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Value-Based Care: What It Is, and Why It's Needed

TOPLINES

Value-based care, which ties the amount health care providers earn to the results of the care they deliver to patients, could correct the misaligned incentives of the U.S. fee-for-service system

By 2030, the Centers for Medicare and Medicaid Services aims to have all Medicare beneficiaries and most Medicaid beneficiaries enrolled in accountable, value-based care programs

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What is value-based care?

Value-based care ties the amount health care providers earn for their services to the results they deliver for their patients, such as the quality, equity, and cost of care. Through financial incentives and other methods, value-based care programs aim to hold providers more

accountable for improving patient outcomes while also giving them greater flexibility to deliver the right care at the right time.

Why is value-based care being tested in the U.S.?

Even though the United States spends much more of its gross domestic product on health care than other countries, it's not getting the best results. Compared with other high-income countries, the U.S. has the highest rate of infant deaths as well as the highest rate of preventable deaths. And a history of inequality in access to care has meant that people of color and individuals with low income are more likely to experience adverse health outcomes than the rest of the population.

Experts agree that these longstanding, widespread problems stem in part from the misaligned incentives built into the nation's traditional, fee-for-service payment model. Under fee-for-service, health care providers like physicians and hospitals are paid for each service they provide. In other words, they are rewarded for volume — they are paid more if they deliver more services, even if they don't achieve desired results. Value-based care programs aim to change that dynamic, so physicians earn more for delivering health care that helps patients get better, while also keeping costs down.

What is the potential benefit of value-based care?

To better understand the potential benefits of value-based care, stakeholders in the public and private sectors have tested a variety of approaches. The Centers for Medicare and Medicaid Services (CMS) has taken a leading role, testing several voluntary and mandatory programs with hospitals, physician groups, health plans, and other health care entities. One example is the voluntary Medicare Shared Savings Program, which allows providers to form groups called accountable care organizations (ACOs). ACOs can earn financial rewards by taking responsibility for caring for a defined group of Medicare beneficiaries and improving the care they receive, largely through better coordination of services. CMS also has tested whether an "episode-based" payment system — in which providers receive a single payment for all the services needed to care for a specific medical issue — can produce savings while maintaining quality of treatment.

Studies of value-based care programs so far suggest that they can reduce costs and improve quality of care, although results have often been mixed and impact modest. Some programs also enable providers to transform the way they deliver care, by promoting collaboration across care teams and encouraging providers to spend more time on services that wouldn't normally be covered under fee-for-service, such as counseling or screening for social needs.

What are the measures of success that providers are held accountable for?

In value-based arrangements, health care organizations are incentivized, or rewarded, for meeting various, interrelated goals. These goals typically aim to improve measures of quality, cost, and equity. If they're not met, organizations may forfeit bonuses or lose a portion of their payment from payers like Medicare, Medicaid, or commercial health insurers. Following are some of the key areas measured.

Quality. With so many dimensions of quality and so many ways to measure it, how — and how often — quality should be measured is a matter of ongoing debate. The National Academy of Medicine has described a useful framework for quality in health care that can be used to hold providers accountable in value-based care models. Its components include:

- *effectiveness*: care is based on evidence and is designed to get results
- *efficiency*: providers don't use resources that are not needed
- *equity*: care does not vary in quality based on personal characteristics such as race, gender, and income
- *patient centeredness*: each patient's values, preferences, and needs are respected
- *safety*: treatment does not cause harm
- *timeliness*: treatment is available without long delays.

Cost. Health care providers may earn more or avoid penalties if they reduce or maintain costs. So, if providers can reduce unnecessary use of high-cost forms of care like emergency department visits and inpatient admissions, they may share some of the savings they produce.

Equity. Efforts to improve health equity aim to reverse practices and policies that have made it difficult for historically marginalized groups, especially people of color, to access and receive high-quality care. As a result, these individuals have had poorer health outcomes. Until recently, many value-based programs did not prioritize outcomes related to equity, such as requiring care providers to measure and reduce health disparities by race and ethnicity. But it's becoming more common for providers to receive financial incentives to ensure that high-quality care is accessible for communities of color, low-income populations, and more. Measures of health care equity may include, among others, the collection of demographic data and the development of a plan to ensure equitable care is provided.

