Better health at lower costs: Why we need Value-Based Care now

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> **“Value-Based Care can benefit employers and employees by delivering greater value at a better price. What we want is to be able to incentivize coordinated care that keeps members healthy, achieves better productivity and contains costs over time.”**

Manny Germano,
Vice President of Value-Based Solutions, Aetna

As the health care delivery system evolves, employers continue to search for ways to curb spending while ensuring their employees receive the care and services they need to stay healthy, happy and productive. Much attention has been focused on the promise of Value-Based Care, or care delivered under value-based contracts. But what does Value-Based Care mean?

Value-Based Care (VBC) is a health care delivery model under which providers — hospitals, labs, doctors, nurses and others — are paid based on the health outcomes of their patients and the quality of services rendered. Under some value-based contracts, providers share in financial risk with health insurance companies. In addition to negotiated payments, they can earn incentives for providing high-quality, efficient care. VBC differs from the traditional fee-for-service model where providers are paid separately for each medical service. While quality care can be provided under both models, it’s the difference in how providers are paid, paired with the way patient care is managed, that provides the opportunity for health improvements and savings in a VBC environment.

We know that health care is consistently identified as a top concern for all Americans. Here we share the key features of VBC and how this approach offers a significant opportunity to relieve some of that concern while helping us achieve better health at lower costs.

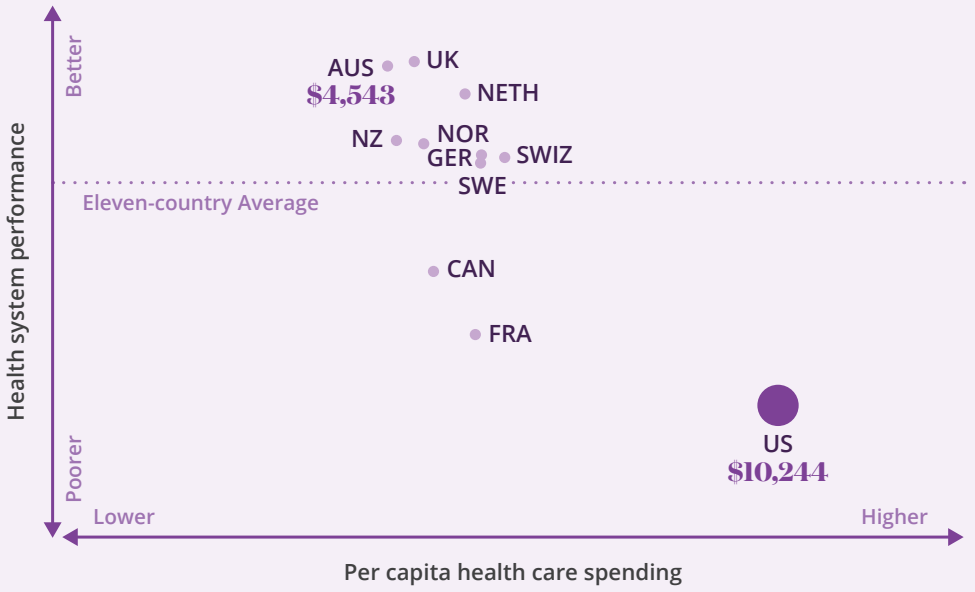
We can't continue to work this way

Health care spending in the United States ballooned from about five percent of the total economy in 1960 to nearly 18 percent in 2016, currently totaling upwards of $3.5 trillion annually.[1] Perhaps the most telling statistic: We spend two to three times more than most developed countries each year, yet achieve worse results.[2] And all of us shoulder that burden.

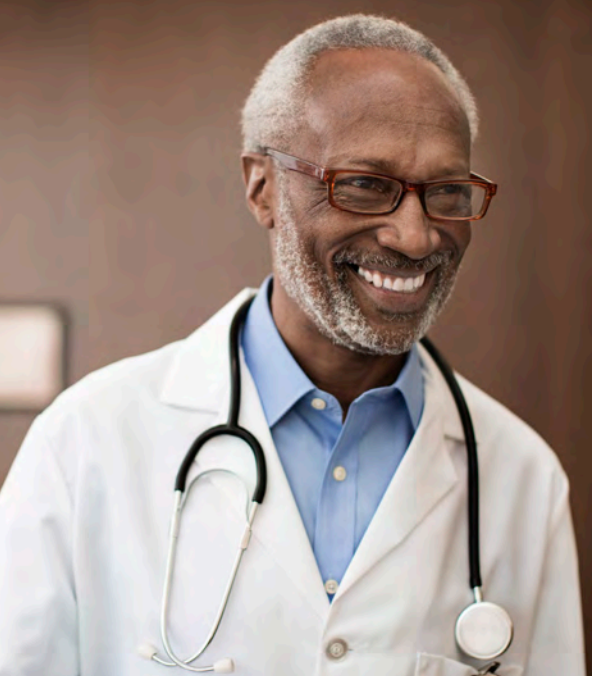
A 2017 **Commonwealth Fund report** compared the health system performance of eleven high-income countries and found that among them, the United States spends far and away the most on health care, but ranks at the bottom for performance as well as for access, equity and health care outcomes. The ten other countries studied were Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the United Kingdom.[3]

We spend too much, and we get too little.

