



**How Value-based Care is  
improving quality and health.**

## Value-based Care means better health, better care and lower costs.

Placing greater emphasis on value in health care is proving successful for everyone who touches the health care system, including consumers, care providers, and all types of plan sponsors, from private employers to state and federal programs.

That's because VBC focuses on quality and using incentives to reward better health and lower costs. This approach continues to drive important improvements in how payers and care providers work together to support people's care.

The data in this report is based on the 110,000 physicians and 1,100 hospitals engaged in a value-based relationship with UnitedHealthcare, and the 15 million UnitedHealthcare members who sought care from those providers in 2017.

## Value-based Care delivers:

### Better Health

Employer-sponsored and individual ACOs are better on

**87%**

of the top quality measures than non-ACOs

**\$90M**

in bonuses were paid to Medicare physicians for improved quality and better care of seniors

### Better Care

Employer-sponsored and individual ACOs have

**10%**

increase in visits with primary care physicians

**50M**

care opportunities were identified and completed for patients between 2013–2017

### Lower Costs

Employer-sponsored and individual ACOs have

**17%**

fewer hospital admissions than non-ACOs

**13%**

less likely to use the ER for members getting care through Medicare ACOs

**Value-based Care increases financial accountability and the level of integration between health plans and care providers.**

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## We're already seeing evidence of sustained benefits and savings.

UnitedHealthcare goes beyond providing insurance and responds to individuals to support their unique care needs. It's part of our commitment to supporting better health and better care, at a lower cost.

Expanding our Value-based Care (VBC) relationships with care providers is critical to this effort. VBC is a seismic shift away from the fragmented fee-for-service payment model.

Emphasizing accountability for all involved, it stresses collaboration rather than volume, outcomes rather than outputs, and looking for missed care opportunities rather than waiting for them to show up in the doctor's office or emergency room.

While value-based relationships can take many forms — from performance-based contracts and primary care bonus programs to fully sharing the risk of patients' medical costs — our review has found that Accountable Care Organizations (ACOs) are making significant progress

achieving the "triple aim" — better health, better care, lower cost.

Orienting our care provider relationships to value and outcomes is improving the quality of care patients receive and the quality of life they enjoy while creating a more financially sustainable health care system.

### Our Value-based programs have broad reach:

# 15M

people nationwide are accessing care from a VBC physician

# 110K

physicians and 1,100 hospitals are in a VBC relationship

# 800

ACO relationships, with a customized approach for each

## We are looking ahead to 2020.

We estimate that by the end of 2020, we will have \$75 billion of our payments to care providers tied to value based care relationships, up from \$64 billion in 2017. This shift in how health professionals and payers work together has already begun to re-shape systems and business models.

### Accountable care organizations:

- ✓ Reduce costs, improve quality and increase care
- ✓ Improve prescribing and patient referrals
- ✓ Avoid unnecessary ER visits and hospital admissions
- ✓ Coordinate care transitions
- ✓ Identify and close gaps in care

**“You’ll engage care providers when an initiative is about quality of care and the patient experience.”**

– Rick Leary, MD Palo Alto Medical Foundation



[Click to Play](#)

#### What is Value-based Care?

For a detailed video about Value-based Care and how it works, visit [uhc.com/VBCVideo](http://uhc.com/VBCVideo).



**Driving clear,  
measurable  
change.**

For employers and individuals, the Value-based Care approach offers real results. Care providers are helping patients get ahead of conditions and better manage medical issues. Their patients spend more time with primary care providers (PCPs) and less time in the ER or in the hospital. These changes, in turn, translate into better value for employers looking for the best care plans for their employees.

### Helping employers provide the best coverage possible.

We continue to develop new products that help employers tap into the value ACOs deliver to both their company and their employees' health and wellness. NexusACO is a next generation product that helps provide more comprehensive services. It organizes top-performing care providers into an integrated approach to patient care delivery through a suite of tiered benefit plans. This leads to better care coordination, better health outcomes, and lower costs for high quality health — all supported by a seamless digital experience.

