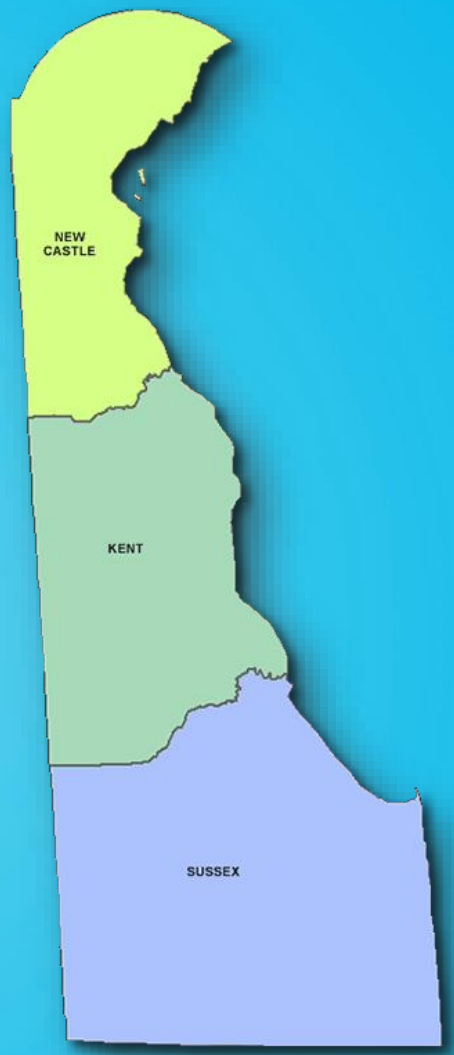
Highmark Delaware Presentation to State Employees Health Plan Task Force

October 8, 2015



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Discussion Topics

- Pay for Value Programs
- Provider Reimbursement
- Fraud, Waste & Abuse
- Care Management Programs
- Transparency Tools
- Questions

Pay for Value Programs

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Pay for Value Programs

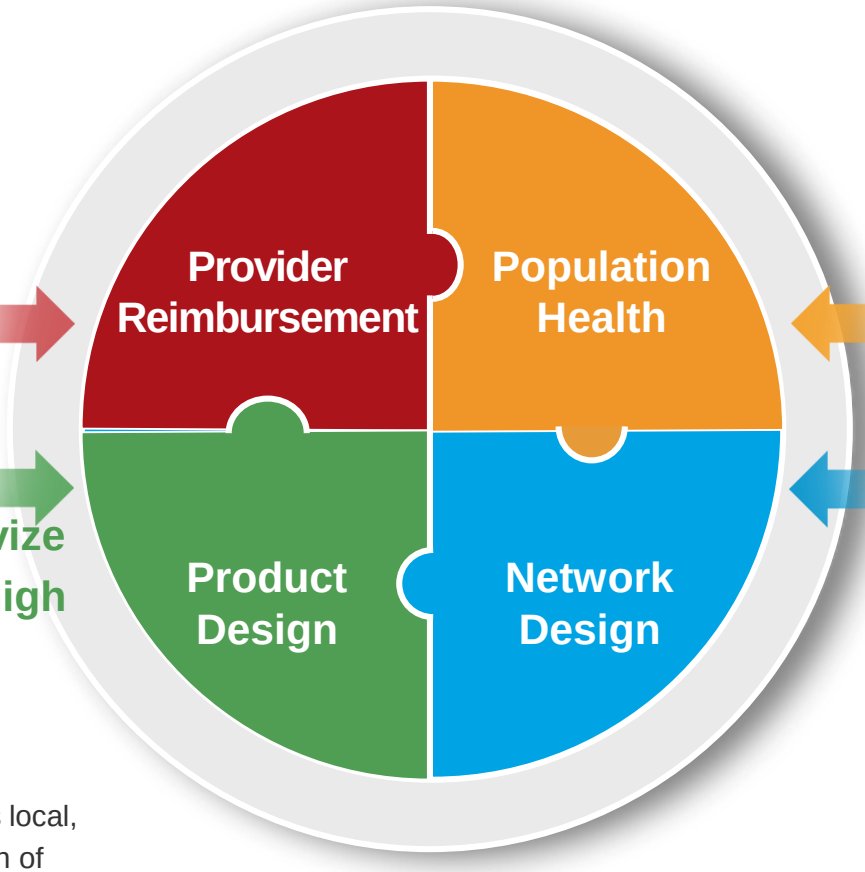
Transforming Health Care Delivery
Locally Delivered, Nationally Leveraged

