CVBA®

Certified Value-Based Administrator

STUDY GUIDE

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Official Study Guide
CVBA® Certification

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Contents

Chapter 1

Foundations of Value-Based Care (VBC)

Value-based care (VBC) is a modern healthcare delivery model that prioritizes patient outcomes and cost efficiency over the volume of services provided. Unlike traditional fee-for-service (FFS) models, which reimburse providers based on the number of tests, procedures, or visits, VBC ties payment to the quality, effectiveness, and coordination of care.

The core goals of VBC are to:

- Improve patient outcomes through evidence-based, preventive, and coordinated care.
- Enhance patient experience by focusing on holistic, person-centered approaches.
- Reduce healthcare costs by minimizing unnecessary interventions, hospital admissions, and duplicative services.
- Address social determinants of health (SDOH) by integrating community resources and support systems into care planning.

VBC depends on collaboration across clinical, administrative, financial, technical, compliance, and community-based teams.

Foundations of the U.S. Healthcare System

To provide you with a better understanding of the importance of VBC and your role as a Certified VBC Administrator (CVBA®), let's look at how it evolved in the U.S. healthcare system.

Historically, U.S. healthcare relied on FFS reimbursement, which encouraged higher service volume without necessarily improving quality. Over time, healthcare costs increased rapidly, while quality and coordination did not improve proportionally.

To address this, CMS and other payers began moving toward payment models that better reflect patient complexity and actual cost of care.

Key milestones

Pre 1990s: United States healthcare reimbursement was based on FFS models, where healthcare providers and organizations were paid based on the volume of services delivered. Payments did not account for patient complexity, health status, social determinants of health (SDOH), or care quality. This structure incentivized higher service volume, often resulting in unnecessary care and rapidly rising healthcare costs without corresponding improvements in outcomes.

Early 1990s: The Centers for Medicare & Medicaid Services (CMS) introduced one of the first capitated Medicare payment models through the Adjusted Average Per Capita Cost (AAPCC). Under this model, health maintenance organizations (HMOs) received fixed monthly payments based on demographics such as age, sex, Medicaid eligibility, and living arrangements. Because AAPCC did not account for patients' diagnoses or health conditions, it led to the development of risk adjustment models that incorporate clinical data to better predict healthcare costs.

Early 2000s: CMS improved risk prediction by incorporating clinical data into payment models and introducing the Principal Inpatient Diagnostic Cost Group (PIPDCG) and the CMS Hierarchical Condition Categories (CMS-HCC) model for Medicare Advantage (Part C). These models combined patient demographic information with diagnosis data and used a hierarchical structure in which more severe conditions override less severe conditions within the same category. Outpatient and physician office encounter data were later introduced into the model, encouraging providers to supply more detailed documentation to support the higher specificity diagnosis codes.

From 2005 to 2010: Pay-for-performance and ACO pilot models expanded. The Physician Group Practice (PGP) model becomes the first pay-for-performance model that uses prospective risk adjustment based on the patient's clinical data. ACO models incorporated risk adjustment coding into their shared savings and payment plans. During this period, CMS continued refining HCC models and began including prescription drug data to improve cost prediction accuracy.

2010: The Affordable Care Act introduced a risk adjustment model, for marketplace plans. While similar to the CMS-HCC model for Medicare Advantage, the ACA model is concurrent, using current-year diagnoses to predict current-year costs. It is also population-specific, with distinct risk categories for infants, children, and adults. Payments are adjusted based on plan metal level, geography, and induced demand. To maintain budget neutrality, funds are transferred from insurers with healthier populations to those with higher-risk populations.

2030: CMS has set a goal to transition all Medicare fee-for-service (FFS) beneficiaries into VBC arrangements by 2030. This shift moves away from volume-driven models toward systems that reward quality, outcomes, and efficiency. To achieve this, CMS is expanding alternative payment models (APMs), such as ACOs, bundled payments, and advanced primary care models

that encourage coordinated care, manage chronic conditions proactively, and address SDOH.

This evolution reflects a major shift from paying for volume to paying for value, quality, and risk-adjusted performance.

Triple Aim: A Foundational Framework for VBC

The Triple Aim established three major goals for healthcare improvement:

1. Improve patient experience
2. Improve population health
3. Reduce per capita healthcare costs

The core idea of the Triple Aim is that these three goals are interdependent and must be pursued simultaneously.

