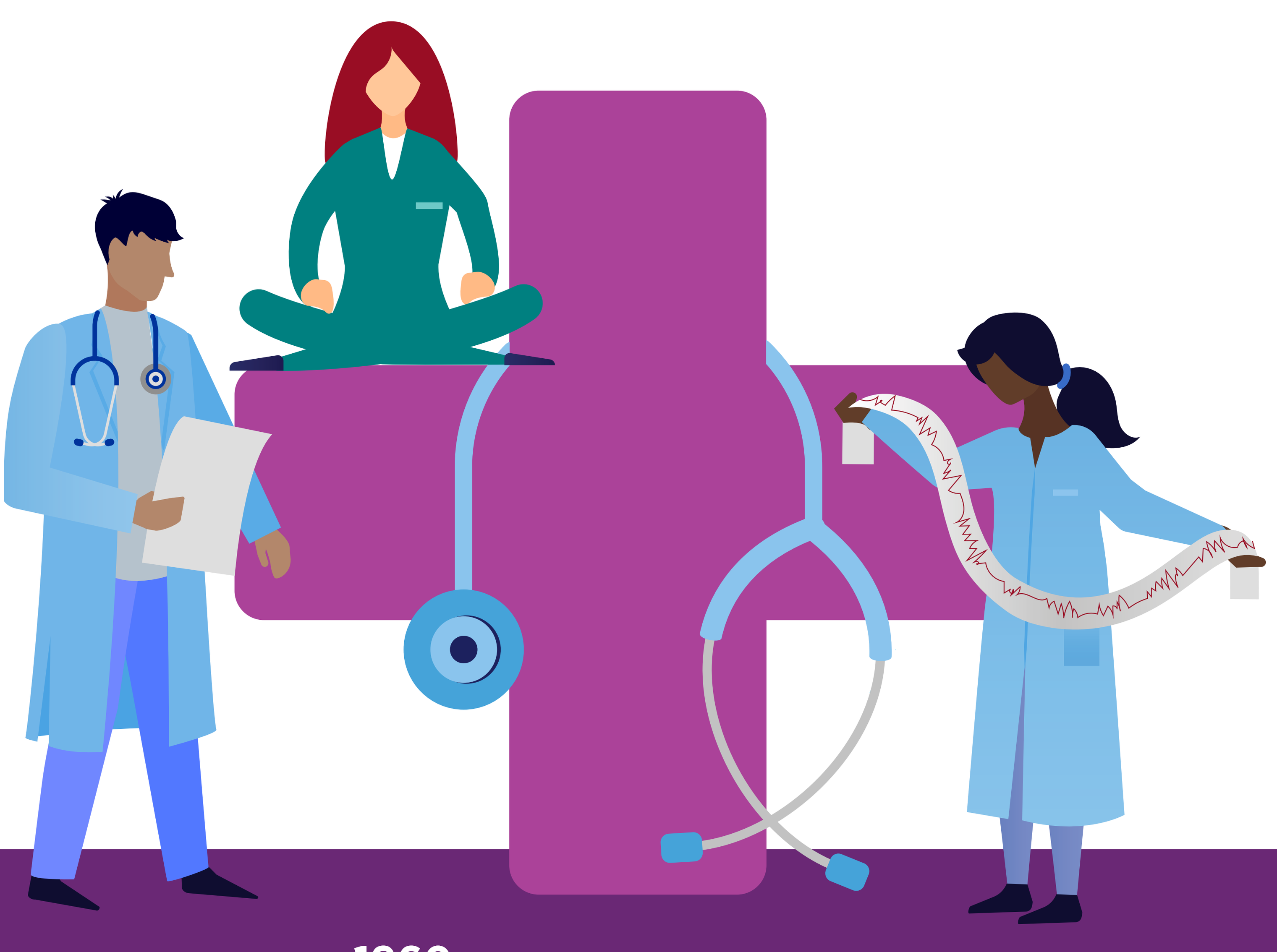
6 Key Milestones in the History of Full-Risk, **Value-Based Care**



Introduced in the late **1960s**, what we now call value-based care (VBC) has remained the preeminent alternative to fee-for-service (FFS). FFS, the dominant healthcare model in the United States, has long been associated with skyrocketing costs, reduced care access, over-reliance on specialty medicine and procedures, and diminished care quality.

Full-risk VBC emphasizes quality over volume, prevention, and primary care. Since the 1970s, full-risk capitated payment structures have been foundational to VBC delivery. These six milestones represent achievements and valuable lessons that helped pave the way for modern full-risk adopters, proving that today's VBC can transform U.S. healthcare.

