

Addressing Adolescent Health Care and Well-Being Through Financial Incentives

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TAKEAWAYS

- Adolescence is a period of significant mental, physical, and emotional development. It is also a time when young people may experience the onset of behavioral health conditions like depression, or engage in risk-taking behavior, such as drug and alcohol use.
- An effective tool to address adolescent wellness is the annual well visit, even though it is underutilized. When young people do attend these visits, they may not receive routine screenings or referrals that address their behavioral health or social needs.
- Financial incentives, including value-based payment (VBP) strategies, can improve adolescent care delivery and wellness by encouraging providers to offer more holistic care that treats physical health concerns and addresses mental health, substance use, and health-related social needs (HRSN).
- This brief identifies five opportunities to incentivize high quality care for adolescents: (1) linking payment incentives to adolescent wellness visits; (2) supporting and incentivizing providers to build rapport with adolescents and their families; (3) promoting multidisciplinary and integrated care; (4) incentivizing providers to address adolescents' behavioral health and HRSN; and (5) pooling money from different sources to support adolescent wellness.

Adolescence is marked by significant mental, physical, and emotional changes, as well as autonomy-seeking behavior as individuals approach adulthood. While it is physiologically one of the healthiest phases of life, adolescence (defined in this brief as ages 12-19) is also a developmental period in which youth may engage in risky behavior, such as experimentation with drugs and alcohol.^{1,2} These risk factors necessitate a tailored approach to health care that recognizes adolescents' developmental needs. Health care services for adolescents are often siloed, which may require adolescents and their families to seek services from multiple providers who may not communicate with one another about patient care. There is also a shortage of adolescent health specialists who focus solely on the unique



developmental needs of this population. Financial incentives, including value-based payment (VBP) models, can improve adolescent care delivery and wellness by encouraging primary care providers to provide more holistic care that treats not only physical health concerns, but also addresses drivers of individual health outcomes like mental health, substance use, and other health-related social needs (HRSN).³

The Center for Health Care Strategies (CHCS), with support from the Conrad N. Hilton Foundation, conducted a literature review and interviewed child health experts, adolescent care providers, child health researchers, child health policymakers, and payment reform experts to identify opportunities and challenges related to better addressing adolescent health and wellness through provider financial incentive strategies.

From these activities and a small group consultation, CHCS developed a set of recommendations for supporting provider financial incentives that can help improve adolescent wellness and care. This brief reviews the current landscape of adolescent care, including opportunities to improve access and delivery, and outlines five key strategies to support the development of incentives for providers to deliver comprehensive, developmentally appropriate care that addresses high-risk behaviors associated with adolescence.

Payment Terminology

For definitions on key payment-related terms used in this brief, see the [Payment Terminology Glossary](#) at the end of this brief.



The Current Standard of Adolescent Care

An annual wellness visit is the only standardized and endorsed guidance regarding the frequency of adolescent care.⁴ Annual well-visits provide a valuable opportunity for providers to influence adolescents' health and development.⁵ The American Academy of Pediatrics (AAP) recommends that adolescents be screened yearly for developmental, behavioral health, and substance use concerns.⁶

While the well-visit provides a single opportunity each year to identify concerns, these visits are often underutilized.^{7,8} A 2009 AAP study found that 38 percent of adolescents had a preventive care visit in the prior year, and that uninsured youth and those living with low incomes were at higher risk for not attending an annual visit.⁹ A 2010 study found that approximately 30 percent of adolescents did not attend a preventive visit at all from ages 13-17.¹⁰ This lack of routine well visits may inhibit providers from establishing rapport, asking appropriate screening questions, and connecting youth to services and supports that meet their individual needs. Additionally, without regular

contact, providers may not be able to identify emerging needs related to adolescents' mental health, substance use, and sexual health.

When adolescents do attend preventive visits, providers may not discuss risk-taking behavior or provide guidance that supports good decision-making to reduce or avoid risky behaviors. One reason for the lack of more regular screenings may be provider knowledge and support. Many providers, especially physicians, report that they do not feel adequately equipped and trained to screen and address adolescents' risky behavior or may not be reimbursed for services.¹¹ Confidentiality may be another barrier to addressing sensitive issues. Adolescents may withhold personal information like sexual activity or substance use even when seeing providers alone, out of fear that such information will be shared with their parents or provider staff.¹² Lastly, when concerns are identified, providers may not refer adolescents for follow-up services because they are not aware of the services available to address those issues.

