

Medicare and the Transition to Value-Based Care

Part 1: Introduction to Medicare payment reform



Whether you're a **field sales rep**, an **account executive**, a **medical liaison**, or **customer service manager**, you are expected to know a great deal about the health care delivery system—and it can be complicated. This five-part series introduces key elements that make up our health care system and the transition from fee-for-service to value-based care (also called value-based payment).

In this first part, you'll learn what Medicare is and how it works, the problems with fee-for-service, and why value-based care is seen as the solution.



Why move to a value-based care model?

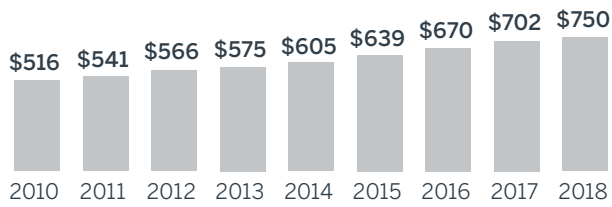
U.S. health care spending is rising fast and is expected to reach nearly \$6.0 trillion by 2027 with today's current laws and infrastructure.¹ To put that in perspective, health care spending was 17.9% of U.S. gross domestic product (GDP) in 2017 (~\$3.5 trillion) and is expected to grow to almost 20% by 2027 (~\$5.7 trillion).² **The takeaway: U.S. health care spending is high, and it's growing faster than the overall economic growth of the country.**

What is fueling the increase in health care spending? There are a number of factors, but a few of the main drivers include population aging, population growth, and disease prevalence.³

Not only is the overall number of people who may require health care growing, but that growth is also creating a larger population of seniors (age 65+), who tend to have a high need for medical care.

To combat increasing health care costs in our 65+ population, the Centers for Medicare and Medicaid Services (CMS) imposed payment reform in Medicare. Like overall U.S. health care costs, Medicare-specific health care costs are steadily increasing (figure 1). In fact, assuming no changes are made to the system, Medicare's hospital insurance fund is expected to become insolvent in 2026.⁴ **The proposed solution to our increasing health care costs is value-based care.**

Figure 1: Total Medicare spending for traditional Medicare and Medicare Advantage is steadily rising (Expenditures in billions of dollars)



What is Medicare and how does it work?

Medicare is a federally funded insurance program for seniors age 65+ and some individuals with disabilities. It currently covers more than 60 million Americans. While many refer to Medicare as a single entity, it is actually made up of four different programs (figure 2):

- **Medicare Part A** (hospital insurance): Covers hospital and post-acute care. It is funded by payroll deductions, so there are no premiums for users.
- **Medicare Part B** (medical insurance): Covers physician services and diagnostic tests. Part B is funded entirely by taxes, and enrollees typically pay a small monthly premium and copayments.
- **Medicare Part C** (Medicare Advantage): Medicare Advantage is essentially privately administered Medicare. Commercial insurers combine the minimum Part A and Part B services, and usually include a few other add-ons. Medicare Advantage plans are funded through enrollees paying premiums and copays as if they were in a commercial plan, but the federal government subsidizes the plans.
- **Medicare Part D** (prescription drug coverage): Part D covers prescription drugs. It is funded through enrollees paying premiums to Medicare.

Figure 2: The four parts of Medicare



Part A: Hospital insurance

- Covers medically necessary services in doctors' offices
- Enrollees do not pay premiums



Part B: Medical insurance

- Covers medically necessary doctor's services, lab tests, preventive care, and durable medical equipment
- Enrollees pay premiums to Medicare



Part C: Medicare Advantage

- Private Medicare plans that combine Part A, Part B, and usually Part D
- Enrollees pay premium to commercial insurer



Part D: Prescription drug coverage

- Subsidizes cost of prescription drugs and prescription drug insurance premiums
- Enrollees pay premiums to Medicare

What is fee-for-service?

Fee-for-service (FFS) is a health care payment model under which providers are reimbursed for each service provided. Payers, such as insurance companies or government agencies, are billed for each procedure, test, or service every time a patient is seen. While this payment model (someone provides a service and gets paid for that service) makes sense in most other industries, it is very inefficient in health care. Since FFS pays providers for each service, the model incentivizes the volume of procedures performed. **The larger the number of procedures performed, the more money the provider receives.**

FFS creates a scenario in which providers aren't incentivized to treat and cure patients as quickly and as cost-effectively as possible. To address this, CMS instituted a new payment structure for Medicare: value-based care. This model ties reimbursement to metric-driven outcomes, proven best practices, and patient satisfaction—better aligning payment with value and quality.

What is value-based care?

