



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans



Medicare Advantage: Improving Care Through Prevention, Coordination and Management



**Blue Cross and Blue Shield
Plan Initiatives to Improve
Care for People with Medicare**

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Executive Summary

One of the greatest challenges facing the Medicare program is managing the care for the increasing numbers of beneficiaries with chronic illnesses. A study by Ken Thorpe of Emory University traced virtually all growth in Medicare spending from 1987 to 2002 to a 20 percent increase in the share of Medicare patients receiving treatment for five or more conditions and predicted that the factors responsible for this growth are likely to continue.

Eighty-two percent of Medicare beneficiaries have at least one chronic condition and 65 percent have multiple chronic conditions and account for 95 percent of all Medicare expenditures.¹ Some of the most costly and prevalent chronic diseases, such as heart disease, diabetes, chronic obstructive pulmonary disease, asthma, and heart failure, are also ones where adverse events can be avoided with better management.

The traditional Medicare program faces significant challenges in managing care for those with chronic illness. According to a report by the Institute of Medicine (IOM), traditional Medicare delivers care that is often fragmented as patients move among different physicians and care settings, and “does little to encourage coordinated, preventive, and primary care that could save money and produce better health outcomes.”²

For the 8.5 million beneficiaries enrolled in Medicare Advantage (MA), a single entity is responsible for providing coverage of all benefits. MA plans provide traditional Medicare benefits plus supplemental coverage in a comprehensive plan whose reimbursement structure encourages a focus on prevention and care coordination, reduces financial barriers to care, and creates an environment that fosters quality care and satisfaction among members.

Medicare Advantage plans have ongoing initiatives to improve care for those with chronic conditions. MA plans identify and provide support to those who could benefit from more specialized care or who have not received recommended preventive care. Through partnerships with physicians and other caregivers, MA plans work to coordinate and improve care for these beneficiaries.

The National Committee for Quality Assurance’s *State of Health Care Quality 2006* documented significant quality improvements in Medicare Advantage plans across multiple health conditions, including improved treatment after heart attack, improved colorectal cancer screening rates, and increased numbers of members whose high-blood pressure is controlled.³

The profiles in this report describe examples of the innovative ways that Blue Cross and Blue Shield Medicare Advantage plans are improving care for Medicare beneficiaries:

- *Blue Shield of California's Congestive Heart Failure Program* is coordinating care through a team of physicians and nurses using special home monitoring equipment. The program reduced expected inpatient admissions and emergency room visits in 2005 by about 20 percent.
- *Highmark Blue Cross Blue Shield's Colorectal Cancer Screening Program* increased screening rates by over 9 percent from 2003 to 2005; its *Osteoporosis Management Program* had a 9 percent increase in members receiving management services after a bone fracture; and its *Diabetes Disease Management Program* demonstrated improvement in HEDIS® diabetes care measures, with scores that exceeded national averages in all measured areas.
- *Independence Blue Cross (IBC)'s Connections Health Management Program* – by providing specialized care to beneficiaries with the five most common chronic illnesses – reduced inpatient days while achieving a very high member satisfaction rate. IBC's *Connections Kidney Program* resulted in 12 percent fewer emergency room visits than expected and 19 percent fewer days at a skilled nursing facility than expected in its first year.
- *Blue Cross and Blue Shield of Massachusetts* implemented a comprehensive disease management program for members with heart failure that has shown significant improvement in perceived quality of life for participants.
- *Blue Cross and Blue Shield of Michigan* provides a comprehensive spectrum of wellness, disease and symptom management, as well as case management opportunities for Medicare Advantage beneficiaries to take an active role in improving their health.
- *Blue Cross and Blue Shield of Florida* has implemented multiple initiatives aimed at improving the quality of health care delivered to Medicare Advantage members, including disease management, complex care management and population health initiatives. BCBSF's HEDIS scores consistently exceed national benchmarks.
- *Blue Cross and Blue Shield of Minnesota* partners with the State of Minnesota to offer a Medicare Advantage Special Needs Plan that provides a coordinated care delivery system for the most vulnerable Medicare population: frail, elderly Minnesotans with low incomes.
- *WellPoint's Diabetes Disease Management Program*, which includes case management, member interventions and a provider pay-for-performance program, resulted in consistent improvement of HEDIS measures in diabetes care.

Introduction

In just four years, the first of the baby boom generation will turn 65. In the ensuing 20 years, one in five Americans will be over age 65. These demographic changes will place enormous financial pressure on Medicare – pressure which the current program is ill-equipped to handle.

The Congressional Budget Office (CBO) estimates that federal spending on Medicare will grow from \$331 billion in 2006 to \$524 billion in 2011. The increasing incidence of chronic disease in the Medicare population is a critical factor leading to this cost growth. A recent study by Ken Thorpe of Emory University traced virtually all growth in Medicare spending from 1987 to 2002 to a 20 percent increase in the share of Medicare patients receiving treatment for five or more conditions during a year.⁴

Eighty-two percent of Medicare beneficiaries have at least one chronic condition and 65 percent of Medicare beneficiaries have multiple chronic conditions and account for 95 percent of all Medicare expenditures.⁵ Some of the most costly and prevalent chronic diseases, such as heart disease, diabetes, chronic obstructive pulmonary disease, asthma and heart failure, are also ones where adverse events can be mitigated or avoided with better management.

Traditional Medicare faces significant challenges in managing care for those with chronic illness as a result of its current emphasis on fee-for-service (FFS) payments. According to a report by the Institute of Medicine (IOM), traditional Medicare delivers care that is often fragmented as patients move among different physicians and across different care settings, provides few disincentives for overuse of high-cost medical services and “does little to encourage coordinated, preventive, and primary care that could save money and produce better health outcomes.”⁶

“The current Medicare fee-for-service payment system is unlikely to promote quality improvement because it tends to reward excessive use of services, high-cost, complex procedures, and lower quality care.” (Institute of Medicine, September 2006)

In its June 2006 report to Congress, the Medicare Payment Advisory Commission (MedPAC) found that only two-thirds of beneficiaries received necessary care for 20 out of 32 indicators. The MedPAC report goes on to explain that “care coordination is more difficult to do in the FFS program because it requires managing patients across settings and over time, neither of which is supported by current payment methods or organizational structures.”⁷

“The strongest incentives in the Medicare program to coordinate care are through the Medicare Advantage (MA) program. Because CMS pays MA plans a capitated amount for all of the enrollee’s care, the plan has an incentive to ensure that beneficiaries with complex needs are well managed across settings and over time.” (MedPAC, June 2006)

For the 8.5 million beneficiaries enrolled in Medicare Advantage, a single entity is responsible for providing coverage of all benefits. MA plans provide traditional Medicare benefits plus supplemental coverage in a comprehensive plan whose reimbursement structure encourages a focus on prevention and care coordination, reduces financial barriers to care, and creates an environment that fosters quality care and satisfaction among members.

