Focus on value results in higher quality of care for Aetna® Medicare members

VBC enables a better care model that delivers improved outcomes when providers partner with Aetna

The United States (US) healthcare system and its stakeholders are facing enormous cost and quality pressures,[1-4] while patients often receive fragmented, uncoordinated, and sometimes unnecessary health care.[5, 6] Patients and providers want a better care experience.[8, 9] These trends stem from systemic issues within our healthcare ecosystem and are reinforced by the traditional, transactional fee-for-service (FFS) health care payment system, which does not inherently prioritize the quality of health care services. In contrast, value-based care (VBC) payment models prioritize patient health outcomes by incentivizing the coordinated delivery of high-quality, evidence-based health care to ultimately improve care and lower costs.[10]

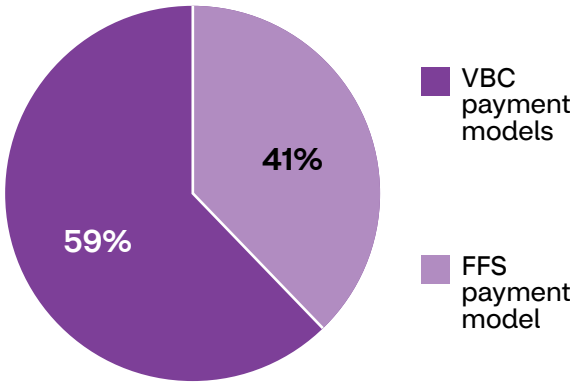
Aetna centers the health plan-provider relationship on members' health and wellness. We leverage VBC models to align payments with a health care experience that prioritizes the quality of care and meeting our members' needs. Providers that partner with Aetna through a VBC payment model are incentivized and supported to deliver whole-person care, which results in high-quality, coordinated, proactive care that decreases avoidable health care utilization and ultimately lowers the total cost of care.

Aetna is not alone in focusing on VBC as a key strategic priority. The Centers for Medicare & Medicaid Services, in collaboration with public and private payers and purchasers, submits data to the **Health Care Payment Learning and Action Network (LAN)** each year. Data indicate that across the US and all population segments, VBC in some form is overtaking fee-for-service as the more prevalent payment model (Fig. 1). Further, Medicare Advantage has more VBC than any other type of insurance.[7]

Over 10 years of evidence has demonstrated that VBC models improve quality and reduce unnecessary utilization in Medicare populations.[11]

At Aetna, we have seen higher quality of care, lower utilization, and $660M in total cost savings when comparing outcomes of members that see VBC providers compared to providers that Aetna pays under a traditional, FFS payment model.[12]

Figure 1. Aggregated payment data for all types of insurance from 2022 with 86.7% of the market represented in the survey. Adapted from public data from the Health Care Payment Learning and Action Network.[7]



Aetna VBC providers delivered

- 35% improvement in total average Star score
- 49% more members achieve HbA1C control
- 7% fewer hospital admissions

Which resulted in

- $114M savings in member out-of-pocket costs
- $660M in total cost savings (3.5% better than Aetna FFS providers)

