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**STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS**

OFFICE OF THE HEALTH INSURANCE COMMISSIONER

IN RE: BLUE CROSS & BLUE SHIELD OF :
RHODE ISLAND CLASS DIR :
NOVEMBER 21, 2008 :

**PRE-FILED DIRECT TESTIMONY OF
AUGUSTINE MANOCCHIA, MD**

Q. Please state your name, title and area of responsibility.

A. Augustine Manocchia, MD, Chief Medical Officer (“CMO”) of Blue Cross & Blue Shield of Rhode Island (“Blue Cross”). I report directly to Richard Farias, Executive Vice President. I oversee Provider Contracting, Provider Relations, and am also responsible for Blue Cross’ efforts to address healthcare affordability.

Q. Within your scope of responsibility, do you have any input into how rates are developed at Blue Cross?

A. Yes. I, along with my staff, and members of the health management team participate in discussions regarding the latest utilization trends and their drivers. We work with our actuarial staff to review the data, and any concerning trends, and then verify that processes and initiatives are in place to attempt to mitigate those trends.

Q. Please provide some examples.

A. Certainly. Some trends are due to new technology being introduced, such as new drug therapies. Others, such as inpatient hospitalizations, may have various contributing factors.

1 We analyze the factors and drill down to determine whether or not we can impact the trend either
2 through modification of current processes (e.g., utilization review) or modifications in a contract
3 (e.g. transitioning to case rates). For example, we recently conducted an audit at a large
4 behavioral health facility whose inpatient trends were exceeding the norm. After a medical
5 record review audit, we found that although the trend was increasing, the stays were within our
6 guidelines of medical necessity. Therefore, we did not see a need to modify our processes.
7 Another example is radiology. We were observing continued increases in the trends for high-end
8 radiology such as magnetic resonance imaging (MRI) and positron emission tomography (PET).
9 After a careful analysis, we implemented a radiology management program to favorably impact
10 that trend. In doing so, we anticipated claims savings, and modified the rates to reflect the
11 anticipated savings.

12 Q. Does Blue Cross provide any health management programs for the Direct Pay
13 population and are they designed to address affordability principles enunciated by the Office of
14 the Health Insurance Commissioner (“OHIC”)?

15 A. Yes. As a part of our existing and ongoing efforts, Blue Cross’ Health
16 Management programs are continuously evaluated and updated accordingly to meet our member
17 health needs while addressing affordability. Our Health Management and Integration Division is
18 staffed by clinical (Nurses, Social Workers, Dietitians, and Board Certified Physicians) and non-
19 clinical (support) personnel whose work has met national standards for performance excellence
20 set by the American Accreditation HealthCare Commission/URAC and National Committee on
21 Quality Assurance (“NCQA”).

22 Our Utilization Management and Medical Policy processes facilitate the use of the least
23 costly, most appropriate setting for care and the use of evidence based medicine, respectively.

1 Chronically ill members are assessed, stratified and actively managed through our Health
2 Management programs. Our Provider Profiling program also promotes cost effective use of
3 resources. Last, our Pay for Performance programs, including “Quality Counts”, and our
4 participation in statewide efforts to promote primary care, demonstrate our support for this
5 important element of the health care delivery system. Collectively, these health management
6 programs are available to all members, including our Direct Pay members.

7 Q. Could you explain how these programs address affordability as enunciated by the
8 OHIC?

9 A. Certainly. There are four principles outlined by the OHIC. They are:

- 10 • Focus on primary care, prevention and wellness
- 11 • Active management of the chronically ill population
- 12 • Use of the least cost, most appropriate setting
- 13 • Use of evidence based, quality care

14 Blue Cross has several initiatives in place that demonstrate our focus on primary care and
15 prevention. These programs are both member and provider driven. Our focus on prevention at
16 the member level is addressed through our comprehensive wellness programs. We recognize that
17 prevention is the first line of defense against chronic illness and rising healthcare costs, so we
18 offer individual, provider, and community-based programs focused on prevention, early
19 detection, and early intervention.

20 Across all plans and products, including Direct Pay, Blue Cross provides the following
21 reminders and education resources, which help members proactively manage their health:

- 22 • Childhood immunization and well-visit reminders
- 23 • Adolescent immunization and well-visit reminders

- 1 • Colorectal cancer screening reminders
- 2 • Cervical cancer screening reminders
- 3 • Mammography reminders

4 These reminders are given to members through mail and telephonic outreach. In addition,
5 Blue Cross provides programs for all life stages and the unique requirements of those stages.
6 Below are brief overviews of these programs. With the exception of the Little Steps® Prenatal
7 Program, Blue Cross members are automatically enrolled in the following programs.

- 8 • **Little Steps Prenatal:** This mail-based program (which is included in the Little Steps®
9 Series) helps take some of the guesswork out of prenatal care. After contacting Blue
10 Cross to enroll, participants receive educational materials for prenatal and newborn care,
11 the opportunity to receive a 20% discount on baby safety tools, and case management
12 services (for high risk pregnancies only).
- 13 • **Little Steps Newborn:** The Newborn program waives copayments, if applicable, for
14 well-baby visits during the first 15 months of life. Parents can also receive discounts on
15 baby safety tools. All eligible members are automatically enrolled in this program after
16 the child is added to the parents' insurance.
- 17 • **Little Steps Toddler:** This program sends parents of children aged 12 to 24 months
18 information about the importance of immunizations and well-care visits. In addition to
19 the Little Steps programs, parents also receive a telephone call reminding them to
20 schedule well-care visits with their child's healthcare provider within the first 15 months
21 of life.
- 22 • **Women's Health:** As women have unique health concerns, Blue Cross provides them
23 with a comprehensive guide that delineates appropriate health screenings for their age

1 and answers common health questions women of all ages may have about screenings and
2 tests. This guide is sent to members who have been non-compliant for one or more
3 health screenings. These members will also receive telephonic reminders to schedule
4 appropriate screenings with their healthcare provider.

