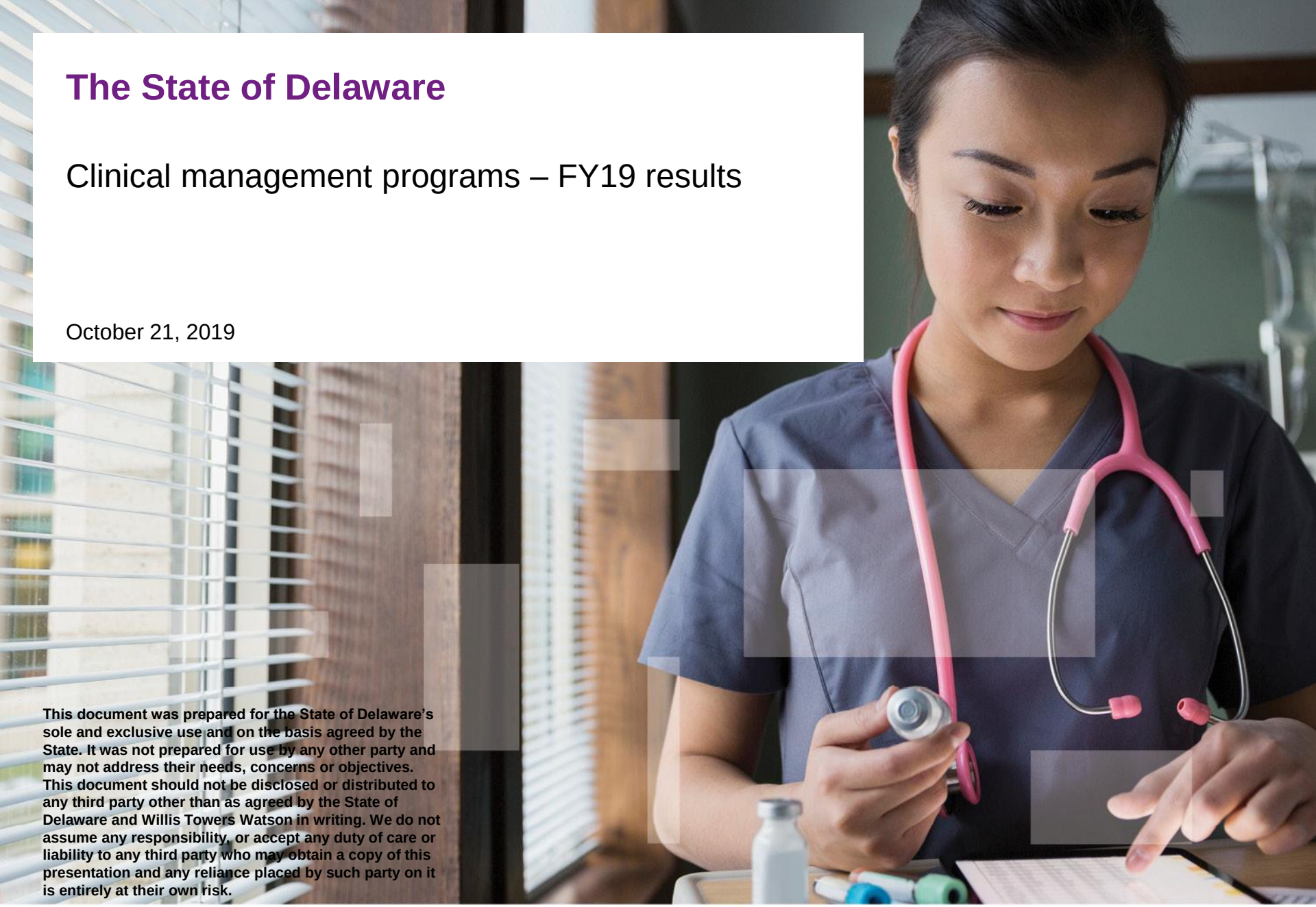
The State of Delaware

Clinical management programs – FY19 results

October 21, 2019



Willis Towers Watson

Clinical management programs – FY19 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 CareNow	Aetna in partnership with ChristianaCare	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 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 continue to be addressed in future meetings with the Health Policy & Planning subcommittee

