Paying for Outcomes:
The Value-Based Revolution

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Introduction by Fady Sahhar

Eight Years of Advocacy, Policy Impact, and Action in Value-Based Payment

For the past eight years, our work in value-based payment (VBP) has been a driving force in advancing advocacy and shaping policy across Medicaid, long-term services and supports (LTSS), and managed care. Through rigorous research, legislative analysis, and collaboration with providers, policymakers, and patient advocates, we have sought to ensure that VBP models become meaningful tools for healthcare equity, sustainability, and improved outcomes.

At the heart of this effort is Cathryn Hilliard, XtraGlobex's Lead Researcher and Editor. Her deep expertise in Medicaid policy, alternative payment models, and LTSS innovation has guided our advocacy-first perspective. Her work ensures that this book not only explains VBP but also interrogates the assumptions that shape it.

This book brings together insights from our advocacy-driven blogs, policy tracking, and direct engagement with decision-makers. Throughout, we ask: *Are value-based payment policies truly improving outcomes, supporting provider sustainability, and advancing equity?*

The Advocate's Perspective: Driving Systemic Change

Our approach elevates the role of advocacy in shaping VBP policies through:

- Policy-Level Advocacy: Ensuring Medicaid waivers expand access, pushing for reimbursement structures that reflect LTSS complexities, and holding policymakers accountable for aligning funding with patient-centered goals.
- Provider-Centered Advocacy: Streamlining reporting requirements, ensuring financial viability for providers transitioning to VBP models, and supporting shared savings arrangements.
- Consumer & Patient Advocacy: Promoting transparency in managed care contracts, protecting consumer rights, and empowering patients through education.

Each chapter reflects this advocate-first approach, highlighting how VBP intersects with Medicaid waivers, provider reimbursement strategies, and the transparency of managed care. Our research indicates that the success of value-based payments hinges on their real-world application by policymakers and providers.

Policy Impacts: How VBP is Reshaping Healthcare

Value-based payment isn't just changing how care is delivered. It is transforming the policies that underpin the healthcare system. From Medicaid to managed care, states and federal agencies are aligning payment with performance to drive better outcomes and more equitable access.

- Medicaid Waivers & LTSS: States are refining waiver structures to ensure flexibility, equity, and access for home- and community-based services.
- Managed Care Accountability: VBP policies are forcing plans to demonstrate measurable quality improvements, influencing payment incentives.
- Alternative Payment Models (APMs) to Shared Savings Models: Legislators are expanding VBP models to balance cost containment with patient-centered outcomes.

Together, these shifts reflect a broader movement toward accountability, innovation, and consumer-centered reform and are redefining what success looks like in healthcare.

Advocacy Priorities: Shaping the Future of VBP

As value-based payment models continue to evolve, advocacy plays a critical role in ensuring these reforms are both equitable and effective. Stakeholders are advocating for policies that prioritize transparency, fairness, and the needs of both consumers and providers.

- Securing Transparency in Managed Care Contracts: Enforcing clear, measurable performance metrics to protect provider interests and ensure transparency.
- Defending Provider Reimbursement Sustainability: Advocating for fair reimbursement models that recognize the complexity of LTSS services.
- Strengthening Consumer Protections in VBP Models: Ensuring consumer voices shape Medicaid-funded care, rather than purely cost-saving strategies.

These priorities are essential to creating a value-based system that delivers on its promises not just in cost savings, but in quality, access, and equity for all.

This book integrates past advocacy work, policy analysis, and future recommendations for shaping VBP models that are financially viable, patient-centered, and equitable. With Cathrine's expertise guiding our research and editorial efforts, this book serves as both a reflection of past insights and a roadmap for future action in value-based payment reform.

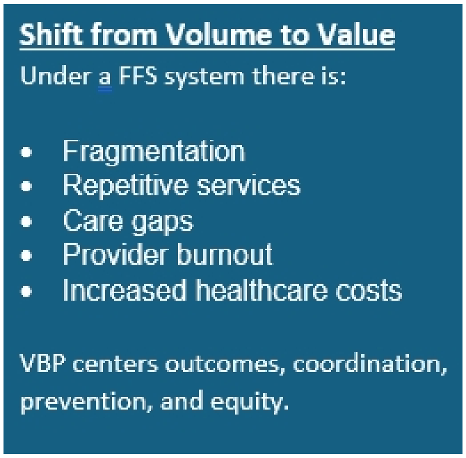
PART I:

THE FOUNDATIONS OF VALUE-BASED PAYMENTS

Chapter 1: From Volume To Value – The Evolution Of Healthcare Payments

Introduction

Healthcare in the United States has long been defined by complexity, fragmentation, and high costs. In 2017, the estimated cost of care for an insured family of four reached nearly $27,000, considering health insurance, payroll deductions, and out-of-pocket expenses. In just one year alone, the out-of-pocket costs rose to 4.3% from 1.9% in the US. That is partially because, for decades, our healthcare system was shaped by a model that emphasized quantity over quality. Known as fee-for-service (FFS), this structure paid providers for every appointment, test, or procedure performed, regardless of the outcome: the more services rendered, the more revenue generated.



Shift from Volume to Value

Under a FFS system there is:

- Fragmentation
- Repetitive services
- Care gaps
- Provider burnout
- Increased healthcare costs

VBP centers outcomes, coordination, prevention, and equity.

While there are benefits to FFS, namely unlimited options for providers and usually little delay, the disadvantages include little coordination between providers, unnecessary duplicate tests, high costs, and very little preventive action. The FFS system divides healthcare into what is known as “silos” – single healthcare structures that are unconnected to each other. The model fosters inefficiencies and encourages overutilization, creating an environment where care is often reactive rather than preventive.

Under FFS, providers faced intense pressure to maintain volume to keep their doors open. Preventive care, chronic disease management, and patient education—services that require time and don't yield immediate profits—were often underprioritized. The result was a system bloated with unnecessary tests, disjointed care episodes, and a mounting administrative burden.

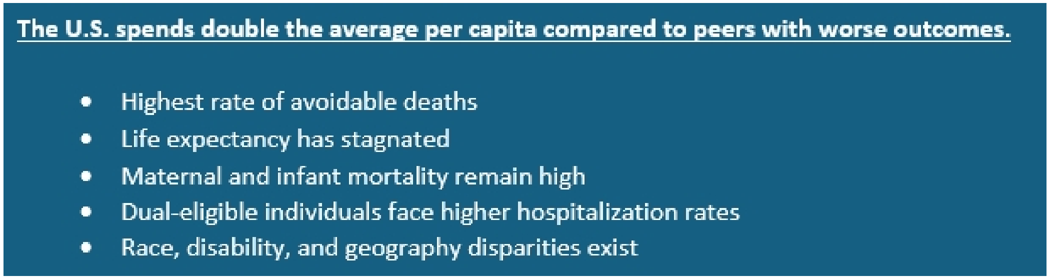
For consumers, this meant more than just inconvenient appointments. It meant experiencing care that felt impersonal and transactional. This is especially true for those with chronic conditions or complex needs, who often fall through the cracks due to poor coordination. Consumers also encountered surprise medical bills, redundant services, and gaps in or total lack of follow-up. Trust in the system began to erode, especially among historically marginalized populations who already faced significant barriers to care.

For providers, it created professional dissatisfaction. Physicians, nurses, and care teams were often stuck on a productivity treadmill, forced to meet volume quotas rather than engage in meaningful patient relationships. Burnout became rampant. Clinicians entered the field to help people, but the system was structured to prioritize billing codes over outcomes. And for payers, whether public programs like Medicare and Medicaid or private insurers, the cost curve climbing. Taxpayer dollars were increasingly funneled into a system that delivered mediocre results compared to other industrialized countries. According to the OECD, the U.S. consistently ranks near the bottom in healthcare outcomes while spending significantly more per capita than its peers.

In this landscape, it became painfully clear that the existing model wasn't only unsustainable but also failing. We needed a new framework, one that focused not on the quantity of care delivered, but on the effectiveness of that care in improving people's lives. Enter value-based payments (VBP), a fundamentally different approach to financing care. Instead of paying providers based on the volume of care they deliver, VBP pays for the outcomes achieved. It centers the patient, rewards efficiency, and emphasizes quality, coordination, and prevention. At its core, VBP is a call for a healthcare system that delivers better care at lower costs, with improved outcomes for everyone, especially those most in need.

Why Value-Based Payments Matter

To understand the urgency behind the shift to VBP, we must look closely at the real-world consequences of the fee-for-service model. The United States consistently ranks as the highest spender on healthcare per capita among industrialized nations. Yet, despite this massive investment, it lags in key public health indicators. According to the Peterson-KFF Health System Tracker, the U.S. spent nearly double the average of other high-income countries. Yet, the U.S. also had the highest rate of avoidable deaths. Life expectancy has stagnated, maternal and infant mortality rates remain alarmingly high, and disparities persist across racial and socioeconomic lines.



The U.S. spends double the average per capita compared to peers with worse outcomes.

- Highest rate of avoidable deaths
- Life expectancy has stagnated
- Maternal and infant mortality remain high
- Dual-eligible individuals face higher hospitalization rates
- Race, disability, and geography disparities exist

The FFS model has played a significant role in these outcomes. By design, it incentivizes volume over value, which creates a dynamic where excessive tests, procedures, and visits are encouraged, even when they offer little benefit to the patient. It discourages preventive care, limits the time spent with patients, and fragments the delivery of services across uncoordinated providers.

Nowhere are the shortcomings of this model more evident than in the care of individuals with complex needs. This includes people with intellectual and developmental disabilities (IDD), severe mental illness, substance use disorders (SUDs), or those dually eligible for Medicare and Medicaid. These individuals often require a variety of services spanning physical health, behavioral health, and social support. Under FFS, each of these domains operates in a silo, leading to miscommunication, missed follow-ups, and inconsistent treatment plans that weren't tailored to an individual's needs. The burden of coordinating care often falls on the individual or their family, who may lack the time, expertise, or resources to navigate multiple providers and systems.

The consequences are not theoretical, either. They are felt in real lives. A dual-eligible adult with diabetes and schizophrenia, for example, may see a primary care doctor, psychiatrist, endocrinologist, and home health aide, none of whom communicate with each other. One may prescribe medications that conflict with those of another. A social need, like housing instability or food insecurity, may go unaddressed entirely. These systemic failures result in repeated emergency room visits, unnecessary hospitalizations, and higher mortality rates.

Research from the Medicaid and CHIP Payment and Access Commission (MACPAC) shows that dually eligible individuals experience worse health outcomes and higher rates of hospitalization and institutionalization than their Medicare-only peers. And the disparities grow wider when factoring in race, disability, and geography. Communities of color, individuals in rural areas, and people with limited English proficiency are often disproportionately harmed.

A value-based payment system, when thoughtfully implemented, is built to reverse these outcomes. Instead of paying for isolated services, VBP rewards integration, collaboration, and measurable improvement. It does this by:

- Encouraging the creation of care teams that span multiple disciplines.
- Supporting technology that allows for shared care plans and real-time communication.
- Facilitating screening and referrals for social determinants of health.
- Focusing on whole-person care.

That is because VBP models can hold providers accountable for outcomes, and most importantly, equity. By tracking outcome disparities and tying financial incentives to closing those gaps, VBP creates a structure for change. These models challenge the long-held notion that more care equals better care, instead prioritizing what helps people live longer, healthier lives. By tying payment to performance, VBP encourages providers to focus on what matters: keeping people well.

Value-based payments also invite a broader conversation about justice, fairness, and the kind of healthcare system we want to build. In doing so, these models open the door to a more equitable and compassionate healthcare landscape where quality, dignity, and whole-person care are at the forefront.

Defining Value In Healthcare

When discussing value-based payments, it is essential to look at what "value" really means. That question was explored in depth in the blog post, *Value-Based Payments: What Does it Really Mean?*, Value isn't just a buzzword. It truly represents a paradigm shift in how we approach healthcare outcomes. In the context of VBP, value is generally defined as health outcomes achieved per dollar spent, however, there's more to the story.

The word "value" has different meanings depending on whose perspective is being considered.
For a hospital administrator, value might relate to risk mitigation and regulatory compliance. For a payer, it might center on financial efficiency. However, for a consumer, especially one navigating chronic illness, disability, or socioeconomic hardship, value is deeply personal. It is the difference between surviving and truly living.

When it comes to the healthcare system, value must be seen through the eyes of the consumer, who deserves care that is effective, timely, respectful, and personalized. It means access to mental health services, social determinants of health (SDoH), and treating the root causes of illness, not just the symptoms. It also means being heard, believed, and supported. Too often, historically marginalized individuals encounter a healthcare system that minimizes their pain, dismisses their experience, or fails to accommodate their language, cultural, or physical access needs. Actual value demands addressing these systemic issues directly.

To truly bring about change, value-based payment models must prioritize four key principles:

1. Quality of Care – Are outcomes improving? Are people receiving the proper care, at the right time, in the right setting? Is the care evidence-based and patient-centered?

2. Whole-Person Care – Are physical, behavioral, and social needs being met in a coordinated way? Does care extend beyond the clinic to encompass housing, food security, transportation, and emotional support?

3. Health Equity – Are all populations benefiting from improved outcomes, or are disparities growing? Are providers being held accountable for addressing structural racism, language barriers, and historical mistrust?

4. Cost of Care – Is the system delivering better outcomes without unnecessary spending? Are avoidable hospitalizations, emergency department visits, and duplicative tests being reduced? Are resources being used efficiently to drive long-term value and sustainability—for payers, providers, and the people receiving care?

These elements are more than ideals; they are measurable. Tools such as patient-reported outcome measures (PROMs), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Healthcare Effectiveness Data and Information Set (HEDIS) measures are used to track how well health plans and providers meet these goals. For example, PROMs give patients the opportunity to share their experiences and health outcomes in their own words, providing a richer understanding of care quality beyond clinical metrics.

The goal is to pay for what works when it comes to improving health outcomes. This involves utilizing data, metrics, and consumer feedback to identify what drives positive outcomes, and then rewarding providers accordingly. To achieve this, investments must be made in upstream interventions, such as community health workers, housing partnerships, and integrated behavioral health teams, which address health at its roots. It also means sharing those savings and efficiencies back into the community and building capacity where it is most needed.

Ultimately, redefining value in healthcare is about putting humanity at the center in a system that has too often prioritized process over people. It is about creating space for care that is compassionate, coordinated, and culturally responsive. It is about ensuring that consumers can count on the healthcare system to deliver the respect, support, and outcomes they deserve, regardless of who they are, where they live, or the challenges they face.

The Origins Of The Shift

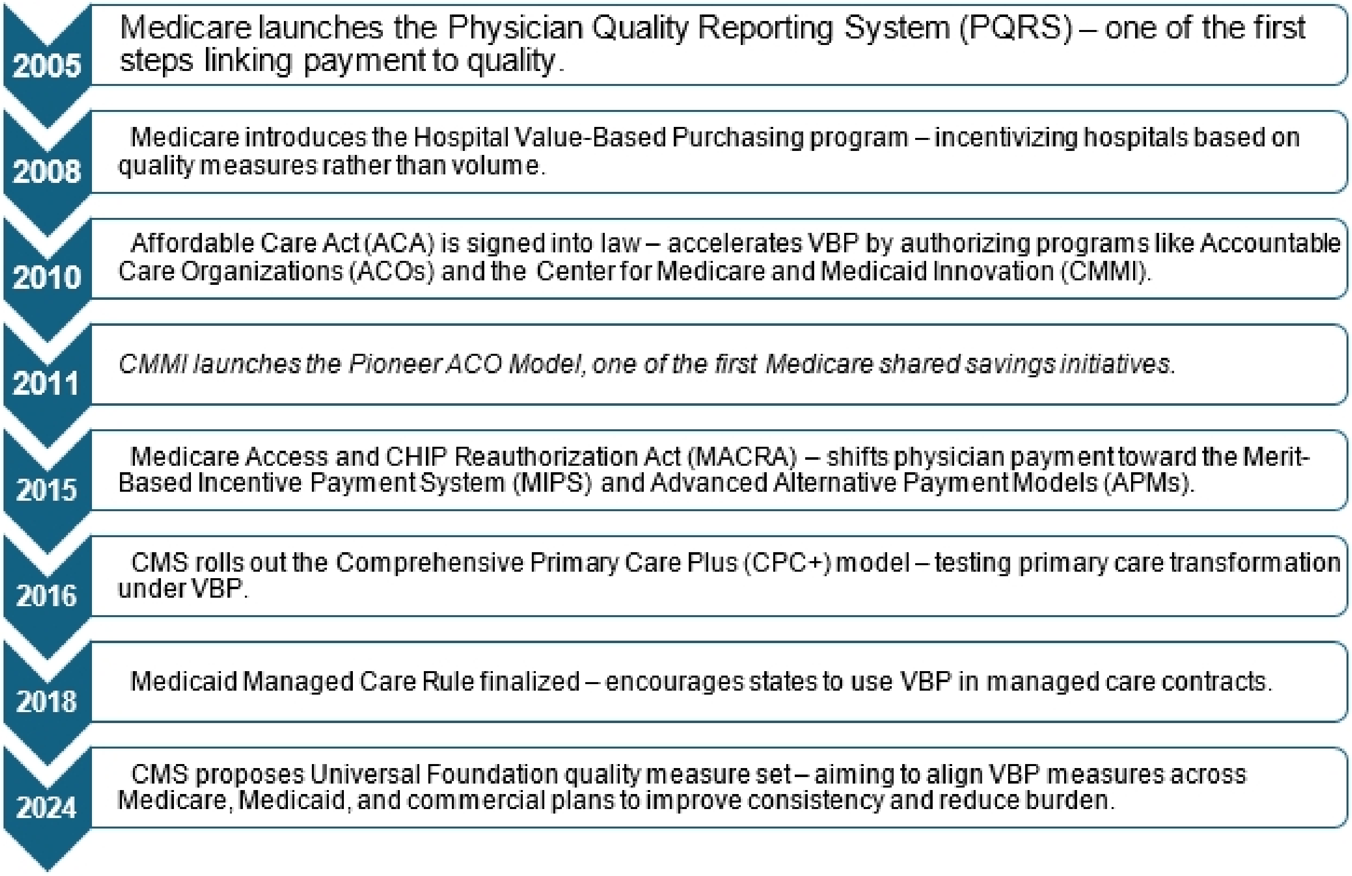
The movement toward value-based care didn't happen overnight. It was accelerated by policy changes and payment reforms launched over the last two decades, which emerged in response to mounting frustration with rising costs, poor outcomes, and inequities built into the fee-for-service system.

In 2010, the passage of the Affordable Care Act (ACA) marked a significant turning point in healthcare. The ACA established the Center for Medicare and Medicaid Innovation (CMMI) to test and expand the ability of new payment and service delivery models to reduce costs while preserving or improving quality. CMMI became the engine for many value-based initiatives, including accountable care organizations (ACOs), bundled payments, and integrated behavioral health pilots.

Shortly after, CMS launched the Medicare Shared Savings Program (MSSP) in 2012, which incentivizes ACOs to lower healthcare spending for Medicare beneficiaries while meeting quality benchmarks. As of January 2024, MSSP covered over 10.8 million beneficiaries and included more than 480 ACOs across the country.

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which replaced the Sustainable Growth Rate formula with a new system that links Medicare Part B payments to performance. MACRA introduced the Quality Payment Program (QPP), which includes two tracks: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), both designed to reward providers for value over volume.

Evolution of Value-Based Payments:



2005 Medicare launches the Physician Quality Reporting System (PQRS) – one of the first steps linking payment to quality.

2008 Medicare introduces the Hospital Value-Based Purchasing program – incentivizing hospitals based on quality measures rather than volume.

2010 Affordable Care Act (ACA) is signed into law – accelerates VBP by authorizing programs like Accountable Care Organizations (ACOs) and the Center for Medicare and Medicaid Innovation (CMMI).

2011 *CMMI launches the Pioneer ACO Model, one of the first Medicare shared savings initiatives.*

2015 Medicare Access and CHIP Reauthorization Act (MACRA) – shifts physician payment toward the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

2016 CMS rolls out the Comprehensive Primary Care Plus (CPC+) model – testing primary care transformation under VBP.

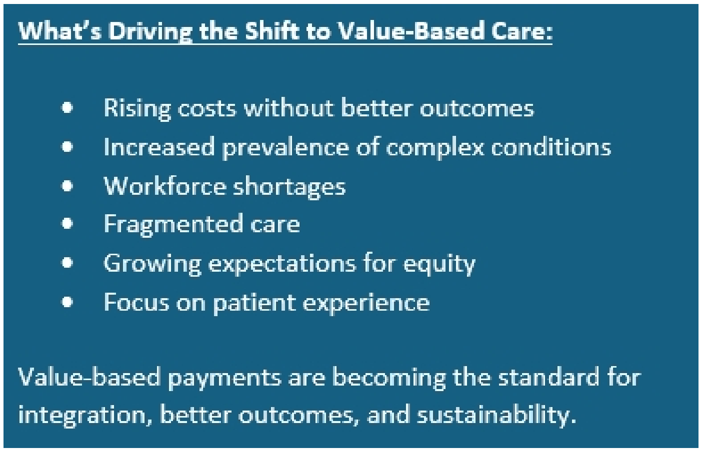
2018 Medicaid Managed Care Rule finalized – encourages states to use VBP in managed care contracts.

2024 CMS proposes Universal Foundation quality measure set – aiming to align VBP measures across Medicare, Medicaid, and commercial plans to improve consistency and reduce burden.

Beyond Medicare, state Medicaid programs also began exploring value-based purchasing. For example, Tennessee's Health Care Innovation Initiative launched episodes of care and primary care transformation programs. New York's Delivery System Reform Incentive Payment (DSRIP) program, launched in 2015, aimed to reduce avoidable hospitalizations by 25% over five years through provider collaboration and value-based contracts.

More recently, the CMS Innovation Center published its "Innovation Center Strategy Refresh," outlining goals to expand accountable care, improve equity, and increase the share of Medicare and Medicaid beneficiaries in relationships with responsible providers. This represents a federal commitment to building a system where value-based care is the standard, not the exception.

And these reforms aren't just about cutting costs. They are about building a healthcare system that makes sense for people, not just payers. Programs such as the Medicare Shared Savings Program, Bundled Payments for Care Improvement (BPCI), and the Home Health Value-Based Purchasing Model have demonstrated that better outcomes and lower costs are not mutually exclusive.



What's Driving the Shift to Value-Based Care:

- Rising costs without better outcomes
- Increased prevalence of complex conditions
- Workforce shortages
- Fragmented care
- Growing expectations for equity
- Focus on patient experience

Value-based payments are becoming the standard for integration, better outcomes, and sustainability.

The blog *Break Through Value-Based Payments* highlighted this point, that transformation requires new ways of thinking. That includes investing in care coordination, embracing interdisciplinary teams, and involving patients as partners in care. It also means breaking down silos between health plans, providers, and community organizations.

The Consumer Voice

When discussing value-based payments, it is essential to keep the consumer's needs at the forefront. Too often, healthcare reform is discussed without considering the voice of the consumer; however, value-based care is only meaningful if it improves the lived experience of those receiving care. For someone with diabetes and depression, value means not having to navigate separate systems for physical and behavioral health. For someone living in a food desert, it means connecting with a provider that can address their physical health needs and connect them with community organizations that can help access healthy meals. For a senior managing multiple chronic conditions, it means having a care team that communicates effectively and the ability to receive care at home, while living independently.

Consumer engagement must be built into every stage of VBP design and implementation, which includes using patient-reported outcomes, incorporating cultural competence, and co-designing care pathways with the communities they serve. Real value is about trust, relationships, and responsiveness, all of which are at the core of value-based payment models.

Real value in healthcare also requires systems to address the power imbalances that have historically marginalized specific communities. These imbalances are often deeply rooted in institutional racism, ableism, and classism, which have long shaped how healthcare is delivered and to whom. Addressing them means moving beyond superficial representation and engaging with the individuals and communities most impacted by inequities.

This begins with eliminating language and access barriers, which requires concrete changes, not just good intentions. This includes ensuring the availability of interpreters, translated materials in plain language, and assistive technologies for people with disabilities. It means training staff in cultural humility and trauma-informed care. It also means rethinking clinic hours, transportation availability, and childcare options to remove practical barriers to care access.

Some states and provider organizations are already leading this work. For example, California's Medicaid transformation through CalAIM mandates engagement with community-based organizations and consumers in planning Enhanced Care Management and Community Supports. New York's Medicaid waiver proposals include equity-focused advisory bodies with consumer membership as a condition for funding. These models demonstrate that embedding equity into value-based payments isn't only possible but also essential for achieving meaningful transformation.

Ultimately, systems must be willing to redistribute decision-making power and redesign care delivery in ways that center dignity, respect, and accountability to the people they serve.

Challenges And Opportunities As We Look Ahead

Of course, the transition from volume to value is not without its challenges. Many providers still operate in mixed environments, juggling fee-for-service and value-based payment incentives.

Other issues include:

- Fragmented data systems
- Inconsistent or irrelevant quality measures
- Poorly measures health equity
- Lack of funding to build infrastructure for care coordination

Despite these challenges, the opportunities are significant. Research suggests that high-performing accountable care organizations have improved quality metrics while generating billions in savings for Medicare. States such as North Carolina and Oregon have launched Medicaid reforms that explicitly link payment to equity and social needs, offering early models for replication. Moreover, technology is helping close gaps. Tools like real-time care coordination platforms, AI-driven analytics, and integrated electronic health records are empowering providers to make more informed decisions. Tools alone are not the solution, though. Cultural change, including a shift in how healthcare views its purpose, is essential.

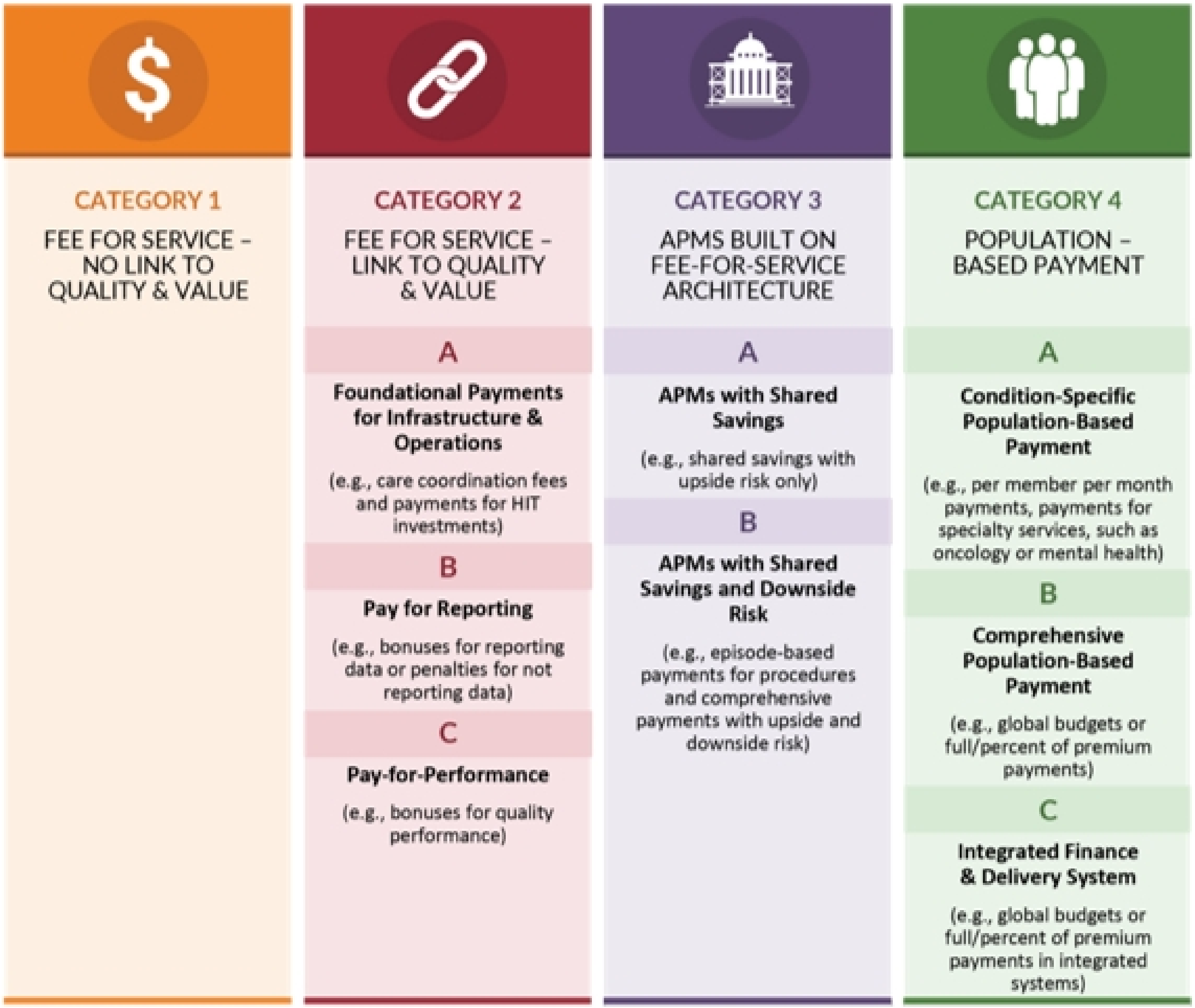
As we continue our journey through this book, we'll explore how VBP is being applied in real-world settings—from ACOs and home health to behavioral health and long-term services and supports. We'll also spotlight where the system is falling short and what must change to deliver on the promise of quality, whole-person, equitable care. Because at the end of the day, this isn't about abstract models or arcane policy. It's about people. And people deserve a healthcare system that works for them, not against them.

CHAPTER 2:
UNDERSTANDING VALUE-BASED PAYMENT MODELS

Introduction

Not all value-based payment models are created equal. As healthcare systems, states, and providers move away from the outdated fee-for-service model, they enter a complex and evolving landscape of alternative payment strategies, which each have diverse levels of risk, complexity, and impact. Understanding these models is essential to building a healthcare system that truly prioritizes outcomes over volume, and people over processes.

To make sense of this transformation, it helps to visualize value-based payment as a continuum. The Health Care Payment Learning and Action Network (LAN) framework, created by CMS and other national stakeholders, describes four broad categories:



CATEGORY 1

FEE FOR SERVICE – NO LINK TO QUALITY & VALUE

CATEGORY 2

FEE FOR SERVICE – LINK TO QUALITY & VALUE

A

Foundational Payments for Infrastructure & Operations

(e.g., care coordination fees and payments for HIT investments)

B

Pay for Reporting

(e.g., bonuses for reporting data or penalties for not reporting data)

C

Pay-for-Performance

(e.g., bonuses for quality performance)

CATEGORY 3

APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

APMs with Shared Savings

(e.g., shared savings with upside risk only)

B

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

CATEGORY 4

POPULATION – BASED PAYMENT

A

Condition-Specific Population-Based Payment

(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B

Comprehensive Population-Based Payment

(e.g., global budgets or full/percent of premium payments)

C

Integrated Finance & Delivery System

(e.g., global budgets or full/percent of premium payments in integrated systems)

As the chart from HCPLAN above shows, this continuum illustrates a gradual shift from paying for volume to paying for value. Early-stage models, like pay-for-performance, carry minimal risk for providers but have only a modest impact on outcomes. More advanced models, such as full-risk capitation, demand greater accountability but also offer greater flexibility to tailor care to patient needs. The goal isn’t necessarily to rush to the end of the spectrum, but to build the right models for the right populations with appropriate supports in place.

According to the Center for Health Care Strategies (CHCS), states are increasingly exploring ways to move their Medicaid programs up this continuum. However, progress varies widely. While some have implemented shared savings arrangements or episodes of care, others are still experimenting with early-stage models. Regardless of pace, all these models reflect a growing consensus: the way we pay for care profoundly shapes the care people receive.

In this chapter, we explore four of the most common and widely discussed VBP models:

- Payment for Process
- Payment for Performance
- Bundled Payments
- Risk-Based Arrangements

Each section explains how the model works, its strengths and weaknesses, and how it can be leveraged to support better outcomes, equity, and whole-person care. Choosing the right payment model can mean the difference between fragmented, reactive care and coordinated, person-centered healing.

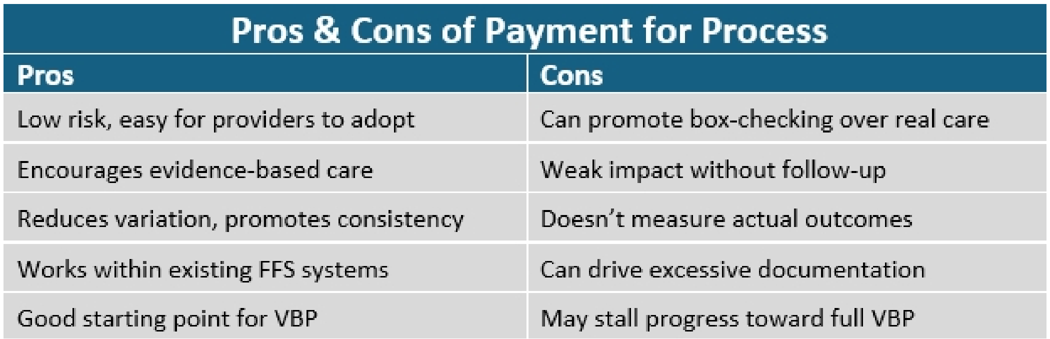
Let’s take a closer look at each model along the value-based continuum.

Payment For Process And Alternative Payment Models

Process-based value models are often the first step healthcare systems take toward reforming payment structures. These models reward providers for following evidence-based protocols and care guidelines, even if the ultimate patient outcomes aren't directly measured. In other words, they pay for "doing the right thing"—completing wellness visits, administering screenings, providing discharge instructions—on the assumption that adherence to best practices leads to better long-term outcomes.

This model is categorized as Category 2 in the LAN framework: Fee-for-Service linked to quality and value. A familiar example might be a Medicaid managed care organization offering an incentive for each diabetic patient who receives an annual eye exam or for providers who consistently document patient-centered care plans. While still rooted in FFS architecture, the payment is explicitly tied to compliance with specific care processes that support quality.

The appeal of process-based payment is its relative simplicity. It requires minimal infrastructure change and doesn't demand complex data tracking or actuarial modeling. For many providers, it's a palatable entry point into value-based care because the financial risk is low and the expectations are straightforward. This model also helps standardize care, reduce variation, and ensure adherence to preventative and chronic care protocols that have been shown to improve outcomes.



Pros & Cons of Payment for Process

Pros	Cons
Low risk, easy for providers to adopt	Can promote box-checking over real care
Encourages evidence-based care	Weak impact without follow-up
Reduces variation, promotes consistency	Doesn't measure actual outcomes
Works within existing FFS systems	Can drive excessive documentation
Good starting point for VBP	May stall progress toward full VBP

However, the model has notable limitations. Critics argue that it can reduce value-based care to a checklist of tasks that may or may not reflect what patients need. Providers may be incentivized to complete documentation or meet quotas without addressing broader context. For example, screening for depression is a worthy process, but without pathways for follow-up behavioral health care, the impact may be limited.

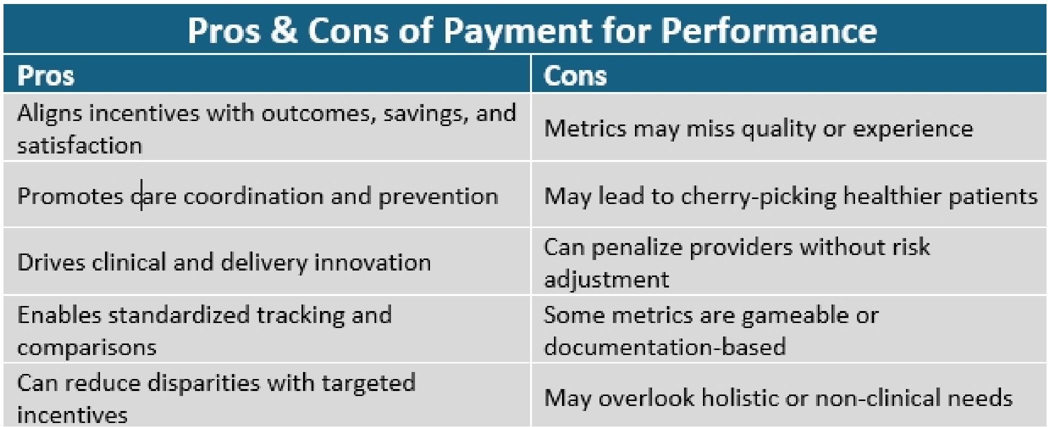
As outlined in the blog post *VBP Payment for Process and Alternative Payments*, the real challenge is ensuring that process-based models serve as a foundation, not just a destination, for VBP evolution. These models are useful tools, but they must be part of a broader transformation that prioritizes outcomes, equity, and integration. Otherwise, they risk reinforcing a system that rewards box-checking rather than true care transformation.

Payment For Performance

Where process-based models reward providers for following care guidelines, payment-for-performance (P4P) models go a step further in paying for results. These arrangements incentivize providers based on improvements in clinical outcomes, patient satisfaction, or reductions in cost. The underlying belief is simple: if providers are rewarded for helping patients get better, they will focus more on delivering high-quality, coordinated care.

