Welcome!

Thank you for joining Highmark for our Summer Edition of the Producer Training Series
We will begin in a few minutes.

- All attendees will be muted upon entry
- Today's session is being recorded
- Both the slide deck and a copy of recording will be shared
- Please use the Q&A feature to submit questions

If you do not hear the speaker, please dial in:
Phone Number: 1-646-558-8656 or 1-669-900-6833
Webinar ID: 946 4750 9131
Password: 629732

HIGHMARK

Fully Insured Clinical Management

HIGHMARK

PRODUCER TRAINING SERIES AUGUST 29, 2022

Well360 Core

Improving health from every angle.

- Holistic health management solution that integrates clinical, wellness, and member services
- Digital Wellness Platform with Sharecare®
- Includes Case Management, our Transition of Care program, and behavioral health for members in need of support
- Member Listening System anticipates next best action and delivers personalized and timely interventions

✓ The Right Fit for a specific health concern, like preventive care or wellness

Well360 Core Program Impacts

ASO Only

$875 PMPM Reduction
in medical cost savings for our Transition of Care program.

$1,500 per inpatient authorization*/
$150 per outpatient authorization*
in Utilization Management savings.

$817 per case*
in Integrated Care Team savings.

**With Well360 Core Enhancements*
Source: Highmark Internal Analysis, 2019-2020

Well360 Core

Helps members navigate care, make healthy lifestyle changes, and manage chronic conditions.

Proactive Specialty Case Management — Integrated Care Team — Baby Blueprints® — Diabetes Prevention Program

Wellness Coaching — Digital Wellness Platform — Utilization Management

24/7 Nurse Line — Member Discounts — Case Management — Comprehensive Behavioral Health Support

NEW FOR 2023

Proactive Specialty Case Management

Proactive outreach occurs before unwanted utilization or high cost

New Specialty Cohort	Value Prop
High Risk Pregnancy with Social Determinants of Health (SDOH)	Complex case managers and social workers provide focused support with SDOH interventions for this high-risk population.
Inflammatory Bowel Disease (IBD)	New specialized team will focus on earlier, proactive engagement to help reduce annual spend for this population.
Proactive Oncology	New team will drive interventions for patients/members identified at or near diagnosis for C1, C2 & C3 cancer groups.
Hemophilia	New specialized team will focus on earlier, proactive engagement to help reduce inpatient admissions and annual spend for this population

Expected ROI 3.4 to 1

Integrated Care Team

Our Integrated Care Team (ICT) is a multidisciplinary clinical care team whose members coordinate and streamline care for our **highest risk, highest cost inpatient members.** ICT provides **end-to-end utilization** and case management services to support members during and after their inpatient admission

2:1 ROI*

Real-Time Intervention

High-Intensity Care Management

Real-Time Intervention Leads to Remarkable Results

Our rigorous analysis showed $817 savings per case which equates to a 2:1 ROI.

This was achieved through a 24% reduction in readmissions, a reduction of 1.14 days for inpatient average length of stay, and lower post-acute utilization rates, including 38% lower skilled nursing, 29% lower long-term acute care, and 12% lower inpatient rehab facilities.*

How It Works

1. Member admitted to hospital / Prior authorization received.
2. Real-time Member Listening System Identifies ICT member.
3. Member is auto-routed to ICT.
   Standard UM begins with prior authorization and is routed to general unit.
4. ICT utilization management (UM) and case management (CM) begin immediately and concurrently.
   Standard CM may begin at discharge, dependent on Well360 Care Management model.
5. Dedicated UM nurse works with provider, facility and CM nurse. **Proactive and high-touch.**

   OR

   Dedicated CM nurse works with member/family and continues post-discharge as long as needed. **Proactive and high-touch.**

Utilization and outcomes will vary by client depending on population and opportunity.

Diabetes Prevention Program (DPP)

Diabetes is preventable. Prediabetes is reversible.

- As many as 1 in 3 U.S. adults are prediabetic.
- DPP is available to all members as part of our preventive schedule.

