STATE OF MAINE
DIRIGO HEALTH AGENCY
211 WATER STREET, 53 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0053

JOHN ELIAS BALDACCI
GOVERNOR

KARYNLEE HARRINGTON
EXECUTIVE DIRECTOR

TO: Joint Committee on Appropriations and Financial Affairs
Joint Committee on Health and Human Services
Joint Committee on Insurance and Financial Services

FROM: Karynlee Harrington, Executive Director, Dirigo Health Agency

CC: Trish Riley, Director of Governor's Office of Health Policy and Finance
Dr. Robert McAfee, Chair of the Dirigo Health Agency Board of Directors

DATE: December 20, 2005

RE: Dirigo Health High-Risk Pool Report per Public Law 2003, chapter 469, Section 6971, 3.

I am pleased to present this report to the Committees on the status of the Dirigo Health High-Risk Pool as required by Chapter 469 of the Public Laws of 2003, Section 6971, 3. Per Chapter 469 of the Public Laws of 2003, Section 6971, 1 (A) (B) A plan enrollee must be included in the high risk pool if:

A. The total cost of health care services for the enrollee exceeds $100,000 in any 12-month period; or
B. The enrollee has been diagnosed with one or more of the following conditions: acquired immune deficiency syndrome (HIV/AIDS), angina pectoris, cirrhosis of the liver, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's Chorea, Juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, heart disease requiring open heart surgery, Parkinson's disease, polycystic kidney disease, psychotic disorder, quadriplegia, stroke, syringomyelia and Wilson's disease.

Request: Disease Management protocols, procedures and delivery mechanisms used to provide services to plan enrollees:

Response: Anthem Blue Cross and Blue Shield of Maine provide the Disease Management services to DirigoChoice members. Please find attached to this report an overview provided by Anthem Blue Cross and Blue Shield which describes the Disease Management protocols, procedures and delivery mechanisms used by Anthem Blue Cross and Blue Shield of Maine to provide services to DirigoChoice members.


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Request: The number of plan enrollees in the high- risk pool; the types of diagnoses managed within the high-risk pool; the claims experience within the high-risk pool and the number and type of claims exceeding $100,000 for enrollees in the high-risk pool.

Response: The data presented in this report is based on paid claims from January 1, 2005 through November 30, 2005.

1. January through November 2005 there was a total of 483 members identified for the high-risk pool of which 59 members have terminated coverage.

2. The number of plan enrollees currently enrolled in the Dirigo high-risk pool as of November 30, 2005 is 424; 418 are in the High Risk Pool based on diagnosis and 6 are in the High Risk Pool based on claims exceeding $100,000.

3. The types of diagnoses managed within the Dirigo high-risk pool are as follows:
   - Angina Pectoris
   - Coronary Occlusion
   - Cystic Fibrosis
   - Heart Disease Requiring Open Heart Surgery
   - HIV / AIDS
   - Hodgkin's Disease
   - Juvenile Diabetes
   - Leukemia
   - Metastatic Cancer
   - Motor or Sensory Aphasia-
   - Multiple Sclerosis
   - Myasthenia Gravis
   - Parkinson's Disease
   - Psychotic Disorders
   - Quadriplegia

4. The claims experience within the Dirigo high-risk pool for those specific diseases identified above are as follows:

	Member Count	Paid Amount
Angina Pectoris	39	$98,480.37
Coronary Occlusion	24	$561,342.04
Cystic Fibrosis	2	$218.81
Heart Disease Requiring Open Heart Surgery	7	$19,444.80
HIV / AIDS	9	$3,186.25
Hodgkin's Disease	5	$47,621.15
Juvenile Diabetes	50	$40,854.50
Leukemia	3	$405.78
Metastatic Cancer	9	$27,915.82
Motor or Sensory Aphasia	1	$1,979.26

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Multiple Sclerosis	16	$11,187.20
Myasthenia Gravis	2	$2,994.78
Parkinson's Disease	7	$6,377.13
Psychotic Disorders	329	$351,808.56
Quadriplegia	1	$555.94
Total	**504**	**$1,174,372.39**

The total paid amount for members identified in the high-risk pool based on diagnosis (including claims paid for the specific diagnoses identified above as well as for claims paid for services not related to the diagnoses above) is $5,534,998.

