Value-based care

Glossary of terms

Fee-for-Service (FFS): A traditional reimbursement model where providers are paid based on the volume of services they provide, rather than the quality or outcomes of those services. VBC contrasts with FFS by focusing on outcomes rather than service quantity.

Value-Based Payment Models: These include various payment arrangements under VBC, such as shared savings, bundled payments, and capitation, where payments are tied to the quality and efficiency of care.

Capitation: A payment model where providers receive a set amount per patient, per period, regardless of the number of services provided, incentivizing efficient, preventative care. Capitation may be either partial or full, affecting the level of risk providers take on.

Bundled Payments: Also known as episode-based payments, these provide a single, consolidated payment for all services involved in a patient's treatment for a specific condition or procedure, encouraging coordination and cost control across a continuum of care.

Accountable Care Organization (ACO): A group of healthcare providers that voluntarily join together to provide coordinated, high-quality care to Medicare patients. ACOs aim to avoid unnecessary duplication of services, reduce medical errors, and share savings achieved from reducing costs.

Shared Savings Program: A financial incentive model where providers share (with the payer) in the savings generated by reducing healthcare costs while maintaining or improving quality. ACOs often participate in shared savings programs as part of their value-based care agreements.

Quality Measures: Metrics used to assess the quality of care delivered, focusing on factors like patient outcomes, care coordination, patient satisfaction, and preventive care. Key quality measures may include hospital readmission rates, patient satisfaction scores, and disease management success.

Population Health Management: Strategies and interventions aimed at improving the health outcomes of an entire patient population by managing chronic diseases, promoting wellness, and addressing social determinants of health.

Total Cost of Care (TCOC): The overall costs associated with treating a patient population, including direct and indirect costs. Reducing TCOC while improving patient outcomes is a primary goal of value-based care.

Care Coordination: Efforts to ensure that patients receive well-organized care across various healthcare services and providers. Effective care coordination is essential in VBC models to avoid duplication, improve outcomes, and control costs.

Interoperability: The ability of different healthcare systems, applications, and devices to communicate, exchange, and interpret shared data accurately. Interoperability is essential in VBC for seamless data sharing between providers and payers, enhancing care continuity.

Risk: uncertainty associated with potential financial gains or losses.

Upside Risk: uncertainty associated with potential financial gains; a risk arrangement that only includes upside risk may be referred to as a "one-sided risk arrangement." In upside-only, or one-sided risk-based arrangements, participants who successfully deliver quality care at a lower cost may be eligible to receive a payment from CMS.

Downside Risk: uncertainty associated with potential financial losses; a risk arrangement that includes both upside and downside risk may be referred to as a "two-sided risk arrangement."

Two-sided Risk: Some risk-based arrangements include both upside and downside risk, also known as "two-sided" risk. In such arrangements, participants who deliver quality care at a lower cost may be eligible to receive a payment from CMS, while participants who increase overall spending may owe a payment to CMS. Further, a model may have different participation options, or tracks, that allow participants to assume varying levels of financial risk that suit their capabilities and experience.