Health Risk Screening for Adolescents: By the Numbers



Just over a third of adolescents received anticipatory guidance on seat belts, helmets, and secondhand smoke, and approximately half received guidance on healthy eating.¹³



Only 40 percent of youth had time alone with their providers.¹⁴



67 percent of primary care providers screened adolescents for mental health, and approximately 35 percent for suicide risk.¹⁵



33 percent of youth were not screened for HRSN in the past year, and when they were, over 75 percent of youth screened positive for at least one major social need.¹⁶



Only three percent of providers reported that they were appropriately compensated for behavioral health and suicide risk screenings.¹⁷



When referring for behavioral health services, only 21 percent of providers received an update from behavioral health providers after making a referral.

The next section outlines recommendations for implementing financial incentives to improve the quality of adolescent care by increasing attendance at adolescent health visits; improving rapport between providers and patients; increasing the use of screenings, including those to address behavioral health and social needs; and increasing overall provider capacity to engage with the adolescent population.

Spotlight: Use of Screening, Brief Intervention, and Referral (SBIRT) in Primary Care

Substance misuse is one of the most prominent issues to emerge during adolescence, yet substance use disorder (SUD) may not be identified or treated in a timely manner. Adolescents may not always recognize the need for treatment or seek it due to experiencing fewer negative consequences of substance use or a failure to recognize their own unsafe behavior.¹⁸ Most individuals who become addicted to substances began using them prior to age 18 and developed SUD by age 20.¹⁹ Adolescents with SUD also show higher rates of psychosomatic concerns, anxiety, relationship issues, and social dysfunction.²⁰ However, social norms and stigma around mental illness and SUD may reduce adolescents' (and/or their parents or caregivers') willingness to seek care.







Screening, Brief Intervention, and Referral to Treatment (SBIRT) is one approach to early identification and intervention for SUD. In the SBIRT model, the patient is screened — typically as part of the standard intake process — to evaluate the level of risk for SUD, and to determine the appropriate intensity of treatment, if any, based on that level of risk. For those who screen at a low level of risk, no intervention is delivered, but rather reinforcement of current attitudes and behaviors around substance use. For those who screen at a moderate risk, a brief intervention to enhance the individual's insight and desire to change behavior is delivered; and those who screen at high risk for SUD are referred for treatment.²¹ While the evidence is extensive for adults and alcohol use, emerging research suggests that SBIRT may be an effective approach to reducing substance use in adolescents.²² SBIRT can be implemented in the primary care setting, and to encourage uptake, providers should be made aware that screening and brief intervention reimbursement codes are available for Medicaid, Medicare, and commercial insurers in many states.²³ There are also simulations and other training tools available for providers who need additional support and practice discussing these issues with youth, which can address any hesitancy or concern about not being adequately trained in this area.²⁴

Both the federal Substance Abuse and Mental Health Services Administration and AAP endorse SBIRT, recommending that providers increase their understanding of youth substance use and incorporate SBIRT practices into universal screening.^{25,26} Additionally, the AAP calls for payers to: (1) promote and pay for standard screening and brief intervention practices; and (2) ensure a standard mechanism for payment for confidential follow-up services for adolescents to receive continuity of care for SUD.²⁷ Creating incentives for providers to take a more comprehensive approach to adolescent health could improve early identification and intervention, and subsequently, reduce rates of SUD among youth and young adults.

Recommendations for the Use of Provider Financial Incentives

There are few examples of successful provider financial incentives for adolescent care. While many provider and payer organizations increasingly pursue VBP arrangements, such models have seen less uptake when applied to the provision of adolescent care. VBP arrangements, some of which are referred to as alternative payment models (APM), are performance-based payments that link financial incentives to providers’ performance on a set of defined measures of quality and/or cost (see Exhibit 1).²⁸

Exhibit 1. Health Care Payment Learning and Action Network Alternative Payment Model Framework

