



Alternatives to Fee-for-Service Payments in Health Care

Moving from Volume to Value

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Introduction and summary

Our nation's health care system is high cost and high volume, but it is certainly not high value. This year, we will spend more than \$8,000 per person on health care, which is more than twice the average of \$3,400 per person in other developed nations.¹ But spending more on health care has not made us healthier.² Even within the United States, different areas of the country spend very different amounts on health care, again with no correlation to better outcomes.³

One of the key reasons for the high level of health care spending and its rate of growth is the predominance of the fee-for-service payment system, which rewards quantity over quality, especially for high-cost, high-margin services. Under this system, health care insurers, including Medicare and Medicaid, pay doctors, hospitals, and other health care providers separately for different items and services furnished to a patient. As of 2008, 78 percent of employer-sponsored health insurance was fee-for-service.⁴

Fee-for-service payments drive up health care costs and potentially lower the value of care for two main reasons. First, they encourage wasteful use, especially of high-cost items and services. Second, they do nothing to align financial incentives between different providers. As a result, patients receive care that they do not need and may not want, and health care providers may not be on the same page about what type of care the patient should receive. It is not just insurers who bear these unnecessary costs: These costs raise premiums, deductibles, and cost-sharing for all health care consumers.

Moreover, the fee-for-service system does nothing to encourage low-cost, high-value services, such as preventive care or patient education—even if they could significantly improve patients' health and lower health care costs throughout the system. Many patients with poorly controlled diabetes or heart failure, for example, enter hospitals needing acute care when their conditions could be managed with better preventive disease management, which would eliminate the need for costly hospital stays.⁵

But there are signs this trend is changing. The Affordable Care Act includes a variety of payment and delivery system reforms designed to control costs and improve care, especially in the Medicare program. These reforms both complement existing private-sector innovations and encourage even wider adoption of alternatives to the existing fee-for-service system. Instead of basing payment solely on the volume and price of the items and services provided to patients, these alternative methods of payment create incentives to encourage preventive care and better care coordination, especially for patients with chronic illnesses.

Although many of these efforts are in beginning stages, early experiences of health care providers piloting these alternatives to fee-for-service are promising. Their initial experiences and results suggest these reforms can lower costs while increasing quality of care.

This paper examines three promising alternatives to fee-for-service payments:

- **Bundled payments**, which are fixed amounts paid to health care providers for a bundle of services or all the care a patient is expected to need during a period of time
- **Patient-centered medical homes**, which are redesigned primary care practices that focus more on preventive care, patient education, and care coordination between different health care providers
- **Accountable care organizations**, which are groups of health care providers who agree to share responsibility for coordinating lower-cost, higher-quality care for a group of patients

This report does not review every health care reform project underway in our nation, of which there are hundreds. Instead, it compiles and highlights recent data from organizations testing each of these reforms. This report also includes new findings from our conversations with a variety of health care providers and payers who are implementing these reforms. Together, these data and feedback highlight key lessons, strategies for success, and implementation challenges that can help guide the movement away from our current, fragmented payment system to one that is high-value and patient-focused.

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Payment reforms in practice

Consider the case of a patient with heart disease who is also in cancer remission. The patient arrives in the emergency room with a broken hip after a fall. Over the next 24 hours, hospital doctors not only treat the broken hip, but also run tests to monitor his heart and check if his cancer has returned; even though he just had his annual check-ins with his oncologist and cardiologist. After three days in the hospital, he is discharged to a nursing home for rehabilitation and further recovery.

During his two-week stay at the nursing home, he travels to and from his cardiologist's office by ambulance to follow-up on the hospital's test results that vary only slightly from the results from his previous check-in. And once he returns home, a home health nurse visits twice a week for three weeks to continue his rehabilitation and monitor his heart. For the first week he is at home, he continues to take a prescription pain reliever.

Here's how Medicare or another insurer would pay for this care under the fee-for-service system:

- Payment to the hospital to cover room and board, nursing services, prescription drugs, other supplies and equipment, and all diagnostic and therapeutic services during the hospital stay
- Separate payments for the services provided by the physicians who cared for the patient during the stay
- A daily payment amount to the nursing facility to cover room and board, nursing services, prescription drugs, and rehabilitation services during his nursing home stay
- Payment to the ambulance company for transporting the patient to and from his cardiologist's office
- Payment to the cardiologist for the visit during the nursing home stay
- Payment to the home health agency for visits after the patient returns home
- Payment for the prescription pain reliever after the patient returns home

This fragmented payment system results in each of these providers having different incentives. Even in this example, where a patient did not undergo particularly expensive treatments, there are inefficiencies and waste. Because the hospital is paid a set fee for the inpatient stay, it has an interest in using fewer hospital resources during the stay and discharging the patient as quickly as possible. At the same time, physicians benefit if the patient needs expensive diagnostic tests

because they are paid per-service and higher-cost items and services have higher payment amounts.

Under the existing system, there is no financial downside to physicians and other health care professionals that provide unnecessary care. And without coordination between each of the different providers, it is even more likely that the patient received duplicative services, all of which are paid for separately under a fee-for-service system.

Each of the three payment reforms highlighted in this report—bundled payments, patient-centered medical homes, and accountable care organizations—is designed to lower costs both for payers and patients and to improve not just patient outcomes but also patients’ experience as they move through the health care system.

Bundled payments

Instead of paying separately for each individual service, the insurer would pay a set amount for the inpatient hospital services and physician services, as well as the post-acute care services. Because the insurer would pay a fixed amount to health care providers to treat the patient following his fall, all providers would have an incentive to coordinate care that the patient actually needs. And because the providers’ reimbursement amounts would depend in part on meeting quality and patient experience measures, the entire team of providers would be focused on improving quality.

Patient-centered medical homes

The goal of this delivery system reform is to encourage preventive care and wellness and prevent unnecessary hospitalizations. In this example, the medical home’s nurse care coordinators may have discussed ways to avoid falling as part of their ongoing preventive care and patient education efforts. And they would also play an important role after his discharge from the hospital to help ensure that he is not later readmitted—either for his injuries from the fall or for his other health problems.

In a medical home setting, the patient would have an ongoing relationship with his primary care physician’s office instead of uncoordinated relationships with various specialists such as his cardiologist and oncologist. The medical home would also be aware of the patient’s health status and recent doctors’ visits.

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Accountable care organizations

Under this payment method, the patient would also benefit from greater coordination between his health care providers. Individual physicians and other providers would continue to be reimbursed separately, but there would be greater coordination, and each provider would have an incentive to provide high-value care. Health care providers who participate in an accountable care organization share in savings if they collectively are able to provide high-quality care to their patients at lower costs.

The rest of this report will look at these three alternatives to fee-for-service payments in more detail, beginning with bundled payments.

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