Care Coordination
Agenda

• Who is CareSource
• What We Learned
  – Enrollment Snapshot
  – Success Factors
• Care Coordination of Newly Insured
• Innovation in Care Coordination
Non-profit, founded in 1989 in Dayton, OH

Comprehensive, member-centric health and life services

Regionally based-serving multiple states and products

MISSION FOCUSED:
To make a lasting difference in our members’ lives by improving their health and well-being.

Product Lines
- Medicaid
- Marketplace
- Duals Demo
- Medicare Advantage

1.52M members

100k Marketplace Enrollment Growth

IN OH KY WV

Marketplace Coverage

Confidential & Proprietary
Why We Were an Early Adopter

MEDICAID □ □ MARKETPLACE

Commitment to uninsured & vulnerable populations

CareSource
**Enrollment Snapshot**

**Common Diagnoses**
- Hypertension
- Lipid Disorders
- Low Back Pain
- Obesity
- Diabetes

**60%**
- Silver Plan

**20%**
- Prior Medicaid

**87%**
- Receive Subsidies

**41.9**
- Average Age
- 18% are under age 35

**46%** Male / Female **54%**

**47-63%**
- Previously Uninsured
Marketplace Success Factors

1. Individual vs. Group Insurance Model
2. Innovative Consumer-Driven Network & Benefit Designs
3. Community-Based Outreach & Partnerships
4. Price Value and Enrollment Retention

Care Coordination
Care Coordination Case Studies

Welcome Call
- Vulnerability Index
- Health Risk Assessment

Identify Members for Care Coordination
Our Care Model
Population Health Approach

Actionable Insight to Slow Member Progression

Who manages member's health?

Who manages member's health?
- Health: Monitoring, Low, Medium, High, Intensive, Complex
- 1:1 Care: Self, Partner, Coordination

Population Risk
- Low
- Rising
- High

Model of Care
- Member Risk
- Triggers

Population Stream
- Maternal/Child
- Behavioral Health
- Chronic Condition
- Acute Medical
- Healthy

Life

Coordination

Evidence-based
Life Services: Managing Social Determinants of Health

HEALTH-RELATED SOCIAL NEEDS

- **ECONOMIC STABILITY**
  - ACCESS TO LONG-TERM EMPLOYMENT
  - ACCESS TO FINANCIAL LITERACY
  - ACCESS TO ADULT EDUCATION & JOB TRAINING
  - INCREASED ASSETS SUCH AS HOME OWNERSHIP

- **HOUSING & NEIGHBORHOODS**
  - ACCESS TO HEALTHY FOODS
  - INCREASED QUALITY OF SAFE & AFFORDABLE HOUSING
  - IMPROVED ENVIRONMENTAL CONDITIONS

- **EDUCATION**
  - EARLY CHILDHOOD EDUCATION & DEVELOPMENT
  - ACCESS TO EXTRACURRICULAR ACTIVITIES & MENTORING
  - INCREASE HIGH SCHOOL GRADUATION
  - ENROLLMENT IN JOB TRAINING OR POST SECONDARY EDUCATION

- **SOCIAL RELATIONSHIPS**
  - SOCIAL COHESION
  - CIVIC PARTICIPATION
  - PERCEPTIONS OF DISCRIMINATION & EQUITY
  - INCARCERATION / INSTITUTIONALIZATION

- **FOOD & NUTRITION**
  - REGULAR & CONSISTENT ACCESS TO HEALTHY FOODS
  - EDUCATION ON NUTRITION & OVERALL HEALTH IMPACTS
  - ADDRESSING FOOD DESSERTS & INEQUALITIES

Health-related social needs are found where people live, learn, work and socialize; they impact health outcomes.

CareSource
Innovation Supports Improved Outcomes

• Health, Wellness and Care Plans
• Health Risk Assessment
• Member Engagement
• Tailored Interactive Member Experience
• Service Access and Utilization
• Overall Cost Per Member / Month Cost
Conclusion

• Innovate
• Population Health
• Care for Everyone
• Care is Local
• Relationships
• Rising Risk
• Social Determinants

CareSource
Place of Delivery Care Model

A collaborative approach for high-risk patient care

Deborah Stewart, M.D.
Regional Medical Director
Florida Blue
June 9, 2016
GuideWell Emergency Doctors
Free-standing ERs staffed by board-certified emergency physicians billing at urgent care (not ED) fees

