



## EXECUTIVE SUMMARY

# Why Value-Based Payment Isn't Working, and How to Fix It

*Creating a Patient-Centered Payment System to  
Support Higher-Quality, More Affordable Health Care*

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## THE STRENGTHS AND WEAKNESSES OF FEE-FOR-SERVICE PAYMENT

There is broad agreement that the Fee-for-Service system currently used to pay for healthcare services is a major reason why healthcare spending has grown faster than inflation without any corresponding improvement in the quality of care or patient outcomes. It is not just that Fee-for-Service creates a financial incentive for providers to deliver more services; there are actually four distinct problems with Fee-for-Service payment systems that need to be addressed:

**Problem #1: Fee-for-Service payment does not assure the services a patient receives are appropriate, high-quality, or achieve the results that the patient needs.**

In other industries, customers expect products and services to have a warranty against defects and a money-back guarantee of performance; providing warranties and performance guarantees rewards sellers of high-quality products and services and it encourages clear definitions of the benefits that products and services can and cannot be expected to provide. In contrast, physicians, hospitals, and other healthcare providers are paid for delivering a service regardless of whether the service was delivered in the highest-quality way, regardless of whether the service had positive or negative effects on the patient, and regardless of whether the service was necessary or appropriate for the patient in the first place.

**Problem #2: Payment rates are often less than the cost of delivering high-quality, appropriate care.** Although there has been considerable attention to the fact that the prices of healthcare services are often much higher than it costs to deliver those services, what has received far too little attention is that many payments are *below* the cost providers incur when they deliver high-quality services only when needed. Because a high proportion of healthcare costs are fixed in the short run, and because fees are based on average costs, providers are financially penalized under Fee-for-Service when they deliver high-quality, appropriate care.

**Problem #3: There are no fees at all for many important, high-value services.** For example, physicians are only paid for face-to-face visits with patients, even though a phone call or email could avoid the need for more expensive services, and there is generally no payment for services patients receive from nurses and other staff, even though the education and proactive outreach they provide can help patients avoid serious health problems and expensive treatments.

**Problem #4: It is impossible for patients or payers to predict the total amount they will need to pay for treatment of a health problem and to compare the amounts across providers.** In other industries, customers know the price of the full product before they buy it and they can compare the prices different manufacturers charge for similar products. In healthcare, patients and payers cannot even obtain an estimate of the combined fees for all of the services they will receive to be treated for a health problem, much less a guaranteed price for an entire package of services.

All of these problems contribute to higher-than-necessary healthcare spending and lower-than-desirable quality and outcomes. However, the Fee-for-Service payment system would not have persisted for so long if it had no redeeming features. In fact, Fee-for-Service payment also has four important strengths:

**Strength #1: A provider is only paid if a patient receives a service.** Although there are clearly serious problems with the quality and cost of the services delivered under Fee-for-Service, the system at least gives patients and payers the confidence that they only pay something if they receive something in return.

**Strength #2: Payments are higher for patients who need more services.** Although it is true that Fee-for-Service rewards “volume over value,” any payment system that doesn’t adequately support a higher volume of services *when more services are needed* can result in worse outcomes for patients and higher long-run costs.

**Strength #3: A provider’s payment does not depend on things the provider cannot control.** In other industries, warranties and performance guarantees are typically limited to correcting defects the producer caused or could have prevented. Although Fee-for-Service payment fails to hold providers accountable for problems they caused or could have prevented, it also does not penalize them for things outside of their control.

**Strength #4: A provider knows how much they will be paid before delivering a service.** Under Fee-for-Service payment, a provider knows exactly what they will be paid for delivering a service before they deliver that service, so the provider can determine whether they are likely to have generate sufficient revenue to cover their costs before they incur those costs.

These four strengths are often taken for granted because they are the aspects of healthcare payment that are most similar to how businesses in other industries are paid. Payment reforms that have failed to preserve these strengths have generally been met with resistance from providers, patients, or purchasers, because they appropriately want to preserve the benefits these strengths provide. The fact that an alternative payment model is *different* from fee-for-service payment does not necessarily mean it is *better*.

In assessing a “value-based payment” system, one should ask:

1. Are providers accountable for appropriateness, high quality, and outcomes of services for each patient?
2. Do payment rates match the cost of delivering quality care?
3. Do providers have flexibility to deliver the highest-value services?
4. Are patients and purchasers able to determine the total amount they will pay?
5. Are providers only paid when patients receive help?
6. Will patients with greater needs be able to receive more services?
7. Are providers only held accountable for things they can control?
8. Will providers know how much they will be paid before services are delivered?

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## WHY PAY-FOR-PERFORMANCE PROGRAMS DON'T WORK

The most common approach to value-based payment has been “pay for performance” (P4P). Under most P4P systems, the healthcare provider is still paid using the same Fee-for-Service structure that existed before the P4P system, but the amount of payment for an individual service is modified based on the provider’s performance on measures of the quality of care for the patients.

