DISCUSSION PAPER

Anchoring Health Financing on Better Outcomes: System Drivers and Opportunities for Reform

Commission on Investment Imperatives for a Healthy Nation

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Executive Summary

Within the US health care system, there is widespread agreement that financial incentives are not designed or aligned for optimal performance. Despite progress over the past decade, primarily through experimentation with value-based payment initiatives, many instances of financial structures that do not support, or even work against, desired outcomes remain. Examples include the following:

- Overreliance on fee-for-service payment, which incentivizes the provision of more—and more expensive—services and penalizes care delivery organizations that keep patients healthy or able to receive care in lower intensity and potentially less costly settings (such as primary care, outpatient, and home environments)
- Disproportionately higher payments for procedural specialties, which fuel shortages of primary care providers
- The absence of an overarching accountability system or entity, which leaves health financing approaches with no clear mechanism for ensuring efficiency, effectiveness, and affordability

To inform future directions, including the work of the Commission on Investment Imperatives for a Healthy Nation, the National Academy of Medicine convened an expert working group to review the landscape of health system financial incentives, identify key drivers of misalignment, and take stock of policy and programmatic levers available to address misalignment. By focusing attention on root causes, fewer actions can achieve more far-reaching results.

The resulting discussion paper describes three core drivers of financial misalignment and 12 levers to address them (highlighted in *Table 1*). The discussion paper does not prescribe a path forward but documents benefits and trade-offs to inform

TABLE 1 | Overview of Financial Misalignment Drivers and Potential Action Levers Discussed in This Discussion Paper

System Misalignment	Potential Action Levers
HEALTH FINANCING. Health financing rewards treatment more than the creation and preservation of health.	1. Align all-payer payment incentives and prospective/global payment approaches across public and private payers to rebalance payments for primary, specialty, and long-term care outcomes. 2. Encourage insurance and risk pooling approaches that support multiyear investments in individual and community health. 3. Expand flexibility in health spending policies to enable support for broader evidence-based services that improve health status and outcomes. 4. Establish mandated all-payer global or total cost of care mechanisms and targets that emphasize effectiveness and efficiency in care patterns and outcomes rather than service volume. 5. Accelerate rollout and testing of innovative payment and incentive models that reward prevention, early intervention, and community-based approaches to health improvement.
COORDINATION/ CONTINUITY. Activities focused on improving health status and care outcomes are fragmented and poorly supported.	6. Create an effective linked national/regional capacity for monitoring and improving health system performance, outcomes, and affordability. 7. Establish strong mechanisms to ensure collaborative multi-agency health-promoting action plans and activities across health, public health, social, educational, environmental, and economic agencies. 8. Expand financing approaches to include a public option for ensuring access to essential health services and continuity of coverage. 9. Explore approaches to eliminating coverage disruptions and barriers to long-term investments in health and prevention that can accompany employer-sponsored insurance.
COMPLEXITY. Fragmented governance and financing policies create unnecessary complexity and inefficiency.	10. Improve alignment among public financing programs to harmonize, simplify, and strengthen accessibility, administration, and accountability. 11. Promote payment consistency across care settings when services and outcomes are comparable. 12. Streamline financing authorities, regulations, and oversight structures to reduce complexity and improve transparency.

SOURCE: Created by the authors.

a more strategic approach. The levers outlined are not mutually exclusive and could be combined for comprehensive health financing reform.

Aligning health financing approaches to drive individual and community health will ultimately depend on the will of public and private stakeholders to activate the levers within their reach. Although many of the levers outlined in this discussion paper are held by government, this emphasis reflects the current distribution of influence, not an intention among working group members to focus on government control. To the contrary, the greatest progress will come when both government and private industry recognize their interests in a shared vision for health system performance and act in concert. Through more coordinated and intentional action, policy makers and health care leaders can transform financial incentives into a powerful driver of health care performance and population health.

Introduction

If, as it often seems, "money talks" in the US health care system, that talk is a cacophony of competing perspectives. Patients report difficulty affording care and often lack clear information about which services are truly necessary, contributing to decisions to skip or delay care altogether (Colla, 2014; Rakshit, Cotter, et al., 2026; Rakshit et al., 2025). Employers report that rising premiums constrain employee wage growth, and insurers cite provider market leverage as a driver of high premium prices (Minemeyer, 2024; Hager et al., 2024; Purchaser Business Group on Health, 2026). Hospitals, in turn, describe financial pressures associated with supply, labor, and pharmaceutical costs that have outpaced growth in hospital prices, as well as substantial administrative expenses related to insurer claim denials and prior authorization requirements (American Hospital Association, 2026). Meanwhile, national health care spending continues to rise, despite lagging indicators of population health (Buntin et al., 2025; Gaydosh, 2023; NASEM, 2021a; Rakshit et al., 2025; Rakshit, Winger, et al., 2026).

The lack of agreement about what (and who) is driving suboptimal system performance makes it difficult to take meaningful, coordinated action toward financing reform. While many agree that wasteful spending (i.e., the billions of dollars directed each year to services that deliver little or no health improvement) and excess profit taking drive up costs, they debate where and how to curtail expenditures (Shrank et al., 2019). At the same time, experts cite a need to increase national spending in historically underfunded areas like social and behavioral factors influencing health (IOM, 2000). Furthermore, Americans displeased with the cost of health care are sharply divided on the role of government in driving solutions (The Commonwealth Fund et al., 2019). This dissonance, emblematic of a highly complex system in which there are no clear heroes or villains, drives dissatisfaction on all fronts, with the main point of consensus being that the health financing system is broken.

Although decades of debate have advanced the conversation on health care payment reform, powerful and flawed financial incentives remain. Rather than examine the hundreds of instances of misalignment in isolation, this discussion paper takes a system-level view, identifying root causes and legal, regulatory, and other tools available to address them. This discussion paper does not prescribe a path forward but documents options (each possessing risks, benefits, and trade-offs) to inform a more strategic approach in which a smaller number of actions may produce far-reaching results.

A Vision for the Health Care System Americans Deserve

Federal health agencies and policy leaders have long articulated goals for improving the performance of the US health care system. The US Department of Health and Human Services (HHS) has consistently emphasized improving the health and well-being of Americans, while the Centers for Medicare & Medicaid Services (CMS) has prioritized high-quality, accessible, and fiscally responsible care, with varying emphasis on issues such as equity, innovation, and outcomes (HHS, 2026; CMS, 2026). Despite differences in framing across administrations, themes of quality, access, affordability, accountability, and population health have remained central to the national health policy discourse.

These priorities align closely with the well-known "Triple Aim" framework—improving the patient experience of care, improving population health, and reducing per capita cost—that has guided delivery system redesign and payment reform efforts for more than a decade (Berwick et al., 2008). The Triple Aim clarifies what the health system should achieve; however, it does not fully characterize the shared values, norms, and reciprocal responsibilities needed to sustain progress toward those outcomes. The National Academy of Medicine's Learning Health System Shared Commitments provide that broader foundation (Madara et al., 2025). Developed through years of

multi-stakeholder engagement and collaboration, the Shared Commitments articulate both performance expectations (such as safety, effectiveness, and efficiency) and the principles necessary to achieve them, including transparency, accountability, and continuous learning. Taken together, the Shared Commitments establish a coherent vision for the health system Americans deserve—one that is enabling, efficient, accessible, and affordable to all. *Table 2* summarizes this work, highlighting what the system should strive to deliver and what people should be able to expect.

Making the health care system work better for the people it serves requires both structural and process financing reform. Structural reform would include more appropriately resourcing public health and social systems to prevent illness from occurring. In federal and state policy environments that emphasize budget neutrality, this may require a reduction in money allocated to illness and injury

TABLE 2 | Shared Commitments for Health and Health Care: A Trust Framework from the Learning Health System

	What the System Should Deliver	What People Should Expect
Engaged	Give primacy to understanding and acting on people's goals.	Care that reflects their values, preferences, and goals.
Safe	Use validated safeguards to prevent harm.	People are helped, not harmed, by the care they receive.
Effective	Apply continuously updated evidence to target goal achievement.	Care is proven, reliable, and focused on achieving the best possible outcomes.
Efficient	Deliver optimal outcomes for resources available.	Care delivers the best possible outcomes without waste or unnecessary cost.
Fair	Advance parity in people's opportunities to reach their full health potential.	Everyone has a chance to achieve their possible best health, no matter who they are or where they live.
Accessible	Offer timely, convenient, interoperable, and affordable services.	Everyone can get the care they need, when and where they need it.
Accountable	Measure what matters, with clear responsibilities and feedback.	Health system organizations are held responsible for providing care that is of high quality, affordable, and accessible.
Transparent	Openly share activities, decision making processes, and results.	Everyone has access to the information they need to make informed decisions that affect their health.
Secure	Use protected data sharing and digital/AI tools responsibly to speed progress.	Personal health information is safeguarded and protected from misuse.
Adaptive	Center continuous learning and improvement in organizational priorities.	The health system improves in response to new information about how to increase access, lower costs, and improve quality.

SOURCE: McGinnis, J. M., H. V. Fineberg, and V. J. Dzau. 2024. Shared commitments for health and health care: A trust framework from the learning health system. *NAM Perspectives*. Commentary, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/202412c.

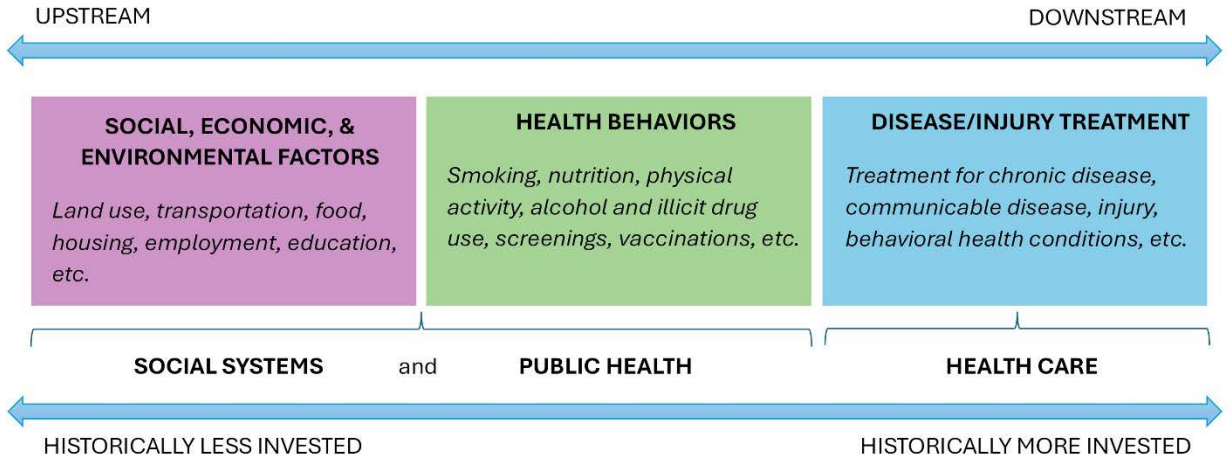

FIGURE 1 | Components of a Comprehensive System for Health
SOURCE: Created by the authors.

treatment, which has been the primary focus of health financing in the United States to date (see *Figure 1*). Process reform would involve aligning health care financial incentives and accountability mechanisms with the performance expectations outlined in *Table 2*. In combination with investments in illness prevention, the result would be a health care system that delivers high-quality care when it is needed while reducing unnecessary or harmful services and preventing avoidable illness.

The US Health Care System Today

The current US health care system falls short of delivering the level of performance people expect and should be able to rely on. At the core of this gap are laws, regulations, and market incentives that often reward service volume, drive fragmentation, or prioritize short-term gains rather than sustained health and well-being. In some cases, these forces not only fail to encourage better outcomes but actively work against them. The sections that follow illustrate how these structural misalignments show up in practice and where opportunities for course correction exist.