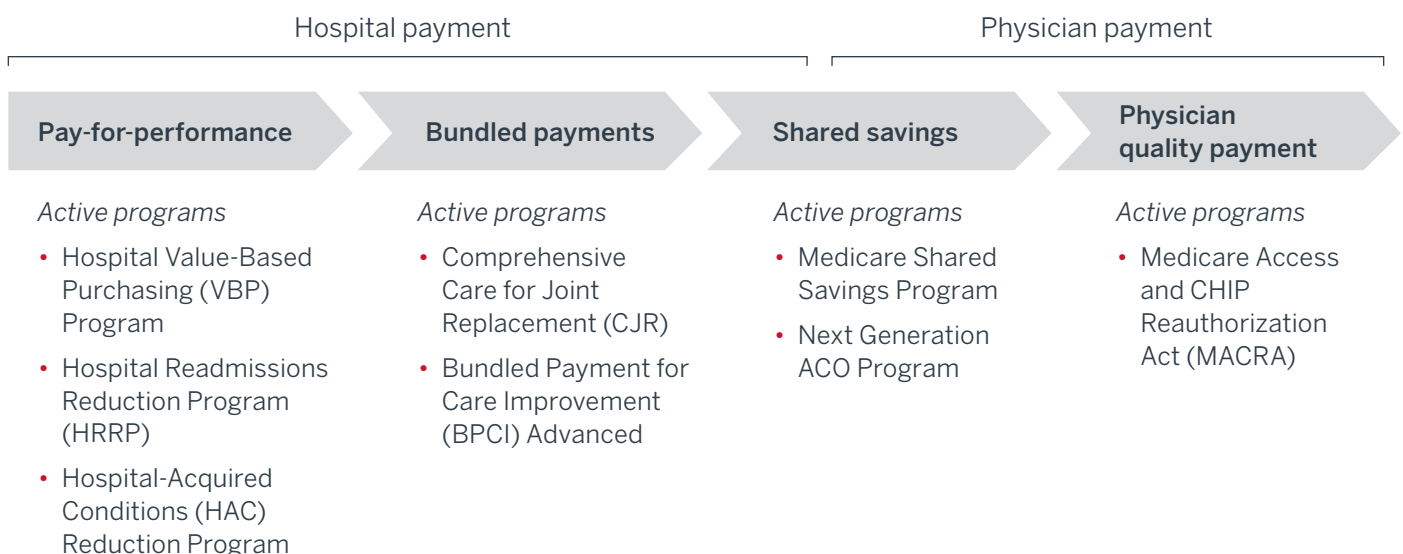
The Institute for Healthcare Improvement, a nonprofit organization dedicated to improving health care worldwide, introduced the concept of the Triple Aim: **better care, healthier people, and**

lower health care costs.⁵ CMS has adopted this concept of value-based care to improve the U.S. health care system. To do this, CMS programs align reimbursements with incentives and penalties, which are tracked by specific quality and cost metrics such as hospital readmission rates, adoption of health care IT, medication safety, and cost per surgery.

A major component in the shift from FFS to value-based care is the financial risk these programs put on providers. In the traditional FFS model, providers were paid whether a patient was successfully treated or not. With value-based care models, reimbursement is tied to the quality of the treatment—if a patient doesn't get better, providers are at risk to lose money. For example, under some value-based programs, providers are given a predetermined budget to treat a patient for a single episode of care. If they are unable to stay within that budget, then they are financially responsible to complete treatment without receiving additional payment.

CMS has created a variety of value-based care programs centered on pushing providers from FFS to value-based care. In figure 3, we show the continuum of Medicare value-based payment programs. As providers move from left to right, they move further away from FFS and take on more financial risk for the care they deliver to patients.

Figure 3: The continuum of Medicare value-based payment programs



Let's recap what we've learned:



- Medicare spending is increasing and, if nothing changes, its funds will become insolvent in 2026.
- To combat this, CMS is implementing new payment models that incentivize providers to focus on value rather than volume.
- A variety of value-based programs have been created. To learn more about these programs, check out the next four articles in this series, which examine the topics of Pay-for-Performance, Bundled Payments, Shared Savings, and MACRA.

▶ [Click here](#) to move to Part 2 of this series:
What is pay for performance?

ENDNOTES

1. "National Health Expenditure Projections 2018-2027," Centers for Medicare and Medicaid Services, Feb. 2018, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHEProjSlides.pdf>
2. Ibid.
3. Dieleman JL, et al., "Factors associated with increases in US health care spending, 1996-2013," JAMA Network, Nov 2017, <https://jamanetwork.com/journals/jama/fullarticle/2661579>
4. "A summary of the 2019 annual reports," Social Security and Medicare Boards of Trustees, April 2019, <https://www.ssa.gov/oact/TRSUM/index.html>
5. "What are value-based programs?" Centers for Medicare and Medicaid Services, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs>



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