Aetna on the Issues
Building a Healthier World through Value-Based Care

According to the Institute of Medicine (IOM), 30 percent of health spending—approximately $750 billion—is wasted on unnecessary services, excessive administrative costs, fraud, and other things that do little to improve patients' health.¹ By focusing on quality rather than quantity, and patient outcomes rather than volume of services, value-based care can deliver higher quality care at lower costs.

Aetna is a leader in value-based care

As one of the founding members of the Health Care Transformation Task Force and a member of the Health Care Payment Learning and Action Network (LAN), Aetna has a significant and growing commitment to value-based care.

Our innovative approach

Aetna's approach to value-based care includes innovative payment arrangements with providers such as capitation, bundled payments, and various forms of risk-sharing arrangements. Working with health systems and Accountable Care Organizations (ACOs), we are improving patient and provider engagement to make sure members receive the right care at the right time and in the right place.

As we deepen our relationships with providers, our goal is to expand the focus beyond “sick care” to “holistic care” in order to meet not just the medical needs, but also the psychological and social needs of our members. We have a multi-year plan to convert our entire network to value-based payment. Our approach is not one size fits all and allows us to meet providers where they are.

About 50 percent of Aetna's Commercial and Medicare claim payments to providers flow through value-based care arrangements

We have over 1,900 value-based contracts with providers

More than 7 million Aetna members have received care from providers with value-based arrangements over the past year

States with an ACO product or plan to have by January 1, 2018 (may also have other value-based products)
States with other Aetna value-based contracts
ACOs with fully insured products*
ACOs with both fully insured and self-funded products*
Joint ventures with fully insured and self-funded products (several pending state DOI licenses)

Above data as of July 2017.
*Deals that meet the industry definition of an ACO: leavittpartners.com/2013/10/really-aco. May represent more than one ACO contract in that location.

©2017 Aetna Inc.
00.03.966.1-L22

www.aetna.com
Federal and state policy options to grow value-based care

Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare fee-for-service (FFS) physicians are paid based on the quality and effectiveness of the care they provide and will earn more for high performance. By design, MACRA is helping accelerate the transition toward value-based care beyond Medicare FFS. It is important to recognize the important role Medicare Advantage (MA) is playing in this regard. About one-third (19 million) of all Medicare beneficiaries are in MA, and that number is expected to increase to more than 40 percent by 2026.

In order to build upon MACRA, we encourage the following:

**Centers for Medicare and Medicaid Services**

1. Count provider participation in both Medicare and Medicare Advantage in Advanced Alternative Payment Models (AAPMs) towards the Medicare thresholds.

2. Establish revenue and risk requirements for Other Payer AAPMs that reflect the successful ongoing efforts by plans to establish value based payment models.

3. Reduce the reporting burden on providers and plans by requiring the minimum information necessary to certify Other Payer models as AAPMs.

**Congress**

1. Revise the Physician Incentive Plan (PIP) requirements to remove the obstacles those regulations present to innovative approaches to contracting.

2. Reform and modernize the Stark law to accelerate the use of alternative payment models, including MACRA.

3. Pass the “PLUS” Act, or the Medicare Program Linking Uncoordinated Services (PLUS) Act, a bill designed to meet the needs of the costliest (top 10 percent) and highest risk beneficiaries in Traditional Medicare.

**States**

With the growth of Medicaid Managed Care, MACRA provides an opportunity to accelerate the adoption of value-based care in Medicaid, and help save money for States and the Federal Government. Approximately 75 percent of Medicaid beneficiaries are enrolled in Medicaid managed care plans nationally.

1. Use value-based contracting by setting minimum thresholds of medical spend in Medicaid Managed Care arrangements.

2. Consider expanded use of multi-payer payment and delivery system models such as Comprehensive Primary Care Plus (CPC+) and State Innovation Models (SIM) Initiative to accelerate value-based care in their state.

Learn more about how Aetna is transforming the member experience with value-based care at


---