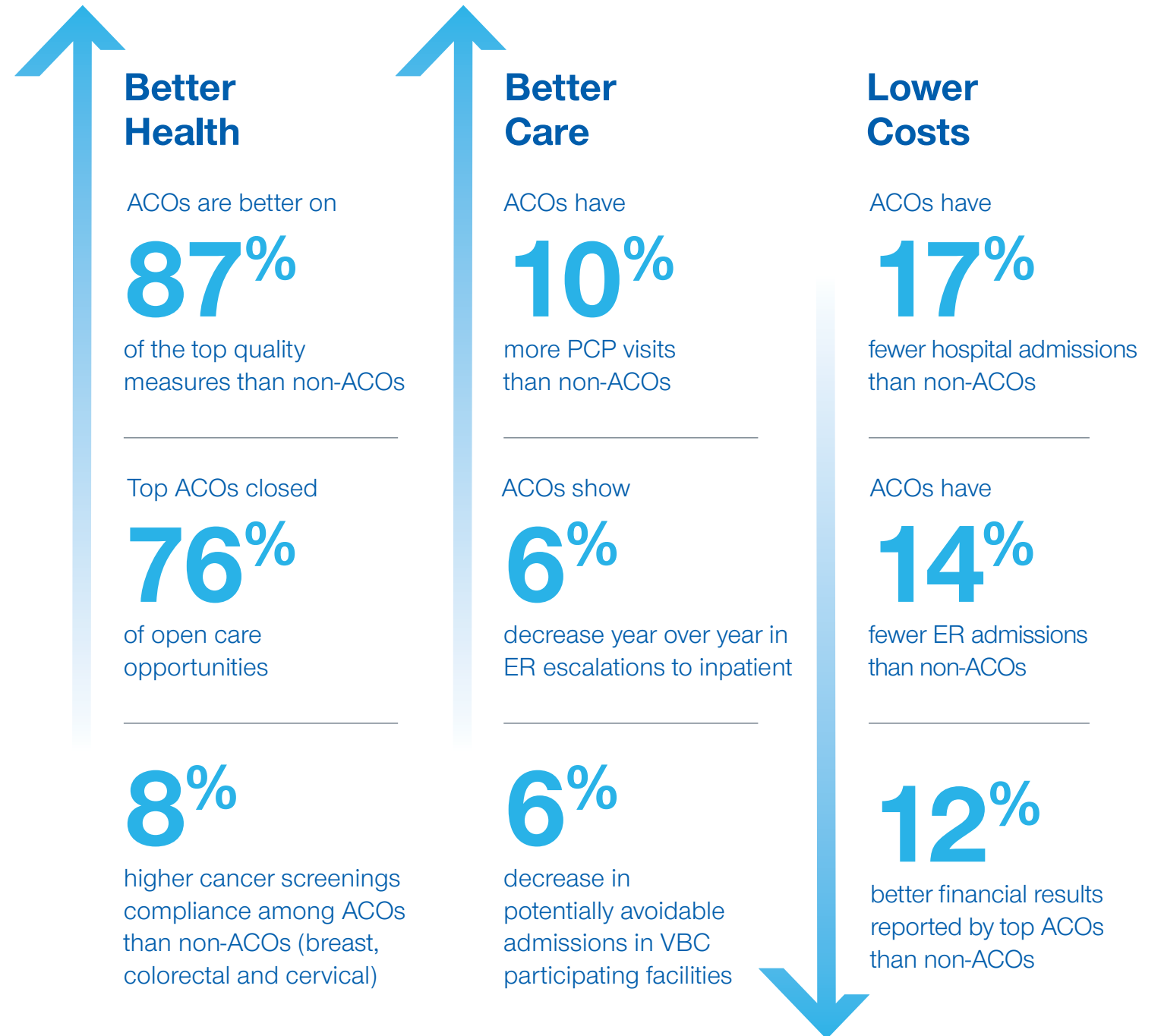
We expect to have over 250,000 people enrolled in NexusACO by the end of 2019.

#### NexusACO delivers strong results.

Employers who choose NexusACO generally save on overall health care costs:

- ✓ 11% fewer hospital admissions.
- ✓ 9% decrease in inpatient length of stay.
- ✓ 8% fewer ER visits per 1,000.
- ✓ 7% fewer readmissions.

### In our employer-sponsored and individual network, value-based care delivers:





**Value-based Care changes the fundamentals.**

Many Medicare members live with chronic conditions, and the fee-for-service model doesn't respond to their needs or help them navigate a complex health care system.

