

# 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 capitated payments to health plans, are a promising way to give providers stronger incentives and greater flexibility to deliver high quality, less costly, and more equitable care that improves population health. 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 health care while also maintaining or improving the quality of care delivered (for example, by reducing unnecessary hospitalizations or increasing preventive care). Several actions are needed to accelerate the adoption of effective population-based payment models:

- **Strengthen and simplify incentives for participants to generate savings while balancing participation goals, including by:**
  - Improving performance benchmarks and risk adjustment methodologies, and
  - Moving to greater provider risk-sharing over time.
- **Strengthen incentives for providers to participate in population-based models, including by:**
  - Increasing mandatory participation,
  - Considering upfront investment and technical support for certain providers, and
  - Making FFS less attractive (more below).
- **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 FFS revenue without assuming any risk also discourages them from participating in alternative payment models. The following policy goals will enable changes to FFS that shift the entire health care system towards value-based care:

- **Strengthen incentives for providers to join 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 only for participating providers, and
  - Reducing the benefit of remaining in FFS, for example by widening the payment differential between FFS and 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.
- **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 focusing on 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 (for example, through beneficiary incentive programs).
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