- 5 • **Men's Health:** Published research indicates that men are generally less engaged in the
6 process of managing their health than women. To support prevention and early detection
7 of the chronic conditions and health risks facing men, Blue Cross launched an
8 educational brochure focused on men's health in 2007. In this program, men aged 25 to
9 64 will receive the *Wellness Reminder: Men's Health* brochure which provides tips on
10 living a healthy life, a checklist for recommended screenings, and additional resources for
11 men's health information.

12 Blue Cross also offers comprehensive educational tools on our website, Blue Cross.com.
13 Members accessing the website have access to provider finders, medical and pharmacy claims
14 trackers, and hospital comparison tools. Throughout the condition-oriented sections of the Health
15 & Wellness Center, the member can learn about their health, fill out a personal health assessment
16 and be directed to Blue Cross's suite of health management services including back care,
17 nutrition, stress and weight management, smoking cessation, and education for asthma, diabetes,
18 and other conditions. This is available to all members.

19 Collectively, during calendar year 2007, Blue Cross made approximately 360,000 outreaches
20 to members to remind them of screenings and other steps that they could take to maintain and
21 promote their health. Blue Cross tracks member utilization and compliance with preventive
22 screenings by running claims data approximately 6 to 8 months after a telephonic or mail
23 reminder intervention has taken place. This data is reviewed and based on that review,

1 modifications may be made to the following year's programs. For example, based upon 2006
2 HEDIS results, Blue Cross increased its efforts in the areas of cervical and breast cancer
3 screenings, as well as focusing resources on Chlamydia and well child visits.

4 Q. What has Blue Cross done to promote primary care?

5 A. Blue Cross has taken three major steps to respond to the principles enunciated by
6 the OHIC regarding enhancing primary care.

7 1. PCP Fee Schedule: Blue Cross recognizes the importance of the primary care
8 physician and, in 2007, began to provide increases in reimbursement specifically to primary care
9 physicians which will continue for the next few years. These increases will bring primary care
10 physician reimbursement to parity with the reimbursement levels in Massachusetts (targeting the
11 same percentage of regional Centers for Medicare & Medicaid Services ("CMS") fee schedule).
12 In addition to fee increases, we continue to provide funding for electronic health records through
13 the Quality Counts program and have also provided funding to Electronic Health Records of
14 Rhode Island ("EHRRI"). We recognize the value of the PCP practice and are providing
15 significant support to ensure financial stability and practice efficiency. We are also pursuing
16 opportunities to work with physician groups and medical schools to provide funding for
17 recruitment of new PCPs in Rhode Island.

18 2. Blue Cross is very active in the implementation of the Chronic Care Sustainability
19 Initiative ("CSI") Pilot which launched on October 1, 2008. Over a two-year period we expect to
20 have 25 PCPs involved in the CSI pilot program. Payment to providers is for the medical
21 management of members, and paid on a per member per month basis, calculated on the number
22 of members each payer has in the selected PCP practices each month. Measures of success of the
23 program will include improved patient satisfaction with their overall experience of care,

1 improved provider satisfaction, reduced inpatient/emergency room utilization, and improved
2 health outcomes. The goal of this project is to align chronic care improvement goals with
3 financial incentives for the delivery of high quality chronic care. This will be accomplished
4 through primary care practice redesign to incorporate the elements of the “Advanced Medical
5 Home/Chronic Care Model” of care. These elements include [but are not limited to] better use of
6 non-physician team members, integration of behavioral health into the primary care practice,
7 enhancements to information systems, links to effective community resources, self-management
8 support, group visits, “brown bag” medication review and electronic “virtual” visits. Each
9 practice will also be staffed with a Nurse Case Manager who will be an employee of each
10 practice but funded by the payers.

11 3. Blue Cross is also in the process of developing several pilot programs, in coordination
12 with providers, to create alternative reimbursement models in an effort to move away from the
13 traditional but often criticized fee-for-service model. Target implementation of the first pilot
14 program is January 1, 2009. PCPs will play a pivotal role in these new reimbursement strategies
15 and will be reimbursed based on patient management of high-risk patients and those with chronic
16 illness. With the help of nurse case managers, the goal is to increase and improve interaction
17 with members, leading to a much more proactive management of their care.

18 Through the implementation of these pilot programs, Blue Cross expects to see;

- 19 • Improved treatment of chronic care
- 20 • More appropriate use of urgent care and emergency rooms
- 21 • Avoidance of unnecessary hospitalizations due to complications of a chronic
22 illness
- 23 • Reduced duplication of services

- 1 • Improved Physician satisfaction with their careers
- 2 • Improved care coordination between hospitals and post discharge care givers
- 3 • Enhanced collaboration and coordination among providers of care
- 4 • Improved member experience of care

5 Q. Does Blue Cross have programs to actively manage chronically ill members?

6 A Yes. Blue Cross has several programs in place to help members with a chronic
7 illness manage their health.

8 Our Chronic Condition and Disease Management (“DM”) Programs are targeted to
9 diseases which are cost drivers for inpatient and outpatient services and the likelihood that
10 interventions can reduce emergency room visits and/or unnecessary hospitalizations. The goal of
11 our programs is to provide our members with the information, tools and resources to effectively
12 self-manage their condition assure they receive appropriate medical care and maintain optimal
13 wellness.

