

CHAPTER

1

**Realizing the promise
of value-based payment
in Medicare:
An agenda for change**

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Introduction

The Commission contends that the growth in spending for the Medicare program poses a significant challenge for the federal government. In 2018, Medicare accounted for 3.6 percent of the country’s gross domestic product, and that figure will grow to 4.7 percent by 2027 under current policies. Most of this growth (70 percent) is due to increases in per capita spending (Congressional Budget Office 2019). The expected growth in per capita spending primarily reflects continued growth in payment rates rather than growth in service use. As the population ages, the number of workers per Medicare beneficiary is expected to decline—from 3.0 in 2019 to a projected 2.5 in 2029—making the financing of the program more challenging. The program’s Part A trust fund, which pays for services such as inpatient care and post-acute care, is projected to exhaust its reserves in 2026, which will force Medicare to sharply reduce payment rates for Part A providers unless policymakers take some other action (Boards of Trustees 2019). A growing share of program spending—for Part B and Part D benefits—is paid for by general revenues, which are partly financed by deficit spending (Medicare Payment Advisory Commission 2020). Without deliberate changes to the program, this growth in spending could result in dramatic changes to the Medicare program and/or its financing.

The Commission contends that policymakers will need to address this unsustainable trend by changing both how

Medicare pays providers and how services are organized and delivered. A common element for these changes should be the use of value-based payment (VBP), which characterizes methods of paying for health care services that provide stronger incentives to control overall costs than traditional fee-for-service (FFS) while maintaining or improving quality.

This chapter outlines a multiyear Commission effort to establish a strategic direction for Medicare payment policy and delivery system design that could be implemented by the Congress and CMS. This work will be guided by the same fundamental principles that serve as the foundation for all of our policy development: ensuring that beneficiaries have access to high-quality care in an appropriate setting, paying providers equitably and giving them incentives to supply efficient and appropriate care, and ensuring the best use of the taxpayer dollars that finance most of Medicare’s spending. This effort will be aimed at identifying changes that broaden the use of VBP by encouraging more providers to organize into entities (which we refer to here generically as “accountable entities”) that are capable of receiving payments from Medicare that require accepting accountability for both the cost and the overall health of a group of beneficiaries. This accountability includes attention to the quality of care, information that beneficiaries can use to compare the care provided by the entities in their area, the systematic provision of preventive services and early detection of

disease, the avoidance of waste, and the delivery of care at the most appropriate and cost-effective site of service.

Medicare Advantage and accountable care organizations could provide a foundation for expanding value-based payment

Although the traditional FFS program has long been Medicare's primary payment mechanism, about 65 percent of the beneficiaries who have both Part A and Part B coverage are now in two other payment models that have stronger incentives to manage overall spending:

- Almost 24 million beneficiaries (about 42 percent of all beneficiaries with Part A and Part B) are enrolled in Medicare Advantage (MA) plans, which receive capitated payments to provide the Part A and Part B benefit package.
- About 13 million beneficiaries (about 23 percent of all beneficiaries with Part A and Part B) are assigned to accountable care organizations (ACOs), which are groups of FFS providers that have incentives to control overall spending and improve quality.¹

The MA and ACO programs could serve as vehicles to broaden the use of VBP in Medicare, but both programs need to be improved before they can realize that potential. While these programs may be capable of reducing spending relative to the FFS program, whether they actually produce substantial savings depends heavily on how they are structured. For example, 82 percent of MA plans indicate in their bids that they can provide the Part A and Part B benefit package at a lower cost than the FFS program, but the current MA program nevertheless increases overall program spending relative to FFS because MA benchmarks are substantially higher than FFS costs in some areas, many plans receive rebates and quality bonuses, and plans can receive higher payments by submitting more diagnosis codes (Medicare Payment Advisory Commission 2020).

The Commission asserts that broader acceptance in Medicare of accountability for overall costs and outcomes will require improvements to both the existing ACO and MA models. Researchers who have studied the various ACO programs that Medicare has operated over the past 15 years have typically found that they generated modest

savings, on the order of 1 percent to 2 percent of total spending. Whether ACOs will produce larger savings in the future is unclear. CMS has made changes to the largest ACO program—the Medicare Shared Savings Program (MSSP)—that have some positive elements, such as encouraging ACOs to bear more financial risk, but on balance the changes may, in fact, reduce savings for Medicare. In this report, we make a recommendation to protect program savings generated by ACOs in the MSSP by using national provider identifiers instead of tax identification numbers to calculate both performance-year and baseline-year spending.