1. **P4P does not ensure that the services a patient receives are appropriate, high-quality, and achieve the desired results for that patient.** Quality measures are typically defined in terms of the percentage of times that some standard or outcome was achieved for a *group* of patients, not for each *individual* patient, and the measures are defined in terms of the results that the provider achieved for patients in the *past*. The provider is still paid when a service is delivered to an individual patient even if that service failed to meet the standard of quality for that patient. On many common performance measures, 30%-50% or more of patients do not receive the care or achieve the outcomes that performance measures define as desirable. The fact that 60% of patients received the care they were supposed to receive is of little comfort to the 40% of patients who didn’t.
2. **P4P does not ensure that payments are sufficient to cover the cost of delivering quality care.** There is no explicit effort to determine whether the size of a P4P bonus payment matches any increase in costs the provider incurs to achieve higher scores on the performance measures, or to ensure that providers’ essential fixed costs can be supported when avoidable utilization is reduced.
3. **P4P does not give providers the ability to deliver high-value services that are not supported under Fee-for-Service.** Since there is no change to the underlying structure of the Fee-for-Service system, there is still no payment for high-value services for which fees are not otherwise paid.
4. **P4P does not enable patients or payers to determine the total amount that will be paid for all services to treat a particular condition, or to compare costs across providers.**
5. **Providers continue to be paid only if they help patients with their problems.** Because P4P is just an adjustment to the amounts paid for individual services, a provider still has to deliver a service in order to be paid.
6. **Providers could be paid less for serving patients with greater needs, thereby making it more difficult for high-need patients to obtain care.** Serving higher need patients could reduce a provider’s performance on P4P measures if it is more difficult to achieve good outcomes for these patients, and this would reduce the provider’s revenue for all of their patients.

7. **A provider’s payment does not depend solely on things the provider can control.** Providers are generally not permitted to exclude a specific patient from a performance measure even if the patient has characteristics that contraindicate the recommended actions, if the patient cannot afford what is needed, or if the patient simply refuses to do what is necessary.
8. **The payment amounts are not known before services are delivered.** In most P4P systems, healthcare providers can’t determine how they scored on the performance measures until after the end of the performance period, and one provider cannot receive a bonus unless another provider receives a penalty, so the bonuses and penalties aren’t known until long after care is delivered.

It is not surprising that evaluations have found little or no impact from P4P systems. The problem with P4P systems is not that the “incentives aren’t big enough,” but that P4P systems don’t actually solve the problems with the Fee-for-Service system. P4P programs also introduce undesirable new incentives that could harm patients and they increase administrative burdens on providers that can lead to reduced access and higher prices. No other industry uses the healthcare pay-for-performance model as a way of paying for products or services.

## WHY SHARED SAVINGS AND SHARED RISK PROGRAMS DON'T WORK

Two approaches that are being widely used to encourage reductions in healthcare spending are “Shared Savings” and “Shared Risk” (often called “two-sided risk”), in which providers continue to be paid under the standard Fee-for-Service system, but they receive a bonus or penalty if the payer’s total spending on their patients is lower or higher than the amount the payer calculates that it would have spent in the absence of the Shared Savings/Shared Risk program. The bonus or penalty is proportional to the difference between the projected spending and actual spending.

1. **Shared Savings/Shared Risk payment systems do not ensure that services delivered are appropriate, high-quality, and achieve the promised results, and they can actually reward lower-quality care.** Since the method of rewarding or penalizing quality is the same as under P4P systems, there is no assurance of high quality care for any individual patient. Moreover, a provider can actually be paid *more* for delivering *lower* quality care if savings are achieved by failing to deliver services that patients need.
2. **Shared Savings/Shared Risk payment models are unlikely to fully align payments with the cost of delivering quality care.** No explicit effort is made to ensure that the payments a provider receives are adequate to cover the cost of high quality, appropriate care. “Savings” are defined in terms of changes in the amounts the *payer pays*, not the changes in the *provider’s costs*.

3. **Shared Savings/Shared Risk programs may not enable providers to deliver services that are not paid under Fee-for-Service.** There are no direct payments for any services that the Fee-for-Service system doesn't pay for, and provisions such as minimum savings rates and rebasing of spending benchmarks can preclude the reliable revenue stream that providers need to support high-value services.
4. **Shared Savings/Shared Risk programs do not enable patients and payers to determine the total amount that will be paid for all services to treat a particular condition, or to compare costs across providers prior to the delivery of care.** The calculation of total spending is made after care has already been delivered, and it is an average for a group of patients, not the actual spending for any individual patient.
5. **Providers could be paid more by not helping patients with their problems.** Shared Savings/Shared Risk payments are based on *total spending* on all of the services the patient receives from all providers, so a provider can actually be paid for *not ordering a service* for the patient, even if the service was necessary.
6. **Providers could be harmed financially for serving patients with greater needs.** Delivering more services to an individual patient will increase the provider's overall average spending per patient, leading to financial penalties. The risk adjustment systems used in Shared Savings/Shared Risk models do a poor job of identifying and adjusting for differences in patient needs that significantly affect appropriate services and spending.
7. **A provider's payment does not depend solely on things that the provider can control.** Since few patients receive all of their healthcare services from a single physician or other healthcare provider, a Shared Savings/Shared Risk program inherently places providers at financial risk for what other providers do or not do, but without giving them any control over other providers' actions.
8. **Providers do not know how much they will be paid before services are delivered.** A provider's Shared Savings/Shared Risk payment depends not only what the provider does for their patients, but also on what other providers do. All of that is determined long after care is delivered.

