# Beyond Cost Control

### *What Value-Based Healthcare Adds to HMOs, ACOs, Lean and Quality Improvement*

*Healthcare has spent decades trying to control cost, utilization, variation and quality. Value-based healthcare asks a different question: What are we actually achieving for patients?*

Review article for healthcare providers

**KEY IDEA**

Lean, Six Sigma, traditional quality improvement, HMOs, ACOs and value-based healthcare are not interchangeable. They operate at different levels of the healthcare system and solve different problems. Their greatest potential comes from deliberate integration: efficient and reliable processes, clinically sound care, financial accountability, coordination across the continuum, and outcomes that matter to patients.

## Why healthcare keeps reforming itself

Modern healthcare reform can be understood as a series of attempts to correct the incentives and failures created by earlier systems. Fee-for-service rewards activity: more visits, tests, procedures and admissions generally generate more revenue. That model can support access and professional autonomy, but it does not inherently reward prevention, coordination or avoidance of low-value care.

Managed care and health maintenance organizations (HMOs) responded by placing greater emphasis on budgets, networks, capitation and utilization management. The economic logic was straightforward. If payment is relatively fixed, unnecessary utilization becomes a cost rather than a source of revenue. Yet the same incentive that discourages overuse can create concern about underuse, restricted choice and the possibility that cost containment becomes the dominant objective.

Accountable care organizations (ACOs) represent another step in this evolution. Rather than simply limiting individual services, ACOs create accountability for the quality and total cost of care for a defined population. In the U.S. Medicare Shared Savings Program, physicians, hospitals and other providers can share savings when spending is below an established benchmark while quality requirements are met; some arrangements also expose organizations to downside risk. In performance year 2024, CMS reported that 75% of 476 reconciled ACOs earned shared savings, with $2.5 billion in net savings to Medicare relative to benchmarks.[1]

Value-based healthcare (VBHC) is broader still. Porter defined value as the health outcomes achieved relative to the cost required to achieve them.[2] The important shift is conceptual: cost is not the sole objective, and quality is not merely a collection of process measures. The organizing goal becomes improvement in outcomes that matter to patients, considered in relation to the resources consumed across the care cycle.

## The reforms are solving different problems

Healthcare discussions often place Lean, Six Sigma, quality improvement, managed care, ACOs and VBHC in the same conceptual category. That obscures their differences.

Lean is principally an operating system for improving flow and eliminating activities that do not create value. In healthcare it is commonly applied to waiting, handoffs, supply movement, unnecessary steps, capacity constraints and workflow design.[3] Six Sigma is more explicitly concerned with variation, defects and process capability. Its statistical discipline is useful where reliability and reproducibility matter. Lean and Six Sigma are therefore primarily methods for improving how work is performed.

Traditional quality improvement (QI) focuses more directly on the reliability, safety and clinical quality of care. It may use methods such as Plan-Do-Study-Act cycles, audit and feedback, clinical bundles, checklists and measurement of

process and outcome indicators. QI can improve important clinical processes without changing the underlying payment system.

