

Worthy

Tying Pay to Healthy Outcomes





Tying pay to healthy outcomes

It is both intuitive and remarkable how people and organizations consistently respond to incentives. While human behavior and decision-making are complex and trying to predict or even influence an individual's decision in a specific situation can be immensely challenging, it isn't that difficult to predict patterns of behavior across large numbers of people and organizations. Turns out, you can have a pretty good idea of what is going to happen just by following the money.

We've all experienced it, in all kinds of situations. In the [Worthy Overview & Current State of Healthcare segment](#), I shared the story of a colleague who started paying his children for cleaning up after the family dogs, only to discover that they cleverly and relentlessly fed the dogs because they were getting paid based on the volume of waste they removed. In British-ruled New Delhi in Colonial India, authorities decided to pay a bounty for dead cobras in order to reduce the number of dangerous snakes in the city, only to discover later that some citizens were breeding cobras in response. Certain professions, such as lawyers, get paid for the amount of time they work, which can make people using their services wary of perceived attempts to extend or add more work. Others get paid on a commission for making a sale, and not surprisingly, focus a lot of energy on making a sale, (e.g., real estate, cars). Companies and organizations are no different.

To be clear, human beings are not financial robots with all of us making every decision based on the expected financial outcomes. Our interests and needs are far more diverse and complex than that. However, it has been proven time and again that when there are substantial, clear financial incentives within individual control, more often than not people and organizations will follow their financial self-interest.

This makes sense. If you pay people or organizations to sell more, they will sell more (not everyone will, but more of them will). If you pay them by the hour, they will tend to work more hours. If you pay them by the number of transactions they process, they will process more transactions. If you pay them to keep their customers happy — then they'll try to make customers happier, or at least ask that customers give them an excellent score on the post-service survey.

Healthcare is no exception. We get what we pay for. Unfortunately, the vast majority of our dollars do not pay for better health, better service, or greater efficiency. As a result, we aren't seeing meaningful improvement in any of these areas. In fact, if there is one lesson I have learned during my more than 30 years working in this industry, it is that we cannot fight financial self-interest. When organizations and individuals have strong incentives to act in

a certain way, they are relentlessly persistent and creative in finding ways to do so. Attempts to stop it from happening are futile in the long-term and can only be successful in the near-term by creating a lot of friction.

So, this Worthy segment is dedicated to describing what is wrong with how we pay for healthcare today and what we need to do to fix it. To understand both, we need to start with the ideal way to pay for healthcare.

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Payment Principles

I'm going to pull out the proverbial "magic wand" that I described in the last Worthy segment titled "[Truly Personalized Care](#)" and envision the ideal way to pay for healthcare. While it is always going to be the case that there are special and/or unusual circumstances in which it might not be possible to pay for healthcare in a manner consistent with these principles (e.g., someone has a medical emergency in a remote area and must be evacuated by helicopter), I believe the vast majority of what we spend on healthcare can be paid this way.

That said, ideally, we want to pay all the entities participating in healthcare when they:

- Optimize the health and quality of life of the people they serve
- Deliver high-quality service consistently
- Are efficient in doing both of the above (to help keep healthcare affordable)
- Adopt standard payment structures/ contracts that keep payment models simple and easy to administer for everyone

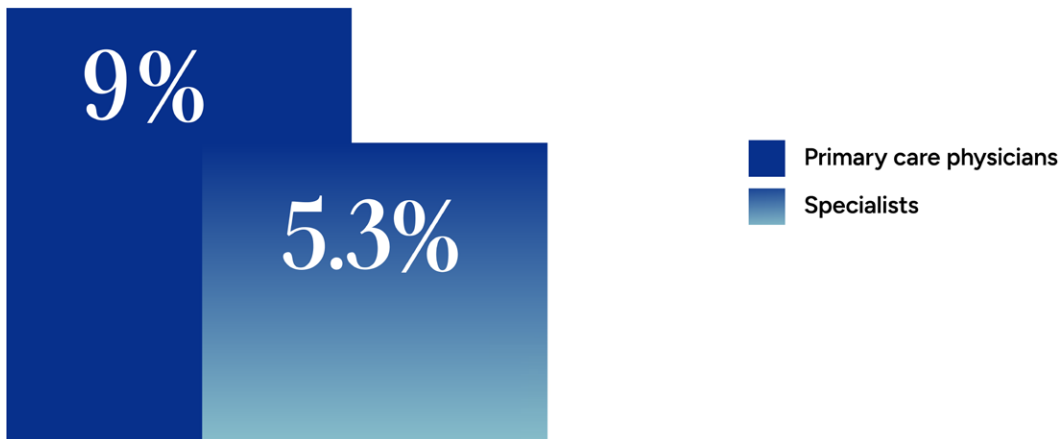
For an individual or healthcare entity to be paid in a manner consistent with these principles, **the majority of the revenue and profit for each entity participating in the system must be tied to doing ALL the things listed above**, in a healthy proportion to one another. Anything short of this is window dressing.

Unfortunately, we've had a lot of window dressing over the years, which is one of the reasons that "value-based care" was first considered high-potential and now evokes skepticism in many quarters. Simply adding a small, single digit percentage bonus on top of a fee-for-service reimbursement model will not create a healthcare system Worthy of us all. And yet there are many examples of this kind of payment being characterized as ground-breaking efforts to pursue "value-based care."

In order to truly fulfill the ambition of tying pay to outcomes, we need every healthcare entity (health plans, hospitals, primary care and specialty physicians, and pharmaceutical companies) to realize that **the only path to financial success is better health outcomes, better service, and lower costs**. We also need everyone to realize that adopting common, standardized payment structures and contracts nationally is necessary to create a healthcare system Worthy of us all.

