AGENDA
State and Public School Life and Health Insurance Board
Benefits Sub-Committee

November 4, 2016
10:00 a.m.

EBD Board Room – 501 Building, Suite 500

I. Call to Order ................................................................. Jeff Altemus, Chairman

II. Approval of October 7, 2016 Minutes................................. Jeff Altemus, Chairman

III. ASE-PSE Financials October, 2016........................... Marla Wallace, EBD Fiscal Officer

IV. ACHI Activities & Update......................................................... ACHI Staff

V. Telemedicine for School Faculty.............................. Michael Manley, David Fletcher,
........................................................................................................ Tina Benton, UAMS

VI. Health/Wellness........................................................................................................

A. Catapult ........................................................................ Lee Dukes & David Michel

B. ActiveHealth................................................................. Mary Kampman

VII. Director’s Report....................................................... Chris Howlett, EBD Executive Director

2017 upcoming meetings:


NOTE: All material for this meeting will be available by electronic means only
ethel.whittaker@dfa.arkansas.gov

Notice: Silence your cell phones. Keep your personal conversations to a minimum.
Observe restrictions designating areas as “Members and Staff only”
The Benefits Sub-Committee of the State and Public School Life and Health Insurance Board (hereinafter called the Committee) met on November 4, 2016, at 10:00 a.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, Arkansas.

**Members Present**
- Janis Harrison
- Dan Honey
- Shelby McCook
- Jeff Altemus
- Claudia Moran
- Ronnie Kissire
- Susan Gardner
- Carla Haugen

**Members Absent**
- Becky Walker

Chris Howlett, Executive Director, Employee Benefits Division (EBD)

**Others Present**
- Geri Bemberg, Michael Manley, UAMS; Marla Wallace, Ethel Whittaker, Eric Gallo, Drew Higginbotham, Matt Turner, Terri Freeman, Stella Greene, Cecilia Walker, EBD; Kristi Jackson, Com Psych; Pam Lawrence, AHH; Sylvia Landers, Minnesota Life; Marc Watts, ASEA; Ronda Walthall, Wayne Whitley, AHTD; Martha Carlson, Takisha Sanders, Health Advantage; Jackie Baker, ASP; Elizabeth Whittington, Mike Motley, ACHI; Suzanne Woodall, MedImpact; Steve Althoff, MTI; Jason Jeremy, DataPath; Treg Long, ACS; Bagby, Lilly; Mary Kampman, Nina Reed, ActiveHealth Mgmt.

**CALL TO ORDER**

The meeting was called to order by Jeff Altemus, Chairman

**APPROVAL OF MINUTES**

Altemus asked for a motion to approve the October 7, 2016, minutes. Harrison motioned for adoption of the minutes. Honey seconded; all were in favor.

Minutes Approved.
ASE PSE FINANCIALS: by Marla Wallace, EBD Fiscal Officer

Wallace reported financials for October 2016. For October PSE, four (4) weeks of medical and pharmacy claims were paid. The quarterly funding from the Department of Education was received. The FICA savings for the month is $486,000. There was a net gain of $7.2 million for the month. The net gain for the year-to-date is $31.8 million. Net assets available are $61.8 million.

For ASE the month of October, four (4) weeks of medical and pharmacy claims were paid. The net gain was $4.1 million for the month. The year-to-date gain is $19.5 million. Net assets available are $19.9 million.

ACHI ACTIVITIES & UPDATES: by Michael Motley, Izzy Whittington, ACHI

In the Arkansas Works Legislation, there is a requirement for an annual wellness visit. The incentive for adhering to the Requirements of a wellness visit is participants would receive an added dental benefit. Several health-care professionals are working diligently to develop the best strategy for the state of Arkansas members.

The working strategy for implementation has three components. In year one of implementation (2017) count any office visit to any PCP (excluding ER, hospital, and urgent care centers. In year two, count any evaluation and management preventive visit CPT code at any PCP (for new patients codes are 99381 through 99387, for established patients codes are 99391 through 99397. In year three, count any evaluation and management preventive visit CPT code at an attributed PCP/clinic.

Whittington spoke briefly on the Choosing Wisely Program. Choosing Wisely is an initiative of the ABIM Foundation to help providers and patients engage in conversations about the overuse of tests and procedures and support efforts to help patients make smart and effective care choices.

TELEMEDICINE FOR SCHOOL FACULTY: by Michael Manley, David Fletcher, Tina Benton, UAMS

Telemedicine was developed in 2003 for telephone and video clinical consultation for non-emergency issues. The purpose of Primary Plus will offer onsite clinical care performed by Arkansas physicians to school faculty and staff.

The program provides nurse-driven telephone triage guided by industry-endorsed best practices guidelines. There is a 24-hour call center available.
There is access to board certified, Arkansas-licensed and credentialed primary care providers, specialists, and subspecialists. Some of the benefits include; after-hours and weekend care in addition to work hour care.

McCook inquired who would be responsible for the cost. Also, will the service be available to all plan members?

Manley reported the cost would be absorbed by EBD.

Dr. Kirtley inquired if the company would act as a vendor or a provider. Benton stated they would serve as a provider. There is the potential to contract providers.

McCook is concerned with a new contract for the services.

**HEALTH/WELLNESS**: by Lee Dukes, David Michel, Catapult

Catapult is an Arkansas BlueCross BlueShield Provider, not a wellness vendor. Catapult delivers preventive checkups at worksites across the country. Check-ups are convenient, efficient, cost effective and highly impactful. Catapult will hire and train local clinical staff, bringing jobs to Arkansas. One of the benefits is the program does not require time off work for blood tests at a local lab, or for a physician office visit.

The following are included in the check-ups: (1) Values measured, (2) Personal health history, (3) Family history, (4) Medications, (5) Cancer screening evaluated, (6) Vaccines administered, (7) Personal action plan, (8) Symptoms captured, (9) Care compliance and gaps in care identified, and (10) Personal results delivered in real time.

McCook requested to revisit the subject at the next meeting.

**HEALTH/WELLNESS**: by Mary Kampman, ActiveHealth

ActiveHealth was founded in 1998 providing evidence-based health and well-being solutions, with proven benefits in quality improvement and cost savings to over 23 million individuals. The broad, national customer base includes State, public sector, self-funded employers, health plans, health systems, TPAs, IPAs, CINs, and ACOs.

Unparalleled analytic power – 160+ data experts, supporting over 1,500 data formats (clinical, financial & administrative) from nearly 300 data suppliers (including 45 payers)
Patented CareEngine; developed by physicians, for physicians – foundation of our services, providing actionable clinical analytics and decision support. Regional model with Chicago office supporting EBD with onsite liaison in Little Rock, AR

McCoom requested additional information to be discussed at the next meeting. The committee scheduled a meeting December 9th for further discussion.

