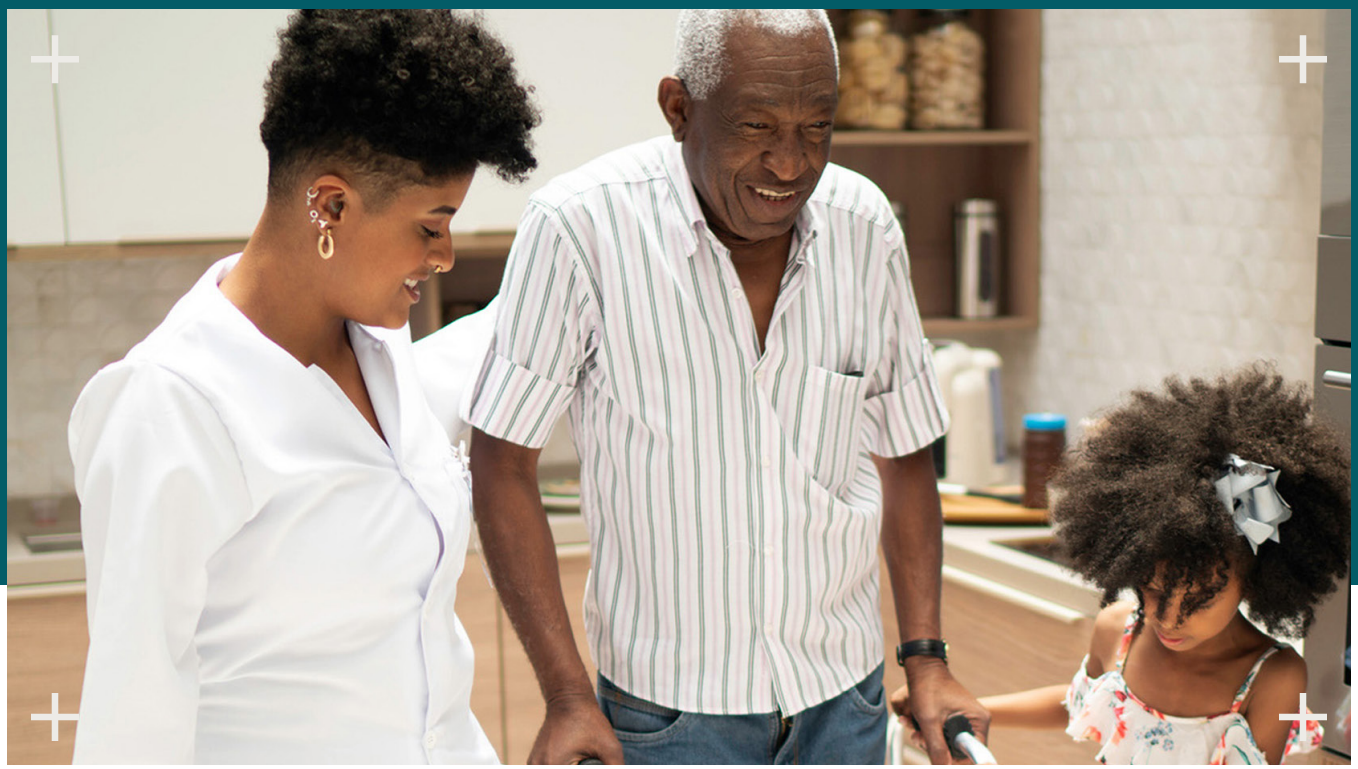
HEALTH FORWARD:

How Value-Based Care Can Change the Trajectory of Health Care Costs



Yvette LeFebvre
Chief Medical Officer
Evernorth Home-Based Care

Melissa Steffan
President
Evernorth Home-Based Care

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HEALTH SERVICES

Health care spending in the U.S. topped $4.3 trillion in 2021.[1] In the years ahead, the spending is projected to rise steadily, reaching $7.2 trillion in 2031.[2] Much of the health care spending — 85 percent in 2021[3] — is attributed to the growing polychronic patient population.

