Course 300: Leading Health System Economics

Module 302: How Providers Get Paid

What You Will Learn

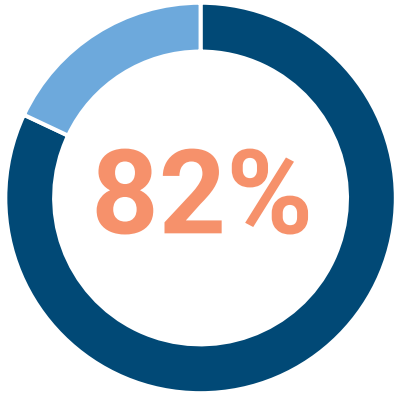
In this video, we will:

- Describe the most common provider payment models and the incentives they create
- Define three key factors that impact provider reimbursement
- Explain how the revenue cycle turns patient care into payment
- Identify the organizations that set provider payment policy and how rate updates impact reimbursement

Most Revenue Starts With Patient Care—and Fee-for-Service Still Dominates

Different Models, Different Incentives

Most revenue starts with patient care and most care is paid for using fee-for-service



Of total LHS revenue comes from patient care reimbursement

3 Common Payment Models

90% of payments

Fee-for-Service (FFS)

- Paid for each individual service (e.g., visit, scan, surgery)
- **Rewards volume**. More services=more revenue.

Value-Based Care (VBC)

- Paid based on patient outcomes and quality performance
- **Rewards efficiency, quality and outcomes**. Better results = bonuses; poor outcomes = penalties.

Bundled Payments (Capitation)

- Paid a lump sum to manage all care for a condition or patient
- **Rewards cost control and coordinated care**. Lower costs and fewer complications = higher margins

Industry Partners

ALIGN YOUR PITCH

FFS: Focus on volume growth, added capacity, revenue lift

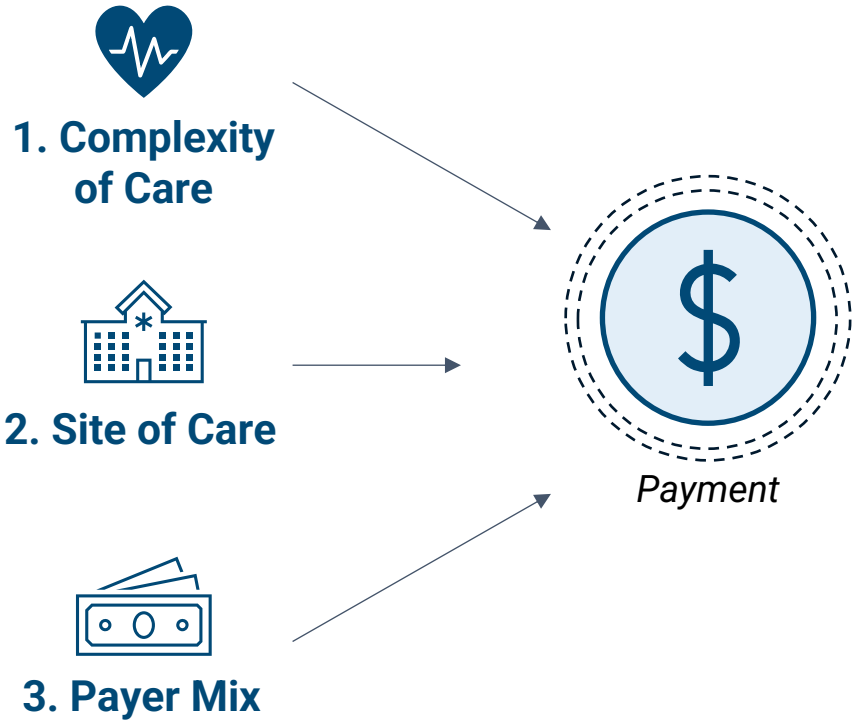
VBC: Show quality improvement, coordinated care, measurable outcomes

Capitation: Emphasize cost control, streamlined care, complication prevention

Sources: Why Healthcare Isn't Just Another Business: Navigating Financial Rigidities, ShiftMed; THMA research and analysis.

From Care Setting to Payer Mix: What Shapes Reimbursement?

3 DRIVERS OF REIMBURSEMENT



HOW THEY IMPACT PAYMENT LEVELS

Lower Reimbursement — *Moderate* — *Higher Reimbursement*

Complexity:	Routine check-up	Chronic condition	Multiple comorbidities
Site:	Telehealth	Outpatient	Inpatient
Payer:	Medicaid	Medicare	Commercial Insurance

The Revenue Cycle: How Systems Turn Care Into Dollars

Key Stages and Risks

Front End

Preparing for patient care

- ✓ Verify patient identity and insurance
- ✓ Confirm co-pays, deductibles
- ✓ Preauthorization

Revenue Risk

⚠ Missing patient info or pre-auth→ Claim rejections or delays

Mid-Cycle

Documenting care

- ✓ Translate care into billable codes for:
  - **Diagnosis (ICD-10):** What's wrong?
  - **Services (CPT, HCPCS, DRG):** What was done?
  - **Site Modifiers (POS):** *Where?*

Revenue Risk

⚠ Under coding or vague documentation→ lower reimbursement or audit risk

Back End

Ensuring accurate, timely payment

- ✓ Submit claims with accurate data
- ✓ Monitor payer responses; track denials
- ✓ Reconcile payments
- ✓ Follow up on unpaid balances— from both payer and patient

Revenue Risk

⚠ Inaccurate claims or late follow-up → Denials and payment delays

How Policy Shapes Provider Payments

It's Not Just Math, There's Policy Too

Who Sets Payment Policy?

