Blue Cross Coordinated Care℠

Commercial Care Management Programs & Collaboration with Provider Delivered Care Management (PDCM)

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April 26, 2024

Who are we? And why do we want to partner with you?

Blue Cross Coordinated Care:

A completely reimagined approach to care management that puts members at the center of care that is personalized and holistic.

The BCBSM Care Management team are **passionate clinicians, just like you!**

Partnership:

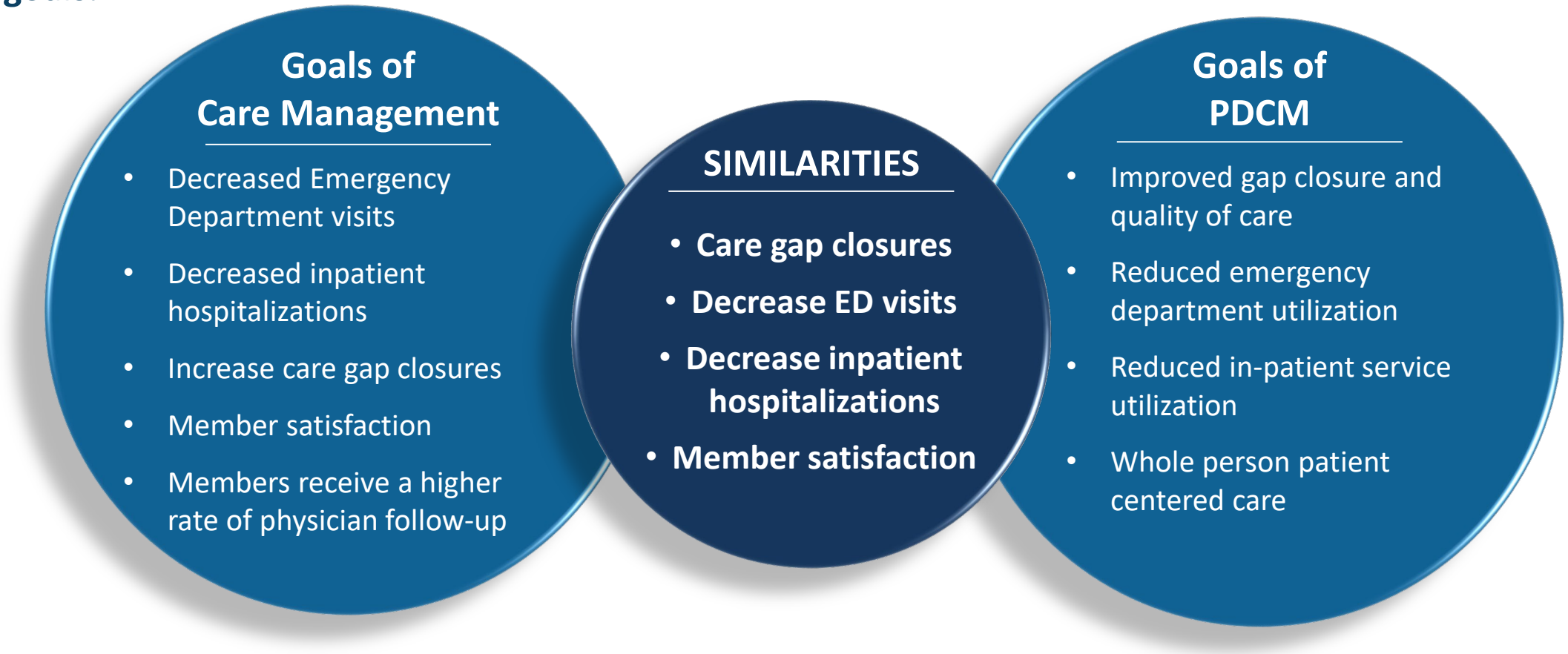
You may have limited resources; we may have limited resources. **Collaboration is key** to provide members with their best outcomes. **Let's leverage each other's skillsets!**

Shortcomings of not working together:

- Avoid the "who's on first" scenario
- Care management staff outreach goes unanswered
- Unaware of member's benefits chosen by employer

Goals of the Care Management Program

The BCBSM Care Management Program and the Provider Delivered Care Management (PDCM) both follow a statewide clinical model that engages patients with chronic conditions, emerging risk, and transitions of care in provider led care coordination and other support services in order to **address member needs, resulting in the same goals.**



