The State of Delaware

GHIP Impact Analysis

December 16, 2019

Willis Towers Watson

Contents

- Overview of recent GHIP initiatives and changes
- Impact on the GHIP
  - Site of care steerage
  - Clinical management programs
- Next steps
- Appendices

Overview of recent GHIP initiatives and changes

Introduction

- A number of initiatives have been implemented since FY16 that have the potential to materially impact GHIP program offerings and its enrolled population; these include:
  - Site of care steerage
  - Clinical management programs
  - Other initiatives and changes, such as those required by legislation
- Today's discussion will focus on conducting a deeper dive into the first two items above, specifically:
  - Review latest results of site of care steerage plan design changes and programs
  - Discuss health of underlying GHIP population that would affect care management program results
- Further dialogue will take place at the January 2020 Financial Subcommittee meeting about:
  - Impact of other initiatives and changes on GHIP program offerings and population
  - Impact of all of these programs that is beginning to play out in emerging GHIP claims, utilization and clinical experience

Overview of recent GHIP initiatives and changes (continued)

	FY17 *(Effective 7/1/16)*	FY18 *(Effective 7/1/17)*	FY19 *(Effective 7/1/18)*	FY20 *(Effective 7/1/19)*
Site of Care Steerage	▪ ***Already in place*:** Aetna infusion therapy site-of-care steerage ▪ Copay changes for urgent care, high-tech imaging* ▪ Third-party telemedicine programs added	(no changes)	▪ Copay changes for basic imaging, high-tech imaging, outpatient labs*	▪ Copay changes for basic imaging, high-tech imaging, outpatient labs, emergency room, and telemedicine* ▪ Implemented Highmark infusion therapy site-of-care steerage program
Clinical Management Programs	(no changes)	▪ Implemented Aetna/Carelink and Highmark CCMU care management programs	▪ Implemented diabetes prevention programs (Retrofit, YMCA)	▪ Implemented Livongo for diabetes management
Other Initiatives and Changes	(no changes)	• Implemented Aetna Enhanced Clinical Review program for select high tech imaging services	▪ HB203 Diabetes monitoring and prevention	▪ Implemented SurgeryPlus surgeons of excellence program

*Details on next page.

Overview of recent GHIP initiatives and changes (continued)

Site of care steerage – copay changes

Highlights copay change

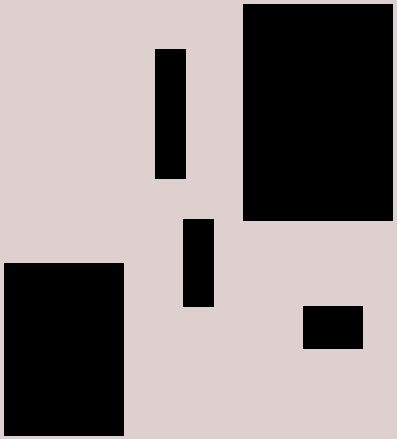
- Chart below reflects recent copay changes for site-of-care steerage in the PPO and HMO plans
- Unless otherwise noted, copays apply to both plans (PPO and HMO)

Copays by type of service	FY16	FY17	FY18	FY19	FY20
Basic Imaging **(X-rays, ultrasounds)** ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $20 copay ▪ $20 copay	▪ $20 copay ▪ $20 copay	▪ $20 copay ▪ $20 copay	▪ $0 copay ▪ $35 copay	▪ $0 copay ▪ $50 copay
High Tech Imaging **(MRI, CT, PET scan)** ▪ Freestanding Facility (preferred) ▪ Hospital-based Facility	▪ $15 HMO / $20 PPO ▪ $15 copay	▪ $0 copay ▪ $35 copay	▪ $0 copay ▪ $35 copay	▪ $0 copay ▪ $50 copay	▪ $0 copay ▪ $75 copay
Outpatient Lab ▪ Preferred Lab ▪ Other Lab	▪ $10 copay ▪ $10 copay	▪ $10 copay ▪ $10 copay	▪ $10 copay ▪ $10 copay	▪ $10 copay ▪ $20 copay	▪ $10 copay ▪ $50 copay
Emergency / Urgent Care ▪ Urgent Care ▪ Emergency Room	▪ $25 HMO / $30 PPO ▪ $150 copay	▪ $15 HMO / $20 PPO* ▪ $150 copay	▪ $15 HMO / $20 PPO ▪ $150 copay	▪ $15 HMO / $20 PPO ▪ $150 copay	▪ $15 HMO / $20 PPO ▪ $200 copay
Telemedicine	• N/A	▪ $15 HMO / $20 PPO	▪ $15 HMO / $20 PPO	▪ $15 HMO / $20 PPO	▪ $0 copay

* Change made to match PCP office visit copay.