Unfortunately, while there can be a lot of self-congratulatory talk within the healthcare industry about how payment models have shifted and are continuing to shift, the reality is that we are a long way from the majority of pay being tied to these principles, as you can see from one example in the chart below.

Share of physician compensation based on quality and cost performance, %¹



¹ Based on 2022 JAMA cross-sectional mixed-methods study on physician compensation arrangements and financial performance incentives.
SOURCE: JAMA

So let's walk through each healthcare participant and describe how they are paid today, what the advantages and disadvantages of these methods of payment are, and what we should do to change payments.

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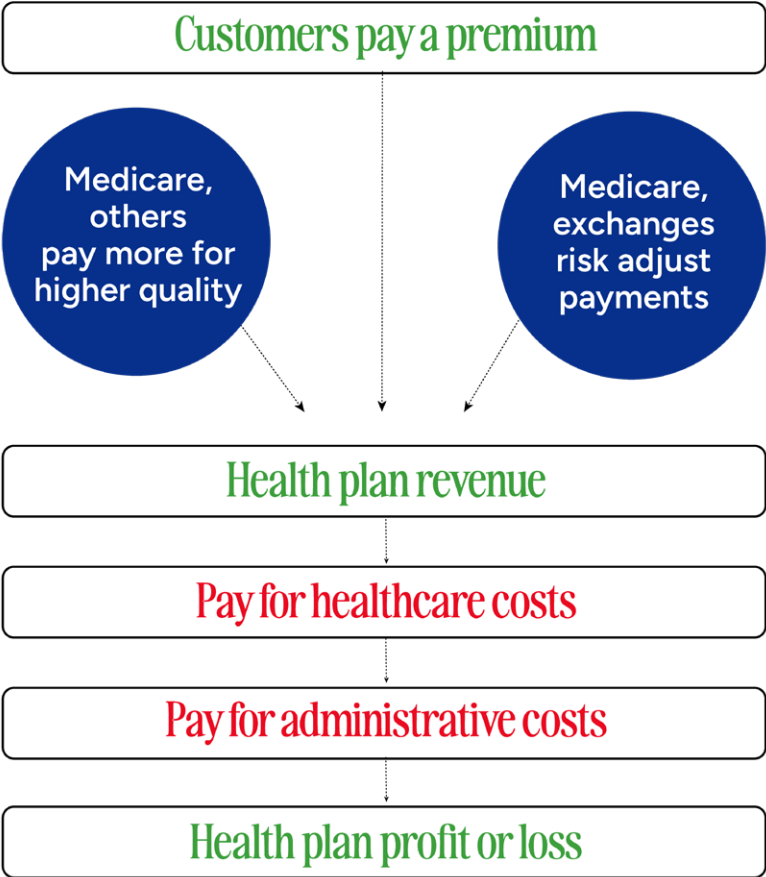
[Health plans](#) →



Health plans

Health plans often provide a lot of different kinds of services, but for most of them, their core business is based on collecting a premium from customers, paying for their healthcare costs and the costs of overseeing the healthcare benefit, and whatever is left over is either a profit (if these costs come in less than the premium) or a loss (if the opposite is true). As you can see from the diagram below, for Medicare Advantage and

Affordable Care Act members, and in some other select cases, the premium received by a health plan is augmented when quality scores are higher and is sometimes, though not always, adjusted for the health risk of a population.



Given this high-level summary, let's now assess how paying health plans stacks up to our ideal principles and what should change.

Payment principle	Advantages of current payment model	Problems with current payment model
Pay tied to optimizing health	<p>Medicare ties substantial health plan pay to Medicare Stars quality performance.</p> <p>Other customers do as well (e.g., some Medicaid plans, some Exchanges).</p>	<p>Few customers other than Medicare tie health plan pay to quality or outcomes.</p> <p>Medicare Stars has a lot of measures – (some of them process-based rather than outcomes-based), with constantly changing scoring weights, unknown “cut points,” and very long lag times – making the process helpful, but suboptimal.</p>
Pay tied to service experience	<p>Medicare Stars includes customer survey input that also holds health plans accountable for the member experience.</p> <p>Large employers often require guaranteed service levels with fees at risk.</p> <p>There is inherent motivation for health plans to retain customers, which requires good service levels.</p>	<p>Pay tied to service experience is limited, with the best example being Medicare Stars.</p> <p>While health plans have an inherent motivation to retain customers and therefore to serve members well, outside of Medicare Stars, there are very few direct financial incentives to improve member service.</p>
Pay tied to efficiency	<p>Because health plans receive fixed revenues in the form of premiums, they have an incentive to improve efficiency/cost effectiveness.</p> <p>With the passage of the Affordable Care Act, health plans cannot reject prospective members for pre-existing conditions, nor drop them from coverage if they become ill. For certain customers, health plans must pay a minimum percentage of their premium on healthcare costs, effectively ensuring</p>	<p>The reality for health plans is that if they can keep healthcare costs lower, they can increase their profitability, which can lead to the worry that a health plan might not authorize care in order to maximize profitability.</p> <p>There are different risk adjustment mechanisms for different lines of business and the payments are typically delayed as long as 18 months, effectively leaving a complicated system that sometimes rewards plans for optimizing coding submissions and/or serving healthier members.</p>

	<p>savings at a certain level go back to the customer.</p> <p>Where there is effective risk adjustment, health plans cannot maximize profitability by trying to serve only the healthiest people.</p>	<p>Most employers do not use risk adjustment payments, which has led some health plans to pursue business practices of trying to obtain the youngest, healthiest employees within an employer.</p>
<p>Standardized, simplified payment structures and contracts</p>	<p>There are likely some local efforts to establish standard contracts between customers, e.g., employers, and health plans, but I am not familiar with them.</p>	<p>For the most part, each plan has its own contract with employer groups, and while they may have standard customer contracts within their individual health plan with certain customers, those payment terms and contracts typically differ by plan.</p>

As you can see, the basic model for paying health plans is heavily weighted towards keeping costs down. It is fair to say that while health plans have not yet accomplished the feat, they are the most financially motivated to try and make healthcare affordable. At the same time, payments tied to better health and better service are inconsistent and suboptimal, leaving health plans vulnerable

to the perception that their financial motivation is to limit access to care for members.

