WORKING WITH EMPLOYEES WITH CHRONIC MEDICAL CONDITIONS

A Report Prepared for the

Legislative Finance Committee

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INTRODUCTION

As part of its interim work the Legislative Finance Committee included developing an understanding of the financial condition of the state employee and Montana University System group benefits. At its June 2016 meeting the LFC requested a report on the interface between state employees with chronic, high cost medical conditions and the state's group benefit plans. The purpose of this report is to provide a summary of concerns and identified potential improvements based on interviews with state employees experiencing chronic medical conditions that can, and have, resulted in high costs to the state's benefit plans. The number of individuals interviewed do not make up a representative sample of members and do not represent the plan as a whole but provide a sample of real experiences for the committee to consider.

CHRONIC MEDICAL CONDITIONS

Chronic medical conditions refer to diseases that have a duration that extends for a period of time, in some cases for the rest of one's life. Common chronic diseases include arthritis, asthma, cancer, diabetes, and hepatitis C. According to the Centers for Disease and Control and Prevention:
Chronic diseases and conditions - such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis – are among the most common, costly, and preventable of all health problems

- As of 2012, about half of all adults – 117 million people – had one or more chronic health conditions. One out of four adults had two or more chronic health conditions
- Seven of the top 10 causes of death in 2010 were chronic diseases. Two of these chronic diseases – heart disease and cancer – together accounted for nearly 48% of all deaths
- Obesity is a serious health concern. During 2009-2010, more than one-third of adults, or about 78 million people, were obese (defined as body mass index [BMI]>30kg/m2). Nearly one in five youths aged 2 -19 years was obese (BMI>95th percentile)
- Arthritis is the most common cause of disability. Of the 53 million adults with a doctor diagnosis of arthritis, more than 22 million say they have trouble with their usual activities because of arthritis
- Diabetes is the leading cause of kidney failure, lower-limb amputations other than those caused by injury, and new cases of blindness among adults

Many of the health cost management strategies required by both state group benefit plans target behaviors to reduce the employee risk of acquiring a chronic disease such as diabetes or heart disease.

INTERFACING WITH CASE MANAGERS

The State Employee Group Benefit Plan (SEGBP) contracts with a third party administrator (TPA) who employs individuals or vendors with medical expertise to assist state employees with chronic disease(s) navigate the nuisances of the plan's benefits and the treatment recommended by medical professionals. Utilizing population risk management tools, the TPA is able to identify individuals with chronic disease conditions in need of assistance. The member is then contracted by a care manager or disease manager to offer programs and assistance with their condition. Should the condition reach a critical level where the member is accessing more benefits, an individual case manager will be assigned to work with the member, providers and the plan to manage the case. This process assigns the case manager only if the member is accessing a high dollar amount of benefits.

Medical professionals in Montana often refer patients to regional hospitals for further diagnostic tests and consultation in cases of rare or refractory chronic medical conditions. For example, Mayo Clinic in Rochester, Minnesota or the University of Washington in Seattle are two well-known diagnostic facilities outside of the state that are used by doctors in Montana. Within Montana there are also hospitals that serve as regional diagnostic centers for conditions such as heart disease, brain injury, or rare and chronic medical conditions. These hospitals are considered comprehensive regional resources central

to the regional medical system. Referral for further diagnosis whether in state or out of state may be an indication of the need for case manager assignment prior to a critical level of benefit costs being reached.

Potential Improvement

While case managers are assigned based on a critical level of benefits or a high dollar amount, patients may be referred to a regional hospital for further diagnosis and treatment prior to identification of a chronic medical condition. Another tool that could considered by the state employee group benefit plans would be to assign case managers when an employee is being treated at a regional diagnostic facility. A referral for treatment, prior to a specific diagnosis or cost level, may indicate a need for case management up front. Assignment of a case manager at this stage of the process could provide employee assistance at the beginning of the medical diagnosis.

Implications When Changing Third Party Administrators

SEGBP and the MUSGBP contract with a third party administrators (TPA) to develop provider networks and pay medical providers for services to state employees. SEGBP has changed the third party administrator of its plan twice in the last five years so, in this period, employees have worked with three different TPAs.

According to Health Care and Benefits Division (HCBD) staff the pre-authorization requirements may change from the new TPA medical policy or SEGBP making changes to their plan document. One individual interviewed did not have their diagnosis or monthly treatment requirement change in the last five years. However, during this period the requirements for authorizing their treatment changed. One administrator required approval every month. Another produced prior authorization on a 90 day basis. The current administrator uses external independent medical review organizations for reviews done during the appeal process.

Having to re-educate medical professionals on the complications of the individual's disease and treatment can occur during the approval process, in part due to the change in TPA professionals determining approval. In the individual's example, the latest TPA required an authorization and initially denied the treatment based on medical necessity/experimental language that requires additional investigation on behalf of SEGBP. The employee was required to appeal the denial to receive treatment that had been provided monthly for almost five years. According to HCBD staff, during the appeal a different medical professional was used as directed by the TPA's policies that the initial reviewer would not review their own work. As a result of this policy, a medical physician with experience in the condition was not utilized until the final step in the appeal.

For the employee, the complications related to the changing TPA approval process resulted in interruption of treatment and further resulted in an extended hospital stay when the monthly approval was not provided in a timely manner.

Potential Improvement

According to HCBD, the state may require in all administrative contracts that upon termination of the TPA contract a list of members in disease management, case management or with outstanding authorizations be provided to a new administrator so members can be contacted in advance and coordination can take place prior to any continued treatment.

As part of the transition process the state employee group benefit plans may wish to consider requiring the third party administrators to utilize an assigned professional that continues to make treatment authorizations throughout the period of the contract. This might reduce requirements on state employees to constantly provide medical records and physician recommendations for ongoing treatment and could reduce costs for unnecessary hospitalizations.

An alternative option would be to develop alternative requirements for prior authorizations, one for individuals that have a chronic or rare medical condition and another for individuals that have a single episode of care that may require prior authorization.

Another consideration may be to have plan case managers familiar with the employee, the diagnosis, and the treatment assist in working with the third party administrator to reduce the number of prior authorizations required if the employee's diagnosis, treatment, and medical condition do not change.

INTERFACING WITH THE STATE EMPLOYEE HEALTH CENTER

Chronic medical condition are, in many cases, complex diseases that require medical specialists to manage all aspects of treatment, including recommending blood work, a variety of tests/scans, or regular physical examinations. Employees with these types of conditions can be seen by medical professional on a weekly or monthly basis and have tests done on a similar schedule. As employees are required to fit medical treatment into busy schedules they may opt to have their medical tests done at the medical specialists' office to reduce time away from work and delays resulting from getting results transferred from one provider to another. Those interviewed forfeit medical discounts offered at the State Employee Health Centers to reduce time away from work, centralize medical care, and facilitate delivery of test results to their specialists.

The State Employee Health Center does not treat these types of complex diseases. They do provide blood work, physical examinations, etc. with copayments eliminated for state employees who utilize them. The copayments are eliminated due to the lower costs of being seen at the State Employee Health Center. However, using these facilities to obtain lower cost blood work or physical examinations requires an employee seeing a medical specialist to go from one medical facility to another and visit additional health professionals, at added costs to the plan.

Since the State Employee Health Centers are licensed as primary care facilities, with health coaching available, they are not set-up to provide specialty care. An employee or dependent must often seek specialty care in the marketplace. More work is needed to help make the health center – outside specialist interface work smoother, to maintain optimum patient convenience and plan cost efficiency.