Impact on the GHIP

Site of care steerage



Recent plan design changes to promote site-of-care steerage

Urgent care – utilization for FY17 through FY19

- From FY17 to FY19, overall utilization of the emergency room for non-emergent and primary care treatable conditions increased slightly, while urgent care utilization increased 14%
  - Data suggest that some members may utilize urgent care centers for acute conditions that could be treated in a primary care setting
  - Additional communications may be necessary to continue to drive patients away from the emergency room in non-emergent situations

Visits[1] *(non-emergent & primary care treatable only)*	FY17	FY18	FY19	Change from FY17	Change from FY18	Change from FY17 to FY19
Emergency Room	12,955	12,534	13,244	(421)	710	289
Urgent Care	48,399	51,799	55,407	3,400	3,608	7,008
Primary Care	156,636	149,658	145,658	(6,978)	(4,000)	(10,978)
Total	217,990	213,991	214,309	(3,999)	318	(3,681)

1 Represents a subset of the total number of visits to emergency rooms, urgent care centers and primary care physicians during each fiscal year. Classification of these types of visits provided by IBM Watson Health and based on a New York University study. Non-Emergent = no immediate care required within 12 hours. Primary Care Treatable = treatment required within 12 hours, but could be provided in a primary care setting.

Source: IBM Watson Health.

Recent plan design changes to promote site-of-care steerage

High tech imaging – utilization for FY17 through FY19

- From FY17 to FY19, overall utilization of hospital-based facility sites of service for high tech imaging increased slightly, while use of freestanding imaging facilities decreased slightly
  - Results suggest that these design changes were only effective in changing behavior in the first year following implementation (FY17, FY19); hospital-based utilization increased in FY18 but decreased in FY19 after additional design changes were put in place
  - Copay differential for high-tech imaging at hospital-based facilities implemented in FY20 expected to continue steering members to freestanding facilities but additional communications may be necessary to sustain utilization over time

High tech imaging services	FY17	FY18	FY19	Change from FY17	Change from FY18	Change from FY17 to FY19
Hospital-based Facility	11,326	12,343	11,806	1,017	(537)	480
Freestanding Facility	7,723	7,563	7,583	(160)	20	(140)
Total	19,049	19,906	19,389	857	(517)	340

Source: IBM Watson Health.

Recent plan design changes to promote site-of-care steerage

Basic imaging – utilization for FY18 through FY19

- Hospital-based facility utilization for basic imaging services (including mammograms, ultrasounds, and x-rays) decreased slightly in FY19, while freestanding facility utilization increased 8%
  - Results suggest that FY19 design changes were effective at steering members to freestanding facilities
  - Copay differential implemented for FY20 expected to continue steering members to freestanding facilities, but additional communications may be necessary to sustain utilization over time

Basic imaging services	FY18	FY19	Change from FY18
Hospital (Outpatient Imaging)	31,833	31,712	(121)
Freestanding Facility	38,439	41,366	2,927
Total	70,272	73,078	2,806

Source: IBM Watson Health.

Recent plan design changes to promote site-of-care steerage

Outpatient lab – utilization for FY18 through FY19

- Hospital utilization for outpatient lab services decreased slightly in FY19, while preferred lab utilization increased 6%
  - Results suggest that FY19 design changes were effective at steering members to preferred labs
  - Copay differential implemented for FY20 expected to further increase utilization of preferred labs, but additional communications may be necessary to sustain utilization over time

Outpatient lab services	FY18	FY19	Change from FY18
Hospital (Outpatient Lab)	54,693	53,823	(870)
Preferred Lab	142,000	151,013	9,013
Total	196,693	204,836	8,143

Source: IBM Watson Health.

Recent plan design changes to promote site-of-care steerage

Summary of estimated savings

- $1.3M in estimated site-of-care steerage savings for high tech imaging, basic imaging and outpatient lab services were built into FY19 budget projections based on estimates provided by Aetna and Highmark:

Estimated savings – best estimate (from December 11, 2017 SEBC meeting):

Carrier	Modeled Design	Annual Claim Savings (%)[1]	Annual Claim Savings ($)	Annual Claim Savings General Fund ($)[2]
Aetna	Recommended Design	0.35%	$0.5m	$0.3m
Highmark		0.20%	$0.8m	$0.5m
Total Savings Opportunity – Recommended Design:			**$1.3m**	**$0.8m**

- Actual savings realized in FY19 for utilization of these services estimated at $660k (see detail on page 11)
  - Savings estimate assumes expected utilization rate of preferred sites of service in FY19 would remain at FY18 levels
  - Estimate then compares FY19 actual utilization rate and net paid amounts per visit by service type to FY18 utilization rate
  - FY18 utilization rates and FY19 net paid amounts per visit by site of service based on IBM Watson Health Urgent Care and High-Tech Imaging FY19 Q4 report

1 Savings for active and pre-65 retiree populations only, for the Comprehensive PPO and HMO plans only; based on number of visits calculated using 7/1/2017 membership count. X-rays, ultrasounds and mammography are grouped under basic imaging, all other radiology services are grouped under high tech. Savings based on the number of unique members that had claims in these categories in the previous year.
2 General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels.