14 Blue Cross has developed and implemented comprehensive disease management
15 programs for Asthma, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD),
16 Diabetes, and COPD (Emphysema). Interventions have also been introduced to educate
17 members on conditions such as high blood pressure and low back pain. In addition, an intensive
18 Telephonic Smoking Cessation program is available to members with chronic conditions who are
19 ready to quit. Members are systematically identified for DM outreach through several methods.
20 Medical and pharmacy claims are analyzed to identify members who meet established criteria for
21 respective diseases and conditions. Predictive Modeling analysis is conducted on a weekly basis
22 to identify members who have an increased probability of incurring high cost medical expenses
23 in the future. Data from completed Personal Health Assessments, which is available to all

1 members on-line, is also utilized to identify at risk members. Members may also be identified
2 through the Care Management Software System as a result of an inpatient stay, multiple
3 emergency room visits, or based upon their specific diagnosis.

4 Identified members are referred to complex case management, health coaching and/or
5 other applicable interventions based on their condition and severity:

- 6 • All identified members are included in education and awareness campaigns for
7 their respective conditions. These typically consist of educational newsletters or a
8 series of mailings containing helpful self-management tips, information on proper
9 use of medication, and tips on nutrition and physical activity.
- 10 • Members with CAD, CHF and Diabetes who are identified as moderate risk, (e.g.
11 inpatient stay or emergency room visit but without medical complexity), are
12 referred to health coaching. These members receive outreach letters and
13 telephone calls offering a member centric educational and self-management
14 program with a registered nurse or registered dietician. The health coach assesses
15 the member's needs and conducts telephonic consultation to work towards
16 completion of their established goals aimed at improving their health. .
- 17 • Members identified with chronic conditions whose cases are determined to be
18 catastrophic or medically complex are stratified as high risk and receive
19 telephonic outreach to participate in our complex case management program.
20 Our team of registered nurses, licensed social workers and medical directors
21 collaboratively set goals and develop a personal plan of care with the member.
22 They also collaborate with the member's physician to confirm their treatment plan

1 and prescribed medications. The program length is determined by the goals
2 established and the member progress toward the goals.

3 During calendar year 2007, Blue Cross outreached to approximately 201,000 members to
4 help them manage their chronic illness. Following is a breakdown of these interventions
5 conducted during 2007, as well as the results:

6 **Asthma Program** (*57,851 touchpoints*): Our Asthma Program is designed to help
7 members self-manage their disease through the use management tools and medication
8 compliance. Members are provided with education, tools and resources through direct mail,
9 newsletter articles, the Blue Cross website asthma classes, and telephonic education.

10 Results: A 35% improvement in the controller to rescuer medication ratio, an indicator of
11 proper use of asthma medication, was experienced over a 12 month period for members who had
12 been included in the asthma patient profiles provided to physicians. The number of asthma self-
13 management kits distributed in 2007 increased by nearly 100% over 2006 as a result of direct
14 promotion to members in mailings.

15 **Coronary Artery Disease/High Cholesterol Program** (*28,595 touchpoints*): This
16 program is designed to help members take control of coronary artery disease and risk factors
17 such as high cholesterol and high blood pressure through educational mailings and available
18 telephonic intervention with registered nurse health coaches and registered dietitians. For those
19 with complex medical situations who need extra help coordinating their care, our certified nurse
20 and social work case manager's work with the patient and healthcare provider to assure both
21 their medical and psychosocial needs are met.

22 Eighty-seven percent of the members who completed the CAD mail program survey
23 indicated that they took steps to reduce their intake of saturated fat, 70% reported that they

1 increased their physical activity and 83% said they take their medicine more regularly as a result
2 of the program.

3 **Diabetes Program** (90,993 touchpoints): Our Diabetes Program is designed to enhance
4 and reinforce good self-management practices through educational literature, screening
5 reminders and telephonic consultation. Multiple resources provide key elements for maintaining
6 a healthy lifestyle. This includes community educational events, periodic reminder mailings, and
7 telephonic health coaching with registered nurses and registered dietitians, who are also Certified
8 Diabetes Educators.

9 The number of diabetics referred to health coaching was increased by 73% in 2007 over
10 2006, resulting in 289 more members who participated in this valuable service. Eighteen percent
11 of the diabetics who received gaps in care reminders in March 2007 had at least one of their
12 missing tests performed in the six month period following receipt of the reminders.

13 **Heart Failure Program** (2,363 touchpoints): This program is designed to help members
14 control their congestive heart failure and improve their quality of life through proper self-
15 management and positive lifestyle habits. The program interventions include self-care kits,
16 telephonic health coaching with registered nurses and dietitians. For members with complex or
17 catastrophic cases, certified nurse case managers and licensed social work case managers are
18 available to help the member with medical, psychological or social needs.

19 Eighty-eight percent of the respondents to the CHF mail program survey reported that
20 they take their medicine more frequently as a result of the program and 76% indicated that they
21 weigh themselves more frequently. Decreases in both emergency room and inpatient usage rates
22 have been experienced as a result of the CHF program. The number of inpatient admissions for
23 heart failure among the Blue Cross population decreased 17.4% from 2006 to 2007.

1 **Chronic Obstructive Pulmonary Disease Program** (4,887 touchpoints): The goal of
2 the COPD program is to better educate members about their condition and methods for
3 maintaining a positive quality of life. Members are identified via claims analysis and depending
4 on the severity of their illness (emergency room visit or inpatient admission as an example), they
5 are provided with educational tools to help them understand and manage their illness and the
6 opportunity to participate in our telephonic high intensity program. During last quarter of 2007,
7 Blue Cross provided over 200 high risk members with this high intensity intervention.

