CVS Accountable Care™

WHITE PAPER

The Future of Health Care Delivery is in Risk-based Payment

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MOST HEALTH CARE PROFESSIONALS and health care consumers agree that health care in the United States is overburdened, under-resourced, and in some cases, broken. Physician burnout continues to be at unprecedented levels, nurses and other clinicians have left the workforce for a variety of reasons, the nation is experiencing provider shortages in urban and rural communities, and the population is aging, adding to the challenge. Most recently, the pandemic spotlighted the inefficiencies and obstacles of America's health care delivery system. The pandemic, however, resulted in a notable ripple effect: a slow-to-change system was forced to quickly transition from one with rigid regulations and policies to one that implemented and adopted innovative technologies, and used the flexibilities to evolve to a more efficient way of delivering health care.

In this white paper, we will share expertise on the significance of transitioning to outcomes-driven, longitudinal care to maintain sustainable health care practices in our nation's ever-evolving landscape. With the imminent transition from fee-for-service models to value-based care, we will educate providers and health care stakeholders on value-based payment models and address the benefits of the Medicare Shared Savings Program (MSSP), Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH), and alternative payment models in Medicare Advantage (MA).

We also affirm the commitment of CVS Accountable Care to support provider practices, regardless of size and type, to adopt and succeed with value-based care and showcase our resources' capacity as we help inform decisions and policies within the Centers for Medicare & Medicaid Services (CMS).

The Evolving Provider-payer Relationship

Diagnosing and treating humans will never be an exact science, but rather, an evidence-based art form. As a result, the health care landscape will always include a degree of uncertainty. However, it is certain that the transition from fee-for-service (FFS) models to value-based care is no longer a question of if it will happen but rather when.

In 2021, the Centers for Medicare & Medicaid Services (CMS) established a goal to have 100% of Original Medicare beneficiaries and the vast majority of Medicaid beneficiaries in accountable care relationships by 2030. The organization continues to reiterate this goal and make advancements in accountable care models.

In the near future, providers who do not participate in taking on risk with Medicare could be paid 5 – 10% less than providers who take on risk.

Value-based care aims to reduce health care costs while maintaining high-quality services and improving patient care outcomes. CMS has placed more onus on providers to take responsibility for patient outcomes and the total cost of care, establishing longitudinal and mutually beneficial accountable care relationships between providers and payers. Aligned incentives are meant to position all parties to better focus on their areas of expertise. Controlling expenditures requires an enhanced level of care coordination and patient engagement, as well as a commitment to identifying and addressing social determinants of health. While providers and payers will face

certain obstacles as they transition to new ways of delivering health care, the advantages of shifting to health care based on value are clear. These advantages are not merely financial. They lead to greater satisfaction of providers, team members, and patients, lower unnecessary, higher-acuity care, and more days patients spend in their homes.

Transitioning to Value-based Care: Challenges and Opportunities

Why the emphasis on change from CMS? The United States boasts the world's most costly healthcare system, with a total expenditure of 1.5 trillion in 2022 and $747 billion dedicated solely to Medicare. Healthcare costs grew 4.5% from the previous years. According to a 2021 report, Americans lag decidedly behind other industrialized nations in life expectancy, infant mortality, and health insurance coverage despite health care costs being far higher than in other developed countries. Actuaries predict that the Medicare Trust Fund will deplete by 2028. Physician fee schedule conversion rates have seen reductions to remain budget-neutral. According to the 2020 Census, the US population aged 65 and above expanded nearly five times faster than the overall population from 2010-2020 compared to the last 100 years. Something simply has to be done, and the solution CMS and other payers are leaning into is value-based care.

The Advantages of Health Care Based on Value Rather Than Fees

Value-based payment models determine reimbursement based on the relative risk of the population and the amount of financial risk providers take. Value-based care emphasizes patient-centered, holistic, individualized care.