Recent plan design changes to promote site-of-care steerage

Summary of estimated savings

	FY19 utilization			FY19 Net Pay Per Visit	Cost / (Savings) in $m[2]
	Actual	Status Quo[1]	Difference		
High tech imaging services					
Hospital-based Facility	11,806	12,022	(216)	$1,509	($0.33)
Freestanding Facility	7,583	7,367	216	$424	$0.09
Total	19,389	19,389	-	$1,085	($0.24)
Basic imaging services					
Hospital-based Facility	31,712	33,104	(1,392)	$249	($0.35)
Freestanding Facility	41,366	39,974	1,392	$123	$0.17
Total	73,078	73,078	-	$178	($0.18)
Outpatient lab services					
Hospital-based Facility	53,823	56,957	(3,134)	$106	($0.33)
Preferred Lab	151,013	147,879	3,134	$30	$0.09
Total	204,836	204,836	-	$50	($0.24)
Total					
Hospital-based Facility					**($1.01)**
Freestanding Facility/Preferred Lab					**$0.35**
Overall Impact					**($0.66)**

- Shift in utilization away from hospital-based facilities yielded approx. $1M reduction in net payments, partially offset by increases in utilization at preferred sites of service with lower cost per visit
- Savings shown are intended to be directional only; true measure of behavior change resulting from copay differentials implemented in FY19 requires deeper dive into procedures at the member level

1 Status Quo utilization represents FY18 utilization rates by site of care, adjusted to FY19 overall utilization levels.
2 Estimated cost / (savings) equals the difference in utilization multiplied by the FY19 net pay per visit

Other interventions to promote site-of-care steerage

Aetna program for infusion therapy

Infusion therapy defined:

- Intravenous administration of certain medications that treat conditions such as autoimmune disorders, enzyme replacement and rare/esoteric diseases
- Administered under the supervision of a medical professional
- Several possible sites of care: outpatient hospital facility, infusion center, doctor's office, or patient's home

Advantages to administering outside of a hospital: *significantly reduced cost of drug administration, reduced risk of patient exposure to hospital-acquired illnesses, enhanced privacy and comfort, potentially reduced travel time and associated expenses*

Aetna Infusion Therapy Site-of-Care Program

Description

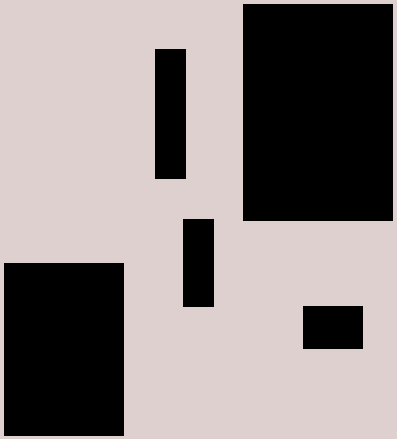
- In place for the State since before FY16
- Drugs are segmented into two categories: Mandatory and Voluntary (based on clinical rule)
- Requires member's doctor to request prior authorization for infusion therapy from Aetna
- Aetna reviews request for medical necessity and clinical appropriateness
- Aetna will reach out to doctor to suggest alternative site of care if appropriate

Results through FY19Q4

- 10 successful conversions from a hospital setting to a lower cost site of care since program inception
- Projected site of care steerage savings of $503K for calendar year 2019
- Two cases are pending conversion and two more are currently under review

Impact on the GHIP

Clinical management programs



Clinical management programs

Overview

- Since FY17, GHIP program offerings have included several enhanced care management programs that are designed to help plan participants maintain and manage their health
  - The following programs are designed to target acutely or chronically ill members and address the highest risk members of the population, regardless of specific health need

Enhanced care management program	Vendor(s) responsible for managing	GHIP population supported
CareVio (formerly 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 and FY19 results was previously presented to the SEBC at the October 21, 2019 meeting
  - While today's discussion will not repeat that presentation in its entirety, it will add further context for those results
- The GHIP also offers other clinical management programs that are focused specifically on diabetes and metabolic syndrome
  - Diabetes prevention program offered in partnership with Retrofit and local YMCAs
  - Livongo for diabetes management – just implemented for 7/1/2019
- Focus of today's discussion will be on the health of the GHIP population during FY2017 – FY2019 , including recent high claimant experience
  - Additional details on how the GHIP clinical management programs are impacting member health will be discussed at the January Financial Subcommittee meeting