aetna®

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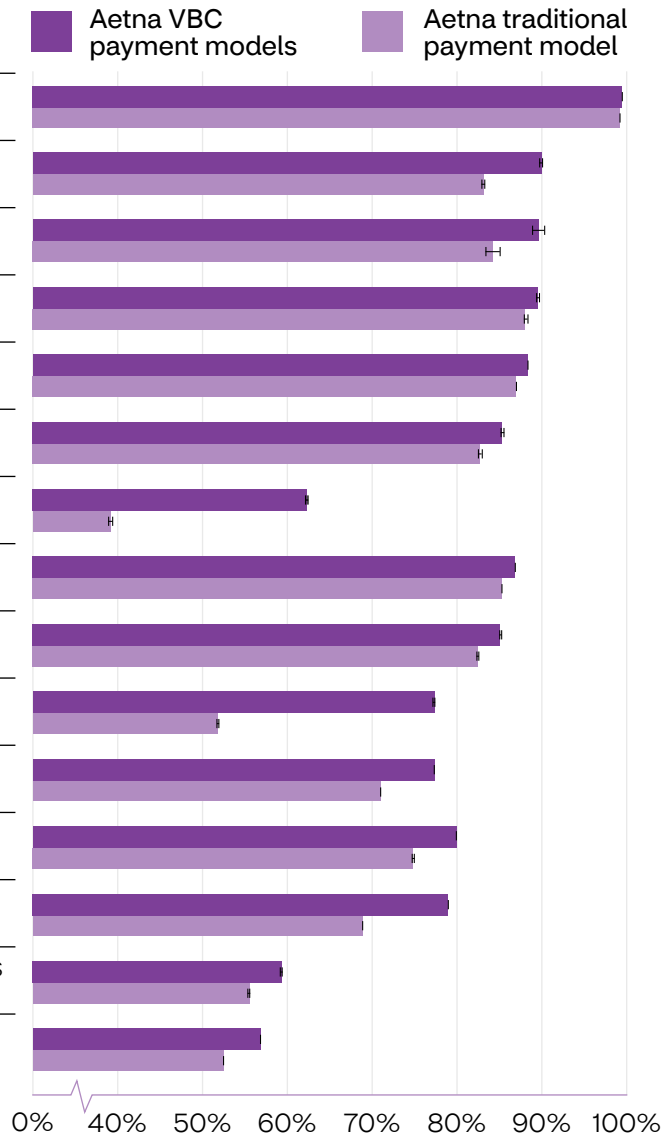
Aetna VBC providers outperform providers paid under a traditional FFS model in closing Medicare Advantage gaps

To understand the impact of VBC compared to traditional FFS payment models on providers' ability to close preventive health care gaps, Aetna conducted an analysis to compare provider performance between those in VBC and traditional payment models for quality and safety metrics in a Medicare Advantage patient population. These data substantiate the value of VBC models in the Medicare Advantage population[12] (Fig. 2).

Figure 2. Comparison of clinical quality performance in Aetna VBC and traditional FFS payment models for Medicare Advantage members. This bar chart shows the clinical categories across Medicare Advantage quality measures to examine the impact of the VBC model on preventive health gap closures.



ED: Emergency department.

Key takeaway

VBC was superior for all measures, with an average difference of +7% (range: 0.3-26%). Notably, blood sugar control, controlling high blood pressure, and colorectal cancer screening were markedly superior in VBC than non-VBC. All comparisons statistically significant p<.001.

Better health outcomes
Healthier people
Healthier populations

Fig. 2 footnote. Mean and standard deviation (denoted by error bars) plotted for percent gap closures by quality measure. Aetna internal network reporting for both Medicare Advantage individual and group members, sourced using 2022 data (Aggregated members, N=3,312,536: VBC, n=1,891,872; FFS, n=1,420,664). Generalized linear model with Tukey post-tests for mean and deviation difference. Includes primary care provider attribution models.

VBC enables person-centered care for Medicare Advantage members

What does this mean for members? Higher quality care means getting the appropriate screenings and preventive care. Lower utilization means members are not in the hospital unnecessarily. Fewer hospitalizations or other unnecessary care means lower out-of-pocket spending on co-pays or co-insurance. In fact, our analysis showed that Aetna members who saw VBC providers saved $114M in out-of-pocket savings compared to those who saw providers with traditional, FFS payment contracts.

Aetna recognizes that members have diverse needs that sometimes require both clinical and non-clinical services. The VBC providers in our network can support those needs across the country, when, where, and how members prefer. When Aetna partners with providers to deliver the best care possible through VBC incentives, clinical collaboration, actionable data, and innovative solutions, care quality improves for members.

Consider Mrs. Lopez

Mrs. Lopez* is due for a mammogram, but both she and her former provider did not know that she had missed an age-based screening.

Now Mrs. Lopez sees a VBC provider, who received a payer-initiated care gap alert and therefore recommended that she complete a mammogram to screen for breast cancer to close this gap in care (Table 1).

The VBC provider and their colleagues even assist Mrs. Lopez by making a mammogram appointment at the time and location that work best for her.

This is the norm in VBC: Mrs. Lopez's clinician works with other health care providers to coordinate and manage her specific health goals and overall well-being, and sometimes include non-traditional and non-medical (i.e., transportation, food insecurity, housing) interventions to meet those goals.

The VBC care team recognized her need to complete a screening mammogram and further supported the identification of a convenient mammogram location, appointment time, and transportation options.

*Fictional example.

Table 1. How does the payment model impact care?

