CONTINUING THE JOURNEY TO VALUE-BASED CARE

Overview

Since the passage of the Affordable Care Act in 2010, there has been increasing focus on reducing health care costs and improving quality and patient experience through value-based reimbursement. Value-based reimbursement pays health care providers based on the quality and efficiency of care delivered rather than the number of services delivered. The industry has made steady progress transitioning to value-based reimbursement models. Payers continue to align more health care spend to value and launch new value-based models designed to support providers' transition to value-based care. Provider adoption also continues, but is variable across markets and types of providers and remains more limited for models that put a degree of provider reimbursement at risk. Despite some headwinds, continued adoption of value-based care is inevitable as customers, clients, and both government and private payers seek more value out of health care spending. Collaboration is critical across all stakeholders to support providers' successful transition.

A brief history of value-based care

Health care quality improvement efforts in various forms have been in focus in the United States for more than a century.[1] In recent decades, federal and state governments and industry stakeholders have focused more on reining in U.S. health care costs, which have climbed significantly since the 1960s, increasing on average 6% each year.[2] Attempts to rein in costs through various regulatory, plan design, payment reform, and cost containment measures had limited success and often resulted in contentious relationships between payers and providers, or restricted choice for customers. Recent efforts have taken a more collaborative approach to achieve greater success in reducing costs while maintaining or improving quality of care.

The Department of Health and Human Services (HHS) has been an accelerating force behind the most recent value-based care transition. Several key legislative efforts have reinvigorated and brought health care quality and efficiency efforts to the forefront, beginning with the passage of The Patient Protection and Affordable Care Act (ACA), comprehensive health care reform, in 2010. A key provision of the ACA was to support innovative care delivery models designed to lower health care costs through the establishment of the Centers for Medicare & Medicaid Services (CMS) Innovation Center. The ACA also created a pathway for Medicare to reward providers that lower expenditure growth while achieving quality standards through the Medicare Shared Savings Program (MSSP).

In 2015, HHS also put pressure on the industry by releasing their value-based payment goal that 50% of fee for service (FFS) Medicare payments be tied to "alternative payment models" (APMs) and 90% of payments

1 Burstin, H. et al, *Journal of internal Medicine*, "The evolution of healthcare quality measurement in the United States," 19 January 2016.
2 PricewaterhouseCoopers, "Medical cost trend: Behind the numbers 2019," June 2018.

will be tied to "value-based arrangements," by the end of 2018.[3] This was the first time in the history of the Medicare program that HHS set explicit goals for value-based payments to providers. In addition, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) with overwhelming bi-partisan support. This landmark legislation was expected to accelerate the shift to value-based reimbursement by radically altering how providers are paid for traditional Medicare patients. MACRA has two tracks for physicians: 1) *the default track, MIPS* (Merit-based Incentive Payment System), a single budget-neutral program that evaluates providers on quality, promoting interoperability, cost, and improvement activities, phased in over a transition period which ends in 2021; and 2) an *Advanced APM track* for qualifying providers which rewards participation in innovative models and encourages risk adoption.[4]

While some commercial payers were testing value-based models before the passage of the ACA, following the passage of the ACA and the announcement of HHS' value-based payment goals, payers increasingly pursued value-based care with contracted providers. Many large commercial payers committed to their own value-based goals and have made strong progress towards achieving those goals. Since commercial payers cannot require value-based care participation through mandatory programs the way CMS can, many commercial models encourage adoption by delivering more data and analytics to inform care coordination decisions as well as the product and network structures that support shared or full risk (e.g., narrow or tiered networks).

Where we are today

The industry has made substantial progress in shifting to value-based care. Value-based payment to providers increased from 38% in 2015 to 59% in 2017 across all lines of business.[5,6] Over the same time period, APM adoption increased by 11 percentage points, from 23% to 34%. The shift to shared or full risk has been more limited, and comprises only about 12% of payments today.[7] However, as the shift to value-based care continues, it is likely there will be an increased focus on shared risk.[8]

Medicare – While there is uncertainty around the future of health reform, the current administration has continued to signal support for provider payment reform. CMS has scaled back on some mandatory value-based payment programs, but has indicated their intent to implement others in their place, and has made changes to the voluntary MSSP that would increase provider accountability for outcomes (See Figure 1). CMS has also eased some MACRA requirements to increase provider flexibility and reduce the regulatory burden of the

Figure 1. In an effort to encourage shared-risk adoption, CMS implemented "Pathways to Success," a MSSP program redesign replacing the 3 tracks in the current program with two tracks. The BASIC track, allows ACOs to begin with shared savings, and slowly accept greater levels of risk as they gain experience. The ENHANCED track is modeled after the current track 3, the highest level risk track.[9] In the original program structure, 75%+ of participants are in track 1, the lowest risk track. The MSSP program has had mixed results since its inception, however, in 2017, it achieved net savings of over $313M for the first time.[10] Many providers indicated they would consider dropping out of the program due to the redesign; so far, there has only been a modest increase in the dropout rate at the end of 2018.[11]

