
Value-Based Care and Orthotics and Prosthetics

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Executive Summary

Background

Value-based care (VBC) can be defined as healthcare that focuses on “quality of care, provider performance and the patient experience, with accompanying payment models that compensate providers based on value delivered.¹ Population-level VBC models fall within a broader spectrum of alternate payment structures and are implemented by organizations that are responsible for the coordination, provision, and total costs of care for a broad group of patients. While initial VBC initiatives have focused on high-cost specialty areas such as chronic kidney disease, cancer, and orthopedics, there is promise in looking to allied health domains, such as orthotics and prosthetics (O&P), to advance the goals of better care at lower costs. This paper uses O&P services as an example to illustrate how VBC models can benefit from incorporating care that focuses on patients’ functional needs.

Core Elements of Value-Based Care Payment Models

While VBC payment models can be structured in a variety of ways (e.g., the services included, the patient population the model applies to, the method for determining payment rates, etc.) there are several core elements that are included in all VBC payment arrangements:

- 1. Risk Amount:** VBC payment models shift the financial risk from payers to providers by offering financial incentives and/or penalties based on care outcomes. The amount of risk a provider incurs varies between contracts.
- 2. Risk Structure:** Contracts are designed one-sided with only “upside risk” (providers are compensated for better care outcomes but not punished for poor outcomes) or two-sided with addition of “downside risk” (providers are at risk for poor care outcomes).
- 3. Payment Timing:** Payments can either be prospective (prior to care) or retrospective (after care is delivered).

O&P Potential in VBC Models

While value-based care payment arrangements can contain nuance, there are various key characteristics of certain types of clinical care that align with the goals of VBC. In their most advanced form, VBC payment models deliver on the quadruple aim: improving population health, improving the patient experience of care, and reducing the cost of health care while bringing joy and a better work life to healthcare providers.² The following are examples of necessary but not sufficient conditions of ideal VBC payment models:

¹ CMS. “[Value Based Care](#).” (accessed November 4, 2024)

² Bodenheimer, Thomas, and Sinsky, Christine. “From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider.” *Analysis of Family Medicine* 12 (November 2014): 573-576. <https://doi.org/10.1370/afm.1713>

- 1. Focus on Preventative Care:** VBC payment models hinge on the clinical outcomes of a patient, as measured by their long-term health. VBC payment models that function as intended will incentivize preventative care to improve long-term patient outcomes and to reduce costs incurred across the entirety of a patient's care journey.
- 2. Care Coordination:** A key component of improving quality is improving the patient experience. Providing seamless care coordination across providers is imperative for improving the patient experience. Successful VBC payment models will ensure robust care coordination to improve the patient experience.
- 3. Patient-Centered Care:** To improve the patient experience, the patient's goals and needs must be at the forefront of a care plan. Care that reconciles a patient's preferences with clinical best practices is critical for supporting a successful VBC payment model. Clinicians operating under a VBC payment model should work with patients individually to determine a care plan that suits their goals and needs.

Given the O&P profession's focus on managing chronic conditions, preventing complications, and individualized care, it is reasonably positioned to adapt to value-based payment models. Early evidence suggests that the individualized, functional improvement-oriented care O&P professionals provide leads to lower overall costs.^{3,4} However, this alignment in goals may not be widely understood. Given the limited interaction between O&P and VBC payment models, researchers and other stakeholders can take the following steps that are characteristic of VBC implementation to prepare for adopting VBC payment models.

- 1.** Coordinate with O&P professionals to collect evidence supporting the value of O&P care, which will be critical in forming initial partnerships with integrated delivery networks (IDNs) and payers to pilot VBC contracts that include O&P.
- 2.** Collaborate with model developers, payers, and IDNs to pilot innovative payment models with O&P care. This should include development and testing of metrics to evaluate the impact of O&P on model success.
- 3.** Use initial pilot programs as an evidence generation tool to further demonstrate the value of O&P care.

