Standing Advisory Committee Meeting

September 14, 2023

MHBE Policy Department

MARYLAND HEALTHBENEFIT EXCHANGE

Agenda

2:00 - 2:05 | Welcome and Vote to Approve July Meeting Minutes
Mark Meiselbach and Dana Weckesser, SAC Co-Chair and Board Liaison

2:05 - 2:15 | Executive Update
Michele Eberle, MHBE Executive Director

2:15 - 2:30 | Overview of Maryland's State Diabetes Action Plan
Pamela Williams, MDH Bureau Director for Cancer & Chronic Disease

2:30 - 2:40 | Overview of Diabetes-Related Benefits and Impact on Reinsurance
Johanna Fabian-Marks, MHBE Director of Policy and Plan Management

2:40 - 3:25 | Presentation of Exchange Carriers' Diabetes Prevention Programs, & Q&A
Rayva Virginkar and Mahalia Ashraf, United Healthcare
Stacy Shapiro, Kaiser Permanente
Tracy Grampp and Ashley Fried, CareFirst

3:25 - 3:45 | SAC Discussion
Johanna Fabian-Marks, MHBE Director of Policy and Plan Management

3:45 - 3:50 | 2025 Plan Certification Standard Update
Johanna Fabian-Marks, MHBE Director of Policy and Plan Management

3:50 - 4:00 | Public Comment

4:00 | Adjournment

Welcome

SAC Members

Mukta Bain
Marcquetta Carey
Matthew Celentano
Jon Frank (Co-Chair)
Benjamin Fulgencio-Turner
Bryan Gere
Deb Rivkin
Emily Hodson
Diana-Lynne Hsu
Sophie Keen
Catherine Johannesen
Evelyn Johnson
Stephanie Klapper
Carmen Larsen
Michelle LaRue
Scott London
Allison Mangiaracino
Jonathan McKinney
Mark Meiselbach (Co-Chair)
Marie Therese Oyalowo
Ligia Peralta
Aryn Phillips
Dylan Roby
Alyssa Sinagra
Douglas Spotts
Dana Weckesser (MHBE Board Liaison)
Kathlyn Wee
Rick Weldon

Vote on Meeting Minutes

Vote on Meeting Minutes

“I move to [approve/approve with amendments] the Standing Advisory Committee meeting minutes from July 13, 2023.”

MHBE Executive Update

Overview of Maryland's State Diabetes Action Plan

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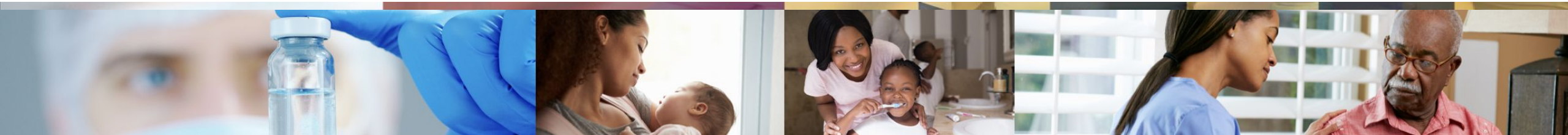
Maryland Diabetes Action Plan

Pamela Williams, MHA, Director, Cancer & Chronic Disease Bureau



Prevention and Health Promotion Mission and Vision

Mission

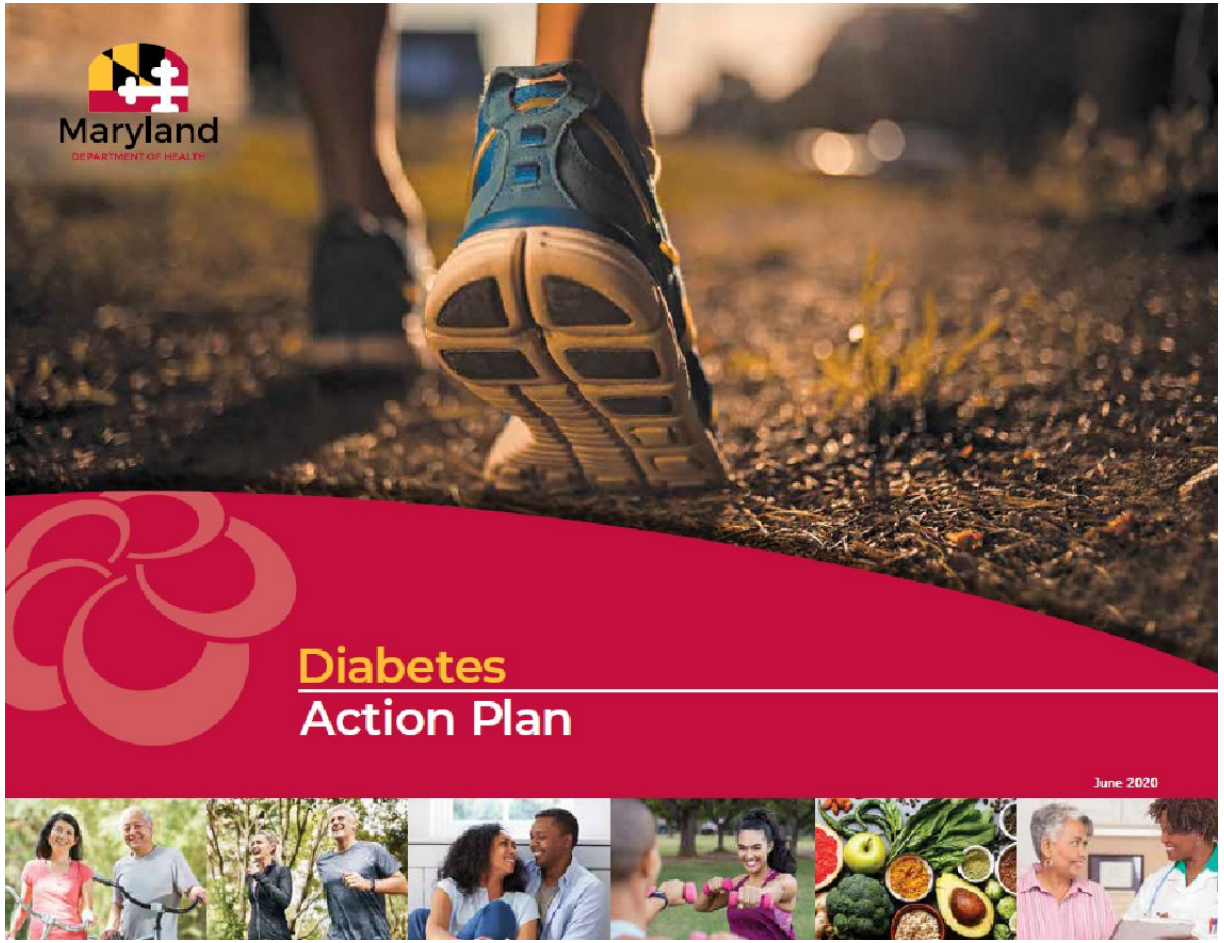
The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

Vision

The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

The Maryland Diabetes Action Plan

https://phpa.health.maryland.gov/CCDPC/Pages/diabetes-action-plan.aspx



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Diabetes Action Plan Goals

- Provide information on the disease burden of diabetes in Maryland and the factors impacting risk
- Identify interventions for the State and its partners to implement to prevent and effectively manage diabetes
- Identify measures of success for each population, and set goals and objectives

Facts About the Impact of Diabetes in Maryland

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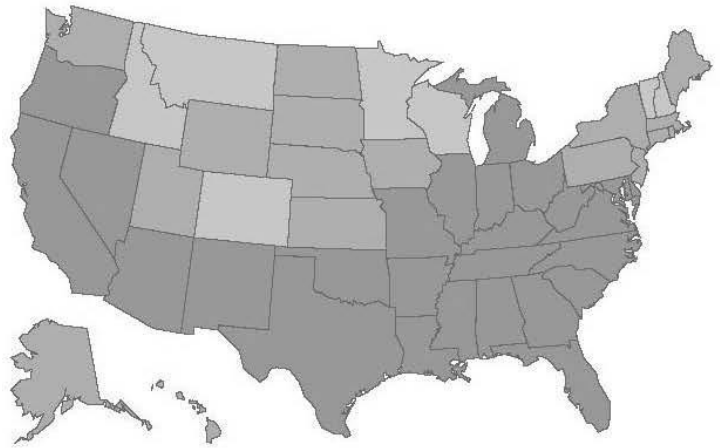
Diabetes by the Numbers

2.3 M

Estimated number of adults with diabetes or prediabetes in Maryland.

100 M+

Estimated number of US adults with diabetes or prediabetes.



575 K+

Maryland adults with diabetes.

1.8 M

Maryland adults with prediabetes, 9 out of 10 do not know they have it.

7th

Leading cause of death in Maryland and is a risk factor for other leading causes of death in the U.S.

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Costs of Diabetes

7B Estimated annual cost to Maryland as a result of diabetes and prediabetes.

2B Annual loss in Maryland economic productivity as a result of prediabetes and diabetes.

4.9B Estimated annual medical costs for Maryland as a result of diabetes and prediabetes.

2-3xs Higher estimated medical expenses for people with diabetes.

1 in 7 Health care dollars spent treating diabetes and its complications.