A wholistic approach to care management

Case Conferences

Peer to Peer Provider Support

Medical Director Complex Case Review

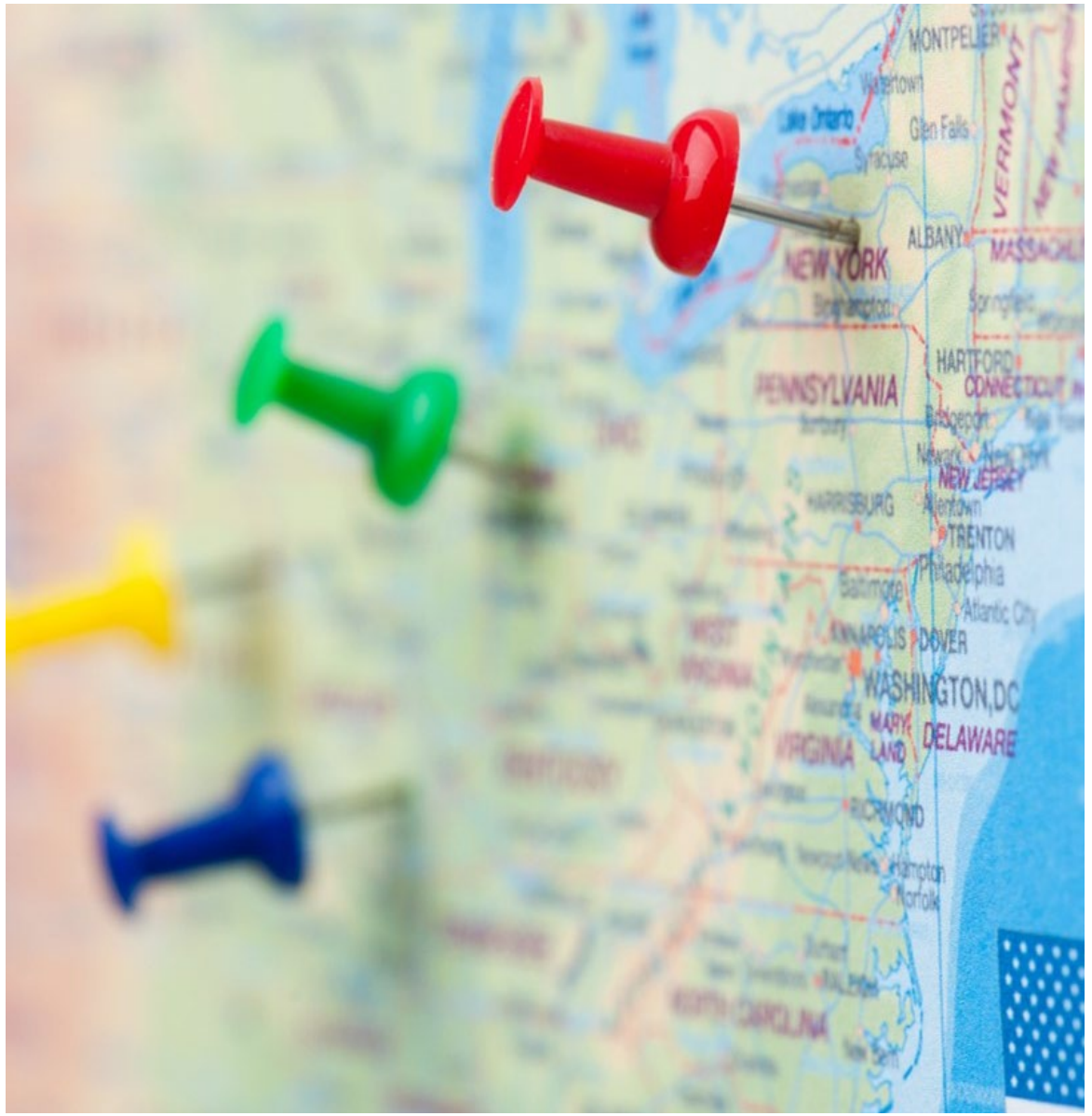
Hours: 8 a.m. to 8 p.m. EST Monday thru Friday

After hour support will be handled by the 24/7 nurse line

Care Teams are Regionally and Community-Oriented

This alignment allows us to:

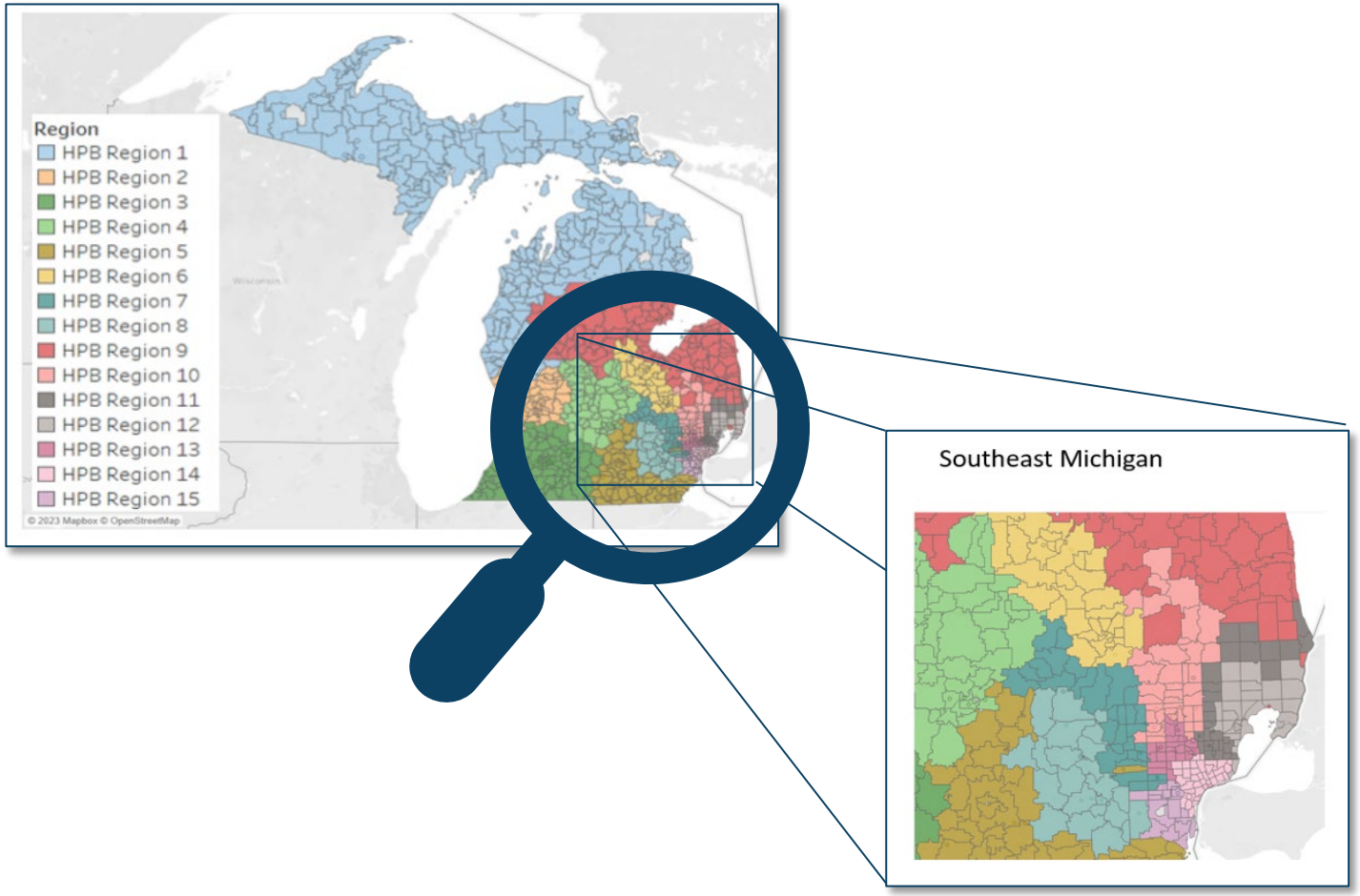
- Develop stronger relationships with community resources
- Collaborate with local providers more closely and develop strong relationships with office staff
- Incorporate unique social determinants of health by region, such as average income, member access to care, food and transportation