**EBD DIRECTOR’S REPORT: by Chris Howlett, EBD Executive Director**

There has been no decision on Mandate 1557. Howlett stated the division is researching the cost that could be associated with the mandate.

The procurement process for actuarial services is in the evaluation phase. EBD hopes to announce the winner of the contract the week of November 14, 2016.

Howlett requested an extension of up to three months for the AHH contract to allow processing time for the new vendor.

Howlett reported there are still unresolved issues with WageWorks and a solution will be provided to the committee before the Thanksgiving holiday.

*Meeting adjourned*
Purpose

Primary Plus will offer onsite clinical care performed by Arkansas physicians to school faculty and staff.
Deliverables

• Telephone and video clinical consultation for non-emergent issues
• Nurse-driven telephone triage guided by industry-endorsed best practices guidelines
Deliverables

• Access to board certified, Arkansas-licensed and credentialed primary care providers, specialists, and subspecialists
Deliverables

• PCP follow-up for notification of care delivered
Deliverables

- Smart-phone, computer, and webcam interoperability
Deliverables

• Clinical emphasis in primary care “plus” the capability to expand to any clinical specialty
Deliverables

• Capacity to deploy services on daytime, nighttime, or around-the-clock bases.
Process

Patient needs a physician consultation
- Nurse contacts on-call physician to arrange video consult
- Nurse gives patient guidance to connect to the video consult
- Provider and patient meet via video to discuss his or her concern
- Provider issues prescription and guidance for self-care
- Nurse forwards record of visit to patient's PCP for follow-up

Patient needs self-management at home
- Nurse provides directions on how to care for concern at home.
- Nurse forwards record of call to patient's PCP for follow-up

Patient needs emergency medical attention
- Nurse urges the patient to go to the nearest emergency room immediately.
- Nurse forwards records of call to patient's PCP for follow-up

Patient needs follow-up PCP appointment
- Nurse forwards record of call to patient's PCP for follow-up
Modalities

- **Smart Phone & Tablets**
  - Primary Plus app, embedded device camera, & secure login

- **Clinical Tele-medicine Carts**
  - Interactive video with peripherals in school nurse offices.

- **Computer + Camera**
  - Primary Plus website, webcam, & secure login

- **Kiosk**
  - Self-contained kiosk at selected locations or schools
Options

CDH will work with the Arkansas Department of Finance and Administration to identify high priority school districts to launch

- After-hours and weekend care
- Work hours care
Benefits

- **After-hours and weekend care:**
  Avoidance of unnecessary emergency room visits and urgent care visits, resulting in significant cost savings
- **Work hours care:**
  Fewer doctors’ visits among school employees
Summary

Guaranteed communication back to the patient’s existing PCP.

Full access to specialist physicians at the state's academic medical center.

CDH's 13 years of experience in telemedicine consultations, existing 24/7 call center, and 400+ site telemedicine network.

Keeping Arkansas' healthcare dollars in Arkansas, employing only Arkansas-based and licensed physicians.
For More Information

Curtis Lowery, MD
UAMS Center for Distance Health
501.686.5847
LoweryCurtisL@uams.edu
Arkansas Center for Health Improvement Update
Benefits Subcommittee Meeting, November 4th, 2016

Contents:
• AR Works Wellness Visit Req./EBD Alignment Update...............p.1-4
• Health Risk Assessment Analysis Update................................p.5-6
• Choosing Wisely Update...........................................................p.7-8
• Arkansas Healthcare Payment Improvement Initiative State Tracking Report Update.............................................................p.9-14
Working Strategy for Wellness Visit Definition

1. In year one of implementation (2017) count any office visit to any PCP (excluding ER, hospital, and urgent care centers)

2. In year two, count any evaluation and management preventive visit CPT code at any PCP (for new patients codes are 99381 through 99387, for established patients codes are 99391 through 99397)

3. In year three, count any evaluation and management preventive visit CPT code at an attributed PCP / clinic

4. Additional Considerations:
   - Carriers will need to generate reports for Medicaid to determine that beneficiary requirement was met
   - This strategy includes multi-payer messaging to network providers to reinforce use of evaluation and management preventive visit CPT codes for year one of implementation and beyond
   - DHS and QHP carriers will need to align on a beneficiary appeals process
### Output 1: For 2014 calendar year: beneficiaries continuously enrolled for 12 months

<table>
<thead>
<tr>
<th></th>
<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>Total</th>
</tr>
</thead>
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<td>M: Total</td>
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<td>5,047</td>
<td>6,353</td>
<td>7,874</td>
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<td>F: %</td>
<td>78%</td>
<td>85%</td>
<td>88%</td>
<td>92%</td>
<td>94%</td>
<td>89%</td>
</tr>
<tr>
<td>M: % with any service</td>
<td>21%</td>
<td>31%</td>
<td>33%</td>
<td>35%</td>
<td>38%</td>
<td>32%</td>
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<tr>
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<td>6%</td>
<td>10%</td>
<td>11%</td>
<td>13%</td>
<td>13%</td>
<td>11%</td>
</tr>
</tbody>
</table>

### Output 2: For 2015 calendar year: beneficiaries continuously enrolled for 12 months

<table>
<thead>
<tr>
<th></th>
<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>M: Total</td>
<td>5,789</td>
<td>4,720</td>
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<td>F: Total</td>
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<td>12,345</td>
<td>14,457</td>
<td>12,944</td>
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<tr>
<td>M: %</td>
<td>61%</td>
<td>81%</td>
<td>88%</td>
<td>88%</td>
<td>92%</td>
<td>83%</td>
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<tr>
<td>F: %</td>
<td>81%</td>
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<td>92%</td>
<td>94%</td>
<td>96%</td>
<td>92%</td>
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<tr>
<td>M: % with any service</td>
<td>28%</td>
<td>32%</td>
<td>33%</td>
<td>37%</td>
<td>40%</td>
<td>30%</td>
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<td>F: % with any service</td>
<td>31%</td>
<td>33%</td>
<td>35%</td>
<td>38%</td>
<td>39%</td>
<td>33%</td>
</tr>
<tr>
<td>M: % with any preventive service</td>
<td>4%</td>
<td>17%</td>
<td>18%</td>
<td>17%</td>
<td>17%</td>
<td>16%</td>
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<tr>
<td>F: % with any preventive service</td>
<td>5%</td>
<td>14%</td>
<td>15%</td>
<td>17%</td>
<td>19%</td>
<td>15%</td>
</tr>
</tbody>
</table>