Innovative reimbursement strategies to create value

- Pay-for-value that rewards continuous improvement
- New gain-sharing and risk-sharing models
- Incentives for referrals to more efficient and higher quality specialists

Products that incentivize members to choose high value providers

- Transparency around provider cost and quality
- Benefit design that encourages local, high value care (e.g. elimination of co-pays for designated specialists)



Outcomes-focused strategies designed to enable provider success

- IT tools and capabilities to support providers
- Care coordination
- Clinical pathways support

Development of comprehensive high value providers networks

- Clear identification of high value PCPs, specialists, and hospitals within our networks
- Incentives for both physicians and members to utilize those providers

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Pay for Value Programs

Highmark P4V evolution is leading the way in shifting how care is delivered and financed

Historical FFS healthcare system (volume focused)	New value-based healthcare system (value focused)
Fee-for-service – paid for doing more, not for performing or managing care better	Pay for **VALUE**, not Volume
Member and provider incentives not aligned to promote better health outcomes	Rewards and incentives for quality, **HEALTH OUTCOMES**, patient satisfaction
Lack of care coordination	**CARE COORDINATED** between primary care, specialists, hospitals, other providers
Lack of integration across the care continuum	**INTEGRATION** of patient care across the care continuum
Duplication in testing and inadequate follow-up care	**TRANSPARENCY**, technology, information, efficiency, reduces duplication

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Pay for Value Programs

HIGHMARK DE PCMH AND ACO PROGRAM OVERVIEW - AS OF 7/9/15

	PCPs		Specialists		Number of Members in Program	% of Total Commercial Membership
	Number of Groups	Number of Individual PCPs	Number of Groups	Number of Individual Specialists		
PCMH:					**42,270*** Fully Insured = 12,380 Self-Insured = 7,659 SOD = 22,231	**5%****
New Castle County	23	66	---	---		
Kent County	11	28	---	---		
Sussex County	9	35	---	---		
Total:	**43**	**129**	**---**	**---**		
MedNet ACO:					**53,106**	**16%**
New Castle County	30	78	63	232		
Kent County	13	30	21	59		
Sussex County	22	41	29	70		
Total:	**64**	**149**	**109*****	**361**		

* Approx. 27k PCMH members are also ACO members
** Calculation excludes 27,000k ACO members.
*** 30 Specialty types are represented across the 109 specialist groups
NOTE: There are also 148 PCP groups participating in the Quality Blue P4V Level 1 Program that are not included in these numbers.

Additional Program Statistics: (Highmark total commercial membership used for calculation: 332,926)

PCPs		Specialists		Members	
Total unique PCPs participating in a Pay-for-Value program:	**278** *(36% of Highmark DE's participating PCPs)*	**Total unique Specialists in a Pay-for-Value program:**	**361** *(25% of Highmark DE's participating Specialists)*	**Total unique members being treated by a Pay-for-Value provider:**	**68,376** *(20% of Highmark DE's total commercial membership)*

Alignment with the State Innovation Plan

1. The Highmark P4V redesign has been developed with the intent to align with the State Innovation Plan where possible. Highmark and DCHI share the same goal of achieving “The Triple Aim.”

2. Collaborative discussions between DCHI and Highmark have resulted in a high percentage of alignment of the quality measures outlined on the Common Scorecard.

3. Highmark and DCHI are having additional discussions regarding Care Coordination and appear to be aligned on DCHI’s Care Coordination approach.

Provider Reimbursement

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Provider Reimbursement – Inpatient and Outpatient Hospital Services

ENVIRONMENT

- Hospital spend represents largest portion of total medical spend.
- Delaware hospital market is dominated by a single hospital or system in each region.
- Hospital acquisitions of physician practices have accelerated and increase costs to the system.
- Hospital payments per adjusted admission are significantly higher in Delaware than other Highmark markets.

INPATIENT SERVICES

- Highmark is converting hospital reimbursement from fee-for-service to DRG-based agreements and is targeting to have migrated 80% of Inpatient claims activity to a DRG-based approach by the end of 2016.
- DRG-based contracts have fixed annual increases based on quality performance.
- Three Delaware hospitals are also participating in Highmark's Hospital Quality Blue Program

OUTPATIENT SERVICES

- Highmark has converted many high volume services from percentage of charges to fixed fee schedules or case rates at most hospitals.
- Products are being modified to incentive use of high-quality cost-effective alternatives.