Maryland Diabetes Action Plan, 2020

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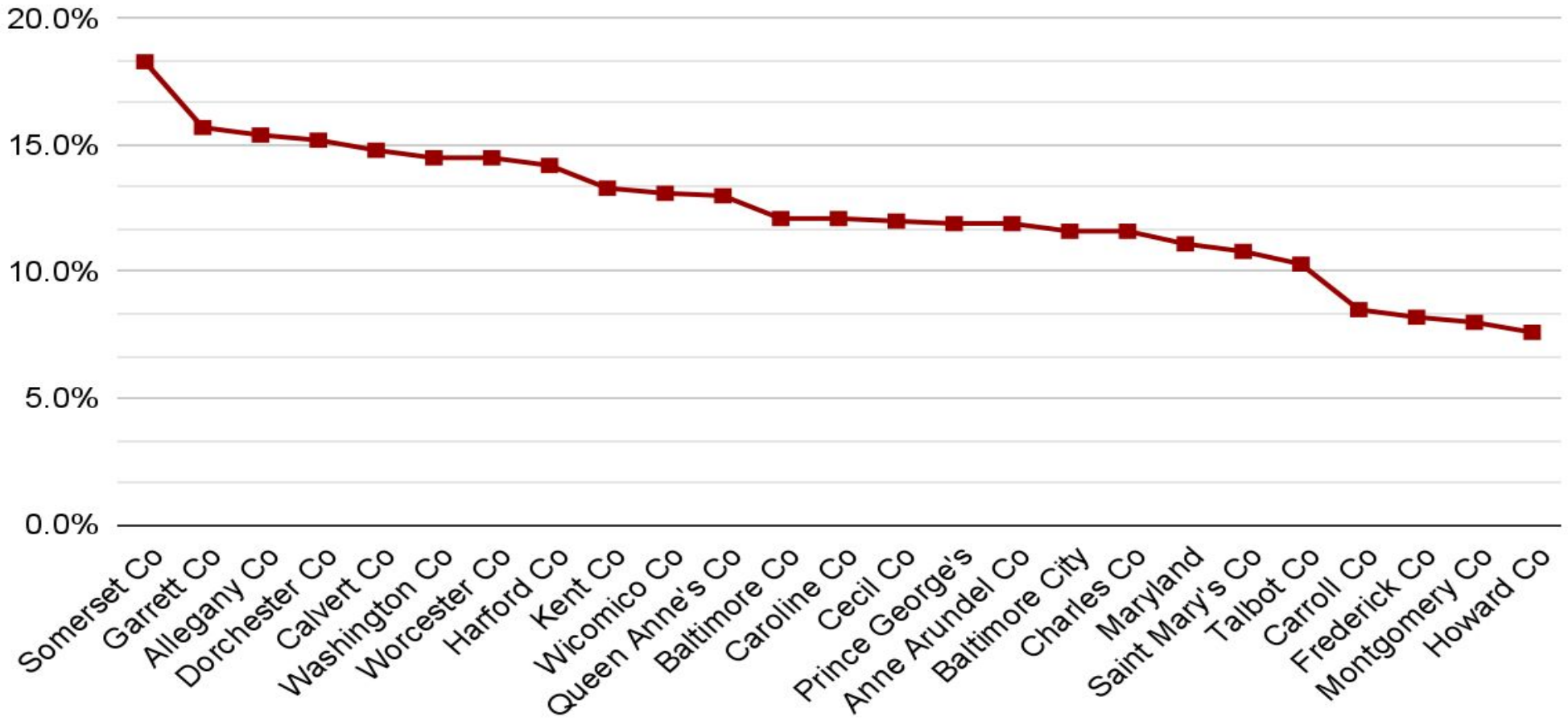
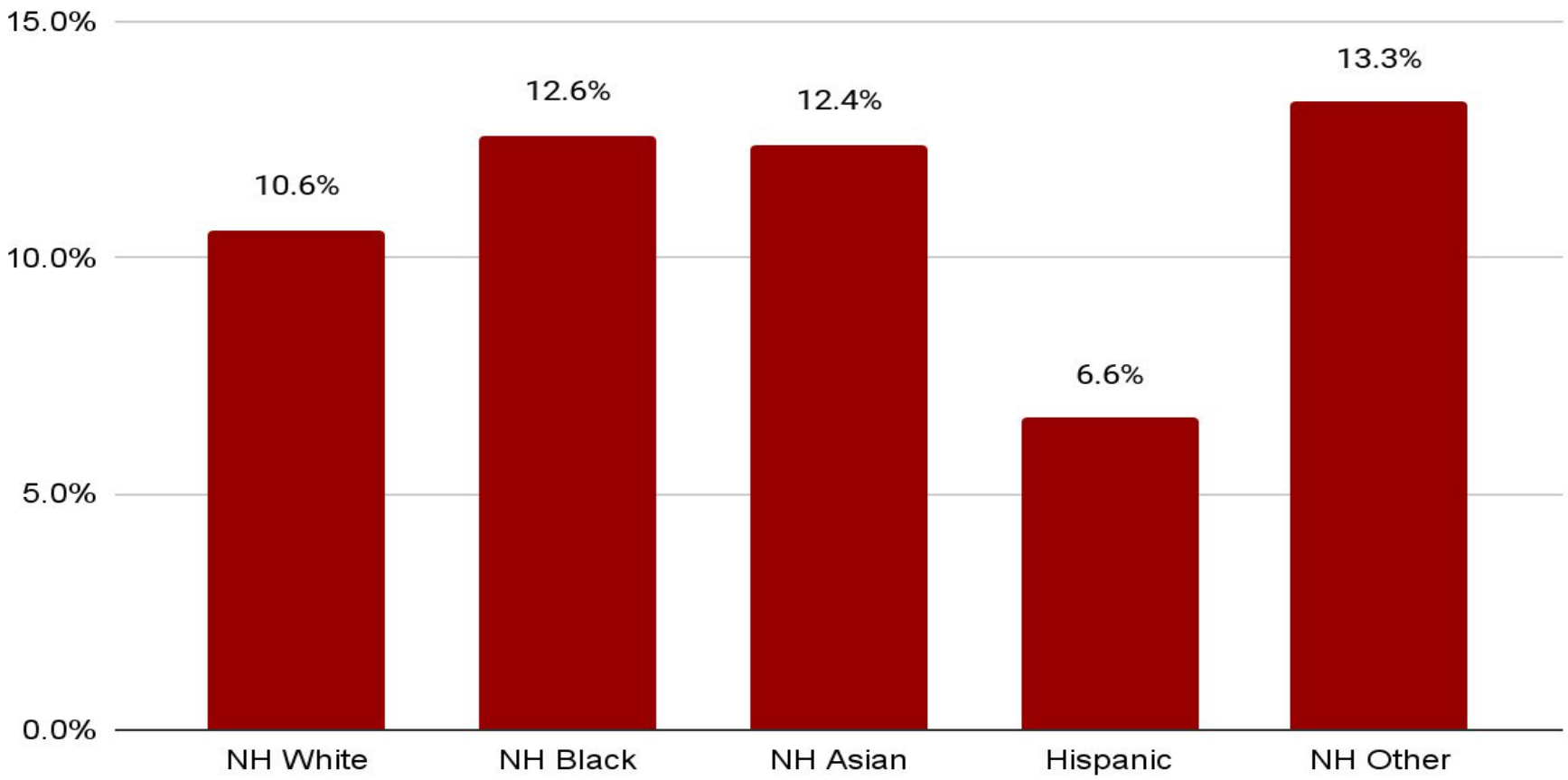
2021 Adult Diabetes Prevalence (%) by Jurisdiction, Maryland



Source: Maryland Behavioral Risk Factor Surveillance System (2021 crude data)

2021 Diabetes Prevalence by Race and Ethnicity



Source: Maryland Behavioral Risk Factor Surveillance System (2021 crude data)

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Population Approach

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Maryland Adult Diabetes Target Populations and Goals

Healthy Weight
1,279,527[1]

Overweight and Obese
2,799,610[1]

Statewide Integrated Health Improvement Strategy Goal:
Through 2026, achieve a more favorable change from baseline mean BMI than a group of control states

Pre-diabetes
1,831,890[2,3]

Outcomes-Based Credit Goal:
Through 2026, increase the number of averted cases of diabetes (difference in diabetes incidence rate between Maryland and a group of control states)

Diabetes and Diabetes Complications
578,446[1]

Diabetes Action Plan Goal:
By 2024, reduce the age-adjusted diabetes mortality by 5 percent.

1. 2022 Maryland BRFSS
2. US 2022 Census
3. Centers for Disease Control and Prevention. National Diabetes Statistics Report website. https://www.cdc.gov/diabetes/data/statistics-report/index.html. Accessed [9/6/2023].