Engaged: Insufficient engagement of individuals and families in shaping policies, designing programs, and defining measures of health system performance has contributed to a disconnect between health financing approaches and people's actual needs. One clear example is that accountability mechanisms for health outcomes remain largely focused on individuals already interacting with the health care system, while overlooking those facing social, economic, and/or environmental conditions that create barriers to access or increase need. As a result, those with the greatest health needs are often least visible within performance measurement and payment systems.

Safe: Despite best intentions and numerous government- and private-sponsored quality improvement efforts, health care organizations regularly cause preventable medical harm to the patients they serve (Bates and Singh, 2018; Bates et al., 2023; Makary and Daniel, 2016; IOM, 2000; HHS-OIG, 2025). While certain medical errors and poor performance on quality measures trigger financial penalties, including nonpayment, financial accountability mechanisms vary greatly in their effectiveness and reach (Brewer et al., 2024; Waters et al., 2022). Some financial penalties for hospital-acquired conditions are too small to be consequential, multiple measures compete for attention, and application of penalties has not been shown to correlate with quality (Lawton et al., 2020; Salmasian et al., 2025; Vsevolozhskaya et al., 2021).

Effective: The prevailing fee-for-service (FFS) payment model compounds quality issues by incentivizing care delivery organizations to provide

more (and more expensive) services, which can lead to overuse/misuse of care and, in some cases, expose patients to avoidable harm. At the same time, it penalizes care delivery organizations that keep patients healthy or deliver only the minimum amount of effective care needed. Numerous value-based payment experiments have aimed to correct these misaligned incentives, but none have successfully uprooted FFS as the dominant form of health care payment in the United States. Some of the more ambitious models, such as the Program of All-Inclusive Care for the Elderly (PACE), have attempted to extend incentive alignment beyond traditional medical care providers to include community-based organizations that address the social and supportive needs that shape health outcomes, though this has yet to become the norm (CMS, 2016).

Efficient: The United States spends more on health care than any of its peer nations, yet this high level of investment does not consistently translate into better outcomes, in part because financial incentives often reward volume and intensity of services rather than their effectiveness (Blumenthal et al., 2024). Although there are clear examples of high-quality care, the system continues to struggle with overuse, underuse, and misuse of services, delivering care that is unnecessary or potentially harmful, failing to provide beneficial care, or providing appropriate care in ways that lead to avoidable complications (IOM, 2001). Although the precise scope of these issues is difficult to quantify, estimates suggest that hundreds of billions of dollars are spent each year on low-value care, poorly coordinated care, and care that does not adhere to clinical best practices (Shrank et al., 2019). These patterns point to a disconnect between spending and the performance achieved, underscoring a fundamental lack of efficiency in how health care resources are used.

Fair: Health system financial incentives can worsen inequities by rewarding care for populations with stable insurance and higher reimbursement, while failing to account for the additional time, services, and coordination required to care for patients facing food insecurity, housing instability, or other environmental stressors. For example, Medicaid programs, which cover people with low incomes, reimburse providers at lower rates than Medicare and commercial insurance, creating an incentive for providers to limit Medicaid patients or avoid service lines (e.g., psychiatric care) and locations where these patients are concentrated, raising barriers to access for a segment of the population that is more likely to have unmet health needs (Mann and Striar, 2022; Holgash and Heberlein, 2019).

Additionally, value-based payment programs that tie financial rewards to desired performance often neglect to include measures directly linked to disparity reduction, or reward improvement toward overall averages or benchmarks, which may advantage providers serving lower-risk populations and mask or widen gaps if gains are concentrated among patients who are already better off (Chisolm et al., 2023; Colla et al., 2020; Jacobs et al., 2023). Together, these dynamics contribute to a system in which access, care experiences, and outcomes vary significantly across socioeconomic and racial and ethnic groups (Mahajan et al., 2021; Ndugga et al., 2025; Nong et al., 2020).

Accessible: Lower reimbursement rates in public insurance programs create financial incentives that limit access to care for the populations they serve. Medicaid and Medicare pay care delivery organizations less than commercial insurers, encouraging providers to locate their facilities in communities with a higher share of people who are privately insured (Mann and Striar, 2022). As a result, people in low-income rural and urban areas, who are more likely to rely on government coverage programs, face greater barriers to care. In 2024, Medicaid physician reimbursement rates were about 71 percent of Medicare rates, particularly disadvantaging people who depend on the program, including nearly half of all American children (Skopec et al., 2025).

Payment incentives also shape what types of care are more readily available, often to the detriment of primary care. For example, the Medicare Physician Fee Schedule pays more for procedures

than office-based evaluation and management services, making primary care less financially attractive for providers. This has contributed to a primary care workforce shortage, as providers-in-training are drawn toward higher paying adult and procedure-based specialties (Frisch, 2013; West and Dupras, 2012). These patterns are reinforced by a graduate medical education system concentrated in hospital-based, urban settings, with limited training in community, rural, and primary care environments despite evidence that clinicians often practice where they train (NASEM, 2021b; Krist et al., 2025).

Accountable: There is currently no authority charged with tracking and ensuring access, affordability, and other key metrics of performance for the US health care system and the organizations operating within it. As a result, "the buck stops nowhere," with the exception of in a few states (such as Maryland, Massachusetts, Vermont, and Connecticut) that have created their own systems of accountability (Berwick et al., 2025; Commonwealth of Massachusetts, 2025; State of Connecticut, 2025; State of Vermont, 2025; State of Maryland HSCRC, 2025).

It is also well understood that the prevailing FFS payment system bestows no accountability for improving health. Alternative payment models (APMs) that aim to prioritize value increase accountability but largely link financial rewards and penalties to process indicators of care quality, as opposed to better outcomes for people or populations, for which measurable improvement can take years to accrue. *Figure 2* provides examples of how current incentives physically and financially harm Americans throughout their lives, underscoring

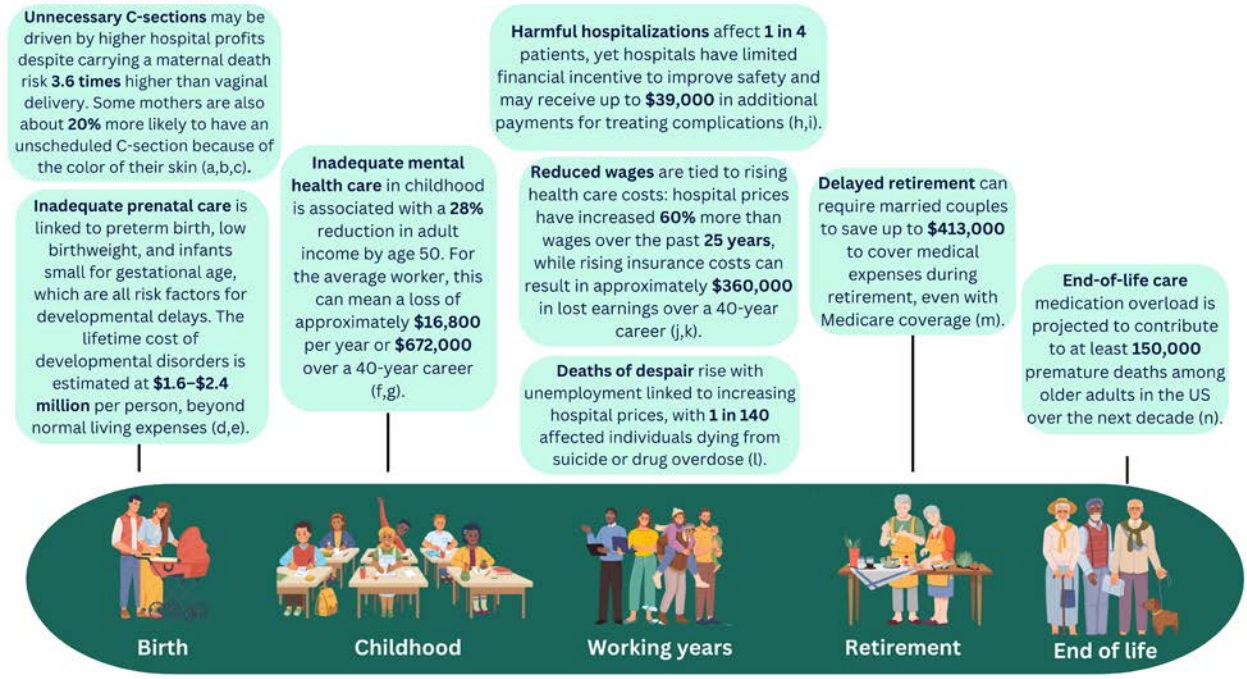

FIGURE 2 | From Birth to Death, How Health Care Financial Incentives Shape People's Lives

SOURCE: Created by the authors.

NOTES: [a] Sakai-Bizmark et al., 2021. [b] Deneux-Tharaux et al., 2006. [c] Corredor-Waldron et al., 2024. [d] My Team ABA, 2025. [e] Cerebral Palsy Guide, 2025. [f] Goodman et al., 2011. [g] Wang et al., 2022. [h] Bates et al., 2023. [i] Eappen et al., 2013. [j] Hager et al., 2024. [k] Families USA and West Health, 2022. [l] Brot-Goldberg et al., 2024. [m] Spiegel and Fronstin, 2024. [n] Garber and Brownlee, 2019.

the urgent need for clearer lines of accountability to ensure that the system delivers on its promise to protect and promote health.

Transparent: Lack of meaningful price and quality transparency in health care has produced a profound level of hidden information that would alert consumers, large purchasers, and policy makers to underperformance and excessive prices. This provides cover for price gouging, price increases from consolidation, and other profit-seeking behaviors to go unnoticed and unchallenged. It is most directly harmful when patients lack information on cost and quality at the point of care. Although the 2021 Health Care PRICE Transparency Act caused the release of an enormous amount of hospital and insurer price data available to the public, making use of the data has been a challenge, undermining the law's intended effect (GAO, 2024; CMS, 2025d).

Secure: As health information is exchanged across fragmented systems to meet administrative and reimbursement requirements, the risk of breaches and unauthorized access increases. Lack of financial incentives to support development and deployment of seamlessly interoperable and secure systems across health care organizations leaves sensitive health data underprotected and vulnerable to misuse.

Adaptive: The health care system's financial structure discourages adaptiveness by rewarding established practices and penalizing responsiveness to new information. FFS payment models, rigid regulatory frameworks, and siloed funding streams limit organizations' ability to test, adapt, and scale approaches that could improve access, lower costs, or enhance quality. Additionally, because most payment is tied to volume and short-term returns, rather than learning and improvement, organizations face financial risk when adjusting care in response to emerging evidence or changing patient needs. As a result, the system is constrained in its ability to evolve as new information becomes available.

Drivers of System Misalignment and Available Levers for Change

Misaligned financial incentives in the US health care system are the logical outcome of public policy, private industry, and cultural choices that dictate how the system is designed and administered. Remedying this misalignment requires a reevaluation of those choices and a willingness to question narratives, shift priorities, and challenge institutional arrangements that have produced the system that is currently in place. The following section outlines three root causes of financial misalignment and presents legal, regulatory, and other options available to address them. *Table 3* provides a summary of these options, including information on implementation time frames and the expectations for health system performance each option might reasonably advance.