Therefore, in an ideal world, we'd make the changes described below for health plan payments.

Recommendation	Description
<p>Standardize quality measures, customer surveys, and risk adjustment</p>	<ul style="list-style-type: none"> As described in the "Digitize, Simplify & Automate" segment, create one standardized set of streamlined quality measures, a standard customer/member satisfaction survey, and one standard risk adjustment measurement system that cannot be gamed/manipulated through coding or other practices, and ensure settlement payments occur at least quarterly. Require regular health plan collection and submission of data for performance on quality, customer satisfaction, and risk adjustment for each line of business and overall.

<p>Implement all the recommendations associated with the proposed Shared Decision-Making model for “Truly Personalized Care”</p>	<ul style="list-style-type: none"> • See last month’s segment “Truly Personalized Care” that describes the shared decision-making model, all the recommendations associated with it, and how to implement them. • Note that this establishes a clear set of rules that health plans would adhere to, but takes approval of treatments out of their hands.
<p>Require a minimum percentage of health plan pay tied to quality scores and customer satisfaction for all federal dollars</p>	<ul style="list-style-type: none"> • For all health coverage that involves federal dollars paying contracted health plans for healthcare coverage, including Medicare Advantage, Medicaid, and the Exchanges, require a minimum percentage of pay tied to performance on quality and customer satisfaction (e.g., 5% of total premium with 2.5% downside risk and 2.5% upside risk depending on performance). • Use standardized quality and customer survey results to measure performance.
<p>Financially encourage employers to adopt the same payment standards for health plans as the government has</p>	<ul style="list-style-type: none"> • For employers to retain the ability to deduct healthcare costs from their income tax liability, they must: <ul style="list-style-type: none"> ◦ Also pay health plans the same minimum for performance on quality and customer satisfaction using the same standardized performance measures (e.g., 5% of fully insured premium or perhaps a larger number like 20% minimum for self-funded administrative fees). ◦ Use the standard risk adjustment model if the employer offers more than one health plan to a minimum number of employees (e.g., > 1,000).
<p>Have Centers for Medicare and Medicaid Services (CMS) establish a standard payment structure for government-funded healthcare</p>	<ul style="list-style-type: none"> • In order to continually qualify to receive payment for Medicare, Medicaid, and the Exchanges, health plans have to adopt standardized payment structure and standardized contract terms associated with receiving payment from these programs for their services.

Making these changes should highly motivate health plans financially to help improve member health, ensure members receive good service, and be efficient. Because payments to health plans remain capped but their costs are not, health plans will continue to be highly motivated to try to manage costs and be efficient. Meanwhile, with widespread risk adjustment adoption, health plans will not be able to maximize profitability by just providing health care coverage to a young, healthy population. Also, since health plans' profit margins are typically 1%-5% of revenue (and more recently have included some significant losses), tying 5% of revenue to quality and customer satisfaction performance means health plans will not be able to make a profit unless they are performing well

in these areas. Additionally, by introducing a robust shared decision-making model with all the associated requirements, it will remove a health plan's ability to refuse to pay for certain types of care as a potential mechanism to increase profits.

Finally, by adopting all the standardization and simplification recommendations in the "[Digitize, Simplify & Automate](#)" Worthy segment and including them in standard payment structures and contracts, it should simplify, clarify, and establish consistency with how health plans get paid across the country.

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[Primary care physicians](#) →



