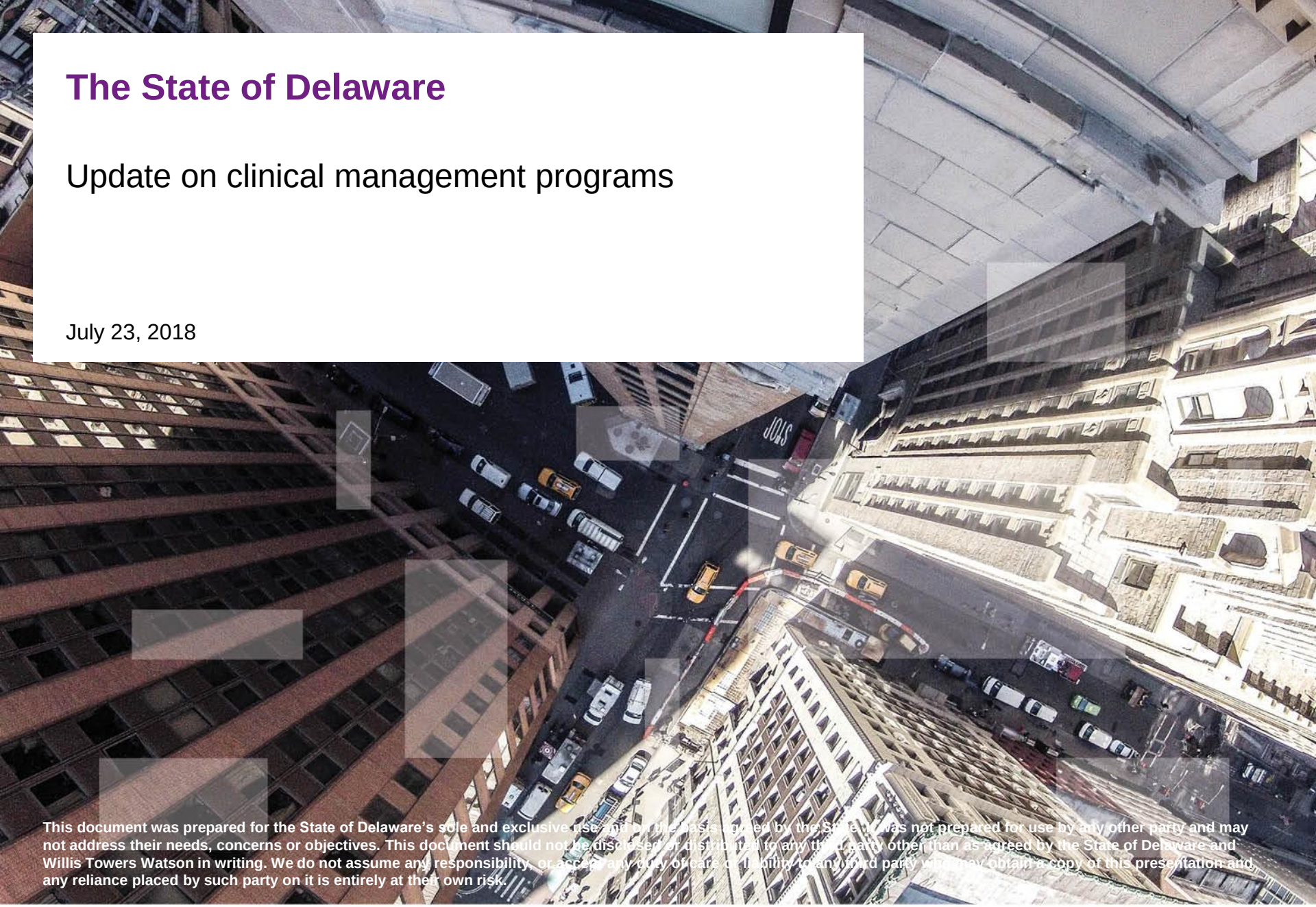
The State of Delaware

Update on clinical management programs

July 23, 2018



Willis Towers Watson

Update on clinical management programs

Overview

- In Spring 2017, the SEBC voted to enhance the clinical programs provided by Aetna and Highmark to support members' health management efforts for the FY18 plan year
  - Aetna implemented a value-based care delivery model powered by Carelink CareNow program for participants in the HMO plan
    - Supports the GHIP population enrolled in the HMO plan
  - CDH Gold plan participants continue to be managed under Aetna's traditional case and disease management program
  - Highmark implemented an enhanced care management program called the Custom Care Management Unit (CCMU), which is available to all Highmark plan participants except those Medicare retirees in the Medicfill plan
- Purpose of today's discussion is to provide the SEBC with an update on the status of member engagement in each of these programs and provide an update on the timeframe for evaluating the broader impact of each program on utilization, clinical and financial outcomes

