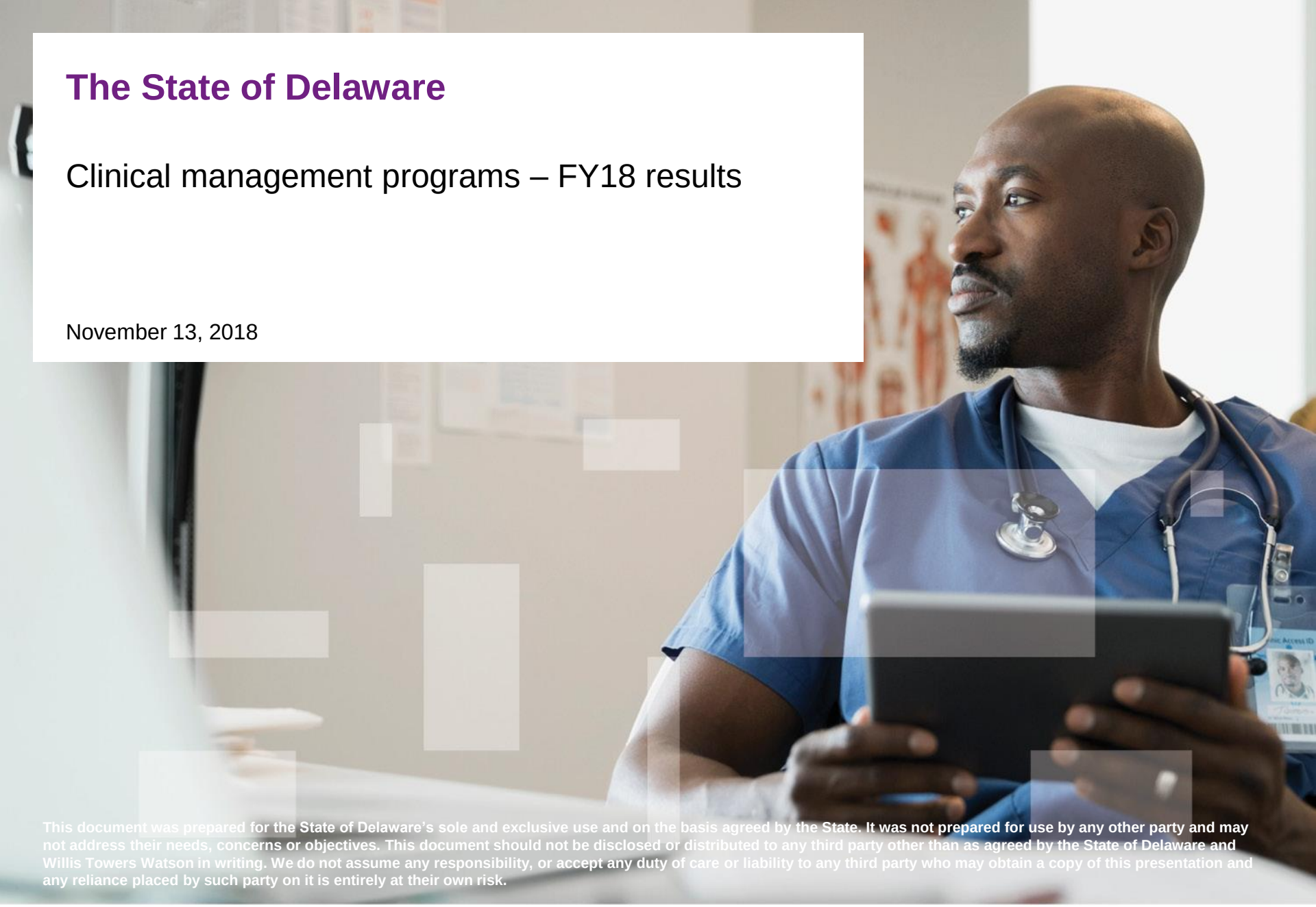
The State of Delaware

Clinical management programs – FY18 results

November 13, 2018



Willis Towers Watson

Clinical management programs – FY18 results

Overview

- The State has implemented several clinical management programs that are designed to help GHIP participants maintain and manage their health
- Results of the following clinical management programs will be reviewed during today's discussion:

Clinical management program name	Vendor(s) responsible for managing	GHIP population supported
Carelink Care Now	Aetna in partnership with Christiana Care Health System	HMO
Case and disease management	Aetna	CDH Gold
Custom Care Management Unit (CCMU)	Highmark	Comprehensive PPO & First State Basic

- A description of each program was previously presented to the SEBC in July 2018 and has been included in the appendix
  - Highlights differences in each program's structure and execution including ways of identifying members for outreach, engaging with members once contact has been made, and providing clinical oversight for members under management
- Additional dialogue on related topics such as member access to and utilization of primary care and mental health services will be conducted in future meetings with the Health Policy & Planning subcommittee

