Payment Reform

Using payment reform to improve efficiency and deliver personalized, high-quality care to patients 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 chronic disease and ranks lower on population health outcomes.[1] 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 motivates clinicians to focus on providing more care regardless of its necessity or effect on patient outcomes. It also fails to incentivize the kinds of services that are important for delivering high-quality personalized care, such as coordinating with other providers and engaging patients to manage chronic conditions.

In addition, FFS reimbursement often does not align well with the value of services, or the true time and resources needed for clinicians to deliver care. This misalignment has led to a "specialty bias" where certain specialty and procedural services are overvalued and overpaid while primary care is simultaneously undervalued and underpaid.[2] Primary care at its best is the foundation of a high-quality, efficient health care system.

SOLUTION: Alternative payment models that hold providers accountable for the total cost and quality of care, including population-based models like accountable care organizations (ACOs) and capitated payments for primary care, are a promising approach.[3] Population-based payment models reward doctors and hospitals for delivering high-quality care at a lower cost and give clinicians more flexibility to address patient needs comprehensively.

Improvements to FFS should be pursued in tandem with efforts to move clinicians to population-based payments to reduce spending on over-valued services and to ensure accurate, sustainable payments, including payments that support high-quality primary care. The following payment reform principles are key to achieving this goal.

1. **Strengthen the design of population-based payment models to increase the share of patients in models that improve accountability 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.[4] Strong model design is important to strengthen clinicians' incentives to participate and reduce wasteful spending.

   - **Strengthen payment model designs to balance participation incentives with savings to Medicare to extend the program's solvency.** Policymakers should:
     - Improve performance benchmarks, or the target used to determine a participant's level of shared savings or losses. For example, performance benchmarks should be designed to avoid the "race to the bottom", where an ACO's success in reducing spending lowers their future benchmark, making it harder to generate shared savings in the future.
     - Improve risk adjustment methodologies to accurately pay providers in alternative payment models for their patient population and to ensure clinicians aren't incentivized to upcode patient health conditions or avoid serving certain groups of patients.
     - Move to greater provider risk-sharing over time, as appropriate based on their size and financial capacity, to drive increased efficiency and care transformation.
     - Provide up-front investment for certain providers, like those serving rural and safety-net communities, so a wide range of clinicians and patients benefit from payment reform.

- **Use population-based, total cost of care models like ACOs as the framework for future payment reform efforts** to harmonize overlapping episode-based models and reduce the number and types of models clinicians may participate in.
- **Enable Medicare beneficiaries in population-based payment models to better understand and benefit from their involvement** in alternative payment models. For example, participating organizations, like ACOs, could be authorized to lower costs for patients attributed to them through cost-sharing waivers for certain services. While patients should not bear the main responsibility for transforming utilization patterns, there are opportunities to enhance patient incentives and ensure they align with their providers' objective to deliver high-value care.

2. **Improve financial & non-financial incentives for providers to partcipate in population-based payment models.**

While there are ongoing efforts to incentivize clinicians to move from FFS towards population-based payment models, incentives to join these models to date have been weak and are eroding over time. A mix of financial and non-financial incentives implemented through legislative and administrative action are needed to ensure clinicians are motivated to shift away from FFS, in addition to the model design changes above which can also affect participation:

- **Strengthen financial incentives for clinicians to participate in population-based models.**
  - Eliminate Medicare's Merit-Based Incentive Payment System (MIPS), which has not been effective at improving quality and undermines incentives for clinicians to join advanced alternative payment models.[5]
  - Widen the payment differential between FFS and advanced alternative payment models over time to reduce the benefit of remaining in FFS relative to APMs. For example, this could be accomplished through budget-neutral changes to FFS reimbursement levels or via changes to ACO benchmark methodology to increase the attractiveness of participating in an ACO.
  - Extend and restructure bonus payments offered to advanced alternative payment model participants, including basing bonuses on a fixed amount per attributed beneficiary, rather than FFS revenue.
- **Consider non-financial incentives for providers to join advanced alternative payment models with greater accountability.**
  - Increase mandatory model participation to enable broader geographic reach, generate greater savings through stronger model designs, and enable stronger methodological design and evaluation opportunities.
  - Give providers participating in certain APMs greater flexibility for certain services (e.g. telehealth).
  - Offer greater technical support for certain providers, such as rural or safety net clinicians, that may have less experience with alternative payment models or fewer resources to invest in payment and delivery system transformation.

3. **Rebalance fee-for-service (FFS) payments and ensure accurate, sustainable payments in medicare.**

Improvements to FFS should be pursued in tandem with efforts to move clinicians to population-based payments. First, ensuring FFS payments accurately reflect the time and resources needed to deliver a service protects the Medicare program and taxpayers from unnecessary spending. Second, because FFS is the foundation for many alternative payment models like ACOs, it is important to improve the underlying payment system, including correcting for the specialty bias, to better align the goals of APMs and the care delivery patterns incentivized by FFS. The following policies will enable changes to FFS that increase efficiency while facilitating the shift to population-based payment models:

- **Address misvaluation and inaccurate payment for services, particularly in the Medicare Physician Fee Schedule,** which determines what clinicians are paid by Traditional Medicare and influences payment rates in the private insurance market. Policymakers should:
  - Correct codes that are known to be over-valued, such as global surgical codes, and regularly re-evaluate codes with high expenditures or codes that are likely to become misvalued over time.[6]

- Establish more accurate, independent data collection on clinicians' true resource and time costs associated with delivering care so reimbursement levels better reflect the value of services.
- Address structural flaws with the current valuation process, which is based on recommendations to CMS from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), including inherent conflicts of interest and a reliance on flawed survey data from medical societies, which undermine payment accuracy and transparency.[7]

- **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 help keep patients healthy such as preventive care and chronic disease management.
- **Ensure physician reimbursement levels that balance access to high-quality care and affordability for patients and taxpayers.** For example, updates to the Medicare Physician Fee Schedule should accommodate clinicians' rising input costs while guarding taxpayers and beneficiaries against higher Medicare spending. Implementing unnecessarily high payment rate updates, such as an update based on growth in the Medicare Economic Index, doesn't appear to be needed to ensure beneficiary access to care, exposes taxpayers and beneficiaries to higher spending, and is not fiscally responsible.[8]

ENDNOTES

1 https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024

2 https://www.healthmanagement.com/wp-content/uploads/Report_PFS-Reform-and-Structural-Topics_F_050624.pdf

3 https://www.annualreviews.org/deliver/fulltext/publhealth/41/1/annurev-publhealth-040119-094327.pdf?itemId=/content/journals/10.1146/annurev-publhealth-040119-094327&mimeType=application/pdf

4 https://www.healthaffairs.org/content/forefront/case-acos-why-payment-reform-remains-necessary

5 https://tobin.yale.edu/sites/default/files/2023-06/20230413_MACRA%20Literature%20Review_0.pdf

6 https://www.healthmanagement.com/wp-content/uploads/Report_PFS-Reform-and-Structural-Topics_F_050624.pdf

7 https://www.gao.gov/assets/d15434.pdf

8 https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_Ch1_MedPAC_Report_To_Congress_SEC.pdf