“Because Medicare Advantage (MA) plans generally have lower out-of-pocket costs than traditional Medicare, enrollment in MA plans could theoretically help improve beneficiaries’ access to care and reduce financial barriers to care. With their potential to emphasize preventive, chronic, and coordinated care, MA plans could benefit many minorities.” (National Academy of Social Insurance, October 2006)

The advantages of Medicare Advantage include:

- **Focus on preventive/primary care and coordination of care.** MA plans place a strong emphasis on preventive health care services that help keep beneficiaries healthy, detect diseases at an early stage, and avoid illnesses. In addition, Medicare HMOs, which still comprise the majority of MA plans, have primary care providers who are assigned responsibility for the care coordination of their patients. In this way, duplication of services as well as risks for inadvertent adverse drug or treatment interactions are reduced for plan members because there is a single point of responsibility for care coordination.

A National Academy of Social Insurance (NASI) report recommends an increased focus on care coordination as one way to reduce racial and ethnic health disparities in Medicare. In its recommendations on ways to improve quality of care, NASI recommends encouraging “organized care management processes” including care coordination, self-care education for patients, and reminders for preventive health visits as well as reminders to physicians at the point of care and enhanced communication between providers and patients.⁸

- **Chronic care improvement/disease management.** While demonstration projects and pilot programs are currently introducing chronic care management into traditional Medicare, disease management has long been offered by Medicare Advantage plans. These programs seek to better coordinate health care to improve the health status of those with the most common and costly chronic conditions such as diabetes, heart disease, and asthma. These programs focus on reducing health care costs and improving quality of life for those with chronic disease conditions over the entire course of a disease, rather than focusing on individual episodes of care.
- **Reduced financial barriers for MA enrollees.** Medicare Advantage plans provide all Medicare covered benefits plus additional benefits not covered by traditional Medicare. Many of these extra benefits come in the form of lower cost-sharing. MA plans tend to have fixed copayments and most have a limit on total out-of-pocket costs. A 2005 CMS analysis estimated that beneficiaries in MA plans save about \$82 a month or nearly \$1,000 a year when compared to the out-of-pocket costs for beneficiaries in traditional Medicare.

- *Innovation.* Since most, if not all, MA plans are sponsored by organizations that serve non-Medicare members, Medicare Advantage organizations can transfer their best practices and proven programs developed for major employers and other private purchasers to their Medicare programs. Health plans have much more flexibility to implement ever-evolving improvements than traditional Medicare, due to its statutory limitations.

The profiles described in this report showcase some of the innovative ways in which Medicare Advantage plans are contributing to improved care for Medicare beneficiaries. The profiles highlight disease management programs targeting specific chronic conditions, broader population health initiatives such as influenza vaccination and colon cancer screening initiatives, pharmacy management programs that target members not taking recommended medications, and a Special Needs Plan that serves a low-income frail elderly population.

Blue Plan Profiles

The case studies described in this report showcase a number of initiatives underway at Blue Cross and Blue Shield Plans that illustrate many of the ways in which Medicare Advantage plans are contributing to improved care for Medicare beneficiaries.

Some of these programs target patients with specific diseases such as heart disease, diabetes, chronic obstructive pulmonary disease, asthma and heart failure, where better management can help avoid adverse events and reduce costs. Others target a broad range of chronic conditions, with particular emphasis on improving care for those with multiple chronic conditions.

These programs, which are only a small sample of programs underway among Blue Cross and Blue Shield Plans, highlight interventions that include:

- *Education and support* programs that provide members with educational materials on their conditions through telephone calls, mailings or videos. These programs are designed to enhance members' understanding of their conditions and to help them manage their care.
- *Health "coaching"* initiatives that provide access to nursing professionals to help educate members about their health conditions, encourage positive lifestyle changes, promote self-care, and make more informed decisions about treatment options.
- *Case management programs* that provide more intensive outreach to those with complex conditions to support specific interventions and assist in the coordination of care through collaboration with members and their health care professionals.
- *Broad population health initiatives* that are designed to improve the rates at which members receive recommended preventive care, such as influenza vaccinations and colon cancer screening, through reminders to members and their health professionals.
- *Collaborations with health professionals* that include such activities as providing notices for member screenings, reports regarding performance on care measures, financial rewards for providing high-quality care, and education materials on chronic care management.
- *Pharmacy management programs* that encourage members to take recommended medications.
- *A Special Needs Plan* that is designed to improve care for frail, low-income elderly by offering a complete range of coordinated benefits through integrating Medicare, Medicaid and other programs.

While some of these initiatives are still evolving, others have a proven track record of producing results, including improvements in key measures of diabetes care, improved colorectal cancer screening rates, reduced inpatient admissions and emergency room use by patients with congestive heart failure and improved osteoporosis management for members who had suffered a bone fracture. Moreover, it is clear that members value these programs, as evidenced by high rates of satisfaction.

Congestive Heart Failure Program

Blue Shield of California

Blue Shield of California's Congestive Heart Failure Program coordinates personalized care through the collaborative effort of a team of physicians and nurses using special home monitoring equipment. The program reduced expected inpatient admissions and emergency room visits in 2005 by about 20%.

Background

Blue Shield of California offers a disease management program for Medicare Advantage HMO members with congestive heart failure (CHF). The program is designed to manage the health of members with significant symptom-limiting CHF and presenting co-morbidities. Key components of the program include coordination of participants' medical management in collaboration with a medication therapy management initiative and facilitating timely intervention with the participant's physician.

Target Population

Members with CHF are further screened for co-morbidities, including all medical conditions and cognitive impairments. A total of 499 MA members were identified during 2005 as potential candidates for this program. Further screening of those 499 members yielded 151 qualified referrals.

