Lowering Costs through Value-Based Care

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The Search for a Lower-Cost Alternative to Fee-for-Service

Under fee-for-service (FFS) payment arrangements, providers earn more when they do more, which tends to drive up costs. As an alternative to FFS payment, value-based care (VBC) can lower healthcare costs by changing providers' financial incentives. VBC arrangements encourage providers to practice medicine that prevents the need for more costly care in the future while discouraging them from delivering unnecessary care or ordering unnecessarily expensive care.

Medicare operates VBC arrangements through the Medicare Shared Savings Program (MSSP) and Center for Medicare and Medicaid Innovation (CMMI) payment models. Medicare Advantage (MA) plans also operate VBC arrangements. In 2022, 41 percent of Traditional Medicare payments and 57 percent of MA payments were made through a VBC arrangement.[1]

Value-Based Care Lowers Costs

Medicare's accountable care organization (ACO) programs demonstrate how VBC lowers costs in Medicare. ACOs are groups of healthcare providers that have agreed to be held accountable for the cost and quality of care for a group of beneficiaries. Medicare has operated both MSSP and at least one CMMI ACO model concurrently since 2012. Research shows that MSSP produced modest savings in its first three to five years of operation when compared to a control group.[2] In the last five years, MSSP has saved Medicare over $7 billion net when compared to spending targets.[3] The Pioneer ACO Model was the first CMMI model to be certified for expansion, saving $254 million net in its first two years, in part by lowering hospital admissions by 3.5 percent.[4] Table 1 shows an accounting of Medicare's ACO programs with published evaluations.

Table 1. Total Gross and Net Savings of Medicare Models*

MSSP 2012–present[5]	- Net savings of $144M in 2015 - Spending grew by 1–2% less for MSSP beneficiaries than non-MSSP beneficiaries in the years leading up to 2016 - MSSP ACOs associated with 0.5% ($1.75B) less spending in 2016 net of bonus payments and including spillover effects - MSSP saved over $7B in last five years: $0.7B in 2018, $1.2B in 2019, $1.9B in 2020, $1.7B in 2021, and $1.8B in 2022**
Pioneer ACO Model 2012–2016	- Gross savings of 2.5%; net savings of $0.25B in first two performance years[6]
Advance Payment ACO Model 2012–2015	- Gross spending of 0.4%; net spending of $0.24B[7]
ACO Investment Model 2015–2018	- Gross savings of 3.4%; net savings of 2.5%[8]
Next Generation ACO Model 2016–2021	- Gross savings of 1.9%; no impact on net spending[9]
Vermont All-Payer ACO Model[10] 2018–2024	- State track: gross savings of $1,177 per beneficiary per year (PBPY); net savings of 9.7% - ACO track: gross savings of $686 PBPY; net savings of 5.7%

** Table shows MSSP and CMMI total-cost-of-care ACO models with at least two performance year evaluations published*
*** Compared to MSSP program's spending targets.*

Other CMMI models demonstrate how VBC lowers healthcare costs. In a review of nine models that focused on acute or specialty care and certain targeted populations, CMS found that every model produced significant reductions in gross Medicare spending, with savings ranging from 1 percent to 17 percent.[11] Savings were driven by significant reductions in inpatient admission and post-acute care spending or utilization. While a subset of these models was evaluated as having led to net losses after accounting for bonus payments care management fees paid to model participants, these models overall showed that VBC led to lower utilization generally and therefore lower spending on healthcare itself.