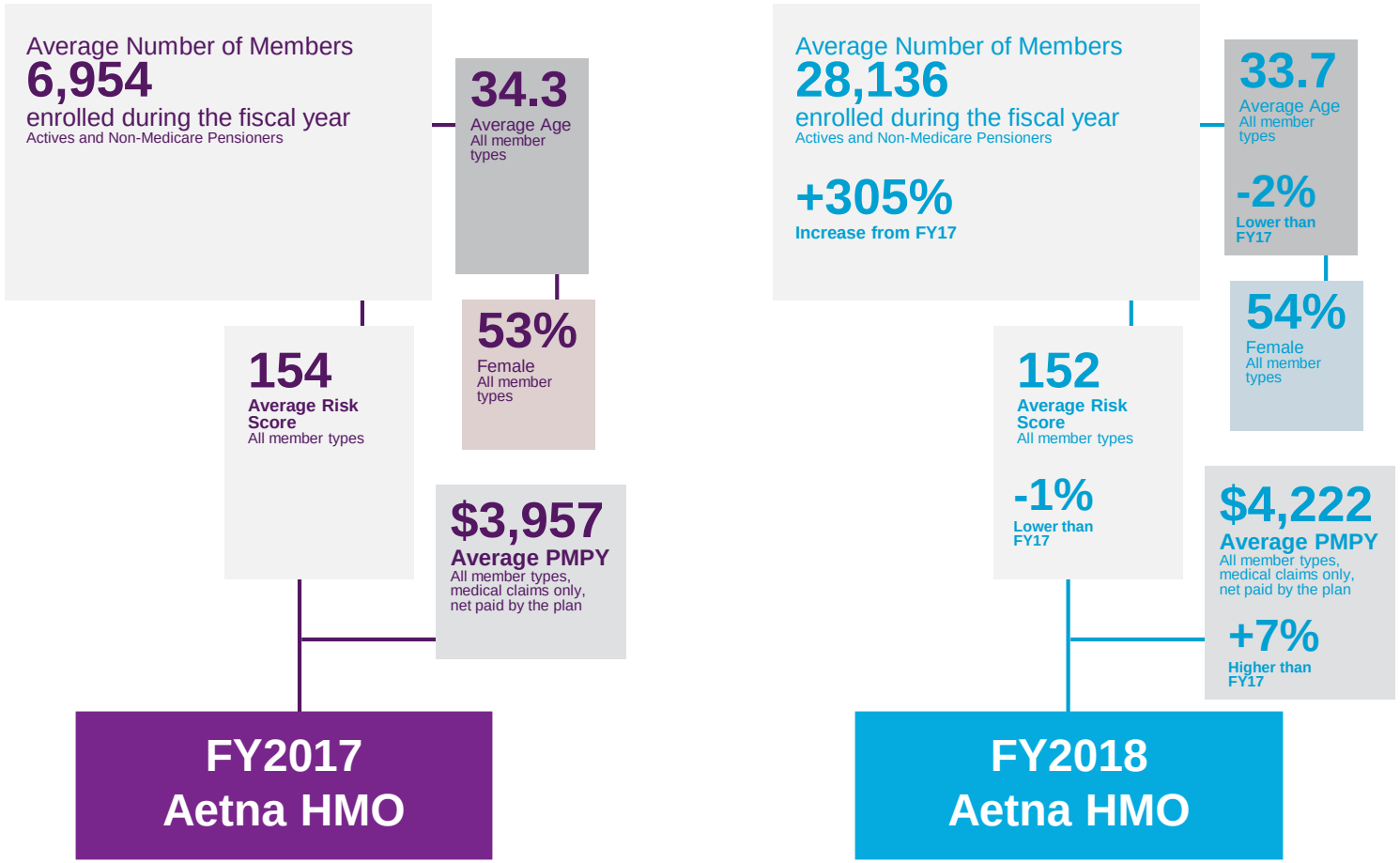
Clinical management programs – FY18 results

Goals and measurement of results

- Despite differences in each program's structure and execution, the goals of all programs remain relatively the same:
  - Engage GHIP participants
  - Promote appropriate utilization of health care
  - Improve health outcomes
- Achievement of these goals should reduce the total cost of care for GHIP participants and the plan over time
  - 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
    - The clinical management programs that are the focus of today's discussion are examples of enhanced care management programs
    - Financial performance guarantees for both Aetna and Highmark programs in FY18 require 6 months of claim run-out and will be reconciled in early CY2019
  - Programs designed to target preventive care and wellness have a longer time horizon associated with a return on investment in the program
    - These programs are often aimed at members with low medical spending, so medical claims cost savings opportunities are limited in the near term

Aetna HMO plan

Member demographics and key statistics



Data sources: FY2017 – Aetna FY17 Q4 Annual Report, 10/19/17. FY18 – Aetna FY18 Q4 Annual Report, 10/18/18.
Average risk scores from IBM Watson Health and reflect expected relative cost risk of a individual during the report time period compared to the average (100) of a national dataset.