Provider Reimbursement –Physician Services

OVERVIEW

Highmark Delaware's base professional fee schedules are reviewed and analyzed annually and have remained unchanged for several years. Cost savings initiatives have included:

- 2009: Reductions in reimbursement for medications administered in office
- 2011: Reductions in reimbursement for diagnostic imaging and laboratory services
- 2015: Reductions to selected professional services priced higher than CMS, especially around high-tech diagnostic imaging

Highmark Delaware will continue to:

- Evaluate current contracts by specialty to incorporate Pay for Value (P4V) components
- Identify outlier contracts based on cost

Provider Reimbursement – Ancillary Services

OVERVIEW

Delaware's ancillary fee schedules are reviewed and analyzed annually and have remained unchanged for many years. Cost savings initiatives have included:

- 2014: Reductions in oxygen reimbursement
- 2015: Reductions in durable medical equipment (DME) paid to non-DME providers
- 2016: Reductions in specialty pharmacy reimbursement

Highmark Delaware will continue to:

- Evaluate current contracts by specialty to incorporate Pay for Value (P4V) components.
- Identify opportunities to leverage savings from consolidated fee schedules including:
  - DME (network-wide)
  - Home Health
  - Infusion

Fraud Waste & Abuse

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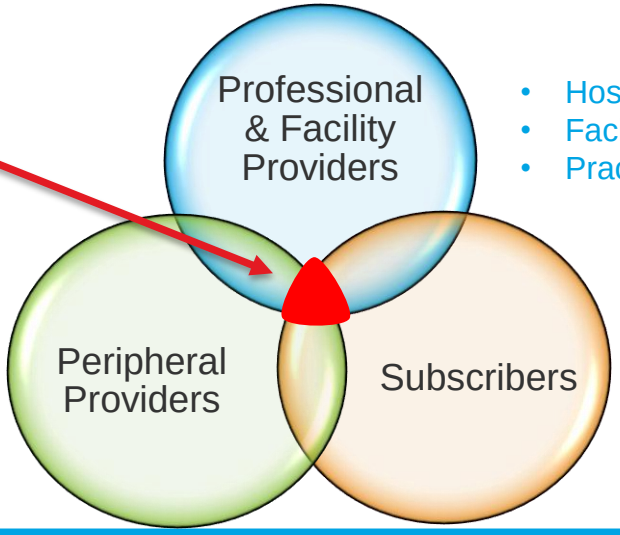
Our Risk Based Approach Drives Results

Highmark's Financial Investigations and Provider Review (FIPR) team takes a risk based approach to combating fraud, waste and abuse. We use data analytic software, CMS recovery vendors and an internal team to target the three domains of healthcare that contain the largest spend and highest risk…

