Public Narrative Report

I. CareFirst Initiatives and Programs that Manage the Costs and Utilization of Enrollees whose Claims were Reimbursed by the State Reinsurance Program in Plan Year 2020

In Plan Year 2020, CareFirst had three Care Management initiatives/programs that had 300 or more enrollees in the individual market that helped to manage the costs and utilization of enrollees whose claims were reimbursed by the SRP: (1) Diabetes Care Management; (2) Diabetes Virtual Care and (3) Behavioral Health

(1) Diabetes Care Management

A. **Name of the Initiative:** Care Management- Diabetes

B. Population(s) Targeted by the Initiative and How They Are Identified

i. We support members with the full-expression or unstable diabetes. Our approach is structured to assign the most appropriate care management intervention based on a member's specific needs.

ii. Using claims, authorizations, hospital admissions, and/or clinical information, CareFirst identifies members for this program if they are diagnosed with diabetes and/or have complications related to diabetes including:

1. Members with an elevated risk score
2. Comorbidity with conditions related to diabetes
3. Hospital utilization
4. Gaps in diabetes-related HEDIS care measures
5. Members identified as future high cost based on clinical judgment
6. Members with complicating social determinants of health
7. Members with multiple diabetes related medications

C. Description of the Initiative

i. Care management is core to the care support we will provide for members. Our integrated care team leverages a dedicated, regionalized primary nurse model of care, employing medical and behavioral health clinicians and non-clinical care coordinators to ensure we address our members' needs holistically.

ii. Clinical care management interventions are administered by licensed registered nurses. The nurses have a minimum of five years of clinical experience in acute care, community/home health care, case management and/or a related specialty field.

iii. Care management for members with diabetes consists of the following processes:

1. Comprehensive Assessment – the collection of in-depth information regarding a member's health care needs as well as social determinants of health (financial, emotional, social needs and safety)
2. Planning – the process of determining specific objectives, goals and actions designed to meet the member's needs as identified in the assessment process
3. Implementation – carrying out the interventions identified in the care plan to accomplish goals and positive outcomes for the member
4. Monitoring – an ongoing process to determine the plan's effectiveness and make appropriate changes, as necessary

5. Continuity – provide ongoing health education and community resources. The goal is to support the members/dependent in moving towards self-care and independence
6. Evaluation – to determine the case management plan's effectiveness in reaching desired outcomes/goals
7. Outcomes – to identify and implement changes in the plan of care to produce results that are positive, measurable, and goal-oriented

iv. Care management interventions may include discharge planning/transition of care management, home care, outpatient and community-based services. Education will be provided to members around the importance of preventive care and appointments will be scheduled by an advocate for preventive care (i.e., routine physicals, cancer screenings, and chronic condition screenings, such as an HBA1c check for diabetes). These actions can help reduce the likelihood of long-term disease, chronic conditions and subsequent health costs. We focus on key HEDIS and CAHPS measures for gaps in care screenings for diabetes, in addition to hypertension, cervical cancer, breast cancer, and colorectal cancer, etc.

D. Intended Goals and/or Outcomes of the Initiative

i. The program is specifically designed to slow the growth of health care costs and improve outcomes. This includes reducing hospital and emergency room use, improving coordination across primary and specialty care and stabilizing medications. In addition, our program elements are intended to provide the most appropriate services for our members precisely when and where they need them.

E. Activities Undertaken to Evaluate the Effectiveness of the Initiative

i. As each member engages in care management for diabetes, the nurse will evaluate if the care management plan's effectiveness in reaching desired outcomes/goals and will adjust the plan in order to achieve positive results.
ii. Holistically, the key performance indicators of the program are monitored by program leadership weekly and reviewed with the senior leadership of the division monthly. All off-target metrics have an action plan with accountability assigned.

F. Methodology for Determining the Initiatives to Include in this Report

i. CareFirst reviewed the conditions for which we provided case management and selected those programs with more than 300 participants.

(2) Diabetes Virtual Care -

A. **Name of the Initiative:** Diabetes Virtual Care – *New Program started May 2020*

B. Population(s) Targeted by the Initiative and How They Are Identified

i. The program targets high-risk type 2 diabetics but can support anyone with the disease.
ii. A Member is deemed eligible for the program if they have an episode of diabetes in our claims experience and meet one or more of the following criteria:
    1. Hemoglobin A1c > 8
    2. Prescribed insulin
    3. Diabetes related hospital admission within the past 6 months
    4. No PCP visit within prior 12 months

iii. Members may also be identified as appropriate for the program by a Care Manager or provider.

