

*A white paper*



# Collaborative Accountable Care

*CIGNA's Approach to  
Accountable Care Organizations*



## Transforming the Health Care System

Successfully transforming the U.S. health care system into a sustainable, high-quality one requires a **transition from a fee-for-service to a reward-for-value system**. For this approach to be successful, it's critical that the incentives of the treating physicians wielding the "order pen" align with their accountability for improving the quality, affordability and experience of care.

Improving quality, affordability and experience of care requires physicians to address practice reform, payment reform and collaboration with health plan resources. Two of the most talked about approaches to improving the health care delivery system are the Patient-Centered Medical Home (PCMH) and the Accountable Care Organization (ACO). These two approaches address practice and payment reform, respectively, but fail to include plan collaboration.

CIGNA has a unique approach to achieving the "triple aim" of improved quality, affordability and experience of care. It's called Collaborative Accountable Care (CAC). CAC enriches the PCMH and ACO models by bringing capabilities critical to enabling rapid and sustainable progress. These capabilities are in three specific areas: information, clinical collaboration and consultation.

Information includes patient-specific actionable information, such as "gaps in care" reports. It also includes performance reports, including total medical cost reports, emergency room (ER) visit reports, etc., which enable a group to understand improvement progress and opportunities.

CIGNA's clinical health coaching services can be a valuable virtual extension of the physician practice's clinical capabilities. These services range from stress management to transplant case management to health advocacy programs, like coaching for chronically ill patients. These health plan components enable maximum success for the medical group and the patients it serves.

A third component of CIGNA's program support is a CIGNA consultant. This consultant works with the medical group and local CIGNA team to provide expert guidance, supporting program implementation and ongoing management.

To better understand this approach, it's useful to first review the principles of the PCMH and ACO.

**Two of the most talked about approaches to improving the health care delivery system are the Patient-Centered Medical Home (PCMH) and the Accountable Care Organization (ACO).**

## The Patient-Centered Medical Home

A PCMH seeks to match patients with a team of health care professionals who will primarily deliver their care. This team becomes *responsible for the care of a patient's full range of health needs throughout their lifetime*.

A medical home is not simply a place but a model of primary care. It delivers care that is:

- Patient-centered
- Comprehensive
- Coordinated
- Accessible
- Continuously improved through a systems-based approach to quality and safety

The National Committee for Quality Assurance (NCQA) has established a program to recognize PCMH practices that meet its standards. These standards describe clear and specific criteria about organizing care around patients, working in teams, and coordinating and tracking care over time. These criteria alone, however, do not hold doctors accountable for achieving the triple aim. Nor do they lead to a reward system that financially compensates doctors for improved quality, affordability and experience of care.

PCMH collaboratives are typically multi-payer, multi-practice, multi-client initiatives that agree to pay primary caregivers (physicians, physician assistants and nurse practitioners) more for achieving levels of PCMH recognition. Many PCMH collaboratives request payment for simply attaining NCQA recognition. These collaboratives are paid based on their implementation costs and measure the impact on affordability and quality after several years. This does not encourage the collaboratives to implement changes likely to have short-term improvements in quality and affordability. It does not encourage long-term improvements which aim to achieve sustainable health improvement for a total population. Nor does it financially reward the individual physicians who take accountability for changing the manner in which they deliver care.

Currently, CIGNA participates in several state-based collaborative initiatives to promote the PCMH principles through enhanced payment to NCQA-recognized physicians and also learn from these efforts. However, CIGNA recognizes the limitations of this “pay for recognition” approach and prefers a more health outcome-based model.

Nationally, the NCQA has recognized more than 11,000 clinicians for meeting PCMH standards.

## Accountable Care Organizations

An Accountable Care Organization (ACO) is any organization that takes on the responsibility for achieving the triple aim—improving the quality, affordability and experience of care for the population it serves. A typical ACO can consist of primary care groups, multispecialty groups or integrated delivery systems, like a multi-specialty hospital system. The key is that the group directly provides or coordinates the majority of their patients’ care.