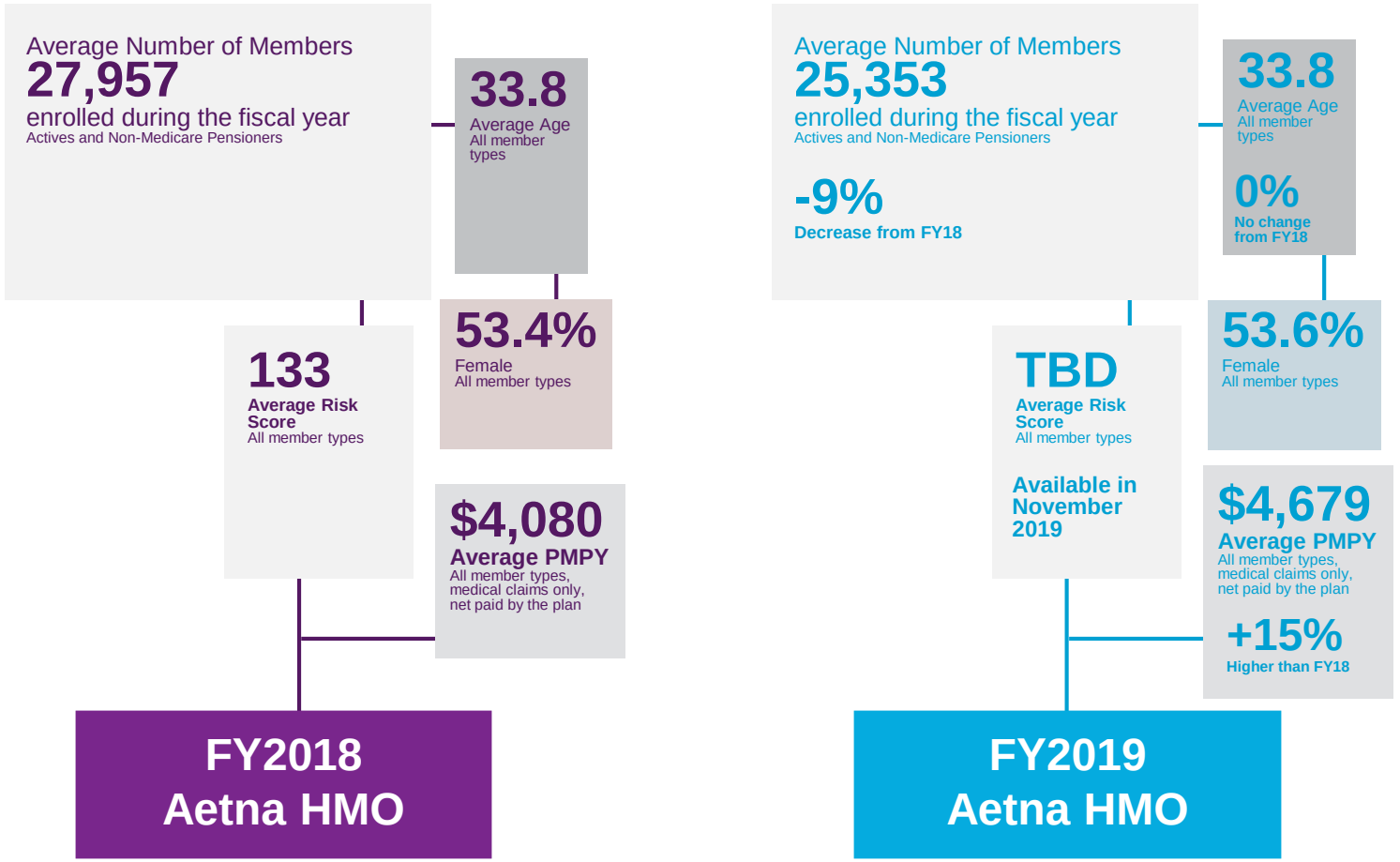
Clinical management programs – FY19 results

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 FY19 require 6 months of claim run-out and will be reconciled in early CY2020
  - 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 source: IBM Watson Health.
Average risk scores from IBM Watson Health and reflect expected relative cost risk of an individual during the report time period compared to the average (100) of a national dataset.

Aetna Carelink CareNow (HMO plan)

Goal – engage GHIP participants

FY19 results

21.2%

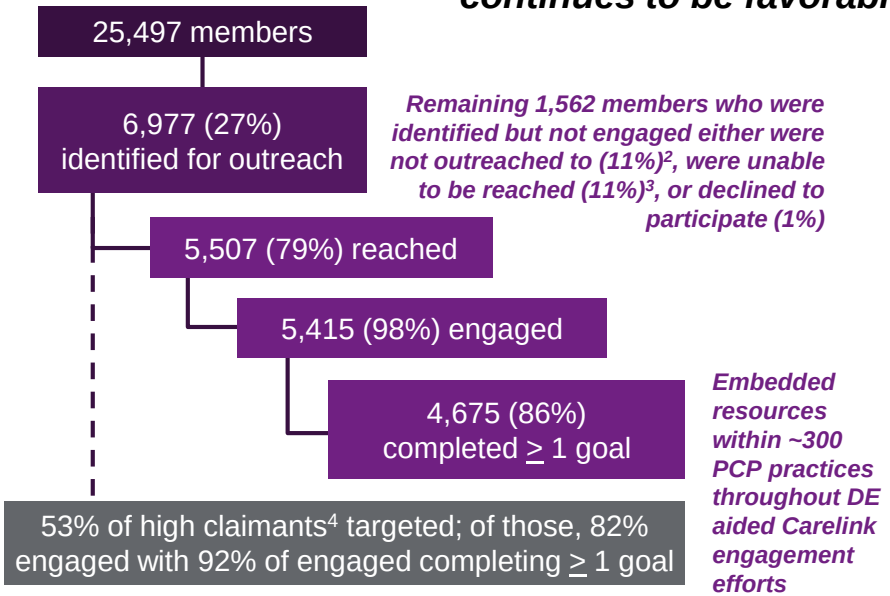
Total engaged as % of eligible population