Introduction

In the context of growth in healthcare costs in the US, payers and providers continue to design and test transformative care delivery and financing models that incentivize value over volume, shifting away from reimbursement based on how many services were provided to paying for better outcomes achieved at a lower total cost of care.⁵ With the goal of preventing illness, injury, and chronic disease complications that result in high utilization of high-cost services like

3 Boone, David. "The economic value of mobility with a prosthesis". *JPO: Journal of Prosthetics and Orthotics* 31 (January 2019): 32-36. [JPO: Journal of Prosthetics and Orthotics](#)

4 Dobson, Allen, et al. "Economic value of orthotic and prosthetic services among Medicare beneficiaries: a claims-based retrospective cohort study." *Journal of neuroengineering and rehabilitation* 15 (2018): 1-12. <https://doi.org/10.1186/s12984-018-0406-7>

5 Peterson-KFF. McGough, Matthew, et al. "[How has U.S. spending on healthcare changed over time?](#)" (Accessed December 4, 2024)

acute hospitalization, VBC initiatives have largely focused on two domains: primary care as the central coordinating hub for managing patients' overall health and high-cost specialty areas like chronic kidney disease, heart disease, cancer, and orthopedics. Results have been mixed,⁶ pointing to the need to continue to evaluate and evolve VBC models across the care continuum.

In the context of VBC arrangements, payers have potential to expand their focus to a broader range of interventions aimed at functional health, which have shown promise in reducing healthcare costs. Improvement in functional health not only benefits patients' quality of life but can potentially reduce healthcare costs.⁷ O&P providers deliver individualized care and services that are crucial to improving patients' physical function, reducing pain, and driving overall health and wellness. In this paper, we will explain the different aspects of VBC, the role O&P professionals can play, and how VBC models could benefit from incorporating O&P services.

What is Value-Based Care?

VBC is a healthcare delivery model that places a greater focus on improving patient outcomes to create greater value of care. Value-based payment models are the financial mechanisms employed to achieve VBC by incentivizing and rewarding the outcome of healthcare services rather than the volume alone. The traditional and most common form of provider reimbursement is fee-for-service (FFS), in which providers are reimbursed for each individual service that they perform. While FFS is a straightforward and structurally necessary mechanism for paying providers for the specific services they are delivering at the intensity that is appropriate for the individual patient, the emphasis is placed on the process of providing services and not the outcome of those services. This disconnection between care delivery and patient outcomes is the gap that VBC models intend to fill.

The goal of implementing VBC payment models is to use financial mechanisms to encourage behavior changes from the provider and payer sectors that will create value by delivering better outcomes. VBC models operationalize these goals through three financial features:

- **Amount of Spend Under Risk.** "Risk" is the concept of bearing responsibility for a population's healthcare costs. In traditional FFS payment, health insurers carry the full risk in that they are accountable for all incurred costs for their insured patients. In value-based payment, increments of risk for incurred costs are shifted from the payer to the providers. The portion of total cost that a provider is responsible for can vary between models. In FFS models, the provider is reimbursed fully for any service that they provide regardless of the results of the services provided. On the other end of the spectrum is full capitation, in which a provider is given a single payment for management of the patient's care. The provider is then responsible for any costs incurred as part of management of that care. In this arrangement, if

⁶ Leao, Diogo, et al. "The impact of value-based payment models for networks of care and transmurals care: a systematic literature review." *Applied Health Economics and Health Policy* 21(3), (February, 2023): 441-466.

⁷ Dobson, Allen, et al. "Economic value of orthotic and prosthetic services among Medicare beneficiaries: a claims-based retrospective cohort study." *Journal of neuroengineering and rehabilitation* 15 (2018): 1-12. <https://doi.org/10.1186/s12984-018-0406-7>


patients require fewer services, or lower-cost services, the provider has greater realized gains. All other payment models fall somewhere between FFS and full capitation.

- **Risk Structure:** In some models (referred to as “shared savings,” “one-sided,” or “upside-only” arrangements), providers receive a bonus for achieving benchmarks associated with healthier patients which will reduce overall utilization, but do not incur financial risk if they fail to achieve these benchmarks. In other models (referred to as “shared risk,” “two-sided,” or “downside risk” arrangements), the provider is still eligible for bonuses if they achieve benchmarks associated with healthier patients but are penalized for not improving patient outcomes. In a fully capitated model, for example, this would result in the provider being responsible for portions of costs that exceed agreed upon per member reimbursement.
- **Timing of the Payment:** Payments can either occur prospectively or retrospectively. A prospective payment occurs prior to delivery of services and is based on anticipated costs of the care delivered, which allows providers to invest in the infrastructure needed to deliver high-value care, such as care coordination capabilities or value-enabling technology (note: this use of the term “prospective” does not refer to the Medicare Prospective Payment System, which is a schedule of prospectively-set fees to be paid retrospectively). Retrospective payment is made after care has been delivered and with the actual services provided as the primary factor driving the payment amount. In a purely FFS system, all payments are retrospective, whereas in a fully capitated system, all payments are prospective. However, many models combine aspects of these two approaches, such as a fixed monthly per-patient per-month payment plus a retrospective payment based on actual services and patient outcomes.

