How To Create Successful Partnerships With Managed Care Organizations: The Payer Perspective On Integration & Medical Homes

Sun W. Vega, MBA, Senior Associate, OPEN MINDS
The 2014 OPEN MINDS Planning & Innovation Institute
June 4, 2014 | 4:15pm – 5:30pm
Agenda

I. The Evolution of Managed Care & Implications For Provider Organizations

II. The Optum Perspectives On Future Integration Models With Daniel E Berger, Director of Application Architecture, OptumHealth

III. The Cigna Perspective On Future Integration Models With William Lopez, M.D., CPE, Lead Medical Director, Cigna Corporation

IV. The Community Care Perspective on Future Integration Models With Lyndra J. Bills, M.D., Regional Medical Director For Physical Health/Behavioral Health Initiatives, Community Care Behavioral Health Organization

V. Questions & Discussion
The Evolution of Managed Care
The Expansion Of Use Of Managed Care Models – New Enrollment & New Populations

Increasing use of managed care financing and service delivery models

- Commercial
- Medicaid
- Medicare
- Dual eligible

New populations

- Complex disabilities
- Long-term care
# U.S. Managed Care Enrollment

<table>
<thead>
<tr>
<th>Health Care Payer Type</th>
<th>% Managed Care: 1995</th>
<th>% Managed Care: 2010</th>
<th>% Managed Care: 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer-sponsored insurance</td>
<td>73.0%</td>
<td>99.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Medicare</td>
<td>0.0%</td>
<td>24.0%</td>
<td>27.0%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>29.4%</td>
<td>71.5%</td>
<td>74.2%</td>
</tr>
</tbody>
</table>
PPACA Effects

- ACOs ‘encouraged’
- Created differential health home funding
- Medical loss ratio provisions
- State option model
- Five million enrolled so far
- Rate of “un–insurance” drops to 15%
## Six Effects Of New Care Management Models In A Market On Service Utilization

<table>
<thead>
<tr>
<th>Market-based provider fees (rather than cost-based reimbursement)</th>
<th>Fewer admissions to inpatient and residential levels of service</th>
<th>Creation of diversion programs and increased investment in community-based alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shorter lengths of stay in inpatient and residential services</td>
<td>More ready acceptance of tech-based alternatives</td>
<td>More value-based purchasing models (P4P, risk-based, etc.)</td>
</tr>
</tbody>
</table>
Key Concerns Of Provider Organization Executive Teams About Managed Care

- Rates
- Administrative requirements - authorization, documentation, billing
- Performance reporting requirements
- “Narrow” networks
- Gain sharing models
- Performance-based contracting
Emerging Service Delivery System Care Management Models Serve As Framework For Integration

- Expanded managed care models – increasing use for SMI, I/DD, and LTC
- Accountable care organizations (ACOs)
- Medical homes and health homes
- Disease management programs
Integrated Versus Coordinated

“Coordinated” and “integrated” care are not synonymous (though often used synonymously)

Coordination is getting appropriate services and minimizing duplicative services for individual consumers through enhanced communication around a consumer’s care.

Integration is more about the operation of an entity than communication between entities. Classically, “integrated care” is the fulfillment of system aims to facilitate cooperation and collaboration among and between the various parts of an organization or a system.
Integrated Care Management Versus Integrated Service Delivery

Integrated care management entities

- Coordinate consumer care as a replacement of, or adjunct to, “managed care.”
- Examples: ACOs, medical homes, health homes, disease statement management programs, wraparound services, coordinated care programs, and more.