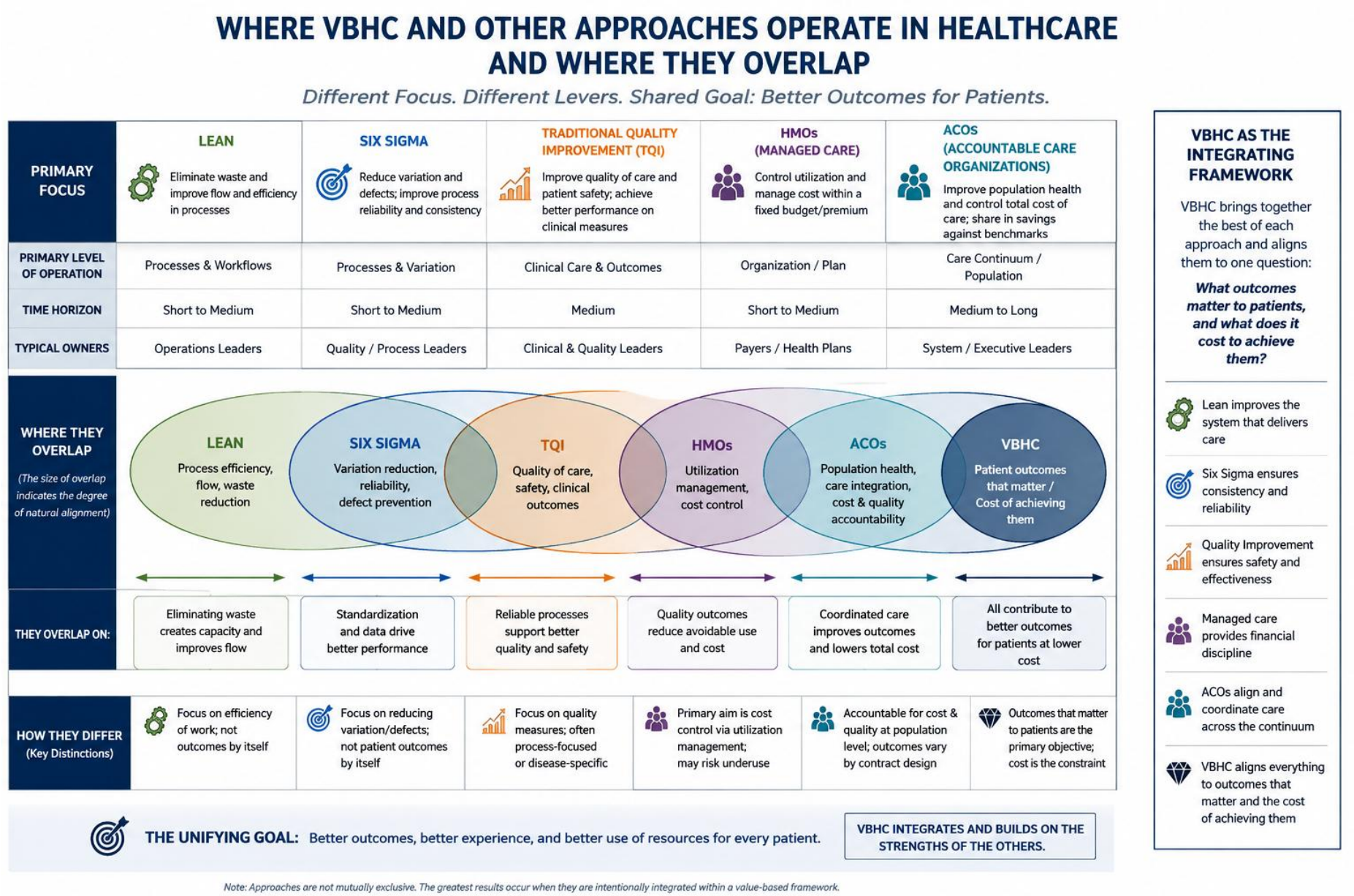
HMOs operate at a different level. They are financing and delivery arrangements that use tools such as networks, capitation and utilization management to influence how healthcare resources are consumed. ACOs extend financial and clinical accountability across populations and care settings. VBHC, in contrast, is best understood as an overarching strategy for organizing care around patient-relevant outcomes and the total resources required to produce them.

This is why asking whether Lean or an ACO is "better" than VBHC is often the wrong question. Lean can make a value-based system more efficient. Six Sigma can make it more reliable. QI can make it safer. Managed care can impose financial discipline. ACOs can align organizations around population-level cost and quality. VBHC provides a unifying objective against which those capabilities can be judged.