C. Description of the Initiative

i. Targeted members will receive mail, email and telephone communications to offer the program to the member. Once the member chooses to enroll, they will download the application from the Google or Apple stores. The member will receive a blood glucose meter and will pair the device with their phone. They will also complete the at-home A1c test and mail it back for processing (pre-paid shipping materials included). The Member will also be assigned a personal care lead. A personal care lead is someone who is trained in general health and wellness, motivational interviewing, and behavior change. They will work one-on-one with the Member throughout the entirety of the program and help to make their experience a very personalized one.

ii. During the registration and onboarding process, a Member is assigned a risk designation, either high-risk or rising-risk, based on their clinical needs and responses to questions during the on-boarding survey.

iii. Member participation includes interacting with their care leads through in-app messaging, setting goals and completing challenges, tracking of blood glucose levels, and for those with a higher level of clinical need, meeting with a Certified Diabetes Educator (CDE) or having a telehealth visit with an Endocrinologist. In some cases, an endocrinologist will prescribe a Dexcom Continuous Glucose Monitor (CGM) for the Member to wear for approximately 15 days to help the care team better understand the Member's blood glucose levels over time and provide additional feedback.

D. Intended Goals and/or Outcomes of the Initiative

i. The goals of the program are to:

1. Reduce A1c levels for Members
2. Support the closure of Gaps in Care for HEDIS measures for diabetes
    a. HbA1c <8%
    b. Blood Pressure <140/<190 mm HG.
    c. Chronic Kidney Disease Screening
    d. Retinal Eye Exam
    e. Statin Therapy Adherence
3. Support Member whole health as measured through two additional surveys
    a. Diabetes Distress Survey
    b. Merck 3 Medication Adherence Survey
4. Member satisfaction, measured as Net Promoter Score

E. Activities Undertaken to Evaluate the Effectiveness of the Initiative

i. The contract with the vendor who provides this service was negotiated to include performance guarantees associated with improvement of HbA1c scores as well as meeting certain HEDIS targets. If these guarantees are not met, a portion of the fees associated with the program must be returned to CareFirst.

ii. All program metrics are tracked and reported on a quarterly basis and reviewed with leadership teams at the Quarterly Business Review meeting. Any identified gaps in performance are discussed and an action plan must be submitted by the vendor to address.

iii. In 2022, an analysis will be completed by a third-party actuarial firm to identify the savings on total cost of care for the members engaged in the program. This timeline

allows time for program ramp up, a year of operating at scale, as well as claims run out to account for the total cost of care of the population.

F. Methodology for Determining the Initiatives to Include in this Report

i. CareFirst reviewed the conditions for which we provided case management and selected those programs with more than 300 participants.

(3) Behavioral Health

A. Name of the Initiative: Care Management- Behavioral Health and Substance Use Disorders

B. Population(s) Targeted by the Initiative and How They Are Identified

i. We support the full coordination of all services for members with behavioral health conditions. Our approach is structured to assign the most appropriate care management intervention based on a member's specific needs.

ii. Using claims, authorizations, hospital utilization, and clinical information, CareFirst identifies members for this program if they are experiencing behavioral health and/or substance use conditions including:

1. Depression
2. Anxiety
3. Eating disorders
4. Addiction
5. Substance Use Disorder, including opioid use disorder

C. Description of the Initiative

i. CareFirst's behavioral health care management includes an integrated care team approach that leverages a dedicated, market-based behavioral health clinician model of care, employing medical and behavioral health clinicians and non-clinical care coordinators to ensure we address our members' needs holistically.

ii. CareFirst's behavioral health care managers are specialty-trained, licensed counselors and social workers who will help improve member treatment outcomes by providing individualized, one-on-one caremanagement. They are the lead clinician for patients experiencing behavioral health and/or substance use conditions.

iii. The behavioral health care managers assess and engage members in a multidisciplinary care plan to help address barriers and ensure members are making progress towards achieving their goals. They coordinate care between the treatment team, including family members and support systems, medical care managers, primary care providers (PCP) and treating behavioral health providers. If a member needs help finding a behavioral health care provider, the behavioral health care managers work to ensure patients get connected to behavioral health providers in their community who can provide assessments and ongoing clinical treatment.

iv. Clinical and behavioral health care management consists of the following processes:

1. Comprehensive Assessment – the collection of in-depth information regarding a member's health care needs as well as social determinants of health (financial, emotional, social needs and safety).
2. Planning – the process of determining specific objectives, goals and actions designed to meet the member's needs as identified in the assessment process.
3. Implementation – carrying out the interventions identified in the care plan to accomplish goals and positive outcomes for the member.