Polychronic patients, those living with three or more chronic conditions, have complex care needs that drive increased health care utilization and costs. The aging population, along with advances in the treatment of chronic diseases, are expected to propel the number of polychronic patients in the U.S. to 83.4 million by 2030, up from 30.8 million in 2015.[4]

Value-based care models are gaining traction as an alternative to traditional fee-for-service models as providers and payers respond to polychronic patient trends.

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THE COST OF CARE[5]

18% of Medicare patients living with 6 or more chronic conditions

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More than half of the total Medicare spend

WHAT'S INSIDE:

[1] National Health Expenditure Data, Centers for Medicare & Medicaid Services, December 2022.
[2] Keehan S, Fiore J, Poisal J, et al. National Health Expenditure Projections, 2022–31: Growth To Stabilize Once The COVID-19 Public Health Emergency Ends, Health Affairs June 2023.
[3] Holman H. The Relation of the Chronic Disease Epidemic to the Health Care Crisis, National Library of Medicine, March 2020.
[4] Waters H, Graf M. The Costs of Chronic Disease in the U.S., Milken Institute, August 2018.
[5] *Chronic Conditions among Medicare Beneficiaries*, Centers for Medicare & Medicaid Services, 2018.

EXPLORING ALTERNATIVES:

What makes value-based care different?

Fee-for-service models have dominated health care delivery in the U.S. The approach pays physicians and other health care providers a fee for individual office visits, tests and procedures. The model essentially incentivizes condition-by-condition care, paying medical care providers based on the volume of services provided rather than the outcome.

In a **fee-for-service model**, health care providers often lack a holistic understanding of their patient's health, contributing behavioral factors and barriers linked to social determinants of health (SDOH). For polychronic patients and their caregivers, the care experience can be complex and cumbersome as they assume the primary responsibility for care coordination. Complex care needs and siloed care management contribute to a cycle of increased hospitalizations and higher costs.[6]

In contrast, value-based care focuses on delivering integrated whole-person care. Reimbursements to health care providers are tied to the quality of care, rewarding providers for effectiveness as well as efficiency based on metrics such as hospital admissions, readmissions and preventive care. The model is designed to leverage evidence-based practices to help reduce the impact and occurrence of chronic diseases and enhance quality of life. In short, the aim of value-based care is to deliver more value for each health care dollar spent.

In a **value-based care model**, the provider typically supports a smaller roster of patients than in a fee-for-service practice. The holistic focus allows a more robust, multi-disciplinary care team to spend more time getting to know patients, understand their health conditions and consider the impact of SDOH factors, such as income level, home environment or transportation access.

Home-based care is an effective element in the delivery of patient-centered, value-based care, especially for polychronic patients. In particular, home-based primary care can help to improve the coordinated management of chronic conditions, ensure ongoing preventive care and address SDOH barriers by leveraging a combination of in-home visits and digital telehealth technology.

HOW IS HOME-BASED CARE HELPING TO TRANSFORM POLYCHRONIC PATIENT EXPERIENCES?

Download the companion report in our "Health Forward" series to explore the emerging role of home-based care.

