



Leveraging Technology and Value-Based Care

Case Study: Hattiesburg Clinic



Research collaboration led by

manatt



This case study focuses on how Hattiesburg Clinic, an independent physician group, achieves success in its value-based care (VBC) arrangements by leveraging technology. This report includes examples of how Hattiesburg Clinic uses technology to:

- Optimize care teams, target patient interventions to improve care, and refine workflows to reduce administrative burden and improve physician satisfaction; and
- Achieve meaningful impact across key areas, including clinical outcomes, access to care, patient, family, and caregiver experience, clinician experience, financial impact, and health equity.

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Introduction

Over the last decade, United States health care payers, physician practices, and hospitals have increasingly adopted value based care (VBC) arrangements. As described in [A Playbook of Voluntary Best Practices for VBC Payment Arrangements](#), developed by the American Medical Association (AMA), AHIP, and The National Association of Accountable Care Organizations (NAACOS), these models seek to align payment with performance on quality, cost, and the patient experience, which in turn can motivate changes in care delivery to further the goals of evidence-based, preventive, equitable, and coordinated whole-person care. Organizations participating in VBC arrangements can enhance their performance by strategically adopting technology solutions aligned with their program goals.

To support these efforts, the AMA is sharing case studies that highlight health care organizations that effectively leverage technology to drive VBC success. This case study is focused on Hattiesburg Clinic, an independent physician group in Mississippi. Nestled in a geographic region with historically poor health outcomes, Hattiesburg Clinic's journey to VBC is an impressive story of how leaders committed to high-quality patient care can leverage technology to meet their organization's needs. This report includes examples of how Hattiesburg Clinic uses data to optimize care teams, targets patient interventions to improve care, and refines workflows to reduce administrative burden and improve physician satisfaction. Hattiesburg Clinic is a testament to the value of leveraging technology to advance VBC.

Background

Hattiesburg Clinic is a large and independent multi-specialty clinic based in Hattiesburg, Mississippi. Established in 1963 by ten local physicians, it has grown to include over 450 physicians and advanced practice providers, located in 17 counties and 70 locations in South Mississippi. As a community health system, its 2,500 employees care for thousands of individuals who live and work in Southern Mississippi every day.

A small southern city which began as a timber town, Hattiesburg is home to about 48,000 people with a population of over 150,000, including the surrounding area. With locations across South Mississippi, it services a broader population of 725,000 patients. In 2023, it provided over 825,000 outpatient visits (excluding dialysis) and over 34,000 outpatient surgeries and procedures. Hattiesburg Clinic's patient population consists of half (51 percent) Medicare, 40 percent commercial, and seven percent Medicaid. Less than a quarter (23 percent) of Hattiesburg Clinic patients live in the city; most patients come from surrounding areas, most of which are rural.

A Challenging Backdrop

In 2023, Mississippi was ranked as the nation's unhealthiest state. A report from the [Commonwealth Fund](#) rated Mississippi one of the worst states for many health categories, including preterm birth rate, infant mortality rate, breast and cervical cancer deaths, and premature deaths. Over the last several years, people of color experienced the steepest declines in health outcomes in Mississippi. The state's obesity and diabetes rates are also among the nation's highest, with heart disease still the state's leading cause of death.

Mississippi health systems also face a challenging financial environment. According to the U.S. Census, the state experiences the highest poverty rate (19 percent) in 2024. According to the [Center for Mississippi Health Policy](#), nearly one-fifth of adults in the state are uninsured and fall below the federal poverty limit.