In the LAN framework, payment for performance often sits at the upper end of Category 2 or the entry point into Category 3. It represents a transitional model that is still grounded in fee-for-service, but with payments linked to specific outcome metrics. For example, a hospital may receive a bonus if it reduces readmissions for heart failure patients or improves diabetes control among its population.

P4P models often use metrics drawn from national standards such as the Healthcare Effectiveness Data and Information Set, the Consumer Assessment of Healthcare Providers and Systems, or CMS-defined quality indicators. These metrics can include everything from blood pressure control to the rate of emergency department visits for chronic disease.



Pros & Cons of Payment for Performance

Pros	Cons
Aligns incentives with outcomes, savings, and satisfaction	Metrics may miss quality or experience
Promotes care coordination and prevention	May lead to cherry-picking healthier patients
Drives clinical and delivery innovation	Can penalize providers without risk adjustment
Enables standardized tracking and comparisons	Some metrics are gameable or documentation-based
Can reduce disparities with targeted incentives	May overlook holistic or non-clinical needs

The advantages of P4P are clear. It aligns financial incentives with the goals of value-based care: better health, lower costs, and higher patient satisfaction. It encourages providers to innovate, to focus on prevention, and to coordinate care more effectively. When designed well, these models can also highlight and reduce disparities by incentivizing improvements for historically underserved populations.

However, tying payment to performance is not without challenges. A key concern is whether the chosen metrics accurately reflect the quality of care. Not all metrics capture what matters to patients, and some can be gamed or achieved through selective patient targeting. There is also a risk that providers serving more complex, high-need populations may be unfairly penalized if adjustments for social risk factors aren't adequately built into the model.

Successful models include robust risk adjustment, transparent methodology, and mechanisms for continuous feedback from both consumers and providers. Stratified data collection is important for detecting and addressing inequities across race, disability status, and geography.

Ultimately, payment for performance represents a meaningful step forward on the value-based payment continuum. It signals a shift in mindset from rewarding activity to rewarding impact, while also laying the groundwork for deeper reform.

Risk-Based Models and Capitation

At the far end of the value-based payment continuum lie the most ambitious models that place providers at financial risk for the total cost and quality of care for a defined population. Known broadly as shared savings, shared risk, or full-risk capitation models, these arrangements move beyond incentivizing individual actions or episodes to create a structure where the provider or care team is fully accountable for maintaining people's health over time.

One of the most widely adopted of these models is the shared savings arrangement. These programs reward providers for reducing healthcare spending below a predefined benchmark, as long as quality standards are met. Shared savings can be “one-sided,” where providers only share in the savings, or “two-sided,” where they are also responsible for losses if spending exceeds expectations. These models serve as a natural transition for organizations moving from fee-for-service to more advanced value-based structures.

Shared savings models are commonly used in Accountable Care Organizations, such as those in the Medicare Shared Savings Program or state Medicaid ACOs. They encourage providers to coordinate care better, manage chronic conditions proactively, and reduce unnecessary utilization. However, implementing shared savings successfully requires clear benchmarks and accurate risk-avoidant behaviors.

As organizations gain more experience and infrastructure, many evolve into shared-risk or full-capitation arrangements. These are classified as Category 4 in the LAN framework: Population-Based Payment. In these models, providers receive a fixed per-member-per-month (PMPM) payment to manage the full spectrum of patient needs, regardless of the number of services utilized. This creates both financial risk and flexibility, incentivizing providers to focus on prevention, long-term outcomes, and cost-effective care delivery.

A key advantage of risk-based models is that they unlock the ability to invest in services not traditionally reimbursed under fee-for-service, including care coordination, home visits, peer support specialists, housing navigation, or mobile crisis teams. These supports are often critical to maintaining health, especially for individuals with complex needs or those affected by the social determinants of health.

Capitated models also support whole-person care by integrating physical health, behavioral health, and social supports into a unified, flexible care structure. Rather than reacting to illness, providers can proactively manage population health and address root causes of poor outcomes.

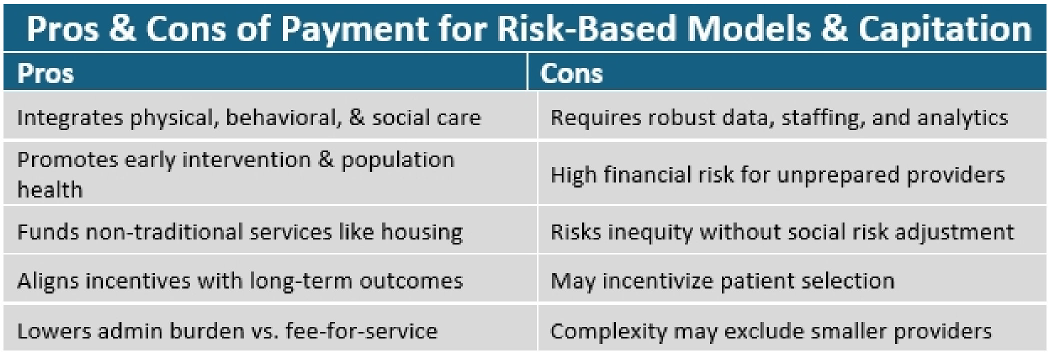
That said, these models require significant infrastructure and operational readiness. Health systems need real-time data analytics, actuarial expertise, interdisciplinary care teams, and robust risk management strategies. Without these supports, providers may face financial hardship or deliver inconsistent care.

Equity is a central concern in these arrangements. If payment rates aren't adequately adjusted for social risk factors like disability, language barriers, or housing insecurity, providers who serve high-need populations may be unfairly penalized. This could lead to cherry-picking patients or underinvestment in certain communities. To mitigate these risks, successful models include strong risk adjustment, transparent quality benchmarks, and consumer protections that ensure care remains accessible and equitable.

While not every system is ready for full capitation, these models represent the frontier of value-based care. When implemented thoughtfully, they offer a sustainable path to comprehensive, personalized, and community-focused care, which is the kind of system consumers deserve.

Choosing the Right Model for the Right Population

Value-based payment isn't a one-size-fits-all solution. Each model along the continuum—from process-based incentives to full-risk capitation—offers different advantages and challenges depending on the population served, the care setting, and the readiness of the provider network. For value-based care to succeed, payment models must be matched thoughtfully to the needs, risks, and preferences of the people they are designed to serve.



Pros & Cons of Payment for Risk-Based Models & Capitation

Pros	Cons
Integrates physical, behavioral, & social care	Requires robust data, staffing, and analytics
Promotes early intervention & population health	High financial risk for unprepared providers
Funds non-traditional services like housing	Risks inequity without social risk adjustment
Aligns incentives with long-term outcomes	May incentivize patient selection
Lowers admin burden vs. fee-for-service	Complexity may exclude smaller providers

For example, bundled payments may be ideal for high-volume, low-variation procedures like hip replacements or cardiac surgery. These episodes are well-defined, outcomes are relatively predictable, and the model encourages coordination among hospitals, surgeons, and rehabilitation providers. However, bundled payments are far less effective for managing the ongoing, unpredictable needs of individuals with serious mental illness, substance use disorders, or multiple chronic conditions.

On the other end of the spectrum, full capitation offers the greatest flexibility to invest in non-traditional supports like nutrition counseling, housing stabilization, and peer recovery services. These services can be vital for high-need populations such as people dually eligible for Medicare and Medicaid or those with complex behavioral health challenges. However, capitation also requires a robust infrastructure, sophisticated data analytics, and deep trust in provider organizations to take on financial risk while maintaining quality and access.

Several states and health systems have already begun tailoring value-based models to their specific populations:

- Oregon’s Coordinated Care Organizations (CCOs) operate under a global budget model for Medicaid enrollees, supporting whole-person care that includes investments in housing, transportation, and nutrition.
- Arkansas Medicaid has implemented episode-based bundled payments for perinatal care and joint replacements, promoting coordination and efficiency across a full episode of care.
- Massachusetts ACOs use both shared savings and shared risk tracks, with design elements specifically aimed at addressing behavioral health, equity, and social needs.
- California’s CalAIM initiative is overhauling Medicaid managed care with enhanced care management and community supports, moving toward population-based models that address medical and non-medical drivers of health.

Nationally, the shift toward value-based payments continue to gain traction. As of July 2022, 41 states had launched at least one value-based payment initiative within their

Medicaid programs, reflecting broad interest in moving away from fee-for-service. Across the country, more than 25% of Medicaid payments were flowing through alternative payment models—evidence that payers are increasingly willing to link dollars to outcomes rather than volume. In the Medicare program, the Shared Savings Program served 11 million beneficiaries and generated $1.6 billion in net savings in 2021 alone, while 67% of participating ACOs improved quality performance during the same period. These results demonstrate that value-based models can be both cost-effective and quality-enhancing when implemented thoughtfully.

These examples underscore how value-based payment models can and must be adapted to local needs. No single model will work for every state or every community. What matters most is that systems remain flexible, accountable, and responsive to the people they serve.
Importantly, value-based payment models must be designed with equity in mind. This means asking challenging questions:

- Who benefits from this model?
- Who might be left out?
- Are quality metrics adjusted for social risk?
- Are community voices involved in shaping payment structures and program design?

Policymakers and payers should also consider how different models impact health equity at the systems level. A model that reduces hospital readmissions among commercially insured populations may look successful on paper, but if it fails to reach or support Medicaid enrollees, it risks deepening existing disparities. Similarly, an alternative payment model that incentivizes digital engagement may inadvertently exclude individuals without broadband access, devices, or digital literacy.

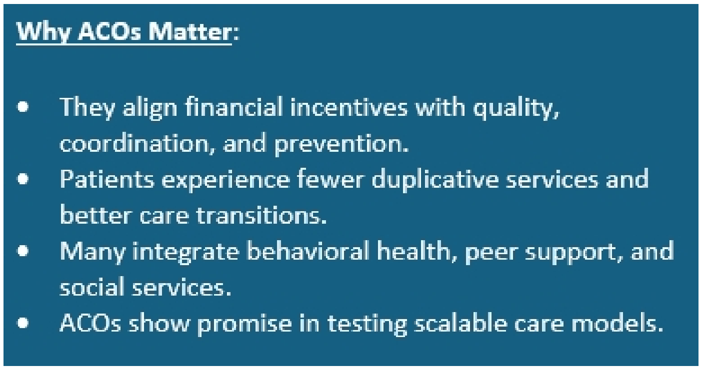
Success in value-based care depends on more than cost savings. It requires the creation of models that are inclusive, transparent, and responsive to consumer needs. That includes collecting stratified performance data, compensating community members for their input, and adjusting payment structures to reflect the realities of social risk.

Ultimately, the goal is not to rush toward the most advanced model, but to build the right model for the right population that balances financial accountability with compassion, innovation with equity, and outcomes with access. Whether it’s a small rural clinic implementing process-based incentives or a large health system managing a fully capitated population, what matters most is that care becomes more responsive, more person-centered, and more just.

CHAPTER 3: THE ROLE OF ACCOUNTABLE CARE ORGANIZATIONS

Introduction: Why ACOs Matter in Value-Based Care

Accountable Care Organizations have emerged as one of the most recognizable and scalable vehicles for delivering value-based care. At their core, ACOs are networks of doctors, hospitals, and other healthcare providers that voluntarily join forces to take responsibility for the quality and cost of care for a defined group of patients. But ACOs are more than just a new payment structure, they represent a shift in how healthcare is delivered, measured, and experienced.



Why ACOs Matter:

- They align financial incentives with quality, coordination, and prevention.
- Patients experience fewer duplicative services and better care transitions.
- Many integrate behavioral health, peer support, and social services.
- ACOs show promise in testing scalable care models.

In a fragmented system built around FFS payments, patients often feel lost in a maze of uncoordinated providers, repeating tests, navigating confusing referrals, and falling through the cracks between primary care, behavioral health, and specialty services. ACOs seek to close those gaps by aligning financial incentives with quality and coordination to promote a system where providers are rewarded for keeping people healthy.

From a consumer standpoint, ACOs hold the promise of more personalized, whole-person care. Patients attributed to an ACO should experience fewer duplicative tests, smoother transitions between settings, and more proactive outreach when something goes wrong. For individuals managing chronic conditions, living with behavioral health needs, or facing social barriers like food or housing insecurity, this kind of coordination can make the difference between stability and crisis.

ACOs also serve as a proving ground for innovation. In both Medicare and Medicaid, ACOs have tested models that go beyond traditional medicine, incorporating community health workers, peer supports, behavioral health integration, and investments in social services. For example, many ACOs are now partnering with housing agencies, transportation providers, and food banks to address the root causes of poor health. Others are using predictive analytics and care management tools to identify high-risk patients before they land in the emergency room.

Over the past decade, the impact of ACOs has become clearer. The Medicare Shared Savings Program, the largest ACO initiative in the country, has saved billions of dollars while improving quality metrics for millions of beneficiaries. In states like Massachusetts and Oregon, Medicaid ACOs are experimenting with models that place health equity and consumer experience at the center of care. And across the country, provider-led ACOs are bringing new energy to value-based reform.

But ACOs are not without their challenges. Questions remain about how well they serve high-need populations, how effectively they integrate behavioral health, and whether risk-sharing models fairly compensate providers who care for the most vulnerable. As we explore the mechanics and outcomes of ACOs in this chapter, one truth becomes clear: the success of value-based care depends not just on how care is paid for, but how it is experienced.

How ACOs Work – Key Features and Models

At their most basic level, Accountable Care Organizations are structured to promote accountability for both the cost and the quality of care. Participating providers, whether large hospital systems or small physician groups, agree to manage the total cost and outcomes of a specific patient population. If they succeed in reducing spending while maintaining or improving care quality, they share financial savings. If they fall short, particularly under two-sided risk arrangements, they may face financial losses.

One of the defining characteristics of ACOs is attribution, which is the method used to assign patients to a particular ACO based on where they receive most of their care. This is often done retrospectively, based on claims data, although some programs allow prospective assignment. Attribution matters because it determines which patients' outcomes and costs the ACO will be held accountable for, and it shapes how providers focus their coordination efforts.

The financial models underpinning ACOs vary, falling along with the value-based payment continuum discussed in Chapter 2. Some ACOs operate under shared savings only, meaning they can earn bonuses if they save money but are not penalized if they don't. Others take on shared risk, meaning they can earn more but are also financially responsible for excess costs. The most advanced models operate under full or partial capitation, receiving a fixed per-member-per-month payment to manage a population's health. This flexibility allows providers to innovate, investing in services not traditionally reimbursed under FFS.

A core element of ACO design is quality measurement. ACOs must report on a range of metrics that assess clinical outcomes, patient experience, and care coordination. These typically include standard tools such as the HEDIS and CAHPS surveys. The inclusion of patient-reported outcomes and stratified quality data is growing, particularly as equity becomes a central priority for CMS and state Medicaid programs.

There are several types of ACOs operating across the country:

- Medicare Shared Savings Program (MSSP): ACOs are the most prominent and established, currently serving approximately 11 million beneficiaries.
- Next Generation ACOs: A now-sunset CMS model, they tested more advanced risk-sharing arrangements and laid the groundwork for future high-risk ACO programs.
- Medicaid ACOs: Similar to those in Massachusetts and Oregon, these are designed to address the needs of low-income populations and often incorporate behavioral health and social services more fully into care planning.
- Commercial ACOs: Operated by private insurers, exist in many markets and may mirror or expand upon the structure of public ACO programs.

In recent years, state-level initiatives have added new energy and experimentation to ACO design. California's CalAIM initiative, for example, has reimagined managed care to include Enhanced Care Management and Community Supports, services that look remarkably like the wraparound supports provided by Medicaid ACOs. Meanwhile, Massachusetts has embedded health equity goals into its ACO contracts, requiring strategies to reduce disparities and integrate behavioral health.

Ultimately, what makes ACOs powerful is not just their structure, but their flexibility. When implemented well, they allow local providers to reimagine care delivery in ways that prioritize coordination, prevention, and person-centered support. They also create an operational environment where investment in equity, access, and community health are supported.

ACOs and Integration of Behavioral Health

Behavioral health has long been siloed from the rest of the healthcare system. For decades, mental health and substance use services operated under separate funding streams, separate provider networks, and separate policies—often resulting in fragmented, inconsistent, and reactive care. But as ACOs aim to deliver more coordinated, whole-person care, behavioral health integration has become a necessity.

ACOs are uniquely positioned to drive this change because they are held accountable for both quality outcomes and total cost of care. This means they have a financial and clinical incentive to address behavioral health as a core part of managing population health. Untreated mental illness and SUDs are major drivers of emergency department use, hospitalizations, and chronic disease exacerbation. By investing in behavioral health integration, ACOs can reduce high-cost utilization while improving overall outcomes and patient experience.

Many ACOs are taking practical steps to bring behavioral health into the fold. These strategies include:

- Embedding behavioral health providers within primary care teams to enable real-time collaboration and warm handoffs.
- Developing interdisciplinary care teams that include social workers, peer support specialists, and behavioral health clinicians.
- Establishing partnerships with community mental health centers and substance use providers to ensure timely referrals and shared care planning.
- Sharing health records and care plans across systems to reduce duplication and ensure continuity of care.

Some ACOs are going further by implementing risk stratification tools that identify patients with co-occurring behavioral health and chronic physical conditions, allowing for targeted interventions and proactive outreach. Others are using digital tools and telehealth platforms to expand access to behavioral health in rural or underserved areas, reduce wait times, and address provider shortages.

CMS has recognized the critical importance of these efforts. In its 2024 strategy documents and Innovation Center models, including the Innovation in Behavioral Health Model and the AHEAD initiative, the agency has called on ACOs and other value-based entities to move beyond siloed services and toward integrated care delivery. These models offer technical assistance, enhanced payments, and flexibility to invest in behavioral health infrastructure.

Real-world examples show what's possible. In Massachusetts, Medicaid ACOs are required to implement behavioral health integration strategies as part of their core operations, including fostering partnerships with certified Community Partners (CPs), which are community-based organizations specializing in behavioral health and long-term services and supports (LTSS). In North Carolina and Oregon, ACO-like structures are funding peer support networks and community-based crisis teams. These are not add-ons, they are essential components of the care model.

Yet integration remains uneven. Many ACOs still struggle with provider network limitations, inadequate behavioral health reimbursement rates, and regulatory hurdles that make full integration challenging. Moreover, not all behavioral health providers are equipped or willing to participate in value-based payment models, creating gaps in participation.

To address these barriers, ACOs need continued investment in behavioral health capacity, including workforce development, data infrastructure, and community partnerships. Equally important is the inclusion of behavioral health outcomes in quality measurement frameworks and risk adjustment methodologies, ensuring that ACOs are not penalized for serving high-need populations.

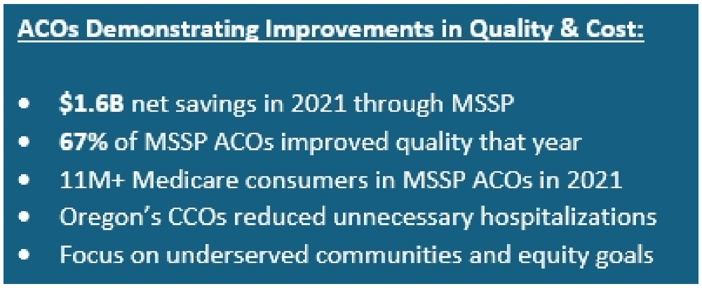
For consumers, behavioral health integration within ACOs means fewer handoffs, more compassionate care, and better outcomes. It means seeing mental health and substance use not as afterthoughts, but as fundamental components of well-being. As ACOs evolve, their ability to fully integrate behavioral health will be a key test of whether value-based care can truly serve the whole person.

Evidence of ACO Success

Over a decade into the widespread rollout of Accountable Care Organizations, the evidence is clear. When implemented thoughtfully, ACOs can reduce healthcare costs and improve patient outcomes. Their success offers proof that value-based models are more than theoretical, they're working in practice, for millions of Americans.

The strongest and most consistent data comes from the Medicare Shared Savings Program MSSP, which is the largest and most established ACO model in the United States. In 2021 alone, MSSP ACOs generated $1.6 billion in net savings to the Medicare program, while improving quality in 67% of participating ACOs. More than 11 million beneficiaries were attributed to MSSP ACOs that year, reflecting widespread reach and scale. These savings weren't achieved by cutting corners, they were accompanied by improvements in preventive care, chronic disease management, and care coordination, as measured by CMS quality benchmarks.

Research shows that ACO participation has led to fewer hospital admissions, lower readmission rates, and increased use of primary care services, especially for patients with complex conditions. Many high-performing ACOs have achieved success by focusing on core drivers of cost and poor outcomes, such as unaddressed behavioral health needs, lack of care after hospital discharge, and unmanaged chronic conditions like diabetes or heart failure.



ACOs Demonstrating Improvements in Quality & Cost:

- **$1.6B** net savings in 2021 through MSSP
- **67%** of MSSP ACOs improved quality that year
- 11M+ Medicare consumers in MSSP ACOs in 2021
- Oregon's CCOs reduced unnecessary hospitalizations
- Focus on underserved communities and equity goals

Beyond Medicare, ACO models are showing promise in Medicaid programs as well. States like Oregon, Massachusetts, and Minnesota have adapted the ACO structure to better serve low-income populations. These Medicaid ACOs typically emphasize integration with community-based organizations, behavioral health, and the social services sector. In Massachusetts, for example, ACOs are required to engage in health equity planning, collect race and ethnicity data, and coordinate with Community Partners that provide behavioral health and long-term services and supports.

In Oregon, Coordinated Care Organizations—functionally like ACOs—operate under global budgets and are required to invest in housing, nutrition, transportation, and other supports that address social determinants of health. Evaluations of the model have shown improvements in preventive care access, maternal health, and reduced unnecessary hospitalizations.

The CMS ACO REACH model, launched in 2023 as a successor to Direct Contracting, is also generating early momentum. It expands participation to provider organizations focused on underserved communities, with explicit goals to reduce disparities and improve care coordination for Medicare beneficiaries. One of the program's key innovations is a focus on health equity benchmarks and community-based partnerships, signaling a shift in federal priorities toward more inclusive value-based models.

While some critics point out that not all ACOs achieve savings or improve outcomes uniformly, the trend is moving in the right direction. Importantly, ACOs that prioritize consumer engagement, robust data infrastructure, and interdisciplinary care tend to outperform those that rely solely on top-down administrative redesign.

Perhaps the most meaningful evidence of success comes from patients themselves. In ACOs that have invested in care coordination, patients report feeling more connected to their care teams, better supported after hospital stays, and more empowered to manage their own health. For older adults, individuals with disabilities, and people living with chronic conditions, these improvements translate into greater stability, fewer crises, and a stronger sense of control.

The ACO model is far from perfect, but it's a step in the right direction and it's working. With continued refinement, investment, and accountability, it has the potential to transform how we measure, deliver, and experience healthcare in this country.

Challenges and Opportunities

Despite the impressive performance of many Accountable Care Organizations and their growing adoption across Medicare, Medicaid, and commercial markets, ACOs still face significant challenges that could limit their long-term effectiveness, particularly when it comes to advancing equity, engaging complex populations, and scaling models sustainably.

One of the most pressing challenges is data sharing and interoperability. ACOs are fundamentally built on the concept of care coordination, but coordinating care is nearly impossible when providers across different systems can't access shared health records. Many ACOs still struggle to aggregate timely, actionable data across hospitals, primary care practices, specialists, behavioral health providers, and community organizations. Without reliable data infrastructure, it's difficult to identify high-risk patients, track performance, or intervene early when issues arise.

Behavioral health integration, though essential, also remains uneven. Many behavioral health providers operate outside the traditional healthcare system or are excluded from value-based contracts due to licensing, credentialing, or payment barriers. Even ACOs with a strong commitment to whole-person care often find it difficult to incorporate behavioral health specialists or community-based treatment providers into their networks. This creates care gaps for patients who could benefit most from integrated support.

Equity is another area where progress has been mixed. While CMS and some state Medicaid programs have introduced health equity benchmarks and required the use of Race, Ethnicity, and Language (REaL) data, most ACOs still lack the infrastructure to collect, analyze, and act on this information. Without stratified quality metrics and meaningful risk adjustment, ACOs that serve more vulnerable or complex populations may be unfairly penalized or avoid enrolling high-risk patients altogether.

Payment adequacy can also be a barrier to success. Many safety-net providers and rural health systems operate on razor-thin margins, making it difficult for them to take on downside risk. Without sufficient financial support, technical assistance, and protections for providers new to value-based care, there is a risk that ACO expansion could widen the gap between well-resourced health systems and under-resourced communities.

And then there's the issue of consumer awareness and engagement. Many patients don't know they are part of an ACO, let alone understand what that means for their care. This limits the ability of ACOs to partner with patients around shared decision-making, health goal-setting, and chronic disease self-management. ACOs that have succeeded in these areas have invested in care navigators, culturally responsive outreach, and community partnerships that build trust and promote continuity.

Despite these challenges, the ACO model remains one of the most promising vehicles for system transformation and several emerging opportunities could further accelerate its impact:

- Policy momentum: CMS Innovation Center strategies, the ACO REACH model, and state-level Medicaid reforms can push for more integrated, equity-centered care.
- Technology advancements: AI-enabled analytics, real-time care coordination tools, and remote monitoring offer new ways to identify needs, personalize care, and reduce avoidable utilization.
- Workforce innovation: Integration of peer support specialists, community health workers, and housing navigators, can help ACOs expand their reach and cultural competency.
- Consumer engagement strategies: Person-centered care planning and shared decision-making platforms can help to close the loop between care delivery and lived experience.

To seize these opportunities, ACOs must continue to evolve, not just as financial models, but as delivery systems that place the consumer at the center. This means addressing the root causes of poor health, elevating community voices, and designing infrastructure that supports integration, transparency, and accountability. The ACO model is not a silver bullet, but it is a foundation. With the right supports, it can be the bridge between traditional healthcare and the future we envision where value is defined by outcomes, equity, and the experience of the people we serve.

Part II:

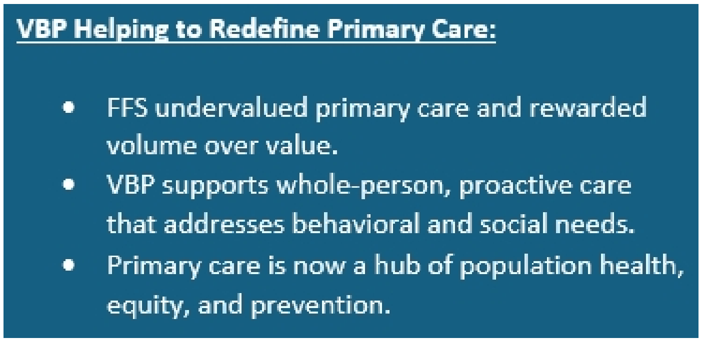
VBP Implementation & Impact Across the Industry

CHAPTER 4: PHYSICAL HEALTH AND PRIMARY CARE TRANSFORMATION

Introduction: A Sector at the Center of Reform

Primary care is often seen as the backbone of the healthcare system. It has the potential to reduce costs, improve outcomes, and help maintain people's well-being. Yet under the fee-for-service model, primary care remained underfunded, overburdened, and structurally undervalued. Rather than being treated as a strategic asset, it was often relegated to a gatekeeping role. Primary care providers were tasked with seeing high volumes of patients in short appointments, with little time or incentive to build meaningful relationships or proactively manage health.

This contradiction was at the heart of many system-level failures. Policymakers, payers, and providers acknowledged the value of strong primary care, but the payment structure did not reflect that recognition. Reimbursement focused on face-to-face visits, not on care coordination, prevention, or patient education. Consumers often experienced rushed appointments, fragmented or no follow-up, and limited access to behavioral or social supports. As a result, care remained largely reactive under FFS models, and individuals with chronic or complex conditions were especially likely to fall through the cracks.



VBP Helping to Redefine Primary Care:

- FFS undervalued primary care and rewarded volume over value.
- VBP supports whole-person, proactive care that addresses behavioral and social needs.
- Primary care is now a hub of population health, equity, and prevention.

The emergence of value-based payments over the past decade has started to shift this dynamic. Among all sectors in healthcare, primary care has been both a logical starting point and a critical proving ground for VBP innovation. Unlike specialized or episodic forms of care, primary care reaches nearly every consumer, presenting a unique opportunity to focus on prevention, early intervention, coordination, and long-term outcomes. In a value-based system, the goal is not only to treat illness when it arises but also to keep people healthier for longer through proactive, integrated care.

Primary care providers were among the first to adopt new payment models such as patient-centered medical homes (PCMHs), shared savings programs, and chronic care management initiatives. These efforts gained momentum through federal support, including the Affordable Care Act and new models introduced by the Center for Medicare and Medicaid Innovation (CMMI). New expectations have emerged over the last 10-15 years regarding population health, care team collaboration, and quality-based incentives for services such as screenings, immunizations, and chronic disease management.

At the same time, the philosophy of care began to evolve. Patients were increasingly viewed as active partners in their health. Shared decision-making, whole-person care, and patient-reported outcomes became more prominent in both policy and practice. Under VBP models, the role of primary care providers expanded, taking on coordination responsibilities for behavioral health, social services, and community-based supports in addition to physical care.

Despite meaningful progress, challenges remain. The shift from FFS to VBP introduced new reporting requirements, unfamiliar benchmarks, and necessitated investments in staffing and technology. Smaller practices have struggled to meet these demands, while larger systems continue to refine their methods for measuring value and delivering equitable outcomes. Even so, the benefits are clear. Value-based payments have elevated the role of primary care and clarified its purpose within a modern healthcare system.

In this chapter, we examine the evolution of primary care in a value-based healthcare system. We examine how consumer partnerships, chronic condition management, and prevention have taken center stage. We also highlight how VBP models are enabling states and providers to redesign care around equity, quality, and trust. When primary care functions as the hub of whole-person care, the entire healthcare system becomes more effective, more sustainable, and more humane.

The Legacy of Fee-for-Service in Primary Care

For decades, primary care in the United States has operated within a system that rewarded volume over value. The fee-for-service model created a landscape where providers were paid based on the number of visits, procedures, and tests they performed, regardless of the quality or outcomes of the care provided. This structure created systemic disincentives for the kind of whole-person, relationship-based care that is essential to realizing the true potential of primary care. Instead of being supported as the foundation of preventive and holistic care, primary care was often reduced to brief, fragmented encounters that prioritized throughput.

Under FFS, primary care providers faced pressure to see more patients in less time, often with appointments scheduled in 15-minute blocks. This limits their ability to address multiple concerns in a single visit, let alone consider the social and behavioral determinants affecting a person's health. The business model did not support prevention, health education, or complex care coordination. These services were either inadequately reimbursed or not reimbursed at all, prompting providers to adopt short-term interventions and reactive care.

Burnout became an all-too-common consequence. Primary care physicians and care teams were overwhelmed by administrative burden and the emotional toll of practicing in a system that constrained their ability to provide comprehensive care. Many reported feeling like they were working on a conveyor belt, unable to give patients the time or attention they needed. According to a recent study published in *JAMA Health Forum*, more than half of primary care clinicians reported symptoms of burnout, with time pressure and demands related to electronic health records cited as major contributing factors.

These structural flaws had profound implications for consumers. Within this model, individuals often found themselves cast in the role of passive recipients. Consumers were seen for their symptoms rather than their stories and processed through a system that valued efficiency over empathy. With little room for shared decision-making or meaningful dialogue, trust in the healthcare system suffered. Preventive care was neglected, chronic conditions were poorly managed, and many patients, especially those from historically marginalized communities, fell through the cracks.

This approach also failed to support the consistent, long-term relationships that are necessary for effective primary care. Rather than fostering continuity, the FFS model encouraged episodic treatment. Patients might see different providers at every visit, receive conflicting advice, or be referred to as specialists without coordination or follow-up. Care was not designed with people and their lived experiences in mind. It was designed around procedures and billing codes.

Consider a patient managing diabetes, hypertension, and depression. In an FFS system, this person might attend three different appointments with three other providers, each focused on one aspect of care without understanding the full picture, and each running their tests. The opportunity to address root causes or integrate services was routinely missed. This fragmentation led to poorer outcomes, higher costs, and unnecessary duplication of services.

Moreover, the FFS model offered no incentives for addressing social determinants of health. Providers were not compensated for helping patients navigate housing, food insecurity, or transportation issues, even when we know these factors are critical to improving health. As a result, whole-person care remained out of reach.

Primary care, in theory, should be the foundation of a high-functioning health system because it sees consumers at least once a year. It is the setting where prevention happens, where conditions are managed before they escalate, and where relationships are built over time. But under fee-for-service, that is not the case. Prevention took a backseat, innovation was stifled, and the potential of primary care was consistently undermined by a financing structure that rewarded quantity over quality.

Consumers suffered the consequences as visits were rushed, diagnoses were delayed, and health literacy was low. This was exacerbated for people with complex needs, where navigating the system was so difficult that it ended in avoidable hospitalizations, unmanaged conditions, and preventable loss.

The limitations of fee-for-service were not abstract policy concerns. They were felt in real lives, in real communities, every day. This broken model underscored the need for transformation. As the next sections will explore, the shift to value-based care represents a necessary evolution that seeks to restore whole-person care and prevention to the heart of primary care.

The Shift Toward Consumer Partnership Through Whole-Person Care and Shared Decision-Making

As primary care began to evolve in response to growing dissatisfaction with the fee-for-service model, a new emphasis emerged: a partnership with the consumer. For decades, patients were passive recipients of care, often told what to do without their values, preferences, or lived experiences considered. However, over the last 10 years, the movement toward value-based care has driven a fundamental rethinking of that dynamic. Consumers are now viewed not just as patients, but as partners in their health journey.

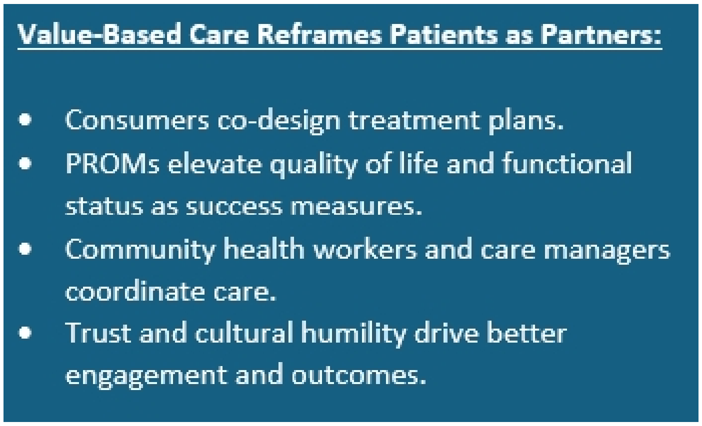
This shift is most reflected in the widespread adoption of shared decision-making, patient-reported outcome measures (PROMs), and care models that prioritize whole-person health. These tools help shift care planning away from a provider-dominated model toward one where collaboration, personalization, and dignity are prioritized. Shared decision-making encourages dialogue between consumers and providers, inviting an active participant in their treatment planning. Rather than a physician choosing a course of action based solely on clinical evidence, the decision is made together, balancing evidence with what matters to the consumer.

Patient-centered medical homes were among the first widespread efforts to embed consumer partnership into primary care. These models emphasized team-based care, expanded access, and enhanced communication, but their core principle was respect for the consumer's role in managing their health. PCMHs demonstrated early promise in improving chronic disease management, preventive screening rates, and consumer satisfaction. They also highlighted the power of structured care coordination that actively includes the patient's goals.

Medicare's Comprehensive Primary Care (CPC) and Comprehensive Primary Care Plus (CPC+) initiatives were built on these early lessons. These programs encouraged practices to incorporate advanced care planning, behavioral health integration, and data-informed population health strategies. Importantly, both initiatives required participating practices to use consumer experience surveys and PROMs to guide quality improvement. This marked a milestone as it meant not just hearing from consumers, but also using their feedback to shape care delivery in real time.

In our blog *What is Whole-Person Care?,* we described how traditional care has often focused on isolated symptoms rather than the broader context of a person's life. Whole-person care challenges that approach. It asks whether an individual's behavioral, emotional, and social needs are being addressed alongside their physical conditions. In whole-person care, providers extend their focus beyond clinical encounters to consider factors such as housing stability, food security, and cultural background. A consumer managing diabetes, for example, may not benefit from increased medication doses unless their stress, access to nutritious food, and support systems are also part of the plan.

Likewise, our blog *The Role of Primary Care in VBP* emphasizes how value-based models have given primary care providers both the responsibility and the flexibility to consider consumer needs. With payment models that reward outcomes instead of volume, providers have a greater ability to invest in care managers, health coaches, and community health workers. These roles help bridge the gap between medical care and daily life, offering consumers trusted guides who can help navigate systems, set goals, and identify challenges before they become crises.



Value-Based Care Reframes Patients as Partners:

- Consumers co-design treatment plans.
- PROMs elevate quality of life and functional status as success measures.
- Community health workers and care managers coordinate care.
- Trust and cultural humility drive better engagement and outcomes.

