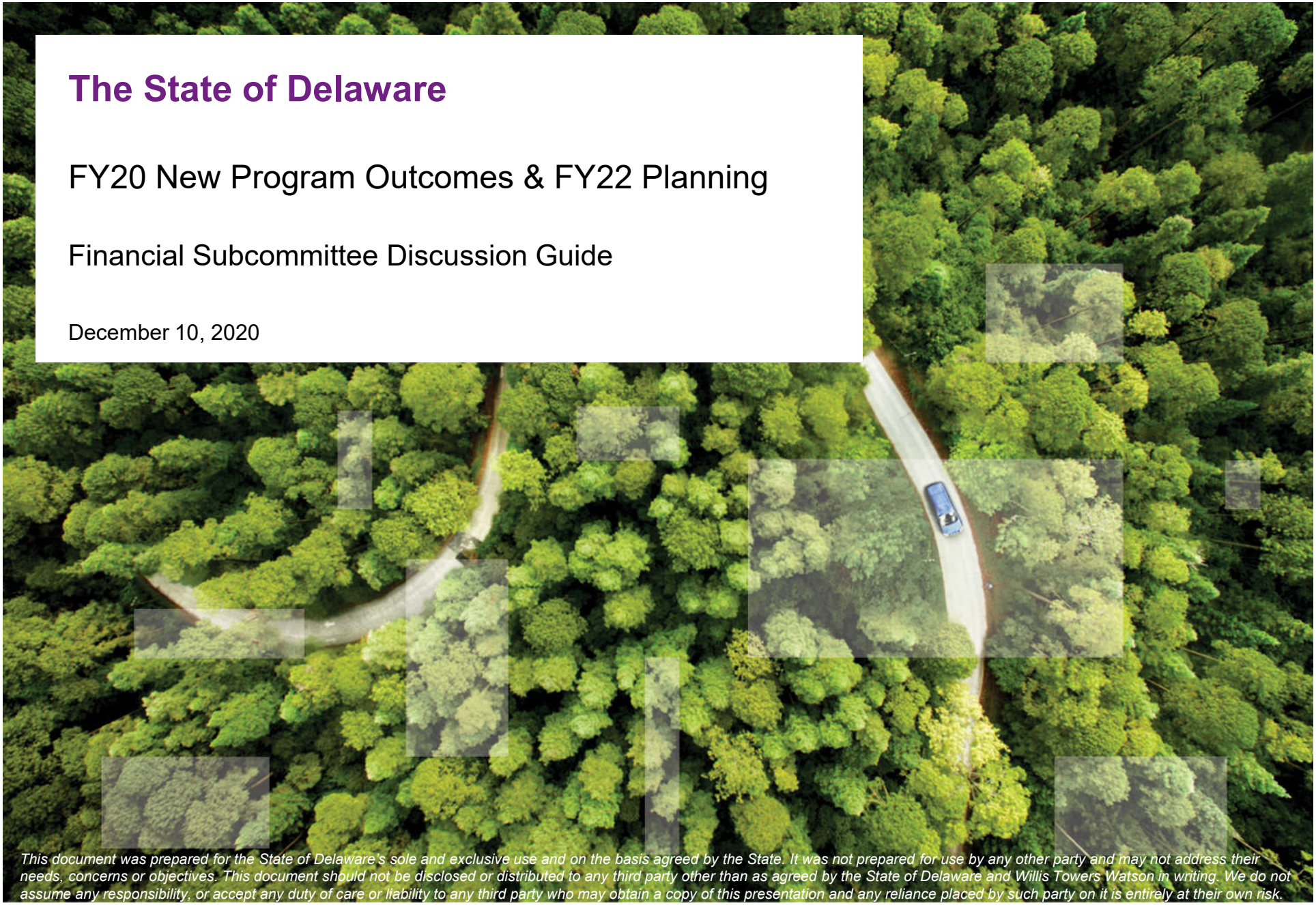
The State of Delaware

FY20 New Program Outcomes & FY22 Planning

Financial Subcommittee Discussion Guide

December 10, 2020



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Overview of recent GHIP initiatives and changes

