Aetna's value-based payment models aim to pay for value delivered, not services rendered

Aetna currently has 22% of spend running through contracts with a value-based component.

Value-Based Contracting models include:

- **ACOs -** offer a member-focused, doctor-driven approach to aligning financial incentives for health systems to effectively manage the health of populations.
- **PCMHs -** encourage PCPs to transform their practice to center around the patient – and reward PCPs who reduce cost and improve quality for attributed patient populations.
- **P4P -** these models offer physicians and hospitals a value-based "starter kit" by rewarding them for hitting incremental goals on a set of cost and quality metrics.
- **Bundled Payments -** these models pay a set amount for a given set of services oriented around an episode of care. Bundles encourage coordination across health providers and hospitals.

Aetna deploys a range of pay-for-performance models to meet providers where they are on the transformation continuum

Aetna has 22% of spend in value-based payment models touching more than 1.5 million lives

With this experience has come a few lessons, including:

- Transparency, provider and patient engagement are keys to success
- Meaningful measures can be difficult to identify, develop, administer
- Purchasers, consumers must be convinced value-based contracting has value
- Population health improvement is longitudinal and not a 'quick hit'
- ROI can be difficult to define and may vary model-by-model

Provider transformation to successful population health management is a work in progress.

However, even as providers adapt to value-based models, purchasers may see trend mitigation and quality improvement in early years, with medical cost reduction to follow.

How is VBC Success Measured?

Provider:

•Performance against 7 efficiency measures and up to 20 quality measures

•Trend-based performance measurement (comparing provider medical trend +/- compared to the trend performance in a defined market), with up to 20 quality measures

•MBR-based performance model with quality measures for FI members/product in a market

•FFS increases tied to benchmarked performance with opportunity for incremental increase.

Purchaser:

- Trend mitigation through FFS offset (PCMH) or significant unit cost concessions in the Accountable Care product model.

- Purchasers are financially and qualitatively better off than in FFS-only models

Other benefits may include:

- **Improved employee health** – VBC may lead to higher quality care through better care coordination, evidence-based medicine.
- **Fewer sick days** – Healthier employees are likely to take less unplanned time off work.
- **Less "presenteeism"** - In addition to taking fewer sick days, healthier employees are more likely to be productive when they *are* at work.

Proposed VBC Report

We are currently developing robust reporting tools. As we continuing refining our reporting format and content, below is a suggested approach to purchaser reporting on value-based contracting, once data are available.

Population size is a consideration on plan sponsor-specific reporting, but book-of-business results is possible to maintain for plan sponsors with spend running through particular providers

Sample view of VBC reporting:

Value-Based Payment Model Results - Company X												
	Type	Spend/Claims			Key Results				Spend/Save			
Specialty P4P	Implementation Type (OB/GYN, Ortho)	Spend/Claims	Plan Sponsor % of Claims	Plan Sponsor Spend with x	Quality Measures Score	Patient Safety Measures Score	Clinical Efficiency Measures Score	Network Efficiency Measures Score	% of Practice Revenue at Risk	% of At-Risk Amount Earned (Scorecard Result)	Other savings (ie-further rate offsets)	Savings for Purchaser ((J-K)*E)+(L*E))
Specialty Group 1	OB/GYN P4P	$x million	%	$x million	%	%	%	%	%	%		$x million
Specialty Group 2	Orthopedics P4P	$x million	%	$x million	%	%	%	%	%	%		$x million
		Subtotal	Subtotal	Subtotal	Subtotal	Subtotal	Subtotal	Subtotal	Subtotal	Subtotal		Subtotal
Hospital P4P	Implementation Type (Hospital P4P)	Spend/Claims	Plan Sponsor % of Claims	Plan Sponsor Spend with x	Efficiency Measures Score	CMS Process of Care Measures Score	Patient Experience Score	National Program Participation Score	% of Hospital Revenue at Risk	% of At-Risk Amount Earned (Scorecard Result)		Savings for Purchaser ((J-K)*E)
Hospital 1	Hospital P4P	$x million	%	$x million	%	%	%	%	%	%		$x million
Hospital 2	Hospital P4P	$x million	%	$x million	%	%	%	%	%	%		$x million
		Subtotal	Subtotal	Subtotal	Subtotal	Subtotal	Subtotal	Subtotal	Subtotal	Subtotal		Subtotal
TOTAL P4P Model Results		Total	Total	Total	Total	Total	Total	Total	Total	Total		Total

What we do to improve performance

To sustain provider investment and commitment to care delivery transformation, purchasers must demonstrate it is a priority.

Providers will compete on cost and quality when purchasers ask them to. What does that mean for purchasers?

- **Exchange** network access (the broadest network) for the "right network" based on cost and quality provider performance.

- **Align** financial incentives for members by selecting benefit plans that have lower out-of-pocket costs when high-performance providers are selected.

- **Recognize** that transformation is not a quick hit, but a systemic change that will take time.
  - FFS is not a sustainable model. As such, we must work collaboratively to set expectations for performance, allow for improvement and then select based on performance.

- **Understand** that while payment methodologies may change (care coordination, savings share), quality performance across measures will improve and medical cost trend will be positively impacted for members in these models.