5. There are six DirigoChoice enrollees that were identified for the High-Risk Pool based on their claims exceeding $100,000. The total claims paid for these enrollees are $707,487. The diagnostic categories related to these enrollees are as follows: hematology, gastroenterology, neonatology, cardiology, malignant neoplasm (2).

6. The total number of DirigoChoice members that have been identified for the High-Risk Pool based on diagnoses and claims over $100,000 is 483 members. The total dollars paid for this group is $6,243,485. The number of members that have terminated coverage during this time period that were identified in the High-Risk Pool is 59.

DirigoChoice members with paid claims experience over $50,000 as a percentage of all paid claims during this period is 19.5%. This compares to Anthem Blue Cross and Blue Shield norm of 20.0%.

Lastly, the loss ratio for DirigoChoice for claims incurred January 2005 through September 2005 and paid through November 2005 is 73.2%. The member months representing this period are 46,940. Claims paid during this period total $11,655,067. A preliminary settlement will be made based on the DirigoChoice actual claim costs using paid claims through December 31, 2005. Six months after the end of the 2005 plan year, the final settlement will occur based on paid claims through June 30, 2006.

Once you have had an opportunity to review the information contained in this report please do not hesitate to contact me with questions.

Anthem

Disease management protocols, procedures and delivery mechanisms used to provide services to plan enrollees.

At Anthem Blue Cross and Blue Shield, our mission is to improve the lives of the people we serve and the health of our communities. Disease management initiatives represent one of our most effective methods of accomplishing this mission. We recognize that health improvement spans the entire continuum of care, from encouraging healthy lifestyles and early screenings to ongoing maintenance of chronic conditions. We are dedicated to identifying programs that will improve the health of our members across the entire continuum of care. Anthem's Regional Quality Steering Committee (RQSC) has direct oversight of all quality programs, including disease management programs. The Anthem Northeast region has implemented asthma, diabetes and cardiovascular disease management programs.

Disease Management Protocols and Procedures

We identify members with asthma, diabetes and cardiovascular disease and automatically enroll them in the appropriate program. Members can opt out, or decline the program. In addition members are stratified into the appropriate severity level. Member outreach is defined by the level of severity. Members considered "mild" or "level one" typically receive general education materials, while members at higher severities will receive increased levels of outreach, including reminders to obtain specific services, and enrollment in the plan's care management program. Further, the plan is committed to improving health outcomes for members with chronic disease. Each program has specified outcome results including HEDIS® and appropriate utilization metrics.

Attached is a program description for the asthma, cardiovascular and diabetes disease programs. These program descriptions include member identification, stratification protocols and outcome metrics for each program.

Delivery Mechanisms

We utilize a variety of delivery mechanisms, or member outreach, to provide information to members with chronic disease. This includes member newsletters, self management tools, home education materials, disease control centers available from *MyHealth@Anthem* powered by WebMD® on **anthem .com**, medication compliance information, disease specific calendars for diabetes and asthma, automated healthy reminder calls for screening tests, and telephonic care management for members who meet the criteria for the program. The plan also provides information and program interventions to the physician community, including practice guidelines, disease management tools and patient specific feedback, such as medication compliance reports. For a complete list of Delivery Mechanisms, please refer to the attachment.

Overview of Asthma Program

Anthem Blue Cross and Blue Shield implemented an asthma disease management program to improve the health of members with asthma. Asthma is a prevalent illness affecting persons of every economic level, demographic category and age group. Asthma is responsible for approximately 14 million missed school days for children and adolescents, and 14.5 million missed workdays for adults annually. However, asthma can be controlled with proper treatment.

The asthma program aims to: promote optimal access and appropriate utilization of services; teach self-management techniques; increase member understanding and awareness of the disease process; improve medication compliance; provide feedback, education and updated clinical guidelines to physicians; and build partnerships between the providers of care, member and health plan in order to ensure that members receive coordinated optimal care with improved outcomes.

