Engaging Consumers in their Care – Experiences from Care Coordination and Beyond
Member Engagement

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## WHO WE ARE

**St. Louis**
Based company founded in Milwaukee in 1984

- **28,900 employees**
- **#124** on the Fortune 500 list
- **#4** Fortune’s Fastest Growing Companies (2015)
- **$39.4 - $40.0 billion**
  - Expected revenue for 2016
- **$7.5 billion**
  - In cash and investments

## WHAT WE DO

**28 states**
- With government sponsored healthcare programs

<table>
<thead>
<tr>
<th>Service</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid (24 states)</td>
<td>24 states</td>
</tr>
<tr>
<td>Exchanges (14 States)</td>
<td>14 States</td>
</tr>
<tr>
<td>Medicare (12 States)</td>
<td>12 States</td>
</tr>
<tr>
<td>Correctional (8 States)</td>
<td>8 States</td>
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</tbody>
</table>

- **2 international markets**
- **11.4 million members**
  - Includes 2.8 million TRICARE eligibles
- **~290 Product / Market Solutions**
Marketplace Footprint

- Providing coverage to the previously uninsured and underserved populations
- Specific focus on lower income, subsidized members under 400% of the Federal Poverty Level
- Committed to collaborating with CMS and state regulators to deliver affordable access to quality care through Marketplace
- Disciplined approach to pricing to ensure sustainable position

State based Marketplaces, Medicaid Expansion

Medicaid Expansion via Marketplaces

Medicaid Expansion, FFM

Non-Medicaid Expansion, FFM

State based, Active Purchaser, Medicaid Expansion
Brand Pillars

Local
- We live and work in the same communities.
- We partner with local health care providers and community organizations to provide access to care for our members.

Helpful
- We offer valued guidance and assistance to make health insurance accessible.
- We remove barriers to make it simple to get well, stay well, and be well.

Affordable
- We offer affordable and reliable health care insurance coverage.
- We provide well-rounded services and choices to help our members achieve their best health.
## Reason for Not making a Binder Payment

<table>
<thead>
<tr>
<th>Reason</th>
<th>New</th>
<th>Renewed</th>
<th>Disenrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial difficulties</td>
<td>5%</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Able to take adv of emp coverage</td>
<td>5%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Moved to another state</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Became eligible for Medicaid</td>
<td>1%</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Changed my mind</td>
<td>1%</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Tried, technical difficulties</td>
<td>1%</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Missing info/Misinformed</td>
<td>1%</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td>Just missed deadline</td>
<td>1%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>I did pay</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>I didn’t intend to acutally enroll</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Marketplace voided it out</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

## Reasons for Non-use

*Base: Those who haven’t/didn’t use at all*

- Haven't needed medical services (e.g., healthy, haven't gotten... 46%)
- Network (e.g., too narrow, poor quality, PDM problems) 44%
- Too expensive to use (e.g., deductible, copays, oops) 22%
- Uniformed (e.g., haven't received member materials, not sure...) 14%
- Poor coverage 19%
- Administrative problems (e.g., billing, PCP assignment, wrong...) 16%
- Haven't needed medical services (e.g., healthy, haven't gotten... 63%)
- Network (e.g., too narrow, poor quality, PDM problems) 44%
- Too expensive to use (e.g., deductible, copays, oops) 22%
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### What can Ambetter do to Earn Back Your Business?

- **More affordable (price of plan increased)**: 15%
- **Lower premium**: 11%
- **Lower deductible**: 4%
- **Lower copay**: 1%
- **Network - Doctors in area**: 12%
- **Network - Accuracy of list**: 3%
- **Network - Hospitals**: 2%
- **Network - My Doctor**: 2%
- **Network - Quality of doctors**: 2%
- **Network - Vision/dental**: 2%
- **Network - Better physician reimbursement/pay claims faster**: 2%
- **Better coverage - General**: 6%
- **Better coverage - Rx/mail order pharm**: 2%
- **Better coverage - Lab, radiology services**: 1%
- **Better coverage - Vision & dental**: 0.5%
- **Better customer service**: 6%
- **Correct errors/Pay me back**: 3%
- **Improve billing process**: 3%
- **Fix rewards program problems**: 1%
- **Fix website/online technical problems**: 1%

- **Nothing**: 15%
- **Not eligible (moved, Medicare, Medicaid, employer)**: 15%
Integrated External Presence