Clinical management programs

GHIP population health

- When evaluating the effectiveness of the State's clinical management programs, a key consideration is the health of the underlying population eligible for those programs during the same time period
- While the PPO continued to attract members with the highest risk score, the CDH Gold and HMO plans saw significant increases in risk scores for FY19
  - Attributable to increased prevalence of high cost claimants[1] in FY19

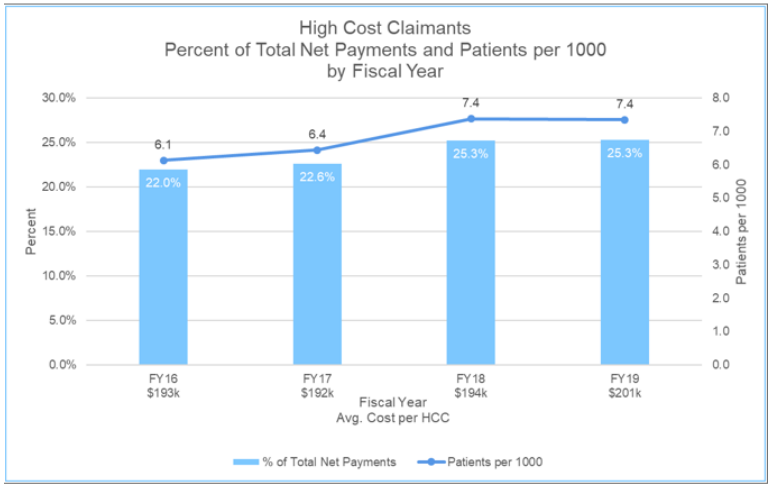
	CDH Gold		HMO		First State Basic		PPO	
	FY18	FY19	FY18	FY19	FY18	FY19	FY18	FY19
Risk score	108.0	117.4	133.1	141.7	111.3	107.0	154.0	154.5
Average number of members enrolled during the plan year	4,874	5,309	27,957	25,353	4,657	5,119	60,264	63,081
Average age of members enrolled during the plan year	33.3	33.5	33.8	33.8	33.4	33.3	35.3	35.1
% female members (as percent of total enrolled)	54.0%	53.4%	53.4%	53.6%	53.0%	53.0%	54.0%	55.0%
Net Pay Med per member per year (paid basis)	$3,039	$3,942	$3,842	$4,679	$3,704	$3,490	$5,778	$5,812
Net Pay Rx per member per year (paid basis)	$935	$1,065	$1,134	$1,266	$840	$914	$1,529	$1,634

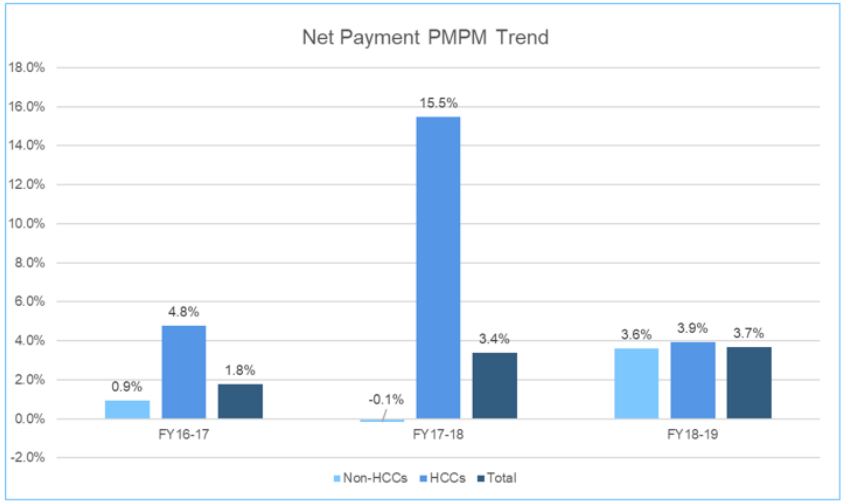
1 High cost claimants are members with $100,000 or more of incurred claims during the specified time period.