### Output 3: For those beneficiaries continuously enrolled for 24 months across both 2014 and 2015

<table>
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<tr>
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<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>M: Total</td>
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<td>3,956</td>
<td>5,219</td>
<td>6,619</td>
<td>6,500</td>
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<td>F: Total</td>
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<td>7,724</td>
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<td>13,757</td>
<td>12,540</td>
<td>50,545</td>
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<td>61%</td>
<td>81%</td>
<td>88%</td>
<td>89%</td>
<td>92%</td>
<td>83%</td>
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<tr>
<td>F: %</td>
<td>81%</td>
<td>91%</td>
<td>92%</td>
<td>94%</td>
<td>96%</td>
<td>92%</td>
</tr>
<tr>
<td>M: % with any service</td>
<td>19%</td>
<td>29%</td>
<td>32%</td>
<td>33%</td>
<td>37%</td>
<td>31%</td>
</tr>
<tr>
<td>F: % with any service</td>
<td>24%</td>
<td>31%</td>
<td>33%</td>
<td>35%</td>
<td>38%</td>
<td>34%</td>
</tr>
<tr>
<td>M: % with any preventive service</td>
<td>4%</td>
<td>17%</td>
<td>19%</td>
<td>19%</td>
<td>20%</td>
<td>16%</td>
</tr>
<tr>
<td>F: % with any preventive service</td>
<td>4%</td>
<td>14%</td>
<td>15%</td>
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</table>

*Source for coding/definitions: EBD Provided Codes - 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99429, G0402, G0438, G0439, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99218

**Source for coding/definitions for QHP ACA preventive services; 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397
### Output 1: For 2014 calendar year: beneficiaries continuously enrolled for 12 months

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Number Beneficiaries</th>
<th>% with any service; any setting; any provider*</th>
<th>% with any service; with a primary care provider*</th>
<th>% with any preventive service; with a primary care provider**</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
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<td>18-24</td>
<td>3,142</td>
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<td>F</td>
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</tbody>
</table>

*Source for coding/definitions; EBD Provided Codes - 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99429, G0402, G0438, G0439, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99218

**Source for coding/definitions for QHP ACA preventive services; 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397
## Output 1: For 2014 calendar year: beneficiaries continuously enrolled for 12 months

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Number</th>
<th>% with any service; any setting; any provider*</th>
<th>% with any service; with a primary care provider*</th>
<th>% with any preventive service; with a primary care provider**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
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<td>18-24</td>
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<td>F: 4,484</td>
<td>M: 85%</td>
<td>F: 90%</td>
</tr>
<tr>
<td>45-54</td>
<td>M: 3,712</td>
<td>F: 5,552</td>
<td>M: 89%</td>
<td>F: 93%</td>
</tr>
<tr>
<td>55-64</td>
<td>M: 3,699</td>
<td>F: 5,072</td>
<td>M: 92%</td>
<td>F: 95%</td>
</tr>
<tr>
<td>Total</td>
<td>M: 15,720</td>
<td>F: 21,470</td>
<td>M: 82%</td>
<td>F: 90%</td>
</tr>
</tbody>
</table>

## Output 2: For 2015 calendar year: beneficiaries continuously enrolled for 12 months

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Number</th>
<th>% with any service; any setting; any provider*</th>
<th>% with any service; with a primary care provider*</th>
<th>% with any preventive service; with a primary care provider**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>18-24</td>
<td>M: 2,725</td>
<td>F: 2,587</td>
<td>M: 90%</td>
<td>F: 90%</td>
</tr>
<tr>
<td>25-34</td>
<td>M: 2,213</td>
<td>F: 2,917</td>
<td>M: 91%</td>
<td>F: 93%</td>
</tr>
<tr>
<td>35-44</td>
<td>M: 2,503</td>
<td>F: 3,976</td>
<td>M: 94%</td>
<td>F: 95%</td>
</tr>
<tr>
<td>45-54</td>
<td>M: 3,296</td>
<td>F: 4,921</td>
<td>M: 84%</td>
<td>F: 92%</td>
</tr>
<tr>
<td>55-64</td>
<td>M: 3,251</td>
<td>F: 4,647</td>
<td>M: 83%</td>
<td>F: 92%</td>
</tr>
<tr>
<td>Total</td>
<td>M: 13,988</td>
<td>F: 19,048</td>
<td>M: 84%</td>
<td>F: 92%</td>
</tr>
</tbody>
</table>

## Output 3: For those beneficiaries continuously enrolled for 24 months across both 2014 and 2015

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Number</th>
<th>% with any service; any setting; any provider*</th>
<th>% with any service; with a primary care provider*</th>
<th>% with any preventive service; with a primary care provider**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>18-24</td>
<td>M: 2,506</td>
<td>F: 2,359</td>
<td>M: 90%</td>
<td>F: 90%</td>
</tr>
<tr>
<td>25-34</td>
<td>M: 1,885</td>
<td>F: 2,478</td>
<td>M: 91%</td>
<td>F: 93%</td>
</tr>
<tr>
<td>35-44</td>
<td>M: 2,307</td>
<td>F: 3,660</td>
<td>M: 94%</td>
<td>F: 96%</td>
</tr>
<tr>
<td>45-54</td>
<td>M: 3,090</td>
<td>F: 4,643</td>
<td>M: 84%</td>
<td>F: 92%</td>
</tr>
<tr>
<td>55-64</td>
<td>M: 3,096</td>
<td>F: 4,487</td>
<td>M: 83%</td>
<td>F: 92%</td>
</tr>
<tr>
<td>Total</td>
<td>M: 12,884</td>
<td>F: 17,627</td>
<td>M: 83%</td>
<td>F: 92%</td>
</tr>
</tbody>
</table>

*Source for coding/definitions; EBD Provided Codes - 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99429, G0402, G0438, G0439, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99218

**Source for coding/definitions for QHP ACA preventive services; 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397
Self-Reported Risks in 2007

HRA Respondents Eligible to Incur Claims (N=59,661)

- Obese 31.2%
- Daily Cigarette Users 4.9%
- Physically Inactive 16.0%
- Other Risks 41%

No Risks 16%
Average Annual Cost by Risk Factor Claims Period (1/1/07-12/31/07)

- Obese: $4,190
- Daily Cigarette Users: $3,640
- Physically Inactive: $4,651
- C+O+P: $4,840
- C+O: $3,647
- C+P: $4,745
- O+P: $5,008
- C: $3,239
- O: $3,942
- P: $4,307
- Other Risks: $3,184

No Risks: $2,969
The Issue
As the nation increasingly focuses on ways to provide safer, higher-quality care to patients, the overuse of health care resources is an issue of considerable concern. Many experts agree that the current way health care is delivered in the U.S. contains too much waste—with some stating that as much as 30 percent of care delivered is duplicative or unnecessary and may not improve people’s health.