Integrated service delivery systems

- Integrate the delivery of services – not the management of services.
- In the current market, this is most often the “one-stop shop” concept of all services in the same organization, i.e., integrated behavioral and primary care.
Payer Perspectives On Future Integration Models
Featured Faculty

- Daniel E Berger, Director of Application Architecture, OptumHealth
- William Lopez, M.D., CPE, Lead Medical Director, Cigna Corporation
- Lyndra J. Bills, M.D., Regional Medical Director For Physical Health/Behavioral Health Initiatives, Community Care Behavioral Health Organization
Essential Information System Capabilities to support Medical/Behavioral integration
June 2014
Where Optum fits within UnitedHealth Group

UnitedHealth Group

Health Benefits
UnitedHealthcare

Helping people live healthier lives

Health Services
Optum

Making the health system work better for everyone

Optum Insight
Optum Health
OptumRx

UnitedHealthcare Community & State
UnitedHealthcare Employer & Individual
UnitedHealthcare Medicare & Retirement
UnitedHealthcare Military & Veterans
Optum At-A-Glance

Making the health system work better for everyone.

~50,000 total employees, including:

- Nearly 1,500 physicians and medical directors
- Nearly 7,000 nurses
- Over 1,000 PhDs, health economists and data scientists

Provide services in nearly 150 countries

Who Optum serves

- 60,000,000+ Individuals
- 300 Health plans
- 5,000 Hospital facilities
- 80,000 Physician practices and non-hospital facilities
- 67,000 Pharmacies
- 350 Government agencies

...by operating across the health system at scale
OptumHealth Specialty Networks

- **Behavioral Health**
  - Comprehensive Behavioral Health
  - Medical/Behavioral Integration
  - EAP and Work-Life

- **Physical Health**
  - Chiropractic
  - Physical Therapy
  - Speech Therapy
  - Occupational Therapy

- **Complex Medical Conditions**
  - Transplant Solutions
  - Kidney Solutions
  - Infertility Solutions
  - Bariatric Resources Solutions
  - Sickle Cell

- **Optum International**
  - Wellness
  - Wellbeing
  - Technology Solutions
  - Network Management
ESSENTIAL INFORMATION SYSTEM CAPABILITIES TO SUPPORT MEDICAL/BEHAVIORAL INTEGRATION
Technologies’ role in facilitating Medical/Behavioral Integration

- Support a single source repository/registry of relevant clinical information
- Data Integration, Transformation, and Presentation
- Facilitate efficient and effective Asynchronous Collaboration
- Notification to prompt action
- Crystallization (focus on relevant information to make decisions)
- Provide more value than administrative burden
Essential Capabilities

- Health Risk Assessment
  - Care Opportunities/Gaps in Care
- Identification & Stratification of Risk
  - Algorithms, Rules, Risk Markers, Neural Networks
- Alerts, Tasking & Tracking
- Referral Tracking
  - Provider-to-Provider Referrals
  - Missed appointments
- Role Based Security
- Electronic Health Record/Personal Health Record
  - Role appropriate translations
  - Consumer participation
Essential Capabilities (continued)

- Health Information Exchange (HIE)
  - CCD Consistency and Stage 2 Meaningful Use
  - Special Behavioral Health Privacy Concerns
  - Role of Private HIEs
- Enterprise Care Coordination
  - Virtual Care Team Collaboration
    - Portals
    - Asynchronous Collaboration
    - Secure Messaging
  - Care Plan & Individual Recovery Plan
    - Symbiosis
- Interoperability
  - EHR/PHR <> HIE <> Enterprise Care Coordination Portal
Technology Vendors Offering Enterprise Care Coordination Capabilities

- Netsmart
- InfoMC
- CentriHealth
- Altruista
- Medecision
- GSI
- MedHok
- Advisory
- Welcentive
Cigna Collaborative Care

Making the connections to improve how care is delivered

- Improved quality
- Lower cost
- Higher satisfaction
Cigna Behavioral Snapshot

**Founded:**

1974 (acquired by Cigna in 1989)

**Customers:**

21.8 million

**Clients:**

Over 5600 Regional, National, Select, including Fortune 500 & Taft-Hartley clients

**Locations:**

National Care Center - Eden Prairie, MN
Regional Care Centers - Glendale, CA; Dallas, TX; and Lutherville, MD

