KEY ISSUES SHAPING THE MARKET FOR COMPLEX CONSUMERS:

A Health Plan Perspective On What Executives Need To Know To Succeed

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OBJECTIVES

1. Discuss change drivers and market disruptors that are shaping the health and human service market

2. Understand how Cigna is working with provider organizations to manage chronic conditions and support consumers with complex needs:
   › Value-based care
   › Partnership with health care providers
   › Management of chronic disease
CHANGE DRIVERS

Less time today....
- Average working hours up by ~180 hours since ‘79

...leading to frustration
- ~18.5 days to schedule a PCP appointment
- ~20 minutes waiting room time in metro areas
- ~80% of patients would consider alternative site of care for minor health services

Expect digital connectivity...
- ~6 hours/day spent online, up from ~3.2 hours in ‘10
- ~44% of consumers prefer online payments
- ~80% of consumers willing to engage in digital health services, but only 23% do today

...and a higher level of personalization
- 82% of consumers believe more customized plans would improve the health system

Inefficient use of high-cost care sites
- ~$38B in wasteful spending from ER overuse
- ~35% of pediatric ER visits only provide reassurance to overly worried parents

...even as the cost of these sites continues to grow
- Average spend per capita for an outpatient visit grew ~7% p.a. from 2009-2013, outpacing inflation

Growing role of the consumer
- ~19M Americans purchase health care entirely on their own as a result of the ACA

Greater access...
- ~17M more consumers have insurance today v. 2010 (growth largely driven by Medicaid)
  - Uninsured population to decrease ~50% by 2023

...but there is a growing shortage of PCPs
- Estimated shortage of 22K PCPs by 2020
- 77% of rural U.S. counties are designated health professional shortage areas
MARKET DISRUPTERS

New Healthcare delivery models

- Robust primary care capabilities
- Control over specialty referral chain
- Propensity to refer to non-hospital settings
- Ability to refer to high value hospitals
CUSTOMER VALUE: MEASURES THAT MATTER

Customer Satisfaction

Affordability/ Financial
- Premium/out of pocket
- Sufficient coverage
- Cost transparency & predictability

Measurements….
- How often are people renewing and staying with us when they have a choice
- Customer lifetime value

Ease of Use
- Confidence in Choosing a plan
- Ease in understanding plan & coverage
- Quality of information
- Clear and relevant communication
- Reduced effort in the customer’s healthcare journey
- Healthcare guidance
- Easy access to care
- Insurer Empathy
- Insurer Proactivity

Measurements….
- Customer effort score

Quality Care
- Network – Breadth & preferred provider availability.
- Provider access (wait time, location)
- Objective provider measures (e.g., credentials, care outcome, etc.)
- Customer reported provider measures (bedside manner, proactivity, empathy, etc.)
- Measures which are leading indicators to health outcomes

“Make it easier for customers to get affordable quality care”

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What are clients willing to pay for, and/or help us make the right decisions around where to focus?
WHAT IS CIGNA COLLABORATIVE CARE®?
Since **2008**, Cigna has been an industry leader in the development and implementation of value-based relationships with physician groups with the following goals in mind:

› Improving quality
› Lowering medical costs
› Improving customer health and satisfaction

Cigna Collaborative Care (CCC) programs give primary care provider (PCP) groups, hospitals, and specialty physician groups opportunities to earn incentive rewards based on how **efficiently** and **effectively** they deliver health care to Cigna customers.
COLLABORATIVE ACCOUNTABLE CARE (CAC)

This program, which began in June 2008, is the most established CCC program, with over 200 contracted groups. It is a primary care-based population health program focused on managing total medical cost (TMC) and quality outcomes for the customers aligned to the participating provider group. Cigna offers a variety of CAC programs, giving us flexibility to meet providers where they are in their value-based journey.

**Goals**

- Improve the medical cost of the aligned population compared to care managed by non-CAC providers in the market.
- Support and incentivize high-quality and effective health care.
- Support the delivery of care that meets or exceeds customers’ expectations for service.
- Improve provider satisfaction.