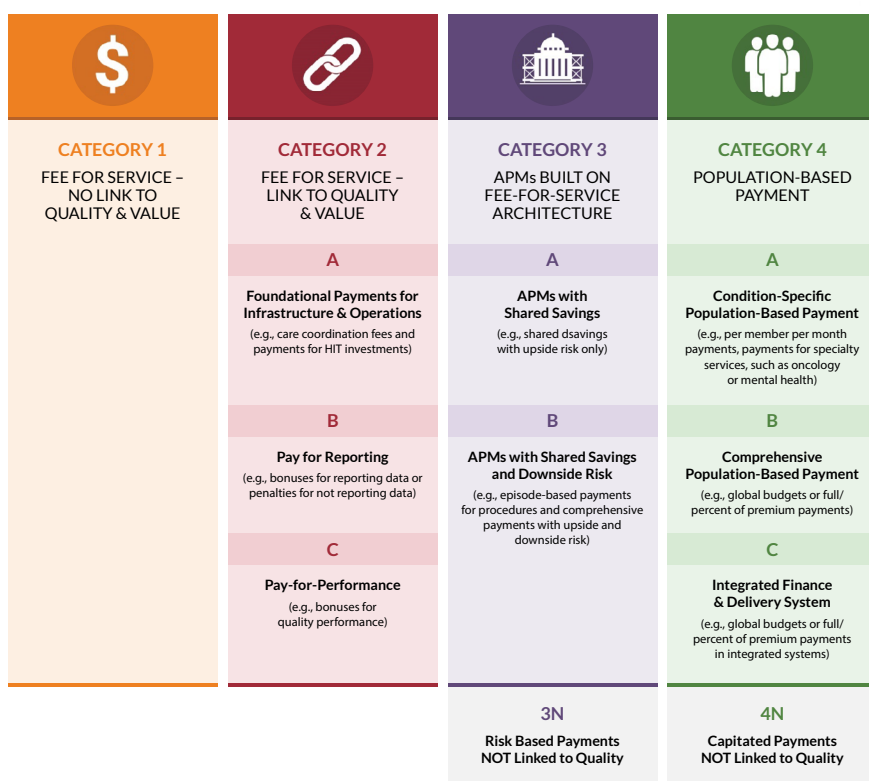
A [recent report](#) found about one-third of Mississippi hospitals are at risk of immediate closure due to financial pressures, which could further reduce access and increase disparities in care. Despite these steep challenges, Hattiesburg Clinic continues to achieve meaningful results by organizing its clinical practice around patient-centric, VBC care.

Experience with Value-Based Care

Under VBC payment arrangements, payments to health care organizations are based on care outcomes and other performance metrics, including cost and quality, which align with contracted program goals. Like many other organizations, Hattiesburg Clinic evolved throughout its VBC journey, as its leadership adjusted to a changing payment environment. Over the years, Hattiesburg Clinic’s leaders made strategic decisions and investments to gradually take on greater financial risk.

VBC arrangements, as outlined in the *Playbook* and the *HCPLAN Alternative Payment Model Framework*, can vary greatly. The chart in **Figure 1** illustrates the range of programs and risk of typical payer arrangements. Like most providers, Hattiesburg Clinic began as a traditional *fee-for-service* (FFS) organization. It initiated its first VBC program with a Medicare Advantage plan, contracting a *pay-for-performance* arrangement in 2007.

Figure 1. Updated Alternative Payment Model Framework



Source: [Health Care Payment Learning & Action Network \(2017\) Action Network](#)

Hattiesburg Clinic then started participating in the Centers for Medicare & Medicaid Services’ Physician Quality Reporting System through the Group Practice Reporting Option (GPRO) in 2012 to understand how its organization was performing compared to other group practices around the nation. It did not perform as well as it had hoped, spurring investment over the next several years in technology solutions to better support its VBC initiatives and improve care. Hattiesburg Clinic continued to participate in GPRO and made successive improvements in its quality measure performance over the next five years.

As Hattiesburg Clinic gained more experience with VBC, it pursued condition specific programs and more comprehensive arrangements with downside risk. In 2014, Hattiesburg Clinic began bundled payments for cardiac care and orthopedics, through the CMS Bundled Payments for Care Improvement (BPCI) Model. Hattiesburg Clinic launched an Accountable Care Organization (ACO) through the Medicare Shared Savings Program (Track 1) in 2016, followed by its first commercial ACO in 2018.

