Well360 Focus: A multichannel clinical care management model with demonstrated lower costs and better health care utilization.

EXECUTIVE SUMMARY

Highmark offers the Well360 Focus clinical care management model within its Well360 portfolio of products and services. Outcomes for members in this enhanced care management model were compared to members in Highmark's standard model, known as Well360 Core, using a retrospective propensity-matched controls method over the year 2019.

Members in Well360 Focus had an average Medical Cost of Care that was $18 lower per member per month (PMPM) than a matched control group of Well360 Core members. The difference was statistically significant and represents a 5% savings on care costs.

Members in Well360 Focus also had statistically significant lower rates of inpatient admission and emergency department (ED) visits and had a higher rate of primary care provider (PCP) visits. The methodology of this study is the same as used for our Well360 Connect evaluation, which was independently validated by a third-party consultant.

INTRODUCTION

Highmark's Well360 portfolio includes a progressive suite of clinical, wellness, and member services offerings. This includes the Well360 enhanced care management models: Well360 Clarity, Well360 Connect, Well360 Focus, and Well360 Lifestyle. The Well360 suite was enhanced in 2019, evolving from the most effective features of Highmark's previous population health and advocacy solutions, and adding new innovative features, such as next generation risk identification, expansion of the multidisciplinary care team, and embedded digital/virtual solutions for chronic conditions, wellness, and second medical opinion consultation.

This evaluation concentrates on Well360 Focus, for which self-funded commercial clients pay an additional per contract per month (PCPM) fee for an enhanced level of care management. It explores whether members participating in Well360 Focus demonstrate a lower medical-only PMPM compared to members who are in the standard clinical model, Well360 Core.

Commitment to evidence-based evaluation:

Highmark is an industry leader in advanced analytics in health care and operates a successful clinical intervention evaluation program, which was adapted to evaluate Well360 Focus. The program is built around two guiding principles:

1. Every intervention Highmark provides for members will be subject to a robust, objective evaluation to determine impact, which in turn should influence future decisions for intervention.
2. Negative results are just as valuable as positive ones. We scale what works and use the evaluation findings to improve upon or replace what does not work.

The program uses an academic standardized methodology, known as retrospective matched controls, and reports the statistical significance of each result. By applying this level of rigor, Highmark has a clear understanding of the value its programs deliver, which is used to influence activity. This capability and commitment to do so differentiates Highmark in the marketplace.

In this study, the approaches used to evaluate specific care management interventions are adapted to study outcomes from one whole year of care in the Well360 Focus clinical care model.

METHODOLOGY

Members from selected Well360 Focus clients were compared to a propensity-matched sample of members from clients in the standard model. The outcomes of the two groups were compared across several cost and utilization metrics over the following year.

For the Intervention Group, Well360 Focus clients were selected to have as consistent an experience as possible from the matching year (2018) and the evaluation year (2019) to avoid introducing bias into the evaluation. This includes the enhanced model itself and performance guarantees (PGs). Five clients were in Well360 Focus in both years, and five clients had the same model and consistent PGs in both years, ensuring the contractual arrangements and clinical and wellness outreach/activity would be consistent.

Clients in the control group were required to have the same basic standards apply in both years. Any clients with nonstandard performance guarantees, fewer than 1,000+ subscribers (an entry requirement for Well360 Focus), or who did not have their case management/disease management provided by Highmark, were excluded from the control group.

Members in both groups were required to be active members (excluding COBRA and retiree groups), have 24 months continuous enrollment with

a complete set of data, be between the ages of 18 and 64, not have received hospice care or benefited from Highmark's Integrated Care Team, and not have changed employers during the study period.

A propensity-matching method (Rosenbaum and Rubin, 1983) was used to select control members, who have as similar as possible characteristics to the intervention members in the base year (2018). A logistic regression model was used to deliver 1-to-1 matching of intervention members to their most similar control group member, training on member utilization in the base year, presence of chronic conditions, age, and location. A range of more than 30 separate metrics, including those in the regression model and others, were inspected for standardized difference between the two groups. The match was considered good when all differences were less than 0.1.

The groups were compared across the following metrics in the study year:

- Total cost of medical care
- Rate of inpatient admissions
- Rate of inpatient admissions for conditions which should be manageable in primary care, such as ambulatory care sensitive conditions, or ACSCs (Billings et al, 1993)
- Rate of ED visits
- Rate of ED visits for avoidable causes (Billings, Parikh and Mijanovich, 2000)
- Primary care provider (PCP) visits
- Care Gap Index (Cotiviti, 2019)

Individual members in both groups who were more than three standard deviations away from the outcome metric mean in the study period were considered outliers. We did not remove them from the assessment of that metric but capped the value at three standard deviations from the mean.

