Value-Based Payment Models

Incentivizing more affordable and accountable care

Published – May 6, 2020 • 5-min read

Key takeaways

• Value-based payment models financially incentivize provider organizations to reduce costs and improve care quality.

• There are several different models that differ in scope, design, complexity, and financial risk.

• Organizations must pursue an evolutionary—rather than swift—approach when taking on full financial risk. An iterative process allows organizations to build infrastructure to reduce costs and improve quality.
What are they?

Value-based payment models are reimbursement structures that incentivize provider organizations to improve the cost and quality of care. Differing in scope, design, and complexity, these models include: Pay-for-performance (P4P), also referred to as value-based purchasing; bundled payments; shared savings, such as Accountable Care Organizations (ACOs), and capitation.

Value-based payment models create performance risk and utilization risk. The P4P and bundled payment models create performance risk by holding organizations financially accountable for clinical outcomes and avoidable costs. These models incentivize coordination and efficiency, not reduction of the overall volume of care. Shared savings models and capitation create utilization risk, incentivizing organizations to reduce the overall volume of services delivered to achieve greater cost savings—a far greater departure from the fee for service (FFS) status quo.

“Value-based” and “risk-based” are two terms that are often used synonymously. They are distinct in that “value-based” does not necessarily imply taking on negative financial risk (such as an upside-risk-only ACO), while “risk-based” does not necessarily imply value or quality (such as capitation without quality measures (like Health Maintenance Organizations in the 1990s).¹ That said, in everyday parlance, these terms mean essentially the same thing.

¹ In the late 1980s and 1990s, insurance companies created Health Maintenance Organizations (HMOs) to receive capitated payments from employers and ultimately curb health care spending. However, insurance companies did not account for the quality of services delivered, causing HMOs to ration care and use PCPs as gatekeepers to care.

Why do they matter?

Value-based payment models are necessary to curb health care costs and improve care outcomes. Currently, the U.S. spends nearly twice as much as the average Organization for Economic Co-operation and Development (OECD) country on health care—totaling 16.9% of U.S. GDP—yet has the lowest life expectancy, highest suicide rates, and highest chronic disease burden among OECD countries.\(^1\)

One driver is that the traditional fee-for-service model, where payers reimburse for services rendered regardless of performance or utilization, is inherently at odds with reducing costs. For hospitals and health systems to focus more on preventing avoidable readmissions, decreasing length-of-stay, standardizing care, managing chronic conditions, and preventing emergent conditions—all of which can reduce the total cost of care and improve quality—payers are increasingly moving to value-based payment models.

Currently, the U.S. spends nearly twice as much as the average OECD country on health care—totaling 16.9% of U.S. GDP—yet has the lowest life expectancy, highest suicide rates, and highest chronic disease burden among OECD countries.

\(^1\) 2018, the Commonwealth Fund.

How do they work?

Value-based payment models differ in scope, design, and complexity. A single provider organization can also be using multiple simultaneously to cover their patients.

P4P models levy penalties or give bonuses to organizations for meeting or failing to meet clinical quality measures, such as readmission rates, patient safety indicators, and patient experience scores. P4P incentives are small relative to total hospital expenditures, but matter given thin hospital margins. While P4P models incentivize efficiency and quality, they have a limited impact because organizations don’t alter FFS billing.

Bundled payments are lump sum payments paid to reimburse a specific episode of care over a period of time. For example, the surgeon, hospital, and post-acute care provider all help treat a knee replacement from acute stay to 90 days post-discharge. By paying them collectively (and often several percentage points less than FFS rates), bundled payments incentivize provider organizations to coordinate care, reduce costs, improve efficiency, and improve quality. However, bundled payments are limited to specific treatments, and organizations still bill FFS.

Shared savings models reward organizations for improving the total cost and quality of care at the population level—or increasingly, levy penalties. Groups of hospitals, such as ACOs, receive a risk-adjusted spending benchmark for their patient population (below FFS levels) and bill FFS while reducing patient utilization. If they bill for fewer services, stay below the benchmark, and meet clinical performance indicators, they receive a portion of the savings (upside risk) as stipulated in their contract. Increasingly organizations are also accountable for losses if they exceed costs or don’t meet clinical measures (downside risk).