Update on clinical management programs

Program description

- Aetna value-based care delivery model – Carelink CareNow
  - Provides care management and primary care coordination in partnership with Christiana Care Health System (CCHS)
  - Includes a financial risk-sharing arrangement with CCHS for managing the health of the HMO population and reducing trend for that plan
  - Leverages a team of CCHS clinicians supported by shared electronic medical records (“Carelink CareNow”) to deliver telephonic and in-person care management at CCHS facilities and at numerous participating primary care physician (PCP) practices across the State of Delaware
  - Technology platform integrates real-time alerts from the Delaware Health Information Network (DHIN) with hospital and PCP electronic medical records and Aetna HMO member claims to provide Carelink Care Coordinators with the latest information about the supported population
  - Highly sophisticated program that is uniquely tailored to the health care IT infrastructure of Delaware with access to a robust dataset enabling targeted identification of a variety of clinical management opportunities

Update on clinical management programs

Program description (continued)

- Aetna traditional case and disease management for CDH Gold plan participants
  - Case management program involves a specialized nurse working in conjunction with the member and their physician to coordinate care and improve health outcomes and/or cost of care
  - Two types of case management opportunities:
    - Complex case management for members who have experienced a health event and are likely to have care and benefit coordination needs after the event
    - Proactive case management for members identified by Aetna who could benefit from support for optimizing their use of the medical plan, such as frequent ER users and members who are not up-to-date with preventive care recommended for their age and gender
  - Disease management program identifies opportunities to engage members in closing gaps in care and supporting members' efforts to self-manage conditions
  - Both programs rely on a combination of member claim data (including Rx claims), utilization management triggers, lab results, and referrals to identify opportunities to engage members in one or both of these programs

Update on clinical management programs

Program description (continued)

- Highmark CCMU
  - Enhanced care management program combining nurse outreach and health advocacy to holistically manage acute, complex and chronic conditions
  - Members with greatest need for care are identified and outreached to in real time, with expanded and focused triggers and earlier identification than in typical care management program, such as:
    - Lower threshold for high dollar claims
    - Lower frequency of ER visits
    - Discharge from inpatient setting
    - Lower member risk score
  - Technology platform leverages predictive modeling using members' medical and Rx claims data (along with other sources such as utilization management triggers, lab results and referrals) to identify opportunities for outreach in a condition-agnostic approach
  - Enhanced clinical staffing levels and care manager training to support higher touch clinical model
  - Health advocates respond to inbound member calls to Highmark customer service; trained in motivational interviewing and with access to the same predictive modeling output as the nurse care managers, these advocates are key to driving further engagement and referrals to nurse care managers and other health resources available to members

Update on clinical management programs

Measuring member engagement

- Direct comparison of the two programs is not possible due to differences in each program's structure and execution
  - Differences include ways of identifying members for outreach, engaging with members once contact has been made, and providing clinical oversight for members under management
  - For the same reason, comparison of each FY18 clinical program to the prior program in place for FY17 will not be on a consistent basis, but it would be reasonable to compare composite measures such as total cost per member per year or population health risk score for FY17 and FY18
- To evaluate the effectiveness of each clinical program, the following will be evaluated:
  - Baseline cost per member per year (FY18) with same metric in subsequent years
  - Baseline health risk score (FY18) with same metric in subsequent years
  - Improvements in health outcomes, targeted to specific clinical conditions (i.e., diabetes) when possible
    - Further dialogue with each vendor regarding reporting capabilities is necessary prior to confirming specific metrics for the SEBC, and is a component of ongoing reporting discussions that occur regularly with the medical vendors

Update on clinical management programs

Timeline for evaluating broader impact

- Additional experience is necessary before the impact of these programs can be evaluated beyond engagement
  - At least 1 full year of plan data is recommended for evaluating the program's early impact on health outcomes of the population and the financial performance of the plan
  - Additional reporting to the SEBC on the impact of these programs based on the results of the first program year is planned for a future meeting in Fall 2018
  - Enhanced care management programs that target acutely or chronically ill members typically start producing a return on investment after the first few years of operation
  - Programs designed to target preventive care and wellness have a longer time horizon associated with a return on investment in the program
    - These programs often aimed at members with low medical spending, so medical claims cost savings opportunities are limited in the near term

Aetna Carelink CareNow (HMO plan)