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 slightly older members who tend to be female employees

Metric[1] – FY19	Engaged	Non-Engaged
Average Age	36.1	34.1
% Female	60%	52%
% member type (i.e., employee vs. spouse vs. other dependent)	Employee = 48% Spouse = 17% Dependent = 35%	Employee = 42% Spouse = 16% Dependent = 42%

Clinical engagement in second year of the program continues to be favorable



1 Reflects engagement statistics for FY19 (7/1/18 – 6/30/19).
2 Reasons for no outreach: member listed as "Do Not Contact", or member is clinically screened and determined to be well-managed or not in need of care management services (e.g., following ER visit for non-emergency issue).
3 Reasons for unable to reach: non-responsive or missing/incorrect contact information.
4 High claimant is a member with > $100k in medical claims paid by the plan in FY19.

Aetna Carelink CareNow (HMO plan)

Goal – promote appropriate utilization of health care

Service utilization	Unit	FY18		FY19		GHIP – HMO plan		Aetna Norm[2]
		Engaged	Non-engaged	Engaged	Non-engaged	FY18	FY19	
PCP office visits	Visits/member	1,293	778	1,291	819	1,985	2,062	1,848
Specialist office visits	Visits/member	2,541	1,196	2,730	1,351	1,830	2,011	1,957
Non-users of health care	% total	5%	24%	4%	27%			n/a
Telemedicine[3]	Visits	311		472		311	472	n/a
Urgent care	Visits/1,000	540	388	650	451			246
Emergency room (avoidable visits)	Visits/1,000	78		82		78	82	77
Observation room	Visits/1,000	107	17	154	16			n/a
Emergency room (all visits)	Visits/1,000	519	84	585	90	231	241	211
Inpatient admissions	Visits/1,000	112	25	139	25	45	44	54
Readmissions	Visits/1,000	3.6	0.8	8.5	0.5			n/a

- In FY19, 83% of Carelink-engaged participants had a PCP office visit vs. 62% of non-engaged
- 4% of Carelink-engaged participants were non-users of healthcare vs. 27% of non-engaged

Data source: Aetna and Carelink CareNow.
1 Data sources: FY18 and FY19 results as reported by Aetna and Carelink Care Now, 10/8/19. Aetna Norms, from Aetna's FY18 Q4 Annual Report (10/17/19).
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, observation room and readmissions/1,000. Norm for emergency room (avoidable visits) was imputed based on Aetna-reported BOB experience for non-urgent ER visits as % of total (36.6%) and total ER visits/1,000 for self-funded HMO plans (211).
3 Telemedicine visits includes third-party telehealth visits (Teladoc) and virtual visits with providers.

Aetna Carelink CareNow (HMO plan)

Goal – promote appropriate utilization of health care

Compliance with condition-specific treatments for select clinical conditions	FY18		FY19	
	Engaged	Non-engaged	Engaged	Non-engaged
Diabetes				
Office Visit	98%	96%	97%	93%
HbA1c Test Rate	90%	85%	95%	93%
Retinal Eye Exam Rate	43%	43%	68%	39%
Microalbumin Rate	79%	71%	92%	81%
Hyperlipidemia				
Office Visit	97%	91%	96%	90%
Hypertension				
Office Visit	98%	96%	97%	93%

- Engaged members with diabetes improved their utilization of services appropriate for their clinical condition in FY19, while non-engaged members had mixed results

Data source: Carelink CareNow.

Aetna Carelink CareNow (HMO plan)

Goal – improve health outcomes

HEDIS[1] Cancer Screenings	Gender, Age Range	Lookback Period	FY18		FY19		Aetna Norm[2]
			Engaged	Non-engaged	Engaged	Non-engaged	
Breast Cancer Mammogram rate	F, 50-74	2 Years	91%	88%	93%	91%	68%
Cervical Cancer Pap Tests rate	F, 24-64	3 Years	74%		74%		74%
Colorectal Cancer Screening rate	M or F, 51-75	10 Years	61%		37%		60%