The best examples of the ACO model today are the 10 groups that participated in the Medicare Physician Group Practice (PGP) Demonstration started in April 2005. Medicare beneficiaries were assigned to a physician group based on their previous use of that group for care. Medicare beneficiaries did not have to sign up for the group and could continue to go to any participating national Medicare physician.

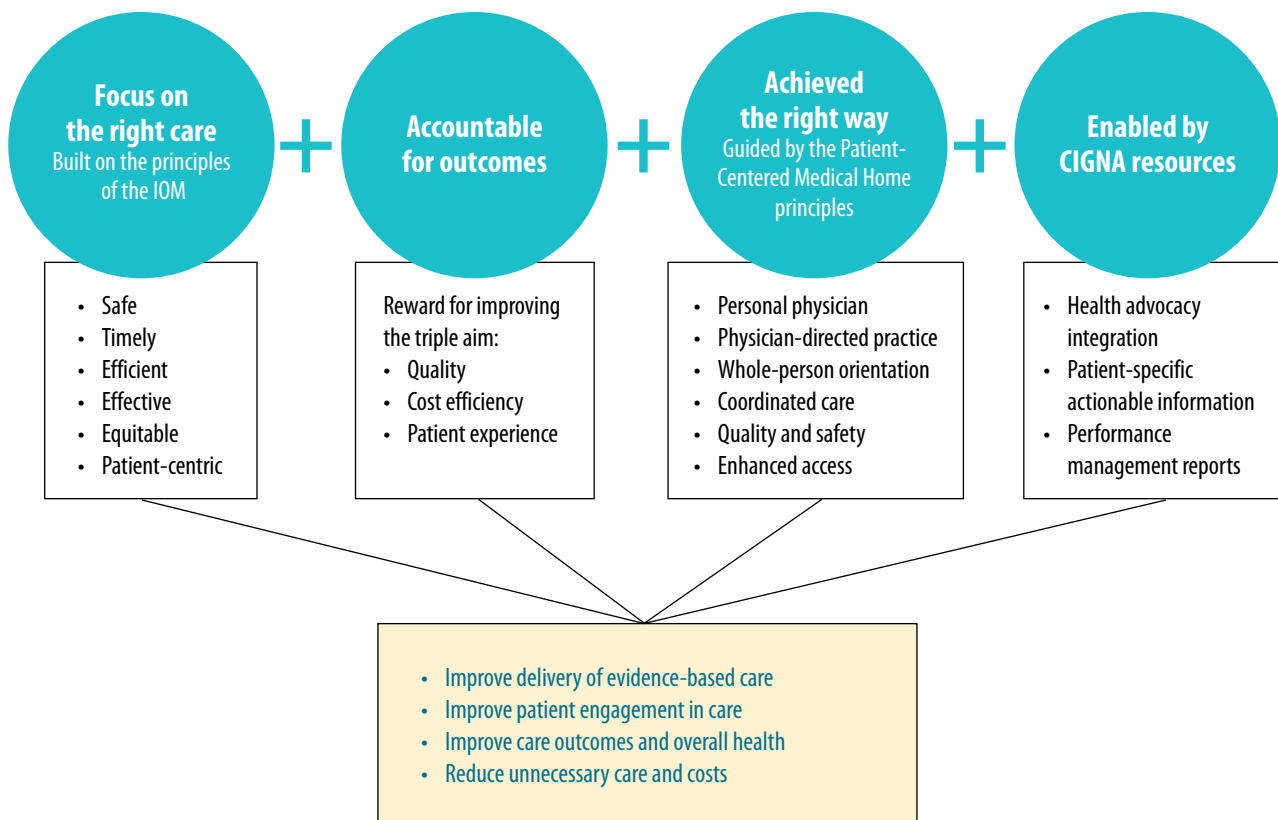
During the five-year demonstration, the Centers for Medicare and Medicaid Services (CMS) rewarded physician groups for improving patient outcomes by proactively coordinating their patients’ total health care needs, especially for beneficiaries with chronic illness, multiple comorbidities and transitioning care settings. Participating doctors received their regular Medicare fee-for-service payments. However, the groups were also eligible for “performance payments” if the practitioners collectively achieved specified quality and cost targets for the beneficiaries “attributed” to their group.