8 **High Blood Pressure Program** (11,987 touchpoints): The goal of the High Blood
9 Pressure Program is to educate members and encourage lifestyle behavior change that will help
10 improve their high blood pressure. Newly Identified members receive a “What You Should
11 Know about Hypertension” booklet and blood pressure tracking card.

12 Forty-seven percent of the members who completed a mail program survey in 2007
13 indicated that they improved their blood pressure as a result of their actions after reading the
14 information.

15 **Telephonic Tobacco Treatment Program** (85 touchpoints): This Program is designed
16 to help members who smoke and have a chronic condition to quit smoking. Members can enter
17 the program by a self referral, referral from a physician, or referral from the disease or case
18 management program. Blue Cross promotes smoking cessation as an educational component
19 within all of its chronic condition management materials. This unique program features an
20 individual treatment program consisting of between seven to ten individual sessions of 20 to 30
21 minutes long. The member receives information about smoking cessation and an individualized
22 plan to quit smoking.

1 Seventy percent of the members who had completed the program remained smoke-free
2 after one year (30/43).

3 **Depression Intervention** (4,018 touchpoints): This intervention is designed to provide
4 physicians with notification that their patient may be non-compliant with their medications by
5 sending them notification via facsimile that a member may be late in refilling a prescription.
6 There was a 3 % increase in compliance noted after these interventions.

7 In addition, we recognize the effect that depression can have on members trying to
8 manage chronic conditions, so our disease and case management programs incorporate our
9 behavioral health brochure, *How Are You Today?* into their interventions. Blue Cross developed
10 a partnership with its behavioral health vendor called the “Integrated Partner” model. In this
11 model, case managers specializing in behavioral health are located onsite at Blue Cross to help
12 co- manage members with a behavioral health component impacting their chronic condition.

13 In addition to these interventions, there is outreach conducted to members in other forms
14 of media. Our corporate website, bcsri.com, contains a comprehensive series of feature pages
15 on each of our targeted conditions. Each page contains informative articles and Q&As from
16 Mayo Clinic Health Solutions, descriptions of available disease management services, and tools
17 such as trackers and logs. Articles on chronic conditions, notices regarding disease management
18 programs and self-care tips are frequently published in *Choices*, our quarterly member
19 newsletter.

20 Q. Does Blue Cross provide any interventions for members that may not have a chronic
21 illness but experience an acute illness?

1 A. Yes. We have what is known as episodic case management: This program manages
2 members who are experiencing a “single” and/or uncomplicated medical event where providing
3 support, direction and education is needed for a limited time.

4 Members are identified, screened and referred by the same methods described above and
5 are enrolled for approximately 1-4 weeks. Examples of episodic case management programs
6 include:

7 **Total Knee and Total Hip Program:** This telephonic outreach program provides
8 counseling to members preparing for knee or hip joint replacement surgeries and includes a
9 safety assessment of the home to promote a safe recovery. Once we are notified of the scheduled
10 admission, the nurse works with the member prior to admission through recovery. The program
11 was developed to support post hospitalization rehabilitation in the more cost-effective setting of
12 Skilled Nursing Facilities (SNF), rather than in the acute rehabilitation hospitals. Rehabilitation
13 in the SNF’s proved effective for members and cost effective for Blue Cross. In 2007, only 10 of
14 968 members undergoing total joint replacement recovered in the acute rehabilitation hospital
15 setting.

16 **Post Discharge Calls:** Calls are made to members following their discharge from an
17 acute inpatient facility to reassess the member’s needs, to ensure the discharge plan was
18 implemented effectively and to verify that the member is experiencing a safe recovery. These
19 calls typically include assessing overall physical condition, discussing caregiver concerns,
20 verifying that medical equipment was delivered, prescriptions obtained, and follow-up medical
21 appointments made, and assessing the member for referral to internal program offerings.

22 **Patient Advocate Program:** In this program the nurses conduct face-to-face visits to
23 members who are hospitalized at two in-state hospitals to assess their needs and provide

1 information on Blue Cross' program offerings. Collectively, we reached out to approximately
2 6700 members.

3 Q. Does Blue Cross evaluate these programs?

4 A. Yes, Blue Cross annually evaluates the effectiveness of our programs and their
5 impact on our members' health and well being. We received a Recognition of Excellence in
6 Disease Management Outcomes Award from the Disease Management Purchasing Consortium
7 (DMPC) in recognition of our performance in achieving the most improved outcomes among
8 organizations included in the DMPC database for inpatient and emergency room avoidance for
9 Asthma & Coronary Artery Disease. The analysis conducted by DMPC demonstrated Blue Cross
10 had reductions for calendar year 2006-2007 in both inpatient utilization and emergency room
11 utilization across all chronic conditions submitted (CHF, COPD, Asthma, Diabetes, CAD). The
12 only exception is Diabetes inpatient percent change which has increased; however, the DMPC
13 noted that if we did not have programs in place this would have been even higher. Utilization
14 changes for 2006-2007 are:

Percent change in ER Utilization	Percent change Inpatient Admits
Asthma -10.1%	-7.1%
CAD -11.7%	-11.5%
CHF -41.6%	-17.4%
COPD -13.4%	-9.5%
Diabetes -14.7%	9.0%

15
16 Q. Are any other types of evaluations done?