**Network:**

128,191- Facilities & Providers
10,656 - Facilities & Clinics
22,082 – Psychiatrists
29,515 – PhDs
76,594 – Master’s
28,769 – EAP Affiliates

**Accreditations:**

NCQA
URAC

**Awards:**

2011 - eValue 8 Innovation Award
2011 - URAC Gold Award
To do more, we created more connections where care is delivered

Innovative solutions that span the delivery system

Creating personalized connections to improve quality, cost and satisfaction

**Goal:**

Majority of customers with high-cost conditions or complex needs are cared for by health care professionals with an incentive relationship with Cigna

- Specialist treatment drives 57% of spend.
- For customers with high-cost conditions or complex needs, large groups treat 20%, hospitals treat 25% and small groups treat 40%.


**Specialties include orthopedics, OBGYN, cardiology, gastroenterology and oncology.
Objective of Integrating Behavioral and Medical

• Assist Primary Care Physicians in understanding the importance of the behavioral health of their patients
  – Provide Education/Training
  – Introduce appropriate BH assessment tools
  – Explore and reduce/eliminate any barriers that currently prevent PCPs from assessing/addressing behavioral health concerns with their patients

• Facilitate relationships between medical physicians and behavioral health care professionals within the community
  – Consultation
  – Easy/Quick Referrals to appropriate health care professionals
  – Assist with de-stigmatizing behavioral health treatment for patients, if PCPs are more open/knowledgeable of their peers in the behavioral health community.
Why Integrate Behavioral?

“Mental Health” Days Hurt the Bottom Line

A hit to medical costs
- $317 billion is the estimated annual cost of serious mental Illness\(^1\)
- 100% jump in hospitalizations for psychiatric/substance abuse problems since 1992\(^2\)

A drain on productivity
- 90% of workers say mental health and personal problems impact their job performance\(^3\)
- By 2020 mental and substance use disorders will surpass all physical diseases as the major cause of disability worldwide\(^4\)

To improve health, optimize productivity, and lower overall costs today and in the future, you must address all the issues that might affect health – mind and body.

Mental illness not rare at all
- A study found that nearly one in five U.S. adults had a diagnosable mental illness in 2011.

<table>
<thead>
<tr>
<th>Mental illness by age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
</tr>
<tr>
<td>26-34</td>
</tr>
<tr>
<td>35-49</td>
</tr>
<tr>
<td>50+</td>
</tr>
</tbody>
</table>

Personalized connections that help improve care delivery

**OPEN EYES**
- Needs
  - Goals
  - Preferences
- Actionable patient-specific information
- Clinical consultation
- Performance improvement opportunities

**PLUG IN**
- Tools
  - Programs
  - Services
- Learning collaboratives
- Embedded care coordinators or clinical liaisons
- Dedicated case managers

**FIRE UP**
- Reward
  - Motivate
  - Excite
- Outcome-based compensation
- “Preferred” designation
- Higher patient volume

**ENGAGED**
Health care professionals

- 19% – 25% better compliance rate with diabetes measures
- 52% conversion rate to lower-cost medications through care coordinator engagement
- 4% – 5% lower total medical cost trend compared to market

---

1. 3Cigna Collaborative Accountable Care, Large PCP Group Results, 2013.
2. Cigna Pharmacy Management integration
3. Cigna
Personalized connections that improve care consumption

OPEN EYES

Needs
Goals
Preferences

Actionable patient-specific information:

• Gaps in care
• Cost-efficient options

PLUG IN

Tools
Programs
Services

• Physician-employed care coordinator
• Cigna support services
• Quality, cost-effective specialists and labs
• Extended office hours and access to urgent care facilities

FIRE UP

Reward
Motivate
Excite

• Lower medical costs*
• Higher quality of care*

ENGAGED customers

50% fewer visits to ER compared to market*

21% more gaps in care closed*

70% better than market referral rate to Cigna Care Designated specialists*

*Cigna Collaborative Accountable Care, Large PCP Group annual results for 2012 versus market average (2013),