The majority of the participating groups performed well enough to achieve a reward. In fact, the pilot was so successful that CMS is planning a new program scheduled to begin in 2012.

A comparison of CIGNA’s approach to the recently announced CMS approach to ACOs is provided at the end of this document.

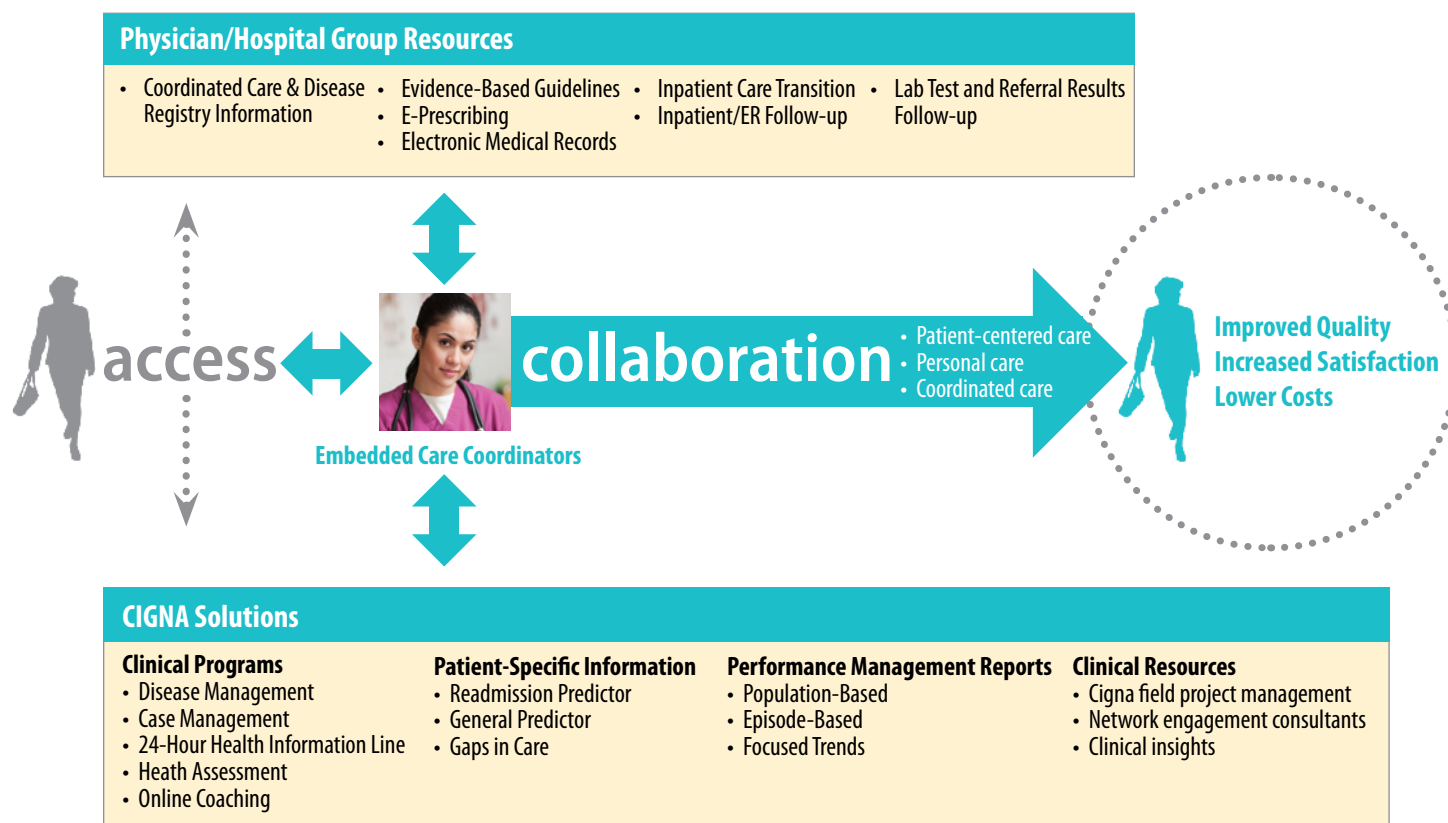
## Collaborative Accountable Care

CIGNA's Collaborative Accountable Care (CAC) initiatives are a variation of the ACO model. The CAC model involves either a large primary care physician group, multi-specialty group, integrated delivery system or physician-hospital organization (PHO). It rewards doctors for improved health outcomes, affordability and experience. The primary difference between this model and the PCMH and ACO approaches lies in the clinical collaboration, consultative guidance, patient-specific actionable information and performance reporting that CIGNA brings to these initiatives.