17 A. Yes. Blue Cross recognizes that there are other types of value to be gained from
18 our health management programs, other than financial savings.

19 Q. Please provide an example.

20 A. Certainly. Some programs produce very little financial savings, but improve
21 member health and help our members navigate the healthcare system. Such is the case for our

1 complex case management programs. Members that participate in our complex case management
2 program are those that typically have experienced a complex, acute catastrophic illness, or have
3 multiple disease conditions. For example, we work with parents whose children are born
4 prematurely and are in the neonatal intensive care unit, sometimes for months. These newborns
5 have multiple discharge needs including private duty nursing to teach parents how to work with
6 complex equipment such as a mechanical ventilator, monitoring of oxygen saturation and pulse
7 rate, and gastric tube feedings. Our nurse and social worker case managers work with the
8 parents to access additional resources and identify support services. Some examples include
9 eligibility for disability waiver programs; Parent Support Network; financial eligibility for
10 additional financial resources; identifying support from clergy, neighbors and relatives; and
11 referrals to mental health clinicians to help the family in coping with their complex situation. We
12 work closely with the parents/caregivers to educate them on identifying early warning signs and
13 symptoms of infections or complications and when to access their healthcare provider. We also
14 educate parents/caregivers on maximizing available benefits and navigating the complex
15 healthcare system. We work with parents to educate them on appropriate care and avoidance of
16 complications; we discuss options, like Synagis, to prevent respiratory syncytial virus (RSV)
17 which is common in premature infants, and educate them as to the benefits available to help
18 ensure their wellbeing through these difficult times.

19 Annually, we review our Case Management Program to determine what changes are
20 needed to ensure we are meeting the needs of our members. One opportunity we found was the
21 length of time that was spent from identification of a member that could benefit, until the time
22 we eventually reached out to the member. To reduce this time, we worked with the analytical

1 team to increase the frequency of our predictive model report. By doing this, we reduced the
2 timeframe by an average of 3 months.

3 Another example is our PCP Collaboration program. We recognize the value that results
4 from the case manager and physician having a discussion around the member's plan of care and
5 review medications, and we have extended the program to include reimbursement to nurse
6 practitioners and physician assistants as well. In addition, to accommodate our members'
7 schedules, we have extended our availability to 6:30 pm. Last, we survey members who have
8 participated in our programs to measure member satisfaction.

9 Q. What programs does Blue Cross have in place to assure the use of the least cost,
10 most appropriate setting?

11 A. Blue Cross performs utilization review on many services including inpatient
12 hospitalizations and acute inpatient rehabilitation to ensure the most appropriate setting of
13 services. In addition, Blue Cross performs utilization review on other selected services such as
14 durable medical equipment, certain injectable drugs and new technology.

15 Q. Does Blue Cross realize any savings with these programs?

16 A. Yes, during calendar year 2007, Blue Cross observed \$.93 pmpm net savings for
17 our Utilization Review programs.

18 Q. Please explain how Blue Cross supports use of evidence based, quality care.

19 A. Blue Cross has several programs that support evidence based quality care. They
20 are described below.

21 **Medical Policy:** The Blue Cross Medical Policy Department develops and maintains
22 guidelines and criteria for coverage of medical services. In addition, the department assists with
23 the management of plan benefits by ensuring that our policies are aligned with plan benefits,

1 national standard, new state and federal mandates and new technology. To ensure that changes
2 are addressed and our policies are up to date with current practice and evidence based literature,
3 all medical policies undergo an annual review. In addition to changes in technology, policies are
4 developed and/or modified for several reasons. For example, we may receive a request for a new
5 policy or modification to an existing policy from providers. Soliciting feedback from local
6 providers is part of the policy development process, and to facilitate this, all draft policies are
7 posted to the web for 30 days to allow all participating providers ample opportunity to provide
8 comments. Comments are reviewed and if applicable, incorporated into the policy. To
9 encourage requests for policy changes from our providers, our policy request form is available
10 on our website.

11 To further ensure that our medical policies reflect current standard of care, our Medical
12 Directors meet at least monthly to review reasons for overturned determinations. As part of our
13 ongoing effort to be responsive to member concerns, if we find a consistent pattern of overturned
14 determinations on a particular policy, the policy is reviewed again to be sure it is within current
15 evidenced based guidelines.

16 Net savings from our medical policy for calendar year 2007 were calculated to be \$.97
17 pmpm.

18 **Radiology:** The goal of this initiative has been to educate physicians regarding the
19 established guidelines for appropriate use of high-end imaging while at the same time reducing
20 the number of clinically inappropriate studies performed. In addition, this program has allowed
21 us to accurately monitor and track the high-end imaging ordering practices of our network
22 physicians. Beginning January 1, 2008, medical necessity review has now become a requirement
23 for high-end radiology services. Year one total savings are projected to be in excess of \$5 to \$6

1 million. Claims run out is required to provide an accurate dollar value, however Blue Cross is
2 seeing trends for Commercial, BlueCHiP for Medicare and Rite Care which historically have
3 been 6%, 7% and 13% respectively significantly reduced through the first 2 quarters of 2008,
4 and they are expected to remain relatively flat through year end 2008.