In addition to emphasizing the financial incentives aimed at lowering cost of care, these models also incorporate an explicit focus on improving quality. The reporting and performance requirements fall into two main categories:

- **Quality Processes and Reporting Mandates:** No matter the degree of financial risk or the payer, every value-based payment model requires participating providers to report certain data demonstrating the quality of care provided and the health outcomes achieved. Additionally, some models require evidence that the provider has implemented processes or structures that improve quality, such as care coordination services, use of clinical decision support tools, or shared decision-making models.
- **Financial Incentives or Penalties for Quality Performance:** Performance results on a model’s quality measures can impact the provider’s financial success in more advanced models. This could be pure performance-based payments such as monetary penalties for poor performance or bonus payments for high performance, or it could be other financially driven quality incentives, such as minimum quality thresholds that must be hit in order to unlock the potential for shared savings, or public quality ratings that impact patients’ selection of health plans and providers.

Table 1. VBC Payment Model Types and Examples



	Description	Example
Fee-For-Service	The traditional and most common method of payment. A provider submits claims and receives retrospective payment for the services they provide, incentivizing quantity of services. Most O&P professionals are compensated through FFS.	Traditional insurance reimbursement e.g., traditional Medicare, commercial preferred provider organization plans
Pay-for-performance (P4P)	Incorporates a small degree of quality measure performance assessment, such as outcomes, efficiency, or cost, to supplement payment decision. P4P models can have one- or two-sided risk.	Hospital value-based purchasing, Merit-Based Incentive Payment System
Pro Fee Capitation	Administer upfront (prospective) payment to providers to reimburse for overhead cost services such as care coordination. Typically employed by specialist-focused models.	Kidney Care Choices Model – Kidney Care First option
Surgical Bundles	Cover the cost of a procedure and related services within a short time frame. Does not factor in previously made care decisions that could have affected the surgery.	Bundled payment for care improvement model (BPCI)
Condition-Based Bundles	Cover the costs associated with a specific condition over a long period of time. Provides incentive for physicians to treat the source of a given condition and rewards preventative care.	ESRD Treatment Choices Model, Enhancing Oncology Model
Population Health	Places risk on providers who are responsible for entire patient populations. Cost benchmarks for the entire population are created for the accountable entity to meet. Incentivizes preventative care and chronic condition management across a population to reduce spending.	Accountable Care Organizations such as Medicare Shared Savings Plan
Full Capitation	Highest degree of risk among all payment models. Payment is based on historical trends and patient risk scores. Require the highest degree of sophistication due to the need to model anticipated costs, monitor patient outcomes, and coordinate between providers and specialists.	ACO Realizing Equity, Access, and Community Health – Global Track

Participating Providers

Primary care physicians have had the highest rates of VBC adoption thus far. Because primary care physicians serve as the central point of coordination for patients' overall care, they arguably have the highest degree of control over what kind of services a patient receives. This has led to many federal and private value-based payment models designed for primary care practices and oriented with the primary care provider as the patient's "medical home." While these models have shown success, primary care providers' ability to impact utilization of high-cost specialty care has not achieved the desired level of success.

Recognizing that achieving overall savings and improving quality at scale must include engagement from specialists, more alternative payment models (APMs) have been rolled out by the Center for Medicare and Medicaid Innovation in the last eight years that target high-volume, high-cost specialty areas like oncology, nephrology, and orthopedics. For example, oncology models focus on episodic care related to chemotherapy. This is a specialty area with a high degree of addressable spend due to the expensive nature of chemotherapy and other cancer treatments complemented by an abundance of clinical evidence and clinical practice guidelines to support providers in delivering high-value care. For similar reasons, orthopedics has started adopting APMs such as bundled payments for total joint replacements, procedures in which there is clear evidence for the best practices that minimize cost and optimize outcomes. While current orthotics and prosthetics patient cost and volume would not support a standalone model, incorporating O&P interventions into relevant care episodes that are typically specialist-focused, such as those in orthopedics, pain management, or psychiatry, has the potential to improve the overall success of the models.

