 4). End Stage Renal Disease and Transplants are excluded since they are covered in 1G and 1H below.

**Level 1B: Catastrophic Events** – sudden catastrophic event or diagnosis causing critical illness but with an expected return to baseline or stability (MVA, trauma, stroke, non-metastatic cancer diagnosis).
Level 1C: Multi-morbid Chronic Conditions – an acute episode within the context of ongoing chronic illness usually with comorbidities present. High risk for impending re-hospitalization or multiple ER visits with continuing chronic conditions expected to present elevated risk for hospital based services into the foreseeable future.

Level 1D: NICU Babies – premature babies, feeders and growers, and babies with complications requiring NICU stays with a high likelihood of follow on care needed.

Level 1E: Special Needs Pediatrics – children with complex medical or congenital conditions requiring hospitalization and high likelihood of extended post discharge services needed.

Level 1F: Complex Infectious/Immunological Conditions (Specialty Pharmacy) – Members with admissions for MS, Rheumatoid Arthritis, HIV/AIDS, Hepatitis C, Growth Hormone Deficiency, RSV, Fertility, Hemophilia and Inflammatory Bowel Disease; such as Crohn’s and Ulcerative Colitis.

Level 1G: Transplant – Members admitted for organ transplant or complications post organ transplant excluding kidney since they are covered in 1H below.

Level 1H: End Stage Renal – A Member receiving kidney dialysis or kidney transplant services.

Level 1I: Other – This is a catch all category for Members who do not fall in one of the categories above or may be in more than one category.

For each Category 1 admission, two additional critical judgments are made by the HTC nurse. The first of these is whether the Member is likely – given their condition(s) and illness(s) – to be considered a “high cost” Member. This applies to Members whose costs could exceed $75,000. These cases are flagged so that they can be given a heightened level of attention and so that they can be tracked in the SearchLight Reporting process (See Part V). These cases either are – or are likely to become – cases that are subject to the ISL protection given Panels in the PCMH Program.

The second judgment is whether the Member should be placed in either a CCM or CCC Care Plan or whether sufficient provision for their post discharge needs can be met by alternative means, including family support and self-directed care.

All admissions involving a behavioral health or substance abuse condition or diagnosis are reviewed by CareFirst’s strategic partner, Magellan. This is described in the BSA Program which is TCCI Program #5.

Figure 21 on the next page shows the flow of Members through the HTC process into the two major categories and then on to CCM, CCC Care Plans or self-directed care.
To support the critical judgments made in the HTC process, HTC nurses complete a LACE Index Score on every Category 1 admission for which they are responsible in order to understand the potential risk of breakdown and Member re-admission.

The LACE Index was developed through independent research (in Canada)\(^{12}\) to help quantify the risk of unplanned re-admissions or early death after discharge from a hospital to the home or community and is useful in determining post discharge support needs for Members at highest risk of poor outcomes and instability following hospital based care.

The LACE Index incorporates a number of values associated with acute length of stay (“L”), acuity on admission (“A”), Charlson co-morbidity (“C”) and the number of emergency visits (“E”) in the six months prior to admission to determine the risk of re-admission to acute care. Scores range from 0 to 19. Scores greater than 10 predict a higher risk for

---

\(^{11}\) Source: CareFirst Data & Informatics. September 2013-August 2014 with claims paid through November 2014.

\(^{12}\) To predict early death or unplanned readmission after discharge from hospital to the community, Carl van Walraven, et al., Canadian Medical Association Journal, April 6, 2010 p. 551-557.
readmission to acute care. Accordingly, these cases are prioritized by HTC nurses as most in need of coordinated post discharge services and are the cases most likely to be referred to the CCM and CCC Programs. The general reliability of the LACE Index in predicting future readmission likelihood can be seen in actual CareFirst experience over the past three years.

The Figures below show different views of Members readmitted, one is based on the LACE score, the other is based on Category 1 and 2 compared to the general CareFirst population.

Figure 22A below shows the percent of admissions by LACE range for all CareFirst Members and shows 2012, 2013 and 2014 results. As noted, the percentage of admissions in each of the LACE ranges has remained relatively constant over three years.

Figure 22B below shows the 30 day readmission rates by LACE range and demonstrates readmissions for Members with high LACE scores (11-19) are 9 times that of Members in the lowest LACE range.

Part VI, Figure 22A: LACE Scores And Readmissions 2012, 2013 And 2014

<table>
<thead>
<tr>
<th>Percent of Admissions by LACE Range 2012-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Admissions</td>
</tr>
<tr>
<td>11-19</td>
</tr>
<tr>
<td>6-10</td>
</tr>
<tr>
<td>1-5</td>
</tr>
</tbody>
</table>

Part VI, Figure 22B: LACE Range And 30 Day Readmission Rates 2012, 2013 And 2014

<table>
<thead>
<tr>
<th>30 Day Readmission (2012-2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 Day Readmission %</td>
</tr>
<tr>
<td>2012</td>
</tr>
<tr>
<td>11-19</td>
</tr>
<tr>
<td>6-10</td>
</tr>
<tr>
<td>1-5</td>
</tr>
<tr>
<td>2013</td>
</tr>
<tr>
<td>11-19</td>
</tr>
<tr>
<td>6-10</td>
</tr>
<tr>
<td>1-5</td>
</tr>
<tr>
<td>2014</td>
</tr>
<tr>
<td>11-19</td>
</tr>
<tr>
<td>6-10</td>
</tr>
<tr>
<td>1-5</td>
</tr>
</tbody>
</table>
Figure 23 below shows the 30 and 90 day readmission rates for 2012, 2013 and 2014 for Category 1 and 2 Members. The stark difference in the rate between Category 1 and Category 2 readmissions - that is concealed in the average – is revealed in this Figure. The readmission rate among Category 1 admissions is four to five times that among Category 2 admissions.

Part VI, Figure 23: 30 And 90 Day Readmission Rates, 2012, 2013 And 2014

Based on actual experience in 2014, 58 percent of admissions were triaged into Category 1 for post discharge follow-up. Approximately 80 percent of these Category 1 admissions go into CCM for an average duration of three to four months. Approximately 15 percent go into CCC for durations of six to nine months or longer. The balance are discharged to home under alternate arrangements when there is a credible basis to believe that the supports Members receive from family and others are adequate to meet their needs. Figure 24 below shows the readmission rates for CCM and CCC Members – clearly revealing the greater illness and instability of CCM and CCC cases. CCM readmission rates have decreased due to a focused effort on managing the most complex individuals. CCC readmission rates have increased as CCC nurses have focused on sicker patients, many of whom are directly transitioned from CCM.

Part VI, Figure 24: Readmission Rates For Subcategories Of Category 1 Admissions

As soon as an HTC nurse believes that a Member will need either CCM or Chronic Care Coordination, the nurse enters the beginning description of the circumstances of the case in the Care Plan Template in the iCentric System. If the HTC nurse
has a Member for whom a referral is suitable, the nurse will alert the CCM or Local Care Coordinator (LCC) prior to the Member’s discharge.

Depending on the Member’s needs, the HTC nurse then sends the case online, via iCentric, to a CCM or LCC who confirms receipt of the case. This includes an initial assessment of the needs of the Member following discharge. No transition of the case can be made without a confirmed affirmation from the receiving CCM or LCC that they have accepted lead responsibility for the case. This is shown and tracked in the iCentric System.

From here, a more complete Care Plan is developed in concert with and under the direction of the lead specialist involved (in the case of CCM) or of the PCP or NP in the case of the CCC Program.

The iCentric System is kept up to date by the responsible CCM or LCC. As the CCM or LCC documents the emerging progress (or lack thereof) of the Member relative to the goals in the Care Plan, the iCentric based Care Plan is immediately viewable by all treating providers at any time to assure timely and up to date understanding on the part of all involved.

In addition, the SearchLight Report records and shows all cases flowing through the HTC process and on to other TCCI Program Elements. This tracking of Members is shown in various views through the SearchLight Report that is updated monthly.

So begins – for these Members – a continuous, longitudinal record of their illnesses and conditions as well as their treatment and progress. This is kept indefinitely in the iCentric System and is available online 24/7.

It is noteworthy that Members chosen for CCM or CCC have higher Illness Burden Scores – as might be expected – than those Members who were not selected for these Programs and are in self-directed care at home. This reinforces the value of the contemporaneous, personalized review and case selections made by the HTC nurses. The differences in the Illness Burden Scores of Members selected for CCM, CCC versus Category 2 admissions is shown in Figure 25 below.

**Part VI, Figure 25: Differences In Illness Burden Scores Of Members In Category 1 And 2**

![Average IB Scores of HTC Transitions to CCM and CCC 2012-2014](chart)

**Noteworthy Changes in Hospital Admission Trends**

Since the Program’s inception, there have been significant decreases in hospital admissions as shown in Figure 26 on the next page. While admissions have shown a significant decrease, readmissions have remained relatively flat in the last several years due to the increased complexity of Members admitted.
Along with the decrease in admission rates, there has been a significant rise in the acuity of the admissions that has occurred with a corresponding increase in the number of Members categorized as 1B (Catastrophic). Figure 27 below shows the increase in Level 1B categorization representing the increased severity of hospitalized Members. During the periods below, the criteria used by the HTC nurses has remained constant. Hence, the rise in 1B admissions clearly demonstrates rising acuity/complexity.

And, as shown in Figure 28 on the next page, depicting Illness Burden Scores, over 70 percent of admissions come from Members in Bands 1 and 2 compared to approximately 50 percent in early 2012. In addition, Figure 29, also on the next page, demonstrates the increasing proportion of Members readmitted to the hospital from Illness Bands I and II. This underscores the increasing complexity, acuity and instability of Members who are being admitted to the hospital.
Enhanced Coordination Between HTC and Hospitalists Beginning in 2015

Members routinely present to hospital Emergency Departments and undergo extensive evaluation, which often includes numerous laboratory tests and imaging procedures. Some are admitted to the hospital and during the course of the hospital stay, hospitalist physicians (Hospitalists), who are usually general internists, provide direct care in collaboration with one or more specialists. Referrals to specific specialists are generally determined by clinical urgency and specialist availability. Discharge plans for follow up care are generally arranged with the referral specialists who have provided inpatient care.

This entire process typically occurs without the awareness of or discussion with the Member’s PCP, who knows the Member the best. PCPs do not make hospital rounds, nor communicate in any way with Hospitalists during the hospital stay to discuss ongoing hospital care, specialist referrals or post-acute follow up plans. This process results in increased
fragmentation of care, unnecessary duplication of imaging and testing by physicians unfamiliar with the patient and the incurral of potentially avoidable expense.

Approximately 43 percent of all CareFirst Member admissions are unplanned and come in through the Emergency Department. This equates to nearly 43,000 unplanned admissions per year.

To mitigate the fragmentation of care associated with these admissions and to assure better communication with and guidance from a PCMH Member’s PCP, CareFirst began in 2015 to enter into amended hospital contracts with certain network hospitals to provide improved communication and Care Coordination between HTCs, Hospitalists and PCPs.

This amended relationship requires the HTC, upon learning of an emergency related admission of a CareFirst Member to:

- Directly call or personally meet with the hospitalist responsible for the Member;
- Discuss with the hospitalist the salient issues, concerns and Member needs in the case after reviewing information in the Member’s MHR and the information surrounding the emergency admission;
- Provide the direct contact information of the Member’s PCMH PCP; and
- Alert the LCC assigned to the PCP that the Member has been or is about to be admitted.

The Hospitalist then promptly seeks to contact the Member’s PCMH PCP so that the circumstances of the Member’s situation can be discussed and a course of action determined under the guidance of the PCP. This includes a discussion of which specialists are to be involved in the Member’s care post discharge as well as during the Member’s hospital stay.

The goal of this enhanced communication is to better assure that the care received by the Member post their unplanned emergency is as planned and coordinated as possible and is carried out by specialists with whom the PCP has an established relationship.

After direct verbal contact has been made between the PCP and Hospitalist, the LCC documents the course of action agreed upon in the MHR and notifies the HTC. Together, the LCC and HTC implement the agreed upon plan. The HTC will monitor the Member through the rest of their hospital stay. Any coordination with Complex Case Management or with the LCC assigned to the Member’s PCP is handled as part of the HTCs usual role.

The Hospitalist also follows the case through discharge and works directly with the HTC, CCM and LCC as well as with the hospital discharge planning staff to assure that care is being coordinated as agreed to with the PCP. This includes additional follow up phone based communication with the PCP as necessary throughout the Member’s hospital stay.

If, at any time in attempting to carry out this enhanced communication and Care Coordination protocol, the Hospitalist is unable to reach the Member’s PCP after three attempts, the Hospitalist will inform the HTC who will work with the LCC involved to overcome whatever has caused PCP unresponsiveness.

This process is intended to be fluid and rapid with a maximum emphasis on verbal communication. Electronic forms of communication between Hospitalist and PCP are not intended to be the principal means of communication but are used to follow up, confirm or clarify aspects of the discussion between the parties and to share the underlying information that is the basis for Care Coordination decision making.

In due course, CareFirst will introduce video capabilities into this dialogue so that PCP, Hospitalist, HTC and LCC can all simultaneously hear, see and consider the facts and circumstances of the Member. This is intended, where appropriate, to include the Member directly or their family/significant other.

**Conclusion**

In sum, the HTC Program provides a critically important way of quickly focusing on the sickest, most unstable Members who are hospitalized and transitioning them into the right subsequent TCCI Program that is best suited to minimize breakdowns and complications that become so costly over time. This is done with the knowledge and concurrence of the Member’s PCP or NP, where possible.
Program #3: Complex Case Management Program (CCM)

By far, the single greatest source of cases that flow into the CCM Program come from HTC referrals — accounting for over 90 percent of all CCM cases.

The Members who make up this flow are typically those at the top of the Illness Burden Pyramid (Band 1 and upper Band 2) whose care is being directed by one or more specialists or super specialists. This target population includes those Members headed toward palliative care. These are all Category 1 Members.

While the PCP or NP of the Member is informed of the admission and post discharge CCM services being coordinated for Members in these circumstances – and can see all aspects of the Care Plan and progress notes entered into the Member Health Record of the Member – the care of these Members is usually in the hands of specialists – at least in the period following discharge from the hospital.

Given this, the Care Plans and subsequent Care Coordination activities carried out for these Members demand specialized nurse case managers who have had considerable clinical experience in the specialty area needed by the Member. To this end, CareFirst employs over 80 full time registered nurses who serve as CCMs. Each CCM handles an active caseload of up to 50 Members in their specialty area.

The specialty categories around which this nurse CCM work force is organized are as follows:

- Adult Oncology
- Pediatric Oncology
- Complex Medical
- Trauma/Rehabilitation
- Specialized Needs/Complex Pediatrics
- High Risk Obstetrics
- Hospice/Palliative/End of Life Care

All nurses in the CCM Program have a minimum of three to five years of clinical experience in their specialty area(s) in a hospital or physician practice. Certified Case Manager certification is attained prior to hire by most of these nurses. Figure 30 below summarizes the qualifications by specialty area that is required for the nurses serving in the CCM Program:

### Part VI, Figure 30: Qualifications by Specialty Area Required For Nurses In The Complex Case Management Program (CCM)

<table>
<thead>
<tr>
<th>Case Management Specialty</th>
<th>Qualifications (in addition to multiple levels/years of experience in each discipline)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Needs/High Risk Pediatrics</td>
<td>Certified Pediatric Nurse, Certified Neonatal Nurse, or Certified in Developmental Disabilities</td>
</tr>
<tr>
<td>Pediatric Oncology</td>
<td>Certified Pediatric Oncology Nurse, Certified Hospice/Palliative Nurse with concentration in Pediatrics, or Certified Pediatric Nurse</td>
</tr>
<tr>
<td>Adult Oncology</td>
<td>Certified Oncology Nurse, Certified Hospice/Palliative Care Nurse, or Certified Clinical Transplant Coordinator</td>
</tr>
<tr>
<td>High Risk Pregnancy</td>
<td>Certified Maternal Health Nurse or Certified Childbirth Educator/Nurse</td>
</tr>
<tr>
<td>Complex Medical Illnesses: Neurology, Cardiology, Pulmonology, Immunology, Gastroenterology, Endocrinology</td>
<td>Certified in Medical/Surgical Nursing or one of the specialty disciplines such as Neurology or Cardiology, Certified Case Manager, or Certified Geriatric Nurse</td>
</tr>
<tr>
<td>Palliative Care/Hospice</td>
<td>Certified Oncology Nurse, Certified Hospice/Palliative Care Nurse</td>
</tr>
<tr>
<td>Trauma/Rehabilitation</td>
<td>Certified Rehabilitation Nurse, Certified Orthopedic Nurse, Certified Neurology Nurse</td>
</tr>
</tbody>
</table>
Over 30,000 cases are handled through the CCM Program in a calendar year. For each, a designated, responsible CCM nurse is assigned. The approximate breakdown of these cases – into the categories shown above – is presented in Figure 31 below.

### Part VI, Figure 31: Breakdown Of Member Conditions/Illness In The Complex Case Management Program (CCM)

<table>
<thead>
<tr>
<th>Program</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma/Rehabilitation</td>
<td>30</td>
</tr>
<tr>
<td>Adult Oncology</td>
<td>20</td>
</tr>
<tr>
<td>Special Needs/Complex Pediatrics</td>
<td>20</td>
</tr>
<tr>
<td>Pediatric Oncology</td>
<td>10</td>
</tr>
<tr>
<td>High Risk Obstetrics</td>
<td>10</td>
</tr>
<tr>
<td>Complex Medical</td>
<td>5</td>
</tr>
<tr>
<td>Hospice/Palliative/End of Life Care</td>
<td>5</td>
</tr>
</tbody>
</table>

For each case, the CCM establishes a written Care Plan in the iCentric template that is composed of a number of parts including a narrative summarizing the Member’s circumstances, actionable goals and progress and encounter notes that track progress toward these goals. The CCM establishes a timeline and tasks for each goal. These are documented in the Care Plan component of the Member Health Record maintained online in the iCentric System.

The CCM works closely with the Member, their family and other supporting persons as well as the specialists involved in carrying out the Care Plan. This is done telephonically. The lead specialist guides and approves the Care Plan that the CCM nurse documents and carries out. The Program serves Members wherever they live – including outside of the CareFirst service region.

When a Member becomes engaged in a Care Plan, the Member and their CCM discuss and outline a targeted “State-of-Being” that, when reached, constitutes completion of the Member’s Care Plan and enables graduation from the Care Plan. Graduation occurs when the Member is stabilized and can better self-manage their condition.

If a Member in the CCM Program progresses to the point where a transition to Chronic Care Coordination is appropriate, the CCM nurse will transition the case to the LCC who is supporting the PCP or NP of the Member. As with transitions from HTC to CCM, the transitions from CCM to CCC must be confirmed in the iCentric System and a formal change in lead responsibility must be established before the transition is complete. Approximately 20 percent of all CCM cases transition to the CCC Program. The balance of Members continue their recovery through self-directed care in accordance with their physician’s instructions.

The CCM may make a referral through the iCentric Service Request Hub to arrange for other TCCI Programs to be brought to bear. Should these additional Programs be arranged, they are made part of the larger Care Plan of the Member – in effect, “nesting” these additional services into the larger plan. All are documented and updated in the iCentric System. The CCM who referred the case remains the lead who is responsible to oversee all Program components.

In order to remain in the Care Plan and continue to receive Care Plan related benefits - including a Cost Share Waiver - the Member must be meaningfully engaged with the CCM, and follow the actions and steps called for in the Care Plan. Specifically, to remain compliant in a Care Plan a Member must:

1. Engage with the CCM at least once each week for the duration of the Care Plan, as measured by the CCM’s documentation of the frequency of successful contacts with the Member in iCentric.
2. Complete the activities outlined in the Care Plan, to assist in stabilizing the Member in order to avoid unnecessary hospitalizations or ER use.
3. Make progress toward the Care Plan’s envisioned State-of-Being for the Member.
When a Member is not adhering to the above requirements the Member is deemed non-compliant and given 30 days to re-engage with the CCM and make progress toward Care Plan goals. If the Member has not appropriately re-engaged after 30 days of non-compliance, the CCM will recommend that the Care Plan be terminated by the treating physician as explained more fully earlier in this Part VI.
Program #4: Chronic Care Coordination Program (CCC)

Care Coordination for Members with multiple chronic diseases is a central goal of the PCMH and TCCI Programs. Without it, little can be done to reduce expensive hospitalizations and the costs associated with the repeated complications and breakdowns that characterize this small portion of the population.

The CCC Program is carried out by a field force of over 250 registered nurses, all of whom have had prior clinical and working experience in various aspects of Care Coordination. This workforce of Local Care Coordinators (LCCs) is organized by sub-region within the CareFirst service area which is divided into 20 sub-regions that represent approximately co-equal portions of the population within the overall region and, yet, recognize the differences that exist among rural, suburban and urban communities.

In effect, these sub-regions recognize the essential micro local nature of primary care and most other health care services. LCC nurses are assigned to a particular sub-region and to a particular practice within a Panel in the sub-region. The overwhelming majority of these nurses live within the sub-region to which they are assigned and often have considerable knowledge of the local physician community before they begin their duties in the PCMH/TCCI Programs.

It should be noted that a separate team of National Care Coordinators (NCCs) is available for Members who live outside these twenty regions. NCCs develop and maintain Care Plans for out of area Members telephonically. These Care Plans are subject to the same standards and review processes as LCC developed plans and are documented in the same way in the iCentric System as well as reported in various views of Panel data provided in SearchLight Reports. A full dataset is kept on Members not attributed to a PCMH PCP or NP inside the CareFirst service area.

Figure 32 below shows the sub-regions within the overall CareFirst service area:

![Part VI, Figure 32: CareFirst PCMH/TCCI Sub-Regions](image)

A registered nurse, who is an employee of CareFirst, is in charge of each sub-region and is responsible to oversee all CCC activities within her sub-region. These nurses are called Regional Care Directors (RCDs). They direct all Care Coordination activities and the implementation of all TCCI Program Elements within their sub-region.
Each of the over 400 Medical Care Panels within the PCMH Program is located within one or more of these sub-regions based on the location of the practices that make up each Panel. So, each RCD has a discrete number of Panels for which he/she is responsible. Their goal is to help the Panels succeed in earning an OIA by coordinating the care of Members with multiple chronic diseases most in need of Care Coordination.

LCCs work intensively with the PCPs and NPs to whom they are assigned. In so doing, they essentially become an integral part of the practice. It is expected that each LCC will build a trusted and active relationship with the practice(s) to whom they are assigned and that they will have daily and even hourly contact and Engagement with the practice. So, while the LCC is not physically embedded in the practice, (s) he is expected to be well known to it and operate as an integral part of the practice.

Most LCCs are employed by Healthways, a major strategic partner of CareFirst. Healthways is a specialty wellness, Disease Management and Care Coordination company with a large established presence in the CareFirst region. All Healthways LCCs work under the direction of the various RCDs. The methods by which this workforce is recruited, trained, overseen and monitored are extensively documented in Appendix C as are their qualifications and performance standards, including the quality of the Care Plans they develop and maintain.

For larger practices – particularly multi-site independent group practices and Panels that are part of large health care systems – the delegation of the LCC role is permitted under carefully controlled circumstances that are governed by a separate delegation agreement. However, all the requirements that apply to Healthways LCCs apply to delegated LCCs. This is described at length in Appendix C.

The level of illness of Members in Care Plans is over five times that of the general population as shown in Figure 33 below. The level of illness in the selection of CCC cases is also shown in Figure 33 below:

### Part VI, Figure 33: Illness Level Of Members In Chronic Care Plans As Of October 1, 2013 And December 1, 2015

<table>
<thead>
<tr>
<th>Region #</th>
<th>Region Name</th>
<th>Average IBS as of 10/1/13</th>
<th>Average IBS as of 12/1/14</th>
<th>Average IBS as of 12/1/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Western Maryland</td>
<td>4.15</td>
<td>5.89</td>
<td>6.52</td>
</tr>
<tr>
<td>2</td>
<td>North Central Maryland</td>
<td>4.77</td>
<td>5.40</td>
<td>6.37</td>
</tr>
<tr>
<td>3</td>
<td>North Eastern Maryland</td>
<td>2.81</td>
<td>6.21</td>
<td>6.16</td>
</tr>
<tr>
<td>4</td>
<td>Towson &amp; I-83 Corridor</td>
<td>3.81</td>
<td>5.61</td>
<td>5.72</td>
</tr>
<tr>
<td>5</td>
<td>North East Baltimore Metro</td>
<td>4.17</td>
<td>5.71</td>
<td>6.40</td>
</tr>
<tr>
<td>6</td>
<td>North West Baltimore Metro</td>
<td>3.67</td>
<td>6.48</td>
<td>5.92</td>
</tr>
<tr>
<td>7</td>
<td>South West Baltimore Metro &amp; City</td>
<td>4.36</td>
<td>6.44</td>
<td>6.76</td>
</tr>
<tr>
<td>8</td>
<td>North Anne Arundel</td>
<td>3.11</td>
<td>5.71</td>
<td>6.92</td>
</tr>
<tr>
<td>9</td>
<td>Annapolis &amp; South Anne Arundel</td>
<td>3.68</td>
<td>4.89</td>
<td>6.94</td>
</tr>
<tr>
<td>10</td>
<td>Howard &amp; Northern Prince George’s County</td>
<td>4.05</td>
<td>5.33</td>
<td>7.12</td>
</tr>
<tr>
<td>11</td>
<td>Northern Montgomery County</td>
<td>3.14</td>
<td>4.08</td>
<td>6.26</td>
</tr>
<tr>
<td>12</td>
<td>College Park, Greenbelt, and Hyattsville</td>
<td>4.58</td>
<td>5.39</td>
<td>5.94</td>
</tr>
<tr>
<td>13</td>
<td>Silver Spring &amp; Wheaton</td>
<td>3.65</td>
<td>5.31</td>
<td>7.03</td>
</tr>
<tr>
<td>14</td>
<td>Rockville &amp; Potomac</td>
<td>2.98</td>
<td>4.22</td>
<td>5.14</td>
</tr>
<tr>
<td>15</td>
<td>Arlington, Alexandria &amp; Annandale</td>
<td>4.44</td>
<td>5.93</td>
<td>6.04</td>
</tr>
<tr>
<td>16</td>
<td>District of Columbia</td>
<td>2.24</td>
<td>5.77</td>
<td>7.45</td>
</tr>
<tr>
<td>17</td>
<td>McLean, Sterling &amp; Leesburg</td>
<td>3.3</td>
<td>5.42</td>
<td>6.54</td>
</tr>
<tr>
<td>18</td>
<td>Southern Prince George's County</td>
<td>4.64</td>
<td>5.42</td>
<td>7.32</td>
</tr>
<tr>
<td>19</td>
<td>Southern Maryland</td>
<td>4.01</td>
<td>4.57</td>
<td>5.87</td>
</tr>
<tr>
<td>20</td>
<td>Eastern Shore</td>
<td>4.07</td>
<td>5.65</td>
<td>6.77</td>
</tr>
<tr>
<td><strong>Overall Average</strong></td>
<td></td>
<td><strong>3.75</strong></td>
<td><strong>5.51</strong></td>
<td><strong>6.44</strong></td>
</tr>
</tbody>
</table>
One of the essential duties of an LCC is to work with the practice to which they are assigned to identify the best candidates for Care Plans from among the practice’s population of Members. This is done in a number of ways as outlined earlier in this Part VI using the scores and indices described. And, as noted earlier, many CCC Plans come from HTC or CCM transitions.

Within the context of various Index Scores, criteria used to make final selecting Members for a CCC Plan are summarized below and stress Member vulnerability, likelihood of breakdown and instability as presented in Figure 34 below:

**Part VI, Figure 34: Member Selection Criteria For Chronic Care Coordination Program (CCC)**

<table>
<thead>
<tr>
<th>Member Selection Rating Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member is clinically unstable demonstrated by many factors, including, but not limited to:</strong></td>
</tr>
<tr>
<td>• Multiple hospitalizations or ER visits in the last three to six months.</td>
</tr>
<tr>
<td>• An Illness Burden Score (IBS) of 5.0 or greater for commercial Members, or 6.0 or greater for Medicare Fee-For-Service beneficiaries (Note: Members with an IBS less than 5.0 may be unstable also).</td>
</tr>
<tr>
<td>• Multiple PCP/specialist visits (more than one visit per month).</td>
</tr>
<tr>
<td>• Multiple urgent care visits for chronic condition management (example: COPD or asthma exacerbation).</td>
</tr>
<tr>
<td>• Medication non-adherence (may include non-adherence due to financial constraints).</td>
</tr>
<tr>
<td>• Deteriorating physiologic indicators.</td>
</tr>
<tr>
<td>• Deteriorating behavioral health status.</td>
</tr>
<tr>
<td>• Other indicators of instability identified by the PCP</td>
</tr>
</tbody>
</table>

**In addition to clinical instability, the Member needs to meet four or more of the below criteria:**

- Three or more abnormal clinical indicators (elevated hemodynamic measurements, elevated tests or diagnostics, etc., such as BMI >50, uncontrolled HTN, Hemoglobin A1C >9. These indicators must demonstrate instability (trending towards poorer values).
- Two or more specialists involved in care (excludes: dentists, optometrists, gynecologists unless the Member has significant clinical conditions in these specialties).
- Eight or more prescribed medications – Polypharmacy with evidence that the patient does not adhere to or understand medication regimen (excludes: vitamins, over-the-counter).
- Two or more barriers to care (financial, psychosocial, cultural, language, access, etc.).
- LACE score (within the last 60 days) of 10-19.
- Drug Volatility Score (DVS) of seven or more.
- Charlson Comorbidity Index Score (CCI) of three or more.
- Member has little understanding of their disease and/or is non-complaint with self-care management (diet, exercise, medication, interventions, preventive screenings, etc.).
- Little evidence of social support system.
- Members with known diagnosed psychiatric conditions such as bi-polar disorder, schizophrenia, paranoia, depression, anti-social disorder, personality disorders, etc.
- Need for home based interventions (home O2, assistive devices, PICC lines, G-tube, etc.)
- Vision or hearing impairments that impede the ability to execute self-care measures.
- New diagnosis of a chronic condition within the last three months.
It is critical that once a Care Plan is developed and maintained by the LCC in the Care Plan Template in the iCentric System, frequent and responsive communication with the Member in the Care Plan occurs. The goal is to prevent breakdowns leading to admission, re-admission and ER visits and to help the Member achieve the highest possible level of independent functioning they are capable of on a sustained basis.

In the next several years, the Member population in Care Plans is projected to increase above 10,000. When this point is reached – together with 40,000 CCM Care Plans – a substantial change in the patterns and use of hospital based services is expected throughout the CareFirst region for CareFirst Members. Evidence of this is already occurring with a 20 percent decline in the rate admission of CareFirst Members in the 2011 to 2015 period – with no corresponding decline in enrollment which has remained essentially flat.

All Care Plans require the consent of the individual Member involved. The best party to seek this consent is the Member’s PCP or NP with the support of an experienced LCC. Consent is obtained in over 85 percent of the cases in which it is sought. The process of obtaining consent is the first step in engaging the Member in his/her own Care Plan and in obtaining the best possible results.

Members in Care Plans are surveyed quarterly through an independent survey process to ascertain whether they perceive they are benefiting from the Care Plan process and whether they have an effective, engaged relationship with the PCP or NP and LCC. Scores on these surveys are consistently high.

It is important to note that each sub-region operates as an integrated team in seeking to develop Care Plans for targeted Members and generally help Panels in the sub-region win an OIA.

The LCC is joined by a Program Consultant who is assigned to the same sub-region on a full time basis and who becomes fully familiar with the patterns of the practices and Panels in the sub-region. The Program Consultant’s job is to continually analyze the data in the SearchLight Reports for the Panels in the sub-region, consult with the PCPs and NPs who make up these Panels and convene Panel meetings to discuss emerging trends.

Another key Member of the regional team is the Program Representative who meets with PCPs and NPs in the practices and Panels in the sub-region to which they are assigned to assure a smooth, knowledgeable and efficient administrative functioning of the Program. This administrative support facilitates attention to the substance of the work to be done and minimizes the level of dysfunction that arises with improperly understood or used administrative features of the Program.

The team of a typical sub-region is shown in Figure 35 below. The director of this team is the RCD in charge of the sub-region.

Part VI, Figure 35: Team Structure At Sub-Regional Level
Finally, it is essential to note that the LCC – like the CCM – has at their disposal the other Elements of the TCCI Program that can be incorporated to any degree necessary in Care Plans or offered individually to Members not in Care Plans if these Program Elements would assist in recovery or stabilization of the Member. These TCCI Elements are a simple, online service request away – easily made through the Service Request Hub in the iCentric System.

This means that a whole array of TCCI Programs and Services, from BSA to CMR, HBS, ECP and EMP can be brought to bear in the treatment and Care Coordination of a Member in a Care Plan.

Only LCCs and CCMs have the role-based authority to order these additional services for Members in Care Plans. The integration of these additional services in the context of a Plan that can be put together under the direction of the Member’s PCP or NP is fundamental the PCMH and TCCI Program designs.
Program #5: Behavioral Health And Substance Abuse Program (BSA)

Preface

One in four Americans experiences a behavioral health illness or substance abuse disorder each year. The majority of these individuals also have a comorbid physical health condition. Typically, medical expenses for Members with behavioral health conditions are twice as high as those in the general population and these conditions account for 10 percent of total hospital admissions. Total health costs for behavioral health are likely understated because these problems often go undetected as well as untreated due to several factors including: lack of access to primary care and behavioral health professionals, lack of proper diagnosis, and concern with the stigma associated with behavioral health diagnoses leading to gaps in care or under treatment.

All of these factors exact a substantial toll on patients, their families, employers and communities as well as the PCPs who are tasked with coordinating care for patients with these significant and complex needs – challenges that increase when they occur along with chronic disease such as diabetes, asthma and heart disease. Behavioral health problems such as depression, anxiety and substance abuse often exacerbate the underlying medical condition in a negative cycle of reduced health and deeper despair. As many as a third of Members who develop chronic diseases such as diabetes, heart disease and chronic pulmonary diseases also suffer from depression. Behavioral health and medical conditions are risk factors for each other and the presence of one can complicate the treatment of the other.

At a time when demand is growing for behavioral health and substance abuse services, PCPs have emerged as the first line of defense in the health care system where they are confronted with a system of support that is fragmented and confusing to use.

CareFirst's BSA Program is carried out by Magellan Health Services, a national managed care company specializing in Behavioral Health and Substance Abuse Care Coordination. Magellan carries out the BSA Program in close coordination and integration with all other TCCI Program Elements. The BSA provides a coherent framework to:

- Identify Members who need help;
- Coordinate the comprehensive range of services that they need; and
- Make available a reliable flow of information about their care to help PCPs integrate and manage their medical and behavioral health care more effectively.

The sections that follow describe the nature and extent of the behavioral health and substance abuse services rendered to Members who need them.

The Challenges for Behavioral Health Care

Identifying Members with behavioral health and substance abuse conditions is often difficult. There are numerous ways in which behavioral health and substance abuse conditions may manifest themselves, resulting in conditions going misdiagnosed or untreated. In some cases, behavioral health disorders such as major depression, bipolar disorder, psychosis, and schizophrenia can present in a typical fashion with challenges revolving primarily around treatment to mitigate symptoms and prevent progression. However, at other times, diagnosis is difficult and conditions can be hidden. This is true in the area of substance abuse disorders as well.

Not infrequently, patients can present suddenly with no previous history. Sometimes, symptoms appear as another condition entirely. For example, schizophrenia commonly presents in 19-26 year olds with no previous history of behavioral health disorders, and bipolar disorder and other mood disorders can masquerade as depression with no obvious signs of euphoria or mania.

The variation of treatment options for behavioral health disorders is expanding and can be difficult for patients, their PCPs and families to understand and access. New pharmacotherapy options can help patients, but also may be misused. Best practices for the use of new modalities such as trans-cranial magnetic stimulation and computerized cognitive behavioral therapy are continually changing, making it difficult to stay abreast of the evolving body of best practice.
In addition, fragmented and/or limited provider networks create an access barrier to achieving optimal behavioral health care for Members. Of all the specialties, psychiatrists and other behavioral health professionals have the fewest incentives to join a health insurance network and are typically the least likely to do so. A study conducted by JAMA Psychiatry found that 55 percent of psychiatrists accepted private insurance compared with 89 percent of other doctors. Many psychiatrists do not accept insurance and the insurance acceptance rate of psychiatrists has declined more than for other doctors, posing challenges for Members trying to select and access behavioral health providers.