In 2021, Hattiesburg launched the BPCI Advanced Model for clinical episodes including sepsis, urinary tract infection, pneumonia, cellulitis, and chronic obstructive pulmonary disease, and in 2022, the Hattiesburg ACO advanced to an MSSP ACO model (Track E) with downside risk. Finally, Hattiesburg signed its first primary care global budget or capitation agreement with a commercial payer in 2023. Today, its VBC programs include the Medicare ACO Track E, commercial ACOs, and a commercial primary care capitation arrangement. Approximately 48,000, or 50 percent of patients with a Hattiesburg Clinic primary care physician are in a VBC arrangement.

As CEO Bryan Batson, MD, describes it, Hattiesburg Clinic's strategy is to "use the quadruple aim as a guiding light," prioritizing health care quality and the patient and clinician experience. Not only have its new efforts resulted in improved quality and experience, but it has also lowered costs. Since 2016, Hattiesburg Clinic has saved Medicare over \$66 million, and received value-based payments of over \$53 million across all plans. Leadership identified technology solutions as critical to achieving these results.

Strategies for Leveraging Technology to Deliver VBC

Leveraging technology evolved in parallel with Hattiesburg Clinic's dedication to VBC. Its clinical leadership was determined to establish a strong technology foundation to support its VBC needs. As its expertise and success in VBC grew, so did its investment in technology and use of data.

Hattiesburg Clinic launched a sophisticated electronic health record (EHR) system with Epic in 2011. This helped Hattiesburg Clinic better understand its patient population and the clinicians that care for them. Dr. Batson articulates that optimizing technology solutions and functionality is critical to a successful VBC program, noting, "VBC is impacted by data and having access to that data." As such, Hattiesburg Clinic prioritized accurate, complete, and transparent data and ensured that its technology provided clinicians with timely access to it.

As Hattiesburg Clinic evolved into more advanced arrangements with shared savings, its use of technology became more sophisticated. Capturing quality metrics and cost data became critical once it launched its first ACO in 2016. It began analyzing social determinants of health (SDOH) data to gain an understanding of available community resources that could better support its patient population. Epic's EHR technology empowered Hattiesburg to accurately identify patient attribution, enabling the allocation of appropriate resources to physicians managing specific conditions. Epic also invited Hattiesburg to benchmark itself against other organizations around the nation to evaluate its performance on a larger scale.

As its reporting capabilities and needs grew, Hattiesburg Clinic recognized that its internal team also needed to grow. It established a new analytics team, which included hiring three full-time staff members to support the VBC initiatives. The primary goal of the new analytics team was to identify at risk populations, support clinical workflows, and connect patients with physicians. Hattiesburg Clinic also developed a quality management department consisting of case managers and social workers to manage population health across the various specialty departments in the organization. The data analysts work closely with the quality management team to ensure accurate and timely data support. All of this supports the creation of actionable information for physicians at the point of care.

Digitally Enabled Value-Based Care in Action

Using Data to Optimize Care Teams

Care teams often perform differently on quality and cost performance measures, which are essential for VBC arrangements. Like many other organizations, Hattiesburg Clinic struggled to find enough primary care physicians to manage the growing volume of patients. Thus, Hattiesburg Clinic began to employ, with physician oversight, advanced practice providers such as nurse practitioners (NPs) and physician assistants (PAs) to support increasing patient populations. While monitoring the outcomes of various care teams, some differences emerged in the data.

The quality management team at Hattiesburg Clinic conducted a large study related to the experience of the clinician delivering care. Its team of analysts reviewed the efficacy of various care team compositions, including teams led by physicians, NPs, and PAs. Analysis of quality metrics found stark differences, which seemed to correspond with the composition of care teams. Across ten quality measures, the analysis found that physician-led care teams performed better across quality measures than the other care providers. For example, there were double-digit differences in flu and pneumococcal vaccination rates in physician-led populations. In addition, patients who saw a physician were much less likely to visit the emergency room (ER). However, the best quality of care was seen in patients who were “co-managed” in primary care, where patients had alternating visits between APPs and physicians.

The EHR data also helped the team better understand cost data related to care team composition. By analyzing cost data, Hattiesburg Clinic discovered that the cost of seeing a team led by an APP was \$43 higher per member per month, compared with those patients who saw teams that were led by a physician. After risk-adjustment for patient complexity, that difference widened to over \$119 per member per month. For an ACO the size of Hattiesburg Clinic, these differences could translate to significant savings. Hattiesburg Clinic’s analytics and evidence-based medicine approach resulted in improved care and significant cost savings for this critical group of patients.

