CHEAT SHEET

Value-Based Payment Models

Incentivizing more affordable and accountable care

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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.

Source: The Essentials of Risk-Based Contracting, Financial Leadership Council, Advisory Board Research.

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.

Source: James B. and Poulsen G.,"The Case for Capitation," Harvard Business Review, August 2016, https://hbr.org/2016/07/the-case-for-capitation.

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.

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1. 2018, the Commonwealth Fund.

Source: Tikkanen R. and Abrams K., "U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?", The Commonwealth Fund, January 30, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019.

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.

Source: C-Suite Cheat Sheet: Bundled Payments, Health Care Industry Committee, Advisory Board Research; C-Suite Cheat Sheet: Shared Savings, Health Care Industry Committee, Advisory Board Research.

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
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