With value-based care, providers can

- **Provide the appropriate care** Deliver the right care in the right place at the right time. This naturally improves patient satisfaction, which helps to enhance patient engagement in their care journey.
- **Improve the patient-provider relationship** Improved communication and understanding that facilitate long-term healthcare relationships.
- **Better manage the needs of complex patients** Patients, particularly those who receive Medicare, frequently have multiple chronic conditions. With care coordination, enhanced data analytics, and improved workflows, providers can better manage patients' lifelong and life-limiting conditions and improve their abilities to prevent, identify, and intervene on potentially serious concerns earlier to keep patients healthier and mitigate avoidable admissions.

Taking more responsibility for patients' health outcomes encourages providers to strategically shift toward risk. These risk-based arrangements include the financial aspects of patient care and the clinical aspects they were educated and trained to perform. Today, many of the nation's providers have not adopted downside-risk arrangements in value-based care, remaining at "zero risk."

Under Internist Dr. Steven Reeves' leadership, Greater Regional Health (GRH) achieved notable progress in patient care through participation in the MSSP with CVS Accountable Care. Dr. Reeves collaborated with CVS Accountable Care to address challenges posed by growing patient loads. Leveraging data on Medicare admissions, he successfully advocated for a dedicated nurse practitioner for high-risk patients. This collaboration resulted in significant outcomes, including a 50% reduction in emergency and hospital admissions, lower prescription medications per patient, increased satisfaction, reduced calls, $3.8 million in new population health revenue and $870,000 in shared savings. Dr. Reeves emphasizes that the ACO model transformed schedules and reintroduced compassion into care, empowering nurses to excel in their roles.

What is zero risk?

Upside-only or shared savings only risk arrangements.

Given the aforementioned levels of current provider burnout and the stresses accompanying the delivery of high-quality health care services amid soaring costs, it's understandable that many providers have yet to transition to new reimbursement structures. Are we asking too much of providers, health systems, and hospitals to make this revolutionary transition without resources and support? We think so.

The Role of the Enabler

The value-based care experts at CVS Accountable Care have established a support model for providers, health systems, and hospitals to successfully transition to value-based care, including taking on the accompanying financial and clinical risks. We specialize in model- and payer-agnostic solutions regardless of the size, provider practice type, experience with value-based care, or payer relationships. Our teams closely align with our provider partner organizations, positioning them for success with all the necessary tools and resources. By enabling our provider partners with demonstrated methodologies and proven tools of success, we have saved Medicare more than $585 million over the past decade.

Who do we work with?

Federal and state government organizations continue to indicate that value-based care is not a passing trend – it is the future of healthcare. CMS and the Center for Medicare and Medicaid Innovation (CMMI) have prioritized value-based payment models with recent policy changes. Enabler organizations, like CVS Accountable Care, support providers and health care organizations as they transition from FFS to value-based care. As health care continues its rapid shift to new care delivery methods, the role of payer-agnostic enablers becomes crucial for providers to successfully navigate the changes, implement new infrastructures, and adapt to new technologies while maintaining operations. Given the complexities of taking on risk, the notion of "going it alone" is arguably the most significant risk providers can take as they learn to take on financial and clinical-related risk payment models. Partnering with a trusted advisor in an enabler organization can help ensure provider organizations have a smoother and simplified path to value-based care by benefitting from proven resources, clinical programs, technologies, and guidance that evolve with their needs on their value-based care journey.

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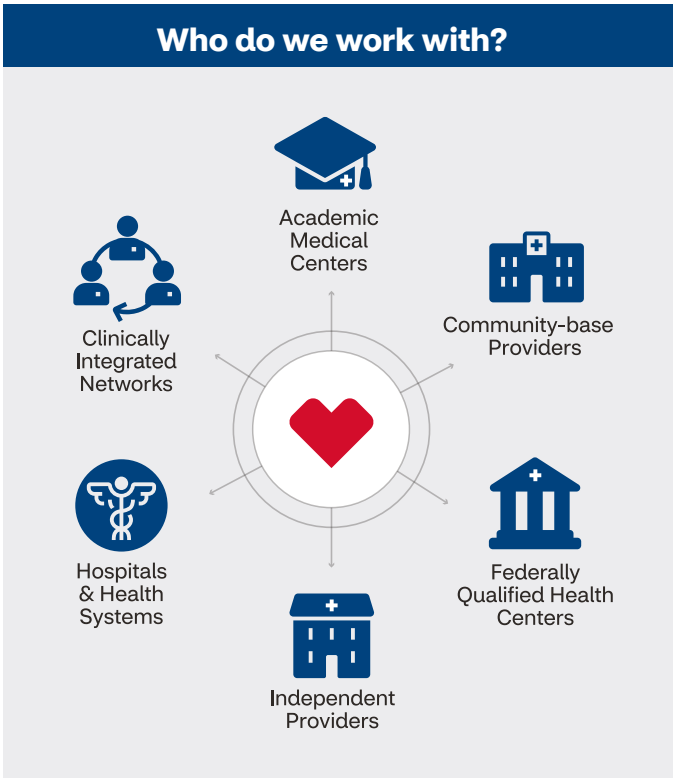