As a result of its analysis, Hattiesburg Clinic reorganized and optimized its care teams using only physicians as leads. Now, APPs “co-manage” patients or function in collaborative relationships with physicians. When a physician’s patient panel begins to grow, Hattiesburg responds by adding an APP to the team, effectively managing the increased volume while maintaining quality care. This approach allows the care team to strike a balance between enabling each member to practice at the top of their license and scaling effectively to accommodate more patients. At the same time, physicians provide appropriate oversight and management, ensuring optimal patient outcomes are achieved.

Using Data to Drive Patient Interventions to Improve Care

Hattiesburg Clinic optimizes its utilization of EHR data to address **chronic care management (CCM)**, **transitional care management (TCM)**, and **health disparities** to prevent unnecessary hospitalizations. The following section describes how technology supports each effort.

Chronic Care Management (CCM) Program

Having a sophisticated EHR has enabled Hattiesburg to deploy targeted care management strategies for specific patient subpopulations of focus, often more complex patients with greater health needs and greater expenses. For example, Hattiesburg Clinic targets patients who have significant comorbidities in its **CCM** program. It uses an analytics model to identify patients who could benefit from this program intervention. The earlier the intervention, the less likely a patient will require hospitalization. Through predictive analytics, it calculates a hospitalization risk score for patients with chronic conditions. Currently, Hattiesburg Clinic has approximately 5,000 patients enrolled in the CCM program.

Patients likely to benefit from this program are included on a centralized CCM list. These patient lists are provided to physicians monthly for outreach. Physician-led care teams ensure these patients are scheduled for follow up visits so the physician can address their chronic conditions and other needs. During these office visits, physicians have real-time access to clinical dashboards.

Physicians can also view the notes of other clinicians providing services to the patient. Hattiesburg Clinic links externally to various health information exchanges, including eHealth Exchange, Carequality, Mississippi Health Access Exchange, and the Veterans Health Administration. These connections enable continuity of care.

Physicians have the ability to see and track patient trends easily through the EHR which helps them anticipate chronic health issues. For example, hypertension-control rates of patients at Hattiesburg Clinic went from an average of 54 percent to 70 percent in about three years. As a result, Hattiesburg Clinic experienced a 12 percent decrease in hospitalization for patients enrolled in CCM. There were also improved clinical quality measures for patients with chronic kidney disease, cardiovascular disease, and diabetes.

Keeping these patients out of the hospital resulted in lower overall costs. When Hattiesburg Clinic compared its average monthly cost to those of Medicare beneficiaries around the nation, Hattiesburg Clinic found its costs were lower. Specifically, Medicare beneficiary patients enrolled in its CCM had \$28 less total cost each month compared to similar beneficiaries in the U.S.

These patient and technology-related interventions have improved care and enabled a more patient-centered approach to caring for patients.

Transitional Care Management (TCM) Program

For hospitalized patients, Hattiesburg Clinic's **Transitional Care Management (TCM)** program supports a seamless transition home from the acute setting. This begins within 48 hours of hospital discharge when Hattiesburg Clinic nurses contact patients and complete a medication reconciliation. Home visits by an NP are performed for high-risk patients who are unable to attend an in-office visit with their physician.

The program emphasizes timely in-person visits for patients identified as high risk for readmission. If a home visit is not feasible, Hattiesburg Clinic will offer a telehealth visit. In 2023, over 130 telehealth visits were provided to TCM patients.

The TCM services have supported meaningful reductions in readmissions to the hospital, a key metric in VBC arrangements. Patients that complete the TCM program are 30 percent less likely to be readmitted to the hospital within 30 days of discharge. Furthermore, people who have difficulty traveling have alternative options to follow-up with their clinicians post-discharge. Patients express high satisfaction and appreciation for receiving timely care in their homes during the vulnerable period after a hospital discharge.