Provider response based on payment model	Traditional fee-for-service payment model	Value-based care payment model
Identify care gaps through payer-enabled capabilities	⊗	✓
Educate patient on age-based screening	⊗	✓
Identify convenient service location to complete mammogram	⊗	✓
Make appointment on behalf of the patient	⊗	✓
Support transportation to/from the appointment	⊗	✓

Aetna VBC providers outperform providers paid under a traditional FFS model in closing Medicare Advantage care gaps

Value-based care models incentivize and empower providers to manage their patients more holistically, advance their preventive care, and ultimately improve the health and well-being of the population. With a VBC model, Medicare Advantage members can see their clinicians more frequently to navigate their often complex health considerations, which enables a durable, long-term relationship with their providers built on trust and understanding. Patient preferences strongly align with models that can provide person-centered, affordable, high-quality, and continuous care to manage their health,[8] which matches the intention of VBC.

The sustainability of Medicare Advantage hinges on the substantial opportunity to identify and reduce avoidable utilization that occurs for these members, as they have the highest per person health care spend.[13] There is a fundamental need to deliver a high standard of care that reduces health care fragmentation in favor of coordinated and efficient care at the right time for the right Medicare Advantage member. In a VBC model, health plans like Aetna share data with VBC providers regarding care gaps, providing them with the information they need to proactively intervene and close those gaps in care. Providers are also incentivized to share data back with health plans. Some of the differences in quality scores between VBC providers and those in traditional FFS payment models may be due to this dynamic, but the results are still clear: providers are demonstrating they are closing care gaps, and members ultimately benefit.

For Mrs. Lopez, the traditional care model left a gap in her care that would have resulted in worse health outcomes and an avoidable burden of illness and cost.

As a comparison for the benefit of VBC in this scenario, when early stage breast cancers are detected in asymptomatic women, they have higher survival rates and lower recurrence rates with an estimated $50–100K in lifetime cost-of-care savings.[2]

Transitioning from a traditional FFS model to a VBC model shifts provider payment based on quantity of services to quality of services, shifts care coordination from the patient to the provider group, and encourages a shift from the treatment of a condition to the prevention of a condition (Table 2).

Table 2. Traditional fee-for-service payment model versus value-based care payment model

Considerations	Traditional fee-for-service payment model	Value-based care payment model
Incentivization	Quantity of care; Volume of services	Quality of care; Value of services
Care focus	Reactive; Treatment of illness/disease	Proactive; Prevention of illness/disease
Care coordinator	Patient	Provider group
Patient-provider relationship	Fragmented and transactional	Holistic, coordinated, and transformational
Provider-health plan relationship	Transactional	Collaborative
Health care utilization	Episodic, duplicative	Coordinated, avoids unnecessary utilization

The ABCs of VBC

The underlying intention of a VBC payment model is to align payments with shared payer and provider goals that support a better health care model and result in better health outcomes. In contrast, the traditional FFS health care delivery payment model incentivizes the delivery of health care services, often by disconnected care teams.

Alternative payment models, such as total cost of care VBC models and pay-for-performance (P4P) (Fig. 3), have evolved from the traditional FFS payment model to better align health care payments with high-quality and coordinated care:[14]

Fee-for-service

Reimburses providers for the number and type of health care services provided to a patient.[15]

Pay-for-performance

Layers incentives for meeting quality and efficiency targets on top of a FFS payment model; reimbursement is tied to health outcomes, utilizing evidence-based practices.[16]