4. Monitoring – an ongoing process to determine the plan's effectiveness and make appropriate changes, as necessary.
5. Continuity – provide ongoing health education and community resources. The goal is to support the member/family in moving towards self-care and independence.
6. Evaluation – to determine the case management plan's effectiveness in reaching desired outcomes/goals.
7. Outcomes – to identify and implement changes in the plan of care to produce results that are positive, measurable, and goal-oriented.

D. Intended Goals and/or Outcomes of the Initiative

i. The program is specifically designed to slow the growth of health care costs and improve outcomes. This includes reducing hospital and emergency room use, improving coordination across primary and specialty care and stabilizing medications. In addition, our program elements are intended to provide the most appropriate services for our members precisely when and where they need them.

E. Activities Undertaken to Evaluate the Effectiveness of the Initiative

i. As each member engages in care management for behavioral health conditions, the behavioral health care manager will evaluate if the care management plan's effectiveness in reaching desired outcomes/goals and will adjust the plan in order to achieve positive results.

ii. Holistically, the key performance indicators of the program are monitored by program leadership weekly and reviewed with the senior leadership of the division monthly. All off-target metrics have an action plan with accountability assigned.

F. Methodology for Determining the Initiatives to Include in this Report

i. CareFirst reviewed the conditions for which we provided case management and selected those programs with more than 300 participants. Since the template separates Mental Health, Substance Use Disorder and Opioid Use Disorder, we have completed all three tabs on the spreadsheet since our initiative provides services for all three conditions.

II. Carrier Actions to Improve the Effectiveness of the Initiatives Reported in our Excel Template

Below find a narrative description of the actions CareFirst is taking or will take to improve the effectiveness of the initiatives reported in the Excel Template.

A. **Efforts to improve outreach, recruitment, and retention in these programs**

CareFirst uses predictive modeling technology to identify potential candidates for its programs. Each month, CareFirst's systems analyze medical data and assign every member a risk score. The Risk Score Methodology consists of a combination of factors such as: demographic information (age and gender), and medical and pharmacy claims. A higher Risk Score generally equates to a greater use and cost of health care services. In addition to the stratified risk profile, CareFirst also employs medical episode groups. This involves gathering every member's claim information from multiple providers of treatment (i.e., institutional, professional, and pharmacy claims) and then grouping that information into similar, clinically relevant episodes.

This predictive modeling is reviewed and adjusted throughout the year. Once members are identified, we engage with the member to help facilitate their care, proactively guiding the member through care management. Our predictive modeling process has evolved to the point where CareFirst can pair face-to-

face intervention with data analytics at the point of service. This process prospectively identifies potential candidates and allows for early intervention and referral to appropriate support programs.

B. Changes to the intervention strategy

CareFirst's quality improvement philosophy is to organize and finance best-in-class health services for optimum member health status improvement, efficiency, accessibility and satisfaction. This is accomplished through strong collaborative partnerships with practitioners, providers and communities. CareFirst uses the scientific methods of continuous quality improvement to design, implement, operate, evaluate and continuously improve services for our members.

C. Development of any new initiatives

While CareFirst's care management program is core to our strategy, CareFirst constantly reviews the effectiveness of programs and the needs of our population. Each year, the team is guided through a data-driven process to identify the need for changes to existing initiatives and the development of new initiatives. *In 2020, CareFirst added a Virtual Diabetes Care initiative and a Virtual Maternity Care Program.*

D. Other actions

III. Methodology to Estimate Savings to the State Reinsurance Program

Below find a description of the methodology CareFirst used to estimate the savings to the SRP that may be reasonably attributed to the initiatives reported in Tab 14 of the Excel template.

CareFirst has established a comprehensive and robust evaluation process. While the Care Management teams are supplied daily with actionable and operational data, there is equal attention on assessing the impact of the team's activities. Through engaging the clinical, financial and analytical teams, outcomes-oriented data are shared with the clinical teams. The economic model used to estimate the savings of the program measure the outcomes of the engaged program population against the outcomes of the screened but not engaged program population. The model measures utilization for each cohort in the 12 months post the engagement against the utilization for each cohort in the 12 months prior to the engagement. The model uses median costs of each utilization break by cohort and period. Savings reflect the differences of each cohort from their pre to post intervention in various utilization categories. Savings represent an average savings from engagement in the program.