3 U.S. Department of Health and Human Services, "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value," News, January 26, 2015. An APM is a payment approach that offers additional incentive payments for high-quality and cost-efficient care.
4 HCPLAN, "2018 APM Measurement Methodology and Results Report."
5 HCPLAN, "2018 APM Measurement Methodology and Results Report." Includes commercial, Medicaid, Medicare FFS, and Medicare Advantage.
6 HCPLAN, "2016 APM Measurement Methodology and Results Report." Includes commercial, Medicaid, Medicare FFS, and Medicare Advantage.
7 HCPLAN, "2018 APM Measurement Methodology and Results Report."
8 HCPLAN, "2018 APM Measurement Methodology and Results Report."
9 Federal Register, *The Daily Journal of the United States Government,* "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success," 17 August 2018.
10 Bleser, William, Muhlestein, David, Saunders, Robert, McClellan, Mark, *Health Affairs,* "Half A Decade In, Medicare Accountable Care Organizations Are Generating Net Savings: Part 1," 20 September 2018.
11 Bleser, William K. et al, *Health Affairs,* "Following Medicare's ACO Program Overhaul, Most ACOs Stay—But Physician-Led ACOs Leave At A Higher Rate," 15 March 2019.

program. However, overall value-based care participation has continued, with 52% of Medicare Advantage payments and 89% of Medicare FFS payments made to providers in 2017 being value-based.[12] As of 2018, approximately 12.3 million Medicare beneficiaries – over 20% – are part of Accountable Care Organizations (ACOs).[13]

Commercial payers – Commercial payers remain committed to value-based care, and approximately 44% of commercial payments are tied to value.[14] Commercial payers have expanded value-based models beyond primary care and large groups to include smaller groups, specialists, ancillary providers, and pharmaceutical companies. Many have invested significantly in capabilities to support providers in moving to value, from clinical resources to data exchange and analytics. However, data privacy laws limit what kind of information is shared with providers and how, and it is a challenge for payers to integrate actionable information into providers' existing workflows due to the disparate electronic medical record systems in use.

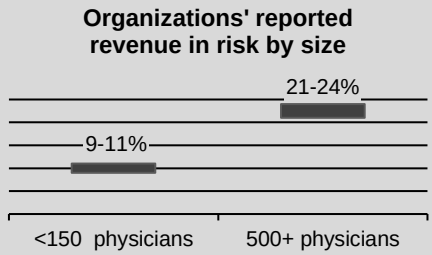
Providers – Nine years after the passage of ACA, there are more than 1,000 ACOs providing coverage to more than 32.7 million individuals in the United States.[15] However, currently, only 25% of provider revenue is in value-based care.[16] There are many reasons why providers remain hesitant to move to value-based care, including:

- Provider uncertainty over health reform and changing regulations / policies
- Proof of ROI – will the financial returns justify the investment needed to support care management capabilities?
- Skepticism regarding the impact of value-based care – only one-third of clinicians think value-based contracts lower cost of care[17]
- Greater administrative burden – simultaneously operating under FFS and fee for value (FFV) arrangements, tracking multiple measures that vary across payers

Provider adoption of risk remains limited and variable across markets, sizes, and types of providers (See Figure 2). Many providers remain hesitant to move to risk due to:[18]

- Variable degrees of bidirectional data exchange and integration into providers' workflows
- Lack of cost and quality transparency to inform decisions
- Need to develop necessary capabilities, competencies, and infrastructure to manage risk

Figure 2. Larger provider organizations indicate greater readiness for and higher current levels of commercial risk participation than smaller organizations.[16]



Still, provider adoption of value-based care is expected to continue given CMS' continued focus on payment reform. In addition, as financial margins compress, some providers may view value-based care as an opportunity to maintain or increase revenue.