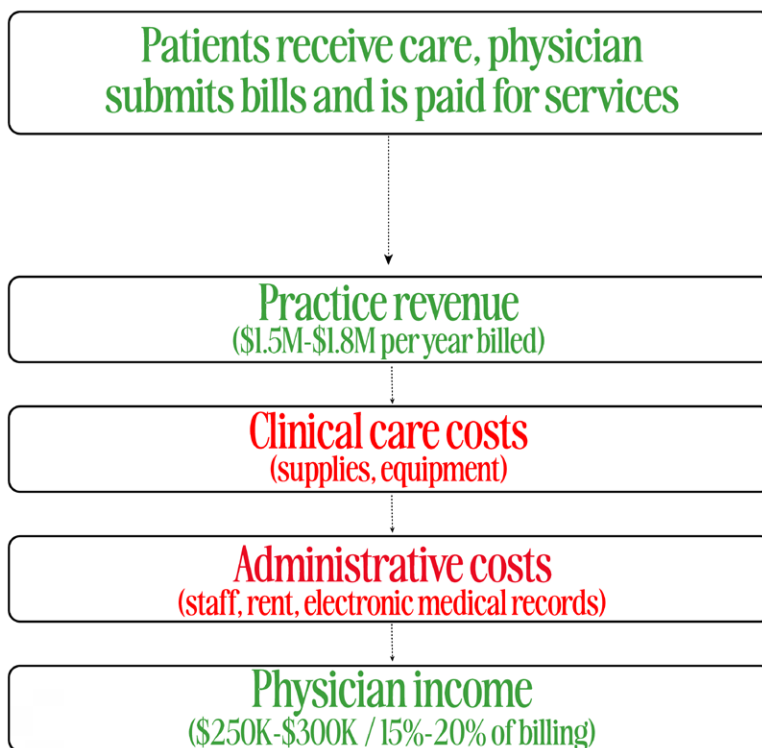
Primary care physicians

Primary care physicians are the medical system's first line of defense. They are the physicians that you typically see for regular exams, vaccinations, managing your high blood pressure, or when a new health problem arises that is serious enough to warrant medical attention. They include family doctors, general practice physicians, internists, pediatricians, geriatricians, and obstetrician-gynecologists (OB-GYNs). (It is worth noting that OB-GYNs are specialists but are often thought of as primary care physicians as well, since they typically do annual exams and other proactive care usually associated with primary care.) While there are several different types of payment models for primary care physicians, including employment (salary with or without a bonus), capitation, and some value-based payment models, "The dominant mode of physician payment in the US is fee-for-service (FFS), representing over 90 percent of primary care practice revenue." (NCBI)

As you can see from the diagram below, that means that physicians (or their employer) bill for each individual service such as office visits, procedures, and tests using a voluminous and complex set of codes (e.g., Current

Procedural Terminology or CPT Codes). The payer, which could be a commercial health plan or government program such as Medicare or Medicaid, then pays for each of these services based on a fee schedule tied to the codes. Ultimately, the physician's income (or that of their employer) will be determined by subtracting the costs of managing the physician's office and practice, such as paying for staff or nurses, rent, malpractice insurance, equipment and supplies, and electronic medical record vendor fees.

While the numbers vary based on a lot of factors, including geography, the median primary care physician practice bills to commercial payers and collects \$1.5 million to \$1.8 million per year according to [this report](#). Also, primary care practices keep \$250,000 to \$300,000 per year for income (or about 15% - 20% of gross billing) according to survey results from [MGMA](#) as well as this report from [DojoBusiness](#).



Given this high-level summary, let's now assess how paying primary care physicians stacks up to our ideal principles and what should change.

Payment principle	Advantages of current fee-for-service payment model	Problems with current fee-for-service payment model
Pay tied to optimizing health	Most primary care physicians only get paid if they see patients and/or do something for them, which gives physicians an incentive to be accessible to patients when they are needed.	Nearly all the financial incentives are to do more, rather than to improve outcomes.
Pay tied to service experience	Physicians have a general incentive to provide decent service, both to keep their current patients and to secure more patient volume in the future.	In the pure fee-for-service model, there is generally no payment tied to the service experience. Because payments for office visits often have a maximum time, the financial incentive is to keep patient visits short.

<p>Pay tied to efficiency</p>	<p>If primary care physicians own their own practice, they are motivated to keep administrative costs down in their office to maximize their income. However, physicians often do not have full control over these costs due to the need to follow processes of other organizations such as health plans. Also, physicians do not have incentives to reduce healthcare costs.</p>	<p>Primary care physicians only get paid if they see patients and/or do something for them, which means their financial incentives are tied to doing more.</p>
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The current fee-for-service model is a long way from being ideal for anyone. Primary care physicians only retain about 15% to 20% of what they charge for their services. They often spend their days packed with back-to-back, 15-minute office visits, and their evenings and weekends doing administrative work, such as completing electronic medical records. Burnout is a common complaint.

Patients often feel the time pressure that these physicians are under and have a suboptimal service experience as a result. Health plans and the entire healthcare system need primary care physicians at their best to prevent the onset of serious illnesses as much as possible, both to keep people healthy and keep healthcare costs down, but that is often not the case, for the reasons described above.

The first thing we need to do is to reduce the costs and administrative burdens on primary care physicians, as described in Worthy’s [“Digitize, Simplify & Automate”](#) segment. The fastest way to improve the professional experience of primary care physicians, increase their incomes, and make them available to more patients is to reduce the cost and time required to do tasks that are not directly

related to providing healthcare. By reducing the need for administrative staff (e.g., employees who enter data from clipboards, fax information back and forth to health plans, or do time-consuming tasks like manually typing information into an electronic medical record) we can simultaneously increase physician incomes and also increase the percentage of time doctors spend focused on clinical care, making them more accessible to patients. For example, increasing the percentage of billed revenue a primary care physician receives by 5% would increase their income by 25%-35%, or \$75k-\$90k per year.

The proposed primary care physician payment model is a combination of fee-for-service and fixed per patient payments. The idea is to continue to pay fees for each of the services that have a demonstrated health benefit like annual wellness visits and immunizations thereby providing incentives to increase their use but to pay fixed per patient fees for other care and support. Pure fee-for-service drives visit volume; pure fixed per patient fees (also referred to as capitation) can incentivize underutilization.

A combination of the two can balance both, rewarding appropriate care delivery while discouraging unnecessary services.

To make the fixed per patient payments work, each person/patient needs to choose a primary care physician in advance, irrespective of the product they are using (e.g., HMO, PPO), so that primary care physicians know in advance the patients for whom they are responsible. People will always be able to change their

designation at any time and the rules governing accessing care for their product would not change. For example, in a PPO product an individual typically can see doctors other than their primary care physician without receiving a referral from their primary care physician and that would continue to be the case.