We empower providers by meeting their needs in their value-based care journey

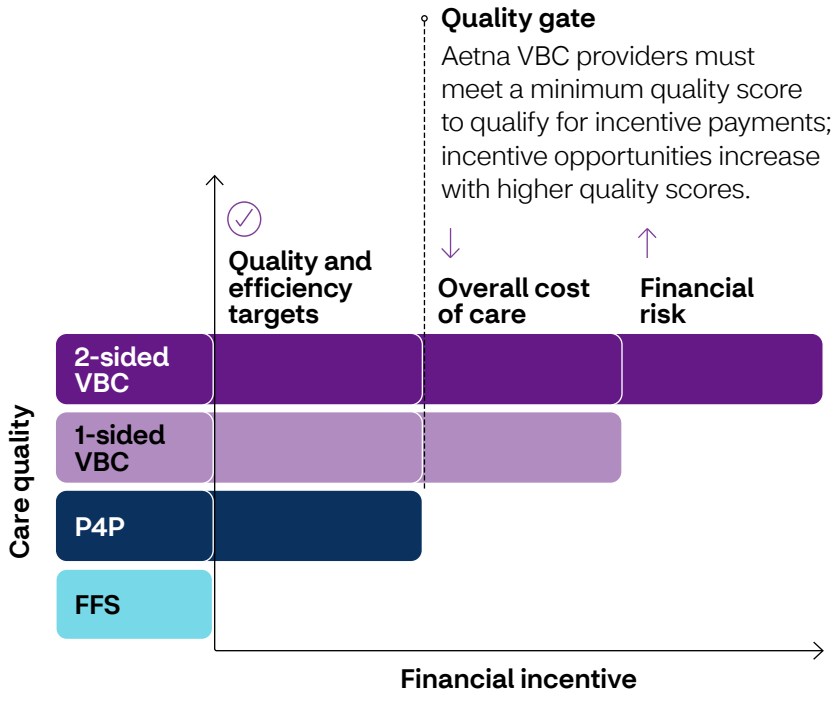
Total cost of care

Holds providers accountable for quality outcomes and total medical costs for an attributed patient population.[10] We will focus on two types here:[17]

- **One-sided (or shared savings):** Providers receive a gainshare incentive payment for meeting quality and efficiency targets, while reducing the total costs of care for the attributed population. These models reward the delivery of high-quality, evidence-based care at a lower cost, but providers do not assume the risk of loss when total costs of care exceed projected costs.
- **Two-sided (or shared risk):** Provide gainshare incentive payments, as well as risk for providers if the total costs of care are higher than projected costs, up to and including the full amount of shared savings or full amount of shared losses.

Figure 3. The path to value-based care

This figure illustrates the different payment models (FFS, fee-for-service; P4P, pay-for-performance; 1-sided value-based care (VBC); and 2-sided VBC) and how they differ by financial incentives (x-axis) and care quality (y-axis).



Aetna offers a range of VBC incentive models (e.g., P4P, 1-sided total-cost-of-care arrangements, and 2-sided risk) to match providers with the right incentive model for their practice. We meet providers where they are in terms of their readiness to take on risk and support them in improving care quality and moving along the risk continuum. Aetna provides actionable data and clinical collaboration, allowing providers to spend their time engaging members, coordinating care, and managing population health to achieve the goals of VBC.

Key takeaways

Traditional fee-for-service payment models have no inherent financial incentive for high-quality care and no financial risk for low-quality care.

Value-based care payment models have financial incentives for high-quality care and can have financial risk for low-quality care.

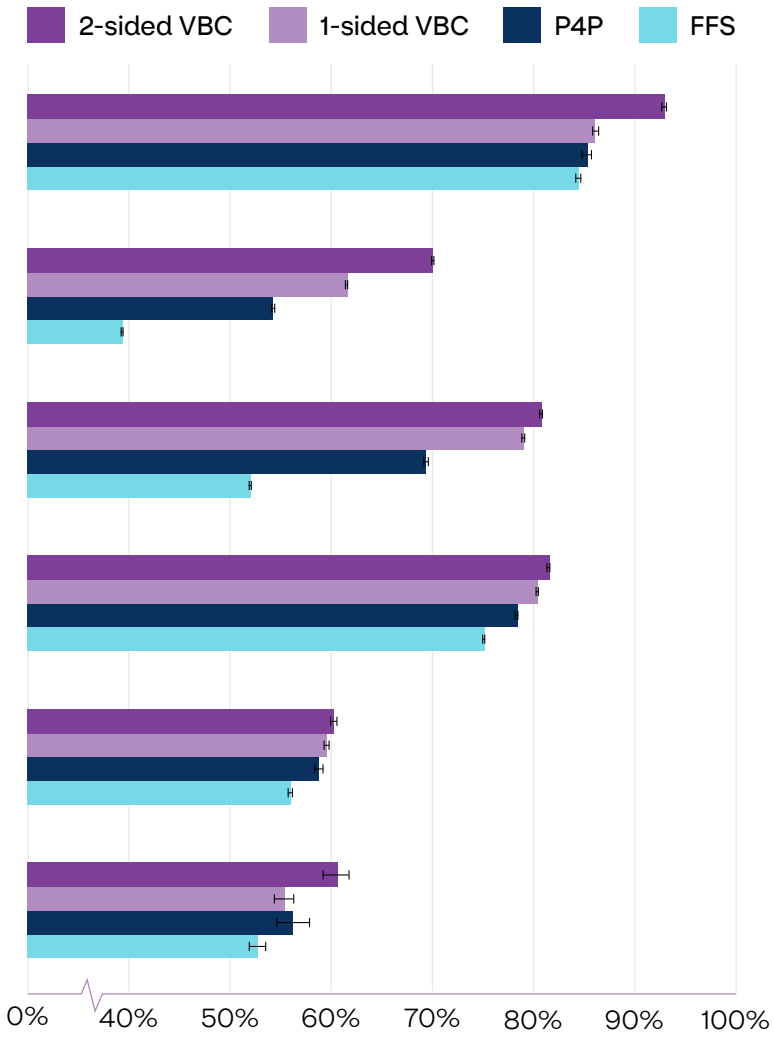
More risk, more reward...