Key Program Elements

Clinical interventions are supported by evidence-based guidelines and promote a collaborative relationship between physicians and members. An individualized, goal-oriented care management plan is developed that addresses the member's CHF and all presenting co-morbidities. This plan includes:

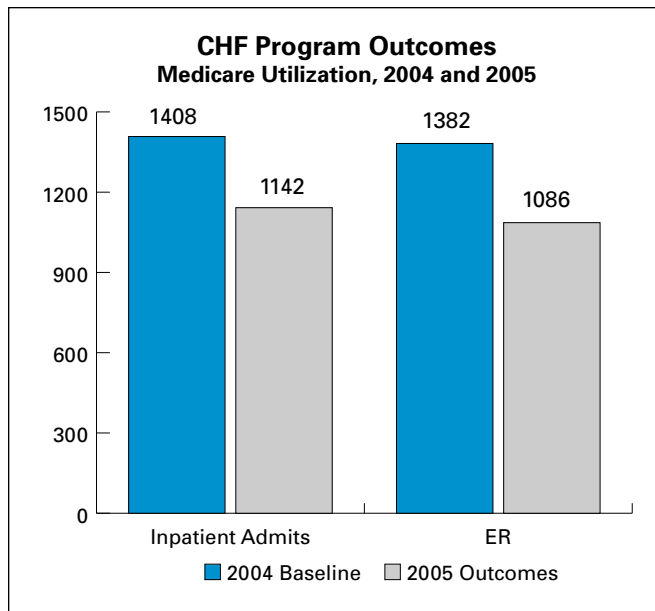
- Designated point of contact for participant
- Daily monitoring of symptoms through use of electronic data transmission from the participant's home
- Identification and reporting of symptoms for timely intervention by the managing physician
- Personalized education from nurse case managers
- Education for physicians and other providers
- Collaboration with physicians and other providers
- Provision of information about hospice care, pain and palliative care, and end-of-life care

This care plan is executed via member-nurse telephone intervention. Frequency of nurse contacts is member and condition specific.

Results

An analysis of 2005 data shows strong program results:

- Enrollment: 62.3 percent of targeted Medicare Advantage members, or 94 of the 151 qualified referrals were enrolled in the program in 2005.
- Utilization:
 - Inpatient admissions decreased 18.9 percent from 2004 to 2005.
 - Emergency room utilization decreased 21.4 percent from 2004 to 2005.



- Member Satisfaction:
 - In 2005, 98 percent of members reported overall satisfaction with the program as “Excellent,” “Very Good,” or “Good.”
 - In 2005, 99 percent of members responded they would recommend the program to others.
- Medication Compliance: For members enrolled in the program for longer than six months, medication compliance was strong. At year-end 2005, the percent of these members using an ACE inhibitor (ACEI) or an angiotensin receptor blocker (ARB) was 98 percent.

Colorectal Cancer Screening Program

Highmark Blue Cross and Blue Shield, Pennsylvania

Highmark Blue Cross and Blue Shield's Colorectal Cancer Screening Program increased screening rates by over 19% from 2003 to 2005.

Background

Colorectal cancer is the third most common cancer among both men and women in the United States; more than 148,000 new cases of colorectal cancer will be diagnosed in 2006. However, colorectal cancer screening rates are lower than those for other common cancers. In an effort to help Medicare Advantage members understand the importance of colorectal cancer screening, Highmark BCBS focuses ongoing efforts on interventions that have improved colorectal cancer screening rates.

Target Population

All Medicare Advantage members between the ages of 65 and 80.

Key Program Elements

- *Education and support.* Through its condition management program, Highmark distributes to its members a videotape developed by the Foundation for Informed Medical Decision Making. The video is designed for people age 50 to 80, who are at average risk for colon cancer, to help decide whether to have screening, and which type of screening to choose. Highmark also distributed free DVDs from the American Cancer Society to provider offices for viewing in waiting rooms. The DVDs explain available screening options to seniors. Highmark published educational articles on colorectal cancer screening in member newsletters to increase their understanding of the importance of colorectal cancer screening.
- *Telephone outreach.* In the spring of 2006, an Interactive Voice Recognition educational telephone outreach campaign was delivered to approximately 72,115 Medicare members, informing them of the importance of colorectal cancer screening and types of screening, as well as soliciting feedback on barriers to receiving screening.
- *Collaboration with health care providers.* Highmark has been working closely with primary care physicians to identify ways to improve colorectal cancer screening, including identifying “best practices” and sharing office protocol. Highmark also published educational articles on colorectal cancer screening in physician newsletters, and provided links to free continuing medical education. Annual publication of Preventive Health Guidelines on the Highmark provider resource center website keeps Highmark providers up to date with the national standards and recommendations.

Results

The colorectal cancer screening measure estimates the percentage of adults 50-80 years of age who have had appropriate screening for colorectal cancer. Since 2005, Highmark's HEDIS rates for its Medicare members for colorectal cancer screening have demonstrated substantial improvement.

In 2005, the most recent measurement year, Highmark's rates for colorectal cancer screening for its Medicare Advantage population were above the national average as determined by the National Committee for Quality Assurance.

Highmark HEDIS Medicare HMO Rates			
2003 Measurement Year	2004 Measurement Year	2005 Measurement Year	2005 National Average
50.12%	55.75%	59.85%	53.90%

Improving Outcomes for Medicare Members with Diabetes

Highmark Blue Cross and Blue Shield, Pennsylvania

Highmark Blue Cross and Blue Shield improved outcomes for members with diabetes by implementing a diabetes care management program that integrated outreach and education, health coaching, and collaboration with health professionals. Highmark's rates for all measurements for its Medicare diabetic population were above national averages established by the National Committee for Quality Assurance.

Background

In an effort to help Medicare Advantage members with diabetes better control their condition and avoid complications, Highmark has focused on member and practitioner interventions that have improved the rate of diabetes-related screenings.

Target Population

Currently, there are nearly 50,000 Medicare Advantage members identified as having a diagnosis of diabetes who are eligible for this program.