Clinical management programs

GHIP high claimant experience

- Highlights from high cost claimant (HCC) experience from FY16 to FY19:
  - Prevalence of HCCs increased (from 6.1 to 7.4 HCCs per 1,000 members)
  - Total cost associated with HCCs increased (from 22% to 25% of net payments attributable to HCCs)
  - Cost per HCC increased (from $108 to $135 net paid per member per month (PMPM))
  - Cost per HCC has been trending higher and with more variability year to year compared to non-HCC cost increases, particularly from FY17 to FY18 (15.5% increase in net paid PMPM for HCCs vs. minimal increase for non-HCCs)





Clinical management programs

GHIP high claimant experience – utilization and trend drivers

- Impact of top clinical conditions for HCCs overall[1] can be observed in top utilization and trend cost drivers for FY19

	Top clinical conditions for HCCs overall[1]	Noteworthy top clinical cost drivers From FY19Q4 Incurred Reporting
1	Newborns, w/wo Complication	Increased PEPM trend for newborns (+14.9%)
2	Cancer – Breast	Increased utilization of outpatient mammograms (+29.8%) and increased PEPM trend (+35.3%)
3	Cancer – Leukemia	
4	Coronary Artery Disease	Increased PEPM trend for coronary artery disease (+13.4%)
5	Cancer – Lung	Increased PEPM trend for chemotherapy (+29.4%) and nuclear medicine (+16.2%) Increased utilization of therapeutic radiology (+18.2%)

Other top clinical cost drivers (not necessarily captured among top 5 HCCs)

- Pregnancy related services (PMPM trend of 7.9%), including +7.6% trend in inpatient maternity services
- Spinal and back disorders (PMPM trend of 5.7%)
- Respiratory disorders (PMPM trend of 11.0%)
- Diabetes (PMPM trend of 18.4%)

1 Data provided for Active and non-Medicare Pensioners and their dependents only; excludes Medicfill population.

Clinical management programs

GHIP high claimant experience by medical plan

Top 5 clinical conditions for HCCs by total FY19 plan payments

For the entire GHIP[1] and split by medical plan

	Entire GHIP	CDH Gold	HMO	First State Basic	PPO
1	Newborns, w/wo Complication[3]	Renal Function Failure	Cancer – Lung[2]	Cardiomyopathy	Newborns, w/wo Complication
2	Cancer – Breast[2,3]	Hypertension, Essential	Coronary Artery Disease	Newborns, w/wo Complication[3]	Cancer – Breast[2,3]
3	Cancer - Leukemia[2,3]	Coronary Artery Disease[2]	Chemotherapy Encounters	Cancer – Leukemia[2]	Renal Function Failure[2,3]
4	Coronary Artery Disease	Cancer – Breast[2,3]	Skin Burns	Condition Rel to Tx - Med/Surg	Crohns Disease
5	Cancer - Lung[2]	Cardiovasc Disorders, Congenital	Multiple Sclerosis	Cancer – Colon[2]	Multiple Sclerosis[2]

- Conditions associated with newborns, breast cancer and coronary artery disease occurred most frequently among the top 5 clinical conditions for FY19 in total and by plan
- Cancers were the most frequently recurring clinical condition within the top 5 in total and by plan across multiple plan years

1 Data provided for Active and non-Medicare Pensioners and their dependents only; excludes Medicfill population.
2 Also among top 5 clinical conditions for HCCs in FY18.
3 Also among top 5 clinical conditions for HCCs in FY17.

Clinical management programs

GHIP population health – preventive screenings

- Routine preventive care and screenings can aid in the early detection of certain cancers and chronic conditions, which can help prevent cases from developing into HCCs
- Screening rates for cervical and colon cancer improved across all plans from FY18 to FY19; however, breast cancer screening rates decreased slightly for most plans over the same time period
- Opportunity to improve adult and well child preventive visits across all plans

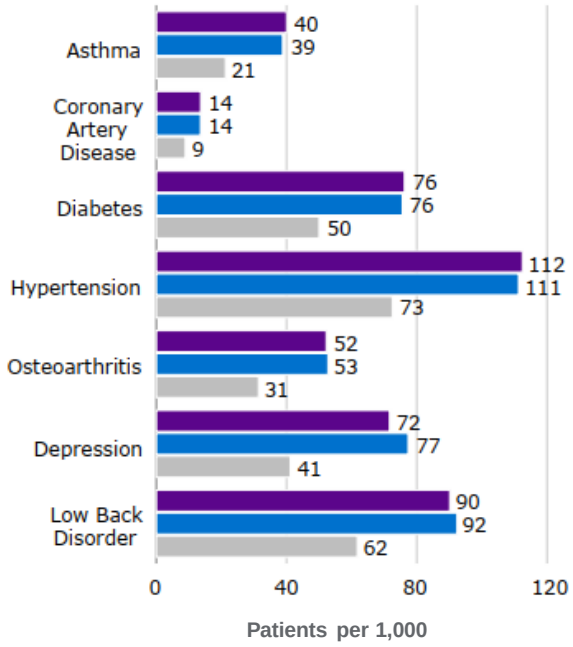
	CDH Gold		HMO		First State Basic		PPO	
	FY18	FY19	FY18	FY19	FY18	FY19	FY18	FY19
Breast Cancer Screen Rate	74.8%	71.7%	72.9%	72.0%	71.0%	67.4%	75.4%	75.5%
Cervical Cancer Screen Rate	68.3%	71.2%	63.1%	68.9%	62.8%	62.7%	65.1%	70.4%
Colon Cancer Screen Rate	37.8%	41.9%	36.1%	44.1%	33.0%	41.0%	37.6%	46.8%
Well Baby Visits per 1000	6,000	5,957	5,689	5,702	5,679	4,832	5,584	5,665
Well Child Visits per 1000	849	903	817	850	754	791	833	867
Adult Preventive Visits per 1000	460	510	456	491	405	409	471	493