In light of these problems, it is not surprising that Shared Savings programs have fallen far short of achieving the kinds of savings that had been expected, and that providers have resisted joining Shared Risk programs. In the first three years of the Medicare Shared Savings Program, spending at nearly half of ACOs increased *more* than expected, and less than one-third achieved enough savings to qualify for a shared savings bonus. In each year, after making the shared savings payments, Medicare spent more on services to ACO patients than it would have spent if the program had not existed.

## THE STRENGTHS AND WEAKNESSES OF BUNDLED PAYMENTS

In a "bundled payment" program, rather than paying separate fees for every individual healthcare service, a patient or payer pays a single "bundled" price for a combination of two more services. There are many different ways to bundle services, and various forms of bundled payments have existed for decades. However, most current "value-based payment" initiatives have focused on two types of bundled payments:

**Procedure-Based Episode Payments**, in which a single, pre-defined payment is made to a provider organization for all planned and unplanned services related to the specific procedure or treatment that are delivered to the patient by any provider during a defined period of time (e.g., 90 days after discharge from the hospital where the procedure was performed). For example, in the Medicare program, this includes the Bundled Payments for Care Improvement Initiative (BPCI), the Comprehensive Care for Joint Replacement Program (CJR), and the Oncology Care Model (OCM).

**(Global) Population-Based Payments** (traditionally called capitation), in which a provider organization receives a fixed payment for each patient every month, and the provider organization is expected to use that payment to pay for all of the planned or unplanned services that the patient receives from any provider during the month. Although this payment system is not used in Medicare, private insurance companies in a number of states, including Medicare Advantage plans, pay some providers using capitation.

1. **Procedure-Based Episode Payments and Population-Based Payments can encourage improvements in some aspects of quality and appropriateness, but they can also create new types of quality problems.** Since treatments for errors or complications must be paid for from the bundled payment, patients and payers receive the equivalent of a "warranty" for any such complications. In addition, there is no financial reward for delivering inappropriate services as part of a procedure or treatment, since the payment does not change based on which specific services are delivered. However, providers have a financial incentive to withhold necessary services that would not create short-term complications, since the payments are not contingent on outcomes and the provider is only accountable for complications that occur within the time period covered by the payment. Quality measures do not solve this problem, for the same reasons they are not effective in either Pay-for-Performance or Shared Savings/Shared Risk programs.
2. **Procedure-Based Episode Payments and Population-Based Payments may or may not align payments with the cost of delivering quality care.** The amount of the bundled payment is typically determined based on a discount below the average spending per patient under the Fee-for-Service system. However, if fees were too high or too low relative to costs, that mismatch continues under the bundled payment.

3. **Procedure-Based Episode Payments and Population-Based Payments can potentially give providers the flexibility to deliver high-value services for which fees are not available.** A key benefit of a bundled payment system is the flexibility it can give providers to deliver services that are not paid for under Fee-for-Service payment without increasing total spending. However, the fact that the bundled payment is *more* flexible than the current Fee-for-Service system does not necessarily mean that it provides the right *kind* of flexibility. For example, if a Procedure-Based Episode Payment is triggered by the use of a particular procedure in the hospital, there is no flexibility to deliver a different procedure or to deliver the procedure outside of a hospital, even if that would be better or cheaper.
4. **Procedure-Based Episode Payments and Population-Based Payments can enable patients and payers to more easily and accurately determine the total amount they will pay for a particular procedure or for management of all of a patient's health needs, and to compare costs across providers prior to the delivery of care.**
5. **Under Population-Based Payments, providers could be paid even if they fail to help patients with their problems.** Since the payments are not tied to particular treatments or procedures, it is possible for a provider or group of providers to accept a Population-Based Payment for an individual patient without actually helping that patient with their problems.
6. **Under Procedure-Based Episode Payments and Population-Based Payments, providers could be harmed financially for serving patients with greater needs.** Current risk adjustment systems fail to adequately increase payment amounts for patients who have characteristics that could require more procedures or more services as part of a procedure.
7. **Under Procedure-Based Episode Payments and Population-Based Payments, a provider's payment does not depend solely on actions and costs that the provider can control unless the patient is restricted to using that provider's services.** In the Medicare program, providers in Procedure-Based Episode Payments are not given the ability to control where the patient receives care. In contrast, capitation payment programs in the private sector limit the patient to using the providers who are receiving the capitation payment.
8. **Procedure-Based Episode Payments and Population-Based Payment amounts are not known before services are delivered.** As long as the Procedure-Based Episode Payment system or Population-Based Payment system defines the payment amounts prospectively, the provider receiving the bundled payment will know how much they will be paid before services are delivered.

In contrast to P4P and Shared Savings/Shared Risk payment models, which merely layer incentives on top of the Fee-for-Service system, bundled payments have the potential to correct some of the fundamental problems with Fee-for-Service. However, neither of the most common approaches to bundled payment – Procedure-Based Episode Payments and Population-Based Payments – solve all of the problems of Fee-for-Service payment, nor do they preserve all of its strengths.