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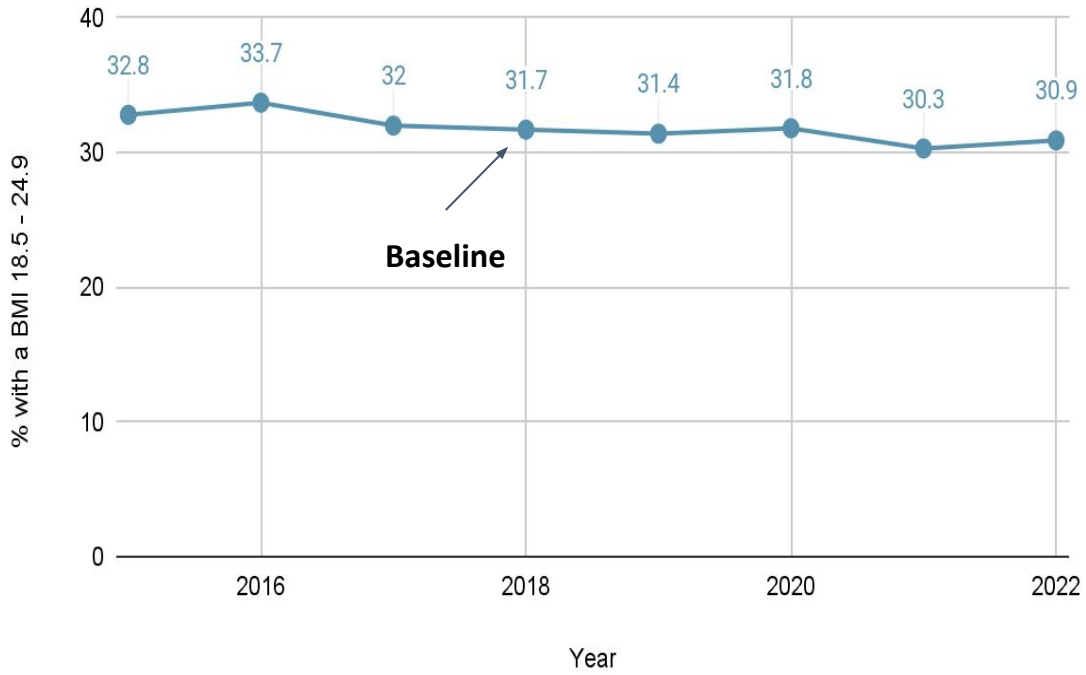
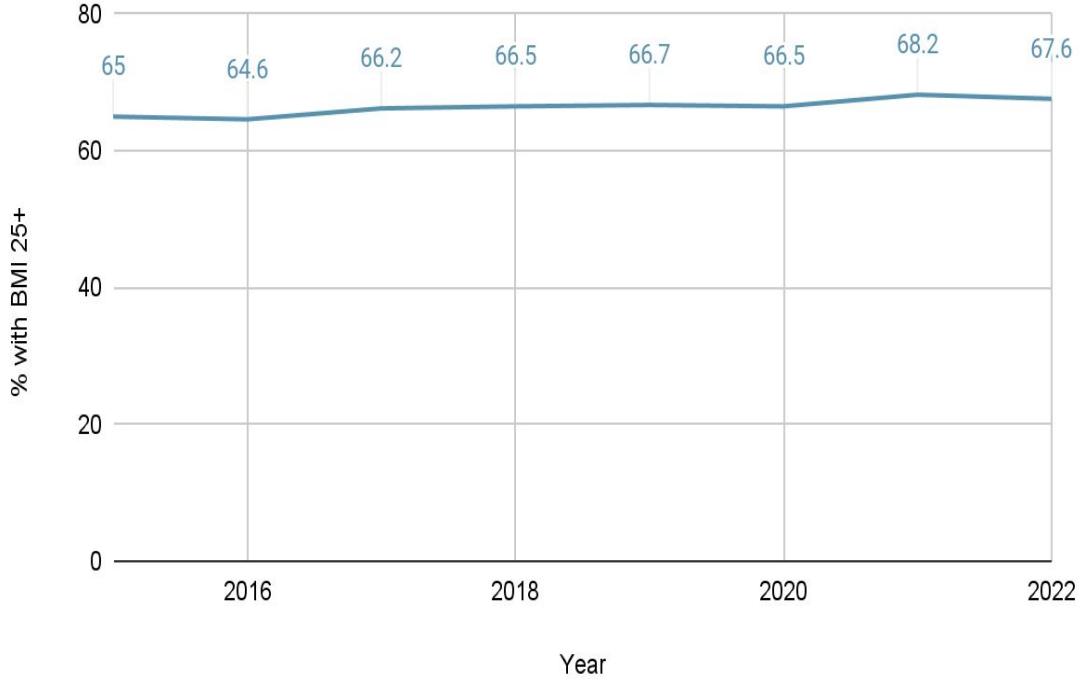
Diabetes Action Plan Population Goals

Healthy Weight: By 2024, 32% of Maryland adults will be healthy weight.



Overweight & Obesity: By 2024, maintain percentage of adults with BMI>25 at 66.5 percent



2022 Maryland Behavioral Risk Factor Surveillance System

Prediabetes

- By 2024, increase the prevalence of Maryland adults who know their prediabetes status by 30 percent
- Estimates from CDC statistics report, based on clinical A1C data (typically combined 4 years of data); this is generally applied to census figures to get state estimates.
- Increase in Marylanders getting diagnosed with prediabetes

CDC Report Years	2014	2017	2020	2021
	37%	33.90%	34.5%	38%

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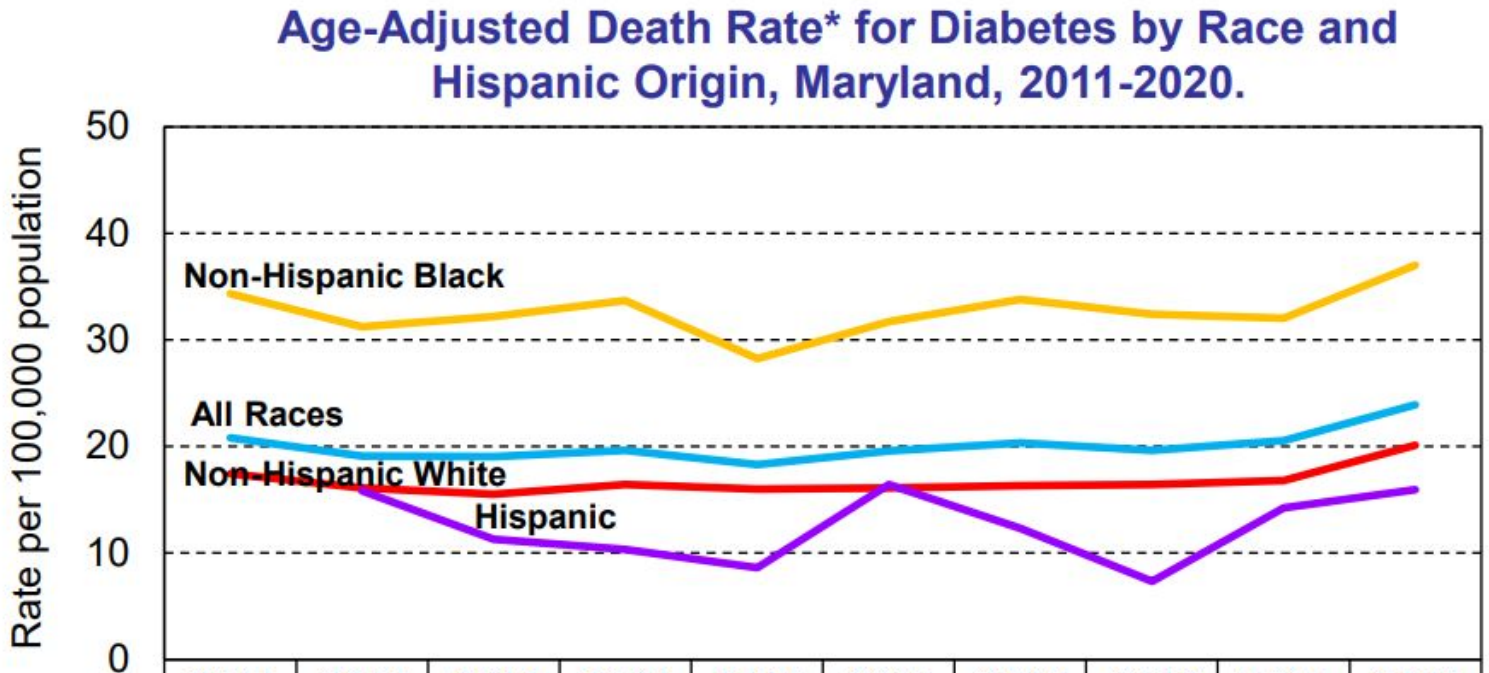
Diabetes

Diabetes was the 7th leading cause of death in 2020.

DAP Goal: By 2024, reduce the age-adjusted diabetes mortality by 5 percent.

*Death rates are age-adjusted to the 2000 U.S. standard population.
**Rates based on <20 events in the numerator are not presented since such rates are subject to instability.



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
All Races	20.8	19.1	19.0	19.6	18.3	19.6	20.3	19.6	20.5	23.9
NH White	17.4	16.1	15.5	16.4	16.0	16.1	16.3	16.4	16.8	20.1
NH Black	34.3	31.2	32.2	33.7	28.2	31.7	33.8	32.4	32.0	37.0
Hispanic	**	15.8	11.3	10.3	8.6	16.4	12.3	7.3	14.2	15.9

Maryland Vital Statistics Report 2020:
https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2020Annual.pdf

Diabetes Outcomes

Meets target	On trend to meet target	Not on trend to meet target	No change from baseline

	Baseline 2018	Target 2024	Update 2022	Trend
Objective 1. By 2024, 32% of Maryland adults will be of healthy weight.	31.7%	32%	30.9%	
Objective 2. By 2024, maintain the percentage of adults with a BMI >25 at 66.5%.	66.5%	66.5%	67.6%	
Objective 3. By 2024, reduce the age-adjusted diabetes mortality by 5%	20.3%	15.3%	23.9%*	

*Please note that 2022 data is not yet available for age-adjusted diabetes mortality. The most recent data available is 2020.