Part of the success of the CCM and TCM programs has been the emphasis on building relationships with patients. Personal outreach helps physicians and nurses establish close ties with these patients. Nurses have weekly calls and offer robust patient education sessions. The clinic utilizes a call reminder system, texting system, patient portal, and regular calls from the staff to engage patients. Patients have expressed gratitude for the personalized care they receive through these programs.

Health Disparities

A critical component of Hattiesburg Clinic's VBC strategy is to identify and address **health disparities**. Addressing SDOH is a crucial element of the care provided through Hattiesburg Clinic. Clinicians routinely collect SDOH data as part of annual wellness visits to identify social needs in five domains: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. When patient SDOH needs are identified, CCM nurses direct patients to utilize community and health plan resources. The CCM nurses assist with educating patients regarding health plan supplemental benefits to address food insecurity and transportation needs. Patient SDOH needs are also prominently displayed at the point of care in the EHR allowing clinicians to address them during office and telehealth visits.

In 2022, Hattiesburg Clinic participated in another program addressing health disparities, the AMGA Foundation's [ASCVD Best Practices Learning Collaborative](#). The Learning Collaborative helps medical groups develop strategies to improve the management and treatment of patients with established atherosclerotic cardiovascular disease (ASCVD). One of the top challenges facing this group is addressing disparities in care. The Learning Collaborative identified an opportunity to improve high intensity statin therapy prescribing for female patients by utilizing a team-based approach consisting of case management nurses, clinical managers, and primary care physicians.

Refining Workflow to Reduce Burden and Improve Physician Satisfaction

Hattiesburg Clinic's leadership continues to evaluate new tools for addressing the clinical, administrative, and logistical challenges of VBC. Such investments have resulted in not only improved health outcomes for patients and savings for the clinic, but also help reduce burden and improve job satisfaction for the staff.

For example, Hattiesburg Clinic uses [ambient scribe technology](#) to lessen the burden of clinic notes from patient visits. It started off with a test group of 35 physicians. In just one month, physicians reported saving up to 60 percent of time working outside of clinic hours. The pilot eventually grew to 68 physicians and seven nonphysician providers. Physicians and other health professionals can opt in to use the ambient scribe service.

In another example, Hattiesburg Clinic has optimized travel time for NPs participating in TCM program. Serving a vast rural region, many patients face challenges traveling to the clinic for post-discharge visits. In address this, Hattiesburg Clinic sends NPs to patient homes instead, as described above. Currently, NPs provide approximately 240 home visits monthly, which presents significant logistical challenges. Long hours on the road made the process time-intensive and inefficient. Clinicians were determined to find a better way to deliver services.

The team leveraged real-time geographic data and predictive analytics to identify patients at the highest risk for readmissions. This approach enables staff to group patients within a similar geographic area, streamlining route planning. By optimizing travel, they reduced drive times while simultaneously increasing the number of patients served through the TCM home visit program. Now, NPs travel more efficiently to deliver home care to more patients in less time.

Overall, Hattiesburg Clinic's efforts to reduce burden and improve workflow have resulted in job satisfaction for physicians. Data from AMA's [Organizational Well-Being Assessment](#) highlighted how 85 percent of Hattiesburg Clinic physicians reported feeling satisfied with their job, which is 16 percent higher than the national benchmark of 69 percent. Its approach has also reduced burden and stress, as 48 percent of physicians have reported job-related stress, compared with 55 percent nationwide.

AMA's ["Return on Health: Moving Beyond Dollars and Cents in Realizing the Value of Virtual Care"](#) report offers a framework to illustrate the many ways in which technology may increase the overall "return on health" by generating a positive impact for patients, clinicians, payers, and society. Figure 2 includes the six value streams that define the ways in which technology generates value and summarizes how Hattiesburg Clinic uses technology to drive impact.