DPP is a structured lifestyle and health behavior change program that is designed to prevent the onset of type 2 diabetes.

With DPP, you get:

- **Expert Coaching**
- **Engaging Lessons**
- **Support of a Community**
- **100% Preventive Medical Benefits**
- **No Member Cost Share**

Baby Blueprints

We offer Baby Blueprints® maternity education and support programs to help expectant mothers better understand every stage of their pregnancy.

This free program provides members with:

Easy and convenient enrollment over the phone.

Access to in-depth educational information on all aspects of pregnancy.

Individualized support throughout their pregnancy from a Women's Health Specialist.

Information on reimbursement for childbirth classes.

At-Risk Maternity Management Strategy

Comprehensive, holistic care throughout the maternity journey.

Focus on high cost drivers – pre-term birth, C-sections, NICU stays

Proactive outreach and engagement in clinical programs

Collaboration with provider and clinical care team

Cost related to high-risk pregnancies continue to rise year over year.

16% of inpatient costs are attributed to maternity and newborn costs.

44% of maternity and newborn inpatient costs are attributed to high-risk pregnancy.

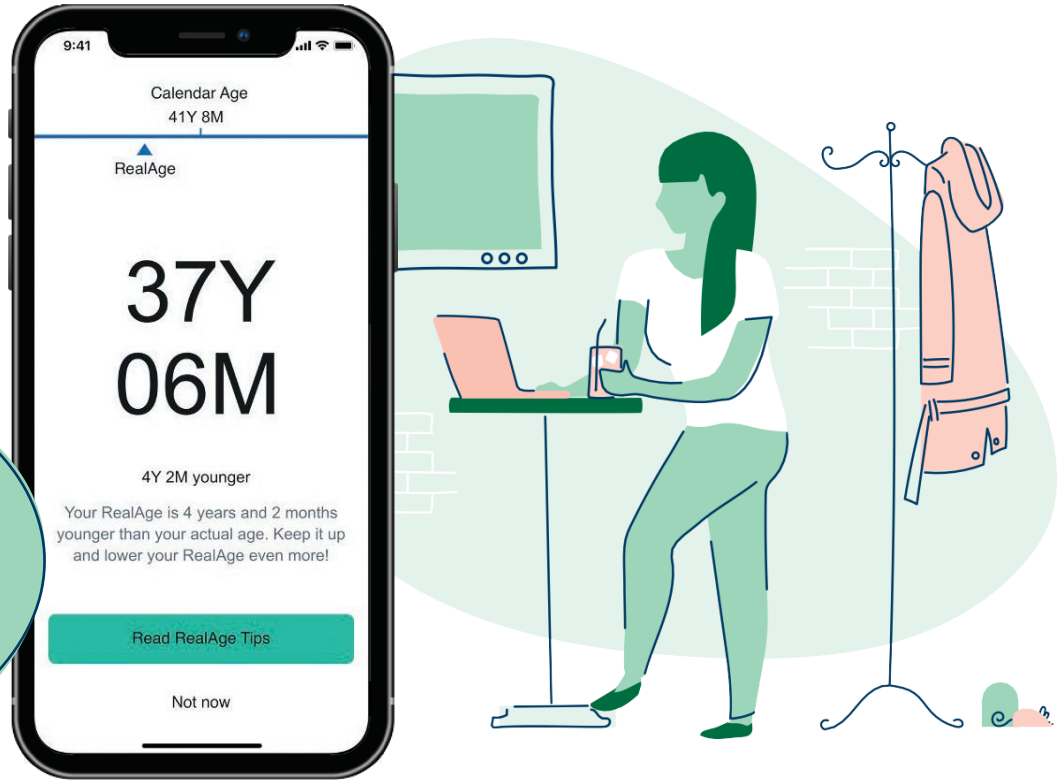
Employees want simple and engaging solutions to guide their care.

Sharecare Platform

RealAge – Next Generation Health Risk Assessment

- Sharecare's RealAge gives members an accurate, science-based measure of their body's actual age vs. their calendar age.
- Members receive personalized recommendations on lowering their RealAge, which helps create intrinsic curiosity and drive continued engagement.