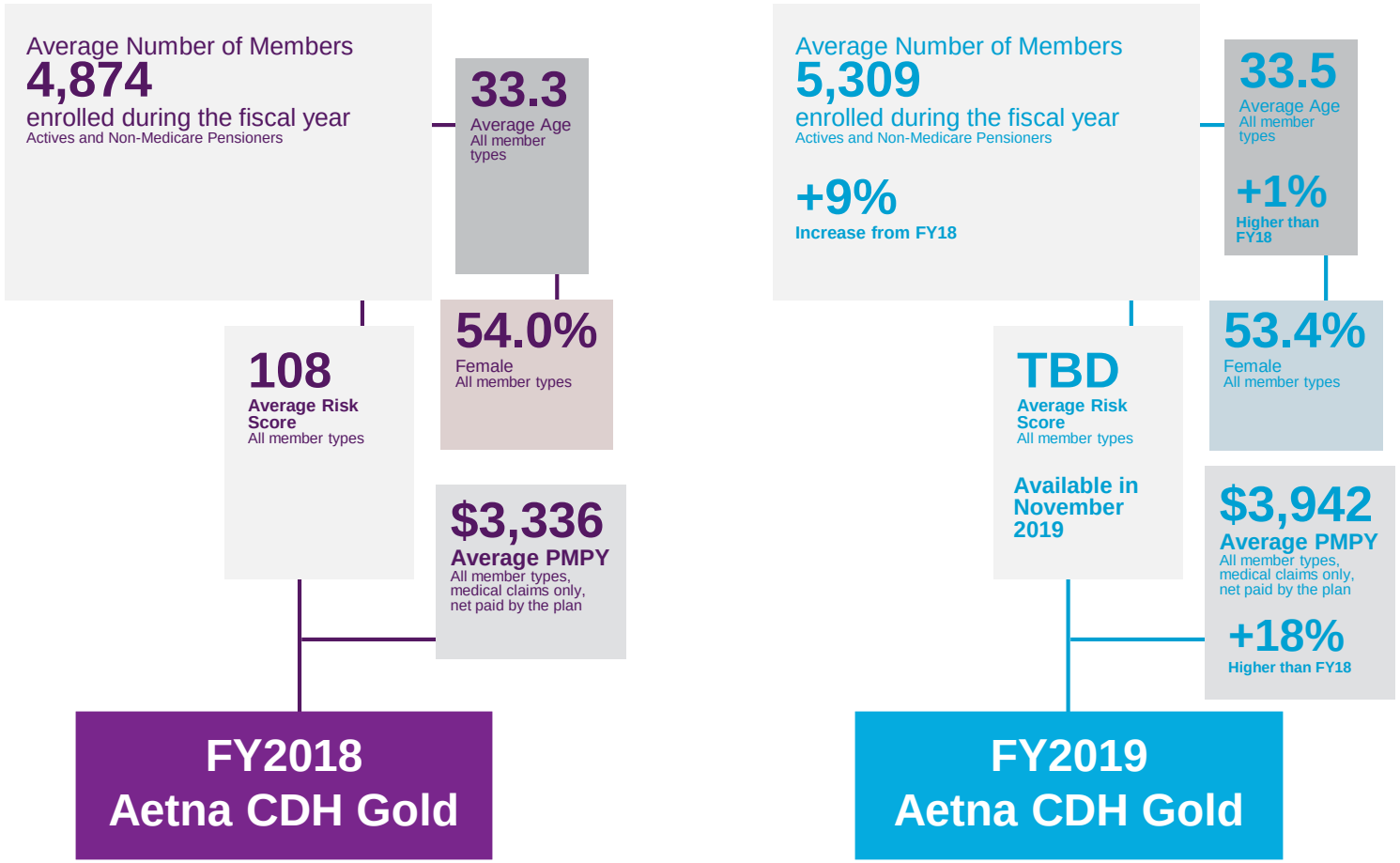
Preventive Visits	Gender, Age Range	Lookback Period	FY18		FY19		Aetna Norm[2]
			Engaged	Non-engaged	Engaged	Non-engaged	
Well Baby care	M or F, 15 mos.	1 Year	44%		43%		38%
Well Child visits	M or F, 3-6	1 Year	96%	94%	96%	95%	n/a
Well Adolescent visits	M or F, 12-21	1 Year	34%		32%		17%
Adult preventive physicals	M or F, 22+	1 Year	10%		12%		6%
Childhood immunizations	M or F, 0-2	2 Years	74%		74%		68%

- FY19 screening rates are generally at or better than Aetna book of business norms
- Opportunity to improve colorectal cancer screening rate

Data source: Aetna and Carelink CareNow.
Note: Some metrics are not tracked by engaged vs. non-engaged members; for those metrics, data has been reported for the entire population.
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 Reflects national average utilization rates. Source: Aetna book of business, self-funded HMO plans.

