Advancing Value-Based Care in the U.S. Health Care System: Executive Summary

Foreword

The U.S. health care system is the most expensive in the world, yet it delivers inconsistent quality, uneven outcomes, and significant waste. A major contributor to high costs and low-value care is the system's reliance on fee-for-service (FFS) payment models, which reward providers for the volume of products and services rather than the effectiveness of care delivered.

Value-based care shifts the focus from treating individual health issues as they arise to actively supporting people in staying healthy and achieving better long-term outcomes.

Value-based care promotes a more efficient, high-performing health care system by emphasizing:

- Preventive services and primary care
- Coordination among providers and payers
- Better outcomes at a lower cost

Unlike FFS, which incentivizes additional procedures and uncontrolled spending, value-based care aligns payments with patient outcomes. Providers are rewarded for keeping people healthy and delivering the right care, at the right time, in the right setting.

UnitedHealth Group (UHG) is at the forefront of the transformation of the U.S. health system. UHG is helping to build a simpler, more connected system that delivers higher-quality care at a lower cost through its different lines of business, including UnitedHealthcare Medicare Advantage plans and Optum Health physician practices.

Moving from Fee for Service to Value-Based Care

Fee for Service	Value-Based Care
Fragmentation within the health care system; providers operate independently.	Encourages collaboration among providers and payers for patient-centered, integrated care.
Payments made for each individual service, regardless of outcome.	Payments tied to quality and effectiveness of care for the patient.
Incentivizes a high volume of costly services.	Prioritizes primary care and prevention to improve health and reduce costs.
Results in inconsistent quality and outcomes with no cost controls.	Delivers higher quality and better outcomes by linking payment to performance.
Leads to substantial overuse and waste.	Focuses on effective care to lower total costs.

Decades of bipartisan efforts have laid the groundwork for value-based care. Today, there is both an urgent need and a strategic opportunity for policymakers and private-sector leaders to accelerate the adoption of value-based care models.

This report explores:

- **Performance of the U.S. Health Care System**
- **Value-Based Care Evolution and Key Concepts**
- **Adoption of Value-Based Payments and Accountable Care Arrangements**
- **Lessons from Government-Funded Value-Based Care Models**
- **Key Drivers of Successful Value-Based Care Program Performance**

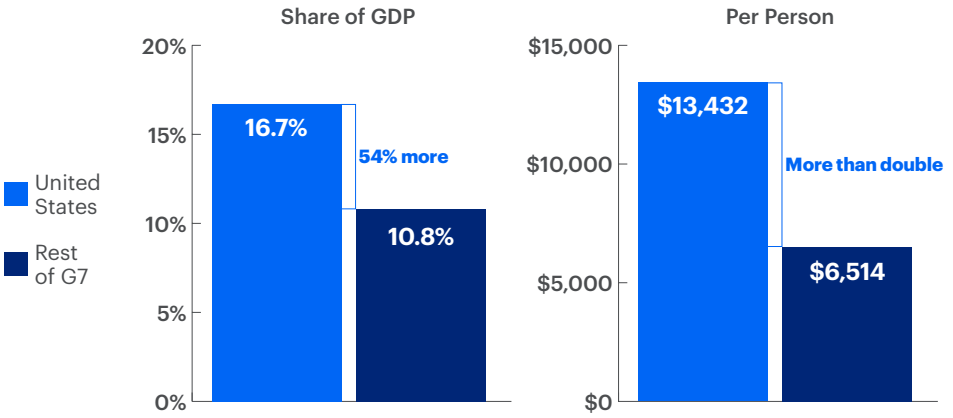
Advancing Value-Based Care in the U.S. Health Care System: Executive Summary

Executive Summary

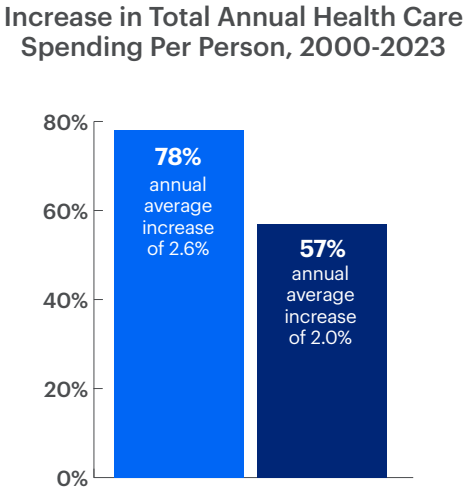
I. Performance of the U.S. Health Care System

Substantial U.S. health care spending continues to yield mixed results on system performance and health outcomes.