With this designation in place, the per patient payment model tied to outcomes could look like this:

Example of pay for outcomes for primary care physicians

Type of pay	Per member per month amount	Notes
Risk-adjusted per member per month base pay	\$20	Primary care physicians receive this payment irrespective of whether patients use any services or not. Amount is risk-adjusted so there is higher payment for less healthy members that need more care.
Payment for health outcomes	Up to \$3.25	Payments tied to improvement on core health outcome measures from a streamlined, standardized set, such as better blood sugar control and better blood pressure control.
Payment for patient satisfaction	Up to \$1	Payments tied to performance on standard member/patient satisfaction survey.
Payment for optimal utilization	Up to \$2.50	Payments tied to optimal use of healthcare resources (e.g., percentage of prescriptions that are generic when a generic is available).
Total potential fixed pay	\$26.75	Note that physicians will receive additional fees for certain services and therefore this does not represent total pay.

A financial model where a high proportion of the overall payment is linked directly to improving health outcomes, improving patient satisfaction, and optimizing utilization aligns with the ideal scenario. In addition to that, by paying on a per patient basis irrespective of the services rendered, primary care physicians will be financially motivated to help all their patients get and remain healthy (i.e., truly focus on prevention) and they will not have to keep a 15-minute per visit schedule.

There are certainly other primary care payment models that could satisfy our criteria and so this proposal is meant to be a helpful, concrete example as opposed to the only workable option. That said, we will be far better off if all payers and physicians develop and follow a common structure nationally. As stated before, it will greatly simplify contracting and reduce administrative costs for health plans and physicians. Therefore, while this proposal is not

the only option, once we choose a payment structure, we should make it a national standard.

Finally, for this new payment model and for the new payment models for specialists, hospitals, and pharmacy, payers should continue to run a fully automated process that calculates what would have been paid to all these entities had the fee-for-service system remained in place. This can be helpful to gain trust in the new payment system, and help create mechanisms to protect against dramatic and unintentional swings in payments as we transition to new payment models.

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[Specialists](#) →



Specialists

There are a lot of different physician specialties and sub-specialties, and the nature of their work and their payment models can vary quite substantially. For example, some specialists work more frequently in hospitals, such as emergency medicine doctors, anesthesiologists, and interventional radiologists. Some may specialize in surgical procedures, such as orthopedic surgeons (who perform surgery on joints such as knees, hips, and shoulders), while others focus on acute conditions, such as oncologists treating cancer patients, or on chronic conditions, such as endocrinologists treating diabetics or cardiologists treating people with heart failure.

What specialists share in common is that they tend to see patients after some significant health issue has been identified, along with the belief that addressing these problems may require their expertise. As a result, it is often (though not always) the case for specialists that their patient engagement is intermittent and time bound. For example, they engage a patient for a specific time period to deal with a specific health issue and then stop engaging with the patient after that health issue has been addressed.

While there is a similar range of payment models for specialists as there is for primary care (e.g., employment is common for hospital-based specialists) the most common form of payment for specialists who are not hospital-based is the fee-for-service model described in the section

above. In the interest of time, we won't repeat a description of that payment system and how we assess it relative to our ideal payment criteria. It is worth noting that unlike primary care physicians, some specialists in certain situations derive substantial income from payments associated with their treatment choices. This includes oncologists, dermatologists, and others (or their employers) getting paid substantial sums for prescribing and administering certain prescription drugs, or surgeons receiving consulting or other fees to advise on the use of certain implants/medical devices.

Therefore, one change that needs to happen in specialist payment models is to eliminate any financial incentive associated with prescribing, recommending, or choosing a specific testing or treatment option for patients. We want all physicians in all situations to simply focus on what is best for our health, not how they can maximize their income by choosing a certain treatment path.

Beyond eliminating these flawed incentives, the proposed payment model for most specialists uses the same principles and structure as for primary care physicians, but ties payments to a specific patient case. Examples of cases include:

- Maternity: a mother delivering a baby
- Chronic or acute joint pain (e.g., knee, hip, or back pain, arthritis)

- Cancer care
- Treatment for chronic illnesses (e.g., diabetes, heart failure, hypertension or high blood pressure, chronic obstructive pulmonary disease)

As you can see, some of these cases are clearly timebound (e.g., maternity), while others could be lifetime ailments (e.g., heart failure). You can also probably recognize with hospital-based

physicians and highly specialized situations that establishing a case-based payment could be very difficult. That said, it feels entirely achievable to create and implement the case-based outcomes payment model described below for the vast majority of care provided by specialists.

With that said, below is an example of a specialist, case-based per patient payment model for breast cancer.

Example of pay for outcomes for oncologist treating breast cancer

Type of pay	Per case amount*	Notes
Risk-adjusted per case amount	\$105,000	Specialists receive this payment to cover a standard course of treatment. The payments are adjusted for key clinical factors such as stage, tumor size, position, disease status and other risk factors.
Payment for health outcomes	Up to \$7,350	Payments tied to core health outcome measures that are part of the streamlined and standardized set (e.g., advanced care plans, adherence to pathways).
Payment for patient satisfaction	Up to \$5,250	Payments tied to performance on standard member/patient satisfaction survey.
Payment for optimal utilization	Up to \$8,400	Payments tied to efficient use of healthcare resources (e.g., percentage of prescriptions that are generic/biosimilar when available, readmission rate).
Total potential pay	\$126,000	

*Case rate illustrative estimates based on an average cost for medical and pharmacy across all stages of breast cancer (0-4) for one year. The illustrative case rate does not include radiation therapy or surgery.