Aetna CDH Gold plan

Member demographics and key statistics



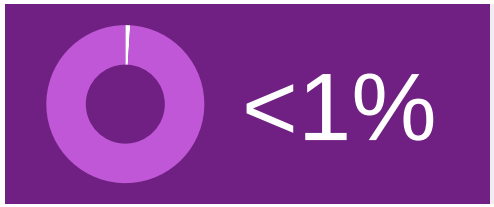
Data source: IBM Watson Health.
Average risk scores from IBM Watson Health and reflect expected relative cost risk of a individual during the report time period compared to the average (100) of a national dataset.

Aetna traditional case and disease management (CDH Gold plan)

Goal – engage GHIP participants

FY19 results

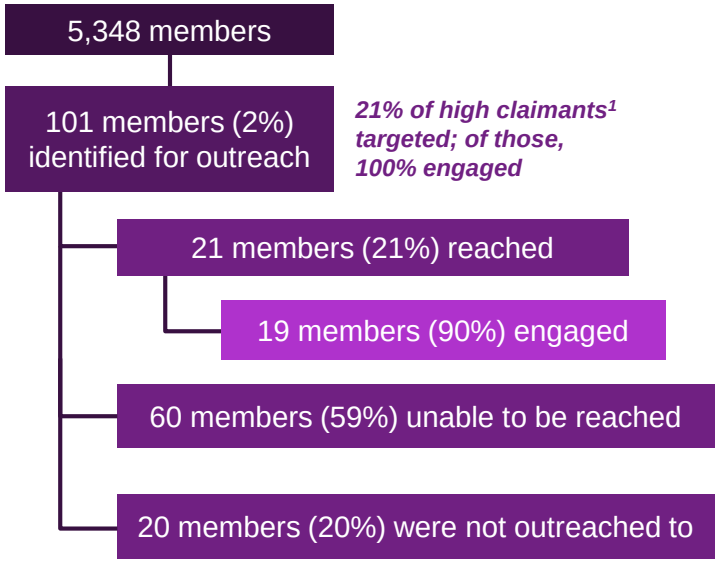
Member engagement in both case and disease management has not materially changed from FY18



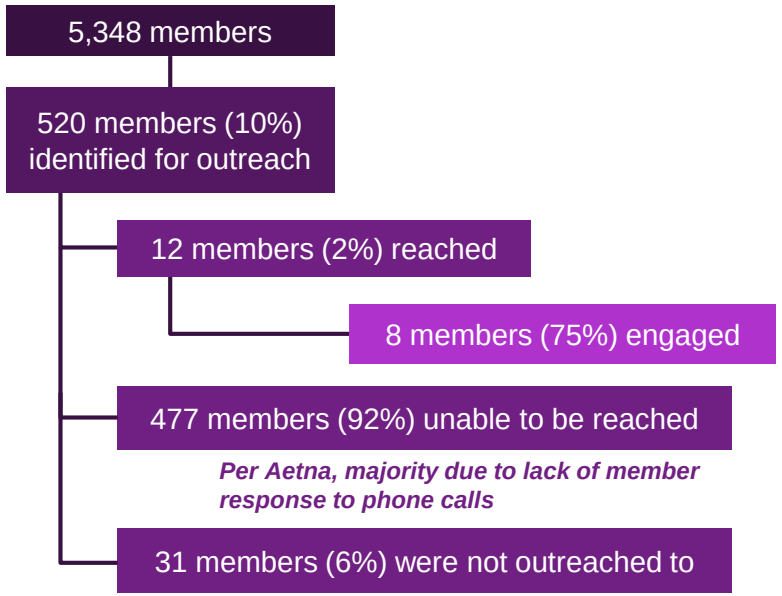
Total engaged as % of eligible population

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



1 High claimant is a member with > $100k in medical claims paid by the plan in FY19.

Aetna traditional case and disease management (CDH Gold plan)

Goal – promote appropriate utilization of health care

FY18 and FY19 results for entire enrolled population

Service utilization	Unit	FY18	FY19	Aetna Norm[1]
PCP office visits	Visits/1,000	1,651	1,690	1,440
Specialist office visits	Visits/1,000	1,866	2,047	1,524
Non-users of health care	% total eligible	17%	15%	n/a
Telemedicine[2]	Visits	82	136	n/a
Urgent care	Visits/1,000	344	409	107
Emergency room (avoidable visits)	Visits/1,000	60	64	50
Observation room	Visits/1,000	9	11	n/a
Emergency room (all visits)	Visits/1,000	192	197	137
Inpatient admissions	Admits/1,000	37	40	39
Readmissions	Visits/1,000	1	2	3

- Improved utilization of PCPs and telemedicine; fewer non-users of health care
- Opportunity to reduce emergency room utilization for avoidable visits
- Readmission rate is low but will continue to be monitored

Data dource: Aetna.

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 Telemedicine visits includes third-party telehealth visits (Teladoc) and virtual visits with providers.