System Misalignment: Health Financing Rewards Treatment More than the Creation and Preservation of Health

Achieving lasting improvements in population health will require a shift in health financing—from reacting to illness toward investing in wellness and prevention. Although there has been some progress toward directing health care spending "upstream" (see *Appendix A*), these efforts have not been sufficient to meaningfully rebalance the weight of financial incentives. Persistent structural and political forces reinforcing the status quo include the following:

- Intense lobbying against resource reallocation by stakeholders that profit under the current payment system
- Extended and often uncertain timelines for a measurable financial return on investment in prevention, which may not coincide with typical budgeting horizons
- The "wrong pocket problem," where one stakeholder makes an investment but a different stakeholder reaps the benefits (due to the

TABLE 3 | Overview of System Misalignment Drivers and Potential Action Levers

System Misalignment	Potential Action Levers	Implementation Time Frame	Expectations for Health System Performance Potentially Advanced
HEALTH FINANCING. Health financing rewards treatment more than the creation and preservation of health.	1. Align all-payer payment incentives and prospective/global payment approaches across public and private payers to rebalance payments for primary, specialty, and long-term care outcomes.	Short *(<5 years)*	Effective, equitable, efficient, accessible
	2. Encourage insurance and risk pooling approaches that support multiyear investments in individual and community health.	Short *(<5 years)*	Equitable, efficient, adaptive
	3. Expand flexibility in health spending policies to enable support for broader evidence-based services that improve health status and outcomes.	Short *(<5 years)*	Efficient, accountable, transparent
	4. Establish mandated all-payer global or total cost of care mechanisms and targets that emphasize effectiveness and efficiency in care patterns and outcomes rather than service volume.	Long *(>5 years)*	Equitable, efficient, accountable, adaptive
	5. Accelerate rollout and testing of innovative payment and incentive models that reward prevention, early intervention, and community-based approaches to health improvement.	Long *(>5 years)*	Engaged, effective, equitable, adaptive
COORDINATION/ CONTINUITY. Activities focused on improving health status and care outcomes are fragmented and poorly supported.	6. Create an effective linked national/ regional capacity for monitoring and improving health system performance, outcomes, and affordability.	Short *(<5 years)*	Accountable, transparent, adaptive
	7. Establish strong mechanisms to ensure collaborative multi-agency health-promoting action plans and activities across health, public health, social, educational, environmental, and economic agencies.	Long *(>5 years)*	Engaged, effective, equitable, adaptive

TABLE 3 | Overview of Financial Misalignment Drivers and Corresponding Alignment Levers *Continued*

System Misalignment	Potential Action Levers	Implementation Time Frame	Expectations for Health System Performance Potentially Advanced
COORDINATION/ CONTINUITY. Activities focused on improving health status and care outcomes are fragmented and poorly supported.	8. Expand financing approaches to include a public option for ensuring access to essential health services and continuity of coverage.	Long *(>5 years)*	Equitable, efficient, accessible, accountable
	9. Explore approaches to eliminating coverage disruptions and barriers to long-term investments in health and prevention that can accompany employer-sponsored insurance.	Long *(>5 years)*	Equitable, efficient
COMPLEXITY. Fragmented governance and financing policies create unnecessary complexity and inefficiency.	10. Improve alignment among public financing programs to harmonize, simplify, and strengthen accessibility, administration, and accountability.	Short *(<5 years)*	Efficient, accountable, transparent
	11. Promote payment consistency across care settings when services and outcomes are comparable.	Short *(<5 years)*	Efficient, accountable
	12. Streamline financing authorities, regulations, and oversight structures to reduce complexity and improve transparency.	Short *(<5 years)*	Efficient, accountable, transparent

SOURCE: Created by the authors.

time it takes for benefits to accrue or become distributed across system or community actors)
- A psychological tendency for individuals, including policy makers, to prioritize near-term over long-term threats, leading to prioritization of highly visible disease/injury treatment over prevention (Leider, 2021)
- A cultural emphasis on individualism and self-reliance that discourages large-scale investments in population health
- A tacit acceptance of poorer health outcomes for low-income families, rural communities, and people of color

The following section presents options to shift incentives so that wellness and prevention become more financially supported goals of the US health care system and an easier path for organizations to pursue (see *Table 4*).

LEVER: *Align all-payer payment incentives and prospective/global payment approaches across public and private payers to rebalance payments for primary, specialty, and long-term care outcomes*

Primary care plays a foundational role in illness prevention and health promotion by enabling early

TABLE 4 | Potential Action Levers to Increase System Focus on Health Creation and Preservation

Potential Action Levers	Implementation Time Frame
Align all-payer payment incentives and prospective/global payment approaches across public and private payers to rebalance.	Short *(within 5 years)*
Encourage insurance and risk pooling approaches that support multiyear investments in individual and community health.	Short *(within 5 years)*
Expand flexibility in health spending policies to enable support for broader evidence-based services that improve health status and outcomes.	Short *(within 5 years)*
Establish mandated all-payer global or total cost of care mechanisms and targets that emphasize effectiveness and efficiency in care patterns and outcomes rather than service volume.	Long *(more than 5 years)*
Accelerate rollout and testing of innovative payment and incentive models that reward prevention, early intervention, and community-based approaches to health improvement.	Long *(more than 5 years)*

SOURCE: Created by the authors.

detection, timely intervention, and management of risk factors before they progress into more serious or costly health conditions. In the United States, there has been a historical lack of investment in primary care, with significantly higher reimbursement rates for specialty care rooted in the prevailing FFS model (AHRQ, 2024; NASEM, 2026). By rewarding service volume and procedural intensity, the system skews financial incentives toward high-cost interventions and away from prevention, chronic disease management, and care coordination. As a result, primary care remains underfunded, contributing to primary care provider shortages and a declining pipeline of medical graduates pursuing the field (Yang et al., 2019).

One way to address this problem is to amend the Medicare Physician Fee Schedule, which sets payments for professional services in Medicare and is also often used as a baseline to set pricing in Medicaid and commercial plans. However, statutory restraints pose a barrier to increasing the valuation of primary care services. First, adjustments to the schedule must be budget neutral (i.e., any increase to the value of one service must be offset elsewhere), sparking immediate opposition from groups whose reimbursement potential is adversely affected. Second, the CMS is prohibited by statute from differentiating payments for the same service based on the specialty of the billing clinician. As a result, when values for office-based visit codes were increased in 2021, the primary-specialty pay gap decreased only modestly, since many specialists also use those codes (Neprash et al., 2023). The 2025 Medicare Physician Fee Schedule's introduction of Advanced Primary Care Management codes that allow practices to bill a monthly payment for advanced care capacities such as population-level management is an important step, but additional action is required (CMS Newsroom, 2024a).

Historically, Medicare Physician Fee Schedule decisions have been heavily shaped by the American Medical Association's Relative Value Scale Update Committee (RUC), an expert panel

TABLE 5 | Scope of Services and Activities for CMS's Valuation of High-Quality Primary Care

Visit-Based Activities
Whole health assessments
Social care intervention
Health coaching and education
Pharmacist care
Nutrition care
Behavioral health services (e.g., counseling, cognitive behavioral therapy)

Non-Visit-Based Activities
After- or between-visit work and care coordination, including the completion and amendment of care planning
Care management
Patient navigation
Data analytics to support population-based interventions
Outreach and engagement interventions
Specialty care referral management
Documentation time
Inbox and results management
Asynchronous phone and electronic communication for both chronic disease management and acute care
Remote monitoring
Prior authorization management
Formulary coordination
Long-term support services, including home-based and community service management

SOURCE: NASEM. 2025. *Improving primary care valuation processes to inform the Physician Fee Schedule*. Washington, DC: The National Academies Press. https://doi.org/10.17226/29069.

of clinicians that provides recommendations on the value of physicians' work based on the time and resource intensity of the services they provide (Laugesen et al., 2012). The RUC has been criticized for conflicts of interest, overrepresentation of specialty care physicians, and the factors that guide its recommendations, calling into question its status as a trusted adviser (Berenson and Emanuel, 2023; NASEM, 2021b; Laugesen, 2016). The CMS's historical reliance on the RUC is due, in part, to the absence of robust alternative mechanisms for collecting valuation data. However, expert working groups examining this topic have identified no regulatory or institutional barrier preventing the agency from supplementing the RUC's input with recommendations from alternative advisory bodies that account for broader measures of clinical value. That has resulted in suggestions that the CMS establish its own advisory group (NASEM, 2021b, 2025; Pay PCPs Act of 2024). The National Academies consensus study released in 2025, *Improving Primary Care Valuation Processes*

to Inform the Physician Fee Schedule, provided a guide to establishing a more comprehensive valuation process by identifying services and activities central to accurate valuation of high-quality primary care (see *Table 5*) (NASEM, 2025).

In the 2026 Physician Fee Schedule, the CMS announced its intention to preferentially consider empiric data, rather than potentially biased and low-response rate survey data from the RUC. The agency also said it will implement an "efficiency adjustment" to better account for the efficiencies garnered in procedures, diagnostic tests, and radiology studies. This would increase the valuation of time-based office visits, care management activities, and behavioral health services due to budget neutrality requirements (CMS Newsroom, 2025b). These are important steps forward in moving away from decades of RUC-recommended values that have created system-wide distortions.

LEVER: *Encourage insurance and risk pooling approaches that support multiyear investments in individual and community health*

A persistent challenge in health care financing is a disconnect between who pays for an intervention and who financially benefits from success. This "wrong pocket problem" is particularly relevant for investments in illness prevention, since the benefits in the form of future costs avoided can take years to accrue. Lack of a guaranteed return on investment fuels organizational hesitance to invest in prevention. This is a particular problem in pediatrics where coverage plans typically change over time, and savings are seen in sectors outside of health care (e.g., education, workforce, juvenile justice) (NASEM, 2024a). Options to help address this problem include multiyear insurance plans that reduce coverage churn and expand the time horizon for insurers to recoup savings from their investments in prevention, risk pooling strategies that distribute both up-front costs and downstream benefits more equitably across payers, and social and financial innovation with shared savings contracts negotiated with downstream beneficiary organizations.

Multiyear Insurance Plans

Today's predominantly one-year health insurance contracts give commercial insurers little financial incentive to invest in services like chronic disease prevention, behavioral health integration, or social support, since a financial return on investment is unlikely to materialize within a single plan year. In this instance of the "wrong pocket" problem, one insurer pays for a preventive intervention, and a different insurer may reap the cost savings if the covered individual switches insurance carriers (Fang et al., 2022). Extending the coverage horizon through multiyear plans would better enable insurers to realize longer-term cost savings from keeping people healthier by reducing enrollment "churn," aligning payer incentives with population health goals. Particular attention would need to be given to incentivize healthy beneficiaries to enroll in multiyear plans and allow flexibility for people to switch plans when moving to new locations.

Advancing this model would require several changes to existing regulatory frameworks. At the federal level, revisions to the Affordable Care Act's guaranteed issue and annual open enrollment requirements may be necessary to give insurers greater flexibility to offer multiyear policies without violating coverage standards or affordability protections. Guidance from the CMS and the Department of Labor would also need to clarify how multiyear arrangements can be structured for employer-sponsored plans and Medicaid managed care plans. At the state level, insurance commissioners and departments of insurance would need to revise regulations defining standard policy durations and limit the use of long-term contracts in the individual and small group markets. States may also need to address rules governing rate review, actuarial value, and renewal terms, which are currently designed for annual plans. Together, these reforms would enable insurers to

design benefit packages and pricing structures that support more proactive investment in health.

Beyond shifting financial incentives, multiyear insurance plans may appeal to consumers. Given the public's general frustration with complex processes like annual open enrollment, a longer-term coverage option could be perceived as simpler and more convenient. Employers could likewise experience benefits from greater coverage continuity, such as reduced administrative burden associated with annual plan selection and contract negotiations with insurers. Greater predictability in benefit design and premiums could also facilitate longer-term workforce planning and budgeting. However, employers may be reluctant to commit to multiyear contracts that limit their flexibility to modify cost-sharing structures, adjust benefit offerings, or switch plan providers in response to changing workforce needs, competitive labor markets, or cost pressures.

Commercial insurers could also benefit from reduced administrative burden, as longer policy durations would lower the frequency of renewal processing, marketing, and underwriting efforts. Conversely, insurers may be wary of no longer being able to adjust premiums annually in response to medical cost inflation or emerging risk trends. Locking in rates over several years could expose payers to financial losses if costs rise faster than anticipated, especially in volatile or high-cost markets.