Aetna Carelink CareNow (HMO plan)

Goal – engage GHIP participants

FY18 results

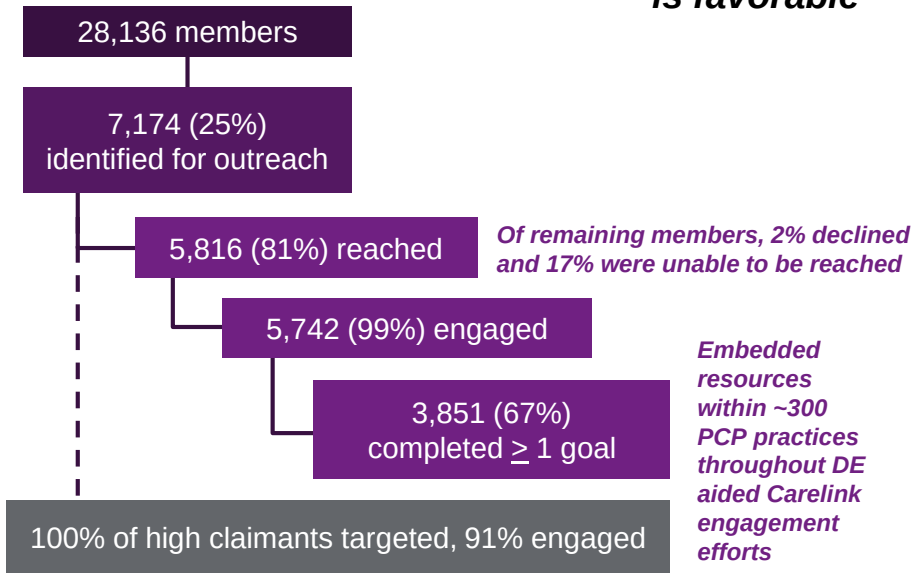
Total engaged as % of eligible population

Engagement defined by Carelink as the distinct count of members who are reached (telephonically, face-to-face or by video) and complete a health assessment or plan of care questionnaire with a nurse care coordinator.

Program is engaging older members who tend to be female employees

Metric	Engaged	Non-Engaged
Average Age	39.5	31.5
% Female	58.5%	51.9%
% member type (i.e., employee vs. spouse vs. other dependent)	Employee = 56% Spouse = 20% Dependent = 24%	Employee = 40% Spouse = 15% Dependent = 45%

Clinical engagement in first year of the program is favorable



Aetna Carelink CareNow (HMO plan)

Goal – promote appropriate utilization of health care

FY17 and FY18 results for entire enrolled population

Change in utilization, all members[1]	Unit	FY17[2]	FY18	Aetna Norm[2]
PCP office visits	Visits/1,000	978	1,078	1,597
Specialist office visits	Visits/1,000	1,765	1,750	2,064
Non-users of health care	% total eligible	*	20%	n/a
Telemedicine[3]	Visits	*	257	n/a
Emergency room (avoidable visits)	Visits/1,000	50	113	n/a
Emergency room (all visits)	Visits/1,000	241	238	283
Inpatient admissions	Admits/1,000	44	45	56
Readmissions	Visits/1,000	1	2	n/a

72% of Carelink-engaged participants had a PCP office visit vs. 42% of non-engaged

5% of Carelink-engaged participants were non-users of healthcare vs. 24% of non-engaged

- Favorable utilization inpatient admissions; readmission rate is low but will continue to be monitored
- Opportunity to increase utilization of PCPs (for non-engaged population), emergency room (avoidable visits) and reduce non-users of health care

1 Data sources: FY17 and FY18 results, and Aetna Norms, from Aetna's FY18 Q4 Annual Report (10/18/18), differences in statistics for engaged / non-engaged participants from Carelink reporting, FY18 results, 10/2/18.
2 Reflects national average utilization rates. Source: Aetna book of business, self-funded HMO plans. Normative data not available for non-users of health care, telemedicine, emergency room (avoidable visits) and readmissions/1,000.
3 Number of telemedicine visits in FY18 estimated based on assumption that 90% of all telemedicine visits by Aetna plan participants were incurred by HMO enrollees (consistent with actual utilization by HMO enrollees in Q3-Q4 FY18).
* FY17 non-users of health care and telemedicine (split by plan) – data not available. Total telemedicine visits in FY17 (across CDH Gold and HMO plans) = 36 visits.

Aetna Carelink CareNow (HMO plan)

Goal – promote appropriate utilization of health care

WTW evaluation of FY18 results

- Significant improvements in outcomes
- Improved outcomes, continue to monitor
- Little / No improvement in outcomes

FY18 results of selected Carelink programs

●	80%	Reduction in unnecessary ER utilization for ***ER Familiar Faces*** program participants	96%	Participants with no ER utilization or improved ER utilization following program engagement
●	32%	Lower likelihood of a ***Transition of Care*** (TOC) participant to incur unplanned ER visit or admission (p=0.005)	7%	TOC participants incurring unplanned ER visit or admission following program engagement
●	16%	Decrease in hospital utilization within 60 days of program enrollment for ***Comprehensive Case Management*** participants	65%	Decrease in ER utilization within 60 days following program engagement
●	42%	Known diabetics with highest risk (HbA1c ≥ 9.0) who were engaged in ***Diabetes*** program	74%	Diabetics who are currently engaged and working on their plan of care with Carelink

Study periods: ER Familiar Faces – Baseline: July-December 2017, Measurement: January-June 2018. Transition of Care – Baseline: July 2016-June 2017, Measurement: July 2017-June 2018. Comprehensive Case Management – Baseline: July 2017 through enrollment in CCM program, Measurement: 60 days following program completion. Diabetes – Baseline: July 2016-June 2017, Measurement: July 2017-June 2018.