5 **Provider Profiling:** Provider Profiling is the process in which individual providers or
6 groups of providers are compared to others in their same specialty with regards to total annual
7 claims cost and overall outpatient service utilization. The data reviewed falls into several large
8 categories, including office visit services, diagnostic imaging, laboratory testing, and
9 surgical/procedural services. Individual providers are provided with an analysis of their practice
10 utilization data. If an analysis detects patterns of service utilization and cost that vary
11 significantly from the doctor's peers, and that cannot be justified, we work with the doctor to
12 demonstrate how they can practice more efficiently and in accordance with evidence-based
13 guidelines. Our Provider Profiling program helps to reduce instances of medically unnecessary
14 testing which leads to lower costs of care and ultimately to improvements in the overall quality
15 of care provided. When providers improve their efficiency and reduce the variability in their
16 practice, unnecessary expenditures are avoided and the quality of care may improve. Blue Cross
17 has found this program to have a definite return on investment over the last several years. In
18 2007, we contacted over 160 physicians as part of this process, either through site visits or
19 educational letters with an average savings of \$5,000 per year for each physician educated
20 through the program.

21 In addition, in cases of extreme outliers, the Provider Profiling program makes referrals
22 to our Special Investigations Unit for analysis of potential fraud issues. In several instances those

1 issues have been confirmed and have led to referral to the RI Attorney General’s Medicaid Fraud
2 Unit and/or the U.S. Attorney’s office for prosecution.

3 Blue Cross also has several pharmacy programs in place to ensure that services are being
4 effectively utilized. These are outlined below.

5 **Specialty Pharmacy Program:** Specialty drugs are high-cost injectable, infused, oral or
6 inhaled medications that typically result from advances in drug development research,
7 technology, and design. They have been the fastest growing segment of drug spending. At the
8 current growth rate, it is anticipated that specialty drug spend will double over the next four
9 years, accounting for more than 25% of all outpatient pharmacy spend by 2008. To address the
10 challenge of managing the utilization of these drugs, Blue Cross has begun, effective April 1,
11 2008, to direct specialty drug volume through a limited distribution network. Specialty
12 pharmacies provide cost savings, as well as enhanced clinical management of the patient.

13 Specialty drugs are best identified by their features. If a drug has some or all of the
14 following features, it may be included in the specialty pharmacy benefit:

- 15 • It treats chronic or long-term diseases that have little or no alternative therapies
- 16 • It targets underlying causes and conditions of a disease, and doesn’t just relieve
17 symptoms
- 18 • It requires customized clinical monitoring and patient support to reduce the risk of
19 undesirable outcomes and/or the potential for serious side effects
- 20 • It requires temperature control, special handling, or drug administration training
- 21 • It costs more than \$500 per prescription

22 This initiative will maximize opportunities to reduce the unit cost of the drugs, improve
23 the clinical management of specialty medications, and ensure appropriate utilization.

1 Administration of the formulary of drugs designated for inclusion in the Specialty Pharmacy
2 Program is overseen by the Specialty Pharmacy & Therapeutics Committee. This committee is
3 comprised of local physician specialists, including gastroenterology, rheumatology, oncology,
4 endocrinology and pulmonology. In addition, the Committee will seek advisory input from other
5 specialists as necessary to review drug products in a comprehensive manner for inclusion on the
6 formulary. The Committee will review and approve appropriate medical criteria required for
7 coverage to insure that the application of criteria is consistent with accepted standard of care
8 guidelines.

9 Blue Cross has established a clinically based education program focused on increasing
10 awareness of the appropriate and evidence based use of first generation antibiotics amongst
11 providers. Blue Cross utilizes a retrospective review program which evaluates the prescribing of
12 antibiotics and whether or not specific physicians could improve their prescribing practices in
13 this regard. This clinically based education program “reminds” doctors to prescribe antibiotics
14 appropriately, using first generation medications before moving directly to more costly
15 antibiotics.

16 **Member Generic Voucher Program:** Blue Cross has a voluntary generic voucher
17 program which targeted members who were filling prescriptions for brand name drugs that had a
18 generic equivalent available. The member receives a letter advising him/her that there was a less
19 expensive generic equivalent available. The member also receives a coupon or voucher which
20 allows him/her to obtain a one month’s supply of the generic at no cost. The Voucher Program
21 has now been in place for 2 years. In calendar year 2007, total savings attributed to the program
22 is \$210,000. Of this amount members received the benefit of \$58,000 in waived co-payments at
23 the pharmacy. The redemption rate for the vouchers mailed to members is stable at

1 approximately 22%. This program has no pre-determined targets for conversion. Only those
2 generic drugs that offer cost benefit savings are targeted for inclusion in the program. This is
3 because often generics that are new to the market have market exclusivity arrangements and do
4 not offer significant savings to claims cost expense.

5 **MedVantx Pilot Program:** Blue Cross continues its partnership with a company called
6 MedVantx to install ATM-like machines known as Sample Centers in physicians' offices across
7 the state. The Sample Center facilitates dispensing of a free 30-day sample of generic
8 medications. Participating physicians receive the Sample Center in their offices at no cost. Blue
9 Cross pays an administrative fee to MedVantx and also pays for the cost of the claim. Currently,
10 there are 38 sample centers installed with 170 providers having access to generic samples. On
11 average, there are 1,870 samples dispensed per month. Through the first 9 months of 2008, a
12 total of 16,816 samples have been dispensed by participants. The MedVantx Program increases
13 the dispensing of generic drugs and decreases the utilization of brand name medication leading to
14 a reduction in the overall drug expenditures and a reduction in member's out-of-pocket expenses.
15 Our overall generic dispensing rate has reached 64% across all lines of business. This program
16 targets practices with three or more providers in order to maximize use of the sample center.
17 Typically Family Medicine and Internal Medicine are the primary participants, rather than
18 specialists; however, we have recently begun to expand our outreach to several cardiology
19 practices.