Investing in VBC Can Lead to Long-Term Savings for Federal Programs

Despite proving that VBC lowers healthcare costs, most CMMI models carried out in the Center's first decade failed to show net savings.[12] When viewed through a wider lens, however, CMMI's importance to the long-term goals of reforming the healthcare delivery system and lowering costs becomes apparent. The following eight factors provide necessary context around CMMI's role in promoting VBC to lower costs:

1. **Before CMMI, providers had little experience delivering VBC.** Prior to 2011, few providers had experience delivering VBC to Medicare FFS beneficiaries. Today, over 45 percent of providers that treat Medicare FFS beneficiaries participate in a CMMI model or MSSP.[13]
2. **CMMI supports providers that must invest to succeed in VBC.** Switching to VBC requires healthcare practitioners to invest in new care delivery, administrative, and financial capabilities over multiple years.[14] CMMI can and has provided funds and care management fees to help participants overcome these startup costs. While funding support makes it harder to achieve net savings, these investments have created a larger base of providers with VBC competencies.
3. **Congress charged CMMI with tackling healthcare's most difficult task**. Healthcare researchers believe quality or access cannot be improved without increasing cost—healthcare's "iron triangle."[15] Yet Congress charged CMMI with testing ways to lower costs without decreasing quality or improve quality without increasing costs. Few cost-saving or quality-improvement policies are held to this standard because it is so difficult to achieve.
4. **CMMI aims to save, but innovation requires risk.** While a CMMI model can be launched only if the CMS Office of the Actuary agrees it has the potential for net savings, the experience from the first decade of models proved net savings are difficult to achieve. The Congressional Budget

Office (CBO) reviewed evaluations of forty-nine models initiated between 2011 and 2020, finding six that generated statistically significant savings.[16] This puts the first decade of CMMI models in line with drug discovery, where 90 percent of clinical drug development fails but the successes become next-generation treatments and cures.[17]

5. **CMMI improves design of new models using lessons from past models**. CMMI uses learnings from past models to improve the likelihood of savings. The Advanced Placement ACO Model failed to achieve net savings, but its lessons informed the design of the ACO Investment Model, which achieved net savings and has been incorporated into MSSP. As mentioned above, CMMI's mandate of either lowering costs without lower quality or improving quality without increasing costs allows CMMI to apply lessons to further both its cost-savings and quality-improvement goals.
6. **Medicare's VBC programs show positive spillover effects.** Medicare's investments in VBC appear to provide benefits for patients more broadly. A 2018 CMS analysis showed declines in spending growth per capita across Traditional Medicare populations in locations with greater MSSP participation.[18] More than half of ACO leaders from the Next Generation ACO Model reported care management services were offered to beneficiaries regardless of whether they were aligned with the model.[19] Relatedly, employers who have long complained their own payment reform efforts could not succeed unless Medicare moved away from FFS payment can now align with Medicare's VBC programs. While greater alignment is needed, spillover effects may lead to greater savings and improved care delivery than model evaluations suggest.
7. **CMMI's first decade coincided with a dramatic drop in Medicare spending per capita.** Medicare spending per capita grew 7.4 percent from 2000 to 2010 but only 1.9 percent from 2010 to 2020.[20] According to a *New York Times* analysis, had Medicare spending continued growing at historical rates, federal spending would have been $3.9 trillion higher since 2011.[21] . Other factors, such as Affordable Care Act policies that lowered payments to hospitals and MA plans, cannot completely account for this decline. CMMI's efforts to promote VBC likely played a significant role, creating a cost-consciousness within the healthcare delivery system that previously did not broadly exist to the same extent.
8. **CBO projects future investment in VBC through CMMI will cost 0.01 percent of total Medicare spending.** Medicare's Trustees estimate Medicare spending from 2021 to 2030 will be $13 trillion. CBO estimates net spending related to CMMI during the same period will be $1.3 billion, or 0.01 percent of total Medicare spending.[22] CBO predicts CMMI will break even by 2029 and deliver net savings to Medicare in 2031 and thereafter.

Lessons for Policymakers

The first decade of VBC in Medicare showed VBC lowers healthcare costs and net savings depend on model design. While not all models produced net savings, they collectively allowed the healthcare system to grow competent in providing VBC within the context of an historic slowdown in the growth of Medicare per-capita spending. Policymakers should consider how best to leverage the healthcare system's improved VBC capabilities and CMMI's de minimis cost structure when investing in future efforts to lower costs through healthcare delivery reform.

Endnotes

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