Since the demand for behavioral health services is likely to continue to outstrip capacity, improving care integration to better manage patient need becomes imperative. If access is not managed properly, the care of patients with concurrent physical and behavioral health disorders can be costly, fragmented and ineffective.

Screening for mental illness and connecting Members to the treatment they need is an important part of primary care, but this taxes the PCP’s time, resources, and capabilities. Care Coordination for Members with persistent and serious psychiatric conditions or long standing substance abuse problems goes well beyond the capabilities of the typical PCP.

Further, behavioral health emergencies can be unpredictable and dangerous. Members who need immediate care for a behavioral health condition could benefit from on-call access to specialized care, 24/7 hot lines, telemedicine capabilities and emergency room care when needed. Frequent users of ER services have a high incidence of behavioral health and substance abuse disorders.

The challenges described above cause behavioral health disorders to have a profound social and economic impact on the community. In many cases, behavioral health conditions are serious enough to cause limitations in daily living, ability to maintain employment, and participate in social activities. Employers are particularly harmed, for example, when behavioral health conditions hinder worker productivity and increase absenteeism. Of all conditions driving overall health care costs (defined as work related productivity loss together with medical and pharmacy costs) depression is ranked number one. Similarly, behavioral disorders account for 50 percent of all disability days. All of these factors drive increased cost of care with poor outcomes.

It follows, therefore, that a proactive Program of Care Coordination for behavioral health and substance abuse conditions is vital to address the needs of Members with these conditions. Helping Members manage and treat their behavioral health conditions is heavily based on a proactive Program of Care Coordination for behavioral health conditions. Integrating these services into the entirety of the medical care continuum is critical to improving overall health outcomes and reduces costs.

CareFirst Population Characteristics

An analysis of CareFirst membership data reveals that over 250,000 Members received treatment for a behavioral health diagnosis in 2013 as shown in Figure 36 on the next page. Identification of these Members was determined by analysis of Members with episode claims for depression and major depressive disorders, anxiety, neuroses, substance abuse, mania, psychoses, personality disorders, obsessive compulsive disorder, autism, schizophrenia, or eating disorders.

While these Members make up roughly 10 percent of the general CareFirst population, they represent almost 25 percent of the total admissions, with 2.5 times the admission rate of the general population. Moreover, the readmission rate among Members with behavioral health conditions is almost 70 percent higher than CareFirst’s overall book of business. As with national data, the annual PMPM cost of a Member with a behavioral health condition is more than twice as high as the general CareFirst population.
### CareFirst Members

<table>
<thead>
<tr>
<th>Illness Band</th>
<th>Members</th>
<th>Avg IB Score</th>
<th>Debits PMPM</th>
<th>Admits Per 1,000</th>
<th>30-Day Readmits</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>%</td>
<td>#</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Advanced/Critical Illness</strong></td>
<td>82,886</td>
<td>3.2%</td>
<td>10.92</td>
<td>$3,504</td>
<td>736</td>
</tr>
<tr>
<td><strong>Multiple Chronic Illness</strong></td>
<td>231,222</td>
<td>8.8%</td>
<td>2.99</td>
<td>$974</td>
<td>189</td>
</tr>
<tr>
<td><strong>At Risk</strong></td>
<td>332,935</td>
<td>12.7%</td>
<td>1.42</td>
<td>$459</td>
<td>64</td>
</tr>
<tr>
<td><strong>Stable</strong></td>
<td>688,214</td>
<td>26.2%</td>
<td>0.55</td>
<td>$202</td>
<td>11</td>
</tr>
<tr>
<td><strong>Healthy</strong></td>
<td>1,292,606</td>
<td>49.2%</td>
<td>0.07</td>
<td>$57</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,627,863</td>
<td>100.0%</td>
<td>1.03</td>
<td>$347</td>
<td>54</td>
</tr>
</tbody>
</table>

### Members with a Behavioral Health Diagnosis

<table>
<thead>
<tr>
<th>Illness Band</th>
<th>Members</th>
<th>Avg IB Score</th>
<th>Debits PMPM</th>
<th>Admits Per 1,000</th>
<th>30-Day Readmits</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>%</td>
<td>#</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Advanced/Critical Illness</strong></td>
<td>16,846</td>
<td>6.4%</td>
<td>11.14</td>
<td>$4,003</td>
<td>1,092</td>
</tr>
<tr>
<td><strong>Multiple Chronic Illness</strong></td>
<td>47,442</td>
<td>18.0%</td>
<td>3.02</td>
<td>$1,111</td>
<td>215</td>
</tr>
<tr>
<td><strong>At Risk</strong></td>
<td>61,876</td>
<td>23.5%</td>
<td>1.43</td>
<td>$506</td>
<td>60</td>
</tr>
<tr>
<td><strong>Stable</strong></td>
<td>105,404</td>
<td>40.0%</td>
<td>0.59</td>
<td>$241</td>
<td>12</td>
</tr>
<tr>
<td><strong>Healthy</strong></td>
<td>31,740</td>
<td>12.1%</td>
<td>0.15</td>
<td>$144</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>263,308</td>
<td>100.0%</td>
<td>1.86</td>
<td>$693</td>
<td>129</td>
</tr>
</tbody>
</table>

### Type of Diagnosis

<table>
<thead>
<tr>
<th>BHSA Diagnoses</th>
<th>Members</th>
<th>Avg IB Score</th>
<th>Debits PMPM</th>
<th>Admits Per 1,000</th>
<th>30-Day Readmits</th>
</tr>
</thead>
<tbody>
<tr>
<td>#</td>
<td>%</td>
<td>#</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>112,730</td>
<td>42.8%</td>
<td>2.01</td>
<td>$766</td>
<td>145</td>
</tr>
<tr>
<td>Anxiety</td>
<td>71,493</td>
<td>27.2%</td>
<td>1.77</td>
<td>$654</td>
<td>113</td>
</tr>
<tr>
<td>Neuroses</td>
<td>62,048</td>
<td>23.6%</td>
<td>1.25</td>
<td>$466</td>
<td>59</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>18,812</td>
<td>7.1%</td>
<td>3.27</td>
<td>$1,453</td>
<td>456</td>
</tr>
<tr>
<td>Manic Episode</td>
<td>13,150</td>
<td>5.0%</td>
<td>2.71</td>
<td>$1,215</td>
<td>348</td>
</tr>
<tr>
<td>Psychoses</td>
<td>8,296</td>
<td>3.2%</td>
<td>3.84</td>
<td>$1,211</td>
<td>335</td>
</tr>
<tr>
<td>Major Depressive Episode</td>
<td>6,673</td>
<td>2.5%</td>
<td>2.79</td>
<td>$1,251</td>
<td>333</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>5,397</td>
<td>2.0%</td>
<td>1.43</td>
<td>$759</td>
<td>200</td>
</tr>
<tr>
<td>Obsessive-Compulsive Neurosis</td>
<td>3,671</td>
<td>1.4%</td>
<td>1.47</td>
<td>$609</td>
<td>88</td>
</tr>
<tr>
<td>Autism</td>
<td>1,927</td>
<td>0.7%</td>
<td>1.78</td>
<td>$794</td>
<td>96</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1,819</td>
<td>0.7%</td>
<td>3.57</td>
<td>$1,431</td>
<td>611</td>
</tr>
<tr>
<td>Anorexia Nervosa</td>
<td>585</td>
<td>0.2%</td>
<td>2.86</td>
<td>$1,856</td>
<td>412</td>
</tr>
<tr>
<td>Bulimia Nervosa</td>
<td>492</td>
<td>0.2%</td>
<td>1.91</td>
<td>$1,393</td>
<td>273</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>263,308</td>
<td>100.0%</td>
<td>1.86</td>
<td>$693</td>
<td>129</td>
</tr>
</tbody>
</table>
Identifying Members in Need

The BSA Program provides capabilities to:

- Identify those Members with behavioral health and/or substance abuse conditions who are in the most need for focused Care Coordination services;
- Complete a care needs assessment of the Member;
- Design a Care Plan that best fits a Member’s individual need;
- Connect the Member to providers and services to address their needs; and
- Monitor progress and ensure that the Member is appropriate for graduation from the Program.

The BSA Program relies on specialty trained, licensed behavioral health professionals. BHCCs collaborate and arrange services in conjunction with PCMH Panels, behavioral health and substance abuse providers and community support agencies to provide an individualized Care Plan.

Behavioral health and substance abuse conditions manifest in the CareFirst membership across a wide spectrum. The continuum ranges from common conditions such as generalized anxiety disorder to a core subgroup of those with serious and persistent mental illness (SPMI). Thus, an essential Element is the identification of those Members who - were it not for the BSA Program - would be most likely to be admitted, readmitted, use ER services and suffer complications. The BSA Program identifies these Members through five main sources:

- Specialized Behavioral Health Hospital Transition Coordinators (BHTCs) who assess all Members admitted to the hospital nearly 100 percent of whom are suitable for BSA case management;
- Data generated identification of Members based on the use of algorithms applied to claims data;
- Referrals from LCCs or CCMs who refer to BHCCs based on a Care Needs Assessment that indicates downstream treatment or Care Coordination needs;
- Pre-service review of carefully selected outpatient services, such as ABA (applied behavioral analysis for autism), ECT (electroconvulsive therapy), Repetitive Transcranial Magnetic Stimulation (rTMS) and Complex psychological testing; and,
- Call for emergency assistance for Members in need.

Key Elements of the BSA Program

Behavioral Hospital Transition of Care

Behavioral Hospital Transition of Care is similar to the HTC used for general medical conditions in that both seek, upon the admission of a Member to a hospital, to identify and assess needs and coordinate the subsequent services the Member needs.

Behavioral Hospital Transition of Care focuses on those Members who have been admitted to a hospital for a behavioral health and substance abuse diagnosis. Any admission to a hospital or a residential treatment center is an indicator of a serious behavioral health event. These Members require special attention to reduce the likelihood of a readmission and to improve their overall outcome.

The Behavioral Hospital Transition of Care process relies on specially trained and licensed behavioral health professionals who expeditiously obtain concurrent clinical information about each hospitalized Member. The Member’s needs are assessed upon admission and during a hospital stay, with a focus on post discharge needs. The assessment triages patients according to need which results in a direction to applicable services post discharge.

Hence, the outcome of the triage authorization process connects the patient according to their needs with service providers who can deliver the needed services. Most often, these are arranged and coordinated through a Behavioral Health and
Substance Abuse Case Manager. The nature and extent of care varies widely, ranging from a hospitalization, to extended residential treatment and home support and counselling. Throughout the process, the Behavioral Hospital Transition of Care nurse and BHCC work together, as necessary, to fit and adjust services to patient need and circumstance.

The Behavioral Hospital Transition of Care nurse follows these 10 process steps for every hospital admission (available anywhere in the United States). They:

- Receive a notification request from the hospital and begin the care needs assessment process immediately;
- Consult as needed with the BSA Medical Director (a psychiatrist) at pre-admission and also while the Member is an inpatient and upon discharge. The Behavioral Hospital Transition of Care nurse and the BSA Medical Director, as needed, work collaboratively with attending providers in selecting the most appropriate care settings for the Member;
- Monitor length of inpatient stay, track progress and assess need for placement into BSACM upon discharge;
- Develop a comprehensive discharge plan that begins on admission;
- Obtain clinical information via phone from attending physicians and social workers on the ward since the patients are often in locked wards and outside staff are not allowed entry;
- Refer Members to CCC or CCM Programs for co-morbid conditions as appropriate;
- Arrange for the use of a same day discharge appointment (commonly called the Bridge Program) in hospitals that have agreed to provide this function;
- Conduct “Welcome Home” calls within 48 hours of discharge to assess the status of the Member and ensure that all components of the discharge plan are understood and identify and resolve barriers to adherence of the treatment plan;
- Verify Member follow up with the provider who has been designated for follow up; and
- Conduct post discharge assessment and initiate as appropriate, the enrollment of the Member into the BSACM Program.

**Care Needs Assessment for non-hospitalized Members**

For those Members identified for the BSA Program through a source other than a hospital admission, Members are categorized by the type of care they need through the use of a Care Needs Assessment. If clinical judgment using minimum qualifications/criteria indicates the need for either Behavioral Health or Substance Abuse Services, a Service Request through the Service Request Hub of iCentric™ triggers initiation of a Care Needs Assessment.

This assessment is performed by a licensed behavioral health professional, psychiatric nurse and psychiatrist using evidence based criteria to select the most appropriate care for the Member. The Care Needs Assessment evaluates the Member for referral to BSACM services (described below). It is estimated that approximately 20 percent of non-acute Members identified through this process will be suitable for case management.

The Care Needs Assessment connects the Member to the most appropriate level and setting of care along a spectrum based on the Member’s needs. Examples include arranging a PCP visit to manage low-level anxiety to introducing Members to 12-step groups for Substance Abuse control or connecting the Member to re-occurring sessions with a psychiatrist to manage serious, persistent illness on the more intensive end of the spectrum. Determinations are based on the individual clinical circumstances of the individual Member and take into consideration socio-cultural factors.
**Behavioral Health and Substance Abuse Case Management (BSACM)**

BSACM relies on specially trained licensed behavioral health professionals. The team delivering these coordinative services is comprised of licensed, masters-prepared, behavioral health professionals with a minimum of five years’ experience in substance abuse or behavioral health issues. They are backed up and overseen by a dedicated Medical Director (a board-certified psychiatrist). These professionals are skilled in motivational interviewing techniques focused on behavioral change. This skill is particularly valuable in caring for Members with substance abuse or combined medical and behavioral conditions. The identification sources used for access to the BSACM Program are shown in **Figure 37** below.

**Part VI, Figure 37: Behavioral Health and Substance Abuse Case Management (BSACM) Identification Sources**

The following are examples of criteria that aid in determining entry into Behavioral Health and Substance Abuse Case Management, as well as the duration and intensity of care. The list is rank ordered with those criteria requiring the highest intensity and duration of attention at the top:

- Three or more inpatient BSA admissions in a rolling 12 month period
- 25 inpatient days in a rolling 12 month period
- Members ages 18-26 with at least one substance abuse related admission
- Pregnant women who have abused substances
- Child, age 12 and under, with any hospitalization
- Inpatient admission for an eating disorder
- Chronic medical condition with depression, anxiety or substance abuse
- Chronic medical condition with co-morbid depression, anxiety or substance abuse
- New cancer diagnosis
- Behavioral health polypharmacy or use of medications used for treatment resistant conditions
- Cluster of behavioral health conditions
- Repeat alcohol/drug testing in the ER over a six month period
- Autism or ADHD and an ER visit or hospitalization
- Members with at least two ER visits with BSA diagnosis
- An inpatient admission for a BSA issue

Once the Member has been identified as a candidate for BSACM and agrees to participate, the BSACM plan’s content, duration and intensity is fine tuned to meet the needs of the Member. Unless services are refused, a minimum of three attempts at contact at different times over three business days are made to gain Member consent. Member consent is required in order to proceed with a Behavioral Health Case Management Plan.
Each Member enrolled in BSACM receives an individualized plan of care based on the results of a complete assessment. The Program serves Members wherever they live – including outside of the CareFirst service area.

The assessment covers, as appropriate, the Member’s behavioral and medical history, clinical circumstances, support system, medications and substance use history, self-management skills, provider status, lethality issues, urgency status, readiness to change and motivations, stressors, cultural issues, and other relevant factors.

Results of BSACM intervention are measured using a standardized, validated Consumer Health Inventory™ (CHI) which is a Health Assessment that measures changes in physical function and mental well-being. The BSACM administers the CHI at the time of enrollment, periodically throughout participation in the Program, and at graduation. Program expectations are that 70 percent of Members graduating from BSACM will show improvement in their CHI Score.

Additionally the Patient Health Questionnaire (PHQ-9) is administered to Members who are at risk but not yet diagnosed with depression. This tool is specifically tailored to measure improvement or worsening of depression.

When referred directly via a LCC/CCM, Members are contacted by a BSA professional within three business days for non-urgent referrals and within one business day for urgent referrals. Members experiencing an emergency or who are in crisis have access to a 24/7 crisis line. When referred via a data triggered referral, Members are contacted by a BSA professional within two weeks. The initial interactive phone-based contact with the identified Member obtains the Member’s consent to participate in case management services and establishes defined goals.

After the initial assessment, the Member is typically contacted weekly by phone for the duration of the Program which generally lasts between three and six months. Each contact is typically between 30 and 60 minutes in duration. Duration of the Program, as well as frequency and length of contact, are adjusted depending on individual progress and needs with more severe circumstances requiring more time.

BSACMs collaborate with the family, treating providers and community supports to build a Care Plan that focuses on recovery and stabilization. A focus is placed on assisting the Member in navigating the behavioral health delivery system and connecting the Member to services and providers needed.

The BSACM assesses gaps in care, links the Member to appropriate services, facilitates referrals, provides assistance with appointments, and follows up to ensure that appointments are kept and prescriptions are filled and taken as directed. The BSACM also ensures that the Member receives the necessary instruction on their condition and that they understand any instructions relating to their care.

For Members who have co-morbidities, such as diabetes, heart failure, chronic obstructive pulmonary diseases or asthma, attention is especially focused on developing the Member’s ability to self-manage their medical condition. BHCCs closely coordinate services with each Member’s LCC or CCM. When found to be appropriate, the BHCC contacts a LCC or CCM to arrange for one or more TCCI Programs. These could include CMR, HBS, EMP, ECP, CBP, CCM or CCC.

Findings, observations and judgments are documented immediately after completion of the contact in the Magellan Clinical System and sent daily to iCentric for entry into the Member’s Member Health Record.

Clinical notes and information recorded by the BSACM and BHTC in the Magellan System are presented in four subsections: patient narrative, medications, assessment and plan, and encounter history. Behavioral Health and Substance Abuse Case Management Plans are evaluated in a manner that adheres to the same principles as the scoring of Care Plans in the CCC and CCM Programs. BSACM plans are scored for appropriateness, documentation completeness, clarity, actionability and quality.

When a Member becomes engaged in a Care Plan, the Member and their BSACM will discuss and outline an envisioned State-of-Being that, when reached, will constitute completion of the Member’s Care Plan and will enable graduation from the Care Plan. The Member and BSACM also establish a target date for graduation in every Care Plan. Graduation occurs when the Member is stabilized, engaged with the appropriate Providers, has community and/or family support, is less at risk for an admission and can better self-manage their condition due to adequate understanding of how to remain stable.
In order to become compliant and achieve healthier outcomes, the Member must be meaningfully engaged with the BSACM, following the actions and steps called for in the Care Plan, and be making progress toward the Member’s envisioned targeted “State-of-Being”. Specifically, to remain compliant in a Care Plan a Member must:

1. Complete the activities outlined in the Care Plan, as evidenced by making and keeping provider appointments and taking medications as prescribed.

2. Meaningfully engage in discussion with the BSACM at least once per week about their progress (or lack thereof) or more frequently as called for in the Plan of Care. This is measured by the Case Manager’s documentation of the frequency of successful contacts with the Member as shown in iCentric based on notes in Magellan’s System that are fed to iCentric based on agreed to specifications.

3. Participate in all relevant Health Inventories and Questionnaires to track progress toward Care Plan graduation.

When a Member is not adhering to the requirements above, the Member is deemed non-compliant and given 30 days to re-engage with the BSACM and make progress toward Care Plan goals. If the Member has not appropriately re-engaged after 30 days of non-compliance, the BSACM will recommend to the Behavioral Health Medical Director that the Care Plan be closed prior to termination for non-compliance. Reasons other than non-compliance to close a BSACM Care Plan occur if the Member notifies the BSACM of a desire to discontinue the Program or the Member is no longer covered under a CareFirst health plan.

**Autism Spectrum Disorder and Applied Behavior Analysis**

Autism Spectrum Disorders (ASDs) are defined as complex neurodevelopmental disorders. Children with ASD display mild to severe, persistent impairments in social interaction and communication. Applied Behavioral Analysis (ABA) therapy focuses on reliable measurement and objective evaluation of observable behavior in settings including the home, school, and community.

Autism is complex but with the right treatment, care team, and resources, families can be empowered to understand the complexities of the disorder while helping to educate and inform others. Masters level (or higher) autism specialists overseen by a certified behavioral analyst work with Providers to verify diagnosis and complete a specialized ABA Treatment Plan based on an assessment of functional impairment. ASD Case Managers work with treating providers to determine what is necessary to complete a thorough evaluation, the number of hours of direct care needed and the level of supervision and care giver training required.

Ongoing consultation by the ASD Case Manager typically occurs up to four times per year, recognizing that developmental issues may require additional time for progress to occur. Case Managers ensure the treatment team is coordinating efforts with other services the child may be receiving such as occupational or speech/language therapy, and that care provided and funded in school settings is properly utilized. ASD Case Managers and a Magellan Medical Director are available for consultation as treatment or benefits issues arise.

ASD Case Managers work directly with families to educate them in all aspects of ASD, provide condition education, and link and make referrals to community resources. This is designed to actively engage the caregivers in the care of the child.

**Behavioral Health Provider Network**

Undergirding the BSA Program is an accessible, high quality BSA network of professional and facility providers for all Members in need of behavioral health and substance abuse care. The networks are continually monitored to ensure Members in need of care have timely access to behavioral health and substance abuse specialists. CareFirst’s network includes Psychiatrists, Psychologists, Clinical Social Workers, Acute Hospitals with Behavioral Health Capabilities, and Specialty Behavioral Health Facilities, such as Residential Treatment Centers and Substance Abuse Facilities. The BSA network complies with all credentialing standards as recognized by the National Committee of Quality Assurance (NCQA).

In addition to broad provider networks, CareFirst maintains relationships with numerous “Key Groups”. Key Groups are multi-specialty behavioral health provider groups recognized for providing high quality care, and are located throughout the CareFirst service area. These groups work closely with Medical Directors, BSACMs and BHTCs to ensure Members in
need receive specialized care in a timely fashion. Key Groups provide easy access, high Member satisfaction, and overall high quality services. Key Group providers are required to see Members with emergent needs within six hours, Members with urgent needs within 48 hours and routine appointments within 10 days. Frequent training and service visits to Key Group providers are made by the Magellan team to secure/maintain these relationships and to secure timely resolution of any operational or administrative issues.

**Daily Bi-directional Data Exchange through the iCentric System**

As noted earlier, all clinical notes and information on each Member who receives any BSACM or other Care Coordination services are entered into the Magellan Clinical System and transmitted to CareFirst for integration into the Member Health Record in iCentric on a daily basis. All data as well as Member narrative notes on progress, type of service, service date, and encounter records are included in iCentric under the BSA portion of the Member’s Member Health Record. The entire care team, including BSA clinical staff, has access to iCentric and the Member Health Record as illustrated in Figure 38 below. All information from all TCCI Programs on BSA Members is viewable by all treating Providers with appropriate access.

**Part VI, Figure 38: iCentric Behavioral Health Screen**
Hence, a complete profile of the services and needs of Members participating in the BSA Program is made available on a timely basis to PCMH PCPs and Panels. This is extended through SearchLight Reporting which identifies the most common diagnoses, most costly Members (“Top 50” lists), and inpatient utilization trends. Searchlight is also used by PCMH providers and LCCs to identify patients who are at high risk but have not had recent treatment by a behavioral health care professional or who are non-adherent to their medications.

**Services Available and Accessible to All Members**

For those Members who have behavioral health conditions but do not require BSACM and/or have not been hospitalized, the BSA Program also provides an array of other supports. Members may call the Magellan Customer Service toll free number and request assistance as outlined below:

**My Care Link Up**

Selecting and accessing behavioral health providers is often difficult and confusing. This is, in part, due to the array of different types of providers who render these services – ranging from social workers to counselors to psychologists to psychiatrists – combined with the challenges associated with the limited number of providers. Additionally, if a Member is having difficulty in obtaining an appointment with a network provider within a desired time frame, they may access My Care Link Up staff for assistance. A designated toll free phone number to connect with My Care Link Up is available to PCPs.

Members may choose to receive direct assistance in identifying an appropriate provider, scheduling an appointment or being sent a provider list to help in their own selection. Follow up is provided to confirm that each Member seeking an appointment obtains a clinically appropriate appointment.

**One Call for Substance Abuse**

Many individuals who have substance abuse issues have difficulty getting the proper assessment and referrals for treatment. The One Call Program encourages ER staff to call a dedicated line for assistance in placing patients in the appropriate treatment Program at any time. The One Call Program connects Members with the next-day care they need. A 24-hour toll-free phone number is provided for the referral of any Member, who is diagnosed with a substance disorder, to enable proper linkage to next-day appointments at an appropriate intensive outpatient clinic.

The Magellan Medical Director and staff conduct in-person visits to emergency rooms to alert the ER staff to the One Call Program, and make literature and posters available for their use.

**At Risk Adolescents**

The At Risk Adolescents Program Element is a special resource for parents or caregivers of teens and young adults who are concerned about their child’s behavior. All calls made to 1-855-85 WORRY are answered by clinicians who complete an assessment regarding the concerning behavior. Depending on the need, these clinicians may refer to a BHCC or a community resource to facilitate referrals for individual or family therapy, or direct parents to online educational materials.
Program #6: Home Based Services Program (HBS)

Preface

Home care services are covered services in most CareFirst benefit plans. Prior to the HBS Program introduction, use of these services for Members with chronic care needs was often random and almost never coordinated. Often, home care services are used for recovery from acute conditions and, because of limits on the number of visits or the degree of cost-sharing in the benefit plans, services are not used for the longer term maintenance of Members with chronic diseases even though they are often urgently needed.

With the creation of the HBS Program, CareFirst has launched an enhanced, purposeful use of HBS for those Members in CCM or CCC Care Plans with the highest risk of hospital readmission or frequent ER visits. The HBS Program offers these Members support at home that is more extensive, more carefully directed and more targeted at longer term, complex cases. It also is more inclusive of a range of services including psycho-social and behavioral health services that are necessary to stabilize Members at home and to ensure their enhanced compliance with prescribed medications and other treatment protocols.

In 2015, CareFirst developed CCM or CCC plans for nearly 50,000 Members that have been carefully selected as having a high likelihood for breakdown if their care is not coordinated. The HBS Program drew from this population. Only Members who are in an active CCM or CCC Care Plans are eligible for an advanced HBS plan provided under the HBS Program.

As noted earlier, the Cost Share Waiver as well as the waiver of visit limits for Members placed in HBS pursuant to Care Plans is essential to encourage these Members to comply and cooperate with their treating providers and the terms of their Care Plans. This provides a special, elevated benefit to Members who meet criteria for the HBS Program and who remain engaged and compliant with their Care Plans.

Due to the focus on multi-chronic Members, home based services are often provided on a sustained basis over a considerable period of time – often many months – and are, therefore, not episodic in nature. Member consent is required in order for each HBS service to be rendered. A PCP, NP or Specialist order is needed as well since the HBS will proceed under their guidance.
Five Home Based Services Program (HBS) Goals:

There are five specific, practical goals of the HBS Program:

- Reduce preventable re-admissions
- Reduce ED visits
- Reduce Member non-compliance/misunderstanding of prescriptions
- Reduce the cycle of breakdown, depression, confusion in the home
- Remove barriers to multiple services in the home by better assuring they are delivered in a coordinated way in the context of a holistic understanding of the Member’s needs

Guidelines for Selection of Members for Home Based Services (HBS)

The selection guidelines for Member referral to the HBS Program are intended to identify those Members who, were it not for the HBS Program, would likely be admitted, readmitted, or inclined to use ER/hospital inpatient services. The selection criteria used to identify candidates for HBS from among those in active CCM or CCC Care Plans are as follows:

1. Lace Score >10
2. Hospital stay >30 days
3. High Drug volatility score (8 to 10 on a 10 point scale)
4. More than three ER visits within the previous six months
5. Two unplanned admissions for the same condition within six months
6. Multiple providers involved in care and treatment simultaneously
7. Multiple chronic diseases
8. Poly-Pharmacy and history and Medication compliance issues
9. Psycho-Social Issues that threaten recovery or compliance with the Care Plan or medications

Selected Home Care Agencies and Process for Referral to Them

As the foundation for the HBS Program, CareFirst has identified and contracted with a select group of Home Health Agencies to carry out services in the HBS Program based on a systemic review of the capabilities of these agencies on such factors as geographic adequacy, quality and cost performance as well as managerial and technical sophistication. Two agencies in each of the twenty PCMH regions have been identified.

The HBS Program begins with a referral from a CCM, LCC or BSACM who has already developed a Care Plan for an individual Member. The referral request is made through the CareFirst Service Request Hub in the iCentric System which then directs the request to the appropriate HBS agency covering the geographic area in which the Member lives.

The HBS Program requires that a Home Care Coordinator (HCC) from the referred to agency to conduct a comprehensive assessment of the Member and the situation in their home within 24 to 48 hours of referral. Based on this assessment, the HCC makes recommendations to the LCC or CCM who referred the case. All relevant facts and aspects of the comprehensive assessment are entered by the HCC into the HBS section of the Member Health Record of the Member in the iCentric System.

After discussion between the HCC and/or the referring CCM, LCC or BSACM, the HCC and referring source solidifies a HBS plan which must be approved by the Member’s PCP or other treating provider (specialist). This plan is incorporated into the larger Care Plan that already exists for the Member and is documented in the HBS section of the Care Plan Template in the online iCentric Member Health Record. The LCC or CCM maintains oversight of the implementation of the Care Plan – including the HBS portion – and stays in close touch with the HCC responsible for the HBS portion of the plan.

Components of Home Based Services (HBS) Plan

Each HBS plan developed by an HCC as a result of a request by an LCC or CCM must include and start with a comprehensive assessment which must cover the Elements listed below:
Environment and Psychosocial Assessment

- Family/care giver support and education
- Advanced Directives
- Home Safety issues
- Functional Limitations and Nutrition

Clinical Assessment

- Vital signs
- Pain Assessment
- Risk Factors
- Behavioral Health Assessment
- Allergies
- Screenings and Immunizations

Community/Resource Needs/Community Based Services

- Financial Situation
- Community Program support-Community Based Services Programs
- Enhanced Monitoring
- Custodial needs
- Transportation

Medications and Assessment

- Complete review and reconciliation

Services Needed

- Equipment required
- Skilled services
  - Social work services
  - Home health aides
  - Behavioral health

Overall Situation Analysis

- Conclusions and key observations
- Basis for recommended course of action for Member

Thus, the Comprehensive Home Assessment entails an analysis of the overall home situation and recommends a clear action plan that is documented in the iCentric Home Based Service portion of the Care Plan template that is applicable to the Member.

Process Guidelines

- The Home-Based Services Member must be referred to the Home-Based Services Program by a Case Manager or Local Care Coordinator (LCC).
- The referral must be sent to the selected agency in the region where the Member lives via a Service Request through the CareFirst iCentric System.
- The home health agency must acknowledge and accept or deny the Service Request within 24 hours from receipt of Service Request. If denied, specific justifiable reasons must be presented and documented in the iCentric System.
- The home health agency must contact the Member, schedule a visit and complete a comprehensive assessment within 48 hours from receipt of the referral.
• The home health agency must document the Comprehensive Assessment in the iCentric HBS Template within 24 to 48 hours after completion of the assessment by entering their findings, observations and analysis into the iCentric Portal. All these sections listed must be completed. The HCC must document ongoing activities in the HBS Plan and/or the Encounter Notes section of the HBS portion of the iCentric System.

• Discussion must occur between the LCC/CCM and HCC before the HBS plan is finalized and the agency must obtain approval from LCC/CCM before proceeding with services pursuant to the Plan.

• The home health agency must communicate, at least once a week, with the referring CCM or LCC and document all follow-up in iCentric.

• The home health agency must monitor and carry out services for the Member in accordance with the Home-Based Services plan.

Overall Member satisfaction is measured by an independent survey arranged by CareFirst and overall Program satisfaction with the home health agency’s services is measured by the CCM or LCC that made the referral.

As each HBS plan proceeds for each Member, the goal is to reach the highest possible functioning level for the Member and to achieve a “graduation date” for the Member that when achieved, will free them from the need for continuing HBS to the maximum extent possible. Such a date must be agreed to by the referring LCC or CCM who is responsible to obtain PCP/NP or specialist consent.
Program #7: Enhanced Monitoring Program (EMP)

Preface

There are a substantial number of CareFirst Members whose chronic conditions warrant careful monitoring to avoid or minimize the ongoing threat of breakdown resulting in hospital re-admissions and repeated ER visits.

Advances in digital technology have made such monitoring in the home practical and effective. Monitoring involves daily information feedback from a Member in answer to questions posed via monitoring equipment (targeted to the Member’s conditions and illnesses) as well as hard biometric readings that indicate whether a Member is heading to a trigger point (decompensating) by passing pre-set parameters for their condition.

There are a wide range of conditions and diagnoses that can be remotely monitored. These correlate closely to the Condition Tracks in the TCCI Continuum and include:

- Heart Failure (HF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes Mellitus (DM)
- Hypertension (HTN)
- Major Depressive Disorder
- Chronic Kidney Disease (CKD)
- End Stage Renal Disease (ESRD)
- Palliative Care
- Post-Traumatic Stress Disorder (PTSD)
- Dementia (Care Giver Support)
- Bi-Polar Disorder
- Schizophrenia

The EMP that is offered as an integral part of the broader TCCI Program is intended to bring this new technology and its related capabilities to bear for carefully identified Members for whom it might be best suited. This is done through a strategic partnership with Medtronic Corporation specializing in remote monitoring services. Medtronic has entered into a provider agreement with CareFirst for this purpose.

Remote monitoring of a Member’s condition at home is carried out through the placement in the home – by Medtronic – of a device that sends digital signals to a central monitoring station staffed by a qualified, trained medical monitoring team that continually tracks the responses and signals from the Member during normal business hours for up to seven days per week. This is the health care equivalent of home security monitoring that has been available on a wide scale for many years. Mobile devices extend this monitoring capability to the worksite or other locations of the Member if this is best.

Depending on the Member’s status, pre-set parameters are established under the direction of the Member’s PCP that are derived from nationally established evidence-based guidelines specific to the Member’s condition. If these parameters are exceeded, contact is made with the Member by a RN in the monitoring station to determine the Member’s status and trigger appropriate follow-up action ranging from a simple discussion and advice to contact with the Member’s PCP or even arranging for an urgent physician or clinic appointment.

The monitoring device placed in the Member’s home can accept multiple biometric measurements from peripheral instruments including blood pressure, weight, blood sugar, blood oxygen levels and lung function.

The device also collects answers to questions provided by the Member on a daily basis. These questions are offered on a yes/no basis with branching logic. For example, a Member would provide responses to questions about shortness of breath, their ability to move or whether they are taking their medications as directed.

Taken together, the combined information from Member responses and hard biometric readings provides a daily stream of data that reveals the Member’s health status. This data reinforces proper behavior on the part of the Member that substantially increases compliance with treatment and medication protocols. Alert parameters are built into this streaming picture of a Member’s status. For example, a Member with Heart Failure who experiences a two to three pound weight gain in one day or a five pound gain in seven days will trigger an appropriate intervention to prevent a break down.
**Initial Focus – Heart Failure, COPD, Diabetes**

The initial focus of the EMP is on three of the most common and expensive chronic conditions: Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD) and Diabetes (DM).

These three conditions are among the most common in Members in Illness Band 2. The statistics relating to these three conditions are startling: While the overall rate of inpatient Member admissions among the general CareFirst population is just above 50 per 1,000 Members, the admission rates per 1,000 among Members with these three conditions are 968, 398 and 150 respectively. While the rate of readmission in the general Member population is approximately 10-12 percent, the rate among Members with these three conditions is as high as 30 to 40 percent (within 90 days of the first admission) with an average cost per readmission in excess of $20,000.

For each of these three conditions, there are clear warning signs that signal trouble ahead for the Member, making them very suitable for enhanced monitoring. Further, all three conditions can be reasonably stabilized with appropriate, consistent behavior on the part of the Member.

**Eligibility/Target Population**

In order to be eligible for EMP services, a Member must be in either an active CCC or CCM Care Plan and be referred for the service by the LCC or CCM responsible for the case. This is accomplished through an online request to the iCentric Service Request Hub causing the request to enter the work queue of Medtronic. Any such request must be approved by the Member’s PCP or NP or other treating provider before being made.