It is urgent that health care providers and patients work together and have conversations about wise treatment decisions. That means choosing care that is supported by evidence showing that it works for patients like them; is not duplicative of other tests or procedures already received; won’t harm them; and is truly necessary.

The Campaign
Choosing Wisely® is an initiative of the ABIM Foundation to help providers and patients engage in conversations about the overuse of tests and procedures and support efforts to help patients make smart and effective care choices. Recognizing the importance of providers and patients working together, leading health care provider organizations, along with Consumer Reports, have joined Choosing Wisely to help improve the quality and safety of health care in America.

As part of Choosing Wisely, each participating provider organization has created lists of “Things to Question” that provide specific, evidence-based recommendations providers and patients should discuss to help make wise decisions about the most appropriate care based on their individual situation.

The resulting lists are helping stimulate discussion about the need—or lack thereof—for many frequently ordered tests or treatments. Participating organizations and the ABIM Foundation are using these lists to support providers in making wise choices and developing tools to help them have these kinds of conversations with patients.

This concept was originally piloted by the National Physicians Alliance, which through an ABIM Foundation Putting the Charter into Practice grant created a set of three lists of specific steps physicians in internal medicine, family practice and pediatrics could take in their practices to promote the more effective use of health care resources.

Consumer Reports, the nation’s leading independent, non-profit consumer organization, has also joined the campaign to provide resources for consumers and physicians to engage in these important conversations. They are coordinating consumer-oriented organizations to help disseminate information and educate patients on making wise decisions.

Continuing the Professionalism Challenge
Choosing Wisely is part of a multi-year effort of the ABIM Foundation to help physicians and other health care providers be better stewards of finite health care resources. It continues the principles and commitments of promoting justice in the health care system through a fair distribution of resources set forth in Medical Professionalism in the New Millennium: A Physician Charter.

Learn more about Choosing Wisely at www.ChoosingWisely.org.
Health Care Provider Organization Partners

- American Academy of Allergy, Asthma & Immunology
- American Academy of Clinical Toxicology
- American Academy of Dermatology
- American Academy of Family Physicians
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American Academy of Nursing
- American Academy of Ophthalmology
- American Academy of Orthopaedic Surgeons
- American Academy of Otolaryngology-Head and Neck Surgery
- American Academy of Pediatrics
- The American Academy of Physical Medicine and Rehabilitation
- American Association of Blood Banks
- American Association of Neurological Surgeons
- American Association of Neuromuscular & Electrodiagnostic Medicine
- American Association for Pediatric Ophthalmology and Strabismus
- American Association for the Study of Liver Diseases
- American College of Cardiology
- American College of Chest Physicians
- American College of Emergency Physicians
- American College of Medical Genetics and Genomics
- American College of Medical Toxicology
- American College of Obstetricians and Gynecologists
- American College of Occupational and Environmental Medicine
- American College of Physicians
- American College of Preventive Medicine
- American College of Radiology
- American College of Rheumatology
- American College of Surgeons
- American Dental Association
- American Epilepsy Society
- American Gastroenterological Association
- American Geriatrics Society
- American Headache Society
- AMDA – Dedicated to Long Term Care Medicine
- American Medical Society for Sports Medicine
- American Orthopaedic Foot & Ankle Society
- American Physical Therapy Association
- American Psychiatric Association
- American Society of Anesthesiologists
- American Society of Clinical Oncology
- American Society for Clinical Pathology
- American Society of Echocardiography
- American Society of Hematology
- American Society of Nephrology
- American Society of Nuclear Cardiology
- American Society of Plastic Surgeons
- American Society for Radiation Oncology
- American Society for Reproductive Medicine
- American Thoracic Society
- American Urogynecologic Society
- American Urological Association
- Commission on Cancer
- The Endocrine Society
- Heart Rhythm Society
- Infectious Diseases Society of America
- North American Spine Society
- Society for Cardiovascular Angiography and Interventions
- Society of Cardiovascular Computed Tomography
- Society for Cardiovascular Magnetic Resonance
- Society of Critical Care Medicine
- Society of General Internal Medicine
- Society of Gynecologic Oncology
- Society for Healthcare Epidemiology of America
- Society of Hospital Medicine
- Society for Maternal-Fetal Medicine
- Society of Nuclear Medicine and Molecular Imaging
- Society of Thoracic Surgeons
- Society for Vascular Medicine
- Society for Vascular Surgery

Consumer Reports also works with many of the specialty society partners to develop patient-friendly materials from the lists of recommendations and disseminates them to consumers through a network of Choosing Wisely consumer partners. See the full list at www.choosingwisely.org.

About the ABIM Foundation:
The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice. To learn more about the ABIM Foundation, visit www.abimfoundation.org.
Arkansas Health Care Payment Improvement Initiative: 2\textsuperscript{nd} Annual Statewide Tracking Report
January 2016

Executive Summary

Participating Payers:

prepared by:

A nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.
Overview

Statewide, multi-payer implementation of Arkansas’s Health Care Payment Improvement Initiative (AHCPPII) has positioned Arkansas as a national leader in value-based health care innovation. Since the first components were launched in the summer of 2012, AHCPPII has supported and incentivized delivery of high-quality, efficient care for a large and increasing number of the state’s citizens. As a key part of the state’s total health system transformation effort, the AHCPPII has fortified broad goals that include improving quality, expanding access, and avoiding unnecessary costs.

Arkansas was one of only six states awarded an initial State Innovation Model Testing grant by the Centers for Medicare and Medicaid Services, receiving $42 million in federal funds to implement the AHCPPII. AHCPPII now has a strong foothold across the state through deployment of two primary strategies: Patient-centered medical homes (PCMH), designed to improve quality and contain costs by supporting the delivery of better-coordinated, team-based care; and a retrospective episodes of care model, designed to improve quality and reduce variation in treatment of acute conditions and delivery of specialty procedures.

A third component, originally introduced in 2012 by the Arkansas Department of Human Services (DHS) was a Health Home model—a client-based support strategy for individuals with needs exceeding the traditional medical home model. The health home strategy proposed to optimize coordination of services for those individuals, including the frail elderly, the severe and persistently mentally ill, and the developmentally disabled. These populations represent a large proportion of the state’s overall Medicaid expenditure. As a Medicaid-only component of the AHCPII, the model has been met with challenges from both the provider community and other stakeholders and has not been implemented. The state is currently weighing alternative options to improve delivery of high-quality and efficient care to these special needs populations and through their deliberations may choose to pursue components of the Health Home model.