FIPR's Focus:
~3-10% of spend is potentially FWA

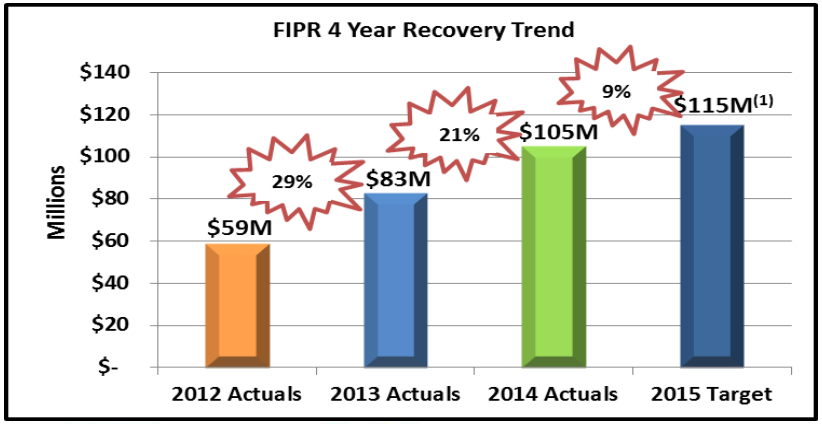


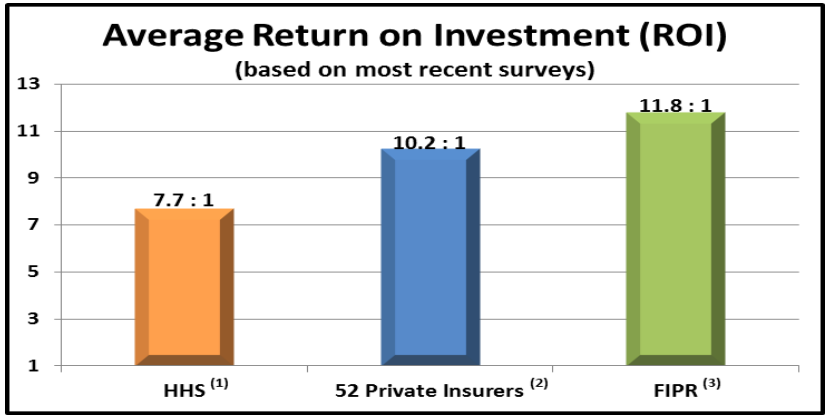
- Hospitals
- Facilities
- Practitioners

Education

- DME
- SNF
- HH
- HIT
- Etc.

- CMS, FEP, ACA
- Groups
- Members





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Business Drivers and Our Impact

Business Drivers

FIPR investigates FWA and recovers overpayments on behalf of Highmark, FEP, other Blue Plans *and* our group customers.

Group Customers: We are stewards of our customers' money. Highmark reviews and investigates potentially fraudulent and/or inappropriate billings submitted by Providers and Participants.

Members: The significant amount of money being spent on healthcare across the country brings risk to patients in the form of unnecessary and otherwise inappropriate procedures and billings.

We work with local, state and federal law enforcement agencies to identify and remove unscrupulous providers from our network.

Highmark's Bottom Line: By recovering overpayments, implementing pre-pay policies and edits and educating providers, we have a direct impact on Highmark's financial performance which helps lower the cost of healthcare.

Government Programs: Highmark sells and administers government funded products including those under Medicare Advantage and the Federal Employee Program. These products are heavily regulated and require FIPR to abide by and report on 21 unique FWA internal controls.

In addition, FIPR has strong relationships with the CMS Medic as well as the HHS and OPM OIG. Our teams frequently collaborate on FWA cases.

Our Impact

The success of our FWA program is measured in the financial impact that we make and the results of our regulatory audits.

Financial and Compliance Impacts:

Our financial impact has grown from $59,000,000 in 2012 to a target of $140,000,000 in 2016. Additionally, we have had zero reportable audit findings.

Our Evolution

Over the last five years, FIPR has invested in our core competencies and changed our approach.

- Enhanced data mining tools
- Best of breed audit partners
- Expanded our audit scope to include high dollar claim reviews, ancillary audits and clinical audits

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Care Management Programs

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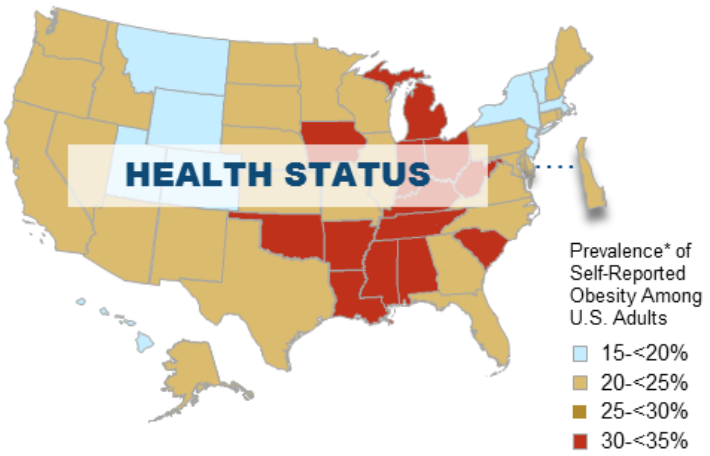
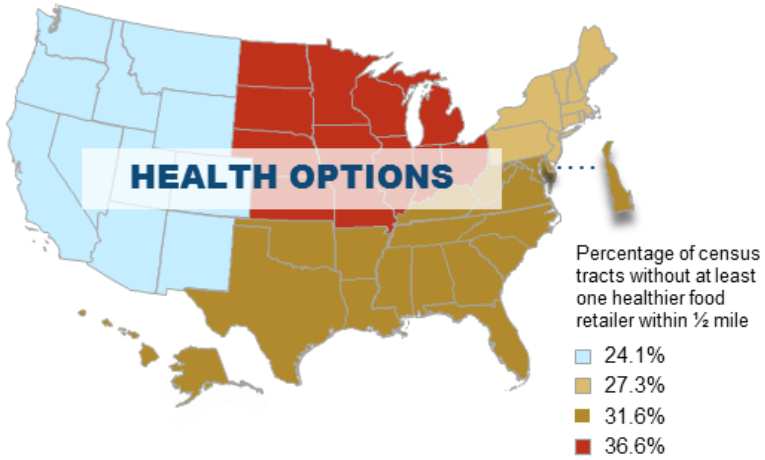
Local Factors Contribute to Cost & Outcomes