The U.S. spends more on health care than the other G7 countries (Canada, France, Germany, Italy, Japan, and the United Kingdom)[1]

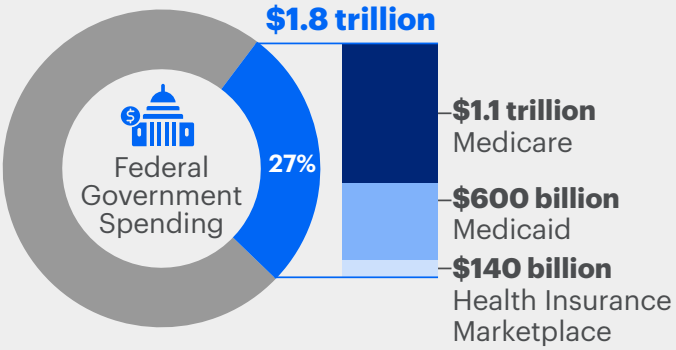


U.S. health care spending has grown faster[2]

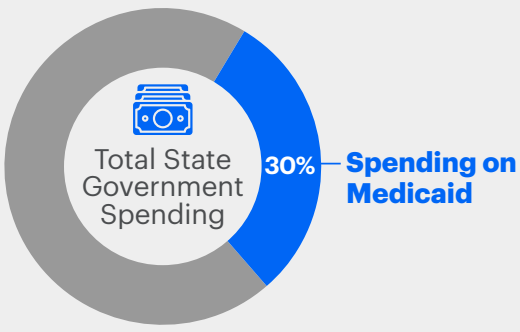


Health care is expected to account for an increasing share of U.S. GDP. Between 2023 and 2032, U.S. health care spending growth (5.6%) is projected to outpace annual average GDP growth (4.3%) by 1.3 percentage points.[3]

Health care will account for 27% of federal government spending in 2025[4,5,6,7]



In 2024, states spent $300 billion on Medicaid[8]



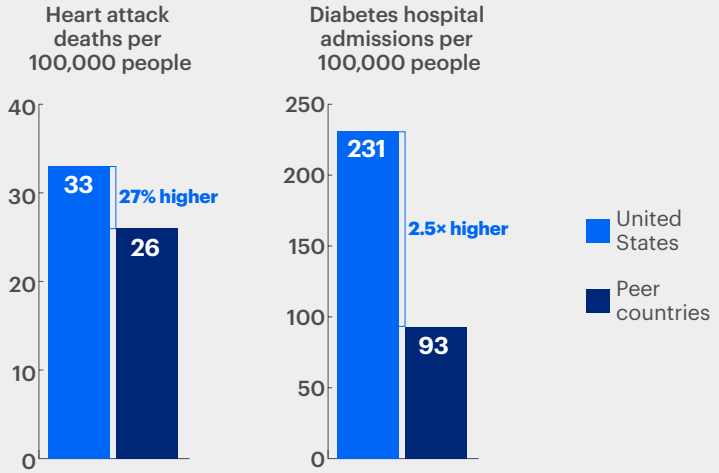
Overall, research indicates that an estimated 25% of total U.S. health care spending[9] – representing about $1.4 trillion out of $5.6 trillion in 2025[10] – is waste, including: failure of care delivery, failure of care coordination, overtreatment or low-value care, pricing failure, fraud and abuse, and administrative complexity.[11]

Significant investment in health care has enabled the U.S. to remain a global leader in medical science, technology, and education.[12,13,14] The U.S. leads in:

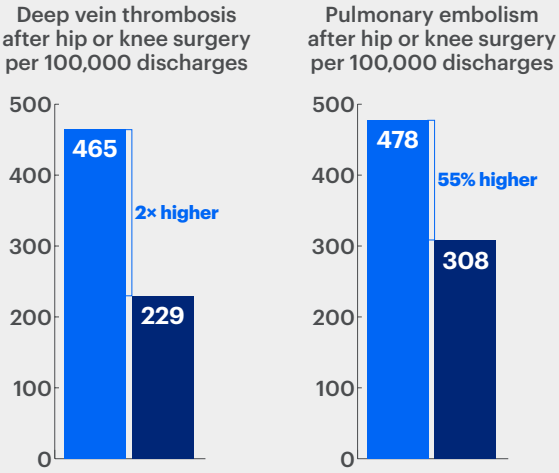
- Medical device and pharmaceutical innovations, including breakthrough technologies and new drug approvals.[15]
- Digital health advancements, such as behavioral health virtual care, on-demand telehealth, and the integration of digital and in-person care models.[16,17]
- Academic research excellence, demonstrated by the global impact of U.S. scientific research and publications and receiving the highest number of Nobel Prizes in chemistry or medicine per capita.[18,19]
- Universities that consistently rank among the world's best for clinical medicine, driven by their emphasis on medical research and specialization.[20,21]

Despite spending more on health care and leading in medical innovations, health outcomes in the U.S. are mixed relative to peer countries.

The U.S. underperforms compared to peer countries in managing chronic conditions[22,23]



Post-operative complications, which are important measures of hospital safety, are more common in the U.S. than in peer countries[24]



Medication and medical errors are slightly more common in the U.S. than in peer countries.[25] Between 2018 and 2020, the frequency of errors reported during care was 13%, compared to 11%.[26]

The widespread use of fee-for-service (FFS) payments is a longstanding cause of the U.S. health care system's fragmentation, inconsistent quality, and high and growing costs.[27]

FFS payments compensate providers for each service they deliver to patients, incentivizing a higher volume of care regardless of clinical value or patient outcomes.[28,29,30] As a result, FFS payments:[31,32]

- Promote the delivery of costly services that may be unnecessary.
- Do not incentivize the delivery of high-quality, individualized, efficient care.
- Do not encourage care coordination and management of patients across providers and settings.

System-wide transitions away from FFS can reduce cost growth by encouraging high-quality, cost-efficient care delivery patterns.[33]

II. Value-Based Care Evolution and Key Concepts

Value-based care is the primary solution to address the legacy and misaligned incentives of the FFS health care payment system. The term "value-based care" advances a framework and metrics to better understand the U.S. health care system's high costs and poor health outcomes,[34] and to chart a course towards progress. The common theme across definitions of value-based care is the shared goal of achieving the best possible health outcomes for patients at the lowest cost,[35] and recognition of the need to shift away from volume-based FFS payments.

The concept of value-based care has roots in the managed care era of the 1970s and 1980s and further evolved during the pay-for-performance era of the 1990s and 2000s, before becoming an explicit cornerstone of policy efforts in the 2010s and 2020s.

In contrast to FFS, value-based care models align providers' incentives with patient outcomes, rewarding providers for keeping their patients healthy and using cost-effective, evidence-based care to treat chronic conditions and acute illness.[36]

Value-based care redefines the physician's role away from providing episodic, condition-specific interventions and toward proactively stewarding patients' health by maintaining wellness and optimizing long-term outcomes.[37] Medical schools and their curricula can help drive the adoption of value-based care by helping physicians reframe their roles in care delivery, redefining effective care, and prioritizing the measurement of outcomes that matter most to patients.[38]

Efforts to spread the adoption of value-based care as an alternative to FFS have been longstanding and bipartisan.

> ***"...We've been moving Medicare toward a payment model that rewards quality of care over quantity of care. And that means we want doctors and hospitals to focus on giving folks the right tests and the right treatment, not just trying to sell more tests and sell more treatments. And that delivers better outcomes."***[39]
>
> —President Barack Obama, 2016

> ***"It is the policy of the United States to protect and improve the Medicare program by enhancing its fiscal sustainability through alternative payment methodologies that link payment to value, increase choice, and lower regulatory burdens imposed upon providers."***[40]
>
> —President Donald Trump, 2019

CMS aims to use value-based care to achieve better care for individuals, better health for populations, and lower costs.[41] These goals were derived from the original "Triple Aim" approach developed by the Institute for Healthcare Improvement (IHI) to improve and optimize the performance of the U.S. health system.[42] Value-based care rewards providers based on patient outcomes.