## How Collaborative Care works

With CAC, CIGNA expects the group to provide care according to PCMH principles. This includes providing better access, using disease registries, electronic health information systems and e-prescribing capabilities, and following up on patient care. However, CIGNA's CAC doesn't stop there. CIGNA also places a heavy emphasis on collaboration between CIGNA and the physician group to help foster more coordinated, comprehensive care. This collaboration comes to life in the role of the "embedded care coordinator."



The embedded care coordinator is a clinician who supports patient care and care plan development. Given the value of this role to the CAC model, CIGNA works with the group to enable them to allocate nurses to fill this role. The embedded care coordinator uses patient-specific information and real-time health improvement opportunities provided by CIGNA to:

- Coordinate the care of patients being discharged from the hospital who are at risk for readmission.
- Proactively reach out to at-risk patients identified through CIGNA's predictive modeling methodology.
- Reach out to patients identified with gaps in care to resolve clinical gaps related to medication adherence, medication safety instructions and preventive care.

Additionally, the embedded care coordinator manages and promotes engagement in the robust health advocacy programs available to CIGNA customers. These programs include case management, disease management and healthy lifestyle coaching. Employers purchase these programs from CIGNA, but they're often underutilized by customers. These programs can be a valuable virtual extension of the practices' clinical capabilities.

## Performance analysis

In addition, CIGNA provides CAC groups with an extensive set of practice profiles to help them identify opportunities for improvement and benchmark progress against baseline. This performance analysis includes total medical cost trend and quality factors such as adherence to evidence-based medicine (EBM) standards for the patient population of the group. Annually, CIGNA identifies opportunities for improvement and works with the group to develop an action plan to drive improvement. CIGNA's reports assess practice performance in five key areas:

- 1. Access:** ER visit rate totals for minor illnesses, chronic illnesses and frequent utilizers.
- 2. Optimal Care Coordination:** Inpatient admission, with a focus on avoidable admissions and readmission rates.
- 3. Adherence to EBM:** Preventive care (e.g., mammography rate), chronic care (e.g., appropriate diabetes testing) and acute care (e.g., high-tech imaging rates).
- 4. Appropriate Prescribing:** Generic fill rate and formulary adherence.
- 5. Value-Based Referrals:** Use of preferred laboratories or preferred specialists to achieve the greatest quality and cost-efficiency results.

Without these reports, a practice is unaware of its performance relative to its accountability goals. It can't be in a position to improve quality, affordability and experience of care.

## How does CIGNA reward physician groups?

Where other health care plans have focused on rewarding recognition (NCQA PCMH achievement) or process (establishing a nurse coordinator role) with little emphasis on outcomes, CIGNA's approach puts quality first. Physician groups must maintain quality at or above market average or improve quality as measured by adherence to EBM standards. If this requirement is not met, there's no financial reward – no matter what the impact on medical trend. If the quality requirement is met, then the reward to the group is based on paying a periodic care management fee per aligned patient. This unique approach creates incentives to achieve *improvement in quality and affordability outcomes*.

Payment usually occurs semiannually. The size of this fee is adjusted up or down based on the group's impact on total medical cost trend the previous year, as well as on how much the group improved quality. Total medical cost is calculated after removal of outlier costs and careful case-mix adjustment, so the physicians are accountable only for clinical results, not insurance risk.