Prevalence of Obesity Among U.S. Adults



Access to Health Food Retailer



In 2009, the CDC-funded Delaware Cancer Consortium (DCC) was awarded the 2009 Exemplary State Comprehensive Cancer Control Implementation award for its cancer prevention initiatives. Major milestones were achieved by DCC in cancer prevention by implementing a strategic 4-year plan and partnering with the American Cancer Society, state policy makers, hospitals and medical practices.

Delaware:

- now leads the nation in the percentage of people who have received a colonoscopy or sigmoidoscopy in the last 5 years
- ranks 7th in the country for the percentage of women older than age 50 who have had a mammogram in the last 2 years
- ranks 11th for the percentage of women aged 18 or older who have had a Pap smear in the last 3 years

Source: Delaware Cancer Consortium Five Year Results 2009-2014

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REACHING ACROSS THE HEALTH CONTINUUM TO IMPROVE CARE OUTCOMES AND CONTROL COSTS

Integrated, proactive approach to health care management involves members at every stage of health and helps clients to effectively manage costs at every phase of care.

Disease Management
Utilization Management
Case Management
Behavioral Health Management
Health Coaching
Maternity Management
24-Hour Nurse Line

Primary Nurse Model
Health Personality Segmentation
Promotion of Preventive Care
Targeted Approach for High Risk Members
Resources for Moderate Risk Members
Member Health & Wellness Resources

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EMPOWERING POPULATION HEALTH AND WELLNESS WITH HEALTH PERFORMANCE SOLUTIONS

DATA DRIVEN

A combination of clinical, utilization, self reported, and financial variables to identify members

- Medical & pharmacy claims (if available)
- Gaps in care
- Wellness profile*

Monthly identification and stratification

- Identifies conditions
- Risk stratifies by severity of condition
- Reviews care gaps / opportunity for coaching intervention

INTENSIVE MODEL

POPULATION = CLIENT RISK POOL

High Risk Members With a Condition and Those At Risk for a Condition Are Identified and Targeted by a Designated Delivery Team

Top 11 to 18% of client's adult population is targeted for outreach, health coaching, and wellness coaching

Programs for Nearly 40 Health Conditions, including:

- Asthma
- Coronary Artery Disease
- Depression
- Diabetes
- Gastrointestinal Reflux
- Hypertension
- Hyperlipidemia
- High Risk Pregnancy
- Low Back Pain
- Obesity
- Migraines
- And more

Our Predictive Risk Model analyzes health care spend, the burden of chronic disease, condition history, co-morbidity impact, and other clinical factors to predict the risk of members from one year to the next.

Wellness profile and biometric data is incorporated into the identification and stratification process.

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Customer Engagement and Transparency