With further Program maturation, Members who are not in a Care Plan, but who meet certain pre-established criteria, may be selected by an LCC, CCM or BSACM for referral through the iCentric Service Request Hub to Medtronic. This is intended to reach a broader spectrum of Members who do not need a full Care Plan but whose conditions or illnesses could be more effectively managed through the EMP Program. All such freestanding requests would require the approval of the Member’s PCP, NP or treating specialist.

The range of conditions monitored will be expanded in 2016 to include those listed above.

**Initiation of Enhanced Monitoring Service**

Member Selection by an LCC or CCM is based on the Member’s course/progression which must demonstrate clinical instability or threat of deterioration with increased likelihood of emergency care and/or hospitalization. Members who need assistance in adhering to a Care Plan or with self-management knowledge and skills are the core of the target population for EMP services.

Educational content regarding the use and benefits of the monitoring device as well as specific Disease Management material is conveyed to the Member by the LCC or CCM with reinforcement from the Medtronic monitoring team. This focuses on Member understanding of discharge instructions, medication adherence issues, coordination of post-discharge services and the Member’s ability to address red flags/warning signs.

**Service Requests**

All service requests for EMP are made using the Service Request Hub in iCentric. Each Service Request must indicate the specific condition or combination of conditions to be monitored and the number of days per week (Monday – Friday or seven days per week) monitoring is needed. The LCC or CCM making the request provides an estimate of how long the Member will need to be in the Program up to a maximum of 180 days. A service request is Medtronic’s assurance that all CareFirst Utilization Management and Medical Necessity requirements have been satisfied for a Member referred for EMP service.

In addition to the days per week of monitoring requested, the Member’s language preference is also entered in the service request along with any other notes that may be relevant to the proper fulfillment of the service request. Any specific parameters (ranges for blood pressure, pulse oximetry, lung function, weight) that may be directed by the Member’s PCP/NP or treating provider must also be noted. Parameters can include “critical” values as well as “rate-of-change” values.
that when noted cause a notification to the Member’s PCP/NP. If parameters are not specified, default parameters are used based on evidence-based guidelines.

Members are contacted in advance by the LCC or CCM to assure their consent, Engagement, and knowledge of the EMP services to be arranged on their behalf. This is noted in the Member’s Care Plan and in the service request itself. The Member’s demographic information and preferred contact information must be contained in the request.

The order entry into the Service Request Hub includes the following data:

- Program Type (Diagnoses)
- ICD9 code and list of peripherals
- Monitoring services five or seven days per week
- Special instructions (e.g., custom triggers and home glucometer brand in use)
- Language preference (Spanish/English)

When making a referral in the Service Request Hub, CCMs and LCCs pick from the following list of diagnoses which drive the Programming of the monitoring device and the peripherals that are shipped to the Member.

- Diabetes: Includes Glucose Cable
- CHF: Includes Blood Pressure Cuff, Scale, Pulse Oximeter
- COPD: Includes Pulse Oximeter
- Multiple Diagnoses with CHF: Blood Pressure Cuff, Scale, Glucose Cable, Pulse Oximeter
- Multiple Diagnoses without CHF: Blood Pressure Cuff, Glucose Cable, Pulse Oximeter

Once the initial order is entered into the Service Request Hub, the iCentric System tracks and reports on key milestones during a Member’s EMP participation. These milestones include:

- Date / Time Service Request Entered
- Date / Time Accepted by Medtronic
- Date the Member is Enrolled
- Date when Monitoring First Occurred
- Date when Monitoring Ended

If a Member refuses to comply with the EMP, Medtronic logs the refusal and automatically creates a Scheduled Action to the referring LCC or CCM for follow-up with the Member.

If the Member completes enrollment, scheduled actions are automatically created that remind the referring LCC or CCM to check on the Member’s progress in the Program.

**Shipping of Monitoring Device and Peripherals**

Within one to two business days of the receipt of a referral through the Service Request Hub, Medtronic contacts the Member, describes the services to be provided, confirms the shipping address and arranges for shipping of the appropriate device and peripherals in accordance with shipping protocols and standards established and approved by the LCC or CCM. Medtronic has full 24/7 access to the Member’s Care Plan through the iCentric System and to all information in the Member’s Health Record in order to aid service fulfillment and ongoing monitoring activities.

Device shipping by Medtronic occurs within one to two business days following contact with the Member. If the Member cannot be reached, the shipping of the device will be delayed. Peripheral options for the device include:

- Blood pressure cuff
- Scale
- Pulse oximetry
- Peak flow meter
- Cable for compatible glucometer
The device shipment contains step-by-step graphic installation instructions with color coded input slots for each peripheral. If the Member needs installation assistance, a Medtronic representative will provide step-by-step directions over the phone.

**Initial Device Activation**

When Medtronic is able to confirm delivery of the device, the Member is contacted by the Medtronic monitoring team to identify and resolve any difficulties with set-up, identify family Members or others who can assist with set-up, if needed, and to explain the benefits and goals of the EMP and how the Member’s health data will be communicated to his or her health care provider. This is referred to as the “Device Setup Call.”

Within two business days following the device setup call, a Medtronic RN will contact the Member to conduct a PHQ 2/9 (depression assessment), a formal self-management assessment and a Member Activation Assessment. In the event the Member cannot be reached on the first attempt, the RN will make multiple staggered attempts to contact the Member (by outbound telephone call) between the hours of 8:00 a.m. and 5:00 p.m. Central Time. If the Member cannot be reached after three attempts, the Medtronic RN so notes in the iCentric System for follow-up by the referring LCC or CCM.

Medtronic promptly notes on a concurrent basis in the iCentric System when the device has been activated and monitoring services have begun. In the event the device has not been activated by the Member within the 10 days following delivery, Medtronic enters a note in the iCentric System through the Service Request for follow up. With the approval of the Member, family Members or other caregivers can remain involved while the Member is participating in the Program including sharing their data and alerts.

Once the device is activated and data begins to be collected on a daily basis, telephonic outreach by Medtronic is matched to meet the gaps, needs and goals of each Member. Typically, there is a higher frequency of contact at the start of the Program as well as following any hospitalization driven by a higher frequency of alerts and gaps in understanding hospital discharge instructions. The increased frequency of outreach in the beginning of the Program (as well as matching the need of the Member to the outreach) is a key building block to Member Engagement and successful outcomes.

Outreach to the Member for an alert reason includes:

- Biometric values (e.g., blood pressure, weight, heart rate, oxygen level) outside of the parameters established at the outset of monitoring.
- Biometric values trending away from evidence-based recommended target values.
- Report of symptoms in response to the questions being asked appropriate to the Member’s condition(s).
- System analytics noting symptom variances (when the patient’s symptom score does not exceed their established threshold but has increased by more than X points in Y days).
- Adherence issues related to medication, dietary, and daily monitoring compliance.
- Report of a recent hospitalization or ER visit.

Outreach to the Member following a hospitalization, in addition to the outreach for alert reasons, is matched to the level of need required to gain understanding of common readmissions issues related to the following areas:

- Understanding of discharge instructions
- Symptoms and/or side effects to watch for
- Who and when to contact for changes in status or questions
- Appropriate follow up appointments
- Assessment of medication, equipment obtainability, compliance and proper usage
- Assessment of family and caregiver support

Based on the above, the level of the intensity of outreach is matched to the needs of each Member. For example, if the Member is showing signs of a potential exacerbation, their alert frequencies will increase, triggering an increase in outreach.

Likewise, if a hospitalization was the reason the Member was placed in the Program or a hospitalization occurred several weeks into the Program, the level of outreach will automatically escalate to meet the care needs of the Member and enhance their level of understanding.
As the Member’s awareness and understanding of how behaviors affect their chronic condition increases, they are expected to become more active participants in managing their health, the frequency of alerts and outreach typically decreases. The Program is designed to deliver services to help Members reach their goals and assure understanding and compliance by intervening at the “teachable moment” thereby effectively engaging the Member and affecting change.

Medtronic RNs have a clearly defined process they use during the initial and subsequent calls with Members in the EMP. The clinical workflows for each call are created using evidence-based clinical guidelines for the specific conditions of the Member. In general, EMP follows the nationally-accepted Coleman, Naylor, and Care Transition models to prevent hospital readmissions, identify precipitating biometric triggers, and coordinate care more appropriately.

Medtronic RNs also assist in the coordination of care needs to help promote Member independence, wellness and safety in the home. This includes assisting the Member and his or her caregivers with Care Coordination between multiple physicians/facilities and obtaining support within the community, in collaboration with the LCC or CCM. All Member responses and biometric data are transmitted in real time to the Medtronic monitoring center where a running record of the Member’s progress is maintained that is accessible by the referring LCC or CCM on a 24x7 basis in iCentric.

After the initial start-up period described above, Members compliant with their daily question and answer sessions and no alerts in 30 days receive a courtesy call to check on general progress.

Management of Alerts

Depending on the specific issue and in accordance with CareFirst-approved operating protocols, a Medtronic RN may take appropriate action, including conducting follow-up phone calls to the Member, notifying the treating physician and LCC or CCM and initiating emergency medical services in situations where a trigger or reason for concern occurs (for example, if the Member is reporting chest pain). All discussions and interventions are documented in the iCentric System. CareFirst approved protocols determine which circumstances dictate specific notification to the treating physician and LCC/CCM.

Outreach for non-adherence alerts (for Members who are non-adherent in the daily use of their Device) consists of outbound telephone call(s) to:

- Provide education and counseling on the importance of daily health monitoring;
- Inquire about concerns that Members may have with regard to use of Devices; and
- Motivation coaching that garners the Member’s support to avoid hospitalizations that may result from non-use of the monitoring device.

The Medtronic monitoring team contacts any Member who has not taken biometric measurements or taken a survey in three consecutive days to determine if there is an equipment malfunction or some other reason for not complying. Medtronic replaces malfunctioning equipment, and notifies the LCC or CCM if the Member ceases participation in the Program, or is otherwise non-adherent.

An alert can result in a health coaching or education session conducted by the Medtronic RN according to evidence-based standards applicable to the Member’s condition(s). When alerts occur that require the intervention of the Member’s PCP or NP or by the LCC or CCM, the Medtronic RN promptly contacts the appropriate party in accordance with CareFirst operating protocols.

Coordination with Existing Care Plan

In every case, the interactions between the Medtronic RN and the Member are coordinated with the Member’s existing Care Plan or Case Management Plan. This assures that communications with the Member (or his or her caregivers) regarding clinical guidelines or plans of care are made in the context of a full understanding of the Member’s case. This entails close coordination between the Medtronic RN and the Member’s LCC or CCM who is responsible for the case.

Management of Hospitalization and Hospital Discharge

If a Member is hospitalized while participating in the EMP or begins the Program on discharge, Medtronic RNs use their access to CareFirst HTC, CCM or CCC Care Plan notes in the Member Health Record to better support the execution of discharge instructions to prevent readmission. This includes communication regarding disease process, decompensation
warning signs, compliance barriers and reinforcement of medication adjustments, scheduling of follow up appointment(s), and assuring access to provider ordered follow-up care.

**Bilateral Data Access**

Medtronic’s monitoring team has full read/write access to each Member Health Record and Care Plan in CareFirst’s iCentric System for those Members enrolled in the EMP. Conversely, LCCs and CCMs, as well as treating PCPs and NPs, have access to the monitoring data and notes collected by Medtronic. This is accomplished by clicking on the EMP tab in the iCentric Member Health Record. When viewing the EMP tab, iCentric users can see the following results:

- History of data collected from the device including days where session was not completed
- Weight graph and grid
- Blood pressure graph and grid
- Glucose graph and grid
- Peak flow graph and grid
- O2 saturation graph and grid
- Heart rate graph and grid
- Vital sign summary grid (includes weight, BP, HR, PERF, Glucose, Sp02 and EMP data on a single summary grid)
- Exception report available with one click in a PDF form
- Encounter notes recorded directly into iCentric

**Member Graduation from EMP**

The goal of appropriate, sustained Engagement on the part of the Member while in the EMP is to progress the Member to an improved state of independence where enhanced monitoring is no longer necessary. Parameters that indicate a Member’s preparedness for graduation are agreed to on a case by case basis between Medtronic and the referring LCC or CCM. The overall guidelines for these parameters are set by the CareFirst Medical Director in concert with the Medtronic medical team. Upon meeting requirements, Members are gradually transferred to less high touch options as their disease state and overall compliance improves.

A Medtronic RN performs routine graduation checkpoint reviews to monitor the Member’s progress towards self-management and graduation 30 days after Program initiation and every 30 days ongoing. These frequent check points allow all involved to work collaboratively to monitor progress towards “graduation” and self-management. At any time the LCC, CCM or Medtronic team can initiate subsequent reviews of the Member’s progress toward graduation. The Graduation Checkpoint Pathway analyzes enhanced monitoring data, nursing intervention(s), Member action(s) and response to intervention(s) along with the graduation pathway driven assessments to gauge Member’s readiness for self-management.

Evaluation for graduation includes the use of following criteria and tools:

- Enhanced Monitoring Member adherence (Reporting ≥90 percent in the previous 30 day period).
- Exception/Alert rate ≤10 percent in the previous 30 day period.
- PHQ 2/9 ≤10 with or without physician oversight and demonstrated depression/anxiety treatment adherence.
- No hospitalizations (non-elective) in the previous 60 days.
- Evidence that the Member has an understanding of their disease process, knows the warning signs of exacerbation and when to report to physician.

The LCC or CCM uses information gathered through the Graduation Checkpoint Pathway and in collaboration with the PCP/NP to determine eligibility for graduation or need for continued monitoring. Graduation is at the discretion of the LCC or CCM in consultation with the Member’s PCP or NP. The graduation is entered in the Service Request Hub which immediately sends notice to Medtronic that services should cease.
Termination of EMP Services

Members may be terminated from Enhanced Monitoring Services by the referring LCC or CCM for failure to comply with the monitoring plan. Low adherence is defined as device usage less than 75 percent of the days the Member is enrolled in the EMP. A low adherence rate requires a review with the referring LCC or CCM to maintain EMP as a viable option.

In the event that the Member is no longer eligible for Covered Services, CareFirst notifies Medtronic by way of a cancellation of the Member’s iCentric service request. Medtronic then discontinues monthly billing for the Member until further notice by the Member’s LCC or CCM. Medtronic is not reimbursed for a Member if it has been notified by CareFirst that the Member is no longer active in the EMP.
Program #8: Community Based Programs (CBP)

Preface

The Community Based Programs (CBP) Element of TCCI brings to bear on a number of pre-selected community-based medical services that are focused on different illnesses and conditions that require specialized capabilities. These Community Based Programs are built on partnerships with key medical providers within the region that, in addition to their specialized capabilities, address various cultural, linguistic and ethnic diversities.

Members who are engaged in CBPs are more likely to follow up with their PCP and actively engage with treatment plans. When an LCC, CCM or BSACM identifies a Member who would benefit from such services, a Service Request is submitted via the Service Request Hub, connecting the Member to the target Program within their community. Additionally, by linking CBPs with other needed services such as HBS, Enhanced Monitoring, and CMR, Members can better achieve the highest level of recovery and stabilization possible.

The compendium of CBPs is growing and as of January 1, 2016 includes:

- Hospice and Palliative Services;
- Skilled Nursing Facility (SNF) Care;
- Chronic Kidney Disease;
- Diabetes Education;
- Pain Management;
- Congestive Heart Failure;
- Cardiac Rehabilitation; and
- Sleep Disorders

CBPs rely on one of the region’s greatest strengths – an array of high quality, innovative medical programs developed by local providers that support Members where they live and work. These Programs are described in the pages that follow.
Hospice And Palliative Care Services Program

Each year, over one million patients in the United States die in hospice care, representing approximately 44 percent of all US deaths. Over the past decade, hospice providers have seen substantial growth in the number of patients served. While these numbers are significant, they are largely driven by the Medicare population.

There is a significant opportunity to expand services and to lengthen the time in hospice and palliative care for the under 65 population. In the event of serious illness, most Americans indicate that they strongly prefer supportive care that addresses pain and discomfort as well as emotional, social and spiritual needs. Many studies have shown that most individuals would prefer to have greater autonomy regarding their end-of-life care options. Notwithstanding this, most terminally ill patients under the age of 65 die in intensive care settings undergoing often futile, invasive procedures not in keeping with the patient’s express wishes.

Hospice is a key way of providing high quality, compassionate care for people facing a life-limiting illness or injury. Hospice care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well.

Palliative care is specialized medical care for people with serious illnesses who may be experiencing persistent pain or other debilitating effects. Although it is often provided in the latter stages of illness or disease, it can be provided at any stage of illness and in both inpatient and outpatient settings. Palliative care treats suffering from serious and chronic illnesses such as cancer, cardiac disease, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), Alzheimer’s, Parkinson’s and Amyotrophic Lateral Sclerosis (ALS).

More specifically, palliative care focuses on alleviating such symptoms as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficulty sleeping and depression. It helps the Member to carry on with daily living despite their health challenges. It also helps Members to have more control over their care by improving communication so that they can better understand their choices for treatment and the course or path of their disease(s) or condition(s).

Hospice is best understood as a form of palliative care specifically designed for Members who are terminally ill. Hospice focuses on caring, not curing. Palliative care is often part of hospice care but can, and often does, stand-alone especially for people without a terminal condition.

Medicare and Carrier Policies

Carrier reimbursement policies influence and shape access to hospice and palliative care services. Since the establishment of the benefit in 1983, many hospice and palliative care benefits are based on the rules governing the Medicare Hospice Benefit which has long dominated how providers view access to hospice and palliative care. Medicare limits access to hospice and palliative care in two ways:

- The benefit explicitly limits access to hospice care to patients with a prognosis of six months or less to live.
- It compels beneficiaries who choose hospice care to forgo “disease-modifying treatment”.

As a result, many patients who might benefit from hospice and palliative care services do not receive them unless they have a short life expectancy and agree to give up on further treatment, causing many to delay enrollment in hospice and palliative care until the last few days of life.

Another impediment is the cultural mindset that is associated with hospice benefits. Many health care providers and Members view advancing illness and death as failures of medicine or of themselves, inhibiting progression to hospice or palliative care because it is seen as giving up.

The CareFirst Hospice and Palliative Care Program advances well beyond the traditional Medicare limits of hospice and palliative care. CareFirst has created a model in which palliative and ongoing disease treatments can be managed concurrently, encouraging the Member to enter hospice/palliative care earlier in advanced disease progression thus improving quality of life as it nears its end. At the heart of the CareFirst Hospice and Palliative Care Program is the belief that each
Member has the right to die pain-free and with dignity, with the necessary services for both the Member and their family. In this context, it is the goal of the entire health care team to provide an extra degree of support to these most vulnerable Members.

In the CareFirst Hospice and Palliative Care Program, the care team is supportive, not prescriptive. Palliative care and hospice services are generally provided in the home setting, with a higher level of quality, patient/family satisfaction and lower cost than intensive services provided in acute inpatient settings.

Impact

In recent years, CareFirst has had approximately 1,100 Members per year who have received home or inpatient hospice services. Total spending for these services approaches $10 million per year with an average duration of 32.7 days. In addition, 67 percent of hospice patients received services in the home and 73 percent of hospice cost is in the home setting.

It is estimated that the total number of CareFirst Members who could benefit from Hospice and Palliative care services far exceeds those who actually receive these services suggesting far greater use of the benefit could be made.

By increasing Member and caregiver awareness of palliative and hospice care, coupled with a strong, carefully selected network of hospice providers, CareFirst seeks to increase the length of time in palliative and hospice care services used by CareFirst Members.

The Hospice Palliative Care Program

To provide a foundation of the Hospice and Palliative Care Service Program, CareFirst has entered into a strategic alliance with five top flight hospice and palliative care providers in its core service area to support patients who are in CCM or CCC Care Plans. In addition, CareFirst has identified an additional 15 hospice providers (out of over 35 hospice providers) in the regions surrounding the core CareFirst service region to fill out a network of top performing hospice and palliative care providers covering the entire CareFirst Service Area.

These providers were selected based on an extensive review of their capabilities, including such factors as clinical quality, geographic access, and financial/contractual considerations, as well as a track record with CareFirst that demonstrates excellent staff relationships, and the willingness to use CareFirst’s iCentric technology in creating integrated Care Plans for those CCM and CCC Members referred for Hospice and Palliative Care services.

In this way, the Hospice and Palliative Care Service Program offers Members support in addressing treatment choices and planning end-of-life care from the most capable of the Hospice and Palliative Care service providers in the area. The LCC or CCM works with the Member, caregiver and certified hospice provider to develop a comprehensive Care Plan to relieve or reduce pain and improve the quality of life and to ensure that the Member’s decisions and treatment choices are followed.

Guidelines for selection of Members and the responsibilities of the Hospice and Palliative Care Program

While Medicare guidelines strictly limit the timeframe for hospice services to six months or less with no further disease/condition treatments, the CareFirst guidelines for a referral to the Hospice and Palliative Service Program do not have such a limit and are intended to expand earlier access to hospice and palliative care. Accordingly, services are not limited to those with a life expectancy of six months or less to live. Each Member is clinically evaluated and some Members may be under hospice care for nine months or more. Further, Members need not cease disease treatments although the course of treatment may very well follow a different course after entry into the Program due to the ongoing communication that occurs following entry into the Program.

Giving Members information about their options leads to increased autonomy regarding end-of-life decisions, which can provide dignity and a sense of meaning and satisfaction with one’s choices. This allows Members to consider alternatives to aggressive, often futile, medical procedures that subject patients to a quality of life few want during the last stages of their illness.
LCCs and CCMs work with the hospice/palliative care team to develop a Care Plan that meets each Member’s individual needs for pain management and symptom control. Only Members in a CCM or CCC Plan are eligible for the special CareFirst Hospice and Palliative Care Program that is part of the larger CareFirst TCCI Program.

The Care Coordination Team usually consists of the Member’s physician, the hospice/palliative care physician, nurses, home health aides, social workers, clergy or other counselors, trained volunteers, and therapists if needed. The focus is on minimizing the symptoms, pain, and stress of a serious illness. The goal is to improve quality of life for both the patient and the family. The Program offers both high touch and high tech support as needed.

Among its major responsibilities, the interdisciplinary hospice/palliative care team:

- Manages the patient’s pain and symptoms;
- Assists the patient with the emotional, psychosocial and spiritual aspects of having a serious illness/dying;
- Provides needed drugs, medical supplies, and equipment;
- Coaches the family on how to care for the patient;
- Delivers special ancillary services like speech and physical therapy when needed;
- Makes short-term inpatient care available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite time; and
- Provides bereavement care and counseling to surviving family and friends.

Cost Share Waiver

As noted, Hospice/Palliative care services are most often provided in the home setting and thus can be identified as eligible for a CSW. Hospice services are covered benefits under most CareFirst benefit plans. Palliative care services are typically not specifically delineated in most benefit plans. Once enrolled in the TCCI Hospice and Palliative Care Program, hospice and palliative care services are covered and out of pocket expenses are waived in accordance with the CareFirst Cost Share Waiver Program that is offered through TCCI for as long as the Member cooperates with the Elements of the Program and their specific Care Plan.

Program Goals

There are five specific Program goals:

- Facilitate access earlier in the health care continuum
- Relieve or reduce pain, provide comfort and improve the quality of life of Members
- Provide transitional services between curative treatment and end-of-life care
- Reduce preventable hospital readmissions and ER visits
- Change the “mindset” regarding hospice and palliative care within the CareFirst region

Key measures of the Program’s success include:

- A measurable increase in the number of Members enrolled in the Hospice and Palliative Care Program
- An increase in the number of LCC and CM referrals through the iCentric Service Request Hub
- An increase in the stabilization of the Member and improvement in their quality of life
- Earlier enrollment into the Program leading to longer duration in the Program

The Program tracks the number of acute hospitalizations and ER visits in the last 30 days of life as well as on any attempts at aggressive last minute treatments and analyzes the efficacy of these efforts as guides to those who follow.

Service Components

The professional hospice/palliative team develops a Hospice or Palliative Care Plan, which is incorporated into the larger CCM or CCC Care Plan that already exists for the Member that is documented in iCentric. The LCC or CCM maintains
oversight of the implementation of the Care Plan, working hand in hand with the certified hospice and palliative care providers.

Just as in the HBS Program, there are two key components of a Hospice/Palliative Care Plan: The initial/subsequent assessment and ongoing Care Coordination. As with HBS, each Hospice/Palliative starts with a comprehensive assessment.

The Comprehensive Hospice/Palliative Care Assessment includes:

**Environmental and Psychosocial Assessment:** This is intended to increase Member understanding of their disease process, home assessment, safety review, identification of a primary caregiver, spiritual/cultural assessment, and to provide a review of Advance Directive and Durable Power of Attorney and development of a transitional End-of-Life Care Plan.

**Clinical Assessment:** This involves evaluation of the type and stage of disease, symptoms and pain assessment, review of medications and treatment, behavioral health assessment, review of functional limitations and activities of daily living.

**Community Resources:** This is intended to help with a review of the Member’s financial situation, spiritual/pastoral care, bereavement services, community Programs, support groups, transportation and volunteer assistance available in the community.

**Services Needed:** This identifies items such as durable medical equipment, skilled services, social work needs, home health aides, and behavioral health services that may be needed.

**Overall Situation Analysis:** This results in a recommended course of action based on key observations.

Thus, the Comprehensive Hospice Assessment entails an analysis of the overall situation of the Member and recommends a clear plan that is documented in the iCentric Hospice and Palliative Care portion of the Care Plan template that is applicable to the Member. The Comprehensive Assessment indicates the level and type of service needed by the Member and their expected prognosis. Each Member managed under palliative care is strongly encouraged to work with their PCP for ongoing care needs.

**Care Plan Process**

CCMs and LCCs always coordinate palliative and hospice care in collaboration with the Member’s treating physicians. The Hospice and Palliative Care Services Program begins with a referral from a CCM or LCC assigned to a Member who is already in an active Care Plan. The referral request must be made through the CareFirst Service Request Hub in iCentric, which then directs the request to the CareFirst palliative or hospice care partner agency covering the geographic area in which the Member lives, or where the Member has chosen to receive the services.

Just as in HBS, the Care Coordination Team has access to iCentric, which provides real-time access to the Member Health Record and the larger, detailed CCM or CCC Care Plan. iCentric is used to connect patients, families and their caregivers with a variety of community-based resources, including meals, transportation, respite care, and various entities involved in serving the needs of terminally ill Members such as cancer support, caregiver support, bereavement and survivor group support.

**Process for Referral through the iCentric Service Request Hub**

- The Member must be referred to the Hospice and Palliative Care Program by a CCM or LCC;

- The referral must have the appropriate level of service defined (palliative or hospice or both);

- The referral must be sent to the CareFirst select agency in the region where the Member lives, or will receive services, via a Service Request through the Service Request Hub;
• The agency or facility must accept or reject the Service Request within 72 hours of receipt of the Service Request (with full explanation in the case of rejection);

• The agency or facility must complete a Comprehensive Assessment;

• The agency or facility must upload the completed comprehensive assessment, treatment plan and ongoing findings in the iCentric System within 48 hours of its completion;

• The Hospice/Palliative Care Nurse who conducted the Comprehensive Assessment must discuss the case and decide on the course of action jointly with the referring LCC or CCM. This must be jointly agreed to before a course of action is commenced;

• There must be communication between the palliative and hospice team, and the CCM or LCC, at a minimum of once a week, and documentation of all follow up in the iCentric System; and

• The palliative and hospice provider must monitor and carry out services for the Member in accordance with the approved Hospice/Palliative Care Plan.

Overall patient satisfaction is measured by an ongoing survey arranged by CareFirst through which overall Member satisfaction with the Hospice/Palliative Care Program and agency is measured. This is reported to the LCC or CCM who made the referral and, through them, to the Member, PCP, and treating provider and is included in the Member Health Record.

**Special Reimbursement**

Hospice/Palliative Care agencies who participate in the Hospice and Palliative Care Program receive additional reimbursement for each Member in the Program to reflect the additional Care Coordination activities they undertake in the Program.
Skilled Nursing Facility Program (SNF)

Most Members hope to go directly home from the hospital after surgery or illness. But even if a Member plans to go home, the recovery may be slower than expected or additional services may be needed to meet recovery goals. As a result, the Member may need to be transitioned to a skilled facility for intensive nursing or rehabilitation services. The TCCI Skilled Nursing Facility (SNF) Program provides care for Members who are not yet able to care for themselves at home, even with home care support. Typically, over 3,000 CareFirst Members are transferred annually from acute inpatient hospitals to skilled facilities.

In the SNF Program, a physician supervises each Member’s care. Skilled nursing care is available 24 hours a day. Other medical disciplines, such as physical and occupational therapists, are also available at the facility. This allows for the delivery of medical procedures and therapies at one location with 24 hour oversight and monitoring that would not be possible in a home setting.

Members typically spend three to four weeks in a Skilled Nursing Facility. The Skilled Nursing Facility Program acts as a bridge to continued-home or outpatient care.

Currently, one in four persons admitted to a Skilled Nursing Facility from a hospital is readmitted to the hospital within 30 days of their stay. In addition to being very costly, this has negative physical, emotional and psychological impacts on the Member. Many readmissions from Skilled Nursing Facilities to the acute hospital are preventable, particularly when the facility attends to wound care, fall prevention and infection control. The SNF Program – as part of CBP - seeks to reduce these hospital readmissions through the use of selected high quality facilities, with a focus on Member and physician Engagement and the development of an actionable Care Plan with specific, agreed upon goals.

TCCI Skilled Nursing Facility Program Goals

There are three specific Program goals for the SNF Program:

- Provide a bridge between acute inpatient care and the home setting for those Members needing intensive Skilled Nursing and/or rehabilitative services.
- Facilitate the Member’s return to their pre-injury/pre-illness baseline by providing the multiple services needed on a daily basis in one location.
- Reduce preventable hospital readmissions and ER visits.

Ultimately, the purpose of the Program is to safely return Members to their homes with the highest possible level of functioning as soon as they are clinically stable.

Skilled Nursing Facility Services Criteria

Most Members are identified for the SNF Program as a result of an acute inpatient admission. Therefore, Members needing SNF services are almost always first identified by a Hospital Transition Coordinator (HTC). Members who require three or more hours of combined professional services daily are candidates for the SNF Program and are evaluated by the HTC.

SNF Program services include:

- Continuous IV therapy (hydration)
- Multiple infusions (IV antibiotics)
- Frequent suctioning
- Extensive wound care
- Pain Management
• Multiple rehabilitative services (PT, OT, SP)
• Ventilator weaning

Professional services include nursing and rehabilitative services, which cannot be adequately performed by a non-skilled individual (family Member, caregiver) or by a home care agency.

When these types of services are identified during hospitalization, the HTC completes a Skilled Nursing Facility Service Request via the iCentric Service Request Hub, which is then sent to a select Skilled Nursing Facility after speaking with the Member and acute care facility team. In this Service Request, the HTC specifies the service sought according to the following four service levels:

**Level 1:** Three hours of professional services daily. Care includes such services as extensive dressing changes or wound care three times per day, IV antibiotics, or three hours of rehabilitative services daily.

**Level 2:** Up to six hours of professional services daily. Care includes such services as Stage 3/Stage 4 wound care, post-cerebrovascular accident care, including rehabilitation, total parenteral nutrition, complex hydration, and respiratory services.

**Level 3:** Over six hours of professional services daily, which include care for multiple injuries post motor vehicle accident/trauma, skeletal traction, or severely deconditioned Members requiring frequent monitoring.

**Level 4:** Ventilator weaning with defined short and long term goals.

**Process for Referral through the iCentric Service Request Hub**

After completing a Service Request, through the iCentric Service Request Hub, the HTC or LCC transitions the Member to a CCM who specializes in Skilled Nursing Facility Care. SNF services are almost always managed and arranged through the Complex Case Management Program. The CCM develops a detailed Case Management Plan with short and long term goals against which the Member’s progress is monitored. The CCM frequently discusses the plan and ongoing progress and treatments with the SNF team, which consists of SNF case managers, social workers, therapists and a lead physician as needed.

The following process is followed in requesting and arranging SNF care:

• The Member must be referred to the SNF Program by a HTC, CCM or LCC (as previously noted, often the HTC will initiate the referral).

• The referral must have the appropriate Level of Service defined (Level 1-4).

• The referral must be sent via a Service Request through the iCentric Service Request Hub.

• The preferred facility must accept or reject the Service Request within 48 hours of receipt of the Service Request (with full written explanation in the case of rejection).

• The facility must then complete a Comprehensive Assessment and Plan within 48 hours of accepting the Service Request.
• The facility must upload the completed Comprehensive Assessment, treatment plan and ongoing findings in the iCentric System within 48 hours of completion.

• The SNF Nurse from the selected facility who conducted the Comprehensive Assessment must discuss the case and decide on the course of action jointly with the referring HTC, LCC or CCM. This must be agreed to by the HTC, CCM or LCC before starting the recommended course of action.
• There must be communication between the SNF Nurse and the CCM or LCC at least once a week.

• All documentation of care must be complete and kept up to date in the iCentric System.

• The SNF must monitor and carry out services for the Member in accordance with the approved Skilled Nursing Facility Care Plan.

For those Members in PCMH, the CCM coordinates with the referring source as discharge from the SNF nears, ensuring early LCC and PCP Engagement post discharge.

Skilled Nursing Facility services are covered benefits under most CareFirst benefit plans. Only Members in a CCM or CCC Plan are eligible for the special CareFirst SNF Program that is part of the larger TCCI Community Based Services Program. Custodial/residential nursing home care is not covered and these services are not a component of the SNF Program.

**Skilled Nursing Facility Assessment and Goals**

The Skilled Nursing Facility care team develops a treatment plan, which is incorporated into the larger CCM Plan that already exists for the Member that is documented in iCentric. The CCM maintains oversight of the implementation of the Care Plan, working hand in hand with the SNF care team/providers.

Just as in the HBS Program, there are two key components of the SNF Program: the initial/subsequent assessment and ongoing Care Coordination. Each SNF Plan starts with a comprehensive assessment.

The Comprehensive Skilled Nursing Facility Services Assessment includes an overall evaluation of the Member’s condition, their understanding of their condition/disease process, medications, functional capabilities and limitations, equipment needs, cultural and spiritual needs, and advanced directives. The Assessment serves as the foundation to identify clear and specific short term and long term goals for the Member as well as a targeted length of stay. Each week, the SNF Nurse will update iCentric and the CCM on the Member’s progress toward their goals and will identify key milestones that have been met or are to be met. The CCM maintains oversight of the implementation of the CCM Plan, working hand in hand with the SNF Nurse.

Thus, the Comprehensive Assessment entails an analysis of the overall situation and recommends a clear plan that is documented in iCentric. The Comprehensive Assessment will confirm and modify, as appropriate, the level of service needed by the Member. Each Member managed under the SNF Program is strongly encouraged to meet with their PCP for ongoing care needs as soon as they are discharged from the facility. For those Members in PCMH, the CCM directly transitions the Member to the LCC for continued Care Coordination ensuring early PCP Engagement post their SNF stay.

**Skilled Nursing Facility Partners**

To provide a foundation for the SNF Program, CareFirst has entered into strategic alliances with four select Skilled Nursing Facility providers in its core service area to support patients who are targeted for the Program. These carefully selected SNF providers cover the region with multiple sites allowing Members to choose the closest local facility for their SNF stay.

SNF providers were selected based on an extensive review of the capabilities of these facilities, including such factors as clinical quality, geographic access, and financial/contractual considerations, as well as a track record with CareFirst that demonstrates excellent staff relationships, and the willingness to use CareFirst’s iCentric technology in creating integrated Care Plans for those CCM and CCC Members referred for SNF services.
Ongoing Oversight and Monitoring

Overall patient satisfaction is measured by an ongoing survey arranged by the CCM through which overall Member satisfaction with the SNF Program and facility is measured. This is reported to the HTC or CCM who made the referral and, through them, to the LCC, PCP (if the Member is in the PCMH Program) and treating providers.
Chronic Kidney Disease Program (CKD)

Chronic Kidney Disease (CKD) is a medical condition that has serious effects on health status, quality of life and total cost of care. Despite the availability of nationally-endorsed, evidence-based guidelines for screening and treatment, CKD is often undiagnosed until it reaches more advanced stages, when complications are beginning to occur. By this point, total cost of care is double that of persons with uncomplicated CKD. 13

Therefore, it is vitally important to diagnose and treat persons with CKD early. Recently-updated expert Chronic Kidney Disease guidelines include the following recommendations:

- Higher risk populations, including all persons with diabetes and/or hypertension, and all persons over age 60 years should be screened for CKD;
- Two lab test results (blood creatinine test and urine albumin test) should be used to categorize persons with CKD into stages;
- Patients diagnosed with CKD should be monitored at specified intervals depending on CKD stage, and
- Members with advanced stages of CKD should be referred to nephrologists at the right time.