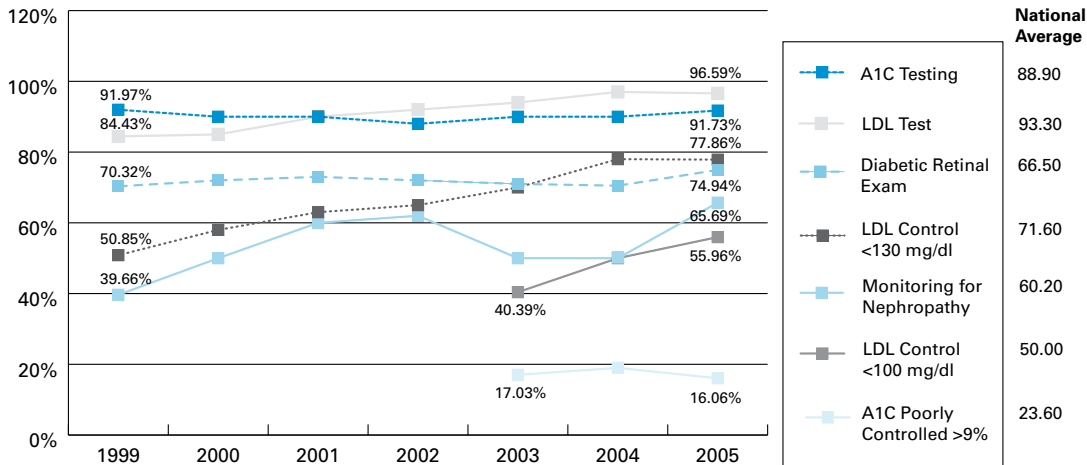
Key Program Elements

- **Member education.** Members newly identified with diabetes and diabetics with gaps in testing receive mailings that include periodic member newsletters containing up to date information on diabetes and personal nutrition counseling.
- **Telephone contacts and health coaching.** Program participants receive support via inbound and outbound access to trained health coaches 24 hours a day, 7 days a week. In 2006, Interactive Voice Recognition educational telephone outreach was added.
- **Collaboration with health care providers.** Highmark sends biannual reports to members' primary care physicians to alert them about critical screenings for their patients with diabetes. The reports also indicate co-morbid conditions that could impact these patients. Additional support to health care providers includes:
 - Annual adoption and dissemination of clinical practice guidelines for diabetes
 - Ongoing education via physician newsletters and free continuing medical education
 - Provider resources available online and via CD
 - A Pay for Performance Quality Incentive Program that offers a financial reward for providing efficient, high-quality health care that includes quality indicators for diabetes

Results

Since 2000, Highmark’s HEDIS rates for its Medicare HMO members with diabetes have demonstrated improvement in all measured areas, including blood glucose (A1C) testing and control, LDL cholesterol testing and control, diabetic retinal exams, and monitoring for nephropathy. In 2005, the most recent measurement year, the Comprehensive Diabetes HEDIS Measure included 21,855 eligible Medicare Advantage HMO members using National Committee for Quality Assurance (NCQA) criteria. Highmark’s rates for all measurements for its Medicare diabetic population were above the national average as determined by NCQA.

Highmark Medicare HMO HEDIS Rates – Comprehensive Diabetes Care 1999 – 2005 Measurement Years



Improving Osteoporosis Management

Highmark Blue Cross and Blue Shield, Pennsylvania

Highmark Blue Cross and Blue Shield's Osteoporosis Management Program demonstrated a 9% increase in members receiving management services after a bone fracture from 2003 to 2005 through enhancing outreach and collaboration with physicians.

Background

In an effort to help Medicare Advantage members understand osteoporosis and their previous fractures as a risk-factor for potential future fractures, Highmark has focused on member and practitioner interventions that have improved the rates of osteoporosis management post fracture.

Target Population

Female members age 65 and older who had suffered a fracture during the measurement year (excluding fractures of fingers, toes, faces, or skulls).

Key Program Elements

- **Mailings and incentives.** In 2005, Highmark sent 1,165 letters to female members age 65 and older who had a fracture. The purpose of the letter was to educate these members about osteoporosis and its prevention and to encourage these women to discuss bone mineral density testing and medications with their health care providers. An incentive, in the form of a pill box, was offered to those members who took the letter to their provider and had it signed. In addition, information about the Highmark Osteoporosis Prevention and Education (HOPE) program was detailed in member newsletters.
- **Telephone outreach.** In the fall of 2005, an Interactive Voice Recognition educational telephone outreach campaign was delivered to 1,563 Medicare members who were identified as having had a fracture.
- **Collaboration with health care providers.** Highmark published educational articles on osteoporosis in physician newsletters, provided links to free continuing medical education programs and sent letters to physicians treating women who had suffered fractures, reminding them to order bone mineral density testing and to consider medications to treat or prevent osteoporosis in these members.

Results

From the time that Highmark first began to analyze data for osteoporosis management post fracture in 2003, Highmark's rates on osteoporosis management have improved from 38.85 percent to 42.32 percent in 2005. The 2005 rate far exceeds the national average of 20.1percent established by National Committee for Quality Assurance.

Highmark HEDIS Medicare HMO Rates				
Measure	2003 Measurment Year	2004 Measurment Year	2005 Measurment Year	2005 National Average
Osteoporosis Management Post Fracture	38.85%	40.34%	42.32%	20.1%

Connectionssm

Independence Blue Cross, Pennsylvania

Independence Blue Cross (IBC)'s Connections Health Management Program – by providing specialized care to beneficiaries with the 5 most common chronic illnesses – reduced expected inpatient days while achieving very high member satisfaction rates. IBC's Connections Kidney Program resulted in 12% fewer ER visits than expected and 19% fewer days at a skilled nursing facility than expected.

Background

Independence Blue Cross (IBC) launched the Connectionssm Health Management Program in 2003. The program focuses on the five most common chronic diseases: asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart failure, and coronary artery disease. It also provides decision support services to members facing significant medical decisions. IBC expanded this program in 2004 with a program to support members with chronic kidney failure. In 2005, IBC added a program for individuals with any of 15 complex chronic conditions, and expanded this to a 16th condition in late 2006.

Connections Health Management Program

Target Population

Program participants are identified and stratified into risk groups. Health care practitioners and case managers may also refer members to the program, and individuals can self-refer. Since its inception in 2003, nearly 85,000 Medicare Advantage HMO and PPO members have been identified as eligible for the program (i.e., as having one of the five targeted conditions).

Key Program Elements

- **Mailings and reminders.** All participants identified with one or more of the five chronic conditions receive mailings with condition-specific information, along with reminders to schedule recommended treatments and procedures
- **Ongoing health coaching.** Members have 24/7 access to health coaches who are registered nurses, dietitians, or respiratory therapists. Members stratified as high risk receive phone calls from coaches. They help members understand and follow physicians' treatment plans; and on average, contact members 5-7 times per year.
- **Enhanced decision support.** Members can speak with health coaches to discuss treatment options for a variety of medical conditions, including back pain, cancer, weight loss surgery, and women's and men's health issues.

Results

- In 2006, IBC's Connections Programs were awarded the "Disease Management Leadership Award for Outstanding Health Plan" from the Disease Management Association of America.
- A 2005 survey of all IBC members found 87 percent of members "satisfied" or "very satisfied" with health coaches' services; 90 percent said they would recommend the program to others.