Evolution of the Quintuple Aim

Over time, healthcare leaders and experts recognized that the Triple Aim was not a complete picture of a high-performing healthcare system. The framework later evolved beyond the Triple Aim to reflect additional priorities that are essential to a high-performing healthcare system:

1. **Quadruple Aim:** Added workforce well-being, recognizing that provider and staff burnout can negatively affect patient care, outcomes, and organizational performance.
2. **Quintuple Aim:** Added health equity to ensure that reducing disparities and improving access became an explicit part of healthcare improvement efforts.

The five components of the Quintuple Aim are:

- Improving the patient's healthcare experience
- Improving the health of populations
- Reducing per capita healthcare costs
- Improving the well-being of the healthcare workforce
- Advancing health equity

How the Triple-Quintuple Aims Relate to VBC

The Triple Aim and its evolution to the Quintuple Aim are closely connected to VBC.

While the Triple and Quintuple Aims define the goals of improving patient experience, population health, cost efficiency, workforce well-being, and health equity, VBC provides the delivery and payment model that helps achieve these goals. Unlike traditional fee-for-service models that reimburse providers based on the number of services delivered, VBC links payment to quality outcomes, care coordination, and cost effectiveness. Models such as accountable care organizations (ACOs) and bundled payments encourage preventive care, chronic disease management, and efficient resource use. Increasingly, VBC programs also include measures addressing provider burnout and health disparities. In this way, the Quintuple Aim serves as the guiding framework for healthcare improvement, while VBC provides the financial incentives and operational strategies needed to move healthcare toward a more patient-centered, equitable, and sustainable system.

These aims are closely tied to value-based care because the Quintuple Aim defines the desired outcomes, while VBC provides the payment structure and operational approach needed to achieve them. In this sense, the Quintuple Aim represents the "what," and VBC represents the "how."

Role of the Certified VBC Administrator

The Certified VBC Administrator (CVBA®) plays a critical role in guiding the organization's transition from FFS to VBC models. This role focuses on overseeing payer contracting, attribution management, data analytics, financial risk mitigation, and integration of emerging technologies such as artificial intelligence (AI). The CVBA® collaborates across departments to ensure care delivery aligns with quality, efficiency, and equity goals, while maintaining compliance with evolving CMS and commercial payer requirements.

Key Responsibilities

- **Strategic program oversight:** Lead the implementation and optimization of VBC initiatives and monitor CMS goals and payer trends to ensure alignment with national VBC objectives, including the transition of Medicare FFS beneficiaries to value-based models by 2030.
- **Payer contracting and attribution management:** Collaborate with legal, compliance, and finance teams to manage value-based contracts and ensure accurate patient attribution and risk model alignment.
- **Data analytics and performance monitoring:** Partner with data teams to develop dashboards and use analytics to monitor quality, costs, outcomes, and identify care gaps for improvement.
- **Financial risk and compliance:** Assess financial exposure under VBC arrangements, implement mitigation strategies, and ensure documentation and coding support accurate risk adjustment and compliance with CMS and payer guidelines.
- **Technology and innovation:** Evaluate and implement AI-driven tools to improve predictive modeling, care coordination, and documentation accuracy while supporting health IT integration for interoperability and real-time data sharing.

Chapter 5

Operationalizing and Administering Value-Based Care (VBC)

Operationalizing VBC means applying payment models, attribution rules, performance measurement, and regulatory requirements to manage population health and financial accountability in daily healthcare operations. This requires understanding core VBC payment models, including capitation, bundled payments, and pay-for-performance (P4P), as well how patient attribution and regulatory frameworks support the transition from fee-for-service to value-based care.

Types of Financial Risk in VBC Contracts and Provider Participation

VBC payment models discussed in this chapter vary in the level of financial risk they transfer to providers, typically described as upside and downside risk. Providers determine how much financial risk to take in VBC contracts based on their experience and capability in managing patient populations and their capacity for financial exposure.

Upside Risk

Upside risk is a financial arrangement in which a provider or health system can earn a bonus or share in a portion of savings generated by keeping healthcare costs below a predetermined target or benchmark. Providers share in savings when spending falls below a benchmark but are not financially responsible for costs that exceed it.

