National Alliance

Best Practices for Health Plans & PBMs

November 15, 2021

National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

National Alliance of Healthcare Purchaser Coalitions
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CONGRATULATIONS!
2021 INNOVATIONS AWARDS FINALISTS

aetna®

Aetna Kidney Support
Leading the Change in Kidney Care

Cigna

Cigna
Distress Screening for Whole-Person Health

KAISER PERMANENTE®

Kaiser Permanente
Community Resource (CRS) Evaluation

NAVITUS PHARMACY BENEFITS REINVENTED™

Navitus
Personalized Member Transitions (PMT) Program

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Premera
Telehealth Addiction Treatment with Boulder Care

US-Rx Care

US-Rx Care
Fiduciary PBM Services

Best Practices for Health Plans & PBMs

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National Alliance
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Driving Health, Equity and Value

Guiding Members Through Smoother Benefit Transitions

November 15, 2021

Personalized Member Transitions Overview

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Facing Member Transition Challenges

- Benefit transitions can be confusing for members, resulting in member dissatisfaction and gaps in care

- Gaps in care can lead to poor heath outcomes and drive up costs, especially in the case of chronic conditions

20% of prescriptions are never filled[1]

50% of filled prescriptions are taken incorrectly[1]

**28%** of patients fail to refill a prescription on time[2]

22% of patients take a lower dosage than prescribed[2]

Personalized Member Transitions turn benefit transitions into positive experiences

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Eliminating Onboarding Stress With Personalized Member Transitions

- Provides high-touch, personalized onboarding and transition experiences for:
  - New members and clients
  - Formulary changes
- Minimizes member disruption by proactively communicating with patients and prescribers
- Helps members navigate the complex health care system with personalized support

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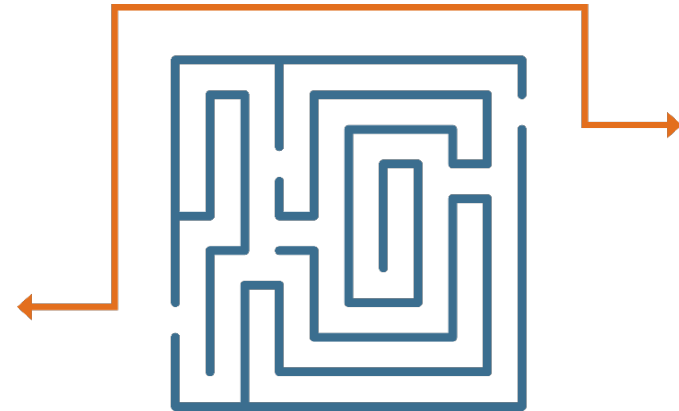
Making Transitions a Positive Experience for All

Creates a positive and seamless member experience when switching to a lower-cost formulary product

Improves member satisfaction with plan benefits while reducing complaints

Enhances speed to fill, preventing gaps in therapy for chronic diseases

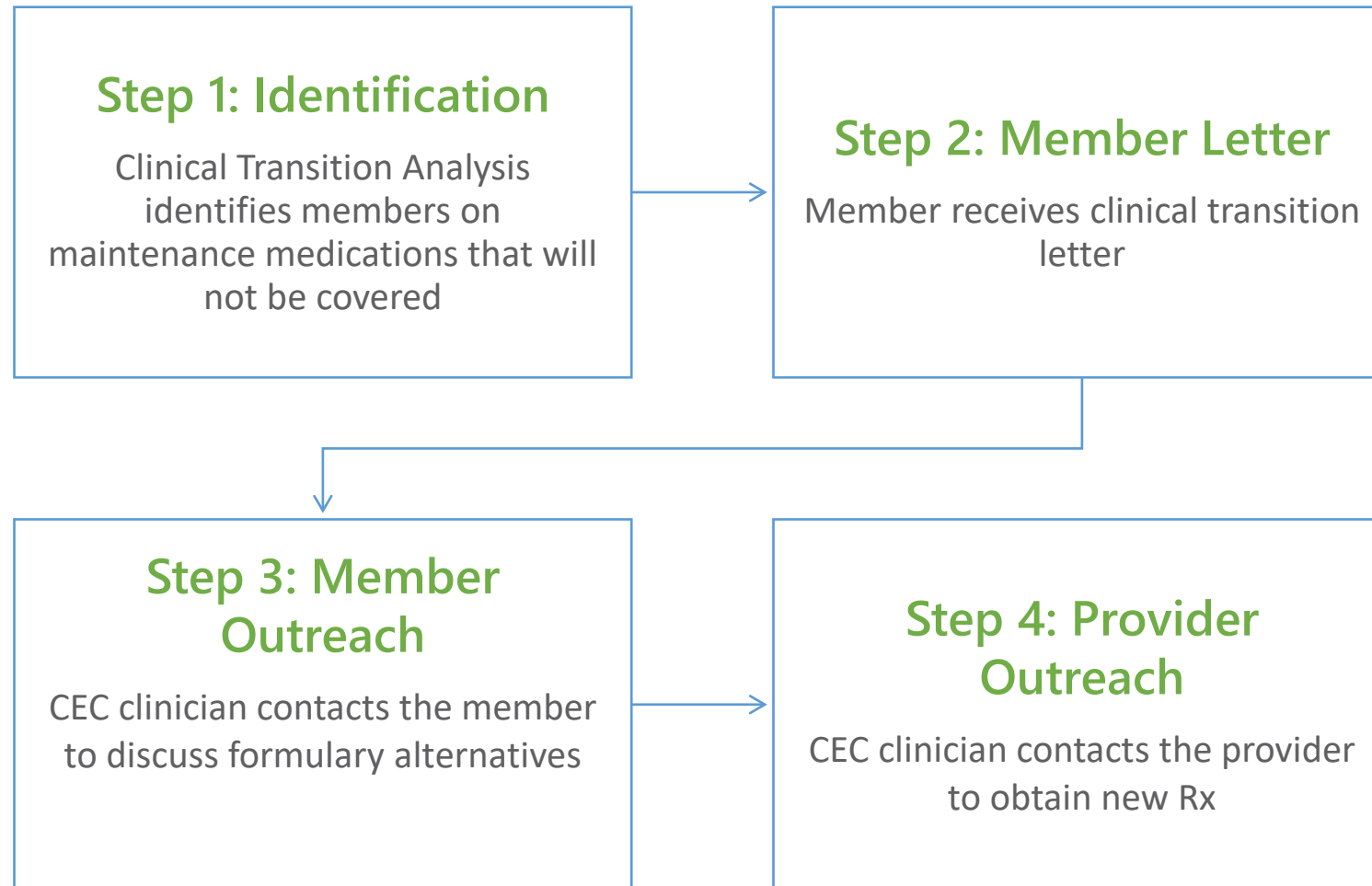Makes the transition process smoother for plan sponsors

NAVITUS
PHARMACY BENEFITS REINVENTED™

"Navitus made my job so much easier and less worrisome. They assisted us in ensuring our significant formulary change went smoothly. Navitus has lived up to its promises."