The Evolution of Polychronic Patient Care

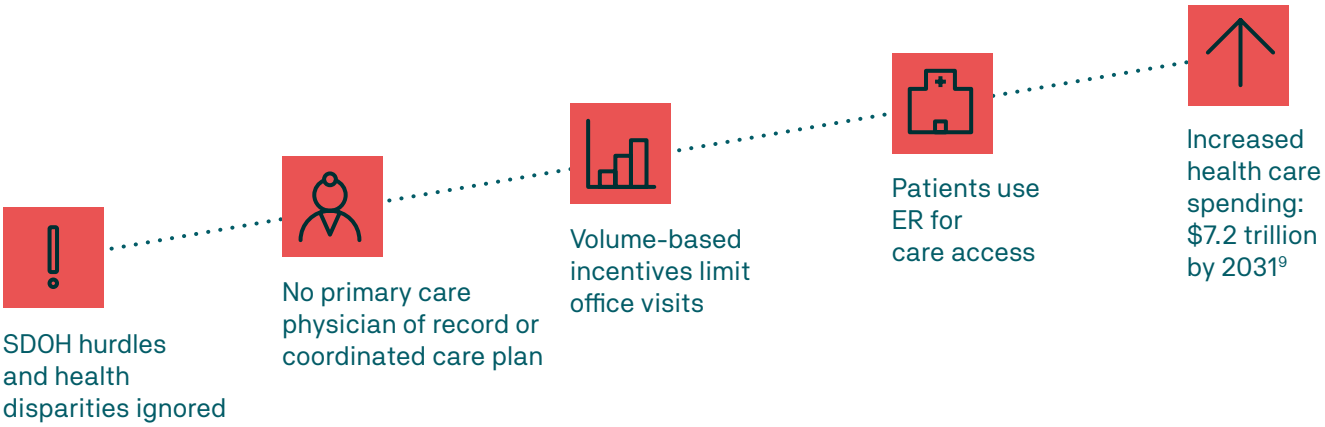
[6] Skinner HG, Coffey R, Jones J, Heslin KC, Moy E. The effects of multiple chronic conditions on hospitalization costs and utilization for ambulatory care sensitive conditions in the United States: a nationally representative cross-sectional study, BMC Health Serv Res., March 2016.

In a study involving Medicare Advantage patients, increased contact with primary care physicians improved patient health outcomes while reducing costs by 28 percent.[7] The results were attributed to a combination of factors related to the increased frequency of contact between patient and physician, including:[8]

+ Better communication resulting in better patient adherence to taking medications
+ More timely diagnoses and treatment of issues that helped patients avoid hospitalization
+ Increased access to preventive care, such as vaccinations and screenings

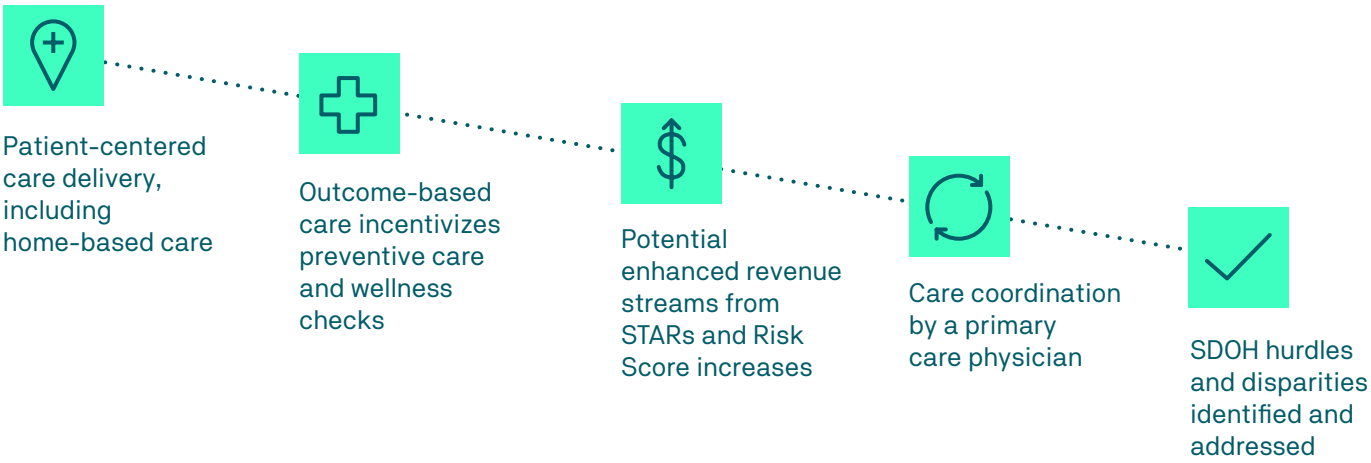
Changing the cost trajectory

FEE-FOR-SERVICE CARE MODELS



VS.

VALUE-BASED CARE MODELS



[7] Ghany R, Tamariz L, Chen G, et al. High-Touch Care Leads to Better Outcomes and Lower Costs in a Senior Population, The American Journal of Managed Care, August 2018.
[8] Id.
[9] Keehan et al. National Health Expenditure Projections, 2022–31

RISK MANAGEMENT:

Evaluating the financial risk options of value-based care

The opportunities value-based care presents to positively impact the patient care experience are clear. But shifting to the model is significant and not without financial risk for provider groups and plans.