No other industry uses “Population-Based Payment” as a way of paying for products or services. In contrast, a Procedure-Based Episode Payment comes much closer to the way businesses in other industries are paid for their products and services than other “value-based payment” systems. However, current versions of Procedure-Based Episode Payments are typically only available for one specific procedure, not for alternative treatments that might be cheaper and better, and the warranties are much shorter and much more limited than what businesses in other industries offer on expensive products and services. Most significantly, however, under current versions of Procedure-Based Episode Payments, the patient and payer still have to pay for the procedure even if it fails to achieve the planned outcome and even if the provider failed to meet minimum quality standards in delivering the procedure.

## NARROW NETWORKS, TIERED NETWORKS, AND CENTERS OF EXCELLENCE

Many employers and health plans have created Narrow Networks, Tiered Networks, and Centers of Excellence, in which patients are either required or encouraged to use a subset of healthcare providers that were selected because they offer services at lower cost or higher quality. In general, the providers continue to be paid on a Fee-for-Service basis, so this is typically described as “value-based *purchasing*,” not “value-based *payment*.”

1. **Narrow Networks and Tiered Networks do not ensure that the services an individual patient receives are appropriate, high-quality, and achieve the promised results.** The quality and cost measures used to select the network providers are averages based on the specific health problems and specific services delivered to the patients the providers saw in an *earlier* year. There is no assurance regarding the quality or cost of care the providers will deliver to patients during the *current* year.
2. **Narrow Networks, Tiered Networks, and Centers of Excellence do not ensure that payments match the cost of delivering quality care.** Providers are often selected based on their willingness to accept a “discount” on their fees for individual services, regardless of whether the discounted fees would be adequate to cover their costs. The presumption is that the provider will offset this discount by seeing more patients, but they may not have the capacity to see more patients, and they could be forced to offset losses by delivering more services to the same patients or charging more to patients of other payers.

3. **Narrow Networks, Tiered Networks, and Centers of Excellence do not give providers the ability to deliver high-value services that are not supported under Fee-for-Service.** Because the providers are still paid under the standard Fee-for-Service system, they will not receive any payment for delivering high-value services that are not eligible for fees.
4. **Under Narrow Networks and Tiered Networks, patients and payers are unable to determine the total amount that will be charged or paid for all services to treat a particular condition, nor are they able to compare costs across providers.**
5. **Under Narrow Networks and Tiered Networks, providers continue to be paid only if they help patients with their problems.**
6. **Under Narrow Networks and Tiered Networks, higher-need patients could have greater difficulty accessing affordable care.** If providers are selected for the network based on their performance on quality or spending measures, a provider that cares for a higher-need set of patients might have worse performance on quality or cost measures and could thereby be dropped from the network.
7. **Under Narrow Network and Tiered Networks, a provider's payment does not depend solely on things that the provider can control.** The cost and quality measures used to evaluate providers are typically based on some services and costs that the provider being evaluated had no ability to control, so the discounts a provider is forced to accept might bear no relationship to their own performance.
8. **Under Narrow Networks and Tiered Networks, the payment amounts are known before services are delivered.**

Clearly, Narrow Networks and Tiered Networks fail to address the problems of Fee-for-Service payment and may weaken some of its strengths. However, a Tiered Network or Center of Excellence approach could be a desirable complement to a truly effective payment model if it encourages patients to use providers who participate in the improved payment model.

## CREATING A PATIENT-CENTERED PAYMENT SYSTEM

None of the “value-based payment” and “value-based purchasing” systems that are commonly being implemented today truly correct the problems with Fee-for-Service payment. Moreover, they can create new problems for patients that do not exist in the Fee-for-Service system, such as risks of under-treatment and reduced access to care, and they can create new administrative burdens for healthcare providers that can also reduce access to quality care or lead to consolidation of providers and ultimately to higher prices for services. It should not be surprising that these payment “reforms” have failed to achieve the desired effects in controlling costs or improving quality and that they have not been enthusiastically embraced by patients or healthcare providers. The cause of the weak results is not that the “incentives” in value-based payment systems aren’t strong enough to “change provider behavior.” Consequently, better results will not be achieved simply by increasing penalties in P4P systems, by adding downside risk to shared savings models, by increasing the magnitude of risk for providers in shared risk models and bundled payments, or by pushing patients and providers into full-risk capitated payment systems. An entirely different paradigm for value-based payment is needed.

Both the Fee-for-Service system and current approaches to value-based payment and purchasing have a common flaw – their central focus is on how to *pay providers for services* or how to *reduce spending for insurers*, not on how to achieve *good healthcare outcomes* for patients at the *most affordable cost* for both patients and their insurers. What is needed is a *patient-centered* payment system that corrects the problems of Fee-for-Service payment while preserving its strengths. A Patient-Centered Payment system would:

- Enable patients to have their specific healthcare need addressed by a team of providers that have agreed to work together to efficiently deliver high quality care and achieve specific, feasible outcomes for that need;
- Enable patients to select which provider team to use based on the quality standards and outcomes that each provider team commits to achieve for that patient and based on the total amount that the patient and their insurer will pay for all of the services the patient will receive with respect to the need that is being addressed;
- Give the team of providers adequate resources and sufficient flexibility to deliver the most appropriate combination of high-quality services to achieve the best outcomes possible given the nature and severity of the patient’s need;
- Hold the team of providers accountable for meeting quality standards and achieving the expected results for each patient in return for the adequate, flexible payment.