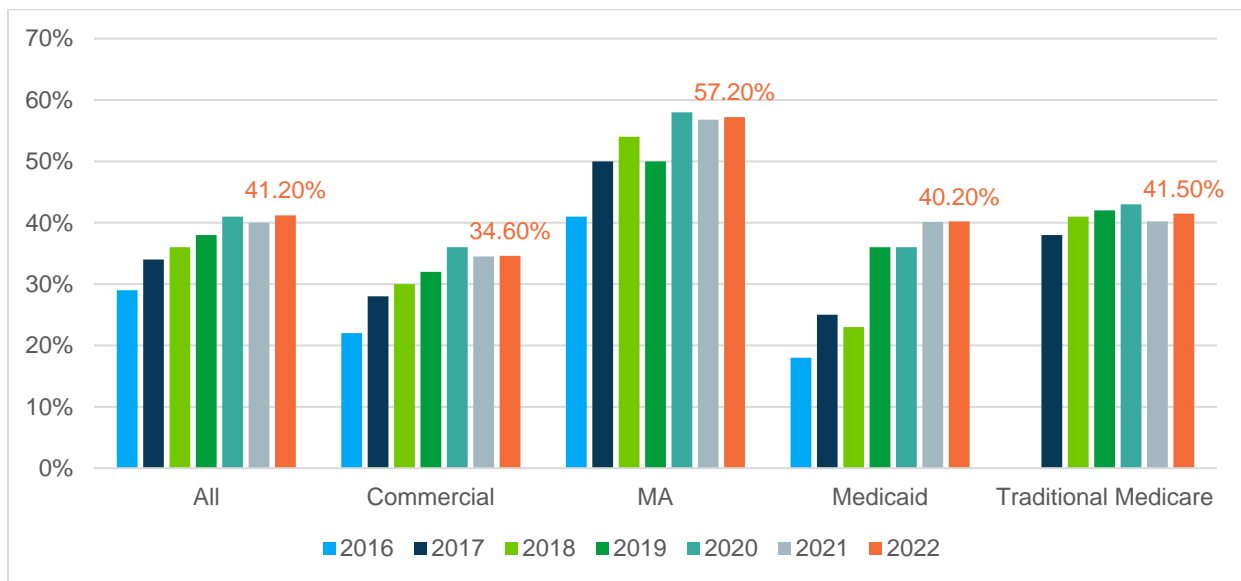
Other non-physician entities including hospitals, skilled nursing facilities, dialysis providers, and physical therapists have engaged in VBC arrangements through multiple channels, either as direct participants taking on risk or as affiliated entities who enter into agreements with the risk-bearing providers. In affiliation arrangements, the entity commits to certain levels of quality and cost in exchange for receiving preferred status for referrals, a preferred tier in the network, or other financial incentives – an ideal method of engagement for clinical providers like orthotists and prosthetists whose percentage of overall healthcare spending is low and are who not positioned to take on financial risk. These entities are vital to the overall success of VBC, especially in broader population health models. They enhance the range of clinical strategies for optimizing outcomes in high-cost services (e.g., optimal dialysis or surgical care), preventing the need for expensive acute interventions (e.g., orthoses to avoid orthopedic surgery or falls), and enabling healthy lifestyle habits that reduce the demand for costly chronic care (e.g., prostheses to encourage increased physical activity).

The Current State and Projected Growth of VBC Models

Value-based care represents a significant area for growth and opportunity over the next several years. The Centers for Medicare and Medicaid Services aims to have 100% of traditional Medicare beneficiaries in a value-based program by 2030. As of October 2023, 48.9% of dollars spent in traditional Medicare were in a value-based payment program, and 24.5% flowed through a two-sided APM. Comparatively, Medicare Advantage (MA), the fastest adopter of value-based care models, had 57.2% of spending in value-based payment models, with 38.9% in two-sided APMs (See Figure 1 for growth of risk-bearing APMs across plan types).