Wendie Carlson

Chief Human Resources Officer, West Tennessee Healthcare

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Guiding Members and Providers
How Personalized Member Transitions work

Step 1: Identification

Clinical Transition Analysis identifies members on maintenance medications that will not be covered

Step 2: Member Letter

Member receives clinical transition letter

Step 3: Member Outreach

CEC clinician contacts the member to discuss formulary alternatives

Step 4: Provider Outreach

CEC clinician contacts the provider to obtain new Rx

Confidential

NAVITUS
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Creating a Better Approach to Member Transitions

Plan Sponsor Benefits

- Personalized Member Transitions turn member transitions into a positive experiences with guidance and support

- This increases member satisfaction while reducing gaps in care

- With Personalized Member Transitions, members will be happier and healthier

Thank You.

Reference List

1. Neiman AB, Ruppar T, Ho M, et al. CDC Grand Rounds: Improving Medication Adherence for Chronic Disease Management — Innovations and Opportunities. MMWR Morb Mortal Wkly Rep 2017;66. DOI: http://dx.doi.org/10.15585/mmwr.mm6645a2. Published November 2017.

2. Medication Adherence in America. National Community Pharmacists Association. http://www.ncpa.co/adherence/AdherenceReportCard_Full.pdf. Published 2013.

DISTRESS SCREENING FOR WHOLE PERSON HEALTH

Dr. Bhuvana Sagar
National Medical Director

**Alysia Swanson RN BSOM CCM**
Clinical Program Sr. Advisor

Together, all the way.®

Cigna®

BACKGROUND

Distress is the unpleasant experience of a mental, physical, social, or spiritual nature. While an expected part of receiving a cancer diagnosis, untreated distress is a problem identified in clinical practice that affects coping, functioning, health decisions, and overall health. The National Comprehensive Cancer Network (NCCN) has developed clinical practice guidelines to support distress screening.

Distress Screening was designed as a standalone screening assessment to accompany existing assessment protocols for Cigna's URAC and NCQA-accredited case management solutions.

Physical

Spiritual/Religious

Family

FIVE DOMAINS

Practical

Emotional
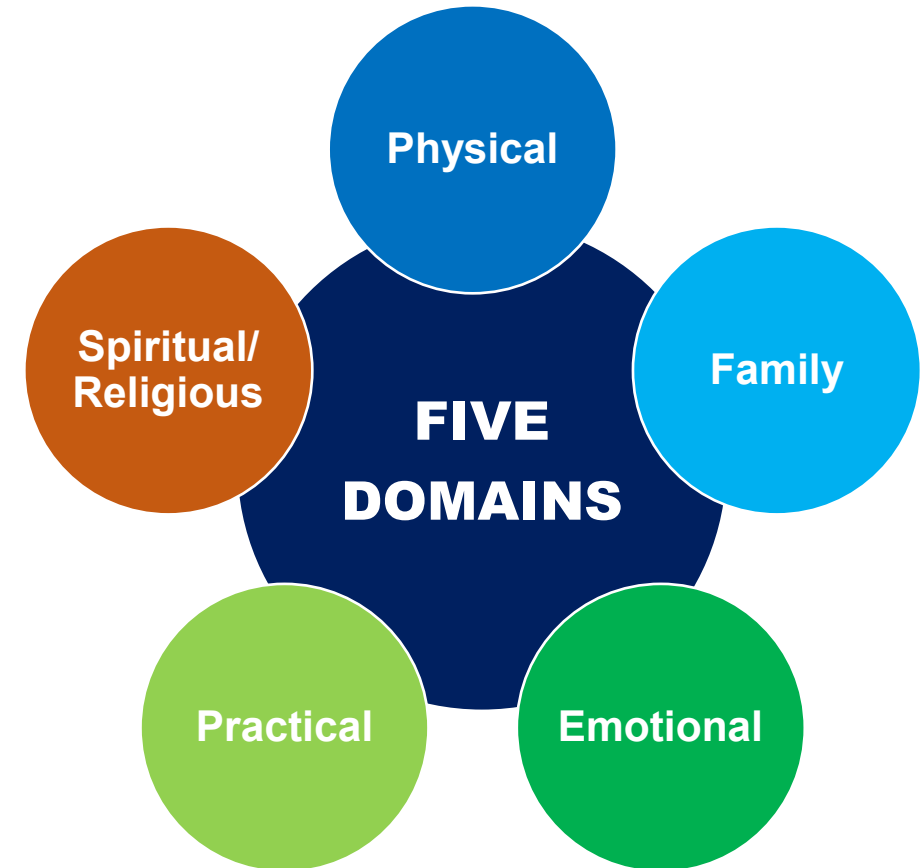
HOW IT WORKS

- Cigna Case Managers practice "active listening" while screening
- Customers measure distress on a scale of 0 (no distress) to 10 (severe distress)
- Problem-focused resource guide:
  - ✓ How to conduct distress screening
  - ✓ Caregiver and nutritional support
  - ✓ EAP
  - ✓ Grief and bereavement
- Connects customers with support, programs, and resources to help with a wide variety of challenges including financial, social, clinical - even transportation
- Case Managers (Cigna Oncology nurses) collaborate with the treating Oncologist as needed to share distress screening results and the implemented case management interventions

RESULTS – DISTRESS SCREENING WORKS!
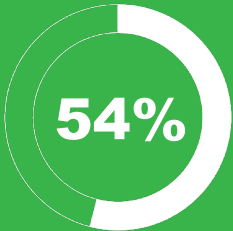
54% of customers reported mild or higher distress