Personalized connections. Powered by innovation.
Collaborative Care: Health Ownership in Action

Peter Hernandez

- Type 2 diabetes – Poorly controlled, frequent ER visitor
- Personalized profile Spanish speaking Engage by phone
- myCigna Mobile App
- Rx text alerts refill reminders*

Incentives
- HSA deposits for completing health assessment and online coaching participation*
- Lower coinsurance for visiting CCD physician

OPEN EYES

- Diabetes-related Gaps in Care
- Embedded Care Coordinator for coaching and follow-up
- Preferred lab and CCD specialist referrals

PLUG IN

- Compensation tied to patient outcome

FIRE UP

- Care gap closed Therapy compliant Controlled health
- Generic Rx* Avoids ER Earned incentive*
- It was easy

Peter’s physician

*Cigna Pharmacy Management and Incentive program integration
This is not an actual Cigna customer experience and is an example used for illustrative purposes only
Confidential, unpublished property of Cigna. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel. © 2014 Cigna
Fully connected health ownership gets everyone to their full potential

- **Improved quality**: 3% better than market average quality performance
- **Lower cost**: 3% better than market average total medical cost
- **Higher satisfaction**: 95% of Cigna Collaborative Care participating doctors would recommend us to colleagues

It’s what makes us different. It’s what delivers industry-leading outcomes.

1Cigna Collaborative Accountable Care, Large PCP Group annual results for 2012 versus market average (2013),
2Cigna 2012 Learning Collaborative meeting of participating Cigna Collaborative Care physicians
3Accountable Care Payers, KLASResearch, assessment of number of collaborative care agreements, July 2013

Confidential, unpublished property of Cigna. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel. © 2014 Cigna
Future State Behavioral and Medical Integration Models

Develop models of Behavioral Health Integration that are tailored to the specific Cigna Collaborative Care Physician Practices, including the following potential options:

- Fully integrated behavioral health clinician to participate as a member of the care team; facilitating behavioral input into the overall treatment plan
- Embedding a behavioral health therapist within the practice(s) (therapist can provide recommended treatment)
- Embedding Employee Assistance Professional within the practice(s) (short-term assess and refer model)
- Direct access to Cigna Behavioral advocates and clinicians that can assist with locating appropriate treatment practitioners
- Align with local multidisciplinary behavioral health clinics for direct referrals from your practice
- Connect patients or primary care practitioners with behavioral health specialists through the use of telemedicine
Integrating Physical & Behavioral Health Care

Lyndra J. Bills, MD, Regional Medical Director
June 2014
About Community Care

• Behavioral health managed care company founded in 1996; part of UPMC and headquartered in Pittsburgh

• Federally tax exempt nonprofit 501(c)(3)

• Major focus is publicly-funded behavioral health care services; currently doing business in PA and NY

• Licensed as a Risk-Assuming PPO in PA

• Serving over 750,000 individuals receiving Medical Assistance in 39 counties through a statewide network of over 1,800 providers

• Accreditation and awards: NCQA-accredited Quality and Disease Management programs, American Association of Community Psychiatrists Moffic Award For Ethics, and 2013 APA Gold Achievement Award for institutional/academic programs
New Models of Care Delivery

New models of care delivery are important for behavioral health (BH):

- World Health Organization ranks depression, alcohol, and tobacco use among the top causes of disability

- Individuals may be at higher risk for health conditions due to the psychiatric medications or other medications they are prescribed

- Individuals who have a serious mental illness (SMI) have a mortality rate that is higher than comparison groups – mostly due to medical conditions, such as cardiovascular disease or diabetes
## Higher Medical Co-morbidities