This relatively higher adoption of value-based payment initiatives—combined with the annual growth of the size of the MA program as more Medicare beneficiaries choose private insurance—has led to rapid spending increases in MA delegated risk arrangements over the last several years. MA spending on population-level value-based payment programs has increased from \$88.2 billion in 2017 to \$219.3 billion in 2022, a 19.98% compound annual growth rate. While less information is publicly available on commercial value-based arrangements, a recent survey by the Health Care Payment Learning and Action Network found that 45.5% of healthcare payments from surveyed commercial plans had some tie to quality and value, and 16.5% percent flowed through two-sided risk models.⁸

Figure 1: Growth in Risk-Bearing APMs as a Percent of Healthcare Dollars Across Total Spend, 2017–2021



Source: [2023 APM - Health Care Payment Learning & Action Network \(hcp-lan.org\)](https://www.hcp-lan.org/2023-APM-Measurement-Survey)

⁸ Health Care Payment Learning & Action Network. "2023 APM Measurement Survey." (Accessed December 4, 2024)

This slower adoption is likely due in part to higher turnover in the patient population. Taking financial risk for a pool of members for whom the benefits of investments in long-term preventive health initiatives may not materialize until after they have left the plan can be challenging and disincentivizing. Additionally, the risk pool of a younger, typically healthier population may not be conducive to savings opportunities, particularly in a population that is either low utilizers of healthcare or highly acute without much room for improved efficiencies. Nevertheless, certain value-based payment models lend themselves to each population: Commercial plans may be more likely to participate in shorter term, episode-based models, while Medicaid private payers may participate in population health models that reward non-clinical interventions which address non-medical drivers of health. The various needs of different patient populations require a tailored approach to VBC for both payers and providers.

As expected, there is a positive relationship between the amount of risk and the level of sophistication involved with APMs. Larger financial risks taken on by providers require that they demonstrate that they have knowledge, skills, infrastructure, and processes to provide high quality, effective care. Being able to concretely demonstrate those capabilities requires advanced technology and an analytics investment for capturing patient information and outcomes. However, many providers lack the capabilities to capture such data. Consequently, VBC adoption effectively lags technological advancements; as technology improves to allow providers to efficiently and accurately collect patient data, they will be better suited to adopt a payment model with higher degrees of capitation. Many organizations are attempting to capitalize on this need by developing and implementing new data structures. As these are built and implemented, VBC adoption is expected to increase across all lines of businesses and specialties.

Introduction to Orthotics and Prosthetics

The O&P profession includes those certified and/or licensed as orthotists, prosthetists, or both, and those who specialize in two clinical domains of optimizing physical function through the use of supportive and adaptive devices: orthotics and prosthetics. Both orthotic and prosthetic care involve “patient evaluation, and the design, fabrication, fitting, modification, maintenance and repair of orthoses/prostheses.”⁹ Additionally, an orthotist and/or prosthetist is responsible for formulating, implementing, and monitoring a specific treatment plan for each individual patient.

Conditions driving the need for an orthotic device are wide-ranging: stroke, diabetes, scoliosis, cerebral palsy, and injuries can all lead to functional deficits that necessitate an orthotic device. Children born with neuromuscular or orthopedic conditions may rely on orthoses for contracture management or slowed progression of deformities. As individuals age, they may require various orthotic devices to assist with walking, running, or general stability while standing. Prosthetic

⁹ American Board for Certification. “[American Board for Certification Scope of Practice for ABC Certified Orthotist, Prosthetist, or Prosthetist/Orthotist.](#)” (Accessed December 4, 2024)

care includes the “patient evaluation and the design, fabrication, fitting, modification, maintenance and repair of prostheses to restore physiological function and/or cosmesis”¹⁰ related to the amputation or congenital deficiency of a limb. There can similarly be a wide range of causes for limb amputation, the most common of which are peripheral vascular disease, diabetes, trauma, congenital limb absence or difference, infection, or tumors. In these cases, patients often require a great deal of individualized support. For example, in the case of lower limb amputation, a prosthetist ensures that not only is the prosthesis functional, but also aligns with and enables the patient’s lifestyle and activity goals. A patient may lead an active lifestyle and require specialized modifications to achieve their goals. Similarly, the prosthetist is needed to constantly reassess the patient’s progress, comfort, and satisfaction while using the device. This type of individualized care is only possible through the prosthetist’s clinical understanding of the patient’s needs and how those align with various prosthetic devices.