The payment method for health care significantly impacts the delivery of services. The implementation and testing of alternative payment models (APMs), which use financial incentives to encourage providers to deliver high-quality, coordinated, and cost-effective care, have driven the evolution and refinement of value-based care efforts nationally. By aligning provider payment incentives with patient outcomes, the more advanced APMs can facilitate improvements in care coordination and reductions in unnecessary services.[43]

III. Adoption of Value-Based Payments and Accountable Care Arrangements

National payment reform efforts aimed at reducing health care costs, increasing clinical efficiency, and encouraging care coordination have focused on value-based models of care delivery that incentivize providers to keep patients healthy, and to treat those with acute or chronic conditions with cost-effective, evidence-based treatments.[44] In an accountable care arrangement, health care providers work with each other to manage their patients' overall health. These arrangements can include accountable care organizations (ACOs), bundled payment arrangements, and managed care arrangements.[45] ACOs are among the most widespread APMs, are provider organizations designed to take accountability for a patient population, invest in infrastructure and redesigned care processes, and enable and incentivize high-quality, coordinated, and efficient care.[46]

Medicare Shared Savings Program (MSSP)[47]

In 2023, ACOs in the MSSP, the largest ACO program in the country with 10.9 million enrollees:

Earned shared savings payments to providers totaling **$3.1 billion**

While also yielding **$2.1 billion** in net savings to Medicare

Recent Growth in Accountable Care Organization Enrollment Across All Payers[48]

81.2 million in 2022

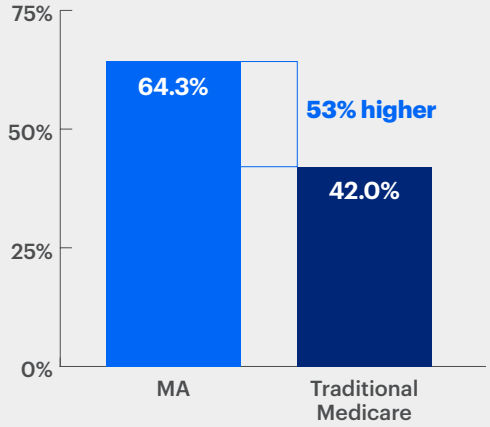
9% increase in one year

88.5 million in 2023

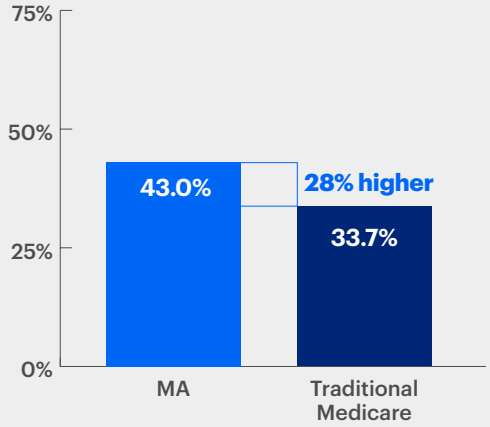
In recent years, there has been systemwide progress shifting payments from FFS to value-based models, including those with two-sided risk where providers can increase their revenue, but also can decrease their revenue, depending on the quality and cost-effectiveness of the care they provide. Between 2019 and 2023, the share of payments to providers flowing through APMs across all payers increased from 38.2% to 45.2%.[49,50]

Medicare Advantage (MA) plans, private managed care plans that administer Medicare benefits, are leading the adoption of value-based payments, with a larger share of payments to providers flowing through APMs and greater use of APMs with two-sided risk than Traditional Medicare and other payers in 2023.[51]

Payments Flowing Through APMs[52]



Payments Flowing Through APMs with Downside Risk[53]