RESULTS

Five Well360 Focus clients, with a total of 37,463 members, met the study inclusion criteria, as did 139 Well360 Core clients, with a total of 693,576 members. After member level exclusions, 17,509 intervention members and 258,910 control members remained in the study. The most similar 17,491 members from both groups were selected by propensity-matching, meaning 18 intervention members did not have a well-matched equivalent in the control group and were therefore excluded. The various exclusions did not notably alter the distribution of contracts and members among clients, which remained well-matched between intervention and control. The ratio of members to contracts for the Well360 Focus intervention group was 1.63 and 1.04 for the Well360 Core control group.

Figure A1 found in the appendix shows the standardized differences of matching and descriptive variables in the base year (2018), before and after matching. After matching, all differences were well under the recommended 0.1 threshold.

Outcome metric difference in 12-month post-period outcomes*	Focus (n=17,491)	Core (n=17,491)	Difference [PMPM]	p-value*	Conclusion
Allowed Amount – Med Only	$4,304	$4,520	-$216[-$18]	0.0001	Core significantly greater
Admissions**	20	30	-10	<0.0001	Core significantly greater
ACSC Admissions**	0.3	0.4	-0.1	<0.0001	Core significantly greater
ED Visits**	90	160	-70	<0.0001	Core significantly greater
Avoidable ED Visits**	20	40	-20	<0.0001	Core significantly greater
PCP Visits**	1,880	1,860	20	0.2423	No statistically significant difference
Care Gap Index	1.79	1.84	-0.05	0.0848	No statistically significant difference

The comparison between matched intervention and control groups in the study period (2019) is shown in Table 1. The mean medical allowed costs for members in Well360 Focus was $4,304 in 2019 ($359 PMPM), whereas the matched control members had mean costs of $4,520 ($377 PMPM), a net savings of $18 PMPM for members in Well360 Focus. The savings were statistically significant, with a p-value = 0.0001. All hospital utilization metrics were significantly lower in the Well360 Focus members, with a reduction of 10 inpatient admissions per 1,000 members, 70 ED visits per 1,000 members, and 20 avoidable ED visits per 1,000 members. In addition, although members in the Core product had a lower Care Gap Index, they did have a higher number of PCP visits. Neither finding was statistically significant. Given the large sample size, it is important to consider the magnitude of the differences when interpreting these results. In particular, the average difference for ACSC Admissions is small. It is important to note that the results reflect the Focus product as a whole and individual outcomes may vary among each client.

* Difference in 12-month post-period outcomes
** Per 1,000 members

DISCUSSION

Overall, members in Well360 Focus had a lower average PMPM and utilization in 2019 compared to members in the Well360 Core model. Well360 Focus members had a statistically significant lower average difference of $18 PMPM on total allowed medical costs, which represents a 5% savings.

Well360 Focus members had a significantly lower average number of inpatient admissions and ED visits, which is a positive outcome suggesting less need for, or reliance on, hospital care.

CONCLUSIONS

Well360 Focus demonstrates a significant reduction in the Medical Cost of Care for members, driven mainly by lower utilization of hospital services. The reduction in care cost greatly exceeds the additional fee for the enhanced service.