2022 Maryland Behavioral Risk Factor Surveillance System
Maryland Vital Statistics Report 2020: https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2020Annual.pdf

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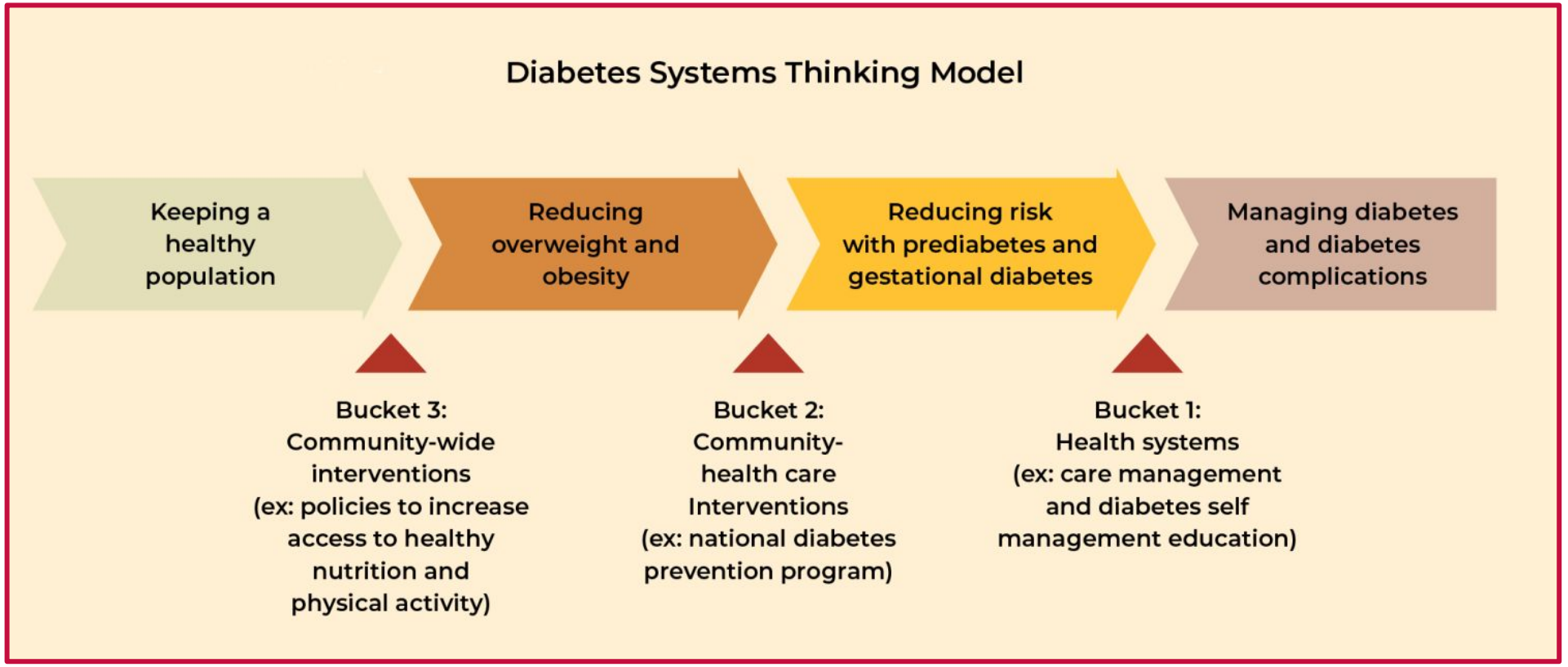
Interventions Across Populations



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Diabetes Investments

Cancer & Chronic Disease Bureau

- Grant funding to increase access to DPP and DSMES programs statewide
- Grant funding to LHDs to expand overweight, obesity, and diabetes prevention activities
- Funding to launch Healthy Maryland Corner Stores pilot in Charles County
- $3.5 million to LHDs to develop Tobacco & Diabetes programming

Medicaid

- Invested $92 million to increase in E&M rates for FY 2022 and $60 for FY 2023
- Provides $5 million per year in the HealthChoice Diabetes Prevention Program
- $250,000 Coverage 2.0 Part 4 Grant funds for capacity-building/infrastructure

MDPCP

- Digital Quality Measures Project: $2.5M fed
- Diabetes PQIs improvement pilot + training for MDPCP staff: $25,000 federal funds via PHS
- CRISP MDPCP Reports: $650,000 annually
- Hilltop Pre-AH Model: $300,000 annually
- MDPCP Physician and Non-Physician Training Series for Diabetes and Hypertension Control

HSCRC

- Issued $86.3 million in five-year cumulative funding to six diabetes-centric consortia via the Regional Partnership Catalyst Program

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Additional Diabetes Action Plan Implementation

- Developed the Statewide Integrated Health Improvement Strategy (SIHIS) with Diabetes as one of the Population Health Domains
- Built capacity with Local Health Improvement Coalitions and develop diabetes strategies in each LHIC and developed a quarterly Community of Practice Learning Collaborative
- Enlist employers to offer enhanced benefits, such as:
  - Eliminate copays and coinsurance for insulin and supplies
  - Free or reduced price gym memberships,
  - Exercise and weight management classes on-site,
  - Monetary incentives for weight loss
- Launch the Maryland Healthy Cornerstore Initiative - piloting in Charles County

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Diabetes Action Plan Implementation

- Establish a Diabetes Quality Task Force to

  Develop clinical measures to incorporate in a Diabetes Dashboard

  Community-Clinical Linkages Workgroup focuses on improving the connection between patients, their families, their physicians, and community partners/resources to help manage and prevent diabetes.

- Develop the Know Your Risk for Prediabetes communications campaign
- Cultivate relationships with partners to include Carefirst, HSCRC, Medicaid, and MDPCP
- Fund LHDs statewide on overweight and obesity initiatives
  a) Expand of National Diabetes Prevention Programs (DPPs)
  b) Develop and Expand of Taking Off Pounds Sensibly Programs (TOPs)
  c) Develop and Expand Healthy Heart Ambassador Programs
  d) Add obesity screening in dental settings in a few jurisdictions
  e) Support initiatives like Washington County, Go for Bold 1 million pound weight loss challenge

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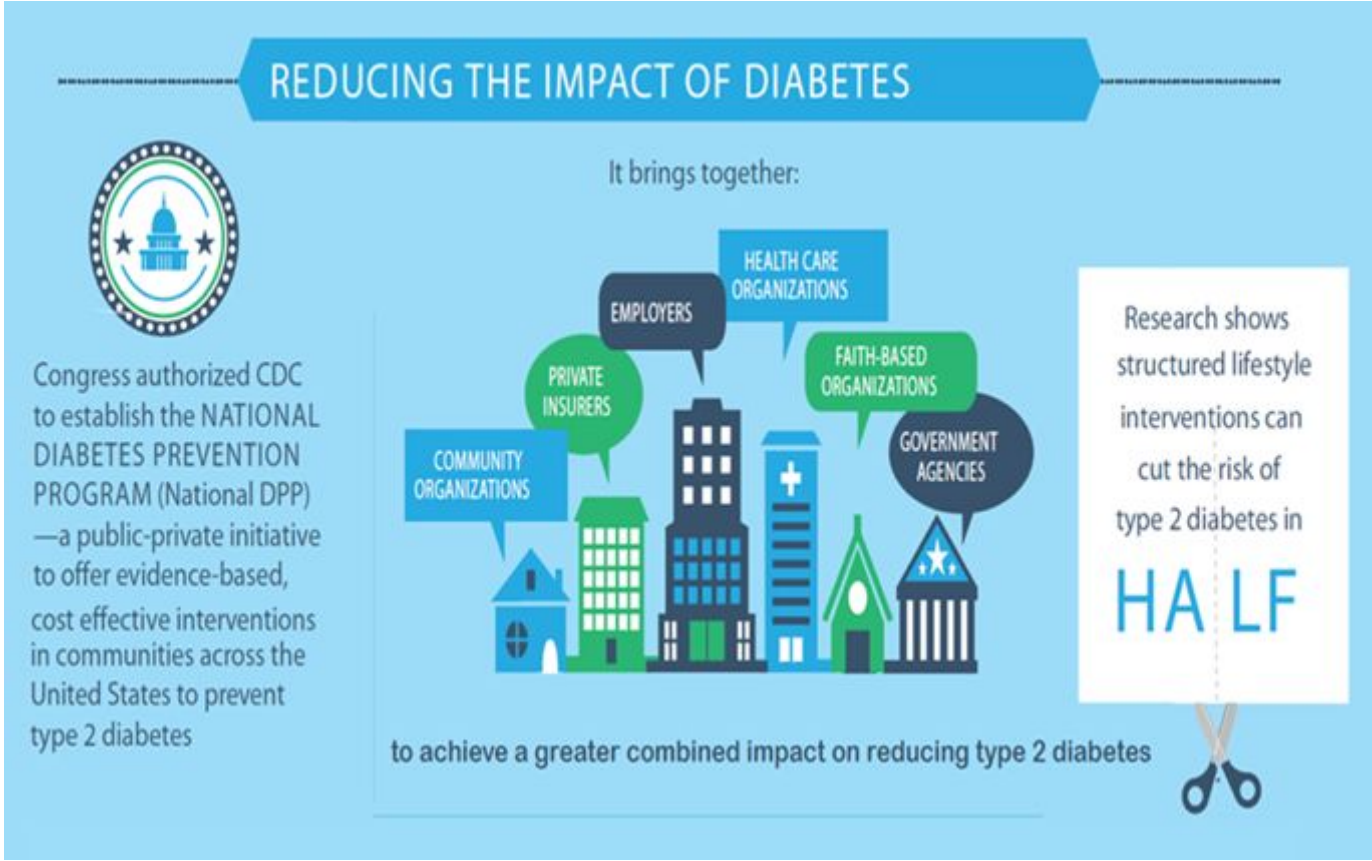
Spotlight: National Diabetes Prevention Program

Largest national effort to mobilize and bring an evidence-based lifestyle change program to communities across the country!