It will be particularly important for payers to run the traditional fee-for-service payment models in a fully automated fashion in parallel for specialists for a period of time given the variation that can happen from case to case. We also do not want specialists shying away from treating the patients with the most complex and difficult symptoms as a way of ensuring better outcomes scores (and potential higher payments for those scores). For specialists, there may well be more instances when adjustments need to be made to the payment model and/or to the payments themselves to ensure that a physician's income does not suddenly plummet or skyrocket due to unforeseen circumstances. As one oncologist told me, "We don't want to turn doctors into insurance companies."

That said, once we transition to this type of payment model, the improvements should be obvious. Specialists will get paid for improving patients' health, providing a high level of service, and doing so efficiently. Because we will insist on standardized structures and contracts for payment, there should be consistency in the incentive and the administrative processes to support them. Also, since we've removed any financial incentives to prescribe a certain drug or type of treatment, specialists should be free to focus on what is best for the patient using the shared decision-making model described in our [last segment](#). In short, while there is some complexity associated with moving to this payment model, it can be managed and it is worth figuring out how to do so.

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[Hospitals](#) →



Hospitals

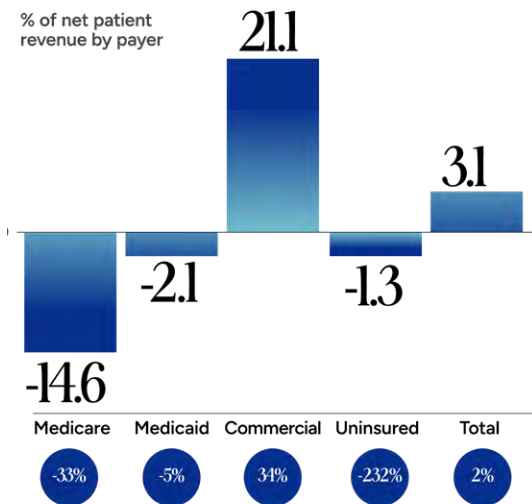
Not all hospitals are the same. There are hospitals, such as academic medical centers, which train doctors and do medical/clinical research. Some belong to large hospital chains whereas others are small, stand-alone entities. For the vast majority of hospitals, their patient base is geographically concentrated near where they are located, which means the patient mix can differ dramatically. For example, hospitals serving geographic areas with a high concentration of Medicaid beneficiaries will have a very different patient mix than those operating in affluent suburbs with a higher percentage of people insured by their employer.

One of the things that hospitals have in common is that they must stay open 24 hours a day, 7 days a week, 365 days per year. They don't get to shut down for any period of time. They have to

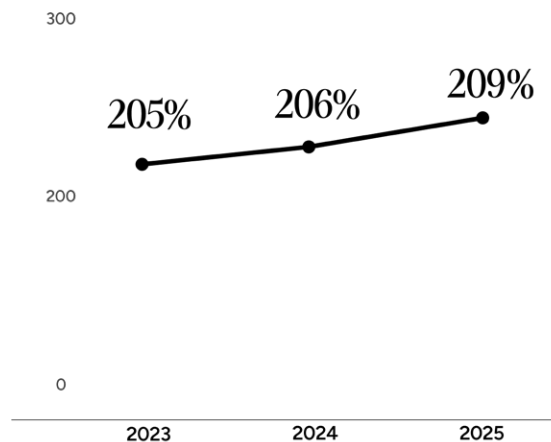
be taking care of patients and prepared to take in more patients all the time. They also have a lot of regulations with which they need to comply, many of them established at the state level. As a result, hospitals have high "fixed costs," meaning there are a lot of costs to building a hospital and keeping it open and in compliance with all applicable laws and regulations, even if there are no patients in the building.

While it is true that reimbursement for primary care physicians and specialists is different (typically lower) for government programs such as Medicare and Medicaid, in comparison to payments from private health plans for commercially insured members, that difference in payment is often much larger for hospitals (see below for examples).

Hospital profit by payer type in California. 2024, \$B¹



National commercial reimbursement as share of Medicare rates for inpatient services, 2023-2025 %²



¹ Based on 2024 Hospital Annual Pivot table published by CalHHS. Calculated as payment shortfall (net patient revenue less expenses) for each payer type aggregated across all CA hospitals. Medicare is sum of traditional and MA, Medicaid Medi-Cal traditional and managed care, commercial under other third parties, and uninsured indigent programs. ² Based on publicly available data reported by Milliman in commercial reimbursement benchmarking reports. SOURCE: CALHHS, Milliman, Milliman

Many hospital executives describe this as commercial health insurance having to pay for under-compensation by government programs. There is certainly some truth to that given how much of a hospital’s costs are fixed. However, there is also evidence that the difference in payments is due to the fact that some hospitals, particularly large systems and/or hospitals without a competitive option in their geographic area, have the negotiating power to demand ever-increasing rates from health plans, and do so to achieve their financial goals instead of improving their financial performance through better cost management. For more information, see these reports on implications relating to provider consolidation: [KFF, Bipartisan Policy Center](#).

Irrespective of your perspective on this question, the current payment system does create a financial incentive for hospitals to favor patient volume from their most profitable (typically commercial) customers, and to do the opposite with their least profitable customers (typically government programs).

While there are different payment models for hospitals (e.g., capitation, percentage of revenue), the majority of hospitals in this country are based on a fee-for-service basis, which means hospitals get paid for providing services (e.g., scans, colonoscopies, hospital stays).

Hospitals also must submit codes for these services to facilitate payment, much like physicians do. However, the sheer number of codes (approximately 160,000 unique codes across multiple coding systems [Tebr](#), [CMS](#)) and the complexity of payment terms (e.g., is the aspirin to be billed and reimbursed separately or is it included in a bundled per day payment?) makes payments to hospitals time- and labor-intensive. This approach is also often fraught with conflict and friction, such as hospitals using “revenue cycle management” to maximize reimbursement through coding and health plans bundling more services and/or down-coding claims.

