

Using payment reform to improve efficiency and patient outcomes in the U.S. health care system

PROBLEM: The U.S. spends more per capita on health care than any other high-income country, yet our nation is plagued by pervasive health inequities and ranks lower on population health outcomes. Fee-for-service (FFS) reimbursement, the predominant payment model in the U.S., contributes to our health system's poor performance. Because FFS pays providers based on the number and types of services delivered, it fails to hold providers accountable for improving patient outcomes and equity, constrains their ability to tailor treatments to meet the distinct needs of their patients, and drives them to deliver more and higher-priced care even if services have no clinical benefit or could harm patients.

SOLUTION: Alternative payment models that hold providers accountable for the total cost and quality of care, including population-based models such as accountable care organizations (ACOs) and global budgets, are a promising approach. Population-based payment models reward doctors and hospitals for delivering high-quality care at a lower cost and give them more flexibility to address patient needs comprehensively. The following payment reform principles are key to achieving this goal.

1 | INCREASE THE SHARE OF PATIENTS IN EFFECTIVE POPULATION-BASED PAYMENT MODELS THAT HOLD PROVIDERS ACCOUNTABLE FOR THE COST AND QUALITY OF CARE.

A growing body of evidence suggests that population-based payment models are one of the most promising ways to improve the efficiency of the health care system and promote personalized, high-quality care. Several actions are needed to accelerate the adoption of effective, population-based payment models:

- **Strengthen incentives for providers to participate in population-based models, including by:**
 - Increasing mandatory participation
 - Considering upfront investment and technical support for certain providers
 - Making FFS less attractive (more below)
- **Strengthen and simplify incentives for participants to generate savings while balancing participation goals, including by:**
 - Improving performance benchmarks
 - Improving risk adjustment methodologies
 - Moving to greater provider risk-sharing over time
- **Harmonize overlapping payment models** by aligning episode-based payment and primary care payments with population-based models.
- **Support alignment of provider incentives across payers** by having government purchasers facilitate broader changes in partnership with private payers.
- **Incorporate measures of low-value care into quality and financial performance systems** to supplement existing measures of preventive care and enhance provider incentives to provide appropriate care to patients.



2 | REBALANCE FEE-FOR-SERVICE (FFS) PAYMENTS AND IMPROVE THE INCENTIVES FOR PROVIDERS TO JOIN ALTERNATIVE PAYMENT MODELS.

FFS undervalues certain high-value services like primary care while overvaluing certain specialty services. The current opportunities for providers to maintain or increase their fee-for-service revenue without assuming any risk also discourages them from participating in alternative payment models. The following policy goals will enable changes to FFS that increase efficiency and high-value care while facilitating the shift from FFS to population-based payment models across the health care system:

- **Strengthen incentives for providers to join advanced alternative payment models with greater accountability by:**
 - Making participation in alternative payment models more attractive to providers, for example, by giving greater flexibility for certain services (e.g., telehealth) only for participating providers
 - Widening the payment differential between FFS and advanced alternative payment models over time to reduce the benefit of remaining in FFS
 - Eliminating Medicare’s Merit-Based Incentive Payment System (MIPS), which has not been effective and undermines incentives for clinicians to join advanced alternative payment models
- **Rebalance FFS payments to result in payments that better reflect the value of services** and that correct the bias for specialty care to ensure appropriate payments in both specialty and primary care.
- **Implement partially capitated payments for primary care** to provide predictable, upfront payments to primary care clinicians and give them greater flexibility to deliver services that are essential to keeping patients healthy such as preventive care and chronic disease management.
- **Reduce payments for low-value services or for providers that deliver high volumes of low-value services.**

3 | ALIGN PATIENT INCENTIVES AND STEER TOWARDS HIGH-VALUE PROVIDERS.

Evidence suggests realigning provider incentives can transform utilization and reduce spending. While patients should not bear the main responsibility for transforming utilization patterns, there are opportunities to enhance patient incentives and ensure they align with those targeting providers to deliver higher-value care:

- **Create high-value plan networks and benefit designs that steer patients toward more efficient providers and high-value services.**
- **Enable Medicare beneficiaries in population-based payment models to benefit from their involvement** by authorizing participating organizations to lower costs for patients attributed to them (e.g., through beneficiary incentive programs)