			
CATEGORY 1 Fee-for-Service, No Link to Quality and Value	CATEGORY 2 Fee-for-Service, Link to Quality and Value	CATEGORY 3 APMs Built on Fee-for-Service Architecture	CATEGORY 4 Population-Based Payment
	A Foundational Payments for Infrastructure and Operations	A APMs with Shared Savings	A Condition-Specific Population-Based Payment
	B Pay-for-Reporting	B APMs with Shared Savings and Downside Risk	B Comprehensive Populations-Based Payment
	C Pay-for-Performance		C Integrated Finance and Delivery System
		3N Risk-Based Payment <u>NOT</u> Linked to Quality	4N Capitated Payments <u>NOT</u> linked to Quality

Adapted from *Alternative Payment Model (APM) Framework: Refresh for 2017*. The MITRE Corporation. 2017. Available at: <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

Note that total cost of care models mentioned in this brief are classified as Category 3 or 4 APMs. While such arrangements have the potential to align payer, provider, and patient interests, there is currently little research or experience with models that have a specific focus on the quality or cost of care for adolescents. This section outlines considerations for the implementation of financial incentives, including VBP arrangements, to improve care delivery for adolescents.

Financial Incentive Opportunities in Adolescent Care

Financial incentives may promote better adolescent care by encouraging the performance of evidence-based practices or provision of beneficial services for adolescents. Five opportunities to employ provider financial incentives to improve adolescent care outlined below include: (1) linking provider financial incentives to wellness visits; (2) encouraging providers to build rapport with adolescents and their families; (3) promoting multidisciplinary and integrated care; (4) encouraging providers to address adolescents' health-related social needs; and (5) pooling money from different sources.

1. Link provider financial incentives to adolescent wellness visits.

An annual adolescent wellness visit is the only point of contact many adolescents have with their primary care provider. Financial incentives could help ensure that adolescent providers encourage their patients to come in for this critical visit.

A quality metric could be used to reward providers for adolescent attendance at annual well-visits. Such a metric would measure the percentage of adolescent patients that had a well-visit over the past year, and tie performance on that metric to either a financial bonus or penalty through a pay-for-performance (P4P) incentive (LAN Category 2B) or a Category 3 or 4 APM. A direct tie to attendance via a P4P incentive offers a clear incentive for providers to improve on this metric, but the effectiveness of P4P incentives, however, is limited.^{29,30} Tying the metric to a shared savings or capitated arrangement would offer a less direct incentive (as a financial reward would also be tied to the adolescent's total cost of care [TCOC]), but it could help to align incentives. For example, while delivery of a fixed fee for care under a risk-adjusted capitated arrangement could create a disincentive to conduct a well-visit since the provider would be paid the same amount whether the adolescent has a well-visit or not, providers may choose to encourage a well-visit to avoid providing future, more costly services and perform better on quality metrics associated with the payment.

2. Support and incentivize providers to build rapport with adolescents and their families.

A cornerstone of adolescent wellness is ensuring that the adolescent trusts that their provider's advice is sound and that their questions and information will be handled confidentially. Adolescents may be hesitant to share their experiences in health care settings if they are not assured of confidentiality, particularly around risk-taking behaviors.³¹ Building and maintaining a rapport with adolescents is key to transparent conversations about their health and preventing or reducing risk-taking behaviors.

Patient experience metrics are one way to evaluate the rapport developed by providers and adolescents, which could be assessed through patient surveys. Questions could be specifically targeted to measure trust and perception of confidentiality, whether the patient perceives that the provider cares about their health and well-being, and whether the youth feel judged or supported around their behavior. Scores on these metrics could be tied to payment through a P4P bonus or using the metric as part of a shared savings, shared savings/risk, or capitated arrangement.

Another opportunity to build adolescent providers' rapport with patients is through provider education on trauma-informed care and culturally congruent care. These educational opportunities are designed to give clinicians knowledge on how to better connect with patients by understanding their perspective based on past experiences or cultural context. While such trainings are common, they may be costly to providers. Creating a financial incentive for providers or provider organizations to complete courses may be an effective way to improve uptake. In addition to building rapport with patients, providers should have a meaningful understanding of adolescents' needs in the context of their families. Educating and engaging parents to help foster healthy environments for their adolescent children is a critical point of care. Additionally, adolescents' parents may have experienced unhealthy patterns in their own upbringing, which can lead to similar unhealthy patterns that result in adverse childhood experiences (ACEs) for their children. Parents may wish to break those generational cycles of trauma and adversity.³² Under the current system of care delivery, however, there may be little time, structure, and incentive for providers to proactively engage parents and families in in-depth conversations about issues that may impact their ability to provide a healthy environment. To ensure these conversations occur, payers should consider reimbursing providers for the time spent with families and their children, jointly and individually.