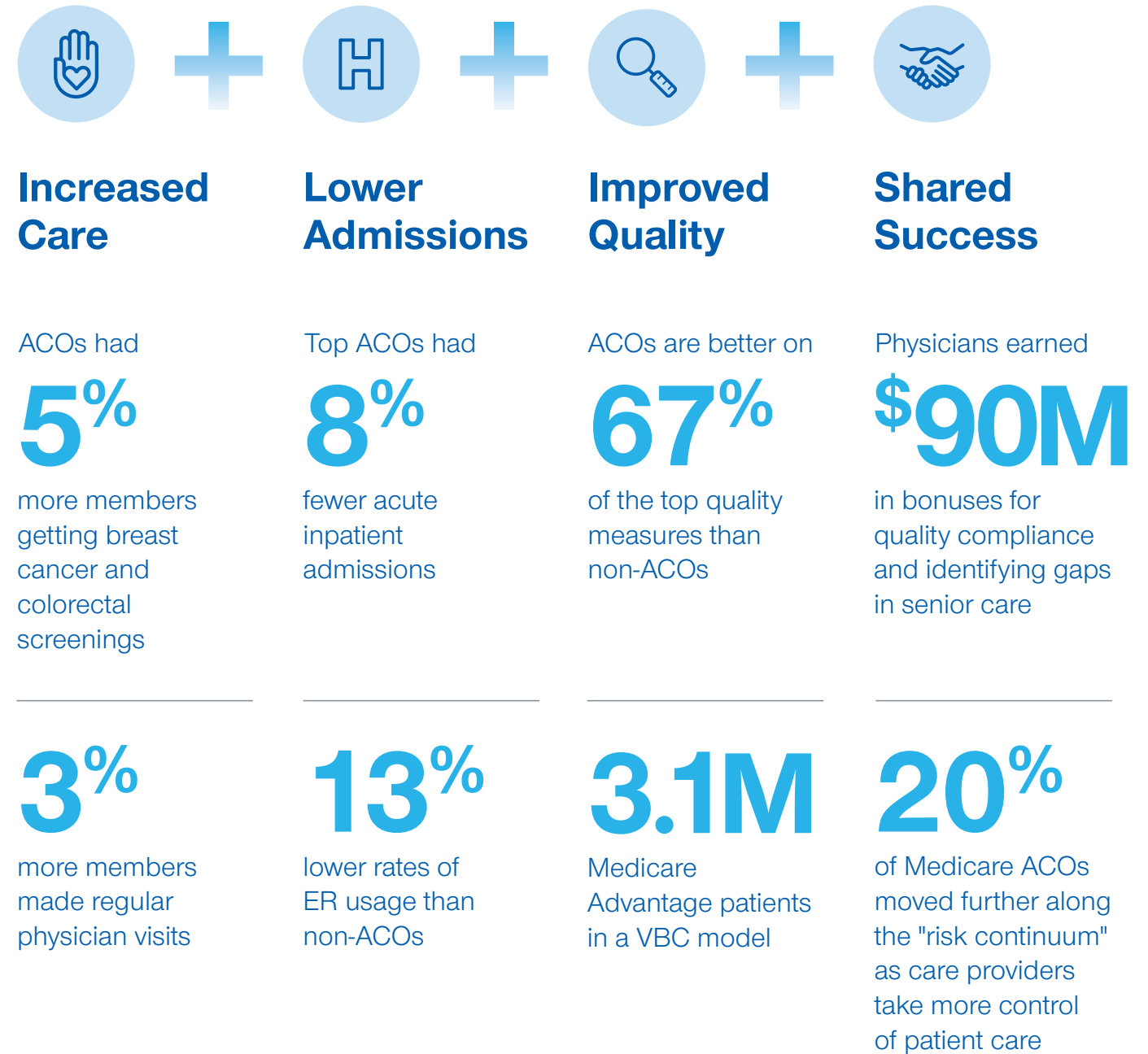
Value-based models promotes patients receiving more proactive and coordinated care earlier, especially in elevated risk areas like diabetes, cancer and heart failure. A focus on outcomes rather than volume of services helps the patient get efficient care without unnecessary tests or time in the hospital.

Today, more than three million Medicare Advantage members are treated by care providers working in a VBC model. As more Americans enter retirement age, the health care system will come under increasing strain. The VBC model demonstrates that there is a different, better way to move forward together.

**“Today’s health care system fails people with multiple chronic conditions. Patients and their families suffer as a result.”**

– Dana Lustbader, MD, ProHEALTH Care

**In our Medicare network, value-based care delivers:**





**Facing complex care challenges head on.**

Medicaid members face some of the most complex care challenges in the health care system. But putting greater emphasis on proactive, coordinated and integrated care that addresses not just symptoms but also the social and environmental factors related to a person's well-being can reverse this trend.