- Year 1 program results indicated that there was a 1.5 to 2 percent reduction in medical cost trend across all eligible IBC members. For Medicare Advantage members, Year 2 results indicated savings in medical cost trend ranging from 3-5 percent. For both years measured, inpatient days for MA members were 9-14 percent less than expected and professional services for these members were 11-16 percent less than expected.

Connections Kidney Program

Target population

This program targets members with end-stage renal disease (ESRD) who are receiving dialysis. There are currently 351 Medicare members with ESRD in the program.

Key Program Elements

- *Contacts and assessments.* Initial contact from program enrollment staff is followed by contact from experienced dialysis nurses, who conduct clinical assessments and meet with participants at their dialysis sites or at home.
- *Care coordination.* Based on these assessments, the coordinators work with the dialysis care teams to provide care and support for all patient needs related to ESRD and other health conditions.
- *Reporting.* Patient-level and practice-level data on outcomes are reported on a quarterly basis to participants' primary care physicians, kidney specialists, and dialysis center staff.

Results

Year 1 program results indicate savings of 5 percent off medical cost trend for ESRD Medicare members. Inpatient days were 3 percent below expected, skilled nursing facility days were 19 percent below expected, and emergency room visits were 12 percent below expected.

Connections AccordantCare

Target population

This program targets individuals with any of 16 complex chronic conditions (e.g., multiple sclerosis, Parkinson's disease, rheumatoid arthritis). As of September 30, 2006, 3,349 Medicare members participated in this program.

Key Program Elements

- *Telephone contact with nurse disease managers.* Identified members receive calls from disease management nurses who assess the members' needs and work to help them follow physicians' treatment plans so they can avoid potential health/medical complications.
- *Information.* Program participants receive monthly newsletters with information about their conditions, and they can access condition-specific information on Accordant's Web site.

Result: Year 1 outcome results are currently being analyzed.

Blue Care Connection for Heart Failure

Blue Cross and Blue Shield of Massachusetts

Blue Cross and Blue Shield of Massachusetts implemented a comprehensive disease management program for members with heart failure that has shown improvement on both clinical measures and perceived quality of life for participants.

The Blue Care Connection for Heart Failure, a comprehensive population-based disease management program for members with heart failure, was implemented in 2001 to improve the support and care to members with heart failure (HF) and their treating physicians. The program focuses on closing gaps in care (e.g., use of ace inhibitors) and empowering members to remain engaged in their care management.

Target Population

The program includes more than 1,700 Medicare Advantage HMO and PPO members diagnosed with congestive heart failure as of January 31, 2006.

Key Program Elements

- **Outreach and education.** Nurses trained in the area of cardiac disease work with treating physicians to support their treatment plans through outreach, education and surveillance. Participants also receive welcome kits with a disease-specific workbook and other educational information. Participants receive calls at least every six weeks, and sometimes as frequently as daily or more as indicated by assessed needs.
- **Initial assessment and follow-up.** Following an individual assessment, participants receive assistance with self-management of their disease through education regarding medication management, adherence to diet and exercise plans, and coordination of physician-ordered services.
- **Additional member interventions include:** individualized self care goals, Standards of Care reminders reports, quarterly cardiac disease-specific newsletters, and home monitoring for members who require additional support. Home monitoring includes an electronic scale, blood pressure and pulse devices with results transmitted to disease managers daily.
- **Physician involvement.** Physicians receive feedback about their patients' status (including data from home monitoring, if applicable) along with regular updates on clinical guidelines that support evidence-based treatment of heart failure. Registered nurses also make visits to physician offices to provide physicians with program specific information and tools such as flu vaccine reminders and patient rosters. A Physician Advisory Council (PAC), including providers in the BCBSMA network, provides clinical input and oversight.

Results

- **Clinical measures.** BCBS MA's Blue Care Connection for Heart Failure program has maintained the gains attained since the program's inception. While there are numerical changes in the rate, none showed any statistically significant differences.

Percent of Medicare Advantage HMO members with heart failure clinical measures	Year 1	Year 2	Year 3	Year 4
Documented EF	84.8	91.9	96.3	94.4
LVSD on ACEI	83.2	91.5	88.6	81.3**

- EF or “ejection fraction” is a measurement of how well the heart is pumping.
- LVSD on ACEI is a measure used to assess the percent of heart failure patients with left ventricular systolic dysfunction (LVSD) and without both angiotensin converting enzyme inhibitor (ACEI) and angiotensin receptor blocker (ARB) contraindications who are prescribed an ACEI or ARB at hospital discharge. The data reported here include those with documented contraindications to ACEI therapy.
- **While the proportion of members prescribed an ACEI for LVSD fell 7.3 percent in Year 4, the change is not statistically significant due to the small sample size. (A sample of medical records is reviewed.) When ARB use is factored in, the rate of ACE/ARB use is 95 percent. ARB is accepted as appropriate first-line therapy for LVSD patients.

- Member satisfaction for the Heart Failure Program is measured at 95 percent.
- Member quality of life. Members’ perceptions of their functional status are measured using the Minnesota Living with Heart Failure Questionnaire, a recognized instrument for assessing quality of life for patients with heart failure, with questions assessing both physical and emotional well-being. Scores that decline from the baseline measurement indicate improvement in perceived functional status – thus, the results below show a significant improvement in perceived quality of life resulting from the Heart Failure program. Follow-up periods are generally one year in length.

Patient Perceptions	Baseline	Follow up 1	Follow up 2	Follow up 3
Total Score	16.43	12.63	12.44	13.65
*Physical	8.84	7.22	7.12	7.98
*Emotional	4.42	3.41	3.37	3.36

*Note: Heart Failure is a progressive condition and despite perceived decrease in physical scores in the third follow-up period, scores did not revert to baseline or higher and gains in the emotional component were maintained.

Initiatives to Improve the Health of Medicare Advantage Beneficiaries

Blue Cross and Blue Shield of Michigan

Blue Cross and Blue Shield of Michigan provides a comprehensive spectrum of wellness, disease and symptom management, and case management opportunities for Medicare Advantage beneficiaries to take an active role in improving their health.

Blue Cross Blue Shield of Michigan (BCBSM) is presently offering or is in the process of finalizing several initiatives geared towards improving the health of its Medicare Advantage (MA) members through its integrated care management program, BlueHealthConnection®.

BlueHealthConnection

Background

BlueHealthConnection provides a comprehensive spectrum of wellness, disease and symptom management, and case management opportunities for Private Fee-for-Service (PFFS) Medicare Advantage beneficiaries to take an active role in improving their health. Program elements are delivered through two partners with significant experience in interacting with Medicare populations. Both have had significant success in understanding the illness burden of Medicare beneficiaries and proactively identifying, through state of the art predictive modeling techniques, who is at risk for high cost, what diseases are present in this population, and whether the health of the population is improving or whether further intervention is necessary.