Regional Teams

Regional Teams Details:

- **15 Regions** in the state of Michigan
- Each team is made up of the following:
  - 7-9 CCM RNs
  - 1 BHSW
  - 1 MSW
  - 1 Registered Dietitian
  - 1 Pharmacist
  - 1 Non-clinical support staff
  - 1 Medical Director



Predictive Algorithms Identify The Most Impactable Members

Predictive analytics query 30+ unique data sources to identify and prioritize members

REACTIVE ANALYTICS

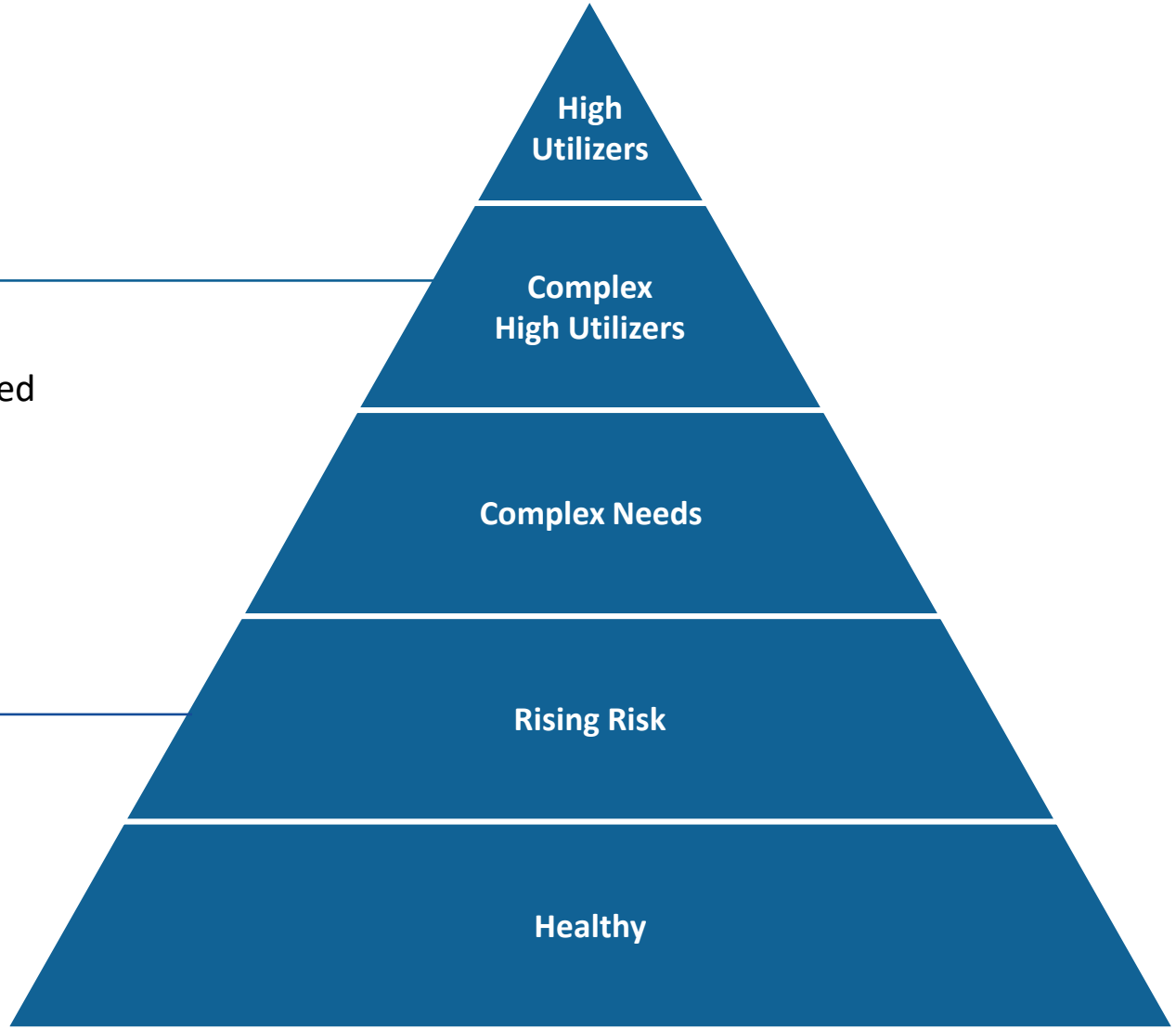
identify high-risk and high-complexity members based on observed acuity, utilization and risk factors

- Multiple inpatient admissions
- High risk for readmission
- Inappropriate emergency room usage
- Utilization driven by unmanaged underlying conditions

PREDICTIVE ANALYTICS

identify members likely to rise in cost and utilization over several years

- Early chronic or newly diagnosed conditions
- Often have several risk factors that lead to higher future utilization
- Social determinants of health



We Identify Cohorts of Members with Addressable Needs

Example Criteria for Identifying Members

High Utilizers

Frequent, potentially avoidable acute events

- Frequency of inpatient visits including multiple visits for same diagnosis
- Number of avoidable emergency dept. visits
- Risk factors for inpatient readmission

Complex High Utilizers

High utilization and complex needs

- Members meet criteria for both 'High Utilizers' and 'Complex Needs' archetypes

Complex Needs

Multiple conditions and risk factors

- Number of chronic conditions
- Prospective risk score
- Maternity risk factors

Rising Risk

Signs of potential future health complications

- New chronic condition diagnosis
- Open care gaps
- Social determinant of health risk factors

Vendor Placemat

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Care management and utilization management programs

Overview for providers

Revised February 2024

Blue Cross Blue Shield of Michigan and Blue Care Network offer the following programs to members. Programs are provided by Blue Cross, BCN and the independent companies listed below. Click the links below to learn more about programs within each category.