Small Group Consultation

The following insights, which were essential to the development of this brief, were shared by child and adolescent health subject matter experts, state officials, and primary care and behavioral health providers during CHCS' small group consultation.



Adolescent Preventive Care and Screening

1. Providers may only conduct screenings if they are reimbursed. In the case that they are paid or incentivized to screen, providers may still be reticent, as they do not want to identify an issue if they lack the tools or information to adequately address it.
2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) does not provide enough specificity related to social needs and does not allow providers a holistic view of an adolescent's well-being, given it is task-oriented and not easily translated across different clinical environments.
3. While ACEs screenings can be helpful tools, they alone are not predictors of adolescents' risk-taking behavior. A more thorough follow-up assessment, such as the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment, can identify emerging concerns, including unsafe behavior.³³
4. The CANS, which gathers information on children's and caregivers' needs and strengths, is not used in most clinical settings. If adopted as a tool in more states and required for Medicaid-enrolled children, this assessment can help providers from a population health perspective as data can be looked at across providers and populations.

Care Models and Understanding Family Needs

1. Employing multilingual staff can help cater to adolescents and families of different ethnic and cultural backgrounds.
2. Having peers or staff of adolescent age part of a provider's practice can help make the clinical environment feel safer for youth.

Strategies to Build Trust with Adolescent Patients

1. Adolescents and providers need avenues in which they can ask one another age and developmentally appropriate questions, such as through intake screenings and standardized questionnaires. Providers may consider allowing adolescent patients to guide their conversations, beginning well-visits with asking what the adolescent needs and what they want to discuss. It is critical for providers to avoid judgment when giving responses.
2. Providers should spend more time with adolescents to take their history, ask them thoughtful questions, allow them to share their concerns, and provide necessary well-visit services.
3. Providers should explore the use of telehealth and text messaging with adolescents, as they may support improved engagement.

3. Promote multidisciplinary care.

Based on interviews, while it is not widely implemented or paid for, using a team-based model could bolster the quality of care for adolescents. Team-based care improves patient experience by having a robust care team of physicians, physician assistants, nurses, specialists, social workers, and other providers work together to tailor and coordinate services to meet the needs of the adolescent.³⁴ Having a care team can promote streamlined care for adolescents and provides opportunities to build rapport and trust with staff. Including peer workers as part of a care team can help provide youth with a sense of safety in the provider environment. With an intentional focus on representation and cultural responsiveness, employing a care team offers the potential for increased cultural and linguistic competency in care staff, which can make adolescents feel more comfortable sharing personal information.³⁵ Payers should consider reimbursing providers at a level that permits the staffing of a comprehensive team.

4. Incentivize providers to assess and address adolescents' behavioral health and health-related social needs.

The conditions in which people live, grow up, work, and age, otherwise known as social determinants of health, can profoundly impact health and well-being.^{36,37} Screening for and addressing health-related social needs (HRSN), such as housing instability or food insecurity, may help improve adolescents' health outcomes by creating opportunities for critical dialogue between the patient and provider, as well as helping identify families' unmet needs.³⁸

Behavioral health screenings, on the other hand, can lead to more conversation between primary care providers and young patients about their mental health and risk factors for mental illness.³⁹ Behavioral health screenings can also encourage discussion about adolescents' risk of engaging in unsafe or unhealthy behavior. In addition to behavioral health screenings, ACEs screenings can help providers identify trauma or toxic stress affecting adolescents, as well as the potential causes of current risky behaviors.⁴⁰

If these screenings indicate the need for more than a brief intervention, providers should ensure linkage to appropriate services and supports. P4P quality metrics tied to social needs screenings are one way to link financial incentives to the use of HRSN screening assessments, but the financial incentive to address positive screens is limited if a provider is not incentivized to follow up with social service providers or community-based organizations to address HRSN. A TCOC arrangement, such as shared savings or capitation, could provide an incentive to address social needs for adolescent patients.