**How is this accomplished?**

- Delivery of actionable, timely information
- Clinical consultation
- Support of care coordination
- Best practice sharing
- Formal education opportunities
- Appropriately designed financial incentives

**How is success measured?**

By tracking improvements in TMCs, true reductions in care consumption, and improvements in quality of care. For example:

- Reducing emergency department usage
- Making improvements in preventive care screenings and well-child visits
HOW IS COLLABORATIVE CARE DIFFERENT?

Traditional care

- Limited information and a cumbersome process; can create frustration and fragmented care

  - “Sick” care = health risks not addressed early or handled separately
  - PCP has limited customer information and support = nobody coordinating care
  - Misaligned financial incentives = unsustainable rising costs
  - Limited collaboration with other providers = limited ability to share and learn best practices
  - Payer not seen as a clinical partner or resource = missed opportunities for cost and quality improvement

Collaborative care

- The right connections and support; enables total population management

  - Actionable, patient-specific information = see and address health risks sooner (well care)
  - Embedded Care Coordinators = help coordinate care and use of available programs to improve whole health
  - Value-based reimbursement model = aligned incentives reward when care quality and costs improve
  - Learning collaborative meetings = share best practices and learn from one another
  - Consultative clinical resources = identify opportunities to improve quality and medical costs, and drive better health outcomes
Goal: To have the majority of customers with high-cost conditions or complex needs cared for by health care providers in a value-based arrangement with Cigna.

Our innovative solutions span the delivery system

- **PRIMARY CARE**: 20 percent of medical spend happens here*
- **SPECIALISTS**: 70 percent of medical spend happens here*
- **HOSPITALS**: 10 percent of medical spend happens in the emergency room*

WHO BENEFITS FROM CIGNA COLLABORATIVE CARE®?

**Providers**
- Earn financial reward for delivering higher value care
- Receive patient-specific reports from Cigna, helping them to focus on their patients with the most needs
- Attend learning collaborative sessions, where they hear more about Cigna’s programs and share best practices
- Have access to clinical resources and programs

**Customers**
- Receive the right support and care at the right time
- Have ongoing care coordination and use of available programs, leading to overall health improvement
- Get support in navigating chronic conditions, leading to improved treatment compliance

**Employer groups**
- Benefit from lower health plan spend
- Have healthier employees
- See greater productivity

**Cigna**
- Collaborates with key providers in the community
- Drives positive change in the health care system
- Directly affects the “triple aim” of improving quality, reducing costs, and increasing customer satisfaction
NATIONAL OPIOID EPIDEMIC: CIGNA’S RESPONSE
CIGNA’S COMMITMENT TO HELP CURB THE OPIOID EPIDEMIC

In collaboration with 1.1 million prescribing clinicians, Cigna reduced prescription opioid use by 25%.

Despite this reduction, opioid overdoses continue to rise. Increase in opioid-related deaths by 345%.

NEW GOAL
Reduce customer overdose by 25% by 2021.

Areas of Focus

Public Policy

The Community

Health Care Providers

Customers and Clients


3. Initial focus will be on the following targeted U.S. communities where a sizable number of Cigna commercial customers reside and where there are higher incidences of overdose. These include: Connecticut, Maryland, New Jersey, Virginia, Chicago, New York City, Philadelphia, Washington, DC.
OPIOID EPIDEMIC

- PREVENTION
- TREATMENT
- RECOVERY

Cigna Health Matters® Program – Behavioral Project

Substance Use Coaching Program

Pharmacy Benefit Oversight

Resources for health care providers

Designated substance use treatment facilities

Identify those at risk through our narcotics therapy Management program

Strengthen prior authorizations and quantity limits to ensure clinical appropriateness and safety

Provide increased access to substance use disorder (detox) drugs and to cost-effective overdose reversal agents
Articles and tools to help health care providers manage chronic opioid usage including:

- patient self-assessments
- education on safe and effective prescribing
- a link to our behavioral health resources
TAKE THE PLEDGE...

to improve the quality of care for those in pain, receiving opioids, or suffering from an opioid use disorder

We, ______________________, representing 1,000 health care professionals, commit to:

- Encouraging prescribers to individually sign the Surgeon General’s “Turn the Tide” pledge (Turnthetiderx.org):
  - Educate ourselves to treat pain safely and effectively
  - Screen our patients for opioid use disorder and provide or connect them with evidence based treatment
  - Talk about and treat addiction as a chronic illness, not a moral failing
- Taking steps to improve the quality and coordination of care for patients receiving opioids.
- Reducing potentially avoidable opioid prescriptions when alternative therapies are available.