CARE MANAGEMENT AND SUPPORT SERVICES — Provide patient support by identifying patients with health risks and working with them to improve or maintain their health and support patients through their health journeys.

Advance care planning
- Vital Decisions

Behavioral health
- Blue Cross and BCN
- Teladoc Health®

Blue Cross Coordinated Care Core℠
- Blue Cross and BCN

Cardiology
- AMC Health
- Teladoc Health

Caregiver support
- Careforth (formerly Seniorlink)
- OncoHealth®

Decision support
- 2nd.MD
- Welvie

Diabetes
- Cecelia Health
- Omada Health
- Solera
- Teladoc Health
- Twin Health

Drugs
- OneOme
- PillarRx Consulting
- Price Edge
- Sempre Health

Elective procedures and services
- 2nd.MD
- Welvie

Health Guide

Health assessments
- Genex Services LLC

Home-based services
- Blue Cross and BCN
- Genex Services
- Landmark Health
- Home & Community Care (formerly naviHealth, Inc.)
- PopHealthCare®

Member lifestyle support

Menopause
- Maven

Oncology
- OncoHealth

Pain management
- Aspire Health

Palliative care
- Aspire Health
- Vital Decisions

Post-acute care
- Home & Community Care

Pregnancy and parenting support
- Blue Cross and BCN
- Maven
- WebMD Health

Pulmonology
- AMC Health

Surgeries
- 2nd.MD
- Welvie

Well-being
- Catapult
- Teladoc Health
- PopHealthCare
- WebMD Health Services

UTILIZATION MANAGEMENT — Through the prior authorization process, ensures that patients get the right care at the right time in the right location. For more information, see the Summary of utilization management programs for Michigan providers document.

Acute inpatient admissions
- Blue Cross and BCN

Air ambulance (non-emergency flights)
- Alacura Medical Transport Management

Behavioral health
- Blue Cross Behavioral Health℠

Cardiology
- BCN
- Carelon Medical Benefits Management

Chiropractic services
- BCN
- eviCore healthcare®

Cosmetic procedures
- BCN

Diabetes
- Northwood, Inc.

Drugs
- Blue Cross and BCN
- Carelon

Durable medical equipment and prosthetics and orthotics
- Northwood

Elective procedures and services
- Blue Cross and BCN
- Vendors listed under other utilization management categories

Home-based services
- Utilization Management
- CareCentrix®

Laboratory
- Joint Venture Hospital Laboratories

Musculoskeletal services
- TurningPoint Healthcare Solutions LLC

Oncology
- Blue Cross and BCN
- Carelon
- eviCore

Physical, occupational and speech therapy
- eviCore

Pain management
- TurningPoint

Post-acute care (SNF, rehab, LTAC)
- Blue Cross and BCN
- Home & Community Care

Radiology procedures, high tech
- Carelon

Sleep studies
- BCN
- Carelon

Surgeries
- Blue Cross and BCN
- TurningPoint

Transplants
- Blue Cross and BCN

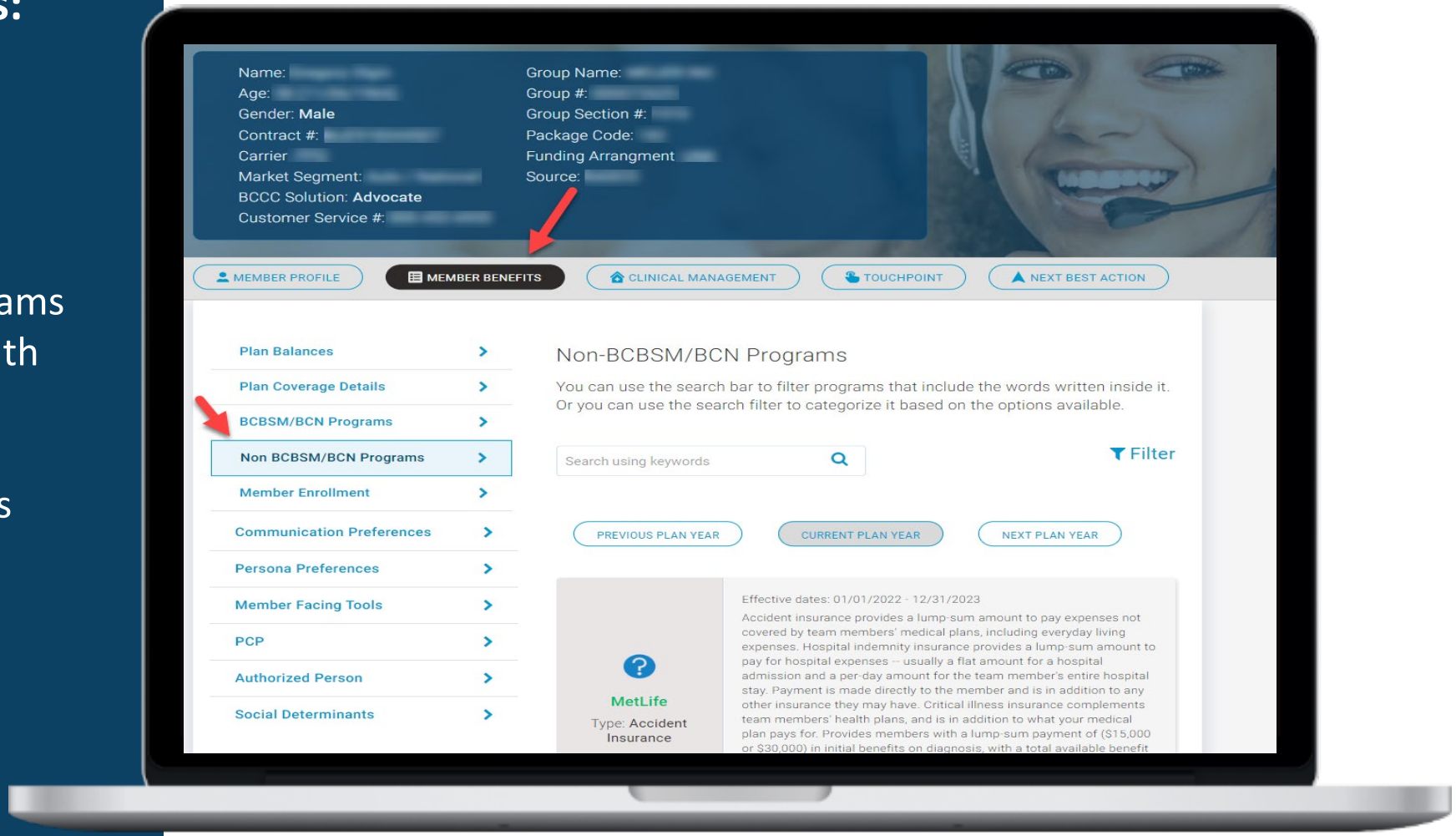
Services available for these products (may not apply to all groups or individual members): Blue Cross commercial · Medicare Plus Blue · BCN commercial · BCN Advantage