PROMs have become especially important in this evolution, amplifying the consumer voice. These tools measure how individuals perceive their health, function, and quality of life. Unlike clinical measures that track blood pressure or cholesterol levels, PROMs give voice to the consumer's perspective. For someone with chronic pain, a decrease in symptom severity might be less significant than being able to return to work or enjoy daily activities. PROMs elevate these priorities, allowing care teams to better align services with what truly matters to each person.

Equity is also a critical element in consumer partnership. Historically marginalized communities often experience a disconnect between what healthcare systems offer and what they need. Embedding whole-person care principles and shared decision-making can help rebuild trust. When providers acknowledge lived experience, adapt communication styles, and create space for individual narratives, they begin to break down barriers that have excluded too many for too long.

The shift toward consumer partnership in primary care is not a trend. It is a structural change driven by the recognition that genuine collaboration has benefits. It's also a cultural transformation, challenging the traditional power imbalance between providers and consumers. As we continue to embrace value-based models, this reorientation toward partnership will remain essential to ensuring care is truly person-centered, equitable, and impactful.

Redesigning Primary Care Around Prevention & Managing Chronic Conditions in a Value-Based System

One of the most critical shifts ushered in by value-based payment models is the reorientation of primary care away from episodic visits and toward the sustained management of chronic conditions. In the traditional fee-for-service world, primary care was often limited to short, reactive visits. Still, for the millions of Americans living with conditions like diabetes, hypertension, heart failure, and depression, care must be continuous, coordinated, and proactive. VBP models provided financial support for that transformation.

Early value-based initiatives, such as the Comprehensive Primary Care and its successor, the Comprehensive Primary Care Plus model, laid critical groundwork. The Center for Medicare and Medicaid Innovation programs introduced enhanced payment streams that supported care management, risk stratification, and the integration of behavioral health services. In CPC+, for example, practices received care management fees and performance-based incentive payments to support longitudinal care planning, medication management, and patient engagement. The model emphasized interdisciplinary care teams, including care coordinators, social workers, and behavioral health specialists, each playing a role in managing the complexity of chronic illness.

The next generation of federal primary care reform will continue this trajectory through the Making Care Primary (MCP) Model. The MCP Model, launched by the Centers for Medicare & Medicaid Services (CMS), is a 10.5-year multi-payer initiative designed to strengthen primary care delivery and improve care coordination across the healthcare system. Set to begin in July 2024, the model will initially operate in eight states—Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, and Washington. MCP supports primary care organizations through three progressive tracks that guide practices from building core capabilities, such as care management and screening for health-related social needs, to fully integrating with specialty and behavioral health services. The model emphasizes accountability for total cost of care, health equity, and patient outcomes, offering enhanced payments and technical assistance to help practices transition toward advanced value-based care. MCP is providing a pathway for smaller or safety-net practices to engage in population health management.

Innovation and transformation are not only occurring at the federal level. States, too, have and are continuing to advance this vision through Medicaid reform. North Carolina's Medicaid transformation initiative required managed care plans to implement care management for high-need individuals, with a special focus on behavioral health and social determinants of health. California's CalAIM initiative expanded access to Enhanced Care Management for those with complex physical, behavioral, and social needs, and emphasized person-centered care planning as a core element of delivery. Both states recognize that effective chronic care necessitates attention beyond the clinic, encompassing stable housing, nutrition, and transportation.

This approach was especially crucial for individuals dually eligible for Medicare and Medicaid. These individuals, who often live with multiple chronic conditions alongside severe behavioral or functional limitations, historically faced some of the worst care fragmentation. Under a fee-for-service model, they were bounced between systems, with little communication between providers. But value-based initiatives tailored to dual-eligibles began to change that. Programs like the Financial Alignment Initiative and Dual Eligible Special Needs Plans (D-SNPs) included features such as interdisciplinary care teams, dedicated care coordinators, and health risk assessments that informed the development of personalized care plans. Some states have implemented Managed Long-Term Services and Supports (MLTSS) programs to meet the daily living needs of dual-eligible individuals by coordinating physical, behavioral, and supportive services.

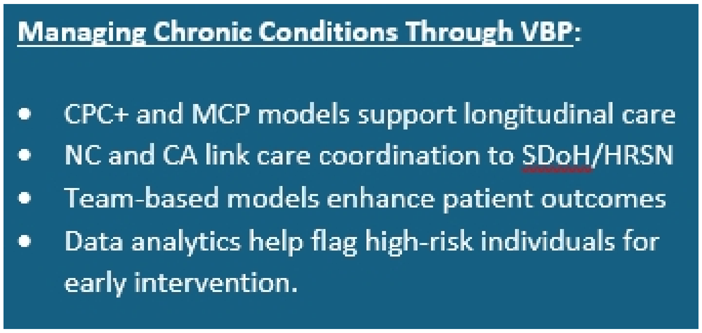
The blog *Medicare & Medicaid Alignment Efforts* highlighted how bridging the silos between these programs can significantly improve outcomes and reduce redundancy. When providers are incentivized to focus on the whole person, and not just the portion of care covered under a single payer, they begin to prioritize long-term stability over short-term encounters. The result is more attention to preventive screenings, medication adherence, and patient education, which are especially important for individuals managing multiple conditions.

In many practices, the implementation of team-based care has been the most visible sign of this change. Primary care providers no longer shoulder the full burden of patient management alone. Instead, they work alongside nurses, social workers, behavioral health clinicians, and pharmacists, each contributing their expertise to a shared care plan. This structure allows patients to receive more comprehensive support, whether that means help with managing blood sugar levels, addressing untreated depression, or arranging transportation to follow-up visits.

Behavioral health integration has also become more common within primary care, particularly in clinics participating in value-based arrangements. For patients with co-occurring mental and physical health conditions, integrated care can prevent avoidable hospitalizations and improve daily functioning. Screening for depression, anxiety, and substance use disorders (SUDs) has become more routine, with structured pathways for handoffs to in-house therapists or partner/community organizations.

The transition to prevention-focused primary care also involves a growing use of data analytics to identify patients at risk and intervene early. Predictive models and risk stratification tools enable care teams to flag those who are most likely to experience complications, hospitalization, or a worsening of their health status. In practices that have embraced these tools, outreach may begin with a phone call from a nurse or care manager, checking in on medication refills, symptoms, or unmet social needs before they escalate into emergencies.

Ultimately, redesigning primary care around prevention has made care more meaningful and manageable for the people it serves. For a patient with COPD and mobility challenges, it might mean avoiding a hospitalization because a nurse visited the home to provide education and check on oxygen use. For someone newly diagnosed with diabetes, it could mean receiving a culturally relevant nutrition plan from a registered dietitian who understands the local community. And for caregivers, it means having a team they can call for support, rather than navigating a maze of disconnected providers alone.



Managing Chronic Conditions Through VBP:

- CPC+ and MCP models support longitudinal care
- NC and CA link care coordination to SDoH/HRSN
- Team-based models enhance patient outcomes
- Data analytics help flag high-risk individuals for early intervention.

The evolution of primary care is ongoing, and not all practices have the tools or infrastructure needed for reforms. Despite this, the evidence is clear: when prevention and chronic care management are supported, outcomes improve, costs decline, and patients experience better, more equitable care.

From Pilots to Policy: State Innovation and System-Level Transformation

The VBP movement in primary care has gained its strongest foothold not just through federal models, but through a wave of state-level innovation. As early efforts revealed the potential of aligning payment with outcomes, states began to take ownership of transformation. Their initiatives have proven that primary care can facilitate the transformation of the healthcare system to one where prevention, coordination, and consumer voice are prioritized.

Over the past decade, Medicaid programs, in particular, have emerged as powerful drivers of value-based care. Unlike Medicare, which is federally administered, Medicaid is jointly managed by states and the federal government. This structure provides states with the flexibility to test innovative delivery and payment models tailored to their local populations. As a result, many of the most ambitious transformations in primary care have come from state-led programs designed to meet the needs of low-income, medically complex, and historically underserved communities.

Oregon was among the first to embrace this shift in a comprehensive manner. In 2012, the state launched its Coordinated Care Organizations (CCOs), regional entities responsible for managing the care of Medicaid enrollees under a global budget. These CCOs were charged with integrating physical, behavioral, and dental health services, as well as addressing social determinants of health. The model allowed for flexible spending on services not typically reimbursed under a fee-for-service model, such as housing support or community health workers. This approach encouraged a preventive focus and local accountability for outcomes.

The early success of Oregon's CCOs prompted other states to develop similar structures. In North Carolina, the Healthy Opportunities Pilots represented a bold experiment in addressing health through non-medical interventions. These pilots, launched as part of the state's Medicaid transformation, enabled managed care plans to cover services such as food delivery, transportation to medical appointments, and home modifications for eligible beneficiaries. These initiatives acknowledged that primary care transformation must extend beyond the clinic and into the social realities that shape health.

As chronic illness and behavioral health needs placed growing pressure on fragmented systems, states also began adopting payment models that moved further along the value-based continuum. Initially, many relied on pay-for-performance models that offered bonuses for meeting certain quality metrics. While these models provided a low-risk entry point into value-based payment, they had a limited impact on care redesign.

The next step was shared savings arrangements, often implemented through Medicaid Accountable Care Organizations or multi-payer initiatives. These models rewarded providers for improving outcomes while containing costs. States like Massachusetts built shared savings into their ACO structure, tying financial rewards to both clinical outcomes and equity targets. Providers were incentivized not just to improve care, but to reduce disparities in measurable ways.

Some states have progressed even further, piloting partial and complete capitation models for primary care. These approaches provide providers with a fixed per-member-per-month payment, offering flexibility to redesign care in ways that meet local needs. Capitated models support investment in team-based care, expanded access through telehealth or after-hours visits, and enhanced care coordination. While they introduce greater financial accountability, they also empower providers to innovate.

These policy shifts are not just theoretical. They are reshaping how primary care looks and feels to consumers. Under these models, patients may be greeted by a team that includes a nurse care manager, a behavioral health clinician, and a community health worker. They may receive outreach after a hospital visit, follow-up on social needs, and personalized care plans developed collaboratively. The experience becomes more relational, continuous, and tailored.

Multi-payer alignment efforts are also reinforcing the rise of primary care in value-based payment. States like Colorado and Vermont have brought together Medicaid, Medicare, and commercial payers to align goals and metrics, creating a more coherent environment for providers. These efforts reduce administrative burden and reinforce a consistent vision for what high-quality, person-centered primary care should look like.

Reflections from the blog *State VBP Adoption Trends* underscore that while each state's journey is unique, common themes are emerging. States that succeed tend to invest in infrastructure, stakeholder engagement, and robust data systems. They also place consumers at the center of design, recognizing that sustainable transformation must reflect the realities of the people served.

Ultimately, state innovation has transformed value-based primary care from a policy aspiration into a practical framework for implementation. It has moved the field from pilot programs to system-level change. As more states adopt comprehensive models that elevate prevention, coordinate care, and invest in community supports, primary care is evolving from a transactional service into a foundation for whole-person health.

The challenge now is scaling these efforts equitably and ensuring that every community —rural or urban, affluent or under-resourced—has access to a primary care system that works for them.

Remaining Challenges and the Road Ahead

The transformation of primary care through value-based payment has laid a robust foundation. Across the country, providers, payers, and states voice engagement. Yet, as this chapter has illustrated, progress has been uneven, and the road ahead is not without obstacles.

Workforce shortages remain a significant concern. Primary care providers, especially in rural and underserved areas, are stretched thin. Many report burnout, turnover, and challenges in recruiting staff for team-based models. While value-based care emphasizes a more holistic and relational approach, delivering that model requires time, resources, and personnel that are often in short supply. Without sustained investment in workforce development and payment models that support team-based care, this strain may limit long-term sustainability.

Technology is another critical pain point. Although health IT and care coordination platforms have advanced, gaps remain in interoperability, real-time data exchange, and consumer-facing tools. For smaller practices or community-based providers, adopting and maintaining these systems can be prohibitively expensive or technically overwhelming. This digital divide undermines the ability of VBP models to function, effectively hindering the effectiveness of VBP models, particularly when care spans multiple settings or involves complex needs.

Even with innovative payment models, providers often face delayed reimbursements, administrative burden, and uncertainty around evolving quality metrics. These friction points can slow adoption and stifle innovation. States and payers that have streamlined reporting requirements and offered technical support have seen greater provider engagement. But scaling this level of support remains a challenge.

Despite these barriers, the field has continued to evolve, supported by emerging best practices that reflect a deeper understanding of what people need to be well. Culturally responsive care, for example, is increasingly recognized as essential, not optional. This includes hiring diverse care teams, offering interpretation services, and integrating community-based partners who understand the social and cultural context of the populations served.

Primary care transformation also now routinely includes a focus on social determinants of health (SDOH). Many practices are adopting standardized screening tools to assess housing, food, transportation, and safety needs. More importantly, they are developing referral pathways and partnerships to respond to those needs. In some states, VBP contracts include payment for addressing non-medical drivers of health, validating their importance within the healthcare ecosystem.

One of the most promising developments is the alignment between primary care and behavioral health. Whether through co-located services, collaborative care models, or the integration of embedded behavioral health staff, providers are finding ways to treat the whole person, not just isolated symptoms. These models are proving especially impactful for populations with complex or chronic conditions.

Looking forward, three forces are likely to define the next phase of primary care transformation: artificial intelligence (AI), community health workers, and equity-linked performance measures. AI has the potential to streamline administrative tasks, predict risk, and personalize care. However, it must be implemented thoughtfully to avoid reinforcing bias or exacerbating access issues.

Community health workers have emerged as essential connectors between clinical care and the community. Their ability to build trust, navigate services, and provide culturally appropriate support makes them indispensable in value-based models. States that have formalized payment for Community Health Workers within Medicaid contracts are setting the pace for inclusive, community-centered care.

Ultimately, equity-linked VBP measures are enabling systems to move beyond generalized improvement and toward targeted change. Stratifying data by race, language, disability, and other relevant factors enables providers to identify gaps, set targeted goals, and track progress in closing disparities. These measures bring accountability to the mission of health equity, making it a measurable and fundable priority.

As we close this chapter, it is worth revisiting how far primary care has come. Once defined by siloed systems, short visits, and a narrow clinical lens, primary care is now evolving into a comprehensive, relationship-based, and equity-driven hub of the healthcare system. This shift did not happen overnight, but the transformation of primary care sets the stage for the next frontier.

In upcoming chapters, we will explore how value-based payment is reshaping more complex sectors like long-term services and supports, intellectual and developmental disabilities, and home-based care. These sectors face unique challenges, but the lessons learned in primary care offer a roadmap for scalable, sustainable change.

CHAPTER 5: SKILLED NURSING AND POST-ACUTE REFORM

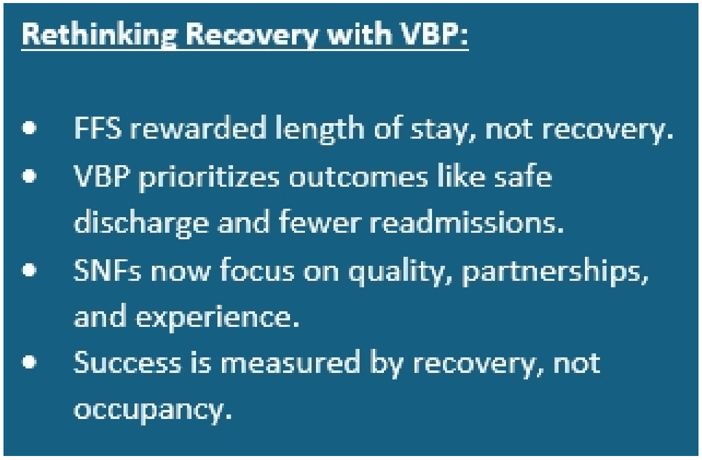
Introduction: A Critical Junction in the Continuum

Skilled nursing facilities (SNFs) and post-acute care providers play a pivotal role in the healthcare continuum. For individuals recovering from hospitalization, especially older adults and those with functional limitations, these settings serve as the bridge between acute care and home. They are often the place where recovery, rehabilitation, and stabilization either take hold or fall short. Yet for many years, this vital segment of care was overlooked in reform efforts. Under fee-for-service, SNFs were reimbursed based on volume and length of stay, not outcomes. The system rewarded occupancy and days billed, not successful discharges or regained independence.

As a result, the emphasis was on throughput, not recovery. Hospitals discharged patients quickly to SNFs, which then operated with little connection back to the acute care system. Communication was fragmented, incentives were misaligned, and the individual's experience of care was secondary to billing priorities. For many consumers, especially those with complex needs, this meant facing care transitions that were disorienting, poorly coordinated, and frequently unsafe.

This model had real consequences. Individuals would arrive at a SNF after surgery or an acute illness, only to be readmitted to the hospital within days. Medication errors, delayed follow-up, and lack of physical or occupational therapy were all too common. Discharge planning was inconsistent, and families were left navigating a maze of services with little support. Despite the critical role of post-acute care in shaping long-term recovery, FFS failed to treat it as an integral part of the care journey.

Over the past decade, value-based payments have sought to change that. By tying reimbursement to performance, outcomes, and care coordination, VBP has introduced new expectations and new opportunities for SNFs. Bundled payments have made facilities accountable not just for their own performance, but for the entire episode of care following a hospitalization. The focus has shifted from how long someone stays in a SNF to how well they recover, whether they avoid rehospitalization, and how effectively care is coordinated across settings. This has led to stronger hospital-SNF partnerships, more attention to functional improvement, and better integration with home health and community-based supports.



Rethinking Recovery with VBP:

- FFS rewarded length of stay, not recovery.
- VBP prioritizes outcomes like safe discharge and fewer readmissions.
- SNFs now focus on quality, partnerships, and experience.
- Success is measured by recovery, not occupancy.

At the same time, the concept of quality in skilled nursing has evolved. No longer defined solely by staffing levels or documentation compliance, quality now includes consumer experience, timely transitions, functional outcomes, and equity. SNFs are being asked to invest in interdisciplinary care teams, advance care planning, and culturally responsive services. Consumers and families are also playing a larger role in shaping what good post-acute care looks like, demanding transparency, respect, and accountability.

This chapter explores how the skilled nursing and post-acute care sectors have transformed in the VBP era. It examines the challenges of the fee-for-service legacy, the rise of bundled payments and shared accountability, and the new definitions of quality that are reshaping care. It also looks ahead to the innovations and policy reforms still needed to ensure that post-acute care truly supports recovery, independence, and equity. When value-based care is done well in these settings, the result is not just lower costs. It is a safer, smoother, and more empowering experience for the people who need it most.

Bundled Payments and the Push for Accountability: Linking Payment to Outcomes

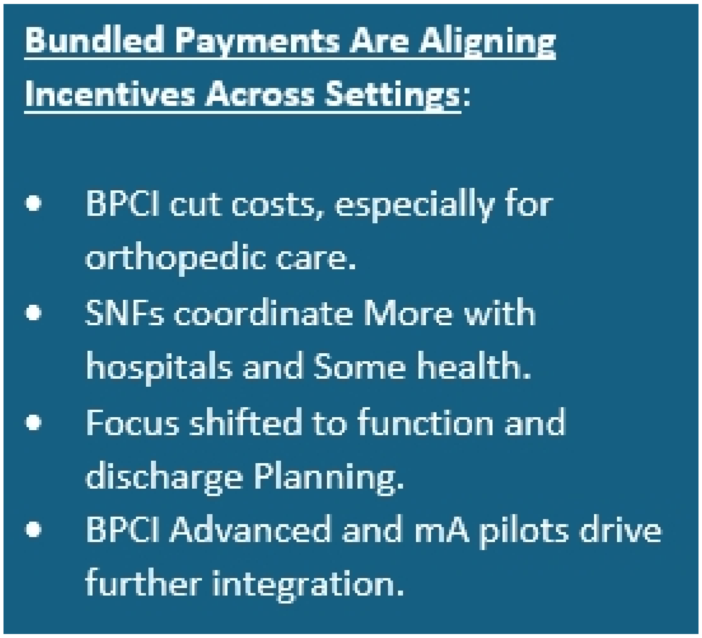
For much of the last decade, bundled payments have served as one of the most significant levers for reforming care in skilled nursing facilities and other post-acute settings. At their core, bundled payment models shift reimbursement from a siloed service-by-service structure to a single payment covering an entire episode of care that typically starts with a hospital admission and continues through rehabilitation or recovery in post-acute care. This model changes the game for SNFs by making them jointly responsible for outcomes and costs beyond their walls.

Historically, skilled nursing care under fee-for-service was reimbursed per diem, meaning the longer a patient stayed, the more revenue the facility generated. While this structure offered predictability, it also incentivized longer stays, regardless of need, and did not reward facilities for preventing rehospitalizations or speeding recovery. There was little financial alignment between hospitals and SNFs, which often led to fragmented care transitions and missed opportunities for collaboration.

Bundled payments were introduced to correct this misalignment. The Bundled Payments for Care Improvement (BPCI) initiative, launched by CMMI, was one of the first major programs to include SNFs as a core part of the post-acute care continuum. The model established a target price for a defined clinical episode and held all involved providers accountable for staying within budget while meeting quality benchmarks. SNFs participating in these bundles had to deliver efficient care, reduce unnecessary rehospitalizations, and ensure successful discharges to home or lower levels of care.

Early results were promising. According to evaluations of the BPCI initiative, bundled payments led to a modest reduction in episode costs without compromising quality, particularly in orthopedic episodes. Skilled nursing facilities that participated in the model adopted new strategies to manage risk, including tighter coordination with hospitals, earlier functional assessments, and more deliberate discharge planning. Facilities that traditionally operated independently began forming closer relationships with upstream hospitals and downstream home health providers to manage care transitions more effectively.

These efforts changed how SNFs approached their role. They were no longer just a stop on the road to recovery. They became active participants in ensuring that recovery continued after discharge. To stay within the bundled payment limits and avoid costly penalties, SNFs invested in care management, functional improvement tracking, and patient education. Some facilities also began implementing telehealth follow-ups and home-based care coordination, recognizing that what happens after discharge is as important as what happens within their walls.



Bundled Payments Are Aligning Incentives Across Settings:

- BPCI cut costs, especially for orthopedic care.
- SNFs coordinate More with hospitals and Some health.
- Focus shifted to function and discharge Planning.
- BPCI Advanced and mA pilots drive further integration.

However, the transition was not without its challenges. Bundled payments require a level of data infrastructure and care coordination that many smaller SNFs initially lacked. Tracking outcomes across the care continuum, attributing patients accurately, and aligning financial incentives among disparate providers proved difficult in some markets. Additionally, there were concerns about risk selection, where SNFs might avoid high-need patients to ensure favorable financial performance under the bundle.

To address these concerns, the BPCI Advanced model introduced new safeguards and offered greater flexibility for participants. Meanwhile, private payers and Medicare Advantage plans began piloting their own bundled models, further pushing SNFs to adapt. Over time, bundled payment participation began influencing standard practice, with or without formal contracts.

While not all SNFs have participated directly in bundled payment models, the broader movement toward outcome-based reimbursement has elevated the importance of their role in the care continuum. Instead of being seen as a holding zone between hospital and home, skilled nursing has become a critical phase for recovery, where high-quality, efficient care can prevent setbacks and support long-term stability. As we'll explore in the next section, this shift has helped reduce hospital readmissions and encouraged greater accountability across the board.

Reducing Hospital Readmissions: From Reactive Transfers to Proactive Stabilization

One of the clearest signals that value-based care has taken root in skilled nursing is the increased focus on hospital readmissions. Historically, SNFs operated largely in isolation from hospitals and health systems, with minimal accountability for what happened after a patient left their care. If a resident took a turn for the worse, the default response was often to send them back to the emergency room even when the issue might have been manageable in place. This revolving door was not only costly, but deeply disruptive to consumers and families.

The introduction of readmission penalties and performance-based reimbursement tied to outcomes has fundamentally changed that equation. For SNFs, preventing avoidable readmissions has become both a clinical and financial priority. These efforts have been reinforced by several major policy initiatives and models from the CMS, as well as by evolving expectations from hospitals, payers, and consumers.

The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program, launched by CMS in 2018, tied a portion of Medicare payments to hospital readmission rates. Facilities that performed well received financial rewards, while those with high readmission rates faced payment reductions. While early iterations of the model were limited in scope, the impact was immediate. Facilities began developing internal tracking systems, reviewing hospital transfer data, and retraining staff on clinical escalation protocols.

In parallel, SNFs participating in bundled payment models or Accountable Care Organizations also faced shared accountability for rehospitalizations. These arrangements encouraged stronger care transitions, better medication reconciliation, and closer monitoring of high-risk residents. Some SNFs began conducting 24–48-hour post-discharge check-ins, implementing “red flag” protocols for early warning signs, and coordinating closely with primary care providers or specialists to manage complex conditions on site.

Facilities that excel in reducing readmissions tend to share common characteristics: strong clinical leadership, interdisciplinary teams, solid relationships with hospitals, and a culture that prioritizes stability and proactive care. Many have introduced clinical pathways for common diagnoses such as heart failure, COPD, or urinary tract infections, ensuring that staff know how to intervene early and escalate care when needed. Others have hired nurse practitioners or physician extenders to provide coverage outside traditional hours, reducing reliance on emergency transfers during nights and weekends.

Technology has also played a role in improved outcomes and processes. SNFs can now use predictive analytics to identify residents at elevated risk of readmission and tailor interventions accordingly. Remote monitoring tools and telehealth consults also allow providers to address issues quickly, even when specialized staff are not on site. These innovations are especially valuable in rural areas, where access to specialists can be limited and transportation poses a barrier.

Despite these advances, challenges remain. Many SNFs still lack the clinical depth or staffing needed to manage high-acuity patients without hospital backup. Payment models have improved but may not fully support the infrastructure required for continuous monitoring or after-hours coverage. Moreover, social determinants, like lack of family caregivers or inadequate home supports, can complicate discharge planning and contribute to readmissions even when clinical care is appropriate.

The COVID-19 pandemic further emphasized the need to reduce unnecessary hospital transfers. During the height of the crisis, keeping residents stable and safely managed within SNFs was essential for protecting vulnerable populations from exposure and preserving hospital capacity. In response, many SNFs strengthened infection control, established COVID-specific wings, and deepened partnerships with local health systems. These emergency adaptations may have accelerated a broader rethinking of how and when residents are transferred to higher levels of care.

Looking ahead, reducing readmissions will remain a cornerstone of SNF accountability. Future iterations of the SNF VBP program will likely incorporate multiple quality measures and risk-adjusted metrics to better capture complexity and equity. Meanwhile, states and payers are exploring integrated payment models that provide SNFs with the flexibility and resources needed to support long-term stabilization, not just short-term recovery.

What Quality Means in Skilled Nursing: Redefining Excellence Beyond Compliance

For decades, “quality” in skilled nursing facilities was primarily defined by compliance, and included following rules, avoiding citations, and meeting minimum standards set by regulatory agencies. Facilities were rated by survey results, staffing ratios, and adherence to infection control protocols. While these metrics remain important, the rise of value-based payments has introduced a broader and more meaningful definition of quality that centers outcomes, person-centered care, and resident experience.

Under the traditional model, issues were identified after they occurred, usually during annual surveys or in response to complaints. In contrast, value-based care requires a more proactive and dynamic approach. Facilities are now expected to track and respond to real-time data, collaborate with other providers, and design care systems that consistently deliver better results for the people they serve.

This shift has prompted facilities to invest in tools that measure quality across multiple domains. The Skilled Nursing Facility Quality Reporting Program (SNF QRP) requires reporting on indicators such as functional status, discharge to community rates, and incidence of pressure ulcers. Meanwhile, the SNF Value-Based Purchasing Program focuses on reducing 30-day hospital readmissions, with plans to expand into broader performance areas. Together, these programs have helped reframe quality as a continuous process of improvement, rather than a static checklist.

Still, many experts argue that current quality metrics do not fully reflect what matters to residents and families. Quality must also account for the lived experience of residents. This includes dignity, autonomy, meaningful social engagement, and alignment with personal health goals. For instance, a resident recovering from a hip fracture may care less about their charted ambulation score and more about whether they feel safe, understood, and supported during their stay.

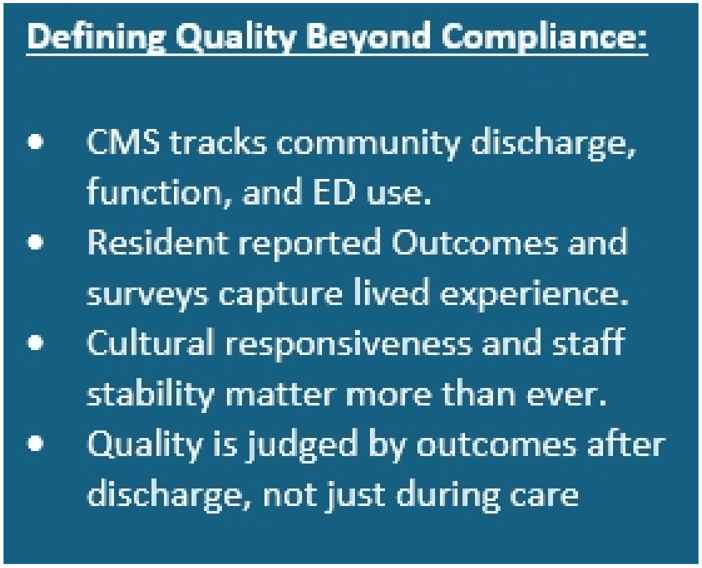
To respond to this evolving definition of quality, some SNFs are integrating patient-reported outcome measures and satisfaction surveys into their care processes. These tools give residents and families a direct voice in evaluating care. Are pain levels being managed effectively? Are staff respectful and responsive? Do residents understand their care plan and feel prepared for discharge? These are the questions that define quality from the consumer’s perspective, and they are increasingly being used in facility improvement plans.

Another key element of quality in a VBP environment is care coordination. High-performing SNFs now operate as hubs in a larger care network. They maintain relationships with hospitals, primary care providers, home health agencies, and community-based organizations. Quality is no longer measured solely by what happens within the facility’s walls, but also by how smoothly and safely residents transition in and out of care. Metrics like discharge to community, medication reconciliation post-discharge, and avoidable emergency department use are becoming essential markers of system-level quality.

Cultural responsiveness has also emerged as a vital dimension of quality. Many SNFs serve diverse populations with varied languages, religious practices, and expectations around care. Facilities are increasingly investing in language access services, staff training in cultural humility, and care models that honor personal identity. This evolution is especially important as quality measurement begins to include equity-linked metrics that identify and address disparities in outcomes.

Staff stability is another critical, if underrecognized, component of quality. High turnover among direct care workers can erode continuity, weaken trust, and increase the risk of errors. Research has shown that facilities with lower turnover and higher staffing levels tend to perform better on a wide range of quality measures. In response, some states have tied workforce investments to quality-based incentives, while others are exploring wage floors or reimbursement enhancements for facilities with demonstrated retention success.

The growing use of bundled payment models in SNF settings has also influenced how quality is defined. Under these arrangements, SNFs share accountability for outcomes and costs across an entire episode of care. This encourages providers to think beyond their walls—anticipating what residents will need after discharge, planning for home supports, and coordinating with primary care or home health.



Defining Quality Beyond Compliance:

- CMS tracks community discharge, function, and ED use.
- Resident reported Outcomes and surveys capture lived experience.
- Cultural responsiveness and staff stability matter more than ever.
- Quality is judged by outcomes after discharge, not just during care

Ultimately, defining quality in skilled nursing is no longer just about avoiding deficiencies; it is also about achieving excellence. It’s about delivering consistent, person-centered care that supports healing, honors choice, and prevents unnecessary disruption. It’s about recognizing the SNF as a critical part of the care continuum where people can recover with dignity, regain independence, and transition to the next phase of life with support and confidence.

Challenges and the Road Ahead

The transformation of skilled nursing and post-acute care under VBP is well underway, but meaningful challenges continue to shape how far and how fast the sector can evolve.

One of the most pressing issues is workforce strain. SNFs operate with limited margins and a workforce that is often underpaid, overworked, and overlooked. Staffing shortages among nurses, certified nursing assistants (CNAs), and support personnel have been exacerbated by the COVID-19 pandemic and persist as a major barrier to delivering high-quality care. Many SNFs struggle to maintain adequate staffing ratios, let alone invest in the training and team-based care infrastructure that value-based models require. Without stronger policy and funding mechanisms to support recruitment, retention, and training, the transition to VBP risks outpacing the capacity of the workforce to deliver.

Data infrastructure is another challenge. While hospitals and health systems have increasingly adopted interoperable electronic health records, SNFs often lag due to cost, complexity, or vendor limitations. This lack of connectivity undermines the coordination required under VBP models. It limits the ability to track outcomes across episodes of care, share real-time clinical information, or engage in proactive risk management. Smaller and rural facilities are particularly disadvantaged, widening the digital divide and creating inequities in care quality and access.

Measurement and incentives also remain complex. Although CMS and many states have introduced quality benchmarks for SNFs, including metrics around readmissions, mobility, infection rates, and patient satisfaction, many providers report confusion over shifting targets, delayed feedback, and limited access to actionable data. In addition, without proper risk adjustment for social factors like housing status, caregiver availability, and language barriers, SNFs serving high-need populations may be unfairly penalized. This can disincentivize providers from taking on the most vulnerable patients, deepening health disparities.

Yet, within these challenges lie opportunities to redefine recovery for the better.

Several SNFs and post-acute networks are embracing culturally responsive care as a core quality strategy. This includes hiring multilingual staff, offering interpretation services, and incorporating cultural norms into care planning. Facilities that partner with community-based organizations are better able to support patients' non-medical needs, such as food access, transportation, or home safety modifications.

Social determinants of health screening is also becoming more common in SNFs. Some organizations are piloting tools to assess patients' social needs upon admission and integrating these findings into discharge planning. For example, identifying a lack of stable housing or caregiver support can trigger early intervention and coordination with case managers or community services. By addressing these needs proactively, SNFs can reduce readmission risk and promote more sustainable transitions.

Behavioral health integration is another emerging best practice. Many SNF residents experience co-occurring cognitive, mental health, or substance use conditions that complicate recovery. Facilities that incorporate mental health clinicians, offer trauma-informed care, or partner with behavioral health providers are better positioned to manage these needs and support whole-person healing. As VBP models continue to emphasize holistic outcomes, integration of behavioral health will only grow in importance.

Looking ahead, technology and innovation are expected to play a larger role. Artificial intelligence (AI) tools are being tested to predict which patients are at highest risk for readmission or functional decline, allowing for earlier intervention. Remote monitoring, medication adherence apps, and telehealth services are also being deployed to support recovery at home after SNF discharge. When combined with strong care coordination, these tools can extend the reach of the SNF beyond its walls and promote more seamless continuity.

Perhaps most importantly, there is growing recognition that equity must be embedded in VBP design. Several new initiatives are tying payment incentives to the reduction of disparities. For example, CMS’s ACO REACH model includes requirements for health equity plans and stratified performance reporting. States like Massachusetts are linking ACO bonuses to the closing of racial and ethnic gaps in care quality. Similar principles can and should be applied to SNFs and post-acute care models. By using disaggregated data, setting equity-focused goals, and compensating providers for reducing disparities, the system can move closer to just and accountable care for all.

As we close this chapter, it is worth acknowledging how far skilled nursing has come. Once defined primarily by custodial care and per diem billing, SNFs are now increasingly recognized as strategic partners in recovery and population health. However, the road ahead requires continued investment in the workforce, infrastructure, and community partnership.

CHAPTER 6: VALUE-BASED APPROACHES IN IDD SERVICES

Introduction: Reimagining Supports for the IDD Community

For decades, systems serving individuals with intellectual and developmental disabilities (IDD) have operated within a FFS framework built on compliance, not outcomes. Funding was often tied to the quantity of services delivered—how many hours of care, how many home visits, how many forms filled out—rather than whether those services helped individuals live the lives they choose.

Yet, as the broader healthcare system has shifted toward value-based payments, the IDD sector is increasingly becoming part of the conversation. VBP asks a fundamental question: What are we getting for the resources we invest in care? In the context of IDD services, which means focusing not on how many services a person receives, but whether those services result in greater independence, community participation, and personal fulfillment.

This shift aligns with the long-standing values of the disability rights movement, including self-determination, inclusion, and dignity. However, integrating those values into payment models and accountability systems is no small feat. The diversity and complexity of the IDD population, combined with decades of institutional history and fragmented service delivery, make transformation both urgent and challenging.

Recent years have seen growing momentum across states and managed care organizations to reimagine how supports for individuals with IDD are financed and delivered. From Florida's new IDD managed care pilots to Tennessee's Employment and Community First CHOICES program, states are experimenting with performance incentives, person-centered metrics, and value-based contracts. These efforts are pushing the field beyond compliance-based oversight and toward systems that prioritize what matters most to the people served.

At the heart of this evolution is recognition that traditional approaches to quality and accountability have fallen short. As explored in the blog *Laying the Ground Work for*

VBP and I/DD, the field is now asking different questions: Are individuals with disabilities living in homes and neighborhoods they choose? Are they supported in meaningful employment? Are their voices central to care planning and system design? These are the outcomes that define a life in the community, and increasingly, they are becoming the targets of state policy and provider investment.

The road to reform has not been smooth. Concerns about managed care in the IDD population, ranging from reduced provider choice to underinvestment in high-need supports, have slowed progress in some areas. But as our blog, *IDD Managed Care Plans – What has changed?*, notes, states are learning from early missteps and incorporating stronger consumer protections, stakeholder engagement, and performance transparency into new models.

