

# Will Fee-for-Service Really Disappear?

Leigh Page

October 29, 2013

---

## Is It Time to Replace Fee-for-Service?

No fewer than 4 major healthcare policy reports<sup>[1-4]</sup> were released in early 2013 calling for a phase-out of fee-for-service payments to physicians.

All 4 reports linked fee-for-service, which pays physicians for each piece of work done, to healthcare inflation, unnecessary services, and fragmented care.



Physicians praise the simplicity of the old fee-for-service system and fear what would take its place. But they needn't worry about an imminent switch because no one plans to get rid of fee-for-service anytime soon. Even the National Commission on Physician Payment Reform, which called for "a rapid transition" to other payments, said it would take 5 years.

The healthcare policy reports, from groups like the Brookings Institution, a liberal think tank, and former senators from both parties said the system should be replaced by "value-based" payments, such as bundled payments and forms of capitation, which reward physicians for efficiency and coordinated care.

The chorus against the current system includes healthcare payment experts, planners in the Obama administration, Republicans pushing for fiscal austerity, major commercial insurers, large employers, and even many leaders in organized medicine.

In fact, it includes just about everyone except for the physicians who actually get paid by the current system. In a survey reported in *JAMA* in July 2013,<sup>[5]</sup> only 7% of physicians expressed enthusiasm for "eliminating fee-for-service payment models."

The Affordable Care Act, which is identified with payments like shared savings through Accountable Care Organizations (ACOs), does not call for an end to Medicare fee-for-service.

The current payment system will continue to be available to physicians for some time to come, says Robert Berenson, MD, a fellow at the Urban Institute and former Vice Chair of the Medicare Payment Advisory Commission, which advises Congress on Medicare policy. "You are not going to get cardiologists to participate in an ACO if they can make \$500,000 a year in the fee-for-service system," he says.

Medicare has not issued any plan to drop fee-for-service or lower reimbursements for physicians who choose to stay with it, says Paul B. Ginsburg, PhD, President of the Center for Studying Health System Change and a proponent of the new payment methodologies.

"Certainly, I can envision a time when there would be incentives for physicians and hospitals to get involved with new payments," Ginsburg says. "You would be able to get potentially higher payments, and eventually there will be lower payments. But that is not the law now."

---

## Push to Change Payments Gains Momentum

Despite all the harsh criticism, fee-for-service still dominates physician reimbursement. Catalyst for Payment Reform, an employer coalition campaigning for value-based payments, estimates that almost 90% of healthcare is paid under fee-for-service, with its complex web of current procedural terminology (CPT) codes for each piece of work done.<sup>[6]</sup>

However, eliminating the old system would not be that extraordinary. In 1982, Congress moved hospitals to diagnosis-related groups, which make a set payment for each diagnosis.

Even Republicans, who want to repeal the Affordable Care Act, are not defending the old payment system. The American Enterprise Institute, a conservative think tank, has called for an end to Medicare fee-for-service,<sup>[7]</sup> and an active bill in the House of Representatives would reduce payments to physicians who stay on the old payment system in exchange for repeal of the sustainable growth rate (SGR), which mandates cuts in physician payments.<sup>[8]</sup>

Ending fee-for-service is often cited as a prerequisite for eliminating the SGR. The old payment system is thought to drive up utilization, which was why SGR was needed in the first place. Physicians' organizations like the American Medical Association, American College of Physicians, American Academy of Family Physicians, and American College of Surgeons have agreed that fee-for-service should be phased out, in conjunction with ending SGR.<sup>[9,10]</sup>

### Front-Line Doctors Beg to Differ

While leaders of organized medicine seem ready to phase out the current payment system, rank-and-file physicians want to keep it. Thomas M. Flake, Jr., MD, a solo general surgeon in Southfield, Michigan, argues that fee-for-service incentivizes physicians to work hard and avert shortages in care. He said this hard work means that healthcare in the United States is number one in its responsiveness to the needs of individual patients and short waiting times.

Flake says new payment methodologies force physicians to worry too much about costs, and their use of teams of caregivers means that no one is accountable. He says he is not against use of the new payments but "don't mess with my practice. Leave me and my patients alone. I just want to be paid fairly for what I do."

"The mantra that fee-for-service is broken cannot go unchallenged," says Robert J. Sobel, MD, a Chicago internist who partners with another physician. The current system, he says, is a "natural" means of payment, used to reimburse many professions across the economy, and it is much simpler to use than the value-based methodologies that would take its place. "You need a bureaucracy to sift through the payment data to determine the value of your work," he says.

Jonathan Oberlander, PhD, Professor of Social Medicine at the University of North Carolina at Chapel Hill, is one of the few policy experts who question the change in payment systems. He noted that physicians in

Canada are almost entirely paid using fee-for-service, and that country's medical inflation has been well below that of the United States.

The difference is that the Canadian system is based on spending budgets set by province-based single-payer systems. Strict budgets may not be popular in the United States, but they are essential, Oberlander says. "Controlling spending is basically a political problem -- agreeing to set budgets -- and not really a matter of finding the right payment mechanism," he says. The new US payment methodologies are still largely untested, he observes.