Blue Cross and BCN - Care management and utilization management programs: Overview for providers (bcbsm.com)

Member Snapshot

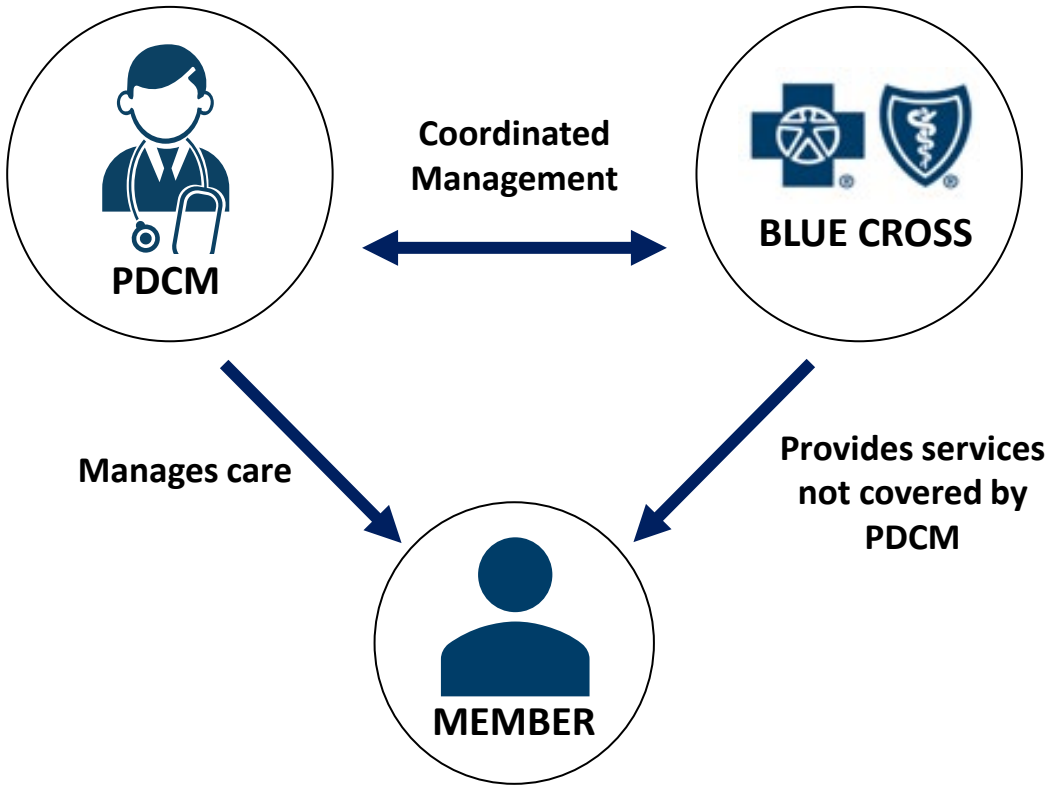
Member Snapshot Details:

- Conditions/Diagnoses
- Member Benefits
- BCBSM Vendors/Programs
- Non-BCBSM Vendors/Programs
- Social Determinants of Health
- BCCC App Dashboard
- Programs (Vendors)
- Communication Preferences
- Persona Preferences
- **Attributed PCP**
- Authorized Person
- Next Best Actions (Personal Recommendations)



We will Coordinate with Provider Staff for Members in Provider Delivered Care Management (PDCM)

Provider Coordination



Collaboration for members in PDCM

- Identify members enrolled in PDCM who also are determined high priority for Blue Cross outreach
- **Blue Cross nurse care manager first calls PDCM provider / staff to discuss whether there are opportunities to collaborate on care management for those members. If not, Blue Cross will close their case**
- Coordinated Care team provides services identified by provider
  - If provider has adequate care management, additional management from Blue Cross is not needed
  - BCBSM Nurse can provide vendors that are available to member (Diabetes, High Risk Pregnancy)
- If Blue Cross provides supplemental care management, case is counted towards total members managed goal

Benefits of Collaboration

Benefits:

Benefits that we are currently seeing when Care Management collaborates with PDCM