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Spotlight: National Diabetes Prevention Program

- A structured lifestyle intervention supported by research to cut the risk of Type II Diabetes by up to **58%** while also reducing risk for heart attack and stroke
- CDC-approved curriculum
- Diabetes Prevention Recognition Program (DPRP)
  - CDC-recognized organizations
  - Trained lifestyle coaches
- Offered formats include in-person, online, distance learning, or a combination
- Group and coach support for a full year

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Next Steps

- Process of updating the Diabetes Action Plan
  - Collecting updated data
  - Subject Matter Experts reviewing existing plan and adding updates
  - Review from external stakeholders will be scheduled in the fall

Overview of Diabetes-Related Benefits and Impact on Reinsurance

Diabetes-Related Benefits

State law limits on cost-sharing

- **§15-822(d)(3)** – Except for in high deductible health plans (HDHPs), diabetes test strips **may not be subject to deductible, copay, or coinsurance**; in HDHPs, the deductible may apply

- **§15-822.1** (2022 HB 1397), effective Jan. 1, 2023 – Copay or coinsurance for insulin may not exceed **$30 for a 30-day supply**

Diabetes-Related Benefits cont'd

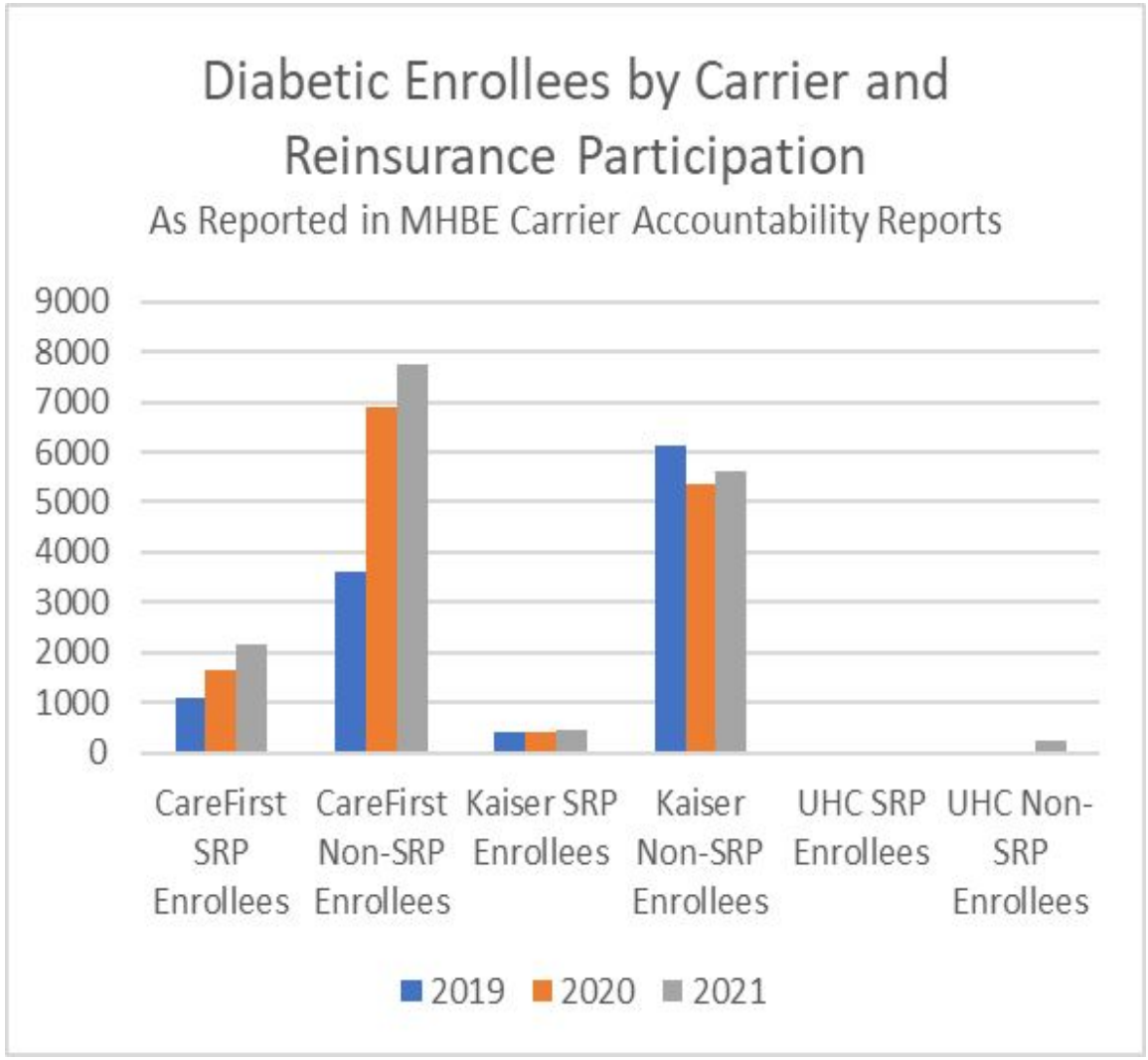
Overview of 2023 and 2024 MHBE Value Plan benefits for diabetes care

- **2023 Value Plans standards** (2023 Letter to Issuers)
  - Diabetic supplies (Insulin, Glucometers, and test strips) **must be covered without cost sharing** (silver and gold value plans)

- **2024 Value Plans standards** (2024 Letter to Issuers)
  - Value plans **must includes $0 cost sharing** for the following diabetes care management services for enrollees with primary diabetes diagnosis:
    - PCP visits
    - Dilated retinal exam (1x per year)
    - Diabetic foot exam (1x per year)
    - Nutritional counseling visits
    - Lipid panel test (1x per year)
    - Hemoglobin A1C (2x per year)
    - Microalbumin urine test or nephrology visit (1x per year)
    - Basic metabolic panel (1x per year)
    - Liver function test (1x per year)
    - A select list of diabetes supplies and medications within the diabetic agent's drug class, as defined by the insurer.

As of July 31, 2023, **65,130** enrolled in value plans. 35.1% of all Exchange enrollees. (MHBE July 31 2023 data report)

Diabetes in the Individual Market



Impact on Reinsurance

State Reinsurance Program (SRP) top hierarchical condition categories (HCCs)

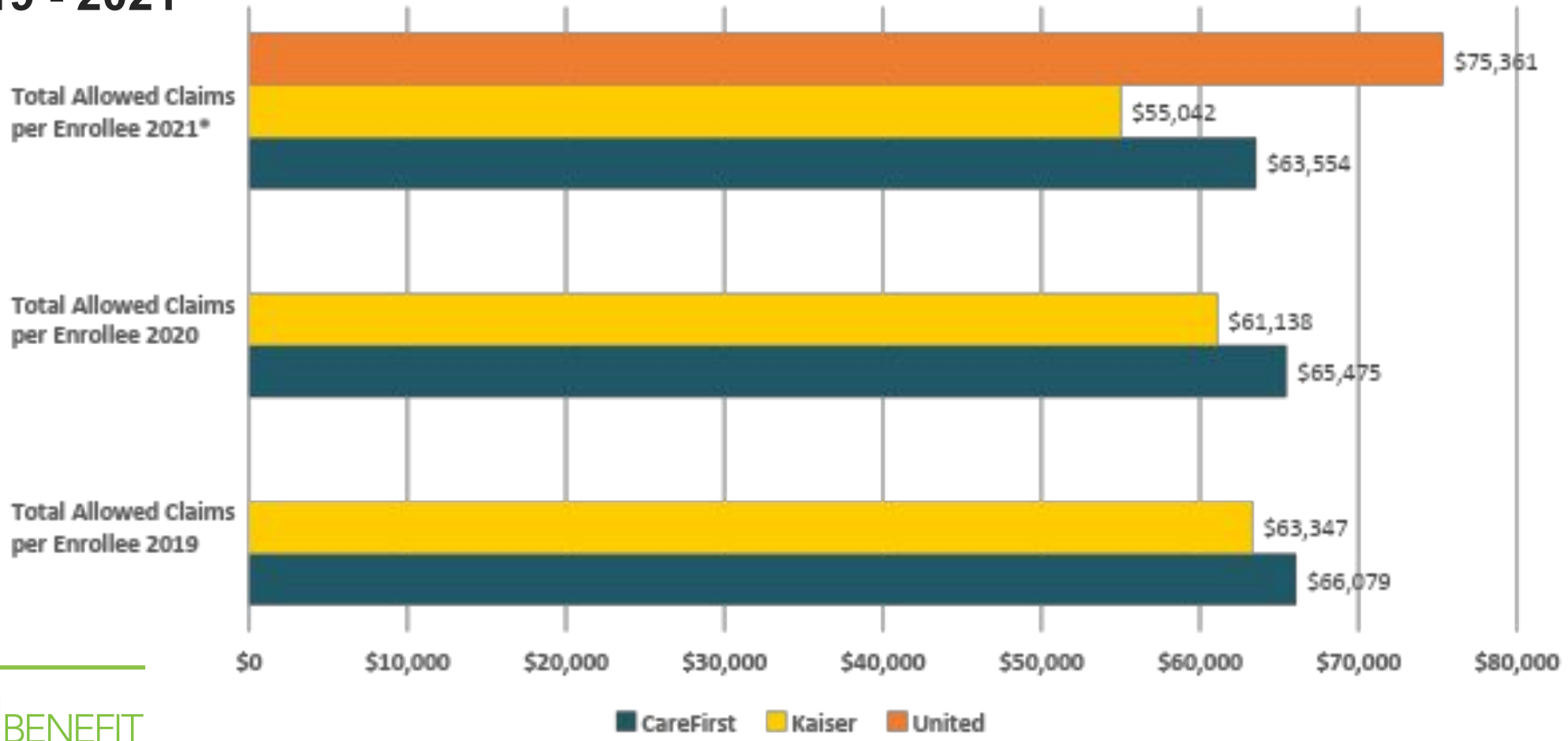
- Diabetes was among the **3 most frequent** HCCs among SRP enrollees in plan years 2019-2021
- Diabetes was among the **top 5 most costly** HCCs among SRP enrollees in plan years 2019 and 2020

MHBE regulations require carriers to submit an annual **Carrier Accountability Report** that describes activities to manage the costs and utilization of the enrollees whose claims were reimbursed by the SRP and efforts to contain costs. MHBE has collected specific information on carrier initiatives targeting state population health goals for multiple conditions, including diabetes.