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The best predictor of future success is past success.

"I think a critical component to value-based care is partnerships and teamwork. One of the things that we decided when initially going in this direction was that we absolutely couldn't continue to layer on responsibilities for our PCPs. And, in order to meet the objectives and deliverables of these programs, we had to really invest in other team members, like pharmacists, social workers, navigators, and nurses, that are connecting with the patient outside of more traditional visits and partnering and creating that teamwork."

Amanda Tosto
RUSH

The Role of CMS in the Evolution of Accountable Care Organizations (ACOs)

The collaborative infrastructure that ACOs offer, including trusted advisors and experienced partners, helps participants improve health care delivery through better care coordination, including identifying gaps in care and enhancing provider and patient engagement. ACO resources help providers to avoid duplicative services that are not only a disservice to patients but also result in higher costs. The Medicare Shared Savings Program (MSSP) is an established, statutory value-based care payment model that provides the opportunity to share in the savings generated by the program when (1) health care costs are reduced and (2) patient care outcomes are either maintained or improved. The MSSP offers different tracks for progressing into risk.

Aware of the "ratchet effect," wherein high-performing providers and organizations who reduce spend and improve outcomes are rebased with lower benchmarks that can hinder achieving savings in the future, CMS has continued its progression toward the goal of administrative benchmarks that are more equitable for all participants. Most recently, for ACOs that start in 2024, CMS has made significant changes to the benchmarks for new agreement periods and new and renewing ACOs. These changes are improvements and get the program closer to a budget-neutral solution that ideally incorporates accurate administrative benchmarks.

To further substantiate CMS's commitment to value-based care payment models, the organization is also considering introducing an "Enhanced Plus" track within MSSP (per last year's Request for Information in the Physician Fee Schedule), signifying a strategic shift in offering more upside for the potential for accepting more downside risk. CMS and the Innovation Center recently developed the ACO Primary Care Flex Model, a hybrid prospective primary care payment CMMI option for PCPs participating in the MSSP. The model will prioritize and allocate investments towards low-revenue ACOs, which are typically composed of physicians.

Improving Outcomes with ACO REACH

When CMMI introduced the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model, the organization aimed to reduce health inequities and improve inclusivity for underserved populations. Through ACO REACH, providers are encouraged to participate in ACOs and take increased responsibility for the total cost of care, particularly for underserved demographics.

The program strategically incorporates requirements that address health equity, including systematically gathering and risk stratifying essential demographic and social determinants of health data for all beneficiaries aligned with the program. The model's Health Equity Benchmark Adjustment (HEBA) model adjusts financial benchmarks to reflect the characteristics of the patient population. The goal of HEBA is to ensure that providers are appropriately incentivized for serving Medicare patients from historically underserved communities, while also accounting for the increased costs associated with caring for these beneficiaries. Also, ACO REACH entities must submit health equity plans, outlining their commitment to analyzing and addressing health disparities within the ACO's work, potentially in collaboration with other organizations.

Looking ahead, CMMI said it will focus on integrating health equity into all its value-based models. Additionally, CMS has adjusted quality scores for MSSP ACOs based on the demographics and underserved status of the patients they serve. Given that health inequities cost the nation $320 billion annually and are expected to increase, healthcare systems must continually prioritize the integration of health equity strategies as a core component of their daily operations. Utilizing advanced analytics and implementing new workflow streams will be instrumental in expanding access and enhancing the impact of efforts to promote health equity within ACO REACH and other value-based payment models.