Screened customers are **16% more likely to be referred** to internal and external resources

Top problems reported:
1. Fatigue, pain, nausea
2. Treatment decisions
3. Insurance/financial
4. Worry

Medical

- **$6,840** PMPY **lower IP costs***
- **10.4%** less likely to have 1+ IP visit
- **14.7%** fewer average # IP visits

Behavioral

- **$18.72** PMPY higher costs (driven by those with highest SDI scores)
- **1.3x** more likely to submit a claim
- **6x** more CM engagements (18 vs. 3)

Case Management

- Engagement rates are **six times higher** than unscreened customers
- **Engage 73 days longer** (184 vs. 110 days)
- **2.5x more likely to achieve goals** (40.4% vs. 20.3%)

*IP results driven by acute visits. No difference in overall TMC, facility outpatient costs, professional visit costs, or ER utilization/costs. Outcomes were not significantly influenced by SDI scores.

The Challenges in Addiction Care

40 million people in the US struggle with a substance use disorder (SUD)

Few people get care

There is a severe, chronic provider shortage

COVID-19 has taken a toll

Rural populations have been hit hard

The stigma persists

Source: https://www.samhsa.gov/data/release/2020-national-survey-drug-use-and-health-nsduh-releases)

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Addiction care, anywhere

Substance Use Disorders in the US

Opioid Use Disorder (OUD)

*Drug overdose is the **leading cause of accidental death for people under 50**.*

3M people in the US struggle with OUD

130 people die every day due to opioid overdose

1000 emergency dept. visits per day are due to opioids

Alcohol Use Disorder (AUD)

*Alcohol is the **third-leading cause of preventable death**.*

28.3M people in the US struggle with AUD

261 people die every day from alcohol- related causes

~42% of people with OUD also have co-occurring AUD

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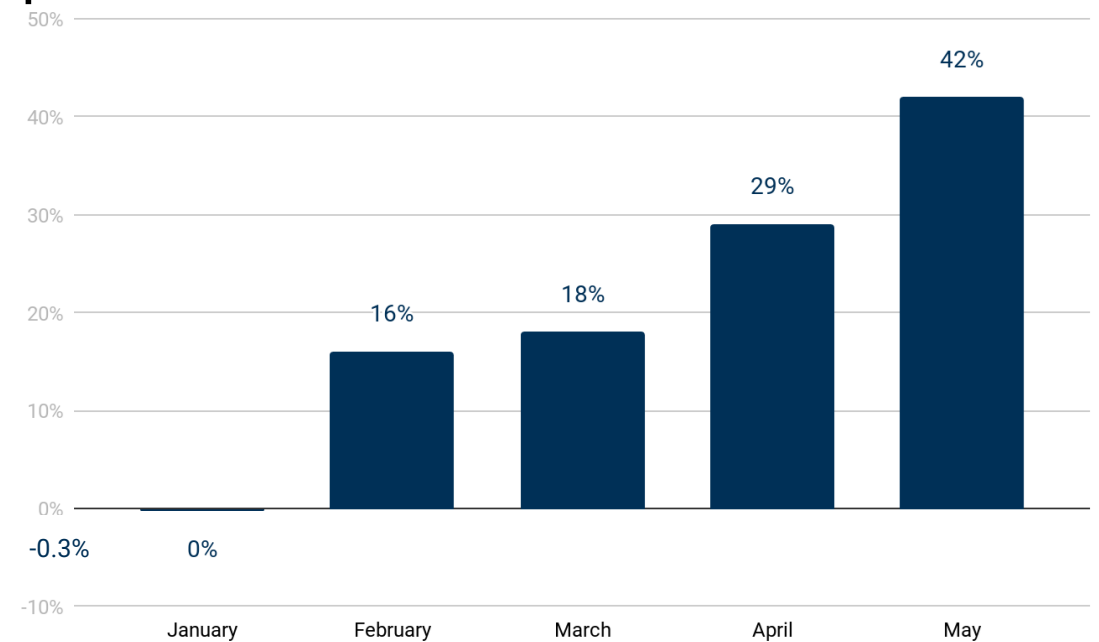# COVID-19 Has Only Intensified the Crisis

13% of US adults started or increased substance use to cope with stress or emotions related to COVID-19 as of June 2020 (CDC)

29% increase in drug overdose deaths in the US in 2020, compared to 2019 (CDC)

Increasing overdose rates during the pandemic *(As compared to the same months in 2019).*

ODMAP data from *The Washington Post. Note*: Percent growth references the 1,201 agencies reporting to ODMAP by January 2019.

