Payment Reform

Using payment reform to improve efficiency and deliver personalized, high-quality care to patients in the United States health care system.

Why Payment Reform is Needed

Our current health care system is not working for patients, employers or taxpayers. The United States spends more per capita on health care than any other high-income country, yet our nation lags behind in health rankings, struggling with lower life expectancies, higher rates of chronic disease, and preventable deaths.[1]

Shifting from fee-for-service (FFS) reimbursement to alternative payment models can be part of the solution. FFS payment, the predominant approach to payment in the United States, contributes to our health system's poor performance, because it can:

- Motivate clinicians to focus on providing more care regardless of whether it improves outcomes for patients
- Fail to encourage coordination between clinicians or to engage patients to manage chronic conditions, services that are important for high-quality, personalized care, and
- Lead to certain specialists and procedural services being overvalued and overpaid while underinvesting in primary care

Payment reform can promote efficiency and innovation, and reorient the financial incentives that drive the United States health care system to focus on improving health and reducing wasteful spending. Changing how we pay for care can change the type and quality of care delivered, and in turn, it can improve outcomes for patients.

4:1

When asked to choose, people prefer a model that pays clinicians for quality rather than quantity of care by a **4:1 margin**.[2]

In a survey, **70%** of physicians believe that at least some physicians provide unnecessary procedures when they profit from them.[3]

MEDICARE AND STATE PAYMENT MODELS OFFER PROMISING RESULTS

Accountable care organizations (ACOs) have generated modest net savings for the Medicare program while maintaining or improving quality.[4]

The Maryland Total Cost of Care Model initially reduced Medicare spending by nearly $1 billion over a 4.5 year period.[5,6] An expanded version of the program reduced total Medicare spending relative to national trends by $689 million.[7] It also reduced acute care hospital admissions by over 16% for Medicare and commercially insured patients.[8]

Rhode Island's Affordability Standards, which combine hospital price controls with requirements for insurers to increase primary care investment, effectively redistributed spending towards primary care.[9,10]

1. https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024
2. https://unitedstatesofcare.org/priorities/value-based-care-patient-first-care/
3. https://pmc.ncbi.nlm.nih.gov/articles/PMC5587107/
4. https://pubmed.ncbi.nlm.nih.gov/40293760/
5. https://www.cms.gov/priorities/innovation/innovation-models/md-tccm
6. https://www.healthaffairs.org/content/forefront/meaningful-value-based-payment-reform-part-1-maryland-leads-way
7. https://www.cms.gov/priorities/innovation/data-and-reports/2024/md-tcoc-1st-progress-rpt
8. https://www.mathematica.org/publications/evaluation-of-the-maryland-total-cost-of-care-model-quantitative-only-report-for-the-models-first
9. https://ohic.ri.gov/policy-reform/affordability-standards
10. https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164

How Payment Reform Can Be Achieved

- **Advance alternative payment models that hold the most promise for saving money and transforming care delivery** such as population-based models like ACOs and hospital global budgets. These models hold clinicians accountable for the total cost and quality of care while giving them greater flexibility to deliver care tailored to patients' needs.
- **Bolster access to comprehensive primary care by changing how we pay for it and redistributing spending towards it.** Primary care at its best is the backbone of a high-quality, efficient health care system. Better continuity in primary care is associated with reduced mortality, lower health care expenditures, and fewer hospitalizations.[11,12] Ensuring appropriate reimbursement for primary care is essential, and experts agree that hybrid capitated, per-patient per-month payments rather than pure FFS reimbursement should be the default payment for primary care.[13]
- **These models can be advanced in several ways:**
  - State Medicaid agencies and employee health plans can leverage their roles as health care purchasers to advance payment reform through changes to contracts with clinicians or through new requirements on managed care plans or plan administrators.
  - The Centers for Medicare & Medicaid Services (CMS) can change payments for physicians that bill Medicare.
  - States can coordinate transformation across Medicare, Medicaid, and private payers through state all-payer models or opportunities through the Center for Medicare and Medicaid Innovation (CMMI), such as the AHEAD model.[14]

11. https://bjgp.org/content/70/698/e600
12. https://www.annfammed.org/content/16/6/492
13. https://thepcc.org/wp-content/uploads/2025/02/Hybrid-Payments-A-Way-to-Make-Primary-Care-More-Patient-Centered.pdf
14. https://www.cms.gov/priorities/innovation/innovation-models/ahead