Figure 2. How Data Analytics Supports Value-Based Care

Value Stream	Evidence of Program Impact
Clinical outcomes, quality, and safety	<ul style="list-style-type: none"> • Twelve percent decrease in hospitalization for patients enrolled in the CCM program • Growth rate in total per beneficiary per month Medicare expenditures in the 12 months after first receiving CCM services was \$28 less than expenditures for comparison beneficiaries • Improved clinical quality measures for patients with chronic kidney disease, cardiovascular disease, and diabetes due to data driven patient interventions • Patients completing TCM program are 30 percent less likely to be readmitted to the hospital within 30 days of discharge
Access to care	<ul style="list-style-type: none"> • Patient access to care has increased through the TCM program, which provides care to patients at home when they cannot travel to the clinic • In 2023, over 130 telehealth visits were provided to TCM patients • NPs provide approximately 240 home visits monthly, enabling patients that otherwise would have trouble visiting the clinic post hospital-discharge to access care
Patient, family, and caregiver experience	<ul style="list-style-type: none"> • Patients and their families have expressed appreciation for timely in-home care through the TCM program and emphasis on the clinician-patient relationship for both the TCM and CCM programs
Clinician experience	<ul style="list-style-type: none"> • Eighty-five percent of physicians at Hattiesburg report feeling satisfied with their job, which is 16 percent higher than the national benchmark of 69 percent • Similarly, Hattiesburg physicians report less stress, as 48 percent of Hattiesburg physicians report job-related stress, compared with 55 percent nationwide • Using ambient scribe, physicians reported saving up to 60 percent of time working outside of clinic hours
Financial and operational impact	<ul style="list-style-type: none"> • Through the ACO, Hattiesburg Clinic has saved Medicare over \$66 million and received value-based payments of over \$53 million across all plans • Hattiesburg Clinic has saved \$10.3 million per year by redesigning care teams
Health equity	<ul style="list-style-type: none"> • Hattiesburg Clinic routinely collects SDOH data as part of annual wellness visits to identify social needs and supports patients in accessing services

Opportunities for Continued Digitally Enabled Innovation Moving Forward

By embracing technology, the Hattiesburg Clinic has strengthened its VBC initiatives, delivering meaningful impact to patients and the clinicians who serve them. Leveraging analytics to guide patient interventions has elevated care quality, while streamlined workflows have enhanced staff satisfaction and alleviated clinician burden.

Looking ahead, Hattiesburg Clinic plans to continue leveraging technology, with an interest in expanding to maternal health care. It is also experimenting with augmented intelligence and remote patient monitoring tools.

The Hattiesburg Clinic journey demonstrates that technology-enabled VBC transformation is possible in all corners of the country. Its leadership is deeply committed to data driven decision-making and investing in technology to enable the delivery of evidence-based, preventive, equitable and highly coordinated care. By leveraging technology to address the community’s evolving health care needs, Hattiesburg Clinic’s consistently achieves impact VBC outcomes year after year.

Glossary

Accountable Care

A person-centered care team takes responsibility for improving quality of care, care coordination, and health outcomes for a defined group of individuals, to reduce care fragmentation and avoid unnecessary costs for individuals and the health system.

(Source: [AHIP/AMA/NAACOS Playbook of Voluntary Best Practices for VBC Payment Arrangements](#))

Artificial Intelligence (AI)

The ability of computers to perform tasks that are typically associated with a rational human being—a quality that enables an entity to function appropriately and with foresight in its environment.

(Source: [AMA Future of Health Report](#))

Augmented Intelligence (AI)

Computational methods and systems that enhance human capabilities and decision-making.

(Source: [AMA Future of Health Report](#))

Attribution

The process by which patients and their associated medical costs are assigned to a physician or entity.

(Source: [AHIP/AMA/NAACOS Playbook of Voluntary Best Practices for VBC Payment Arrangements](#))

Benchmark

The financial target in a VBC payment arrangement with which performance year expenditures are compared.

(Source: [AHIP/AMA/NAACOS Playbook of Voluntary Best Practices for VBC Payment Arrangements](#))

Bundled Payment

A payment structure in which different health care providers who are treating a patient for the same or related conditions are paid an overall sum for taking care of the condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

(Source: [HealthCare.gov](#))

Capitation

A fixed sum of money, per patient per period of time, or global budget for providing services.