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The Role of Telehealth in SUD Treatment
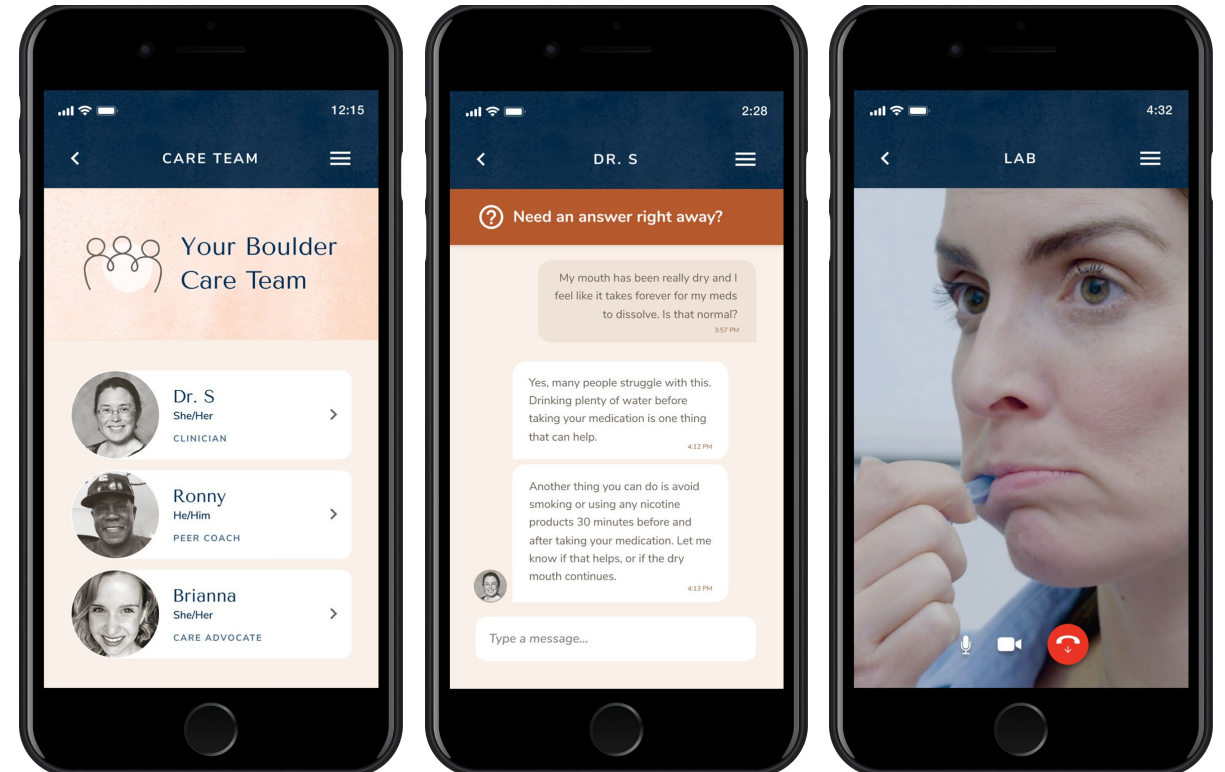
Addresses workforce shortage

Extends access to the 80% of communities in the US that don't have a single buprenorphine prescriber.

Accessible 24/7

Patients can access care anytime, anywhere through secure video, phone, and messaging.

Reduces stigma

No need to show up to a clinic, which can be a deterrent to seeking care.

The Partnership

Premera is the first health plan to partner with Boulder Care to offer long-term virtual support and treatment for SUD.

Eliminates access barriers	**Empowers patients**	**Delivers high quality**
by delivering care 24/7 through secure video and messaging on mobile app and offering treatment within 48 hours	with a broad suite of recovery services and delivers low barrier care with health equity in mind	member experience and retains 3 out 4 patients in care at a year

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The Solution

Connects patients to SUD treatment through the Boulder Care digital platform and an easy-to-use mobile application.

Provides digitally secure treatment to members from the convenience their own home.

Delivers individualized care plans, therapies, coaching, and monitoring privately to members through secure video and texting.

Provides a comprehensive approach to addiction therapy that includes medication assisted treatment (MAT).

Assists patients who have additional psychiatric disorders that Boulder Care does not address and connects them with nearby behavioral health care.

How the Program Works

Three components:

Public health interest	Program administration	Populations served

Measuring Success for Premera

Net Promoter Score of 91.

58% 6-month retention rate in OUD medication treatment.

48 hours median time from new inquiry to clinician visit.

79% of patients report positive sentiments toward their recovery progress in the last 30 days, as part of the CDC-endorsed Health Related Quality of Life (HRQoL) survey.

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How Premera and Boulder Care are Making a Difference

Changing the face of rehabilitation by:

- **Allowing physicians to create personalized programs** in terms of the duration of peer support, dosage of medication, and how long a person stays on medication

- **Providing patients access to a care advocate and a peer recovery support specialist** who support them through the program and sobriety

- **Providing ongoing treatment with no end date** and continued access to Suboxone for as long necessary to mitigate addiction

- **Eliminating access barriers** by reaching patients where they are

- **Providing the medication, resources, and support** to help patients succeed on their own terms, wherever they are in their journey

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Questions

Thank you

Appendix

Public Health Interest

Positively impacts the health and well-being of the community at large by reducing:

- Economic impacts to family systems by providing affordable cost of care

- The strain on traditional health systems

- Absenteeism, turnover rates, and overall employer healthcare costs

- Systemic health disparities stemming from social determinants

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Program Administration

Reaching the target audience by:

- Referral to Boulder Care by providers

- Self-referral (available 24/7)

- Providers directing members to self-refer

Unique features for patients include:

- Care advocates

- Peer Recovery Support Specialists for goal setting and housing/transportation/social determinants

Program has no end date

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Populations Served

- 2.5 million Premera members ages 18 or older with an established diagnosis of OUD or AUD

- Any member who feels their use of substances has adversely impacted their lives

- Minimal exclusion criteria

- Commitment to providing specialized, high-touch support to members who are often underserved

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Addiction care, anywhere

Boulder Care's Treatment Approach

Every Boulder patient has a dedicated care team comprised of a **Prescribing Clinician, a Care Advocate, and a Certified Peer Coach.**

Caregivers work together to provide accessible, high-touch care for **opioid and alcohol use disorders** to members by secure message, phone, and video through Boulder's telehealth platform.

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Addiction care, anywhere

Aetna Kidney Support

- **Danée Harrison, Senior Director, New Product Development, Aetna**

- **Sara Martin, Senior Director, CVS Kidney Care**

Danée Harrison
Sr Director,
New Product Development, Aetna

Sara Martin
Sr Director,
CVS Kidney Care

Introducing Aetna Kidney Support:

Helping to delay end-stage renal disease

Identifying
where care is needed through advanced analytics

Unique algorithms

CVS analytics will help us:

- Find members earlier
- Predict chronic kidney disease progression
- Target interventions

Enabling
tailored and meaningful care coordination

Chronic kidney disease-specific nurses and care managers provide support including:

- Ongoing care coordination and education
- Help with diet, medications, comorbidities and needed resources

Empowering
members to choose what's right for them

Live, in-person* sessions educate people choose a therapy and:

- Connect those interested in transplant to resources
- Prepare to transition to chosen therapy

Goals

| Delay onset of kidney failure | Increase number of transplants | Increase uptake of home modalities | Reduce hospitalizations | Increase percentage of planned dialysis starts |

It's a win-win: Improved quality of life for members and cost savings for plan sponsors

$26K savings

per avoided unplanned start to dialysis*[4]

$57K
savings

per successful avoidance to dialysis*[1]

$20K
savings

per avoided admission*[5]