Introduction

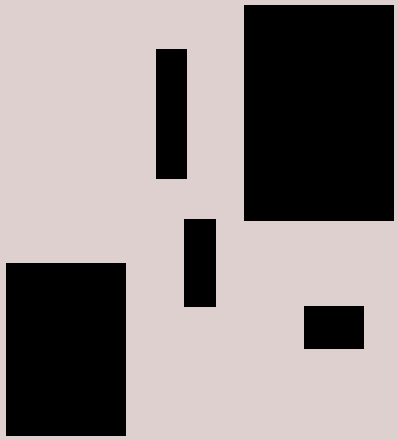
- A number of initiatives have been implemented since FY16 that have the potential to materially impact GHIP program offerings and its enrolled population; these include:
  - Site of care steerage
  - Clinical management programs
  - Other initiatives and changes, such as those required by legislation
- Today's discussion will focus on conducting a deeper dive into the following items:
  - Discuss health of underlying GHIP population that would affect care management program results
  - Begin discussion of care management program results for FY20
- Further dialogue will take place at the January 2021 Subcommittee meeting about:
  - Deeper dive into differences in population health experience and select care management program results by medical plan
  - SurgeryPlus program results for FY20

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

GHIP population health

Overview of FY20 experience



GHIP population health

Overview

- 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
- Factors influencing population health include:
  - Demographic factors
  - Adherence to preventive care
  - Prevalence of chronic disease and lifestyle risk factors
  - Prevalence and nature of high cost claimants[1]

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

GHIP population health

Demographic factors

- GHIP population demographics remained relatively stable from FY19 to FY20
- While some differences exist among the age of the State's population relative to each vendor's book-of-business norm, they are unlikely to be material
- The State has a higher percentage of female members relative to Highmark's book-of-business, which may drive additional cost among members younger than 45 years old

Demographic factors[1]	Aetna			Highmark		
	FY19	FY20	2020 Norm	FY19	FY20	2020 Norm
Average number of enrolled employees / retirees	13,411	13,139	n/a	31,124	32,141	n/a
Average family size (ratio of members to employees)	2.3	2.3	n/a	2.2	2.2	n/a
Average age of members enrolled during the plan year	33.7	33.7	35.4	34.9	34.7	33.7
% female members (as percent of total enrolled)	54%	54%	n/a	55%	55%	49%

1 For active employees, non-Medicare retirees and their dependents. Source: Vendors' FY20 Q4 quarterly reports. 2020 Norm reflects vendors' book-of-business normative data.

GHIP population health

Adherence to preventive care

- While GHIP members are generally adherent with preventive cancer screenings, there remains an opportunity to improve colorectal cancer screening rates among Aetna plan participants
- Opportunity remains to increase adult preventive visits to primary care providers
- Slight reductions in some of these measures for FY20 may be attributable to deferral of care as a result of the COVID-19 pandemic

	Aetna[2]			Highmark		
	FY19	FY20	2020 Norm	FY19	FY20	2020 Norm
Breast Cancer Screen Rate	72%	73%	71%	70%	69%	71%
Cervical Cancer Screen Rate	69%	65%	79%	74%	73%	71%
Colon Cancer Screen Rate	44%	44%	66%	67%	67%	57%
Adult Preventive Visits (% of eligible)	12%	12%	7%	42%	36%	34%

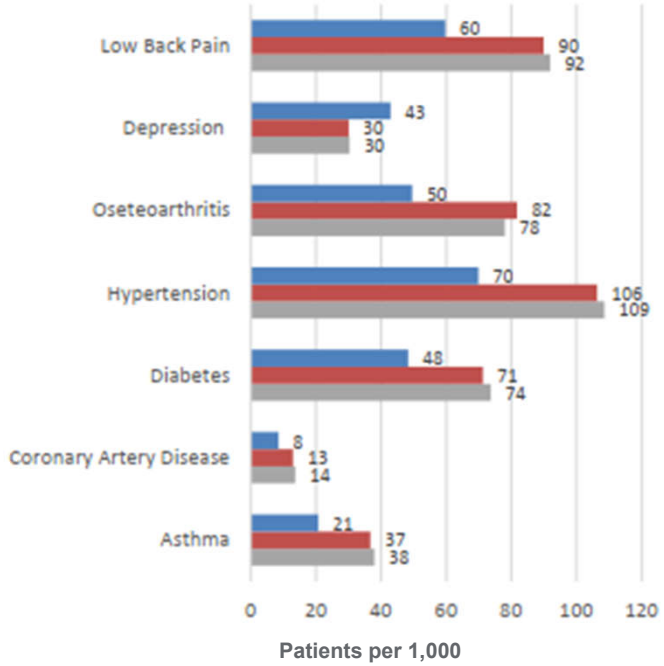
1 For active employees, non-Medicare retirees and their dependents. Source: Vendors' FY20 Q4 quarterly reports. 2020 Norm reflects vendors' book-of-business normative data.
2 Aetna data reflects enrollment-weighted average between metrics reported for the HMO and CDH Gold plans.