Aetna Carelink CareNow (HMO plan)

Goal – improve health outcomes

FY17 and FY18 results for entire enrolled population

HEDIS[1] Cancer Screenings	Gender, Age Range	Lookback Period	FY17	FY18	Aetna BoB[2]
Breast Cancer Mammogram rate	F, 50-74	2 Years	73%	67%	67%
Cervical Cancer Pap Tests rate	F, 24-64	3 Years	73%	69%	73%
Colorectal Cancer Screening rate	M or F, 51-75	10 Years	60%	60%	56%
Preventive Visits	**Gender, Age Range**	**Lookback Period**	**FY17**	**FY18**	**Aetna BoB[2]**
Well Baby Care	M or F, 15 mos.	1 Year	39%	44%	37%
Well Child Visits, Ages 3-6	M or F, 3-6	1 Year	76%	67%	74%
Childhood Immunizations	M or F, 0-2	2 Years	49%	46%	47%
Adolescent Well Care Visits	M or F, 12-21	1 Year	51%	45%	43%

- Opportunity to improve cervical cancer screening rate
- Significant improvements in well baby care, offset by opportunity to increase well care visits for children and adolescents

Contractual shared savings agreement between the State and Carelink based on evaluation of the following quality metrics:

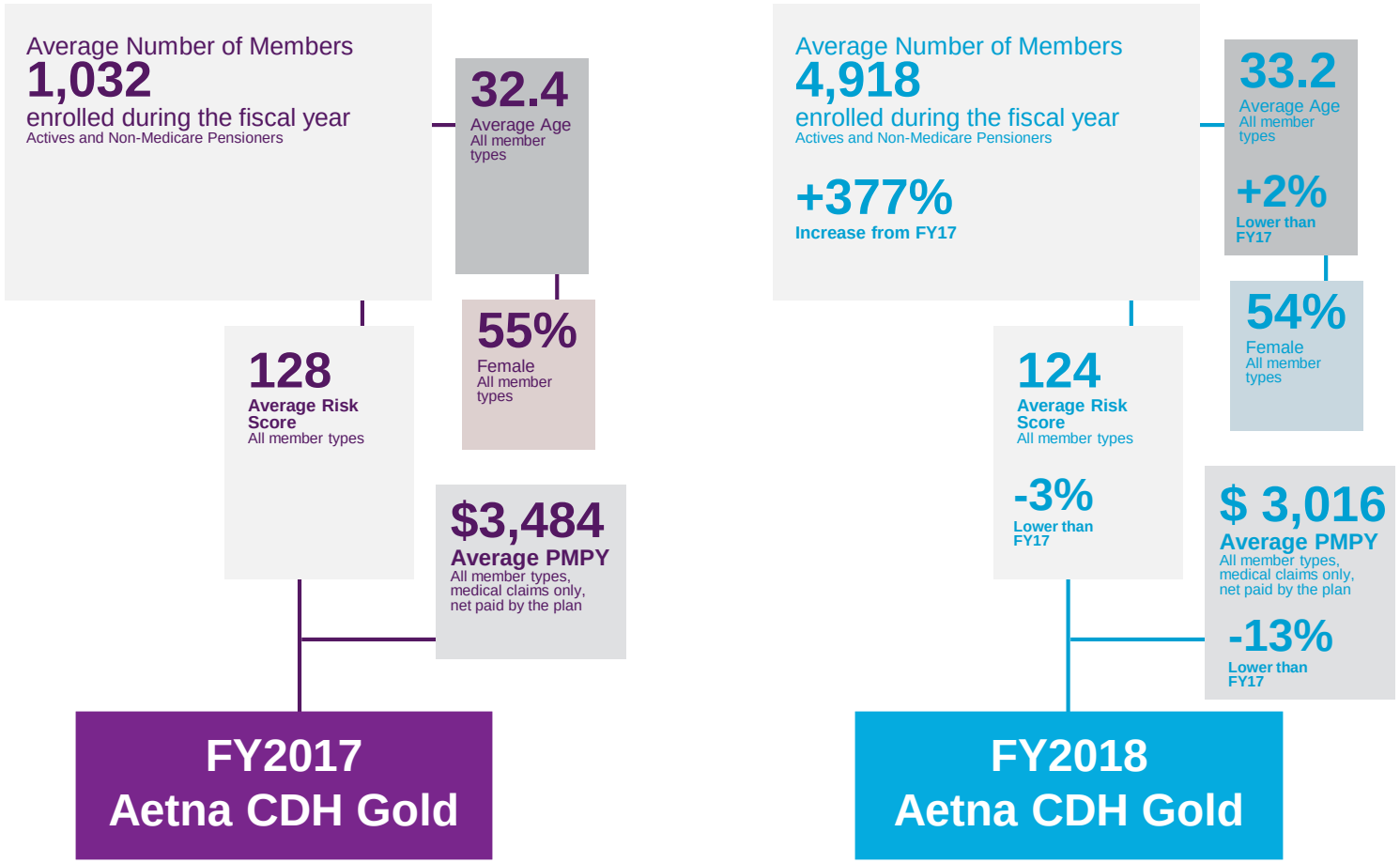
- HbA1c testing
- HbA1c control > 9
- Well child visits, ages 3-6
- Mammogram screening rate

Results of the above measures (variance to FY18 baseline results, with performance measurement beginning in FY19) will be used to determine funding level of potential shared savings bonus for Carelink.