Source: MHBE SRP 5th annual forum presentation

Impact on Reinsurance cont'd

Total Allowed Claims Per Enrollee for SRP Enrollees with Diabetes by Carrier, PY 2019 - 2021



*:United began participating in the SRP in 2021.

Impact on Reinsurance cont'd

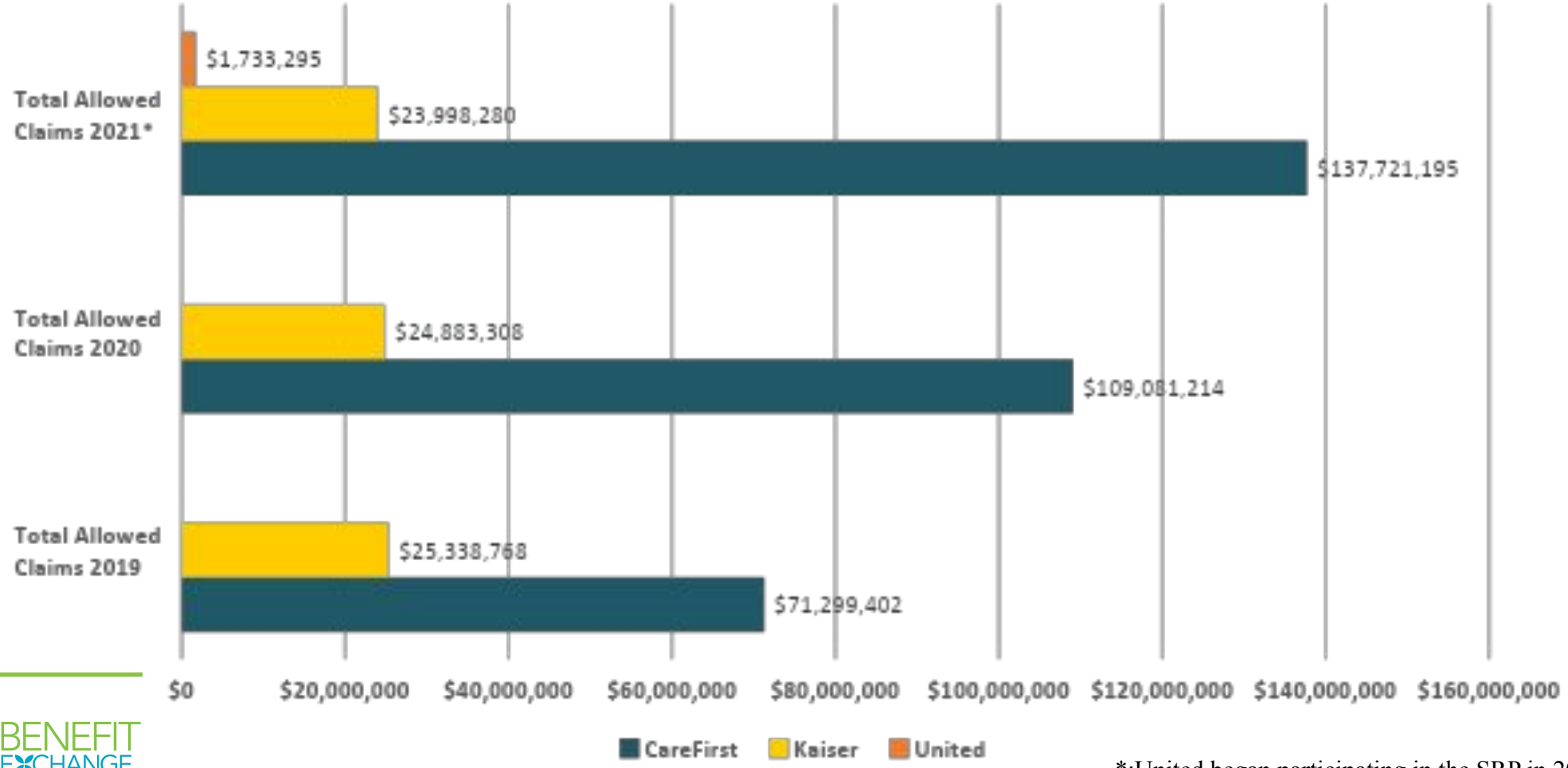
Allowed Claims Per Enrollee for SRP Enrollees with Diabetes by Carrier and Initiative Enrollment, PY 2019 - 2021

Carrier	2019			2020			2021		
	Enrolled in Initiative	Not Enrolled in Initiative	Total	Enrolled in Initiative	Not Enrolled in Initiative	Total	Enrolled in Initiative	Not Enrolled in Initiative	Total
CareFirst	$77,961	$61,114	**$66,079**	$85,227	$45,723	**$65,475**	$84,362	$55,457	**$63,554**
Kaiser	$59,321	$59,355	**$63,347**	$60,025	$61,788	**$61,138**	$45,832	$59,584	**$55,042**
United*	---	---	**---**	---	---	**---**	$0	$75,361	**$75,361**
Total for All Carriers	**$71,393**	**$60,674**	**$65,340**	**$81,381**	**$49,511**	**$64,624**	**$76,974**	**$56,344**	**$62,244**

*:United began participating in the SRP in 2021.

Impact on Reinsurance cont'd

Total Allowed Claims for SRP Enrollees with Diabetes by Carrier, PY 2019 - 2021



*:United began participating in the SRP in 2021.

Impact on Reinsurance cont'd

Allowed Claims for SRP Enrollees with Diabetes by Carrier and Initiative Enrollment, PY 2019 - 2021

Carrier	2019			2020			2021		
	Enrolled in Initiative	Not Enrolled in Initiative	Total	Enrolled in Initiative	Not Enrolled in Initiative	Total	Enrolled in Initiative	Not Enrolled in Initiative	Total
CareFirst	$24,791,485	$46,507,916	**$71,299,402**	$70,994,148	$38,087,066	**$109,081,214**	$51,207,726	$86,513,468	**$137,721,195**
Kaiser	$10,262,535	$15,076,233	**$25,338,768**	$9,003,778	$15,879,531	**$24,883,308**	$6,599,846	$17,398,433	**$23,998,280**
United*	---	---	---	---	---	---	$0	$1,733,295	**$1,733,295**
Total for All Carriers	**$35,054,020**	**$61,584,150**	**$96,638,169**	**$79,997,926**	**$53,966,597**	**$133,964,523**	**$57,807,573**	**$105,645,197**	**$163,452,769**

*:United began participating in the SRP in 2021.

Presentations on Carriers' Diabetes Prevention Programs, Q&A

United Healthcare

MHBE Standing Advisory Committee Meeting: UHC Individual & Family Plans Diabetes Management Programs & Interventions

September 14, 2023

United Healthcare

Current Approach to Supporting Members with Diabetes & Pre-Diabetes

Covered Services for Members with Pre-Diabetes

Our benefit design includes coverage of preventive screenings and services to help members prevent diabetes. We cover:

- All U.S. Preventive Services Task Force recommendations with an A or B grade as preventive at $0 costs, including recommended screenings for prediabetes and type 2 diabetes in adults aged 35 to 70 years who are overweight or have obesity.
- Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services when the provider certifies the services are necessary to treat elevated or impaired blood glucose levels induced by prediabetes.

Current Diabetes Programs for 2023

- Diabetes is a high priority for our business, as it is both prevalent among our membership and a key UHC Individual & Family Plans (IFP) quality focus area
  - Approximately 8.8% of our members in Maryland have diabetes
- **Our primary strategy for PY2023 is focused on diabetes management** via in-home Hemoglobin A1c (HbA1c) testing and disease management supports via telephonic case managers and our virtual PCP partner, Galileo

Quality Improvement Intervention: In-Home Testing	Care Management Supports	Diabetes Management Program via Galileo
• Mail in-home HbA1c test kits in Q4 2023 to MD IFP members with an open care gap	• Connect members with Telephonic Case Management nurses who support HbA1c control, diabetes-related gaps closure, and manage any diabetes-related complications	• Partner with Galileo to offer an in-depth diabetes management program to assigned members

HbA1C In-Home Test Kit Program

- **Intervention:** Launching an HbA1c in-home test kit later this year (targeting Oct. 2023)
  - Members are mailed all the necessary supplies to obtain a blood sample
  - The member's sample is sent to a lab, and they subsequently receive a letter with the results
  - Elevated results are sent directly to the member's assigned PCP and the member is encouraged to follow-up with their PCP

- **Eligibility criteria**: Actively enrolled members with an open care gap for the Hemoglobin A1c Control for Patients With Diabetes (HBD) quality measure within the Quality Rating System measure set.*

- **Prior program results:** Program was launched last year in early November 2022 with a total of 6,517 kits and a return rate of 8.1% nationally (526 returned kits across all IFP states)

HBD Measure Description: *The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (Hba1c) was <8.0% during the measurement year.*

Diabetes Interventions Provided in our Case Management Program

- On average, 71 Maryland IFP members are actively enrolled in case management per month.
  - Among those actively enrolled and engaged, **22.5% (16 members) are receiving diabetes management supports**

- **Goals of Intervention:**
  - Connect members with Telephonic Case Management Nurses who conduct assessments, identify potential diabetic care gaps and offer relevant resources
  - If a member with diabetes meets the criteria for long-term management, they are referred for Complex Condition Management

- **Leverages two Persistent Super Utilizer algorithms to identify eligible members. The algorithms look for the following:**
  - Top 5% of health plan cost from the prior 12 months
  - High probability of being in top 5% in total medical and pharmacy spend in the next 12 months
  - High probability of being in top 15% of medical spend in the next 12 months
  - Opportunity to impact the members' condition(s) and/or outcomes
  - Emerging risks