Prevalence and Cost of CKD

Approximately one in 10 adults in the U.S. has some level of CKD,14 with greater prevalence associated with comorbid conditions and increasing age. Persons with both diabetes and hypertension have the highest prevalence of CKD (four to five times the general adult population under age 60), closely followed by all persons age 60 years and older, then those under 60 with either diabetes alone or hypertension alone, as indicated on the following chart 14 F

---

14 Report from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).
CKD has enormous impact on well-being, health status, and economic cost. A recent study estimates that spending by Medicare, Medicaid and private insurers on persons with CKD reached approximately $350 billion in 2014, and that early detection and treatment could reduce these costs substantially. 16

Medicare spending for CKD patients at any stage is higher than for non-CKD patients and up to 3.0 times higher for Stage 4 CKD. An analysis of CareFirst members who had lab tests in 2014 showing reduced kidney function demonstrated similar findings, with annual costs rising dramatically with worsening kidney function, as indicated on the following graph.

**Part VI, Figure 40: Average Per Member Per Year (PMPY) Costs For CareFirst Members Increases With Worsening Renal Function** 17

---

**Definition of Chronic Kidney Disease (CKD)** 18

According to the guidelines: Kidney Disease: Improving Global Outcomes (KDIGO), CKD is defined as “abnormalities of kidney structure or function, present for at least three months, with implications for health.” CKD is classified into one of five stages, based on two laboratory tests: a simple blood test (serum Creatinine) and a urine test (Albumin). Both tests are required for this classification system.

Creatinine is a normal waste product of muscle activity, which is cleared by a normally-functioning kidney. When there is kidney damage, the serum creatinine rises in proportion to the degree of damage. The creatinine lab value is used to estimate kidney function, the estimated Glomerular Filtration Rate (eGFR). The eGFR takes into account serum creatinine level, as well as age, race and gender.

With kidney damage, albumin (protein) spills into the urine, also in proportion to the degree of damage. Albuminuria lab results, the second factor used to calculate the CKD stage clusters into three categories, based on the degree of kidney damage. Thus, the two lab test results are used in concert, as indicated on the following three charts. These charts illustrate the appropriate determination of a Member’s CKD stage and the appropriate intensity of recommended treatment, which forms the basis of CareFirst’s Program.

---


17 Source: Lab data and claims for CareFirst Members 2014

18 Kidney Disease Improving Global Outcomes (KDIGO) 2012 Clinical Practice Guidelines for the evaluation and management of Chronic Kidney Disease. This document includes matrices with recommendations for monitoring and referring, as indicated on the following pages.
Part VI, Figure 41: Prognosis Of Chronic Kidney Disease (CKD) According To Stage Determined By eGFR And Albuminuria Values

<table>
<thead>
<tr>
<th>GFR categories (ml/min/1.73 m²)</th>
<th>Persistent albuminuria categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1 Normal or high</td>
<td>Normal to mildly increased</td>
</tr>
<tr>
<td>G2 Mildly decreased</td>
<td>Moderately increased</td>
</tr>
<tr>
<td>G3a Mildly to moderately decreased</td>
<td>Severe decreased</td>
</tr>
<tr>
<td>G3b Moderately to severely decreased</td>
<td></td>
</tr>
<tr>
<td>G4 Severe decreased</td>
<td></td>
</tr>
<tr>
<td>G5 Kidney failure</td>
<td></td>
</tr>
</tbody>
</table>

Part VI, Figure 42: Recommended Frequency Of Kidney Function Monitoring Per Year By Chronic Kidney Disease (CKD) Stage

<table>
<thead>
<tr>
<th>GFR categories (ml/min/1.73 m²)</th>
<th>Persistent albuminuria categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1 Normal or high</td>
<td>Normal to mildly increased</td>
</tr>
<tr>
<td>G2 Mildly decreased</td>
<td>Moderately increased</td>
</tr>
<tr>
<td>G3a Mildly to moderately decreased</td>
<td>Severe decreased</td>
</tr>
<tr>
<td>G3b Moderately to severely decreased</td>
<td></td>
</tr>
<tr>
<td>G4 Severely decreased</td>
<td></td>
</tr>
<tr>
<td>G5 Kidney failure</td>
<td></td>
</tr>
</tbody>
</table>
CKD Program

The CKD Program enables PCPs who identify higher-risk Members to refer them for appropriate monitoring and treatment by community-based kidney care specialists. CareFirst designed its community-based CKD Program in collaboration with national and regional kidney care experts, including representatives from the National Kidney Foundation (NKF).

The CKD Program relies on the Metabolic Index Score, which combines laboratory data with biometric measurements, to identify Members with CKD who could benefit from the Program. The Program identifies Members with CKD as early in their course as possible with the goal to delay or prevent migration to higher CKD stages.

The Program relies on support from community-based nephrologists who have agreed to support PCPs with Care Plans for these Members and who agree to timely see those Members with advanced CKD. It also relies on specialized Home-Based Monitoring services to enable Members with CKD to manage their disease and related comorbidities.

In short, the Program is designed to restrain the progression of CKD to advanced stages, when lifetime dialysis or kidney transplant becomes necessary to preserve life.

The following Elements constitute CareFirst’s CKD Program:

**Awareness of PCMH Panels**

Most Members who have early-stage CKD (up to 90 percent, according to the NKF) are not aware they have the disease and many PCPs report they are unsure how best to treat such Members once diagnosed. To successfully delay the progression of CKD, PCPs must manage their Members with early stage CKD. CareFirst has partnered with the National Kidney Foundation, which has identified local nephrologists who are willing to meet with PCMH Panels to educate them on the proper diagnosis and treatment of CKD. Program Consultants coordinate these education sessions, which review recommended treatment guidelines and how to appropriately identify potential Members with early stage CKD.
Identifying Potential Members for the CKD Program

There were over 17,000 CareFirst Members with a diagnosis of CKD in October, 2015 with an average IBS of over eight. While inpatient admits/1,000 in the general CareFirst population were 52/1,000 in Q4, 2015, those Members diagnosed with CKD showed over 375/1,000 with medical costs of approximately $30,000 per year.

All of CareFirst’s Care Coordinators actively seek to identify patients with abnormal kidney function and work with PCPs to define the best means of treatment and the development of Care Plans when appropriate. Selection criteria for the CKD program includes both Members who have full expression of CKD as well as those who are at higher risk for developing CKD.

There are three processes through which Members are identified for the Program based on analyses of laboratory and/or medical claims data.

- LCCs use the Metabolic Index Score (MIS) to identify Members with abnormal kidney function, with or without coexisting medical conditions. The MIS is a highly sensitive indicator for abnormalities of kidney function, as well as comorbid conditions diabetes and hypertension. The LCC reviews all identified Members with their assigned PCPs to determine if the CKD Program is appropriate.

- HTCs flag all Members with CKD/ESRD who are admitted to the hospital for any reason, using a unique category designation (Level 1H), and through the Service Request Hub notify the LCC of any attributed Members who may benefit from the CKD program.

- CCMs also identify all advanced/complex Members with CKD/ESRD and make Service Request Hub referrals to notify the LCC of any attributed Members who may benefit from the CKD Program.

In addition, the Program identifies Members who are at higher risk for developing CKD/ESRD but do not yet have screening laboratory results. LCCs and PCPs identify Members who should have received nephropathy (kidney damage) screening tests through systematic review of the Adult Quality Scorecard. The Quality Scorecard lists Members at risk for CKD (those with diabetes and/or hypertension) who have not had the recommended screening tests and identifies them for screening and subsequent referral to the CKD Program if the lab results are consistent with decreased renal function.

Assigning CKD Stage

Each LCC reviews the lab results of identified individuals with the PCP to assign the appropriate CKD Stage, as defined in the Kidney Disease Improving Global Outcomes (KDIGO) guidelines (represented in Figure 41). The CKD stage is assigned based on two different laboratory results, the blood creatinine test (which is used to calculate the “gold standard” of kidney function, the estimated glomerular filtration rate, or eGFR) and the urine test for protein (also called the albuminuria test). Both tests are sensitive indicators of kidney function. The assigned CKD stage aids the PCP to decide on an appropriate course of treatment, the need for a Care Plan, the frequency of kidney function monitoring and the timing of referral to kidney care specialists and other related community-based resources (e.g., renal nutritionists).

The NKF has identified local nephrologists who are recognized thought leaders in kidney care, and who are available via telemedicine consultation with the PCP to confirm the treatment course, and to help decide whether a Member should be referred to a Nephrologist at that time or continue to undergo monitoring by the PCP. The use of such video consultations will ensure adequate access for those who specifically need timely in-person consultation with renal care specialists.

Develop Specialized Care Plans

Once identified as having CKD, PCPs working with their LCC, develop chronic condition Care Plans for Members consistent with KDOQI guidelines. Such Members have access to all TCCI services and are eligible for the cost-sharing waiver, as appropriate. Elements of a Care Plan at a minimum include:
• Pharmaceutical treatment of kidney disease to delay its progression, including a CMR to ensure the avoidance of medications associated with acute kidney injury as well as promote adherence to kidney-sparing medications;

• Management of underlying conditions, most often diabetes and/or hypertension;

• Prevention of cardiovascular disease progression and other metabolic abnormalities; and

• Nutritional management, provided by renal nutritionists, in person or by telemedicine.

The Care Plan identifies the appropriate intervals to monitor kidney function by standard laboratory tests, as indicated on Figure 42. KDIGO guidelines recommend performing these tests from one to four (or more) times per year, depending on the CKD stage. Based on clinical judgment, for selected Members who have poor control of underlying comorbidities or who are otherwise fragile and would benefit from intensive virtual coaching, the care team also considers the use of Home-Based Monitoring services.

Medtronic has developed specific protocols in collaboration with the NKF and CareFirst clinicians for the monitoring of CKD patients. These protocols monitor Members’ key biometric data (weight, blood pressure, glucose) using in-home electronic devices and provide targeted CKD adherence and self-management information and education on a daily basis. Each Member receives tailored messaging daily - depending on their response to brief questionnaires - that helps them with:

• medication Adherence,
• avoidance of potentially dangerous medications (such as those that are associated with acute renal injury),
• renal-specific nutritional information (calorie, salt and protein intake),
• reminders for monitoring tests and visits, and
• screening for behavioral health issues.

This messaging reinforces and supports the very same information that the care team provides to the Member during weekly Care Coordination visits (in person, video or telephone calls).

For Members with advanced CKD (eGFR < 30 or severe albuminuria), the care team ensures timely referral to a Nephrologist, consistent with KDIGO guidelines represented on Figure 43. Referral to a nephrologist at the appropriate time is associated with significantly improved clinical and economic outcomes by allowing for careful planning and preparation for Renal Replacement Therapy (including dialysis and kidney transplantation).

The extensive CareFirst network includes credentialed board-certified nephrologists of whom approximately 160 are considered high-volume nephrologists in the service area. These higher volume nephrologists have sufficient Members and episodes of care for specialty ranking with their peers as High, Medium or Low Cost, color coded as Red-Yellow-Green on the PCMH SearchLight. Program Consultants ensure that all PCMH practices have reviewed this information and have identified trusted, high-quality, cost effective nephrologists for referrals as needed.

LCCs, working in consultation with the PCP and during weekly interactions with the Member, continue to monitor Members’ progress (biometrics, laboratory tests, medication adherence, office visits) based on KDIGO guidelines. For Members who meet criteria (eGFR less than 30 and/or severe albuminuria) for referral to the nephrology team, the LCC works to ensure timely appointments and that care is comprehensive and coordinated with other community-based resources, including specialized renal dieticians, vascular surgeons, dialysis centers, transplant services, and advanced Care Planning/palliative care as appropriate.

Each involved LCC, through the Service Request Hub, carefully tracks the number of Members identified with CKD, the development of Care Plans, and referrals to local nephrologists. For those identified Members, the LCC collects the following set of outcomes metrics to evaluate overall impact of the Program:

• Utilization of inpatient and ED services related to renal disease, comorbidities or complications, with expected decreases over time;
• Total cost of care decrease for patients with any stage of CKD;
• Use of prescription medications (ACE and ARB inhibitors) increase;
• Glucose and blood pressure control improvement;
• Measures of migration from one CKD stage to another, with less migration to advanced stages;
• Timeliness of referral (between nephrologist referral and renal replacement therapy (RRT) initiation), with goal of nephrology referral at least six to 12 months prior to RRT initiation; and
• Utilization of RRT modalities (peritoneal or hemodialysis) and site of service (home or dialysis center), expecting increasing use of the home setting where clinically appropriate.

Conclusion

While approximately 17,000 CareFirst Members have the diagnosis of CKD or End Stage Renal Disease, it is very likely that this number represents only a portion of CareFirst Members who actually have CKD.

CareFirst’s comprehensive CKD Program includes screening of high risk individuals, treatment of underlying diabetes and/or hypertension with special attention to medication adherence, and collaboration with select community-based renal care providers.

The best possible health and economic outcomes result when CKD is diagnosed and treated early using two readily available screening tests (eGFR and albuminuria). The results of these two tests provide the basis for categorizing Members with CKD into stages to determine the risk of disease progression, the frequency of periodic monitoring and the timing for referral to kidney care specialists.

Most patients with CKD have relatively mild expressions of the disease and can be managed by the PCMH PCP with medications, dietary advice and promotion of healthy lifestyle behaviors, including regular exercise and smoking cessation. Periodic kidney function monitoring uncovers the trajectory for Members who are more rapidly deteriorating and need more aggressive intervention. As some Members move to more advanced CKD stages, their care is co-managed by their PCMH PCP and a selected nephrologist practicing in a multi-disciplinary setting is the most appropriate health professional to manage the patient, including preparing the patient for renal replacement therapy (dialysis or kidney transplant).
UPDATE PENDING
Congestive Heart Failure

UPDATE PENDING
Sleep Management Program

Obstructive Sleep Apnea (OSA) is a common chronic disease prevalent in approximately 20 percent of the U.S. adult population. The incidence of OSA increases with age from 18 to 45 years and plateaus at 55 to 65 years of age with a predisposition for African Americans and Asians possibly related to facial structure. However, the overwhelming majority of people with OSA go undiagnosed until they are being evaluated for some other co-morbid condition.

OSA involves partial collapse or repetitive collapse of the airway during sleep. The resulting disrupted sleep leads to daytime sleepiness and diminished cognitive performance, often times leading to chronic diseases, catastrophic motor vehicle accidents, and even death. Major defined risk factors for OSA include obesity (BMI >35), craniofacial abnormalities, and upper airway soft tissue abnormalities. Other risk factors include smoking, nasal congestion, and heredity.

OSA is associated with multiple chronic medical illnesses, such as coronary artery disease and heart failure, stroke, hypoventilation syndrome, chronic obstructive pulmonary disease, pulmonary fibrosis, and mental illness. Increasingly, OSA is being considered a predisposing factor for the development of diabetes, systemic hypertension, cardiovascular diseases, and other chronic conditions. Numerous trials have reported that effective Continuous Positive Airway Pressure (CPAP) therapy reduces systemic blood pressure and improvements in other comorbidities have also been noted.

Given the demographics of CareFirst Members and the myriad of diseases associated with OSA, proactive diagnosis and early intervention for members with undiagnosed OSA present an opportunity to reduce long-term morbidity, curtail avoidable cost and even prevent mortality.

Economic Impact of OSA

In the United States, the economic cost of unmanaged OSA (moderate-to-severe) is estimated to be between $65 and $165 billion, which is greater than the cost associated with asthma, heart failure, stroke, and hypertension. Members with unmanaged OSA are known to incur higher rates of hospitalizations, contacts with healthcare specialists and increased medication use.

In 2014, CareFirst Members received over 28,000 sleep studies costing nearly $34 million, the vast majority of which (~90 percent of total sleep studies) were performed in a sleep lab, clinic or outpatient facility. Sleep studies performed in a clinical setting are known as polysomnography or PSG. During that same period, claims for CPAP machines/supplies for treatment of OSA cost $29 million. Members on CPAP therapy were managed by over 30 different vendors/providers.

New Technology and Approaches

Technology has advanced considerably in the last five years and now, for Members whose conditions are not complicated by certain comorbidities, Home Sleep Tests (HST) have proven effective, while proving to be a much more convenient and comfortable alternative than tests performed in a lab or hospital setting.

While sleep studies typically have ranged from $3,500-$5,000 per study, the equally effective HST costs range from $200 - $500 for the same actionable diagnostic results. Thus, there is tremendous opportunity to reduce diagnostic cost while also providing early intervention measures that have been proven effective. It is further thought that by making HST more accessible and convenient, more of the population suffering from OSA may be reached resulting in downstream cost savings and improved overall health.

---

Sleep Management Program Goals

CareFirst’s Sleep Management Program provides a multifaceted approach to identifying, diagnosing, and engaging Members for sleep studies and appropriate follow-up management.

The two goals of the Sleep Management Program are to:

1. Ensure a more cost effective, yet clinically appropriate, setting for sleep studies by shifting unnecessary facility based sleep tests and outpatient testing to home settings resulting in lower cost and improved Member experience.

2. Intensively monitor and improve Member compliance with CPAP equipment provided by selected equipment vendors to promote better outcomes.

Prior Authorization for Facility Based Sleep Studies

Starting on January 1, 2016, Members needing an attended sleep study performed in a lab, office, clinic or hospital setting will require Prior Authorization. Members having an unattended sleep study done in the home do not require Prior Authorization.

CareFirst has collaborated with local board certified Sleep Medicine physicians to develop a clear, comprehensive medical policy based upon sound clinical judgment for sleep management services which clearly indicates the diagnoses/conditions that are appropriate for attended sleep study in a lab and unattended sleep study at home. This medical policy is available to all Members and providers online at www.carefirst.com.

As with other services, providers submit authorization requests via iCentric. Requests are reviewed by the CareFirst clinical team and Prior Authorization is given when medical necessity criteria are met. Individual clinical circumstances not meeting the criteria are always reviewed by a CareFirst Medical Director.

For most Members, a lower copayment of $20 applies for sleep studies done in the Member’s home. For Members who undergo a freestanding sleep study in a lab, a higher copayment of $100 applies in addition to a copayment of $200 for hospital-based tests. The Prior Authorization requirement combined with the site of service differential in Member cost sharing is meant to encourage medically necessary care in the most appropriate setting.

Member Access to the Sleep Management Program

Specialization in sleep medicine is generally found in two medical specialties – Neurology and Pulmonology. To ensure visibility and access to the best possible network of sleep medicine specialists, CareFirst has established a credentialing category of “Sleep Medicine Specialist”. To be considered a Sleep Medicine Specialist, physicians must be credentialed by the American Board of Medical Specialties (ABMS) in Sleep Medicine. Members needing sleep studies or sleep management services are not required to use a designated Sleep Medicine physician. However, these credentialed sleep medicine physicians are separately listed in the CareFirst Provider Directory that is available online under the specialty category “Sleep Medicine”.

When sleep services are needed for Members in a Care Plan, LCCs work with the PCMH PCPs to identify and select these credentialed sleep providers. Members without a PCMH PCP can access the list of credentialed sleep medicine physicians using CareFirst’s online Provider Directory through a simple query. In addition, any provider can access the listing of credentialed sleep services specialists. Providers and Members are advised of the Sleep Management Program through the CareFirst website and targeted communications in BlueLink and Member newsletters.

Once sleep study results are reviewed by the PCP or Specialist and OSA is diagnosed, a treatment plan is developed based upon the clinical and physical findings. In cases where CPAP services will be ordered by the physician, a referral is sent to one of CareFirst’s designated CPAP vendors through the iCentric Service Request Hub.

CareFirst has selected five preferred sleep service equipment vendors to support the Sleep Management Program. These vendors not only supply the needed equipment, but provide ongoing monitoring and hence, are part of the TCCI Enhanced Monitoring Program. Each vendor has been thoroughly evaluated by CareFirst for access, timeliness, quality, oversight and
Member satisfaction. The preferred vendors provide stringent oversight, continuous monitoring and preferred pricing for CareFirst Members in the Sleep Management Program.

Although Members are not required to use a preferred vendor for CPAP equipment, PCMH PCPs and Sleep Medicine Specialists will connect the Member to a preferred CPAP vendor whenever possible. CareFirst will reach out to these physicians to ensure a thorough understanding of the CareFirst Sleep Management Program and the benefits of using a preferred vendor. The preferred vendors provide a higher level of Member service, reaching out to Members to assess compliance, barriers to compliance, and equipment related issues. They also provide follow up OSA and CPAP coaching and devise ongoing plans to address barriers.

**Initiation, Oversight and Monitoring Process for Members on CPAP Therapy**

The service standards set forth below guide the work of these preferred vendors:

1. The preferred vendor receives an order from a provider for a Member requiring CPAP therapy.

2. The vendor completes a Service Request (SR) in iCentric within 72 hours of receiving the order.

3. CareFirst requires that CPAP equipment have auto titration functionality and an internal modem. The vendor delivers this CPAP equipment to the Member’s preferred address or provides a convenient office location for equipment pick up, if that option is preferred by the Member.

4. A licensed Respiratory Therapist or Registered Nurse thoroughly reviews the CPAP equipment set up in person with the Member and trains the Member on the use and maintenance of the equipment including the overall health benefits of CPAP compliance.

5. The CPAP device must be equipped with an internal wireless modem to monitor therapy daily and feed the results back to the vendor each morning.

6. The vendor must contact the Member after the first night of therapy to review the Member’s progress and addresses Member questions/concerns.

7. If therapy is successful, the Member is contacted on days 7, 30, 60, and 90 from the date of setup. If the Member continues to be compliant with therapy, the Member is contacted every six months, thereafter, for the duration of therapy.

8. The preferred equipment vendors each have performance standards in place as a part of their contract. The preferred vendors will ensure that 100 percent of the CareFirst Members on service are compliant with therapy a minimum of four hours/night 70 percent of each month.

9. At any point, if an individual Member’s compliance drops below 70 percent for five or more consecutive nights, as measured electronically by the device, the vendor must contact the Member to address barriers to compliance. Members are provided with options that improve compliance including appropriate mask-fitting education; tubing, filter replacement, or water chamber replacement; or other appropriate device related issues.

10. The vendor must develop an action plan to address compliance barriers. If compliance continues below 70 percent and/or the Member does not comply with the action plan, the vendor must notify the ordering physician for further evaluation and recommendation.

11. The vendor must staff a 24-hour on-call line with Customer Service Technicians/Respiratory Therapists available to address Member questions and concerns regarding the functionality of the equipment.
The Service Request Hub tracks activity metrics/outcomes such as the number of Members on service, number of Members compliant vs. non-compliant, barriers to compliance such as a mask leakage, and improvements in quality of life.

**iCentric Integration With Sleep Monitoring Devices**

On a weekly basis, the five designated equipment vendors send monitoring data directly to iCentric to enable CareFirst’s Care Coordination Teams and other providers to view Member compliance and progress on the CPAP machine. The Hub monitors the weekly data feeds and alerts the Care Coordination Team as needed to any problems, untimeliness or unavailability of data.

**Conclusion**

With the advent of the Sleep Management Program, CareFirst seeks to provide a comprehensive approach to identifying, diagnosing, and engaging Members for sleep studies and appropriate follow-up management. By shifting unnecessary facility-based CPAP sleep tests to the home setting, costs are reduced and Member experience is improved. Through preferred equipment vendor arrangement, ongoing CPAP services are intensively monitored to improve Member compliance with needed equipment. The Sleep Management Program connects Members with the most cost effective site of service and trusted equipment vendors to minimize cost for Members and Accounts, ensuring the best possible health outcomes.
Program #9: Comprehensive Medication Review Program (CMR)

Understanding the Need for a CMR

Prescriptions are the most important treatment method in healthcare today. Annually, nearly 30 percent of the CareFirst medical dollar is spent on prescription drugs – the highest category of spending and more than is separately spent on inpatient or outpatient hospital care.

The effectiveness of prescription drugs is heavily contingent upon a Member’s adherence. Yet, the average medication adherence rate is 50 percent or less and is even lower for individuals on multiple medications. Over 35,000 CareFirst Members are on eight or more prescriptions at the same time, often prescribed by as many as six or more specialists as well as what is prescribed for them by their PCP or NP. Major consequences of poor adherence to medication regimens are poor health outcomes and increased health care costs.

Designed for Members with the highest potential medication-related issues, CareFirst’s Comprehensive Medication Review Program (CMR) engages a specialized pharmacist to address the question: “What medications should the Member be on?” While the CMR Program is closely integrated with the RxP overall, the importance of prescription management for the chronic or multi-chronic Member warrants a distinct focus to assure their drug treatments are optimized. For specially identified Members on large numbers of medications or on medications that create instability in the Member, the CMR Program seeks to review and mitigate the issues that arise when multiple medications are prescribed for a single Member, including:

- Poor compliance and confusion;
- Duplicative prescribing patterns across multiple providers (PCPs, specialists, ER physicians);
- Dangerous drug-to-drug interactions;
- Adverse side effects from multiple prescriptions; and
- Compounding effects of using medications to treat the effects of other medications.

Perhaps the most important focus is on Members who have been prescribed medications that when taken as directed, make them unstable, depressed or psychotic.

Figure 44 below shows the number of CareFirst Members on eight or more drugs at any given time over a three month period, along with their average Illness Burden Score (IBS) and total spend.

Part VI, Figure 44: Member Multi-Drug Use And Costs In 2014 (Data Spans A Three-Month Interval)

<table>
<thead>
<tr>
<th>Number of Prescribed Drugs</th>
<th>Number of Members</th>
<th>Avg IBS</th>
<th>Total Medical Cost</th>
<th>Total Pharmacy Cost</th>
<th>Total Cost</th>
<th>Total Cost PMPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>8+ Drugs</td>
<td>35,715</td>
<td>3.82</td>
<td>$134,435,282</td>
<td>$79,258,365</td>
<td>$213,693,646</td>
<td>$5,983.30</td>
</tr>
<tr>
<td>9+ Drugs</td>
<td>24,380</td>
<td>4.25</td>
<td>$104,441,467</td>
<td>$62,131,819</td>
<td>$166,573,286</td>
<td>$6,832.37</td>
</tr>
<tr>
<td>10+ Drugs</td>
<td>16,563</td>
<td>4.70</td>
<td>$80,957,548</td>
<td>$47,059,952</td>
<td>$128,017,501</td>
<td>$7,729.13</td>
</tr>
<tr>
<td>11+ Drugs</td>
<td>11,226</td>
<td>5.13</td>
<td>$60,907,396</td>
<td>$35,210,769</td>
<td>$96,118,165</td>
<td>$8,562.10</td>
</tr>
<tr>
<td>12+ Drugs</td>
<td>7,639</td>
<td>5.65</td>
<td>$46,400,555</td>
<td>$26,912,914</td>
<td>$73,313,468</td>
<td>$9,597.26</td>
</tr>
<tr>
<td>13+ Drugs</td>
<td>5,222</td>
<td>6.11</td>
<td>$34,748,559</td>
<td>$20,300,898</td>
<td>$55,049,457</td>
<td>$10,541.83</td>
</tr>
<tr>
<td>14+ Drugs</td>
<td>3,578</td>
<td>6.43</td>
<td>$26,564,986</td>
<td>$14,969,758</td>
<td>$41,534,744</td>
<td>$11,608.37</td>
</tr>
<tr>
<td>15+ Drugs</td>
<td>2,444</td>
<td>6.93</td>
<td>$19,708,209</td>
<td>$11,184,515</td>
<td>$30,892,724</td>
<td>$12,640.23</td>
</tr>
</tbody>
</table>

21 Source: Healthcare Analytics, CareFirst, 2014.
Members who are prescribed multiple medications generally have multiple chronic conditions and diseases. They often experience frequent breakdowns, resulting in hospital-based care and suffer complications due to the side effects of the medications they take. For Members with behavioral health or substance abuse issues along with chronic or severe medical issues (which is common), lack of compliance is a heightened concern. Additionally, adverse interactions are more likely to occur when a Member takes a number of medications concurrently. For example, the prescription drug Nexium, used to treat acid reflux, has been shown to reduce the effectiveness of Plavix, an anti-blood clot medication, when the two are taken under the same regimen.

Further complicating the situation is the fact that the prescribing physician often lacks knowledge of the medications other physicians are prescribing for the Member, potentially resulting in overdosing or the triggering of dangerous drug-to-drug interactions. The combination of these factors creates a compelling need to conduct a medication review for those Members whose sheer number or type of medications heightens the dangers of complication, breakdown and non-compliance.

**Finding the Right Members for a CMR**

Members are identified as needing a CMR in two primary ways:

- The exercise of clinical judgment by LCCs and CCMs who interact with a Member and the Member’s PCP; or
- Through automated criteria that trigger an identification based on the number and nature of drugs (e.g., eight or more) a Member is taking along with other meaningful predictors of medication-related risk (e.g., behavioral health issues).

For each PCMH Medical Care Panel, CareFirst generates three “Top 50” lists that identify the top Members in the Panel based on high drug spend, high drug utilization, and high Drug Volatility Score (DVS). Factors such as the number of prescribing providers, likelihood of adherence problems, drug-to-drug interactions, and serious drug induced side effects are reflected in the DVS. Identifying Members with a high level of likely instability requiring heightened review, monitoring, and possible intervention is a core goal in selecting Members for a CMR.

Many of the identified Members appear on all three Top 50 lists. After removing overlaps, the lists generate unique Members each month who warrant a closer review for possible medication issues. LCCs use clinical judgement to bring forward potential CMR candidates for discussion with the PCP. Upon the PCP’s review and agreement, a Member is referred for a CMR. In addition, CCMs identify Members in Complex Case Management Plans who could benefit from a CMR.

**Finding the Right Mix of Drugs and Dosages**

As already noted, the central question for the Members who are selected for a CMR is, “What should they be taking?” To properly answer this question, a CMR is conducted by a pharmacist who systematically reviews the Member and all the prescribers of medications for the Member, and the entire list of medications the Member is taking.

The CMR Program recognizes that often the most frequent interaction people have with the health care system is with their pharmacist. This interaction forges a trusting relationship between Members and pharmacists, positioning the pharmacist as the best party to conduct a CMR and to provide clarity into the total list of drugs prescribed by the various physicians who are the prescribers for a Top 50 list Member. Furthermore, a pharmacist’s point of view spans and is complementary to the specific medical knowledge of each of the various prescribing physicians involved.

**Sending Lists of Members for CMR**

Members selected for a CMR are routed through the iCentric Service Request Hub to CVS Caremark on a daily basis. All CMR referrals are tracked through the Service Request Hub to assure completion and proper follow up action.

Members in a high-deductible health plan are typically not targeted until they have met their deductible. This is to ensure these Members are not charged for the cost of a CMR which cannot be waived (under IRS rules) for Members in high deductible plans. For all other Members, CareFirst uses the Cost Share Waiver to provide this service at no cost to the Member. Any Members that request no contact are removed from the CMR list for the remainder of the calendar year.
The CMR

The first step in a CMR is for the pharmacist to understand what medications the Member is on. Claims history helps clarify most of the Member’s medication list. However, since Members may take over-the-counter (OTC) medications or pay for prescriptions without using their coverage benefit, claims history alone cannot completely reveal the Member’s medications. Therefore, a medication reconciliation is necessary. In the case of Members in CCC, CCM or BSACM Care Plans, this reconciliation is performed by the LCC, CCM or BSACM before referral for a CMR. For all other Members who are selected for a CMR based on trigger criteria, this reconciliation is performed by a CVS pharmacist.

The medication list for each Member is sent with the Service Request to the pharmacist responsible for the CMR. The pharmacist views the Member’s profile online through access to the Member Health Record, clinical notes (if the Member is in a Care Plan) and claims history.

The pharmacist reviews all information made available online through iCentric and discusses with the prescriber(s) via phone call the dosages, duration, drug combinations and any other pertinent issues called for by the unique circumstances of each Member. At any time during the process of conducting a CMR, at the pharmacist’s discretion, the Member may be interviewed to gain additional insight.

After the appropriate consultations occur, the pharmacist will recommend the overall package of drugs and dosages that best fits the Member’s needs and circumstances. No change is made in prescriptions by the pharmacist without the express authorization of the prescribing physicians.

The objective during the pharmacist’s conversations with PCPs, specialists, and Members is to gain insight into:

- Current medication regimen to assure that:
  - Medications taken (including OTC or other supplements) are appropriate
  - Dosages are appropriate and effective
  - Administration method is correct
  - Dosing times are correct for maximum effectiveness
- Adherence history
- Whether side effects associated with medications are understood and accounted for
- Whether Members are taking high-risk medications for their age and health status that may create instability or harm

The reviewing pharmacist discusses any and all recommendations based on the items above with all prescribing physicians and follows up on all changes that are recommended. If any prescribing physician is inaccessible for phone consultation, the pharmacist refers this to the PCP for direct follow up by the PCP with the specialists involved. The LCC may assist in seeking contact with the PCP as needed.

As the pharmacist discusses the recommendations with prescribing physicians, there may be particular issues which are of high risk or concern. A CMR is not considered complete until open questions of significance, as judged by the pharmacist, are acted upon by the prescribing providers.

As the CMR Program grows, CVS pharmacists will be teamed to specific PCMH provider Panels to gain familiarity with prescribers and build a clinician-to-clinician relationship encouraging direct communication through enhanced relationships with the PCPs. The pharmacists and PCPs may also use video conferencing capabilities to virtually connect during the CMR process.

Conduct of the CMR

Because the Members selected for a CMR have the highest potential medication related issues, it is critical that initiation of a CMR happen in a timely manner. The reviewing pharmacist initiates a CMR referred through the iCentric Service Request Hub within three business days of its receipt by CVS Caremark. This is evidenced by the pharmacist’s attempt to contact one or more parties (Member or a prescribing physician) involved in the CMR.
Once all prescriptions for a Member have been reviewed and any questions or concerns of a material nature have been resolved in the judgment of the reviewing pharmacist, the completed CMR is transmitted to CareFirst for display in iCentric. The pharmacist sends both fixed field information and free form notes for a complete summary of the CMR.

Any potential drug therapy problems (DTPs) are noted in an explanation column as are inappropriate dosing or duplication of drugs, adherence issues, inadequate efficacy, or safety concerns. In addition, the pharmacist provides free form text that outlines the recommendations made and the reason(s) for these changes. The recommendations range from a drug being discontinued, changed, confirmed as is, or left pending due to a physician needing to meet with the Member for further discussion.

When these recommendations are compared to the original medication list sent with the Service Request, the result shows a “before and after” view of the Member’s prescriptions and dosages at a National Drug Code level, as shown in Figure 45 below. This is placed in the Member Health Record and allows all caregivers to have view what medications the Member should be on.