The Commission plans to conduct further analysis to identify specific policy changes that will improve ACOs and ACO-like models. Any policy changes that we might recommend would be aimed at making ACOs more effective; changes that would, for instance, simply increase funding for ACOs or encourage the creation of ineffective ACOs would provide little, if any, incremental value. Two examples of areas where additional work may be needed (which are discussed in more detail later, in this report's chapter on ACOs) illustrate the complex challenges involved:

- ACOs may be more effective in the longer term if they also have incentives to manage the use of costly prescription drugs. ACOs are currently responsible for the cost of Part A and Part B services only, which includes physician-administered drugs covered under Part B, but does not include outpatient prescription drugs covered under Part D. However, making ACOs more accountable for outpatient prescription drug costs would be challenging because a separate group of entities (Part D plans) already has some financial responsibility for those costs.
- ACOs may be more effective if they have the understanding and support of beneficiaries, who usually do not know that they have been assigned to an ACO and may not be aware of the potential benefits of better-coordinated care. Beneficiaries might be more engaged with ACOs if there were changes to Medigap coverage of out-of-pocket costs and/or financial incentives from ACOs that would encourage beneficiaries to receive care from ACO providers.

Any changes that we might recommend in these and other areas would be intended to increase the chance that these models will be successful. As models improve, we would

support Medicare increasing incentives for providers to participate in them and improve delivery of care.

This work also includes improving the accountability of MA plans to the program and beneficiaries. Over the past several years, we have highlighted numerous shortcomings in the system that Medicare uses to reward plans with high quality ratings. In this report, we recommend the adoption of a new MA value incentive program that would reduce program spending and give beneficiaries better information about the quality of the plans in their area. In the future, we may examine other important aspects of the MA program, such as the benchmarks that help determine plan payment rates and the risk adjustment system.

The Commission may also explore ways to expand the use of value-based payment outside of the scope of the current ACO and MA programs. For example, there is some concern that hospitals have relatively weak incentives, or actually counterincentives, to reduce program spending under the ACO approach. One potential alternative that could give hospitals stronger incentives, but also raises challenging design issues, would be for Medicare to pay hospitals using global budgets that cover all of their inpatient and outpatient services. The state of Maryland is currently testing the use of global budgets for its hospitals in a demonstration under which the hospitals are paid on an FFS basis, but their rates are adjusted to ensure that their overall payments equal a predetermined amount. However, the demonstration's effects have been mixed (hospital spending has decreased, but the effect on overall spending is unclear) and Maryland's approach would be difficult to use at the national level because the state's hospital payments are much higher than traditional Medicare payments. Another issue that may deserve further examination is the possibility of expanding the use of other payment models, such as bundled payments for certain episodes of care, and the need to ensure that those models are well integrated with ACOs.

The problem of fee-for-service payment

Beyond improving the current ACO and MA models, the Commission asserts that, where possible, Medicare should look for ways to further evolve away from the traditional FFS model by identifying policy changes that would dampen its incentives to provide more services while, at the same time, maintaining or improving quality.

Medicare has already made significant efforts to reduce the incentives to provide more services:

- Many FFS payment systems use prospective payments and bundle the payments for related services into a single rate. For example, Medicare pays hospitals a fixed amount for many condition-based episodes of service (through the diagnosis related groups (DRGs) used for inpatient services and the ambulatory payment classifications used for many outpatient services), pays for home health on a per episode basis, and pays for skilled nursing care and most hospice care using daily rates. This approach gives providers an incentive to deliver care efficiently by constraining costs within the episode of service, but it does not limit the number of episodes provided and, to the extent that payments for certain episodes are profitable, could actually spur the provision of unnecessary services.
- Medicare pays private insurers in the MA program a monthly prospective payment for each enrollee. Some plans, in turn, pay delivery system intermediaries (such as an integrated delivery system) a prospective payment for each enrollee. This approach is one example of how providers can be paid using prospective global payment, sometimes referred to as “capitation payment.” However, most plans pay providers on a traditional FFS basis. Consideration could be given for Medicare to encourage plans to increase the use of such global payments to providers. One potential benefit of global payments is that providers would have more predictable revenues than they do under FFS, which could mitigate instability during service disruptions such as those that many providers have experienced due to the coronavirus pandemic.
- Medicare pays ACOs based on a variety of payment models, such as bonus-only payments for meeting quality and cost management benchmarks or bonuses based on both upside and downside risk. A small number of ACOs are paid using a capitation model. ACOs may pay individual physician providers based on a variety of payment methods, such as FFS payment, salary with or without volume incentives, or value arrangements such as quality bonuses. Consideration could be given for Medicare to encourage ACOs to pay providers in ways that encourage the delivery of appropriate services

and discourage the provision of unnecessary or inappropriate services.

These and other exceptions to the pure FFS payment model are attempts to constrain the unit cost of services, the number of services provided, or both. These different payment models have had varying levels of success: DRGs have helped constrain Medicare costs, but payments to MA plans have consistently been higher than FFS costs due to the way that Medicare sets plan payment rates, and ACOs have generated only modest savings.