GHIP population health

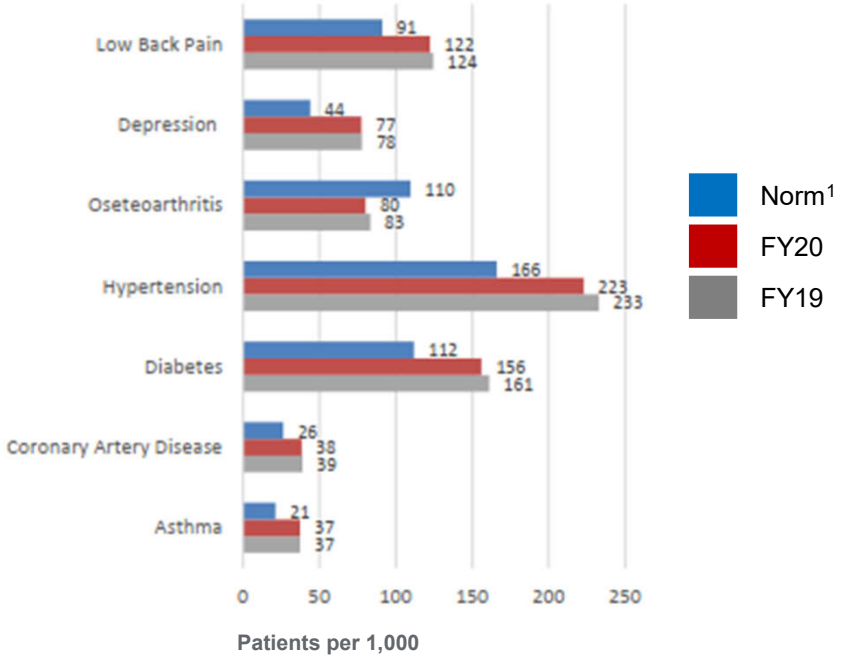
Prevalence of chronic disease and lifestyle risk factors

- Unmanaged or poorly managed chronic disease can also contribute to higher prevalence of high cost claimants
- Prevalence of common chronic diseases for both Actives and non-Medicare pensioners is higher than benchmark[1] for most clinical conditions
  - Depression in the active employee population may be under-reported relative to the Norm

Active employees and dependents



Non-Medicare pensioners and dependents



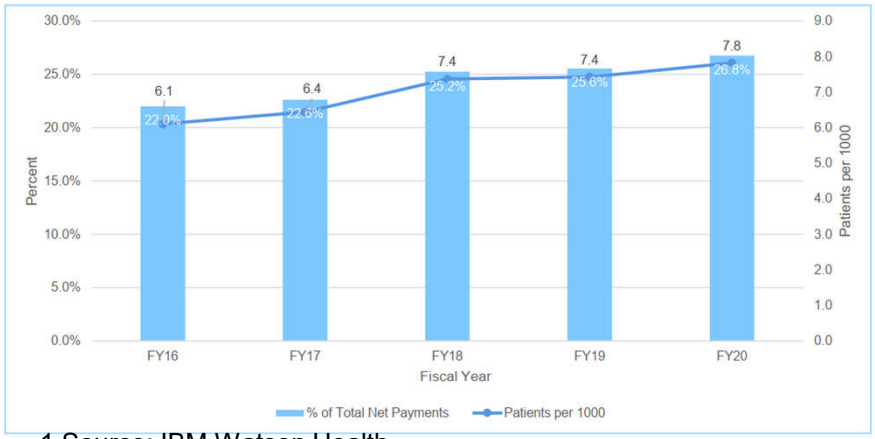
1 Source: IBM Watson Health.