STRENGTHS AND LIMITATIONS

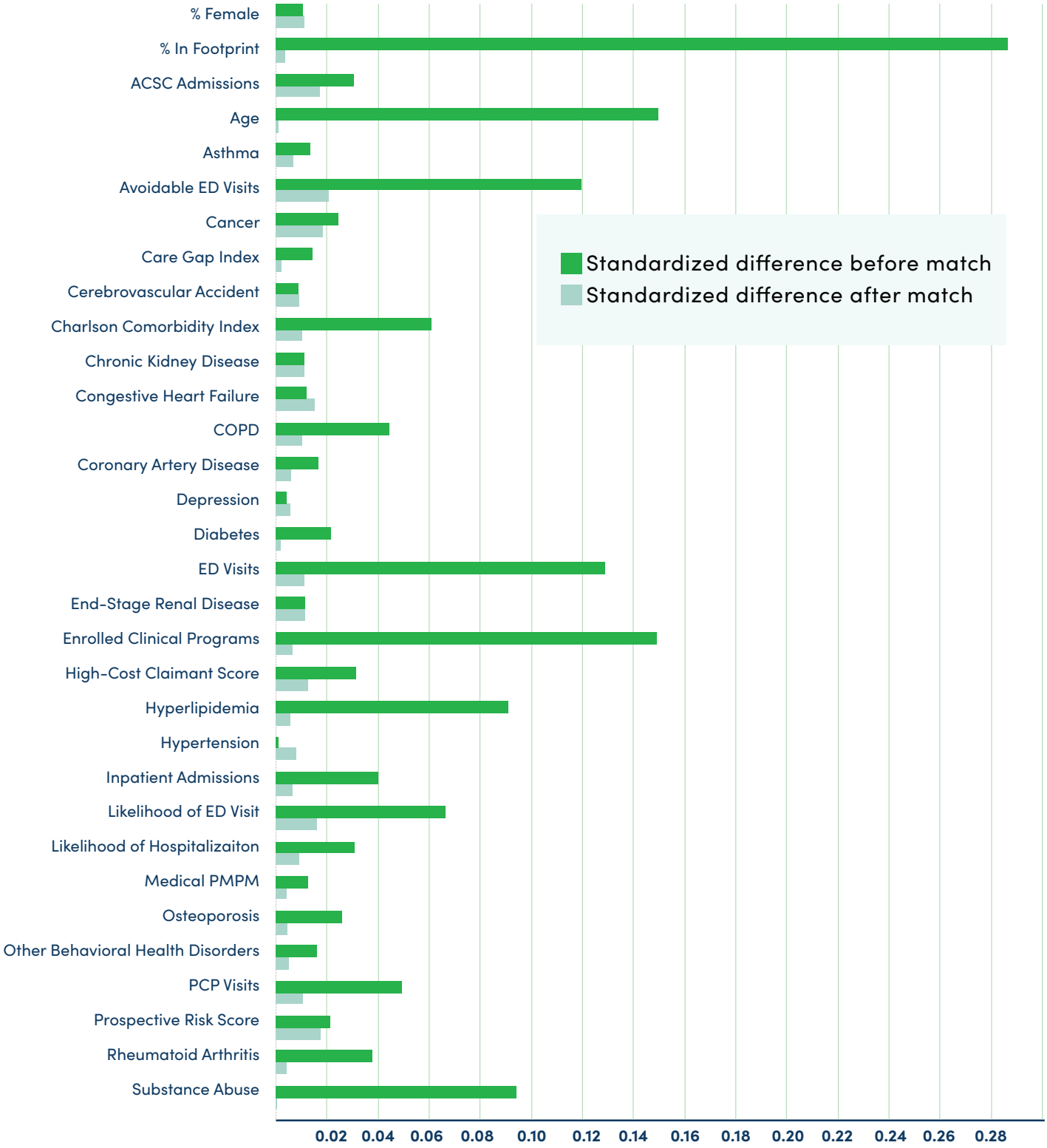
Retrospective propensity-matched control groups is a commonly used method to deliver evaluations with minimized selection bias. Clients and members in both groups were rigorously selected to ensure the only difference between them was the level of clinical intervention. Groups were matched in the year before the study period, meaning that the matching was not influenced by the outcomes under investigation. Standardized differences across matching and descriptive metrics were all within the recommended threshold (Austin, 2009). The sample sizes provided more than adequate statistical power to observe differences between the outcomes.

As with any matched control study, the influence of characteristics unobserved in the data cannot be completely discounted. Given the large sample size, it is important to consider the magnitude of the differences when interpreting these results. In particular, the average difference for ACSC Admissions is extremely small. The results reflect the intervention as a whole and outcomes may vary for specific clients. While the groups were balanced on characteristics and outliers were capped, future analyses could explicitly exclude additional members with unavoidable high-cost events such as those with transplants or those with an allowed amount over a specified threshold. This may be difficult to impact due to inherent complexities or highly regulated standards of care.

EXTERNAL VALIDATION

The methods used for this study were the same for our Well360 Connect evaluation, which was independently validated by a third-party consultant.[1]

APPENDIX


% Female
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ACSC Admissions
Age
Asthma
Avoidable ED Visits
Cancer
Care Gap Index
Cerebrovascular Accident
Charlson Comorbidity Index
Chronic Kidney Disease
Congestive Heart Failure
COPD
Coronary Artery Disease
Depression
Diabetes
ED Visits
End-Stage Renal Disease
Enrolled Clinical Programs
High-Cost Claimant Score
Hyperlipidemia
Hypertension
Inpatient Admissions
Likelihood of ED Visit
Likelihood of Hospitalizaiton
Medical PMPM
Osteoporosis
Other Behavioral Health Disorders
PCP Visits
Prospective Risk Score
Rheumatoid Arthritis
Substance Abuse
Standardized difference before match
Standardized difference after match
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0.04
0.06
0.08
0.10
0.12
0.14
0.16
0.18
0.20
0.22
0.24
0.26
0.28

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[1]Highmark Health Advanced Analytics (2021).Well360 Connect: An integrated clinical care management advocacy model with demonstrated lower costs and better health care utilization.

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