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Practice representative signature

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Print name

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What’s inside:

- **Understand** CDC guidelines
- **Educate** patients on risks, benefits and alternatives to opioid treatment
- **Screen** for behavioral concerns prior to an initial script
- **Check** the PDMP prior to an initial script
- **Establish** a pain management contract for the primary care setting
- Know local resources
  - Pain management
  - OUD treatment
  - Cognitive behavioral therapy
  - Medication assisted therapy
- **Review** Narcan availability
COMPREHENSIVE PAIN MANAGEMENT PROGRAM

PURPOSE:
Provide PCPs with evidence based workflows, clinical tools and collaborative provider partners (Pain Specialists, Mechanical Therapy and Behavioral) to more efficiently and effectively manage patients with low back pain.

CLINICAL RESOURCE GUIDE INCLUDES:

- Evidenced Based Low Back Pain Treatment Guidelines & Objectives
- Validated Assessment Tools (e.g. Oswestry, VAS/Pain Scales, PHQ 4 or 9, GAD 7, CAGE AID, Opioid Risk Tool)
- Pain Management (medication based) Protocol for LBP (based on clinical phase)
- When to Refer to Pain Specialist
- Safe Opioid Prescribing Guidelines
- Care Coordination & Referral Guide
- PCP Treatment Summary & Educational Resources
- Healthwise Back Pain Educational Materials and Exercise Guide

PROGRAM PREPARATIONS:
- Shared Materials
- Self-Serve Delivery
- Full Serve Operational Execution
Facilities in Cigna’s behavioral network that have earned a top ranking for patient outcomes and cost-efficiency, based on Cigna measures.
• Provide one-on-one coaching and education for customers with chronic pain or addiction to facilitate access to appropriate treatment
• Arrange services and support for entire family, and collaboration between inpatient and outpatient
• Support engagement in outpatient treatment
COLLABORATION WITH THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)

Provide ASAM with two years of claims data

Used to “test and validate” what’s worked (and not) in substance use prescribing

Used to develop guidelines for treatment and prevention

Provide guidelines to Cigna Collaborative Care doctors – incentives will shift from volume to value, rewarding for using proven therapies to improve patient outcomes

Reward health care providers for using proven therapies
Shatterproof™ is a national nonprofit organization dedicated to ending the devastation that addiction causes families.

Goals

The ultimate goal is to end addiction.

Over the next 20 years we will focus on three specific, measurable goals:

• Reduce by 50% the number of Americans addicted to alcohol and other drugs.

• Reduce by 50% the number of Americans who die from alcohol and other drugs

• Reduce by 50% the societal cost of alcohol and other drugs
BEHAVIORAL HEALTH INTEGRATION
COLLABORATIVE CARE MODEL
CORE PRINCIPLES

- **Patient-centered team care**
  Primary care and behavioral health providers collaborate effectively using shared care plans.

- **Population-based care**
  The care team shares a defined group of patients tracked in a registry to ensure no one “falls through the cracks.” Practices track and reach out to patients who are not improving.

- **Measurement-based treatment to target**
  Each patient’s treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved.

- **Evidence-based care**
  Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.
BEHAVIORAL HEALTH INTEGRATION

Integrated care promotes improved quality outcomes and more affordable costs. That’s good for individuals, their families, and the health care system.

- Behavioral conditions cost more than any other medical condition: $201 billion in 2013. This demonstrates the need for behavioral health to be a part of a holistic medical care plan – particularly in light of direct or indirect behavioral complaints in the medical setting.

- Medical costs are two to three times higher for those who have chronic medical conditions that are comorbid with unmanaged mental health and substance use disorders (MH/SUDs) than for those who don’t have comorbid conditions, or for those whose care is well managed. This is largely attributable to an increase in medical services.

- For example, the medical cost for a customer with diabetes and a comorbid behavioral health concern may be between $67-$325 per member per month more.

- By integrating behavioral health care into the medical practice setting, an estimated 9-16 percent of the increased spend may be saved.