1 HEDIS = Healthcare Effectiveness Data and Information Set, a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
2 BoB = Book of Business, self-funded HMO plans.

Aetna CDH Gold plan

Member demographics and key statistics



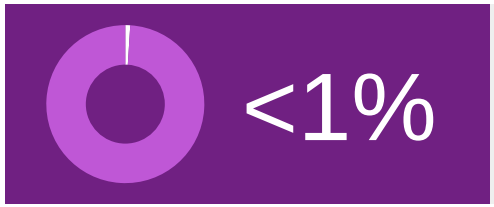
Data sources: FY2017 – Aetna FY17 Q4 Annual Report, 10/19/17. FY18 – Aetna FY18 Q4 Annual Report, 10/18/18.
Average risk scores from IBM Watson Health and reflect expected relative cost risk of a individual during the report time period compared to the average (100) of a national dataset.

Aetna traditional case and disease management (CDH Gold plan)

Goal – engage GHIP participants

FY18 results

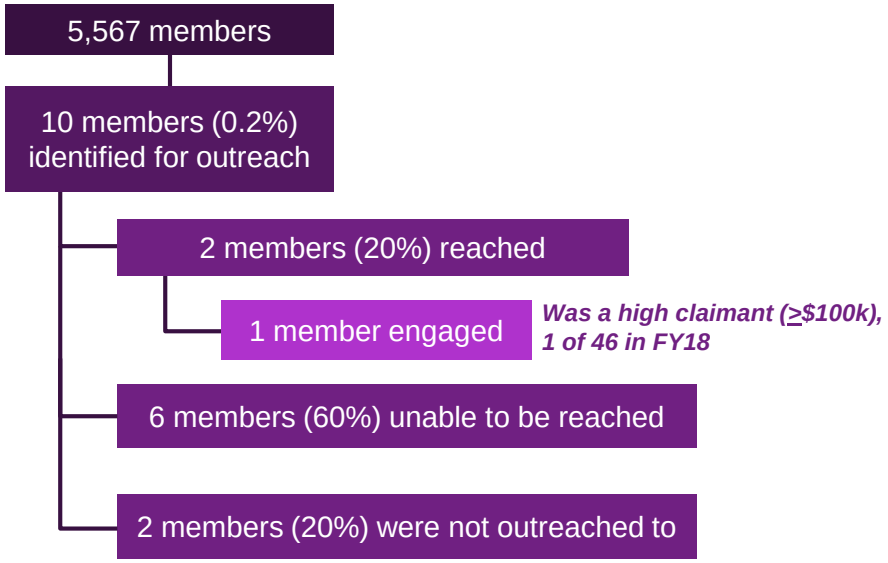
Member engagement in both case and disease management has not materially changed from FY17



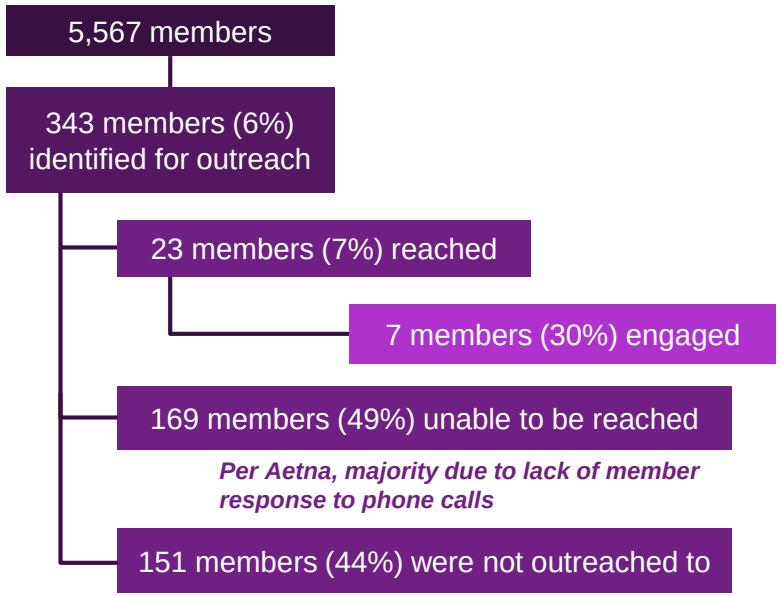
Total engaged as % of eligible population

Engagement defined by Aetna as members with at least 1 completed phone call with a care management nurse for case or disease management.