Individualized Diabetes Support

Case Managers support members' unique diabetes management needs. Examples include:

Medication adherence


Appropriate provider involvement (e.g., endocrinology, if indicated)


Appropriate lab work and follow-up

Yearly screenings


Member understanding of and adherence with physician's plan of care

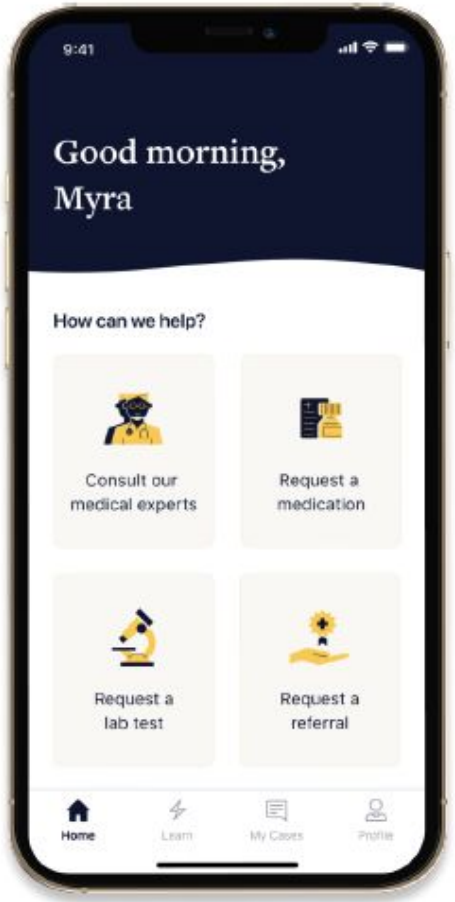
Diabetes Interventions Provided in our Case Management Program cont.

- RN Case Managers conduct a Clinical Risk Assessment on all members engaged in case management to review for potential gaps
- Within this Assessment, Case Managers focus on supporting members with Diabetes:

Activity	Description
Evaluate the member's diabetes action plan	• Gauge the member's understanding of disease process and provider goals of care
Focus on Hemoglobin A1C and Glycemic Control	• Includes both education and review of member specific goals • Blood glucose monitoring according to physician set parameters • Look for signs and symptoms of hyper and hypoglycemia
Encourage member to complete necessary diabetic screenings	• Includes eye and foot care
Support member in managing any diabetes-related complications	• Open wounds or sores • Vision disabilities • Kidney disease • Neuropathy • Heart Disease • Stroke • Vaccines • Statin use • Blood pressure management

Innovative Virtual First Product* with Galileo

- End-to-end **app-based virtual care provided by Galileo** to members of all ages
- **24/7 $0 unlimited virtual on-demand urgent and comprehensive primary care** delivered via video or text
- For Virtual First plans, all members are auto-assigned to Galileo as their PCP, unless they choose otherwise
- **Focus on diabetes management**
- End-to-end Spanish-speaking experience
- Galileo manages referrals to high value, in-network, in-person providers and services for labs, procedures, specialists, and other services as appropriate



*Virtual First product will change to "Virtual Access" naming convention for Plan Year 2024.

Galileo's Approach to Diabetes Population Health Management

Data from UHC

Use unified record to stratify population
Example: Diabetes gaps in care

HCC Description	Count of HCCs	% of Total
Sensitive and redacted HCC	7,380	37%
HCC group: Asthma/ Pulmonary Disease	2,140	11%
Seizure Disorders and Convulsions	1,947	10%
HCC Diabetes group (without complications/with chronic complications/ with ..	1,755	9%
Adrenal, Pituitary, and Other Significant Endocrine Disorders	1,018	5%
(Ongoing) Pregnancy without Delivery with No or Minor Complications	514	3%
Vascular Disease with Complications	461	2%
Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis	400	2%
Heart Failure	211	1%
HCC group: Respiratory Distress or Arrest	209	1%

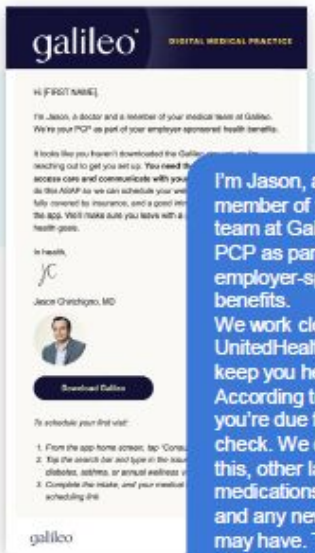
Gaps Data

Patient ID	AWV	HbA1c	Kidney Labs
Patient A	5/25/23	6.3	✓
Patient B			
Patient C	6/16/22		
Patient D	2/05/23	7.1	✓
Patient E	3/03/23	8.4	

Automated outreach

Direct Mail, Email, + In-app

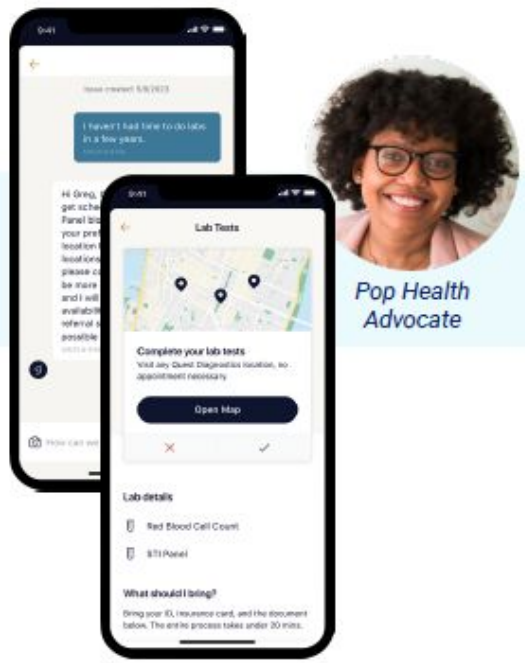
Patients B, C and E receive outreach through flow of automated → 1:1 until patient engages & completes task



I'm Jason, a doctor and a member of your medical team at Galileo. We're your PCP as part of your employer-sponsored health benefits.
We work closely with your UnitedHealthcare plan to keep you healthy.
According to our records, you're due for an A1c check. We can help with this, other labs, medications, eye exams, and any new concerns you may have. To get started, please fill out this Diabetes intake form and we'll connect you with a clinician.

1:1 outreach

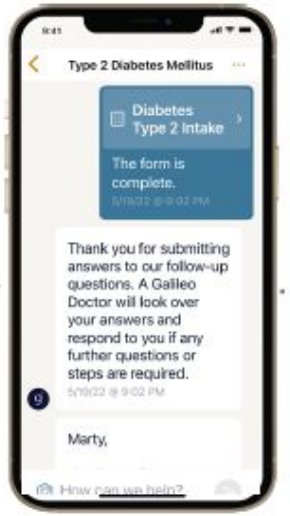
In-app follow-up, SMS text, + phone



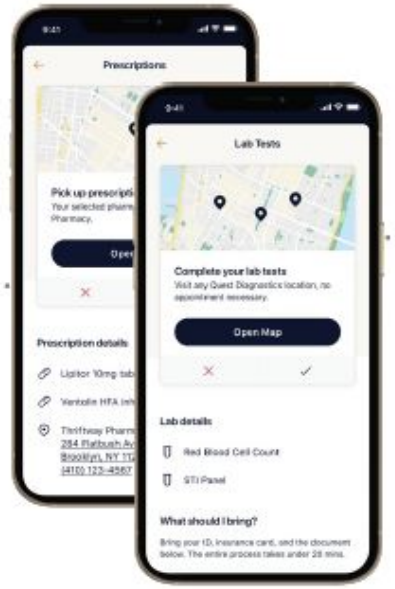
Pop Health Advocate

Galileo Diabetes Management Care Pathway

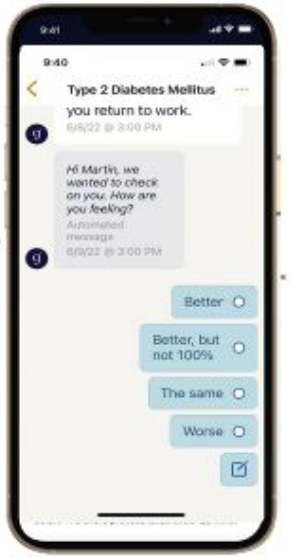
DATA-DRIVEN INTAKE



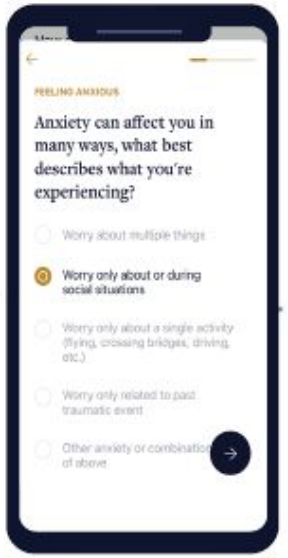
MEDICATION MANAGEMENT & CARE PLAN (LABS/EXAMS)



FREQUENT CHECK-INS



ADDRESS COMORBIDITIES



NAVIGATOR HANDLES

- Medical Records Exchange
- In-Network Referrals Appointment
- Finding/Scheduling
- Closed Loop To-Dos
- Re-Engage Patient
- Claims/EOB Reviews
- Medication
- Refill/Cost Support

Galileo Care Pathway for Patients with Poorly Controlled Type 2 Diabetes

Program Overview

- Detailed care plans
- 1:1 sessions with a health coach
- Group sessions with a certified diabetes educator (CDE)
- Patient education materials
- Navigator outreach

Educational Modules

Galileo's program has 4 classes and associated handouts that discuss the following topics:

- Type 2 Diabetes Basics
- Diet Tips for Type 2 Diabetes
- Exercise Tips for Type 2 Diabetes
- Home Care for Type 2 Diabetes
- Medical Monitoring and Care for Type 2 Diabetes
- Monitoring Your Blood Sugar with Type 2 Diabetes
- How to Recognize and Treat Low Blood Sugar
- Day-to-Day Tips for Coping with Diabetes
- Sick Day Rules for Diabetes (Not on Insulin)
- Sick Day Rules for Insulin
- Insulin Basics
- How to Use Insulin
- How to Use Your GLP-1 Medication

"Terri was amazing the way she help me **understand things about my diabetes**. The one on ones helped me so much."