Measurable outcomes are tracked to show the value of a CMR. The main component of value is documenting the number and savings of changes recommended and acted upon through a CMR. While pharmacy cost may increase with the addition of a prescription due to a gap in care, the CMR Program is aimed at reducing overall total cost of care for the Members. In addition, the following metrics are reviewed, amongst others, to validate the CMRs positive effects:

- increase in adherence
- increase in Medication Possession Ratio (MPR)
- reduction in breakdowns and ED visits

Part VI, Figure 45: Before And After View

<table>
<thead>
<tr>
<th>Starting Drug List</th>
<th>Result</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IREBETAN</strong> 150mg</td>
<td>Discontinued</td>
<td>Issues, Pharmacist Recommendations and Prescriber Response: 2/1/2015. Dr. Smith agrees to discontinue Irebetan and hydrochlorothiazide and replace with irbesartan HCT 300/12.5 mg. Dr. Smith will fax New Rx to pharmacy of choice and notify member. 2/2/2015. Consideration to change therapy from individual dosages of Irebetan 150mg and hydrochlorothiazide 0.3 mg to a single combination tablet of irbesartan HCT 300mg/12.5 mg. This combination tablet will provide the patient with the same dosage of medication and improve the patient’s compliance. Member Communication: Please change all 300mg every day and Hydrochlorothiazide 12.5mg every day. These two medicines come together in one pill, called IRBETAN.</td>
</tr>
<tr>
<td><strong>HYDRO CHLOROTHIAZIDE</strong> 12.5mg</td>
<td>Discontinued</td>
<td>Issues, Pharmacist Recommendations and Prescriber Response: 2/1/2015. Dr. Smith agrees to discontinue Irebetan and hydrochlorothiazide and replace with irbesartan HCT 300/12.5 mg. Dr. Smith will fax new Rx to pharmacy of choice and notify member. 2/2/2015. Consideration to change therapy from individual dosages of Irebetan 150mg and hydrochlorothiazide 0.3 mg to a single combination tablet of irbesartan HCT 300mg/12.5 mg. This combination tablet will provide the patient with the same dosage of medication and improve the patient’s compliance. Member Communication: Please change all 300mg every day and Hydrochlorothiazide 12.5mg every day. These two medicines come together in one pill, called IRBETAN.</td>
</tr>
<tr>
<td><strong>IREBETAN</strong> 300/12.5mg</td>
<td>Added</td>
<td>Irebetan HCT 300/12.5mg</td>
</tr>
<tr>
<td><strong>IREBETAN</strong> 150mg</td>
<td><strong>Notes</strong></td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td><strong>IREBETAN</strong> 300/12.5mg</td>
<td><strong>Notes</strong></td>
<td><strong>Notes</strong></td>
</tr>
</tbody>
</table>

**Encounter Notes:**

**Filter Encounter Notes by:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Submit</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td></td>
</tr>
</tbody>
</table>

**Display Results:**

<table>
<thead>
<tr>
<th>Display Results: 10 per page</th>
<th></th>
</tr>
</thead>
</table>

**Date:** 11/29/2014 11:30PM

**Reason:** BT will have knee surgery in Dec... RA stopped pain will have a lot of pain - walking to start new meds, not sure what she is going to do with RA... will continue with Kobe for RA... needs help with RA and wants to be back on 50 mg. 120/130/80, no disc... swelling in ankles but not sure if from RA or retraining... Chol: didn’t have it checked yesterday, not sure how high... was last time... will make appointment with PCP once everything was settled down... can have chol checked... has an increase in cholesterol for years, switched to potassium... works some days more than others, thinks potassium worked best but doesn’t want to change anything now until she starts new RA meds... New having b12 and mag level checked... had b12 levels last in 2013... BS: no issues Blood stasis, PCP: doesn’t have one. | **Submit** |

**Date:** 12/09/2014 02:20PM

**Member:** Member mentioned near end of call he thought the program was going to be about saving money - Sugg setvastatin, simvastatin for Creator; Sugg prednisone for arthritis asploidate, prednixin, actos etc... Lynita: member had skin to work with it... wanted to work with it... needed help to walk up stairs... generic... sugi needed help paying for medicine could use it if any other resources to lower cost of it all... OM: made to write said it was a waste of time to write it down and now is taking Ibuprofen... needs to work with it... status good 120/80. Chol: not recently checked. **NEXT TIME** did make any changes to meds for lower cost? DM - flag new a1c eye exams/inf. Vaccines?.
CMR Communications

The success of a CMR is dependent on a sound communication process. The foundation of the process relies on the successful Engagement of the prescribing physician(s) by the pharmacist. All communications:

- Use an actively engaged model with direct provider contact;
- Are conversational with understandable content;
- Reiterate the importance and benefit of the Program to the prescribers;
- Seek to increase awareness of the provider and/or Member on medication related issues.

For CMRs that are submitted for Members in active Care Plans, the LCC indicates the preferred contact date and time for the pharmacist to reach the PCP. If the pharmacist is unable to speak with the prescribing providers on their initial outreach they will attempt to schedule a specific appointment time for the pharmacist to call back.

The pharmacist makes, at a minimum, three attempts to reach the prescribing providers. These attempts to contact and speak by telephone with prescribing providers are documented through systematic daily data feeds to iCentric. If the pharmacist is unsuccessful in reaching a specialist they make this known to the PCP for direct follow up by the PCP with the specialist. If the pharmacist is unsuccessful in reaching a PCP for a CMR, the pharmacist seeks assistance from the LCC in contacting the PCP.

In an instance where the prescriber wishes to meet with the Member prior to acting upon a CMR recommendation, the pharmacist notes this in the system so that the need for follow up with the prescriber is known to all parties. A subsequent prescriber fax serves as a supplement to a phone conversation and never in place of one. In the instances when a prescribing physician requests the pharmacist recommendations in writing, the pharmacist may submit the prescriber fax but this occurs after the verbal discussion.

After successful PCP Engagement, the pharmacist may seek to call the Member. The pharmacist uses this opportunity to provide medication education and among other things, judge the Member’s understanding and comfort with the medication they are taking and with any recommended changes.

A maximum of six attempts are made over a two-month period to reach Members for each service request referral. For Members unreachable via telephone, a letter is mailed requesting that the Member call in to participate in a medication review. Members not reached on the initial service request referral may be re-identified at a later time for another outreach. A total of 12 attempts are made to reach the Member within a 12 month period.

After successful Member Engagement, the pharmacist reaches out to the prescribing physicians to communicate any changes in the drugs used by Members.

If the pharmacist believes a Member’s lack of understanding may deter positive outcomes from the CMR, the Member will be flagged for a follow up phone call during which the Member may receive additional counseling to review misunderstandings and gaps in knowledge of the Member. All Members that are successfully engaged by the pharmacist will be mailed a personal

Completion of the CMR

A CMR is considered complete when all prescribers have been successfully contacted and when any pending review of a specific drug ordered by a prescriber is not considered to pose a likelihood of material change and/or risk/concerns for the Member. In addition, a CMR is considered complete when the Member has been successfully contacted by the reviewing pharmacist to confirm their understanding and consent to the recommended/confirmed regimen of drugs resulting from the CMR.
Program #10: Pharmacy Coordination Program (RxP)

Preface

There are five key Elements in the TCCI Pharmacy Management Coordination Program (RxP) that confer substantial value in controlling pharmacy spend and improving quality outcomes for Members. Pharmacy costs are among the most rapidly growing costs borne by health benefit plans and taken as whole, now account for the single greatest portion of the medical dollar for CareFirst Members.

The Comprehensive Medication Review Program (CMR) Element is described in its own right as TCCI Program Element #9. This is because of its centrality to the Care Plan process carried out by CCMs and LCCs.

In addition to CMR, there are five Elements of the Pharmacy Coordination Program (RxP) that are described in this section:

- **RxP Element #1:** Drug Pricing And Ingredient Cost Control
- **RxP Element #2:** Formulary Offerings And Compound Drug Containment
- **RxP Element #3:** Pre-Authorization And Case Management For Specialty Drugs
- **RxP Element #4:** Behavioral Health Pharmacy Coordination
- **RxP Element #5:** Medication Therapy Management – Focus on Adherence, Gaps In Care, Safety, And Fraud Management

These five Elements, when taken together, have a significant impact on the level of drug spending as well as on the efficacy of this spend through enhanced Member compliance/adherence. As Figure 46 below shows, the total billed drug costs to CareFirst have rapidly increased since 2013 from $3.1 billion to nearly $3.9 billion in 2015 yet, the total allowed drug cost has risen more modestly during the same period from $1.8 billion to $2 billion due to the impact of the RxP and CMR Programs.

Part VI, Figure 46: TCCI Elements Effect on Drug Spend, 2013-2015
It is well to keep in mind that the most explosive portion of pharmacy spending is for specialty drugs which is expected to continue to grow as a portion of all pharmacy related spending in the coming decade. For CareFirst, the portion of all pharmacy spending that is dedicated to specialty drugs (generally infusible or injectable drugs) is now approximately 36 percent – and this is expected to rise to 50 percent over the next five years.

Hence, strategies and capabilities cannot be limited to the usual undertakings of maximizing generic use, encouraging mail order for maintenance drugs or tuning the tiering of drugs in model formularies as a way of steering Member use to preferred (cost effective) drugs as important as these initiatives are. These strategies are important but do not sufficiently address the full spectrum of needed capabilities. This is discussed in the pages that follow.

In the end, the integration of all Elements of the TCCI Pharmacy Coordination Program with the rest of the Program Elements in TCCI is critical to achieving better outcomes and cost results. This is so because drugs are the single most important means used in treating disease and chronic conditions.

To this must be added the observation that we are entering a new era in which medications will be finely tuned to the genetic map of individual Members and, in so doing, will deliver ever more effective treatments that either protect or enhance the duration and quality of life in a way that was never before possible. This will come at very considerable cost even after considering offsets in the costs associated with less advanced therapies and approaches in use today.
RxP Element 1: Drug Pricing And Ingredient Cost Control

Cost control of prescription drug spend is central to the RxP. CareFirst spent approximately $1.28 billion in 2014 on pharmacy benefit costs under its Members’ pharmacy benefits and another $4 billion under their medical benefits. Changes in benefit design, formulary structure, rebate contracting and pharmacy network pricing can result in changes amounting to hundreds of millions of dollars in savings. An integrated approach to management of the complex Elements of pharmaceutical services is required to maximize outcomes while holding down growth in costs.

When the health care system is looked at as a whole, prescription drug spending represents the third largest spending category behind hospital care and physician and clinical services. Of the $2.8 trillion spent on health care in the United States in 2013, prescription drug spending, flowing through the pharmacy benefit alone, accounted for approximately $271 billion and has consistently represented around 11 percent of overall healthcare spend as shown in Figure 47 below. This figure includes all populations (Medicare, Medicaid, Commercial, Veterans, etc.).

Part VI, Figure 47: Portion Of U.S. Healthcare Spending By Category, 2014

By analyzing drug spend, regardless of whether the medication is covered under the medical or pharmacy benefit of a Member, CareFirst has identified that pharmacy is the single greatest contributor to the overall medical dollar at approximately 29 percent of total health care spend, as shown on the next page in Figure 48. Despite TCCI Program services, prescription drug spending, increases have maintained double digit levels in 2014.

In formulating its strategy to contain the expected growth in pharmacy trend, CareFirst sought superior manufacturer rebates, competitive ingredient costs and a high level of service that could be integrated into the PCMH and TCCI Programs.

CareFirst has 1.2 million Members with a pharmacy benefit as part of their health care coverage with the company. These Members fill 12 million prescriptions per year (33,000 per day) at some 60,000 pharmacies across the United States and account for approximately $1.28 billion in prescription drug spending.

In order to test the market and ultimately maximize the value to CareFirst, its Members and self-funded groups, CareFirst put its Pharmacy Benefit Administration Program out for bid in early 2013. This followed a period in 2012 during which CareFirst collected important market data to assure the release of the most incisive Request for Proposal (RFP) possible.

Five leading Pharmacy Benefit Managers (PBMs) submitted RFP proposals in early 2013, which included the four industry standard price components of Ingredient Cost, Manufacturer Rebates, Dispensing Fees, and Administrative Fees, with each variable relating to drug classification (i.e., brand or generic), dispensing method (i.e., retail or mail order), and prescription length (e.g., 30-day or 90-day).

Since the eventual price Members pay for their prescription drugs depends on which pharmacy they frequent and the mix of brand and generic drugs they use, pricing terms (Ingredient Cost) provide the first line of cost savings to CareFirst. Therefore, CareFirst requested that each PBM respondent perform a re-pricing exercise based on eight calendar quarters of

---

23 Source: CareFirst Health Care Analytics, 2015 Data.
historical CareFirst pharmacy claims data. These historical claims were re-priced by each PBM reflecting what would have been paid for the specific drug, on the specific date of fill, at the pharmacy where the drug was obtained had the PBM role been with them. These analyses were then compared to determine which PBM had the lowest administrative fees, the strongest rebate contracts, and the best actual pharmacy network pricing. CareFirst took great care in evaluating the proposals by conducting multiple levels of analysis of the data supplied.

To maintain competition in the negotiation all the way through contract execution, contracts were negotiated with the two finalists simultaneously. When each contract was ready for signature, CareFirst awarded the business to CVS Caremark which distinguished itself on all pricing Elements below:

- Superior ingredient costs across a large pharmacy network
- Superior manufacturer rebate levels and guarantees
- Waived dispensing fees for all 90-day and mail-order fills
- Competitive dispensing fees for 30-day prescription fills
- Aggressive performance guarantees

In addition to securing these preferable contractual terms, a process was established to set up various formulary optimizations and Care Coordination activities to increase Member adherence to complex drug therapies as well as enhance coordination and support of specialty drug use as described further in the Pharmacy Coordination Program (RxP) section of the PCMH/TCCI Program Description and Guidelines.

**Historical Context of Pharmacy Trend: Value of Generics**

The average annual growth of retail prescription drug spending (i.e., excluding inpatient spending) from 1992 to 2012 was nine percent, as reported by the Centers for Medicare and Medicaid Services (CMS). Figure 49 on the next page shows pharmacy trend peaking in the late 1990s at 18 percent, which was due primarily to price inflation, increased usage of new, often more expensive drugs and increased overall utilization associated with the growing population and increased promotional spending by pharmaceutical manufacturers.

A focus on utilization of generic drugs in the first decade of the 2000s was a main driver in containing prescription drug spending growth to less than 10 percent after 2004. The trend has continued to decline and reached a historic low of 0.4 percent in 2012 when six of the 10 top-selling brand prescription drug products on the U.S. market faced their first generic competition. It is estimated that generic competition eroded $67 billion in top drug companies’ annual sales in the U.S. between 2007 and 2012.

Prescription drug spending growth slowed during 2007 to 2012, primarily due to the recession and several blockbuster brand prescriptions drugs going off patent. In 2014 drug expenditures started to rise when the ultra-expensive Hepatitis C medications Sovaldi and Olysio hit the market and as millions of Americans took advantage of insurance offerings authorized under the Affordable Care Act. This trend is expected to continue, with CMS projecting average annual drug spending growth of nearly six percent.
While the increase in broad availability of generic drugs has helped to mitigate inflation increases over the past few years, the rate of brand patent expirations will ebb going forward and the “patent cliff” in the pharmaceutical industry will ebb with it. Still, it is expected that the market value of blockbuster brand drugs losing their patents will fall to $11.4 billion annually by 2016 - from a high of three times that in 2012- as shown in Figure 50 below.

Part VI, Figure 50: Market Value Of Blockbuster Brands That Lost Or Are Expected To Lose Patents

---


Market Impact of Brand Drug Patent Expirations

When a new drug therapy is released, it can have a dramatic effect on the market. For example, when brand name drug Sovaldi was introduced to treat hepatitis C in early 2014, the treatment options changed dramatically from a chronic blend of shots (interferon) and pills that came with unpleasant side effects, to the much milder Sovaldi. While the reported cure rate of Sovaldi is 90 percent, the cost of $84,000 for a full 12-week course of treatment dramatically increased costs for payers in the short term. This cost is being included in premium rates in 2015 and onward.

The price at which Gilead Sciences, Inc. introduced Sovaldi provides evidence of a pattern of higher prices in the pharmaceutical industry for specialty drugs. As drugs become more specialized and face less competition, drug manufacturers are able to command a higher price due to the perceived value the drug brings to patients and the cost savings expected to be realized by preventing further disease-related deterioration and complex medical procedures (e.g., Hepatitis C-related Cirrhosis and Liver transplants) over the long term. No longer are drug manufacturers claiming markups solely to cover expensive Research and Development (R&D) activities. Instead, more recent pricing decisions appear to be based on the estimated value the drug brings and what “the market can bear.”

Conversely, when a novel drug reaches expiration of its patent and generic equivalents or alternatives are introduced, the price of the brand drug usually declines dramatically with increased competition. Typically, patients are directed by their health plans to the lower cost generic versions. When the cholesterol-lowering drug Lipitor, reputed as the best selling prescription drug in world history, began being widely manufactured and sold in its generic form (atorvastatin) in May 2012, the out-of-pocket price for most consumers dropped from the brand level co-pay cost of $25 to the co-pay level of other generics, which is $10 or less for a month’s supply.

Pfizer, the manufacturer of Lipitor, used a variety of techniques to maintain revenue levels. These included effectively blocking the sale of the generics from pharmacies in exchange for rebate offers to PBMs and insurance plans to increasing the retail price just prior to the patent expiration. These and other tactics have become common practice by brand drug manufacturers, and ultimately lead to higher costs through increased premiums for publicly funded pharmacy programs, such as Medicare Part D.

The savings resulting from a generic launch can be substantial. The introduction of a generic equivalent for Aciphex in 2013 dropped the daily ingredient cost from $12.56 to $1.31. Even with only 1,000 Members on Aciphex, the savings resulting from the generic launch were close to $3 million for CareFirst.

There are five brand drugs that lost their patent in 2014, which include Celebrex from Pfizer, used to treat Rheumatoid Arthritis (RA); Evista from Lilly, used to prevent and treat osteoporosis in postmenopausal women; Loestrin 24 Fe from Warner Chilcott, which is a form of oral birth control; Nexium from AstraZeneca, a proton pump inhibitor used in the healing and symptomatic relief of erosive esophagitis (heartburn); and Vytorin from Merck, used to manage cholesterol levels. Figure 51 on the next two pages list brand drugs that have or are expected to have generic competition in 2015 and 2016.
<table>
<thead>
<tr>
<th>Brand</th>
<th>Generic Name</th>
<th>Manufacturer</th>
<th>Primary Indication</th>
<th>Generic Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aciphex</td>
<td>Rabeprazole</td>
<td>Eisai</td>
<td>Gastroesophageal reflux disease</td>
<td>2013</td>
</tr>
<tr>
<td>Actos</td>
<td>Pioglitazone</td>
<td>Takeda</td>
<td>Type II diabetes</td>
<td>2012</td>
</tr>
<tr>
<td>Actoplus Met</td>
<td>pioglitazone/metformin</td>
<td>Takeda</td>
<td>Type II diabetes</td>
<td>2012</td>
</tr>
<tr>
<td>AndroGel 1%</td>
<td>Testosterone</td>
<td>Solvay</td>
<td>Testosterone deficiency</td>
<td>2016</td>
</tr>
<tr>
<td>Atripla</td>
<td>efavirenz/emtricitabin/tenofovir disoproxil</td>
<td>Gilead</td>
<td>HIV</td>
<td>Uncertain</td>
</tr>
<tr>
<td>Ævaprox</td>
<td>Irbesartan</td>
<td>Bristol-Myers Squibb</td>
<td>Hypertension</td>
<td>Generic available</td>
</tr>
<tr>
<td>Avodart</td>
<td>Dutasteride</td>
<td>GlaxoSmithKline</td>
<td>Enlarged prostate</td>
<td>2015</td>
</tr>
<tr>
<td>Benicar</td>
<td>Olmesartan</td>
<td>Daiichi Sankyo</td>
<td>Hypertension</td>
<td>2016</td>
</tr>
<tr>
<td>Benicar HCT</td>
<td>olmesartan/hydrochlorothiazide</td>
<td>Daiichi Sankyo</td>
<td>Hypertension</td>
<td>2016</td>
</tr>
<tr>
<td>Boniva</td>
<td>Ibandronate</td>
<td>Roche</td>
<td>Osteoporosis</td>
<td>Generic available</td>
</tr>
<tr>
<td>Caduet</td>
<td>amlodipine/atorvastatin</td>
<td>Pfizer</td>
<td>Hypertension</td>
<td>Generic available</td>
</tr>
<tr>
<td>Celebrex</td>
<td>Celecoxib</td>
<td>Pfizer</td>
<td>RA</td>
<td>2014</td>
</tr>
<tr>
<td>Combivir</td>
<td>lamivudine/zidovudine</td>
<td>GlaxoSmithKline</td>
<td>HIV</td>
<td>Generic available</td>
</tr>
<tr>
<td>Crestor</td>
<td>Rosuvastatin</td>
<td>AstraZeneca</td>
<td>High cholesterol</td>
<td>2016</td>
</tr>
<tr>
<td>Cymbalta</td>
<td>Duloxetine</td>
<td>Lilly</td>
<td>Depression</td>
<td>2013</td>
</tr>
<tr>
<td>Detrox</td>
<td>Tolterodine</td>
<td>Pfizer</td>
<td>Urinary incontinence</td>
<td>2012</td>
</tr>
<tr>
<td>Diovan</td>
<td>Valsartan</td>
<td>Novartis</td>
<td>Hypertension</td>
<td>2012</td>
</tr>
<tr>
<td>Diovant HCT</td>
<td>valsartan/hydrochlorothiazide</td>
<td>Novartis</td>
<td>Hypertension</td>
<td>2012</td>
</tr>
<tr>
<td>Evista</td>
<td>Raloxifene</td>
<td>Lilly</td>
<td>Osteoporosis</td>
<td>2014</td>
</tr>
<tr>
<td>Focalin XR</td>
<td>dexamethasone/fepridox</td>
<td>Novartis</td>
<td>ADHD</td>
<td>2012</td>
</tr>
<tr>
<td>Geodon</td>
<td>Ziprasidone</td>
<td>Pfizer</td>
<td>Schizophrenia</td>
<td>Generic available</td>
</tr>
<tr>
<td>Gleevec</td>
<td>Imatinib</td>
<td>Novartis</td>
<td>Leukemia</td>
<td>2015</td>
</tr>
<tr>
<td>Levaquin</td>
<td>Levofloxacin</td>
<td>Ortho-McNeil-Janssen</td>
<td>Bacterial infections</td>
<td>Generic available</td>
</tr>
<tr>
<td>Lexapro</td>
<td>Escitalopram</td>
<td>Forest</td>
<td>Depression</td>
<td>Generic available</td>
</tr>
<tr>
<td>Lipitor</td>
<td>Atorvastatin</td>
<td>Pfizer</td>
<td>High cholesterol</td>
<td>Generic available</td>
</tr>
<tr>
<td>Loestrin 24 Fe</td>
<td>ethinyl estradiol/norethindrone acetate/ferrous fumarate</td>
<td>Warner Chilcott</td>
<td>Birth control</td>
<td>2014</td>
</tr>
<tr>
<td>Lovaza</td>
<td>omega-3-acid esters</td>
<td>GlaxoSmithKline</td>
<td>High cholesterol</td>
<td>2015</td>
</tr>
<tr>
<td>Lunesta</td>
<td>Eszopiclone</td>
<td>Sepracor</td>
<td>Insomnia</td>
<td>2012</td>
</tr>
<tr>
<td>Lyrica</td>
<td>Pregabalin</td>
<td>Pfizer</td>
<td>Fibromyalgia</td>
<td>2013</td>
</tr>
<tr>
<td>Namenda</td>
<td>Memantine</td>
<td>Forest</td>
<td>Dementia</td>
<td>2015</td>
</tr>
<tr>
<td>Nexium</td>
<td>Esomeprazole</td>
<td>AstraZeneca</td>
<td>Heartburn</td>
<td>2014</td>
</tr>
</tbody>
</table>

Source: CVS Health Generic Prospective Pipeline Summary - Launch Expected 2015 to 2016 - Sorted by Year and Quarter. Updated 5/8/15.
Recent Generic Drug Pricing Surges

While the availability of generic forms of drugs has helped to contain pharmaceutical spending, recent data suggests that drug manufacturers and distributors are sharply increasing costs for certain generic drugs by as much as 9,000 percent over a six month period. Some of the most notable increases are highlighted in the table below:

<table>
<thead>
<tr>
<th>Drug</th>
<th>AWP Prior</th>
<th>AWP Post</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxycycline</td>
<td>$0.63</td>
<td>$3.36</td>
<td>433%</td>
</tr>
<tr>
<td>Albendazole</td>
<td>$5.92</td>
<td>$119.58</td>
<td>1920%</td>
</tr>
<tr>
<td>Captopril</td>
<td>$0.01</td>
<td>$0.40</td>
<td>2750%</td>
</tr>
<tr>
<td>Clomipramine</td>
<td>$0.22</td>
<td>$8.32</td>
<td>3682%</td>
</tr>
</tbody>
</table>

This issue has come to the attention of several Members of Congress, including Representative Cummings, Ranking Member of the House Committee on Oversight and Government Reform, and Senator Sanders, Chairman of the Subcommittee on Primary Health and Aging, Senate Committee on Health, Education, Labor and Pensions, who have initiated an investigation. In October, 2014, these Congressmen requested information from 14 drug manufacturers about the escalating prices of generic drugs used to treat everything from common medical conditions to life-threatening illnesses. It is unclear what is causing the staggering price increases for generic drugs, as the market introduction of generics is generally thought to induce downward price pressure. However, studies have shown that for competition to bring price

---

27 Data from the Healthcare Supply Chain Association, Survey of Group Purchasing Organizations (Oct. 2013 to Apr. 2014) indicates that a bottle of 500,100 mg tablets of Doxycycline Hyclate increased from an average market price of $20 in October 2013 to $1,849 in April 2013.

down significantly, at least four or five companies need to be making the drug. Recent industry consolidation and changes in supply due to temporary factory closures could be driving the phenomenon, which is reportedly impacting patients, healthcare providers, and hospitals across the country considerably and will surely have significant impact on CareFirst Members and self-insured accounts if left unaddressed.

CareFirst is working with CVS Health to monitor large upswings in generic drug pricing and to optimize dosage to minimize costs while maintaining clinical efficacy. Furthermore, CareFirst will keep a close eye on developments of the aforementioned investigation, particularly when opportunities arise to provide input into potential cost reduction measures.

**Pharmaceutical Research and Development (R&D) Competition and Outlook**

While forecasting the level of generic competition is important in evaluating cost savings opportunities, it does not tell the whole story. It is critical to also monitor the pipeline of drugs in development to foresee how potential new therapies might impact Members. The number of drugs in each phase of clinical trials is shown in **Figure 53** below.

Development of new treatments is a long and rigorous process, and it has become more costly and complex over the last decade. Even among the new drug candidates reaching Phase III trials (the last phase before submission for FDA approval), about one-third fail. Companies “race” to bring the first medicine in a class to market, and just two in ten approved drugs are commercial successes.

**Part VI, Figure 53: Medicines in Development By Regulatory Phase Globally, 2014**

![Figure 53: Medicines in Development By Regulatory Phase Globally, 2014](image)

Competition among pharmaceutical companies has intensified and the availability of alternative therapies and competing treatments for a given disease state has increased. **Figure 54** on the next page shows a large increase in the percentage of first-in-class medicines with a competitor already in phase II clinical testing at time of approval. There are currently over 7,000 medicines in development worldwide, and nearly 70 percent of these are thought to be first-in-class.

---

Part VI, Figure 54: Percentage Of First-In-Class Medicines With A Competitor Already In Phase II Clinical Testing, 2014

<table>
<thead>
<tr>
<th>Decade</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970s</td>
<td>23%</td>
</tr>
<tr>
<td>1980-1984</td>
<td>50%</td>
</tr>
<tr>
<td>1985-1989</td>
<td>71%</td>
</tr>
<tr>
<td>1990-1994</td>
<td>77%</td>
</tr>
<tr>
<td>1995-1999</td>
<td>90%</td>
</tr>
</tbody>
</table>

Competition now develops more quickly for those with a first-in-class advantage. Figure 55 below shows the decrease in the time between approvals of a first-in-class medicine and the appearance of a second drug in the same therapeutic class. Drug manufacturers are experiencing a compressed period in which to recoup the significant costs associated with research, development, and clinical trials required to bring a new drug to market.

Part VI, Figure 55: Time Between Approval Of First And Second Drugs In A Therapeutic Class (Years)

<table>
<thead>
<tr>
<th>Decade</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970s</td>
<td>10.2</td>
</tr>
<tr>
<td>1980s</td>
<td>4.1</td>
</tr>
<tr>
<td>1990s</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Innovation in Specialty Drugs

The pipeline of drugs in development is increasingly filled by specialty drugs. These are biologics that typically require infusion, injection or other special handling or compounding. By 2018, it is expected that specialty drugs will make up 6 of the top 10 drugs in terms of overall use. In 2015, nearly 400 of the 7,300 drugs in development by biopharmaceutical companies were biotechnology drugs. Of these, 70 percent are first-in-class strategies. The breakdown of these new medicines by therapeutic area is shown in Figure 56 below.

Further, biopharmaceutical companies have increased Research and Development investment in personalized medicine by 97 percent between 2000 and 2015. Personalized medicine is treatment that is based on the molecular characteristics of the individual patient. These investments are primarily concentrated in oncology and infectious diseases and conditions that are chronic and complex in nature. While the field of personalized medicine continues to develop, the expectation is that the ability to preemptively assess and manage an individual’s predisposition or reaction to a particular disease and associated treatment will lead to better outcomes than current standard approaches and medications.

Therefore, the overall rise in prescription drug trend will continue to be driven mainly by specialty drugs, which are typically classified as those drugs:

- used to treat chronic, complex and/or rare disease states
- requiring special handling, storage, inventory and/or administration
- that are part of an FDA-mandated Risk Evaluation and Mitigation Strategy Program (REMS)
- requiring clinical assessment to optimize safety and adherence
- that are in limited distribution
- that are high cost

The Specialty drug cost trend has exhibited double digit levels for years and is expected to continue to rise rapidly into the future. As shown in Figure 57 on the next page, overall drug spend is expected to rise at a Cumulative Average Growth
Rate (CAGR) of over seven percent from 2012 to 2018, while specialty drug spend is expected to grow at a CAGR of 17 percent over the same period.

Several states are considering enacting laws to limit the level of Member cost sharing for specialty drugs. For example, Maryland has limited Member cost sharing for specialty drugs to $150. It is essential that health plans and PBMs develop new strategies to ensure responsible spending, reduction in waste, and high levels of Member adherence to their specialty medications. This is the primary impetus for **RxP Element #3** within the Pharmacy Coordination Program described in the pages that follow.

**Biosimilars**

To date, large molecule biologic medications have not been subject to generic competition when patent protection expires due to the intricate synthesis from specialized cell lines. Since manufacturers are unable to make an identical copy of biologics that would meet FDA standards for small molecule generic drugs, the industry turned to Biosimilars, which are different molecules that create a bioequivalent effect when compared to the parent molecules. Biosimilars have been available through a separate approval process in Europe since 2004, and produce discounts of 25 percent or more compared to the reference products. In 2010 one of the provisions of the Affordable Care Act provided the regulatory framework for the development, approval, and sale of Biosimilars. The first product, Zarxio a Biosimilar of Neupogen® which is approved to treat neutropenia associated with cancer chemotherapy. It is too soon to estimate savings from this agent, but it has been estimated that Biosimilars could produce overall savings of $44.2 billion between 2014 and 2024.

**Forecasting Trend for the Next Three Years**

The growth in prescription drug spend is driven by rising utilization and price inflation across brand, specialty, and generic drugs. In 2013, the Average Wholesale Price (AWP) trend was 14.4 percent, 10.5 percent, and 2.6 percent for brands, specialty, and generics respectively, which equates to an overall ingredient cost increase of 7.6 percent year-over-year, as reported by CVS Caremark (“Insights 2014: 7 Sure Things”). This was in addition to an increase in utilization of over two

---

percent and was mitigated by a decrease in the proportion of brand vs. generic drugs being dispensed. Overall drug cost trend in 2013 increased approximately five percent when all these factors are taken into account.

Thus, the prescription drug market is characterized by a number of factors, including the sheer number of market participants, the fluidity of new products entering the market, and the overall lack of transparency in product cost and pricing. Hence, no single strategy or set of tactics is sufficient and constant. Vigilant attention to changes and emerging trends as well as upcoming events is required.

**TCCI Approach to Managing Prescription Drug Trend**

Against this background, CareFirst’s approach to pharmacy management is multifaceted and offers options to self-insured employers as to the degree of aggressiveness with which they wish to pursue control of prescription drug costs. These include the implementation of new formulary designs, extensive support for Care Coordination, and an exclusive, cost effective source of specialty drugs.

Of note, a key aspect of specialty drug management is the fact that many specialty drugs are covered under the medical benefit portion of a Member’s coverage plan, not the pharmacy benefit (some are covered under both). The cost and efficacy of a specialty medication depends on a number of factors, such as site of service and who administers the service (e.g., self-administered at patient home or administered by a NP with careful physician oversight). This means that Care Coordination efforts and formulary strategies must span both the medical and pharmacy benefit portion of coverage.

**Value of Ingredient Cost Control**

Through the strategies in the RxP Program, CareFirst has seen a major and abrupt change since the CVS Health partnership took effect. Figure 58 shows how the PMPM pharmacy cost changed from 2010 through the first quarter of 2015. Most notably, through the realignment with CVS Health, CareFirst saw an immediate drop in pharmacy PMPM of 12.2 percent. Without this implementation, CareFirst would have likely proceeded on the steep upward climb in costs evident through quarter four, 2013. However, as shown, costs have continued to rise since due to the factors described above.

*Part VI, Figure 58: Pharmacy Per Member Per Month (PMPM) Allowed Amount Including Impact Of Rebates 2010-2015*
RxP Element #2: CareFirst Formulary Offerings And Compound Drug Cost Containment

There are approximately 5,000 drugs (including brand, generic and specialty) on the market in the U.S. The U.S. Food and Drug Administration (FDA) categorizes all of these drugs into 158 Therapeutic Classes ranging from Analgesics to Skeletal Muscle Relaxants. There are typically multiple drug choices – often a mix of Brands and Generics – in each Therapeutic Class.

Health plans typically organize these choices into benefit coverage tiers with different cost sharing in an attempt to encourage Members and Providers to choose the least expensive option in each therapeutic class when the differences in clinical efficacy are negligible as determined by the Food and Drug Administration. As pharmaceutical manufacturers lose their patents on drugs and generics become available, major changes in pricing occur and drive large market shifts in utilization to less costly medications.

Equivalent and Alternative Drug Choices Drive Formulary Design

When the active ingredient in a Generic and Brand name drug is the identical molecule, the FDA considers the compounds to be therapeutically equivalent. In other cases, there are drugs with different molecular structures but with similar therapeutic effects. These are classified by the FDA as generic or brand alternatives.

For example, the brand drug Lipitor recently lost its patent and was immediately replaced on most formularies with the therapeutically equivalent generic drug atorvastatin. Other well-known brands with generic equivalents include Ambien (equivalent zolpidem), Prilosec (equivalent omeprazole), and Prevacid (equivalent lansoprazole).

One of the best known examples of this substitution is for Crestor whose manufacturer (AstraZeneca) maintains patent protection for the chemical compound, rosuvastatin. There are many therapeutic alternatives that are in the same chemical classification and have similar impact on the human body, such as atorvastatin, fluvastatin, lovastatin, simvastatin and pravastatin. On most Formularies, the generic atorvastatin would be available at a lower copay than the brand drug Crestor. In other cases, two brand alternatives may exist, but one competing manufacturer might offer a superior rebate to a payer, thereby earning it more favorable placement on the plan’s formulary.

Common Formulary Structures in the Market

The key goal of a tiered formulary is to provide financial incentives to Members to direct demand to specific, cost effective drugs within a therapeutic class. Essentially, tiering is a strategy to drive Member and prescriber behavior by encouraging the selection of the most cost effective medication(s) in a therapeutic class by varying cost sharing levels through copayments or coinsurance. Formularies generally consist of four or five tiers. There is often a “Tier 0” reserved for $0 copay drugs which are generic drugs used to manage chronic diseases. Figure 59 below provides an example of a typical four tier design.

<table>
<thead>
<tr>
<th>Tier Number</th>
<th>TierName</th>
<th>Copay Amount</th>
<th>Drug Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 0</td>
<td>Preventive / Maintenance</td>
<td>$0 Copay</td>
<td>Trivora</td>
</tr>
<tr>
<td>Tier 1</td>
<td>Generics</td>
<td>$0 Copay</td>
<td>atorvastatin</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Preferred Brand</td>
<td>$25 Copay</td>
<td>Crestor</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Non-Preferred Brand</td>
<td>$45 Copay</td>
<td>Lipitor</td>
</tr>
<tr>
<td>Tier 4</td>
<td>Specialty</td>
<td>$150 Copay</td>
<td>Epogen</td>
</tr>
</tbody>
</table>

Part VI, Figure 59: Model Four Tier Structure
Five tier designs generally divide generics into preferred and non-preferred categories. Some generics have multiple competing manufacturers and are purchased from pharmacies at a Maximum Allowable Cost (MAC). These drugs are said to have “MAC Pricing” or appear on the “MAC List.” Other generics have less competition and are able to command a higher price, thus leading to an additional tier for generics as shown in Figure 60 below.