Not surprisingly, the fee-for-service payment model for hospitals has the same problems as it does for physicians, as you can see in the table below.

Payment principle	Advantages of current fee-for-service payment model	Problems with current fee-for-service payment model
Pay tied to optimizing health	Hospitals have an incentive to be accessible given that they get paid for providing services.	Nearly all the financial incentives are to do more, rather than to improve outcomes.
Pay tied to service experience	Hospitals do have a general incentive to provide good service to secure future patient volume.	In the pure fee-for-service model, there is generally not anything tied to the service experience.

<p>Pay tied to efficiency</p>	<p>While hospitals can improve financial performance by managing costs, the steady rise in prices and revenue over the past two decades has made revenue growth the more common focus. The U.S. hospital care expenditures increased from approximately \$692 billion in 2007 to \$1.63 trillion in 2024, growing more than 2.3x over that period (CMS).</p>	<p>The current payment model rewards doing more, not using healthcare resources efficiently.</p>
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While the issues are similar, I believe the negative consequences of staying on a fee-for-service model are even more significant for hospitals than they are for physicians. The reason is that major capital investments made by hospitals to build or expand/renovate facilities or make major equipment purchases represent probably the biggest driver of future healthcare costs. Therefore, one of the top priorities for making healthcare affordable is to figure out how to serve our growing and aging American population while minimizing building/expanding more hospitals and making other large capital purchases.

However, a hospital’s financial reward system is related to having more people use the hospital and its services. The inevitable consequence if we stay in this fee-for-service model is that hospitals will have to build/expand a lot more to serve our growing and aging population, and this will cripple our efforts to make healthcare affordable. Therefore, it is imperative that we shift to paying hospitals in a way that rewards them for helping keep people healthy and out of the hospital, so they can serve a bigger/broader population effectively without having to make major capital investments to expand.

We should move hospitals to a global hospital payment model structure. In this model a hospital will have a predetermined, fixed budget (set annually, with monthly payments) covering the majority of inpatient and outpatient facility spend. Annual and mid-year adjustment factors such as patient acuity, patient volume, and market shifts will be applied. This model allows hospitals to focus time on prevention and optimizing where care is delivered without fear of losing revenue. A portion of the hospitals revenue in this model is also directly tied to health outcomes, patient satisfaction, and optimal utilization. This type of payment creates predictable steady revenue streams that can allow hospitals to focus on helping keep a population healthy versus episodic billing. A model like this also can help reduce administrative burden by reducing claims processing complexity, denials, disputes, and health plan care management programs such as concurrent review.

Example of pay for outcomes for hospitals

Type of pay	Hospital monthly payment	Notes
Monthly fixed payment	\$3,650,000	A predetermined amount for a specific set of services provided to a population for a defined duration. To account for variables outside of the hospitals control a variety of adjustment factors will be applied annually (e.g. acuity, volume).
Payment for health outcomes	\$217,000	Payments tied to core health outcome measures that are part of the streamlined and standardized set (e.g., Sepsis, Catheter-Associated Urinary Tract Infection (CAUTI)).
Payment for patient satisfaction	\$72,000	Payments tied to performance on standard member/patient satisfaction survey.
Payment for optimal utilization	\$72,000	Payments tied to optimal use of healthcare resources (e.g., 30 day all cause readmission rate).
Total potential pay	\$4,011,000	This example would represent payments from one payor and not total hospital revenue

The positive effects of shifting to such a payment model would be dramatic. The mindset of hospitals would quickly shift from getting patients in to use the hospital towards prevention and keeping them healthy enough to stay out of the hospital while ensuring that when the hospital needs to be used it is providing high quality care and excellent service levels. Granted, it could lead to hospitals trying to push patient volume to their competitors, but by tracking in parallel the payments hospitals would have received through the fee-for-service model, that kind of behavior can be monitored and appropriate adjustments would be made.

Most importantly, long-term hospital planning will be focused on making large capital outlays

for new equipment and expansions only when it is absolutely necessary, which will be critical to make healthcare sustainably affordable. It should also rid us once and for all from the mindset that advancing/improving technology increases costs as there is no logical reason for that to be the case. Hospitals should become much more cost-conscious shoppers for new medical equipment and start demanding that medical equipment suppliers do what all other technology hardware companies do: create better equipment for lower prices.

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[Pharmaceutical companies](#) →



Pharmaceutical companies

While the kickbacks in the form of rebates and fees associated with administering and distributing prescription drugs are dizzying and entirely inappropriate ([see the Worthy segment on pharmacy distribution here](#)), the financial model for pharmaceutical companies is generally pretty simple: they get paid for each pill, injection, or dose purchased. There are some payment models tied to performance, particularly for very expensive therapies such as stem cell treatments, but they are the exception to the general rule. Not surprisingly, when companies get rewarded when a higher volume of medicines are purchased at a higher price, they focus on driving both of these things higher.

One of the keys to moving some pharmaceutical drugs to more value-based payment models is to establish standard definitions for and measurement of value. If a drug helps extend someone's life and/or improve their quality of life, what is that worth? This is not a question I am going to try and answer definitively, as it requires a much broader societal discussion. But it is important to note that it will be very difficult to tie a large number of drugs to performance-based pay unless we address these kinds of questions.

In a future Worthy segment, I will propose a new pricing and payment model for pharmacy, including how we should set up a process for defining value and tying the price of drugs to that value. For now, suffice to say that we are generally getting a higher volume of more expensive drugs because our system rewards it, and we will need to reform both the distribution system and the pricing process to change that.