GHIP population health

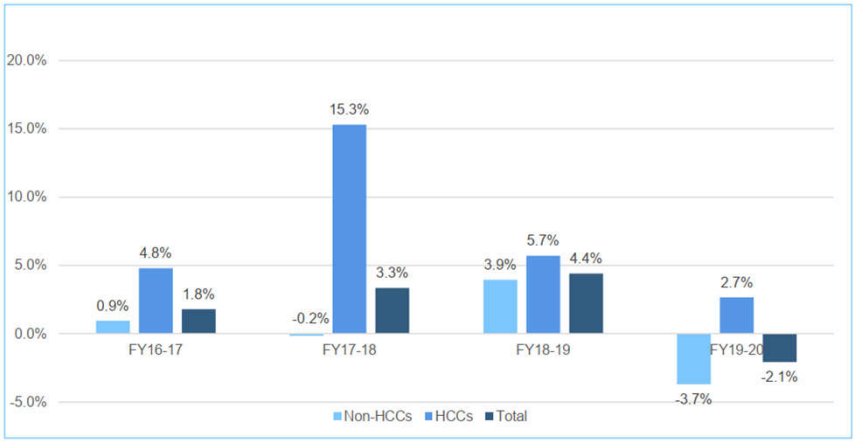
Prevalence and nature of high cost claimants

- Highlights from high cost claimant (HCC) experience from FY16 to FY20:
  - Prevalence of HCCs increased (from 6.1 to 7.8 HCCs per 1,000 members)
  - Total cost associated with HCCs increased (from 22% to 26.8% of net payments attributable to HCCs)
  - Cost per HCC increased (from $108 to $141 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 (15.3% increase in net paid PMPM for HCCs vs. minimal increase for non-HCCs)

High Cost Claimants Trends (FY16 – FY20)
Percent of Total Net Payments and Patients per 1,000



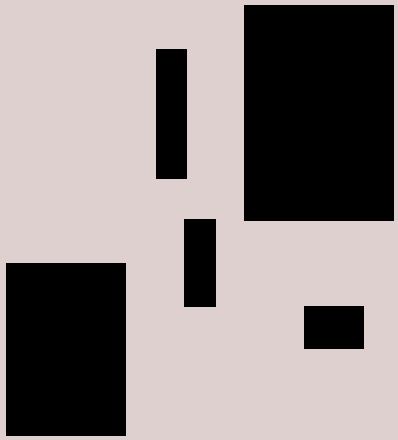
Net Payments per Member per Month Trend
for High Cost Claimants and Non-High Cost Claimants, FY16-FY20



1 Source: IBM Watson Health.

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

- In addition to these programs that directly face members, each vendor's clinical team provides "behind the scenes" support for members including:
  - Other medical management such as precertification, concurrent review, and case management
  - Input into communication campaigns reminding members about preventive care, cancer screenings, etc.
- The GHIP also offers other clinical management programs that are focused specifically on diabetes and metabolic syndrome
  - Diabetes prevention program offered in partnership with the Livongo Diabetes Prevention Program and local YMCAs
  - Livongo for diabetes management

Clinical management programs – FY20 results

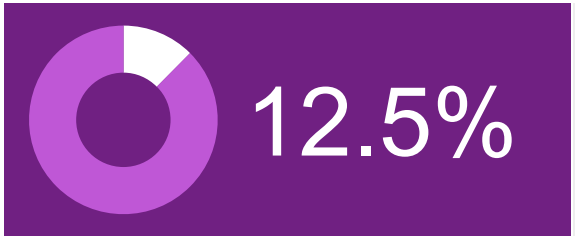
Goals and measurement of results

- 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 FY20 require 6 months of claim run-out and will be reconciled in early CY2021
  - 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 CareVio (HMO plan)

Goal – engage GHIP participants

FY20 results



Total engaged as % of eligible population

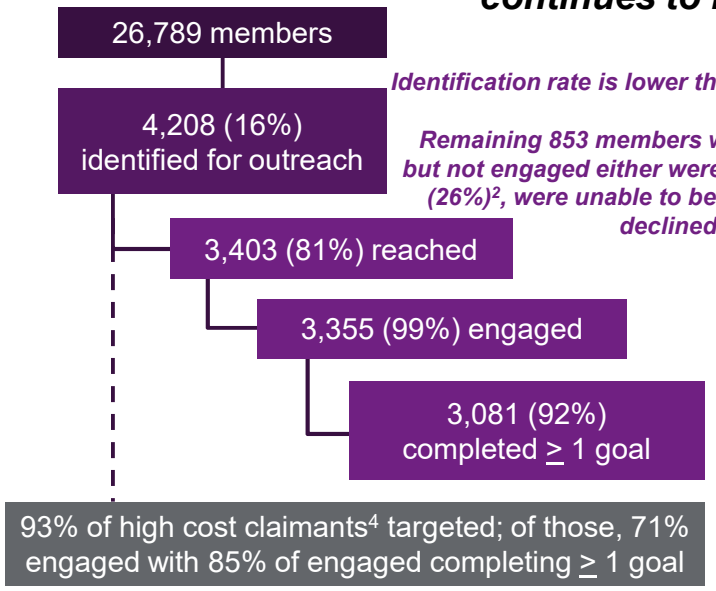
Engagement defined by CareVio as the distinct count of members who are reached (telephonically, face-to-face or by video) and complete a health assessment or plan of care questionnaire with a nurse care coordinator.