20 **Over the Counter ("OTC") Option Program:** The OTC Options Program is a
21 voluntary program, designed to communicate to our members that OTC medications offer a safe,
22 effective, and lower-cost alternative to many brand-name drugs. For example, OTC loratadine
23 (Claritin) is generally lower cost than other drugs used to treat allergies such as Allegra,

1 Clarinex, or Singulair. Assume the cost of loratadine is \$6 versus the branded drug cost of \$80
2 per month. If a HealthMate Coast-to-Coast Direct member were to fill a prescription for
3 Clarinex, their copayment would be 50% or \$40 versus just \$6 if they used OTC loratadine.
4 Participants of this program are able to receive the OTC medication at no charge for a period of
5 12 months. The results of this program have been compiled and revealed significant savings as
6 measured by the total cost of care for these medications. When comparing a similar time period
7 for the year prior to the availability of this program, the out of pocket savings for members was
8 approximately \$475,000 and plan savings of \$280,000 for a total estimated savings of \$750,000
9 in drug costs. The products included in this program by definition need to offer clinically
10 equivalent therapy for targeted drug conversions along with OTC status. The program is
11 expanding to include stomach acid products such as Prilosec OTC and its generic equivalents as
12 alternatives to the prescription versions of these medications.

13 Q. Please describe what other programs and initiatives Blue Cross provides that
14 addresses the issue of affordability.

15 A. Blue Cross negotiates contracts with physicians, providers, facilities and a
16 pharmacy benefit manager with the goal of obtaining discounts which will reduce our overall
17 claims expenditure. In an effort to maintain market competitive physician fees and address
18 affordability, Blue Cross reviews our contracts and fee schedule annually with the goal of
19 maintaining the most reasonable fee schedule and discounts possible, encouraging cost effective
20 utilization, addressing the underlying cost of healthcare and resulting in simple and effective
21 administrative processes. Both hospital and physician payment strategies have guiding principles
22 that incorporate a component that focuses on paying for improved performance from a clinical
23 (quality of care) and from an efficiency (lower cost) stand-point.

1 The hospital contracts that are due for renewal in 2009 and 2010 will be closely
2 evaluated, and Blue Cross will seek to negotiate an appropriate rate of increase taking into
3 account premium affordability, hospital margins, efficiencies, approved Certificate of Need
4 projects and many other factors. Blue Cross will continue to attempt to negotiate the best
5 discounts reasonably possible from hospital charges. Keep in mind all of our subscribers
6 including our Direct Pay subscribers enjoy the benefits of our negotiated discounts when they
7 pay for hospital and physician services falling within their deductible responsibility. Moreover,
8 Blue Cross through the Blue Cross Blue Shield Association is able to realize savings through
9 negotiated discounts from hospital charges nationwide. The current savings associated with the
10 current discounts for this out-of-state hospital program amount to \$300,000,000 on an annual
11 basis corporate-wide. Direct Pay subscribers also directly benefit from these arrangements.

12 Blue Cross has also implemented a Hospital Pay for Performance (P4P) program. This
13 program provides financial incentives for specific quality improvement initiatives, focusing on
14 improvements related to systems, process and outcomes. The program emphasizes quality
15 improvement efforts endorsed by key stakeholder groups, e.g. CMS, The Leapfrog Group,
16 Institute for Healthcare Improvement. The program is coordinated through Blue Cross' clinical
17 staff who works closely with the hospital's quality improvement staff and clinicians. For
18 example, a process of care measure may be selected from CMS' Hospital Compare Program as
19 one initiative due to the specific hospital's poor performance relative to its peer group. Each
20 initiative has a defined improvement target that must be achieved within a specified timeline.
21 The program is individualized and flexible to address each hospital's unique opportunities. The
22 set of initiatives are collaboratively examined at the end of the evaluation cycle to determine if
23 new initiatives should be added and whether existing initiatives should be continued.

1 Under the Blue Cross program, hospitals are provided incentive funding if they achieve
2 specific targets that are collaboratively established. The approach is interactive and provides a
3 foundation for continual quality improvement. For example, we may focus on opportunities for
4 improvement relating to adult smoking cessation counseling (CMS), percent of surgery patients
5 whose preventative antibiotic(s) are stopped within 24 hours (CMS) or promoting computerized
6 physician order entry systems (Leapfrog Group).

7 **Centers for Excellence:** Blue Cross continues to promote the establishment of Blues
8 Distinction Centers of for Specialty Care in Rhode Island to reduce the migration of members to
9 institutions located outside of the state. As a result of this program, studies have shown a
10 significant decrease in readmission rates between designated Blue Distinction Cardiac Centers
11 and non-designated cardiac centers. We have also found the cost per cardiac event to be less at a
12 designated Blue Distinction Cardiac Centers than non-designated cardiac centers. Structure,
13 process and outcomes are measured and weighed to earn the designated distinction. Currently,
14 two hospitals have qualified for cardiac care and complex and Rare Cancers and one hospital has
15 qualified for bariatric surgery.

16 Q. Does Blue Cross have any contracts that promote cost-effective, quality care?

17 A. Yes. Blue Cross has been involved in (“P4P”) contracting with a number of PCP
18 groups over the last four years. These programs involve creating contracts that incentivize
19 doctors to provide high quality, cost-effective care, which is also measurable. This activity has
20 expanded over the last year, with more dollars at stake and more physicians involved in our
21 programs. In general, our pay for performance contracts take into account all the principles of
22 affordability as is outlined below.