When we conducted a deeper analysis of VBC payment models to assess clinical quality performance, incremental improvement in care quality outcomes was observed as providers assumed more financial risk (Fig. 4).

Figure 4. Comparison of clinical quality performance in Aetna traditional pay-for-performance and total cost-of-care VBC models. This bar chart shows the clinical categories across Medicare Advantage quality measures to examine the impact of the care model on preventive health gap closures.

Category	Quality measure
Care for older adults	Functional status assessment [a, c, d, e]
Heart disease	Controlling high blood pressure [a–f]
Diabetes	Blood sugar control [a–f]
Cancer screening	Breast cancer screening [a–f]
Care coordination	Follow up after ED visit for patients with multiple chronic conditions [c, e, f]
Patient safety and treatment for older adults	Osteoporosis management in women who had a fracture [a, b, c, d]

ED: Emergency department.



Key takeaways

Overall, 2-sided VBC had higher performance on quality measures than all other payment models, with 1-sided VBC with the next overall highest, then P4P, and FFS had the lowest performance (p<.001).

More provider risk equals more reward for the entire healthcare ecosystem

We help people manage their health now and into the future by addressing the risk factors that impact health.

Fig. 4 footnote. Mean and standard deviation (denoted by error bars) plotted for percent gap closures by quality measures. Aetna internal network reporting for both Medicare Advantage individual and group members, sourced using 2022 data (Aggregated members, N=3,312,536: 2-sided VBC, n=592,157; 1-sided, n=933,541; P4P, n=348,670; FFS, n=1,420,664). Generalized linear model with Tukey post-tests for mean and deviation difference for pairwise comparisons (e.g., a-f labels). Pairwise comparisons statistically significant p≤.01: [a]2-sided VBC vs. 1-sided VBC, [b]2-sided VBC vs. P4P, [c]2-sided VBC vs. FFS, [d]1-sided VBC vs. P4P, [e]1-sided VBC vs. FFS, [f]P4P vs. FFS. Includes primary care provider attribution models.

Mrs. Lopez has other needs, too—clinical needs beyond what was brought into this example, as well as social and access needs.

Her VBC providers recognize that Mrs. Lopez is more than a single clinical interaction and will address her whole-person needs with the support of our clinical network.

Mrs. Lopez has a dedicated care team (e.g., PCP, pharmacist, behavioral health) that listens to all aspects of her health, her goals, and other factors that could affect her health and well-being.

Further, Mrs. Lopez's VBC providers can reinvest their VBC incentives into their practice to support continued care transformation.

Value-based care and the Quintuple Aim

VBC inherently supports the Quintuple Aim of Healthcare to:

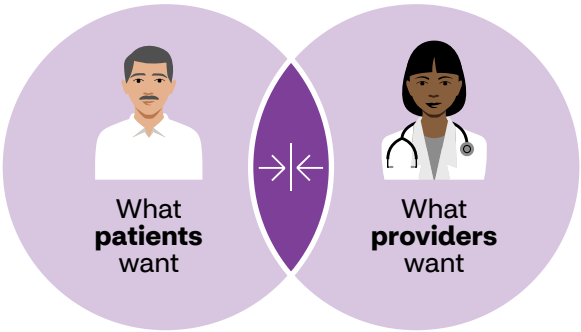
- Improve population health
- Enhance the care experience
- Reduce costs
- Reduce healthcare workforce burnout
- Advance health equity[18]

VBC aligns the priorities of all major healthcare ecosystem stakeholders—patient, provider, plan sponsor, payer, and government organizations—by improving health outcome metrics and decreasing unnecessary costs,[19-22] and by focusing on what patients and providers care about most[23-26] (Fig. 5).