VPB Reimagining Services and Supports For the IDD Community:

- Legacy IDD services prioritized compliance over outcomes.
- VBP emphasizes independence, inclusion, and personal fulfillment.
- Person-centered metrics and state innovation are reshaping supports.
- Equity, flexibility, and empowerment are guiding the transformation.

Value-based care is not a one-size-fits-all solution, but when done well, it holds promise for delivering on the values that the IDD community has championed for decades. It offers a framework to align funding with goals like independent living, social inclusion, and long-term stability,

In this chapter, we explore how value-based payments are reshaping the IDD landscape. We examine the transition from compliance to outcomes, the rise of person-centered planning, and the new emphasis on metrics that reflect real life, not just regulatory benchmarks. We also highlight the opportunities and risks ahead as states scale these models and redefine what quality truly means for people with IDD. Because for too long, systems have focused on keeping people safe. It's time to also focus on helping people thrive.

The Legacy System—Compliance Over Outcomes

Before the emergence of value-based payment models, intellectual and developmental disability services were primarily defined by their inputs and not their outcomes. Individuals received support based on eligibility and service authorizations, with providers reimbursed for delivering specific units of care. In theory, this structure ensured accountability and access, but in practice, it often resulted in a system that was overregulated, under-resourced, and profoundly disconnected from the lives it aimed to support.

The legacy fee-for-service model in IDD care rewarded compliance with processes rather than progress toward personal goals. Providers documented hours of habilitation, personal assistance, or respite services, but those records rarely answered critical questions: Did the person build meaningful relationships? Were they working in the community? Did they feel heard in planning their care? These human-centered outcomes were often left out of the equation, not because they didn't matter, but because they weren't measured or funded.

As described in the blog *Let's Jump Back In to Managed Care in IDD*, the system was structured around "checking boxes." Audits and site reviews focused on whether paperwork was filled out correctly and whether visits occurred at the required frequency. Yet many of those interactions, while necessary, did little to help individuals move toward greater independence or self-direction. Quality, as defined by the system, had little to do with the lived experience of the people it served.

This approach has created unintended consequences. Providers learned to focus on documentation and compliance to avoid penalties. Case managers spent more time chasing signatures than coordinating meaningful services and individuals with IDD were routinely placed into slots within a system that was more focused on maintaining regulatory requirements than on meeting individual preferences.

Under this model, innovation was difficult. Providers had little flexibility to tailor supports or explore non-traditional strategies for helping individuals build skills, find employment, or engage in their communities. Funding mechanisms were tied to rigid service definitions, leaving little room to invest in social determinants of health, assistive technology, or peer-based supports. Even when individuals voiced new goals, the system was not designed to shift with them.

The *IDD Managed Care Update* blog highlighted how this compliance-based system also reinforced inequities. Individuals from marginalized communities, rural areas, or underrepresented language groups often face greater barriers to accessing services that fit their needs. Yet because success was not measured by equitable outcomes, these gaps were rarely addressed with the urgency they required. Instead, providers were incentivized to focus on volume and consistency and not personalization or impact.

The problem wasn’t lack of commitment from providers or professionals. Many in the field entered this work with a deep desire to support people with disabilities in living whole, self-determined lives. Unfortunately, the structure they operated within constrained that mission and the system’s metrics didn’t align with its values.

In addition, the reliance on historical models of service delivery—including sheltered workshops, group homes, and day habilitation centers—reinforced outdated norms about what life for a person with IDD “should” look like. While person-centered language became more common, the underlying infrastructure often remained the same. Funding and oversight continued to prioritize safety and containment over opportunity and growth.

That is not to say the legacy system provided no benefit. For many individuals and families, it offered access to much needed supports that weren’t available elsewhere. But it was not built for continuous improvement or responsive design. It was built to deliver defined services within a tightly regulated framework and to document that delivery more than anything else.

The limitations of this model became increasingly evident as the broader healthcare system moved toward outcomes-based reimbursement. While sectors like primary care, behavioral health, and long-term services and supports began aligning payments with value, the IDD system lagged. Its unique complexity and vulnerability to unintended harm made states understandably cautious about adopting sweeping reform.

Yet the call for change has grown louder. Self-advocates, families, and disability organizations have long argued that measuring hours of service does not equate to measuring quality of life. They have pushed for a shift toward funding what matters: relationships, autonomy, housing stability, and inclusion. These are not “soft” goals, they are the foundation of what it means to thrive in the community.

The transition from compliance to outcomes is still in progress. But states and providers are beginning to understand that a system focused on documenting services cannot truly support a well-lived life. It’s not enough to ask, “Was the service delivered?” We must shift our frame of thinking to ask, “Did it make a difference?”

Elevating Person-Centered Planning: Supporting Lives, Not Just Services

At the heart of the value-based transformation in intellectual and developmental disability services lies a deceptively simple question: What does the individual want? For decades, this question was often secondary, if asked at all. Now, as the IDD field shifts toward outcomes-based care, person-centered planning has emerged not just as a philosophy, but as an operational strategy for aligning supports with what matters most to each person.

Person-centered planning (PCP) is not new. It has long been a required component of Medicaid home- and community-based services (HCBS) waivers, and it has been championed by self-advocates and disability rights organizations for decades. What's changed in the era of VBP is that person-centered planning is gaining traction as a measurable, accountable foundation for service delivery and payment. Instead of simply recording a person's goals in a document that sits on a shelf, systems are beginning to tie funding to whether those goals are actively supported and achieved.

As described in the blog *A New Era of Medicaid Managed Care: Transforming IDD Care in Florida*, the state's new managed care model includes contractual language that emphasizes meaningful engagement with individuals and families in the care planning process. Health plans are expected not just to complete a plan of care, but to ensure that they reflect the person's preferences and life aspirations. This signals a significant shift that person-centered planning is no longer a compliance task, it's becoming a quality metric.

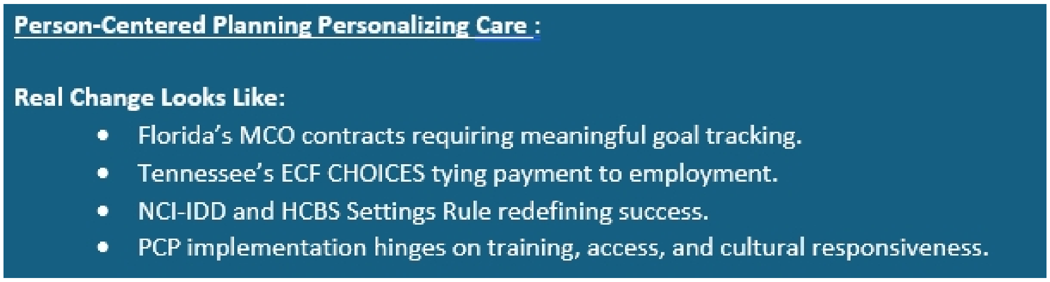
This evolution builds on broader policy changes, including the federal HCBS Settings Rule, which requires that services be delivered in a manner that supports community integration, individual rights, and autonomy. At the same time, states and national initiatives are testing new ways to measure whether person-centered goals, such as employment, housing choice, and social inclusion, are being met. The *NCI-IDD (National Core Indicators for IDD)* suite, for example, includes outcomes like "Does the person have control over daily decisions?" and "Does the person have friends and relationships?"

In our blog *IDD & LTSS Sectors Getting a Boost from Value-Based Payments*, we noted that states like Tennessee and Maine have been piloting approaches that move beyond tracking service hours to understanding whether services support life outcomes. Tennessee's Employment and Community First CHOICES program, for instance, explicitly ties some payments to measures like community-based employment and reduced institutionalization. These measures are grounded in person-centered planning and reflect a broader understanding of what success looks like.

One of the challenges in embedding PCP into VBP is ensuring that providers, case managers, and health plans have the necessary training and infrastructure to implement it effectively. Person-centered planning is not simply a form or checklist. It's a facilitated, collaborative process that requires listening, empathy, and flexibility. It often means creating supports that don't fit neatly into a billing category, like helping someone explore a new hobby, reconnect with a sibling, or volunteer. These goals may not be "medical" or "habilitative," but they are core to a meaningful life.

To make this work in a value-based system, states are beginning to fund service coordination roles more adequately, develop tools for tracking goal achievement, and require managed care organizations to incorporate PCP into their contract oversight. Some are experimenting with electronic person-centered plans that directly link goals to service authorizations, making it easier to determine whether a person's services align with their stated desires.

However, person-centered planning must also grapple with issues of power and bias. Too often, people with IDD, especially those with limited communication abilities or those from marginalized communities, have not been included meaningfully in decisions about their care. Instead, systems have defaulted to planning "for" people instead of "with" them. Accurate person-centered planning requires systems to slow down, create accessible processes, and honor the dignity of risk. It means accepting that the individual is the expert on their own life, even when professionals disagree with their choices.



Person-Centered Planning Personalizing Care :

Real Change Looks Like:

- Florida's MCO contracts requiring meaningful goal tracking.
- Tennessee's ECF CHOICES tying payment to employment.
- NCI-IDD and HCBS Settings Rule redefining success.
- PCP implementation hinges on training, access, and cultural responsiveness.

This approach is also deeply tied to equity, and systems must address cultural, linguistic, and systemic barriers that prevent some individuals from fully participating in the care planning process. For example, a Spanish-speaking family may not feel comfortable advocating for specific goals if meetings are not held in their language. A person of color may hesitate to share their real interests if previous experiences with providers have been dismissive or discriminatory. Embedding person-centered planning into a value-based framework requires training, outreach, and cultural responsiveness to ensure that everyone's voice is truly heard.

Ultimately, person-centered planning is about more than aligning care with individual preferences. It is a mechanism for shifting power. It forces systems to step back from rigid categories and ask: "Is this helping the person move closer to the life they want?" In a value-based system, that question becomes central to both how services are designed and how providers are paid.

Empowerment Through Outcome-Based Models: How Value-Based Payments Shift the Power Dynamic

For people with intellectual and developmental disabilities, empowerment is more than a buzzword—it is a right and a guiding principle of modern disability policy. Yet for far too long, the systems designed to support this community have been shaped more by provider convenience and regulatory compliance than by consumer choice. Value-based payments are beginning to shift this dynamic. By tying payment to meaningful outcomes rather than service volume, these models are creating new incentives to empower individuals with IDD to direct their lives, participate in their communities, and achieve personal goals.

This shift represents a profound rebalancing of power. Under traditional models, individuals with IDD often had little say in how services were structured, who provided them, or whether they aligned with their aspirations. Once assessed for a level of need, services were "assigned," not co-designed. Value-based systems seek to turn that around. By rewarding progress toward individualized goals, rather than hours of service delivered, these models give consumers more influence over the care they receive.

As discussed in the blog *How Florida is Aiming to Make Managed Care Work for Individuals with IDD*, the state's pilot program requires managed care organizations (MCOs) to develop outcome-based care plans and monitor consumer progress toward goals such as employment, housing stability, and community inclusion. Payments are structured to reflect more than just service delivery, they account for consumer satisfaction, independence, and engagement. This approach encourages providers to ask better questions: What does success look like for this person? What will it take to help them get there?

One of the most significant changes in this model is the use of performance-based incentives. Rather than simply reimbursing providers for a fixed number of hours or visits, VBP contracts may include withholds or bonuses tied to outcomes like competitive integrated employment, reduced reliance on institutional settings, or improved quality of life scores. In Florida's case, health plans are scored on their ability to help individuals achieve person-centered goals, and that score affects future contract payments.

The blog *Quality Measures for the I/DD and MLTSS Communities*, highlights a growing effort to define and standardize what meaningful outcomes look like in IDD services. These include both objective indicators like days worked, number of social activities, or housing status, and subjective metrics, like consumer-reported satisfaction, sense of autonomy, and trust in support staff. States and national organizations are working to build robust measurement systems that can reliably capture these dimensions and use them to drive funding decisions.

Employment is one of the clearest examples of this approach. In traditional systems, people with IDD were often funneled into segregated day programs or sheltered workshops with little opportunity to pursue real work for real pay. Under VBP models, however, competitive employment is increasingly viewed as a core health outcome. Programs like Tennessee's Employment and Community First CHOICES offer performance bonuses for helping individuals find and maintain jobs in the community. Providers are supported to invest in job coaching, employer engagement, and skills development, all of which become financially sustainable under a value-based framework.

This shift also supports self-direction and consumer control. Value-based payment opens the door to funding more flexible and individualized services, including those managed by the person receiving care. Self-direction programs, where individuals hire their own staff and manage their own budgets, are a natural fit for systems that reward outcomes over standardized service packages. As states redesign their VBP strategies, many are exploring how to expand these options, especially for people who have been historically excluded from formal decision-making.

However, there is also a need to address potential pitfalls. Tying payment to outcomes can backfire if models are not carefully risk-adjusted or inclusive. For example, individuals with more significant disabilities, limited family support, or complex behavioral needs may require more time and effort to achieve specific goals. If providers are penalized for working with high-need individuals, it can create perverse incentives to "cherry-pick" easier cases or reduce access to those who need the most support. States must ensure that value-based models are equitable, transparent, and flexible enough to accommodate diversity across the IDD population.

Empowerment is no longer just a value statement. It is becoming a measurable objective. Through outcome-based models, individuals with IDD are gaining more tools, more control, and more opportunities to shape their own lives. And for a population that has too often been excluded from the design of the systems that serve them, that is real progress.

Innovation Across States: State-by-State Experiments in Value-Based IDD Care

While federal policies have encouraged the adoption of value-based payments in Medicaid, the transformation of IDD services has primarily been driven by state-level innovation. From pilots in Florida to broader system redesigns in Tennessee and Arizona, states are experimenting with how to align person-centered goals, quality measurement, and funding. Though the models vary widely, the underlying vision is shared: to move beyond compliance and toward services that empower individuals with IDD to live meaningful lives in the community.

In Florida, a wave of reform began with the state's managed care pilot for individuals with IDD. The pilot required participating managed care organizations to not only provide traditional services but also to document and report on individualized outcomes such as increased independence, competitive employment, and access to integrated community activities. This outcome-based approach was additional territory for Florida, which had long relied on fee-for-service models that emphasized service quantity over life impact.

To make this shift work, Florida focused on strengthening its quality oversight tools. The state's Agency for Health Care Administration implemented performance-based contracts that rewarded MCOs for engaging in person-centered planning, meeting equity benchmarks, and collaborating with community-based organizations. Importantly, these changes were not only about payment, but they also created a culture shift among providers, who began to view quality as something shaped by consumer goals rather than agency policies.

Tennessee's Employment and Community First (ECF) CHOICES program remains one of the most advanced examples of IDD-focused value-based care. In this model, providers are held accountable for progress toward individualized outcomes, such as stable housing, reduced hospitalizations, and community-based employment. ECF CHOICES integrates care coordination, employment supports, and personal assistance under a managed care umbrella, enabling flexible funding and service delivery. While Tennessee's model has faced challenges in scaling up access and ensuring sufficient provider networks, its clear outcome orientation has made it a national model.

In Arizona, long a pioneer in Medicaid managed care, the Arizona Long Term Care System–Developmental Disabilities (ALTCS-DD) program blends managed care with longstanding principles of person-centered service delivery. As highlighted in our blog *Local Engagement in IDD Managed Care with AZ and MI*, the state contracts with a single MCO to deliver all IDD services statewide. This allows for strong accountability, integrated financing, and streamlined oversight. The plan is expected to track member satisfaction, independence goals, and quality of life as part of its future outcome-based strategy.

Other states are building value-based strategies into their IDD services more gradually. In Iowa, for example, managed care implementation has been controversial, with advocates raising concerns about reduced provider access and inconsistent care planning. However, the state has committed to building stronger oversight and transparency into its contracts with MCOs. North Carolina is rolling out Tailored Plans to serve people with complex behavioral and developmental needs, with quality targets tied to employment, housing, and crisis prevention.

Texas offers another unique example with its STAR+PLUS Pilot Program (SP3), which introduces performance-based contracting and data collection for providers serving individuals with IDD. Though still in the early stages, SP3 represents a deliberate step toward aligning funding with outcomes in a fee-for-service environment. By building a shared understanding of what success looks like, Texas is laying the groundwork for more robust VBP models in the future.

As summarized throughout our blogs, these state efforts reveal several common threads:

- Flexibility is essential
- Measurement drives improvement
- Stakeholder engagement matters
- Infrastructure is key

Yet no single model has all the answers. States are still grappling with how to fairly adjust for risk, avoid adverse selection, and fund the supports that people need to thrive. Still, the momentum is real. In the past, IDD services were often the last segment of Medicaid to adopt new models. Today, they are becoming a proving ground for what person-centered, value-based care can look like when thoughtfully applied. As more states pilot, test, and refine their approaches, they are generating a body of knowledge—and a set of expectations—that will shape the future of disability services nationwide.

Lessons Learned and the Road Ahead: Building Systems That Support a Life in the Community

The shift to value-based payment in IDD services has opened new possibilities, but it has also surfaced long-standing barriers that cannot be ignored. As states design and implement outcome-based models, it has become clear that while value-based care holds great promise for supporting independence, choice, and inclusion, that promise is not automatic. It requires sustained investment, equity-minded design, and a deep commitment to elevating the voices of consumers.

Among the most pressing challenges is workforce capacity. Direct support professionals (DSPs) form the backbone of IDD services, yet many are underpaid, undertrained, and underappreciated. Value-based models rely on DSPs to implement person-centered goals, support independence, and foster relationships, but systemic workforce shortages make it challenging to deliver. If VBP programs do not account for the recruitment, retention, and support of the workforce, they risk reinforcing the very gaps they aim to solve.

Another critical challenge is data infrastructure. Most states still lack reliable, standardized systems for collecting outcomes that truly reflect quality of life. While traditional healthcare measures are robust, IDD services require different types of metrics, such as community integration, employment satisfaction, relationship-building, and personal autonomy. These measures are inherently more subjective and more complex to quantify, but they are essential to meaningful reform.

Risk adjustment is also an ongoing concern. Outcome-based payment models must be calibrated to recognize that individuals with more complex disabilities may need longer timelines, more flexible service options, or specialized supports. Without appropriate adjustments, providers serving the highest-need individuals may face financial penalties or be incentivized to avoid them altogether. That's not value-based care, it's risk aversion masquerading as accountability.

And yet, there is a great deal of hope and momentum. Emerging practices are demonstrating how to move the system forward in inclusive and responsive ways. For example, some states are piloting shared savings models in which providers who help individuals achieve employment or housing goals share in the financial benefits of reduced institutional or crisis service use. Others are offering outcome-based grants or incentives for community engagement, transportation access, and culturally specific peer networks.

Similar to other sectors across the healthcare landscape, technology is playing a growing role. AI and data analytics are helping to identify gaps in services, track quality at the population level, and personalize care coordination. However, these tools must be applied with care. If not designed with equity in mind, algorithms can perpetuate bias, exclude underrepresented communities, or prioritize cost-efficiency over consumer outcomes.

Why Risk Adjustment Matters in Value-Based IDD Care

- People with significant disabilities may require **longer timelines** to reach goals
- Their care plans often involve **more intensive, flexible, and specialized supports**
- Without adjustments, systems may **incentivize avoidance** of high-need individuals

VBP cannot not reward simplicity over impact.
Risk adjustment is essential to ensure equity, protect access, and uphold the promise of person-centered care.

Another promising development is the increasing recognition of community health workers, peer mentors, and family navigators as vital contributors to value-based models. These roles offer culturally grounded, trust-based support that bridges the gap between systems and lived experience. States like Michigan and Tennessee are exploring how to formally include these supports in contracts.

So, what lies ahead? The most successful value-based systems for the IDD community will be those that prioritize three guiding principles:

1. Flexibility: honoring the unique goals, timelines, and preferences of each individual
2. Transparency: using clear, meaningful measures to track whether the system is working
3. Co-creation: building systems not just *for* people with IDD, but *with* them, at every stage

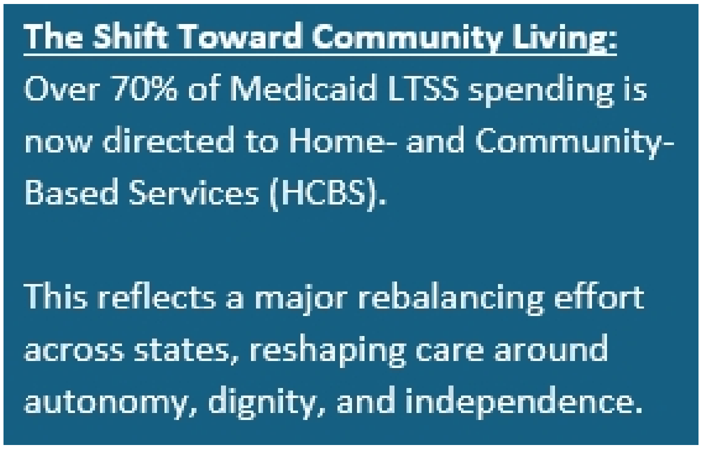
As this chapter has shown, the IDD field is moving from compliance-based care to outcomes-driven systems grounded in dignity, choice, and belonging. While this shift is still evolving, early efforts in Florida, Tennessee, Arizona, and beyond prove that transformation is possible. It is no longer enough to ask whether services were delivered; we must also consider whether they were delivered effectively. We must ask whether those services helped someone live the life they choose.

CHAPTER 7: LONG-TERM SERVICES AND SUPPORTS (LTSS)

Introduction: Reimagining Independence Through LTSS

Long-Term Services and Supports (LTSS) represent one of the most critical and often overlooked components of the U.S. healthcare system. For millions of older adults, people with disabilities, and those managing chronic or complex conditions, LTSS is not just an add-on to medical care; it's the cornerstone of daily life. Whether it's assistance with dressing, bathing, preparing meals, or managing medications, these services enable individuals to live with dignity, autonomy, and a sense of connection to their communities.

Historically, LTSS has been delivered through institutional settings such as nursing homes and intermediate care facilities. These environments often prioritized efficiency over personal choice and reinforced a model of care rooted in dependency rather than empowerment. But in recent years, a shift has begun. Fueled by Medicaid innovations and value-based payment initiatives, long-term services and supports are being reimagined to prioritize home- and community-based services, person-centered care, and greater consumer control.



The Shift Toward Community Living:
Over 70% of Medicaid LTSS spending is now directed to Home- and Community-Based Services (HCBS).

This reflects a major rebalancing effort across states, reshaping care around autonomy, dignity, and independence.

At the center of this shift is Managed Long-Term Services and Supports (MLTSS), a model that integrates long-term services and supports into managed care delivery. MLTSS aligns funding and incentives to promote independence, prevent unnecessary institutionalization, and improve health outcomes for beneficiaries. By rewarding providers for keeping individuals safely at home, coordinating care across settings, and achieving person-centered goals, MLTSS is helping redefine what quality truly means in long-term care.

This chapter explores how MLTSS is advancing equity and independence through state-led innovations, new quality measures, and emphasizes self-direction. We'll examine what's working, where challenges remain, and how to best serve those who rely on it most.

MLTSS and the Shift Toward Person-Centered Independence

The emergence of Managed Long-Term Services and Supports has brought about a significant shift in how long-term care is delivered in the United States. Traditionally, LTSS was funded on a fee-for-service basis, where each medical task or service, regardless of quality or outcome, was reimbursed separately. This model often incentivized volume over value, favoring institutional placements that were easier to bill for, even when individuals would have preferred to remain in their homes and communities. MLTSS disrupts that pattern by embedding LTSS into Medicaid managed care programs and holding plans accountable for outcomes that matter to consumers.

At the heart of MLTSS is a growing recognition that long-term services are not just about managing decline but about supporting life and independence. This means recognizing that an older adult who needs help bathing, or a person with a disability who requires a home health aide, still has the right to autonomy, choice, and self-direction. Person-centered care is no longer a buzzword. Through VBP models, it is becoming an operational requirement. States implementing MLTSS must ensure that managed care organizations deliver care through individualized service plans that reflect each member's goals, preferences, cultural identity, and desired level of independence.

To meet these expectations, many MCOs now employ interdisciplinary care teams and assign care managers who work directly with members to assess needs, plan services, and monitor outcomes. These care managers are trained not only to identify clinical risks but also to understand the social and environmental context of each person's life. Does the individual have reliable transportation? Do they feel safe at home? Do they have access to fresh food or opportunities to engage with their community? The answers to these questions are often more predictive of well-being than clinical metrics alone.

A key advancement in MLTSS is the use of value-based payment arrangements within the managed care structure. Instead of paying providers or health plans solely based on the number of services rendered, states are increasingly tying a portion of payments to performance metrics such as reducing hospital readmissions, preventing institutionalization, and increasing member satisfaction. In Tennessee's ECF CHOICES program, for example, payment incentives are tied directly to helping individuals with IDD find and keep competitive employment, which is something that would have been considered outside the scope of healthcare a decade ago.

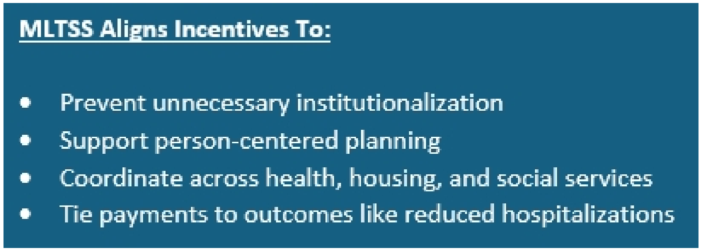
MLTSS also enables more efficient coordination across service systems. Individuals who require long-term services and supports often have complex needs that span multiple areas, including healthcare, behavioral health, housing, transportation, and nutrition. Under managed care, there is an opportunity, and a financial incentive, to connect these dots. Care coordinators are empowered to refer individuals to community-based organizations, apply for rental assistance, or secure respite care for family caregivers. These supports reduce avoidable hospitalizations and improve quality of life, aligning both the health plan's bottom line and the individual's lived experience.

Significantly, MLTSS models also elevate the role of consumer feedback. Several states now incorporate member experience surveys and quality-of-life measures into plan evaluations. For example, states may use the HCBS CAHPS to measure how well plans respect individual preferences, support autonomy, and communicate with members. These metrics serve as a reminder that success in LTSS isn't just about medical outcomes. It's also about helping people live the lives they choose, with the supports they need.

As more states expand or refine their MLTSS programs, the model continues to evolve. Some are layering in value-based provider contracting within MCOs, others are integrating behavioral health and LTSS under a single contract, and many are experimenting with new ways to measure community integration and social connectedness. What unites these efforts is the understanding that value in LTSS cannot be measured in units of service alone. Independence, connection, and consumer control must also be taken into account. Because when done right, MLTSS transforms long-term care from a system of dependency to one of empowerment.

State Spotlights: What's Working in MLTSS

Across the country, states are reimagining how long-term services and supports can be delivered more effectively, efficiently, and compassionately through Managed Long-Term Services and Supports (MLTSS) programs. While every state's Medicaid program operates under different waivers, populations, and political climates, a few have emerged as national leaders in implementing MLTSS with value-based principles that prioritize outcomes over volume and independence over institutionalization.



MLTSS Aligns Incentives To:

- Prevent unnecessary institutionalization
- Support person-centered planning
- Coordinate across health, housing, and social services
- Tie payments to outcomes like reduced hospitalizations

Tennessee is frequently cited as one of the most innovative states in this space, primarily due to the evolution of its CHOICES and Employment and Community First (ECF) CHOICES programs. CHOICES serves older adults and individuals with physical disabilities, while ECF CHOICES focuses on people with intellectual and developmental disabilities. What sets Tennessee apart is its explicit integration of value-based payment within Managed Long Term Services and Supports. In ECF CHOICES, provider payments are directly tied to helping people find and maintain employment or independent housing, which are goals that go far beyond traditional medical benchmarks. The results are evident, with reports showing that 24% of individuals in ECF CHOICES receiving employment supports have secured competitive jobs —a remarkable feat for a population historically excluded from the workforce. These metrics are not only tracked but incentivized, signaling a meaningful redefinition of what “success” looks like in LTSS.

Arizona has long been considered a pioneer in managed care for long-term services and supports, with the Arizona Long Term Care System (ALTCS). ALTCS contracts with both for-profit and non-profit health plans to provide comprehensive, capitated services for individuals requiring institutional levels of care, most of whom now receive those services at home or in the community. The state’s early embrace of full-risk managed care, along with its consistent rebalancing efforts (shifting care away from institutional settings), has led to impressive HCBS penetration rates. Arizona also uses encounter data and member satisfaction surveys to evaluate MCO performance, rewarding plans that meet benchmarks in preventive care, care coordination, and consumer satisfaction.

In New York, the state’s Managed Long Term Care (MLTC) program represents a large-scale experiment in delivering long-term services and supports through partially capitated plans that coordinate Medicaid LTSS for dually eligible individuals. While the program has faced oversight challenges, it has also incorporated value-based contracting into its design. Plans are required to enter into VBP arrangements with a percentage of their provider network, including arrangements at Level 2 and Level 3 (i.e., shared savings and full-risk models). This pushes provider organizations to think holistically about their members' needs and design services that reduce avoidable hospitalizations, improve care transitions, and elevate member engagement.

Pennsylvania has emerged as another strong example through its Community HealthChoices (CHC) program, which provides long-term services and supports for older adults and individuals with physical disabilities. CHC emphasizes rebalancing and consumer choice, requiring MCOs to demonstrate that more than half of their long-term services and supports population is being served in the community. The program also includes performance metrics related to nursing facility transitions, participant satisfaction, and care coordination. In the early years of CHC, the state saw a notable uptick in individuals successfully transitioning out of institutional care, a clear indication that managed care was being used as a tool to expand, not restrict, access to community living.

North Carolina is preparing to launch its Tailored Plans, which will integrate physical health, behavioral health, and long-term services and supports under a single managed care entity for individuals with complex needs. Although still in the early stages, the state has emphasized the importance of whole-person care and community-based supports in the development of these plans. The state's prior experience with the Innovations Waiver, which supports individuals with intellectual and developmental disabilities (IDD), has laid a foundation for personalized, flexible services that are expected to be enhanced through Managed Long Term Services and Supports and value-based structures.

It's clear when looking at these different models that there is not a one-size-fits-all formula, but each is using managed care and VBP as a vehicle for transformation. Each state has tailored its approach to local needs and population priorities. Still, all are moving in the same direction: away from institutional care as the default, and toward systems that promote community integration, self-determination, and outcome accountability.

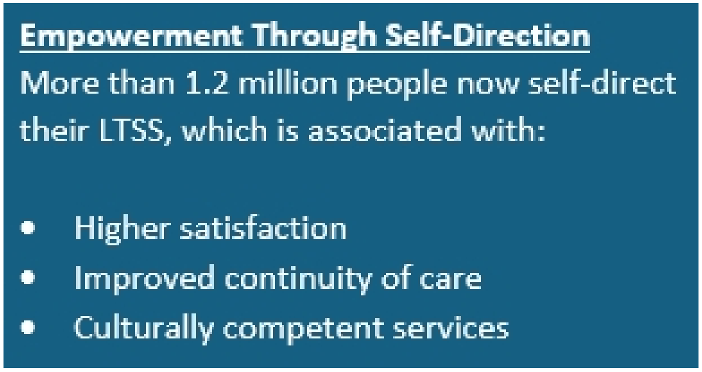
While challenges remain—including rate setting, oversight, workforce shortages, and ensuring access in rural areas—these state models demonstrate that MLTSS can be more than a financing mechanism. It can be a platform for person-centered reform. By tying payments to what matters to people and designing systems that reward flexibility and innovation, states can reshape long-term services and supports to support autonomy, independence, and quality of life.

Empowering Consumers Through Self-Direction

At the heart of the value-based transformation in long-term services and supports lies the simple idea that individuals should have control over their own lives. Self-direction, also known as consumer-directed care, empowers individuals to choose who provides their services, when and how those services are delivered, and in many cases, the ability to manage their budgets. In a system that has historically prioritized institutional convenience over personal preference, self-direction is truly revolutionary.

Self-direction aligns naturally with the core principles of value-based care: dignity, autonomy, satisfaction, and outcomes that reflect the consumer's own goals. Under traditional models, care decisions were often made by agencies or case managers, leaving individuals with limited say over who entered their homes or how their days were structured. However, when people are empowered to hire family members, neighbors, or trusted aides, to train them directly, and to manage their service hours, the care becomes more personalized, consistent, and trusted.

Federal policy has long supported self-direction through mechanisms such as 1915(c) Home and Community-Based Services (HCBS) waivers, 1915(j) State Plan options, and more recently, Section 1115 demonstrations. The 2002 Independence Plus initiative by CMS helped states create infrastructure for consumer control, and in recent years, the pandemic reinforced the value of flexible, home-based service delivery. As workforce shortages escalated and institutional settings became high-risk environments, the ability to direct care at home wasn't just a philosophical preference—it became a lifeline.



Empowerment Through Self-Direction

More than 1.2 million people now self-direct their LTSS, which is associated with:

- Higher satisfaction
- Improved continuity of care
- Culturally competent services

Self-direction models typically fall into two categories: authority over employer and budget authority. Under employer authority, individuals select, hire, train, and schedule their caregivers. Under budget authority, they manage a flexible service budget with assistance from a financial management services (FMS) entity, also known as fiscal intermediaries (FI). Some states, such as California, offer both options under their In-Home Supportive Services (IHSS) program, which is one of the most extensive self-directed programs in the country. Others, like Kansas, integrate self-direction into their broader MLTSS framework through KanCare, giving participants a high degree of flexibility while still operating under managed care oversight.

Importantly, self-direction is not only about administrative control. It is also about redefining the role of the consumer. People who direct their care often report higher satisfaction, better continuity of support, and a stronger sense of identity. This is especially true for individuals from historically marginalized communities, who may feel more comfortable receiving care from someone who understands their cultural or linguistic background. In this way, self-direction becomes a tool for both equity and engagement.

However, self-direction is not without its challenges. Many individuals need support navigating employer responsibilities such as background checks, payroll, and training. States must strike a balance between flexibility and safeguards to ensure safety, prevent exploitation, and maintain quality. Financial management services and fiscal intermediaries are essential infrastructure to help individuals succeed, but not all programs offer sufficient assistance. Furthermore, as states push toward managed care, integrating self-direction into MLTSS plans requires careful alignment of roles, responsibilities, and funding streams.

Still, the momentum is growing. According to data from 2023, more than 1.2 million individuals are now using some form of self-directed services across the country, and that number continues to rise. States are expanding their self-direction options within MLTSS to meet consumer demand and respond to workforce shortages. Plans that embrace these models report not only improved satisfaction but also fewer service disruptions, lower turnover, and in some cases, lower costs.

Ultimately, empowering consumers through self-direction is one of the clearest ways to ensure that value-based LTSS honors its promise to put people first. It represents a shift in power, from systems to individuals, and reminds us that the person receiving care is not just a passive recipient but an active agent in their own life. In a field often defined by regulation and compliance, self-direction restores the most important outcome of all: control.

The Future of LTSS in a Value-Based System

As the healthcare system continues to pivot toward value over volume, the transformation of long-term services and supports is essential. The future of LTSS will be shaped by how well we can align payment models with what individuals want, which is the ability to live independently, make their own choices, and receive care in the least restrictive setting possible. For value-based care to succeed in this space, it must go beyond medical outcomes and focus on quality of life, community integration, and equitable access.

One of the most promising developments in this direction is the increasing integration of physical health, behavioral health, and long-term services and supports under unified managed care contracts. States such as North Carolina, Pennsylvania, and Arizona are leading this effort, developing integrated programs that account for a person's full range of needs. This approach prevents fragmentation and enables better care coordination, particularly for individuals with complex or co-occurring conditions. In a value-based environment, these integrated models enable states and health plans to design cross-sector interventions—like combining in-home nursing with social work visits or pairing personal care attendants with behavioral health supports—that would have been nearly impossible to coordinate under fee-for-service silos.

Another essential element is the development and refinement of HCBS-specific quality measures. For years, policymakers and advocates struggled with the fact that LTSS quality was often measured using medical proxies, such as hospital readmissions or emergency room visits. Today, new tools like the Home and Community-Based Services Consumer Assessment of Healthcare Providers and Systems and the National Core Indicators (NCI) are helping states and Managed Care Organizations (MCOs) track what really matters to people: choice and control, respect and dignity, the ability to participate in community life, and satisfaction with services. Embedding these tools into managed care contracts and VBP arrangements gives real weight to the consumer voice and ensures that people are receiving the type of care they deserve and want.

Social determinants of health will also play a significant role in the value-based long-term services and supports landscape. Many people who use LTSS face barriers beyond their disability or diagnosis: they may be isolated, living in poverty, experiencing housing instability, or lacking access to reliable transportation. Value-based models offer a financial structure to address these non-medical drivers of health. States like Pennsylvania and California are incorporating housing supports, nutrition programs, and caregiver respite into MLTSS contracts, which are services that may not be traditionally reimbursed in a clinical model but are essential to preventing institutionalization and improving well-being.