**“Why do we do this? Because when you have an integrated health program, it boils down to one thing, and that’s the patient experience.”**

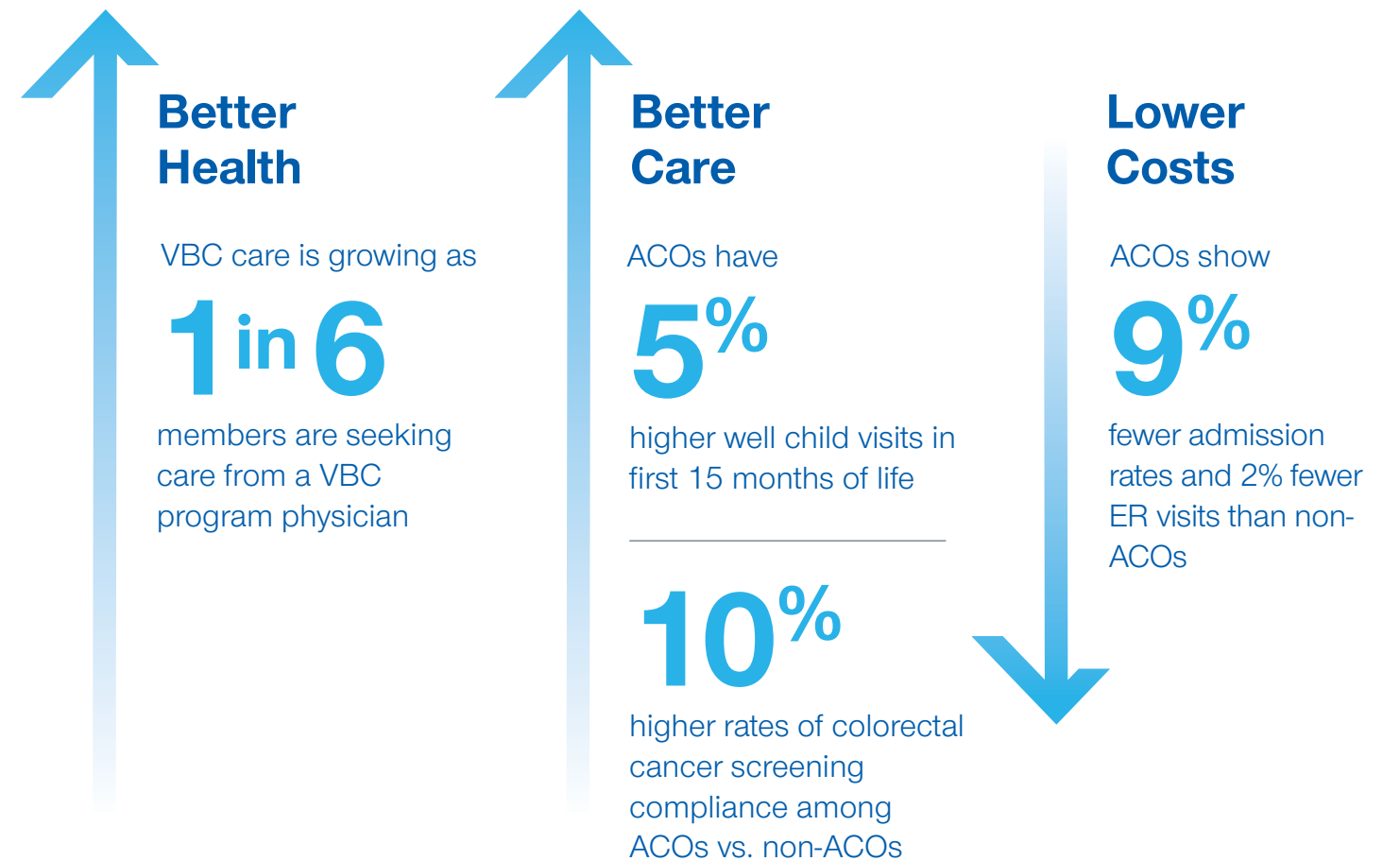
– David A. Gonzales, MD  
Presbyterian Medical Services

Effectively supporting the care of our Medicaid members means moving towards “whole person care,” recognizing and responding to social and environmental factors along with medical ones, and getting out ahead of the risks, rather than responding when the worst has already come to pass.