In a shared savings funding model, a provider receives a payment to cover all the services a patient needs based on a health assessment. If the provider delivers appropriate care that exceeds a predetermined baseline amount but is less than the contracted payment, the savings are shared between the provider and payer. However, if the amount exceeds the contracted payment, the provider is not penalized.

As rising costs accelerate the need to find efficiencies and savings, full-risk payment models offer providers another option. Under a full-risk value-based care model, the provider takes full financial responsibility for the costs of a patient's care. Providers pay for preventive, specialty or emergency care while keeping the savings produced by improved care management.

In a full-risk model, the care team is able to align and deliver the care patients need without having to consider whether it's covered or billable. Along with preventive care and earlier interventions when a patient's health changes, providers can address transportation issues with ongoing home-based visits and telehealth check-ins. Or they can spend extra time ensuring patients understand prescription instructions and dosages. Overall, the primary physician-coordinated approach helps to create better patient experiences, reduced hospitalizations and fewer ER visits.[10]

Still, adopting a full-risk model requires significant change and, as its name implies, financial risk. As value-based care continues to mature, a variation of the full-risk payment model is emerging. In a guaranteed-savings risk model, provider groups and regional Medicare Advantage plans partner with a health care services firm to delegate the financial risk and access resources designed to optimize the delivery of whole-person care. Based on the health care services partner's multi-disciplinary clinical resources, support system and financial and actuarial acumen, the partner sets a capitated rate below what the plan currently pays. As a result, the plan is guaranteed savings from day one.

EXAMPLE: COMPARING FUNDING MODELS

Shared Savings

- Health care services partner receives a portion of the savings achieved
- Ability to tailor the structure
- Upfront administrative fee until savings are reconciled
- Minimal financial administrative burden

Guaranteed Savings

- Health care services partner is financially responsible for the medical cost of guaranteed programs
- Capitated rate set below current rate guarantees savings and negotiated gain-share arrangements
- No administrative fees
- Moderate financial administrative burden

[10] Ghany R, Tamariz L, Chen G, et al. High-Touch Care Leads to Better Outcomes and Lower Costs in a Senior Population, The American Journal of Managed Care, August 2018.

THE VALUE OF PARTNERSHIP:

Unlocking the full potential of value-based care

Shifting to a shared savings or full-risk value-based care model requires different tools and skill sets that many regional Medicare Advantage plans and provider groups may not have. Choosing a health care services partner to assist in the delivery of whole-person care and share the financial risk is an important decision with direct impacts on patient health outcomes and savings.

Building a strong partnership with a risk-sharing health care services organization is essential to unlocking the full potential of value-based care.

When evaluating partners, gauge capabilities across a range of core areas, including:

+ Clinical expertise and multi-disciplinary care solutions, such as home-based care, post-acute care management and telehealth options
+ Integrated technology for effective tracking of outcome-based measures without creating an administrative burden
+ Analytical expertise to assess population health, forecast care needs and provide comprehensive short- and long-term financial projections

Take the next step to elevate health by partnering with Evernorth Home-Based Care.

Learn more at Evernorth.com
Contact us at HomeBasedCare@Evernorth.com

About Evernorth Home-Based Care

In response to the changing tides in health care, Evernorth leverages more than 25 years of experience providing comprehensive, in-home primary care, post-acute care (PAC) management and advanced analytics to provide a game-changing offering: Evernorth Home-Based Care.

Today, Evernorth Home-Based Care works with 30+ clients (health plans, Medicare, dual eligible special needs plans, commercial and more) to solve complex challenges and bring care home — to the whole person — for more than 26 million members.

Our home-centered care delivery and enablement organization focuses on improving each patient's unique health journey through integrated care solutions, including:

- In-home primary care
- Home health
- Post-acute care
- Transition of care
- Comprehensive health assessments
- Sleep management
- Durable medical equipment

We work closely with our clients to improve quality measures, reduce hospital readmissions and upgrade the patient experience and care delivery coordination.