CliniSanitas
Culturally relevant, comprehensive care addressing needs of Central and South Americans

Florida Blue Retail Centers
Retail centers that engage, educate, enroll, provide health assessments and in several locations attached to care providers
Transforming our Medical Management Model

Historically

- Disease-Centric Approach
- Moderate Array of Support Services
- Non-Scalable Care Model
- Post-Event Care Interventions
- Limited Engagement Channels
- Almost Exclusively English-Based
- Average Quality Ratings

Future State

- Member–Centric Approach
- Robust Continuum of Services
- Model Scaled to Support Product/Network Arrangements
- Real Time and Prospective Care Support
- Leveraging Most Effective Engagement Channels for Population
- Culturally Competent to Serve Target Markets
- Competitive Results on all Quality Standards

Progress 80% Future State
Why the POD Model?

• Improve quality, utilization and cost outcomes for members.
• Coordinates care for high-risk members in the community where they receive their services.
• Builds and improves relationships with members and their medical provider.
• Leverage national best practices.
Current Environment

“Old World”
- Employer-based coverage
- Large open provider networks
- Self directed care management

“Future World”
- Consumer-centric care
- Geo-and product specific networks
- Collaborative care management (ACOs, PCMHs, CCMs)
- Population care management model
How We Make the Greatest Impact

PODs focus on complex-care members who drive 60% to 70% of costs.

This breaks down to:

- 1% of the fully insured
- 5% of Affordable Care Act (ACA)/individuals under 65
- 10% of Medicare Advantage members

70% of costs

Complex-Care Membership Cost
Eleven (11) locally based, collaborative POD care models:

- Geo-specific, inter-disciplinary teams who manage the care needs of high-risk members.
- Florida Blue staff includes nurses, network liaisons, analysts, coding educators, service consultants, pharmacists and social workers.
- Staffing levels customized to each POD’s unique membership and provider arrangement needs.
- Accountable for clinical and quality outcomes for target population.
POD Design and Implementation

POD Clinical Support by Vicinity

Statewide
- Clinical Lead (1)
- Business Lead (1)

Regional
- Medical Directors (3)
- Pharmacists (5)
- Network Liaisons (5)
- Quality RNs (5)
- Analysts (3)

Local POD Teams (11)
- Population Care managers (12)
- RNs (132)
- Social Workers (11)
POD Model Success Measures

- Admits/1000
- ER Visits/1000
- Per member/per month (PM/PM) cost
- Pharmacy spend
- Stars & HEDIS rates

- Quality results (Stars, HEDIS)
  - Trend compared to targets and market
  - Per member/per month (PM/PM) cost compared to target and market

- Contracting trend
  - Services performed by preferred providers (value based)

- Customer surveys
  - Target operational satisfaction metrics
## ACA Inpatient Admits, Readmits

<table>
<thead>
<tr>
<th></th>
<th>Admissions</th>
<th>Readmission Rates</th>
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<tbody>
<tr>
<td><strong>Jan. 2015</strong></td>
<td>93 admits/1,000</td>
<td>11.5%</td>
</tr>
<tr>
<td><strong>Jan. 2016</strong></td>
<td>76 admits/1,000</td>
<td>10.7%</td>
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PODs fully implemented Sept. 2015
CMS Marketplace Forum
Care Coordination

UPMC Health Plan
Adam Pittler, MBA Director Consumer Products
Roseanne Degrazia, Associate VP Clinical Affairs
June 9, 2016
UPMC’s Integrated Delivery and Financing System Approach

- **UPMC Has Been An IDFS Since 1998** We’re committed to improving the health of our members and community, implementing cost-effective solutions, creating innovative product offerings, service excellence, and leveraging our unique structure to partner with community providers, our patients, our members, and our purchasers.

- **Provider-focused, integrated systems are best positioned** to create innovative clinical models that improve care and reduce expenses – the imperative we must embrace in order to thrive in the future.

- **Continued support of physicians coupled with investments** in our systems and infrastructure enables the ongoing success of our integrated delivery and financing model.