The AHCPPII has the strength of multiple payer engagement with the participation of a majority of the state’s health care payers including Arkansas Medicaid, Blue Cross and Blue Shield (AR BCBS), QualChoice (QC), Centene, and United Healthcare, along with Walmart, the State and Public School Employee benefits program, and other self-funded employers. Support for AHCPPII includes a broader team of individuals at the Arkansas Department of Human Services, Hewlett-Packard, General Dynamics Health Solutions, Arkansas Foundation for Medical Care, Qualis Health, and the Advanced Health Information Network, among others.

As a result of continued progress and demonstrated success, additional payers have shown interest in joining the AHCPPII. Importantly, leaders at the Center for Medicare & Medicaid Innovation (CMMI) have acknowledged the success of Arkansas’s model and approached the state regarding expanding the program to include federal support for the approximately 71,000 Medicare beneficiaries in the state’s PCMH program. As additional practices enroll, more of the state’s 400,000 Medicare Part A and B beneficiaries could be served in a PCMH. CMMI has committed to assisting the state in exploring this opportunity—one that, if successful, would make Arkansas only the second state in the nation (behind Maryland) to receive a Federal Medicare waiver for a state-specific, value-based model.

AHCPPII progress as well as quality and cost impacts are captured in the second annual AHCPPII Statewide Tracking Report. The Arkansas Center for Health Improvement (ACHI) has worked with individual payers and providers to gather content for development of this report, designed to track progress and to help identify challenges and lessons learned.

Patient-Centered Medical Homes (PCMH)

This multi-payer, team-based primary care strategy has received legislative support and been adopted widely by providers across the state. Primary care clinics are given responsibility for total cost of care for their panel of patients and receive upside gain-sharing if they meet quality metrics and bring total costs under preset thresholds. Provider

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b Medicaid PCMH data provided by Arkansas DHS, pulled from PCMH Q4 reporting as of December 10, 2014. Enrollment figures include practices that enrolled for 1/1/14, 7/1/14 and 1/1/15 start dates. Commercial carrier data provided by individual carriers.
Arkansas Health Care Payment Improvement Initiative  
Statewide Tracking Report, January 2016

enrollment in the program is voluntary. The Medicaid PCMH results depicted in this report are for beneficiaries that are managed by Arkansas Medicaid and do not include results for those beneficiaries who are covered under a commercial qualified health plan (QHP). Results from the QHP beneficiary PCMH experience are anticipated to be available for inclusion in the next annual Statewide Tracking Report.

**PCMH Highlights**

- Medicaid has more than 80 percent of its beneficiaries under this model.

- In 2014, Medicaid realized $34.3 million in direct cost-avoidance through trend reduction. Of the $34.3 million in savings, $12.1 million went toward care coordination payments to providers. The remaining $22.2 million in net cost avoidance was shared between the state and those providers who met both quality and cost savings requirements. Shared savings checks were issued in October 2015, with several clinics receiving over $100,000.

- In 2014, enrolled practices experienced a cost decrease of 1.2 percent, beating both the 2.6 percent benchmark trend increase and the 0.6 percent cost growth of non-participating practices.

- In 2014, the vast majority of practices met transformation milestones and either improved or maintained prior-year levels for 78 percent of PCMH quality metrics. Quality metrics include: increased pediatric wellness visits, Hemoglobin A1c testing, breast cancer screenings, improved Attention Deficit Hyperactive Disorder (ADHD) management, and thyroid medication management.
• AR BCBS has recognized value and extended attribution of patients to all of its covered lives; AR BCBS has publicly stated intent to increase payment to primary care through markedly increased per-member per-month (PMPM) payments and hold/reduce fee-for-service (FFS) payments for services rendered over time.

• The federal Medicare program has approached the state to expand their participation to all Medicare beneficiaries (participation is currently limited to the original 69 clinics in the Comprehensive Primary Care Initiative). Arkansas would be only the second state for which Medicare has modified national payment strategies to support local payment transformation.

• Qualified health plans operating on the insurance exchange and dual-specialized needs managed care plans are required to participate in the state PCMH program by either legislative or regulatory requirements.

• Performance target requirements for a proportion of hypertensive and diabetic individuals under clinical control are proposed to explicitly link population health needs and clinical performance expectations.

Enrollment for Arkansas Medicaid (as of October 2015):

- 136 practices are participating out of 263 eligible (52%). For 2016, Medicaid will continue recruitment of new practice participants as will both AR BCBS and Ambetter.
- 780 primary care providers are participating (69% of eligible Medicaid providers)
- 331,000 eligible Medicaid beneficiaries are covered under the state PCMH program (82%)

Enrollment for Commercial Carriers: (PCMH beneficiary attribution is still underway for the commercial carriers. These are estimates for the number of attributed beneficiaries for each payer)

- AR BCBS: 157,000 attributed beneficiaries
- QC: 4,300 attributed beneficiaries
- Centene / Ambetter: 44,000 eligible beneficiaries (final attribution numbers pending)
- United Healthcare: United is offering a QHP and will attribute members in 2016

Enrollment for Self-Insured Payers:

Self-insured payers are also participating in the program, with an anticipated increase in 2016 and beyond. Two of the largest self-insured participants are Walmart and Arkansas State Employee and Public School Employee (ASEPSE) Plans, each with substantial numbers of employees served under a PCMH:

- Walmart: ~21,000 beneficiaries
- Arkansas State Employees and Public School Employees: ~30,000 beneficiaries

Retrospective Episodes of Care

This model to improve quality and efficiency and eliminate variation has achieved both quality enhancement and cost-saving goals. Since 2013 there have been 14 types of episodes launched with new episode development focused primarily in the areas of surgical intervention and hospitalization management. While employers, consumers, and the state strive to optimize the value of their health care expenditures, Arkansas’s episodes of care model puts the clinical leader in charge and aligns incentives to achieve the highest quality at the lowest cost.

In an ongoing coordinated effort that includes close involvement with providers and other stakeholders, Arkansas Medicaid, AR BCBS, and QC all participate in the episodes model. Providers benefit from consistent incentives and reporting tools across payers. Together these payers cover a majority of Arkansas citizens, generating enough scale to promote change in practice patterns.