Aetna traditional case and disease management (CDH Gold plan)

Goal – improve health outcomes

Health outcomes – Diabetes	FY18	FY19	Aetna Norm[2]
HbA1c Test Rate	68%	88%	88%
Microalbumin Test Rate	20%	60%	50%
Retinal Eye Exam Rate	22%	36%	52%

Changes in the underlying population are likely to have played a prominent role in driving differences between FY18 and FY19 results

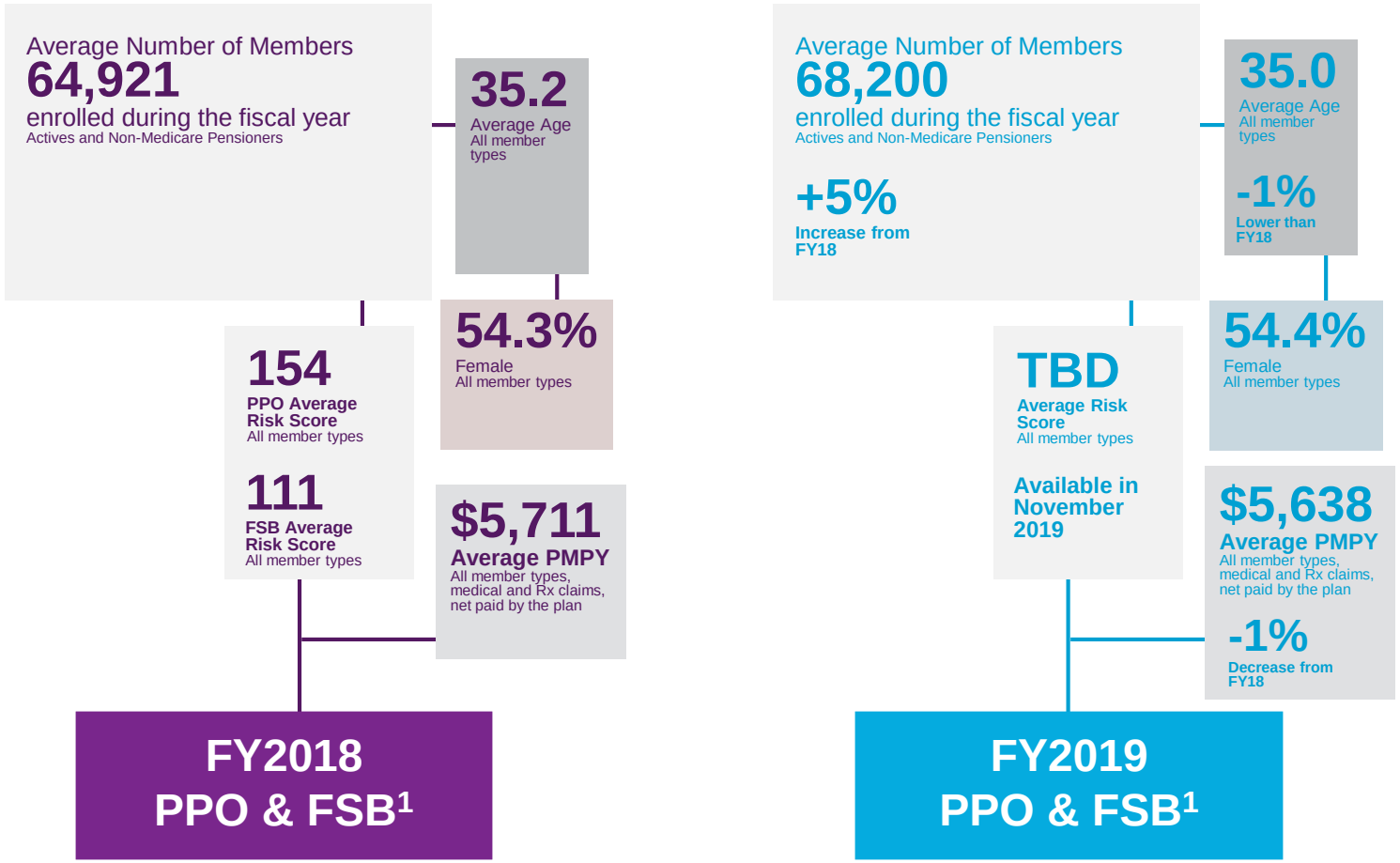
HEDIS[1] Cancer Screenings	Gender, Age Range	Lookback Period	FY18	FY19	Aetna Norm[2]
Breast Cancer Mammogram rate	F, 50-74	2 Years	74%	76%	79%
Cervical Cancer Pap Tests rate	F, 24-64	3 Years	79%	80%	72%
Colorectal Cancer Screening rate	M or F, 51-75	10 Years	53%	33%	58%

Preventive Visits	Gender, Age Range	Lookback Period	FY18	FY19	Aetna Norm[2]
Well Baby care	M or F, 15 mos.	1 Year	83%	76%	63%
Well Child visits	M or F, 3-6	1 Year	83%	76%	63%
Well Adolescent visits	M or F, 12-21	1 Year	65%	67%	30%
Adult preventive physicals	M or F, 22+	1 Year	20%	25%	9%
Childhood immunizations	M or F, 0-2	2 Years	77%	71%	56%

Note: Some metrics are not tracked by engaged vs. non-engaged members; for those metrics, data has been reported for the entire population.
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 Reflects national average utilization rates. Source: Aetna book of business, self-funded PPO plans.