$4K
savings each month

that a start to dialysis is delayed**[2,3]

$132K
savings
per year

over a 5-year period for each person who has a kidney transplant instead of being on dialysis**[2,3]

*Not everyone will progress to dialysis; of those who progress we assume we can only reduce unplanned starts by 20%. Not double counting between avoided admissions and increasing planned starts; some admission savings included in planned start savings.
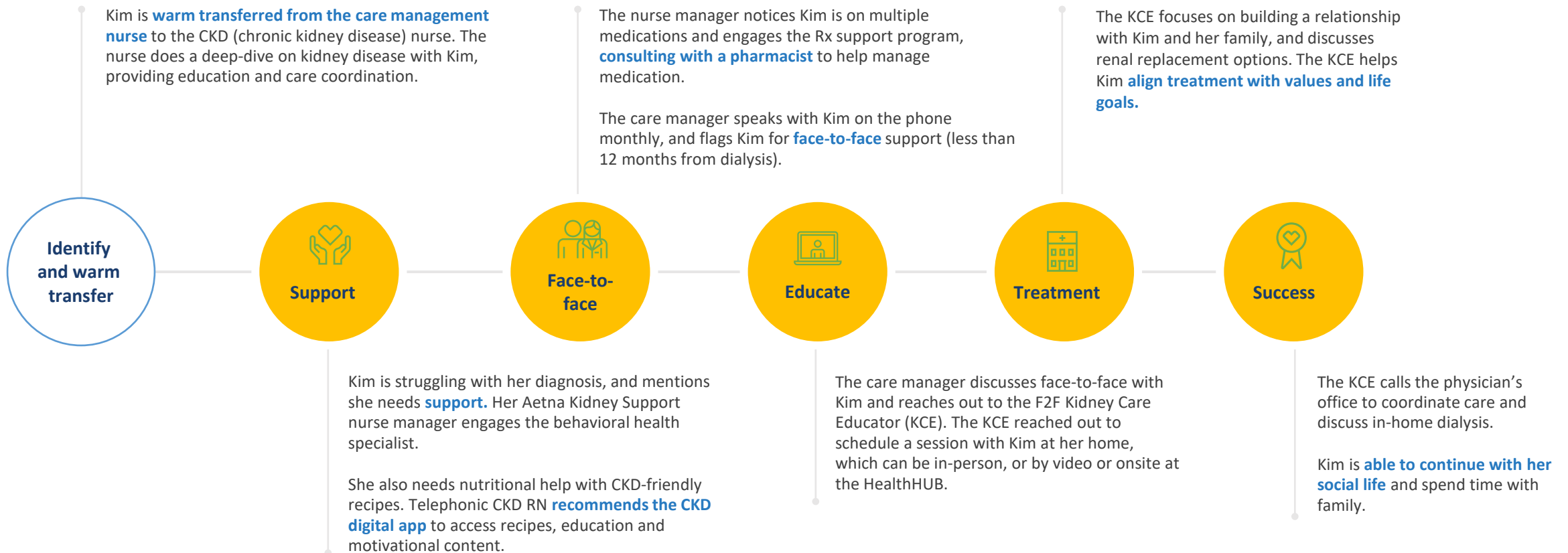**Commercial estimates for dialysis events based on 4x Medicare. Individual results may vary.
1. CVS Health Transformation, 2020. P1003940220. 2. United States Renal Data System. 2018 USRDS annual data report: Epidemiology of kidney disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2018. 3. Gorman Health Group: CMS 2012 5% Sample of Medicare Claims: Evaluation for Dialysis Clinic, Inc. Gorman Health Group, Washington DC, 2015. 4. CVS Health Transformation, 2020. P1003950220. 5. CVS Health Transformation, 2020. P1003960220.

A member journey: Integrated approach to kidney care every step of the way

Kim is in remission from breast cancer, and has been working with Aetna care management. She has now been flagged as less than 18 months progression to dialysis and identified as someone who will benefit from Aetna Kidney Support.*

Kim is **warm transferred from the care management nurse** to the CKD (chronic kidney disease) nurse. The nurse does a deep-dive on kidney disease with Kim, providing education and care coordination.

The nurse manager notices Kim is on multiple medications and engages the Rx support program, **consulting with a pharmacist** to help manage medication.

The care manager speaks with Kim on the phone monthly, and flags Kim for **face-to-face** support (less than 12 months from dialysis).

The KCE focuses on building a relationship with Kim and her family, and discusses renal replacement options. The KCE helps Kim **align treatment with values and life goals.**

Identify and warm transfer

Support

Face-to-face

Educate

Treatment

Success

Kim is struggling with her diagnosis, and mentions she needs **support.** Her Aetna Kidney Support nurse manager engages the behavioral health specialist.

She also needs nutritional help with CKD-friendly recipes. Telephonic CKD RN **recommends the CKD digital app** to access recipes, education and motivational content.

The care manager discusses face-to-face with Kim and reaches out to the F2F Kidney Care Educator (KCE). The KCE reached out to schedule a session with Kim at her home, which can be in-person, or by video or onsite at the HealthHUB.

The KCE calls the physician's office to coordinate care and discuss in-home dialysis.

Kim is **able to continue with her social life** and spend time with family.

*For illustrative purposes only. Does not reflect events experienced by an actual member.

Community Resource Specialist Evaluation

Cindee DeWitt
Program Manager

KAISER PERMANENTE®

The **Community Resource Specialist** Role at KP Washington

Evolved from the LINCC study

- Funded by the Patient-Centered Outcomes Research Institute, 2014 – 2016

- Included patients as partners in designing the study and the CRS role

CRSs are members of the primary care team

- Interact with patients as social needs surface during care

- Provide information, connection, referral to serves, and coaching

LINCC design event participants Amina Moalim, licensed practical nurse with Kaiser Permanente Washington (left) and Laura Malarcher, LINCC project patient partner (right)

CRS is now part of the **standard staffing model** in primary care

CRS staffing

- 26 CRS staff members
- Working in 30 medical centers
- Based on 1 CRS/ 20,000 patients
- Primary care departments and recently added to oncology

CRS competencies & qualifications

- WA state DOH Community Health worker training
- Motivational Interviewing
- Understanding of socioeconomic, environmental, and cultural factors that impact health
- Strong computer, communication and organizational skills
- Skilled in providing collaborative, team-based care
- Connection with community orgs

Patient interactions

- Nearly **2000** unique patients per month
- Around **3300** patient encounters per month
- In person, telephone, video visit, as well as walk in or warm handoff from primary care team
- All patient interactions are documented in EHR and standard SDOH assessment is completed

Learning Health System partnership to implement & evaluate the CRS role

Quantitative survey to assess impact compared to a control group

- Social needs and self-efficacy

- Coping, symptoms, and functioning

- Engagement and utilization

Qualitative interviews with patients and care teams

- **Experience** with health system, wellbeing, perceived burden of social need and patient engagement

- CRS impact on care team functioning, team integration

- Contextual factors to inform implementation strategies

- **3,383** members surveyed

- 1,159 completed baseline

  - Single CRS visit (N=384)

  - More than 1 CRS visit (N=354).