### Part VI, Figure 60: Model Five Tier Structure

<table>
<thead>
<tr>
<th>Tier Number</th>
<th>Tier Name</th>
<th>Copay/Coinsurance Amount</th>
<th>Drug Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 0</td>
<td>Preventive / Maintenance</td>
<td>$0 Copay</td>
<td>Chantix</td>
</tr>
<tr>
<td>Tier 1</td>
<td>Preferred Generics</td>
<td>$10 Copay</td>
<td>irbesartan</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Non Preferred Generics</td>
<td>20% After Deductible</td>
<td>eprosartan</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Preferred Brand</td>
<td>30% After Deductible</td>
<td>Benicar</td>
</tr>
<tr>
<td>Tier 4</td>
<td>Non Preferred Brand</td>
<td>40% After Deductible</td>
<td>Cozaar</td>
</tr>
<tr>
<td>Tier 5</td>
<td>Specialty</td>
<td>40% After Deductible</td>
<td>Epogen</td>
</tr>
</tbody>
</table>

In the fourth quarter of 2014, CareFirst’s average cost per brand name drug fill was $500 per fill vs. an average cost of $32 for a generic fill. This $462 difference illustrates the importance of encouraging Members and providers to select the option that provides the desired therapeutic effect at the lowest cost.

Studies have shown that a 100 percent increase in out of pocket cost for a Member (e.g., $20 copay to $40 copay) can cause significant reductions – ranging from 22 percent to 65 percent – in the use of higher cost drugs within as little as one calendar quarter. This shows how powerful tiering can be. Furthermore, 70 percent of Members who choose a lower-cost drug say they do so to save money.

Hence, a well-constructed Formulary can drive use toward preferred products and result in substantial savings. Driving greater generic use nearly always makes sense. A formulary can also be “tuned” to encourage the maximization of rebates on brand drugs. Striking the right balance of generic utilization and rebate maximization, while minimizing Member disruption, is the hallmark of a thoughtful formulary. Utilization management techniques (i.e., prior authorization, step therapy, quantity limits, etc.) can then be added to assure that certain drugs are used only when medically necessary and only when less expensive options have been attempted first.

Improving access to cost effective drugs through benefit design also has a key clinical benefit. Members with lower cost medications tend to be more adherent to their prescribed medications because of lower out of pocket expense. This inhibits disease progression and reducing the downstream medical spending associated with breakdowns.

### Pharmaceutical Manufacturers Endeavor to Thwart Formulary Strategies

In response to payers’ efforts to direct drug use through benefit design and utilization management programs (prior authorization, step therapy, quantity limits, etc.), pharmaceutical manufacturers have developed a number of strategies to thwart these efforts. See Figure 61 on the next page for a breakdown of marketing expenditures by pharmaceutical manufacturers.
Part VI, Figure 61: Pharmaceutical Manufacturer Marketing Expenditures, 2013

The strategies shown in Figure 61 above are designed to create demand for specific brand products. Prescribing behavior has been correlated with the relative spending levels of pharmaceutical companies in targeted therapeutic classes. Direct to Consumer advertising has also been effective in getting up to 20 percent of patients to request an advertised drug. As seen in Figure 62 below, top drug manufacturers in the U.S. spend more on sales and marketing than on research and development. In order to thwart benefit design and tiering approaches, manufacturers have created coupons, copay cards, direct-to-Member rebates, and other financial assistance programs to steer demand for their product in their direction.

Part VI, Figure 62: Pharmaceutical Manufacturer Expenditures For Sales And Marketing vs. Research And Development, 2013

---


Given the above, there are two necessary Elements for effective Formulary design:

- Getting the right mix of brand and generic drugs in all Therapeutic Classes so that Members’ needs can be met;
- Determining on which tier a particular drug is to be placed to properly encourage cost effective use.

**ACA Impact on Formulary Design**

Formulary designs have been greatly impacted by the introduction of the Affordable Care Act (ACA). The ACA defines how formularies should be constructed by introducing the concept of a “benchmark formulary.” CareFirst’s formulary is the benchmark formulary in Washington, DC and Maryland and Anthem holds the benchmark in Virginia. The CareFirst formulary is considered an open formulary with coverage for virtually every drug on the market. Anthem’s benchmark formulary in Virginia is similarly open. These generous benchmarks exceed what is typical across the United States.

ACA requires that a plan must cover at least the greater of one drug in every therapeutic class or the same number of drugs in each category and class as the Essential Health Benefit (EHB) benchmark plan. Plans may go beyond the number of drugs offered by the benchmark. CMS has clarified that if the EHB benchmark plan in a state does not cover drugs in a specific category, the health plan must cover at least one drug in each class. However, health plans do not have to cover drugs on a particular tier merely because that was the tier identified in the EHB benchmark plan.

In determining which drugs to cover, a health plan’s benefit design may not discriminate based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Insurers may, however, use reasonable medical management techniques to prevent waste or excessive usage. These typically include step therapy, prior authorization and quantity limits. The states and health benefit exchanges are responsible for monitoring health plans for their compliance with these requirements as part of their enforcement and certification responsibilities.

**CareFirst’s Formulary (2013-2014)**

For many years, CareFirst managed its own formulary and rebate negotiations with pharmaceutical manufacturers. At that time, the company believed that based on its scale in the region, it could negotiate the best rebates. CareFirst’s scale, however, is small in comparison to a national PBM with millions of covered lives. While CareFirst’s formulary was open – covering all 5,000 drugs – the rest of the industry (PBMs and CareFirst competitors) was moving in a different direction toward more restrictive formularies, including the outright exclusion of certain drugs from formulary coverage.

In total, CareFirst spent approximately $1.6 billion on pharmaceuticals in 2013 pursuant to its open formulary. Of this, $1.2 billion was covered under the drug portion of benefit coverage and $0.4 billion was covered under the medical benefit (mostly for certain oncology and specialty drugs). Drugs covered under the medical benefit typically are those medications that cannot be self-administered by the patient, such as injectable or infusible drugs. **Figure 63** on the next page depicts the portion of spending under each of the benefits in 2014.
CareFirst’s Current Formulary Options

As of January 1, 2015, CareFirst offers three formulary options for its subscribers and employer group customers. The three options are:

**Formulary 1: Open Formulary (offers coverage for the highest number of available drugs)**

This open formulary continues to offer broad, open access to over 5,000 drugs with optimized tiering to drive Member behavior and attain rebate value without the introduction of brand drug exclusions. This formulary adjusts the tier positions of some drugs to leverage CVS Caremark’s manufacturer rebate contracts to the benefit of CareFirst risk and non-risk accounts.

**Formulary 2: Rebate And Generic Enhanced Formulary**

This formulary is similar to Formulary 1 except that certain brand drugs and high priced generics (for which alternatives are available) are excluded to drive higher rebates from the manufacturers whose drugs remain on the formulary. Formulary 2 is now the standard formulary for CareFirst with approximately 65 percent of Membership on this formulary. The formulary is available to ASO accounts that wish to be more aggressive in their pursuit of rebates, so the share of all CareFirst membership on this formulary is expected to grow.

This formulary excludes approximately 120 brand drugs for which strong alternatives exist. All other features of Formulary 1 (e.g., tiering, number and range of cost-effective generics available, etc.) are the same. The exclusions are only made when there are ample alternatives and often as a response to manufacturer’s couponing or copay card tactics.

---

35 CareFirst Health Care Analytics, 2014 Data.
The decision to exclude products is made only after reviewing several factors, including drug class categories with several clinically interchangeable options, price inflation, manufacturer share shift strategies (including copay cards), and the ability to negotiate improved pricing for preferred product placement. When the conditions exist to consider a drug exclusion, these are used in negotiations with pharmaceutical manufacturers to procure improved rebates. A higher rebate payment from one manufacturer can result in another manufacturer with an alternative drug being excluded from the formulary. This can result in increased generic utilization when compared to Formulary 1 as well.

Formulary 2 increases rebates by nearly 25 percent over Formulary 1, thereby reducing the effective level of overall spend by nearly 4.5 percent when compared to Formulary 1. The net effect on cost varies by market segment or employer group based on the starting point for generic dispensing rate, brand drug utilization, preferred vs. non-preferred utilization, etc.

**Formulary 3: Generic And Rebate Maximization Formulary (Lowest Net Spend)**

Formulary 3 captures additional value by expanding brand drug exclusions to approximately 200 (from approximately 120 in Formulary 2) but maintains sufficient coverage in each therapeutic class to assure good clinical care. This formulary aims to further improve utilization of generic drugs and focuses on maximization of rebate value because manufacturers will tend to pay a higher rebate value than they may on the Formulary 2 in order to maintain their presence on this Formulary which has a net spend level that is nearly 4.5 percent lower than Formulary 2.

**Review Available for Members on Drug Choices/Needs**

Each of the three formularies provides a “safety valve” for Members who may need a certain brand drug. Any Member and their physician can point out facts related to medical need that may require them to take a particular brand name drug.

Once this information is received, the facts will be reviewed by a pharmacist. If the pharmacist deems the drug to be medically necessary, an exception is granted and the Member and physician are notified. However, if the pharmacist does not approve, the review will proceed to a physician. If the physician does not grant an exception, the Member can seek a further review via appeal up to 180 days after the determination. If the Member appeals, the subsequent review is conducted either by a different physician or an Independent Review Organization (IRO).

**Credibility in Formulary Governance**

CareFirst relies heavily, but not exclusively, on CVS Caremark’s Pharmacy and Therapeutics (P&T) committee in making formulary decisions. The Committee consists of 19 independent health care professionals (including 16 physicians, one of whom is a medical ethicist) practicing in a broad array of specialties. There are also three pharmacists included. No Member of the P&T committee is an employee of CVS Caremark.

The P&T committee makes decisions in a non-biased, quality driven and evidence-based way. The clinical merit of each drug, not the cost, is the primary consideration. The committee also reviews and approves how and to what extent prior authorization, step therapy and quantity limits are applied.

The Committee conducts drug reviews in a structured way. Drugs recently approved by the FDA are reviewed along with all clinical trial evidence and FDA labeling information to determine eligibility for the formulary. Prior formulary decisions are reviewed in light of the ever-changing environment and updated information. Periodically, a full review of a therapeutic class of drugs is conducted to assure the right mix of clinical options exist and to identify opportunities for ingredient cost savings or maximizing rebates. The composition of therapeutic classes are reviewed at a minimum of every 18 months.

CareFirst maintains oversight of the P&T decision-making process. CareFirst’s Senior Medical Director and pharmacy team monitor and review the actions of CVS Caremark’s P&T Committee meetings and provide periodic reports to CareFirst’s Pharmacy Oversight Committee. The Pharmacy Oversight Committee is composed of CareFirst physicians, community physicians, and pharmacists. This Committee periodically reviews the actions of the CVS Caremark P&T Committee to assure alignment with local medical practice. This CareFirst review governs all decisions affecting CareFirst pharmacy benefits.
Combating Inappropriate Drug Compounding

Drug compounding is a process in which a pharmacist alters or combines multiple ingredients to create a distinct drug or dosage. These “designer” compounds are outside of the usual bounds of clinical appropriateness or regulatory oversight.

Compounded drugs make up one to three percent of the $300B prescription drug market. There is growing concern in the industry with compounding pharmacies that mail large numbers of prescriptions to individual patients or facilities in multiple states with no compliance with the same safe manufacturing practices that drug manufacturers must follow.

Drug compounding is regulated by state boards of pharmacy, which have varying laws from state to state. There are several reasons for concern with compounded medications including:

- No clinical trials to prove the compound is safe or effective
- No FDA requirement for stability testing
- No requirement to provide patient information on appropriate use
- Higher blood levels of active ingredients compared to commercially available products
- No post-manufacture monitoring requirements

There has been an unprecedented increase in the dispensing of compounded drugs despite these safety concerns. From 2007 to 2012 a five-fold increase in compounded prescriptions has occurred. CareFirst has experienced an extremely rapid rise in compounded prescription spend. CareFirst’s compound drug spend from 2012-2014 is presented in Figure 64 below.

Part VI, Figure 64: CareFirst Prescription Compound Spend 2012-2014

Much of the cost associated with these compounds is attributed to bulk powders, which can increase the ingredient costs considerably. Many of the compounds submitted to CareFirst in 2014 had three or more ingredients, further increasing the overall cost of the product. From January 1, 2014 to August 31, 2014, the top 25 prescribers of compound drugs prescribed 1,205 compounds for CareFirst Members. These compounds had an average cost of $3,534.76, with the most expensive

56 Source: CareFirst Pharmacy Operation, 2015.
compound submitted costing $16,667.63. These 25 prescribers generated $4.26M in compounds, representing 18.5 percent of all compounds during the measurement period. The top specialties represented were in Podiatry, Orthopedic Surgery, Pain Management, Physical Medicine & Rehabilitation, and Anesthesiology.

Many of the ingredients in these compounded prescriptions are available in commercially available products that have been tested and approved by the FDA at a significantly lower cost. Safety concerns, together with these exploding costs, have prompted CareFirst to develop a strategy for controlling the use of compounded drugs.

CareFirst excludes all compounds containing:

- Drugs with no FDA approved indication
- Drugs for cosmetic use
- Drugs for performance enhancement
- Hormone therapy for Menopause or Androgen decline

Due to the concerns above, CareFirst began to require, in late 2014, a Prior Authorization for all compounds greater than $300 in cost. To combat pharmacies trying to split bill the compound and get around this limit, CareFirst also limits Members to one unique compound per month. The compounding strategy is integrated with the Fraud, Waste, and Abuse Program to monitor the top compound prescribers for troublesome prescribing patterns.

Based on results through July of 2015, as indicated in Figure 65 below, the CareFirst compounding strategy effectively shields accounts and Medical Care Panels from the vast majority of the prior annual spend for compounded drugs. Through seven months, the average compound spend per month in 2015 is $160,000, as compared to $2,900,000 in 2014. Yet, the strategy continues to allow access to compounds with safe and effective ingredients. CareFirst believes this strategy will keep compound spending at appropriate levels going forward.

**Part VI, Figure 65: CareFirst Prescription Compound Spend 2014-2015**

![Chart showing CareFirst Prescription Compound Spend 2014-2015]

$\text{39 Source: CareFirst Pharmacy Operations, 2015}$
**RxP Element #3: Pre-Authorization And Case Management For Specialty Drugs In The Medical And Pharmacy Benefits**

**Sharply Rising Cost Trends, Promising Therapies**

As noted in the Preface to the RxP, specialty drugs are typically used to treat conditions that are complex, genetically caused, chronic, progressive and life-threatening. The definition of a “specialty drug” varies but is often a large molecule protein requiring injection or infusion or oral drugs that are very expensive or require special handling. Members using them often need expert clinical support. Specialty drugs are almost always prescribed by specialists.

Members taking specialty drugs often take a number of other drugs as well. In 2014, only two percent of all CareFirst Members were taking specialty drugs yet this small population accounted for nearly 36 percent of all drug spending. Specialty drugs are covered under both the Members’ pharmacy benefit plan as well as the medical benefit plan. A complete picture of spending necessitates combining these two portions of coverage.

Introductions of new specialty drugs can cause dramatic shifts in cost over short periods of time. CareFirst’s spending on specialty drugs covered under the pharmacy benefit package jumped over 14 percent between Q1 and Q2 2014, largely due to the introduction of one new drug to treat Hepatitis C (Sovaldi).

A large and increasing portion of specialty pharmacy costs are covered under the medical benefit portion of coverage. When taken together, the percentage of spending on specialty drugs as a percentage of all spending on drugs is shown in Figure 66 below. National spending on specialty drugs is expected to increase at a CAGR of over 15 percent in the next several years and is expected to account for half all spending on pharmacy benefits by 2018. The portion spent on specialty drugs is projected to grow considerably by 2017 as shown in Figure 67 on the next page.

**Part VI, Figure 66: Specialty Spending Under The Medical and Pharmacy Benefit Coverage As A Share Of Total Pharmacy Spending, 2014**

---

40 CareFirst Health Care Analytics, 2013 Data.

---
For many self-insured employer groups, the era of the carved-out pharmacy benefit (i.e., where pharmacy benefits are with a different carrier or PBM than the medical benefit) may be coming to an end due to the combination of increasingly costly specialty drugs and the need to manage them across both Pharmacy and Medical benefits. In order to assure the best cost and quality outcomes, the artificial separation between these two benefits must be removed.

As costly as specialty drugs can be, it must be recognized that Members who use them also use the overall health care system at higher rates and are among the costliest to treat. This relationship is shown in Figure 68 below which displays a representative list of conditions commonly treated with specialty medications.

Yet, these new drugs offer enormous promise for those struggling with certain serious diseases. Specialty drugs can help to slow disease progression, prevent adverse events and improve the quality of life for Members beyond what is possible without them. The diseases treated with specialty medications are estimated to affect five percent of the world’s population.

---

41 Source: CVS Caremark. “INSIGHTS-Trend 2014”.

42 CareFirst Health Care Analytics, 2014 Data: Members with both a Medical and Pharmacy benefit.
The promise of specialty drugs is only realized if they are used properly. If not, the Member will almost certainly experience a breakdown incurring the cost of both the drug and the breakdown. Avoiding this scenario requires substantial support, often beyond the support offered by the prescribing physician. This is the impetus for the creation of the Pre-Authorization and Case Management, RxP Program Element #3 for specialty drugs.

Specialty Drugs in the Pipeline

In placing specialty drugs in perspective, it is useful to recall – as noted earlier – that we are only just at the beginning of the specialty pharmacy era. The quantity of specialty drugs in the pipeline – in various stages of FDA approval is extensive and is shown below in Figure 69 below.

Part VI, Figure 69: Global Specialty Drugs In Development By Clinical Trial Phase
(Total Drugs In 2014 = 5,408)  

While the figure above shows where drugs are in the trial phases, Figure 70 on the next page shows in more detail the growing number of drugs and the varying disease states that specialty drugs are targeted to treat.

---

These figures underscore the importance of a Specialty Pharmacy Coordination Program as more drugs come out of the pipeline for more disease states in coming years.

Specialty Spending Today is Concentrated in 10 Disease States

To place the cost of specialty drugs in fuller perspective, a focus on one area – the drug costs for CareFirst Members with Rheumatoid Arthritis – is illuminating. All CareFirst Members are paying $5.68 more each month in their premiums just to cover Specialty Medications for the 0.002 percent of Members with this disease. If there ever were a case to be made for providing broad-based support to a small, identifiably ill population, this would be it.

In this vein, it is useful to understand that 10 diseases account for 94 percent of the overall CareFirst specialty pharmacy drug spend. These are shown in Figure 71 below.

<table>
<thead>
<tr>
<th>Disease State</th>
<th>Pharmacy Drug Cost</th>
<th>Medical Drug Cost</th>
<th>Total Specialty Drug Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>$39,937,415</td>
<td>$105,114,281</td>
<td>$145,051,696</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>$55,528,040</td>
<td>$6,906,166</td>
<td>$62,434,206</td>
</tr>
<tr>
<td>Crohn’s / Colitis</td>
<td>$19,397,045</td>
<td>$23,373,544</td>
<td>$42,770,588</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>$28,401,329</td>
<td>$13,324,844</td>
<td>$41,726,173</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>$41,461,540</td>
<td>$0</td>
<td>$41,461,540</td>
</tr>
<tr>
<td>IVIG</td>
<td>$0</td>
<td>$22,648,907</td>
<td>$22,648,907</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>$17,309</td>
<td>$14,450,217</td>
<td>$14,467,526</td>
</tr>
<tr>
<td>Infertility</td>
<td>$12,337,401</td>
<td>$22,246</td>
<td>$12,359,647</td>
</tr>
<tr>
<td>Human Growth Hormone</td>
<td>$8,006,687</td>
<td>$33,434</td>
<td>$8,040,121</td>
</tr>
<tr>
<td>RSV</td>
<td>$0</td>
<td>$2,106,053</td>
<td>$2,106,053</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$205,086,766</strong></td>
<td><strong>$187,979,692</strong></td>
<td><strong>$393,066,458</strong></td>
</tr>
</tbody>
</table>

* HIV, Transplant, and Renal Disease Drugs are excluded.


45 CareFirst Health Care Analytics, 2014 Data.
Given this concentration, **RxP Element #3** consists of Care Coordination processes tailored to the unique needs of Members within each of these disease categories. The top 10 disease states are monitored quarterly for any changes in cost based on the specialty drug pipeline. These tailored efforts have been purposefully designed to be integrated with CareFirst’s PCMH Program and other relevant Elements of the TCCI Program.

**Identifying the Specialty Rx Population**

**RxP Program Element #3** begins with timely identification of CareFirst Members who have been prescribed a specialty drug.

The three means of identification are as follows:

- **Prior Authorization (PA):** The vast majority of specialty drugs require Prior Authorization which are entered by prescribers into a special website that is available on CareFirst.com. The Prior Authorization website collects information about the Member’s condition and need for the targeted therapy. The approval of a Prior Authorization request triggers an enrollment in the Program through CareFirst’s Service Request Hub.

- **Analysis of pharmacy a medical claims data:** CareFirst also scans claims data to identify Members who may benefit from the Program. When a Member is identified through this mechanism, the Member is enrolled in the Program through the Service Request Hub.

- **Service requests placed by CareFirst Care Coordinators (LCCs and CCMs):** A Service Request from an LCC or CCM through iCentric’s Service Request Hub will cause enrollment of these Members in the **RxP Element #3**.

**Case Management Provided to Identified Members**

CVS Health provides dedicated specialty pharmacy case managers who are trained in the diseases and specialty drugs that are preauthorized through the CareFirst website or that are referred through the iCentric Service Request Hub. This offering is separate from, but complementary to, case management services provided by CareFirst to Members in the general medical field. The individualized Care Coordination provided by CVS Health case managers occurs after a detailed initial phone assessment with the Member and incorporates monitoring health status, education and joint goal setting. This includes:

- Comprehensive assessment at program initiation and introduction including a thorough evaluation of risk and creation of mitigation strategies;
- Specialty nurse outreach to engage the Member. The Engagement specialist or nurse will call the Member six times within 12 weeks and then follow-up every three to four weeks thereafter for six months;
- Enhanced access via convenient mail order shipping or pick-up at dedicated local pharmacies;
- Injection training coordination;
- Medication and dosing appropriateness determination;
- Education on medication adherence and side effects;
- Inventory coordination to reduce drug waste;
- Drug-drug interaction review;
- Refill reminders; and
- 24 x7 telephonic access to a specialty pharmacist to provide support for Member questions.

Members with the most complex diseases or therapies receive these additional services including:

- A uniquely tailored Care Plan incorporating all clinical factors:
- Integration of the Care Coordination Team with the PCP via iCentric to assure continuity of care in all settings.
• Linkage to CCMs, Behavioral Health Case Managers, or Local Care Coordinators as needed for Members managing other comorbidities in addition to the condition requiring specialty medications.
  
  o 24 x 7 telephonic access to a specialty pharmacist or nurse to provide support for Member questions or help with the management of side effects to reduce the possibility of emergency room visits or hospitalizations
  o Disease-specific and co-morbidity education
  o Enhanced disease self-management skills
  o Disease complication prevention
  o Drug optimization
  o Enhanced Member coping skills training / mentoring

Up to date documentation on each Member in this Program is available within the iCentric Member Health Record based on daily updates made by the CVS Case Management system.

The Care Coordination plans for each of the top 10 disease conditions above are designed to provide the right level of support for the disease condition and therapy used. In some cases, a pharmacist with expertise in the drug being used is sufficient. In other cases, the pharmacist is supplemented with a Registered Nurse with expertise in the disease.

**Continuous Monitoring**

A pharmacist (or pharmacy support representative) contacts Members prior to the fill of their initial specialty drug prescription, and regularly (typically every 30 days, depending upon need) thereafter to reassess the safety, appropriateness and efficacy of therapy, as well as the Member’s ability to manage their therapy. The frequency of this contact is tailored to the specific disease and therapy of the Member. Regular check-ins focus on the following areas:

• Side effects and Member concerns
• Challenges with self-injection, including injection site reactions
• Difficulty adhering to the therapy regimen

**Specialty Rx Care Coordination with Condition Specific Management Registered Nurses**

In order to achieve the best outcomes, some diseases and therapies call for a broader skill set to support the Member. This involves teaming a CVS Registered Nurse trained in the Member’s disease condition with the pharmacist. This allows for a focus not just on the Member’s set of prescribed drugs, but on the specific needs of the Member that must be addressed to assure the highest possible level of adherence and therapeutic value.

A CVS RN is involved in situations in which an assessment and ongoing monitoring can make a significant positive impact on Member health outcomes, compliance with their prescribed plan of care and knowledge about their condition. Members receive a description of the Program and are asked when they are available to speak with an RN. Since the Program requires Member consent, the Member can opt out. If the Member opts out, they are reminded of the Program’s availability at the time of their next specialty medication refill.

To assure coordination with other TCCI Programs, CVS RNs have 24 x 7 access to the Member’s full CareFirst CCC or CCM Plan (if there is one) as well as the Member Health Record. This enables timely and coordinated clinical intervention to further improve medication and Care Plan adherence, to reduce emergency room visits and hospitalizations, resulting in an improved quality of life and overall decrease in health care costs for the Member. When CVS RNs interact with Members, notes of their interactions are visible to all treating providers and to others on the Member’s care management team via the Member Health Record.

When a Registered Nurse is involved in the case, additional Elements are considered including:

• The Member’s psychosocial status and other disease-specific and general wellness topics.
• The Member’s enhanced understanding of the signs and symptoms of disease progression.
Based on the interaction with the Member, the Nurse:

- Augments the coaching available and points the Member to additional training / educational resources
- Collaborates with and informs CCC and CCM Care Coordinators
- Adds additional notes and documentation to the Member Health Record of the Member

Upon completion of the assessment, the Registered Nurse will create a Disease Management Plan (DMP) and define the outreach frequency based on the patient’s clinical condition, severity of the disease, and current medication regimen. Clinically-relevant information from the DMP will be integrated into the Member’s overall Care Plan. The Member will then be stratified into one of three disease-specific levels of intervention categories: High, Medium or Low.

- **High**: Calls may occur as frequently as daily, based on case complexity.
- **Medium**: Calls occur intermittently in addition to scheduled risk assessments (for example, Member who is not as stable as he or she has been in the past may require an additional outreach call before the next scheduled risk assessment). Outreach frequency may be weekly or multiple week intervals, depending on individual patient needs and the duration of therapy.
- **Stable (Low)**: Calls are made at least once every six months as long as the Member is stable.

Updates resulting from calls are uploaded into the iCentric Member Health Record on a daily basis.

**Specialty Pharmacy Care Coordination for Members Diagnosed with Cancer**

Patients diagnosed with cancer often have a complex course of disease that can be further exacerbated by the medications used to treat the disease. Many chemotherapy medications used to cure or slow the progression of cancer can cause debilitating side effects that may destabilize the Member and possibly increase ER visits and hospitalizations. In particular, there is a cohort of chemotherapy drugs that have severe side effects. Patients on these drugs can benefit from a high touch Care Coordination Program.

In this Program, specially trained Oncology nurses coordinate with other TCCI Programs to provide longitudinal case management that will augment the Member’s overall Care Plan. The Oncology Specialty Coordination Program provides an array of supportive services that include:

- Providing an additional avenue for Members to discuss and ask questions about their diagnosis, treatment and possible side effects with a specially trained nurse;
- Assisting with medication management of side effects to help prevent costly ER visits or hospitalizations;
- Addressing individual treatment-related needs;
- Helping manage co-morbid conditions that overlap with side effects of chemotherapy;
- Assisting with Member support/coping skills;
- Providing emotional support of spouse/caregiver;
- Coordinating resources with treating Oncologist;
- Promoting active communication between the Member and Oncologist; and
- Discussing palliative care, end of life and hospice options, if needed.

The Oncology Care Management Program has shown that aggressive outpatient support for Members with side effects caused by certain chemotherapy can change the pattern of ER/hospital utilization and achieve better treatment outcomes.

**Coordination with CCM, CCC, BSACM**

If a Member is on a Specialty Drug and has other complicating factors requiring attention, such as a behavioral health issue, the likelihood of breakdown is far greater. Thus, a more holistic approach to the Member’s overall needs is required.
In such cases, the CVS RN will directly contact the CareFirst CCM or LCC, where appropriate, with condition information and patient health or compliance concerns, to provide a two-way feedback loop enabling the sharing of critical and/or proactive information with other Members of the health care team.

Members with one or more co-morbidities are typically enrolled in other CareFirst TCCI Programs. Based on need, the CVS RN may refer Members to the full array of TCCI Programs via a dedicated referral line. This includes:

- Direct telephonic warm transfer to Behavioral Health Support (Magellan) for urgent situations
- Direct telephonic transfer to the TCCI intake Complex Case Management group
- Alerts through iCentric to the Member’s PCP and LCC

**Tracking and Reporting on Progress and Results**

Pharmacy and medical claims data on each Member in the SPC Program is incorporated into SearchLight Report displays that are available to the PCP, and Panels and treating specialist(s) of the Member. This gives treating providers the ability to see what treatment course is being followed and what results are being obtained for each Member.

Over time, SearchLight data enables the tracking and monitoring of results for cohorts of Members with specific diseases or conditions. This is critical to evaluating the larger patterns associated with emerging results.

**Exclusive TCCI Integrated Specialty Pharmacy**

Since specialty drugs are expensive and their effectiveness depends on Member adherence to the prescribed regimen, the best possible arrangement for specialty drug management is to coordinate their use and to assure that the total care needs of the Member are coordinated as parts of a comprehensive plan that is monitored closely by qualified professionals as described above. In order to benefit from the value of these coordinative services, all prescriptions for specialty drugs must be filled at a set of exclusive (to CareFirst) designated CVS Caremark pharmacies that are integrated with the TCCI Program.

Better outcomes (both clinical and financial) are derived from the avoidance of breakdowns. This is accomplished through the actions of the highly engaged pharmacists and nurses described above who are an integral part of the operation of the exclusive CVS specialty pharmacy. These professionals enhance the Member’s understanding of their medication, anticipate problems, assess psycho-social issues that could impact adherence, support the management of side effects, and are available to answer the Member’s questions. Improved adherence results in a reduction of costly breakdowns.

In contrast, if a Member receives their specialty drug from multiple or alternative sources (separate from the exclusive CVS pharmacy) the effectiveness of **RxP Element #3** is greatly reduced. Engagement statistics through 2014 show Members are three times as likely to engage with the care management nurses described above when filling a prescription through the exclusive CVS specialty pharmacy.

The laws governing the use of an exclusive specialty pharmacy vary by State and, in some cases, by product line. For example, Maryland PPO contracts must maintain an open specialty network until 2016, regardless of the benefits of concentrating Care Coordination activities in one specialty pharmacy. Nevertheless, Maryland HMO contracts may use an exclusive specialty pharmacy and this is already reflected in the TCCI Program. In the District of Columbia, all risk groups use the CVS designated exclusive pharmacy. Virginia prohibits the designation of exclusive specialty pharmacies for risk groups.

**Standards Related to Member Engagement and Frequency of Contact**

Upon receipt of a prescription for a specialty drug by the CVS Health exclusive Specialty Pharmacy, a pharmacy technician specializing in Member Engagement (Engagement Specialist), nurse or other pharmacy team Member will attempt to seek to call the Member up to six times within a twelve week period to secure their Engagement. This occurs before the prescription is filled for the Member. After the twelve week period, the SPC Program staff Member will call every three to four weeks for up to six months until the Member makes a decision regarding participation.
Members not referred through the Specialty Pharmacy (i.e., those identified through other methods) are sent an introduction letter. Once identified, an Engagement Specialist or nurse initiates calls seven days after the letter is sent. From that time onward, the call pattern and timing/cadence mirrors that described above.

Upon receipt of the prescription for a specialty drug by the CVS Health exclusive Specialty Pharmacy, a Pharmacy Services Representative introduces the Program when speaking with the Member about the delivery of the medication. The RN is notified of the introduction and begins outreach to the Member within days of notification or at a time specified by the Member. If the RN does not reach the Member on the first attempt, additional attempted calls are made by an Engagement Specialist. Once the Engagement Specialist reaches the Member, the call is transferred to a nurse. Six attempts to reach the Member are made proactively.

Once engaged, the RN interacts with the Member based on the acuity level established in the previous call. Call frequency typically occurs two to four weeks after the prior call but can be as long as six months after the previous call, if warranted. The RNs refer Members to the CareFirst CCM or CCC Programs, based on nursing judgment. At the time of the referral, the RNs collaborate with an LCC or CCM, as necessary, regarding additional follow up. In addition, Members are reminded during refill interactions that the RN is available to speak with them. A warm transfer is offered, if desired.

**Additional Considerations for Specialty Drugs Covered by the Medical Benefit**

Care management services provided to Members through the RxP Program, Element #3 are the same regardless of whether the services are covered under the Member’s Medical or Pharmacy benefit. But, there are two additional considerations for management of specialty drugs under the Medical benefit that are addressed by CareFirst’s approach to specialty drug management. These are described below.

**Site of Care Alignment for Infusion Services**

In most cases, infusions can occur outside of a hospital in an infusion clinic and even in the home. This is far less expensive and usually far more convenient for the Member. Because about half of oncology patients are cared for in large academic medical centers which have their own infusion centers on-site, there is little incentive for these centers to offer Members less expensive or more convenient options.

Encouraging the less costly sites is accomplished in the TCCI Program through an analysis of prior authorization requests which reveal which Members are beginning courses of infused medications. Outreach is then conducted to offer them options for their site of care. CareFirst also engages large group employers in this transition to educate Members about the benefits available to them for alternate sites of care.

Infusion centers are available at convenient locations throughout the region and are often able to provide the service more cost effectively. Additionally, CVS retail stores have been expanded to offer infusion services in the Baltimore region in early 2015, providing another convenient location for Members to receive infusion therapies at the best possible cost. CareFirst benefit designs encourage the use of the most cost effective settings – with less cost sharing for non-hospital based sites.

**Heightened Specialty Claims Management for Drugs Provided in the Medical Benefit**

Due to their increased use and cost, specialty drugs are subjected to heightened review during the claims adjudication process. Among other errors, Providers sometimes bill for dosages that are much higher than would be indicated by available clinical evidence.

Specialty drug claims are edited and the excess amounts corrected. For example, the weight of the patient generally drives the appropriate dosage. If CareFirst receives a claim for a 150 pound Member showing a dosage for a 300 pound Member, the claim is edited for the correct amount. Without the information captured during the process, this may be missed.

This claims-editing system occurs in conjunction with a comprehensive provider education campaign. Providers learn of edits to specific claims when they see partial denials in their Notices of Payment. Providers who have a legitimate reason to believe they deserve payment for a specific claim that has been changed during review can submit an appeal with additional documentation supporting their case.
This Program is not disruptive to Members. In most, if not all cases, Members will not be aware of the edit to the claim and experience no financial impact.

Conclusion – A Holistic Approach to Specialty Case Management

In summary, Members beginning a course of specialty drugs are most reliably identified through pre-authorization. This process not only assures that the Member is a good candidate for the therapy based on available medical evidence, but also collects information about the Member that helps to assure accurate, effective support.

Pre-authorization also provides notice to the specialty drug case managers that a new Member will require outreach. This allows a pharmacist and nurse to become involved in the case at the time of the first treatment, rather than waiting to be notified when the claim arrives some time later and therapy is already under way.

Further, with use of an exclusive specialty pharmacy where permitted by law, CareFirst is able to assure an integrated experience for the most at-risk Members which starts with the preauthorization of their drugs to all aspects of their compliance and adherence through ongoing monitoring.

Finally, through pre-established daily data feeds that populate the Member Health Record and CCC/CCM Care Plans with timely data from CVS Health, the progress of Members on specialty drugs can be carefully monitored and made available to all treating providers.
RxP Element #4: Behavioral Health Pharmacy Coordination

Medication coordination for Members who have Behavioral Health disorders is intended to promote the safe and effective use of their medications. This coordination requires close alignment among the Member, treating physician, pharmacist and behavioral health Care Coordinators to connect Members to the appropriate TCCI Program to best meet their needs.

Currently, more than 260,000 CareFirst Members have a behavioral health or substance abuse diagnosis and 17,000 pharmacy Members use psychiatric medications in a given year. Effective and systematic medication management is a key part of the recovery process and/or on-going support for people who have behavioral health disorders.

Medications used to treat behavioral disorders, such as Depression, Schizophrenia, Bipolar Disorder, Anxiety Disorder, and Attention Deficit Hyperactivity Disorder (ADHD) are among the most complicated pharmaceuticals on the market today due to unpleasant side effects, importance of adherence, potential for abuse, and the individualized dosage of these medications. Effective management requires each Member and his/her care team to determine the right medication, right dose, and ideal treatment plan to ameliorate symptoms effectively while meeting the Member’s individual needs and medical situation.