As the nation's health care landscape evolves, so has ACO REACH. The program has incorporated elements from Next Gen ACO that have not yet been added to the MSSP, including the option for relief through cost-sharing and beneficiary enhancements like non-provider in-home visits and assessments after hospitalization and for patients at risk for hospitalization. Participating providers and their extended care teams benefit from valuable tools and resources for comprehensive patient care and engagement and the flexibility to contract rates with

inspira® HEALTH NETWORK

Inspira Health, a prominent network of around 1,300 healthcare providers in southern New Jersey, faced inconsistent financial results while operating its own ACO from 2015 to 2020. Seeking the success demonstrated by CVS Accountable Care in managing ACOs of diverse sizes and backgrounds, Inspira joined CVS ACO in 2021. Following this collaboration, Inspira achieved steady shared savings of $1.7 million in 2021 and $1.9 million in 2022, marking a significant improvement over previous financial inconsistency. Additionally, Inspira successfully transitioned to the MSSP's Enhanced Track, allowing them to earn greater financial incentives while operating under increased risk. April Venable, SVP of Operations, Strategy, and Transformation at Inspira Health, highlights the attractiveness of CVS Accountable Care's willingness to share the risk, emphasizing the accelerated improvement in provider performance and shared savings through the disciplined model introduced by CVS Accountable Care.

high-value downstream and specialty providers. Patients and their caregivers benefit from targeted, individualized support. Additionally, ACO REACH offers payment flexibilities, a full risk global track and a high-needs population track, encouraging new providers and those that are ready for full risk to enter the program.

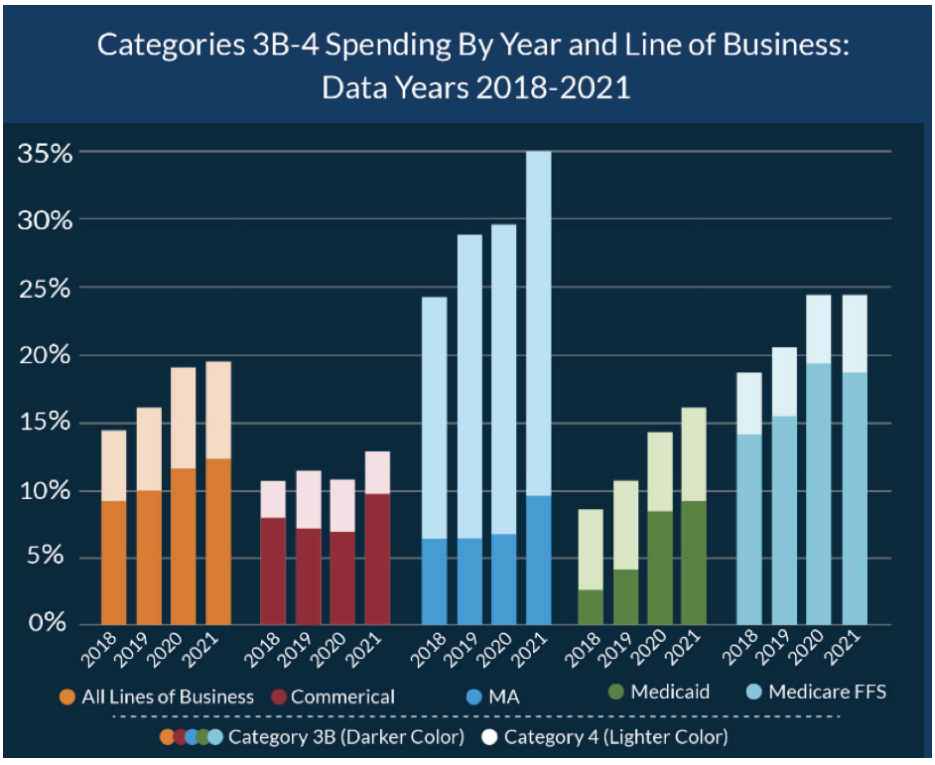
The Financial Advantages of Value-based Care