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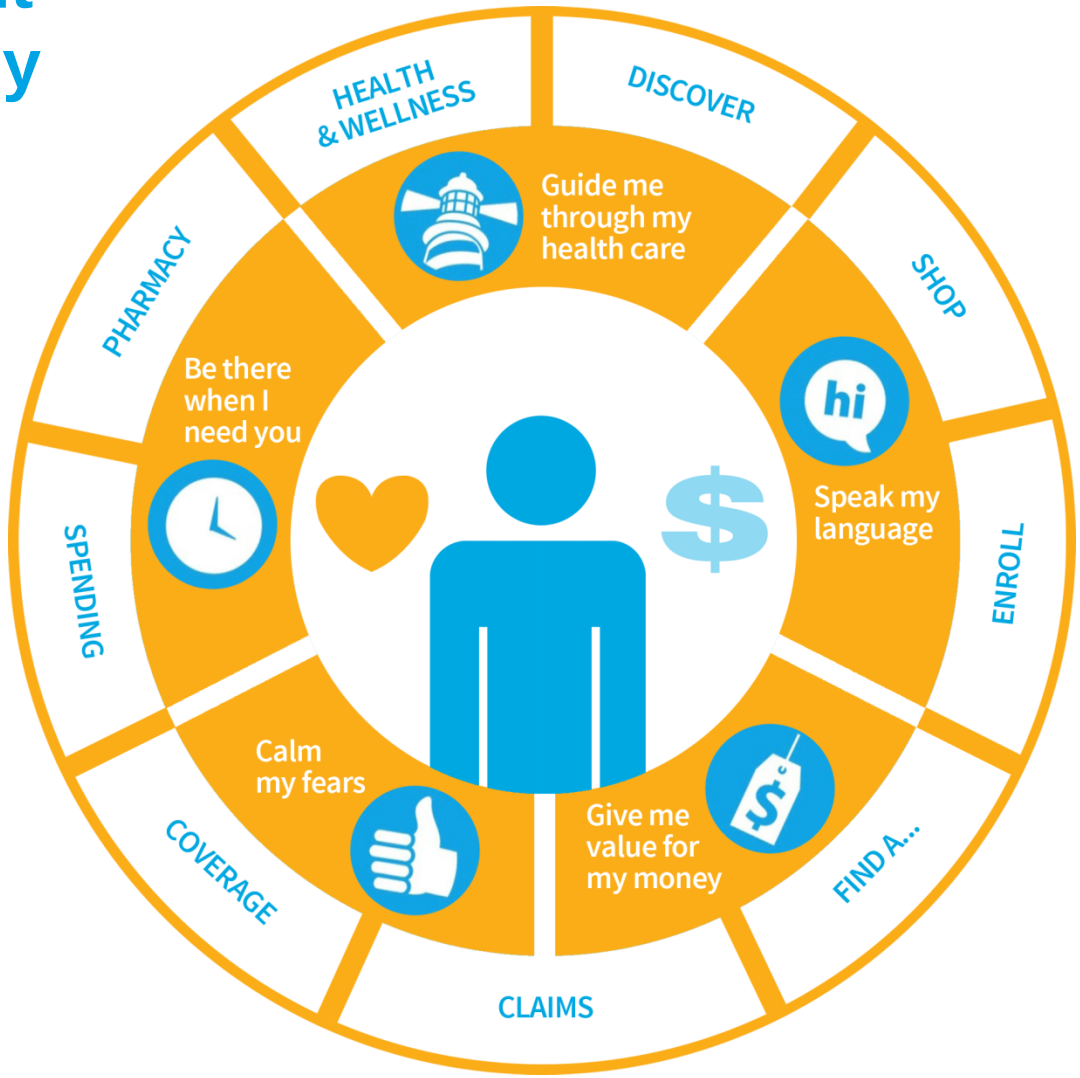
Customer Engagement and Cost Transparency

At Highmark, our approach to consumer engagement and transparency is informed by research-based guiding principles that reflect the member's voice