While there is not a direct incentive for providers to address HRSN under such an approach, it provides flexibility for health care organizations to perform high-value services (such as HRSN screenings) that may not be reimbursed under a fee-for-service (FFS) model. Addressing HRSN also has the potential to impact costs associated with these needs, which could allow providers to achieve financial incentives under a shared savings or capitated arrangement.

Considerations for Coordination with Behavioral Health

One of the most significant barriers to accessing comprehensive care for adolescents and their families is navigating the health care system, including understanding which provider or care setting to go to for needs other than routine well care or emergencies.⁴¹ Behavioral and physical health care are often siloed, which can lead to fragmented care, especially if coordination is not proactively supported.⁴²



Coordinated physical and behavioral health care could greatly improve adolescent health outcomes and can be encouraged through financial incentives. By holding physical health and behavioral health providers financially accountable for behavioral health metrics (through P4P, shared savings, or capitation models) and/or including behavioral health services in a total cost of care (TCOC) calculation in a shared savings or capitation payment arrangement, providers serving adolescents would have a strong financial incentive to coordinate care with behavioral health providers.

Based on providers' feedback during CHCS' small group consultation, behavioral health providers may have more interaction with adolescents than primary care providers, given the frequency of behavioral health appointments and the intentional focus on relationship building as part of the therapeutic process. There is a need for systemic attention to the behavioral health workforce, such as increased numbers of behavioral health providers overall and increased representation of racial and ethnic minorities in the social work field, to foster better cross-sector work in improving adolescent care. This can also help foster more trust between behavioral health providers and adolescents of color.

The literature on effective practice strongly supports individuals being served in their communities; however, there is a considerable behavioral health workforce shortage in both rural and urban areas.⁴³ Behavioral health workers may need incentives to both join and stay in the field in areas of shortage. Additional funding is needed to support behavioral health workforce development, such as through paid trainings, internships, and student loan forgiveness, as well as in different practices where clinical hours can be supported. Of note, workforce licensing rules can be prohibitive, especially for people of color due to testing, residency, and language requirements, and other barriers.⁴⁴ States may consider revising licensing rules to remove cumbersome requirements that unnecessarily restrict these populations and/or result in disparate access.

5. Pool money from different health and social service funding streams.

Braided or blended funding mechanisms combine health care funding streams with those of social services, public health, or other areas.⁴⁵ Under a braided funding approach, each funding source must be used for its designated purpose, but a single organization or group of organizations can coordinate the funding across silos. In a blended funding arrangement, separate funding streams are combined into one funding stream. Such models offer increased flexibility for providers or other organizations to spend funding on what patients need most, whether it be medical care or helping to address social needs.

Blended and braiding funding at the payer level can help achieve better care for adolescents. States receiving federal funding for services may be limited by narrow federal requirements on covered services. Braided funding is one approach that promotes provision of additional services despite potential limitations.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive dental, physical, behavioral health, and specialty care for people under age 21 enrolled in Medicaid, is a robust benefit; however, federal requirements can inhibit flexibility and the ability to implement new models.⁴⁶ For example, federal regulations regarding waivers for children and adolescents can limit innovation. While the Centers for Medicare & Medicaid Services have the authority to waive Medicaid regulations, it cannot waive rules around data sharing and child welfare funding. Payers should consider how other funding streams (e.g., Every Student Succeeds Act education funding and child welfare funding authorized through the Family First Prevention Services Act) can be leveraged to avoid over-reliance on Medicaid, and unnecessarily limiting services and supports to those that are Medicaid-reimbursable.

High-Level Considerations for Financial Incentives

While the options provided in this brief offer opportunities for financial incentives to improve adolescent care, there is also a need for innovation. A review of case studies and states' VBP programs show that there is no single solution to effectively reimburse different types of providers for different types of activities.^{47,48,49,50} Further, many activities that benefit adolescents are not reimbursable under an FFS model.⁵¹ As a result, additional financial incentives, including VBP approaches, offer payers the opportunity to reimburse for care, time spent, and adequate staff to help keep adolescents well.

Traditionally, payers do not incentivize cost savings for adolescents due to the assumption that adolescents typically have minimal health care needs and are rarely high cost.^{52,53} However, studies have shown that Medicaid expenditures for children and youth receiving behavioral health services are significantly higher than those who do not have behavioral health needs, including adolescents.⁵⁴ Preventive services, effective screenings, and intervening before a crisis develops, however, can lead to better outcomes and lower costs later in life. Following are broad considerations for payers offering financial incentives to providers of adolescents.