Case Management



Disease Management



Aetna traditional case and disease management (CDH Gold plan)

Goal – promote appropriate utilization of health care

FY17 and FY18 results for entire enrolled population

Change in utilization, all members	Unit	FY17	FY18	Aetna Norm[1]
PCP office visits	Visits/1,000	1,661	1,635	1,876
Specialist office visits	Visits/1,000	1,974	1,860	2,160
Non-users of health care	% total eligible	*	17%	n/a
Telemedicine	Vists[2]	*	29	n/a
Emergency room (avoidable visits)	Visits/1,000	125	108	n/a
Emergency room (all visits)	Visits/1,000	216	196	155
Inpatient admissions	Admits/1,000	51	39	40
Readmissions	Visits/1,000	1	1	n/a

- Favorable or improved utilization of emergency room (avoidable visits) and inpatient admissions
- Opportunity to increase utilization of PCPs and reduce non-users of health care
- Readmission rate is low but will continue to be monitored

1 Reflects national average utilization rates. Source: Aetna book of business, self-funded PPO plans (comparable network platform to CDH Gold plan). Normative data not available for non-users of health care, telemedicine, emergency room (avoidable visits) and readmissions/1,000.
2 Number of telemedicine visits in FY18 estimated based on assumption that 10% of all telemedicine visits by Aetna plan participants were incurred by CDH Gold enrollees (consistent with actual utilization by CDH Gold enrollees in Q3-Q4 FY18).
* FY17 non-users of health care and telemedicine (split by plan) – data not available. Total telemedicine visits in FY17 (across CDH Gold and HMO plans) = 36 visits.

Aetna traditional case and disease management (CDH Gold plan)

Goal – improve health outcomes

Change in health outcomes[1] for specific clinical conditions	All Members			Engaged Members		
	FY17	FY18	Aetna Norm[2]	FY17	FY18	Aetna Norm[2]
Diabetes						
HbA1c Test Rate	77%	84%	88%	90%	90%	89%
HbA1c Control (<7% or improved by ≥10%)	n/a	58%	62%	n/a	55%	63%
Retinal Eye Exam Rate	28%	40%	51%	24%	45%	60%
Coronary Artery Disease (CAD)						
LDL (Lipid) Test Rate	67%	74%	77%	70%	64%	79%
Medication Adherence	47%	65%	69%	55%	76%	73%
LDL Well Controlled (met LDL target for vascular condition or improved/decreased by ≥10%)	n/a	82%	81%	n/a	84%	84%

- Favorable improvements in key metrics across all members, though changes in the underlying population (i.e., improved health status) may play a greater role due to low member engagement in traditional case and disease management programs

1 Based on the Healthcare Effectiveness Data and Information Set (HEDIS), a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
1 Reflects national average utilization rates. Source: Aetna book of business, self-funded PPO plans (comparable network platform to CDH Gold plan).
FY17 HbA1c Control and LDL Well Controlled – data not available.

Aetna traditional case and disease management (CDH Gold plan)

Goal – improve health outcomes

FY17 and FY18 results for entire enrolled population

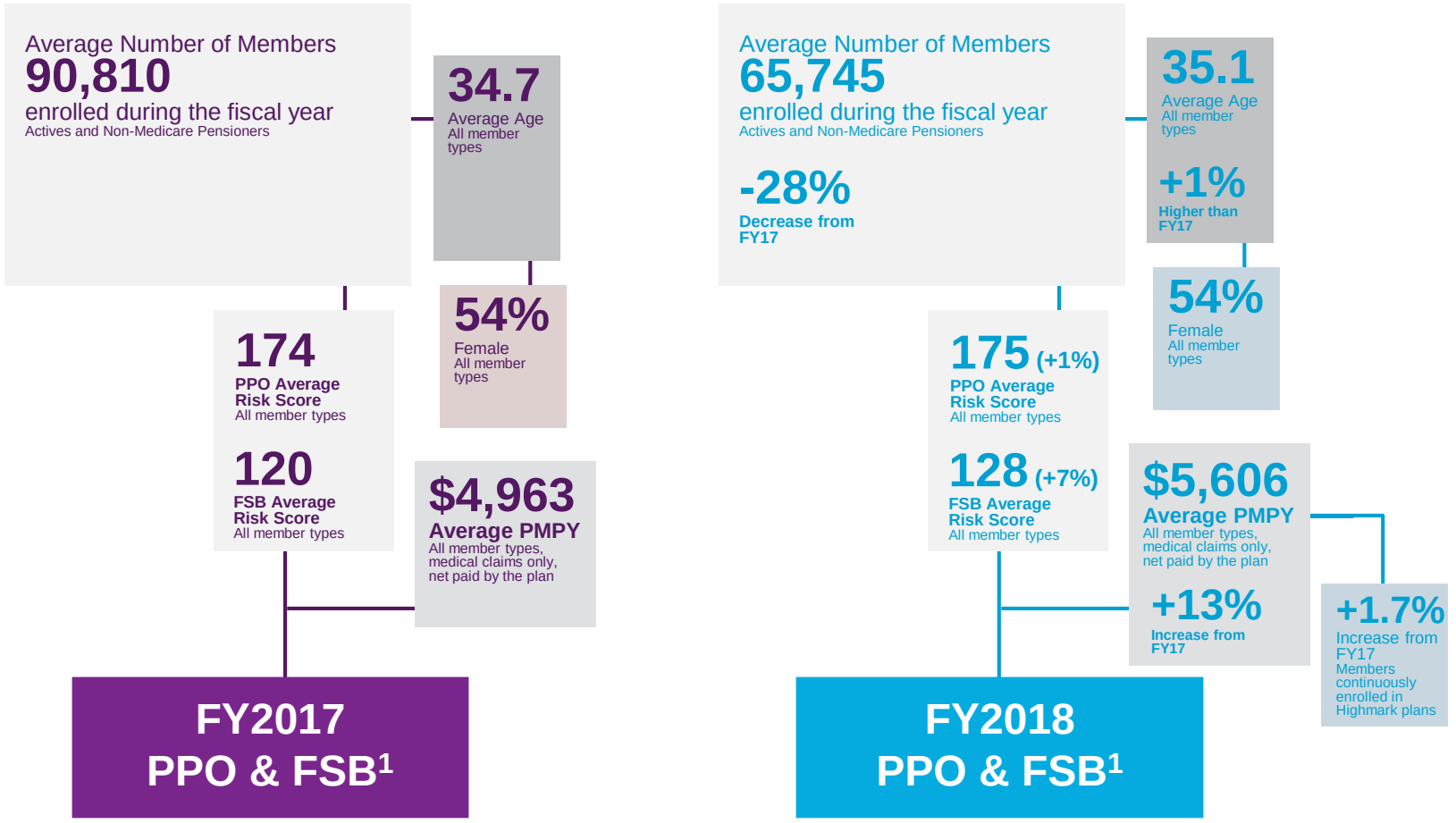
HEDIS[1] Cancer Screenings	Gender, Age Range	Look-back Period	FY17	FY18	Aetna BoB[2]
Breast Cancer Mammogram rate	F, 50-74	2 Years	68%	69%	69%
Cervical Cancer Pap Tests rate	F, 24-64	3 Years	72%	70%	72%
Colorectal Cancer Screening rate	M or F, 51-75	10 Years	48%	50%	55%
Preventive Visits	**Gender, Age Range**	**Look-back Period**	**FY17**	**FY18**	**Aetna BoB[2]**
Well Baby Care	M or F, 15 mos.	1 Year	76%	82%	64%
Well Child Visits, Ages 3-6	M or F, 3-6	1 Year	66%	76%	74%
Childhood Immunizations	M or F, 0-2	2 Years	40%	33%	37%
Adolescent Well Care Visits	M or F, 12-21	1 Year	53%	53%	44%