Risk Pooling Strategies

Risk pooling strategies, implemented in concert with multiyear insurance plans, could further reduce insurer hesitance to invest in population health by allowing insurers to share both the financial burden of early interventions and the eventual benefits of avoided costs. Risk pools could take multiple forms, including the following:

- A reinsurance program in which insurers pay into a shared pool, and claims for high-cost preventive services that offer uncertain or delayed return on investment would be partially reimbursed
- Market-level risk-sharing agreements under which payers could jointly fund interventions for high-risk populations (e.g., maternal health supports to reduce future neonatal intensive care unit stays)
- Wellness or innovation pools (modeled on Massachusetts's Prevention and Wellness Trust or the Collaborative Approach to Public Good Investments) that combine dollars from insurers and other sources to finance state- or community-level disease prevention and health promotion efforts, then track and distribute shared savings (Institute on Urban Health Research and Practice, 2020; Urban Institute, 2025)

LEVER: *Expand flexibility in health spending policies to enable support for broader evidence-based services that improve health status and outcomes*

Medical Loss Ratio (MLR) requirements exist to ensure that commercial insurers use a majority share (80 or 85 cents) of every dollar collected from their customers' monthly insurance premiums to pay medical claims or quality improvement activities (CMS, 2012). Reimagining this framework as a Health Loss Ratio (HLR)—through amendment of Section 2718(b) of the Public Health Service Act, Section 1001 of the Affordable Care Act, and separate requirements established by some states—would expand the definition of allowable spending to include evidence-based investments that enhance overall health, not just medical care (NASEM, 2024b). Under this approach, insurers would retain accountability for a certain level of health-directed spending, while gaining the flexibility to fund interventions targeting upstream drivers of health. To ensure alignment with local needs and reinforce community infrastructure, guidance on HLR implementation could include requirements for health plans to seek to engage

with community-based social service providers when deciding where and how to distribute nonclinical health investments in a local market area.

HLR requirements could be accompanied by provisions that enforce transparent, standardized reporting to reveal precisely how plan enrollees' premiums are being used (e.g., payment for medical claims, quality improvement activities, nonclinical health investments, and administrative expenses). For vertically integrated payers, special attention could be paid to dollars flowing to the care delivery organizations owned to eliminate opportunities for gaming, for example, by directing profit that would exceed MLR/HLR thresholds to owned provider organizations, which may then be returned to the parent organization in an untraceable form (Frank and Milhaupt, 2023).

LEVER: *Establish mandated all-payer global or total cost of care mechanisms and targets that emphasize effectiveness and efficiency in care patterns and outcomes rather than service volume*

A key drawback of FFS payment is that it financially penalizes care delivery organizations for keeping people healthy or using the least number of services to achieve the optimal outcome. Fewer illnesses translate to fewer billable services for care delivery organizations, directly reducing operating revenue. As a result, financing structures remain oriented toward treating illness rather than preventing it. Global payments (a.k.a., global budgets) seek to address this misalignment by offering care delivery organizations a fixed, prospective payment that covers all care for a defined population over a set time period, regardless of how many services are delivered. Organizations that deliver cost-effective care or prevent illness can keep the savings but are also responsible for covering the excess if patient care ultimately costs more than the global payment allotted.

Global budgets can also be deployed as a core feature of statewide total cost of care (TCOC) initiatives, in which states establish targets to limit overall health care spending growth and align multiple payers around shared financial and delivery system goals. Spending growth targets may also include aims to increase investment in primary care to redirect resources "upstream" and support sustained improvements in population health. Maryland, Rhode Island, California, Oregon, Massachusetts, and Washington are among the states that have experimented with this approach (Foubister, 2025; Brown et al., 2025).

The best evidence on the effects of combining global budgets with statewide spending benchmarks and primary care investment targets stems from Maryland, which pioneered all-payer global budgets and later integrated them into a TCOC approach. An evaluation of the model found that Maryland's TCOC initiative substantially reduced hospital spending; increased spending in outpatient, physician, and other nonhospital settings; improved quality measures related to potentially preventable use and care management; and demonstrated meaningful potential to advance equity. The evaluation concluded that state-level accountability plus provider-level incentives (especially for hospitals and primary care) were central to observed changes in use, spending, and quality (Peterson et al., 2024).

The use of all-payer global budgets by other states has been constrained by a key regulatory barrier: Maryland possesses a long-standing Medicare waiver, codified in Section 1814(b) of the Social Security Act, that exempts the state from the Inpatient and Outpatient Prospective Payment Systems and allows it to set hospital rates across payers (State of Maryland HSCRC, 2025). This authority ensures that Medicaid and commercial payers reimburse hospitals at the same rate for the same service—an essential feature of Maryland's model that is not broadly available to other states. Although other states, including Pennsylvania and Delaware, have experimented with global budgeting in more limited ways, broader adoption would

likely require addressing this regulatory constraint (CMS, 2025i; Nemours Children's Health, 2025). Should this barrier be addressed, lessons from Maryland's experience could guide other states in developing effective global budgeting approaches. Examples include the following:

- The limitations of applying global budgets solely to hospitals, which can encourage the shifting of medically complex patients to other sites of care (Sharfstein et al., 2017)
- Challenges that can arise from basing global budgets on historical spending for a given population, which may neglect to account for unmet need and historical divestments that have fueled health inequity
- A tendency for organizations paid through global budgets to favor investments that offer short-term cost savings (secondary prevention) as opposed to longer-horizon, preventive initiatives (primary prevention) that might change the trajectory of a person's health (Cheng, 2023)
- The benefits of pairing global budgets with standardized rates paid by all payers operating in a service area or region (Avalere Health, 2022)
- The political and practical importance of structuring rate-setting bodies (e.g., the Maryland Health Services Cost Review Commission) to balance firsthand care delivery experience with safeguards against regulatory capture, ensuring that expertise informs decision making without reinforcing the status quo or diluting reform efforts

LEVER: *Accelerate rollout and testing of innovative payment and incentive models that reward prevention, early intervention, and community-based approaches to health improvement*

The Advanced Research Projects Agency for Health (ARPA-H) is a federal agency charged with accelerating breakthroughs that transform Americans' health. Inspired by the Defense Advanced Research Projects Agency (DARPA), ARPA-H embraces a high-risk, high-reward research model in which program managers are empowered to pursue bold, time-limited initiatives aimed at solving complex challenges (ARPA-H, 2025b). The agency's design avoids slow-moving, traditional, and/or bureaucratic processes in favor of a nimble, performance-based approach (ARPA-H, 2025a). Structures such as the Project Accelerator Transition Innovation Office and Health Innovation Network foster collaboration and partnerships with private industry organizations and investors to ensure that transformative innovations shepherded by ARPA-H are financially sustained after the agency's role is complete (ARPA-H, 2025a; Gravitz and Patterson, 2024).

TABLE 6 | Potential Action Levers to Remedy System Fragmentation

Potential Action Levers	Implementation Time Frame
Create an effective linked national/regional capacity for monitoring and improving health system performance, outcomes, and affordability.	Short *(within 5 years)*
Establish strong mechanisms to ensure collaborative multi-agency health-promoting action plans and activities across health, public health, social, educational, environmental, and economic agencies.	Long *(more than 5 years)*
Expand financing approaches to include a public option for ensuring access to essential health services and continuity of coverage.	Long *(more than 5 years)*
Explore approaches to eliminating coverage disruptions and barriers to long-term investments in health and prevention that can accompany employer-sponsored insurance.	Long *(more than 5 years)*

SOURCE: Created by the authors.

FIGURE 3 | Vital Conditions for Health and Well-Being

SOURCE: The Rippel Foundation. 2022. *Federal Plan for Equitable Long-Term Recovery and Resilience for Social, Behavioral, and Community Health*. Available at: https://rippel.org/wp-content/uploads/2025/02/Federal-Plan-for-Equitable-Long-Term-Recovery-and-Resilience-ELTRR-Full-Plan.pdf (accessed May 26, 2026).

One of the agency's areas of focus is "reducing the likelihood that people become patients" through innovations that detect and neutralize myriad (viral, bacterial, chemical, physical, and psychological) threats to Americans' health (ARPA-H, 2025d). ARPA-H launched the Health Care Rewards to Achieve Improved Outcomes (HEROES) program to trial and validate a novel approach to incentivizing preventive care. The program provides direct payments to individual "health accelerators" that design and implement campaigns that successfully reduce adverse health events. Harms of focus include heart disease, alcohol-related incidents, opioid overdoses, and severe complications during pregnancy or birth. The program will work with commercial insurers, employers, and others suited to "purchase" outcomes in the geographic areas their organizations serve (ARPA-H, 2025c).

The HEROES program is an example of ARPA-H's potential to drive a portion of health system dollars upstream by designing and testing novel incentives that spur innovation in service of illness prevention, health promotion, and population-level health improvements. By assuming the financial risk of seeding new approaches, offering a platform for rapid-cycle experimentation, and prioritizing partnerships with private sector organizations, the agency is uniquely positioned to pilot novel incentives in a way that would be attractive to health care payers and care delivery organizations alike. ARPA-H's status as a federal agency also provides advantages, such as the ability to flag and work with peer agencies to address regulatory hurdles that would make it difficult to put validated strategies into action.

System Misalignment: Activities Focused on Improving Health Status and Care Outcomes are Fragmented and Poorly Supported

The US health system is often referred to as an "accidental system," because it evolved in a piecemeal fashion reliant on prepaid health care, employer-sponsored/commercial insurance, and a patchy government safety net, none of which guarantee that all of the nation's residents receive coverage for care. The result is a health care payment "system" composed of many different payment systems functioning largely independently of one another.

The accumulation of uncoordinated payment policies has created a tangled web of incentives that are often contradictory, administratively burdensome, and costly, ultimately impeding optimal performance. Much like the risks of taking multiple medications without understanding how they interact, payment policies might encourage one behavior or outcome in isolation but produce an unanticipated effect when combined, hampering efforts to improve both individual and population health. The following section presents options to help correct the system's piecemeal design by modifying structures to increase accountability, coordination, and streamlined function in the service of population health (see *Table 6*).

LEVER: *Create an effective linked national/regional capacity for monitoring and improving health system performance, outcomes, and affordability*

One approach to addressing the absence of system-wide accountability is to create a linked national and regional capacity for monitoring and improving health system performance, outcomes, and affordability. Such a capacity could build on existing models, including the Massachusetts Health Policy Commission, the California Health Care Affordability Board, and the Federal Reserve, while drawing from policy literature conceptualizing a national, independent, and nonpartisan entity for assessing and reporting on health system performance across key domains, including access, affordability, quality, and administrative efficiency (Berwick et al., 2025; Weinstein et al., 2021). Drawing from state accountability bodies and national monitoring capabilities such as the Agency for Healthcare Research and Quality (AHRQ) National Quality Report, this capacity could support all manner of health system stakeholders–Congress, federal agencies, states, and others–by identifying where activities to improve system performance, outcomes, and affordability remain fragmented or poorly supported and outlining proposals for more coordinated and sustained investment. Unlike existing advisory bodies such as the Medicare Payment Advisory Commission (MedPAC) or Medicaid and CHIP Payment and Access Commission (MACPAC), which focus on single federal programs, this capacity could take a broader view across payers, sectors, and levels of government.

A central design question is whether such a capacity would serve primarily in an advisory role, possess enforcement authority, or adopt a hybrid approach. An exclusively advisory model may have limited influence if its findings and recommendations are not tied to policy, purchasing, regulatory, or payment decisions. At the same time, an enforcement-oriented model could raise concerns similar to those that surrounded the Independent Payment Advisory Board, which was ultimately dismantled amid concerns about rationing. A blended model, with an advisory role in some domains and enforcement authority in others, may offer a more balanced path to system-wide oversight, mitigating concerns of overreach. In all cases, the objective is to establish a pragmatic, trusted body capable of taking a holistic view of health system performance and optimizing the whole rather than individual policy or programmatic realms.