VBC models reduce healthcare burnout because they encourage team-based care, which frees up teams and resources (e.g., time, brainpower, support personnel, etc.). Further, VBC promotes health equity[10] because providers and their care teams are incentivized and supported in identifying and addressing social and other nonclinical drivers (e.g., health literacy, access to transportation, etc.) that can influence the health of a patient or a community.[27]

It's a win-win-win-win-win for the patient, provider, plan sponsor, payer, and public health.

Figure 5. Value-based care enables patients and providers to focus on what matters most



Value-based care

- Shared decision-making
- A connected, meaningful relationship
- Effective communication
- Patient empowerment
- Accessible care
- Affordable care
- More time together
- Interconnected, accessible health data
- Growth over time

Table 5. Quintuple Aim outcomes assessed in Mrs. Lopez's clinical interaction

Let's examine Mrs. Lopez's clinical scenario to determine if the quintuple aim was satisfied.

Outcomes reviewed	Quintuple Aim satisfied?	Description
Improve health outcomes	✓	Mrs. Lopez avoided unnecessary illness related to delayed mammogram screening
Decrease costs	✓	Mrs. Lopez avoided excessive financial burden related to advanced breast cancer treatment
Improve patient experience	✓	Mrs. Lopez will have improved quality of life with early diagnosis and treatment; spends more time with care team and gets to know them long-term, building trust and supporting continuity of care
Decrease care team burnout	✓	Mrs. Lopez's provider and multi-disciplinary care team collectively spend more time with patients like Mrs. Lopez, improving their job satisfaction; VBC incentives allow Mrs. Lopez's providers to continue to improve the quality and efficiency of the care they provide, decreasing risk of provider burnout
Advance health equity	✓	Mrs. Lopez's social needs (e.g., transportation), which were a barrier to accessing adequate and timely care in the past, were addressed

Aetna is committed to value-based care

Our VBC models are built on a people-first foundation. Aetna partners with over 1,200 value-based health care providers to support 2.4 million Medicare Advantage members. More than 80% of the total Aetna Medicare Advantage spending is with provider partners in VBC.

We overlay our VBC contractual incentives with clinical collaboration support: we regularly meet with our provider partners to co-develop a care transformation strategic roadmap, consult to advance their continuous improvement processes, and collaborate on clinical cases.

We also engage in bidirectional data sharing, which provides valuable insights into members' holistic needs and facilitates earlier engagement of members with complex and/or urgent care needs. Further, these data can also be used by providers to create customized care plans that address a patient's unique and evolving needs, ensuring patients receive the right care at the right time where they want to—in their communities.

Value-based care meets member needs, increases engagement with providers, and delivers a better care model, which creates a better care experience and drives savings.

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Acknowledgments

We would like to thank Sue Roeser, Mike Hur, Karen McClay, Robyn Andersen, Kim Eafano, Sarah Ericksen, Rose Miller, Jessica Berger, Derek Wise, and Ali Khan, MD for their support, guidance, and leadership.

References

[1] US Employer Health Care Costs Projected to Increase 6.5% Next Year [press release]. Aon; August 18 2022.

[2] Brenan M. Record High in US Put Off Medical Care due to Cost in 2022. Gallup Wellbeing: Gallup Wellbeing; 2023 January 17.

[3] Keehan SP, Fiore JA, Poisal JA, Cuckler GA, Sisko AM, Smith SD, et al. National Health Expenditure Projections, 2022-31: Growth To Stabilize Once The COVID-19 Public Health Emergency Ends. Health Aff (Millwood). 2023;42(7):886-98.

[4] Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2024 May 6.

[5] Kaltenborn Z, Paul K, Kirsch JD, Aylward M, Rogers EA, Rhodes MT, et al. Super fragmented: a nationally representative cross-sectional study exploring the fragmentation of inpatient care among super-utilizers. BMC Health Serv Res. 2021;21(1):338.