- Similar to the prior page, changes in the underlying population (i.e., improved health status) are likely to have played a prominent role in driving difference between FY17 and FY18 results

1 HEDIS = Healthcare Effectiveness Data and Information Set, a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
2 BoB = Book of Business, self-funded PPO plans (comparable network platform to CDH Gold plan).

Highmark PPO & First State Basic plans

Member demographics and key statistics



1 FSB = First State Basic plan

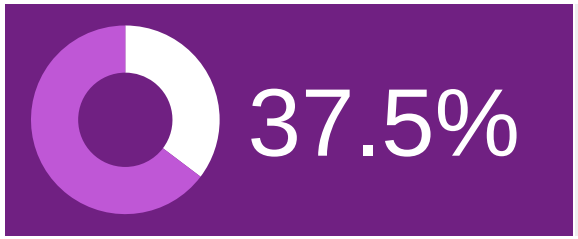
Data sources: FY2017 – Highmark FY17 Q4 Combined Annual Report, 10/19/17. FY18 – Highmark FY18 Q4 Combined Annual Report, 10/11/18.

Average risk scores from IBM Watson Health and reflect expected relative cost risk of a individual during the report time period compared to the average (100) of a national dataset.

Highmark Custom Care Management Unit (CCMU)

Goal – engage GHIP participants

FY18 results



Total engaged as % of eligible population

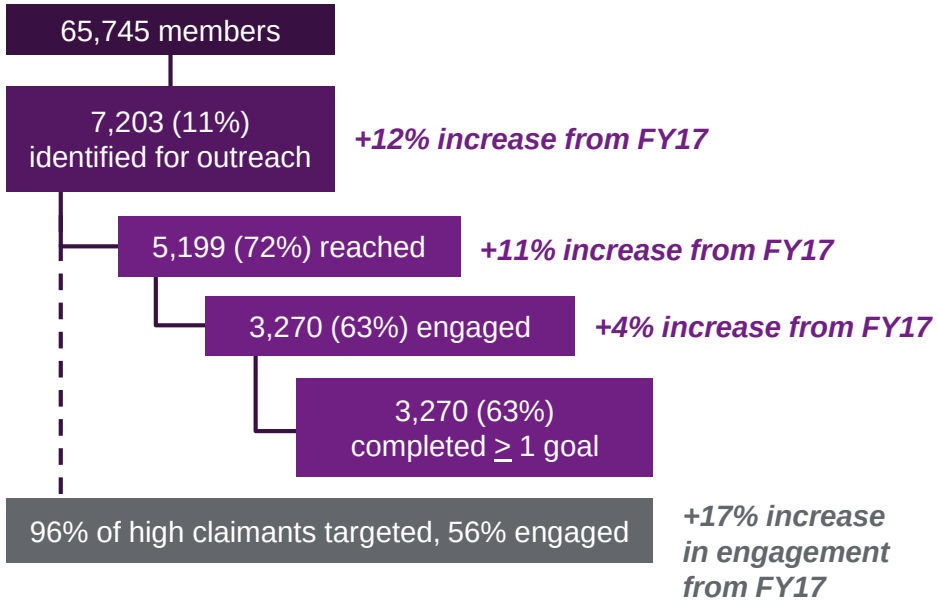
Engagement defined by Highmark as members who have been reached and are actively participating in an eligible program with a Health Coach.