Consumer-directed care will continue to evolve as well. As more people express interest in managing their services, technology will play a vital role in simplifying administration, offering real-time communication with support brokers, managing timesheets, and ensuring compliance with Medicaid requirements. Mobile platforms, voice assistants, and digital planning tools will increasingly empower people to make decisions on their terms without needing to navigate a labyrinth of forms, phone calls, and intermediaries.

Yet as we move forward, challenges remain. Workforce shortages continue to threaten the availability of reliable caregivers. Many direct support professionals and personal care aides earn low wages, receive limited training, and experience high turnover rates, creating instability for individuals who rely on their support. To make a genuinely sustainable, value-based long-term services and supports system, payment models must also reward and support the workforce, not just through rates, but also through training, advancement pathways, and meaningful recognition.

Ultimately, health equity must be at the forefront. Black, Indigenous, and People of Color (BIPOC) communities, immigrants, and LGBTQ+ individuals are often underserved in traditional LTSS programs and may face additional barriers to culturally competent care. Value-based programs must explicitly measure and address disparities across race, ethnicity, language, and geography. This includes disaggregated data collection, equity-focused incentives, and inclusion of marginalized voices in planning and oversight.

The future of LTSS within a value-based system holds promise, but only if we stay focused on what matters most: the lives, choices, and dignity of the people we serve. LTSS are often thought of as peripheral to the healthcare system, but for millions of people, LTSS *is* the system. It's the difference between living at home and in an institution, between community participation and social isolation, between autonomy and dependence.

While Managed LTSS programs have emerged as a powerful tool to modernize how we deliver and pay for long-term care, for the transformation to take root systemwide, challenges must be addressed head-on: stabilizing the workforce, ensuring equity across populations, and embedding non-medical supports into care coordination. We must also continue to collect and act on feedback from those who rely on LTSS, recognizing that lived experience is the most critical data point we have.

Ultimately, elevating LTSS within value-based care isn't about creating something new; it's about leveraging existing resources. It is about finally giving full weight to what has always mattered: dignity, independence, and choice. When we align payment with people's goals and build systems around their voices, we do more than deliver care—we support thriving lives.

CHAPTER 8: HOME HEALTH AND HOME CARE

Introduction: Bringing Healthcare Home

Healthcare is undergoing a fundamental transformation, and at the center of that change is the home. What was once considered a setting for only the most basic medical services or end-of-life care is now a viable and preferred site for everything from post-acute recovery to hospital-level treatment. This shift has been driven by a perfect storm: an aging population, rising healthcare costs, persistent hospital capacity issues, and, above all, consumer demand to receive care on their terms. With the proper supports, the home is no longer an alternative to institutional care. It is a proactive choice.

Over 75% of aging adults say they would rather receive long-term support in their own homes than in facilities. The *2024 Home Health Trends* blog highlights that this preference is driving industry growth, with consumer empowerment influencing policy and innovation toward more home-centric models. This isn't just a preference for comfort either. It's a demand for dignity, independence, and person-centered care. The COVID-19 pandemic accelerated this shift, but the momentum has not slowed. It has revealed what many in the disability, aging, and complex care communities have known for decades: care that is delivered at home can be just as safe, more responsive to social needs, and far less costly than care delivered in hospitals or nursing homes. It can also lead to better outcomes.

Home-based care spans a broad continuum, from non-medical personal care and private duty nursing to home health, home-based primary care, and hospital-at-home programs. Home health services are increasingly supported by value-based payment models, which are designed to reward providers for achieving outcomes, rather than focusing on volume. When done right, it means supporting caregivers, addressing social determinants of health (SDoH), and enabling people to live where and how they choose.

As states, payers, and providers explore new models of care that meet people where they are—literally—the role of home health and home care will only grow. From Medicare's expanded Home Health Value-Based Purchasing (HHVBP) Model to the explosive rise of hospital-at-home programs and payvider networks, we are witnessing a rebalancing of healthcare infrastructure that places the home at its center.

In this chapter, we explore how this transformation is unfolding. Through it all, we focus on the same core question that underpins every chapter of this book: How can value-based payments create a healthcare system that is not only more efficient, but more humane?

The Home as the Center of Care

For decades, the home was considered a peripheral setting in the healthcare system, or a place where non-clinical supports were delivered after hospital discharge or where services were triaged when no better options existed. Today, the home is emerging as a dynamic, legitimate, and increasingly essential care setting across the full continuum. This shift is being driven not only by patient preferences and technological advances, but also by policy changes, value-based payment incentives, and the evolving definition of what constitutes effective, person-centered care.

75% of adults would prefer to receive care at home.

The data supporting this shift is compelling. A recent study found that 75% of adults would prefer to receive ongoing living assistance in their own homes as they age. Other research indicates that patients recovering from acute illnesses or surgery often fare better at home than in institutional settings. As highlighted in our blog *How Hospital at Home is Revolutionizing Patient Care*, hospital-at-home models are not just innovative—they're proving effective at delivering safe, hospital-level care while reducing emergency department visits, improving sleep quality, and increasing patient satisfaction. At Johns Hopkins, patients in a hospital-at-home pilot program experienced fewer adverse events and reduced costs by as much as 30%. Similarly, Mount Sinai and Presbyterian Healthcare Services reported improved patient satisfaction and lower emergency department use among participants.

These improvements are not just anecdotal. They represent a systemic advantage. Receiving care at home reduces exposure to hospital-acquired infections, improves sleep and nutrition, and allows for family engagement and cultural alignment in the care plan. Just as importantly, it provides a window into the consumer’s life that no hospital room can replicate. In our *Healthcare at Home Blog Series: Addressing SDoH with Healthcare at Home*, we explored how in-home care settings enable more personalized care planning, allowing clinicians to address social risk factors that would otherwise go undetected in facility-based settings. This includes physical safety risks, food insecurity, medication management issues, and other SDoH. This contextual understanding is crucial for delivering whole-person care that meets both medical and non-medical needs.

Technology plays a major role in enabling this transformation. Advancements in telehealth, wearable devices, remote monitoring, and mobile diagnostics now enable the delivery of complex clinical interventions in the home. Patients can be connected to nurses, therapists, and physicians through virtual platforms, while vital signs and other data are transmitted in real time to care teams. Some hospital-at-home programs even integrate IV medications, imaging, and 24/7 clinical oversight without the need for a brick-and-mortar facility. These tools enable flexible, scalable, and cost-effective care delivery, which is increasingly competitive with facility-based care.

The growth of hospital-at-home programs, in particular, signals a significant shift. Since CMS launched the Acute Hospital Care at Home waiver in 2020, nearly 300 hospitals in 37 states have been authorized to deliver hospital-level care in the home. Programs like these are redefining care delivery, but they are not without challenges. Infrastructure needs, staffing shortages, liability concerns, and digital access gaps (particularly in rural communities) can all impede implementation. Additionally, some programs have placed unintended burdens on family caregivers, who are often expected to provide basic care instead of trained staff. These issues must be addressed with proper support, reimbursement, and regulatory clarity if the model is to scale equitably.

Despite these hurdles, it’s becoming increasingly clear that the home is no longer a passive backdrop for recovery, but a fully activated setting for high-quality, person-centered care. As value-based models continue to mature, and as both payers and consumers demand better outcomes and lower costs, home-based care will become not just a niche offering, but a central pillar of the healthcare system.

Lessons from the Home Health Value-Based Purchasing Model

The expansion of the Home Health Value-Based Purchasing (HHVBP) Model marks one of the most important policy shifts in home health care in recent years. Originally launched in 2016 as a demonstration across nine states, HHVBP was designed to test whether tying Medicare payments to quality metrics—rather than volume—would improve outcomes and reduce costs. After just a few years, as discussed in our blog, the results showed that home health agencies in HHVBP states performed better, spending less while delivering higher-quality care. In response, CMS finalized the nationwide expansion of the program, which took effect in January 2023.

The HHVBP model rewards or penalizes home health agencies based on their performance across several domains, including improvement in functional status, timely initiation of care, hospital utilization, and patient satisfaction as measured by the HHCAHPS survey. These measures reflect the broader goals of value-based care, ensuring that care is not only delivered efficiently but also aligned with patient-centered outcomes and experiences.

The early years of the model offered compelling evidence. According to CMS evaluations, the original HHVBP pilot saved Medicare over $600 million between 2016 and 2019. Home health agencies in the participating states saw 8% higher quality scores than those in non-HHVBP states. Emergency department visits, hospital admissions, and unplanned discharges were all reduced. Notably, the model didn't just lower costs, it did so while increasing the quality of care delivered at home.

But beyond the statistics, HHVBP has changed the way providers think about their role in the continuum of care. Agencies are now investing more in patient education, care coordination, and technology because those investments directly impact performance and payment. For example, agencies are leveraging predictive analytics and remote monitoring to identify patients at risk of hospitalization. Others are using automated scheduling tools and mobile apps to improve the timeliness of visits. These operational changes not only improve metrics but also enhance patient trust and satisfaction.

One key area of impact is the HHCAHPS survey, which captures patients' perceptions of their care experience. Patients are asked whether providers explained things clearly, listened carefully, and treated them with courtesy and respect. These seemingly subjective experiences carry significant weight in a value-based framework. They also intersect with broader issues, such as cultural competency, language access, and equity. For agencies serving diverse populations, achieving high scores on patient experience requires investments in staff training, interpreter services, and inclusive communication practices.

Still, the HHVBP model has limitations. For one, as discussed in our blog *Does the Expanded HHVBP Model Effect All Home Health Consumers?,* it applies only to Medicare-certified home health agencies. It excludes Medicaid-funded home care and non-medical personal assistance services. This leaves a large segment of the home-based care system, particularly the direct care and home care workforce, outside of its scope. In addition, the model doesn't yet reward care that addresses social determinants of health, nor does it directly support family caregivers, who often provide the bulk of ongoing support for patients at home.

Another challenge is equity. Research shows that minority patients are more likely to receive care from lower-rated agencies, which could be penalized under HHVBP without targeted support to address structural disparities. Without safeguards, these penalties could further reduce access to high-quality care for already underserved populations. As the model matures, CMS and states must consider adjustments to ensure that performance-based incentives are not only fair but also aligned with health equity goals.

Despite these challenges, the HHVBP model offers a powerful blueprint for how value-based payment can drive improvement in home health care. It has proven that when financial incentives are aligned with person-centered outcomes, providers can innovate and patients can benefit. As we consider how to extend these lessons to the broader home care system—including Medicaid-funded services, caregiver supports, and Hospital at Home programs—the core principle remains the same: better care, not more care, should be what gets rewarded.

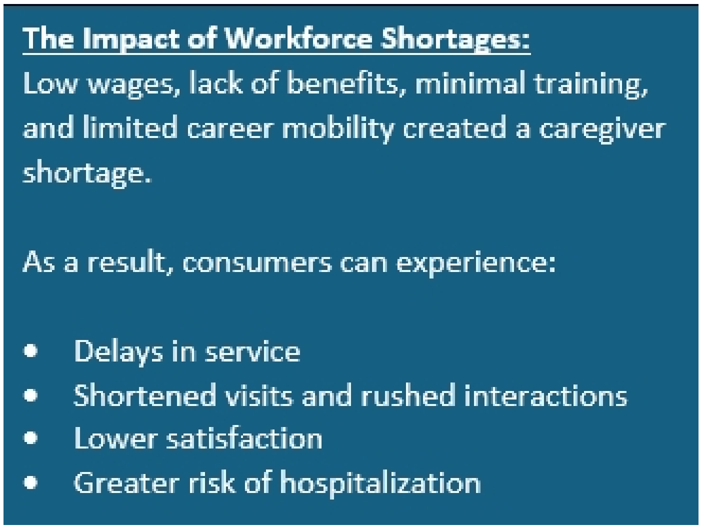
How Caregivers Fit Into the Value Equation

Behind every successful home health encounter is a caregiver who is often invisible in policy discussions but essential in practice. Whether they are family members managing complex medication regimens or paid aides providing daily support, caregivers are the backbone of home-based care. As value-based models expand across the healthcare system, the question arises: where do caregivers fit into the value equation?

Today, the home health and home care sectors face a dual crisis. On the one hand, there is an unprecedented demand for caregiving services driven by the aging population, chronic illness, and a growing preference for aging in place. On the other hand, there is a persistent shortage of workers willing and able to meet this need. As discussed in our blog, *Continued Labor Shortage To Put a Strain on the Industry But Innovative Solutions Can Help*, the U.S. Bureau of Labor Statistics projects that by 2031, more than one million new home health and personal care aide jobs will be needed. But many agencies report difficulty filling even current roles.

The reasons are well documented: low wages, lack of benefits, minimal training, and limited career mobility have long plagued the direct care workforce. As discussed in *Bridging the Gap to Address the Home Health Care Workforce Shortage*, addressing these issues is critical to ensuring agencies can meet demand and maintain quality standards under value-based models. Home health aides and personal care assistants—most of whom are women, and a significant proportion of whom are immigrants or people of color—are among the lowest-paid workers in the U.S. In a 2023 survey, 89% of home care agencies said they had to deny care due to insufficient staffing. Some reported turning away as many as 500 hours of care per month.

The implications for consumers are significant. Delays in service, shortened visits, and rushed interactions can lead to worse outcomes, lower satisfaction, and greater risk of hospitalization—all metrics tied to reimbursement under value-based models like HHVBP. In this way, workforce instability directly threatens the success of value-based care.



The Impact of Workforce Shortages:
Low wages, lack of benefits, minimal training, and limited career mobility created a caregiver shortage.

As a result, consumers can experience:

- Delays in service
- Shortened visits and rushed interactions
- Lower satisfaction
- Greater risk of hospitalization

The solution is not only better pay (though that is critical), but also a reimagining of caregivers as key contributors to quality. Some states and organizations are leading the way. In Wisconsin, an online training program supported by the state certifies new aides and connects them to jobs. In Maine, caregivers can pursue career ladders in dementia care and receive incentives to reduce burnout. These programs offer not just financial rewards but also professional recognition, which is an essential ingredient for workforce retention.

Immigrant caregivers play a particularly vital role. Over 30% of home care workers in the U.S. are immigrants, many of whom bring multilingual skills and cultural alignment that improve patient trust and communication. This matters not only for dignity and satisfaction, but also for metrics like the HHCAHPS survey used in HHVBP. When patients feel respected and understood, they are more likely to engage with their care plan and care highly.

Meanwhile, family caregivers are often unsupported in both policy and practice. Their contributions are often overlooked in most payment models, and they rarely receive training, respite, or financial assistance. Yet when they falter, the entire system suffers. States like Washington and Hawaii have begun offering stipends or tax credits for family caregivers, while managed care organizations in some Medicaid programs are exploring ways to integrate caregiver supports into care coordination and performance measures.

Technology also offers promise. From mobile apps that support scheduling and documentation to AI-enabled tools that predict burnout or flag gaps in care, digital solutions can reduce administrative burden and help agencies better support their workforce. Organizations are leveraging applicant tracking software to streamline hiring, while marketing firms are targeting recruitment through social media and digital landing pages, like those offered by XG Onward Marketing, meeting the next generation of caregivers where they already are.

If value-based care is to succeed in the home, caregivers must be recognized not as a cost center but as a value driver. It means tying caregiver training and retention to quality bonuses, and designing models that reward continuity, efficiency, equally alongside efficiency.

Ultimately, the future of home health and home care will be determined not only by payment models and policy shifts, but by whether we choose to value the people doing the work. In a system built around person-centered care, caregivers must be seen, not just as helpers, but as essential partners in health.

Equity, Social Determinants of Health, and Whole-Person Care

As value-based care continues to reshape the delivery of home health and home care, it also presents an opportunity to address the systemic inequities that have long defined access and outcomes in these settings. Health disparities are not a new phenomenon in home-based care. But value-based payment models, if implemented thoughtfully, offer tools to close those gaps by prioritizing quality, outcomes, and whole-person care across diverse populations.

The disparities in access are well documented. As discussed in our blog, *Addressing Racial Disparities in Home Health Care*, a 2023 study found that Black Medicare consumers are significantly less likely than their white counterparts to be referred for home health care following hospital discharge, despite having similar levels of clinical readiness. When these patients do receive home health services, they are more likely to be treated by lower-rated agencies with fewer resources and higher staff turnover, factors directly linked to poorer outcomes.

These gaps are not incidental—they are structural. They reflect long-standing racial and socioeconomic inequities in healthcare, reinforced by fee-for-service models that incentivize volume over quality and fail to consider cultural or community context. The shift to value-based care allows for a new approach. By tying payment to performance, including consumer experience and outcomes, VBP can incentivize agencies to improve equity and deliver culturally competent care.

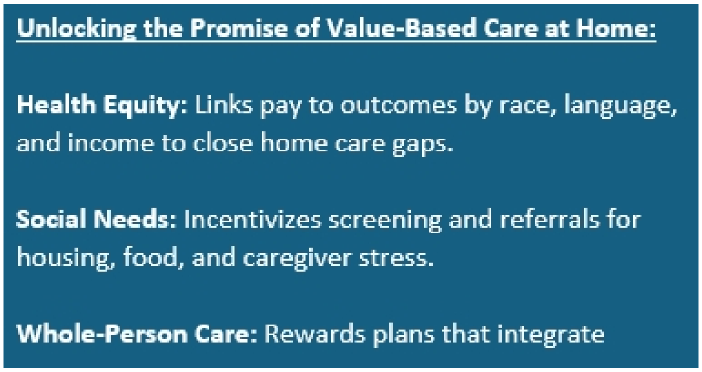
Cultural competency is not an optional add-on; it's a prerequisite for quality. As the U.S. population ages, it is also becoming more diverse. By 2040, over 34% of Americans over age 65 will be racial or ethnic minorities. Agencies that fail to invest in interpreter services, culturally responsive training, or staff who reflect the communities they serve will not only deliver substandard care but also score lower on HHCAHPS and other key performance indicators that determine reimbursement.

Training in cultural competency is being increasingly adopted by forward-thinking providers. Programs may include role-specific education on respectful communication, implicit bias, and cross-cultural care strategies. Other best practices include hiring bilingual staff, offering printed materials in multiple languages, and involving family in planning. These efforts are responsive to patient needs and are also strategic business decisions under a value-based framework.

Beyond culture and language, home-based care presents a unique opportunity to observe and address social determinants of health. By entering the home, providers can directly assess food insecurity, housing instability, access, and caregiver stress. This "front row seat" into patients' daily lives is one of the most powerful yet underutilized, tools in the care delivery toolbox.

Some home health agencies and hospital-at-home programs are beginning to formalize this insight. Providers are utilizing screening tools to document Social Determinants of Health (SDoH) during intake visits, integrating these findings into care plans, and developing partnerships with community-based organizations to provide comprehensive support. States like Pennsylvania have invested in data-sharing tools, such as RISE PA, a closed-loop referral system that connects healthcare providers with social service organizations and tracks whether needs are being met. Other platforms, allow providers to make referrals for food, housing, transportation, and other support services. Findhelp (formerly Aunt Bertha) enables providers to make referrals for food, housing, transportation, and other support services based on ZIP code-level directories.

CMS has also recognized the importance of SDoH in home-based care. In 2021, the agency encouraged state Medicaid programs to incorporate Social Determinants of Health into their managed care strategies and explore value-based models that reward whole-person care. This includes support for non-traditional services, such as home hazard assessments, nutrition education, and caregiver respite—critical interventions that improve health and reduce long-term costs.



Unlocking the Promise of Value-Based Care at Home:

Health Equity: Links pay to outcomes by race, language, and income to close home care gaps.

Social Needs: Incentivizes screening and referrals for housing, food, and caregiver stress.

Whole-Person Care: Rewards plans that integrate

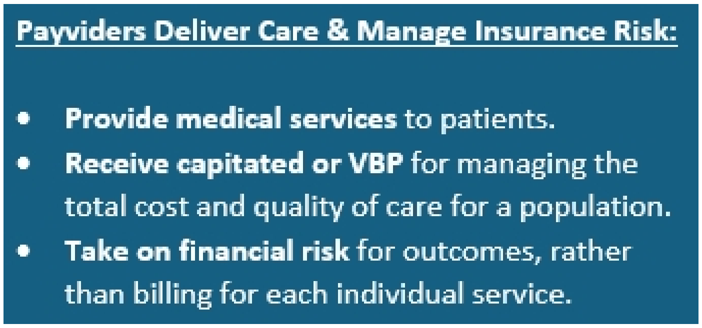
Still, integrating SDoH into value-based home care does not come without barriers. Many agencies lack the infrastructure to effectively screen for and address SDoH. Others face limitations in reimbursement, particularly in Medicaid-funded home care, where financial constraints and program silos can prevent holistic care planning. Without disaggregated data, it is difficult to track progress on equity goals or identify areas where interventions are most needed.

To address these challenges, value-based programs must go further. Equity metrics, such as disparities in readmissions, patient experience, or care quality by race and income, should be built into payment formulas. Agencies should be rewarded not only for improving outcomes but also for closing gaps between populations. Community engagement and culturally rooted care models must be elevated as quality strategies, not sidelined as compliance checkboxes.

In the evolving world of home health and home care, equity is not a secondary concern. It is central to the promise of value-based care. A system that claims to prioritize outcomes must ensure those outcomes are available to everyone, regardless of race, language, income, or zip code. By building equity into every aspect of home-based care —training, technology, partnerships, and payment—we can create a healthcare system where every person, in every home, has the opportunity to thrive.

Emerging Market Trends and the Rise of Payviders

As home health and home care continue to evolve within a value-based framework, the industry is not only adapting, it is also being restructured. New players are entering the market, existing organizations are merging or expanding, and novel business models are challenging traditional care delivery. Among the most consequential shifts is the rise of the “payvider” model, where health insurers and care providers merge into a single entity. This convergence is reshaping incentives, scaling operations, and sparking critical debates about equity, access, and patient experience.



Payviders Deliver Care & Manage Insurance Risk:

- **Provide medical services** to patients.
- **Receive capitated or VBP** for managing the total cost and quality of care for a population.
- **Take on financial risk** for outcomes, rather than billing for each individual service.

The payvider model has gained momentum as Medicare Advantage enrollment expands and value-based payments gain traction. In the home health sector, major players such as UnitedHealth Group and Humana have taken bold steps into this space. UnitedHealth has acquired LHC Group and Amedisys, creating a post-acute care footprint that spans home health, hospice, and palliative care. Meanwhile, Humana has restructured Kindred at Home into CenterWell Home Health, a payer-agnostic provider network that now serves hundreds of thousands of patients annually. These integrations allow insurers to directly manage care delivery, streamline operations, and capture savings under risk-based arrangements.

For consumers, this can offer real benefits. Payviders are often better equipped to coordinate care, use data to predict and prevent hospitalizations, and align services with health goals. These models can also reduce administrative friction, enabling more seamless transitions between services and lower overall costs. Because they are paid based on outcomes, not volume, payviders have financial incentives to invest in preventive care, caregiver supports, and whole-person interventions that traditional fee-for-service arrangements often overlook.

However, the model is not without its risks. As discussed in our blog, *Are Payviders Good for Home Health Consumers?,* one major concern is the potential erosion of consumer choice. As payers acquire more provider networks, consumers, especially those enrolled in Medicare Advantage, may be funneled into narrower networks with limited options. While this might reduce duplication or fragmentation, it also raises concerns about monopolization and loss of patient autonomy.

Another challenge is maintaining care quality and transparency when financial and clinical decisions are made within the same organization. While aligned incentives can improve efficiency, they can also create conflict. Will cost containment take priority over patient preference? Will proprietary algorithms determine access to services? These are critical questions, particularly for vulnerable populations who already face barriers to care.

The emergence of private equity and venture capital in the home health space adds another layer of complexity. Firms are developing vertically integrated platforms that blend telehealth, mobile care, and remote monitoring into scalable business models. While innovation is welcome, concerns persist about whether these new entrants prioritize shareholder returns over patient outcomes. Reports of care triaging, use of lower-credentialed staff, and uneven regulatory oversight highlight the need for guardrails as the market expands.

At the same time, home health agencies are diversifying their service offerings to stay competitive in a shifting landscape. Many are expanding beyond traditional skilled care to offer outpatient therapies, behavioral health, durable medical equipment, and social care coordination. This diversification is not only a business strategy but also a response to the reality that value-based care requires holistic solutions. Agencies are also embracing technology, using AI tools to predict readmissions, optimize staffing, and flag unmet social needs. These innovations are essential for improving quality while managing costs.

Technology is also reshaping the consumer experience. Remote patient monitoring devices, voice-activated support systems, and app-based care coordination platforms are making it easier for patients to take an active role in their care. These tools help caregivers manage schedules, clinicians track outcomes in real time, and payers monitor adherence to care plans. When deployed thoughtfully, they enable the kind of proactive, person-centered care that value-based models aim to promote.

Still, rapid market transformation brings with it a clear imperative: systems must remain grounded in the needs of the people they serve. As payvider models expand, equity must be protected, and the consumer voice must be elevated. States and regulators have a role to play in ensuring transparency, accountability, and access in these new care arrangements. VBP frameworks should include safeguards to prevent profit-driven decisions from compromising care quality or narrowing access.

The payvider revolution and related market shifts are not inherently good or bad—they are tools. Whether they drive progress or deepen disparities depends on how they are structured, regulated, and evaluated. If designed well, these models can help deliver the triple aim of better care, lower costs, and improved outcomes. But they must never lose sight of the fourth aim: ensuring that care remains compassionate, accessible, and responsive to every individual, in every home.

Conclusion: Building a Home-Based Future for Healthcare

As care delivery models continue to evolve, home health and home care have emerged as foundational components of a value-based system. They represent the intersection of consumer preference, clinical effectiveness, cost containment, and dignity. What was once considered an afterthought to institutional care is now at the forefront of innovation, strategy, and policy reform.

The shift toward delivering care in the home is being propelled by demographic change, workforce necessity changes, workforce needs, and the proven clinical benefits of treating individuals in familiar, supportive environments. Programs like the Home Health Value-Based Purchasing Model have demonstrated that tying payment to quality works. When providers are incentivized to reduce hospitalizations, coordinate care, and improve patient satisfaction, outcomes improve and spending drops. The same logic applies to expanding Hospital at Home programs, remote patient monitoring, and broader home-based models—all of which have shown that care delivered at home can be safer, more effective, and less expensive.

However, the value of home-based care cannot be measured solely by health outcomes. Actual value also depends on how we support the caregivers who make this care possible. Whether they are professionals managing multiple high-need clients or family members navigating complex systems with no training and little support, caregivers are essential. Their inclusion in workforce strategies, performance metrics, and payment models is a requirement for sustainable, quality home care.

Equally essential is a renewed focus on equity. Disparities in referrals, quality ratings, and patient experiences remain deeply embedded in the home health landscape. Black and Latino patients are still less likely to be referred for services or to receive care from high-performing agencies. Social determinants of health continue to shape outcomes, which is why it is essential to address them. A truly equitable home care model must integrate culturally competent care, language access, and community partnerships into its core operations—and must be paid to do so.

The market is responding, rapidly. With the rise of payvider models, the influx of private equity, and the growth of platform-enabled care delivery, home health and home care are entering a new era of scale and sophistication. But this growth brings new challenges: Will consumer choice be preserved? Will quality standards hold? Will technology enhance care—or replace it? These questions demand vigilance from advocates, regulators, and policymakers alike.

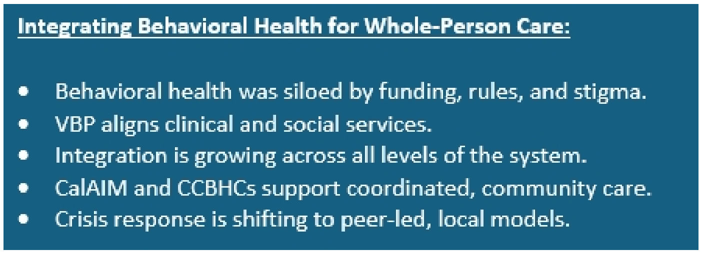
Ultimately, building a home-based future for healthcare requires alignment. Alignment between what patients want and how the system is designed. Between what caregivers provide and what they're paid. Between what communities need and what markets deliver. Value-based payment is the mechanism that can make this alignment possible—if we use it wisely.

CHAPTER 9: BEHAVIORAL HEALTH INTEGRATION AND CRISIS SERVICES

Introduction: From Fragmentation to Whole-Person Care

Behavioral health, which encompasses both mental health and substance use disorder (SUD) services, has long existed on the margins of the healthcare system. Separated by funding streams, regulatory structures, and entrenched stigma, behavioral health has often been treated as an afterthought, siloed from physical health, and disconnected from social supports. The result? A fractured system that leaves individuals navigating crisis after crisis with limited coordination, high costs, and inconsistent outcomes.

But change is underway.



Integrating Behavioral Health for Whole-Person Care:

- Behavioral health was siloed by funding, rules, and stigma.
- VBP aligns clinical and social services.
- Integration is growing across all levels of the system.
- CalAIM and CCBHCs support coordinated, community care.
- Crisis response is shifting to peer-led, local models.

In recent years, the healthcare landscape has begun to shift toward a more integrated, person-centered model of care, and value-based payment systems are central to this evolution. That is because they align financial incentives with outcomes that matter: improved health, greater access, and reduced avoidable utilization. VBP models offer a critical lever to break down silos between mental and physical health, between clinical care and social supports, and between crisis intervention and long-term stability.

This transformation is being led by states, providers, and federal agencies alike. In California, the CalAIM initiative is creating new infrastructure to integrate behavioral health with physical care, addressing the social determinants of health that often underpin both. Nationwide, the expansion of Certified Community Behavioral Health Clinics (CCBHCs) and the newly launched Innovation in Behavioral Health (IBH)

Model from CMS are laying the groundwork for a reimagined behavioral health system that is accessible, accountable, and equity-driven.

Crisis response is also evolving. With the rollout of the 988 Suicide & Crisis Lifeline, communities across the country are investing in mobile crisis teams, peer-led support models, and stabilization centers that divert individuals from emergency rooms and law enforcement systems. These developments reflect a growing consensus that behavioral health emergencies require tailored, community-based solutions and that those solutions can be supported and sustained through value-based approaches.

This chapter will examine how VBP is advancing behavioral health integration across three key areas. First, we'll examine efforts to unify mental health, substance use disorder (SUD) treatment, and primary care into cohesive, whole-person models. Then, we'll explore how CalAIM serves as a roadmap for aligning behavioral health services with SDoH-driven supports in Medicaid. Finally, we'll look at how crisis response systems are being restructured to improve outcomes, equity, and accountability.

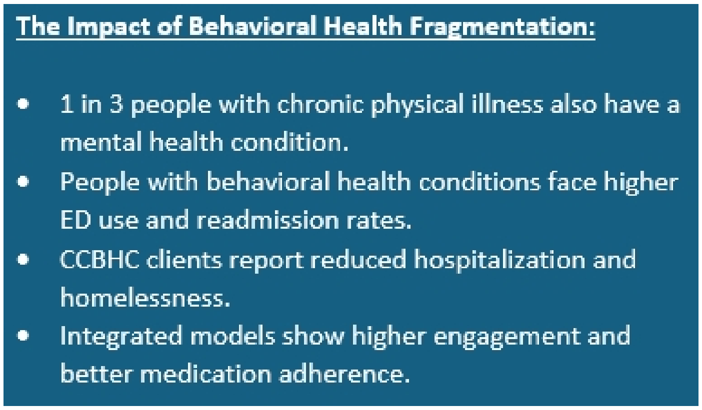
The path to integrated behavioral health is not without barriers. Administrative burdens, workforce shortages, and policy fragmentation persist as significant challenges. But the promise of a reimagined system—where the mind and body are treated together, where crisis is met with care instead of containment, and where social needs are part of the clinical conversation—is too important to ignore.

Breaking the Silos: Mental Health, Substance Use, and Primary Care

As we discuss in our blog, *The Connection Between Physical and Behavioral Health*, for too long, the U.S. healthcare system has treated the mind and body as separate domains. Mental health services, substance use disorder treatment, and physical health care have operated in parallel but disconnected systems—often with individual providers, funding sources, and regulatory structures. This siloed approach has led to fragmented care, higher costs, poor outcomes, and a healthcare experience that fails to reflect the realities of people's lives.

Value-based payment models are challenging this status quo.

It's important to understand that the link between behavioral and physical health is not theoretical. Individuals with behavioral health conditions are more likely to experience chronic diseases such as diabetes, heart disease, and asthma. Conversely, people with chronic physical illnesses are significantly more likely to suffer from depression, anxiety, or other mental health conditions. One study estimates that nearly one-third of people with a long-term physical health condition also have a co-occurring mental health issue.



The Impact of Behavioral Health Fragmentation:

- 1 in 3 people with chronic physical illness also have a mental health condition.
- People with behavioral health conditions face higher ED use and readmission rates.
- CCBHC clients report reduced hospitalization and homelessness.
- Integrated models show higher engagement and better medication adherence.

This bidirectional relationship drives up healthcare costs and complicates treatment plans. People with co-occurring behavioral health conditions often experience higher emergency department utilization, greater hospital readmissions, and lower medication adherence. Yet traditional fee-for-service payment structures do not reward the kind of team-based, integrated care needed to manage these complex needs. That's where value-based payments come in.

VBP models create financial incentives to improve coordination, reduce avoidable utilization, and reward outcomes rather than volume. When applied to behavioral health, these models can transform how care is delivered. Providers are encouraged to work collaboratively by sharing information, coordinating services, and addressing the full spectrum of a person's health needs.

Accountable Care Organizations have emerged as one promising vehicle for this integration. Many ACOs are now embedding behavioral health providers within primary care teams or contracting with community mental health centers to ensure rapid hand-offs, and seamless handoffs. Some have adopted technology platforms that use predictive analytics and registries to identify behavioral health needs, track outcomes, and support shared care plans. Others have partnered with organizations to bring behavioral health services into consumers' homes, allowing care to be delivered in a more comfortable and accessible setting.

Meanwhile, states are leveraging Medicaid managed care as a platform for integration. In the past, many states carved out behavioral health from managed care contracts, creating a wall between physical and behavioral health services. Today, that trend is reversing. Most states now include some or all behavioral health services within their Medicaid MCO contracts, and several—including Arizona, Kansas, Florida, and California—have developed integrated models targeting individuals with serious mental illness (SMI) and SUD. These models instead enable coordinated care management, unified health records, and the use of "in lieu of" authorities to cover non-traditional services that address behavioral health needs.

The Certified Community Behavioral Health Clinic model is another major step toward breaking silos. CCBHCs are designed to deliver comprehensive behavioral health care, including mental health, SUD treatment, primary care screening, crisis intervention, and care coordination. With prospective Medicaid funding, CCBHCs are not dependent on individual billing codes but are instead resourced to meet community needs in a flexible, integrated manner. So far, results have been promising. People receiving care at CCBHCs report significant reductions in hospitalization and homelessness.

Still, challenges remain. Many providers report that administrative complexity, particularly in Medicaid managed care, hinders their ability to integrate care. Multiple MCOs, inconsistent documentation requirements, and long credentialing processes all create barriers. In addition, workforce shortages continue to strain capacity, particularly in rural areas or communities of color. Behavioral health professionals are in short supply, and many providers are hesitant to accept Medicaid due to low reimbursement rates or delayed payments.

Yet despite these barriers, the movement toward integration is gaining traction. CMS's new Innovation in Behavioral Health Model further illustrates federal commitment to redesigning care for people with SMI and SUD. Under this model, community-based behavioral health clinics—not just primary care providers—are positioned as care coordinators, leading multidisciplinary teams that address behavioral, physical, and social needs.

In short, we are entering a new era where behavioral health is no longer an adjunct to care, it is central to the care model. VBP is a critical lever to support this shift, enabling providers to collaborate, innovate, and deliver care that reflects the true needs of the whole person.

CalAIM as a Roadmap for SDOH-Driven Models

When it comes to integrating behavioral health with physical health and social services, few initiatives have drawn as much national attention as California Advancing and Innovating Medi-Cal (CalAIM). More than just a policy overhaul, CalAIM is a blueprint for how value-based care can transform Medicaid by breaking down silos, aligning incentives, and addressing the SDoH that drive health outcomes—particularly for individuals with complex behavioral health needs.

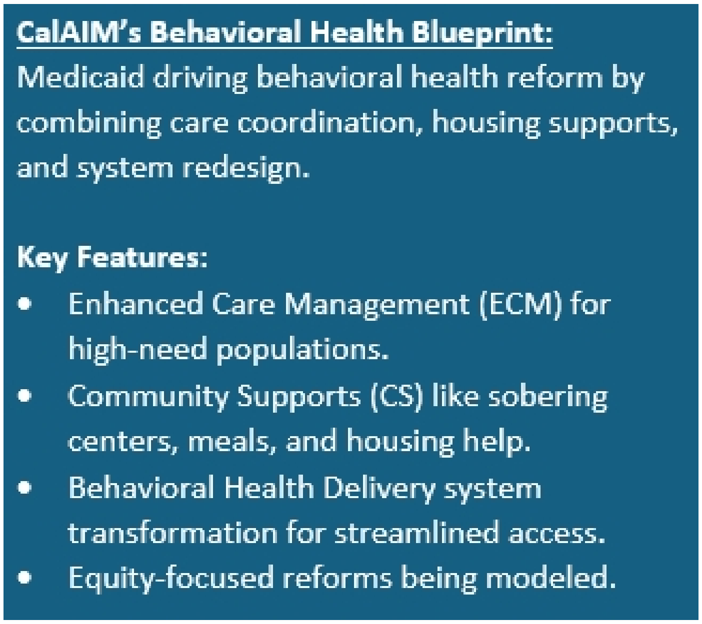
CalAIM recognizes what many in the behavioral health space have known for decades: people do not experience their health in silos, and our systems should not treat them that way. For individuals with SMI, SUD, or co-occurring physical and behavioral health conditions, fragmentation across providers, agencies, and services has long led to poor outcomes and high costs. CalAIM's multi-pronged strategy directly addresses this issue through three critical mechanisms: Enhanced Care Management (ECM), Community Supports (CS), and a redesigned Behavioral Health Delivery System.