[6] Doty MM, Tikkanen R, Shah A, Schneider EC. Primary Care Physicians' Role In Coordinating Medical And Health-Related Social Needs In Eleven Countries. Health Aff (Millwood). 2020;39(1):115-23.

[7] Health Care Payment Learning & Action Network. Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Traditional Medicare Programs. 2023 October 30.

[8] CVS Health. Health Care Insights Study. 2022.

[9] Ducharme J. Exclusive: More than 70% of Americans Feel Failed by the Health Care System. Time [Internet]. 2023 October 8, 2024. Available from: **https://time.com/6279937/us-health-care-system-attitudes/**.

[10] Centers for Medicare & Medicaid Services. Value-Based Care [Internet]. CMS; [cited 2024 Sept 16]. Available from: **https://www.cms.gov/priorities/innovation/key-concepts/value-based-care**.

[11] Value-Based Payment As A Tool To Address Excess US Health Spending. Health Affairs Research Brief [Internet]. 2022 October 8, 2024 [cited 2024 October 8]. Available from: **https://www.healthaffairs.org/content/briefs/value-based-payment-tool-address-excess-us-health-spending**.

[12] Network and VBC Story Slides. Aetna; 2023.

[13] Centers for Medicare & Medicaid Services. National Health Expenditure Fact Sheet [Internet]. Baltimore (MD): CMS; 2022 [cited 2024 Sept 16]. Available from: **https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet**.

[14] Centers for Medicare & Medicaid Services. Alternative Payment Models (APMs) [Internet]. CMS; [cited 2024 Sept 16]. Available from: **https://www.cms.gov/priorities/innovation/key-concepts/alternative-payment-models-apms**.

[15] American Medical Association. What is value-based care? [Internet]. AMA; 2024 [updated Aug 20; cited 2024 Sept 16]. Available from: **https://www.ama-assn.org/practice-management/payment-delivery-models/what-value-based-care**.

[16] What Is Pay for Performance in Healthcare? Catalyst Carryover. 2018;4(2).

[17] Centers for Medicare & Medicaid Services. Risk-Based Arrangements in Health Care [Internet]. CMS; [cited 2024 Sept 16]. Available from: https://www.cms.gov/priorities/innovation/key-concepts/risk-based-arrangements-health-care#:~:text=This%20structure%20incentivizes%20participants%20to%20improve%20quality%20and,be%20eligible%20to%20receive%20a%20payment%20from%20CMS.

[18] Nundy S, Cooper LA, Mate KS. The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity. JAMA. 2022;327(6):521-2.

[19] Arkansas Center for Health Improvement, Arkansas Health Care Payment Improvement, Initiative. 4th Annual Statewide Tracking Report. Little Rock, AR; 2019 Aug.

[20] NORC at the University of Chicago. Evaluation of the Vermont All-Payer Accountable Care Organization Model: 2018–2022. Bethesda, MD: University of Chicago; 2024 June.

[21] Oregon Health Authority Health Policy & Analytics Division. CCO 2.0 Recommendations of the Oregon Health Policy Board. Portland, OR; 2018 Oct.

[22] Okeke N, Schmidt C, Alborn S, Kumian E. Implementing Value-Based Primary Care Delivery in Federally Qualified Health Centers. Popul Health Manag. 2021;24(1):78-85.

[23] Hirpa M, Woreta T, Addis H, Kebede S. What matters to patients? A timely question for value-based care. PLoS One.2020;15(7):e0227845.

[24] Mohammed K, Nolan MB, Rajjo T, Shah ND, Prokop LJ, Varkey P, et al. Creating a Patient-Centered Health Care Delivery System: A Systematic Review of Health Care Quality From the Patient Perspective. Am J Med Qual. 2016;31(1):12-21.

[25] Natafgi N, Ladeji O, Blackwell S, Hong YD, Graham G, Cort M, et al. Similar values, different expectations: How do patients and providers view 'health' and perceive the healthcare experience? Health Expect. 2022;25(4):1517-28.

[26] Bitton A, Rouleau K. Primary Care Is Essential and Under Siege. NEJM Catalyst. 2023;4(7).

[27] Teisberg E, Wallace S, O'Hara S. Defining and Implementing Value-Based Health Care: A Strategic Framework. Acad Med. 2020;95(5):682-5.