Highmark PPO & First State Basic plans

Member demographics and key statistics

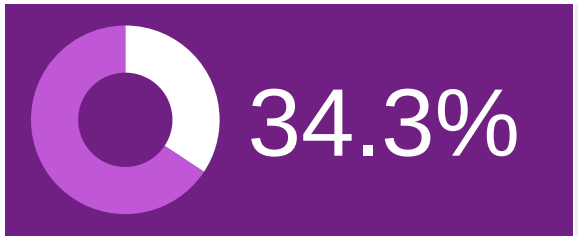


1 FSB = First State Basic plan
Data source: IBM Watson Health.
Average risk scores from IBM Watson Health and reflect expected relative cost risk of a individual during the report time period compared to the average (100) of a national dataset.

Highmark Custom Care Management Unit (CCMU)

Goal – engage GHIP participants

FY19 results



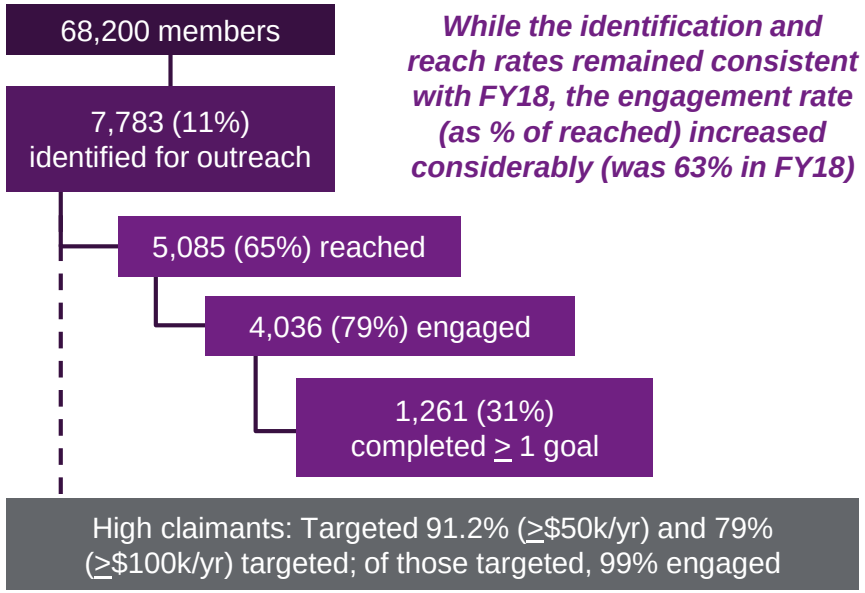
Total engaged as % of eligible population

Engagement defined[1] by Highmark as members with at least 1 completed phone call with a Health Advocate (non-clinical engagement only).

Program is engaging higher cost, older members who tend to be female employees

Metric[2] – FY19	Engaged	Non-Engaged
Average Age	48.5	34.4
% Female	61.4%	53.9%
% member type (i.e., employee vs. spouse vs. other dependent)	Employee = 63% Spouse = 23% Dependent = 13%	Employee = 44% Spouse = 16% Dependent = 40%
Medical Paid PMPM[3]	$3,827	$258

Clinical engagement has improved in FY19



While the identification and reach rates remained consistent with FY18, the engagement rate (as % of reached) increased considerably (was 63% in FY18)

1 Health Advocate engagement includes assistance with use of websites/tools on Highmark's member portal, consumerism education and referrals to other GHIP vendor partners. Health Coach engagement includes completion of a clinical assessment and development of a plan of care.

2 Reflects engagement statistics for FY19 (7/1/18 – 6/30/19).

3 PMPM = per member per month.

Highmark Custom Care Management Unit (CCMU)

Goal – promote appropriate utilization of health care

Service utilization	Unit	FY18		FY19		GHIP – PPO & FSB plans		Highmark Norm[2]
		Engaged	Non-engaged	Engaged	Non-engaged	FY18	FY19	
PCP office visits	Visits/1,000	2,609	1,528	2,920	1,520	1,581	1,598	2,030
Specialist office visits	Visits/1,000	4,896	1,915	5,507	1,927	2,062	2,125	2,190
Non-users of health care	% total	7%		8%		7%	8%	13%
Telemedicine[3]	Visits	8	123	20	338	131	358	n/a
Urgent care	Visits/1,000	579	474	627	510	479	516	289
Emergency room (avoidable visits)	Visits/1,000	101	38	146	37	41	43	n/a
Observation room	Visits/1,000	29	5	41	4	6	6	13
Emergency room (all visits)	Visits/1,000	572	189	855	184	208	221	253
Inpatient admissions	Visits/1,000	248	44	437	25	54	48	58
Readmissions	Visits/1,000	7	2	16	1	2	2	1