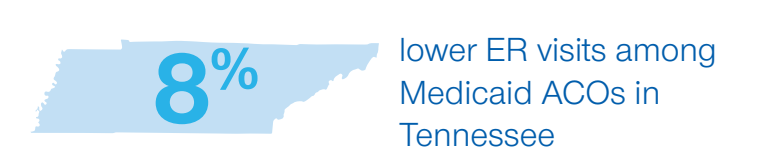
Working with Medicaid care providers in Value-based Care programs is an integral part of this, and better care provider relationships have already begun to help us drive better quality care and better value for our Medicaid members and state partners. Given the essential services we help Medicaid members access–

from pre- and post-natal care to managing high risk and often complex co-morbidities – this approach becomes incredibly important.

**Medicaid Value-based Care delivers:**



**Medicaid ACOs at the state level show success.**



## ACO best practices in action.

In October 2017, leaders from more than 50 of the top-performing ACOs working with UnitedHealthcare gathered in Colorado for an ACO Summit. Organizations share their experiences and perspectives at this annual event. Participants shared ideas for applying technology and data-driven reporting, better integration of medical and behavioral care, and using their passion to fuel a patient-centered health care system.

### Among the more profound sentiments voiced by ACOs were:



#### They're seeing results — but it takes time.

ACO partners reported progress toward the Triple Aim of better care, better health and lower costs. Working together, ACOs and UnitedHealthcare are implementing projects that address nuances of physical, behavioral and social determinants of health in member populations, close gaps in care, and deliver better care. On average, it takes 12–18 months for results to start to show.



#### ACOs are creating communities of health.

As ACOs gain momentum, they're strengthening relationships with other providers throughout the communities they serve. ACOs create an atmosphere where everyone who touches a person's health — PCPs, specialists, hospitals, rehab and nursing facilities, therapists and pharmacists — must coordinate with each other. The result is the creation of genuine communities of health.



#### They're at the forefront of innovation.

As one attendee commented after a breakout session, "This is groundbreaking stuff." ACOs shared strategies to bring back to provider practices, and UnitedHealthcare shared ideas on how to help care providers with data and information. View the [ACO Summit recap report](#).

### 5 critical elements for a successful ACO:

Successful ACOs require a shift in an organization's resources and mindset.

- 1. Improving high-risk patient care.** A practice must be able to identify its most at-risk patients and help them get care.
- 2. Expanding access to care.** From extended hours and same-day appointments to redirecting care, ACOs must help patients get convenient, timely care.
- 3. Reducing avoidable readmissions and ER use.** Getting daily discharge data lets doctors better manage care transitions and follow-up care.
- 4. Identifying and closing missed care opportunities.** When payers and providers share data, they can see across a patient population, making it easier to identify risk and care gaps.
- 5. Improving patient satisfaction.** Data from a payer can help providers more proactively engage with their patients to create a better health care experience.



**David Hanekom, MD, FACP, CMPE**  
Chief Executive Officer  
Arizona Care Network

"Arizona Care Network truly transformed from a transactional fee-for-service way of doing business to one that improves the quality of care for people," said Dr. Biuso. What's more, "it shows how the payer and clinical network can align themselves in a collaborative fashion."

Arizona Care Network and UnitedHealthcare launched an ACO on May 1, 2014, to improve care quality and reduce costs for thousands of Phoenix-area residents enrolled in UnitedHealthcare's employer-sponsored health plans. Now including more than 5,000 clinicians in Maricopa and Pinal counties, the ACO has already elevated quality and reduced health care spend by millions of dollars for UnitedHealthcare members, including reducing acute hospital admissions by 22 percent and reduced the

## Arizona Care Network and UnitedHealthcare Collaborate on Impressive Results

Dr. Thomas Biuso, the West region senior medical director for UnitedHealthcare, has witnessed some impressive performances by ACOs during his 11 years with the company, but the Arizona Care Network stands out.

average patient's length of stay in the hospital by 25 percent.

Dr. David Hanekom, CEO of Arizona Care Network, said reports provided by UnitedHealthcare on topics such as closing gaps in care, treating patients with multiple chronic conditions, and handling monthly claims data were key to their improvements. Arizona Care Network was also included in UHC's premium designation program, which uses quality and cost efficiency criteria to help members make more informed choices about their care. And the two companies established collaborative working groups to identify additional opportunity to improve care and services.