Careful oversight of medications used to treat these conditions can have a positive impact on outcomes, helping Members and physicians avoid costly hospital encounters and fragmented care that ultimately reduces costly breakdowns. Members with behavioral health conditions often suffer from co-morbid medical conditions and demonstrate a higher overall Illness Burden Score, higher average costs, and higher utilization of costly hospital services (ER visits, admissions and readmissions) than the overall CareFirst population.

For example, among Members with ADHD, 19 percent had an ER visit and 10 percent had a hospital admission in the last year. Some of the key characteristics of this population compared to the CareFirst population without a behavioral health or substance abuse diagnosis are shown in Figure 72 below and Figure 73 on the next page.

**Part VI, Figure 72: Analysis Of CareFirst Population With Behavioral Health And Substance Abuse (BSA) Diagnoses**

<table>
<thead>
<tr>
<th>All Behavioral Health Categories</th>
<th>Members</th>
<th>Average IB Score</th>
<th>Debits PMPM</th>
<th>Admits Per 1,000</th>
<th>30-Day Readmits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness Band</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>$</td>
<td>#</td>
</tr>
<tr>
<td>Advanced/Critical Illness</td>
<td>15,229</td>
<td>5.9%</td>
<td>10.81</td>
<td>$3,935</td>
<td>1,005</td>
</tr>
<tr>
<td>Multiple Chronic Illnesses</td>
<td>45,265</td>
<td>17.7%</td>
<td>3.01</td>
<td>$1,137</td>
<td>211</td>
</tr>
<tr>
<td>At Risk</td>
<td>60,423</td>
<td>23.6%</td>
<td>1.42</td>
<td>$523</td>
<td>61</td>
</tr>
<tr>
<td>Stable</td>
<td>104,193</td>
<td>40.7%</td>
<td>0.59</td>
<td>$249</td>
<td>11</td>
</tr>
<tr>
<td>Healthy</td>
<td>30,863</td>
<td>12.1%</td>
<td>0.15</td>
<td>$143</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>255,973</td>
<td>100.0%</td>
<td>1.80</td>
<td>$687</td>
<td>119</td>
</tr>
</tbody>
</table>

*6 CareFirst Health Care Analytics, 2014 Data.*
### Part VI, Figure 73: Population Without Behavioral Health And Substance Abuse (BSA) Diagnoses

<table>
<thead>
<tr>
<th>Illness Band</th>
<th>Members</th>
<th>Average IB Score</th>
<th>Debits PMPM</th>
<th>Admits Per 1,000</th>
<th>30-Day Readmits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Advanced/Critical Illness</td>
<td>57,877</td>
<td>2.6%</td>
<td>10.73</td>
<td>$3,736</td>
<td>811</td>
</tr>
<tr>
<td>Multiple Chronic Illnesses</td>
<td>173,255</td>
<td>7.7%</td>
<td>2.97</td>
<td>$979</td>
<td>175</td>
</tr>
<tr>
<td>At Risk</td>
<td>259,968</td>
<td>11.5%</td>
<td>1.42</td>
<td>$453</td>
<td>60</td>
</tr>
<tr>
<td>Stable</td>
<td>569,971</td>
<td>25.3%</td>
<td>0.55</td>
<td>$190</td>
<td>6</td>
</tr>
<tr>
<td>Healthy</td>
<td>1,193,089</td>
<td>52.9%</td>
<td>0.07</td>
<td>$50</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,254,160</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>0.90</strong></td>
<td><strong>$317</strong></td>
<td><strong>47</strong></td>
</tr>
</tbody>
</table>

In addition to ensuring that Members are effectively being treated by prescription drugs, CareFirst has an interest to address issues of prescription abuse, worrisome prescribing patterns that do not align with treatment guidelines, Member adherence problems, or “drug seeking” behavior from substance abuse patients that is often difficult to recognize and avoid.

The combination of these Member and physician challenges spurred the creation of the **Behavioral Health Pharmacy Coordination Program RxP Element #4**. The Program relies on pharmacy claims data and Member medical history to identify patterns or triggers that place Members or physicians at risk of medication mismanagement. Once identified, Behavioral Health Care Coordinators work with these Members and their physicians to connect these Members to the most appropriate care management programs or other interventions.

**Drug Triggers for Behavioral Health Conditions with Medication Treatment**

A small number of conditions make up the majority of Members with behavioral health diagnoses as illustrated in Figure 74 on the next page. Of these, the Behavioral Health Pharmacy Coordination Program focuses on five persistent conditions where medications are highly used.

Medications work differently for different individuals, often with varying duration of treatment, drug choice, dose, combination, and side effects. Many patients require treatment with several of these medications to achieve symptom relief. For these conditions, Behavioral Health Care Coordinators and Case Managers can play a valuable role in evaluating the treatment plan, monitoring compliance, avoiding unpleasant side effects, and ultimately increasing the likelihood of medication effectiveness.

---

47 Source: CareFirst Health Care Analytics, 2014 Data.
Part VI, Figure 74: Members With Behavioral Health Conditions By Condition

<table>
<thead>
<tr>
<th>Select Condition</th>
<th>Total Members</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Depression</td>
<td>108,694</td>
</tr>
<tr>
<td>ADHD</td>
<td>46,109</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>21,889</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>19,596</td>
</tr>
<tr>
<td>Schizophrenia and Psychoses</td>
<td>8,549</td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>3,650</td>
</tr>
<tr>
<td>Autism</td>
<td>2,258</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>1,698</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>782</td>
</tr>
<tr>
<td>Anorexia nervosa</td>
<td>614</td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>553</td>
</tr>
<tr>
<td>Total</td>
<td>214,476</td>
</tr>
</tbody>
</table>

CareFirst has identified a list of behavioral health and substance abuse medications that typically indicate a need for intervention. A sample list of these drugs is represented here:

**Depression** is most commonly treated with antidepressant medications. The most popular types of antidepressants include: fluoxetine (Prozac), citalopram (Celexa), sertraline (Zoloft), paroxetine (Paxil), and escitalopram (Lexapro), venlafaxine (Effexor), duloxetine (Cymbalta), and bupropion (Wellbutrin). Side effects such as headache, nausea, and sleeplessness or drowsiness are common in the first few weeks of use and safety risks arise when Members are not compliant with their treatment plan.

**ADHD** occurs in both children and adults and is commonly treated with stimulants such as methylphenidate (Ritalin), amphetamine (Adderall), and dextroamphetaime (Dexedrine, Dextrostat). Side effects are often minor, but can be dangerous in rare cases among young adults. Prescription abuse is also a growing concern with this class of drugs.

**Substance Abuse** treatment medications are helpful during detoxification and can also become an essential component of an ongoing treatment plan for opioid addiction. Effective medications include methadone (Dolophine or Methdose), buprenorphine (Subutex), and naltrexone (Depade, Revia, and Vivitrol). As a general class of drugs, opioid addiction medications are tightly controlled and have a high potential for abuse.

**Bipolar Disorder**, also called manic-depression illness, is commonly treated with mood stabilizers, sometimes in combination with antidepressants or antipsychotics. Common medications to treat Bipolar Disorder include lithium, olanzapine (Zyprexa), aripiprazole (Abilify), risperidone (Risperdal), clozapine (Clorazil) and lurasidone (Latuda). Side effects are strong, and a Member’s treatment plan often needs to be frequently changed or adjusted to be effective. Treatment works best when it is continuous, and Member adherence is critical.

**Schizophrenia** is treated with antipsychotic medications, and some of the more commonly used medications include chlorpromazine (Thorazine), haloperidol (Haldol), perphenazine, fluphenazine, and clozapine (Cloazril). Long-term medication use is typically required for Members with Schizophrenia, sometimes triggering a relapse where symptoms return or get worse.

---

48 CareFirst Health Care Analytics, 2014 Data. IB score as of December 2014. / Excludes Medicare Primary Members.
Pharmacy Data Enables Rapid Identification

Pharmacy claims data is timely, very actionable and reveals a great deal about the conditions and diagnoses of Members. Pharmacy data can identify Members needing treatment for behavioral health and substance abuse that are also in other TCCI Programs. CareFirst monitors pharmacy claims and behavioral health and substance abuse diagnoses – effectively serving as an early warning system for the identification of emerging risks in the population.

The Behavioral Health Pharmacy Management Program uses criteria-based flagging of Member or Provider medication use patterns that indicate a high risk of breakdown and seeks to apply corrective measures proactively. The Program draws on clinical understanding of the integration between medical, mental health and pharmacy in order to develop appropriate criteria resulting in referrals to other TCCI Programs designed to address these risks.

Additionally, CVS Health scans pharmacy claims data to identify Members and Providers for possible intervention by the following patterns as defined by CareFirst and its care partners. These include:

1. **Side Effects Management & Drug-Drug Interactions**
   - Combinations of drugs likely to exacerbate side effects of psychiatric medications
   - Polypharmacy drug-drug interactions for Members being treated for medical conditions that could interfere with behavioral drug efficacy or safety

2. **Adherence Concerns**
   - Missed refills, particularly for Member with newly prescribed drugs
   - Dose checks for newly prescribed Members to minimize side effects
   - Back-to-back scripts for similar drugs suggesting change in treatment plan due to adherence or drug effectiveness concerns

3. **Prescription Drug Abuse**
   - Multiple scripts for the same or similar drugs from different prescribers and different pharmacies
   - High refill frequency outside of recommended guidelines

4. **Vulnerable Populations**
   - Contra-indicated medications for women during and after pregnancy
   - Antidepressant use in young adults
   - ADHD medication abuse in young adults
   - Polypharmacy among older adults with potentially many co-morbid chronic conditions in addition to behavioral health condition

5. **Prescriber Non-compliance with Established Guidelines**
   - Providers who demonstrate prescribing patterns outside of evidence-based guidelines
   - Injectable antipsychotics (which are identified via medical claims) and opioid pain medications

**Referral to TCCI Programs**

The Behavioral Health Pharmacy Program serves as the central source for identifying Members, who could benefit from TCCI Programs through established partnerships with CVS Health, Magellan Health, and Healthways, as illustrated in Figure 75 on the next page.

Once identified, CVS produces a daily list of Members or Providers whose use patterns have been flagged for further attention by Magellan BSACMs where Members are evaluated via an intake assessment, and are connected with the right TCCI Program to meet their needs.
BSACMs in turn, initiate referrals through the iCentric Service Request Hub to the appropriate TCCI Program, as necessary. The documentation included as part of the Service Request details the reason why the Member was identified (e.g., presence of medical drug prescription likely to exacerbate side effects of anti-depressant).

The entire array of TCCI Programs is available to Members identified through the CVS Health criteria including Behavioral Health Case Management, Chronic Care Coordination, Comprehensive Medication Review, Multi-dose packaging, or Medication Therapy Management. CVS reviews the medication history of any Member that is initially flagged but not referred to a TCCI Program within six months to evaluate any changes in medication history that might indicate more follow-up or connection to a TCCI Program is appropriate or necessary.

Part VI, Figure 75: Making The Connection - Identification And Referral Of Members To TCCI Programs

Prescriber Tracking and Interventions

Prescribers of the medications described above are tracked and trended to identify outliers. Pharmacy claims are scanned for worrisome prescribing patterns not in compliance with established guidelines. Once identified, CareFirst Pharmacy and Medical Management teams work closely with Magellan to respond to these alerts through provider education and intervention as a first step, or may recommend termination of the provider from the network for egregious fraud and abuse.

Figure 76 below shows the interventions and possible courses of action used when errant prescribing patterns are identified.

Part VI, Figure 76: Identifying Non-Compliant Prescribing Patterns For Intervention
Prescription Drug Abuse

In an effort to reduce prescription drug abuse in the behavioral area, an analytical approach to identify “pill mill” prescribers identifies physicians and other prescribers who prescribe an extremely high number of controlled substances relative to other practitioners with similar listed specialties. Once identified, the Behavioral Health Pharmacy Coordination Program reviews the case and may put a systematic stop on filling prescriptions from these clinics, or institute provider education to expose the patterns to the provider as a “first warning”. This review is carried out by Magellan.

ADHD Medication Abuse

Data profiling in the area of ADHD identifies physicians with prescribing patterns outside of accepted guidelines for medications used to treat ADHD. Magellan counsellors work with these providers to follow current guidelines for ADHD medication use, help them recognize and detect indicators of abuse among patients, and avoid common pitfalls like increasing dosage too quickly. Medications used to treat ADHD can, like any medication, be abused in a variety of ways, particularly among young adults. College-age students face unique challenges with what are commonly referred to as “study drugs” to enhance their academic performance. Responsible prescribing among physicians plays an important role in reducing the likelihood of ADHD medication abuse.

Medication Assisted Therapy for Substance Abuse

When Members are identified as using medications for the treatment of Substance Abuse, Magellan notifies the Member’s physicians to ensure that the Member’s entire care team is aware of the condition. Magellan case managers are also available to arrange other non-medication treatment or services that these Members may need.

Adherence for Antipsychotic Medications

A provider-focused service carried out by Magellan works with physicians whose Members are non-adherent to their medication treatment plan, especially for classes of drugs where stopping a medication without notifying the prescribing physician can be dangerous. Once patterns that suggest non-adherence have been identified, BHCCs communicate with prescribing physicians as necessary and appropriate.

Guidelines Support

The American Psychiatric Association’s practice guidelines provide evidence-based recommendations for the assessment and treatment of behavioral health conditions. As guidelines evolve with respect to behavioral health medications, physicians may unknowingly prescribe treatments that are not compliant with current guidelines. At a time when demand is growing for behavioral health services and medication, PCPs have emerged as the first line of defense in the health care system where they are confronted with a system of support that is fragmented and confusing to use. Pharmacy claims data is used to identify prescribers outside of guidelines and Magellan provides education, literature, and tools to bring these physicians back into compliance.
**RxP Element #5: Medication Therapy Management – Focus On Adherence, Gaps In Care, Safety, And Fraud Management**

Nearly three quarters of CareFirst Members use their pharmacy benefit each month. From a clinical pharmacy program perspective, there are two layers of service. **Program #9: Comprehensive Medication Review (CMR)** – aims to serve the most complex Members with the highest potential for medication related issues. The CMR program utilizes dedicated pharmacists for medication reviews and direct prescriber telephonic communications. Completed CMR’s are billed as medical claims that debit the PCP’s provider care account.

For the vast majority of Members who will never need to be the subject of a CMR Program Element #5 of the Pharmacy Coordination Program – Medication Therapy Management (MTM) – is a CMR-lite process designed to reduce cost and assure a correct course for Members long before they qualify for more intense TCCI interventions. Using pharmacy claims data, the MTM Program is a highly effective way to identify Members in need of a focused intervention by their pharmacist or a telephone call to address gaps in care, adherence, and appropriateness of drug regimens. All of this is done at no cost to accounts or Members.

At any point in time, CareFirst supports hundreds of thousands of Members on maintenance medications for conditions like high blood pressure, cholesterol, and diabetes that are in the early stages of their disease progression. It is startling that approximately 50 percent of these Members do not take their prescribed medications as directed. This leads to disease progression at a much faster rate resulting in major downstream breakdowns.

Thousands of other Members are prescribed a medication regimen that can be delivered more efficiently. An example is a high-cost brand drug that can be changed to a generic reducing cost for both the plan sponsor and the Member. A dose of 10mg twice a day can, in some cases, be changed to a dose of 20mg once a day again reducing cost for all parties. These interventions also simplify the Member’s daily regimen in a way that increases adherence.

Still other Members are taking one kind of medication while common medical practice generally requires a companion therapy that is missing – a gap in care. These gaps in care can result in serious complications for the Member and tremendous downstream cost. For example, failure to take a statin after a heart attack can result in a second heart attack and death.

**Drug Advisories**

Under **RxP Program Element #5**, continuous monitoring of the flow of pharmacy claims data for all Members is accomplished. Pharmacy claims data is run through clinical targeting analyses that identify “Drug Advisories” intended to help improve Member compliance and the correctness of their prescriptions. These Drug Advisories are delivered to Members and prescribers via the three components of the RxP Element #3 as outlined below:

- Improving Adherence and Reduce Gaps in Care
- Evidence-based Therapy Optimization
- Identification of Possible Fraud, Waste and Abuse

**Drug Advisories to Improve Adherence and Reduce Gaps in Care**

Drug Advisories designed to improve adherence and close gaps in care are forwarded to a pharmacist for follow-up and intervention, which is often simultaneous with the prescription fill at the pharmacy. Intervening at these "teachable moments" increases the effectiveness of the Program and yields good closure rates on Drug Advisories.

These advisories are divided into the following categories:

- Gap in Medication Therapy counseling;
- Adherence counseling; and
  - New to Therapy/First Fill education
  - Late to Refill counseling
  - Ongoing Adherence Counseling, as needed

Copyright © 2016
All rights reserved
Health Management Program referral (e.g., Member with a diabetes medication is informed of the plan sponsor’s Diabetes Management Program).

Drug Advisories operate in two dimensions – issues related to particular disease states and issues related to certain therapeutic classes of drug. The disease states included in the Program are focused on the ten most common and costly chronic conditions, the progression of which can be slowed or stopped with effective medication therapy. These include:

- Diabetes
- Hypertension
- High Cholesterol
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Osteoporosis
- Breast Cancer
- Benign Prostatic Hypertrophy (BPH)
- Parkinson’s Disease
- Behavioral Health

Interventions to Improve Adherence and Close Gaps in Care

Approximately 30 percent of CareFirst Members fill their prescriptions at CVS retail pharmacies. CVS retail pharmacists automatically receive advisory messages in their point of sale system that flags Members who have been identified for intervention through one of the Drug Advisories listed above. Given that the Advisories are native in the CVS system, appropriate intervention is seamlessly integrated into the pharmacists’ workflow. Below is a list of the approaches used at CVS retail locations:

- Face-to-face first-fill counseling with condition-specific educational materials.
- Follow-up calls to address common reasons for non-adherence and help ensure timely refills.
- Face-to-face counseling addresses non-adherence, gaps in medication therapy and Member questions.
- Phone-based non-adherence counseling from Members’ local pharmacist if a face-to-face opportunity does not arise.
- Coordinated physician communications, as needed based on the type of intervention, by fax or phone to close gaps in care and improve adherence.

Members filling prescriptions via mail order or at other retail pharmacies are contacted directly by CVS via telephone by a program pharmacist to complete the identified intervention based on CareFirst’s clinical criteria. This ensures all Members are receiving monitoring and advice, irrespective of their source of fill. If telephone contact proves difficult, the Member is contacted by mail.

The nature and frequency of an intervention is carefully tuned to each Member. To successfully engage Members and modify behaviors, pharmacists focus conversations on targeted interventions. For example, one month, a Member may be contacted about an adherence issue. At the next refill, the Member may be engaged to address possible gaps in medication therapy. Some Members with a targeted condition may not have a gap or adherence opportunity during the Program period and will only receive the welcome communication. The level of Engagement varies for each Member, based on his or her needs.

Impact of Adherence and Gap Closure Interventions

In a population of one million Members, hundreds of thousands of Drug Advisories are identified in a year’s time. A subset of these result in changes in prescribed therapy. Results of each intervention are, therefore, measured in terms of annual savings from avoided adverse medical events. These savings are netted against any increased cost of additional utilization.
improved adherence to therapy, addition of needed companion drugs to close gaps) to determine the overall effect of the Program on cost of care.

Savings from increased adherence to prescribed therapy is shown in Figure 77 below by disease state.

### Part VI, Figure 77: Annual Savings From Optimal Adherence By Top Disease States

<table>
<thead>
<tr>
<th>Disease State</th>
<th>Estimated Annual Savings per Conversion to Optimal Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma / COPD</td>
<td>$1,038</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$3,756</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>$7,823</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>$1,258</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$3,908</td>
</tr>
</tbody>
</table>

Savings from Drug Advisories which reveal gaps in care are shown below in Figure 78 below.

### Part VI, Figure 78: Annual Savings Resulting From Closure Of Gaps In Care

<table>
<thead>
<tr>
<th>Gap</th>
<th>Estimated Annual Savings per Gap Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes: No ACE, ARB or Antihypertensive</td>
<td>$527</td>
</tr>
<tr>
<td>Diabetes: No Antihyperlipidemic</td>
<td>$310</td>
</tr>
</tbody>
</table>

### Drug Advisories to Encourage Evidence-based Therapy Optimization

Evidence-based Therapy Optimization Drug Advisories identify opportunities for improved prescribing and utilization (for prescriptions filled at mail and retail) according to accepted evidence-based prescribing criteria. Clinical pharmacists help maximize savings and improve clinical outcomes while minimizing Member disruption.

Claim review of mail order prescriptions occurs before a prescription is dispensed. Retrospective review of the retail prescriptions occurs within 72 hours of adjudication and triggers a follow-up physician touch point if no response is received from the initial outreach. Physician outreach is through fax and letters.

Drug Advisories fall into three categories listed below:

#### Appropriateness of Therapy

- Age-Appropriate Therapy (e.g., Member on a medication not appropriate for their age group).
- Alternative Cost-Effective Therapy (e.g., Member on a drug where therapeutic alternatives have been shown in the evidence to be just as effective but less costly).

---

49 CVS Health, Pharmacy Care Economic Model (PCEM).

50 CVS Health, Pharmacy Care Economic Model (PCEM).
• Inappropriate Therapy for Condition (e.g., Member taking a medication that may intensify an existing disease state).

• Dose Optimization (e.g., Member taking a medication twice-daily that can be simplified to once daily or multiple medications that can be combined into one tablet).

• Duration of Therapy (e.g., Member taking a medication beyond the duration indicated by the evidence).

**Drug Safety**

• Contraindication to Prescribed Medicine (e.g., a Member on a drug with sulfa component with a sulfa allergy).

• Appropriateness of Therapy (e.g., a Member with Parkinson’s on a dopamine blocker and an antipsychotic; the combination of these medications can induce or worsen neurological symptoms).

• Duplicate Therapy (e.g., the Member on two anti-anxiety medications).

**Targeted Generic Alternative Messaging**

• Generic Alternatives for select single source, non-preferred brand medications.

The impact of changes to therapy based on clinical evidence is typically measured in reduced prescription drug cost for the Member receiving the successful intervention. Savings from brand to generic switches, dose optimization, and elimination of duplicate therapy (all interventions which result in the change of a prescription) is calculated by taking the actual savings from each change and, for long term maintenance medications, multiplying the savings by 12 months.

Preliminary reports from the first half of 2015 show over 100,000 prescriber interventions were delivered with an estimated drug cost gross savings of $8.6 million resulting from therapy optimization as a result of the monitoring described above.

**Drug Advisories that Identify Possible Fraud, Waste and Abuse**

In addition to disease states listed above, certain therapeutic classes of medications, prone to abuse or misuse that create safety concerns are also monitored by **RxP Program Element #5**. The Program identifies these by looking at high numbers of controlled substance claims, multiple prescribers, multiple pharmacies, excessive use or high total claim cost. A pharmacist reviews flagged profiles and verifies the need for prescriber intervention. This not only reduces the costs associated with prescription fraud, misuse and abuse but also protects Members from overdose and other serious health consequences.

Claims data is analyzed to identify Members for:

• Total number of controlled substance claims
• Total number of controlled substance prescribers
• Whether prescriptions are filled at multiple pharmacies
• Excessive utilization
• Geographic distribution of prescribers and pharmacies
• Excessive claim cost

The following drug classes are targeted:

• Narcotic/narcotic combination drugs
• Anti-anxiety and sedative/hypnotic agents
• Non-benzodiazepine sedatives/hypnotics
• Muscle relaxants (Flexeril and Soma are included)
• CNS stimulants
Prescribing Physician Involvement

Since pharmacists cannot change a prescription without the authorization of the prescriber, all Drug Advisories are communicated to prescribers along with clinical recommendations which are made regarding a drug class, not a specific drug.

Physicians are notified via fax when Members are late to fill a medication and/or when Members have gaps in medication therapy. If a Member remains non-adherent after the initial fax is sent, the pharmacist will call the prescribing physician to discuss the Member’s adherence. If the gap in medication therapy remains open after the initial fax is sent, a second fax will be sent. If the second fax receives no response, the pharmacist will call the prescribing physician. If the gap remains open after all three attempts to reach the physician, the physician will be re-targeted again six months later in an attempt to close the gap in medication therapy again.

Additionally, physicians are also notified via fax regarding actionable Member-specific drug therapy recommendations based on appropriateness of therapy and drug safety. If a physician ignores the initial outreach and prescribes the same medication, another fax is sent to notify the physician about safety and savings opportunity. In more serious situations, such as drug-drug interactions, a prescriber will be contacted via phone. If there is no fax information available for physicians they are notified by letter.

Finally, when a reviewing pharmacist determines that physician intervention is necessary regarding possible fraud and abuse, the physician is contacted via fax. A fax is sent to each prescriber of targeted drugs and contains a Member profile, including all prescriptions for targeted drugs by physician and pharmacy. There is also a return request included whereby the physician is asked to indicate whether the patient is theirs and whether they prescribed the medication.

Integration with iCentric

iCentric receives a daily feed of all Drug Advisories. These are then displayed in the Member Health Record of each impacted Member so that any treating provider or Care Coordinator can see Drug Advisories and have an opportunity to act in coordination with the pharmacist.

When an intervention is completed, the completion is documented and imported into the iCentric System so that the activity can be tracked by those on the care management team.

SearchLight Reporting

Each completed intervention results in an estimated savings amount based on the criteria outlined above. The results of these interventions are made available in the SearchLight Reports for both accounts and Panels in the PCMH Program.
Program #11: Expert Consult Program (ECP)

Many CareFirst Members, particularly those in Band 1 and upper Band 2 of the Illness Burden Pyramid, suffer from serious conditions that are very costly to manage and are often characterized by uncertainty in diagnosis, treatment, and prognosis. It is not surprising that these Members become frustrated by relentless severe symptoms and seek definitive diagnosis and treatment by obtaining multiple medical opinions from varieties of specialists. Inevitably these Members are subjected to costly and sometimes questionable diagnostic procedures and treatments, with unclear clinical and financial outcomes.

The Expert Consult Program (ECP) is tailored to those Members who find themselves in these challenging situations. The purpose of the Expert Consult Program is to provide the best possible clinical review and recommendations to Members who are at a key decision point, facing major diagnostic or treatment options or whose choices may be unnecessarily risky, extremely costly or of questionable value.

The Expert Consult Program – delivered in partnership with Best Doctors, a key strategic partner of CareFirst – provides a service called “InterConsultation,” which is based on expert physician review of an entire case by nationally-renowned physicians in the appropriate medical and surgical subspecialties. The roster of expert physicians is selected using a “peer polling” process which, in essence, identifies the “physician’s physician,” or those experts to whom physicians would turn themselves for a family Member. Through the peer polling process, which is repeated regularly, the top five percent of practicing physicians throughout the United States have been identified.

In many cases, the InterConsultation process results in affirmation of the proposed diagnostic and/or treatment plan, providing reassurance to both Member and treating physician. In other cases, the Expert Review results in a changed diagnosis or the presentation of alternative options to the Member and treating physician. Either way, it gives peace of mind to the Member and his/her caregiving team that all options/paths of what could be considered are being given full consideration.

Member Selection Process

CareFirst CCMs and LCCs – in collaborative discussion with a Member’s PCP or NP and other treating providers – identify Members likely to benefit from the Program. These Members must have serious, complex conditions and be at a crossroads or decision point regarding diagnostic testing and/or treatment options. In many cases the diagnosis may be unclear despite severe symptoms (such as intractable pain, gastrointestinal symptoms, and neurological symptoms, among others). In other cases, there may be multiple differing opinions from various physicians regarding the best course of treatment for the Member.

The Members selected must be in an active Care Plan (either CCC or CCM). There are no limits on diagnoses or conditions for selection to the Program, although the CareFirst clinical team has developed a list of “trigger” diagnoses to be considered for referral to the Program. The most important Elements for selection are the severity of symptoms, uncertainty of diagnosis, and/or the risk and cost of anticipated diagnostic testing or treatment. The cases selected are either already high cost cases or are expected to be so.

A CCM or LCC initiates the process by creating a Service Request via the Service Request Hub in the iCentric System, which automatically routes the case to a CareFirst Medical Director to be reviewed for appropriateness. Following review and approval by the Medical Director, the Service Request is electronically routed back to the CCM or LCC who then contacts the Member, and introduces and describes the Program to them to make certain that the Member understands all aspects of the Program and consents to go forward.

Once this is accomplished, the CCM or LCC authorizes the Service Request Hub to route the case to Best Doctors who then receives an email notification that a new Service Request is pending. The Cost Share Waiver Program protects eligible Members from out of pocket expenses for this Program.

Generally, only cases that have or are expected to exceed $75,000 in annual spending are considered for the Program.
InterConsultation Service

Best Doctors takes responsibility for providing the review through completion. Following notification, designated staff at Best Doctors access iCentric to accept the request and obtain contact information for the Member, who is already aware that a phone call is to be expected from the CCM or LCC. The Best Doctors’ Member Advocate (a Registered Nurse) contacts the Member and affirms that all required consents for medical record reviews and data sharing are in hand. The Member Advocate reviews the Member Health Record and Care Plan in iCentric, and then conducts a comprehensive telephonic intake directly with the Member to obtain additional information as well as the detailed Member perspective on their situation.

At the outset, Best Doctors also contacts the treating physician to describe the Expert Consult Program, engage the physician in the process and seek their assessment of the situation.

The next stage is gathering all possible information relevant to the Member’s clinical situation. This includes all pertinent medical records across all sites of service (inpatient hospital, emergency department, physicians’ offices). As appropriate for the individual case, the actual images and pathology specimens (not just the reports) are also requested for individualized case review.

A Clinical Review Team (composed of the RN Member Advocate, Case Coordinator, Lead Physician and Associate Physician Reviewer) then reviews all the clinical information and develops a comprehensive clinical summary. Based on this review and clinical summary, the Clinical Review Team identifies the most appropriate expert physician(s) to perform the review and assessment. In some cases, this may involve more than one physician in the same or multiple subspecialties. These nationally-renowned physicians are located at leading medical centers throughout the United States, and are expected to provide the best, most thoughtful and unbiased review of the clinical case with actionable recommendations.

After a thorough review of all case materials, the expert physicians submit a detailed case description, a set of recommendations and clinical/treatment options, all backed up with relevant published medical literature citations. To reach these options and recommendations, the consulting physician experts may talk to the Member’s treating physicians as necessary or appropriate during the review process.

The entire report is then reviewed by the Lead Physician on the Clinical Review Team for consistency and understandability, as a part of the quality assurance process. Two versions of the report are provided, one for the Member’s treating physician(s) and one written in language easily understood by a non-medical person. Included in the report are the detailed biographies of the expert physicians, including medical training, credentials and publications.

Copies of the reports are sent electronically to the Member and their treating physician(s). If there is a difference of opinion (diagnosis or treatment) between the expert physician reviewer(s) and the treating physician(s), Best Doctors arranges for a conference call between them and provides Continuing Medical Education credits for the treating physician(s) for participating in the clinical discussion.

The Member also receives an encrypted flash drive that contains the entire history, clinical summary, journal references and Expert Consult Report. This provides ready access for any clinician’s review, at any time, at the Member’s discretion.

When the consult report is complete, Best Doctors posts the Expert Consult review as a PDF file directly to the Member Health Record in iCentric, where it is available to all treating providers on the Member’s care team.

The Clinical Review Team contacts the Member by phone at six weeks and six months after the report to follow-up on the treatment plan and on the health status of the Member. All key observations resulting from these follow-ups are noted in the Member Health Record in iCentric.

Since the inception of the Program there have been over one thousand referrals from Care Coordinators. The Program has demonstrated a positive clinical impact on the care of Members, as well as acceptance by their treating physicians. There has been a change in diagnosis in over 25 percent of these complex cases along with many recommended treatment changes, the majority of which were accepted by both Members and their doctors. The specialties where the greatest clinical impact has been observed are Oncology, Gastroenterology, Neurology, Rheumatology, and Orthopedics. Over 90
percent of Members surveyed have given the Expert Consult Program the highest rating in the ability to meet their needs and would recommend this Program to their family or friends.

**Process Steps Once a Case is Accepted**

Once Best Doctors has accepted the Service Request, a series of status updates are provided as follows:

**Accepted:** The case has been retrieved from the Hub and is accepted into the Expert Consult Program.

**Medical Records Collection:** Medical records, pathology specimens and/or original images have been requested and are being collected.

**Clinical Summary Completed:** The Clinical Review Team has reviewed all available records, images and specimens and has identified the appropriate expert physician reviewer(s).

**Expert Physician Review:** All materials are in the hands of the expert physicians for their review and report.

**Quality Assurance:** The Expert Physician Report has been received by Best Doctors and is being reviewed for consistency and understandability.

**Communicated:** Report has been simultaneously sent to the Member, treating physicians and posted to the Member’s Member Health Record. Email notification to the CCM or LCC is sent that a report is ready.

**Follow-up six week call:** Best Doctors contacts Member at six weeks. Observations recorded in the Member Health Record.

**Follow-up six month call:** Best Doctors contacts Member at six months. Observations recorded in Member Health Record.

**Case Closure:** End of InterConsultation process.

**Additional Program Components**

In addition to the full InterConsultation services offered as part of the Expert Consult Program, Best Doctors provides a dedicated/embedded clinical integration specialist in the Baltimore-Washington area. This is an RN who works with CareFirst TCCI team members to make sure that the Program works as designed in a fully integrated way with other TCCI Programs. Best Doctors also provides a dedicated account representative to ensure that all aspects of how the Program is operating meet high standards.

**PCP and NP Awareness and Consent**

It is the responsibility of the referring LCC or CCM to fully inform the Member’s PCP or NP of the review and the results as well as the course of action flowing from it. Prior to undertaking an Expert Consult review, the PCP or NP is asked for their consent and virtually all PCPs take great interest in the outcomes achieved through the Program.

**Reporting**

All Members whose cases are reviewed through the ECP are followed closely in the following weeks and months and their care experience, costs and results are available to the PCP or NP as well as other treating providers as part of the Member Health Record update process as well as in SearchLight Reporting.
Program #12: Urgent And Convenience Care Access Program (UCA)

Background

In many primary care practices today, the limited availability of extended weekend hours, combined with a lack of patient knowledge of alternative sites of care, results in patients going to the Emergency Department (ED) of a hospital when faced with sudden care needs – the most expensive site of service available – even when better alternatives exist that can deliver the same quality of care in a less expensive and more convenient setting.

The Urgent and Convenience Care Access Program (UCA) is designed to help PCPs minimize this problem with flexible and convenient options for their Members. The various Elements of the UCA Program offer an array of access choices to Members that support PCPs with back-up care while maintaining and protecting the PCPs central role in the Member’s care.

CareFirst benefit designs discourage Members from using Emergency Department (ED) facilities for medical treatment when care could have been provided in a less costly setting. The average cost per ED visit in 2013 was $900 compared with $125 for Urgent Care and $55 for Convenience Care in a setting such as a CVS Minute Clinic.

A typical Panel spends about $500,000 to $600,000 per year for ED services that are appropriate for an ED only 20 percent of the time. Increased use of the ED drives increased Medical costs, thereby generating high-dollar debits to Panel PCAs that could have been avoided. The average cost for common procedures when administered in an ED compared to an Urgent Care Center or Convenience Care Center is shown in Figure 79 below and underscores the potential savings from arranging services in the least costly setting.

Part VI, Figure 79: Comparison Of Costs For Common Conditions Treated In The Emergency Department (ED), Urgent Care Center (UCC), Convenience Care Center, 2013

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ED</th>
<th>UCC</th>
<th>Convenient Care</th>
<th>Potential Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Bronchitis</td>
<td>$795</td>
<td>$123</td>
<td>$69</td>
<td>85% - 91%</td>
</tr>
<tr>
<td>Acute Pharyngitis</td>
<td>$593</td>
<td>$94</td>
<td>$74</td>
<td>84% - 87%</td>
</tr>
<tr>
<td>Acute Sinusitis</td>
<td>$589</td>
<td>$105</td>
<td>$67</td>
<td>82% - 89%</td>
</tr>
<tr>
<td>Acute Upper Respiratory Infections</td>
<td>$576</td>
<td>$113</td>
<td>$68</td>
<td>80% - 88%</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>$390</td>
<td>$101</td>
<td>$56</td>
<td>74% - 86%</td>
</tr>
<tr>
<td>Cough</td>
<td>$681</td>
<td>$93</td>
<td>$66</td>
<td>86% - 90%</td>
</tr>
<tr>
<td>Influenza</td>
<td>$804</td>
<td>$128</td>
<td>$83</td>
<td>84% - 90%</td>
</tr>
<tr>
<td>Otitis Media (Middle Ear Infection)</td>
<td>$467</td>
<td>$94</td>
<td>$69</td>
<td>80% - 85%</td>
</tr>
<tr>
<td>Streptococcal Sore Throat</td>
<td>$678</td>
<td>$112</td>
<td>$76</td>
<td>84% - 89%</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>$940</td>
<td>$108</td>
<td>$55</td>
<td>88% - 94%</td>
</tr>
</tbody>
</table>

This information represents a sample of conditions commonly treated in all three settings and includes all Members with these diagnoses, but does not take into account the severity of their illness. Costs are based on average CareFirst Members in 2013 for the top 10 most common conditions and may not represent patient’s actual cost of care.
Five Levels Of UCA Care

The UCA Program offers Members five levels of access within different treatment settings based on the type and severity of their health needs as shown in Figure 80 below.