Program is engaging higher cost, higher risk members

Metric[1]	Engaged	Non-Engaged
Average Age	49.5	34.9
% Female	59.8%	53.9%
% member type (i.e., employee vs. spouse vs. other dependent)	Employee = 61% Spouse = 23% Dependent = 17%	Employee = 44% Spouse = 17% Dependent = 39%
Prospective Risk	5.25	1.43
Paid PMPM	$2,922.60	$314.87

1 Reflects engagement statistics for FY18 (7/1/17 – 6/30/18). Paid PMPM (per member per month) reflects average monthly plan cost for members that incurred claims during FY18. Highmark prospective risk reference range: Very High Risk >=3; High Risk 1.5-2.9; Moderate Risk 1.0-1.49; Low Risk 0.5-0.99; Very Low Risk <0.49.

Clinical engagement has improved in FY18



Highmark Custom Care Management Unit (CCMU)

Goal – promote appropriate utilization of health care

FY17 and FY18 results for entire enrolled population

Change in utilization, all members	Unit	FY17	FY18	Highmark Norm[1]
PCP office visits	Visits/member	2.26	2.23	1.96
Specialist office visits	Visits/member	3.09	3.29	2.07
Non-users of health care	% total eligible	8%	7%	11%
Telemedicine	Visits	82	164	n/a
Urgent care	Visits/1,000	510	577	254
Emergency room (avoidable visits[2])	Visits/1,000	207	215	211
Observation room	Visits/1,000	0	0	11
Emergency room (all visits)	Visits/1,000	231	238	230
Readmissions	Visits/1,000	*	2	n/a

- Favorable or improved utilization of PCPs, non-users of health care, telemedicine and urgent care
- Opportunity to further manage emergency room usage which does not result in an admission
- Readmission rate is low but will continue to be monitored

1 Reflects national average utilization rates. Source: Highmark BCBS of Delaware. Normative data not available for telemedicine visits and for readmissions/1,000.
2 Emergency room visits that did not result in an admission.
* FY17 Readmissions/1,000 – data not available.

Highmark Custom Care Management Unit (CCMU)

Goal – improve health outcomes

FY17 and FY18 results for entire enrolled population

Change in health outcomes[1] for specific clinical conditions	FY17	FY18
Diabetes		
Office Visit	99%	99%
HbA1c Test Rate	87%	87%
Retinal Eye Exam Rate	36%	37%
Lipid Test Rate	77%	77%
Microalbumin Rate	67%	67%
Medication Adherence	66%	73%
Hyperlipidemia		
Office Visit	98%	98%
Medication Adherence	48%	52%
Lipid Test Rate	95%	94%
Hypertension		
Office Visit	99%	99%
Medication Adherence	68%	75%

Health outcomes for key clinical conditions have improved or stayed constant year-over year

1 Based on the Healthcare Effectiveness Data and Information Set (HEDIS), a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

Highmark Custom Care Management Unit (CCMU)

Goal – improve health outcomes

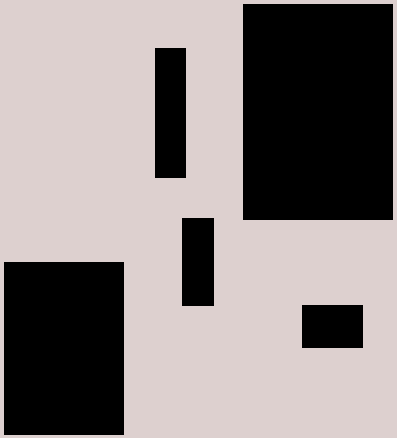
FY17 and FY18 results for entire enrolled population

Change in preventive care utilization, all members	FY17	FY18	Highmark Norm[1]
Breast Cancer Screening (Mammogram)	67%	67%	62%
Cervical Cancer Screening (Pap Test)	69%	70%	60%
Colorectal Cancer Screening	58%	63%	58%
Preventive Physical Exam	22%	24%	27%

Preventive screening rates have improved or remained constant year over year and are higher than Highmark's national norm

1 Reflects national average preventive screening rates. Source: Highmark BCBS of Delaware.

Appendix



Aetna value-based care delivery model – Carelink CareNow

Program description

- For members enrolled in the HMO plan
- 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 an interdisciplinary team of clinicians using an IT enabled population health management platform that interfaces with the DHIN to support primary care 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

Aetna traditional case and disease management

Program description

- For members enrolled in the CDH Gold plan
- 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

Highmark Custom Care Management Unit (CCMU)

Program description

- For members enrolled in the Comprehensive PPO and the First State Basic plans
- 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