Employers – Employers are looking for more affordable, predictable health care solutions. While employers have been generally supportive of value-based care, they are more confident that it will help to improve quality

12 HCPLAN, "2018 APM Measurement Methodology and Results Report."
13 National Association of ACOs, "NAACOS Overview of the 2018 Medicare ACO Class," retrieved 12 February 2019: https://www.naacos.com/overview-of-the-2018-medicare-aco-class.
14 HCPLAN, "2018 APM Measurement Methodology and Results Report."
15 Muhlestein, David, et al, *Health Affairs*, "Recent Progress In The Value Journey: Growth Of ACOs And Value-Based Payment Models In 2018," 14 August 2018.
16 NEJM Catalyst, "Transitioning Payment Models: Fee-for-Service to Value-Based Care," November 2018.
17 NEJM Catalyst, "Transitioning Payment Models: Fee-for-Service to Value-Based Care," November 2018.
18 American Medical Group Association, "Taking Risk, 3.0: Medical Groups Are Moving to Risk…Is Anyone Else? AMGA's Third Annual Survey on Taking Risk," December 2017.

more so than costs.[19] As a result, many employers are hesitant to transition employees from broad network plans to more tailored plans built around specific value-based providers with benefits that guide customers to those providers. They are also cognizant that changing plans can be disruptive and they do not want to limit choice, or give the perception that there is less choice. In these broad networks, customers can choose when and where they seek care. Therefore, providers are typically less willing to take shared or full risk in these products as it is more difficult for them to control or know where and when customers seek care.

Looking to the Future

Continued adoption of value-based care is inevitable given CMS' continued focus on payment reform, widespread commercial payer support, and employer and consumer demand for affordability, quality and experience. To accelerate the transition and support providers' on this journey, payers need to:

- Prove the value of participation in value-based models for providers to invest in the capabilities needed to manage population health
- Appropriately reward providers for delivering good outcomes through enhanced reimbursement and more patient volume
- Help customers and providers choose providers based on outcomes they deliver
- Offer providers the right information and tools and increased transparency to enable them to be successful in a value-based model
- Integrate pharmacy and behavioral into value-based models to address the "whole" person, allowing the provider and their patient to more effectively manage their conditions and achieve better outcomes

Value-based care adoption will be most successful if all stakeholders are willing to participate and see a path to success.

Cigna's vision for value-based care

Cigna believes that value-based relationships with providers are key to continually improving sustainable affordability, quality care and experience. The Cigna Collaborative Care® program is Cigna's set of value-based provider collaboration models aimed at delivering better health, affordability, and customer and provider experience. We meet providers where they are in terms of risk readiness, experience, and their own strategic goals, and work with them to help ensure their success in value-based care. We do this through aligned incentives, peer-to-peer consultative support, actionable information, and alignment with our consumer health engagement programs.

We launched our first value-based care relationship with a large primary care physician group in 2008, and since then have expanded Cigna Collaborative Care to include hospitals and specialty groups. Over the past decade, we have refined our program based on insights from our collaborative providers to better support them and their journey to value-based care, and have launched a payer-agnostic solution to work with independent providers. Today, over 50% of our payments in our Top 40 markets are in alternative payment models[20], and we have more than 650 commercial value-based arrangements nationwide, with strong results[21]:

19 National Business Group on Health, "Large Employers' Health Care Strategy and Plan Design Survey," August 2017.
20 Cigna January 2019 analysis of medical payments in the top 40 US markets as of Q4 2018.
21 Cigna internal analysis of existing arrangements as of April 2019. Subject to change.

- *Since 2013, Cigna's commercial Accountable Care program has achieved $606M in savings*[22]
- *Top performing commercial ACO providers have demonstrated a -9% or better trend relative to market*[23]
- *Top performing commercial ACO providers demonstrated a quality performance of 11% better than market*[24]

We are building on our success with Cigna Collaborative Care to deliver sustainable affordability and quality, while preserving customer choice and delivering a differentiated customer and provider experience. We are doing this by:

- Continuing to grow and innovate in Cigna Collaborative Care, expanding our model types to address areas of care where medical costs are highest.
- Taking a “whole” person view of the customer by integrating behavioral and pharmacy into value-based models.
- Connecting customers with quality doctors across all network solutions and helping them along their health journey based on their unique needs and preferences.
- Helping providers succeed in value-based care by delivering the right incentives and tools to support care coordination and anticipating and addressing obstacles to good outcomes.
- Delivering more affordable, cost predictable solutions to employers and support a healthier, more productive workforce.

To deliver our vision, we need to support providers to successfully manage the health of their patients, work with employers to guide their customers to value-based providers who are delivering good health outcomes, and help customers make informed health care decisions. Together, we can make it easier for customers to access affordable, quality care and promote our collective goal of building a more sustainable health care system.

22 Cigna January 2019 analysis of national Accountable Care program groups with effective dates from 2013 through 2017. Reimbursements already paid to groups are subtracted from the savings to reflect overall investment.

23 Cigna June 2018 analysis of data for top 5 Accountable Care program groups nationally, compared to local market in 2017. Accounts for 19,200 aligned customers. Comparisons to market are established using Cigna internal claims data.

24 Cigna June 2018 analysis (weighted average) of top five national Accountable Care program groups per metric compared to local market in 2017. Accounts for 23,405 aligned customers. Comparisons to market are established using Cigna internal claims data.