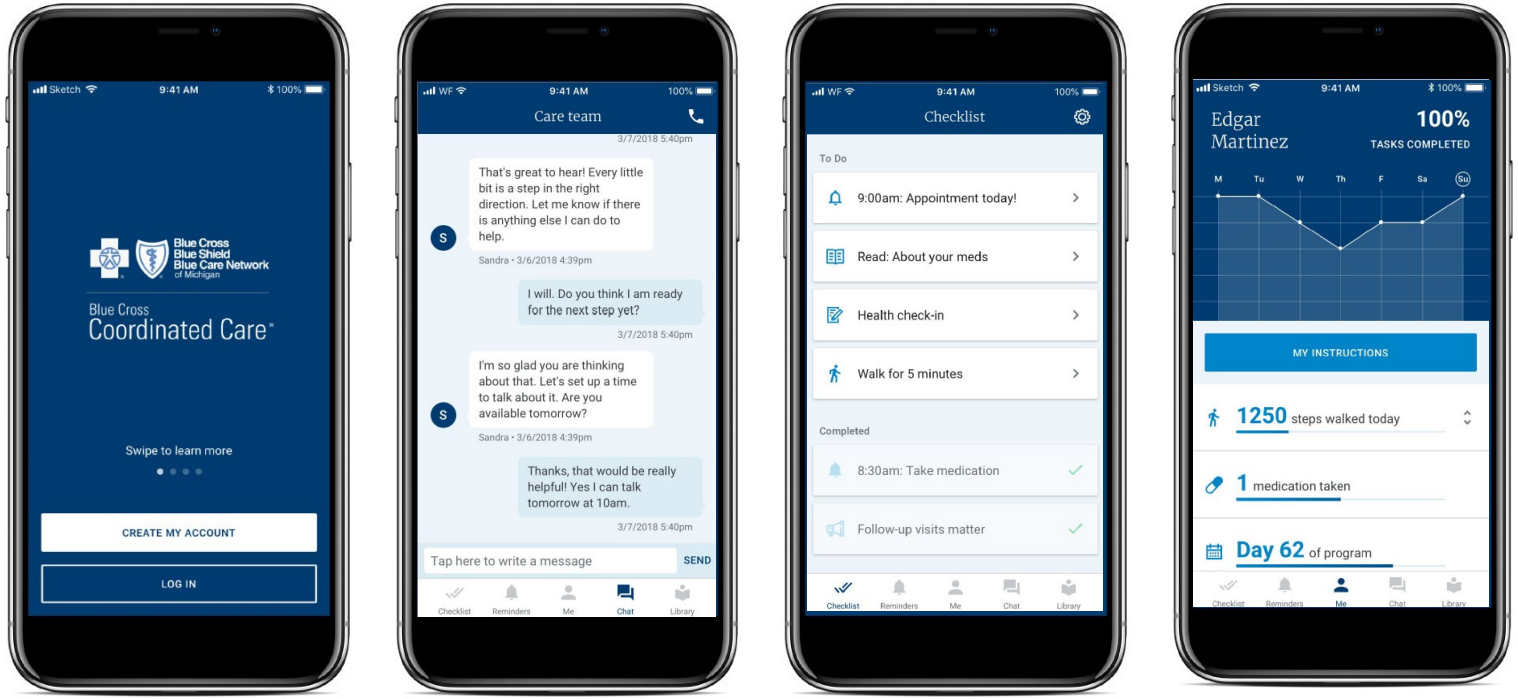
- Improved member/patient health outcomes
- Improved clinical outcomes for members with chronic conditions
- Decreased hospitalizations
- Decreased ED visits
- SDOH assessment and address
- Care gap closure
- Multi Disciplinary Team (MDT) collaboration
- Increased member/patient satisfaction: Better patient experience
- Success and Reinforce Vendors
- Lower readmission rates
- Increased patient engagement in their healthcare
- Reinforce plan of care for the member

Social Domain Needs that are Addressed in Care Management

Social Need Domains	Examples
Food Insecurity	Limited or uncertain access to adequate food
Housing Instability	Homelessness, unsafe or unhealthy housing conditions, inability to pay mortgage/rent, frequent housing disruptions, eviction
Utility Needs	Difficulty paying utility bills, shut off notices, access to phone
Financial Resource Strain	Inability to afford essential needs, financial literacy, medication under-use due to cost, benefits denial
Transportation Challenges	Difficulty accessing or affording transportation (medical or public)
Exposure To Violence	Intimate partner violence, elder abuse, community violence
Socio-Demographic Information	Race and ethnicity, educational attainment, family income level, languages spoken

Source: Health Leads, based on recommendations from Institute of Medicine, CMS

Digital App Connects Members to Care



Star Rating on App Store

We interact with the leading consulting houses across the country. Here's their feedback:

"The bi-directional text-based messaging app available to members is a differentiator in the industry and the Blue Cross team demonstrated skillful mastery of use of this app as another avenue to interact with members in a way that is convenient and approachable to members. The interactions are recorded seamlessly within the BCBSM clinical documentation system."

WTW, 2022

Easy two-way communication between members, their family and the Coordinated Care Team

Mobile app for members and their family members, supports preferences

Personalized content that includes educational materials, and surveys

Daily health checklists and tasks for your members and their family members

Integration with Apple Health and Google Fit to track physical activity

Coordinated Care App Overview Video

BCBSM Care Manager and Member Experience

BCBSM Care Manager Lisa:

- Lisa worked at a large PO in a PDCM setting for 10 years
- Previous experience working in MICU, SNF and HHC
- Certified Case Manager

Member Gloria:

- 55 years old
- Diabetes
- Recent inpatient hospitalization
- No mammogram
- No labs
- Multiple ED Visits

A LOOK AT GLORIA'S JOURNEY

MAINTAIN AND MANAGE HEALTH

Blue Cross Blue Shield Blue Care Network of Michigan

Gloria's Experience

BCCC Care Manager reaches out to Gloria:

- Reviews Member Snapshot and outreaches to PDCM

Gloria engages with her nurse:

- Gloria establishes relationship with her Nurse
- Completes an assessment and care plan
- Helps Gloria enroll in Livongo for diabetes management*
- Addresses and closes care gaps
- Educates Gloria on how to use the BCCC app to contact her care team, ask questions, access education and resources
- Helps her schedule an appointment with her PCP
- Follow-up calls continue in an effort to support all of Gloria's needs
- consults with multi-disciplinary care team (pharmacist)

*Key differentiator

A LOOK AT GLORIA'S JOURNEY

MAINTAIN AND MANAGE HEALTH

Blue Cross Blue Shield Blue Care Network of Michigan

Gloria's Experience

Nurse completes robust assessment of Gloria's care needs:

- Calls Gloria's PCP to discuss care plan
- Assists Gloria with locating her durable medical equipment
- Schedules regular appointments with Gloria to ensure she is following her care plan
- Discusses medication adherence-sets a care plan goals, BCCC app, reminders, etc.
- Provides preventive service recommendations*

*Key differentiator

A LOOK AT GLORIA'S JOURNEY

MAINTAIN AND MANAGE HEALTH

Blue Cross Blue Shield Blue Care Network of Michigan

Gloria's Experience

Gloria's nurse coordinates with additional team resources to support her care needs. Gloria can interact with these resources directly if she chooses.