(Source: [AHIP/AMA/NAACOS Playbook of Voluntary Best Practices for VBC Payment Arrangements](#))

Downside Risk

A risk arrangement that includes downside risk, or the potential for losses. A risk arrangement that includes both upside and downside risk may be referred to as a “two-sided risk arrangement.” (Source: [CMS](#))

Fee-for-Service (FFS)

A method in which doctors and other health care providers are paid for each service performed.

(Source: [HealthCare.gov](#))

Generative Artificial Intelligence (Gen AI)

Artificial intelligence systems that can generate novel text, images, videos, or other outputs, typically based on foundational models. (Source: [AMA Future of Health Report](#))

Group Practice Reporting Option

A mechanism that allows group medical practices to report quality and performance data to Medicare under programs like the Merit-Based Incentive Payment System, with the goal of evaluating and rewarding high-quality care. (Source: [CMS](#))

Health Information Exchange (HIE)

An HIE allows health care providers to improve patient care by efficiently and securely sharing a patient's digital medical information. (Source: [AMA](#))

Machine learning (ML)

A subtype of AI in which complex algorithms are trained to make predictions about future outcomes. ML can be supervised or unsupervised. (Source: [AMA Future of Health Report](#))

Medicare Shared Savings Program (MSSP)

A voluntary program that promotes accountability for a population of Medicare beneficiaries, improves the coordination of FFS items and services, and encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery. (Source: [CMS](#))

Medically Underserved Area (MUA)

MUAs have a shortage of primary care health services within geographic areas such as a whole county, a group of neighboring counties, a group of urban census tracts or a group of county or civil divisions. (Source: [HRSA](#))

Natural Language Processing (NLP)

An algorithm's ability to interpret and/or translate language. (Source: [AMA Future of Health Report](#))

Pay-for-Performance

Under a pay-for-performance approach, the payer compensates physicians according to an evaluation of physician performance on defined metrics, typically as a potential bonus on top of the physician's FFS compensation. The bonus is not paid per transaction but, rather, at a defined time period (e.g., quarterly or annually). (Source: [Evaluating Pay-For-Performance Contracts, AMA](#))

Risk Adjustment

A statistical method that converts the health status of a person into a relative number. (Source: [AHIP/AMA/NAACOS Playbook of Voluntary Best Practices for VBC Payment Arrangements](#))

Shared Risk

A payer arrangement whereby there is potential upside or downside reimbursement, in addition to FFS reimbursement, depending on whether aggregate population health care costs are more or less than a predefined baseline amount. The "savings" or "losses" are shared between the payor and the physician (or among physicians). (Source: [AMA Payor Contracting Toolkit](#))

Shared Savings

Shared savings is a payment strategy that offers incentives for providers to reduce health care spending for a defined patient population by offering them a percentage of net savings realized as a result of their efforts. (Source: [The Commonwealth Fund](#))

Total Cost of Care (TCOC) Arrangement

Refers to a contract, often between three and five years in length, between a health plan and a VBC entity where the VBC entity takes responsibility for the total cost and quality of care for an attributed patient population that is calculated for a defined performance period, usually one year, and in exchange can receive or retain a portion of achieved savings or pay back any losses based on predetermined spending and quality targets or benchmarks.

(Source: [AHIP/AMA/NAACOS Playbook of Voluntary Best Practices for VBC Payment Arrangements](#))

Upside Risk

A payer arrangement whereby there is uncertainty associated with potential financial gains only. A risk arrangement that only includes upside risk may be referred to as a “one-sided risk arrangement.”

(Source: [CMS](#))

VBC Payment Arrangement

Refers to the contracted terms between a health plan and VBC entity and/or participating practice(s) that links payment to performance on cost, quality, patient experience, or other defined metrics to encourage delivery changes that are expected to result in better patient outcomes, greater patient experiences, and/or cost efficiency. Payment to participating VBC entities and/or participating practice(s) is increased when quality of care increases and/or costs decrease, while payment is reduced when quality of care decreases and/or costs increase.

(Source: [AHIP/AMA/NAACOS Playbook of Voluntary Best Practices for VBC Payment Arrangements](#))