Key Program Elements

- **Health coaching.** Health coaches provide proactive outreach and interaction with a personal health care coach to address a full range of health care decision needs, including management of chronic conditions (asthma, diabetes, coronary artery disease, congestive heart failure, and chronic obstructive pulmonary disorder) as well as “preference sensitive” conditions, such as cancer, benign uterine conditions, and back pain. The program is focused on building self-reliance, and seeks to inform members by providing balanced information, transferring skills and confidence, and enabling members to take action. Program initiatives include:
 - Inbound phone calls to a 24/7 toll-free nurse call line, as well as outbound calls and mailings to identified at-risk beneficiaries
 - A “whole person care management” approach that includes healthy living support, urgent needs support, condition management and complex care support
 - A coaching process that disseminates information, teaches self-reliance and self-care skills, supports the provider relationship and provides an opportunity for members to discuss values and preferences and their readiness to change

As a result of the coaching intervention, participants (and/or their care givers) are well informed about their conditions, understand and follow their treatment plans, and know what to do when their plans are not working. They are more confident of their ability to navigate the health care system and get the help they need, and actively participate in making health care decisions with their doctors, relying on evidence and honoring their own values.

- *Case management.* A case management program focuses on high-cost members/those impacted by multiple co-morbidities (typically 3-5 percent of the population), and its *complex case management* focuses on the highest-cost members/those with the most complex care requirements (1-2 percent of the population). Case and complex case management are collaborative processes that assess, plan, implement, monitor and evaluate options and services to meet an individual's health care needs and assist patients in understanding and participating in their health care planning. These initiatives provide telephonic and face-to-face assessments, develop collaborative care plans with physicians and beneficiaries, and use evidence-based guidelines to measure compliance and treatment success. Interventions include:
 - Regular interactions with member, physician and family members to monitor health status, progress and compliance
 - Telemonitoring devices
 - Ongoing clinical and psychosocial needs assessments

Senior Care Solutions

Blue Cross and Blue Shield of Florida

Blue Cross and Blue Shield of Florida has implemented disease management, complex care management and population health initiatives to improve the quality of health care for Medicare Advantage members. BCBSF's HEDIS scores consistently exceed national benchmarks.

Background

Blue Cross and Blue Shield of Florida's Senior Care Solutions include multiple initiatives aimed at improving the quality of health and health care delivered to its Medicare Advantage members. Three program areas are highlighted here: disease management; complex care management; and population health management programs.

Disease Management Programs

Current disease management programs include those that focus on diabetes, heart failure and asthma. These programs adhere to NCQA and HEDIS guidelines with scheduled performance measures to identify effectiveness and opportunities for future programs. Expansion of programs for the conditions of coronary artery disease and chronic obstructive pulmonary disease are anticipated in 2007.

Key Program Elements

- Identification of members with targeted conditions
- Health risk assessments for functional, cognitive and safety evaluations
- Educational information
- Member and/or caregiver health coaching
- Telephone contact with follow-up. Members and/or caregivers can make inbound phone calls for symptoms, event-driven questions or referrals. They are provided resources and education on the importance of adhering to physicians' treatment guidelines and educational support to achieve and maintain optimal health conditions
- Collaboration between primary care providers and specialists identifies opportunities to narrow clinical gaps

Care Management Programs

Complex care management programs focus on the top 2 percent of Medicare Advantage members who contribute to the top 15 percent of medical costs. These programs provide focused and individualized approaches to assist members with achieving health care goals that are consistent with their culture and beliefs while also minimizing their out-of-pocket expenses. Expansion of these programs to include promotion of pneumonia vaccination, palliative care, chronic kidney and stroke is anticipated in 2007.

Key Program Elements

- Personal contact with members/caregivers to promote adherence to medications
- Self-management and informed participation in health care decisions
- A dedicated point of contact for eligibility, benefits and available programs
- Enhanced provider engagement
- Identification of community resources
- Promotion of evidence-based medicine

The expansion of the CMS-required Health Risk Assessment for early identification of barriers to health care access, personal and environmental safety and/or adherence to physician treatment plans are another component of these programs.

Population-Based Preventive Care Initiatives

Population-based care initiatives encourage preventive immunizations and screening to promote quality of care, quality of life and to decrease medical costs. Immunization and screening schedules for the senior population are recommended by national organizations. These programs include influenza/pneumonia vaccination campaigns and identification and education of members for colorectal cancer screening.

Key Initiatives

- **Influenza/pneumonia vaccination campaign.** National organizations recommend annual influenza vaccination and a pneumonia vaccination every five years for people over 65 years of age. BCBSF partners with a vendor to provide annual “flu-clinics” that are administered throughout Florida to its senior members. These clinics are advertised via news releases and radio.
- **Colorectal cancer screening.** BCBSF has collaborated with the American Cancer Society (ACS) and health departments to encourage colorectal cancer screening for identified senior members who do not have evidence of previous screening in claims data. These members are mailed letters that include ACS brochures indicating the importance of colorectal cancer screenings and follow-up with their physicians. The BCBS Florida Web site also provides a direct link to the ACS website and informational reminders for appropriate screening. Provider education includes Continuing Medical Education credit from the ACS and information in provider newsletters.

Subsequent initiatives will continue to inform members of the benefits of screening. Additional efforts may include follow-up with specific members as well as their primary care provider, oncologist and other specialists.

Results

Recently developed senior programs for a current population of 21,000 Medicare Advantage members include monitoring of program results with continuous quality improvement. Historically, BCBSF’s HEDIS scores for Medicare HMO members have consistently exceeded National Committee for Quality Assurance (NCQA) national benchmarks for the following indicators:

HEDIS Measure	2004	2006	2006 Nat’l Avg
Diabetes - HbA1C Test	88.10%	97.57%	89.10%
Diabetes - Lipids Test	95.90%	98.05%	93.50%
Diabetes - Lipids Controlled <130	75.90%	77.62%	71.40%
Diabetes - Nephropathy Exam	42.30%	73.24%	58.60%
Controlling High Blood Pressure	74.90%	67.43%	64.70%
Beta Blocker After Heart Attack	89.90%	96.00%	94.00%
Colorectal Cancer Screening	NR	52.72%	52.60%

SecureBlue – a Medicare Advantage Special Needs Plan

Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Minnesota partners with the State of Minnesota to offer a Medicare Advantage Special Needs Plan that provides a coordinated care delivery system for the most vulnerable Medicare population: frail, elderly Minnesotans with low incomes.

