Value-Based Care 2025: Providers Must Win the War on Costs

written by Theresa Hush | January 22, 2025

Health systems and ACOs: Prepare yourself for the return to cost containment as the central objective of Value-Based Care in 2025. While cost measures have always been part of CMS Value-Based Care quality programs, their impact was small relative to the total MIPS score for physician groups. Likewise, ACO savings look big in dollars but comprise only a few percentage points of total Medicare spending. All that is about to change.

In short, cost-cutting is the new administration's top priority, and the track record on Value-Based Care cost control is not good enough to resist budget crunching. ACOs are the largest Value-Based Care program of the federal government, but they can't show proof of their impact on total Medicare spending due to program particulars. The Congressional Budget Office (CBO) projects a small increase—not decrease—in federal spending for Center for Medicare and Medicaid Innovation (CMMI) payment models from 2023-2033, even as it suggests that savings should subsequently accumulate.

The new administration ran on a platform that called for change, less government, and tax cuts. Improving access to care or health equity is no longer the focus.

Instead, 2025 will be the beginning of a shift to reduce Medicare and Medicaid spending, lower business costs of employee health care benefits, and turn savings into tax cuts for Americans. These won't necessarily be popular strategies with consumers or providers. In fact, a good number of people believe that more spending in Medicare is needed, according to a recent Kaiser Family Foundation tracking poll.

But time has run out for provider-led cost control. There are already administrative proposals on the table for cuts in hospital reimbursements and a redefinition of reimbursement formulas, elimination of coverage under Medicaid expansion, and other levers to reduce payments to providers. If the issues are couched in terms of waste under the banner of Value-Based Care, support for cuts are inevitable. That's why you need to be prepared to identify and eliminate any excess costs—starting now.

The most pressing question is whether cost containment will happen to your organization in the form of top-down cuts, or whether you will successfully adopt more rigorous and risk-based payment models. Convincing the administration that they can bank on these savings will be difficult. Even if you rejected value-based payments previously, your best hope is that such payment models will still be open to you, rather than the cuts already being proposed. You must be ready to demonstrate savings. Here is how you do it:

Step One: Arm Yourself to Reduce Costs

Unlike recent years, don't count on a long glide path for the next phase of Value-Based Care. Start planning now with these tools:

1. Aggregated clinical data

If you've delayed aggregation of data from all your providers, correct course immediately. "All your providers" includes physician practices at both inpatient and outpatient facilities. If you have an ACO or Clinically Integrated Network (CIN), or a Physician Hospital Organization (PHO), you have the vehicle to aggregate costs; if not, you will need to create the organization.

The data must be complete with significant clinical diagnoses and results of labs and diagnostic

tests, therapies and procedures, medications, plus utilization and referral information. If you're wondering why you need all this data about your patients, understand that we are talking "Total Cost of Care" and "Per Patient Care Costs," both of which mean clinical costs. Your goal is to understand what is contributing to costs by type of care to find your opportunities for savings.

2. Claims data

To fill in the missing elements of care outside your network, you need claims data to show full costs. If your organization is participating in a CMS payment model that receives CMS claims, you'll gain a huge advantage by developing a full model to examine treatments and procedures. Negotiate with commercial carriers for this data, even though many providers have found it challenging to get.

3. Cost Technology for examining total cost of care and per patient costs

The most viable comparable analytics are clinically developed Episodes of Care. Roji Health Intelligence creates clinical Episodes of Care to show variation by procedures and to identify the drivers of higher (or lower) cost. Roji Episodes are also constructed for specific payment models, such as the Enhancing Oncology Model. Condition-based Roji Episodes identify patients with higher risk or worsening outcomes. Clinical episodes create the trusted database you need to engage clinicians in cost control—assuming that you share the data with them in a way they can validate.

Step Two: Take Action

Reviewing and innovating change often arouses administrators' concerns about future revenues. You won't get derailed, however, if you can focus on efficiency and best practices in a collaborative process, using data. This should include:

1. Clinician Engagement in Cost

Physicians must see Episodes of Care data. They should be able to compare their outcomes and costs with others performing the same function or treating similar patients. They must be able to respond to identified cost issues within the cost technology.

2. Improvement Strategies and Interventions

Your cost technology should identify variances in care by screening for interventions in your standard of care for chronic disease. Procedural cost variations can be identified within each procedure type and by specialty. Potential interventions, such as a change in a clinical pathway or an individual treatment plan, should be part of the clinician review process.

The Consequences of Delay: Cost Containment Will Hit You and Your Patients Harder

Providers have made great leaps in adoption of EHRs, Value-Based Care strategies, and technologies over the past few years. While cost control has lagged, now is *not* the best time to let payers and government define the methods of cost control by reducing benefits or lowering provider rates. You can pivot to costs using investments you have already made in data, quality reporting, and alternative payment models.

To learn more about how to pivot to costs using Episodes in Care or quality reporting data, contact Roji Health Intelligence.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Sergey Kotenev