Clinical management programs

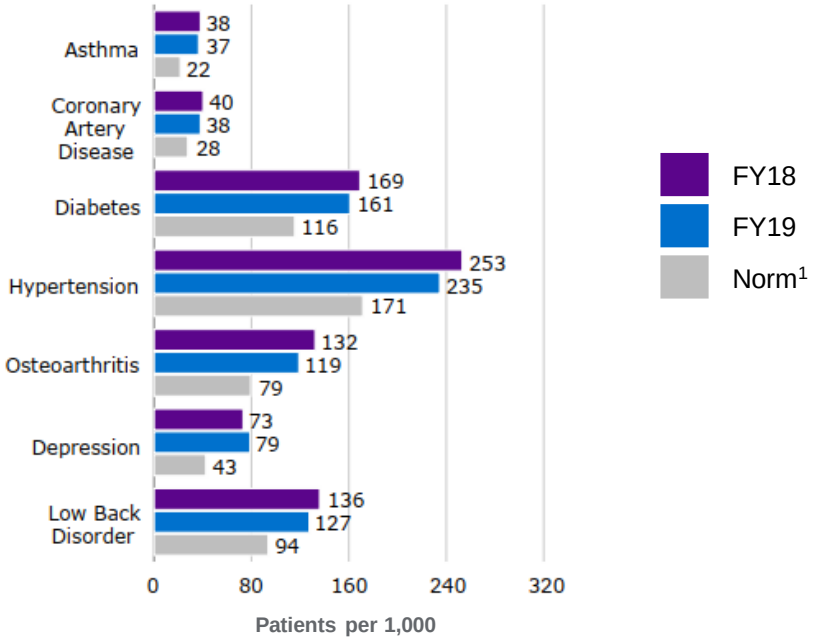
GHIP population health – chronic disease prevalence

- Unmanaged or poorly managed chronic disease can also contribute to higher prevalence of HCCs
- Prevalence of common chronic diseases for both Actives and non-Medicare pensioners is higher than benchmark[1]

Active employees and dependents



Non-Medicare pensioners and dependents



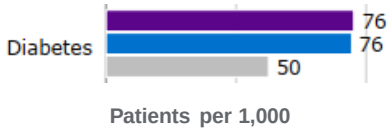
1 Source: IBM Watson Health.

Clinical management programs

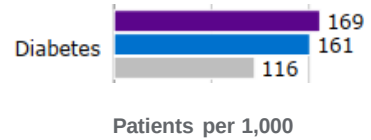
GHIP population health – diabetes prevalence

- Additional reporting on prevalence of diabetes and metabolic syndrome (pre-diabetes) in light of GHIP program offerings that specifically target these conditions
- Diabetes was the most expensive episode of care in FY19 ($45.2M net paid for medical/Rx claims, with a PEPM trend of +18.4%)

Active employees and dependents



Non-Medicare pensioners and dependents



FY18 FY19 Norm[1]

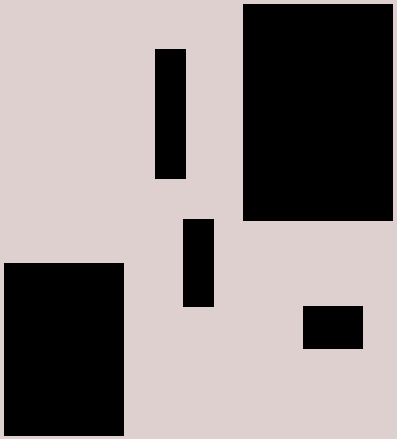
Excerpt from HB 203 Final Report on Diabetes to the Delaware General Assembly (June 30, 2019) – For total GHIP population, FY18

