CCMU FOLLOW UP ANSWERS

1. Is the DHIN being leveraged as either an input into Highmark's predictive model to identify/stratify members, or for any other purpose within Highmark's health management programs?

    Highmark receives a file listing emergency department users from the DHIN daily. From that list, Highmark's clinical team selects members with non-emergent conditions and calls them to educate on appropriate use of the emergency room and other alternatives (i.e., PCPs, urgent care center, etc.) They also assess members who have acute and/or chronic illnesses and may benefit from Disease Management or Case Management. Attached are Highmark's guidelines used for these calls (DHIN TOCs.docx).

    In addition to the DHIN, other claims sources that Highmark uses to identify members for outreach are its medical claims and the Rx claims sent to Highmark by ESI. These claims are put through an algorithm via Verisk software that generates the 'ID and stratification' list, which is Highmark's main source for identifying members for outreach calls.

    Highmark's Health Coach Team also makes outreach calls based on other sources such as Utilization Management authorization and claims invoice reports received weekly. This often allows for quicker outreach than relying solely on the predictive modeling identification and stratification process.

2. Please provide more specific clinical outcomes for the CCA/CCMU programs. To what extent can you share additional details / reports showing positive health outcomes produced by these programs? Do either program's performance guarantees include improvements in clinical metrics? If so, can you provide examples?

    Please see the attached case study for more details on clinical and other outcomes from the CCMU program.

    Both the CCA and CCMU PGs include improvements to clinical outcomes. Examples include: Improvements in A1C, increases in preventive care utilization, and improved medication compliance.

3. Are there any requirements that the State demonstrate a certain threshold level of engagement in order for the PGs within the CCA and CCMU models to apply? If so, (1) what are they, and (2) do you have any concerns about the State's ability to meet those requirements, given what you know about the behavior of their population and how that may be impacted by those enhanced care management models?

The engagement caveats that exist within the State's current contract with Highmark is not part of the CCA/CCMU PGs. In fact, there are no engagement requirements for the CCMU PGs to apply. Caveats for the PGs include the fact that year over year measures require 12 months of historical data to be available and Highmark must have valid phone numbers for 70% of targeted members. Further, Highmark indicated that they are not concerned about the State ability to 'qualify' for any PGs that may trigger under CCA/CCMU.