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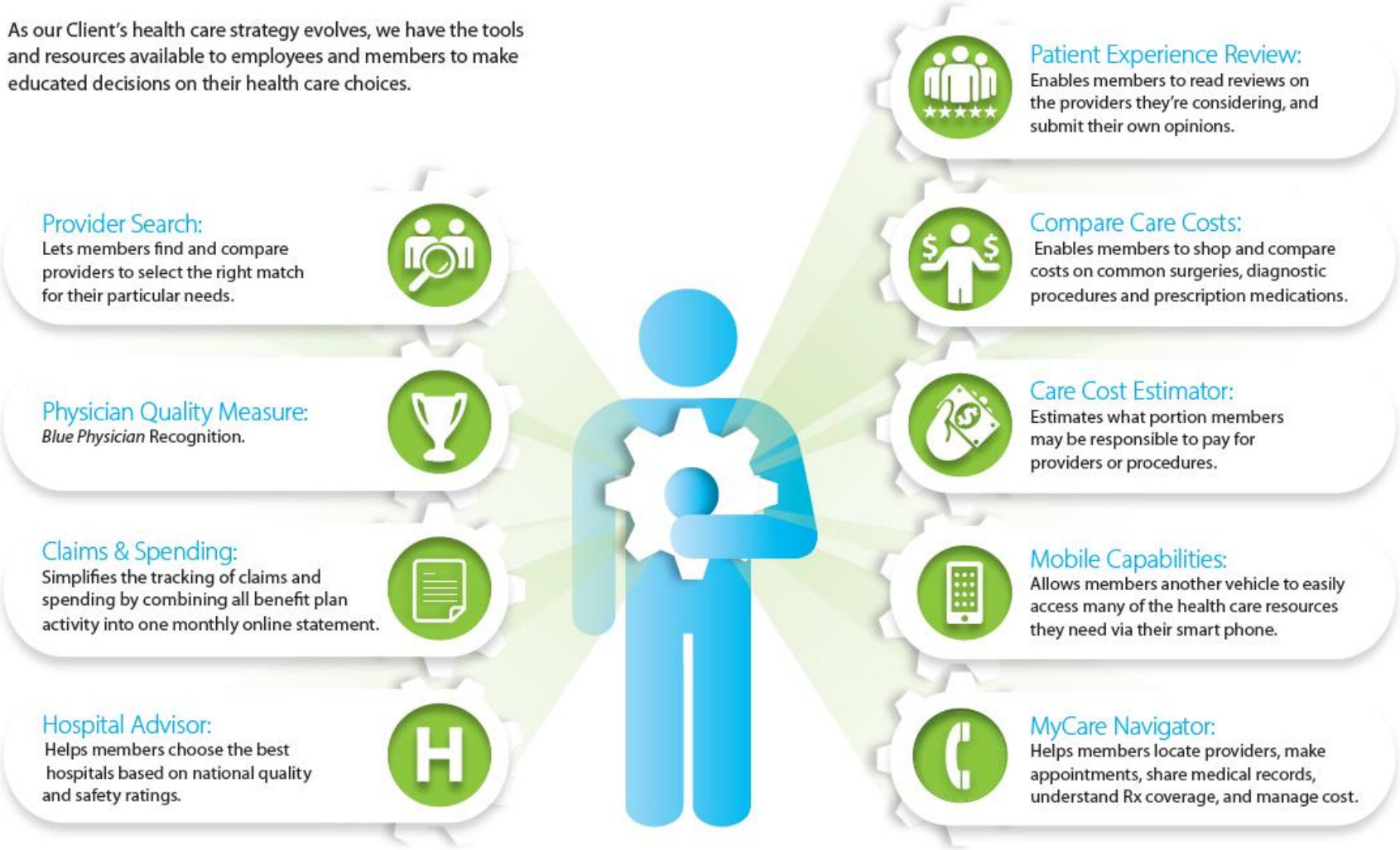
Member Engagement Tools

EDUCATING THE MEMBER

As our Client's health care strategy evolves, we have the tools and resources available to employees and members to make educated decisions on their health care choices.



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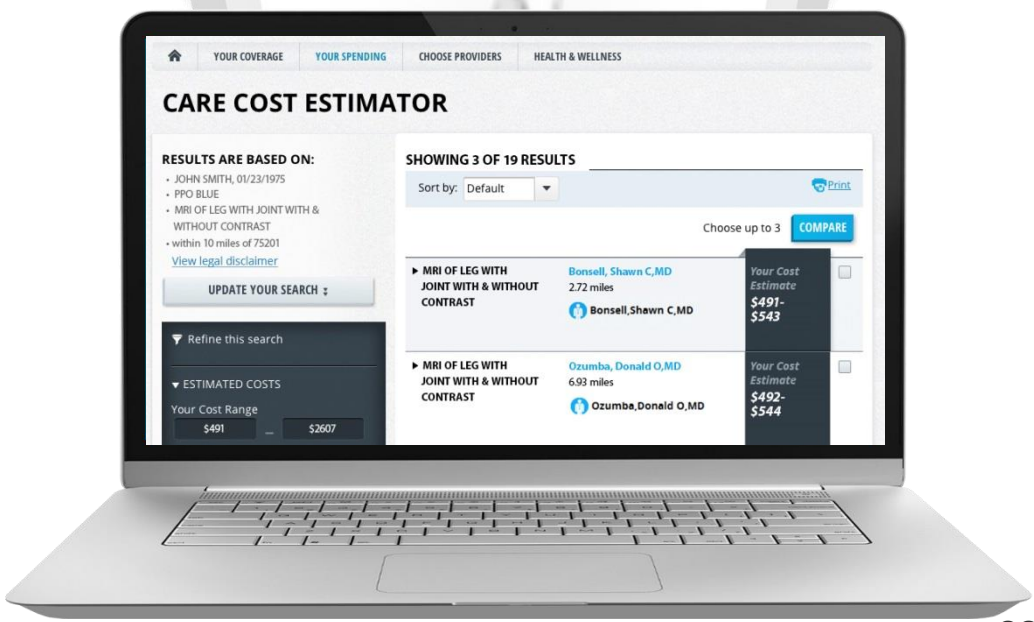
Care Cost Estimator