  - Control group (N=421)

- Interviews with 25 CRS's

- Observations with 16 CRS's

- Interviews 10 primary care team members

- Brief care team survey at 4 clinics

- Interviews with 45 Patients

Key results from the evaluation

A snapshot of our 3 main learnings

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1 **The CRS role is valued by members & care teams, reflects well on KP, & sets us apart in the market.**

Benefits commonly mentioned by members:
- Makes them feel cared for
- Provides a human connection
- Builds trust
- Creates a stronger link to the care team

Care teams: CRS **fills an important care gap** & benefits members and care teams:

80% - 94% "Having a CRS has allowed me to **better use my training and time**"

86% - 100% "Having a CRS has **improved the care** we're able to give to patients"

Range of responses across 4 clinics: Fed Way, Olympia, Pt Orchard, & Riverfront

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2 **Members who had 2 or more CRS encounters reported positive changes & were very satisfied with the CRS—but members may need more than 1 encounter to benefit.**

Members who saw the CRS improved more on self-rated health than comparison patients who did not see the CRS. (no other outcome differences detected)*

Compared to members with 1 encounter, those with 2+ encounters:
- Had **higher efficacy** to fulfill care plan
- Had **more trust** in their care team
- Felt more like their **care team is on task**
- Felt more of a **bond with their care team**

76% of members with at least 1 CRS encounter "agree" or "strongly agree" that they **feel supported** by the CRS.

Members with 1 CRS encounter :
- Struggled more with things like food security, self efficacy, trusting the care team
- Were much less satisfied than members who had 2+ encounters

33%
43%
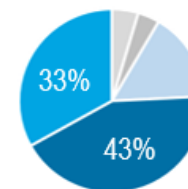
- Strongly agree
- Agree
- Undecided
- Disagree
- Strongly disagree

☛ The new CRS dashboard in Epic helps track whether members' needs are met and helps ensure follow up.

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3 **Members have a lot of unmet social needs the CRS role can help address & many need significant support to overcome barriers to accessing resources & the stigma of asking for help.**

59% of members surveyed endorsed 1 or more social needs. Of those members:
- **>90%** would like help meeting those needs
- **Nearly 25%** had 3 or more social needs

But our comparison group **did not get access to the CRS** despite being good candidates for the service (e.g., struggling to fulfill their care plan, endorsed social needs).

"I worked with a woman who had a young kid. She was staying in the car and I gave her the resource to call for housing …and she got housing within that week. **I could hear it in her voice, the follow-up call.** She was like, 'I got in, we're moving in.'" – CRS

Normalizing the need for help emerged as an important aspect of the CRS role—as did **providing motivation and accountability** to follow up on plans and resources.

This benefit for members will likely be even more important in the COVID-19 era.

Fiduciary Pharmacy Risk Management Services

US-R$_x$ Care

Leading Change

US-Rx Care

- Leader in *Pharmacy Benefits/Risk Management* services

- Over two decades of service

- Over 5 million lives

- Over $1 billion in drug cost savings generated for clients

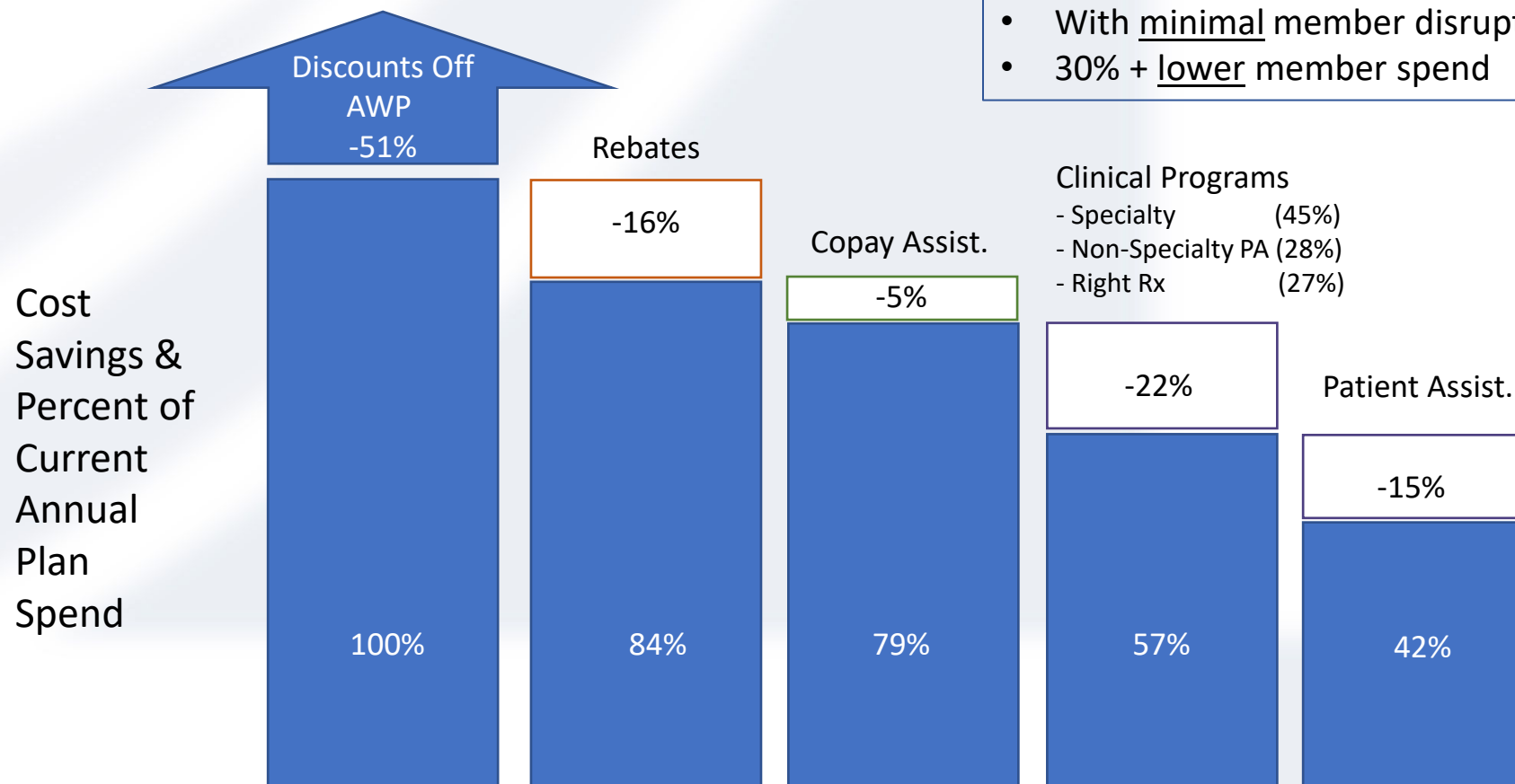- Expertise in all aspects of pharmacy risk including acute, chronic, and specialty medications