## A practical comparison

| Approach | Primary problem | Main lever | Typical level | Core risk |
|---|---|---|---|---|
| Lean | Waste, delay, poor flow | Process redesign | Workflow / service line | Efficiency without outcome focus |
| Six Sigma | Variation and defects | Measurement and process control | Process / production system | Technical optimization without patient relevance |
| Traditional QI | Safety and quality gaps | Clinical measurement and improvement cycles | Clinical team / organization | Metric compliance can substitute for meaningful outcomes |
| HMO / managed care | Utilization and affordability | Capitation, networks, utilization management | Health plan / delivery organization | Underuse or cost control dominating care |
| ACO | Fragmentation and total cost growth | Shared savings/risk plus quality accountability | Population / care continuum | Benchmark focus and measure burden |
| VBHC | Misalignment between resources and patient benefit | Outcomes, cost measurement and care redesign | Condition / pathway / system | Difficult measurement; "value" reduced to cost cutting |

**Figure 1. Where VBHC and other approaches operate in healthcare and where they overlap**




*Conceptual framework: the approaches are complementary rather than mutually exclusive. VBHC is shown as an integrating framework centered on patient-important outcomes and the resources required to achieve them.*

## From volume to utilization control

The transition from fee-for-service to managed care illustrates why payment reform matters. Under fee-for-service, preventing an admission may be clinically desirable but financially disadvantageous to a hospital or physician group that is paid for the admission. Under capitation, the same avoided admission may improve financial performance.

This reversal of incentives was one of managed care's major contributions. It made utilization visible as an economic variable. But it also exposed an enduring problem: controlling utilization is not identical to creating value. A service can be expensive and highly valuable, or inexpensive and ineffective. Reducing utilization indiscriminately can therefore lower spending while worsening access or outcomes.

For clinicians, this distinction is critical. The relevant question is not simply whether fewer services were used. It is whether unnecessary services were avoided while necessary care remained timely, appropriate and effective.

## What ACOs add

ACOs attempt to reconcile cost control with clinical accountability. They retain many elements of traditional delivery while creating a population-level budget or benchmark and linking financial performance to quality. CMS describes ACOs as groups of clinicians, hospitals and other providers that voluntarily coordinate high-quality care while being accountable for cost, quality and patient experience.[4]

This architecture changes the unit of accountability. Instead of asking whether a single admission or procedure was profitable, the organization increasingly asks what happened to the patient across settings and over time. Avoidable emergency visits, duplicative testing, preventable admissions and poorly coordinated transitions become clinically and financially relevant.

The model nevertheless has limitations. Quality measures can become proxies for outcomes rather than outcomes themselves. Benchmarks can dominate strategic attention. Attribution of patients to organizations can be imperfect. Savings can depend on local market conditions and baseline spending. ACOs therefore move healthcare toward value, but an ACO contract is not synonymous with a value-based delivery system.

## What VBHC adds

VBHC changes the objective function. Porter argued that value should be defined around the patient rather than around the volume of services, the profitability of individual units or the achievement of isolated process metrics.[2] Care should therefore be organized around the patient's condition or need, outcomes should be measured across the full cycle of care, and costs should be understood across that same cycle.

This is a more demanding standard than cost containment. A hospital cannot claim high value merely because it reduced length of stay. The shorter stay must be considered alongside mortality, complications, readmissions, functional recovery, patient experience and the resources required after discharge. Similarly, an expensive intervention may represent excellent value when it produces a large and durable improvement in outcomes.

The concept also prevents “quality” from becoming detached from resource stewardship. Excellent outcomes achieved with unnecessary duplication, avoidable complications or excessive resource consumption are not maximally valuable. Value requires simultaneous attention to outcomes and resources.

## Where Lean, Six Sigma and QI fit

The operational disciplines become especially useful once the objective is clear. Lean can redesign the pathway so patients spend less time waiting and clinicians spend less time on non-value-adding work. Six Sigma can reduce unwanted variation in processes such as laboratory turnaround, medication administration or procedural reliability. QI can improve adherence to evidence-based practices and reduce preventable harm.