LEVER: *Establish strong mechanisms to ensure collaborative multi-agency health-promoting action plans and activities across health, public health, social, educational, environmental, and economic agencies*

From 2022 to 2024, a federal initiative aimed to establish "a whole-of-government approach to unlock America's full potential by helping all people and places to thrive together" with no exceptions (Office of Disease Prevention and Health Promotion, 2022). Over 35 federal agencies committed to harmonizing federal resources to help foster seven "vital conditions" for health and well-being (see *Figure 3*), demonstrating the potential for structured, multi-agency collaboration across health, public health, social, educational, environmental, and economic domains. The collaborative produced a plan to guide strategy,

regulation advancements, and initiative development across the federal government, while also beginning to build the infrastructure needed to routinely coordinate agency action on programs, policies, and investments that shape the vital conditions (The Rippel Foundation, 2022). At the request of the administration and Congress, this initiative could be continued and strengthened through more durable mechanisms for cross-agency coordination, shared accountability, and implementation. Parallel efforts at the state and local levels (e.g., Health in All Policies approaches) would reinforce federal action and support strategies that promote population health across sectors and levels of government (National Association of County and City Health Officials, n.d.).

LEVER: *Expand financing approaches to include a public option for ensuring access to essential health services and continuity of coverage*

The absence of universal health coverage in the United States is one of the clearest signals that the current system is not designed well to support individual or population health. Unlike other high-income nations that treat coverage as a foundational element of public well-being, the United States relies on a fragmented mix of employer-based insurance, public programs, and individual market options with no guarantee of coverage for all. This patchwork arrangement results in millions of Americans living un- or underinsured, leading to delayed diagnoses, unmanaged chronic conditions, and preventable deaths (McDonald, 2022; Valenzuela et al., 2024; Heavey, 2009).

A public health insurance option could help remedy the system's patchwork evolution and bring the nation closer to a health system designed to serve everyone. One model, described in the 2025 National Academy of Medicine Vital Directions for Health and Health Care series, would provide plan purchasers access to buy into the full network of

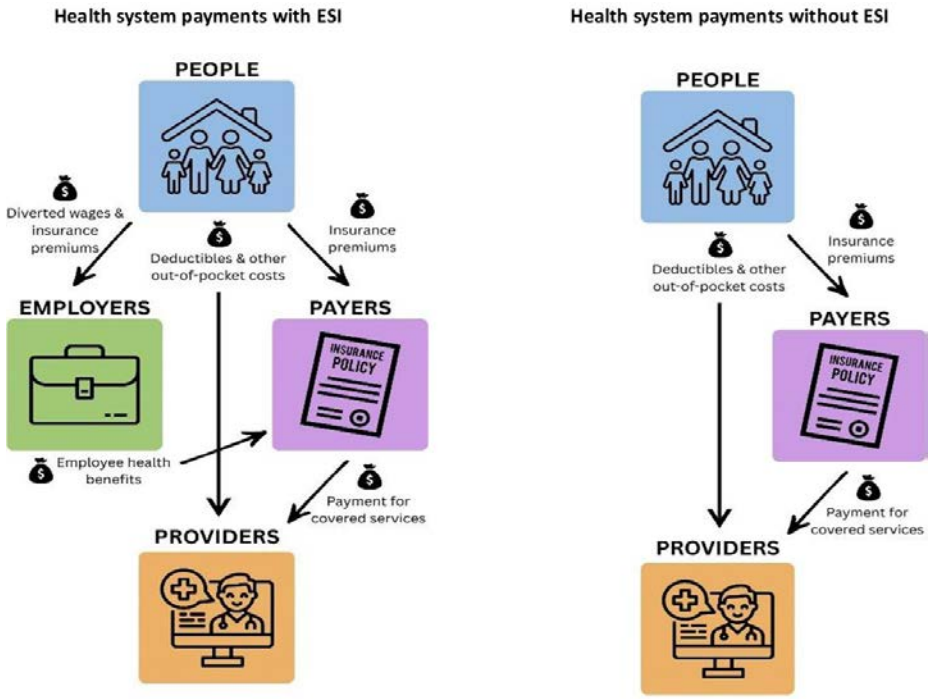

FIGURE 4 | Flow of Health System Payments from People to Providers with and Without Employer-Sponsored Insurance (ESI)

SOURCE: Created by the authors.

Medicare-participating providers and pay some markup over typical Medicare prices (Berwick et al., 2025). Patient cost sharing would be income based, with an annual cap to ensure that no household spends more than a modest percentage of its income on health care. All providers who accept Medicare payment would be required to participate in this option (and could be reimbursed at rates above Medicare to support their participation), ensuring broad access and system-wide consistency. In addition to increasing consumer choice in coverage options, such a public option may create competitive premium pricing pressure in the insurance market to help lower cost growth and improve value. A similar program would be needed for maternal child health services.

State experiments with public health insurance options (in Washington, Colorado, Nevada, and Minnesota) suggest a growing recognition that a more deliberate, inclusive, and affordable coverage model is essential for population health (Murray and Whaley, 2025). Cost and use data emerging from these state-level initiatives can provide an empirical basis for extrapolating potential effects on national health care spending, allowing regulatory and policy making bodies to model how similar approaches might scale across diverse markets and populations. In this way, these experiments can inform a national approach by offering early evidence on the budgetary, access, and affordability implications of broader implementation.

LEVER: *Explore approaches to eliminating coverage disruptions and barriers to long-term investments in health and prevention that can accompany employer-sponsored insurance*

While public option models offer a way to bridge disconnects in the system's current patchwork design, a complementary approach would be to reconsider elements of the health system's structure that contribute to fragmentation. One such structure is employer-sponsored insurance, a legacy feature of the system's piecemeal design.

The United States is the only developed nation that heavily relies on employers to offer its citizens health care coverage. While the strategy offers some benefits, like administrative convenience for employees and a recruitment and retention instrument for employers, the trade-offs present a case for change:

- Insurance tied to employment means people lose coverage when they quit their jobs or reduce their hours (e.g., moving from full-time to part-time work). This can create a situation in which people feel unable to leave or change jobs for fear of losing health care coverage,

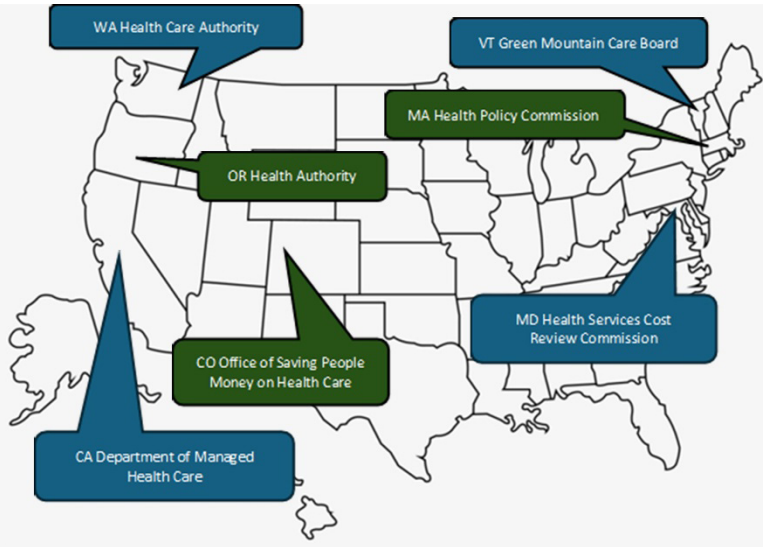

FIGURE 5 | Examples of Novel State Authorities with Health Financing Influence
SOURCE: Created by the authors.

fueling economic inefficiency by constraining labor mobility and stifling entrepreneurship that would allow economic resources (i.e., human talent) to be used in the most productive and beneficial way.
- Job-based insurance is vulnerable to economic downturns. During the COVID-19 pandemic, millions of people lost coverage when they lost their jobs, precisely when access to care was most essential (Center on Budget and Policy Priorities, 2022).
- Employer-sponsored insurance works mainly for full-time, higher-wage, and "white-collar" workers, leaving part-time, gig, and lower-income workers under- or uninsured.

Currently, large employers that choose to fund their own insurance coverage plans for their employees are regulated by the Department of Labor under the federal Employee Retirement Income Security Act (ERISA). In these self-funded plans, employers take on the financial risk of paying employee health claims and typically hire a commercial insurance carrier as a third-party administrator to manage the plan. In a fully funded rather than self-funded plan, the employer purchases coverage from a state-regulated commercial insurance carrier for a per-member premium. This further adds to the fragmentation created by employer-sponsored insurance, as it creates separate pathways for setting standards and accountability for different types of commercial insurance plans.

The persistence of employer-sponsored coverage is reinforced by long-standing tax policy dictated by Congress. Employer contributions to health insurance premiums are excluded from employees' taxable income, representing the single largest tax expenditure in the federal budget. This exclusion reduces costs for workers and creates a strong financial incentive for employers to maintain coverage. However, the exclusion locks in the employment-based coverage model and complicates efforts to build alternative approaches that could deliver more equitable and efficient coverage.

From a policy perspective, disconnecting health insurance from employment would be logistically complex and would need careful implementation to avoid coverage losses in the near term. Investments in state and federal insurance marketplaces would be needed to ensure the platforms could support higher volumes of shoppers and maximize ease of navigation and choice. Moreover, eliminating employer-sponsored insurance without a requirement for all people to purchase coverage or the guarantee of subsidies to help could bankrupt insurers if healthier people choose to forgo coverage while people who are sick seek to be insured. The risk pooling strategies and multiyear insurance plans described in this discussion paper, as well as transitionary subsidies (e.g., Individual Coverage Health Reimbursement Arrangement vouchers using employers' contributions) could help ensure the viability of this approach (HHS, 2019). Consumer protections such as essential health benefits, standards allowing more direct comparison between plans (Corlette, 2019; Rasmussen and Taylor, 2021; Chu et al., 2021, Essential Health

TABLE 7 | Potential Action Levers to Increase Consistency and Efficiency

Potential Action Levers	Implementation Time Frame
Improve alignment among public financing programs to harmonize, simplify, and strengthen accessibility, administration, and accountability.	Short *(within 5 years)*
Promote payment consistency across care settings when services and outcomes are comparable.	Short *(within 5 years)*
Streamline financing authorities, regulations, and oversight structures to reduce complexity and improve transparency.	Short *(within 5 years)*

SOURCE: Created by the authors.

Benefits Requirements, 2010), and affordability criteria built into processes for health plan rate review may also be necessary to ensure a balanced focus on people and profit. Provided the proper incentives and protections, the result would be a simpler, more efficient purchasing arrangement with responsibility for health distributed across a fewer (though still significant) number of organizational actors (see *Figure 4*).

System Misalignment: Fragmented Governance and Financing Policies Create Unnecessary Complexity and Inefficiency

Authority for health financing in the United States is distributed across a wide array of federal, state, and private entities. This fragmented structure leads to inconsistent rules, competing incentives, high administrative costs, and limited coordination in the development of coverage and payment policies.

Federal Fragmentation

At the federal level, legislative authority over health financing rests with Congress, which has divided jurisdiction over public and private health care among numerous committees, making it difficult to pursue a cohesive, system-wide improvement strategy. This legislative fragmentation is mirrored on the regulatory side within the HHS, where multiple agencies hold key financing responsibilities. The CMS oversees Medicare coverage for older adults, certain people with disabilities, and individuals with end-stage renal disease, while also administering Medicaid and the Children's Health Insurance Program in partnership with states, the District of Columbia, and Puerto Rico. The CMS also manages major subsidy streams, including Medicare-supported Graduate Medical Education payments to care delivery organizations. Within the CMS, the Center for Consumer Information and Insurance Oversight oversees private insurance purchased by individuals and small- to mid-sized employers alongside state insurance departments. Other HHS agencies with health financing influence include the following:

- The Health Resources and Services Administration administers health care programs for people who are geographically isolated and economically or medically underserved, in addition to the 340B Drug Pricing Program, which influences provider revenue in participating organizations.
- The Indian Health Service funds tribal and urban American Indian health programs (but does not directly provide insurance coverage).
- The Centers for Disease Control and Prevention (CDC) administers grant programs that finance public health initiatives.