1970

Pediatrician and healthcare reformer Dr. Paul Ellwood coins the term Health Maintenance Organization (HMO).

Dr. Ellwood saw HMOs as nonprofit organizations offering comprehensive care within a designated provider network in exchange for fixed annual payments. Dr. Ellwod envisioned cost containment primarily via preventive medicine, including annual exams, screenings, and immunizations.

1973

The Health Maintenance Organization (HMO) Act of 1973

Based on Dr. Elwood's ideas, this legislation created a Federal assistance program supporting the establishment and expansion of HMOs operating under a capitation model.

Source: https://www.ssa.gov/policy/docs/ssb/v37n3/v37n3p35.pdf

1982

Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982

TEFRA established Medicare C (now called Medicare Advantage), which authorized the use of Medicare funds for private, capitated HMO plans.

Studies showed the program's benefits included:

- An average of **16.8% shorter hospital stays** compared to FFS patients.
- Patients receiving care of the same quality as those in the FFS system with lower out-of-pocket costs and better coverage.
- Costs across hospital, physician, home health, and skilled nursing facilities were around 10.5% less than reimbursement to FFS providers for the same services.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193415/

1990s

The Demise of HMOs

Changes in healthcare's financial and legislative landscape derailed traditional HMOs and allowed for-profit HMOs to take over the market.

To increase the bottom line, for-profit networks began leaning on providers to limit patient visits and deny medical services, leading to poorer clinical outcomes.

Consumer backlash caused a sharp HMO enrollment decline, and FFS again became the primary U.S. healthcare model.

Source: https://facultystaff.richmond.edu/~bmayes/pdf/RMayes_MMA_JHealthLaw.pdf

> "Although only about a quarter of Americans are now enrolled in HMOs, the HMO movement has changed almost every part of the health care system. HMOs helped draw attention to health care costs, encouraged the use of evidence-based guidelines for clinical care, and, to some extent, promoted the advantages of primary care and preventive services."
>
> – **The Rise and Fall of HMOs:** An American Health Care Revolution by Jan Gregoire Coombs, 2005.

2006

Michael Porter and Elizabeth Olmsted Teisberg coin the term "Value-Based Care"

In their landmark book, **Redefining Healthcare**, Porter and Teisberg state that competition in healthcare should be based on value to the patient instead of zero-sum competition focused on shifting costs, increasing bargaining power, or restricting services.

2010

The Affordable Care Act (ACA)

Among its many other provisions for reform, the ACA codified values-based care reimbursement, encouraging providers to adopt new models of care that prioritize value over volume.

The ACA and Medicare Advantage

The ACA restructured payments to Medicare Advantage (MA) to close a cost gap between MA and Original Medicare. Studies show these cuts didn't significantly decrease care access or increase costs for enrollees.

Since the passing of the **ACA**, MA has realized the following:

- **50%** Increase in enrollment
- **99%** Beneficiaries with a $0 premium
- **98%** Beneficiaries with Part D prescription coverage
- **100%** Enrollees that have preventive care services fully covered

Almost **100%** of beneficiaries now have access to a **Medicare Advantage** plan in their area.

Sources: https://www.ajmc.com/view/did-medicare-advantage-payment-cuts-affect-beneficiary-access-and-affordability

https://www.fiercehealthcare.com/payer/medpac-majority-medicare-beneficiaries-to-be-ma-by-2023-but-coding-issues-remain-rampant

Full-Risk VBC Today

As health plans increase MA contract options, more providers are realizing improved quality of care delivery, better health outcomes, enhanced patient experience, and a greater sense of purpose and fulfillment.

Real cost-savings and increased preventive care utilization

From 2020-2021, Healthcare spending was **$70 million lower** for organizations in the Blue Cross Blue Shield of Michigan MA program compared to other providers. Participating organizations also saw increased colorectal and breast cancer screening rates, childhood immunizations, and improved diabetes management.

Source: https://healthpayerintelligence.com/news/provider-orgs-join-full-risk-value-based-care-contracts-with-bcbsm

ChenMed: Pioneering Full-Risk VBC, Then and Now

In the late **1990s**, Dr. James Chen first entered an HMO contract for senior care. Unlike most practices, Dr. Chen succeeded in the full-risk model by seeing his patients more often. Since then, ChenMed has stayed at the forefront of the full-risk VBC renaissance through its transformative care model, focusing on the provider-patient relationship, prevention, care continuity, and addressing social determinants of health to promote health equity.

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