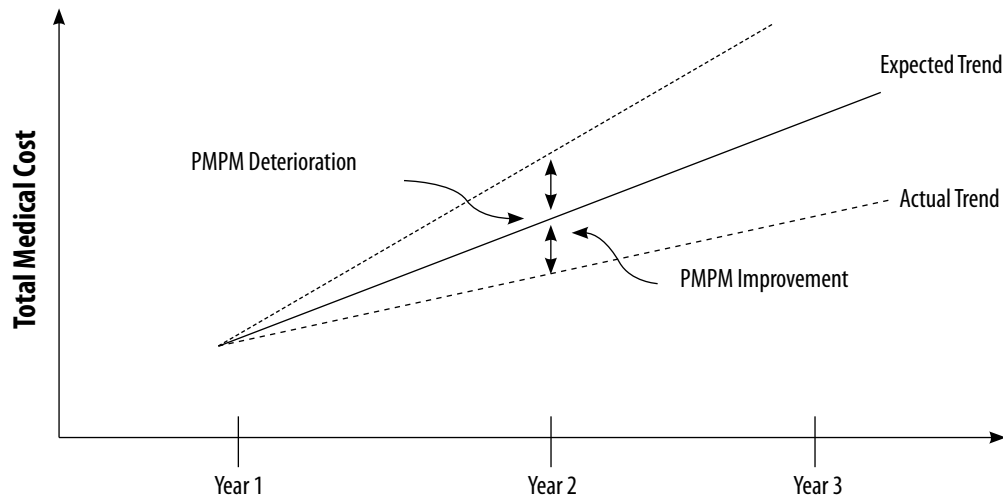
In the initial year, CIGNA pays a very modest first-year care management fee based on a group's contractual commitments to change their practice. These changes may include the establishment of the embedded care coordinator role, enhanced access or implementation of e-prescribing.

**CIGNA's approach puts quality first. Physician groups must maintain quality at or above market average or improve quality as measured by adherence to EBM standards.**

## Collaborative Accountable Reward

Must pass elements compared to market.

- Quality: EBM improved or maintained at better-than-market average
- Affordability: TMC trend better than market average



## How do patients benefit?

The best way to describe how patients benefit from collaborative care is through an actual example. Let's take a look at one of our participating groups, Medical Clinic of North Texas (MCNT).

### About MCNT

In 2009, CIGNA partnered with MCNT to offer a patient-centered approach to care called the "medical home." This was a first in Texas. A medical home is designed to streamline the process for sharing claims and utilization information, predictive health risk data and clinical resources. This is all done in an effort to improve the health of patients while lowering total health costs for employers. Due to this unique collaboration, MCNT doctors now have an integrated view of a patient's health and medical history. This results in a more educated interaction and, ultimately, in better, more personalized care for every individual.

### Meet Celia

Celia is a 63-year-old MCNT patient. Currently, she's being treated for type II diabetes and suffers from congestive heart failure. In 2010, Celia was admitted to the hospital a total of nine times, five of which were ER visits. Celia's readmissions indicate her difficulties in managing her condition on her own.

## Celia's Challenge

Celia's primary care doctor and endocrinologist created a comprehensive daily health care plan to address all of her medical conditions. This included getting weighed, testing her glucose repeatedly, special injections for anticoagulant therapy and taking several different medications at scheduled times throughout the day. However, Celia lacked the ability to manage her diabetes and other resulting issues without help. She didn't follow her prescribed diet and lacked a strong support system at home.

To help prevent additional readmissions and improve her overall health, Celia was referred to Jane, a registered nurse at MCNT who is her designated embedded care coordinator.

## Jane's Solution

Working directly with a CIGNA case manager, Jane was able to place Celia in a home visit program. Celia completed a total of 15 home health visits, where she and her family learned how to eat better, how to maintain a healthy weight and the importance of taking the right medication at the right time. Celia also discovered how keeping glucose and weight diaries could help her control her conditions, especially after reviewing both with her primary doctor.

Once she was ready, Jane helped Celia transition out of her home health program and into an outpatient congestive heart failure clinic for further care. She helped Celia schedule weekly visits with her doctor for the continuation and monitoring of her lab work, and also signed Celia up for CIGNA Home Delivery Pharmacy, making it easier for her to receive, and therefore take, her medications.

## The Outcome

With Jane's help, coordinated communication between all of Celia's doctors and caregivers was greatly improved. More importantly, Celia became an active participant in her own care. She now understands how to stick to her diet and care regimen, and recognize the signs and symptoms she needs to immediately report to her doctor.