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## How a Patient-Centered Payment System Should Be Structured

A truly Patient-Centered Payment system must customize the method of payment to match what the patient needs as well as what is feasible for providers to manage. Nine types of payments will be needed to adequately address the differences in outcomes and services for four key groups of patient needs:

**Preventive Care.** Two separate types of payments are needed to support services that help a patient avoid developing new health problems.

1. **A Monthly Preventive Services Management Payment.** A Preventive Care Management Team selected by the patient should receive a monthly bundled payment to provide proactive monitoring of the patient's preventive care needs. The Preventive Care Management Team should be accountable for ensuring that the patient is up to date with all preventive care.
2. **Procedure-Based Bundled Payments for Appropriate Preventive Services.** A Preventive Service Team should receive a bundled payment to deliver all of the services associated with a preventive procedure, and the Team should be accountable for doing so in accordance with quality standards and without any avoidable complications.

**Diagnosis and Treatment Planning.** Two types of payments are needed to help patients obtain an accurate diagnosis and an objective assessment of their treatment options.

3. **Diagnosis and Treatment Planning Episode Payment.** For common symptoms, combinations of symptoms, and diagnoses where standardized protocols can be used for determining the diagnosis, a Diagnostic Team led by a Diagnostic Coordinator selected by the patient should receive a bundled payment for all of the diagnostic testing and evaluation services necessary to accurately determine the diagnosis for the patient's symptoms and to help the patient understand the treatment options available and decide on a course of treatment.
4. **Diagnosis Coordination and Treatment Planning Payment.** For unusual symptoms, complex combinations of symptoms, and relatively rare diagnoses, a Diagnostic Coordinator selected by the patient should receive a Diagnosis Coordination and Treatment Planning Payment to enable them to arrange and manage all of the examinations, testing, and referrals to other providers that are required to accurately determine a diagnosis and to help the patient decide on a course of treatment. A provider selected by the Diagnostic Coordinator to perform one of the individual services during this process should receive a pre-defined fee or bundled payment for that service.

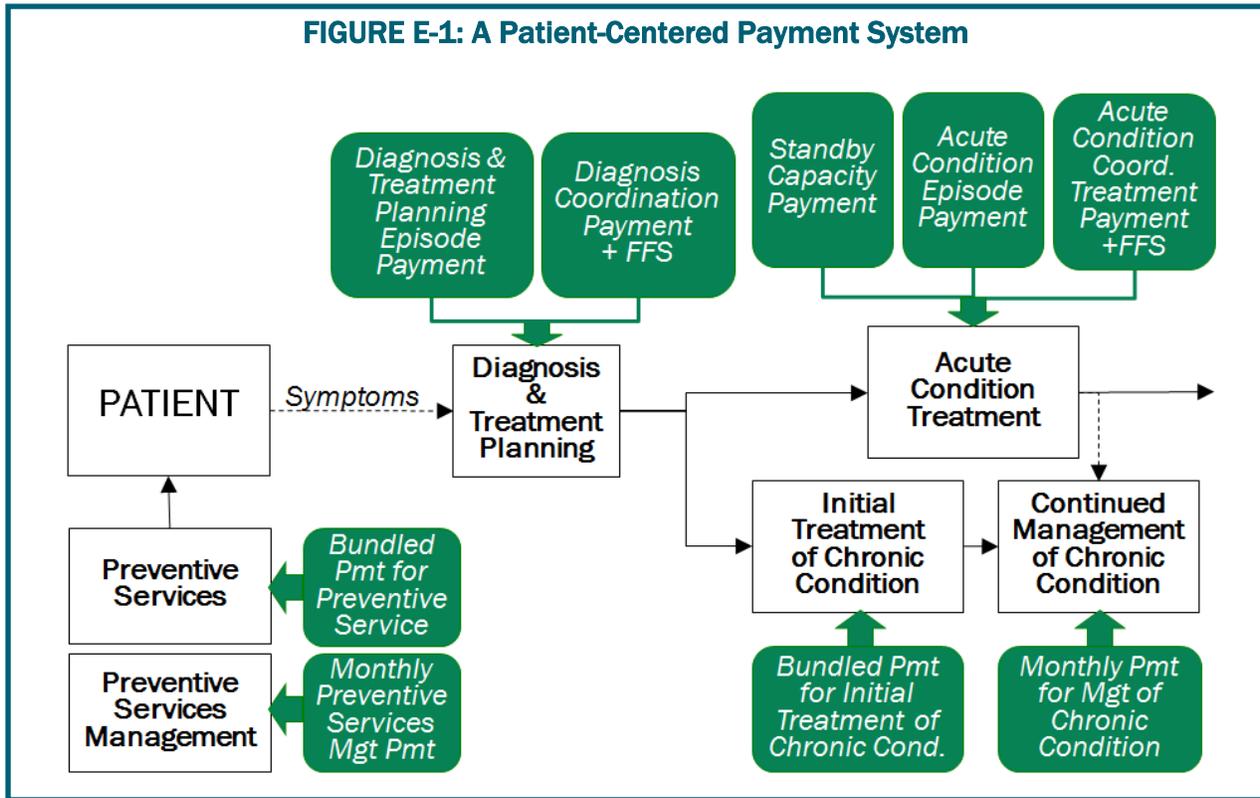
**Treatment of an Acute Condition.** Three separate types of payments are needed to support treatment services for diagnosed acute health conditions.