In addition to the financial prospects associated with ACO REACH, there are also fiscal opportunities within the Medicare Advantage (MA) plan. There is a palpable shift in demographics as increasing numbers of individuals elect to enroll in MA plans rather than traditional fee-for-service Medicare. According to the United States Census Bureau, in 2020, one in six Americans was 65 years of age and older, confirming that the United States population is older than ever. MA's comprehensive coverage is well-suited to an aging demographic and has the added benefit of giving providers more regulatory flexibility. With additional supplemental benefits and special needs programs that address the needs of specific populations, like dual-eligibility and multiple chronic conditions, MA is an appealing option for many beneficiaries. For providers, having a comprehensive strategy and the appropriate partner can streamline the management of your entire Medicare Population within the principles of value-based care

The Role of Risk

A catalyst for transformation, risk requires providers to adopt a more patient-centered approach to their practices with financial incentives that are no longer tied to the number of services but rather emphasize improved patient outcomes.

According to data from the Learning Action Network, adopting two-sided risk alternative payment models (APM) is on an upward trend, with 83% of payers anticipating a growth in APM activity over time.



The LAN began collecting APM spending by LOB and subcategory in 2018 (2017 data year), however, not all plans that were surveyed in 2018 (2017 data year) included a breakdown of expenditures by subcategory. Therefore the subcategory breakdown is not shown in graphic.

What's another way to describe risk? Patient-centered care.

- Risk requires providers to transition from reactive health care practices to proactive practices.
- Risk rewards providers for quality and health outcomes.
- Risk means providers take ownership of holistic patient management to address medical-related concerns and non-medical social determinants.
- Risk involves financial support, training, and resources to facilitate a smooth transition.

The Role of Payer Agnostic Provisions

The optimal position for provider practices is participating in a multi-payer alignment of risk-based contracts that can fully capture the financial reward for the care they provide to their patients. In these agreements, every payer has contracts that are similar and allow a practice to manage all patients in a way that is analogous or payer-agnostic, which simplifies operations for everyone. This approach results in an optimized environment for delivering value-based care employing patient-centric approaches.

Our Future

For provider practices across the United States, there are a lot of takeaways from this paper to consider. As the state of health care continues to evolve, the successful transition to value-based payment models and the implementation of risk-based care strategies will ensure success in the future. CMS is clearly committed to this new way of delivering health care, and in the competitive field, providers want to be included. They need to be included. There is now a greater sense of urgency as CMS' 2030 goal quickly approaches providers to shift their practices toward patient-centered models that can assume risk and benefit from the financial prospects of doing so.

Lessons learned from ACO REACH will likely inform the development of future models of care much like its predecessor, the Accountable Care Organization Investment Model or AIM, did a few years ago. With an emphasis on caring for and delivering improved health care to underserved populations, the ACO REACH model proves that addressing social determinants of health and disparities will continue to be critical to health care practices that improve patient outcomes and reduce or minimize overall costs.

The Role of CVS Accountable Care

As value-based care enablers with a proven history of success, CVS Accountable Care is a strategic partner who support our provider partners in optimizing analytics, implementing innovative technology, enhancing provider's workflows and care model, and stabilizing the workforce for a successful future in risk-based payment models. Our long and successful history in value-based care positions us to identify needs and advocate for more flexible payment structures, including capitation models that help provide the financial latitude to deliver high-quality, comprehensive, patient-centered care.

The administrative burden can be a challenge for providers transitioning from FFS to value-based care, and we have successfully advocated for equitable programs and options that simplify compliance requirements by aligning reporting, rules, and quality measures.

Together, we can navigate the complexities of risk, initiate transformative change, and develop a health care future that prioritizes patients and providers. At CVS Accountable Care, we position our partners for success.

For more information on CVS Accountable Care, visit CVSACO.com.

"You have to be a little bit of a risk-taker. Because of shared savings, it is easy for us to justify the [ACO] program. Our patient satisfaction scores are better, and we have doubled the number of patients enrolled in chronic care management."

Kathy Lee, MBA
Director of Population Health
Coryell Health