As a result, Celia decreased and stabilized her blood sugar levels in just four short months. And in 60 days, she hasn't had a single ER visit. In short, Celia is now able to successfully manage and control her diabetes.

**With help from Jane and her CIGNA case manager, Celia became an active participant in her own care and successfully managed her diabetes.**



## What are current examples of success?

Since 2007, CIGNA has been piloting our new care delivery model with several physician and hospital groups across the country. CIGNA has studied both specific program components and overall achievement of quality and total medical cost goals. Results from some of our earliest pilots show the model is working to drive better results:

### **Dartmouth-Hitchcock Clinic, New Hampshire**

One important component of our CAC initiative is the embedded care coordinator role within the practice and, in particular, the effort this clinician makes to reach out to patients with “gaps in care.” In New Hampshire, a matched-case control study compared CIGNA customers in two groups. The first group was receiving care from the Dartmouth-Hitchcock system with its embedded care coordinator. The second group of customers was receiving standard care from other health care professionals in New Hampshire without care coordination support. The study<sup>1</sup> showed:

**10.4%** higher overall improvement in gaps in care closure rates over six months

**13.8%** higher gaps in care closure rate for high-priority patients

**16%** higher gaps in care closure rate for patients with hypertension

**8.1%** higher gaps in care closure rate for patients with diabetes

### **Medical Clinic of North Texas (MCNT), Texas**

During the program’s first year, Medical Clinic of North Texas improved its adherence to evidence-based medicine. MCNT also improved patient access to care by expanding office hours, contributing to more primary care office visits. Improved access to care, targeted outreach to potentially at-risk patients being discharged from the hospital, and enhanced care coordination all contributed to **achieving a medical cost trend that was more than two percentage points lower than the market.**

**7%** reduction in avoidable emergency room visits, as well as a significant decrease in hospital readmissions<sup>3</sup>

**6.3%** better than market adherence to evidence-based medicine

**3%** improvement in control of blood sugar levels for patients with diabetes, and also improved management of cholesterol and blood pressure levels for these patients

### **CIGNA Medical Group (CMG), Arizona**

For an example with broader results, let’s examine the Cigna Medical Group (CMG) in Arizona. CMG has achieved market-leading results in quality and affordability due to a strong focus on the patient and improved care coordination. Again, using a matched case control study design, patients at CMG were shown to experience lower health care costs without a reduction in use of health services. Results included:

**3%** increase in overall preventive care visits<sup>4</sup>

**12%** increase in adult preventive care visits

**11%** decrease in outpatient surgery and costs

**3%** higher quality compared to market<sup>5</sup>

**7%** lower total medical costs compared to market

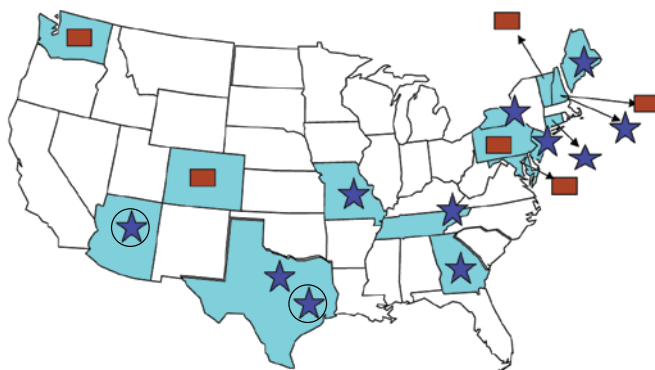
**At CMG in Phoenix, a strong focus on the patient and improved care coordination has resulted in average annual per patient savings of \$336.**

## What else is CIGNA doing?

CIGNA is committed to working with physician groups to learn what works and what doesn't. To that end, we have established a quarterly learning collaboration to share findings and encourage information-learning among participants. These participants include representatives from all CAC sites, including group leadership, physicians and embedded care coordinators, along with CIGNA medical directors, case managers and informatics analysts. By regularly bringing these groups together, we can better establish best practices and further develop these initiatives.