Impact of O&P Devices on Mobility and Quality of Life

A well-fitted orthotic or prosthetic device can improve mobility, alleviate pain, or prevent progression of musculoskeletal deformities which have significant downstream impacts on healthcare outcomes and cost by reducing the incidence of falls, reducing the risk of mobility-related complications, lessening frequency of surgery, improving the ability to participate in therapy or exercise regimens, and/or enabling someone to continue or resume employment.¹¹

O&P care typically occurs in the outpatient or ambulatory setting, though inpatient services are available in select circumstances, particularly inpatient rehabilitation. However, one unusual aspect of O&P care is the mechanism of reimbursement. While O&P professionals are trained clinicians whose expertise, clinical assessment, and clinical decision-making is required to select, customize, fit, fabricate, evaluate O&P devices, and educate patients, their care is paid under a health plan’s durable medical equipment benefit for the specific device used, without a separate payment for the clinical care associated with the device.

With O&P professionals’ services intrinsically linked to the devices, the O&P professional may be seen as simply the supplier of a device. Similarly, because there are numerous prefabricated, off-the-shelf orthotic devices that can be purchased over the counter, payers may not have a high degree of visibility into the specific services provided by O&P professionals.

Often orthotists and prosthetists are patients’ primary point of contact in their care journey; O&P professionals educate their patients on how best to achieve their functional goals, and in turn adapt and adjust their care plans as patient needs, abilities, and goals change. Secondly, an O&P professional is often the liaison between the patient and other forms of care. If a patient

10 American Board for Certification. “[American Board for Certification Scope of Practice for ABC Certified Orthotist, Prosthetist, or Prosthetist/Orthotist.](#)” (Accessed December 4, 2024)

11 Dobson, Allen, et al. “Economic value of orthotic and prosthetic services among Medicare beneficiaries: a claims-based retrospective cohort study.” *Journal of neuroengineering and rehabilitation* 15 (2018): 1-12. <https://doi.org/10.1186/s12984-018-0406-7>

requires physical, occupational, or specialty therapy, the O&P professional acts as the de facto care coordinator for connecting a patient to these services. Finally, many orthoses require a large degree of customization. An orthotist will meet with a patient and determine their individual goals and needs. These criteria then influence the orthotist's care plan and how they select, customize, and/or fabricate a specific device. The process for properly fitting an orthosis to a patient can be lengthy and may require multiple visits and readjustments to ensure that it meets the patient's individual needs.

O&P Potential in VBC

As the VBC environment matures and expands beyond the current focus on high-cost utilization to encompass more longitudinal and patient-centered care models, other clinical providers who can impact patient outcomes will have the opportunity to demonstrate their value in making progress towards the quadruple aim.¹² With the focus of O&P on functional improvement, the profession is reasonably well-positioned to play a role in future models. Considering the need for prostheses, a recent report demonstrated that there are over 5.7 million Americans living with limb loss or limb difference; this number is expected to double by 2050.¹³ Similarly, due to an aging population and the burden of chronic disease, demand for orthoses will continue to rise, as evidenced by an expected compound annual growth rate of 3.36% over the next four years for orthopedic devices.¹⁴

These trends, together with the growing recognition that “value” should sharpen its focus on patient-centeredness and equity, the innate patient-centeredness of O&P care lends itself to some level of participation in VBC models. Much of the work in O&P is an ongoing dialogue between patient and provider, continuously reevaluating the patient's progress against their goals, and reconciling those with the treatment plan. The consensus in O&P care and research is moving away from typical lab measurements, such as movement patterns and gait measures, and towards patient-reported outcomes to gauge the effectiveness of these types of patient-centered interventions. The implementation of quality improvement mechanisms like patient-reported outcomes and increased usage of shared decision-making in O&P would be a natural progression from the current state and align with care coordination mechanisms embedded in today's high-performing value-based care delivery organizations.