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Anthem Blue Cross and Blue Shield
Asthma Disease Management Program

Member Identification and Stratification Protocols and Procedures

Member Identification for Program Participation		Plan members 5-56 years of age identified with administrative claims for asthma (ETGs 386-389) identified from Impact Pro risk stratification (an illness classification methodology that provides a medically meaningful statistical process to identify appropriate members).		
Enrollment Process		All members meeting the requirements of stratification criteria (see below) are automatically enrolled in the disease management programs. Members are given the opportunity to opt-out (or decline) the program, at which time their name is removed from any communication interventions and their name is logged into a central database to assure that they are excluded from further communications.		
Stratified Level 1 Criteria		**Stratified Level 2 Criteria**	**Stratified Level 3 Criteria**	**Stratified Level 4 Criteria**
Plan members 5-56 years old identified with asthma according to Impact Pro ETG criteria (ETG 386-389)		Plan members identified with asthma according to Level 1 criteria who had a prescription for any long-term control medications for the asthma ETGs	Plan members identified with asthma according to Level 1 criteria who had an ER visit and/or inpatient admission for asthma during the calendar year. Also, members identified with asthma according to Level 1 criteria who had a prescription for oral corticosteroid burst for the asthma ETGs	Members who meet criteria for Proactive Care Management
Level 1 Delivery Mechanisms		**Level 2 Delivery Mechanisms**	**Level 3 Delivery Mechanisms**	**Level 4 Delivery Mechanisms**
Pharmacy benefit member outreach initiative to improve medication use among members with asthma Asthma Wellness Member newsletter Access to *MyHealth@Anthem* powered by WebMD® on **anthem.com**, a monthly online		All Level 1 interventions Educational mailing on medications, when to call your provider, asthma control myths and facts. 2005 Asthma calendar which includes management information, a way to record daily peak flow 2005 asthma calendar survey	All level 1 and 2 interventions	All level 1, 2, and 3 interventions Member-specific telephonic care management to eligible members.

asthma newsletter, and a comprehensive asthma self care center					

Physician Asthma Interaction

Physician Asthma Interventions:

Physicians are involved in level of the Plan's disease management programs. Physicians are active participants in the Plan's quality improvement committee and they are also involved in the review of intervention materials, including practice guidelines, before distribution to members.

In regards to the asthma disease management program, providers receive the following interventions:

- Notification of a member's admission to the hospital for an asthma attack
- Pharmacy benefit management generated letters to providers regarding members utilization of asthma medications (overutilization of beta2agonists without use of inhaled corticosteroids)
- Notification of the Plan's chronic disease and prevention programs including information about the asthma program and program measures
- Notification regarding the availability of the asthma practice guidelines on line or hard copy, providing optimal pharmacotherapy, using asthma action plans and the MH@A asthma resource
- Physician newsletter/bulletin articles regarding the Plan's asthma HEDIS rates and the importance of following the guidelines and using asthma action plans.

Outcome Results

Measures	2002 Rate	2003 Rate	2004 Rate
HEDIS: Increase use of appropriate medications for asthma for members 5-56	71.5%	76.8%	78.6%
Decrease percent of members with 1 or more inpatient admission for asthma ages 5-56	1.8%	0.6%	0.5%
Decrease percent of members with at least one emergency room visit for asthma ages 5-56	7.5%	5.1%	5.5%

Overview of Cardiovascular Disease
Primary and Secondary Prevention Programs

Anthem Blue Cross and Blue Shield implemented a cardiovascular disease management program that focuses on members with high blood pressure as well as those members who have had a cardiovascular event (AMI, CABG, PTCA). The goals for this program include HEDIS♦ measures for blood pressure under control, cholesterol screening and management (LDL-C <130, and LDL-C<100) after a cardiovascular event, as well as beta-blocker treatment after a heart attack and long term adherence with beta blockers after a heart attack. In addition to these HEDIS♦ measures, the plan is also looking to increase the percentage of post cardiac event members who participate in a cardiac rehabilitation program.

The cardiovascular disease management program aims to: promote optimal access and appropriate utilization of services; increase member understanding and awareness of the disease process; teach self-management skills; provide care management services to appropriate members; improve medication compliance; tailor educational materials to meet each member's needs according to severity; and provide feedback, education and updated guidelines to physicians. Both programs work to build collaborations among providers of care, members and the health plans to ensure that members receive coordinated, optimal care and improved outcomes.