Outside of the HHS, additional federal agencies play important roles in health coverage and financing. The Veterans Health Administration (VHA) regulates and issues coverage for veterans and their families, and the US Department of Defense does the same for active-duty military personnel and their families. Meanwhile, the US Department of Labor oversees insurance plans offered by self-insured employers.

State Fragmentation

State legislatures, Medicaid agencies, insurance departments, attorneys general, state employee benefit plans, and varying novel authorities (see *Figure 5*) further shape financing rules through eligibility requirements, payment models, consumer protections, and requirements on commercial health insurers that vary from state to state. Frequent lobbying by organizations and interest groups adds another layer of inconsistency and complexity, often prioritizing narrow interests over system-wide goals.

Commercial Sector Fragmentation

In the private sector, commercial insurers and self-funded employers independently make financing decisions within state- and/or ERISA-determined regulatory and legal bounds. Decisions include which services their plans will cover (beyond federally mandated essential health benefits), which providers (including categories of providers) they will contract with, how much they will pay for

covered services, and the payment methods they will use (e.g., FFS, bundled payments, or global payment) (Song et al., 2019). This creates an even more diverse array of incentives that ultimately lead to differences in access, cost, and quality of care for the nearly 217 million Americans (65 percent of the population) relying on private health insurance coverage (Keisler-Starkey et al., 2024).

Taken together, this array of authorities creates a complex and often confusing system characterized by varying coverage rules, documentation standards, payment models, reporting requirements, and incentives, fueling variation in access, affordability, and quality across the health system. The following section describes options to increase consistency in health financing policy and the incentives that result (see *Table 7*).

LEVER: *Improve alignment among public financing programs to harmonize, simplify, and strengthen accessibility, administration, and accountability*

The CMS administers a wide array of programs that shape health financing, yet these programs often evolve independently of one another, creating duplicative requirements, inconsistent incentives, and fragmented administrative processes that burden providers and the populations they serve. In recent years, CMS has launched efforts to harmonize requirements and increase consistency

BOX 1 | Key Themes from CMMI-Tested Models: At-a-Glance

Of over 50 models tested by the Center for Medicare and Medicaid Innovation (CMMI), six have reduced costs, two have improved quality, and four were deemed eligible for expansion [a]. This does not include models that have been partially scaled without certification and have contributed to permanent changes in Traditional Medicare, such as the Million Hearts Model (that demonstrated a reduction in mortality and was expanded as cardiovascular care management payment codes in the Physician Fee Schedule [b]), the Accountable Health Communities model (where cost-saving elements were expanded as care navigation codes in the Physician Fee Schedule), the Accountable Care Organization Investment Model (which successfully recruited providers and expanded into the Medicare Shared Savings Program [c]), among others. Recent analyses have concluded that CMMI's activities have increased net federal spending, prompting an agency focus on spending reduction [d, e]. CMMI announced early termination or cancelation of six models in 2025 [f].

SOURCE: Created by the authors.

NOTES: [a] Congressional Budget Office. 2023. *Federal budgetary effects of the activities of the Center for Medicare & Medicaid Innovation*. Available at: https://www.cbo.gov/system/files/2023-09/59274-CMMI.pdf (accessed August 22, 2025). [b] Blue, L., A. Steiner, D. Kinber, J. Pu, A. Markovitz, J. Rollison, M. Williams, R. Powell, K. Kranker, K. Stewart, R. Wang, D. Magid, N. McCall, and G. Peterson. 2023. *Evaluation of the Million Hearts Cardiovascular Disease Risk Reduction Model: Final evaluation report*. Washington, DC: Mathematic Inc. and Rand Corporation. https://www.cms.gov/priorities/innovation/data-and-reports/2023/mhcvdrrm-finalannevalrpt. [c] Trombley, M., B. Fout, C. Zhou, S. Brodsky, B. Morefield, M. McWilliams, and D. Nyweide. 2020. Factors associated with reduced Medicare spending in the Accountable Care Organization (ACO) Investment Model. *Health Services Research* 55(S1):123-124. https://doi.org/10.1111/1475-6773.13507. [d] Avalere Health. 2022. *Analysis of CMMI models projects costs rather than savings*. Available at: https://advisory.avalerehealth.com/insights/analysis-of-cmmi-models-projects-costs-rather-than-savings (accessed August 21, 2025). [e] CMS. 2025j. *Strategic direction*. Available at: https://www.cms.gov/priorities/innovation/about/strategic-direction (accessed August 25, 2025). [f] CMS Newsroom. 2025b. *CMS Innovation Center announces model portfolio changes to better protect taxpayers and help Americans live healthier lives*. Available at: https://www.cms.gov/newsroom/fact-sheets/cms-innovation-center-announces-model-portfolio-changes-better-protect-taxpayers-help-americans-live (accessed May 20, 2026).

across its many areas of oversight. A prime example is the agency's ongoing Universal Foundation initiative to align and reduce the number of quality measures in use across CMS programs. Additional opportunities include standardizing covered benefits across CMS programs and reducing the number of APMs in circulation at a given time. By fostering coherence across its programs, CMS can set a clearer baseline for consistency in health financing policy, making it easier for other payers to align with federal standards and for providers to focus on improving outcomes rather than navigating conflicting rules.

Standardizing Covered Benefits Across CMS Programs

Standardizing covered services across Medicare and Medicaid would bring greater consistency to health financing policy, reducing challenges for patients and providers. For patients, a more uniform benefit structure would support smoother transitions between programs as life circumstances change, simplify coverage for individuals dually eligible for both Medicare and Medicaid, and mitigate inequities in access or treatment based on program enrollment. Providers, in turn, would benefit from a clearer understanding of what services are covered and reduced billing complexity. Integration and uniformity of Medicare and Medicaid benefits for complex and high-spending populations have begun through Dual-Special Needs Plans, but penetration remains relatively low (Velasquez et al., 2023).

Standardization could take the form of a core benefit package spanning Medicare and Medicaid that would establish a common foundation of covered services while allowing flexibility for additional benefits tailored to the needs of specific populations, such as long-term care services, chronic illness management, or early intervention services for children with developmental delays. States and Medicare Advantage plans could continue to administer add-on benefits beyond the core, preserving opportunities for innovation and responsiveness to local or population-specific needs.

Progress toward cross-program standardization is constrained by a number of factors, first of which is the absence of statutory authority for the CMS to unify benefit design. Under current law, Congress—not the CMS—defines Medicare benefit categories (through Section 1861 of the Social Security Act). An amendment to Title XVIII granting the CMS the authority to make core benefit package decisions would, therefore, be required. Title XIX of the Social Security Act would also require amendment to direct state Medicaid programs to cover, at minimum, the federally defined core benefit package. States and Medicare Advantage plans would retain the ability to supplement the package with additional benefits, balancing consistency with flexibility.

Beyond statutory barriers, other challenges would need to be addressed:

- State-level resistance: Policy makers and Medicaid agencies in states that would need to expand covered benefits to align with a standardized structure may oppose the change, as it could require raising taxes or diverting funds from other programs. While increased federal subsidies for Medicaid benefit expansion could offset state costs, securing bipartisan support for such subsidies could be difficult.
- Restrictions on the use of cost-effectiveness evidence: Section 1182 of the Social Security Act and Section 1194(e)(2) of the Inflation Reduction Act prohibit the HHS Secretary from relying on cost-effectiveness research in determining coverage, payment, or incentive programs under Medicare. While these provisions were intended to prevent discriminatory valuation of treatments for individuals with disabilities or chronic illness (National Council on Disability, 2022), they also limit the CMS's ability to design a standardized benefit package informed by evidence of clinical effectiveness and economic value.

This could lead to the inclusion of high-cost, low-value services as well as the exclusion of cost-effective alternatives in a standardized benefit package and offers less flexibility to adapt coverage to the needs of patients with complex and costly conditions.

Overcoming these barriers would represent a major step toward a more consistent coverage framework—one that aligns incentives across programs and ensures all beneficiaries have access to a shared foundation of essential services.

Reducing the Number of APMs in Circulation

Since its establishment by the Affordable Care Act in 2010, the CMS's Center for Medicare and Medicaid Innovation (CMMI) has launched more than 50 experimental care models in Medicare and Medicaid, many of which are classified as APMs. APM model testing is important because it allows the agency to experiment with FFS alternatives with the goal of controlling costs and maintaining or improving quality of care (MedPAC, 2021). One important trade-off, however, is added complexity to the health financing landscape as APMs are rolled out concurrently (MedPAC, 2021; Lewis et al., 2017). *Box 1* provides a high-level overview of the CMS's APM landscape and recent developments (see *Appendix A* for additional details).

Experts are divided on the merits of reducing the number of APMs in circulation as a means of simplifying financial incentives. Some note that while it conceptually makes sense to deploy APMs until the CMS has enough information to strategically narrow the models deployed, it is not clear whether experiments thus far have yielded the necessary insights. Despite identifying four models as satisfying the CMS's criteria for expansion, the criteria (enforced by establishing legislation [Social Security Act §1115A]) may overemphasize cost neutrality/savings in model evaluation. This makes models that require short-term spending increases to generate long-term savings and improved health outcomes the likeliest candidates for premature elimination.

A common hesitation around reducing the number of APMs is the fear that doing so would lower the overall share of health spending tied to quality, cost, and value or decrease the number of providers willing to participate. However, this share could be preserved, or even expanded, if the CMS were to incorporate value-based elements directly into the Medicare Physician Fee Schedule. More importantly, embedding accountability and population-oriented payment structures within the fee schedule represents a critical pathway for driving more systemic change, rather than relying on a fragmented set of time-limited models.

The recent creation of advanced primary care management (APCM) codes illustrates how value-based elements can be incorporated directly into the Medicare Physician Fee Schedule. Instead of paying only for individual services, these codes provide payment for a set of primary care capabilities, such as care coordination, patient communication, and ongoing management, and require clinicians to report on cost and quality measures as a condition of payment. The APCM codes move toward hybrid prospective payment, offering support for these capabilities without requiring that each activity be delivered or billed separately in a given month for a given patient. However, they still rely on monthly billing through FFS codes and remain subject to patient cost sharing. Because these codes are embedded in the permanent fee schedule rather than in a time-limited pilot, they allow physicians to build familiarity over time and enable broader uptake across Medicare Advantage, Medicaid, and commercial insurers.

Expanding this approach—by incorporating greater accountability for outcomes and more flexible, population-based payment elements into the FFS chassis—could accelerate the transition toward value-based care at scale. Rather than serving solely as a safeguard against regression, this strategy positions the fee schedule itself as a vehicle for aligning incentives with value, fostering consistency across payers, and reducing reliance on fragmented pilot programs.

TABLE 8 | Overview of Private Industry-Held Levers for Change

Potential Action Levers	Industry Actor
Encourage insurance and risk pooling approaches that support multiyear investments in individual and community health.	Commercial payers
Accelerate rollout and testing of innovative payment and incentive models that reward prevention, early intervention, and community-based approaches to health improvement.	Commercial payers
Promote payment consistency across care settings when services and outcomes are comparable.	Commercial payers

SOURCE: Created by the authors.

