

FACT SHEET:

Payment Models that Prioritize Quality Over Quantity (AKA Value-Based Care)



Since 2019, United States of Care has engaged in in-depth research to comprehend people’s health care needs. Through focus group studies and messaging tests, our aim is to reshape the public view of value-based care. We intend to create a standardized communication guide, assisting advocates and policymakers in clearly conveying the benefits of value-based care compared to traditional fee-for-service health care.

Why Value-Based Care?

Value-based care, an approach tying health care costs to care quality, redefines the patient-provider dynamic by emphasizing health outcomes over fee-for-service models. Research indicates patients and providers prefer this focus on specific health needs and a system that mitigates provider burnout, reinforcing their roles as healers.

United States of Care Focus Groups

In February 2023, USofCare’s focus groups revealed public preference for health care:

Public Preferences

- ★ Value-based over fee-for-service
- ★ Reduced wait times
- ★ A holistic care approach
- ★ Provider accountability



Overall Messaging Findings

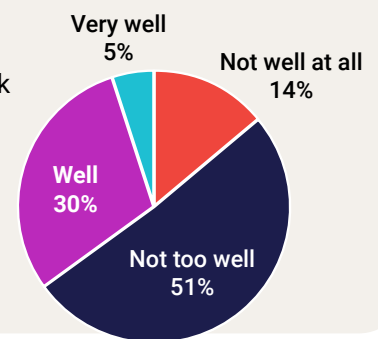
They intuitively attribute many of the issues that come with an assembly line experience to how health care is typically paid for today – the fee-for-service approach.

- ★ **Just 35% believe the current approach works well** while 65% do not think visits and treatments being paid for separately and doctors and providers being compensated based on the number of patients they see and the number of treatments they prescribe works well.
- ★ **The term “Quality-Focused Care” resonates most** (89% approval) as a potential replacement for “value-based care,” reflecting a preference for quality (58%) over affordability (15%), convenience (9%), and value (5%) in health care assessments.

89% of respondents approve of “quality-focused care”

86% of respondents approve of “patient-first care”

How well do you think the current fee-for-service approach works in delivering high quality care to patients?



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Value-Based Care in Action: Success Stories

State-led value-based care models offer key insights for future federal-level considerations:

Arkansas

Arkansas' Health Care Payment Improvement Initiative (AHCPII) has, since 2012, integrated patient-centered medical homes with episode-based payments to bolster patient outcomes and manage costs. As of 2019, most primary care providers adopted this model, contributing to a 75% improvement in preventive care metrics for Medicaid¹. Furthermore, Arkansas Blue Cross and Blue Shield fulfilled two-thirds of the Patient-Centered Medical Home (PCMH) quality metrics.

Oregon

Oregon's Coordinated Care Organization (CCO) Model targets Medicaid spending while enhancing health access and quality. By integrating medical, behavioral, and oral health services via a "global budget," the model saved an estimated \$2.2 billion from 2013-2017, all while elevating care quality.²

Vermont

Vermont's All-Payer Accountable Care Organization (ACO) Model, active since 2018, transitions Medicare from fee-for-service to quality-driven care. By encouraging a statewide, all-payer ACO and setting specific goals for growth, payer, provider participation, and care quality, the model has achieved notable cost reductions and quality improvements in its first three years.³

¹ Arkansas Center for Health Improvement, Arkansas Health Care Payment Improvement Initiative, 4th Annual Statewide Tracking Report, Little Rock, AR: ACHI, August 2019

² Oregon Health Authority Health Policy & Analytics Division. CCO 2.0 Recommendations of the Oregon Health Policy Board. Portland, OR. 2018 October.

³ NORC at the University of Chicago. "Evaluation of the Vermont All-Payer Accountable Care Organization Model (VTAP)." Bethesda, MD. 2022 December.