Background

Medicare Advantage special needs plans (SNPs) are a new type of coordinated care plan established by the 2003 Medicare Modernization Act. Created to encourage more opportunities for special needs individuals to access managed care, the SNP option allows Medicare Advantage plans to specialize in care for beneficiaries who are residing in long-term care facilities, dually eligible for Medicare and Medicaid, or chronically ill. With the SNP designation, plans may limit enrollment to one of the special needs populations, tailoring benefits and provider networks to best meet the needs of these vulnerable groups.

Originally launched on a limited scale in 1997 for the Minneapolis-St. Paul area, Minnesota Senior Health Options (SHO) is a Medicare Advantage SNP that is administered by multiple health plans, including Blue Cross Blue Shield of Minnesota, which offers SecureBlue as its SHO program through its HMO affiliate, Blue Plus.

The plan combines Medicare and Medicaid benefits and community services into a seamless program for individuals who qualify. By design, SHO consolidates all payment sources for Medicare and Medicaid to eliminate paperwork and confusion for eligible members, their providers and their families. The program also coordinates nursing home, assisted living, home health, community services, case management, equipment services and other service programs that may be unique to each county. Each enrollee gets an initial health and needs assessment, and the seamless coordination and provision of services they need to enjoy their best health.

Target Population

The program serves more than 35,000 of the state's most vulnerable Medicare population: frail, elderly Minnesotans with low incomes. These individuals live at home and in institutional settings, and are scattered throughout the state both in metropolitan Minneapolis-St. Paul and the largely rural communities of greater Minnesota. SecureBlue serves nearly one-third of all SHO members (10,000 enrollees) in 58 of Minnesota's 87 counties.

Key Program Elements

- *Providing care and services closer to home.* Because of its history of successful collaboration with county agencies, SecureBlue contracts with counties to provide local care coordination services to many of its members who are enrolled in SHO. This contracting arrangement brings care and community support closer to home for Medicare and Medicaid members across the state, which is especially important in the rural areas of Minnesota, where the population overall is aging.

"The Blues were instrumental in leading the charge in developing relationships with counties for home based services, especially in rural areas, so we can capitalize on existing capabilities and bring enrollees into a care management situation where more attention can be paid to chronic health conditions."

Pam Parker, manager of special needs purchasing for the State of Minnesota.

- **Offering personalized care coordination.** As a hallmark of the program, each SecureBlue member is assigned a care coordinator to assist with questions, community service referrals, interaction with providers and insurance companies, and any other care-related concerns. The care coordinators are professional nurses or social workers. The unique coordination possible under this Medicare Advantage SNP allows for an integrated care delivery system that creates greater efficiencies for everyone involved, especially members, their families and their providers.

“Care coordinators have direct contact with the seniors and, in many ways, are in the best position to assess how they are really doing at home. What many people don’t realize is that seniors have more than just medical care and related service needs. There might be mental health issues, chemical health concerns, financial barriers, and formal and informal support issues to consider. By staying in close contact, the care coordinator can learn about these issues and help members find resources to meet their specific need.”

Jodi Wentland, social services supervisor for Otter Tail County Human Services

- **Integrated whole-person care.** Integrated services include health care, transportation, Meals On Wheels, home visits, alternative living and accessibility services, additional safety features such as drug dispensers, telemedicine – especially important in rural areas – and other innovative approaches to care in the home. Best of all, working with local county agencies means that the counties are already familiar with the care and needs of these enrollees.

Results

Although the SNP program is too new to have reported any results, Violet’s story shows how the program’s integrated approach can benefit Medicare Advantage members.

Violet’s Story

Early in 2006, Violet, a 70 year-old SecureBlue member, was discharged from the hospital with a tube inserted in her trachea, so a ventilator could help her breathe. She was authorized for a short-term stay at a skilled nursing facility, and there were concerns whether she would ever be healthy enough to return home.*

Violet’s sister – her only living relative – resided at the same facility and provided companionship. But Violet needed more. She needed aggressive, professional care coordination, and her SecureBlue care coordinator became her lifeline. She maintained close contact with the facility about Violet’s condition. At first, Violet worsened. She needed the ventilator nightly and all expected that her short-term stay would become permanent long-term care.

When her sister died, Violet decided it was time for her to leave the facility, as well. She wanted to go home. By then her condition had improved and she no longer needed the ventilator, but she did need an extra hand at home and someone to look out for her.

Violet’s SecureBlue care coordinator made it all possible. She worked with the skilled nursing facility on Violet’s discharge planning, arranged skilled nursing and home health aide visits, a Lifeline phone unit, and a wheelchair accessible ramp for her home. Almost three months after Violet entered the skilled nursing facility, she was living in her own home again, managing her health and confident that her SecureBlue care coordinator would help her weather any health situation to come.

*The member’s name has been changed.

Care Management for Members Living with Diabetes

WellPoint – Anthem Blue Cross and Blue Shield

WellPoint's Diabetes Disease Management Program, which includes case management, member interventions and a provider pay-for-performance program, resulted in consistent improvement of HEDIS measures in diabetes care.

Background

Medicare Advantage members who have diabetes have the opportunity to participate in a robust disease management program offered by WellPoint-Anthem in partnership with Health Management Corporation (HMC), a division of WellPoint.

Target Population

Eligible members are identified each quarter.

Key Program Elements

- **Risk stratification.** Diabetic members are stratified into high- and low-risk categories based on HMC's proprietary stratification tool Accustrat. Members who are at low risk receive traditional education materials, while those at higher risk receive these materials and outreach phone contacts to better assist in the management of their conditions. The stratification process is repeated each quarter to ensure appropriate interventions. Members with co-morbid conditions receive additional education regarding those conditions through supplemental printed materials and the outreach phone process.
- **Coordination with case management program.** This program is closely linked to a comprehensive case management program. Members whose condition is too complex for traditional diabetes disease management interventions are referred to case management, which allows more specific interventions, and more frequent telephonic outreach to support the needs of these members.
- **Member interventions include:**
 - Annual reminders of preventive care (appropriate for age and gender)
 - Flu and pneumonia vaccines
 - Education and reminders for annual eye exams, lipid screening and management, blood pressure management, HgA1C etc.
 - Medication compliance reminders
- **Pay for performance.** WellPoint is committed to payment for value or pay-for-performance, and its current programs include measures for diabetes disease management. These programs will continue to expand to include more primary care physicians throughout Anthem states.