LEVER: *Promote payment consistency across care settings when services and outcomes are comparable*

Medicare currently pays more for services when they are provided in hospital outpatient departments than when they are provided in freestanding physician offices or ambulatory surgical centers. This is because payments to hospitals include a "facility fee" to account for overhead and labor costs. Commercial payers have followed suit, resulting in different payments for the same or similar services provided at different sites of care (Congressional Budget Office, 2022). Site-neutral payments would reduce health care financing complexity while also eliminating an incentive for hospitals to acquire physician practices and convert them to outpatient departments to which they can refer patients, increasing costs to the system and to patients (when they could be appropriately treated in less expensive physician offices or ambulatory surgical centers) (Post et al., 2021; Dranove and Ody, 2019).

While MedPAC has recommended aligning payment rates for services that "can safely be provided in more than one clinical setting" (MedPAC, 2025), proposals to implement site-neutral payments have mostly failed. One exception is the CMS's 2021 decision to reduce Medicare payment for visits at outpatient departments located off hospital premises to match Medicare rates for services delivered in an office setting. Outpatient departments located on hospital premises, however, were excluded from that policy change. More recently, the CMS proposed adjusting indirect practice expense payments (which cover administrative staff salaries, overhead, and rent), reducing them for facility-based services and increasing them for community-based practices (CMS, 2025f). The proposal reflects recognition that many physician offices are now owned by hospital systems, where indirect expenses such as overhead and staffing are captured in facility fees. If finalized, the change would represent another step toward advancing site-neutrality goals.

Despite incremental progress, strong industry opposition to site-neutral policies remains a barrier to simplifying health care financing in this respect. Future proposals must grapple with industry concerns that site-neutral payments may (1) reduce hospital reimbursement rates to the point of service cuts or closures and (2) trigger cost-cutting measures that threaten care quality (given differences in the complexity of caring for patients who present at inpatient versus outpatient sites). Concerns could potentially be mitigated if rates were equalized to a point above the current rates for services in an outpatient setting.

LEVER: *Streamline financing authorities, regulations, and oversight structures to reduce complexity and improve transparency*

Congress has access to several advisory bodies to produce analyses and recommendations for streamlining the statutory frameworks that

TABLE 9 | Overview of Government-Held Levers for Change

Potential Action Levers	Government Actor(s)
Create an effective linked national/regional capacity for monitoring and improving health system performance, outcomes, and affordability.	Congress
Expand financing approaches to include a public option for ensuring access to essential health services and continuity of coverage.	Congress, states
Explore approaches to eliminating coverage disruptions and barriers to long-term investments in health and prevention that can accompany employer-sponsored insurance.	Congress
Streamline financing authorities, regulations, and oversight structures to reduce complexity and improve transparency.	Congress
Establish mandated all-payer global or total cost of care mechanisms and targets that emphasize effectiveness and efficiency in care patterns and outcomes rather than service volume.	Congress, states
Align all-payer payment incentives and prospective/global payment approaches across public and private payers to rebalance payments for primary, specialty, and long-term care outcomes.	Congress, CMS
Expand flexibility in health spending policies to enable support for broader evidence-based services that improve health status and outcomes.	Congress, CMS
Improve alignment among public financing programs to harmonize, simplify, and strengthen accessibility, administration, and accountability.	CMS
Encourage insurance and risk pooling approaches that support multiyear investments in individual and community health.	CMS, Veterans Health Administration (VHA), Department of Defense (DoD), states
Promote payment consistency across care settings when services and outcomes are comparable.	CMS, VHA, DoD, state Medicaid agencies
Accelerate rollout and testing of innovative payment and incentive models that reward prevention, early intervention, and community-based approaches to health improvement.	ARPA-H, government payers (CMS, VHA, DoD)
Establish strong mechanisms to ensure collaborative multi-agency health-promoting action plans and activities across health, public health, social, educational, environmental, and economic agencies.	All agencies

SOURCE: Created by the authors.

distribute federal health financing authorities, if so charged. The Congressional Research Service can provide background analyses to help members understand the complex history of statutes that define agency roles, though it is not structured to lead large-scale projects or issue formal recommendations. The Congressional Budget Office, while not a policy-recommending body, plays a critical role in producing budget and revenue estimates for any proposed statutory changes. For more comprehensive evaluations of agency performance and opportunities for greater efficiency, the Government Accountability Office (GAO) may be better positioned, given its mandate and staffing model.

In addition, the MedPAC and the MACPAC could play targeted roles consistent with their statutory charges. MedPAC advises Congress on payment policy, access, quality, and other issues affecting the Medicare program, while MACPAC provides policy analysis and recommendations regarding Medicaid and CHIP, including program financing, eligibility, coverage, and interaction with the broader health care system. Although their authorities are limited to specific federal programs, both commissions possess deep expertise in payment design and system performance and could provide program-specific analyses and recommendations to inform broader statutory reforms. Taken together, insights from Congressional Research Service, Congressional Budget Office, GAO, MedPAC, and MACPAC can help Congress consider revisions that better align, synergize, and simplify health financing authorities.

A Path Forward: Building the Will of Stakeholders to Pull the Levers for Change

There is broad recognition among health system stakeholders that restructured financial incentives are necessary to achieve shared expectations for system performance. Nevertheless, efforts to advance health financing reform often stall when proposed changes are perceived to threaten revenue streams, expand governmental authority, or increase administrative burden on providers. In addition, reform proposals are frequently advanced in isolation, without a comprehensive vision that illustrates how multiple policy levers could work together to reduce trade-offs and improve system performance as a whole. The result is repeated identification of potential solutions that lose momentum prior to implementation and scale.

Building the will for private industry and government to pull the change levers available to them will require not only clear and tailored value communication but also articulation of a coherent, system-wide vision that demonstrates how reforms can align incentives, mitigate unintended consequences, and generate shared benefit across stakeholders (see *Table 8*).

Activating industry-held levers will require the following:

- **Business case development:** Models or real-world case studies/evidence that demonstrate how use of the lever in question could enhance market competitiveness and profitability for the lever-holder (e.g., commercial payers) and impact key partners (through improved member experience, reduced burden for contracted providers, etc.).
- **Collaboratives for experimentation:** Trusted, neutral venues (established by independent or standard-setting bodies) and antitrust safe harbors to support industry competitors in sharing knowledge without exposing proprietary strategies or violating antitrust laws (designed to prevent collusion, price fixing, and monopolistic behavior).
- **Policy signals that shape market behavior:** State and federal policies establishing shared expectations (such as statewide health care spending growth targets and primary care investment targets) to catalyze coordinated strategies that may not emerge through voluntary action alone.

Governmental levers are most likely to be deployed if they can be linked to (see *Table 9*):

- **Areas of bipartisan agreement:** In an environment where health policy debates are often

politically contested, reforms anchored in widely shared values such as safety, effectiveness, and efficiency face less resistance, are more likely to attract cross-party support, and have a greater chance of advancing through legislative and regulatory processes. Policies grounded in shared values are also more likely to endure changing political leadership, providing the stability necessary for long-term system transformation.

- **Issues of public (particularly constituent) concern:** Public opinion influences which policy priorities gain traction, as policy makers seek to build legitimacy and trust by responding to constituent concerns. The health care affordability crisis, for example, is a deeply felt and highly salient issue for many Americans, and sustained public frustration creates fertile ground for a concerted campaign to address underlying drivers. Advocacy and communication efforts that connect lived experiences (such as high premiums, medical debt, and unpredictable billing) to structural misalignment in health financing can help translate public concern into momentum for reforms that align incentives across health system stakeholders and sectors. A central challenge, however, lies in educating the public about the often complex and technical drivers of system failures in ways that are accessible, accurate, and empowering, and that invite informed civic engagement rather than resignation.
- **State-level action and accountability:** State-level health policies often achieve greater success because they can be tailored to the specific demographic, epidemiological, and resource contexts of a given jurisdiction, allowing for more precise targeting of interventions and rapid adaptation to emerging data. Moreover, states typically face fewer bureaucratic hurdles and enjoy stronger political accountability to local constituencies, which can expedite implementation and generate sustained public support.

It is important to acknowledge that many of the levers discussed in this paper are held by government, which today exercises substantial authority over the design and oversight of health financing arrangements. This emphasis reflects the current distribution of influence within the health system, rather than an intention among working group members to expand government control. The working group recognizes that deployment of levers on both sides—private industry and government—is vital to health financing that drives expectations for health system performance. The will of both groups of actors to engage the levers available to them will increase if they can recognize their own interests within a shared vision for reform.

Final Thoughts

Reconfiguring the financial underpinnings of the US health system is no small undertaking. Over the past decade, progress has been made, but deeper structural issues perpetuate health system financial incentives that fail to deliver efficient or optimal outcomes. The most effective way forward is not piecemeal, incremental corrections of misaligned incentives one at a time but instead a deliberate focus on addressing the underlying drivers that consistently generate them. By tackling root causes directly, fewer but more consequential changes can unlock meaningful system-wide improvement.

Appendix A: The Slow Evolution of Health System Financial Incentives

Over the past several decades, health care financing has moved slowly away from its deep reliance on the FFS model toward models that reward value and consider social determinants of health. The FFS model continues to dominate, even as policy makers and payers have introduced APMs intended to promote efficiency, quality, and patient-centered care. More recent efforts to invest in nonmedical health drivers, such as housing, nutrition, and transportation, reflect growing recognition that health depends as much on social and environmental conditions as on clinical care. Notable examples are described in *Box 2*. Despite progress, reforms remain incremental, leaving the system caught between entrenched payment structures and the promise of more transformative approaches.

Shortcomings of the FFS Payment Model

The FFS payment model financially rewards providers for the volume of services they deliver and thereby incentivizes the provision of services with the highest payment rates and profit margins. Under FFS, there is no financial accountability for improving health outcomes, nor incentives for preventing illness or addressing disparities (Lofton and Isasi, 2022). Continued decline in the per-unit valuation of clinician services under Medicare compared to inflation has exacerbated volume incentives and accusations of "upcoding," as clinicians must perform more services to financially tread water.

The consequences of a largely FFS environment include underinvestment in health-related social needs, uncoordinated care, overtreatment, and uncontrolled costs of care. The issues with FFS are compounded by how it is operationalized, including being based on a fee schedule that disproportionately rewards procedures and specialty care over primary and preventive care, and through differences in FFS rates across health care payers. These differences can perpetuate inequities by making some treatments or the treatment of some individuals more lucrative than others.

Tracking the Movement from Volume to Value

Despite roughly two decades of experimentation with APMs, the goal of replacing FFS as the dominant form of payment has not yet been achieved. On paper, there has been substantial progress in the movement "from volume to value" and toward APMs since the early 2000s, when a small portion of providers participated in non-FFS payment. However, as of 2024, approximately 55 percent of payments across public and private payers remained either FFS with no link to quality and value or FFS linked to quality (such as a pay-for-reporting or pay-for-performance programs) (HCP-LAN, 2025). These models have, thus far, delivered modest results (Smith, 2021).

The Medicare Shared Savings Program and the creation of the CMMI, along with parallel efforts by commercial payers and self-insured employers, have expanded provider and patient participation in APMs. Between 2015 and 2024, the share of payments across public and private payers tied to "value" (ranging from shared savings programs to global budgets) rose from about 25 percent to about 48 percent (HCP-LAN, 2025). Among payers, Medicare Advantage plans have the highest proportion of payments in these categories, followed by traditional Medicare and Medicaid, while commercial insurers have the lowest. It is important to note, however, that visibility into Medicare Advantage arrangements remains limited. While there is some evidence that Medicare Advantage plans can deliver better outcomes, many sub-capitated arrangements appear to increase risk-coding (given the financial incentive to do so) or exploit Medical Loss Ratio requirements within vertically integrated plans, generating profits without necessarily improving value for beneficiaries (Cohen et al., 2025). Therefore, the percentage of payments flowing through APMs is not, on its own, a reliable indicator of whether value-based care is being successfully implemented. Many models do not include accountability for total cost of care (including payments for prescription drugs) and still rely on an FFS framework.