Research indicates that incorporating O&P into coordinated care models could improve long-term outcomes while reducing total cost of care. A 2013 study of orthotic and prosthetic use in the Medicare population showed a lower total cost of care and improved quality of life for those individuals provided with orthotic or prosthetic devices vs. those who did not receive one¹⁵.

12 Bodenheimer, Thomas, and Sinsky, Christine. “From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider.” *Analysis of Family Medicine* 12 (November 2014): 573-576. <https://doi.org/10.1370/afm.1713>

13 Amputee Coalition. Caruso, Megan, et al. “[5.6 Million++ Americans are Living with Limb Loss and Limb Difference: New Study Published](#)” (Accessed December 4, 2024)

14 Statista. “[Orthopedic Devices - US | Statista Market Forecast](#).” (Accessed December 4, 2024)

15 Dobson-Davanzo & Associates. “[Retrospective Cohort Study of the Economic Value of Orthotic and Prosthetic Services Among Medicare Beneficiaries Study](#).” (Accessed December 4, 2024)

Another study demonstrated that use of advanced microprocessor-equipped lower limb prostheses increased quality-adjusted life years and reduced incidence of falls with injury.¹⁶

Exploring the potential of O&P in VBC requires engagement from both the O&P profession and from the entities at the forefront of value innovation, including model developers, payers, and IDNs. The O&P profession will need to generate the evidence that demonstrates their value and actively seek out potential partners to develop and pilot innovative value-based arrangements inclusive of O&P. Evidence that supports the use of O&P to improve patient outcomes—specifically that the inclusion of an O&P professional on the care team improves outcomes and drives lower cost—will be critical to garnering the interest of those potential partners and to the optimal design of the partnership structure. IDNs and payers can consider partnership opportunities to improve orthotic and prosthetic care for current patients and also consider clinical conditions and populations that may benefit from this type of treatment. Researchers, advocacy organizations, and O&P practices themselves will need to commit the time and resources to developing this real-world evidence and then actively seek out opportunities to pilot non-traditional arrangements with payers and provider organizations.


Figure 2: Potential Stakeholder Actions to Prepare for Non-Traditional Arrangements

Build the evidence base	Health economics & outcomes research, including demonstration of improved patient-centered outcomes and impact to total cost of care will be critical to presenting a compelling value story for O&P
Establish development partnerships	Identify target organizations, such as IDNs, to collaborate with in developing and piloting value-based arrangements inclusive of O&P
Learn from and spread successful models	Evaluate the outcomes of pilot models, learning from their successes (and points of failure) to refine and spread successful models

Unique Challenges for O&P Providers Participating in Value-Based Care Payment Models:

As part of the explorative process to determine whether O&P practices can be incorporated into value-based payment models, O&P professionals will need to make specific considerations. Unique characteristics of O&P care create distinct challenges that O&P organizations may need

¹⁶ Rand Corporation. Liu, Harry, et al. "[Economic Value of Advanced Transfemoral Prosthetics](#)." (Accessed December 4, 2024)



to recognize before committing to a value-based payment arrangement. Prior to entering a value-based payment model, these characteristics can be used to frame the payment model itself to ensure a successful arrangement. These characteristics of O&P care may include:

- Population heterogeneity (i.e., different underlying etiologies requiring O&P care that have inherently different prognoses)
- Highly customized devices (e.g., the same ankle-foot orthosis may be prescribed but be constructed very differently to facilitate different levels of success)
- High dependency on technology which inevitably has an increasing cost of materials eroding potential margins with same level of care (e.g., a microprocessor knee may increase in cost due to rising costs of microprocessors)
- Fragmented healthcare services (i.e., O&P providers are often subject to the referral systems for timely and effective care),
- “Upstream” hospitalizations and complications (e.g., a patient with diabetes has a hospitalization episode unrelated to their orthosis, resulting in downtime and subsequently impacting device fit).

There are also potential regulatory and compliance challenges to be considered based on the payment arrangement. These factors, in addition to other potential issues based on individual practice characteristics, are among some of the unique challenges and risks that O&P providers should consider before participating in any value-based payment models. Despite these considerations, the continued priority of payers and providers to incentivize and deliver high-value care indicates that O&P, like all sectors of the healthcare ecosystem, must be prepared to adapt.

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