Published on *American Council on Science and Health* (https://www.acsh.org)

A Modern Payment Model for 21st-Century Cures

By Robert Popovian — June 13, 2019

Photo: Managed Healthcare Executive [1]

We no longer can avoid the inevitable: We need to engage in an honest debate about how we pay for health care in the United States.

For decades, our health care system has relied on a fee-for-service model where services are unbundled and paid for distinctly. This payment approach creates an incentive for providers to require patients to undergo additional tests that may not be necessary, or even incur costly hospital stays when outpatient services are more appropriate because their revenue is dependent on the quantity, rather than the quality, of care. In 2017, a survey of American Medical Association members found that 70.8 percent [2] believe that physicians are more likely to perform unnecessary procedures when they profit from them.

Because of these inherent financial rewards, it's been difficult, if not impossible, for those who benefit from this profit-maximizing FFS model to progress to one based on value and quality. However, payer consolidation through vertical integration provides us with the perfect opportunity to re-engineer the payment model and rethink the unthinkable — a return to a capitated payment model.

Capitation, an idea born in the late 1980s, is a payment arrangement where the insurer pays a set amount for each enrolled person, per enrollment period, regardless of whether that person seeks care. A capitated payment system has four distinct advantages over an FFS payment plan.

— It provides increased incentives to use preventive care.

— It offers a stimulus for health care systems to become more coordinated.

— It has the capacity to decrease bias toward institutional care.

— It promotes continuity and consistency of care by assigning responsibility for care to a designated provider or health system.

One potential problem with capitation is its tendency to encourage under-usage to decrease the economic exposure of the provider or health system. Economists term such behavior as a “moral hazard.” To guard against such bias, policymakers in partnership with patient and provider groups and academicians should champion development of patient-centered quality and outcomes measures to ensure appropriate care is rendered.

With the proper safeguards in place to prevent the tendency toward under-usage, a capitated payment model would ensure that the most cost-beneficial intervention is utilized. For example, if an equally efficacious and safe oral therapy can keep the patient out of the hospital or an infusion clinic, then that therapy would be favored.

If a patient requires a biologic treatment, a biosimilar would be preferred for that patient if it is less expensive and a better value. Vaccinations would be routine, especially for adult patients who are not commonly immunized. Step therapy, prior authorization and other administrative cost-saving tools, as well as potential physician incentives to prescribe the most expensive therapy so that they make more money through buy-and-bill, would no longer exist.

Most importantly, capitation would reduce the need for providers to require patients to come in for an office visit in order to be reimbursed for their services. Providers would be able to institute innovative interventions such as telemedicine to provide patient care.

For the health care system to successfully institute payment reform, it is essential that we ensure that providers and health systems that take on financial risk have complete access to utilization and clinical data from insurers so that they can use analytical tools to manage care. They also need complete autonomy in developing formularies for medicines, devices or tests that best suit their practice, as well as unimpeded access to a network of peers that they may refer care to. Finally, they must have the ability to directly negotiate financial terms as well as value and outcomes-based contracts with manufacturers, diagnostic companies and other health care entities.

We can’t continue to strive for 21st-century cures while we hang on to an outdated payment model. As we innovate new technologies, medicinal treatments and delivery models, a modernized payment method for health care services requires the attention of policymakers.

This opinion piece originally appeared [3] in the June 13 Morning Consult. Reprinted with permission.

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[1] https://www.managedhealthcareexecutive.com/article/pfizer-vp-robert-popovian-talks-value-based-reimbursement
[2] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970#pone.0181970.ref001
[3] https://morningconsult.com/opinions/modern-payment-model-21st-century-cures/