45M
RealAge
Test Takers



Inpatient and Outpatient Utilization Management

Inpatient Admissions:

Acute care (hospital)

Long-term acute care

Inpatient rehabilitation facility

Skilled nursing facility

Outpatient Procedures:

Sleep studies

Bariatric surgeries

Varicose vein treatment

Reconstructive surgeries

Hysterectomies

Specialized Utilization Management

RADIOLOGY AND CARDIAC IMAGING

Magnetic resonance imaging (MRI)

Positron emission tomography (PET) scans

Computerized tomography (CT) scans

Stress testing

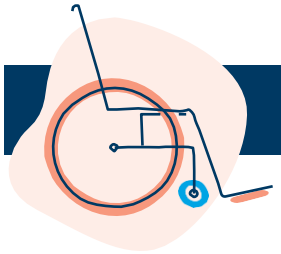
Myocardial perfusion imaging

Cardiac CT and MRI

Echocardiography

Diagnostic heart catheterization

MUSCULOSKELETAL MANAGEMENT



Interventional Pain

Spinal injections/ denervation

Stimulators/pain pumps

Spine Surgery

Fusions

Decompressions

Disc replacements

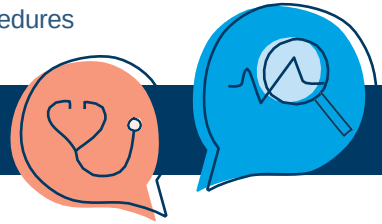
Large Joint Surgery

Joint replacement

Arthroscopy

Open procedures

LABORATORY RELATED GENETIC TESTING