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Anthem Blue Cross and Blue Shield
Cardiovascular Disease Management Program

Member Identification and Stratification Protocols and Procedures

Member Identification for Program Participation		Members with Hypertension: Plan members age 48-85 years old with administrative claims data for essential hypertension as identified by Impact Pro Post Cardiac Event Members: Cholesterol screening and management: Plan members age 18-75 years old with administrative claims data for CABG, PTCA, and/or AMI as identified by Impact Pro Beta blockers after a heart attack: Plan members 35 years and older with administrative claims data for AMI as identified by Impact Pro				
Enrollment Process		All level 3 post event members are automatically enrolled in the CVD disease management program. Members are given the opportunity to opt-out (or decline) the program, at which time their name is removed from any communication interventions and their name is logged into a central database to assure that they are also excluded from any further communications. Level 3 Members with severe hypertension are invited to participate in a home education program and opt-in to the program.				
Stratified Level 1 Criteria		**Stratified Level 2 Criteria**		**Stratified Level 3 Criteria**		**Stratified Level 4 Criteria**
Plan members 46-85 years old with administrative claims data for essential hypertension AND no additional comorbid conditions		Plan members 46-85 years old with administrative claims data for essential hypertension AND hyperlipidemia		Plan members 46-85 years old with administrative claims data for essential hypertension AND/OR diabetes AND/OR CHF AND/OR Cardiac event AND/OR PAD (peripheral artery disease) AND/OR LVH (left ventricular hypertrophy)AND/OR nephropathy AND/OR retinopathy AND/OR angina AND/OR TIA (stroke-transient ischemic attack)) Plan members 18-75		Members who meet criteria for Proactive Care Management

				years old with administrative claims for AMI, CABG, PTCA		
Level 1 Delivery Mechanisms		**Level 2 Delivery Mechanisms**		**Level 3 Delivery Mechanisms**		**Level 4 Delivery Mechanisms**
Healthy Solutions general member newsletter articles Access to *MyHealth@ Anthem* powered by WebMD® at **anthem.com** which includes a comprehensive CVD self care center		All level 1 interventions *Wellness Landscape* newsletter chronic disease newsletter Targeted bi-annual newsletter regarding hypertension and cholesterol Post card mailing regarding the importance of cholesterol screening and management		All level 1 and 2 interventions Comprehensive home education programs for members with hypertension and/or post event members		All level 1,2 and 3 interventions Member-specific telephonic care management to eligible members
Level 1 Measures		**Level 2 Measures**		**Level 3 Measures**		**Level 4 Measures**
Blood pressure under control (HEDIS)		Blood pressure under control (HEDIS)		Blood pressure under control (HEDIS) Cholesterol screening after a cardiovascular event (HEDIS) Cholesterol management after a cardiovascular event (LDL <130 and LDL<100) (HEDIS) Beta blocker treatment after a heart attack (HEDIS) Long term adherence with beta blockers after a heart attack (HEDIS)		Same as Level 3 Measures

				Participation in Cardiac Rehabilitation		

Physician Interaction

Physician CVD Interventions:

Physicians are involved in level of the plan's disease management programs. Physicians are active participants in the plan's quality improvement committee and they are also involved in the review of intervention materials, including practice guidelines, before distribution to members.

In regard to the CVD disease management program, providers receive the following interventions:

ACE, beta blocker, and/or statin compliance programs which include information regarding patient medication compliance (including a medication history)

PCP newsletter mailing to review CVD program and highlight important practice guideline indicators as well as informing providers of CVD HEDIS® rates

Cardiovascular disease practice guidelines highlighting blood pressure under control, cholesterol screening and management after a cardiovascular event and compliance with beta blockers

Physician newsletter/bulletin regarding CVD HEDIS® rates and disease management programs

Outcome Results

Measures	2002 Rate	2003 Rate	2004 Rate
Increase the percent of members with blood pressure under control (≤140/≤90)	60.71%	61.83%	71%
Maintain or increase the percent of members with beta blocker treatment after a heart attack	97%	96%	97%
Increase the percent of members with long-term adherence with beta blockers after a heart attack	NA	NA	76.2%
Increase the percent of members with a cholesterol screening after acute cardiovascular event	81.25%	83.49%	83.5%
Increase the percent of members with cholesterol management after acute cardiovascular event (LDL<130 mg/dL)	67.41%	67.45%	70%
Increase the percent of members with cholesterol management after acute cardiovascular event (LDL<100 mg/dL)	NA	46.7%	47.6%
Increase the percent of members who participate in a cardiac rehabilitation program after a cardiovascular event	NA	NA	41.3%

Overview of Diabetes Program

Analysis of plan data reveals that diabetes has a significant impact on Maine members. From ETG data 3/1/03 to 2/29/04, Anthem Blue Cross and Blue Shield in Maine managed care products had an annual diabetes prevalence of 25/1000 and diabetes ranked 6th in claims costs. The plan has been monitoring diabetes outcomes since the mid 1990s and has seen consistent improvement in all measures.