Enhanced Care Management (ECM) is the program's centerpiece for high-need populations, including individuals experiencing homelessness, those with multiple chronic conditions, and those with significant behavioral health challenges. Under ECM, a Lead Care Manager coordinates the full range of services for a member, including medical, behavioral, and social, ensuring that care is not only accessible but also person-centered and culturally responsive. Early results show ECM is improving engagement, reducing duplication, and helping individuals stabilize after years of bouncing between emergency rooms, jails, and shelters.

As we discuss in our blog, Community Supports, the second pillar, takes a bold step in recognizing SDoH as legitimate health interventions. Medi-Cal plans can now offer services like medically tailored meals, housing navigation, home modifications, and sobering centers as substitutes for traditional medical benefits. For people with behavioral health conditions, this is a game-changer. Stable housing, nutritious food, and safe living environments are often the foundation upon which mental and physical recovery is built.

In behavioral health specifically, CalAIM is also working to untangle a notoriously complex system. Historically, California split responsibility for behavioral health between Medicaid MCOs and county behavioral health departments. This led to confusion, duplicative assessments, inconsistent access, and limited accountability. CalAIM's Behavioral Health Delivery System Transformation seeks to clarify these roles, integrate mental health and SUD services at the county level, and streamline clinical documentation to reduce administrative burden. The initiative also includes a new benefit—contingency management—for individuals with stimulant use disorders, an evidence-based approach that rewards positive behavior and treatment adherence.

CalAIM's ambition is matched by its scale. By integrating physical, behavioral, and social care across one of the nation's largest Medicaid programs, it is not only improving care in California—it is shaping the national conversation. CMS is closely watching the initiative, and many elements of CalAIM are reflected in the Innovation in Behavioral Health (IBH) Model released in 2024. The IBH Model, like CalAIM, places behavioral health providers at the center of care coordination, includes funding for health IT and telehealth, and requires participating states to implement Medicaid alternative payment models aligned with equity, SDoH, and whole-person care.



CalAIM's Behavioral Health Blueprint:
Medicaid driving behavioral health reform by combining care coordination, housing supports, and system redesign.

Key Features:

- Enhanced Care Management (ECM) for high-need populations.
- Community Supports (CS) like sobering centers, meals, and housing help.
- Behavioral Health Delivery system transformation for streamlined access.
- Equity-focused reforms being modeled.

Still, the early rollout of CalAIM has revealed critical lessons for other states considering similar reforms. As we discuss in our blog, *CalAIM & Behavioral Health – An Update on California's Progressive Pursuit*, flexibility is essential. What works in urban Los Angeles may not apply in rural Humboldt County. Stakeholder engagement—including providers, counties, and consumers—is also key to ensuring successful implementation and equitable access. And perhaps most importantly, infrastructure matters. CalAIM's success hinges on workforce availability, interoperable data systems, and clear lines of accountability between MCOs and county behavioral health plans.

These are not minor hurdles, but they are not insurmountable. CalAIM demonstrates that with the right structure, incentives, and flexibility, states can meaningfully integrate behavioral health with medical and social services—and that doing so improves both individual outcomes and system-level performance.

As other states look to replicate CalAIM's approach, the key takeaway is clear: value-based care must address the full spectrum of a person's life. Focus cannot just be on a diagnosis, ignoring their housing, their food, their relationships, and their goals. For people with behavioral health needs, this kind of care is not an extra—it is essential.

Conclusion: Advancing Behavioral Health Through Integration and Accountability

The future of behavioral health lies not in isolated programs or short-term fixes, but in a system that treats the whole person—body, mind, and circumstance. As this chapter has shown, the legacy of fragmented care is slowly being replaced by a vision of integrated, community-based, and accountable services driven by value-based payment (VBP) models. This evolution is long overdue.

From the rise of ACOs embedding behavioral health into primary care, to the expansion of Certified Community Behavioral Health Clinics and Medicaid managed care models that incentivize integrated treatment, the healthcare system is beginning to reflect what consumers have always needed: a seamless connection between mental, physical, and social well-being. The integration of services not only improves health outcomes—it reduces duplication, lowers costs, and enhances the experience of care for those most at risk.

California's CalAIM initiative has served as a national case study for how Medicaid can lead this transformation. Through Enhanced Care Management, Community Supports, and behavioral health delivery reform, CalAIM is showing how a state can invest in upstream care, reward coordination, and address the social determinants of health that so often drive crisis. Its lessons—on flexibility, stakeholder engagement, infrastructure, and equity—are guiding federal efforts like the Innovation in Behavioral Health (IBH) Model.

Equally important is the recognition that behavioral health crises must be met with compassionate, community-based responses—not police encounters or emergency room holds. The rollout of the 988 lifeline, mobile crisis teams, and peer-staffed stabilization units marks a paradigm shift in how we define and deliver crisis care.

But significant work remains. Administrative burdens, workforce shortages, inequities in access, and variability across states continue to pose challenges. If behavioral health integration is to succeed, it must be backed by clear accountability, adequate funding, consumer engagement, and strong data systems. Most importantly, it must be grounded in the belief that mental health and substance use disorders are not peripheral—they are central to health.

Value-based care offers the tools to turn that belief into reality. By tying dollars to outcomes, aligning incentives across systems, and building in equity from the ground up, VBP models can move behavioral health from the margins to the center of care. In doing so, we don't just improve metrics—we restore lives, dignity, and hope.

Part III:

Technology and the Future of Value-Based Care

CHAPTER 10: TECHNOLOGY, AI, AND DATA INNOVATION IN VALUE-BASED CARE

Introduction: Technology With a Purpose

The promise of value-based care is simple in theory but complex in practice: improve health outcomes while reducing costs by focusing on what matters most to people. To make that promise real, we need more than care coordination and outcome measures. We also need tools that can providers see people clearly, respond to their needs in real time, and plan care that reflects both their medical and social realities. That is where artificial intelligence (AI) and data innovation come into the picture.

Just a decade ago, data systems in healthcare were largely siloed. In some instances, they still are. Providers lacked access to real-time information, care plans were generic, and non-medical needs—like housing instability or food insecurity—were either unrecorded or buried deep in unstructured notes. As value-based models began to evolve, so did the demand for tools that could capture complexity, surface actionable insights, and support individualized care at scale.

Today, AI is no longer a futuristic concept. It's being used to predict health risks, optimize resource allocation, screen for social needs, and personalize care plans for individuals with chronic conditions, behavioral health challenges, or complex conditions.

Some examples include:

- Machine learning models can detect subtle changes in home monitoring data and prompt early intervention.
- Natural language processing tools can identify health-related social needs buried in EHRs, filling the gaps that diagnostic codes leave behind.
- AI helping to align care with people's lives—reducing hospital stays, enabling home-based recovery, and supporting independent living.

In home health, for instance, these capabilities are transforming the care landscape. Providers are now using predictive analytics to anticipate when patients with COPD or heart failure may experience issues. Remote monitoring and virtual assistants are allowing older adults to manage medications, connect with care teams, and remain safely in their homes. And hospital-at-home programs—powered by AI, real-time data, and mobile diagnostics—are offering acute-level care without a hospital stay. Technology advances are not just making life more convenient, they are reshaping the healthcare system around patient preference, equity, and whole-person wellness.

And the implications go further. AI is helping by:

- Uncovering and addressing health-related social needs that once went unseen
- Automating connections to community resources and social services
- Relieving administrative burdens for care teams, freeing up providers to focus on human connection instead of documentation.

As advancements continue, however, it's important to remember that these benefits come with risks. Bias in algorithms, data privacy, digital exclusion, and the erosion of trust are real concerns. When used carelessly, AI can reinforce the very inequities value-based care aims to dismantle. If systems are not transparent, if consumers are not included in design, and if incentives prioritize efficiency over ethics, innovation can cause harm.

This chapter examines the dual reality of AI and data in value-based care, its potential to transform, and its responsibility to do so in a responsible manner. We will trace the evolution of the healthcare data landscape, highlight the tools making a difference today, and explore how predictive analytics and real-time insights are supporting personalized, preventive, and independent care. And we'll examine how the integration of AI must be done with intention. Because at the heart of every algorithm is a person, and the future of value-based care depends on how well we remember that

A Decade Ago—What Was Broken?

To understand the full potential of AI and data innovation in healthcare, we must first look back at what the system lacked just a decade ago. Before the rise of real-time analytics, remote monitoring, and personalized care planning, much of healthcare operated in the dark. Providers lacked access to timely data, systems failed to communicate, and those who relied most on care were often invisible to the institutions meant to support them.

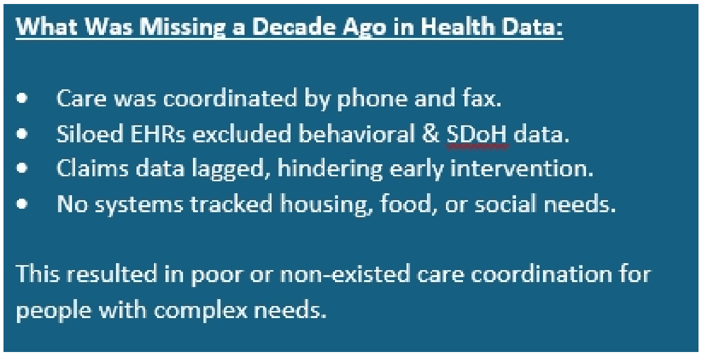
Electronic health records (EHRs) were beginning to take hold in many clinical settings. But even as systems digitized, they remained fragmented. Primary care providers had no easy way to see behavioral health histories, specialists could not access care plans from home health agencies, and data, when it existed, was trapped in silos. Fax machines and phone calls were the primary tools for coordination. Unfortunately, that meant essential changes in a person's condition often went unnoticed until a crisis occurred.

At the same time, the dominant fee-for-service payment model disincentivized investment in technology and care planning. Providers were paid for volume, not for outcomes. There was no financial reason to invest in infrastructure that could track health over time, support collaboration, or tailor care to the individual. Whole-person care was a philosophical goal, not a funded priority. With some providers operating on razor-thin margins, infrastructure investments just wasn't in the cards.

This fragmentation had particularly harsh consequences for Medicaid beneficiaries, individuals with disabilities, and people managing multiple chronic conditions. In many cases, no one entity was responsible for the full picture of a person's care. Physical health, behavioral health, long-term services, and social needs were addressed in isolation—if they were addressed at all. These same individuals were often excluded from early conversations about health innovation. Their needs were labeled "too complex," "too expensive," or "too individualized" for scalable solutions.

What passed for data integration a decade ago would not meet today's standards. Care plans were often paper-based or buried in PDFs. Claims data lagged by weeks or months. There was no way to identify a person who had missed multiple appointments, no way to flag that they had run out of medication, or that they had been admitted to the emergency room twice in one month. The tools needed to manage risk and support independence simply weren't available.

Equally troubling was the invisibility of non-medical needs. Even as research made clear that factors like housing, food, transportation, and social connection were driving health outcomes, these issues remained largely unrecorded in health systems. There was no place in most EHRs to document housing insecurity, no billing code for loneliness, and little coordination between healthcare providers and community-based organizations that could help.



What Was Missing a Decade Ago in Health Data:

- Care was coordinated by phone and fax.
- Siloed EHRs excluded behavioral & SDoH data.
- Claims data lagged, hindering early intervention.
- No systems tracked housing, food, or social needs.

This resulted in poor or non-existed care coordination for people with complex needs.

In this environment, AI and data innovation emerged not as luxuries, but as necessities. They offered a way to see patterns across systems, to elevate risk signals before a crisis, and to make visible what had long been hidden in unstructured notes and disconnected workflows. They provided the technical backbone for the vision that value-based care put forth: a system that could respond to the person, not just the diagnosis.

What began as an effort to modernize billing and reduce paperwork has since evolved into something much more powerful—a reimagining of how healthcare understands people, plans care, and defines success.

The Power of AI in Personalized, Preventive Care

One of the most transformative promises of artificial intelligence in healthcare is its ability to move systems from reactive to preventive, and from generalized to personalized. In value-based care, where providers are accountable for improving outcomes rather than delivering more services, that shift is essential.

AI allows providers to anticipate what patients might need before a crisis occurs. It does this by analyzing a vast array of inputs: clinical history, current medications, social determinants of health, care utilization patterns, and even behavioral data. These inputs are processed by machine learning models that identify trends, spot early signs of deterioration, and recommend interventions tailored to the individual. And this is not theoretical, it is already happening in the field.

In home health, predictive analytics are being used to flag individuals who are at risk of hospital admission due to medication non-adherence, worsening chronic conditions, or lack of support at home. Providers can then respond early by adjusting the care plan, dispatching a nurse, or offering telehealth support. For example, patients recovering from heart failure can now be monitored for changes in weight or blood pressure through remote devices that automatically trigger alerts to care teams.

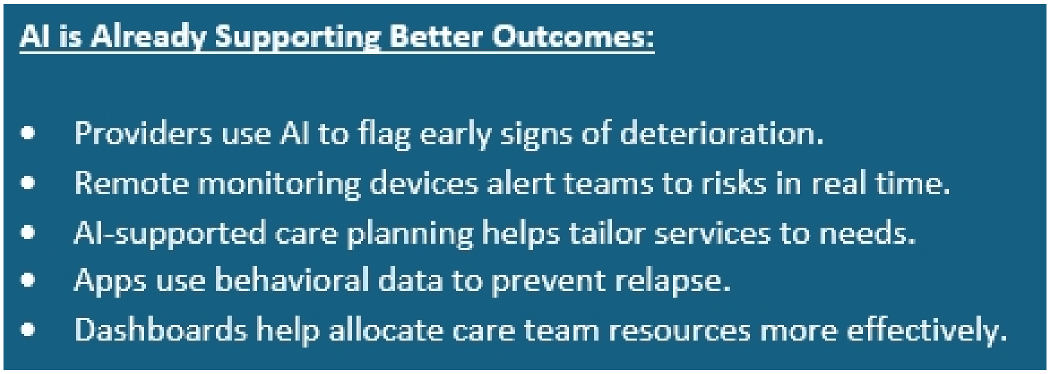
As we discuss in our AI Revolution Series blog, *How AI Can Be Used in Behavioral Health*, this kind of precision is equally powerful in managing behavioral health and substance use disorders. Apps like Addicaid and Triggr use AI to track behavior patterns and flag when someone may be at risk of relapse. These tools analyze data from texts, check-ins, and engagement metrics to generate real-time risk scores. If something changes like sleep disruption, increased isolation, or missed appointments, the system can notify a peer support worker or case manager to check in. This is preventive care, scaled and personalized, and it is making a positive impact.

AI is also making it easier to develop and update care plans that reflect the full person, not just the condition. AI-enabled care platforms can synthesize medical history, goals, and preferences to generate living documents that update in real time and guide multidisciplinary teams. These platforms can also translate clinical data into plain language, making it easier for patients and families to understand what's happening and participate in decisions.

For people with intellectual and developmental disabilities or complex chronic conditions, personalized care planning can be the difference between maintaining independence and being institutionalized. AI can help caregivers and care teams understand how best to support an individual's daily routines, behavioral needs, or sensory sensitivities. And when paired with remote monitoring, it can help identify when something subtle is off so support can be offered before a more serious problem arises.

These tools are not only improving care. They are transforming how value-based payment models operate. When providers can use predictive analytics to manage risk, they can better allocate resources, reduce emergency department use, and meet quality benchmarks. Plans and provider groups are now using AI dashboards to stratify populations, identify patients with high unmet needs, and prioritize outreach accordingly. This approach allows limited resources—like care managers or peer specialists—to be deployed where they can have the greatest impact.

At its best, AI makes healthcare more human, not less. It gives providers back the time and information they need to build relationships and make good decisions. It helps patients feel seen, and it makes the system smarter about how and when to intervene. But this promise depends on how well AI is implemented. If tools are trained on incomplete or biased data, or if they are used to enforce rigid protocols instead of supporting clinical judgment, the result can be depersonalization rather than personalization. That's why implementation—how the technology is introduced, used, and evaluated—matters as much as the algorithms themselves.



AI is Already Supporting Better Outcomes:

- Providers use AI to flag early signs of deterioration.
- Remote monitoring devices alert teams to risks in real time.
- AI-supported care planning helps tailor services to needs.
- Apps use behavioral data to prevent relapse.
- Dashboards help allocate care team resources more effectively.

Real-Time Monitoring and the Infrastructure of Proactive Care

As value-based care moves beyond measuring past performance and toward actively shaping future outcomes, the need for real-time data infrastructure has become critical. Predictive analytics may help identify who is at risk, but it is real-time monitoring and response systems that allow care teams to act on that information before a crisis occurs. For providers operating under VBP models, this infrastructure has become the backbone of proactive care.

These tools allow case managers, clinicians, and care coordinators to track patient status across multiple domains, including appointments, medication adherence, vital signs, home safety alerts, transportation needs, and more. In real time, these systems surface actionable insights that support whole-person care.

For example, in California's Enhanced Care Management (ECM) program under CalAIM, lead care managers are tasked with overseeing individuals who often face a web of disconnected services. Real-time platforms enable them to coordinate care across housing supports, substance use treatment, and primary care providers, all while monitoring client engagement and progress. These systems do more than store data too. They facilitate communication between previously siloed entities, making it possible to respond dynamically to emerging needs.

In the home health space, real-time infrastructure supports the use of wearable devices, ambient sensors, and remote monitoring tools that track health indicators such as heart rate, sleep patterns, and mobility. When these indicators shift outside of normal ranges, alerts can be sent to care teams or family caregivers. For patients with chronic conditions like COPD or diabetes, early signs of trouble can be addressed through a telehealth check-in or a medication adjustment, avoiding a costly emergency department visit or hospitalization.

This infrastructure is also transforming population health management. Payers and accountable care organizations are using real-time dashboards to identify rising-risk individuals—those who may not yet be “high utilizers” but are trending in that direction. By intervening early, these organizations can attempt to reduce avoidable utilization and improve outcomes, which is a key metric in most VBP contracts.

In managed long-term services and supports, this infrastructure enables providers to manage large caseloads without compromising quality. Care coordinators can receive notifications when a client has been discharged from the hospital, missed a scheduled home visit, or failed to refill a prescription. These notifications allow for timely outreach, often preventing complications that might have gone unnoticed in a less connected system.

Real-time systems are also helping address non-medical needs, as discussed in *Addressing Health-Related Social Needs With AI.* Some platforms integrate tools for tracking food insecurity, transportation access, or caregiver strain, allowing organizations to identify social determinants of health and respond with referrals or supports. This integration is especially valuable in Medicaid populations, where unmet social needs are both prevalent and predictive of higher healthcare utilization.

Importantly, real-time monitoring is not just about surveillance—it’s about responsiveness. When implemented well, it gives care teams the ability to be present even when they are not physically there. It helps ensure that care is timely, personalized, and efficient. And it supports a model of care that is guided by data, but delivered with empathy. However, building and sustaining this infrastructure requires investment. Many of the providers most critical to value-based care operate on thin margins and lack access to advanced IT systems. VBP programs must recognize this and include infrastructure funding, technical assistance, and shared platforms that allow smaller organizations to participate in data-driven care.

When supported appropriately, real-time monitoring becomes more than a technical upgrade. It becomes a way to transform healthcare from episodic and reactive to continuous and person-centered. It allows providers to anticipate needs, support independence, and fulfill the central promise of value-based care: the right care, at the right time, in the right place.

Ethical Implementation and Equity in Tech-Enabled VBP

As artificial intelligence, predictive analytics, and real-time monitoring become embedded in the fabric of value-based care, the urgency to implement these tools ethically and equitably has never been greater. While technology can expand access, improve efficiency, and enhance outcomes, it can also reinforce disparities and erode trust if not developed and deployed with care. We talk about this in our AI Revolution Series blog, *Addressing Concerns of AI Implementation in Healthcare*.

One of the most pressing concerns is algorithmic bias. AI systems are only as good as the data they are trained on. If historical data reflects unequal access to care, underdiagnosis, or systemic racism, the models built on that data may replicate or even amplify those inequities. For example, risk scores that rely heavily on healthcare spending may underestimate the needs of Black and low-income patients, who historically use fewer services, not because of better health, but because of barriers to access.

To prevent this, developers and healthcare organizations must adopt an equity-by-design approach. This means:

- Auditing algorithms for racial, ethnic, and geographic bias
- Building models that incorporate social determinants of health
- Engaging stakeholders in the design and testing phases
- Focusing on transparency so patients and providers can understand AI systems

Equity also depends on access to the infrastructure that enables digital care. Many Medicaid beneficiaries and individuals with disabilities lack reliable broadband, smart devices, or private spaces for virtual care. Without deliberate investments in digital inclusion, these populations risk being left behind. Some VBP models are starting to address this by reimbursing for remote monitoring devices, covering broadband as a community support, or funding community health workers who can assist with digital literacy. These are important first steps, but broader systemic support is needed.

Another challenge is privacy and data governance. As more sensitive data is collected, including behavioral health, housing, income, or criminal justice involvement, concerns about misuse, stigma, and surveillance grow. Healthcare providers must be transparent about how data is stored, shared, and protected. Consent must be meaningful, not buried in fine print, and data systems must be designed to protect people with complex lives and complex needs.

Incorporating patient-reported outcomes and lived experience is essential to maintaining ethical alignment. If AI systems prioritize efficiency at the expense of individual goals, person-centered care is undermined. For example, a system might recommend reduced home care hours for a person whose utilization appears stable, ignoring that the person is only stable because of those very supports. Metrics must reflect quality of life, autonomy, and satisfaction—not just cost savings.

Ethical implementation also extends to the workforce. Predictive analytics should support, not replace, human decision-making. Tools that suggest care interventions must be interpretable, adjustable, and respectful of clinical judgment. For direct care workers, AI should reduce administrative burden and enable more time with patients, not become another layer of surveillance or complexity.

Finally, VBP programs themselves must embed equity measures into their design. This includes stratifying quality metrics by race, ethnicity, language, and disability status; rewarding reductions in disparities; and holding plans accountable for ensuring equitable access to digital care. Initiatives like CalAIM and the CMS Innovation in Behavioral Health Model are beginning to require these measures, setting a new standard for what ethical, data-driven care should look like.

In short, AI and data tools are not inherently equitable or inequitable. Their impact depends on how they are designed, who they are built for, and what values they reflect. In value-based care, where the stakes are high and the focus is shifting from volume to outcomes, getting this right is not optional. It is foundational.

Conclusion: Innovation Anchored in People

The past decade has brought about sweeping changes in how healthcare data is collected, analyzed, and utilized. What was once a disconnected system of faxes and paper files is now an ecosystem of real-time dashboards, predictive analytics, and algorithm-driven insights. These tools are now enabling care teams to anticipate risk, allocate resources more effectively, and tailor services to individual needs.

But as this chapter has shown, the true power of artificial intelligence and data innovation lies not in the technology itself, but in how it is applied. When used effectively, AI can help identify unmet needs, prevent avoidable crises, and support customized care plans that reflect a person's unique life realities. Real-time infrastructure can alert providers before an issue occurs, not after. Predictive models can help keep people in their homes, supported by the services that matter most to them. Together, these innovations are reshaping the foundation of care, shifting it from reactive to proactive, and from provider-centered to person-centered.

These tools also have the potential to transform how we define success. No longer limited to visit counts or billing codes, value-based systems can now track outcomes that truly matter—like reduced emergency visits, increased care plan adherence, and improved health equity. For Medicaid populations, in particular, this shift means that systems can finally start measuring what patients have long asked for: stability, connection, and respect.

Yet technology alone is not the answer. AI must be implemented thoughtfully, transparently, and with full attention to equity and ethics. It must be designed not just to optimize care, but to restore trust. If these systems are built without input from the people they aim to serve, or if they prioritize efficiency over humanity, they risk repeating the very mistakes that value-based care is trying to correct.

What will make the difference is intention. Do we use AI to support decisions or to replace them? Do we build systems that reflect lived experiences or that reduce them to data points? Do we invest in infrastructure that includes everyone or that deepens the digital divide?

The answers to these questions will shape the future of healthcare.

AI and data innovation are not just technical upgrades. They are opportunities to fundamentally improve how we understand people, plan care, and achieve better health outcomes. But they must always be grounded in relationships, community, and compassion because the heart of value-based care is helping people live healthier, more stable, and more self-directed lives.

CHAPTER 11: TECHNOLOGY-ENABLED INDEPENDENCE AND ACCESS

Introduction: From Isolation to Connection

In a healthcare system built on value, independence is a measurable outcome. For older adults, people with disabilities, and individuals managing chronic conditions, the ability to live at home, engage in daily routines, and maintain control over one's care is central to dignity and well-being. In recent years, technology has emerged as a powerful force in making that independence not just possible, but sustainable.

Where care delivery once depended on brick-and-mortar facilities, in-person visits, and paper records, we now live in a landscape shaped by digital tools. From telehealth and voice assistants to smart sensors and mobile apps, the tools of modern care are becoming increasingly portable, personal, and integrated into everyday life. Simply put, these technologies are redefining what care means.

It's no secret that the COVID-19 pandemic accelerated this transformation. In a matter of weeks, virtual care shifted from fringe to frontline.

- Telehealth became the default option for behavioral health and chronic care.
- Remote monitoring allowed providers to care for patients without entering the home.
- Families learned to navigate digital care portals.
- Policymakers responded with sweeping reforms.

What emerged from this crisis was a broader truth: people want to receive care in their communities, and technology can help them do it. For Medicaid programs and managed care organizations, this has meant rethinking not only where care is delivered, but how independence, engagement, and experience are built into value-based payment models.

This chapter examines how technology is enabling consumers to lead more autonomous lives while remaining connected to the care and support they need. It will examine how digital tools are strengthening relationships between consumers and providers, how telehealth is reshaping access post-COVID, and how assistive technologies are supporting daily life for people with intellectual and developmental disabilities (IDD), older adults, and others who rely on home- and community-based services.

It will also confront the digital divide. While innovation brings opportunity, it also risks deepening inequity if not implemented with care. For technology to support independence, it must be accessible, culturally responsive, and designed in partnership with those who use it. Because true independence in a value-based system is not about doing everything alone—it's about having the tools, the choices, and the support to live well, in the way that each person defines for themselves.

Using Technology to Support, Not Replace, Relationships

At the heart of effective, person-centered care is a relationship between the individual and the care team built on trust, respect, and understanding. As technology becomes more embedded in value-based care, it must serve to strengthen those relationships, not substitute for them. For consumers managing complex health needs, especially those who receive care at home, digital tools can be robust connectors, but only if they are used with intention.

One of the most important ways technology supports relationships is by facilitating communication across time and distance. For people living in rural areas, those with mobility challenges, or those without access to transportation, tools like telehealth platforms and secure messaging apps allow for meaningful engagement without requiring in-person travel, including:

- A behavioral health provider can check in with a client via video call.
- A care coordinator can follow up on a missed appointment through text.
- A peer support worker can help a client navigate community services using mobile chat.

In value-based care, continuity of care and consumer engagement are closely tied to outcomes—and, therefore, reimbursement. Digital communication enables more frequent and less burdensome interactions, which can reduce hospitalizations, increase adherence, and foster a sense of partnership. Instead of being a passive recipient of care, the consumer becomes an active participant in their own care.

As we discuss in *Introduction to AI Applications in Healthcare*, AI also supports collaboration between providers, especially in systems where care is delivered by multiple professionals across various domains. Shared care plans housed in cloud-based platforms allow primary care providers, behavioral health specialists, and social workers to see the same up-to-date information, flag concerns, and coordinate next steps in real time. This transparency prevents duplication while also communicating to the consumer that their care team is working together on their behalf.

Notably, technology can also support relationships between individuals and their own goals. Personal health apps, wearable trackers, and digital coaching tools enable consumers to monitor their health, set reminders, and celebrate their progress. For individuals with diabetes, a mobile app can provide customized tips and send reminders to test blood sugar levels. For someone with anxiety, a wearable device might detect an elevated heart rate and recommend a calming exercise. These tools help translate clinical advice into daily practice, reinforcing autonomy and self-efficacy.

But not all technology enhances connection. Poorly designed tools can frustrate users, overload providers, or automate interactions to the point of disconnection. Consumers may abandon patient portals that are hard to navigate, and providers may resent documentation systems that pull attention away from the person in front of them. To avoid this, technology must be developed with a human-centered design approach, incorporating feedback from both consumers and care teams to ensure it is accessible, usable, and responsive to real-world needs.

This is especially true for populations often left out of design conversations, including people with disabilities, individuals with limited English proficiency, and those with low digital literacy. For these groups, thoughtful design means more than intuitive interfaces. It means screen readers for the visually impaired, simple language summaries of care plans, and tools that work on smartphones without requiring high-speed internet.

Digital Tools Increasing Access, Coordination & Communication:

- Telehealth expands therapy and coordination for consumers.
- Shared care plans connect teams across disciplines.
- Wearables and apps support self-management and autonomy.
- Human-centered design ensures tools fit real-world use.
- Accessible tech includes screen readers, plain language, and mobile-friendly formats.

The most effective technology does not attempt to replace human relationships. It amplifies them. It extends the reach of care teams, reduces barriers to engagement, and helps consumers stay connected to both their goals and the people who support them. In a value-based system that rewards not just clinical outcomes but satisfaction and experience, that connection is a core component of quality.

The Rise of Telehealth and the Post-COVID Shift in Care Delivery

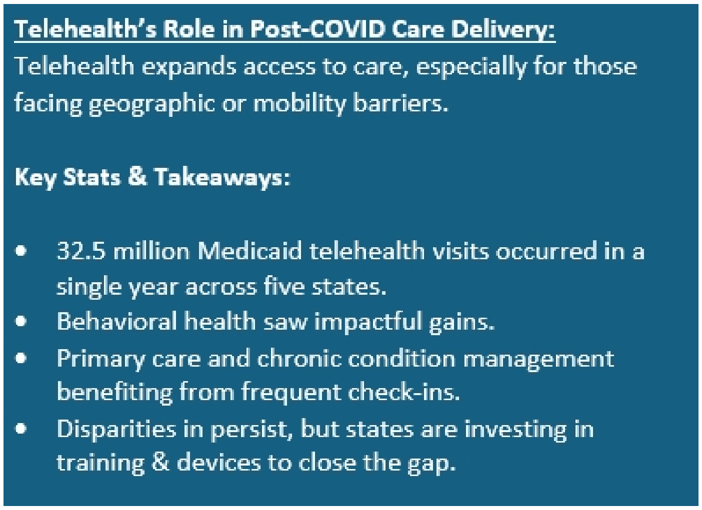
When the COVID-19 pandemic brought in-person healthcare to a halt, it also opened a door. Practically overnight, telehealth transformed from a limited, underutilized tool into a core strategy for delivering care, particularly for those most at risk of isolation, disruption, and disengagement from the health system. The pandemic didn't just change how care was delivered; it also changed where and how people expected to receive it.

The policy response was swift. Emergency waivers issued by the Centers for Medicare & Medicaid Services (CMS) temporarily expanded telehealth access by lifting geographic and originating site restrictions, reimbursing for a broader range of services, and allowing providers to serve patients from their homes. In Medicaid, states adopted parallel flexibilities that enabled audio-only services, cross-state licensure, and coverage of telephonic case management. Between March 2020 and February 2021, telehealth visits across five Medicaid programs surged from 2.1 million to over 32.5 million—a fifteenfold increase that demonstrated both the need and the possibility.

For individuals with limited mobility, unreliable transportation, or behavioral health needs, this expansion was a life-changing development. Telehealth was especially impactful during this time in behavioral health. Many community mental health centers shifted quickly to video-based therapy and medication management. Some patients with anxiety or trauma histories found it easier to participate in virtual visits from the safety of home. Substance use disorder treatment providers began offering virtual recovery groups and tele-prescribing. These services not only filled a gap during the pandemic, but they also highlighted longstanding barriers to in-person care that telehealth helped overcome.

In primary care, telehealth enables routine check-ins, chronic disease management, and urgent consultations without the need for travel or exposure. For individuals managing conditions like hypertension, diabetes, or asthma, this flexibility supported medication adherence, reduced emergency room visits, and fostered stronger provider relationships. Many health systems and Medicaid managed care plans have begun incorporating telehealth into their population health strategies and are using it as a frontline tool for preventive care.

Yet the pandemic-era surge in telehealth also revealed deep inequities. Broadband access, device ownership, and digital literacy varied dramatically across communities. A 2022 study found that while telehealth usage increased across all demographic groups, patients in low-income and rural areas faced more frequent barriers, particularly when services relied on video platforms for communication. This digital divide mirrored, and in some cases widened, existing health disparities.



Telehealth's Role in Post-COVID Care Delivery:
Telehealth expands access to care, especially for those facing geographic or mobility barriers.

Key Stats & Takeaways:

- 32.5 million Medicaid telehealth visits occurred in a single year across five states.
- Behavioral health saw impactful gains.
- Primary care and chronic condition management benefiting from frequent check-ins.
- Disparities in persist, but states are investing in training & devices to close the gap.

In response, some states and plans began offering digital literacy coaching, distributing tablets or smartphones, or reimbursing community health workers for in-home tech support. These innovations underscore an essential lesson: telehealth's promise is only realized when accompanied by intentional efforts to make it accessible to those who need it most.

Today, the post-pandemic landscape is still taking shape. Some federal flexibilities have been extended, and CMS continues to evaluate how telehealth can be integrated into long-term Medicaid and Medicare policy. Many states have made pandemic-era expansions permanent, particularly those related to behavioral health and chronic care management. But reimbursement, licensing, and quality measurement standards remain in flux.

What is clear, however, is that telehealth is no longer considered an "alternative" to in-person care. It is now a standard component of value-based delivery. However, equity must remain a central concern. Studies have shown that the communities that benefit most from telehealth are also those most likely to face access barriers. Closing these gaps will require not only technology, but policy, including broadband subsidies, culturally responsive platform design, flexible reimbursement, and workforce training.

In the context of value-based care, the true success of telehealth is not measured by the number of visits it enables, but rather by how well it supports the autonomy, stability, and wellness of those who rely on it. For many, especially those with disabilities or aging in place, telehealth has made it possible to receive care without leaving home. For others, it has created new ways to build trust, ask for help, and stay connected to care teams.

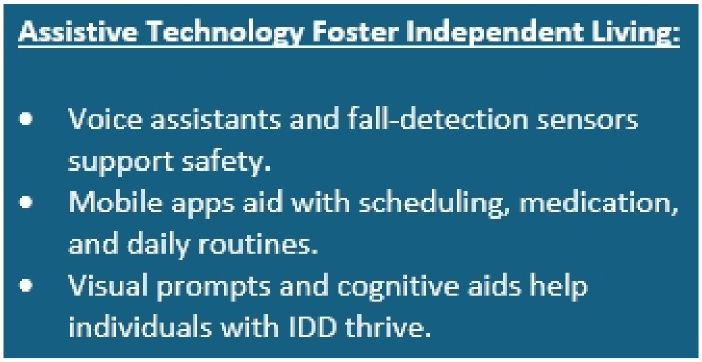
As we shift from pandemic response to long-term transformation, telehealth will remain a cornerstone of independent, accessible, and person-centered care, but only if we commit to building the systems that make it work for everyone.

Technology and Independent Living: A Foundation for Autonomy

One of value-based care's most powerful outcomes is the ability for consumers to live independently. For older adults, individuals with intellectual and developmental disabilities, and people managing complex conditions, independence isn't just about mobility. It is also about control, choice, and the ability to participate in life on their terms. Increasingly, technology is making that possible.

Across long-term services and supports, as well as home- and community-based services, assistive technology is becoming central to efforts that help people live safely in their homes while keeping connections to care. These technologies go beyond convenience, instead forming the foundational supports that reduce reliance on institutional care, extend caregiver reach, and promote self-determination. For value-based payment (VBP) models, they also represent a way to improve outcomes while respecting the autonomy of the individual.

Today, a growing array of technologies is helping people live independently with greater confidence. Smart home devices, such as voice assistants, automated lighting, and fall-detection sensors, provide real-time monitoring and safety support. Medication reminder systems, mobile scheduling apps, and cognitive aids help individuals manage routines without direct supervision. For people with IDD, apps that support visual schedules, communication, and daily task prompts are improving functionality and reducing the need for around-the-clock staff.



Assistive Technology Foster Independent Living:

- Voice assistants and fall-detection sensors support safety.
- Mobile apps aid with scheduling, medication, and daily routines.
- Visual prompts and cognitive aids help individuals with IDD thrive.