Capitation is the most advanced model, as organizations incur full financial risk for a group of patients per period of time up front. The payer calculates the payment based on patient risk and utilization, pays the organization, and they attempt to reduce total cost of care, owning 100% of the profits or losses.
Conversations you should be having

01. Decide what level of financial risk your organization can take on and what model(s) might be right for you.

02. Figure out how many patients you currently serve under value-based payment models, and if there are changes coming to these models that you will need to address.

03. Explore how your organization can reduce costs and improve clinical outcomes to meet increasingly strict criteria under these payment models.

Take stock of your organization’s infrastructure to handle increased risk, evaluate the evolving landscape for any value-based payment models you are currently using, and focus on clinical practice changes that offer the greatest cost savings and quality improvements.
Related resources

CHEAT SHEET
C-Suite Cheat Sheet: Bundled Payments
advisory.com/bundledpaymentcheatsheet

CHEAT SHEET
C-Suite Cheat Sheet: Accountable Care Organizations
advisory.com/ACOcheatsheet

TOOL
Pay-for-Performance Customized Assessment
advisory.com/P4Passessment

REFERENCE GUIDE
Care Delivery Innovation Reference Guide
advisory.com/caredeliveryreferenceguide
CHEAT SHEET
Value-Based Payment Models

Physician Executive Council

Project Directors
Clare Wirth
wirthcl@advisory.com
202-266-6823

Ryan Furr-Johnson
rfurrjo@advisory.com
202-266-5373

Program Leadership
Megan Clark
Sarah Evans

LEGAL CAVEAT

Advisory Board has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and Advisory Board cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, Advisory Board is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member’s situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither Advisory Board nor its officers, directors, trustees, employees, and agents shall be liable for any claims, liabilities, or expenses relating to (a) any errors or omissions in this report, whether caused by Advisory Board or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by Advisory Board, or (c) failure of member and its employees and agents to abide by the terms set forth herein.

Advisory Board and the “A” logo are registered trademarks of The Advisory Board Company in the United States and other countries. Members are not permitted to use these trademarks, or any other trademark, product name, service name, trade name, and logos of Advisory Board without prior written consent of Advisory Board. All other trademarks, product names, service names, trade names, and logos used within these pages are the property of their respective holders. Use of other company trademarks, product names, service names, trade names, and logos or images of the same does not necessarily constitute (a) an endorsement by such company of Advisory Board and its products and services, or (b) an endorsement of the company or its products or services by Advisory Board. Advisory Board is not affiliated with any such company.

IMPORTANT: Please read the following.

Advisory Board has prepared this report for the exclusive use of its members. Each member acknowledges and agrees that this report and the information contained herein (collectively, the “Report”) are confidential and proprietary to Advisory Board. By accepting delivery of this Report, each member agrees to abide by the terms as stated herein, including the following:

1. Advisory Board owns all right, title, and interest in and to this Report. Except as stated herein, no right, license, permission, or interest of any kind in this Report is intended to be given, transferred to, or acquired by a member. Each member is authorized to use this Report only to the extent expressly authorized herein.

2. Each member shall not sell, license, reproduce, or post online or otherwise this Report, in part or in whole. Each member shall not disseminate or permit the use of, and shall take reasonable precautions to prevent such dissemination or use of, this Report by (a) any of its employees and agents (except as stated below), or (b) any third party.

3. Each member may make this Report available solely to those of its employees and agents who (a) are registered for the workshop or membership program of which this Report is a part, (b) require access to this Report in order to learn from the information described herein, and (c) agree not to disclose this Report to other employees or agents or any third party. Each member shall use, and shall ensure that its employees and agents use, this Report for its internal use only. Each member may make a limited number of copies, solely as adequate for use by its employees and agents in accordance with the terms herein.

4. Each member shall not remove from this Report any confidential markings, copyright notices, and/or other similar indices herein.

5. Each member is responsible for any breach of its obligations as stated herein by any of its employees or agents.

6. If a member is unwilling to abide by any of the foregoing obligations, then such member shall promptly return this Report and all copies thereof to Advisory Board.