- Diabetes was #1 highest cost clinical condition ($64.9M)
- Prevalence within GHIP (% of members): diabetes – 9.4%, pre-diabetes – 8.3%
- Top 3 comorbidities for members with diabetes: hypertension, infections and arthropathies / joint disorders
- Diabetic members have higher utilization rates of medical services and prescription drugs, and therefore have significantly higher claim costs
- Diabetic member risk scores are 1x – 2x higher than overall population, implying greater likelihood of higher future costs
- Pre-diabetes rates higher in females over 18, in Kent County and in Aetna HMO plan

	CDH Gold		HMO		First State Basic		PPO	
	FY18	FY19	FY18	FY19	FY18	FY19	FY18	FY19
Diabetes HbA1c Test Rate	83%	83%	85%	84%	75%	78%	86%	85%
Diabetes Nephropathy Rate	79%	85%	85%	85%	79%	82%	87%	85%

1 Source: IBM Watson Health.

Next steps

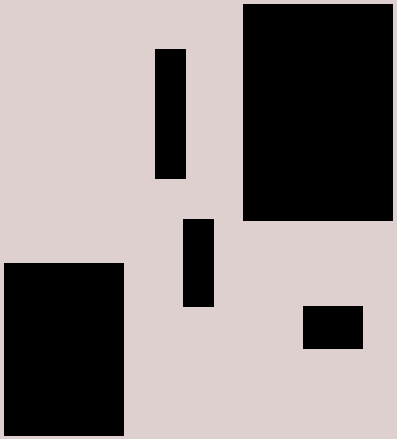


Next steps

- Opportunities based on data reviewed today:
  - Additional member education and promotion of alternative sites of care (copay differentials, how to identify when those alternative sites are appropriate, where to find those providers, etc.)
  - Address significant increases in outpatient facility cost per member, and explore services and programs that can support members in those top cost/condition categories
  - Increased adult and well child preventive visits across all plans
  - Ongoing member communications about the importance of and steps to take in order to effectively manage chronic conditions, especially diabetes
- Further dialogue planned will take place at the January 2020 Financial Subcommittee meeting about:
  - Impact of other initiatives and changes on GHIP program offerings and population
  - Impact of all programs that is beginning to play out in emerging GHIP claims, utilization and clinical experience
- Continue to monitor the impact of ongoing initiatives, and enhance reporting to capture impact of initiatives implemented for FY20
  - Opportunity to leverage this reporting to support measurement of GHIP strategic framework goal to limit inflation of total cost of care
- Consider opportunities to incorporate changes into upcoming medical TPA contract renewals that modify current arrangements related to areas of concern about member engagement, education, utilization and cost of programs and/or providers

Appendix A

Intro to IBM Watson Health Incurred Quarterly Reporting, as presented at 12/5 Financial Subcommittee Meeting



Key findings

- Top clinical conditions driving medical trend:
  - Chemotherapy encounters +29.4% PEPM trend (+$3.9M increase in net medical paid)
  - Newborns, w/wo complication +14.9% ($1.6M)
  - Coronary artery disease +13.4% (+$1.6M)
  - Respiratory disorders +11.0% (+$1.3M)
  - Pregnancy without delivery +7.9% (+$1.4M)
- The costliest episode of care (including medical and Rx spend) is diabetes at $45.2M net paid
- Specialty drugs continue to be a significant cost driver
  - Days supply of the top 50 specialty drugs increased 24.2% driving a $12.0M increase in net paid for these drugs
  - Immunosuppressants (+10.2% increase in utilization, +$4.1M net paid), antineoplastic agents (+21.1% utilization, +$3.7M net paid) and hormones & synthetic substitutes (+36.4% utilization, +$2.1M net paid) are the costliest therapeutic classes of specialty drugs
  - Professional specialty drug claims increased $3.1M (14.3% trend)
- Utilization of behavioral health services are on the rise:
  - Mental health outpatient visits +11.5%, office visits +5.9%
  - Substance abuse inpatient visits +16.7%, outpatient visits +13.3%, office visits +10.3%
- Inpatient maternity costs increased $1.8M (+7.6% trend)

Key findings (continued)