Virtual companions such as ElliQ—an AI-powered device that offers conversation, reminders, and mental health check-ins—are being adopted by older adults to support both emotional well-being and adherence to care routines. These tools are potent for individuals aging in place alone, providing both structure and connection.

And the good news is that states are beginning to formalize their support for these tools through public investment. In 2024, the New York State Office for People with Developmental Disabilities (OPWDD) awarded grants to eight organizations to expand the use of assistive technology in support of independent living. These awards fund tools such as remote monitoring, home automation, and environmental sensors designed to increase safety while respecting individual autonomy. This type of initiative reflects a broader shift in Medicaid toward outcome-based models that recognize independence as a key success metric, rather than just a luxury.

Programs like California's CalAIM also support the use of assistive technology under its Community Supports benefit, reimbursing for home modifications and enabling technologies that help individuals avoid unnecessary institutionalization. Similarly, in Tennessee's Employment and Community First CHOICES program, managed care plans enable people with disabilities to live and work in the community with remote support.

Value-based payments are making this happen by aligning autonomy with incentives. Value-based care thrives on measurable outcomes. Traditionally, these initiatives have focused on reducing hospital readmissions, decreasing emergency department use, or achieving cost savings. However, states and health plans are increasingly recognizing that autonomy, stability, and engagement are equally important indicators of success. Independence-focused metrics, such as time spent in the community, participation in meaningful activities, or avoidance of restrictive settings, are being tied to quality scores and contract incentives.

However, despite its promise, access to technology that supports independence is far from universal. Some individuals lack broadband access or the digital literacy needed to benefit. Others face language barriers or cognitive differences. Addressing these disparities will require not only funding but also co-design with users, culturally responsive tools, and integrated technical support.

Policymakers and payers have a role to play in scaling what works. That means including assistive technology in covered benefits, funding infrastructure and training, and supporting the organizations that bring these innovations into people's homes. It also means aligning payment models to reward not just clinical outcomes, but human ones. Because at its core, value-based care is not just about staying out of the hospital. It's about staying in control. Technology, when used thoughtfully, helps deliver on that promise—not by making people more dependent on systems, but by giving them more freedom from them.

Conclusion: Autonomy, Access, and the Future of Home-Based Care

For decades, conversations about healthcare innovation centered on hospitals, clinics, and procedures. What we've learned over the last few years is that the most transformative technologies of our time are not confined to exam rooms or operating theaters. They're in people's homes, on their phones, and embedded in their daily lives—quietly supporting independence, enabling connection, and redefining what it means to receive care.

Technology is not a replacement for care, but it is an extension of it. For older adults and individuals with disabilities, technology-enabled supports are making it possible to live where and how they choose, surrounded by familiarity and empowered by autonomy. For care teams, these tools create new channels for engagement, allow for real-time responsiveness, and reduce administrative burdens. And for families and communities, they offer peace of mind and a tangible reminder that care can be both high-tech and deeply personal.

In value-based care, outcomes like safety, satisfaction, and stability matter just as much as traditional clinical metrics. Technology is helping measure and deliver those outcomes, whether through telehealth platforms that maintain continuity or assistive devices. These assistive devices promote self-reliance by aligning teams across physical, behavioral, and social support services through shared care plans. These tools enable a model of care that is not only more accessible but also more human.

But we must be clear-eyed about what comes next. The digital divide remains real. Without access, affordable devices, culturally relevant design, and digital literacy training, the people who would benefit most from these innovations may be the least able to access them. Ensuring equitable implementation is the defining challenge of today.

The future of home-based care is bright. By utilizing digital tools to enhance autonomy, cater to diverse needs, and foster care environments that align with the lives people aspire to live, we can develop a healthcare system that prioritizes independence as a measurable, fundable, and achievable goal. In a value-based system, independence is not a luxury; it is a necessity. It is a success story. And with the right tools, policies, and partnerships, we can make that story possible for everyone.

CHAPTER 12: HEALTH EQUITY AND SOCIAL DETERMINANTS OF HEALTH

Introduction: Equity is the End Goal of Innovation

The goal of value-based payments is to improve health outcomes ultimately, lives. To do that, we must confront the reality that most of what shapes a person's health happens outside the walls of a clinic or hospital. The food they eat, the air they breathe, the home they live in, the stress they carry—these are the proper drivers of health and well-being. They are also the foundation of one of the most important and misunderstood concepts in modern healthcare: social determinants of health, otherwise known as SDoH.

So, what are the social determinants of health? As discussed in, *Exploring Social Determinants of Health*, SDoH refers to the non-medical factors that influence health outcomes. They include the social, economic, and environmental conditions that shape the context of people's lives and directly affect their ability to maintain health, access care, and recover from illness.

The World Health Organization defines SDoH as "the conditions in which people are born, grow, live, work, and age." In practice, SDoH include:

- Economic Stability: This influenced by factors such as employment, income, expenses, debt, medical bills, and financial support.
- Education Access and Quality: This includes aspects such as literacy, language, early childhood education, and vocational training.
- Healthcare Access and Quality: Examples include health insurance coverage, access to primary care, and cultural competence of providers.
- Neighborhood and Built Environment: Things like housing quality, transportation, safety, walkability, and pollution exposure.
- Social and Community Context: Includes social integration, support systems, community engagement, and exposure to discrimination or violence.

Each of these domains exerts a profound influence on health outcomes. A person who has access to safe, stable housing and nutritious food is far more likely to manage a chronic condition successfully than someone facing eviction and food insecurity. Yet, for decades, these factors were ignored mainly in healthcare policy, practice, and payment.

That is now changing. While SDoH refers to the broader societal conditions, health-related social needs (HRSN) are the individual-level manifestations of those conditions that require specific interventions. In short, SDoH describes the environment, while HRSN reflects how that environment impacts the person.

For example:

- A lack of affordable housing in a city is a social determinant
- A patient experiencing homelessness is facing a health-related social need

This distinction matters in healthcare delivery. Value-based care models are increasingly being designed not only to acknowledge Social Determinants of Health at the population level, but also to identify and address Health Related Social Needs at the individual level. Medicaid managed care organizations are now screening for HRSN, such as:

- Housing instability
- Food insecurity
- Transportation barriers
- Utility needs
- Interpersonal violence or safety concerns

And importantly, they are beginning to pay for the supports that address them through innovations like In Lieu of Services (ILOS), community health worker programs, and flexible Medicaid benefits under Section 1115 waivers.

We've reached a turning point in healthcare, where health equity and social needs are no longer just buzzwords, but priorities. This chapter will explore how VBP models are evolving to include equity as a core outcome, how technology is being used to identify and respond to HRSN, and how states and plans are integrating consumer voice into the design of these interventions. At the center of it all is a simple but radical premise: we cannot improve health without changing the conditions in which people live.

Addressing SDoH Through Medicaid Innovation

If social determinants of health shape the direction of health outcomes, then Medicaid is the path that many of the most vulnerable individuals follow to access care. As the nation's largest payer for low-income individuals, people with disabilities, and older adults, Medicaid has become the primary engine for integrating health and social care, and the innovation is accelerating.

Over the past five years, states have taken bold steps to reimagine what Medicaid can and should pay for. Increasingly, they are using the tools of value-based care—alternative payment models (APMs), managed care contracts, and Section 1115 waivers—to address HRSN as part of comprehensive care delivery. The logic is that if food insecurity, housing instability, or a lack of transportation lead to worse health outcomes, higher costs, and a lower quality of life, then addressing these needs is essential.

Section 1115 Demonstration Waivers have become a significant vehicle for Social Determinants of Health (SDoH) reform. These waivers allow states to test innovative approaches within Medicaid, including reimbursement for non-traditional services that support health outcomes. Recent approvals in states like North Carolina, California, Oregon, and Washington explicitly allow Medicaid dollars to be used for housing navigation, tenancy supports, medically tailored meals, and other interventions that were once considered out of bounds.

In Lieu of Services authority—used extensively in California's CalAIM initiative—is another powerful lever. Under ILOS, Medicaid managed care plans can substitute traditional services with cost-effective, medically appropriate alternatives that address social needs. For example, instead of multiple ER visits, a plan can provide short-term housing stabilization, or instead of transportation reimbursement to a clinic, a plan can offer a mobile health visit at home. These services, though non-medical, are covered as Medicaid benefits and tied to quality metrics under the plan's value-based care strategy.

The American Rescue Plan Act (ARPA) and the enhanced federal match for Home- and Community-Based Services also gave states unprecedented flexibility to fund community infrastructure that supports social care. States have used these funds to invest in:

- Housing and transportation partnerships
- Community health worker (CHW) initiatives
- Data systems that track social needs and service referrals

These investments make it possible for SDoH interventions to move from pilot projects to sustainable components of care delivery.

We've seen states taking action to address SDoH and HRSN as well. As discussed *in CalAIM and SDOH: The Crossroad for Complex Care Needs*, California's CalAIM continues to lead the field. Under this initiative, managed care plans are required to offer both Enhanced Care Management (ECM) and a menu of Community Supports that address social needs. These include:

- Medically tailored meals
- Home modifications
- Recuperative care
- Asthma remediation
- Housing transition and tenancy services

ECM and Community Supports are tied to member engagement, outcome tracking, and integration with physical and behavioral health providers, which makes them core to the VBP model.

North Carolina has taken a different but equally comprehensive approach through its Healthy Opportunities Pilots. These pilots test the use of Medicaid funding to pay for evidence-based services addressing housing, food, transportation, and interpersonal safety. Managed care plans contract directly with community-based organizations (CBOs), who deliver these services through a coordinated platform and submit documentation for reimbursement.

Other states are taking notice. In Kansas, managed care contracts now require health plans to report on social risk screenings and track social determinants of health related outcomes. In Arizona, Medicaid managed care organizations are incentivized to reinvest savings into community supports and social care partnerships.

Historically, SDoH-related efforts in Medicaid were optional add-ons or isolated grants; however, this is rapidly changing as well. Today, social care is being built into:

- Capitated payment models
- Risk adjustment methodologies
- Quality measurement frameworks

This integration represents a shift in both philosophy and practice. Health is no longer narrowly defined by clinical metrics alone. In value-based Medicaid, success is measured by stability, safety, connection, and the ability to live well in one's community.

Technology as a Tool for SDoH Integration and Equity

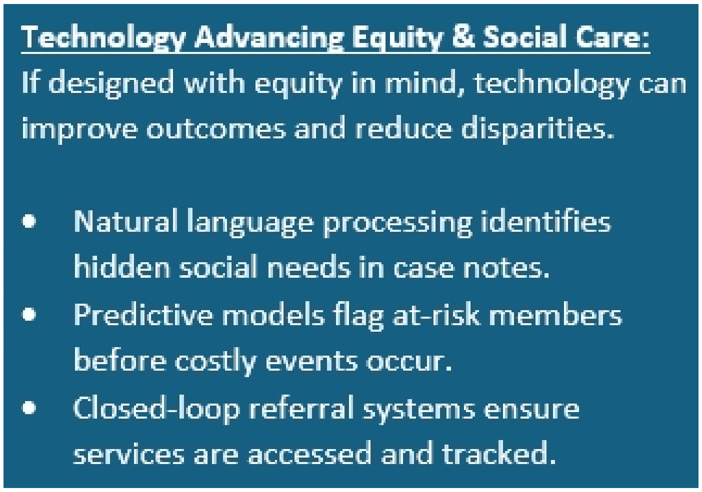
As Medicaid programs and managed care organizations deepen their commitment to addressing social determinants of health, they face an undeniable challenge: identifying needs quickly, coordinating resources efficiently, and tracking outcomes in real time. As discussed in *Addressing Health-Related Social Needs With AI,* this is where technology, especially artificial intelligence, has begun to play a pivotal role.

Historically, data related to health-related social needs was either not collected at all or buried in unstructured case notes, inaccessible to the very systems that could act on it. Now, AI-powered tools are helping uncover those hidden needs. Natural language processing (NLP) is being used to scan clinical documentation and case manager notes for patterns that may indicate housing instability, food insecurity, or lack of transportation. These insights can trigger referrals to community services or flag a member for care management outreach.

Predictive models are also being trained to identify members who are at high risk for health deterioration based on a combination of medical claims, demographic data, and social risk factors. Rather than waiting for an emergency department visit to reveal a gap, these tools allow providers and plans to get ahead of the curve. A member who has recently missed multiple appointments and has no pharmacy activity for two weeks may be flagged as potentially facing a transportation barrier or caregiver disruption. In a value-based care model, that early warning could lead to a check-in call, a ride-sharing voucher, or even the delivery of medications. These are all small interventions with enormous downstream value.

Some platforms are going even further, creating integrated SDoH referral systems that identify needs and track whether services were accessed and whether they made a difference. Closed-loop referral platforms like Unite Us and findhelp.org are increasingly embedded into provider workflows, allowing clinicians and care teams to document social needs and connect patients to community-based organizations in the same way they would order a prescription or schedule a follow-up. Data from these tools helps plans understand what's working, where gaps exist, and how to continuously improve outcomes for diverse populations.

Importantly, technology is also being used to reduce disparities in access to these services. AI models that once relied heavily on healthcare utilization are being retrained to incorporate non-clinical indicators, ensuring they don't overlook members who underutilize services due to historic inequities. Some states are investing in digital navigation programs to help members use telehealth and care portals. Others are tying managed care incentives to improvements in equity-focused performance measures, such as the reduction of racial disparities in chronic disease management or maternal health outcomes.



Technology Advancing Equity & Social Care:
If designed with equity in mind, technology can improve outcomes and reduce disparities.

- Natural language processing identifies hidden social needs in case notes.
- Predictive models flag at-risk members before costly events occur.
- Closed-loop referral systems ensure services are accessed and tracked.

But for all its promise, the use of AI and digital tools in social care raises valid ethical concerns. If algorithms are not transparent, if datasets are incomplete or biased, or if communities are not part of the design process, these tools can replicate the very inequities they aim to solve. Ensuring that predictive models are explainable, regularly audited for bias, and aligned with lived experience is essential for responsible use.

Equity, in this context, is not just about expanding access to technology. It's about using technology to expand access to opportunity, to stability, to care that reflects a person's whole life—not just their lab results. When deployed thoughtfully, these tools can help reorient care around people's needs instead of institutional processes. They allow providers to be more proactive, more precise, and more person-centered.

As value-based care continues to evolve, technology will not replace the need for community health workers, case managers, or social service organizations. But it will empower them. And in doing so, it will help bridge the divide between health and life—the very gap that social determinants have long revealed.

Equity Measures in Value-Based Payment Programs

Equity is no longer a soft goal in healthcare—it is an operational priority. As value-based care continues to expand, payers and policymakers are recognizing that quality and cost savings cannot be meaningfully achieved without addressing the inequities that pervade the healthcare system. To that end, equity is increasingly being formalized within VBP frameworks through performance metrics, risk adjustment, and contractual requirements that push the system to do more than treat disease.

Historically, Medicaid and Medicare payment systems have rewarded volume, not fairness, but a growing number of states are shifting this paradigm by embedding equity directly into their managed care contracts and VBP arrangements. One of the most common strategies is the stratification of quality metrics by race, ethnicity, language, and disability status. This allows health plans and providers to not only track overall performance but to identify gaps between population groups. This is important because these are gaps that often reflect systemic biases and structural barriers to care.

For example, a plan may discover that while overall rates of diabetes control are improving, outcomes for Black or Latino enrollees remain stagnant. Rather than seeing that as a data anomaly, VBP models treat it as a performance gap that requires targeted intervention, resource investment, and accountability.

In addition to performance stratification, some states and national payers are experimenting with equity-based risk adjustment, which means modifying payment rates based on the social complexity of the population served. This is a critical advancement because providers who serve populations with higher social risk often struggle to meet standard quality benchmarks through no fault of their own. Without risk adjustment, these providers are penalized for caring for the people who need them most. With it, they are more fairly compensated and supported in tailoring interventions to the communities they serve.

Beyond metrics, VBP is also being used to support workforce and infrastructure development in historically underserved areas. States like Oregon and Massachusetts include specific funding streams for community health workers, peer support specialists, and care navigators within their VBP arrangements. These roles are not only effective in improving outcomes, but are trusted, community-embedded agents of health equity.

Technology plays a complementary role in measuring and advancing equity. Dashboards now allow providers and payers to visualize disparities across lines of difference, identify where care is falling short, and adjust strategies accordingly. Predictive analytics and real-time reporting can help track whether interventions are closing those gaps or widening them. However, these tools must be used with care. Data without context can mislead, and metrics without community input can misfire.

That’s why equity measures must always be paired with lived experience. A dataset may show improved asthma control, but it won’t capture the fear of eviction that undermines treatment adherence. A metric may indicate that more people are attending appointments, but it won’t reveal whether those encounters were culturally safe or linguistically appropriate.

Still, the direction is clear. VBP models that once focused narrowly on clinical outcomes are now being recalibrated to reflect a broader vision of health that includes fairness, access, and justice as measurable, fundable goals. Equity is not an add-on. It is a benchmark. And for value-based care to succeed, it must be achieved.

Designing with Consumers, Not Just for Them

In recent years, healthcare leaders have adopted a common refrain: “Put the patient at the center.” But when it comes to addressing social determinants of health and advancing equity through value-based care, being at the center is not the same as being in control. Too often, interventions are designed around what institutions believe people need and not what people say they want.

True equity requires not just identifying disparities, but transforming the processes that created them. That transformation begins by shifting power to the individuals and communities most affected by health inequities. It means designing with consumers, not just for them.

This shift is especially important in SDoH initiatives. The barriers people face, whether housing instability, food insecurity, or transportation limitations, are not abstract issues. They are daily realities shaped by context, culture, and lived experience. Solutions must reflect that reality. When they don’t, even well-funded programs fail to connect.

Consider food insecurity. A managed care plan might reimburse for weekly grocery deliveries. But if the food is unfamiliar, difficult to prepare, or mismatched to cultural or dietary needs, it won’t be used. Similarly, a referral to housing services might check a box, but if the intake process is inaccessible, or the provider lacks disability accommodations, the support will never reach the person.

That’s why consumer voice must be integrated into every stage of program development from needs assessment and service design to implementation and evaluation. States like Pennsylvania, with platforms like RISE PA, and North Carolina, through NCCARE360, have taken early steps by partnering with community-based organizations (CBOs) and including community feedback loops in their infrastructure. These models enable individuals to rate services, share their experiences with barriers, and contribute to continuous improvement.

At the federal level, CMS has called for more participatory approaches in Medicaid demonstration waivers and health equity initiatives. Guidance now encourages states to involve consumers in the development of equity metrics, to require MCO advisory boards that reflect enrollee demographics, and to partner with trusted community messengers in outreach and education.

Importantly, consumer involvement should not be performative. It must be ongoing and structured in ways that respect time, privacy, and accessibility. Community members should not be asked to educate the system for free or relive trauma for the sake of stakeholder engagement. They must be treated as experts.

Designing Care With Communities:
Equity depends on lived experience, which means:

- Involving consumers in service design and evaluation.
- Partnering with trusted messengers and CBOs.
- Creating feedback loops through platforms.

The benefits of this approach are tangible. Programs designed with consumer input are more likely to be used, trusted, and effective. They are also more adaptable to diverse populations, helping avoid one-size-fits-all solutions that leave people behind. Value-based care promises to realign incentives around outcomes that matter. So if we fail to ask people what matters most to them, we will miss the mark. Health equity isn't just about better data or broader access. It's about respect. It's about voice. And it's about building systems that respond not only to the metrics, but to the people behind them.

Conclusion: From Conditions to Change

Social determinants of health are not new. Communities have long known that health is shaped more by housing, food, income, and education than by anything that happens in a clinical setting. What is new is the growing will and the emerging tools to finally do something about it at scale. In value-based care, we now have both the policy frameworks and the payment mechanisms to begin addressing these foundational drivers of health, not as ancillary efforts, but as core components of care.

Throughout this chapter, we've explored how Medicaid programs and managed care organizations are moving from short-term compliance to long-term transformation. From CalAIM's Community Supports to North Carolina's Healthy Opportunities Pilots, states are demonstrating that it is possible to build systems that treat housing and food access as medical interventions. Section 1115 waivers, ILOS, and risk-adjusted contracts are creating the financial space to invest in social care infrastructure, while technology is helping us identify needs, coordinate services, and track outcomes in real time.

We've also seen that technology is not just streamlining healthcare delivery. It's changing how we understand need, how we reach people, and how we measure equity. When built and used responsibly, these tools have the power to uncover invisible risks, support targeted interventions, and bridge gaps between medical care and daily life. However, their effectiveness will always depend on whether they are designed with the people they aim to serve. Equity can't be engineered from the outside in. It must be lived, led, and informed by those closest to the challenge.

This is the real promise of SDoH integration in value-based care: not simply to screen, refer, and report, but to remake healthcare as a system that supports whole lives. That means building accountability not just for health outcomes, but for equity. It means compensating care teams for reducing disparities, not just achieving averages. And it means listening deeply to what people say they need, not what the system assumes they do.

To move from conditions to change, we must align funding, technology, and design with human experience. We must recognize that autonomy, stability, safety, and trust are as essential to health as any prescription. And we must hold our systems accountable for delivering care that reflects this truth.

Value-based care gives us a structure. Health equity provides us with the reason. Social determinants of health provide us with a roadmap. The next step is ours to take.

CHAPTER 13: CENTERING THE CONSUMER VOICE

Introduction: The Future of Value Is Personal

Value-based care is built on the premise that better health outcomes should be rewarded, not the number of services provided. The issue lies in defining what "better" means—and for whom. And that requires something more than data. It requires listening. If value-based payment models are to succeed, they must be guided not only by clinical evidence and cost efficiency, but by the voices of the people these systems are designed to serve.

For decades, consumers, especially those enrolled in Medicaid, living with disabilities, or from historically marginalized communities, have had little say in how healthcare is delivered. Systems have measured success in claims, not conversations; and in benchmarks, not well-being. Plans and providers often made decisions without input from the individuals whose lives and outcomes were most directly affected. As a result, interventions have often fallen short, and trust has eroded.

That's beginning to change.

The shift to value-based care has opened the door to a new kind of accountability that emphasizes outcomes over outputs, relationships over transactions, and person-centered goals over rigid protocols. In this model, care teams are increasingly judged not just by the number of services they provide, but by whether those services help individuals remain stably housed, return to work, reconnect with their community, or manage a condition in a way that fits their lifestyle. But outcomes like those cannot be defined solely by the healthcare system. As we discuss in the Advocate's Perspective of all of our VBP blogs, they must be shaped by consumers themselves.

Centering the consumer voice means moving beyond patient satisfaction surveys or token advisory panels. It means co-designing programs, including community members in governance, compensating them for their time, and ensuring their perspectives shape metrics, workflows, and investment decisions. In a truly person-centered VBP model, success isn't declared by systems. The people in them define it.

In this chapter, we'll explore what it means to build value-based systems around lived experience, including:

- Why consumer-led care is more than an ethical imperative
- How trust is earned in communities that have been repeatedly underserved or harmed
- How outcomes can and should reflect the goals people set for themselves
- How states, plans, and providers are embedding consumer voice into the fabric of value-based contracts

At its core, this is not just a story about improving healthcare. It is about redistributing power. It is about ensuring that value-based care does not replicate the paternalism of the past but instead fulfills its promise: a system where value is defined by the people who experience it.

The Case for Consumer-Led Care

The healthcare system has long talked about being "patient-centered," but for many individuals this phrase has often rung hollow. Decisions are made without them, goals are set for them, and care is delivered to them, rather than with them. In a value-based care system that claims to reward outcomes, this approach is inequitable and inefficient.

Consumer-led care is the next evolution in value-based payment. It recognizes that people are the experts in their own lives, and that systems cannot claim to deliver high-value care without understanding what "value" actually means to those they serve. When individuals are included in care planning, program design, and outcome definition, care becomes more relevant, more effective, and more sustainable. It becomes whole-person care not just in name, but in practice.

The foundation of this shift is choice. As outlined in *The Power of Choice – Understanding Consumer-Directed Personal Care Programs*, autonomy is not just a preference. It is a determinant of engagement, adherence, and trust. When people are allowed to select their providers, participate in shared decision-making, and set personal health goals, their experience improves. They are more likely to stick with a care plan, to speak openly with care teams, and to view healthcare as something they are actively shaping.

This is particularly important for populations that have traditionally experienced medical paternalism. Individuals with disabilities, for instance, have often been subjected to care systems that assume their limitations without exploring their strengths. Involving these individuals in setting their own care goals—whether that means working part-time, living independently, or managing care through assistive technology—reframes the system around ability, not assumption.

Similarly, individuals with behavioral health needs or chronic conditions may prioritize goals that don't align with traditional medical metrics. A person with schizophrenia may value housing stability over medication adherence in a given moment. A person recovering from substance use may focus on reconnecting with family before addressing physical health. Value-based care must be flexible enough to accommodate these priorities, and to see them not as deviations from the plan, but as the plan itself.

Incorporating consumer voice also leads to more culturally relevant and linguistically accessible care. As discussed in *Embracing Cultural Competency and the Diverse Immigrant Workforce*, when programs are shaped by people who reflect the communities being served, they are more likely to consider real barriers—such as transportation, childcare, language, and stigma—that impact access and outcomes. Community health workers, peer navigators, and care coordinators with lived experience are essential in this process. They not only connect systems to consumers, but also embody what it looks like to center voice in care.

Value-based models increasingly support these roles. Many states are building CHW reimbursement into their VBP arrangements, recognizing their effectiveness in engaging members, improving adherence, and reducing costly utilization. These team members bridge the gap between system priorities and personal priorities, and in doing so, help deliver care that actually matters to people.

Ultimately, consumer-led care is not a soft concept. It is a performance strategy. Plans and providers that co-create care with consumers see better results because the goals are more aligned, the relationships are stronger, and the care is more personalized. In a system where payment is tied to outcomes, there is no longer a separation between what is ethical and what is operationally smart. Value-based care cannot fulfill its potential if it continues to define success from the top down. It must be built from the lived experiences of those it seeks to serve.

Rebuilding Trust in Systems that Have Caused Harm

Trust is the currency of care. Without it, even the most well-intentioned interventions fall flat. A provider may offer an evidence-based treatment plan, a managed care organization may authorize the most comprehensive set of services, and a state may design the most flexible benefit structure, but if the individual receiving that care does not feel safe, heard, or respected, they may not engage at all. In value-based care, where outcomes rely on sustained relationships and long-term engagement, trust is essential.

Yet for many individuals—particularly Black, Indigenous, and people of color (BIPOC), LGBTQ+ individuals, people with disabilities, and Medicaid enrollees—trust in the healthcare system has been fractured by a long and painful history of neglect, discrimination, and systemic harm. This history is not theoretical. It is recent, personal, and ongoing. It lives in stories of misdiagnosis, forced sterilization, denial of pain medication, inaccessible facilities, unreturned calls, and policies that prioritize institutional convenience over individual dignity.

In Rebuilding Trust in Healthcare Starts with the People and Communities, this reality is explored through the lens of trauma-informed systems. It emphasizes that trust cannot be restored by information alone, it must be rebuilt through relationships, transparency, and repeated, demonstrated commitment to doing better. For VBP models, this means ensuring that every element of the care experience, from the design of services to the delivery of support, honors autonomy and actively works to undo harm.

One of the most powerful ways to rebuild trust is to center relationships over transactions. Consumers must feel that their care teams are not just checking boxes, but listening, and that that their priorities are guiding decisions. That care is something done with them, not to them. This requires time, continuity, and flexibility, all of which are elements that VBP models can and should fund. Contracts that reward long-term outcomes over short-term throughput allow providers to spend the time needed to build rapport and address social needs before jumping into medical tasks.

Another trust-building strategy is peer-based and community-embedded care. Peer support specialists and community health workers often come from the same communities as the individuals they serve. They may share lived experiences with mental illness, substance use recovery or navigating disability. They bridge the gap between clinical systems and community knowledge, between formal training and lived understanding. VBP models are increasingly reimbursing for these roles, recognizing that they are critical to outcomes like engagement, adherence, and member retention.

Transparency is also key. Too often, healthcare systems make decisions behind closed doors or present plans that are impossible to interpret. Consumers need clear, honest information about their rights, their options, and what to expect. They need care plans they can understand, not ones buried in clinical jargon. They need to know that their data is being used ethically and with consent, particularly when AI and predictive analytics are involved. And they need meaningful avenues to give feedback, along with seeing that it is acted upon.

Importantly, trust is not built by a single encounter or a new piece of technology. It is earned over time, and it can be lost in a moment. VBP programs must account for this by embedding trust-building into every facet of care, including staffing, training, reimbursement, evaluation, and governance. That means investing in cultural humility, trauma-informed approaches, language access, and anti-racism. It means measuring not just what services were delivered, but whether they were delivered in a way that made the person feel safe and respected.

Rebuilding trust also requires humility. Systems must be willing to name their past failures, to acknowledge current disparities, and to share power with the people they have historically excluded. They must be willing to listen to hard truths and to change course in response. In a value-based system, trust is a performance driver. When people trust their care teams, they are more likely to follow through with treatment, to share sensitive information, and to seek help before a crisis occurs. Trust reduces unnecessary utilization, improves coordination, and strengthens every outcome that VBP models seek to measure.

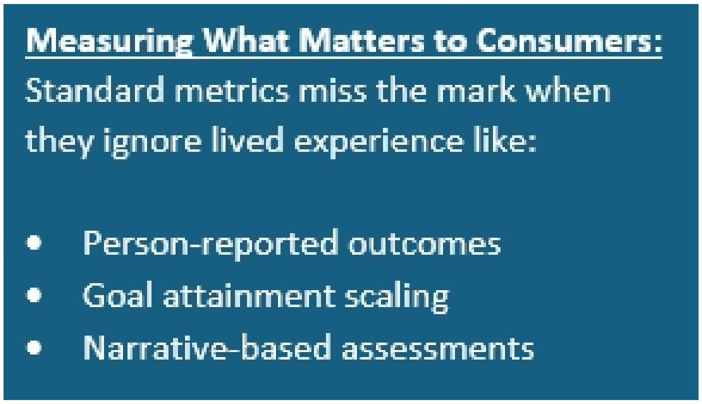
But more than that, trust is a matter of justice. A healthcare system that has caused harm must not ask for loyalty. It must earn it. And in doing so, it must prove that value is not just a financial term, it is a commitment to respect, partnership, and healing.

Metrics That Reflect Lived Experience

In a healthcare system increasingly driven by data, what we measure becomes what we prioritize. For value-based care to achieve its promise, the metrics used to define “success” must align with the values and realities of the people receiving care. Yet many of today’s measurement systems still rely on clinical utilization or cost savings. Unfortunately, these are indicators that often fail to capture what truly matters to individuals navigating complex health and social challenges.

For someone with a disability, success may mean being able to get out of bed and dress independently. For a person with schizophrenia, it might mean avoiding hospitalization while reconnecting with family. For someone living with multiple chronic conditions, it may be the ability to work part-time or live at home with support. These are not abstract goals. They are deeply personal. When care systems fail to acknowledge them, they risk delivering services that miss the mark.

Traditional quality metrics often measure what is easy to track like blood pressure control, hospital readmission, and emergency room use. These data points are important, but incomplete because they offer a snapshot of clinical performance, not a reflection of quality of life, dignity, or autonomy. In a system funded by value-based payments, these gaps can distort both care delivery and incentives.



Measuring What Matters to Consumers:
Standard metrics miss the mark when they ignore lived experience like:

- Person-reported outcomes
- Goal attainment scaling
- Narrative-based assessments

Based on this knowledge, a growing number of payers and policy leaders are calling for a redefinition of value—one that includes consumer-defined outcomes. Person-reported outcome measures, goal-attainment scaling, and narrative-based assessments are emerging as powerful tools for capturing progress on what individuals actually care about. These approaches allow consumers to define their own goals and assess whether those goals are being met.

In California's Enhanced Care Management program, some providers are piloting the use of consumer-authored care goals and tracking them alongside traditional clinical indicators. In Massachusetts and Oregon, Medicaid demonstration waivers include specific language around the inclusion of lived experience in quality improvement and outcome tracking. These efforts are still in their early stages, but they reflect a shift in both mindset and approach.

Metrics that reflect lived experience also support equity. When outcomes are defined in collaboration with consumers, they are more likely to reflect cultural, linguistic, and social context. A one-size-fits-all benchmark like attending six behavioral health sessions may not account for transportation barriers, caregiver schedules, or cultural perceptions of mental health. A flexible, individualized goal, such as "I want to learn coping skills to manage anxiety at work," creates space for relevance, nuance, and meaningful progress.

Technology can play a role here, too. Digital tools are making it easier to collect feedback in real time, document consumer-defined goals, and visualize individual progress. Apps and care platforms can enable users to prioritize their needs, rate their experience, and track how well their care aligns with their goals. This data, when integrated into VBP contracts, can reshape how providers are paid, which is not just for doing more, but for doing what matters.

Still, some challenges include:

- Standardizing person-centered measures across diverse populations

- Ensuring that these measures are not overly burdensome to collect and that they genuinely reflect the voice rather than provider interpretation
- Integrating these insights into risk adjustment and reimbursement systems

While there are challenges, the path forward is clear. If value-based care is to move beyond box-checking and cost-cutting, it must embrace metrics that reflect the fullness of people's lives. That means tracking not just how many appointments were completed, but whether the person felt empowered. Not just whether housing was provided, but whether it felt like home. Not just whether care plans were documented, but whether they were co-created and meaningful.

When consumers define success, systems become more accountable, care becomes more personal, and outcomes become more honest. That is the future of value. And it starts by asking and genuinely listening to the question: What matters to you?

Operationalizing Voice in VBP Models

The call to center consumer voice is no longer confined to mission statements or community outreach campaigns. It is becoming a measurable, fundable expectation in VBP models. Across the country, states and managed care organizations are transitioning from theoretical commitments to practical implementation, which includes embedding consumer input into governance, service design, and quality improvement in ways that are systematic, sustained, and accountable.

This operational shift reflects a growing understanding that voice is not a one-time survey or a quarterly focus group. It must be an ongoing feedback loop that must be built into the architecture of care delivery. Just as value-based care holds systems accountable for outcomes like experiences, preferences, and priorities.

Several states are leading the way. In New York, Medicaid managed care organizations are required to convene consumer advisory boards and to include member representatives in governance structures. In California's CalAIM initiative, plans offering Enhanced Care Management and Community Supports are expected to engage community stakeholders in shaping how these benefits are delivered. And in North Carolina, the Healthy Opportunities Pilots mandate contracts with community-based organizations that reflect the populations they serve, along with performance evaluations that include consumer feedback.

Technology is helping enable this shift. Many managed care organizations are implementing digital feedback tools that enable members to comment on their care in real time. These platforms can flag concerns, identify service gaps, and help plans adjust before problems escalate. Some systems allow a window of insight into changing priorities and preferences. This dynamic approach makes care more responsive, more personalized, and ultimately, more effective.

Operationalizing voice also includes workforce strategies. Community health workers, peer support specialists, and cultural navigators are not just service extenders—they are embedded voices of the community. Their perspectives, grounded in lived experience, are increasingly seen as essential inputs in program development and evaluation. States like Oregon and Massachusetts are incorporating them into VBP contracts to guide care teams on cultural context, trust-building, and consumer-defined success.

Still, challenges remain. Not all organizations are equipped to manage participatory processes. Recruiting diverse voices, supporting accessible engagement, and responding to feedback with transparency and action all require investment, training, and accountability. When done poorly, engagement risks just checking a box rather than shifting the balance of power.

That's why consumer voice must be built into the structure of value-based systems, and not just as a temporary input, but as a standing requirement. Plans and providers must be evaluated not only on outcomes and costs, but also how they listen, respond, and evolve, as well as how they adapt their approach based on what people say they need. Incentives should reward plans that close feedback loops, publish consumer-informed changes, and demonstrate continuous improvement based on lived experience.

Value-based care was created to reimagine the healthcare system around outcomes. Centering voice is how we ensure those outcomes are real and tangible. It's how we align payment with purpose, data with dignity, and strategy with lived truth. The final step is making this not just a best practice, but a baseline.

Conclusion: From Patient-Centered to People-Led

Value-based care began with a bold proposition that healthcare should be judged not by how much is done, but by how well people live. Yet for far too long, those same people have had little influence over how "well" is defined. Systems have promised patient-centeredness while continuing to design around institutional convenience, actuarial models, and regulatory metrics.

But value cannot be delivered from the top down. It must be built from the inside out, guided by the people most affected by the decisions being made.

In this chapter, we explored what it means to move from patient-centered care to people-led care. We've seen that lived experience and rebuilding trust are essential.

Metrics are only meaningful when they reflect the goals of the people they claim to measure, and consumer voice is the foundation of that.

Across the country, Medicaid programs and value-based payment models are starting to reflect this understanding. States are embedding consumer advisory councils into governance, requiring community-based partnerships in service delivery, and compensating individuals for their insight and leadership. Technology is enabling real-time feedback and personalized goal tracking. Care teams are integrating community health workers and peer navigators to bridge the gap between system design and lived reality.

These changes are strategic ones. Consumer-led care leads to better engagement, greater trust, more accurate assessments of need, and more sustainable outcomes. All of these are central to the success of value-based payment models. In other words, centering the consumer voice is not a detour from the goals of Value-Based Payment. It is an essential component to achieving them.