BOX 2 | Examples of Policies that Drive Health Care Dollars Upstream

Several recent federal and state initiatives demonstrate movement toward financing approaches that recognize and address the drivers of health:

Medicaid waivers and state options: The approval of Section 1115 waivers and other mechanisms (such as state plan amendments, Section 1915 waivers, managed care "in lieu of" services, and CHIP Health Service Initiatives) by the Centers for Medicare & Medicaid Services (CMS) authorizes payment for services that address health-related social needs (HRSNs) and culturally appropriate care (KFF, 2025; CMS, 2025c; CMS Newsroom, 2024a). However, recent administrative changes have rescinded guidance released in 2023 and 2024 on coverage for HRSNs and will only consider supporting waivers on a case-by-case basis in this area (CMS, 2025i).

Z codes: The establishment of Z codes enables providers to document patients' social circumstances (e.g., literacy, employment, housing). Though they are generally not associated with payment, recent changes to the Inpatient Prospective Payment System recognize Z codes for homelessness as a complication that can increase Medicare Severity Diagnosis Related Group payments (CMS Newsroom, 2024b).

Drivers of health risk assessment: The 2024 Medicare Physician Fee Schedule introduced billing codes to support systematic assessment of social risks. Initial uptake was promising, though the 2026 Medicare Physician Fee Schedule finalized alteration of the code to focus only on physical activity and nutrition (CMS, 2025g).

Community health integration: The 2024 Medicare Physician Fee Schedule introduced billing codes to support payment for community health workers who address upstream drivers of health (CMS Newsroom, 2024a; Medicare Learning Network, 2024). The 2026 Medicare Physician Fee Schedule finalized an expansion of the array of providers eligible to bill for these services, consistent with the focus on chronic disease and prevention (CMS, 2025b).

Advanced primary care management (APCM): The 2025 Medicare Physician Fee Schedule created APCM codes to support the delivery of chronic and transitional care (CMS Newsroom, 2024a; CMS, 2025a). The 2026 Medicare Physician Fee Schedule expanded billing to incorporate new add-on codes for behavioral health integration in advanced primary care settings (CMS Newsroom, 2025a).

Accountable Care Organization (ACO) investments: Advanced Investment Payments and Prepaid Shared Savings options in the Medicare Shared Savings Program enable ACOs to invest in interventions that address unmet social needs (CMS, 2025h).

Medicare GUIDE Model: The Medicare GUIDE Model links reimbursement to comprehensive dementia care that integrates clinical services, caregiver support, and community-based resources (CMS, 2025d).

Nonprofit hospital community benefit requirements: The Affordable Care Act amended Section 501(c)(3) of the Internal Revenue Code to require nonprofit hospitals to regularly assess and invest in community health—through community health needs assessments and community health improvement plans—as a condition of their tax exemptions. Community building activities (including but not limited to housing improvements, economic development, environmental improvements, and workforce development) are signaled as areas in which hospitals may invest (Congress.gov, 2025).

BOX 2 | Examples of Policies that Drive Health Care Dollars Upstream *Continued*

These efforts signal important progress in redirecting health care dollars upstream, but challenges remain. For example, provider documentation of Z codes has been low. Strengthening the community benefit requirements for nonprofit hospitals to ensure that investments meaningfully reflect local needs is a topic that remains hotly debated (Hendricks-Sturrup et al., 2024; KFF, 2023).

SOURCE: Created by the authors.

Pediatric care is less likely to be in advanced APMs than adult care and is still dominated by FFS. This is likely driven by children's lower per capita costs, which reduce payer incentives, and by the fact that pediatric outcomes unfold over long time horizons, making return on investment harder to measure and often realized in the "wrong pockets." Addressing maternal child health population outcomes will require attention to their unique needs, benefits package, and payer mix.

Impediments to Widespread APM Adoption

The slow evolution of health care payment toward greater reliance on APMs can be attributed to several factors, including model complexity, lack of transparency and insufficient data, difficulty changing business models, provider hesitance to assume financial risk, and requirements for CMMI-led models to generate savings as a condition of continuation. Furthermore, limited alignment across payers has constrained the ability of care delivery organizations to redesign business and operational models around value-based care, as providers often must navigate multiple, and sometimes conflicting, payment structures simultaneously. The following sections describe these impediments in detail.

Model Complexity, Lack of Transparency, and Insufficient Data

A significant barrier to progress in the "volume to value" movement has been how entrenched and familiar FFS payment is to providers. The relative complexity of APMs (demonstrated in *Box 3*) tips the balance in favor of the status quo. As payers have experimented with financial model design, APMs have become both plentiful and nuanced in their incentives. This has resulted in a complex set of regulations, policies, and processes that make the financial and clinical implications of model adoption difficult for clinicians to predict, thereby reinforcing an inherent caution about change.

Making an informed decision about participating in an APM program requires understanding complex financial methodology related to spending targets, the intricacies of risk adjustment and coding regimens, and a host of quality metrics and related incentives tied to performance. Participation then requires extensive access to, and interpretation of, data on use, necessitating robust health information exchange. Since the bulk of provider payment remains FFS, even within these models, there is a significant disconnect between the intent of the APM and the incentives at the front lines of care.

Moreover, provider organizations wanting to participate in multiple APMs (e.g., across traditional Medicare, Medicare Advantage, Medicaid, and commercial markets) may face different financial and clinical performance requirements and accountability mechanisms, depending on plan or payer type. Smaller practices and provider organizations may lack capacity to navigate this maze even though the CMS has created incentives such as an advanced investment payment to allow small provider-led practices to participate in an Accountable Care Organization (ACO). Additional efforts to embed value-based programs into

BOX 3 | An Example of APM Complexity

In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was passed to accelerate movement toward alternative payment models (APMs) and improve quality and cost accountability in traditional Medicare. MACRA created two paths for participating clinicians: a pay-for-performance path called the merit-based incentive payment system (MIPS) and an APM path. The MIPS path tied greater percentages of payment to performance on quality and cost over time, with the maximum bonus (or penalty) set at 9 percent of payments for covered professional services. The APM path created an incentive payment for participation in advanced APMs (i.e., models that feature downside risk). The maximum APM incentive payment for qualifying participants was 5 percent from performance years 2017 to 2022, 3.5 percent in 2023, and 1.88 percent in 2024 plus increased Physician Fee Schedule payments. In 2025, qualifying participants received increased Physician Fee Schedule payments alone (Quality Payment Program, 2025).

In practice, both programs are fraught with complexity for clinicians seeking to understand their choices. The following pertain to MIPS:

- Clinicians choose from over 300 potential quality measures in different categories (though some specialties have few measures from which to choose).
- Efforts to improve the program, such as MIPS value pathways that group measures more meaningfully, are available only to certain specialties.
- Health systems with employed practitioners often choose primary care measures that are not impacted by specialist activities.
- The available measures have not proven to be predictable indicators of performance.
- Many clinicians are exempt from participation altogether.

Meanwhile, clinicians seeking participation in the APM path must receive at least 50 percent of Medicare Part B payments, see at least 35 percent of Medicare patients through an advanced APM, or be part of an all-payer advanced APM (Quality Payment Program, 2025). The complex layering of requirements continues to be confusing for clinicians.

Multiple issues and misaligned incentives arise as a result of this complex program. First, the maximum bonus for remaining in FFS exceeds the maximum bonus for participating in an advanced APM. Second, the ability to choose from a large number of measures in pay-for-performance MIPS may lead clinicians or practices to report on measures for which they already perform well rather than driving improvements, limiting comparability across clinician participants. Third, MIPS is expensive. The average practice spends over $12,000 on reporting for MIPS, wasting funds on measurement that is broadly viewed as not producing meaningful information or changes in practice (Khullar et al., 2021). For these and other reasons, MedPAC has recommended repealing MIPS but maintains that advanced APMs hold promise (MedPAC, 2024). Better driving the required connection between what is billed in traditional Medicare and the quality measures that are required to be reported through MIPS may also simultaneously simplify the program and prevent widespread gaming (i.e., selecting the quality measures on which clinicians are already performing best).

SOURCE: Created by the authors.

payment, such as the APCM codes, are attempting to offer an "off-the-shelf" way multiple payers can align behind a single payment model (CMS, 2024).

Unfortunately, many of the models' specifications, such as risk adjustment and benchmarking, make projections difficult, and paradoxically, successful providers experience downward trends in payments to successful providers result from re-benchmarking, eliminating shared savings over time. For example, some elements of CMMI contracts and design features are available only to model participants, making it difficult for clinicians interested in adoption to understand what they are committing to. CMMI has initiated efforts to reduce model complexity and make model parameters, requirements, and other critical details more transparent (CMS, 2025e).

Difficulty Changing Business Models

Providers that seek to transition from FFS toward APMs often underestimate the organizational impact on their business that occurs. Under the FFS system, providers build their business models to optimize FFS outcomes; this includes their electronic health record, supply chain, contracts, patient intake and discharge processes, training and recruitment, management structures, and investment in facilities, among other elements. When transitioning toward value-based payments, providers must often operate under both FFS and value-based arrangements simultaneously, requiring them to operationalize potentially competing business models. The difficulty in transforming business models, coupled with the lack of viable pathways to move fully away from FFS, stymies organizational transformation.

Hesitance to Assume Financial Risk

Provider hesitancy to assume financial risk, driven in part by model complexity and lack of transparency, has limited uptake of voluntary models that include "downside" risk, where providers face financial penalties for failing to meet performance metrics. Participation in these models requires sophisticated tools and resources to manage unfamiliar risks, which are often out of reach for smaller, rural, and independent practices. Imperfect processes for risk adjustment (intended to protect providers serving high-need patients) built into APMs are also a concern (Colla et al., 2020). Even so, most providers participating in the Medicare Shared Savings Program, the nation's largest APM, operate under contracts that include downside risk.

According to actuarial analyses, downside risk does not automatically translate to greater savings: taxpayers have realized more savings from upside-only risk arrangements, as ACOs that take on downside risk have not consistently generated enough savings to offset their higher assumed risk (Miller, 2018). This indicates that simply pushing more providers into risk-bearing models is not inherently the right solution; rather, the design of incentives and supports matters more than the level of risk itself (Trombley et al., 2022; Ouayogodé et al., 2021; Ouayogodé and Colla, 2025).

Cost Savings Requirements for CMMI Models

Another barrier to transition away from FFS has been CMMI's statutory requirement to generate savings (or maintain cost neutrality while improving quality) as a condition of model continuation. Many models base spending targets on historical use, which may be at odds with the resource level required to appropriately provide care to groups of people that have traditionally been underserved. CMMI began to tackle these challenges in 2023 by expanding adjustments (CMS, 2025f). Still, newer models designed to support infrastructure building, including models for maternity care, dementia care, and behavioral health, may ultimately be deemed unsuccessful against CMMI's savings requirements. This statutory requirement prioritizes short-term cost savings over the long-term health and well-being of patients and communities. Additionally, actuarial comparisons of savings have not taken the relatively substantial market transition toward Medicare Advantage into account.

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For decades, the United States has invested more in health care than any other nation. US medical practitioners are world class. Scientists are making breakthrough discoveries, and our culture of innovation is admired worldwide. Yet so many Americans experience care as confusing, costly, and disconnected from their health needs, goals, and priorities, making the word "broken" an all-too-common description of the health care system. Too often, care is organized around services and transactions rather than the outcomes people value most: living the life they want, managing illness without it defining them, and staying independent and safe as they age. That gap raises a central question: how can the system evolve to better support health as people experience it every day?

The National Academy of Medicine Commission on Investment Imperatives for a Healthy Nation was established to reimagine a US health care system that puts people first. As part of its work, the Commission will publish papers on individual and community health goals, health financing, digital and data architecture, and private equity investments, describing their vision for a new health system, the priorities that must be considered, and the actions that can be taken to make their vision a reality.