Sources:
- Health Affairs, Datawatch, June 2016.
- Cigna business intelligence.
TRENDS AND FORCES

Awareness of behavioral health concerns, and impact to holistic health, continues to increase as a required element of a population health strategy.

- **Patient need**
  - 44 million adults struggle with a behavioral health concern

- **Provider engagement**
  - Pressure on existing workforce – capacity and competencies

- **Cost trends**
  - Patients with a behavioral concern cost 2–3 times more

- **Operational requirements**
  - Clinical and reimbursement models promoting holistic care
Mary is a Cigna customer with diabetes and depression.

**Primary Care Physician**
- Unable to improve diabetes status and medication adherence
- Unaware patient has prior diagnosis of depression
- Aware the patient needs additional support but doesn’t have resources to assist

**Behavioral Provider**
- Unable to engage patient in ongoing treatment

**Cigna Behavioral Case Manager**
- Unable to engage customers, despite outreach attempts, after an integration referral
- Aware of behavioral history and sees opportunity for engagement

**Cigna Medical Case Manager**
- Able to talk with Embedded Care Coordinator about patient
- Aware of Cigna outreaches based on risk score

**Others – Specialists, Pharmacists, Disability Coordinator, etc.**
- Supporting patient with various needs and health concerns
- Unaware of the big picture

**Key Concerns**
- Disjointed treatment team and care plans
- Lack of actionable clinical insights
- Many touch points for the customer
- Lack of behavioral resources in the medical setting
SOLUTIONS | INTEGRATED CARE

KEY IMPROVEMENTS

Early identification and engagement through analytics

Proactive consent process to allow for information sharing

Multidisciplinary Care Coordinator

Embedded Behaviorist

Catalyst: Multidisciplinary Care Coordination Activated by Insights & Consent

Result: Coordinated Team Working Together

Mary is now effectively managing her diabetes and depression.

- Streamlined contacts due to coordinated care
- Improved medication adherence
- Appropriate use of care
- Improved productivity
- Financial resources identified

Cigna

Multidisciplinary Care Coordinator

Behavioral Care

- Community Therapist
- Community Psychiatrist

Medical Care

- Primary Care
- Embedded Behaviorist
- Embedded Care Coordinator
- Specialty Care

- Medical Care Management
- Behavioral Case Management
- Pharmacy Coach
- Disability Coordinator

Cigna • Medical Care Management • Behavioral Case Management • Pharmacy Coach • Disability Coordinator
Cigna is currently piloting this innovative model of care to measure effectiveness in achieving optimal outcomes, cost and satisfaction.

- Effective for all ages, and includes adolescent depression
- 80 randomized, controlled trials demonstrate quality, cost and satisfaction improvement
- Grounded in patient-centered, population-based care with a focus on evidence-based treatment
INTEGRATED APPROACHES TO CARE DELIVERY

Flexibility in both approach to integration as well as patient care, based on acuity and ability to engage, is critical to success.

C O M P R E H E N S I V E  C O L L A B O R A T I V E  C A R E

Proactive identification of emerging or high risk patients

Evidence-based assessment and treatment

Holistic reimbursement of integrated behavioral services

**M E D I C A L**

- Screening
  - Acuity-based referrals
  - Care management

- Coordination of care for emerging/high-risk patients

**B E H A V I O R A L**

- Identify local specialty provider for defined referral and collaboration processes

- Co-locate a provider for immediate access to care

- Embed a behavioral provider for holistic screening, brief intervention, care management and consultation with the medical team

- Medically focused intervention

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REQUIRED INSIGHTS FOR MAKING THE RIGHT INVESTMENT

How Cigna can be of assistance in helping to achieve an integrated care setting

- Telepsych for behavioral coordination of care and psychiatric consultation
- Care delivery platforms
- Holistic screening tools
- Care pathway/decision making support
- Mental Health First Aid
- Competency development
- Reimbursement model development
- Stamp out Stigma
- Clinical support evolution
- Patient education and engagement materials
- Local behavioral provider for referral, collaboration, and co-location
MAKING GETTING BETTER EASIER

Connecting Data + People + Programs

- We help doctors achieve better outcomes
- We help customers get personal care and get healthier
- We help clients get better value
THANK YOU!

Q & A