Four key organizations design and direct how provider payment works, from fee schedules to payment models

Medicare Payment Advisory Committee (MedPAC)

Advises Congress on Medicare **payment policies**

Centers for Medicare and Medicaid Services (CMS)

Within HHS; implements Medicare & Medicaid payment rules

Congress

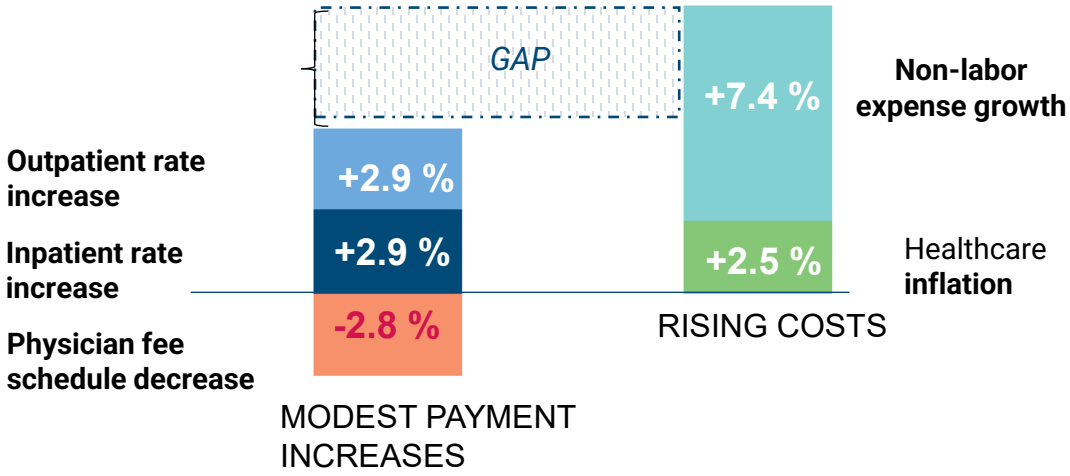
Sets vision, budget, and law; directs CMS to implement

Center for Medicare and Medicaid Innovation (CMMI)

Test new payment models to reduce cost, and improve quality

Payment Rate Updates Lag Behind Cost Growth

2025 Medicare Payment rates include modest increases to inpatient/outpatient reimbursement, and cuts to physician fees– creating a growing gap between revenue and cost growth



Provider payment is shaped by policy decisions, budget tradeoffs, and evolving payment rules.

Sources: Comprehensive Guide to the 2025 Medicare Physician Fee Schedule , 100plus; Senate Narrowly Passes HR1, Sending It Back to House for Final Approval, VGM & Associates; Health Care Inflation in the United States, US Inflation Calculator; THMA research and analysis.

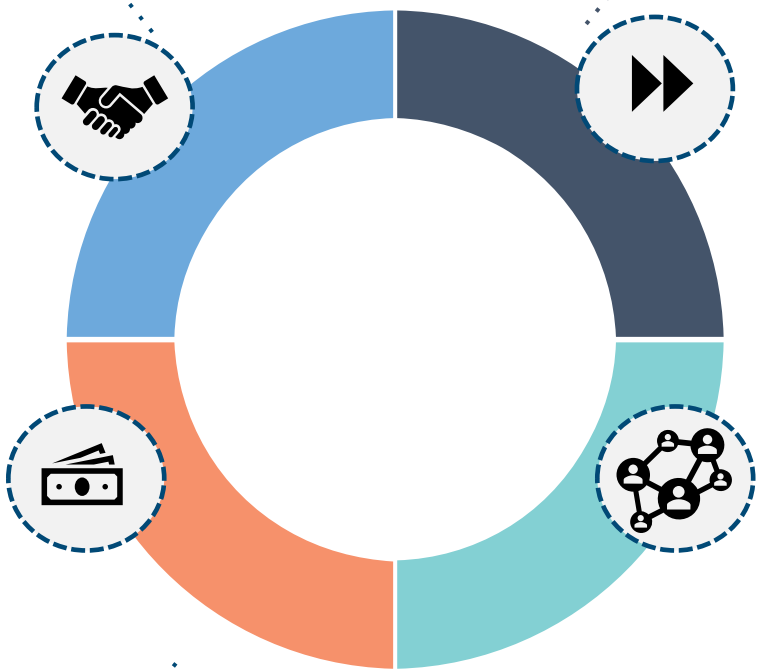
Four Things to Know About Commercial Reimbursement

1. Every Contract Is Unique

Each health system negotiates **one-on-one** with every commercial payer Rates are often shaped by factors like market strength, provider network, and quality outcomes.

2. Medicare Sets the Pace

Commercial payers often mirror CMS changes in rates and payment models like ACOs and bundles.



3. Commercial Pays More — Sometimes Much More

Rates are typically 20–60% higher than Medicare, and in some cases 200–300% more.

4. Many Kinds of Payers

From provider-owned plans to national insurers, the payer mix shapes reimbursement strategies

Key Takeaways

1. **Patient care drives revenue — and FFS still dominates.** Payment models directly shape health system priorities, so get to know the dominant payment model. It will tell you where they're most motivated to invest and grow.

2. **Three factors set reimbursement: site, payer, and complexity.** The same service can bring in vastly different revenue depending on these levers. Understanding them helps you spot where your solution can directly protect or grow revenue.

3. **A strong revenue cycle is essential to financial health.** Accurate coding, clean claims, and timely follow-up keep revenue flowing — and every step is a place where industry partners can help.

4. **Policy pressures are real.** Rate increases lag behind cost growth, putting pressure on margins. When payment rates lag behind cost growth, leadership must find ways to protect margins. This is when solutions that improve efficiency, productivity, or cost control stand out..