## Where is CIGNA engaged in this initiative today?

Today, unlike many other health plans that focus on HMO or Medicare Advantage populations, CIGNA has CAC initiatives available across all lines of commercial business. We have 12 active CAC initiatives spanning a variety of group types, including integrated delivery systems, multi-specialty groups and primary care groups. CIGNA is also participating in six multi-payer PCMH collaboratives.



### **CIGNA COLLABORATIVE ACCOUNTABLE CARE: Pay for outcomes**

Dartmouth-Hitchcock Clinic, NH (6/08)  
Medical Clinic of North Texas, TX (8/09)  
ProHealth, CT (10/09)  
Eastern Maine Healthcare Systems, ME (1/10)  
Piedmont Physician's Group, GA (6/10)  
Mercy Clinic, MO (7/10)  
Holston Medical Group, TN (8/10)  
Health Choice, TN (8/11)  
Partners in Care, NJ (10/11)  
Weill Cornell, NY (10/11)



### **CIGNA COLLABORATIVE ACCOUNTABLE CARE: Pay for outcomes with benefit incentives available**

Cigna Medical Group, AZ (1/10)  
Kelsey -Seybold Clinic, TX (Q4/11)



### **PATIENT-CENTERED MEDICAL HOME COLLABORATIVES: Pay for recognition**

Pennsylvania Governor's Chronic Care/PCMH Coalition (5/08)  
Vermont Blueprint for Health (7/08)  
Colorado Multi-Payer Collaborative (6/09)  
New Hampshire Citizen's Health Initiative (6/09)  
Washington Medical Home Reimbursement Pilot (5/11)  
Maryland Medical Home Reimbursement Pilot (8/11)

## What are CIGNA's expansion plans – and who will we partner with?

We're committed to a thoughtful and controlled expansion with capable partners, and expect substantial expansion. By 2014, our goal is to be in partnership with the most able groups in key markets.

We recognize that our expansion plans are largely dependent on the readiness of the medical groups to effectively improve quality, affordability and patient experience for the populations they serve. Some of the characteristics we look for in effective potential group partners include:

- Strong C-Suite leadership (business and medical) committed to achieving the triple aim.
- Strong foundation of primary care serving at least 5,000 CIGNA customers.
- Track record of population health improvement as measured by high rates of HEDIS-type measurements or NCQA PCMH recognition.
- Willingness to invest in additional resources to improve quality, affordability and care satisfaction.
- Ability to commit to a robust first-year action plan likely to have a substantial positive impact on quality, affordability and satisfaction.
- Commitment to modify physician take-home compensation commensurate with the rewards program.

## How does CIGNA's CAC initiative compare to CMS's proposed ACO pilot?

In 2011, CMS issued proposed rules regarding an ACO pilot program they intend to launch in 2012. In our roles as payers, CMS and CIGNA are completely aligned in constructing programs that financially reward health care professionals for improving the quality, affordability and satisfaction with care. However, CIGNA is also a health services organization with robust health informatics and clinical health coaching services. As a result, CIGNA can go beyond the role of payer and be an active collaborator in enabling the health care professional group to achieve their goals. We do this by sharing actionable information and arranging for CIGNA health coaching services to be a virtual extension of the physician's practice.

## Conclusion

As health care reform and industry trends continue to change our health care system, the ways to best manage costs are changing, too. CIGNA's Collaborative Accountable Care approach is one way to significantly improve health and reduce costs. By focusing on quality – not quantity – CIGNA has already proven that these initiatives deliver more efficient and more affordable quality care in hospitals, clinics and physician practices across the nation. And when patients receive more appropriate care and achieve better outcomes, it helps reduce overall medical costs for employers and increases employee health and productivity.



1. "Matched Case – Control Evaluation of CIGNA's and Dartmouth-Hitchcock's PCMH Gap Closures", CIGNA Informatics, August 2010.
2. "Collaborative Accountable Care: Cigna Medical Group 2009 OAP Total Medical Cost", CIGNA Informatics, August 2010.
3. "Practice Level Evidence Based Medicine Report", Cigna Medical Group – PCP Performance, CIGNA Informatics, December 31, 2009.

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