Still, there is more work ahead. Centering voice requires a redistribution of power that challenges historical hierarchies, values diverse forms of knowledge, and demands structural accountability. It requires systems to ask new questions, listen with humility, and shift course in response to what they hear.

Ultimately, a value-based system that does not listen cannot be just. And a system that does not center voice cannot be sustainable. But when healthcare honors choice, co-creates care, and follows the lead of the people it serves, it does more than deliver value—it restores it.

Part IV:

Realigning Healthcare Around Equity & Outcomes

CHAPTER 14: REDEFINING SUCCESS IN VALUE-BASED CARE

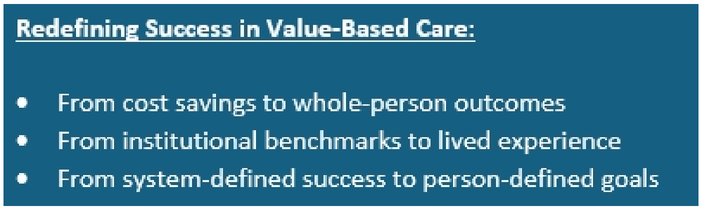
Introduction: When Value Means More Than Savings

Value-based care was born out of frustration with a system that rewarded quantity over quality, that fragmented care across providers and payers, and that left too many people behind. In its early iterations, value was defined as better outcomes at lower costs. That definition was a step forward, but as this model has evolved, so has the understanding of what success looks like.

For years, success in healthcare was measured by institutional benchmarks, such as fewer hospital readmissions, reduced emergency room visits, and improved medication adherence. These are important, but incomplete. They say little about whether someone feels safe in their home, connected to their community, or empowered in their care. They don't reflect whether a person has food in the fridge, stability in housing, or the support to return to work. They also rarely capture whether care was respectful, culturally relevant, or trauma-informed.

The true promise of value-based care is not just to reduce costs; it is also to improve patient outcomes. It is to reimagine what it means to be well and to build systems that make that vision possible for everyone. That requires us to expand our definition of success.

This chapter explores how that redefinition is already underway. From states embedding equity metrics into managed care contracts, to providers adopting person-reported outcome measures (PROMs), to Medicaid plans investing in social supports, the future of value-based care is no longer only about how much we save—it's about what we make possible.



Redefining Success in Value-Based Care:

- From cost savings to whole-person outcomes
- From institutional benchmarks to lived experience
- From system-defined success to person-defined goals

Success must be measured not only in clinical outcomes, but in lived ones. Did someone avoid a preventable hospitalization? Yes. But also: Did they feel heard? Did they regain housing? Did they reconnect with family? Did their care reflect their goals?

As we look ahead, it's clear that value-based payment models must go beyond efficiency to deliver dignity, equity, and trust. In this chapter, we will examine how success is being redefined by the metrics we use, the people we listen to, and the outcomes we reward.

Moving Beyond Cost and Utilization Metrics

When value-based care was introduced, it marked a long-overdue shift from a system that paid for services to one that sought to pay for results. However, in its earliest form, "results" were often narrowly defined. Metrics such as reducing emergency room visits, avoiding hospital readmissions, and decreasing high-cost imaging were the markers of success. While important, they offered only a partial picture.

Cost and utilization metrics were chosen not because they told the full story of health, but because they were readily measurable within existing infrastructure. They relied on claims data that was clean, standardized, and available at scale. They allowed payers and policymakers to demonstrate return on investment and justify the shift away from fee-for-service models. However, they also reinforced a system that prioritized institutional efficiency over individual experience.

In practice, this has meant that providers are incentivized to prevent costly events, but not necessarily to invest in the supports that make day-to-day life more stable or meaningful for the people they serve. A VBP model may track the number of hospitalizations avoided, but not whether the person avoided eviction. It may reward a reduction in inpatient days, but it does not indicate whether someone regained custody of their children or returned to school.

As *The Benefits of VBP for Consumers and Providers* and other emerging thought leaders emphasize, the future of value-based care must move beyond cost containment and embrace a broader vision of success rooted in well-being, autonomy, and equity. This shift is already visible in a growing number of state Medicaid programs and managed care contracts that are layering in new metrics tied to whole-person outcomes.

Some examples include:

- States requiring health plans to report on housing stability, social needs resolution, or workforce participation among enrollees.
- Providers are incorporating person-reported outcome measures into quality dashboards to capture goals like improved mental well-being, reduced isolation, or greater independence in daily tasks.
- Plans using goal-attainment scaling tools, where individuals define what success looks like for them, whether that's managing anxiety, reconnecting with family, or returning to work, and those goals are tracked over time.

The challenge, of course, is that these new metrics are often harder to standardize, validate, and incorporate into actuarial models. The difficulty of measurement should not be an excuse for exclusion, though. The metrics that matter most to people whether they engage in care, trust their providers, and stay out of crisis, must be seen as essential, not optional.

Federal policy is beginning to catch up. CMS is increasingly encouraging states to include equity-focused and person-centered measures in quality reporting, waiver applications, and managed care evaluations. Recent guidance allows for the use of social risk data in payment adjustments and encourages the consideration of non-clinical outcome domains, such as community integration, housing retention, and service satisfaction.

At the same time, some Medicaid agencies are developing new infrastructure to support this expanded vision of value. Platforms that collect real-time consumer feedback, stratify outcomes by demographic factors, and integrate non-medical data sources are beginning to power the next generation of analytics. These tools help translate individual goals into actionable insights, creating accountability for systems to deliver on more than just utilization targets.

Moving beyond cost and utilization metrics does not mean abandoning financial sustainability; it simply means considering additional factors that contribute to overall economic health. It means broadening the definition of value to include the outcomes that matter most to people. It means measuring whether care fosters stability, dignity, and independence, not just whether it reduces claims. It also means aligning payment with purpose, so that what gets funded reflects what truly matters.

Measuring What Matters to People

If value-based care is meant to center outcomes over volume, then we must ask: whose outcomes are we centering? Historically, the healthcare system has addressed this question with a narrow scope, focusing on clinical performance measures such as blood pressure control, A1c levels, and emergency department utilization. For individuals navigating complex health and social needs, these metrics only scratch the surface and provide little insight into safety, stability, self-determination, or a sense of belonging.

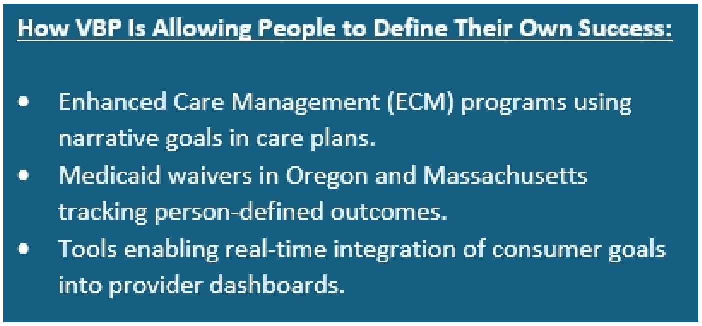
Measuring what matters to people means shifting our performance frameworks to reflect the realities of people's lives and the goals they define for themselves. It's the difference between tracking medication adherence and understanding whether someone has a safe place to store their medications. Between monitoring appointment attendance and asking whether those visits support the person's life goals. Between counting how many days someone avoids hospitalization and recognizing the value of helping them reconnect with their child, finish a degree, or remain stably housed.

This shift requires a more profound commitment to listening and co-creation. Person-reported outcome measures, narrative assessments, and shared goal-setting tools are already being used. In some states, such as California, Enhanced Care Management (ECM) programs are embedding person-driven care planning into quality expectations, utilizing individual goals not only as documentation but also as dynamic markers of success. These include aspirations like "returning to work after injury," "living without daily anxiety attacks," or "cooking meals independently again."

Such goals are not ancillary. They are central to how people experience health. When individuals set their own goals, they are more likely to stay engaged in care, follow through on services, and report satisfaction with their experience. When care teams are aligned around those goals, rather than imposing their standards, they foster a trust that is essential to lasting outcomes.

Measurement systems are beginning to adapt as well. States like Massachusetts and Oregon are incorporating goal-based metrics and person-centered outcomes into their Medicaid demonstration waivers. Some managed care organizations are investing in tools that allow integrating them in real-time, enabling them to incorporate these goals into care plans and quality tracking dashboards. Federal conversations are also increasingly focused on advancing equity through person-centered, culturally grounded indicators of well-being.

Still, scaling this work remains a challenge. Standardizing consumer-defined goals across populations and ensuring reliability for accountability purposes is difficult. That difficulty should not deter us. Instead, it should push the system to evolve because if we continue to measure only what's easy to quantify, we will miss the essence of what healthcare is supposed to achieve.



How VBP Is Allowing People to Define Their Own Success:

- Enhanced Care Management (ECM) programs using narrative goals in care plans.
- Medicaid waivers in Oregon and Massachusetts tracking person-defined outcomes.
- Tools enabling real-time integration of consumer goals into provider dashboards.

Technology can help with that. Digital platforms can visualize progress over time. The shift is not just technical, though. It is also cultural. It requires systems to relinquish control over the definition of success, to trust that individuals know what matters in their lives, and to build accountability mechanisms that reflect that trust.

In VBP, we get what we pay for. If we pay for task completion and volume, we get throughput. If we pay for outcomes defined by systems, we may get technical success without human impact. If we pay for person-defined progress, though, we can get what healthcare was always meant to deliver: better lives, on people's terms.

Reinvesting in Community Priorities

If the goal of value-based care is to improve outcomes, then communities, not just institutions, must have a say in what gets prioritized. Too often, healthcare investments reflect the needs of payers and providers rather than the lived experiences of the people those systems are meant to serve. VBP has the potential to change that. By tying payment to population outcomes rather than service volume, VBP models create a financial imperative to address root causes and an opportunity to reinvest savings in the priorities that matter most to communities.

Across the country, Medicaid programs are beginning to align their payment systems with local priorities. In Arizona, managed care organizations are required to reinvest a portion of any surplus back into community health infrastructure, including affordable housing initiatives, transportation supports, and employment services. In North Carolina's Healthy Opportunities Pilots, Medicaid dollars are flowing directly to community-based organizations to deliver services like food boxes, home remediation, and interpersonal violence support. These aren't peripheral programs; they are central components of the state's value-based strategy.

Reinvestment is also happening through shared savings models, where providers and plans that achieve improved outcomes and reduced costs can use a portion of the savings to fund upstream interventions. In some cases, this means hiring more community health workers, building stronger partnerships with faith-based organizations, or supporting digital access programs that close the technology gap. These investments are strategic, helping to prevent avoidable crises, reduce churn, and improve member engagement.

Importantly, reinvestment must be guided by the people it's meant to benefit. This means engaging consumers in participatory budgeting, advisory roles, and needs assessments that inform how savings should be used. It means asking residents what services would help them live healthier lives, and funding those answers, even when they fall outside traditional medical care. If a community identifies safe parks, youth programming, or mental health support as priorities, those should be considered legitimate, fundable interventions under a broad definition of health.

There are also promising examples of Medicaid programs supporting capacity-building within the community-based organizations they increasingly rely on. In California, for instance, CalAIM Community Supports funding includes infrastructure grants to help smaller nonprofits invest in data systems, hire staff, and meet reporting requirements. This is essential. If VBP is going to depend on social care partners, it must support their ability to deliver, not just outsource responsibility.

Reinvestment also offers a path toward equity. When VBP models prioritize outcomes that reflect social and structural barriers, such as housing stability, school attendance, or reduced incarceration, they help shift healthcare's role from crisis responder to community builder. They redirect funds from reactive care to proactive prevention, from high-cost interventions to locally determined solutions.

This shift requires transparency, though. Reinvestment strategies must be public, measurable, and tied to clear outcomes. Consumers and community leaders must be included not just in consultation, but in governance. Plans and providers must report on how dollars are spent, what results they yield, and how community input was incorporated. Without this accountability, reinvestment risks becoming performative by generating goodwill without real structural change.

Ultimately, VBP is not just a financial model. It's a moral opportunity. It allows the resources saved through better care to build the conditions that make good health possible in the first place. When reinvestment is community-led, equity-focused, and tied to real outcomes, it becomes more than a policy tool. It becomes a declaration of values.

Conclusion: Realigning the System Around What Matters

The evolution of value-based care began with a question: What if we paid for health, not just for services? In answering that question, the healthcare system has made a move from a fee-for-service model toward one that rewards coordination, prevention, and outcomes. As this transformation continues, though, it is time to ask an even more fundamental question: What kind of outcomes are we rewarding, and who gets to define them?

For too long, success has been defined in institutional terms, such as lower costs, reduced utilization, and improved adherence to clinical protocols. These goals are not wrong, but they are incomplete. They fail to capture the things people value most in their lives: stability, connection, self-determination, and dignity. When systems reward the wrong outcomes, they risk reinforcing a model of care that is efficient but not equitable, cost-effective but not compassionate.

Redefining success in value-based care means centering people, not just as patients, but as partners. It means measuring progress not only in fewer hospitalizations, but in more stable housing, restored family relationships, and regained independence. It means using metrics that reflect lived experience, setting goals by individuals themselves, and co-designing accountability structures with the communities they serve.

It also means rethinking where healthcare dollars go. When plans and providers are rewarded for outcomes rather than volume, they must have the flexibility and the responsibility to reinvest in what improves lives. Sometimes that's a clinic. Sometimes it's a community garden, a phone charger, a ride to work, or a trauma-informed case manager. In a value-based system, all of these can be health interventions if we are willing to see them that way.

This redefinition is already underway. States are layering equity metrics into contracts. Providers are using person-reported outcome tools. Medicaid programs are funding community supports and social care platforms. However, to fully realize the potential of value-based care, this shift must be embedded in every facet of the system—from payment formulas and quality dashboards to care planning and community investment.

Core Principles for Aligning Payment with Purpose:

Equity: Rewarding outcomes that close gaps.
Co-creation: Designing with, not for, communities.
Flexibility: Funding services that support stability, connection, and dignity.

The ultimate promise of value-based care is not just better outcomes; it is also improved patient experience. It is better alignment between what we pay for and what people need to live well. That alignment is not a destination. It is an ongoing process that requires humility, co-creation, and a deep commitment to honoring the full humanity of those we serve.

CHAPTER 15: POLICY, POWER, AND THE FUTURE OF VBP

Introduction: Rewriting the Rules of the System

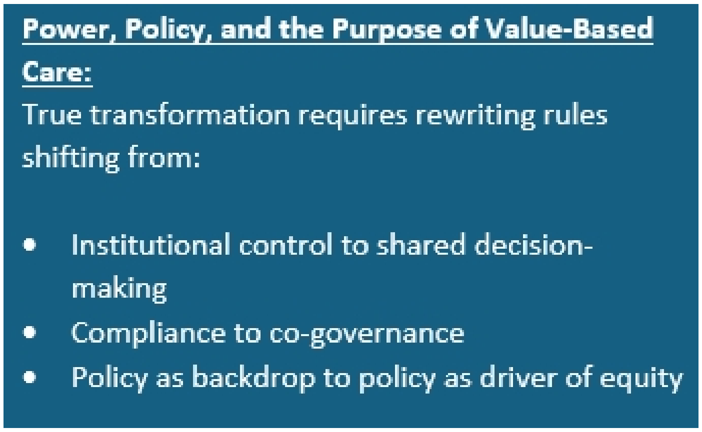
The architecture of American healthcare is built on rules that determine who gets care, how it's delivered, what gets paid for, and who has the authority to decide. For generations, those rules have favored institutions over individuals, volume over value, and compliance over collaboration. Value-based payments were introduced as a reform to challenge those rules. However, as the field matures, it's clear that reform isn't enough. The future of VBP is not just rooted in what we pay for, but in who holds power.

This chapter examines how public policy can either perpetuate the status quo or serve as a catalyst for structural change. While earlier chapters addressed how care is delivered, this chapter focuses on how systems are designed: who sets the priorities, who controls the funds, and how communities are represented or ignored in the process.

From Section 1115 waivers and Medicaid managed care contracts to federal demonstration projects and equity mandates, the levers of policy are becoming more flexible and more ambitious. States are encouraging managed care organizations to adopt equity-driven innovation. However, these same tools can also reinforce imbalances when community-based organizations are underfunded, advisory boards are under-resourced, and consumer engagement is symbolic rather than genuine.

The next generation of value-based care must do more than incentivize outcomes. It must confront the power dynamics that shape who gets left out. That means expanding who sits at decision-making tables, how funding decisions are made, and what counts as expertise.

In the pages ahead, we'll look at how states are using policy to realign healthcare with justice by rewriting the rules so that equity is not an aspiration but an operational standard. Because if VBP is truly about changing what we value, then it must start with changing who has the power to decide.



Power, Policy, and the Purpose of Value-Based Care:

True transformation requires rewriting rules shifting from:

- Institutional control to shared decision-making
- Compliance to co-governance
- Policy as backdrop to policy as driver of equity

State Innovation and Federal Levers for Change

The past decade has proven that policy is not just a backdrop to healthcare transformation. It is the engine. From Medicaid expansion to the rise of managed care and the proliferation of alternative payment models, public policy has created the conditions that made value-based care possible. As the system matures, though, it's clear that policy must also evolve to support more profound change in how care systems are governed, who benefits from innovation, and how communities shape the future of health.

Across the country, states are demonstrating that Medicaid policy can be a laboratory for equity. Through Section 1115 demonstration waivers, states are delivering care and addressing social determinants of health. These waivers allow Medicaid dollars to be used for services previously deemed "non-medical," such as housing navigation, medically tailored meals, transportation, and peer supports.

California's CalAIM initiative has become one of the boldest examples of state-led policy reform under a value-based framework. By offering Community Supports as "In Lieu of Services" (ILOS), CalAIM allows managed care plans to use funding for non-clinical interventions tied to health outcomes. These include home modifications, short-term post-hospitalization housing, and asthma remediation, all of which are services that may not traditionally appear in medical charts, but that have profound impacts on health.

In North Carolina, the Healthy Opportunities Pilots are directing Medicaid funds to community-based organizations that deliver food assistance, housing support, and transportation services. The state developed a standardized platform (NCCARE360) to coordinate and reimburse these services, demonstrating that local nonprofits can become part of a managed care ecosystem when supported with infrastructure, clear contracts, and performance standards.

Oregon's Medicaid transformation includes a requirement that Coordinated Care Organizations (CCOs) reinvest profits into local health priorities and include community members in governance. This model explicitly links payment to community outcomes and shared leadership between managed care entities and the communities they serve.

These state efforts are made possible by federal flexibilities and increasingly by federal encouragement. CMS has released guidance encouraging states to incorporate equity plans into managed care contracting, stratify quality metrics by race and ethnicity, and build community engagement into Medicaid governance. CMS is also promoting the use of Medicaid Managed Care instead of Services (ILOS) and Section 1915(i) options to expand HCBS-like services without requiring an institutional level of care.

The federal government is also testing broader models through the Center for Medicare and Medicaid Innovation CMMI, such as the ACO REACH model and the recently announced Innovation in Behavioral Health (IBH) Model, which explicitly requires participating organizations to address health-related social needs and partner with community-based organizations.

Flexibility alone is not enough, though. States must be intentional about how policy design distributes power. When waivers create new services but fail to adequately fund community-based organizations, or when they require documentation systems without providing infrastructure support, the result can be further consolidation of control in the hands of large institutions. Likewise, if managed care organizations are held accountable for outcomes but not for equitable reinvestment or authentic community partnership, transformation efforts may stall or deepen existing inequities.

States as Laboratories of Justice:
States are using Medicaid waivers and federal tools to integrate housing, food, and community services into VBP.

Policy Innovations:
- CalAIM's In Lieu of Services for housing, meals, and home modifications.
- North Carolina's infrastructure for reimbursing CBOs for SDoH.
- Oregon's community reinvestment and shared governance through CCOs.

To ensure that VBP policy truly shifts systems toward equity, state and federal agencies must build in guardrails and incentives that prioritize shared governance, consumer voice, and reinvestment in community infrastructure. That includes:

- Requiring plans to include consumers and community representatives in decision-making and quality oversight.
- Funding technical assistance and capacity-building for smaller providers and nonprofits.
- Embedding transparency into how savings are calculated, reported, and reinvested.
- Supporting data-sharing platforms that are accessible to both institutional and grassroots stakeholders.

These policies do more than enable better services. They change who gets to shape the healthcare system.

Ultimately, policy is not merely a mechanism for directing funds. It's a blueprint for values. The more our policies reward community-defined outcomes, fund upstream investments, and require partnership over paternalism, the closer we come to realizing a value-based system that serves everyone.

Shifting Power Through Governance and Procurement

For value-based care to deliver on its promises of equity and accountability, the transformation must reach beyond how care is funded and delivered. It must extend to how decisions are made, who has the authority to make them, and how power is shared across healthcare systems, public agencies, and the communities they serve. That means rethinking governance and restructuring procurement to elevate the voices of those historically excluded from healthcare.

Too often, governance in value-based models is dominated by institutions: health plans, hospital systems, consultants, and government officials. While these stakeholders bring operational and policy expertise, they rarely represent the lived experience of those most affected by the healthcare system. Even when community voices are invited to participate, the structures in which they operate, such as advisory boards, listening sessions, and stakeholder comment periods, often lack real decision-making power.

Shifting this dynamic requires more than inviting diverse participation. It requires building shared governance structures that embed consumers, community-based organizations (CBOs), and frontline workers into the DNA of value-based programs.

Some states are already beginning to model this shift. In Oregon, Community Care Organizations (CCOs) are required to have community advisory councils with real influence over funding priorities, community benefit investments, and equity strategies. In Massachusetts, behavioral health reform efforts have included people with lived experience on design teams and oversight boards, ensuring that those most affected are co-architects of the system. And in New York, recent waiver proposals include requirements for consumer involvement in governance, with funding set aside to support participation.

However, governance is only part of the picture. Procurement, which involves how states and health systems contract with vendors, plans, and community organizations, is a powerful yet underutilized lever for equity and power-sharing. Too often, procurement processes favor large, legacy organizations with the staff, infrastructure, and legal support to navigate complex applications and compliance systems. Smaller, community-rooted organizations, which are often the most trusted and most responsive, are locked out.

Reforming procurement means making intentional decisions about who is eligible to receive funding, how applications are evaluated, and what supports are in place to ensure equitable access to contracting opportunities. It means simplifying requirements where possible, providing technical assistance and pre-development grants, and explicitly valuing community trust, cultural competency, and lived experience alongside traditional qualifications.

Some states and systems are experimenting with set-asides and equity scoring in procurement. For example, contracts may award additional points to CBOs led by people of color or require managed care organizations to subcontract a percentage of their value-based care delivery to minority-owned or community-led entities. These strategies help redistribute resources and embed equity into the core of service delivery.

Other innovations include participatory budgeting and community co-design of Requests for Proposals (RFPs). These approaches provide residents and stakeholders with the opportunity to define funding priorities, shape program requirements, and select partners based on what their communities need.

Procurement reform also plays a critical role in ensuring that social care integration is grounded in equity. As more states use Medicaid dollars to fund housing supports, food access, and peer services, stakeholders need to know they’re not just vendors in a supply chain but partners in a shared mission. That requires leveling the playing field so they can compete, participate, and lead.

Embedding Equity in Governance and Procurement:
VBP requires elevating community voices and structural reforms, including:

- Consumer seats on boards with real authority
- Equity-based scoring in procurement processes
- Community co-design of RFPs and funding

Shifting power through governance and procurement is not about sidelining traditional institutions; it is about empowering them. It’s about balancing the table and recognizing that community voice is not a supplement to expertise, but a form of knowledge in its own right. When implemented effectively, these reforms enhance system responsiveness, foster trust, and lead to care models that reflect the needs and wants of people.

Ultimately, the future of value-based care depends not only on paying differently but also on deciding differently, and on making different decisions. The question is no longer how we pay for care; it is also how we provide it. It is who gets to shape it. When communities are given that power, value-based care becomes more than a funding strategy. It becomes a platform for justice.

Funding the Infrastructure for Equity and Engagement

Building an equitable, consumer-driven healthcare system is a matter of infrastructure. Shared governance, authentic community engagement, and integrated social care all require time, staffing, data systems, and technical capacity. Yet in many value-based payment environments, these enabling structures are underfunded, underbuilt, or entirely overlooked.

While much attention in value-based care is focused on how providers and plans are reimbursed, the ability to deliver on equity and engagement goals depends on whether the system is willing to invest in the scaffolding that supports them. When community-based organizations are asked to participate in care delivery but not funded to scale, report, or coordinate, the burden falls on the very entities least resourced to carry it. When consumers are asked to engage in governance or advisory roles without compensation, the result is often exclusion, rather than inclusion.

Infrastructure is what turns a good policy into a working system. It includes the technology to share data across sectors, the people to coordinate care across silos, the training to support cultural and linguistic responsiveness, and the funding to build and sustain trusted local networks. Without this foundation, even the most progressive VBP models risk replicating the very disparities they aim to address.

Investing in the Infrastructure for Equity:

- Data platforms for care coordination and performance tracking.
- Compensation for consumer participation and peer leadership.
- Funding to scale small, community-based partners.

Fortunately, more states are recognizing that VBP must include infrastructure funding, especially when social care integration and community engagement are central goals. In California's CalAIM, implementation funding was provided to help plans and providers build the necessary systems to deliver Community Supports, including contracting with Community-Based Organizations (CBOs) and developing data-sharing platforms. Some counties received dedicated investments to train care managers, integrate housing navigation services, and launch digital tools for cross-sector collaboration.

Funding infrastructure also means investing in consumer participation. States like Oregon and Massachusetts are compensating Medicaid members who serve on governance bodies, valuing their time and insight as essential to the system's success. Some health plans have started paying stipends to peer reviewers who evaluate service quality from a lived experience perspective. CMS has also encouraged states to include engagement infrastructure, such as training, transportation, translation, and digital access, in their Medicaid administrative budgets.

Technology plays a significant role in this equation. Cross-sector data platforms, real-time feedback tools, and goal-tracking apps are all operationalize whole-person, consumer-defined care. These tools require investment in onboarding, interoperability, and ongoing support, especially for small providers and community-based partners. When plans or states expect CBOs to participate in performance measurement without providing the necessary funding for these tools, the system becomes extractive rather than collaborative.

Equity infrastructure also includes investment in the non-clinical workforce. Community health workers, peer navigators, and care coordinators are essential bridges between institutions and communities, and cannot be excluded from strategic workforce planning. VBP models must ensure that these roles are reimbursed, protected, and integrated. They should not be seen as side programs, but as core components of quality care.

Ultimately, a value-based system that prioritizes outcomes that make those outcomes possible. That means budgeting not just for what we deliver, but for how we build the systems that deliver it. It means investing in the long game: in relationships, infrastructure, and the capacity of communities to lead.

Without this investment, value-based care risks becoming a strategy that benefits only those who are already well-positioned. With it, we can begin to create a system that not only rewards health but also enables it.

Conclusion: Power With, Not Power Over

The most meaningful changes in healthcare won't come from new billing codes or reimbursement models alone. They will come from a shift in who has the power to shape the system and how that power is shared. Value-based care may have started as a technical fix for a broken payment system. Still, its future lies in its capacity to restructure relationships: between institutions and individuals, between funders and frontline workers, and between healthcare and the communities it serves.

In this chapter, we've explored how public policy is the proper infrastructure of transformation. Through waivers, contracts, procurement rules, and engagement mandates, policymakers hold the tools to realign healthcare around justice. States are proving that Medicaid can serve as a platform for innovation. We're not just talking about in-care delivery, but in governance, equity, and accountability. Federal guidance is opening the door to deeper integration of social care and consumer voice. These shifts will only matter if they come with real investments in processes, and partnerships, accompanied by real investments in these areas.

To create a system where value means more than cost reduction, policy must support power with, not power over. That means building decision-making structures where consumers aren't just consulted, but co-leading. It means contracts that don't just reward outcomes, but require transparency, reinvestment, and participation. It requires giving community-based organizations the resources to compete, the data to engage, and the seat at the table they've always deserved.

It also means recognizing that every policy choice is a statement of values. When procurement favors scale over trust, we prioritize efficiency over equity. When engagement is unfunded, we reinforce exclusion. When we fail to fund infrastructure, we send the message that transformation can happen without tools, which it can't.

The promise of value-based care remains real, but it cannot be achieved solely through metrics and incentives. It must be grounded in a new theory of change that honors lived experience, redistributes influence, and funds the infrastructure that enables collaboration.

In the end, healthcare isn’t just about services. It’s about systems, and systems change when power shifts. That is the future of VBP, and it’s a future built not on control, but on partnership.

CHAPTER 16: A BLUEPRINT FOR A MORE EQUITABLE SYSTEM

Introduction: From Framework to Future

Throughout this book, we've explored how value-based payments have evolved from a cost-containment strategy into a vehicle for transformation. What began as an effort to rein in spending and reduce duplication has grown into something far more ambitious: a platform for whole-person care, a tool for advancing equity, and a mechanism to shift power toward consumers and communities.

Yet for all its promise, value-based care remains at a crossroads. Many of its models are still constrained by outdated infrastructure, rigid metrics, or institutional inertia. Too often, equity is mentioned but not measured. Engagement is invited but not supported. Social care is acknowledged but not funded.

The future of value-based care will depend on our ability to close the gaps between aspiration and action, and between pilots and permanence. We need not just programs, but systems. Not just innovations, but investments. And not just new payment models, but new values embedded into the policies, processes, and partnerships that shape healthcare delivery.

This final chapter outlines a blueprint for a more equitable system, providing a set of principles and actionable steps for health plans, providers, states, and advocates working to ensure that value-based care fulfills its highest purpose. The blueprint doesn't just aim for better outcomes. It asks: better for whom, by whose definition, and with whose leadership?

We will close this book by identifying the core shifts that must happen to move to a value-based framework because the most enduring innovation isn't in what we pay for—it's in who we listen to, how we share power, and what kind of system we are brave enough to build together.

Principles for Equity-Driven Value-Based Care

Building an equitable healthcare system through value-based payment is not simply a matter of adding equity metrics to existing frameworks. It requires a more profound reorientation toward relationships over transactions, communities over institutions, and trust over control. To guide this shift, we must ground our systems in a clear set of principles that reflect not only what we want to fund, but who we want our systems to serve and how.

These principles are drawn from the lessons and innovations explored throughout this book. They are rooted in the idea that equity is not an outcome we achieve at the end of a contract; rather, it is a continuous process. It is a process that must shape every decision along the way.

1. Start with Lived Experience: The most effective systems begin not with top-down assumptions, but with the knowledge of those who navigate them every day. Consumers, caregivers, and community-based organizations must work together to define what value means. Their insights must be reflected in care models, metrics, and payment design. Lived experience is not anecdotal—it is expertise.

2. Redefine Value Around People, Not Just Utilization: Traditional VBP models often define success as reducing hospitalizations or cutting costs. However, a person-centered system must look beyond utilization and measure outcomes that reflect stability, connection, and autonomy. This means incorporating person-reported outcomes, goal-based metrics, and culturally responsive measures that track what matters most to people.

3. Share Power at Every Level: True transformation requires rebalancing decision-making. This means embedding consumer voice in governance, funding community-led solutions, and creating procurement systems that enable smaller organizations to compete. It also means holding plans and providers accountable for co-designing services and structures with the communities they serve. This means not after the fact, but from the start.

4. Fund the Infrastructure for Equity: Equity doesn’t scale without support. Data systems, care coordination platforms, community partnerships, and peer-led models all require stable funding to function effectively. Similarly, efforts such as engagement initiatives, advisory councils, and culturally competent workforce development are also significant. Value-based care cannot demand transformation without resourcing the people and processes that make it possible.

5. Invest in Relationships, Not Just Outputs: Trust is a measurable health outcome, and a foundational one. Systems must make space for continuity, respect, and relationship-

building. This includes funding models that reward time spent understanding consumer goals, supporting non-clinical staff like CHWs and peer specialists, and designing care around healing, not just efficiency.

6. Embed Equity into Accountability: Equity must be built into the scorecard and not treated as an optional add-on. That means stratifying quality measures by race, disability, income, and language. It means tying payment to a reduction in disparities, not just to average improvements. It also means requiring transparency around who benefits from savings, services, and influence.

These principles are not just philosophical; they are operational. They translate directly into contract language, oversight structures, program design, and quality frameworks. When applied consistently, they make equity actionable, measurable, and fundable.

Principles alone are not enough, though. In the next section, we'll explore the practical steps that states, payers, providers, and advocates can take to embed these values into the real-world implementation of value-based care.

Practical Steps for Realigning Systems Around Equity

To truly move the healthcare system toward equity through value-based care, every stakeholder must translate ideals into action. That means changing how contracts are written, how data is collected and utilized, how funding is allocated, and how accountability is enforced.

Below are practical strategies that can be adopted by states, health plans, providers, and advocates to realign systems around equity:

1. Require Equity Metrics in All VBP Contracts
States and payers must move beyond generalized quality scores and begin requiring equity-specific performance indicators. This includes:

- Stratifying all core metrics by race, ethnicity, language, and disability status.
- Including incentives or penalties based on reductions in disparities.
- Measuring access to social supports, housing stability, community integration, and culturally responsive care.

These metrics must be accompanied by transparent public reporting and integrated into ongoing quality improvement efforts, rather than being buried in optional dashboards.

2. Build Community Engagement Into Governance and Procurement
Operationalizing voice means:

- Mandating consumer and community representation in Medicaid managed care governance bodies and waiver oversight councils.
- Funding engagement infrastructure, including stipends, transportation, interpretation services, and digital access.
- Including equity scoring and set-asides in procurement processes to ensure community-based organizations can compete for contracts.

When these structures are built into program design, not just tacked on at the end, community participation becomes real, not symbolic.

3. Fund Capacity-Building for Community-Based Organizations

Community-based organizations (CBOs) are increasingly being asked to deliver care, address social needs, and participate in data systems. The issue is that many cannot comply with traditional healthcare contracting requirements. States and plans should:

- Provide technical assistance and pre-development grants for CBOs.
- Offer simplified contracting models with tiered compliance expectations.
- Create shared infrastructure platforms that reduce administrative burden.

Without this investment, CBOs will be sidelined in favor of larger providers, even when they're more trusted and effective.

4. Integrate Consumer-Defined Outcomes Into Care Planning and Reimbursement

Providers should adopt shared goal-setting models and use person-reported outcomes as part of care coordination and quality measurement. Plans can tie portions of reimbursement to the achievement of these individualized goals.

Some approaches include:

- Goal-attainment scaling in care management platforms.
- Digital tools that allow members to update their goals and track progress.
- Training for care teams to develop culturally sensitive, strengths-based goals with members.

This personalization ensures that value is defined by the people receiving care, not just by institutional checklists.

5. Expand and Sustain the Equity-Focused Workforce

States and plans must embed funding for community health workers, peer support specialists, and cultural navigators into their value-based payment models. And not just as pilots, but as core elements of care delivery. This includes:

- Establishing certification pathways and reimbursement structures.

- Including non-clinical workers in multidisciplinary teams.
- Funding supervision, ongoing training, and career pathways.

A workforce that reflects the communities it serves is not a cost center; it is an investment. It is a health equity intervention.

6. Reinvest Savings Into Community-Identified Priorities
Shared savings models must include requirements, at a minimum, incentives for reinvesting a portion of the savings into initiatives defined by consumers and community leaders. This can be formalized through:

- Participatory budgeting processes.
- Community investment boards.
- Transparent tracking of reinvestment commitments and outcomes.

These reinvestments can extend beyond clinical care to support upstream drivers, including housing, education, digital equity, and youth development—all of which have a measurable impact on health.

Taken together, these strategies offer a roadmap for transforming value-based care from a technical model into a justice-driven movement. They demonstrate how to move from metrics to meaning, from engagement to co-leadership, and show how to transition from equity as a goal to equity as a standard.

Conclusion: Delivering the Promise of Value

Value-based care was never meant to be just a new way to pay for healthcare. It was meant to be a new way to define it.

At its best, value-based payment offers a powerful realignment of incentives away from institutional priorities and toward individual needs. Whether that realignment leads to equity or simply to new versions of old systems depends on what we choose to value.

Throughout this book, we've seen that fundamental transformation demands more than financial reform. It requires a shift in culture, in power, and purpose. It asks us to see care not as a series of services, but as a relationship grounded in trust. It asks us to define success not in spreadsheets, but in stories of stability regained, autonomy restored, and communities strengthened.

Delivering the promise of value means centering lived experience, measuring what matters to people, and funding the infrastructure that makes care truly accessible and accountable. It means holding systems responsible not just for outcomes, but for how those outcomes are achieved and for whom.

This work is urgent. Because the gaps in trust, in access, in opportunity—especially for Medicaid beneficiaries, people with disabilities, and those navigating multiple systems—are not abstract. They are daily realities with life-altering consequences. If value-based care continues without equity at its core, it will replicate the very harm it seeks to repair.

There are challenges, but if we get it right, value-based care can be more than a payment model. It can be a platform for human dignity, building systems that care not only about outcomes, but also about the people behind them.

That is the future we must choose. That is the future we must fund. And that is the future that value-based care, reimagined through the lens of equity, can finally begin to deliver.

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