Accept Nothing Less

- ✓ Transparency

- ✓ Fiduciary Compliant

- ✓ Risk Management Experience

Typical Path To 50%+ Lower Plan Spend

- With <u>no</u> change In benefit design
- With <u>minimal</u> member disruption
- 30% + <u>lower</u> member spend

Cost Savings & Percent of Current Annual Plan Spend

Discounts Off AWP -51%

Rebates -16%

Copay Assist. -5%

Clinical Programs
- Specialty   (45%)
- Non-Specialty PA (28%)
- Right Rx   (27%)

-22%

Patient Assist. -15%

100%

84%

79%

57%

42%

Recent Client Examples

Georgia County Government	Call Center / Marketing Services
• 2,930 Covered Lives	• 1,280 Covered Lives

(000's)   Annual Rx Spend

34% Cost Reduction

(000's)   Annual Rx Spend
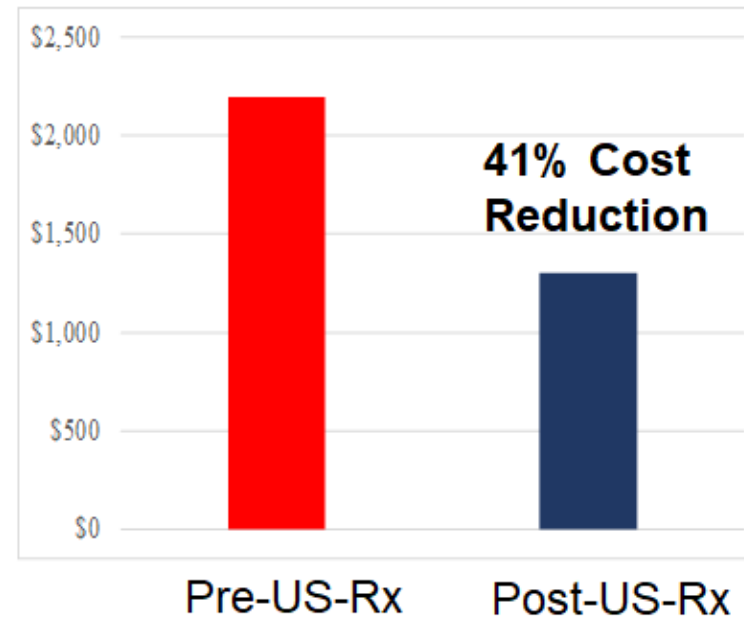
41% Cost Reduction

Another Client Example

$ Per Member Per Month
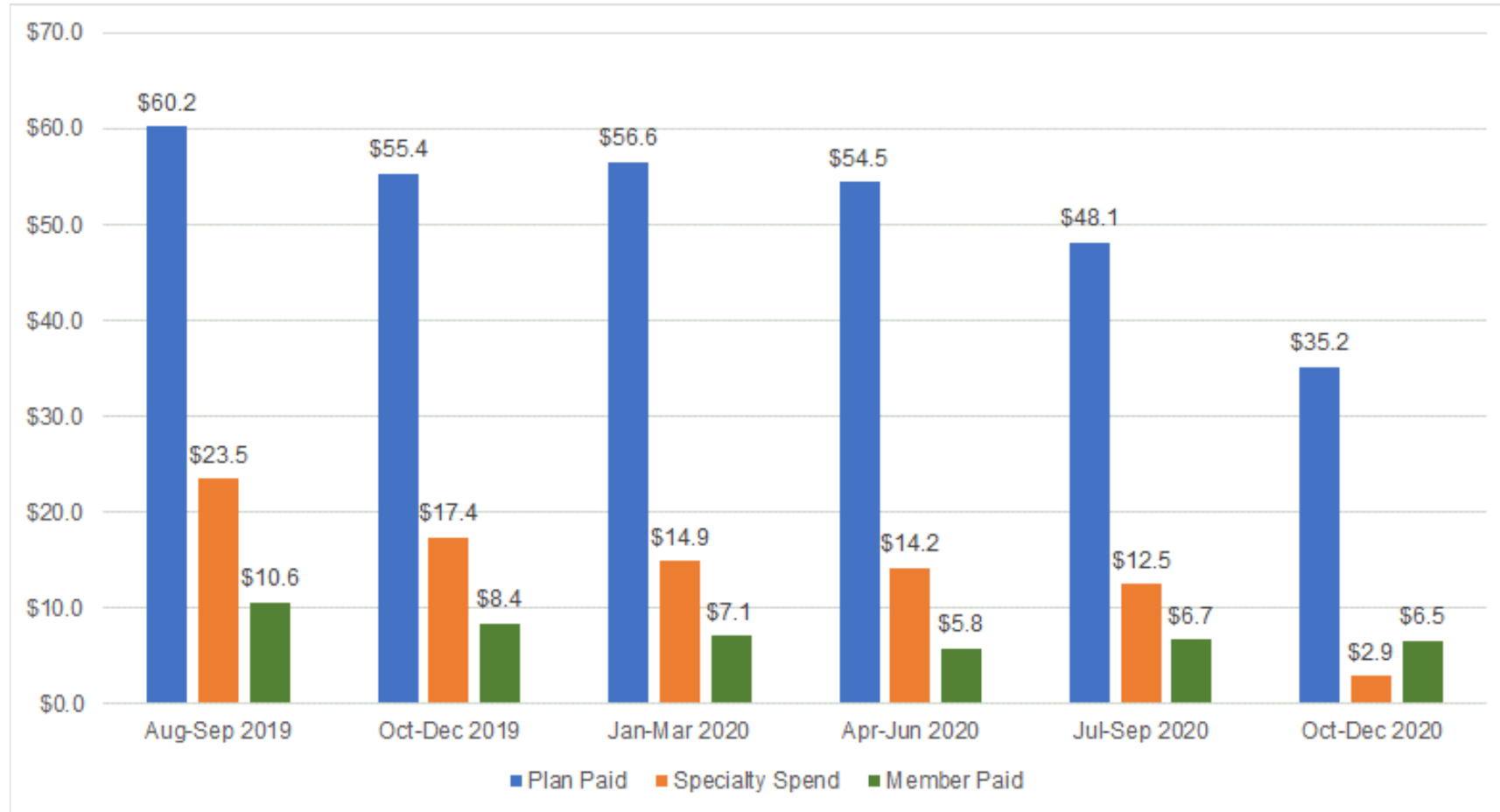
Waste Pro Pharmacy Benefit Spend
Three Year Trend