5. **Standby Capacity Payment to Support Emergency Services and Other Essential Services.** Hospitals and some other providers in the community where an individual resides should receive a monthly or annual payment for that individual in order to sustain the minimum capacity for emergency services and other essential local services needed in case the individual needs one of those services.
6. **Acute Condition Episode Payment.** When a patient has a common acute condition and no other unusual characteristics, an Acute Condition Treatment Team selected by the patient should receive a one-time bundled Acute Care Episode Payment to deliver all of the treatment needed by the patient for that condition. This Team should be accountable for meeting standards of quality in the delivery of the treatment services, for avoiding complications of treatment, and for achieving pre-defined outcomes for the patient.
7. **Acute Condition Coordinated Treatment Payments.** When a patient has an uncommon acute condition or when a patient has a common condition but has other characteristics that require special approaches for treatment of that condition, an Acute Condition Treatment Team selected by the patient should receive (a) fees for each of the individual services the members of the Team deliver to treat the condition and (b) a Treatment Coordination Payment to ensure that all of the services are effectively coordinated and that quality standards are met.

**Management of a Chronic Condition.** Two types of payments are needed to provide the care that a patient diagnosed with a chronic condition will need over an extended period of time.

8. **Bundled Payment for Initial Treatment of Chronic Conditions.** When a patient is newly diagnosed with a chronic condition or combination of conditions, a Chronic Care Management Team selected by the patient should receive a one-time or monthly Bundled Payment to deliver initial treatment, education, and self-management support services for a pre-defined period of time. The Team should be accountable for meeting standards of quality in the delivery of the services (including coordinating those services with treatments the patient may be receiving for other conditions), and for achieving short-term outcomes for the patient.
9. **Monthly Bundled Payment for Continued Management of Chronic Conditions.** After initial treatment for a chronic condition or conditions has been completed, a Chronic Care Management Team selected by the patient should receive monthly Bundled Payments to deliver ongoing treatment, education, and self-management support services to the patient. The Team should be accountable for meeting standards of quality in the delivery of the services (including coordinating those services with treatments the patient may be receiving for other conditions), and for achieving both short-term and longer-term outcomes.

**FIGURE E-1: A Patient-Centered Payment System**



### Key Differences Between Patient-Centered Payments and Fee-for-Service

Patient-Centered Payments should be structured in ways designed to correct the major weaknesses of the Fee-for-Service payment system while preserving its key strengths:

- Payments should cover complete bundles of services appropriate to the patient’s needs.
- Payments should be made to Teams of providers that can deliver complete bundles of services.
- Patients should choose Teams rather than individual providers.
- Payment amounts should differ for different health problems.
- Payment amounts should differ for patients with different characteristics and needs.
- Provider Teams should receive additional payments for costs they cannot control.
- Provider Teams should only be paid for services to a patient if quality standards were met and pre-defined outcomes are achieved for that specific patient.
- Care should be coordinated where coordination is most needed.

### How Patient-Centered Payments Solve the Problems With Fee-for-Service While Preserving Its Strengths

1. **Patient-Centered Payments would assure appropriate, high-quality care and good outcomes.** Because payments would be triggered by a specific health condition, there would be no reward for delivering unnecessary services. Moreover, there would be no payment at all if quality standards were not met and pre-defined outcomes were not achieved. Standards and outcomes would be based on evidence as to what a Team could achieve for most patients with a particular condition and other characteristics; the outcome standards would be different for patients with characteristics that made good outcomes more challenging, so that higher-need patients were not precluded from receiving treatment. Teams that were willing to achieve higher standards could commit to those standards in advance and compete for patients on that basis.
2. **Patient-Centered Payments would match the cost of high-quality, appropriate care.** Initial payment amounts would be set based on the costs incurred by Teams that actually deliver high-quality care with good outcomes. The amount of payment the Team would receive for the patients for whom the performance standard was achieved would be set at a level designed to cover all or part of the cost of the services to the patients for whom the standard was not achieved. Moreover, payment amounts would be higher for patients with greater needs. Teams that could deliver equivalent outcomes at lower costs could charge a lower price to attract patients.