Pay providers for outcomes rather than volume of services — but be flexible.

Increasingly, payers are focused on paying for quality and outcomes of services rather than volume to improve the patient experience and population health and reduce the per capita cost of care. Payment models like P4P, however, may feel like micromanagement to providers, increase administrative burden, not offer enough of an incentive to change behavior, and may not result in improved health outcomes. As a result, some payers and providers still prefer FFS to P4P. More comprehensive strategies, such as capitated payment models that link payment to measurable outcomes, could allow providers more flexibility and deliver greater improvements on cost and quality, and potentially reduce administrative burden.

Develop more holistic approaches to payment that address health-related social needs.

In addition to regular medical care, adolescents can benefit from more comprehensive approaches that address their HRSN. Braided and blended funding can allow for additional funding, coordination, and flexibility across silos to care for adolescents. More holistic approaches, however, can also be hard to organize, as many silos have

unique regulatory requirements. Federal waivers can be used to remove barriers to cross-sector collaboration, but these also require a formal review and approval process and negotiation with the Centers for Medicare & Medicaid Services.

Align requirements across payers to ease provider burden.

Aligning payment models and approaches across payers is critical for reducing burden on providers. While VBP approaches hold promise to improve patient care and control costs, they are typically more administratively complex than FFS. To help ease the burden, payers can strive to align where possible on quality metrics, infrastructure and reporting requirements, and other factors. Complete alignment, however, should not be the goal either, as some variance is needed for different populations, care settings, or focusing on areas of improvement. Alignment of payment models and incentives for adolescents should be based on provider goals in caring for this age group relative to others.

Conclusion

Many providers, child health quality experts, policymakers, and state-level officials agree that fundamental changes in funding (for primary care practices, provider organizations, etc.), care coordination, and consistency in cross-silo standards for care need to be implemented for adolescents. The strategic use of financial incentives — including those that pay for both quality and outcomes rather than quantity — can support more holistic opportunities to address adolescent-related health issues. These value-based payment strategies also aim to improve cross-sector partnerships to transform how adolescent needs are met in the primary care setting and beyond. Although financial incentives alone may not be sufficient to influence improvements in adolescent care access and delivery, they support the provider’s role in educating and engaging adolescents in their own health care and represent an area of pediatric care primed for intervening before risky health related behaviors set the course for avoidable long-term poor health outcomes and their associated expense.



Payment Terminology Glossary

- **Alternative Payment Models (APMs):** Value-based payment models specifically defined by the Health Care Payment Learning and Action Network (HCP LAN) [Alternative Payment Model Framework](#). Many payers and providers use this framework to define value-based payment models.
- **Bundled Payment:** An upfront payment for a defined set of services, delivered over a defined period of time. Such payments are typically used for episode of care models.
- **Episode of Care:** A measure of a defined set of services over a defined period of time. Such episodes are triggered by an event, and generally used for specific time-limited interventions involving multiple providers (e.g., a knee replacement) or management of a specific condition (e.g., maternity care, diabetes). Episodes of care typically are coupled with a shared savings/risk arrangement or bundled payment.
- **Fee for Service (FFS):** Payments to providers made for units of service delivered.
- **Global/Capitated Payment:** Payment model in which providers receive an upfront payment to cover a wide range of services for a patient or population. These payments are usually made on a per member per month (PMPM) basis.
- **Pay for Performance (P4P):** Payment models in which providers may earn incentives or penalties for performance on quality or efficiency measures. Such models can be used in conjunction with a Fee for Service model, or as part of a Total Cost of Care Model.
- **Shared Savings/Risk Arrangements:** Payment model in which providers that succeed in keeping costs below a total cost of care benchmark keep a percentage of the savings generated. Under shared risk models, providers are also accountable for downside risk, paying a portion of the costs above the benchmark should that benchmark be exceeded.
- **Total Cost of Care (TCOC):** Term used to define and measure cost benchmarks and performance for value-based payment models. Refers to the amount of cost generated by serving a patient or population over a defined period of time. Shared Savings/Risk arrangements, bundled payments, and global/capitated payments typically use total cost of care calculations.
- **Value Based Payment (VBP):** Broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality, cost, and/or resource use.

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ENDNOTES

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