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Risk Among Persons with SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>2-3x higher</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>2-3x higher</td>
</tr>
<tr>
<td>HIV</td>
<td>Higher, but varies</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>5-11x higher</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Higher</td>
</tr>
</tbody>
</table>
Adult Heart Disease Risk Factors

Risk Factors for Adult Heart Disease are Embedded in Adverse Childhood Experiences

Odds Ratio

ACEs

© 2014 Community Care Behavioral Health Organization

Dong et al, 2004
Collaborating Framework

• Integration of health, wellness, prevention activities, and PH/BH interventions are best achieved through local collaborations

• The existing BH system can be enhanced to support good health outcomes for persons with SMI and/or substance use disorders, and concurrent serious physical conditions
  – Community Care’s commitment to overall health- and recovery-based programs for membership
BH/PH Integration

- Implemented use of Medicaid PH pharmacy data in the development of disease management programs for mental illness; identification of best practices

- Supporting protocols to expand access to BH services in primary care settings (especially IMPACT model)

- Developed implementation strategies for chronic care model of integrated BH/PH, including two-way data sharing with PH-MCOs

- Participation in SMI Innovations Project with OMHSAS and Center for Healthcare Strategies (Connected Care in the Southwest region)
Connected Care Program

• Initiative to improve the connection and coordination of care for those with SMI among health plans, PCPs, and BH providers in outpatient, inpatient, and emergency department settings

• Based on Patient-Centered Medical Home model with integrated care team and care plan to address all medical, behavioral, and social needs

• Partnership between:
  – Center for Health Care Strategies (CHCS)
  – Department of Public Welfare (DPW)
  – UPMC for You and UPMC for Life Specialty Plan
  – Community Care
  – Allegheny County Department of Human Services
Connected Care Outcomes

- Decreased mental health admissions and re-admissions
- Increased number of days in the community between admissions
- Connected Care Expansion
  - Designed to demonstrate the efficacy of care coordination of PH/BH services for individuals with SMI and co-occurring medical conditions in a Medicaid and dual-eligible BH carve out
  - Combines technological infrastructure, data management, and clinical expertise of a BH-MCO and a BH provider-based care coordination model
Behavioral Health Home Plus (BHHP)

- Designed to demonstrate the efficacy of care coordination of PH/BH services for individuals with SMI & co-occurring medical conditions

- Developed as collaborative effort with Behavioral Health Alliance of Rural Pennsylvania (BHARP): 23 North Central counties

- Expands on existing knowledge base
  - Strong health care navigator training & technical assistance
  - Embedding medical expertise within behavioral system
  - Self management strategies for common concerns, such as smoking cessation & exercise
  - Person-directed personal health record

- Initial sites included four rural BH providers
Health Home Team Members

- RN (wellness nurse)
- Certified peer specialist
- Case manager
- Primary physical health provider
- Psychiatric provider
- Community Care specialized care manager
- Health Plan special needs resources
Role of Community Care

• Analyze and stratify the population

• Standardize the model across behavioral health providers, including training and technical assistance

• Utilization, cost, and outcomes reporting

• Facilitate information exchange and provide notice of key events

• Provide specialized high-risk care management, including pharmacy management, with:
  – Oversight/consultation of person-centered planning
  – Facilitation of data and information sharing with the health home team
Initial Results Are Positive

• Strong engagement by members

• PH and wellness concerns become routine part of recovery plan

• Nurses and case managers partner to address PH concerns

• Became basis for PCORI grant application
• Optimizing Behavioral Health Homes by Focusing On Outcomes That Matter Most for Adults with Serious Mental Illness
  – Three-year, $1.7 million grant from the Patient-Centered Outcomes Research Institute (PCORI)
  – Focus on patient- and provider-directed interventions to address wellness and PH concerns
  – Builds on prior work in North Central state option region of Pennsylvania
Promising Strategies

Provider-Supported Integrated Care

• Uses registered nurses on staff at participating facilities to work with patients on:
  – Coordinating their care
  – Enhancing communication between providers
  – Providing patient wellness support and education