Power of Blues data reveals true cost for procedures to members

- Members compare costs, with a goal of making health care a 100 percent shop-able experience
- Turns them into super smart shoppers
- Integrates with claims and spending so members can manage their budget.



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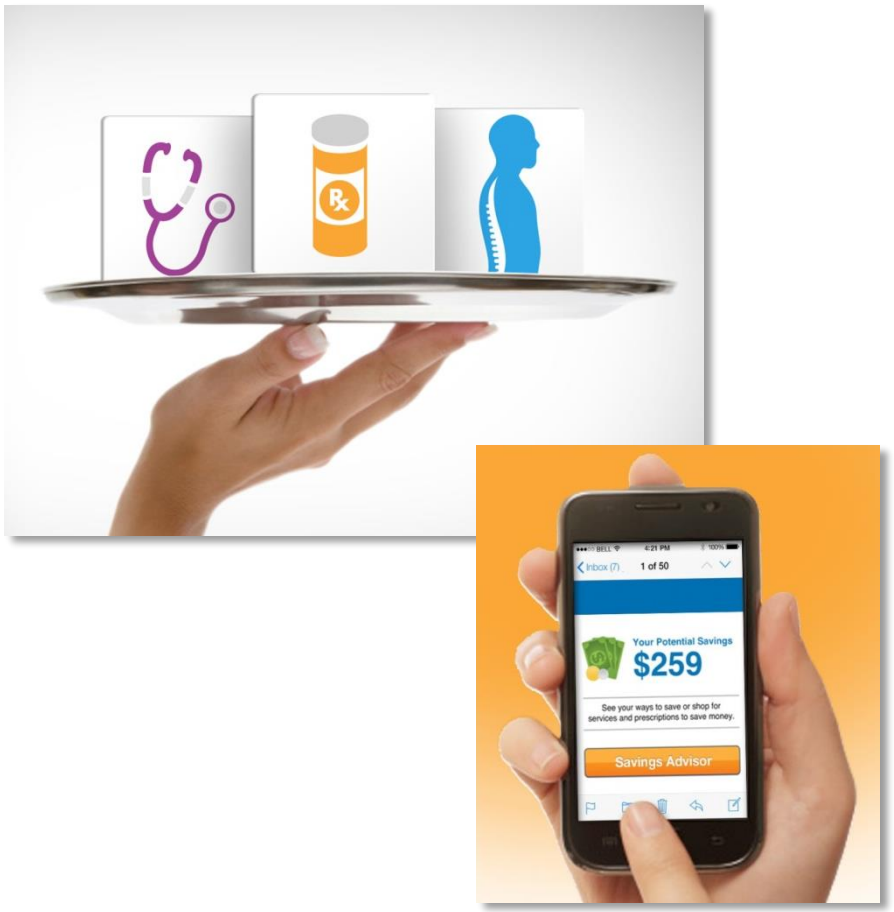
Personalized Savings Messages

Maximizing opportunities for engagement using outbound messages to members, aggregating data to tell them about ways they can save

- Teaches the value of shopping
- Sends email or text savings alerts monthly
- Integrates messages into web experience



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Executive Summary

Highmark BCBS Delaware will:

- Continue to lead **provider transformation** through reimbursement models that reward right behaviors and better outcomes
- Evaluate and renegotiate *all* provider (PCP's, Specialists & Hospitals) contracts to include **pay-for-value** components
- Continue our collaboration with SEBC on **consumer engagement** strategies that empower Delawareans to be better consumers of health care.
- Remain focused on **care management** programs that ensure right care – right place – right time that is coordinated across the delivery system

Improving Health	Increasing Patient Satisfaction	Reducing Cost

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Questions

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