The U.S. spends the most on health care, but has the worst outcomes and highest disease burden among developed nations.[3] [4]



[1] Centers for Medicare and Medicaid Services. National Health Expenditure Data. Accessed March 14, 2019.
[2] U.S. Organization for Economic Cooperation and Development (OECD). Health Spending. Accessed March 14, 2019.
[3] Schneider EC, Sarnak DO, Squires D, et al. Commonwealth Fund. Mirror, Mirror 2017. Accessed March 14, 2019.
[4] Peterson-Kaiser Health system Tracker. How does the quality of the U.S. healthcare system compare to other countries? Accessed March 14, 2019.



What's more, disease burden in the U.S. is the highest among developed countries. Six in ten Americans have at least one chronic condition — high blood pressure, diabetes, mental illness — and four in ten are managing more than one.[5] A staggering 90 percent of health care dollars spent each year is for people with chronic health conditions.[6]

Additionally, an Institute of Medicine report found that waste, including unnecessary or repetitive tests, accounts for more than 30 percent of all health care expenditures. That's more than $910 billion each year.[7]

It's clear the U.S. health system needs improvement. Value-Based Care represents a critical step in the right direction.

How can VBC help us meet these challenges?

We're used to a health care system that takes care of people after they're already sick. VBC's triple aim is to improve the health care experience, improve the health of individuals and populations and reduce the costs of health care. To do this, VBC moves beyond sick care and adopts a proactive, team-oriented and data-driven approach to keeping people healthy.

Collaboration across the health care ecosystem is key to VBC success

At the center of VBC models is a robust, team-oriented approach, often led by the patient's primary care doctor. Patients aren't left to navigate the health care system on their own. The care team is there to support them along their health care journey. Teams are expected to focus on prevention, wellness, strategies and coordination throughout the care continuum, priorities especially important for those managing chronic conditions.

The multidisciplinary care team may include case managers, mental health specialists, social workers, pharmacists, dieticians, educators, psychologists, health coaches, administrators and others. While not all team members provide direct medical care, they work together with the patient and caregivers to help identify and address each individual's health care needs. The idea is to engage patients, help them solve problems and better manage their total health.

While VBC contracting and a team-based approach may be available within a carrier's high-performance network or within foundational models like patient-centered medical homes and bundled payments, the most advanced types of VBC, often called "next-generation" models, are showing the greatest potential for improved outcomes and lower costs. Next-generation models include Accountable Care Organization (ACO) products, which are comprised of integrated groups of doctors, hospitals and other health care providers that work together to provide high-quality coordinated care, and Joint Ventures (JVs), a VBC model where two organizations, such as a health system and an insurance company, partner to form a new company and a new health plan.

[5] Sawyer B, Gonzales S. Rand Corporation. Multiple Chronic Conditions in the United States. Accessed March 14, 2019.
[6] Centers for Disease Control and Prevention. Health and Economic Costs of Chronic Diseases. Accessed March 14, 2019.
[7] Institute of Medicine. Best Care at Lower Costs. Accessed March 14, 2019.

Success story: early intervention pays off

Multidisciplinary care teams help patients better manage chronic conditions

Meet James.* He is a 47-year-old with chronic kidney disease (CKD), living in Houston, Texas. James is supported by a team within the **Aetna Memorial Hermann Accountable Care Network**. He visited the hospital with shortness of breath and swelling in both legs, indications that the symptoms of his disease were not controlled.

CKD affects about 15 percent of adults in the U.S. It can be an expensive disease that becomes costlier as it progresses towards kidney failure.[8] Research indicates that multidisciplinary care programs can be an effective way to slow the progression of kidney disease, reducing the need for dialysis and other costly interventions while extending life expectancy.[9]

James, under Value-Based Care

- A nurse care manager works closely with James to educate him about kidney disease and specific ways to improve his health.
- A dietitian helps James start a kidney-friendly diet, and his health improves.
- A social worker helps James apply for disability to relieve some of his financial worries.
- With his symptoms under control, the care team works with James to get him on the kidney transplant waiting list.
- James' team is with him through every step of his transplant. He returns to work and feels confident that he can manage his health.