Hereditary cancer screening

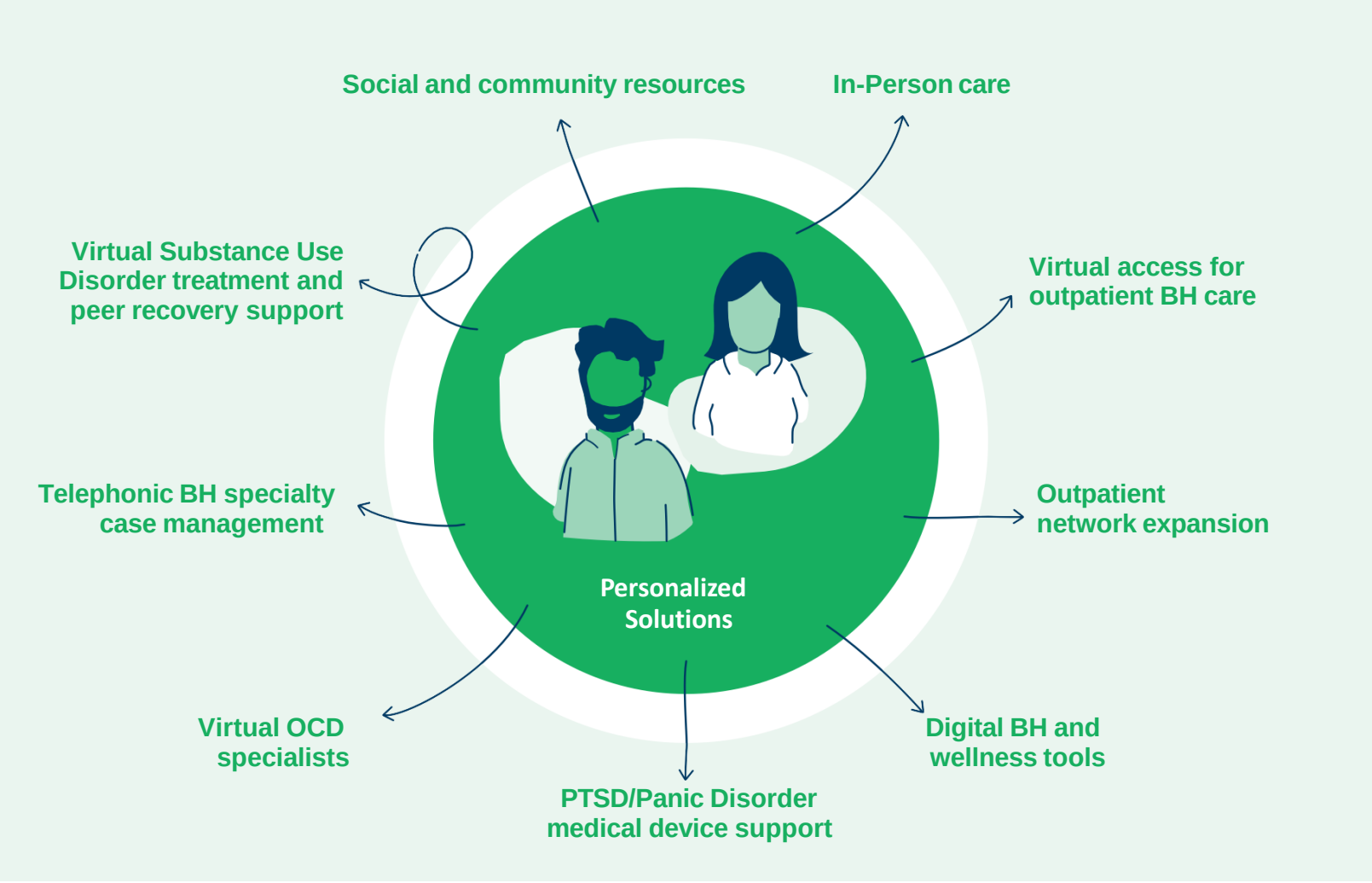
Carrier Screening

Neurologic disease testing

RADIATION ONCOLOGY

Radiation oncology treatments

Ecosystem of Personalized Solutions Addressing a Range of Behavioral Health Needs



Existing Highmark BH Solutions & Resources

In-Person Clinical and Ancillary Care
- PCP
- Specialists
- Virtual Visits
- Pharmacists
- ER

Virtual BH Treatment
- Well360 Virtual Health
- NOCD
- Meru
- Freespira

Child and Adolescent BH
- Well360 Virtual Health
- NOCD
- JOON

Virtual Substance Use Disorder Treatment
- Bright Heart Health
- MAP Healthcare

Virtual Alcohol Use Disorder
- RIA
- Tempest

Online Mental Health Resources
- Sharecare
- Sharecare Windows
- Sharecare Ask MD

Case Management
- BH High Acuity Team
- BH Maternal Opioid Mental Health Support
- Social Support
- Disease Management
- Transition of Care
- Wellness Coaching
- Children's Health Insurance Program
- Self-Management Support Program
- Clinical Pharmacy Program