Program is engaging slightly younger members who tend to be female employees or are the parents of female dependents

Metric[1] – FY20	Engaged	Non-engaged
Average Age	32	35
% Female	58%	53%
% member type (i.e., employee vs. spouse vs. other dependent)	Employee = 40% Spouse = 16% Dependent = 44%	Employee = 43% Spouse = 16% Dependent = 41%

1 Reflects engagement statistics for FY20 (7/1/19 – 6/30/20).
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 cost claimant is a member with > $100k in medical claims paid by the plan in FY20.

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



Identification rate is lower than FY19 (was 27%)

Remaining 853 members who were identified but not engaged either were not outreached to (26%)[2], were unable to be reached (68%)[3], or declined to participate (6%)

Embedded resources within ~300 PCP practices throughout DE aided CareVio engagement efforts

Aetna CareVio (HMO plan)

Goal – promote appropriate utilization of health care

Service utilization	Unit	GHIP – HMO plan		Aetna Norm[2]
		FY19	FY20	
PCP office visits	Visits/member	2,062	2,068	1,247
Specialist office visits	Visits/member	2,011	4,633	4,218
Telemedicine – Teladoc	Visits	378	1,079	n/a
Telemedicine – Other providers[3]	Visits	447	4,047	n/a
Emergency room (avoidable visits)	Visits/1,000	82	65	75
Emergency room (all visits)	Visits/1,000	241	192	169
Inpatient admissions	Visits/1,000	44	50	45
Readmissions	Visits/1,000	1.6	2.4	3.3

Telemedicine service utilization reflects combined usage for HMO and CDH Gold plans

- Changes in service utilization are largely consistent with overall trends due to COVID-19 pandemic
- PCP visit rates continue to be higher than the Aetna norm
- Increased specialist visits warrant further review with Aetna to determine cause
- Increases in inpatient admissions and readmission rate reflect opportunity for further study

Data source: Aetna.
1 Data sources: FY19 and FY20 results as reported by Aetna in the FY20 Q4 and FY19 Q4 reports.
2 Reflects national average utilization rates. Source: Aetna book of business.
3 Telemedicine visits includes third-party telehealth visits (excluding Teladoc) and virtual visits with providers.

Aetna CareVio (HMO plan)

Goal – promote appropriate utilization of health care

Compliance with condition-specific treatments for select clinical conditions	FY19		FY20	
	Engaged	Non-engaged	Engaged	Non-engaged
Diabetes				
Office Visit	97%	93%	62%	55%
HbA1c Test Rate	95%	93%	100%	100%
Retinal Eye Exam Rate	68%	39%	12%	12%
Hyperlipidemia				
Office Visit	96%	90%	61%	54%
Hypertension				
Office Visit	97%	93%	56%	54%

- Despite impact of COVID-19 on deferral of care, engaged members had significantly more PCP visits than non-engaged members
- Further information about the program's ability to improve health outcomes will be provided at the January 2021 Subcommittee meeting

Data source: CareVio

Aetna traditional case and disease management (CDH Gold plan)

Goal – engage GHIP participants

FY20 results

Member engagement in both case and disease management has not materially changed from FY19