Our flexible, evidence-based care plans produce:

- Value-based care with data-driven measurable improvements
- Targeted planning through early identification and proactive gap closure
- Better coordination and smart utilization management optimization

EVERNORTH'S "HEALTH FORWARD" SERIES

The Evolution of Polychronic Patient Care

How Modern Home-Based Care Is Helping to Transform Polychronic Patient Experiences

About Evernorth

Evernorth Health Services creates pharmacy, care and benefits solutions that includes Home-Based Care, a suite of health care service solutions provided by various Evernorth affiliates. Clinical services are provided by licensed health care providers through medical practices managed and/or contracted with Evernorth Home-Based Care's health services management organization, as well as by other network providers. Clinical services delivered through MDLIVE's virtual care platform are provided by medical practices affiliated with MDLIVE, Inc. Medical management, utilization management/utilization review, network management, and third-party administrator services related to the Evernorth Home-Based Care suite of solutions are provided by eviCore healthcare MSI, LLC, an Evernorth affiliate.

Meet the Authors Behind Evernorth's Health Forward Series

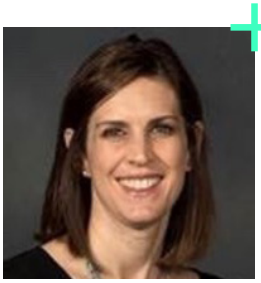
Yvette LeFebvre, DO
Chief Medical Officer
Evernorth
Home-Based Care

Yvette LeFebvre serves as Chief Medical Officer for the Evernorth Home-Based Care business. As the clinical leader for home-based care services, Dr. LeFebvre oversees the strategy, development and implementation of innovative clinical programs that ensure the delivery and enablement of high-quality in-home care and services for the 26 million patients the business manages.

Since joining the company in 2016, Dr. LeFebvre has progressed through roles of increasing responsibility, including serving as Associate Chief Medical Officer of Post Acute Care, Durable Medical Equipment and Sleep Management Services where she was responsible for clinical performance and oversight of patient care guidelines. Prior to this, she served as a medical director for Anthem's Medicare Advantage East Region. She has been a practicing physician for nearly 20 years and is an experienced physician and health care leader, having spent the first 10 years of her medical career as an attending Emergency Department physician, urgent care staff physician and physician training manager.

Dr. LeFebvre currently sits on the national board of directors for ecoWomen and is a member of the University of New England College of Osteopathic Medicine (UNECOM) Deans Advisory Council on Wellness.

Dr. LeFebvre completed her undergraduate studies in Biology at Boston College and earned her Doctor of Osteopathic Medicine (DO) from the University of New England College of Osteopathic Medicine. She is board certified in Emergency Medicine by the American Osteopathic Board of Emergency Medicine.



Melissa Steffan
President
Evernorth
Home-Based Care

Melissa Steffan serves as President, Home-Based Care for Evernorth.

In her role, Melissa oversees Evernorth's portfolio of home-based care solutions, which provide in-home primary care and post-acute care enablement for millions of patients, including comprehensive care for those with multiple chronic conditions and complex care needs. She is responsible for leading Evernorth Home-Based Care's strategic direction and growth, and driving differentiated value for the patients and clients they serve.

Melissa joined Evernorth in 2022 and is an experienced leader who is deeply committed to serving underserved populations and has a strong track record for driving business growth. Her extensive care delivery experience spans home and senior care services, independent medical groups, and large regional health systems where she was responsible for new business development, client retention, M&A and operations.

Prior to joining Evernorth, she served as a Regional Vice President for The Evangelical Lutheran Good Samaritan Society, one of the largest not-for-profits providing senior care and services, where she oversaw operations and revenue strategy for the southwest region. Prior to this, she held leadership roles at Propeller Health and Presbyterian Healthcare Services.

Melissa is actively involved in her community and global missions that help impoverished countries, and she serves on the board of directors for Healing Haiti.

Melissa has a Bachelor's degree from the University of New Mexico and earned both a Master of Healthcare Administration (MHA) and a Master of Business Administration (MBA) in Finance from Grand Canyon University.

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