- 1
- The implementation of Electronic Health Records: Blue Cross has created an
2 increased fee schedule for PCPs that have and utilize a qualified EHR in their
3 office. Providers are required to complete an annual application regarding
4 their EHR and frequency of use of various EHR functionalities to qualify for
5 the fee schedule. We now have supported, in total, over 300 PCPs in their
6 purchase and implementation of an EHR , and 125 of those physicians have
7 now qualified for the top tier fee schedule based on their use of those EHRs.
 - P4P measures have been put into place with some physician groups providing
8 financial compensation for generic prescribing rate above the Blue Cross
9 network average. As a result of this initiative one large physician group
10 increased their generic utilization from 52% to 63.5%.
 - Frequency of electronic prescribing: Through contract incentives one group
11 has been able to submit 74% of their prescriptions electronically in 2008.
12 (38.4% e-prescribed, 35.4% fax)
 - Childhood immunization scores: In 2007 a large group was able to achieve
13 95% pediatric immunization rates and the same group is expected to continue
14 to exceed the 90% target in their contract by the end of 2008.
 - Smoking cessation programs: One P4P initiative requires one group to achieve
15 a target of 85% in 2008 for the smoking cessation program and they are
16 currently on track to meet or exceed this target by year end.
 - Evidence based care of patients with diabetes: Blue Cross has implemented
17 performance measures to improve the quality of care for members with
18 chronic disease, such as diabetes (HgbA1c testing) and coronary artery
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1 disease (lipid profiles). In order to meet the contractual target, physician
2 groups have implemented administrative processes to verify the proper testing
3 for their chronically ill patients, as per evidence based guidelines. Examples
4 include:

- 5 • Building reports using real-time EMR data
- 6 • Sending lists of patients in need of testing to physicians
- 7 • Entering reminders into the EMR
- 8 • Mailing letters to patients
- 9 • Following up with specialist offices to obtain test results

- 10
- 11 • Discussions with members regarding end of life care/advance directives: Blue
12 Cross has implemented performance targets with several large physician
13 groups that incentivize those physicians to discuss advanced directives with
14 members. This has resulted in one group having advanced directives with 60%
15 of their BlueCHiP for Medicare members.

16 In addition, our Quality Counts program which was designed to incentivize PCPs to
17 purchase, implement, and utilize EHRs in their practices, now has 80 physicians who are in
18 various stages of electronic health record implementation and outcome reporting. Program
19 activity in 2007 remained focused on electronic health record implementation. In addition, one
20 physician practice implemented a care management program at the practice level, focused
21 primarily on Diabetes and physician office redesign (i.e. encouraging referrals to care manager
22 for outreach and TeamWorks group program). The care management program had some very
23 significant improvements in both clinical and process measures as follows:

24 **Clinical Outcomes:** Patients living with diabetes who had at least two HbA1c readings
25 (n=29) experienced a 10% decrease in the average HbA1c; of those with at least three HbA1c

1 results (n=14) they experienced an average HbA1c decrease of 20%; of those with at least 4
2 HbA1c results (n=4) they experienced an average HbA1c decrease of 46%.

3 **Process Outcomes:** The care manager facilitated a change in culture within the physician
4 practice by bringing in the chronic care model concept and organizing chronic condition
5 management educational events such as TeamWorks and Smoking Cessation. In addition, the
6 care manager has educated physicians on the primary goal of case management in the physician
7 office and an established rapport with the physicians to facilitate referrals to case management,
8 participate in care planning, and encourage patient participation. Moreover, one physician took a
9 lead role in creating documentation templates for the care manager to document her findings and
10 care plans directly into the electronic health record. This proved to facilitate communication
11 between the care manager and the physician as evidenced by increased referrals from physicians
12 over the course of the year.

13 Blue Cross' contracts with two large primary care groups in Rhode Island include
14 incentives to implement EHRs into their practices. Some physicians have successfully
15 implemented the EHR's into their practices and others are at various stages of active
16 implementation. We anticipate 170 physicians in these two practices will fully implement EHR's
17 by the end of the year.

18 Q. Does Blue Cross have any other programs that promote quality and efficiency?

19 A. Yes. Blue Cross provides support for programs that improve the quality for not
20 just our members but for the system as a whole. These are described below.

21 We continue to support the adoption and implementation of fully functional ambulatory
22 electronic health records ("EHR") into physician practices in Rhode Island. Many national
23 studies over the last several years support the concept that widespread use of EHRs lead to

1 improvements in quality of care and patient safety while at the same time reducing the overall
2 cost of care. Examples of our support for the adoption of EHRs include:

3 **Electronic Health Records of Rhode Island (“EHRRI”):** During 2008, we continued
4 our financial commitment by giving EHRRI \$850,000 (\$300,000 for infrastructure and \$550,000
5 for physician EHR purchase). Blue Cross has instructed EHRRI to provide additional funding to
6 provider practices that have just three physicians or fewer to offset the high cost of implementing
7 an EHR.

8 **RI Quality Institute (“RIQI”):** This organization, along with the Rhode Island
9 Department of Health, has taken the lead in the development of the statewide Health Information
10 Exchange. We are very much involved with the activities of RIQI. Our Chief Executive Officer,
11 Mr. James Purcell, is a major participant on their Board of Directors, and we support this group’s
12 activities financially with the largest annual contribution of any stakeholder.

13 Q. Do the programs you have described directly benefit the Direct Pay population?

14 A. Yes. These programs benefit all subscribers, including Direct Pay.

15 Q. Are the corporate-wide savings you alluded to above for programs and initiatives
16 relevant to the Direct Pay class?

17 A. Yes. All of the programs are applicable to Direct Pay and should benefit the
18 affordability of Direct Pay rates.

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