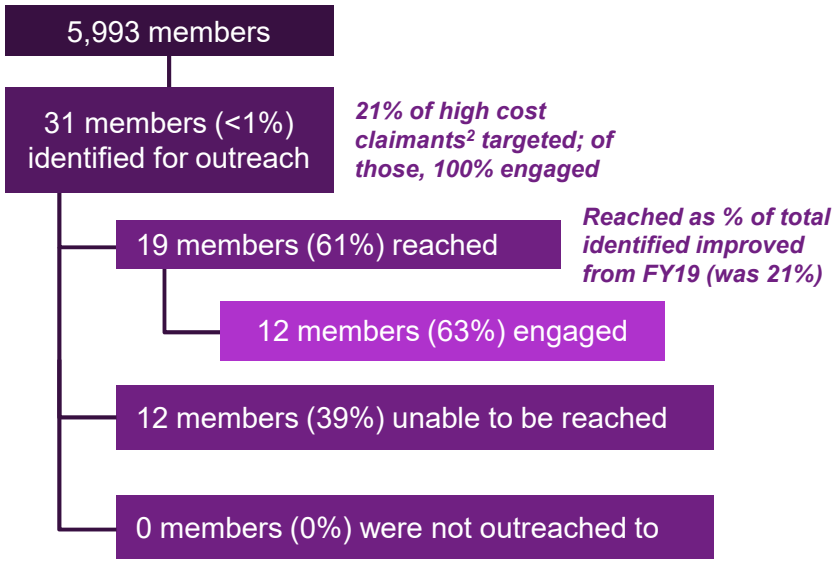
Total engaged as % of eligible population

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

Program is engaging older members who tend to be female employees

Metric[1] – FY20	Engaged	Non-engaged
Average Age	47.5	33.9
% Female	67%	59%
% member type (i.e., employee vs. spouse vs. other dependent)	Employee = 67% Spouse = 17% Dependent = 17%	Employee = 48% Spouse = 15% Dependent = 37%

Case Management



1 Reflects engagement statistics for FY20 (7/1/19 – 6/30/20).
2 High cost claimant is a member with > $100k in medical claims paid by the plan in FY20.

Aetna traditional case and disease management (CDH Gold plan)

Goal – promote appropriate utilization of health care

Service utilization	Unit	GHIP – CDH Gold plan		Aetna Norm[2]
		FY19	FY20	
PCP office visits	Visits/member	1,708	1,735	1,247
Specialist office visits	Visits/member	2,060	4,836	4,218
Telemedicine – Teladoc	Visits	378	1,079	n/a
Telemedicine – Other providers[3]	Visits	447	4,047	n/a
Emergency room (avoidable visits)	Visits/1,000	64	48	75
Emergency room (all visits)	Visits/1,000	197	154	169
Inpatient admissions	Visits/1,000	45	41	45
Readmissions	Visits/1,000	2.0	1.2	3.3

Telemedicine service utilization reflects combined usage for HMO and CDH Gold plans

- Changes in service utilization are largely consistent with overall trends due to COVID-19 pandemic
- Opportunity to increase PCP visit rates
- Increased specialist visits warrant further review with Aetna to determine cause

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

Compliance with condition-specific treatments for select clinical conditions	FY19		FY20	
	Engaged	Non-engaged	Engaged	Non-engaged
Diabetes				
Office Visit	100%	71%	100%	81%
HbA1c Test Rate	100%	60%	86%	57%
Lipid Test Rate	100%	60%	86%	52%
Microalbumin Test Rate	50%	16%	57%	29%
Hyperlipidemia				
Office Visit	100%	69%	100%	85%
Hypertension				
Office Visit	100%	69%	100%	83%

- Changes in the underlying population are likely to have played a prominent role in driving differences between FY19 and FY20 results

Highmark Custom Care Management Unit (CCMU)

Goal – engage GHIP participants

FY20 results

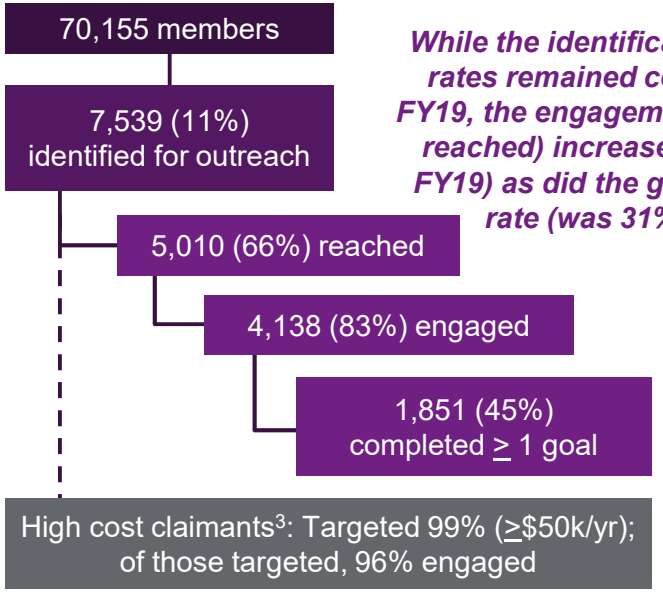
Total engaged as % of eligible population