3. **Patient-Centered Payments would give providers the flexibility to deliver the highest-value services.** Payments would be tied to the *results* that a Team of providers achieved for one or more specific health conditions, not to the specific *services* that the providers deliver.
4. **Patient-Centered Payments would enable patients and purchasers to predict the total cost of care for specific health problems and compare provider Teams on cost and quality.** For common types of patient symptoms, conditions, and characteristics, Patient-Centered Payments would enable each patient and their purchaser to know in advance the full amount they would have to pay a provider Team for diagnosis of a symptom, for treatment or management of a diagnosed acute or chronic condition, for delivery of preventive care, and for maintenance of emergency service capacity in the community. For uncommon symptoms, conditions, and characteristics, the patient and purchaser would *not* know in advance the exact amount they would have to pay, because the services and costs associated with those patients are *not predictable* by either providers or purchasers.
5. **Providers would only receive Patient-Centered Payments when patients receive help.** A team of providers would only be paid for a specific patient if (a) the patient receives help for the specific condition, symptom, or risk factor the patient has and (b) the help that is provided to that patient meets pre-defined standards for quality and achieves pre-defined outcomes for that patient.
6. **Under Patient-Centered Payments, higher-need patients would be able to receive treatment for their conditions.** Provider Teams would not be discouraged from treating higher-need patients because patients with specific characteristics that made poor outcomes more likely would be placed in a separate payment category, and the quality standards and outcomes for those patients would be based on what evidence showed provider Teams could achieve for patients with those characteristics. A Provider Team that can commit to better outcomes for a category of patients will attract those patients, enabling competition to improve outcomes as well as costs for all patients over time.
7. **Patient-Centered Payments would depend only on what the provider Team can control.** Payments would only be made to a *team* of providers that could control all of the services needed to achieve good outcomes for the condition(s) being treated. Costs that cannot reasonably be controlled by a provider Team, such as the prices of single-source drugs, would be paid for separately by the patient or purchaser.
8. **Under Patient-Centered Payment, the provider Team would know in advance what they would be paid for services.**

As shown in Table E-1, a Patient-Centered Payment system meets the eight criteria for value-based payment better than any of the value-based payment and value-based purchasing approaches currently being pursued by Medicare and other payers. It addresses all four of the major problems with standard Fee-for-Service payments, but it also preserves all four of the strengths of Fee-for-Service payment that have made providers, patients, and even many purchasers reluctant to move to other alternative payment systems.

As shown in Figure E-2, Patient-Centered Payment does much more to provide accountability for outcomes than any current value-based payment models do, and it avoids the risks of both overtreatment and undertreatment that represent serious weaknesses of other value-based payment models.

A Patient-Centered Payment system looks like far less of a radical change if one compares it to the payment systems used to pay for products and services in many non-healthcare industries:

- Patient-Centered Payment delivers patients a “complete product” at a pre-defined price that has been assembled by experts, rather than expecting the patient to choose from a list of services and prices offered by different providers with no assurance they will “fit” together, and rather than allowing providers to deliver and be paid for extra services that may not be needed or wanted by the patient.
- Patient-Centered Payment gives patients a warranty on defects and a money-back guarantee based on pre-defined performance standards. But similar to the limits on warranties in other industries, the provider Teams would be held accountable only for outcomes and costs that they can reasonably be expected to control.
- Provider Teams could compete in setting prices under Patient-Centered Payments to ensure the payment amounts were as low as possible but adequate to cover their costs, and they would compete to offer higher standards of performance.

## Transitioning to a Patient-Centered Payment System

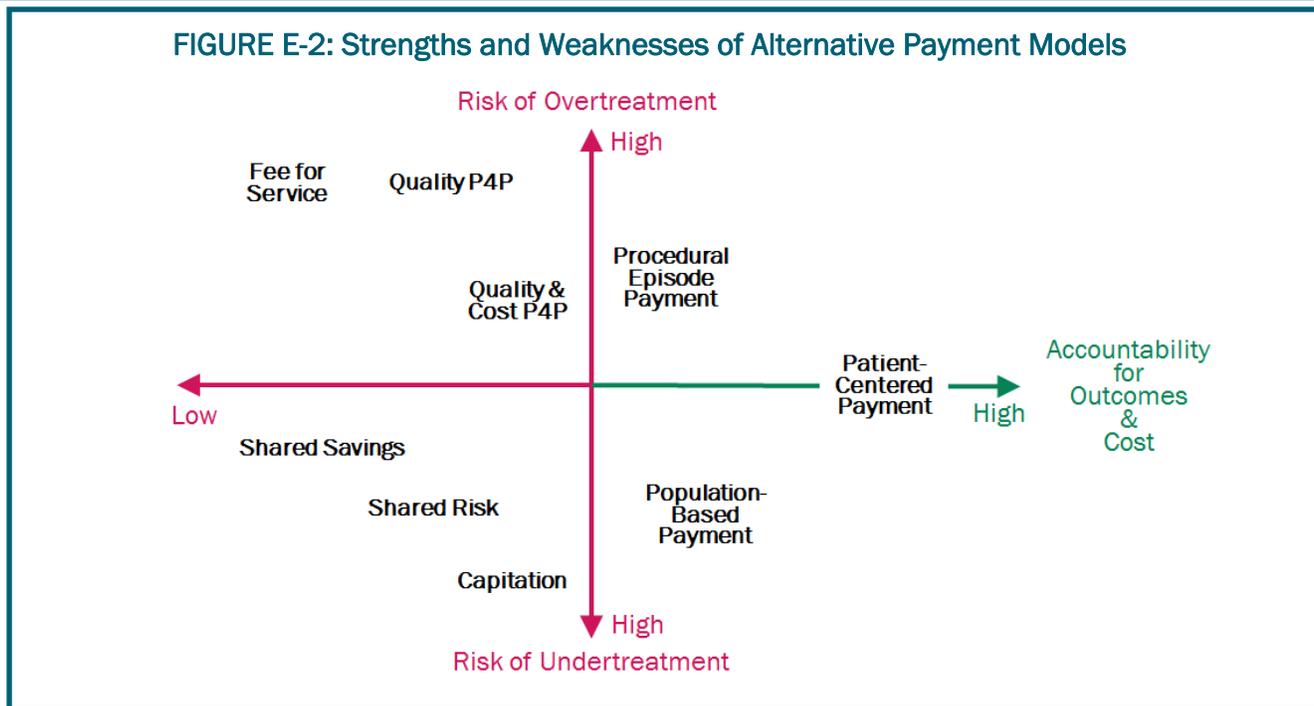
Because a Patient-Centered Payment System represents a significant change from both Fee-for-Service payment and current value-based payment systems such as P4P, Shared Savings, Procedure-Based Episode Payments, and Population-Based Payments, a multi-year transition process will be needed in which the following steps are performed:

- The patient characteristics that significantly affect outcomes and affect the costs of delivering care that achieves those outcomes will need to be identified in order to define patient categories for each type of condition-based payment;
- The performance standards and outcomes expected for different conditions and patients will need to be defined and measured in order for payments to be based on whether those standards and outcomes are achieved;

**TABLE E-1: Evaluation of Alternative Payment Models**

| Desirable Characteristics of a Value-Based Payment System   | Fee-for-Service | Quality P4P | Shared Savings & Shared Risk | Narrow & Tiered Networks | Procedure-Based Episode Payments | Population-Based Payment | Patient-Centered Payment |
|---|-----------------|-------------|------------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| 1 Are providers accountable for appropriateness, high-quality, and outcomes of services for each patient? | No              | No          | No                           | No                       | Partially                        | Partially                | Yes                      |
| 2 Do payment rates match the cost of delivering quality care?   | No              | No          | No                           | No                       | Not Always                       | Not Always               | Yes                      |
| 3 Do providers have flexibility to deliver the highest-value services?                                    | No              | No          | No                           | No                       | Partially                        | Yes                      | Yes                      |
| 4 Are patients and purchasers able to determine the total amount they will pay?                           | No              | No          | No                           | No                       | For the procedure                | Yes                      | Yes                      |
| 5 Are providers only paid when patients receive help?   | Yes             | Yes         | Yes                          | Yes                      | Yes                              | No                       | Yes                      |
| 6 Are patients with greater needs able to receive more services?  | Yes             | Not Always  | Not Always                   | Not Always               | Not Always                       | Not Always               | Yes                      |
| 7 Are providers only held accountable for things they can control?  | Yes             | No          | No (Shared Risk)             | No                       | Not Always                       | No                       | Yes                      |
| 8 Do providers know how much they will be paid before services are delivered?                             | Yes             | No          | No                           | Yes                      | Yes                              | Yes                      | Yes                      |

**FIGURE E-2: Strengths and Weaknesses of Alternative Payment Models**



- The services required to achieve the standards and outcomes and the cost of those services will need to be identified in order to set prices for the condition-based Patient-Centered Payments; and
- The providers that will be involved in delivering the services will need to form Teams, and in order to accept condition-based bundled payments, those Teams will need to determine how they will deliver essential services cost-effectively and how they will allocate the bundled payment among themselves.

It will be impossible to confidently specify all of the parameters of a Patient-Centered Payment System (i.e., category definitions, outcome requirements, and payment amounts) until after the payment system has actually been in place for several years. Consequently, during the transition period, initial parameters for Patient-Centered Payments will have to be established with the full expectation that they will be modified shortly after implementation begins and then modified again on a rapid-cycle basis for a period of time thereafter. During the transition, the goal should be to achieve benefits while avoiding negative impacts on patients, providers, and purchasers so they can continue participating until full implementation occurs.

Once the payment system is fully implemented, competition among providers will enable prices to be reduced and outcome standards to be increased over time, the same way that happens in other industries. Not all providers will need to participate initially, but once the providers participating in the Patient-Centered Payment system demonstrate they can deliver better outcomes at lower costs, patients and purchasers will only want to use providers who can produce similarly high-value results.

To accomplish this, the Centers for Medicare and Medicaid Services (CMS) will need to make significant changes in the way it implements new payment models,

and private purchasers will need to take leadership in working with providers to implement Patient-Centered Payments for commercially insured patients.

## CHOOSING THE RIGHT PATH TO THE FUTURE

Health *insurance* will never be affordable unless the cost of health *care* is reduced. Current approaches to value-based payment and value-based purchasing have shown little benefit in terms of either reducing costs or improving quality, while creating heavy administrative burdens for providers and undesirable incentives to deny care to patients. The problematic structure of these approaches makes it highly unlikely that results will improve with more time or by making the incentives bigger, whereas the harms will likely continue to grow.

A better path is to design and implement a Patient-Centered Payment system that is specifically designed to solve all of the problems with Fee-for-Service payment while also preserving its strengths. Patient-Centered Payment supports patient-centered care, which is what patients want to receive and what physicians and many other healthcare providers want to deliver. But unlike current value-based payment models, Patient-Centered Payment also requires the kind of accountability for cost and quality that both patients and purchasers need and that is feasible for providers to accept.

Successful implementation will require a multi-year transition process, and all of the stakeholders in healthcare – providers, purchasers, and patients – will need to work together collaboratively to ensure success. Individual communities that want to move forward quickly should be encouraged to do so and they should receive the support they need, rather than being forced to wait for a one-size-fits-all national approach.