Although the FFS program encourages greater service use, one positive feature of the program is that most of its payment systems use administered prices to pay for services. The use of administered pricing has been helpful in exerting financial pressure on providers and has played a key role in constraining cost growth, especially in recent years as providers have consolidated and negotiated higher commercial rates. For example, Medicare's control over prices is the primary reason its costs have grown more slowly than commercial insurance premiums in recent years. Since Medicare is on a financially unsustainable trajectory, efforts to broaden the use of value-based payment (which focus largely on changing patterns of service use) should be carefully carried out to ensure that they do not inadvertently undermine the program's control over prices.

However, under FFS payment, Medicare beneficiaries may experience significant variability in the quality and appropriateness of services provided and in their resulting outcomes. For example, rates for avoidable hospitalizations and emergency department visits vary across market areas, indicating that there may be opportunities to improve the quality of FFS ambulatory care (Medicare Payment Advisory Commission 2020). There can also be substantial variation in quality within a given type of provider, such as inpatient hospitals (Medicare Payment Advisory Commission 2019). Unfortunately, policymakers now have little ability to compare quality across the FFS, ACO, and MA sectors, and in response, the Commission has supported the use of a small set of outcome, patient experience, and value measures to facilitate those comparisons (Medicare Payment Advisory Commission 2018).

Beneficiaries in the FFS program may also face significant out-of-pocket costs. Traditional Medicare has deductibles for Part A and Part B services, charges copayments or coinsurance for many services, and does not have an

annual cap on beneficiary out-of-pocket costs. As a result, almost 90 percent of beneficiaries have some type of supplemental coverage, such as a Medigap policy, that protects them from high out-of-pocket costs (but also encourages them to use more services). Unlike the FFS program, all MA plans have an annual cap on out-of-pocket costs and cover some Part A and Part B cost sharing. Plans often finance these extra benefits using their MA rebates, which allows many enrollees to obtain some of the same protections as a Medigap policy without having to pay a premium. These extra benefits are one reason that MA plans have become increasingly popular, with many new beneficiaries first enrolling in FFS and then switching to a plan a few years later.

Beneficiaries also experience variable levels of support outside of their direct, physical contact with the delivery system. For example, FFS Medicare does not cover supporting services like transportation, nor does it support the development of preemptive care plans such as population health models that identify gaps in care and seek to close those gaps.

Although administered pricing has helped control spending growth in many parts of the FFS program, it nonetheless has drawbacks. Some services are inevitably mispriced, and payment rates that are too high may encourage inappropriate growth in utilization, as has happened in the past with services such as advanced imaging, therapy in skilled nursing facilities, and durable medical equipment. FFS payment also may contain incentives to overuse new services or lack incentives to provide services that do not have a distinct billing code, such as efforts to address social determinants of health. MA plans and some ACO models may have more opportunity to develop innovative care models in these areas.

A need for change

FFS contains inherent incentives for the delivery system to provide more services and thus receive more payments.² The effects of those incentives are not limited to the FFS program; they also affect how MA plans and ACOs are paid (see next paragraph). Medicare has some counterincentives to avoid the provision of unnecessary or inappropriate services, but they need to be strengthened. The FFS system increases Medicare costs, based on higher than necessary use of services and, in some instances,

the provision of care at higher cost sites of service. The incentive to provide more services also potentially exposes beneficiaries to unnecessary health risks, such as hospital-acquired infections, and to the extra out-of-pocket costs of unnecessary or inappropriate services. Delivery systems that provide care coordination across the continuum of care settings are the exception rather than the norm. There are clearly opportunities for Medicare to provide better value given the large amounts that taxpayers and beneficiaries spend on the program. Finally, the current system does not support sufficient accountability or transparency, such as providing beneficiaries with information that compares the quality of care provided by different models such as FFS, health plans, or ACOs.

The Commission asserts that the development of alternative payment models and care delivery models needs to accelerate.³ There have been numerous efforts by the Congress, CMS (most notably through the Center for Medicare & Medicaid Innovation (CMMI)), and the private sector to address these challenges through MA plans, ACOs, and smaller scale payment and delivery models such as Bundled Payments for Care Improvement (which gives providers incentives to reduce the overall costs for an episode of care) and Comprehensive Primary Care Plus (which makes extra payments to primary care practices that provide more extensive care coordination). Despite these efforts, the development of new payment and care delivery models has had relatively little impact on the average beneficiary and has lagged well behind what is possible and desirable. Policymakers should look for ways to make CMMI more effective so that Medicare can better serve the growing needs of its enrollees.

The Commission contends that unless changes are made to how Medicare pays for services, the cost of the Medicare program will become unsustainable for the country, which could necessitate dramatic changes to the Medicare program and/or its financing. The Commission also contends that the quality of the program will be best served if incentives are aligned between Medicare, the delivery system (through accountable entities), and beneficiaries.