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 older members who tend to be female employees

Metric[2] – FY20	Engaged	Non-Engaged
Average Age	48.3	34.2
% Female	62.2%	54.1%
% member type (i.e., employee vs. spouse vs. other dependent)	Employee = 64% Spouse = 22% Dependent = 14%	Employee = 44% Spouse = 16% Dependent = 40%

Clinical engagement continued to improve in FY20



While the identification and reach rates remained consistent with FY19, the engagement rate (as % of reached) increased (was 79% in FY19) as did the goal completion rate (was 31% in FY19)

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 FY20 (7/1/19 – 6/30/20).
3 High cost claimant is a member with > $100k in medical claims paid by the plan in FY20.

Highmark Custom Care Management Unit (CCMU)

Goal – promote appropriate utilization of health care

Service utilization[1]	Unit	GHIP – PPO & FSB plans		Highmark Norm[2]
		FY19	FY20	
PCP office visits	Visits/1,000	1,598	1,692	2,030
Specialist office visits	Visits/1,000	2,125	2,146	2,190
Telemedicine[3]	Visits	390	1,752	n/a
Emergency room (avoidable visits)	Visits/1,000	42	35	n/a
Emergency room (all visits)	Visits/1,000	209	179	225
Inpatient admissions	Visits/1,000	56	55	36
Readmissions	Visits/1,000	1	1	1

- Changes in service utilization are largely consistent with overall trends due to COVID-19 pandemic
- Opportunity to increase PCP visit rates and further explore the causes for higher inpatient admissions among the GHIP population relative to Highmark norm

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	FY19		FY20	
	Engaged	Non-engaged	Engaged	Non-engaged
Diabetes				
Office Visit	99%	98%	99%	98%
HbA1c Test Rate	82%	82%	81%	79%
Retinal Eye Exam Rate	99%	98%	35%	32%
Lipid Test Rate	72%	74%	72%	70%
Microalbumin Rate	68%	62%	68%	57%
Hyperlipidemia				
Office Visit	99%	97%	99%	97%
Lipid Test Rate	76%	77%	73%	73%
Hypertension				
Office Visit	99%	98%	99%	97%

- Despite impact of COVID-19 on deferral of care, engaged members had slightly higher rates of compliance with condition-specific treatments than non-engaged members, which is similar to the prior plan year's results
- Further information about the program's ability to improve health outcomes will be provided at the January 2021 Subcommittee meeting

Clinical management programs summary

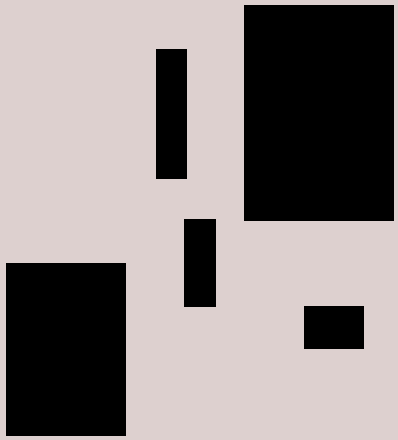
- The goals of all care management programs remain relatively the same:
  - Engage GHIP participants
  - Promote appropriate utilization of health care
  - Improve health outcomes
- Both CareVio and the CCMU are making progress toward achieving these goals and have demonstrated some performance improvements in Year 3
  - CareVio has maintained goal closure rates among engaged members and continues to drive improvements in engaged 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 cost 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

Livongo for Diabetes Management

- Livongo for diabetes management was implemented effective 7/1/2019
- Initial savings estimates provided by Livongo were dependent upon engaging 3,633 participants in the program for at least 6 months
  - Based on Livongo engaging approximately 30% of diabetic members in the GHIP
- Actual participation rates in FY20 fell short of initial estimate; 1,589 plan participants engaged with the program in FY20
- Opportunity exists to encourage additional members to engagement in the program
- Additional analysis of member outcomes for plan participants who did engage in Livongo program is ongoing and will be presented to the Subcommittee in January 2021

Appendix

Care management program descriptions



Aetna value-based care delivery model – CareVio

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 CareVio 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