*Aetna member experience, 2017. Names and some details have been changed or omitted to protect member privacy. Past results aren't indicative of future performance.
[8] Centers for Disease Control and Prevention. National Chronic Kidney Disease Fact Sheet, 2017. Accessed March 14, 2019.
[9] Lin E, Chertow G, et al. PLoS Med. Cost-effectiveness of multidisciplinary care in mild to moderate chronic kidney disease in the United States: A modeling study. Accessed March 14, 2019.

Patients are part of the team

Patients like James may spend only a few hours each year in their doctors' care but many more hours in self-care. Open communication and sharing of information among care teams, carriers and patients enhances trust and engagement and empowers patients to take better care of themselves between visits, critical elements for the success of prevention strategies and care management programs.

Evidence shows that care teams involved in VBC are more likely to:**

Recognize that **engaging patients** in conversations about treatment plans and medications will help them achieve their desired outcomes

Be **aligned with patients' motivations** for their health goals

Coordinate with community resources like nutritionists, social workers, in-home liaisons and mental health counselors to **help patients meet their goals**

Data and technology empower VBC teams to improve outcomes and performance

We live in a digital world with extraordinary access to a wealth of information. The ability to receive, analyze and share health care data facilitates communication and collaboration by connecting patients and their health care teams with actionable clinical information.*** Members of the care teams within ACOs and JVs, for example, all have rapid access to the same data, providing the best opportunity to deliver the right treatment at the right time.

VBC gives carriers and care teams the opportunity to work together to analyze data, identify gaps in care and proactively reach out to patients who are due for a primary care visit or a preventive screening. This kind of timely data analytics also helps identify and help those who are managing conditions and may be struggling with the treatment plan, haven't filled a prescription or need to make an appointment for follow-up care.

> **"Our mission is to deliver personalized digital experiences. By leveraging data and analytics, we can improve the overall health care experience, improve health and reduce medical costs."**
>
> **Firdaus Bhathena,**
> **Chief Digital Health Officer,**
> **CVS Health**

** Health Ambitions Survey 2018 Data
*** Data sharing and access is subject to applicable privacy laws.

Additionally, the use of new and existing technologies allows patients to capture and share self-generated data. And it can help extend care coordination beyond the clinic, further boosting engagement and collaboration. For example:

Online engagement tools and apps help patients **better understand** their conditions and treatment plans.

Wearable technology, like the Apple Watch, collects important health data individuals can use to track their own health. And the data can be shared with clinicians, allowing them to monitor patients' progress and **intervene more quickly when necessary.**

Telemedicine can improve outcomes and lower costs for patients who would not otherwise seek needed care through traditional means. This can be especially helpful in mental health care, where **stigma still keeps many from seeking services.**

> **"We are in the midst of a revolution in terms of changes to the clinical delivery model."**
>
> **Brigitte Nettesheim, President of Transformative Markets, Aetna**

Importantly, VBC models reflect the fact that health is more than the absence of disease. Incorporating data related to the social determinants of health — the communal, physical and economic conditions of the environments where people live, work and age — provides a path to address many of the causes of health care disparities that lead to increased costs and poor outcomes.

Examining social determinants of health data can help identify populations and individuals who may benefit from initiatives that address food insecurity, housing instability, poor access to health care, education or employment opportunities, and the mental health toll of community violence. Many carriers have developed **programs** that operate in tandem with the expansion of value-based contracting. Examples include community gardens, affordable housing initiatives and programs that provide greater access to local health care. This kind of holistic care delivery provides all individuals the best opportunity to be healthier.

Your ZIP code matters

250%

People living in poverty are 250% more likely to be diagnosed with type 2 diabetes than those with greater income stability.[10] [11] [12]

Why? Poor communities have less access to...

[10] U.S. Department of Health & Human Services. Poverty Guidelines. Accessed March 14, 2019.
[11] Healthy People 2020. Social Determinants of Health. Accessed March 14, 2019.
[12] Braverman PA, Cubbin C, et al. American Journal of Public Health. Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us. Accessed March 14, 2019.

How does all of this add up to improved outcomes?

Here's what can happen when health care is coordinated and efficient, data and technology are utilized effectively and patients are engaged in care.

- Individuals have a better experience navigating the health care system.
- More people get preventive services like colonoscopies, mammograms and flu vaccinations.
- Risk factors and early disease are more rapidly detected and addressed.
- Chronic diseases, like high blood pressure, diabetes and kidney disease are more likely to be under control.
- There are fewer emergency room visits, hospitalizations and re-admissions.

Want to see how care teams can help patients get chronic conditions under control and live a better life? Here's Juan's story.