The UCA Program five-level system of after-hours care:

- **Emergency Department (ED)** for true emergency situations
- **Urgent Care Centers (UCC)**
- **Convenience Care Centers**, or “Retail Clinics”
- **Physician On-Demand Telemedicine**
- **Nurseline**

Part VI, Figure 80: Urgent And Convenience Care Access Program (UCA) Provides Ways To Access Care

Nurseline

All CareFirst Members have free access to a nurse by telephone or web chat 24/7 to answer questions about new or worsening symptoms they may be experiencing. The nurse has instant access (following HIPAA validation) to information about the Member including:

- The Member’s web-based Member Health Record through iCentric
- History of earlier calls by the Member to the Nurse Information Line
- The Member’s benefits
- Locations of UCA Program options in the Member’s area

All nurse interactions with CareFirst Members are documented via a daily electronic data feed to the Member Health Record in iCentric. This enables all caregivers and Care Coordinators to see the nature and results of any calls made by a particular Member to the Nurse Information Line. In addition to text notes of the interactions, structured data fields are available for SearchLight Reporting on Nurse Information Line utilization patterns at the Panel and Group Account levels. SearchLight Reports provide information on the following:

- Call volumes
- Call reason
- Intent of caller at beginning of call
- Intent of caller at end of call
- Condition of caller upon follow-up call
- Likely cost avoided by redirection of callers to more appropriate care setting

Nurseline nurses are knowledgeable about CareFirst TCCI programs enabling appropriate referrals to be made to Care Coordinators for appropriate program placement through CareFirst’s Service Request Hub. Further, the Nurses have access to other UCA providers including CareFirst’s telehealth line, the nearest location of CareFirst’s preferred Convenience Care

Copyright © 2016
All rights reserved
Clinics (MinuteClinic) and their hours, the locations of Urgent Care Centers, as well as the locations of the nearest emergency rooms near the Member, if required.

Recommendations as to the level of care required following the nurse’s interaction with the Member are made based on the use of defined algorithms periodically reviewed and approved by the CareFirst Medical Director. When appropriate, the Nurse will provide information as to the relative cost of the services at various sites of care based on the Member’s benefit design. For example, nurses can tell the Member that Convenience Care would result in a $10 copay while an Emergency Room visit would carry a co-pay of $500.

Members identified by Nurses that are clearly in need of a Disease Management Program or who do not have a PCP are advised by the nurse and provided information on the availability of such Programs and a list of PCMH PCPs in their area.

Primary Care practices who participate in CareFirst’s PCMH Program are encouraged to provide the Nurse Information Line telephone number for CareFirst Members as a first line of afterhours contact rather than suggesting that their patients seek ED-based services. The Nurse Information Line notifies the Member’s PCP the next day of any calls from their patients overnight.

Physician On-Demand Video Visits

All Members have 24/7 access to on-demand, video consultations (“Video Visits”) with physicians licensed and located in their state. Members can seek treatment advice for common conditions such as: bronchitis, sinusitis, upper respiratory infection, allergies, urinary tract infections, strep throat, etc., and where medically indicated, have a prescription electronically sent to their preferred pharmacy.

To request a Video Visit, Members can contact CareFirst’s telehealth line via mobile phone or website to connect with a physician within one hour of request.

The results of all Video Visits are documented in the MHR in CareFirst’s iCentric System and are reported in SearchLight Reports showing various statistics about these visits including:

- Consultation volume
- Consultation time (regular business hours or after hours)
- Consultation reason
- Intent of caller at beginning of consultation
- Intent of caller at end of consultation
- Condition of caller upon consultation follow-up
- Likely cost avoided by consultation

Convenience Care Centers

CareFirst contracts with three Convenience Care providers offering Members 74 locations within the CareFirst service area. MinuteClinic is the largest provider with 55 locations. Some examples of conditions suitable for Convenience Care include cold or flu symptoms, ear infections, strep throat, bandaging for minor cuts and scrapes, or common vaccinations.

Urgent Care Centers

As a step up in care from Convenience Care Centers, CareFirst maintains a network of Urgent Care providers in 127 locations within its service area. Patient First is the largest provider with 23 locations. Urgent Care Centers are distinguished from EDs and Convenient Care Clinics by the scope of conditions treated with on-site diagnostic equipment including phlebotomy and x-ray equipment, as well as exam rooms equipped to perform minor medical procedures. Some examples of conditions suitable for Urgent Care include: sprains; painful sore throats; flu; and, ear or eye infections. While Urgent Care Centers are not typically open 24-hours a day, most centers in the CareFirst region are open seven days a week from 8:00 AM to 7:00 PM.
Emergency Departments

The most intensive level of care is the Emergency Department of a hospital. EDs are open 24 hours a day, seven days a week. All 74 EDs in the CareFirst region participate in the CareFirst network of providers. ED care is required for major, life-threatening illness or injury. Examples of medical emergencies include chest pain, trouble breathing, head trauma, bleeding that does not stop when pressure is applied, and loss of consciousness.

Figure 81 below shows the range of illnesses or injuries that can be treated in an ED vs. the other care settings included in the UCA Program.

<table>
<thead>
<tr>
<th>Illness/Injury</th>
<th>Telemedicine</th>
<th>Convenience Care Center</th>
<th>UCC</th>
<th>ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Illness or Injury (Broken Bones, Burns, Bleeding)</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Chest Pain, Shortness of Breath, and Other Symptoms of Heart Attack or Stroke</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Significant, Uncontrolled Bleeding</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>No Pulse</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Spinal Cord or Back Injury</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Labor</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Poisoning</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Minor Fracture</td>
<td></td>
<td>*</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Animal Bites</td>
<td></td>
<td>*</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>X-rays</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stitches</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back Pain</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sprains and Strains</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea, Vomiting, Diarrhea</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild Asthma</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Headaches</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign Object in Eye or Nose</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Work</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Bumps, Cuts, and Scrapes</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Rashes and Minor Burns</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Fevers</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Ear or Sinus Pain</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Eye Irritation, Swelling, Pain</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Vaccinations</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Minor Allergic Reaction</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Coughs and Sore Throat</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Cold or Flu Symptoms</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>
Benefit Design

CareFirst benefit designs discourage Members from using ER facilities for medical treatment when care could have been provided in a less costly setting. While copayments vary based on group coverage, the typical range of copayment for each level of service within the UCA program is shown in Figure 82 on the next page.52

<table>
<thead>
<tr>
<th>Site of Care</th>
<th>Member Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Visit</td>
<td>$200</td>
</tr>
<tr>
<td>Urgent Care Center Visit</td>
<td>$50</td>
</tr>
<tr>
<td>Convenience Care Center Visit</td>
<td>$25</td>
</tr>
<tr>
<td>Physician On-Demand Telemedicine Encounter</td>
<td>$40</td>
</tr>
<tr>
<td>Nurseline Encounter</td>
<td>$0</td>
</tr>
</tbody>
</table>

Many Locations For Easy Access

With 127 Urgent Care and 74 Convenience Care service locations in the CareFirst service area comprised of Maryland, Washington, D.C., and Northern Virginia, the proximity of these centers is such that Members are effectively able to reach a site easily in most cases with no more than a 10 to 15 minute drive. UCA providers are available in all 20 sub-regions of the CareFirst overall service area. And with back up provided by video based telemedicine and Nurseline support available on a 24/7 basis, Members have easy, consistent access to Urgent and Convenient Care when they need it and cannot get in to see their PCP or NP.

System Integration of Urgent And Convenience Care Partners

Urgent and Convenience Care providers send treatment information to the iCentric System in order to enhance continuity of care. In return, CareFirst provides its UCA partners access to the Member Health Record of each Member that is contained within the iCentric System. UCA provider partners login to iCentric at the point of care to obtain available medical history (including medications) on the Member they are treating.

Following treatment, the UCA providers send CareFirst a record of all Members seen, examined, and treated with complete clinical notes from these encounters. This data is uploaded into iCentric daily where it is easily viewable by PCPs and Care Coordinators. This enables the PCP to maintain visibility into their patients minor and urgent health episodes when rendered by UCA providers. CareFirst also requires UCA partners to refer patients back to their PCPs for follow-up treatment, underscoring the primary relationship with the PCP.

Patient First and Righttime are the core of the Urgent Care network while CVS MinuteClinic fulfills this role for the Convenience Care network. These partners have demonstrated the technical ability to participate in the daily bi-directional data exchange of patient information with CareFirst and PCPs in the PCMH Program to promote continuity of care and have solid reputations in the community.

MinuteClinic also serves as a resource center for Members to visit for educational Programs including patient education for smoking cessation, nutrition assessment and weight loss. These patient education services free up valuable PCP time, and PCPs can trust that the education services are delivered through a partner who will share the details of these encounters within iCentric and has an obligation to refer their patients back to them for follow-up.

52 This is a representative sample. Actual benefits vary by product.
When viewing the iCentric System, providers can see the following results from UCA partners as illustrated in Figure 83 below.

**Part VI, Figure 83: Urgent And Convenience Care Access Program (UCA) Partner Visit Results Documented In iCentric**

![Urgent Care Medical Records](image)

Mobile Enabled Access

The UCA Program is supported through CareFirst’s mobile application for Members. Members can use their mobile devices to access convenient geo-mapping results when searching for Urgent or Convenience Care providers in a prescribed radius around their current location. Once a Member locates a UCA site, driving directions, contact information and facility hours are one click away. The “find a doctor” functionality on the CareFirst website and Member mobile application provides Members with locations and list of services offered by UCA providers.
Consultant Support

PCMH Program Consultants play an important support role in helping PCPs identify Members who are frequent users of ED services, particularly for procedures known to be available through Urgent or Convenience Care Centers. Program Consultants actively scan the Panel’s PCA and SearchLight Report data for these patients and bring the results to the attention of PCPs and LCCs for intervention. Program Consultants also work closely with each PCMH practice to identify the nearest network of UCA providers and the services available through these providers. Program Consultants provide easy-reference sheets for hours of operation and contact information for UCA providers within close proximity of each Panel.
Program #13: Centers Of Distinction Program (CDP)

About half of inpatient admissions paid by CareFirst are for a planned procedure, such as knee or heart surgery. Through careful analysis of its claims information, CareFirst has observed distinct patterns in care provided in hospitals throughout the service area. Specifically, the total cost of care for different procedures differs significantly depending on where the specific procedure is performed. For example, in 2014, the average cost of inpatient admission in a high-cost hospital was almost double the average cost of admission in a low-cost hospital. Moreover, certain hospitals have achieved quality distinction through an independent rating process for specific procedures that have high variability in quality and costs.

One of the primary goals of the PCMH and TCCI Programs is to promote the delivery of care at those settings that produce the highest value and quality outcomes for select procedures and categories of care. To further this goal, CareFirst has established the Centers of Distinction Program (CDP) to encourage use of the best performing hospitals for certain high volume and/or high cost hospital-based procedures which are typically scheduled in advance by specialists.

Hospitals designated as a “Blue Center of Distinction” (BDC) hospital are those that meet specified quality criteria as described below, while also meeting cost-effectiveness criteria. CareFirst Members are not required to receive their care at these hospitals but are encouraged to do so because of the better outcomes and higher value care provided for these selective services. In effect, the BDC designation establishes a “network-within-network” for select procedures.

Because of their distinction in these services, CareFirst seeks to highlight BCD hospitals to its PCMH Panels and Members by identifying to PCMH Panels the specific physician specialists that perform these selected procedures at BDC hospitals.

Determination of Blue Distinction Centers (BDC)

Starting at the most basic level, hospitals that receive the BDC designation must be accredited by a national organization such as The Joint Commission (TJC) as well as Healthcare Facilities Accreditation Program of the American Osteopathic Information Association (HFAP), National Integrated Accreditation Program for Healthcare Organizations of Det Norske Veritas Healthcare, Inc. (NIAHOSM), or Center for Improvement in Healthcare Quality (CIHQ).

To this baseline, three dimensions of capability/quality are considered:

- Structural measures—the availability of key clinical services, including diagnostic, medical and multi-disciplinary services and features.
- Process measures—the adherence to evidence-based (or clinically based) care processes.
- Patient outcome measures—including complication rates and lengths of stay.
There are seven categories of BDC hospitals as described below:

- **Bariatric Surgery** - These designated hospitals provide a full range of bariatric surgery care services, including inpatient care, post-operative care, outpatient follow-up care and patient education. Each selected hospital meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery (ASMBS), the Surgical Review Corporation (SRC) and the American College of Surgeons (ACS).

- **Cardiac Care** - These designated hospitals provide comprehensive inpatient cardiac services including, coronary artery bypass graft surgery (CABG) and/or heart valve surgery and Percutaneous Coronary Intervention (PCI). Each selected hospital provides onsite services for Percutaneous Coronary Intervention (PCI) and has 24/7 primary PCI staff coverage, meeting National Cardiovascular Disease Registry® (NCDR) CathPCI Registry® volume and measuring targets, participating in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database.

- **Knee and Hip Replacement** - These hospitals demonstrate superior outcomes for Members of comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement. BDC centers must meet Knee and Hip Replacement Program structure and process, volume and outcome measures standards set such as hospital-level Risk-Standardized Complication rate (RSCR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) and, hospital-level 30-day, all-cause Risk-Standardized Readmission Rate (RSRR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).

- **Spine Surgery** - These hospitals provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures. BDC centers must meet measures set for Spine Surgery Program structure and process, volume, and Spine Surgery Program complication denominator volume and specific outcome measures such as Readmissions and Surgical Site Infection (SSI). BDCs are accredited by at least one of the following: The Joint Commission (TJC) (without provision or condition) in the Hospital Accreditation Program, Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Information Association (AOIA), National Integrated Accreditation Program (NIAHOSM), Acute Care of DNV GL Healthcare, Center for Improvement in Healthcare Quality (CIHQ) in the Hospital Accreditation Program.

- **Maternity Care** - These hospitals must meet standards set using publicly available data from hospital compare’s December 2014 data for Early Elective Delivery (PC-01), and selected patient experience measures at the facility level from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Severe Maternal Morbidity (SMM) Rate from the Centers for Disease Control (CDC) will be used to further enhance hospital awareness and stimulate quality improvement. BDC hospitals must be designated as Baby Friendly Hospital by Baby Friendly USA or identified as a Mother Friendly Hospital using processes established by the Coalition for Improving Maternity Services (CIMS).

- **Complex and Rare Cancers** - These hospitals meet structure, process and outcome measures for complex and rare cancer services, including team and volume requirements or be designated through the National Comprehensive Cancer Network (NCCN), National Cancer Institute (NCI) Comprehensive Cancer Center, NCI Clinical Cancer Center, American College of Surgeons’ Commission on Cancer Teaching Hospital Cancer Program (THCP) or a Community Hospital Comprehensive Program (COMP). BDC hospitals offer quality care based on patient assessment, treatment planning, complex inpatient care and major surgical treatments for adults; all delivered by teams with distinguished expertise and subspecialty training for the types of complex and rare cancers listed on the next page.
Bladder Cancer
Bone Cancer – Primary
Brain Cancer – Primary
Esophageal Cancer
Gastric Cancer
Head and Neck Cancers
Liver Cancer – Primary
Ocular Melanoma
Pancreatic Cancer
Rectal Cancer
Soft Tissue Sarcomas
Thyroid Cancer – Medullary or Anaplastic
Acute Leukemia (Inpatient/Non-Surgical)

Transplants (BDCT) - These hospitals are included in a national network of transplant centers that provide comprehensive transplant services through a coordinated, streamlined referral management program. Each hospital meets stringent clinical criteria, established in collaboration with expert physicians and medical organizations recommendations, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR) and the Foundation for the Accreditation of Cellular Therapy (FACT), and is subject to periodic re-evaluation as criteria continue to evolve. Blue Distinction Centers and Blue Distinction Centers’ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.

Each of the BDC Transplant hospitals is designated for one or more of the following types of transplants:

- Heart
- Lung
- Liver (deceased and living donor)
- Pancreas (adult transplants only)
- Bone Marrow/Stem Cell

Awareness of BDC Hospitals by PCMH Panels

Promotion of BDC hospitals is made in one of two ways: 1) through working with PCMH Panels; and 2) through the provider directory.

As a condition of being a BDC hospital, the hospital provides the names of all of its specialists that perform the designated procedure in their facility. Those specialists rated by CareFirst as low- or mid-cost are provided to Program Consultant who educate the PCMH Panels to which they are assigned so that they can make informed referral decisions. The goal is that a growing share of CareFirst Members will receive care at these designated facilities, especially BDC facilities.

PCMH Panels can track how many of their Members receive services at BDC and non-BDC hospitals through monthly SearchLight Reports.

Provider Directory/Member Portal

In addition to working closely with PCPs, CareFirst prominently displays BDC designated hospitals in its provider directories as shown in Figure 84 on the next page.
In addition, CareFirst Members can find additional information about BDC hospitals at CareFirst’s MyAccount Member Portal.
Program #14: Preauthorization Program (PRE)

Pre-Authorization of High Cost, High Impact Services Program

Seeking Pre-Authorization of services often creates a burden for providers and Members and is viewed as an obstacle by Members to receiving needed care or services. In addition, if not structured thoughtfully, pre-authorization can unnecessarily increase administrative costs as well. However, some services are either so expensive or subject to misuse that they justify the use of a Pre-Authorization requirement.

CareFirst maintains a list of approximately 670 Current Procedural Terminology (CPT) codes for which Pre-Authorization is required. This is out of the 9,000 or more CPT codes that exist. These Pre-Authorization codes affect a small percentage of CareFirst’s overall membership (less than five percent), yet this small population accounts for a high percentage of total health care spending. Members for whom Pre-Authorization applies, typically require combinations of authorizations such as medical, drug and Durable Medical Equipment (DME).

Of the more than 670 codes requiring Pre-Authorization:

- Surgical Procedures including Cosmetic and Reconstructive procedures account for 360 codes; and
- DME and Home Care Services account for 190 codes.

Further, there are 10 Categories of Specialty Medications that also require Pre-Authorization since these medications cost nearly $.5 billion annually with $1.3 billion in associated medical costs for a total of $1.7 billion in annual medical and pharmacy spend for approximately two to three percent of all Members.

Pre-Authorization focuses on services or procedures that are:

- extremely complex
- highly variable and/or potentially unnecessary
- require complex clinical judgment
- experimental or investigational
- extremely high cost
- more effectively provided in an alternative setting (site of service)
- potentially subject to patterns of abuse, or
- if used inappropriately, harm the Member

The procedures and services meeting these criteria listed above are grouped into 10 categories as follows:

- High Cost DME and Home Care
- Genetic Testing
- Air Ambulance
- Complex Surgeries (e.g. Transplants) and Reconstructive/Cosmetic Procedures
- Admissions to Skilled Nursing and Acute Rehab Facilities
- Emerging Technologies
- High Cost Radiation Therapy such as Proton Beam and IMRT
- Out of Network Services (When required by contract)
- High Cost Specialty Medications and Specialty Infusions
- End Stage Renal Conditions

The majority of medical services that require pre-authorization are medically necessary and are required for the health and well-being of the Member. The Pre-Authorization Program serves as a check and balance to assure that the right service for the Member in the right setting at the right time is provided. For medical services, Pre-Service Review Nurses (PSRNs), apply evidence-based medical policies. The PSRNs have extensive clinical and medical review experience and are extremely knowledgeable in the application of criteria. The nurses also have backgrounds in fraud and abuse, special
investigations, medical policy and benefit administration. They have access to Member specific contracts to ensure the Member's benefits are being applied in accordance with the Member’s Benefit Contract.

The PSRN’s triage Pre-Authorizations for Member admissions and services, assess the clinical details using evidence based criteria, and quickly determine medical appropriateness and care needs. All involved on the clinical review team interact with iCentric, documenting clinical notes in the Member Health Record.

If an authorization request does not meet evidence-based criteria, a CareFirst Medical Director provides an additional level of review, with an opportunity for peer-to-peer discussion between the referring physician and the CareFirst Medical Director.

Sentinel Effect

The high cost, complex procedures that are subject to pre-authorization are ordered by distinct subsets of providers or specialists, some of whom are employed by the institutions that own the equipment that will be used to administer the treatments. Once the physicians who frequently order procedures on the prior authorization list become familiar with CareFirst’s Medical Policy, the number of Pre-Authorization requests usually drops with only requests for Members who actually meet the evidence-based criteria for a procedure or service being submitted. It is not uncommon to see denial rates for Pre-Authorization requests drop below five percent as providers become more aware of evidence-based medical policy.

Online Pre-Authorization Request Process

The CareFirst Provider Portal offers providers access to the specific list of services requiring Pre-Authorization and enables them to enter the request for a specific Member and receive an immediate determination – either an approval or a message indicating further review is required.

Pre-Authorization Process for Medical Services:

1. The provider accesses the Request Authorization tab in iCentric and enters basic Member demographic information and the service being requested.

2. Many services meet criteria and are immediately approved for medical necessity.

3. When a provider requests authorization for one of the identified services or codes on the Pre-Authorization List, a series of condition specific questions must be answered.

4. The provider may attach medical records or any pertinent clinical information.

5. The request, along with all of the submitted documentation, is electronically routed to a PreService Review Nurse for review.

6. The PSRN thoroughly evaluates every case identified for review referring back to the Member’s benefit contract to ensure needed services are covered within the Member’s contract.

7. The PSRN documents all findings in the clinical Authorization record within iCentric and communicates with the requesting provider.

8. If the request is approved, the PSRN will issue a Pre-Authorization which will flow through iCentric to the provider, immediately notifying the provider of the approval.

9. The provider can view all of the clinical information and PSRN notes within iCentric.
10. If, after an extensive PSRN review, the request cannot be approved, the PSRN will route the case, including all of the clinical information, through iCentric to the CareFirst Medical Director for a physician level review.

11. The CareFirst Medical Director will access all of the clinical and contractual information beginning with the provider’s initial submission and clinical responses and will render a determination based upon the documentation submitted, clinical judgment, evidence based criteria and national medical policies.

12. If the request cannot be approved, the CareFirst Medical Director will offer a peer to peer review consultation with the requesting provider.

13. The Member and the provider are promptly notified of the determination.

14. All documentation is housed within iCentric and can be viewed by the entire Care Coordination Team.

**Pre-Authorization for Specialty Pharmacy Services**

Medication specific authorizations are a key component of the Preauthorization Program due to the substantial cost and often complex regimens for proper administration of certain medications.

Approximately 120 specific medications require a pre-authorization out of more than 5,000 medications available under CareFirst formularies.

The pre-authorization of these medications allows CareFirst to identify Members who are using these medications. Once identified and authorized, this permits follow up by specially trained nurses who are experts in the proper administration of these medications in support of Members who are taking them (For more, see section titled Case Management Provided to Identified Members in RxP Element #3: Authorization and Case Management for Specialty Drugs in the Medical and Pharmacy Benefits).

**Coordination with PCMH and TCCI Programs**

At any time, a PSRN or Rx Nurse Case Manager can connect the Member with a Local Care Coordinator (LCC) or Complex Case Manager (CCM) if the Member’s condition and/or treatment are appropriate for PCMH or TCCI management.

Due to the nature of the Pre-Authorization process, the PSRN Rx or Nurse Case Manager may become aware of hospitalizations before the Hospital Transition Coordinator (HTC). In this instance, the PSRN will route the Pre-Authorization to the HTC, thus engaging the HTC and initiating Care Coordination before the Member is even admitted to the acute care setting.
Program #15: Video Visit Telemedicine Program (TMP)

Telemedicine has emerged as a critical component of an efficient health care system that can improve access to timely, cost-effective care. Due to advances in technology, telemedicine has spread rapidly and is becoming integrated into the ongoing operations of physician offices. When performed correctly – in a secure and easy-to-use way that protects privacy – telemedicine can offer Members a convenient way to reach their PCP and improve the relationship between Member and physician.

A long standing PCMH Program requirement has been to encourage participating practices to offer extended hours of operation and flexible primary care backup services to their membership. The Telemedicine Program (TMP) supports this goal by encouraging real-time, integrated audio and video telecommunication between a Member and their PCP or between conferring providers about a specific Member’s care.

The Telemedicine Program is available to participating PCMH practices and all Members. The system is free-of-charge to the provider and enables online video conferencing capabilities as an alternative to in-office visits. Care Coordinators may also access this technology to engage CareFirst Members in Care Plans. In addition, Members themselves can access telemedicine services directly through the CareFirst website when they are in need of immediate, on-demand physician care. Telemedicine visits – Video Visits – are fully covered by all CareFirst plans, and are reimbursed at the same level as an in-office Evaluation and Management (E&M) visit.

Two Pathways to Telemedicine Services

The Telemedicine Program provides two pathways to access a physician via Video Visit on a 24/7 basis if their PCP is unavailable.

Pathway #1

This pathway is initiated by a Member and can be scheduled to begin immediately. While Members are always encouraged to access the health care system through their PCP, Members seeking treatment advice for common conditions (e.g., allergies, bronchitis, strep throat, eye or ear infections, etc.) have 24/7 access to on-demand video consultations with board certified physicians through a convenient link located on the My Account Member website. This Pathway is used when access to the Member’s PCP or back up PCP (in a Panel) is not available.

The link connects Members to a special, secure webpage where they can enter their contact information and reason for a Video Visit. Upon clicking to submit the request, the Member receives an email with a link and instructions for accessing the Video Visit service.

Members can access the link to Video Visits from their home or office anytime and anywhere via mobile device or laptop with sufficient broadband internet access. The link connects Members to a Board Certified physician to assist with the treatment of any non-emergency medical conditions. The physician conducting the Video Visit may diagnose symptoms, prescribe medications, and send prescriptions to the Member’s pharmacy of choice. Detailed documentation of the Member’s Video Visit encounter is stored in the Member Health Record for viewing by the Member’s PCP or other care team providers.

Pathway #2

This pathway supports PCPs and Care Coordinators in the PCMH Program with Video Visits delivered through the iCentric platform. iCentric assists with the scheduling of a secure audio-visual connection to enable PCPs to perform routine visits and deliver extended hours of care without regard to physical location, making them generally more available to Members.

Pathway #2 supports a range of situations, as outlined below, that enable enhanced communication and rapidity in service/consultation. This is the preferred route in most cases, but Pathway #1 is most useful when a Member’s PCP is not immediately available – as noted above.

The two pathways are illustrated in Figure 85 and described on the next page.
Part VI, Figure 85: Two Pathways To Initiate A Video Visit

Pathway #1 – On-Demand Video Visit for all Members

Pathway #1 is considered part of the Urgent And Convenience Care Access (UCA) Program. More information about this Program can be found in the Guidelines under the UCA description contained in this Part VI under TCCI Program Element #12. This Pathway is supported by American Well, a CareFirst partner, and by AxisPoint, the CareFirst 24-hour NurseLine.

Pathway #2 – Video Visits for PCMH Panels Target Population

Pathway #2 is designed to support eight different use-case scenarios as an integral capability provided to Panels that enables them to offer better access to care and improves the quality of care for Members in the PCMH Program. These use-cases are designed to promote stronger relationships and effective care interactions among Members, PCPs, and LCCs. The eight use-cases are described below.

Medical Follow-up: A PCP can conduct a Video Visit with a Member to follow-up on a broad range of conditions after an initial diagnosis. The Video Visit platform is particularly effective for reducing the need of a Member to travel for follow up care.

Maintenance Visit: During business hours, after hours and on weekends, PCPs can schedule Video Visits with Members and Care Coordinators to review progress and setbacks in achieving Care Plan objectives.

PCP - Specialist Consult: A PCP can conduct a consult with a specialist remotely via a Video Visit appointment and involve a Member or an LCC.

After-hours Care: A PCP can provide after-hours coverage through a Video Visit with a Member to improve diagnosis and triage urgent conditions to improve coordination of care.

Remote Location Access: A PCP in a rural area can use a Video Visit to improve access to medical care for Members who are unable to travel to the office or need the services/consultation of a specialist who would otherwise be unavailable.

Coordination of TCCI Services: A Video Visit can be used for all aspects of TCCI Care Coordination, including but not limited to performing Comprehensive Medication Reviews, reviewing results of Expert Consultants, conducting pain management review sessions, and evaluating the results of Enhanced Monitoring.

Hospital Discharge Follow-up: A PCP can use a Video Visit to perform seven-day and 14-day Transitional Care Management assessments on patients recently discharged from the hospital.

Chronic Care Management: A PCP can monitor progress of Members with chronic conditions in a convenient manner by conducting a Video Visit for routine follow-up care of Members.
Pilot Experience

CareFirst launched a telemedicine pilot in 2015 to evaluate the use-cases described above and to test the iCentric capabilities built to support real-time audio-visual communication. 33 Panels participated in the pilot with 57 physicians. Early findings showed that Members and participating providers found telemedicine to be convenient and overall would recommend the service to others.

Members enjoyed the ability to connect with their providers in their home environment, and felt they had their providers’ undivided attention in this setting. Telemedicine also emerged as a useful capability in urgent care situations. In the cases evaluated in the pilot, Members’ symptoms were easy to diagnose and treat, while maintaining the security of the doctor-patient relationship.

Examples of physicians using telemedicine during the pilot are described below:

- A child was seen in the office for a concussion. Follow up was required the next day, and the doctor was able to conduct balance testing via telemedicine in the child’s home the following day without the child’s parents needing to leave home. The CareFirst Video Visit platform enabled the parents of the child to save time, money, and the child did not miss school hours. In this case, the child was also cared for in the security of his home with his parent’s right next to him, where he was comfortable with his provider asking him questions about a scary situation.

- During a snowstorm, many Member appointments were being cancelled. Several doctors using the Video Visit platform called their Members and asked if they would like to have a Video Visit rather than cancel their appointments. This eased the minds of the Members as they were still able to follow up with their provider and receive their medical review without delay.

- Following a three week hospitalization, a medically fragile Member was discharged from the hospital. At the time, the Member was home bound due to their medical condition. Using the CareFirst Video Visit service, the Member’s PCP was able to see her within the first week following discharge. This follow up visit would not have been possible for the Member at this time without this service.

- On a Saturday, a Member noticed a concerning wound on his arm that needed his PCPs assessment and he wanted medical advice on how to care for it. In five to 10 minutes the PCP, Member, and his spouse conducted a Video Visit. The Member benefited from talking to a Physician who he already had a relationship with, and stated that he felt that seeing his own PCP expedited his diagnosis and treatment with his own doctor rather than seeing someone new or going to an ED of a hospital.

One of the key insights gained from the pilot was that, to be effective, most physicians require a very simple, intuitive technology interface. They made important suggestions for how to improve the platform’s capabilities which are now in place. Further, some Members felt that providing an increased feeling of privacy and data security during the consultation would make them feel more at ease during the consultation.

Members and providers both suggested testing of the technology on their devices prior to the scheduled visit to ensure a smooth connection and sign-on at the time of the Video Visit. The pilot revealed that scheduling needed to be more carefully integrated into the providers’ workflow in order to decrease the overall administrative impact of Video Visits on the practice’s day-to-day operations. Overall, feedback from the pilot greatly informed the creation of the Video Visit Telemedicine Program.

Accessing the Video Visit Program

The Video Visit capability is available to all PCPs in PCMH practices free of charge from CareFirst. Interested practices contact their Regional Care Director (RCD) or Program Consultant to request access to the capability. All registered iCentric users in a practice are able to have their iCentric access modified to include the ability to use the Video Visit platform. PCPs and NPs have the ability to schedule and conduct visits. Further, practice administrative staff with iCentric access, gain the ability to schedule and manage Video Visits on behalf of the practitioners in the practice.
When a practice joins the TMP, they receive instructional materials and assistance with accessing and using the Video Visit platform from the PCMH RCD, PC, and the PCMH team. The instructional materials indicate how to schedule and manage Video Visits within iCentric, and instructions on conducting Video Visits with the Member.

Before beginning the Telemedicine Program, participating practices consider how to best accommodate the Video Visit capability into the usual work flow of their office. The iCentric Video Visit platform offers features designed to seamlessly integrate Video Visits, including a scheduling tool, access to the Member Health Record, email notifications to providers and Members, and a virtual waiting room with messaging.

These features are available to:

- assist practices with verifying Member insurance eligibility,
- collect cost-share when appropriate, and
- coordinate with PCP and NP appointment schedules to ensure timeliness.

**Scheduling Video Visit with a PCP**

PCMH practices can choose to use the Video Visit platform on a pre-scheduled or on-demand basis. In situations where the appointment is pre-scheduled, scheduling is conducted within iCentric. The scheduling process involves confirming the Member’s eligibility, providing the Member’s contact email address, selecting a date and time for the appointment, and optionally, including notes on the reason for the appointment.

Once an appointment is scheduled, iCentric automatically sends a schedule reminder email to both the PCP or NP, and the Member, indicating the time of the appointment, including instructions for the Member to set up the software, log in, and use the Video Visit capability. To ease future scheduling needs, the Member’s contact information and email address are stored within the iCentric Member Health Record after the first appointment is made.

Some PCMH practices also choose to use the Video Visit platform as an on-demand service for their Members. In these situations, the Panel decides on which of the PCPs and NPs are “on call” for which date and times – thereby enabling Video Visit whenever there is courage.

**Secure Connection**

All Video Visits are conducted through CareFirst secure servers. The Video Visits platform is password protected, encrypted and HIPAA compliant. Each meeting invite is unique to the Member and PCP. To maintain the privacy of the CareFirst Member, Video Visits should be conducted in a quiet, private location, where health information cannot be overheard by unauthorized individuals. CareFirst does not record the contents of a Video Visit, but logs Member and provider contact information for reporting purposes.

**Simple Setup**

PCPs and NPs who use the Video Visit platform may use office computers installed with speakers, a microphone and a web camera. Additionally, they may use most tablets or smart phones after installing the CareFirst supplied Video Visit communication tools. Participating Members may also use the same types of equipment. A high-speed internet connection is needed, particularly over Wi-Fi or a cable connection.

**Member Benefits and Billing**

Video Visits occurring through either Pathway 1 or 2 are a covered benefit for the majority of CareFirst Members. Telemedicine is expected to deliver the same level of care as the equivalent face-to-face service. Therefore, all requirements for a face-to-face contact also apply to a Video Visit. Documentation in the medical record must support the services rendered, as is the case with any visit.

Billing for Video Visits is performed in the usual way and uses an appropriate CPT code with the HCPCS modifier “-GT”. Billing for appointments that cannot be completed due to scheduling or technical difficulties is forbidden. A successful
Video Visit must consist of both an audio and a video connection between the Member and the provider. That is, to be billable, a Member must always be present.

To bill for a Video Visit, eligible providers should select the appropriate CPT code for “Outpatient visit for Evaluation and Management” (CPT code range 99211-99215) along with the telehealth modifier “-GT” to signify that the encounter occurred “via interactive audio and video”. If more than one treating provider is present for the appointment (e.g., PCP and Specialist), each can bill separately.

PCPs and NPs who are conducting face-to-face Hospital Transitional Care Management via Video Visit use the standard Transitional Care Management codes, as appropriate to the Member’s situation and the jurisdiction in which care is provided.

Jurisdiction specific laws and regulations, as well as provider licensing, for telemedicine apply based on the location where the Member receiving services is physically located at the time service is provided.
Program #16: Dental-Medical Health Program (DMH)

UPDATE PENDING
Program #17: Detecting And Resolving Fraud, Waste And Abuse (FWA)

UPDATE PENDING
Program #18: Automating And Improving The Accuracy Of Provider Practice Data

UPDATE PENDING