What strategies are used to promote value-based care?

Payers and federal regulators can use a variety of incentives and mechanisms to motivate health care providers and organizations to deliver higher-quality, cost-effective care.

Financial incentives. Also known as value-based payments, financial incentives are a key component of value-based care. These payments may link clinician, hospital, or health system compensation to performance on specific cost, quality, and equity metrics. The structure of these payments varies widely, but some factors that may motivate providers include the following:

- *Upside and downside risk.* Some models have upside-only risk — providers stand to gain revenue if they exceed expectations on quality, cost, or equity targets. Other programs also include downside risk — providers lose revenue if they fail to meet these goals. Some evidence suggests that models that include both upside and downside risk, also known as two-sided risk, may generate better outcomes, such as fewer hospitalizations. Although risk of revenue loss can be a strong motivator, two-sided risk may prevent risk-averse providers from joining a value-based program in the first place.
- *Prospective versus retrospective payments.* In the U.S., most health care is paid for on a retrospective, fee-for-service basis, with providers reimbursed for services they've already delivered. Prospective payments, on the other hand, are given upfront to providers to manage care for a defined set of patients and procedures — and, in some cases, for a defined period. This type of payment is commonly referred to as "capitation." Prospective payments may create a stronger financial incentive for providers to lower the cost of care so they can retain more revenue.
- *Percentage of providers' revenue tied to value-based payments.* Evidence suggests providers are more motivated to change how they deliver care when more of their revenue comes from value-based payments, since more is at stake. When more revenue is tied to value-based payment, there's also less administrative burden for providers that often receive payment from a variety of sources.
- *Timing, size, and delivery of incentives.* Providers are more likely to be motivated by financial incentives that are offered to them directly and given without delay. Incentives should be clearly linked to specific outcomes and large enough to be meaningful.

Nonfinancial incentives. Nonfinancial incentives also can encourage clinicians, health systems, and payers to improve quality, safety, and cost outcomes. For example, participation in value-based care models that offer greater flexibility to deliver the right care at the right time can contribute to providers' sense of purpose, mission, and professionalism. And, when health care entities perform well in value-based care, it can elevate their reputation as a provider of high-quality, affordable care.

Measurement. How health and hospital systems and individual clinicians are paid can depend on how well they perform on measures of quality and safety, such as death rates or patients' ability to access timely care, as well as measures of equity and cost. To gauge providers' performance at one moment or over time, public and private sector health care entities and regulators collect and analyze data on specific measures.

Accreditation. CMS can require health care entities to adhere to the quality and safety standards set by certain third parties to participate in the Medicare or Medicaid programs. For example, Joint Commission accreditation is required for hospitals and health systems to receive Medicare or Medicaid reimbursement.

Regulation. Government agencies can create rules that encourage providers to meet specific standards of quality, equity, and cost-effective care. For example, CMS sets rules requiring managed care plans to include a certain number of providers in their network so Medicaid beneficiaries can access services.

Public reporting. Publicizing how well health care providers and health plans perform on certain measures can drive them to improve performance. For example, people can search Medicare.gov to find out the rate of complications for hip and knee replacement surgeries at a hospital. Or, if they are looking to enroll in a particular Medicare Advantage plan, they may search the site to find out how members rate the plan.

What's next for value-based care?

CMS aims to have all Medicare beneficiaries and most Medicaid beneficiaries enrolled in accountable care programs by 2030, and the agency is committed to promoting health equity through its value-based initiatives. One example of a value-based care program focused on health equity is the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model. In this new voluntary program, providers are required to develop a plan to improve care for underserved communities and are rewarded for providing high-quality, well-coordinated care to Medicare beneficiaries. Interest and participation in value-based care in the commercial sector also appears to be increasing.

Although participation in value-based care programs is on the rise in the U.S., many health care providers are still not in one. To encourage participation, future models in both the public and private sector would likely benefit from being more accessible and financially rewarding, particularly to those serving disadvantaged or rural populations. Moreover, further research is needed about how these programs impact patients, providers, and the health care system overall, as well as which factors are associated with success.

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