But none of these methods, by itself, determines whether the healthcare system is optimizing outcomes that matter to patients. A perfectly efficient process can efficiently deliver low-value care. A highly reliable process can reliably

perform an unnecessary test. A hospital can meet dozens of quality indicators while patients experience fragmented care and poor functional recovery.

VBHC therefore does not replace operational improvement. It gives operational improvement a destination.

## The danger of confusing cost with value

This distinction has become increasingly important as health systems face workforce shortages, rising labor costs, expensive technology and fiscal pressure. When budgets tighten, organizations naturally focus on visible inputs: staffing, salaries, pharmaceuticals, devices, diagnostic testing and length of stay.

Those inputs matter. But controlling an input price does not demonstrate that value has improved.

Consider physician labor. If one physician costs more than another, the lower-cost physician is not automatically the higher-value choice. The relevant comparison may include access, clinical productivity, diagnostic accuracy, complications, unnecessary testing, length of stay, readmissions, patient outcomes and downstream utilization. Conversely, high compensation is not evidence of high value. A highly paid clinician who provides little measurable contribution, poor availability or unnecessary utilization can represent very low value.

The same principle applies throughout healthcare: cost must be linked to what the resource produces.

This is where the distinction among HMO-style cost control, ACO-style accountability and VBHC becomes especially useful. Managed care asks whether utilization and expenditure can be controlled. An ACO asks whether total cost can be reduced or held below a benchmark while meeting quality requirements. VBHC asks whether the resources consumed are producing outcomes that matter to patients.

## A clinically useful operating model

For healthcare providers, the most practical approach may be to treat these frameworks as layers rather than alternatives.

At the process layer, use Lean to remove waste and improve flow and Six Sigma where variation and defects require disciplined measurement. At the clinical layer, use quality improvement to make evidence-based care reliable and safe. At the financing and organizational layer, use managed-care and accountable-care mechanisms to create responsibility for utilization, coordination and total cost. At the strategic layer, use VBHC to define what the entire system is trying to accomplish.

The hierarchy matters. If cost control sits at the top, every lower-level intervention risks becoming a mechanism for spending less. If patient value sits at the top, efficiency, reliability, utilization management and financial accountability become tools for producing better outcomes with responsible use of resources.

## What should clinicians ask?

A value-oriented clinical organization should be able to answer a small set of difficult questions. What outcomes matter most to the patients we serve? Are we measuring them, including functional and patient-reported outcomes where appropriate? What does the complete care pathway cost rather than only the individual encounter? Where does unnecessary variation occur? Which processes consume clinician time without improving care? Where does fragmentation create avoidable utilization? Are incentives rewarding volume, cost reduction, metric performance or actual improvement in patient outcomes?

These questions also expose a common misconception. “Value-based” is frequently used as shorthand for alternative payment, risk contracts or cost reduction. Payment can enable value, but it does not create value by itself. A health system can hold a value-based contract while continuing to organize clinical care around departments, transactions and volume. Conversely, clinicians can redesign a pathway around meaningful outcomes even before reimbursement fully catches up.

## Conclusion: the next phase of healthcare reform

The history of healthcare reform is not a story in which one model repeatedly replaces another. It is a story of accumulating capabilities.

Managed care demonstrated that utilization and incentives matter. Lean showed that waste and flow matter. Six Sigma demonstrated the importance of variation and reliability. Quality improvement made safety and clinical performance measurable. ACOs expanded accountability across populations and the continuum of care. VBHC attempts to connect these capabilities to a common purpose: achieving outcomes that matter to patients while using resources responsibly.

That distinction is more than semantic. Healthcare organizations make consequential decisions about staffing, physician compensation, technology, hospital capacity and service lines. If those decisions are judged primarily by their effect on expenditure, cost containment can be mistaken for improvement.

The better question is not simply, “What does this cost?”

It is, “What are we achieving for patients with the resources we are using?”

That question should sit at the center of the next generation of healthcare reform.

> **If we measure what physicians cost without measuring what they produce, have we actually measured value?**

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