"I feel amazing praise God. I have been working really hard to get my A1c down I am extremely proud of myself. And I greatly appreciate all of the Doctors At Galileo **thank you guys for sticking in there with me**."

IFP Member Snapshot: Mrs. O

Sept. 2022: Uncontrolled diabetes

- 61 yo woman with type 2 diabetes, CKD-2, and prior pulmonary embolism
- On insulin
- A1c = 12.5
- Blurry vision, neuropathy, and polyuria; all complications from uncontrolled DM

Sept. – Dec. 2022: Interventions

- Galileo started her on Trulicity
- Patient Support team found & referred her for a diabetes eye exam
- Participated in all 4 group classes on important DM topics, a 1x1 visit with a CDE, and coaching visits to make long-term lifestyle changes
- Galileo was able to stop her insulin due to good readings

Dec. 2022 - Today: Controlled

- December 2022 A1c = 6.1
- August 2023 A1c = 5.6
- Patient no longer has any signs or symptoms of neuropathy, kidney, or eye damage

12.5 → 5.6

Reduction in A1C

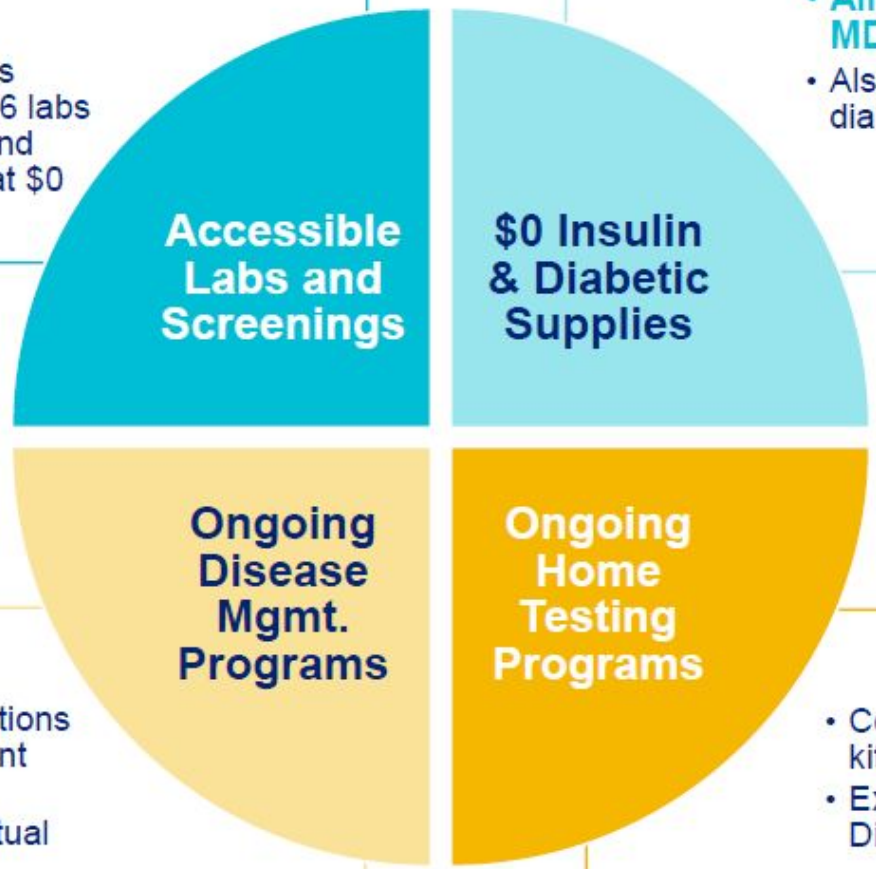
"Thank you. I am so very happy about my test results too. It is encouraging. I am committed to getting in the best shape possible and keeping the diabetes in control. My goal is to see my A1C lower within 6 months. The Galileo diabetes team were amazing in their support and education through this process!"

PY2024 Approach to Supporting Members with Diabetes

2024 Diabetes Benefits & Programs

In 2024, we are focused on aligning our benefit design and quality strategies to support members in obtaining evidence-based care and proactively managing their diabetes. IFP diabetes-related benefits extend beyond the three Value Plans and apply to all plan offerings in Maryland.

- **$0 Diabetes Labs and Screenings**
- Support affordable diabetes management by providing 6 labs and screenings to Type I and Type 2 diabetic members at $0 cost share



- **All IFP plan offerings in MD cover insulin at $0**
- Also cover glucagon and diabetic supplies at $0

- Continue diabetes interventions as part of Care Management
- Continue Galileo diabetes management as part of Virtual Access Plans

- Continue in-home HbA1c test kits
- Exploring offering in-home Diabetic Retinal Eye Exams

Six $0 Diabetes Labs/Screenings

Provide 6 diabetes labs/screenings to members with a Type 1 or Type 2 Diabetes diagnosis

$0 Diabetes Labs and Screenings*

Benefit	Description
Hemoglobin A1c screening	Assess glucose control
Kidney Health Evaluation for Diabetes	Assess renal function, blood count etc.
Metabolic Panel	Assess kidney health
Urinalysis Panel	Assess kidney health
Lipid Panel	Assess cholesterol levels
Diabetic retinal eye exams	Ophthalmological services Limit one exam per member per plan year Includes AI imaging

Exclusions: *Members with pre-diabetes or gestational diabetes diagnoses do not qualify for this $0 cost share benefit*

Kaiser Permanente

CareFirst

CareFirst

CAREFIRST WELLBEING

Inspiring Positive Change

- 1:1 personalized health coaching based on principles of motivational interviewing
- Telephonic, digital enrollment

DISEASE MANAGEMENT

Targets 10 Chronic Conditions: Asthma, diabetes, CAD, COPD, congestive heart failure, chronic low back pain, osteoarthritis, Afib, IBS, fibromyalgia

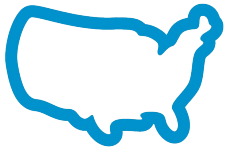
A RN delivers clinical support to members who are newly diagnosed with a chronic condition as well as members with longstanding condition(s)

CareFirst

Diabetes Virtual Care

CareFirst

Diabetes Virtual Care



A national program to support members living with uncontrolled type 2 diabetes through connected devices and a virtual care team

Mobile app connects members to virtual care, education and tools

Management tools include connected blood glucose meter, test strips and continuous glucose monitor

Access to specialized care team including team lead, certified diabetes educator and endocrinologist

Member Selection Criteria

Members are eligible for the program if they have been diagnosed with type 2 diabetes and are at least 18 years of age.

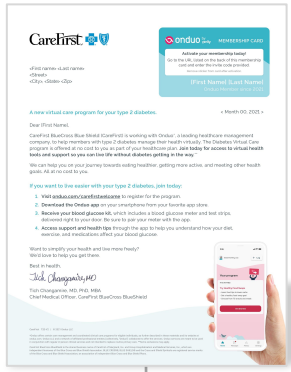
Members are deemed high-risk if they have been diagnosed with diabetes and:

- Has an A1c of >= 8.0%;
- Has been prescribed insulin or sulfonylurea;
- Has a hospital admittance in the preceding 6 months related to the Member's diabetes; or
- Has not had a primary care visit in the preceding 12 months.

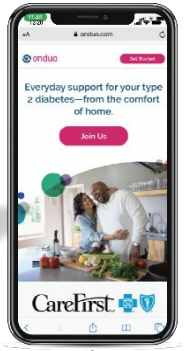
Members are excluded if they present with one of the following elevated clinical risks:

- Pregnancy
- Liver failure
- End-stage renal disease (stage 4 or 5)
- Congestive heart failure (grade C or D)
- Organ transplant or bone marrow transplant
- Cystic fibrosis
- Malignant neoplasm diagnosis or treatment

Member Experience At a Glance



Receive invitation



Download app & register

Meet your designated Care Lead via message or call

Receive your Welcome Kit

Pair your BGM & A1c value

Onboarding, goal setting, accomplish challenges and behavior change. Clinical intervention when needed.

Care Lead refers you to CDE & endocrinologist for med optimization and prescriptions (including CGM)

Outcomes

60% Avg. Engagement

After 6 months since program launch in 2020

73% of enrolled Members have a baseline A1c*

With consistent increases year over year

1.2+ points improvement

for Members with A1c>8*

The average A1c reduction for Members with a baseline A1c ≥ 9 was **1.9*.**

Members are reducing their A1c and maintaining those improvements

73.0% NPS

Net Promoter Score

Source: CareFirst BOB outcomes through 2022

*As of Dec 2022, A1c Improvement N = 1,020 with baseline & follow up readings. Baseline Readings must be taken within 180 days before enrollment through 90 days post enrollment.

THANK YOU

QUESTIONS?

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CareFirst

SAC Discussion

Discussion Questions

- Are there any topics or issues you would you be interested in the Standing Advisory Committee addressing in the next year?

- Other comments, questions, or suggestions?

2025 Plan Certification Standards

2025 Plan Certification Standards

Anticipated:

- Value plan adjustments as needed to remain within federal actuarial value ranges (pending release of the draft 2025 AV calculator)
- No other Value Plan changes contemplated at this time

Questions & Discussion

Public Comment