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Data provided by QualChoice in October 2015.
Medicaid has achieved quality improvements and cost avoidance\(^d\)

- **Perinatal**: C-section rate reduced from 39 percent to 34 percent, with an estimated 2-4 percent direct savings to date.
- **URI**: 17 percent reduction in antibiotic prescriptions; episode costs remained flat despite a 10 percent increase in drug prices.
- **ADHD**: Average episode cost fell by 22 percent, with 400 providers contacted by Medicaid regarding appropriate stimulant prescribing.
- **Total Joint Replacement**: Number of episodes down from 141 to 101; 30-day all-cause readmission rate reduced from 3.9 percent to 0 percent; estimated 5-10 percent direct savings to date.
- The most recent gain and risk sharing calculations from finalized episodes resulted in 648 providers receiving gain-share payments totaling $642,200 and 605 providers deemed eligible for risk sharing totaling $710,034.

### Episodes of Care: Reducing Cost

<table>
<thead>
<tr>
<th>Episode Type</th>
<th>Reduction in Costs</th>
<th>Providers Receiving Gain-Share Payments</th>
<th>Risk Sharing Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>1.5%</td>
<td>648</td>
<td>$642,200</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>10.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal</td>
<td>1.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AR BCBS reported that this year they will pay out nearly $1.3 million in shared savings with approximately $250K being recovered in the form of risk-sharing payments.

Following Arkansas’s lead, Medicare has now implemented its own version of mandatory episodes for hip and knee replacement in 50 market areas nationally —inclusive of Hot Springs and Memphis\(^e\).

\(^d\) Data provided by Arkansas DHS/Medicaid. Information was presented by Arkansas Medicaid Director Dawn Stehle to the Arkansas Legislative Health Care Task Force on July 16\(^{th}\), 2015.

\(^e\) [https://innovation.cms.gov/initiatives/cjr](https://innovation.cms.gov/initiatives/cjr)
Implementation of Episodes for Specialty, Surgical and Hospital Care

- Additional episodes of care were launched by AR BCBS in January 2015, including Percutaneous Coronary Intervention (PCI), Coronary Artery Bypass Grafting (CABG), Asthma, and Chronic Obstructive Pulmonary Disease (COPD).
- Medicaid and AR BCBS are considering potential development of additional episodes including appendectomy, pediatric pneumonia, hysterectomy, and urinary tract infection (when an ER visit is involved). AR BCBS is also reviewing tympanostomy (ear tube procedure) for possible episode development.
- Experience from episode analysis is aiding in the creation of chronic disease profiles, which can be used by PCMHs in coordinating care for high risk patients as they pursue per member, per year cost curve management.

System Infrastructure Development

The episode and PCMH models would not be possible without development of an advanced analytic infrastructure allowing participating payers to process large amounts of data. This analytic capability has been developed including a multi-payer portal on a common platform, enabling production of quarterly reports to providers. These new tools detail utilization and quality indicators to support better decision making and improved clinical outcomes. A large and increasing number of providers have accessed their reports:

- Approximately 500 million medical claims have been processed through the analytic engines for both episodes and PCMH. For episodes, those claims resulted in over 3.78 million episodes.
- As of October 2015, for episodes 31,781 reports were delivered to 2,252 distinct principal accountable providers (PAP).  
  - Through September 2015, for PCMHs 1,918 reports have been provided to practices.

Conclusion

Today, the state’s Medicaid growth rate is relatively flat, the PCMH program has demonstrated quality improvements and system savings, private payers have reported quality improvements and cost avoidance in episodes of care, and providers and patients are benefitting from practice support and improvements in quality of care. While results are encouraging, early challenges have helped identify opportunities to improve the AHCPII. Continued engagement and input from providers, patients, state leaders, and others is necessary to sustain progress of this initiative.

Acknowledgements

The staff at ACHI appreciate the opportunity to work with individuals leading the implementation of the Arkansas Health Care Payment Improvement Initiative. The production of this report would not have been possible without the efforts of:

The Arkansas Department of Human Services, Division of Medical Services staff including Lee Clark, Sharon Donovan, William Golden, MD, Kiral Gunter, Brandi Hinkle, Lech Matuszewski, Maggie Newton, Sheila Nix, Anne Santifer, Dawn Stehle, Shelley Tounzen, David Walker, Michelle Young-Hobbs and other members of the Arkansas Medicaid team.

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Arkansas Blue Cross and Blue Shield Staff including Alicia Berkemeyer, Matt Flora, David Greenwood, Randal Hundley, MD, Steve Spaulding, and Sarah Wang among others.

QualChoice staff including Mark Johnson, Lubna Maruf, MD, and Stephen Sorsby, MD.

ACHI staff including Michael Motley, Debra Pate, Leah Ramirez, and Joseph W. Thompson, MD, MPH.

This report was made possible in part by grant funding from Walmart.

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1 Reporting totals provided by Arkansas DHS, October 2015
A National Preventive Healthcare Practice
Identify  Engage  Connect

Delivering Preventive Care at the Worksite
CONVENIENT
30-40 minute checkups performed at the worksite in just one visit, labs processed onsite in real time

EFFICIENT
Each checkup includes diagnostic blood tests, medical history, physical measurements & clinical consultation with a board certified Nurse Practitioner

COST EFFECTIVE
A clinical preventive checkup at about half the cost ($130) of brick and mortar checkups ($200-300)

HIGHLY IMPACTFUL
Cohort studies show greatly reduced health risks for Diabetes, Hypertension & Heart Disease

Catapult delivers Preventive Checkups at worksites across the country
Catapult maximizes impact of other healthcare investments

COORDINATION OF CARE
Results and gaps in care sent immediately to patient’s PCP. Patients without a PCP are assisted in finding one.

REFERRALS
Patients who are eligible for health management programs are referred directly into those programs at record numbers.

REPORTING
Aggregate, de-identified Population Health and Cohort Comparison Reports deliver key metrics at State and agency levels.
Catapult is an Arkansas BlueCross BlueShield Provider, not a wellness vendor

Catapult is already a covered benefit for State of Arkansas BCBS plan members

All-inclusive fee paid as a medical claim through Arkansas BlueCross BlueShield

No implementation fees, no administrative fees, no travel fees, no recurring monthly fees

8 MD Medical Directors

200+ licensed & board certified Nurse Practitioners
Catapult specializes in serving state, school and municipal employees

**State of Louisiana - Office of Group Benefits**
3-year relationship, 135,000 plan members, terrific partnership!

**State of Mississippi**
New relationship, 180,000 plan members, launching with agencies / schools / universities

**Schools**
Dozens of secondary schools and colleges served

**Municipalities**
28 cities and counties served
Catapult Health
Examples of Public Sector Clients
Why Catapult?

- Convenient, efficient, cost effective alternative for State of Arkansas plan members
- Does not require time off work for blood tests at local lab, or for a physician office visit
- Catapult will hire and train local clinical staff … we’ll bring jobs to Arkansas
- Proven clinical results – a recent Clinical White Paper documented remarkable health improvements sustained over 4 years
# What’s Included in a Catapult Checkup?