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What are the benefits of tying pay to outcomes?

Projecting changes in future performance on healthcare outcomes, service experience, and affordability that can be attributed to making a transition to new payment models is challenging. While payment models with similarities to the ones described here have been introduced and studied on a limited scale, extrapolation of those results can be tricky. For starters, there is a range of results and perhaps more importantly, there is a big difference between experimenting with something new on a limited scale as opposed to having everyone adopt it everywhere for everything.

As you have read in this segment, the real impact of shifting to these new methods of payment is to change the mindset of all the major participants in the system. By making it impossible to be financially successful without performing well on health outcomes, service, and affordability, all of the system's participants will shift to dedicating themselves to figuring out how to improve performance across all these dimensions as soon as possible. This wholesale industry shift in mindset simply cannot be truly replicated in a pilot.

Which is why I believe that the results of making this transition will be substantially better than the results from studies of smaller scale attempts. That said, I'm going to base performance projections on a summary of some of the payment reforms in these studies by researchers at [Harvard](#), [Cambridge](#), and [McKinsey](#).

What these studies have generally shown is that with payment models tied to outcomes/value:

- Incremental but measurable improvements in quality and costs are possible and even probable (e.g., 2% to 5% reduction in healthcare costs)
- It requires both time (multiple years) and capabilities to achieve more substantial results

Currently, healthcare coverage cost is projected to increase 6.5% to 10% per year with the [Business Group on Health survey](#) indicating that employers are expecting a 9% increase for 2026. Using these data points and the assumptions outlined in the [appendix](#), moving to these new payment models will not only improve the health of Americans, but it will save over \$600 billion by the fourth year and approximately \$900 billion by the fifth year.

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[The path forward](#) →



The path forward

Federal and state governments pay more than 40% of our total healthcare costs every year through Medicare, Medicaid, subsidies for the Exchanges, and other programs. The Centers for Medicare and Medicaid Services (CMS) has substantial, though not complete, authority to define the way all the healthcare participants are paid for these government programs. Employers pick up a similar percentage of healthcare costs as our governments do with consumers paying the balance. Therefore, the best way to tie pay to outcomes nationally is to pass a federal law that:

- Empowers and requires the Centers for Medicare and Medicaid Services to transition all eligible payments* for healthcare within 2 years to standard pay-for-outcomes models that meet minimum criteria such as the ones outlined in this segment
- Requires employers paying for healthcare coverage to do the same in order to preserve the tax deductibility of their health care costs

** Eligible payments should include payments to health plans, hospitals, primary care physicians, and specifically identified specialists for whom it is feasible to do case-based payments. Pharmacy pricing and payments will be covered in a separate Worthy segment.*

With the passing of this law, health plans, hospitals, and physicians will realize that the world is changing and will all be motivated to help create a payment structure standard that makes sense. While I'm sure the process will be messy and even chaotic at times, with a deadline looming and no option to extend or repeal it, all the participants will likely lean in to help create something that is not perfect, but really good.

Because employers will be financially motivated to abide by this approach, it is highly likely that they will adopt these new payment models thereby making them nearly universal. As we've seen from the analysis in this segment, universal adoption of these models by all the healthcare participants will be a huge step toward creating a healthcare system Worthy of us all.

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[Incentives matter →](#)



Incentives matter

At the risk of repeating the obvious, incentives matter. Humans and organizations respond to them, and in my experience, trying to get individuals and companies to behave in a manner that runs contrary to their financial self-interest is self-defeating.

Our current payment models to primary care physicians, specialists, hospitals, and pharmaceutical companies generally reward doing more at the highest possible price. By contrast, health plans have incentives to try and manage costs, but limited rewards for quality and service. Not surprisingly, health plans have been trying to push back on the relentless drive to raise prices and do more, but not very successfully given the cost trends in healthcare and consolidation which gives insurers less negotiating leverage to pursue different payment models.

If we want healthcare that is Worthy of us all, we need to financially reward all the players who actually do just that — and not reward them for anything else. There is nothing that will focus the minds of the leaders of the healthcare industry more than realizing the only way to make financial ends meet is to help people get healthier, serve them better, and do it more efficiently, including in a highly standardized manner. Money matters. Let's start spending it as if the lives of our loved ones depend on it.

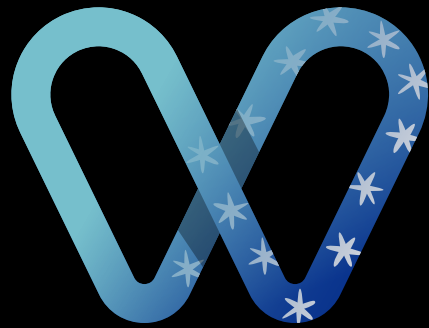
Appendix

Assumptions and projections for cost savings

- Baseline healthcare costs are \$5 trillion (\$5.3 trillion in 2024 minus savings projected in previous segments).
- Without any changes, healthcare costs will increase 9% in year 1, 8% in year 2, and 7% in years 3-5.
- These trends will be reduced by 1% in year 1, 2% in year 2, 3% in year 3, and 4% in years 4 and 5.

Dollars in billions

	Year 1	Year 2	Year 3	Year 4	Year 5	Cumulative
National healthcare costs with projected trend	\$5,450	\$5,886	\$6,298	\$6,739	\$7,211	
National healthcare costs with trend reduction	\$5,400	\$5,724	\$5,953	\$6,132	\$6,315	
Cost savings	\$50	\$162	\$345	\$607	\$895	\$2,060



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