- Traditional Media
- Local Advertising
- Community Events
- Digital Media
- Social Media
- Owned Media
Quick Guide Cards

- Insurance jargon simplified!
- Subsidy education
- Buying a plan on the Health Insurance Marketplace
- Essential Health Benefits
- Important Enrollment Dates
- Importance of making timely payments
Ongoing Member Engagement

Pre Member

Member Onboarding

Renewal
MyHealth Pays Reward Program

• A unique incentive program that rewards members for healthy behaviors
• Members can earn rewards for **Annual Wellness Visits** ($50), **Flu Shots** ($25), filling out a **Member Welcome Survey** ($50), and going to the **Gym** 8 times per month ($20/month)
• The reward dollars are loaded onto a limited use card that can be used to pay out of pocket costs (copays, deductibles, etc) or monthly premium payments

![Rewards Program Card]

**Rewards Program**

**myhealthpays™**

EARN REWARDS FOR STAYING HEALTHY:

- $50 Complete your online Ambetter Welcome Survey
- $50 Complete your annual wellness exam
- $25 Get your annual flu vaccine

Use your rewards to help pay for:

- Doctor copays*
- Deductibles
- Coinsurance
- Monthly premium payments

* My Health Pays™ rewards cannot be used for pharmacy copays.
Government Markets Complex Care Model is oriented around 5 key components

<table>
<thead>
<tr>
<th></th>
<th>Target members</th>
<th>Programs and interventions</th>
<th>Staffing model</th>
<th>Approach to member management</th>
<th>Program effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify members with clinical needs that can be addressed by Highmark care team and that have greatest opportunity for impact</td>
<td>Align suite of programs and interventions to address unique needs of the target population and to focus on opportunities for greatest impact</td>
<td>Create role specialization, engage multidisciplinary care team members to fullest extent and allow clinicians to work at top of license</td>
<td>Assign ownership over geo-based panels to improve coordination and continuity of care with local vendors, providers and community resources</td>
<td>Shift away from heavy focus on process metrics towards a comprehensive view of both process and outcome based metrics, e.g., clinical, cost, utilization</td>
</tr>
</tbody>
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The Complex Care Model targets high risk members with characteristics that indicate opportunity for impact

Target members from clinical segments

- Late Stage
- Complex Conditions
- Early stage chronic
- Healthy Risk Factors
- Healthy Independent

Case Mgmt.

- Case mgmt. targets members with characteristics that indicate an opportunity to improve health and well-being and holistically manage member needs while positively impacting outcomes and the ability to help member reduce utilization and spend (e.g., members with ESRD are excluded)
  - Individual ACA members that fall into this population typically have an avg. annual cost of $27K
  - Risk score, likelihood of hospitalization and number of care gaps for these members is higher than 90% of all members
  - Many of these members also have diagnoses for behavioral health

Disease Mgmt.

- Disease management targets members with one of 5 chronic conditions, COPD, CAD, CHF, Diabetes, Asthma, that have a high enough risk score or care gap index indicating opportunities to improve member’s health

While the model does not focus on engaging healthy members, these members are included in the Complex Case Manager’s geo panel and will naturally show up on Complex Case Manager’s radar if their health deteriorates
The approach to more effective member management through the Complex Care Model is oriented around 3 guiding principles

1. MA and ACA members are managed in geo-based panels to improve coordination and continuity of care with local vendors, providers and community resources

2. Case managers act as ‘quarterbacks’, fully owning their member panel and engaging a multidisciplinary care team to holistically manage member needs

3. The multidisciplinary care team is organized in pods across geos, flexing their role in member management based identified member needs
Care Management: Health Plan Complex Care Model

Leveraging the strengths of a multidisciplinary team to meet member needs through a telephonic engagement approach

Case Manager
Geographic panels developed for Med Adv and ACA members to strengthen connections with members and providers by creating continuity of case management resources.

Complex Case Managers serve each geography with knowledge of the local community needs and resources.

Target members where we can make a difference

Keep healthy members healthy

Highmark Dedicated Multidisciplinary Team

Disease Manager
Behavioral Health Specialist
Social Worker
Pharmacist
Medical Director
Coordinator

Manage Medical Costs
Improve Care Coordination
Strengthen Connections

Late Stage
Complex Conditions
Early Stage Chronic
Healthy Risk Factors
Healthy Independent
Q&A Session

To engage on social media use the following hashtag: #issuerinsights

To submit questions remotely, email us at:
Partnership@cms.hhs.gov