The diabetes program aims to: promote optimal access and appropriate utilization of services; teach self management techniques; increase member understanding and awareness of the disease process; improve medication compliance; and provide feedback, education and updated clinical guidelines to physicians. The health plan strives to build partnerships between the providers of care, the member and the health plan in order to ensure that members increase coordinated optimal care with improved outcomes.

Anthem

Anthem Blue Cross and Blue Shield
Diabetes Disease Management Program

Member Identification and Stratification Protocols and Procedures

Member Identification for Program Participation		Plan members 18-75 years of age identified with administrative claims for diabetes identified from Impact Pro risk stratification (an illness classification methodology that provides a medically meaningful statistical process to identify appropriate members).		
Enrollment Process		All members meeting the requirements of stratification criteria (see below) are automatically enrolled in the diabetes disease management program. Members are given the opportunity to opt-out (or decline) the program, at which time their name is removed from any communication interventions and their name is logged into a central database to assure that they are excluded from further communications.		
Stratified Level 1 Criteria		**Stratified Level 2 Criteria**		**Stratified Level 3 Criteria**
Plan members 18-75 years old with diabetes (according to Impact Pro ETG criteria) who are compliant with the following in the past year: HbA1c, dilated retinal eye exam, LDL-C, and microalbumin		Plan members 18-75 years old with diabetes (according to Impact Pro ETG criteria) who are non compliant with one or more of the following tests in the past year: HbA1c, dilated retinal eye exam, LDL-C, and./or microalbumin		Members who meet criteria for Proactive Care Management or Admission Based Care Management
Level 1 Delivery Mechanisms		**Level 2 Delivery Mechanisms**		**Level 3 Delivery Mechanisms**
Diabetes calendar mailing *Wellness Landscape* chronic disease newsletter *Healthy Solutions* general member newsletter articles *MyHealth@Anthem* powered by		All level 1 interventions Automated telephone reminders to non compliant members Reminder mailings to get important health exams and tests Mailed literature regarding importance of non-compliant exams		All level 1 and 2 interventions Member-specific telephonic care management to eligible members

WebMD® interactive Web site contains Diabetes Condition Center and ability to subscribe to an e-diabetes newsletter. *Special Offers @Anthem* provides access to discounts for medical ID jewelry and medication reminders.		
Level 1 Measures	**Level 2 Measures**	**Level 3 Measures**
Dilated retinal eye exams (HEDIS) HbA1c testing - once a year (HEDIS) HbA1c > 9 (HEDIS) LDL screening (HEDIS) LDL control (<130 and <100) (HEDIS) Nephropathy screening	Same as Level 1	Same as Level 1 and 2

Physician Interaction

Physicians are active participants in the plan's quality improvement committee and they are also involved in the review of intervention materials, including practice guidelines, before distribution to members.

In regard to the Diabetes disease management program, providers receive the following interventions:

ADA Diabetes guidelines available to PCPs and specialists
Provider newsletter/bulletin article regarding diabetes related topics.
Physician newsletter/bulletin regarding Diabetes HEDIS® rates and disease management programs.
Office tools to help members with diabetes self-management.

Anthem

Outcome Results

Measures	2002 Rate	2003 Rate	2004 Rate
Increase the rate of HbA1c testing	89.18%	90.83%	95.27%
Decrease the rate of HbA1c >9.5 (2002); >9.0 (2003)	23.38%	20.74%	21.08%
Increase the rate of Diabetic Eye Exams	73.16%	65.28%	72.04%
Increase the rate of lipid (LDL) screening	87.45%	87.99%	94.19%
Increase the rate of lipid control (LDL<130)	45.67%	57.42%	68.82%
Increase the rate of nephropathy screening	58.87%	51.09%	58.92%
Increase the rate of lipid control (LDL<100) NEW for 2003	NA	31.22%	45.59%