"UnitedHealthcare produces some of the best reports I've seen in my career from any payer," Dr. Hanekom said. "The willingness of UnitedHealthcare to share that information with us means we can take responsibility for optimizing our

**"This is the kind of relationship that helps transform our health care system."**

organization to meet the needs of our patient population."

Furthermore, he said, the mutual willingness of UnitedHealthcare and Arizona Care Network to share information and data demonstrated a shared commitment to putting patients at the center of the process and improving health care for the people in the surrounding communities. "When an organization like UnitedHealthcare decides to share this kind of unique insight with a trusted collaborator like Arizona Care Network, you get rapid results. This is the kind of relationship that helps transform our health care system," he said.

## Addressing both medical and social needs helped give a woman her life back.

Beth,\* in her early 60s, was battling depression, obesity and diabetes. Her mobility was limited and her breathing was labored. She felt overwhelmed, isolated and rarely left her home.

But in 2014, things started to change for Beth. Based on state reports provided to UnitedHealthcare for the Medicaid members it serves, a concerning pattern was noticed in Beth's health and well-being. UnitedHealthcare stepped in to enroll Beth in the insurer's Health Home program, which supports some of the most vulnerable individuals within Washington state's Medicaid population.

Thanks to the program, UnitedHealthcare was able to connect Beth to Halina French, a care coordinator from Aging and Long Term Care of Eastern Washington, a social services organization.

Halina collaborated with specialists and social services agencies to develop a tailored care plan that helped Beth manage her conditions, address barriers to care, and ensure that both her medical and social needs were met.

"Beth's story shows the impact of coordinated care that brings together

different social and medical care providers – and puts the patient at the center of everything," said Sharon Williams, UnitedHealthcare, West Regional Health Home Director.

These caring individuals became the core members of Beth's "Care Team," collaborating with her to set personal health goals, connecting her to community support groups, and visiting her at home on a monthly basis.

Beth and her Care Team established a goal that she would one day soon leave her home without the use of a wheelchair or oxygen.

Through meaningful and consistent engagements, Halina became one of Beth's biggest champions. In the three years that she was enrolled in the Health Home program, she dramatically improved her health, received better quality health services, had regular primary care and behavioral health appointments, reduced her medical costs and became more active in her community. Beth is now involved in personal growth workshops such as improving self-esteem, and attends support groups and classes on Wellness Recovery Action and Post-Traumatic Stress Disorder.

Today, Beth is living a healthier and

happier life. In a recent home visit, she excitedly reported that she attends two fitness classes a week and is exhausted from using the fitness center's pool." She has lost more than 10 pounds and has now achieved the recommended Body Mass Index (BMI) needed for a surgery to help Beth's chronic neck and back pain.

### How does Health Home work?

A Health Home is not a place, but rather a group of services. After enrolling, UnitedHealthcare members meet with their assigned, community-based Care Coordinators to develop a Health Action Plan and get:

- ✓ Personalized, in-person support with the member and their doctors.
- ✓ Assistance accessing meaningful community services.
- ✓ Options for unique and customized activities tailored to their needs.

\*Note: Beth is not the patient's real name; her name has been changed to preserve her privacy.

### Beth's quality of life increased while her health care costs decreased.

Beth began going to regular PCP visits, participating in personal growth workshops and attending fitness classes twice a week at her local fitness center.



## The future is encouraging.

UnitedHealthcare will continue working with care providers to encourage greater adoption of Value-based Care models. The momentum is strong, but many challenges still lie ahead. Based on feedback, we'll continue to focus on three of the most commonly cited challenges.



#### Strengthening the primary care model.

Care providers are looking for payers to have stronger PCP requirements in place, consumers need to form stronger relationships with PCPs, and there needs to be more transparent data available to help guide referrals.



#### Sharing actionable data and analytics.

Data needs to be delivered in multiple ways, in real time and translated into usable solutions. Bilateral data sharing, and more refined reporting accessed through easy-to-use, visual tools, rather than spreadsheets, between payers and providers is critical.



#### Creating new forms of physician and executive engagement.

We'll work to improve the payer-provider relationship and quality of care. Executive leadership is needed to drive change within provider organizations, while physician champions are critical to clinical success.

### Collaboration is key.

Collaboration is at the core of the payer/provider Value-based Care relationships, and it will be needed to build on the success we've already seen. We look forward to working with care providers and groups across the country because we know what it can mean to the health outcomes, quality of care, and savings for members.