- **UPMC, through its Integrated Delivery and Financing System, is partnering with community hospital systems and physicians** to create the highest quality, cost effective care to improve the health of the communities we serve.
UPMC’s Individual Market Experience

2014

- 2014 Lowest Plan $133
- PA Average Lowest $221
- UPMC Select $236
- National Avg Lowest $243

Health Plan Membership

- 4,500

2015

- UPMC Partner $140
- UPMC Select $147
- UPMC Premium $169
- 2014 Lowest Plan $147
- PA Avg $173
- National Avg $224

- 55,100

2016

- UPMC Partner $154
- UPMC Select $170
- UPMC Premium $195
- 2014 Lowest Plan $166
- PA Avg $210
- National Avg $250

- 122,000

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UPMC’s Individual Market Network Strategy

Develop High Quality/Low Cost network options at the local level

- **Premium Network**
  - Traditional Commercial Network
  - Full 29 County Service Area

- **Select Network**
  - UPMC + Local Community Hospitals
  - 80%+ Shared Savings/PCMH PCPs

- **Partner Network**
  - UPMC Focused
  - Available in counties where UPMC has a hospital presence
Aligning Plan and Provider Effectiveness
Advantages

• Creates synergistic provider and payer business growth and development strategies
• Combines provider and payer expertise to drive improved outcomes
• Aligns clinical and financial incentives to create value
• Creates administrative efficiencies
UPMC Continues to Focus on People, Process and Technology to Unleash the Power of an Integrated System

Value Network

Right Infrastructure
- People
- Process
- Technology

Right Clinical Model
- Standardized Protocols & Registries
- Care Transition Programs
- Patient Centered Services
- Chronic Care Management Models
- Lifestyle Coaching & Education

Right Consumer/Patient Supports
- Consumer Incentives
- Transparency: Cost/Quality
- Shared Decision Support Tools

Right Economic Incentives
- Gainsharing
- Capitation and Bundled Payments
- Care Management Payment
- Performance Payment
- Benefit Designs

Improved Quality and Cost and Patient Experience
UPMC Health Plan 5th Year of Medical Home Transforming Care Delivery

- UPMC Health Plan 422 active sites in Medical Homes
- ~1,000 primary care physicians participating
- Improved care coordination and quality outcomes
- Data and physician report cards drive results
- Integrated primary care and Health Plan coaching teams

UPMC Health Plan Stars Ratings -
Shared Savings Program v. Rest of Network
2011 - 2015
Marketplace Population Health and Care Management
Improving Strategies for CY16

- Project Flashlight Stratification
- Product Specific Strategies
  - Silver & Platinum in Top 6 Counties
- Dedicated Case Managers
- Member Incentives
  - (See PCP & Do Health Risk Assessment)
- PCMH Performance Profiling & Support

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Proactively Identifying this Population
Data sources & Risk Factors – continuous stratification using cost experience

Lifestyle Preferences & Demographics
- Acxiom Marketing Data
- Member Demographic Data

UPMC Doctor’s Office Information (EPIC)

History of Complex Conditions
Medipac Data Extraction of Inpatient and ER Encounters at UPMC Facilities

MARS Data

Pharmacy Utilization
Pharmacy weekly claims data

Prior Medicare Data

14 medical diagnoses

<table>
<thead>
<tr>
<th>Disease</th>
<th>Disease</th>
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<tbody>
<tr>
<td>Cancer</td>
<td>Hemophilia</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Sickle Cell</td>
</tr>
<tr>
<td>HIV</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Atrial Fibrillation</td>
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<tr>
<td>CHF</td>
<td>Transplant</td>
</tr>
<tr>
<td>CKD</td>
<td>Obesity</td>
</tr>
<tr>
<td>COPD</td>
<td>Premature delivery</td>
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14 medications

<table>
<thead>
<tr>
<th>Medication</th>
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<tbody>
<tr>
<td>Anti-rejection drugs</td>
<td>Hemophilia</td>
</tr>
<tr>
<td>Depression combination therapy</td>
<td>Hepatitis C</td>
</tr>
<tr>
<td>Polypharmacy DUR meds</td>
<td>Inflammatory bowel disease</td>
</tr>
<tr>
<td>Long acting injectable antipsychotics</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>Oral chemotherapy</td>
</tr>
<tr>
<td>HIV</td>
<td>Sickle cell</td>
</tr>
<tr>
<td>&gt; 9 medications</td>
<td>17P (maternity)</td>
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Proactively Identifying this Population

Individual Market Model Example:

• What creates the initial & early prediction?