This model is often considered a safer entry point for providers new to VBC, because it allows them to gain experience in managing patient populations and improve care coordination without the full financial exposure of a two-sided risk model. Examples include one-sided shared savings programs, where providers receive a percentage of the savings.

Downside Risk

Downside risk is also known as two-sided risk, is a financial arrangement where providers are financially rewarded for keeping costs below a benchmark but are also financially penalized for exceeding it. This arrangement holds providers accountable for both the positive and negative financial outcomes of their patient population. The potential for penalties makes the financial incentive much stronger and encourages providers to focus on efficiency and cost management. Because providers share in both savings and losses, downside risk creates more balanced financial incentives for cost control and quality performance.

As providers become more comfortable with VBC contracts, they can transition to models with two-sided risk. The Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (Advanced APMs) in the Quality Payment Program (QPP) are examples of this progression. Advanced APMs, which require providers to take on more financial risk, offer a 5 percent bonus on Medicare payments. The level of risk a provider assumes is often aligned with their capabilities and financial readiness to manage the statistical variations in healthcare costs.

Measuring Success in VBC Contracts

Regardless of the VBC payment model, data analytics and performance dashboards are essential tools for transforming raw data into actionable insights that drive operational and financial decision making in VBC contracts. Dashboards provide real-time views of key performance indicators (KPIs), helping clinicians manage their attributed patient panels, identifying high-risk individuals, and enabling administrators and payers to verify the quality and value delivered by their provider networks.

Example: Value-Based Care Performance Dashboard

Metric	Current Performance	Target	Trend	Operational Action
Diabetes A1C Control	72%	80%	↑ Improving	Outreach to uncontrolled patients
30-Day Readmission Rate	14%	≤12%	↓ Worsening	Care management follow-up calls
Preventive Screening (Mammogram)	68%	75%	→ Stable	Generate screening reminder list
Average Cost per Patient	$6,300	$6,000	↑ Rising	Review high-cost patient cases
Risk Adjustment Capture Rate	91%	95%	→ Stable	CDI review of chronic conditions

Data analytics is crucial for implementing core VBC strategies like risk stratification and care gap detection. Analytics tools help identify care gaps and generate outreach lists so care teams can intervene earlier and improve quality performance.

Basic Payment Models in VBC

In value-based care (VBC), reimbursement is linked to the quality and cost-effectiveness of care rather than the volume of services delivered. The core payment models include capitation, bundled payments, and pay-for-performance (P4P). In practice, many VBC contracts combine these models to balance quality incentives, cost control, and financial accountability.

Capitation

In capitated models, providers receive a fixed per-member-per-month (PMPM) payment to cover the cost of care for a defined population. It incentivizes coordinated care delivery and preventive care, as providers bear the financial risk for higher-than-expected costs. Capitation can be full or partial, with partial capitation offering some fee-for-service payment alongside a capitated amount.

To make this arrangement fair, the payment is adjusted using risk adjustment. A provider who has a patient panel with a higher-than-average risk score (reflecting a sicker or more complex population) will receive a higher total capitated payment to cover the anticipated costs. Accurate clinical documentation is essential in capitated models. If chronic conditions are not fully documented, risk scores may be understated, which can reduce the PMPM payment below what is needed to care for a medically complex population.

Bundled Payments

In this model, a single payment covers all services related to a specific episode of care. This model encourages collaboration among the provider network and care coordination to manage costs within the defined episode of care. Bundled payments are often seen as a stepping stone between the low financial risk of fee-for-service and the high financial risk of full capitation.

Some bundled payment models use upside-only incentives where providers can share in savings if episode costs fall below a target price. In contrast, two-sided risk is a model where providers are financially rewarded for keeping costs below a benchmark and financially penalized for exceeding it.

Pay-for-Performance (P4P)

P4P models are a category of VBC that use financial incentives to reward healthcare providers for meeting or exceeding specific quality and efficiency goals. These metrics can cover a range of areas, including clinical quality (e.g., controlling blood pressure), efficiency (e.g., reducing readmissions), and patient experience. Financial incentives may include bonus payments, shared savings, or payment reductions tied to performance.

Many of these models are structured with one-sided risk to encourage provider participation, so they are not penalized for failing to meet a metric. The overall purpose of P4P is to drive continuous quality improvement, encourage the adoption of best practices, and ultimately create a more efficient healthcare system that delivers better results for patients.