Juan Ovalle lives in Phoenix, Arizona, and at 56 he has a history of unmonitored diabetes, high blood pressure and depression. The care team at the **Banner | Aetna** Joint Venture helped Juan find a primary care doctor, a diabetes educator and a health coach. He was also connected to the **AbleTo**® program, which provides counseling sessions with therapists through phone calls or video chats. This proactive approach is helping Juan get his chronic conditions under control and avoid future illness. He says, "I am doing fabulous. I feel like there is hope again."

How can VBC save money?

VBC's proactive, data-driven approach means providers, patients and insurance companies are better aligned in the goals of keeping patients healthy and keeping costs down over time. It's no surprise that addressing risk factors and early-stage disease is better for patients and less expensive than late-stage interventions and hospitalizations. Similarly, well-controlled chronic conditions incur fewer costs compared to uncontrolled conditions that often progress. Enhanced care coordination and data sharing can also help streamline administrative processes and reduce wasted spending.

The savings comes from:

- Early detection and proactively addressing risk factors
- Enhanced patient engagement and better management of chronic conditions
- Standardization of care and use of Centers of Excellence
- Better use of evidence-based decision making, leading to personalized treatment plans
- Informed referrals and best site of service, such as utilizing walk-in clinics and urgent care sites rather than emergency rooms, when appropriate
- Improved care coordination, fewer complications and hospitalizations
- Fewer unnecessary or duplicative tests and procedures
- More prescribing of generic medications when possible

> **"Savings don't come from the denial of services; they come from ensuring that our members are receiving the right level of service at the right time and in the right setting."**
>
> **Manny Germano, Vice President of Value-Based Solutions, Aetna**

How much savings can be expected over time?

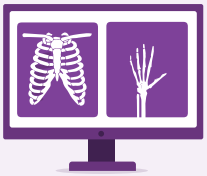
In 2013 Aetna joined with Inova, a health system serving more than two million patients in Northern Virginia. A new company was formed, a Joint Venture called Innovation Health. Focused on better consumer experience and care coordination, Innovation Health has seen many improvements, including 14 percent fewer inpatient admissions, 9 percent fewer high-tech radiology visits, and 5 percent more generic prescription use.[†]

> **“Innovative clinical management strategies coupled with value-based solutions allow us to achieve enhanced engagement rates, resulting in these impressive trend results.”**

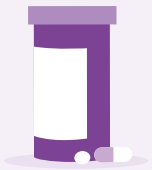
Sunil Budhrani,
MD, MPH, MBA, CEO and Chief Medical Officer, Innovation Health

Success metrics at Innovation Health

14% ↓
Inpatient admissions



9% ↓
Radiology visits



5% ↑
Generic Rx

As you can see, VBC is already leading to better care at lower costs, but even greater value can be expected over time. In the years ahead, good preventive care may yield returns in cost savings and improvements in population health. And ultimately, a proactive approach to care should lead to less disease burden, healthier communities and an even greater savings to the health system as a whole.

[†] Actual results may vary, depending on a variety of factors, including Innovation Health plan model. Data represents Innovation Health commercial members. Data from baseline period, January 1, 2017 – December 31, 2017; current period, January 1, 2018 – December 31, 2018; claims period through December 31, 2018.

Are you taking advantage of Value-Based Care?

When evaluating plans, ask not just whether an insurance carrier offers VBC, but also how invested in it they are. Here are some questions you might ask.

How much of your medical spend is provided under value-based contracts?
(Aetna, for example, has more than 2,000 value-based contracts in place, representing more than 50 percent of medical expenditures.)

What savings are you seeing from your VBC products today?
(Aetna Whole Health℠, Aetna's ACO product, can save as much as $675 per member per year.††)

Are there any next generation VBC models available in your plan?
(For comparison, Aetna currently is a partner to five JVs: **Innovation Health** in Northern Virginia; **Allina Health | Aetna** in Minneapolis; **Banner | Aetna** in Arizona; **Sutter Health | Aetna** in San Francisco/Sacramento; **Texas Health Aetna**) in Dallas/Fort Worth, and hundreds of Aetna Whole Health℠ ACOs across the country.)

Aetna's rapid shift to Value-Based Care

We're committed to the promise of Value-Based Care. We believe that when your workforce is healthy, your company is healthy, too.

To learn more or determine what VBC options are available to you, **contact us.**

†† Compared to the control group in a retrospective matched cohort design over 2015-2017; six-month baseline period prior to ACO effective date and 12-month study period after ACO effective date. The ACO group consisted of 31,388 members; the matched control group consisted of 79,798 members. Most members included in the study resided in Texas, Arizona, Illinois and Pennsylvania.