Self-Directed Care

• Service delivery at self-directed facilities to focus on providing tools, education, and resources that activate patients to be more informed and effective managers of their health and health care
Implementation Underway

• Training in 2013

• Over 1,100 members enrolled in study

• 11 additional sites implementing BHHP model in 2014

• Using IHI Learning Collaborative Model for implementation with intensive technical assistance from Community Care

• Results in 2016
Evaluation Underway

• Primary Outcomes
  – Health status, activation in care, and engagement in primary/specialty care

• Secondary/Exploratory Outcomes
  – Mental health symptoms, hope, quality of life, medication use, functional status, emergent care, lab monitoring, and individual and family satisfaction with care

• Covariates
  – Engagement in interventions, social support, severity of mental illness, medical stability, patient demographic, and clinical characteristics
Learning Collaborative Underway

• Process Aims (target of 80% by November 2014)
  – Completion of the wellness planning tool
  – Established connection between PH and BH providers as evidenced by minimum of two reciprocal contacts
  – Case manager consultation with wellness nurse (provider-supported only)
  – Member use of at least one self-management tool (self-directed only)

• There is variability in performance on the process aims
  – Consultation is highest performing Process Aim (70%)
Learning Collaborative Underway

• Measuring impact of the intervention on staff and individuals in service through Outcome Aims (target of 80% by November 2014)
  – BH service providers report high confidence in their ability to assist service users with their PH and wellness needs
  – Service users rate their BH service provider as highly understanding and respecting of their PH and wellness needs and goals
  – Service users report being highly involved in working with their BH service provider on PH and wellness

• Survey completions by staff and individuals on confidence, respect, and involvement using a 0-10 scale; high ratings = 9 or 10
Q1 Progress on Outcomes Aims

- Confidence: 40.0%
- Respect: 79.1%
- Involvement: 42.2%
Promoting a Culture of Wellness

• Both strategies promote a culture of wellness and utilize case managers and certified peer specialists as health navigators

• Wellness coaching supports the development of a behavioral health home model and a foundation for a culture of wellness and recovery
  – Training program developed by national wellness expert, Dr. Peggy Swarbrick
C-SNP

• Chronic Condition Special Needs Plan (UPMC Community Care)
  – Medicare Special Need Plan (SNP) for persons with serious mental illness (SMI) led by behavioral health MCO and based in behavioral health provider settings
  – SMI is defined as having one of the following:
    • Bipolar Disorder
    • Major Depressive Disorder
    • Paranoid Disorder
    • Schizophrenia
    • Schizoaffective Disorder
  – Plan may serve persons who are dual eligible (Medicare and Medicaid) and non-dual (Medicare only)
C-SNP Goals

- Improve member experience through communicative, convenient, accountable and customer service oriented health care plan

- Better coordination of benefits through Medicaid and Medicare

- Build a model in primary and behavioral health care coordination

- Initial implementation underway
Contact Information

Lyndra J. Bills, MD
Regional Medical Director, Community Care
billllslj@ccbh.com

Community Care Behavioral Health Organization
One Chatham Center, Suite 700
112 Washington Place, Pittsburgh, PA 15219
412.454.2120  |  www.ccbh.com
Questions & Discussion
Panelist Questions

- In terms of your integration projects, what are you looking for in a partner provider?
- What types of value-based contracting do you currently have with providers around new integration models?
- Are you setting any particular outcomes and/or performance measures for your integration models?
- Is there a particular challenge you are faced with today with regard to integration (i.e. population management, contracting with state Medicaid systems and financing)?
- I am a medium-sized physician practice that is interested in health integration, but needs support. What are the first steps that you would recommend? How should I approach my managed care organization about my ideas?
The market intelligence to navigate. The management expertise to succeed.

20+ years of market intelligence and management consulting
500+ years of collective team experience
40,000+ executive subscribers