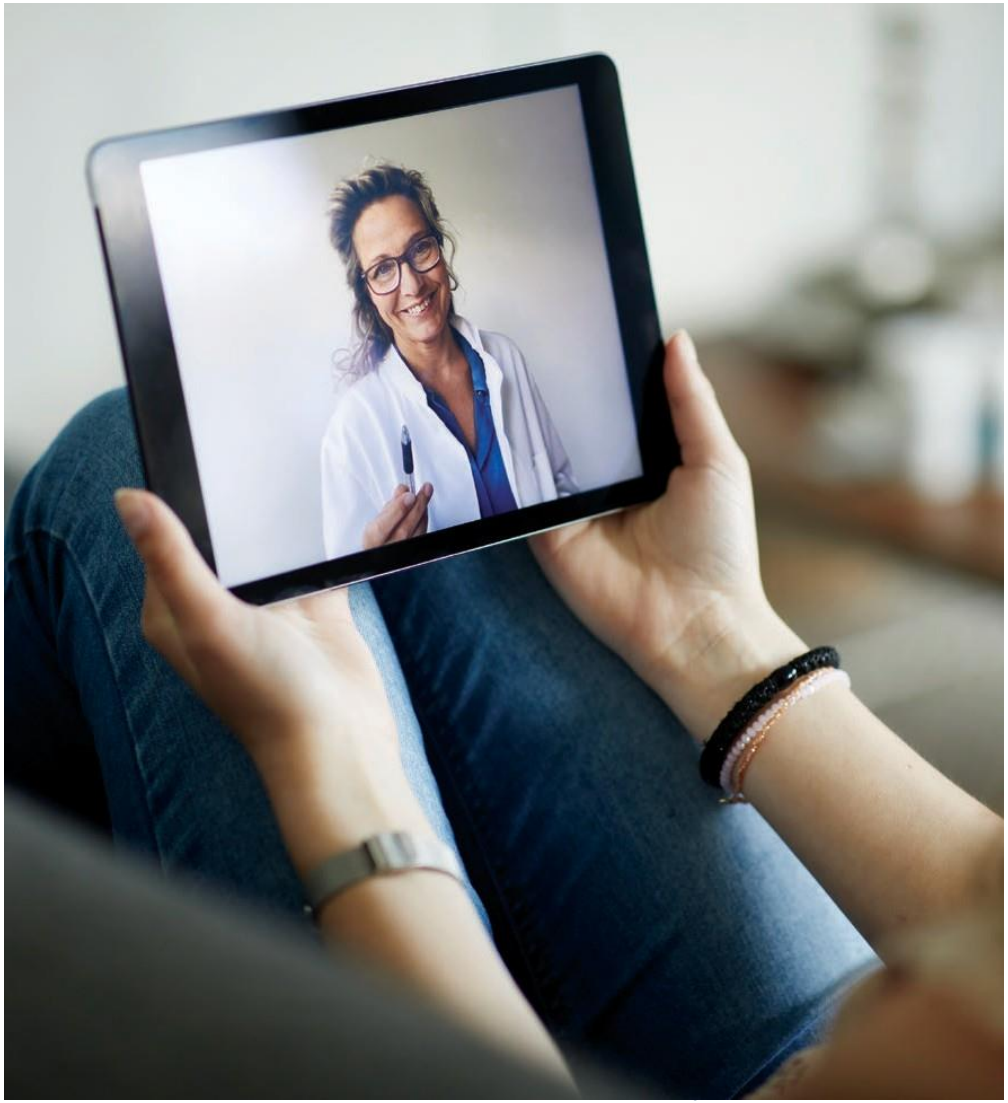
Additional Wellness Resources
- Speak with a Highmark Wellness Coach
- Time to Sleep Well Program
- The Daily Steps to Less Stress Coaching Program

Comprehensive Virtual Behavioral Health Care

Well360 Virtual Health

Comprehensive therapy and psychiatry services are specifically designed to close the gap in provider shortages and reduce the costs of behavioral health care.

Meet members' behavioral health needs by connecting them with psychiatrists and licensed therapists.



Well360 Diabetes Management — *Powered by Onduo*

Using the Onduo platform to bring the most up-to-date care to people living with type 2 diabetes anytime, anywhere.

The Onduo program helps people achieve their goals through building relationships and on-demand care.

- A virtual health clinic that includes access to telehealth services with endocrinologists
- Blood Glucometer & Test Strips included
- Continuous Glucose Monitoring systems (CGMs) to those who qualify
- Interactive app includes food and activity tracking with summary reports to correlate daily choices with blood glucose

Delivering the Right Interventions and Supports for Your Members — Where and When They Need It Most