Future vision for the Medicare program

Medicare has used an FFS model to pay for services throughout its history. The FFS program continues to play a central role today, even within the MA and

ACO programs. For example, MA plans bid against benchmarks that equal a percentage of FFS spending, and MA plans are allowed to use FFS rates to pay out-of-network providers (instead of the much higher rates that commercial insurers typically have to pay in those situations). Similarly, the benchmarks that determine whether ACOs qualify for shared savings are tied to FFS spending, and Medicare continues to pay the vast majority of providers affiliated with ACOs on an FFS basis. Medicare's FFS rates are also widely used as a reference point or benchmark by other parts of the health care system.

The FFS model is deeply embedded in our health care system and will probably continue to play an important role after new payment and delivery models are developed. For example, policymakers might use FFS rates to inform the determination of funding amounts for accountable entities, accountable entities might pay for out-of-network or referral services on an FFS basis, and Medicare might continue using the FFS model to pay for care in areas that do not have accountable entities, such as rural areas. Policymakers should thus work to improve the FFS model even as they pursue the development of new payment and delivery models.

Nevertheless, the Commission asserts that the use of FFS payment for Medicare services should be replaced, over time and to the degree feasible, by systems that have incentives to:

- reduce Medicare's financial burden on taxpayers and beneficiaries;
- provide all necessary covered services, including preventive services and early disease detection;
- avoid delivering unnecessary, inappropriate, or low-value services;
- control the costs of providing appropriate and necessary services;
- deliver chronic care services through a care model that features care coordination among providers;
- improve the quality of services and the patient experience of care;
- address and coordinate both the medical and nonmedical needs of beneficiaries; and

- embrace the use of new technologies within payment models that have incentives to reduce program spending or improve quality.

As policymakers develop accountable entities, they may need to consider whether Medicare should support the use of value-based payment by specifying the mechanisms that those entities use to pay individual providers. This approach would represent a departure from current Medicare policy. Medicare has typically stayed out of “downstream” payment arrangements that entities such as MA plans and ACOs use to pay their providers: For example, MA plans have flexibility to negotiate their own payment arrangements with providers, and ACOs have flexibility to determine how shared savings payments are allocated among their participating providers.

Policymakers could find it difficult to develop requirements that account for the range of provider types that deliver Medicare services and the variation in local health care delivery systems. Efforts to promote the use of VBP in the commercial sector have had relatively modest effects to date, and CMS might find that developing and administering requirements in this area would be challenging and prone to unintended consequences. Given these concerns, one approach would be for policymakers to focus on giving accountable entities stronger incentives to control costs and improve quality and then rely on those entities to develop the most effective payment arrangements to meet those goals.

However, as Medicare gains experience with value-based payment, policymakers may be able to develop ways to assess and monitor downstream payment arrangements and determine which methods of value-based payment are more effective. If this happens, Medicare could consider creating incentives that encourage accountable entities to use these models more widely, which could lead to a reduction in the provision of inappropriate and unnecessary services, encourage the delivery of preventive and early disease detection services, facilitate better care coordination among providers, and lower beneficiary out-of-pocket costs, thus justifying the added administrative burden.

Under an improved Medicare program, most beneficiaries would be able to receive their care through a variety of accountable entities that have incentives to both control overall costs and improve quality. Medicare would ideally design incentives that encourage beneficiaries to choose one of these entities to receive their care. Medicare could also strengthen providers’ incentive to participate by reducing FFS payment rates for providers that are not part of an accountable entity. The Commission recognizes that, traditionally, the health care delivery system has been slow to change, and as a result, much of Medicare’s payment apparatus remains connected to legacy payment models. However, the coronavirus pandemic has demonstrated that the system is capable of rapid change when circumstances require it to do so. The Commission asserts that the financing challenges facing the program, its beneficiaries, and the taxpayers who fund it require a similar systemic response to ensure Medicare’s ongoing sustainability. ■

Endnotes

- 1 That figure includes approximately 1 million beneficiaries in Maryland's total cost of care program.
- 2 The FFS incentive to provide more services is reinforced by the widespread use of supplemental coverage to cover some or all of Medicare's out-of-pocket costs. Almost 90 percent of beneficiaries have some type of supplemental coverage. A Commission-sponsored study estimated that spending for elderly beneficiaries with Medigap coverage was 33 percent higher than for those with no supplemental coverage, after controlling for demographics, education, income, and health status (Hogan 2009).
- 3 The steps taken by policymakers and health care providers to address the coronavirus pandemic demonstrate that the delivery system is capable of rapid change. Policymakers and researchers will need to evaluate the effects of recent legislative and regulatory changes on Medicare spending and outcomes to determine which policy changes are worth keeping in place once the pandemic has ended.

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