**Plan Paid Amount
(Per Enrollee Per Month)**

**Plan Paid Amount
(Annual)**
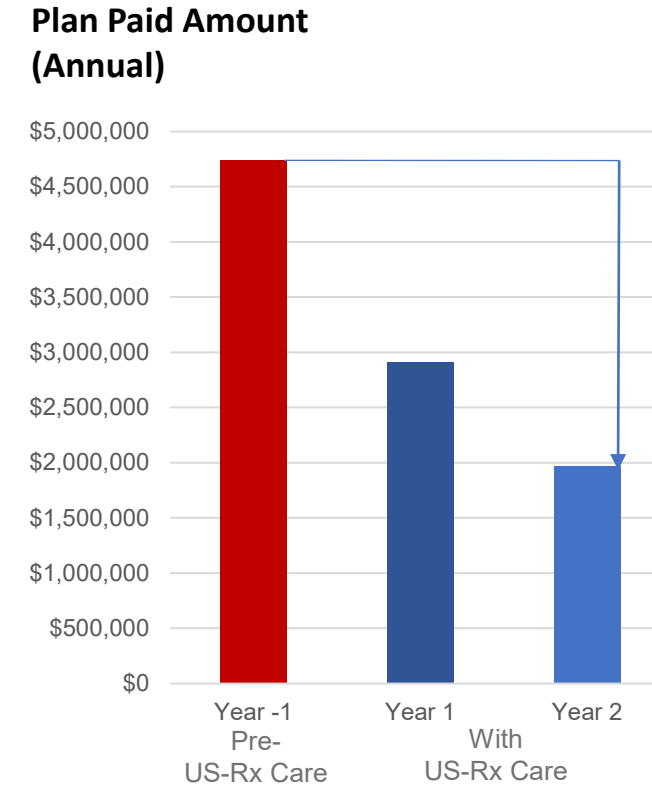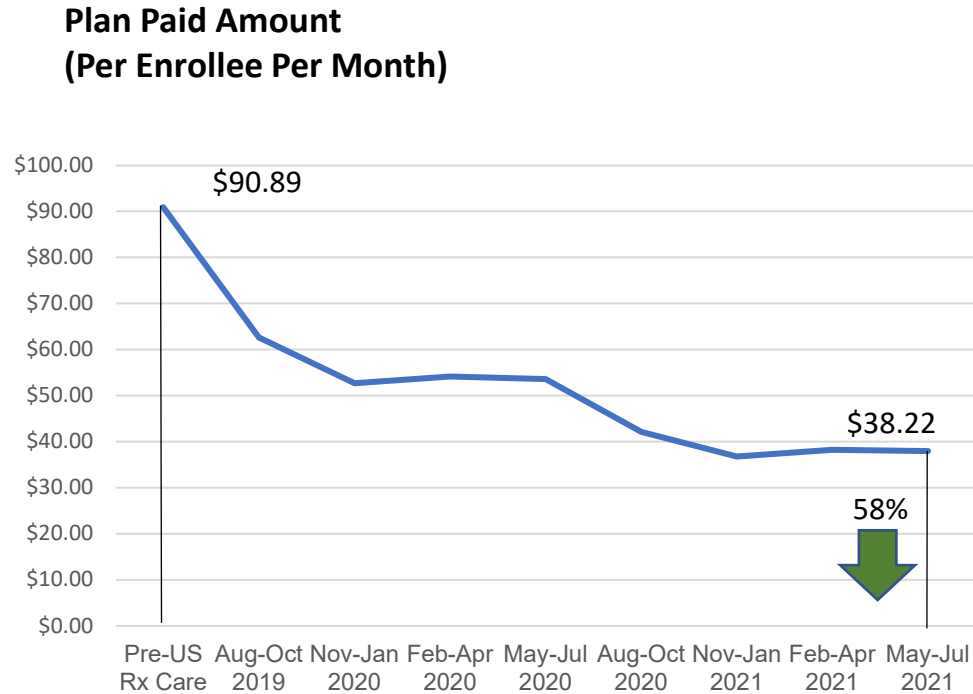
> ➢ $2.8 MM Annual Cost Reduction
> ➢ $4.6 MM Two-Year Cumulative Savings

Coordination and Communication Across The Quality of Care Continuum

Prescribers

Members

Medical & Rx Data

Clinical Service Providers

- Pharmacies
- Diagnostic Facilities
- Other

Thank You!