MA plans offer extra benefits – which are not covered by Medicare FFS – at no additional cost to the federal government and with out-of-pocket (OOP) savings to the beneficiary by leveraging care and cost management strategies, including care coordination programs, utilization management programs, negotiated provider networks, and risk sharing arrangements with providers.[54]

IV. Lessons from Government-Funded Value-Based Care Models

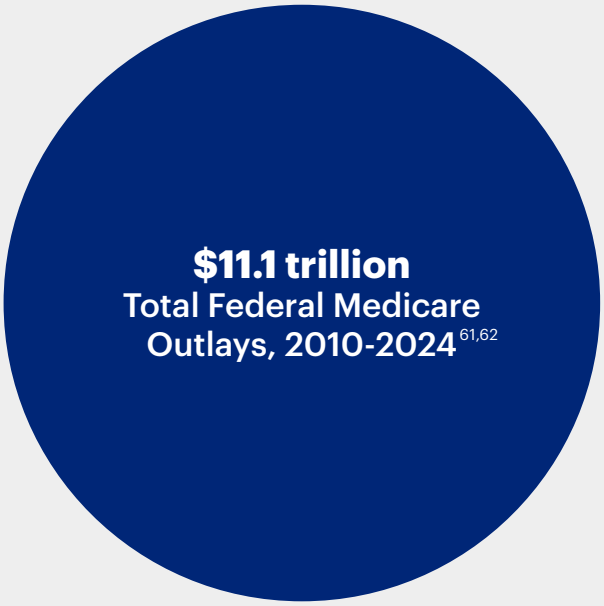
Since its establishment in 2010 within CMS, the Center for Medicare and Medicaid Innovation (CMMI) has developed and implemented over 50 novel payment and care delivery models aimed at improving patient care, lowering costs, and better aligning payment systems to promote patient-centered practices.[55] CMMI uses evaluations of prior models to inform the creation and implementation of new models with the aim of identifying and scaling sustainable and impactful value-based programs nationally. By analyzing the outcomes and lessons learned from previous models, the Center can identify best practices and areas for improvement.

In recent years, CMMI has shifted its broader strategy after most of its models did not yield meaningful cost savings and qualify for national expansion.[56] In 2025, CMMI shifted its focus to emphasize evidence-based prevention, patient empowerment, and greater choice and competition.

Key components of CMMI's current strategy include:[57]

- Requiring models to have downside financial risk and requiring individual providers to assume some of that downside risk
- Reducing the role of state governments in setting provider payment rates
- Refining and simplifying the methodology for model benchmarking – the process of evaluating and comparing model performance using standardized metrics and datasets

To date, twelve of CMMI's over 50 models have produced cost savings to the federal government and taxpayers, of which four have been expanded by CMS and HHS.[58,59,60]



$2.7 billion, 0.02%
Net Medicare Savings From Four CMMI Models Certified for National Expansion[63]

Overall, CMMI's activities increased net federal Medicare spending by an estimated **$5.4 billion** between 2011 and 2020,[64] as the savings generated by some CMMI models were more than offset by the net cost of other CMMI models and the Center's operating costs.

V. Key Drivers of Successful Value-Based Care Program Performance

Despite the challenges related to precisely evaluating the performance of each complex and varied CMMI model, past evaluations have produced useful policy and operational insights into the critical elements, approaches, and strategies that facilitated or inhibited the achievement of quality improvements and cost savings. Findings from academic scholarship, independent evaluation reports, and government analyses indicate that drivers of program success relate to:[65,66]