The different types of P4P contracts are categorized by the type of financial incentive they use:

1. Bonus-Based Contracts (Rewards for Good Performance)

These are the most common and often considered the least risky for providers. The incentive is framed as a reward for achieving specific targets.

Shared savings: In models like accountable care organizations (ACOs), providers can earn a bonus by keeping the total cost of care for their patient population below a predetermined benchmark while meeting quality standards. The bonus is a share of the savings generated.

MIPS adjusts Medicare payments based on performance in four categories:

- Quality
- Cost
- Promoting interoperability
- Improvement activities

EXAMPLE: CALCULATING A QUALITY PERFORMANCE RATE

Quality performance measures in value-based programs are commonly calculated using a **numerator and denominator**.

Formula

Performance Rate = Numerator ÷ Denominator

Example

A clinic tracks blood pressure control for patients diagnosed with hypertension.

- Eligible patients (denominator): **500**
- Patients with controlled blood pressure (numerator): **380**

Calculation

380 ÷ 500 = **0.76**

Performance Rate = **76%**

This percentage represents the provider's performance on the measure and may influence incentive payments in value-based care programs.

2. Penalty-Based Contracts (Penalties for Poor Performance)

In this model, a portion of a provider's payment is withheld and can be lost if they fail to meet specific performance targets.

- **Withholding payments:** A percentage of a provider's fee-for-service payment may be withheld and only paid out if they meet certain quality or efficiency goals. If they fail, they lose the withheld amount.
- **Payment reductions:** A provider's entire payment can be reduced based on poor performance.

3. Combined/Hybrid Models (Rewards and Penalties)

Many P4P contracts use a combination of bonuses and penalties.

- Two-sided risk models allow providers to share in both savings and losses.

Patient-centered medical homes (PCMH) combine per-patient payments with performance incentives to support coordinated primary care while providing predictable funding for care coordination infrastructure.

4. Other Types of P4P Contracts

These models can also be distinguished by the specific goals and metrics they target:

- Pay-for-reporting
- Pay-for-process
- Pay-for-outcomes

Global Capitation and Financial Risk Models

Global capitation is the most comprehensive and high-risk VBC payment model. Providers receive a fixed per member per month (PMPM) payment to cover everything from primary care and specialist visits to hospitalizations, post-acute care, and sometimes even prescription drugs. This model creates predictable revenue while encouraging prevention and coordinated care.

The defining characteristic of global capitation is the transfer of financial risk from the payer to the provider:

- Provider assumes full risk
- Incentive for efficiency and prevention
- The "insurance" role

Role of Risk Adjustment in Global Capitation

Risk adjustment is used to ensure fairness in global capitation payments. A provider with a patient panel that has a high average risk score will receive a higher total capitated payment, which is necessary to cover the anticipated costs of caring for a sicker population.

Submission Timelines and Operational Calendars

Measuring success in value-based contracts requires more than monitoring performance metrics. It also requires disciplined adherence to submission timelines. Risk adjustment data, quality measure reporting, encounter submissions, and internal performance reviews all operate within defined cycles. Missed deadlines can result in lost revenue, reduced Star Ratings, compliance exposure, or inaccurate performance projections.

For this reason, high-performing organizations maintain a structured VBC performance calendar. A VBC performance calendar defines responsibilities, establishes internal checkpoints, and tracks required documentation. A well-managed submission calendar transforms regulatory compliance into a predictable operational workflow.

Understanding Submission Cycles in VBC

Value-based reporting typically operates across multiple submission cycles:

1. **Plan-Facing Submissions**
   These include encounter data, risk adjustment files, and quality reporting submitted to health plans or Medicare Advantage organizations.
2. **Payer-Facing or CMS-Facing Submissions**
   These include formal submissions required by CMS or other payers, such as risk adjustment and quality reporting files.
3. **Internal Performance Cycles**
   These include internal monitoring activities such as quality reviews, CDI audits, and performance dashboard updates.

Each cycle operates on its own timeline, and internal workflows must align accordingly.

The VBC Performance Calendar Concept

A VBC performance calendar organizes submission responsibilities into a structured framework that answers three questions:

- What must be submitted?
- Who owns the submission?
- What documentation must be retained as evidence?

This structure helps convert compliance requirements into a predictable operational workflow.

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