Results

The diabetes disease management program has resulted in consistent improvement of HEDIS measures in diabetes care among Medicare Advantage HMO members. A summary of measures are indicated below. Results are reported for Ohio and Kentucky. (These two states represent the bulk of WellPoint's senior membership.)

HEDIS Measure	2004	2005	State
Annual HgA1C	86%	89%*	KY
	84%	90%*	OH
Annual Eye Exam	59%	62%	KY
	55%	60%	OH
LDL Screening	90%	94%*	KY
	85%	92%*	OH
LDL <130	61%	71%	KY
	64%	71%	OH
LDL <100	41%	47%	KY
	37%	44%	OH

* Represents the 90th Percentile in the 2005 NCQA Quality Compass

Medicare Advantage: High Overall Quality

One of the ways in which CMS measures the quality of care for MA plans is through the Health Plan Employer Data and Information Set (HEDIS), a widely used set of performance measures in the managed care industry which assesses and reports the quality of care provided by organized delivery systems.*

The National Committee for Quality Assurance's *State of Health Care Quality 2006*⁹ documents significant quality improvements for MA members across multiple health conditions:

Heart Attack

Background: Cardiovascular disease is the single largest killer of Americans. Every 26 seconds, an American suffers a coronary event; about every minute, an American dies from one. The American Heart Association and the American College of Cardiology strongly recommend beta-blocker treatment following heart attacks.

Improvement: In 2005, 93.8 percent of Medicare Advantage enrollees who suffered a heart attack were prescribed beta blockers to help prevent a second, and often fatal heart attack, up from 89.3 percent in 2000.

Colorectal Cancer

Background: Colorectal cancer is the third most common cancer among both men and women in the U.S.; more than 148,000 new cases will be diagnosed and as many as 55,000 Americans will die from the disease in 2006. However, more than 90 percent of those whose cancer is detected and treated early live five years or longer.

Improvement: Colorectal cancer screening rates in general are lower than those for other common cancers. Still, in 2005, 53.9 percent of MA enrollees were screened for colorectal cancer, slightly higher than the rate for commercial health plans (52.3 percent), and up over four percentage points from 2003 (when screening rates were 49.5 percent).

High Blood Pressure

Background: Almost half of Americans age 45 and older have high blood pressure or hypertension. Hypertension doubles one's risk of stroke and puts people at risk for other cardiovascular illness, such as coronary heart disease.

Improvement: In 2005, the percentage of hypertensive Medicare Advantage enrollees whose blood pressure was controlled rose to 66.4 percent, up significantly from 46.7 percent in 2000.

Smoking

Background: Over 20 percent of Americans over age 18 are smokers. Diseases caused or made worse by smoking include various types of cancers, cardiovascular diseases, and others. About 440,000 smokers or former smokers die prematurely each year. Smokers who quit decrease their risk of disease dramatically.

Improvement: The percentage of MA enrollees who are current smokers who received advice from their practitioner to quit smoking within the past year reached 75.5 percent in 2005, up over 12 percentage points from 2003 (63.3 percent).

* Plans collect data on HEDIS measures by reviewing administrative claims, electronic data and medical records. Among MA plans, HMOs report on all HEDIS measures (PPOs report HEDIS measures that do not require medical record review). Rates computed from medical records data are more accurate and are generally higher than rates calculated from administrative data.

Conclusion

One of the greatest challenges facing the Medicare program is managing the care for the increasing numbers of beneficiaries with chronic illnesses. According to a recent study, health care spending for a person with a single chronic illness is two times greater than spending for those without chronic care needs, while spending for individuals with five or more chronic conditions is 14 times as great.¹¹

The profiles in this report illustrate some of the ways that Medicare Advantage plans play an important role in improving care for Medicare beneficiaries. These profiles are only a sample of initiatives that Blue Cross and Blue Shield Plans across the country have adopted to increase the quality of care delivered to Medicare beneficiaries. These initiatives focus on providing preventive care, and implementing programs designed to improve coordination and help beneficiaries manage chronic conditions. Investment in these programs is demonstrating results in terms of improved performance on quality of care and patient satisfaction.

As Medicare prepares for a future in which population growth and the increasing incidence of chronic disease will strain the program, continued investment in Medicare Advantage will be critical to ensure that beneficiaries have access to the preventive benefits, coordination and management they need. Because of the tremendous importance of early intervention in treating chronic illnesses, MA plans' focus on prevention and care coordination and management provides beneficiaries with additional tools to help them manage their health more effectively and avoid preventable complications.

1. Wolff, Jennifer L, Starfield, Barbara, and Anderson, Gerard, "Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly," *Archives of Internal Medicine*, November 11, 2002.
2. "Rewarding Provider Performance: Aligning Incentives in Medicare," Institute of Medicine, 9-21-06 <http://www.nap.edu/catalog/11723.html>
3. "The State of Health Care Quality 2006: Industry Trends and Analysis," National Committee for Quality Assurance, 2006 http://www.ncqa.org/Communications/SOHC2006/SOHC_2006.pdf
4. Thorpe, Kenneth and Howard, David, "The Rise In Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity," *Health Affairs*, August 2006, <http://content.healthaffairs.org/cgi/reprint/25/5/w378?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=thorpe&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>
5. Wolff, Jennifer L, Starfield, Barbara, and Anderson, Gerard, "Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly," *Archives of Internal Medicine*, November 11, 2002.
6. "Rewarding Provider Performance: Aligning Incentives in Medicare," Institute of Medicine, 9-21-06 <http://www.nap.edu/catalog/11723.html>
7. MedPAC June 2006 Report.
8. "Strengthening Medicare's Role in Reducing Racial and Ethnic Health Disparities," National Academy for Social Insurance, October 2006 http://www.nasi.org/usr_doc/Strengthening_Medicare%92s_Role.pdf
9. "The State of Health Care Quality 2006: Industry Trends and Analysis," National Committee for Quality Assurance, 2006. http://www.ncqa.org/Communications/SOHC2006/SOHC_2006.pdf
10. "What Consumers Say About the Quality of Their Health Plans and Medical Care," 2006 CAHPS Health Plan Survey Chartbook, September 2006 https://www.cahps.ahrq.gov/content/ncbd/Chartbook/2006_CAHPS_HealthPlanChartbook.pdf
11. Sidorov, J. and Schlosberg, C., "Disease Management and the Medicare Modernization Act: 'It's the Insurance, Stupid,'" *Disease Management*, Volume 8, No. 6, 2006.





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