1. **Downside financial risk.** Two-sided risk agreements provide downside financial risk, along with upside incentives for providers to meet quality targets and reduce unnecessary spending and care for specific patient populations or care episodes.[67] Of the twelve CMMI models that have produced net savings to Medicare, ten included providers accepting two-sided risk arrangements.[68]
2. **Upside incentives.** Financial incentives are critical levers to influence provider behaviors and promote the delivery of high quality and cost-effective care.[69] The effectiveness of incentives is determined in large part by their size, as well as their clarity, and alignment among different models.[70,71,72]
3. **Alignment of models.** The establishment of CMMI accelerated the proliferation of value-based care programs with varying approaches and designs for cost and quality interventions. Increasing alignment across models' design and implementation processes to the extent possible facilitates broader provider participation and scalable and sustained care delivery transformation.[73]
4. **Provider and patient engagement.** Providers and patients are key drivers of the successful adoption of value-based care programs at the practice level.
5. **Performance targets.** Performance benchmarks, cost and quality targets against which providers are measured, serve as the basis for assessing progress toward the goals of value-based care and creating accountability for provider's performance.[74]
6. **Data and other quality improvement support.** Significant investments in infrastructure, including electronic health record enhancements, staffing, and data analytic support, are often required to participate in models.[75] As a result, providers serving vulnerable populations, including rural and low-income patients, face barriers to participation in value-based care models, thereby excluding many underserved populations from assignment into these models.

Evaluation of the history and successes of CMMI's past pilots suggests that well-designed value-based care models have the potential to yield meaningful improvements in cost and quality. While the health care system has reached a series of important milestones in its shift to value-based care, past initiatives have yet to achieve large-scale, systemic change.

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[47] CMS, "Medicare Shared Savings Program Continues to Deliver Meaningful Savings and High-Quality Health Care," October 2024.
https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-continues-deliver-meaningful-savings-and-high-quality-health-care
At the time of analysis, 2023 was the most recent evaluation data published for all value-based care models cited in this report. Since then, 2024 results were released for MSSP, but not for other models included. The most recent year of data cited in this report is 2023, to ensure consistency and to allow aggregating results across multiple models.

[48] HCPLAN, "APM Measurement: Progress of Alternative Payment Models, 2024 Methodology and Results Report," November 2024.
Estimate uses survey data from the HCPLAN, BCBSA, AHIP, and CMS and represents partial industry data. Arrangements in Categories 3 and/or 4 are considered accountable care arrangements and must also be longitudinal in nature (i.e., the care is intended to last six months or longer) and cover the total cost of care (TCOC). Estimate may be an undercount due to potential underreporting in 2023 data.

[49] HCPLAN, "APM Measurement: Progress of Alternative Payment Models, 2020 – 2021 Methodology and Results Report," December 2021.

[50] HCPLAN, "APM Measurement: Progress of Alternative Payment Models, 2024 Methodology and Results Report," November 2024.

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[54] Milliman, "Value of Medicare Advantage to the Federal Government," April 2024.
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[55] CMS, "About the CMS Innovation Center," August 2023. Updated February 26, 2025.
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[56] CMS Innovation Center, "Innovation Center Strategy Refresh," October 2021.
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[59] Congressional Budget Office, "Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation," September 2023.
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Only one of the four expanded models took place subsequent to 2018.

[60] CMS Innovation Center, "2024 Report to Congress," December 2024.
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[61] Medicare Board of Trustees, "2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds," June 2025.
https://www.cms.gov/oact/tr/2025
The 2025 Medicare Trustees report provided 2015 through 2024 expenditures.

[62] Medicare Board of Trustees, "2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds," July 2015.
https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/tr2015.pdf
The 2015 Medicare Trustees Report provided 2010 through 2014 expenditures.

[63] Estimate was created by summing the net savings to Medicare produced by each of CMMI's expanded models according to their most recent available evaluation. Please see Appendix C-1 for net savings results by program.

[64] CBO, "Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation," September 2023.
https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf
Estimate does not include savings accrued to Medicare through its permanent ACO program, known as the Medicare Shared Savings Program, which is not administered by CMMI.

[65] Damberg, C. et al., "Measuring Success in Health Care Value-Based Purchasing Programs Summary and Recommendations," RAND Corporation, ASPE, 2014.
https://aspe.hhs.gov/sites/default/files/private/pdf/118466/rpt_vbp_summary_0.pdf

[66] CMS Innovation Center, "Innovation Center Strategy Refresh," October 2021.
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[67] HCPLAN, "APM Measurement: Progress of Alternative Payment Models, 2024 Methodology and Results Report," November 2024.

[68] Risk models were identified using CMS model websites and model evaluation reports. See information included in Appendices.

[69] CMS Innovation Center, "Innovation Center Strategy Refresh," October 2021.
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