Multi-Disciplinary Team (MDT) Collaboration

Pharmacist:

- Conducts a medication reconciliation to ensure her medication list is up to date and accurate
- Calls CVS to ensure they have Gloria's prescriptions
- Helps Gloria locate coupons for her insulin
- Identifies that Gloria has some underlying mental health concerns based on medications

Social Worker:

- Connects her with her employer EAP program
- Connects Gloria with a diabetic support group in her city
- Connects Gloria with a local food pantry
- Introduces Gloria to free weekly virtual well-being webinars

Dietitian:

- Helps with nutrition resources and meal planning

If Gloria's condition becomes more complex:

- Medical director talk to the PCP or perform a case conference (physician consultant)
- Attends Gloria's Dr. appt to help her better understand her care plan if her condition progressed to complex
- Pre-admission/post-discharge services*
- Provide in-home care management

*Key differentiator

Demonstrating Value Through Cost Savings and Reduced Utilization

A rigorous program evaluation that compared members that were managed by Coordinated Care will be compared to members that were targeted for the program but did not participate.

The results of this evaluation revealed:

Frequent IP Admissions

25%

REDUCTION
in medical spend

Risk for Readmission

32%

REDUCTION
in inpatient admissions

High Risk

19%

REDUCTION
in medical spend

High Risk Maternity

2X

REDUCTION
in inpatient admissions

Emerging Risk

16%

REDUCTION
in medical spend

Blue Cross Coordinated Care Leading Indicators

Connecting Members with their Physician Prevents Avoidable Utilization and Readmissions

Blue Cross Blue Shield Blue Care Network of Michigan

PCP Attribution

90%

prior year - 83%

28%

Higher than BOB

Timely Provider Follow-up After Discharge (7 Days)

53%

prior year - 48%

5%

Higher than BOB

Post Engagement Provider Visits

85%

prior year - 86%

12%

Higher than BOB

Avoidable ED

21%

prior year - 20%

11%

Lower than non-managed

April 2022 – March 2023

Prior Year: April 2021- March 2022

How do the PDCM teams know a member is engaged with BCBSM

Member Engagement with BCBSM Overview

Files that are received at the offices show BCBSM Internal Care Management

Feel free to reach out to any leaders in the appendix to further collaborate

If our BCBSM internal teams reach out to your offices, please call us back and let us know if there are opportunities to collaborate

If we don’t hear back, we will keep our case open

PO Collaboration Success Story

Key Insights

- BCBSM CM and large PO met to discuss Care Management
- Open discussions occurred and information sharing amongst both teams
- Provider Organization staff reached out to get assistance and collaborate with BCBSM on Behavioral Health Resources for a member in their time of need
- Member was able to successfully obtain resources. Key partnership formed because of this collaboration

Process to Refer to BCBSM Commercial Care Management

Opportunity

- You're support and guidance is an integral part of what makes this program successful!
- Blue Cross' first and foremost **objective** is to **support the care that members receive from their provider.**
- This partnership program cannot exist without provider participation.
- If you think your patients could benefit from this type of support and guidance, encourage them to contact Blue Cross.

Action

Contact Us!

- Commercial Care Management Referrals (HMO, PPO)
- Complex medical and behavioral health needs
- Provide members name, DOB, Contract ID, phone number, reason for referral

CoordinatedCare@bcbsm.com

1-800-775-2583

More information is available on:

Blue Cross Coordinated Care Core website

FAQ

Key Takeaways

1

Opportunities exist to improve member care

- Partnership is key
- Collaborate with regional teams

2

Common goals for our members

- Decreased ED visits
- Decreased inpatient hospitalizations
- Increase care gap closures
- Member satisfaction
- Improved member health outcomes

3

Care Management team is a valuable resource

- Community resources
- Inpatient hospitalization notification
- SDOH resources
- Provide employee sponsored vendor information (example: EAP, employer vendors)

Regional Team Contact Information

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Questions?

Blue Cross Blue Shield Blue Care Network of Michigan

Thank you!

Appendix

Blue Cross Coordinated Care Member Testimonials

Hear what our members are saying about our program! Blue Cross member Alma, Ricardo and Laura talk about their experiences with Blue Cross Coordinated Care program and how it changed their lives.

Alma:
https://youtu.be/NKRHH9g8XjQ
Laura:
https://youtu.be/5qm43GKOIgc
Ricardo:
https://youtu.be/wsytNCd2kew

A Blue Cross Coordinated Care Core Success Story

Blue Cross Blue Shield Blue Care Network of Michigan

Member profile:

- 60-year-old female, recent inpatient hospital stay for heart valve tear
- Member had fluid around lungs, edema in legs, feet, and hands
- Heart valve unable to be repaired d/t member is not strong enough for surgery
- History of High Blood Pressure, ordinarily alert and oriented, with some episodes of memory loss, wheelchair bound
- Member's daughter lives with the member, needs help in the home due to inadequate support system
- In need of coordination of services for HHC and DME
- Symptoms of depression, in need of counseling centers resources
- Member in need of new glasses and dentures; member with a limited budget

We respect our members' right to privacy; the names and images used in our care profiles are pseudonyms.

Interventions:

- Nurse reviewed discharge instructions, coordinated services with HHC, Palliative care, and DME
- Nurse provided education on conditions and signs and symptoms to watch for
- Nurse offered consultations to social worker for needed resources, behavioral health for depression and pharmacy for cost savings on meds and copays
- Nurse helped to identify and eliminate safety hazards in home
- Nurse helped daughter with life planning decisions and hospice/palliative care services
- 24 Hour Nurse Line provided

Success Outcomes:

- Nurse was able to get member needed medical equipment for home
- Home Care initiated
- No ER or in-patient hospital admissions
- Nurse educated caregiver on proper home care for member
- Member went into hospice and nurse was able to provide emotional support, active listening and compassion to daughter
- Nurse provided support to daughter during a difficult time and able to make a difference for member and her daughter

"I felt so alone before joining this program and just feel really grateful to my Mom's nurse. Her nurse deserves a promotion and a raise."