Digital interventions

- Backed by leading behavioral science and user experience research

Customizable care team

- Care leads, clinical care specialists, educators, and physicians

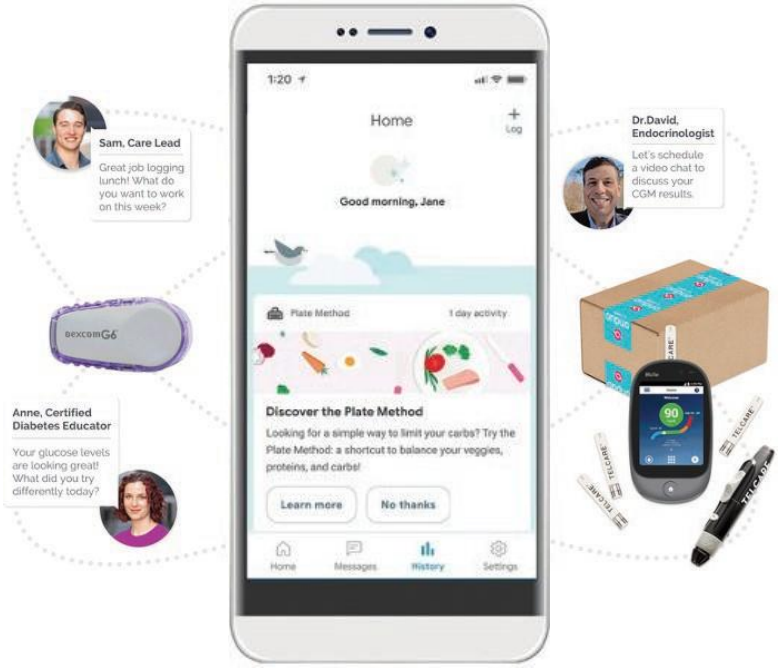
Telemedicine clinic

- Supports members between visits with their PCP
- Visit summaries provided electronically to PCP via e-fax

Medication adherence

- Help optimize medication regimens and drive medication adherence

Spanish/multilanguage support



Introducing the Kidney Care Management program

WHOLE-PERSON APPROACH

The whole-person approach works to understand conditions, clinical risks, behaviors, and preferences to create a personalized experience that's simplified for better outcomes.

Our white-glove Kidney Care Management approach gives the member a liaison between their provider and their health plan.

EARLY IDENTIFICATION	SLOW THE PROGRESSION	REDUCE ED, ADMISSIONS, READMISSIONS	PLANNED DIALYSIS STARTS	OPTIMIZE RENAL REPLACEMENT THERAPY

	PROGRAM VALUE
MEDICATION MANAGEMENT	Adjust meds for all conditions to accommodate eroding kidney function and reduce adverse events.
COORDINATE SPECIALIST CARE	Right care at the right time, managing comorbidities to slow disease progression.
ADDRESS SOCIAL DETERMINANTS OF HEALTH	Improves access to care, including customized meals, home visits, transportation, and dialysis adherence.
MEMBER EDUCATION AND PLANNING	Reduces "crashes" into ESRD through planned vascular access, diet control, and early transplant planning.
MOST APPROPRIATE DIALYSIS SITE OF SERVICE	Moving from in-center dialysis to in-home provides convenience and improved quality of life.

The provider and member experience

PROVIDER EXPERIENCE

IDENTIFY

Identify provider and patient and the best ways to improve care.

- Providers including PCP and specialists

ENGAGE

Introducing program and choosing how and when to communicate.

- Program introduction
- Omnichannel approach
- Confirm diagnosis, treating MD
- Care Continuum coordination (e.g., endocrinologists, cardiologists, dialysis, hospitals, labs, etc.)

COORDINATE

Proactive identification and coordination of care gap closures and intervention opportunities.

- Patient education
- Medications
- Specialty visits
- Labs
- Transplants and dialysis
- SDoH barriers

COLLABORATE

Quality measure reporting tools.

- Track patient progression
- Provider performance insights and benchmarking

MEMBER EXPERIENCE

IDENTIFY

- Evaluate claims file
- Attribute physicians

ENGAGE

- Welcome and program introduction letters
- Care Navigators reach out to member
- Conduct Health Risk Assessment
- Establish preferred omnichannel approach

COORDINATE

- Frequency of engagement depends on stage and assessment
- Home visits are initiated for some patients
- Health Action Plan (HAP) created
- Examples of coordinated actions include SDoH or Medication Management

COLLABORATE

- Joint decision making between the patient and their physician, facilitated by their care navigator
- Community resources are accessed when they can support the patient, e.g., transportation and support groups