- Engaged members are utilizing medical services more frequently than non-engaged members
- Opportunity to reduce emergency room visits (in total) among engaged members

Data source: Highmark Delaware.
1 Active employees, pre-Medicare pensioners and their dependents. Excludes Medicare pensioners (Medicfill plan).
2 Reflects national average utilization rates for Highmark Delaware. Normative data not available for telemedicine visits or emergency room (avoidable visits).
3 Telemedicine visits includes third-party telehealth visits (Doctor On Demand and American Well) and virtual visits with providers.

Highmark Custom Care Management Unit (CCMU)

Goal – promote appropriate utilization of health care

Compliance with condition-specific treatments for select clinical conditions	FY18		FY19	
	Engaged	Non-engaged	Engaged	Non-engaged
Diabetes				
Office Visit	99%	98%	99%	98%
HbA1c Test Rate	86%	82%	82%	82%
Retinal Eye Exam Rate	99%	98%	99%	98%
Lipid Test Rate	76%	73%	72%	74%
Microalbumin Rate	72%	63%	68%	62%
Hyperlipidemia				
Office Visit	100%	98%	99%	97%
Lipid Test Rate	79%	77%	76%	77%
Hypertension				
Office Visit	100%	98%	99%	98%

- Utilization of services appropriate for key clinical conditions have stayed relatively constant year-over year
- While diabetes health care utilization for engaged members is more consistent than non-engaged members, there was a reduction in some measures in FY19

Highmark Custom Care Management Unit (CCMU)

Goal – improve health outcomes

HEDIS[1] Cancer Screenings	FY18		FY19		Highmark Norm[2]
	Engaged	Non-engaged	Engaged	Non-engaged	
Breast Cancer Mammogram rate	70%	71%	70%	70%	61%
Cervical Cancer Pap Tests rate	70%	74%	74%	75%	60%
Colorectal Cancer Screening rate	71%	65%	74%	67%	60%

Preventive Visits	FY18		FY19		Highmark Norm[2]
	Engaged	Non-engaged	Engaged	Non-engaged	
Well Baby care (0 – 15 months)	45%	77%	61%	81%	n/a
Well Child visits (3 – 5 years old)	56%	44%	63%	45%	n/a
Well Adolescent visits	22%	19%	26%	20%	n/a
Adult preventive physicals	42%	62%	47%	64%	27%
Childhood immunizations	58%	60%	56%	59%	n/a

- Preventive screening rates among engaged members have improved year over year
- For the GHIP population as a whole, screening rates are higher than Highmark's national norm

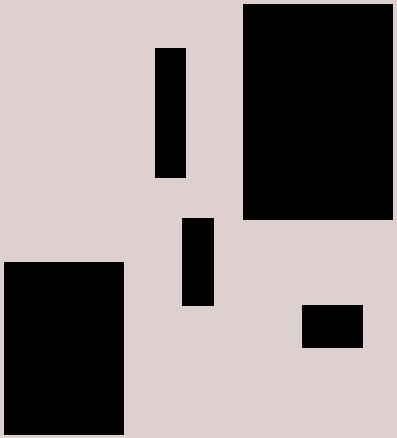
Note: Some metrics are not tracked by engaged vs. non-engaged members; for those metrics, data has been reported for the entire population.
1 HEDIS = Healthcare Effectiveness Data and Information Set, a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).
2 Reflects national average utilization rates. Source: Highmark Delaware book of business. Highmark norm not available for well baby care visits, well child visits, well adolescent visits, and childhood immunizations.

Summary

- The goals of all care management programs remain relatively the same:
  - Engage GHIP participants
  - Promote appropriate utilization of health care
  - Improve health outcomes
- Both Carelink CareNow and the CCMU are making progress toward achieving these goals and have demonstrated some performance improvements in Year 2
  - Carelink CareNow has improved goal closure rates among engaged members and continues to drive improvements in diabetic members' compliance with recommended screenings
  - CCMU has improved overall clinical engagement rates and member compliance with preventive screenings and well visits
- Areas of opportunity for continued improvement include:
  - Continued emphasis on coaching members to utilize the most appropriate site of care to reduce avoidable emergency room visits (i.e., via telemedicine, PCP visits, urgent care, etc.)
  - Targeting additional high claimants >$50k/year for outreach
- Aetna's traditional case and disease management programs have increased their member identification rates but need continued focus on engaging a greater percentage of the population

Appendix

Care management program descriptions



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 ChristianaCare
- Includes a financial risk-sharing arrangement with ChristianaCare 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