High Risk Maternity Success Story

Blue Cross Blue Shield Blue Care Network of Michigan

Member profile:

- 34-year-old pregnant person
- Past Medical history of 3 previous fetal losses, preeclampsia
- Birth plan is for member to carry until 37 weeks and undergo a Cesarean section
- Limited budget and reports she is no longer able to afford her injectable progesterone used to prevent spontaneous rupture of membranes (SROM) and preterm labor
- Expressed need for food assistance and creating an Advanced Directive
- Vague understanding of signs and symptoms of preeclampsia

We respect our members' right to privacy; the names and images used in our care profiles are pseudonyms.

Interventions:

- Assessed member needs
- Educated on signs and symptoms of labor, preeclampsia, and other complications of pregnancy with ongoing teach back
- Consultations to social worker for needed resources
- Care Management pharmacist consulted for obtaining progesterone
- Pharmacist coordinated with OBGYN office to develop a plan ensuring member was able to access and afford her final progesterone doses in a timely manner

Success Outcomes:

- Pharmacist ensured member was able to continue injectable progesterone for her final weeks of pregnancy
- Community resources provided on food resources, allowing adequate nutrition for mom and baby, including childcare and homeowner assistance
- Due to education provided by Nurse and Social Worker, member was prepared to go into labor safely
- Avoided preterm labor *no complications for mom or baby. Avoided NICU stay*

"Thanks for your support. You saved me and my baby!"

A BCCC Advocate Success Story

Member profile:

- 23-year-old female member was contacted by the Care Advocate after being identified for the ED Outreach Campaign
- Member presented to the ED with complaints of left lower quadrant abdominal
  cramping, pain, and vomiting. She was administered IV fluids and had lab work drawn. Was discharged with instructions to eat a bland diet.
- Symptoms continued and member presented to a different ED. She again was administered IV fluids, had lab work drawn, as well as abdominal x-ray and ultrasound. She was diagnosed with a UTI and uterine fibroids and was discharged with antibiotics and an antiemetic.

We respect our members' right to privacy; the names and images used in our care profiles are pseudonyms.

Care Advocate Interventions:

- Provided active listening and the ability to talk about her health concerns in a private manner
- Reviewed the discharge instructions with the member to ensure understanding
- Educated the member on her diagnosis and pain control
- Emailed her educational material to support and enhance education
- Assisted member in finding a PCP and OB/GYN in her area
- Educated on the appropriate levels of care and provided information about the 24-Hour Nurse Line, BCBSM On-Line Visits and employer benefits

Success Outcomes:

- Member was able to establish a relationship with a PCP and OB/GYN Physician
- Member is now knowledgeable of Advocacy Teams that are available for additional support
- Member was thankful for the support and guidance
- Member contact employee provided benefits

"Thank you so much for the support you provided!

A Blue Cross Coordinated Care Core Success Story

Member profile:

- 10-month-old male
- Born prematurely, at 28 weeks' gestation
- Medical conditions: Brain bleed, hyperbilirubinemia, kidney disease
- Admitted to Neo-natal Intensive Care Unit (NICU)
- Developed numerous complications related to early delivery
- Underwent numerous medical procedures

We respect our members' right to privacy; the names and images used in our care profiles are pseudonyms.

Interventions:

- Parents educated on members multiple conditions
- Coordinated with Hospital Social Worker to help improve members status and move toward a sooner and safe discharge home
- Coordinated Home Health Care
- Educated on importance of NICU provider follow ups
- Care Manager reviewed discharge plans with member's parents early on
- Educated first time parents of a NICU baby what to expect and how to keep member safe at home
- Provided emotional support for working father who had to manage driving wife to and from the hospital several days each week
- Behavioral Health resources provided to parents

Success Outcomes:

- Nurse was able to get secure members needed equipment
- Home care initiated
- Connected family with employers Employee Assistance Plan (EAP)
- Ensured timely follow up to specialists
- No new ER or in-patient hospital admissions
- Nurse educated caregiver on proper home care for member
- Employer group vendors provided

"I can't thank you enough for your help and support through all of this with my baby. Here are pictures of the baby you helped."

A Blue Cross Coordinated Care Enhanced Success Story

Blue Cross Blue Shield Blue Care Network of Michigan

Member profile:

- 33-year-old pregnant female, identified for High-Risk Maternity Cohort
- History of prior miscarriage, high blood pressure in pregnancy, depression, anxiety, uterine fibroids
- Member with anxiety over previous miscarriage at 19 weeks, current high-risk pregnancy and knowledge deficit related to high blood pressure, pre-eclampsia and nutrition
- Member with open care gaps related to high blood pressure (Controlling BP)
- Member had post- delivery care needs regarding signs and symptoms of blood clots and post-partum depression

We respect our members' right to privacy; the names and images used in our care profiles are pseudonyms.

Interventions:

- Member onboarded to digital app and voiced satisfaction in the ability to text care team at any time for support or questions
- Nurse educated member on signs and symptoms of pre-eclampsia, high risk pregnancy complications, when to call doctor, COVID and importance of PCP/OB follow up
- Nurse reviewed medications and importance of monitoring BP at home
- Registered Dietician worked with member on healthy eating, calories, and normal weight gain in pregnancy
- Nurse coordinated with member's PCP/OB regarding possible blood clot post delivery
- Nurse provided extensive post-partum education self and infant care, nutrition, breast feeding, mastitis, post partum bleeding and importance of family/psychosocial support

Success Outcomes:

- Nurse supported member through High-Risk pregnancy and uncomplicated delivery without ER visits, inpatient admissions, readmissions or NICU admissions.
- The member remained compliant with her medications, plan of care and follow up with her PCP, OB/GYN and Behavioral Health Provider.
- The member improved her understanding and management of her High-Risk Pregnancy preventing complications.
- Member used community resources such as online support groups and obtained psychosocial support through her family and counselor as encouraged by CM

"Thank you for checking in on me! I appreciate the care and advice you all have given me thus far in my pregnancy!"