Initial engagement results

- Carelink team has engaged[1] 5,641 unique members since July 2017 in a variety of care management activities, including:
  - Following up with members recently discharged from the hospital
  - Outreach to members and/or their providers based on a variety of alerts (e.g., ER visits, hospital admissions, abnormal test results, high claimant activity)
  - Delivery of condition-specific programs focused on disease management, wellness and comprehensive case management
- Early engagement results:
  - Sustained engagement of members participating in condition-specific programs
    - Total of 5,069 condition-specific programs have been launched
    - Average duration of program enrollment is 100 days, with closure occurring due to completion of the program (67%), inability to reach member (20%), or transfer of the member into a different program
  - Through April 2018, 55% of highest cost[2] and/or highest risk[3] claimants (725 members total) were engaged with Carelink, with remainder under review for referral to a care coordinator
    - Includes 82% of high cost and high risk claimants, 77% of high cost only and 49% of high risk only
  - Improvements in high ER utilization among frequent users (i.e., 2 or more visits in 12 months)
    - Out of 809 members with high ER use, Carelink engaged 576 members (71%)
    - 334 of those (58%) completed Carelink's transition of care program
      - Average ER visits following program completion (0.4 visits / member) are lower than before (2.5 visits / member)
      - 63% of those (210) have had no ER visits since program completion, and only 3% (11) have had 2+ ER visits

1 Defined by Carelink as the distinct count of members participation in programs, reached telephonically, face-to-face or by video, or through assessment or plan of care questionnaires.
2 Defined by Carelink as having greater than $75,000 in combined medical and pharmacy costs in the most recent 12 months.
3 Defined by Carelink as having a prospective health risk score (predicted health expenditures over next 12 month period) above a specified threshold.

Engagement data reflects time period from July 2017 through June 2018.

Aetna traditional case and disease management (CDH Gold plan)

Initial engagement results

- Through March 2018, fewer than 10 members were targeted for case management, though none of them have engaged
- During each quarter in FY18, Aetna has identified an average of 7% of enrolled members (about 300 people) for disease management
  - Fewer than 2% of those (about 5 members) actively engage[1] with a disease management nurse
  - About 32% of those (about 100 members) are unable to be reached
  - Approximately 68% (about 200 members) are actively monitored by disease management nurses, who remain in contact with those members' treating providers, even though the members are not actively engaged with a disease management nurse
  - The remaining 30% (about 100 members) receive supportive monitoring with no interaction with a disease management nurse

1 Defined as the member participating in at least one conversation with a disease management nurse.
Engagement data reflects time period from July 2017 through March 2018.

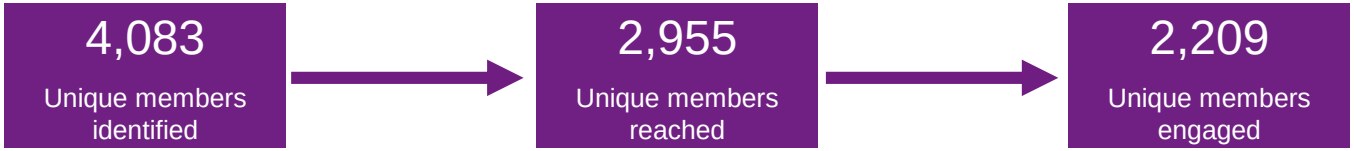
Highmark Custom Care Management Unit (CCMU) (all plans except Medicfill)

Initial engagement results

- CCMU team interacts with members through a variety of approaches including inbound calls by the member to health advocates and outbound calls by nurse care managers, with a focus on:
  - Closing gaps in care
  - Improving health care utilization and clinical outcomes (i.e., avoiding readmissions, reducing unnecessary ER visits, improving medication adherence)
  - Support for navigating the health care needs of the member and their family
- Member engagement[1] in the program has been increasing throughout the year

FY18	Q1	Q2	Q3
Total unique engagement	20.0%	28.4%	34.7%

- Of the members that have been targeted for an outbound call, 72% have been reached, and 75% of those reached have been successfully engaged YTD in FY18



- CCMU nurses have been able to engage at least 50% of high claimants (>$50k claims) each quarter
- Anecdotal reports of reductions in avoidable ER use among engaged members has been reported consistently; further drill-down into this experience will be conducted once full FY18 results are available
- Majority of members have been satisfied with their CCMU experience
  - 95.8% satisfaction rate based on 78.4% survey response rate (total of 1,815 completed surveys)

1 Defined by Highmark as the total number of members who have had an Advocate Engagement, Health Coach Interaction and Health Coach Engagement/total number of members.
Engagement data reflects time period from July 2017 through March 2018.