**Values Measured**  
Lab-accurate measurements in less than 15 minutes

- GLU
- TRIG
- CHOL
- HDL
- LDL
- VLDL
- AST
- ALT
- A1C for diabetics
- Blood Pressure
- Height
- Weight
- BMI
- Waist Cir.
- Calculated Framingham Risk

**Personal Health History**  
Reviewed by the Nurse Practitioner during consultation

- Allergies
- Asthma
- Cancer
- Coronary Artery Disease
- Diabetes
- Heart Failure
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Kidney Disease
- Obstructive Sleep Apnea
- Stroke

**Family History**  
Reviewed by the Nurse Practitioner during consultation

- Diabetes
- Coronary Artery Disease
- Stroke
- Breast Cancer
- Colon Cancer

**Medications**  
Reviewed by the Nurse Practitioner during consultation

- Compliance
- Effectiveness Review
- Potential Reactions among Multiple Meds
- Generic Options
**What’s Included in a Catapult Checkup? (page 2)**

### Cancer Screening Evaluated
*Reviewed by the Nurse Practitioner during consultation*
- Breast Exam
- Colorectal Screening
- Pap Smear

### Vaccines Administered
*Optional service available by request*
- Influenza (seasonal)
- Tdap (Tetanus, Diphtheria, Pertussis [Whooping Cough])

### Personal Action Plan
*Developed with the Catapult Board Certified Nurse Practitioner*

### Symptoms Captured
*Reviewed by the Nurse Practitioner during consultation*
- Aches from Medication Reactions
- Bladder Infections
- Chest Pain
- Circulation Problems
- Foot Ulcers
- Gum Infections
- Pain While Walking
- Seizures
- Shortness of Breath
- Skin Infections
- Sleeping Problems
- Slow Healing Wounds
- Swelling of Hands or Legs

### Care Compliance and Gaps in Care Identified
*Reviewed by the Nurse Practitioner during consultation*
- Asthma
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Diabetes
- Hypertension

### Personal Results Delivered in Real Time
- Secure Patient Portal (responsive design)
- Apple Health Card
- NP Audio Recording of Checkup Summary
NEW Catapult Findings

108,071 first-time Catapult checkups resulted in the following NEW assessments

<table>
<thead>
<tr>
<th>RISK CATEGORY</th>
<th>NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-hypertension</td>
<td>35,958</td>
<td>33%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>5,268</td>
<td>5%</td>
</tr>
<tr>
<td>Severe hypertension</td>
<td>1,095</td>
<td>1%</td>
</tr>
<tr>
<td>Pre-Diabetes</td>
<td>18,749</td>
<td>17%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1,300</td>
<td>1%</td>
</tr>
<tr>
<td>Lipid Disorder</td>
<td>24,099</td>
<td>22%</td>
</tr>
</tbody>
</table>
Improvement in Blood Pressure

66% Overall Improvement (4 year cohort)

Year 1: Stage I - 22.1%, Stage II - 6.5%
Year 2: Stage I - 11.9%, Stage II - 2.3%
Year 3: Stage I - 10.0%, Stage II - 1.6%
Year 4: Stage I - 9.1%, Stage II - 1.5%

Overall Improvement: 66% (4 year cohort)
Improvement in Medication Compliance

56% Overall Improvement (4 year cohort)

Year 1: 23.0%
Year 2: 26.3%
Year 3: 28.6%
Year 4: 35.9%

Overall Improvement: 35.9%
Improvement in Metabolic Syndrome

22% Overall Improvement (4 year cohort)

Year 1: 33.5%
Year 2: 31.7%
Year 3: 29.8%
Year 4: 26.1%
5 Year Diabetes Trend per 1,000 patients for Employers With Catapult

This analysis is based on the annual trend (1.0202) of a Catapult cohort group (n=27,744) and the CDC trend (1.0466) from 2008-2013. This graph displays the number of patients per 1,000 who are expected to develop diabetes over the next 5 years at the CDC national trend (black line) compared to actual Catapult Health 4-year cohort patient data (red line).
Catapult’s Customer Satisfaction

Net Promoter Scores of Leading Brands - 2015

-8 22 38 62 63 66

Patients love Catapult more than their iPhones!
Summary

For about half the cost of brick-and-mortar checkups, and in just 30-40 minutes at worksites across Arkansas, employees are:

- **Tested**
  with a NASA-developed blood analyzer

- **Assessed**
  by a licensed Nurse Practitioner

- **Engaged**
  action plan delivered on-the-spot

- **Connected**
  to their PCP, or to a local practice that is accepting new patients

- **Enrolled**
  in the appropriate care management or lifestyle management programs
With Catapult, everyone wins...

State & School Employees  ARBenefits  Local Healthcare Providers
Empowering Individuals to Improve their Health
Better together
Strategic Partner

• Evidence-based health and well-being solutions, with proven benefits in quality improvement and cost savings to **over 23 million individuals**

• **Broad, national customer base** includes State, public sector, self-funded employers, health plans, health systems, TPAs, IPAs, CINs and ACOs

• **Unparalleled analytic power - 160+ data experts**, supporting over 1,500 data formats (clinical, financial & administrative) from nearly 300 data suppliers (including 45 payers)

• **Patented CareEngine®** - developed by physicians, for physicians - foundation of our services, providing actionable clinical analytics and decision support

• **Regional model** with Chicago office supporting EBD with onsite liaison in Little Rock, AR
Differentiators

CARE ENGINE INTELLIGENCE PLATFORM
Personalized insights and analytics drive more meaningful engagement and relevant care management

DATA SYNCHRONIZATION
Real time data, expanded sources and types—and ability to ingest big data

ENHANCED ANALYTICS
Deeper insights, refreshed monthly with more predictive models

INTELLIGENT OUTREACH
Precise, personalized and integrated messaging, based on member segments and insights

ENGAGEMENT
Multi-modalities (with preference), integrated and aligned content leveraging motivational interviewing engagement framework

REPORTING
Clear demonstration of impact and value, each step of the way
Driving Healthy Behaviors

Wellness Overview
Our philosophy on behavior change

While there are many aspects to behavior change (with many theories), we **embrace** and **focus on three proven practices**:

- **Building a strong “why”**
  Our approach is rooted in the principles of “self-determination theory” and enables us to help people, based on their personal path.

- **Creating a precise, personalized “how”**
  We use a variety of cognitive and behavioral techniques across all our services.

- **Leveraging nudges to keep people motivated**
  We help get individuals to the party (helps motivate the “why” and “how”) and then stimulate the ongoing actions (selectively and strategically) **Motivational interviewing** techniques are **integrated across our programs**, modalities of **outreach** and **communications**.