<table>
<thead>
<tr>
<th>Metal Level</th>
<th>Subsidy</th>
<th>Area Deprivation Index</th>
<th>Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic Region</td>
<td>Property Type</td>
<td>Length of Residence</td>
<td>Network</td>
</tr>
<tr>
<td>Age</td>
<td>Sex</td>
<td>Marital Status</td>
<td>NULL</td>
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<table>
<thead>
<tr>
<th>Predicted TCOC Risk Category</th>
<th>% Exchange Population</th>
<th>Median TCOC PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>59.4%</td>
<td>$232.86</td>
</tr>
<tr>
<td>Medium</td>
<td>30.9%</td>
<td>$482.55</td>
</tr>
<tr>
<td>High</td>
<td>9.6%</td>
<td>$733.97</td>
</tr>
</tbody>
</table>

• Risk Categories / Rules

• Validation
  • Vendor Risk Score Model – Uses claims data to predict future risk.
  • DOHE new Individual Exchange Member model
What happened in CY15 with members identified at risk?

Prioritized Members @ Risk
MA Member: 1.3X more costly
Individual Member: 2.5X more costly

Individual Members
99% Reached (3,856)
- 57% Assigned a Medical Home
- 6% ED Visit Without Prior Doctor Visit
- 51% PCP Visit
- 4% Inpatient Admission

Medicare Advantage Members
83% Reached (3,876)
- 53% Assigned a Medical Home
- 4% Inpatient Admission
- 60% PCP Visit
- 0.5% ED Visit Without Prior Doctor Visit

Goal: facilitate connection with PCP
Goal: Reduce Unplanned Care
CY2016 Individual Product enrollee pool

- Currently indicating higher predicted risk mix than CY2015 enrollee pool with net impact (to-date):
  - 3.7% increase in high risk member share
  - 2.2% increase in medium risk member share
  - 5.8% decrease in low risk member share

<table>
<thead>
<tr>
<th>Enrollment Period</th>
<th>Enrollees</th>
<th>High Risk</th>
<th>Medium Risk</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY2015 Final</td>
<td>60,562</td>
<td>9.6% (n=5,814)</td>
<td>30.9% (n=18,714)</td>
<td>59.4% (n=35,974)</td>
</tr>
<tr>
<td>CY2016 (enrolled-to-date)</td>
<td>18,864</td>
<td>21.3% (n=3,984)</td>
<td>40.7% (n=7,613)</td>
<td>37.5% (n=7,011)</td>
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</tbody>
</table>

CY2016 Medicare Advantage Product enrollee pool – Stable Mix

- Currently indicating similar predicted risk mix as CY2015 enrollee pool.

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<th>Enrollees</th>
<th>High Risk</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY2015 Final</td>
<td>NULL</td>
<td>24.9%</td>
<td>75.1%</td>
</tr>
<tr>
<td>CY2016 (enrolled-to-date)</td>
<td>6,819</td>
<td>26.7% (n=1,821)</td>
<td>73.3% (n=4,998)</td>
</tr>
</tbody>
</table>
2016 New Member Clinical Outreach – Project Flashlight

Total Population Referred *
(n= 19,906)

Members Outreached 86.7%
(n=17,267)

Members Reached 59.1%
(n=10,211)

Members with Clinical Session 82.7%
(n=8,440)

Members’ Problems Solved or Goals Met 81.3%
(n=8,300)

Members with Personal Health Review 77.0%
(n=7,867)

Members with Unplanned Care Orientation 72.9%
(n=7,441)

Members with Open Cases 7.0%
(n=719)

Members’ Declined Coaching Intervention 8.0%
(n=818)

* Data as of 5/16/16

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22% of total 2016 membership have completed some portion of the incentive

Members with HRA And/or PCP 22%  
(n=25,897)

Completed HRA & PCP 39%  
(n=10,186)

Completed HRA Only 9%  
(n=2,422)

Completed PCP Only 52%  
(n=13,289)

45% of 2016 membership targeted by members services has completed an HAS (8,477)
- 21% (1,780) referred over to HM based on triggers
Member Services Welcome call
- 5 Q HRA Individual
- Medicare Getting to Know You Survey including 5 Q Predicative HRA questions
- Selecting a PCP

Clinical Team
- Provide early intervention and care management assistance.
- Assist member in selecting a PCP and schedule PCP appointments
- Provide a direct point of contact between the Provider, Health Plan and member/caregiver(s)
- “Unplanned Care School”
- Facilitate member engagement into health management & wellness programs

✓ Engage the care coordination team early including the Provider, Case Manager, Social Worker to build relationships