- An overall increase of 10.2% in the PEPM trend for outpatient radiology services driven by:
  - Increased utilization of outpatient mammograms (+29.8%) and therapeutic radiology (+18.2%)
  - Increased PEPM trends for mammograms (+35.3%), x-rays (+20.1%), ultrasounds (+18.7%) and nuclear medicine (+16.2%)
- Outpatient surgery trend increased 10.2% (+$7.0M net paid) with relatively flat utilization. The following procedures experienced the largest overall cost increases relative to FY18:
  - Cardiac ablation ($2.1M total paid)
  - Upper GI endoscopy ($1.8M)
  - Cardiac catheterization ($1.3M)
  - Shoulder arthroscopy ($1.1M)
- While inpatient surgery has a modest overall trend (+1.0% increase in PEPM), there are some significant trends for the First State Basic (+ 28.1%), HMO (+25.5%), and CDH Gold (+12.6%) plans. The following factors contributed to plan-specific trends:
  - First State Basic – heart transplant at an out-of-state facility
  - HMO – mix of procedures (skin grafts, cardiovascular, gastrointestinal) linked to high cost claimants[1]
  - CDH Gold – cardiovascular procedures likely related to high cost claimants

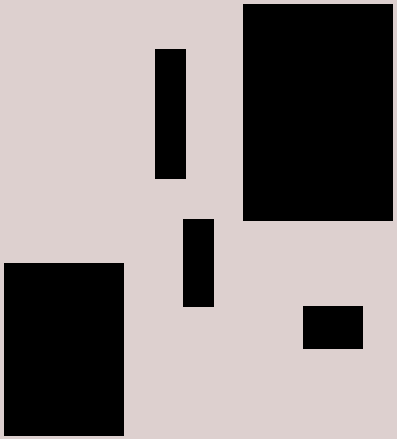
1 High cost claimants are members with $100,000 or more of incurred claims during the specified time period.

Next steps

- Opportunity to continue promoting GHIP programs that support diabetes prevention and management to mitigate this condition as a top cost driver
- Evaluate member engagement in maternity care management programs and review adequacy of GHIP resources to help members navigate their care needs before, during and after pregnancy
- Evaluate GHIP resources related to cancer to ensure plan participants have support for navigating their individual care needs
- Evaluate the competitiveness of the GHIP's drug pricing through Express Scripts (currently underway via contract renewal negotiations)
- Continue promotion of all behavioral health resources available through the GHIP (including through the EAP) to ensure plan participant awareness of all pathways to engage with a behavioral health professional

Appendix B

Intro to IBM Watson Health High Cost Claimant Analytic, as presented at 12/5 Financial Subcommittee Meeting



Key findings

- While high cost claimants1 (“HCC”) enrolled in the GHIP during FY19 spanned all age ranges, member types (employee, spouse, etc.) and status groups (Active, non-Medicare Pensioner, etc.), these claimants were most often:
  - Aged 50-59 years old (35% of all HCC)
  - Spouses (61% of all HCC)
- Over the last 4 fiscal years (FY16 – FY19):
  - Prevalence of HCCs increased (from 6.1 to 7.4 HCCs per 1,000 members)
  - Total cost associated with HCCs increased (from 22% to 25% of net payments attributable to HCCs)
  - Cost per HCC increased (from $108 to $135 net paid per member per month (PMPM))
  - Cost per HCC has been trending higher and with more variability year to year compared to non-HCC cost increases, particularly from FY17 to FY18 (15.5% increase in net paid PMPM for HCCs vs. minimal increase for non-HCCs)

1 HCCs are patients with $100,000 or more of incurred claims during the reporting period.

Key findings

- Of the 776 HCCs in FY19, 283 (36.4%) incurred costs of $100,000 or more in multiple fiscal years and 43 (5.5%) met this threshold in all of the past four fiscal years (FY16 – FY19)
  - Top clinical conditions driving multi-year HCCs include conditions associated with newborns, cancer (breast, leukemia, lung) and coronary artery disease
  - One of the top 10 most expensive HCCs in FY19 has been a HCC for all four years and has been continuously enrolled in the First State Basic plan as a non-Medicare pensioner; this claimant is currently engaged with a Highmark CCMU nurse care manager
- Top clinical conditions driving total HCC costs in FY19 are similar to those of multi-year HCCs
- Skin burns, congenital respiratory disorders, and mental health treatment associated with schizophrenia have the highest costs per patient, but are not necessarily the top conditions driving overall costs (relatively few number of each of these types of claimants)

Key findings

- While not possible to prevent all HCCs, a multi-pronged effort can be effective in mitigating HCC cost and potentially preventing some members from becoming HCCs; this effort includes:
  - Member education to promote health engagement
  - Age/gender-appropriate preventive screenings
  - Effective management of chronic conditions (i.e., primary care)
  - Supporting members in navigating the health care system
  - Care management programs that support members with the most acute health care needs
- Opportunity to evaluate the effectiveness of third party administrators (TPA) in delivering programs that support the State across the components noted above
  - Completion of this evaluation within the next 2-3 months would allow for incorporation of any findings into the TPA contract renewal process for FY21