---

20 to 50% increase in engagement shown with MI at no added cost¹
Engagement options from high-touch to high-tech

We understand the need to augment traditional care management models with technologies that meet people where they are:

- **One-on-one support** services focus on high opportunities.
- While our **online group meetings** focuses on moderate risk.
- And **digital coaching** targets individuals with the lowest risk.
- **Onsite services** are also available using the same, deep clinical expertise available in all of our care management offerings.
It works better...together

Taking wellness further with the MyActiveHealth personalized engagement platform

Total interconnectivity:

- Comprehensive health data capture, with deep analysis
- Precise, evidence-based health action messaging
- Digital coaching and other health support
- Integrated incentives/rewards

CareEngine delivers insights and recommended actions via MyActiveHealth as Health Actions

We reward for information and behaviors – tracked within the fully integrated Rewards Center

Health Actions drive to engagement in programs, such as digital coaching (or group coaching or 1:1); MAH provides other resources and information

Information/data capture (health assessment, tracking, etc.) from mobile, event or device drives personalized insights (CareEngine)
2015 Executive Summary Report

26,426
Events Conducted in 2015

99.5% Participant Satisfaction Rating
98.9% Health Professional Attendance
99.8% Quality, Error-Free Rating
<24 HR Speed of Results Delivery

Highest quality and consistency
• Credentialed network of 10k+ Health Professionals with training on client-specific requirements
• Event Management System℠ allows us to manage your events end to end: planning, staffing, training, event execution and reporting

Superior data access and personalized engagement
• Tablet technology automates onsite paperless applications and delivers quality, consistency, and fast data transmission
• Industry leading accuracy and turnaround time of biometrics and lab data
• On-site health consultation will be tailored to drive engagement into ActiveHealth wellness and disease management

Flexible screening solution
• Maximum compliance with legal, clinical and regulatory requirements
• Walk-in labs, physicians forms, individual screenings and more
Well-being coaches with extensive experience

**Natalie**
- MPH in Health Behavioral Health Education from Univ of Michigan
- ACSM Certified WellCoach & Personal Trainer
- Tobacco Dependence Treatment Specialist trained at UMDNJ

**Gabe**
- MS in Nutrition with focus in clinical dietetics
- Certified Strength & Condition Specialist (CSCS)
- BS in Exercise Science
- Performance nutrition expert

**Sonja**
- MS in Health Education
- ACSM Certified WellCoach
- ACE Exercise Certified
- Author, *Live Your Ideal Life Now*

**Communications model**

**Motivational and clinical support**
- Registered nurses
- Licensed practical nurses (LPN)
- Registered dietitians
- Nutritionists
- Exercise physiologists
- Licensed counselors

**Specialty – focused advanced training**
- Health coaching
- Tobacco cessation
- Personal training
- Weight management
- Stress management
- Diabetic educator
- Oncology specialists
- Maternity specialists

Average of 18 years of coaching experience in health & wellness
Best Practice Impact
Onsite program statistics

Beginning in mid 2014, Mississippi began offering an option for members to participate in their weight management program via Onsite Wellness Presentations provided by the ActiveHealth Onsite Wellness Team.

<table>
<thead>
<tr>
<th>Onsite Statistics</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Presentations</td>
<td>564</td>
</tr>
<tr>
<td>Participants</td>
<td>5,428</td>
</tr>
<tr>
<td>Webinar Participants</td>
<td>1,082</td>
</tr>
<tr>
<td>Number of Surveys</td>
<td>1,025</td>
</tr>
<tr>
<td>Positive Responses</td>
<td>99%</td>
</tr>
</tbody>
</table>
Onsite program statistics

Beginning in late March, PEEHIP began offering a third option for members to complete their coaching requirements through Onsite Wellness Presentations provided by the ActiveHealth Onsite Wellness Team.

### Onsite Statistics – Completed

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Total Presentations</td>
<td>128</td>
</tr>
<tr>
<td>Unique Sites</td>
<td>161</td>
</tr>
<tr>
<td>Participants</td>
<td>4,883</td>
</tr>
<tr>
<td>Number of Surveys</td>
<td>681</td>
</tr>
<tr>
<td>Positive Responses</td>
<td>99.6%</td>
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</tbody>
</table>

### Onsite Statistics – Year 2

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Presentation/Wellness Booths</td>
<td>215</td>
</tr>
<tr>
<td>Unique Sites</td>
<td>172</td>
</tr>
</tbody>
</table>

The team has a full schedule up to the incentive deadline!
North Carolina State Health Plan

Consistently exceeding expectations...

88% Engagement Rate in 2015

94% Satisfaction Rate

5 out of 6 Clinical measures improved since 2015

>$473M in savings (2011-2014)

Expanding Solutions

Added in 2015: PCMH Practice Support Pilot, ESRD/CKD CM, MAPCP members, Transition of Care + packet, Medication Therapy Management
Implementation

99% Satisfaction
Implementation strategy

The six-phased approach

**PHASE 1**
Discovery
Product confirmation, contract, project team, kick-off meeting, project plan, vendors, communication strategy

**PHASE 2**
Data Acquisition & Connectivity
Data sources, file requirements, transmission protocols, establish connectivity, NDA’s

**PHASE 3**
Data Reviewed & Program Set-up
Format and analyze data, confirm file transfer process, finalize account structure, perform application set-up and configuration, finalize workflows and transition process

**PHASE 4**
Training & Testing
Test data and application configuration, approvals on product letters, finalize staffing, training, space and equipment, telephony set-up, load data

**PHASE 5**
Initiate Production
Process production files, load data to applications, activate clinical and customer service, activate telephony, begin communications, begin telephonic outreach

**PHASE 6**
Post Implementation
Monitor success, evaluate program output, monitor feedback, re-define role and responsibilities, close out implementation, transition to account manager

Go-Live 7/1/17

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Why partner with us?

**Total health management: infrastructure and execution**

- Proven flexibility, experience, patented technology, and savings working with States.
- Strategic partnership focus, throughout all phases, driving results across the health continuum.
- Single vendor implementation and communication strategy; leveraging multiple user friendly, tailored, engaging modalities.
- Providing engaging and effective well-being programs and follow-up services.
- Award winning, customized, engaging and secure web-portal/app including a dynamic health risk assessment and intuitive personalized health actions.
- One expert experienced vendor managing data ingest, integrated care management, positive health outcomes, incentive tracking, reporting and fulfillment, biometric screening and lowering medical spend.

**Integrated and actionable reporting**
Questions and Next Steps