Oberlander says that US healthcare planners have an exaggerated fondness for new payment systems, going back to the call for capitation and health maintenance organizations (HMOs) in the late 1990s. Capitation -- paying a set monthly amount for each enrolled person, whether or not that person seeks care -- is credited with briefly controlling healthcare spending, but the public revolted against HMOs, and physicians with sicker patients lost money. Policymakers concluded that capitation, in its purest form, contained a powerful incentive to withhold care.

---

## Benefits of a New Payment System

François de Brantes, Executive Director of the Health Care Incentives Improvement Institute, a nonprofit organization that develops new payment models, believes physicians' devotion to fee for service is really "a fear of the unknown." Under the old system, "you know it's about volume, and you know how to produce volume," he says.

De Brantes and other healthcare planners have been devising new controls to address the counterproductive attributes of capitation. Partial capitation, for example, covers only the professional fee or certain types of patients, and bundled payments encompass all the care for certain patient groups, such as people with chronic conditions, or certain procedures, such as all the care required for a hip replacement. In arrangements like the patient-centered medical home, a variety of caregivers team up to provide care.

Also, improved information technology can better pinpoint physicians' spending targets and monitor outcomes to make sure that patients are getting the care they need.

De Brantes says that the current payment system relies on the resource-based relative value unit, which favors procedures over office visits, forcing primary care physicians who rely heavily on office visits to work longer hours just to break even.

De Brantes says that the payment imbalance has also driven practices to consider adding more procedures that can bring in new sources of revenue. "Physicians are aware that extra services are being ordered that are not needed," he says, pointing to the American Board of Internal Medicine Foundation's Choosing Wisely® campaign, which spotlights services that have no clinical benefit.<sup>[11]</sup>

De Brantes says that the new payment methodologies would be simpler for physicians to administer. Rather than billing for a long string of CPT codes, practices could report the total episode of care and be paid for approaches that traditional insurance won't pay for, such as emails and follow-up calls with patients.

There are signs that this approach can lead to big savings by avoiding duplication of services and keeping patients out of the hospital. For example, UnitedHealthcare reported that in 4 states, for every extra dollar it paid for medical homes, it realized \$2 in savings.<sup>[12]</sup>

## Switching to a Pay-for-Performance Model

In a 2013 survey of health plans by Availity Research, a revenue cycle software company, one fifth of plans reported that at least half of their business was "supported" by value-based payment models.<sup>[13]</sup> Almost half planned to reach that level in 3 years.

But these changes do not necessarily mean a break from fee-for-service. The survey showed that currently the most common value-based arrangement is pay-for-performance (P4P), which continues fee-for-service payments, often at a reduced rate, and adds a bonus for meeting certain targets.

While new systems like bundled payments are supposed to be easier for practices to administer, P4P is actually more difficult because reporting metrics for bonuses vary widely by payer, prompting complaints from many practices, according to a report by the Massachusetts Medical Society.<sup>[14]</sup>

WellPoint, which operates the Blue Cross Blue Shield licenses in 14 states, considers itself one of the leaders in the move to "value-based" payments. "We're not kidding," says Jill Hummel, Vice President of Payment Innovation at WellPoint. "Value-based payment is our new normal." She says such payments, which now reach \$25 billion a year, include some capitated models, but the prevalent mode for smaller practices is a version of P4P.

Hummel says that many practices still aren't ready for the more sophisticated models. "We're trying to get providers comfortable with tools and information," she says. "It's not so much that fee-for-service is going to go away overnight; it's more that its role will change over time."

P4P payments are also the basis of the shared savings program for Medicare ACOs, although ACOs have the option to use capitated payments.

Berenson, the former Medicare Payment Advisory Commission Vice Chairman, says that for payers to fully move to the new payment systems, they would have to change the entire way they do business -- replacing fee schedules, overhauling computer systems, renegotiating contracts, and retraining staff. "It will take a while to build the infrastructure to administer most of the new payment models," he says.

Indeed, the Availity Research survey found that 90% of surveyed plans still used some manual elements in their information exchange, which makes it hard to compile information needed for new payment methods.

According to de Brantes, the payment innovation expert, Medicare has fallen behind commercial payers in adopting new methodologies like bundled payments. CMS's new Center for Medicare & Medicaid Innovation has inaugurated disappointingly few demonstration projects for bundled payments, he says.

De Brantes has greater hopes for bundled payments in Medicaid. The states, with their budgetary problems and upcoming Medicaid expansions, have "a higher degree of urgency," he says, based on the fact that Medicaid financial problems are becoming more severe. He points to a new initiative by Arkansas Medicaid, which started a year ago.

---

## Multiple Payment Systems in the Future

Will physicians still be getting fee-for-service payments 10 years from now? Even proponents of the new payment systems believe that there will always be a place for fee-for-service.

"I think there will be fee-for-service forever -- not as the sole method of payment but as one of many," says Berenson.

De Brantes agrees, noting that one obvious area for continued payments is preventive care, such as flu shots. For such services, "you want to encourage volume, and fee-for-service is by far the best way to do that," he says.

## References

1. National Commission on Physician Payment Reform. Report of the National Commission on Physician Payment Reform. March 2013. [http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician\\_payment\\_report.pdf](http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician_payment_report.pdf) Accessed October 4, 2013.
2. Daschle T, Domenici PV, Frist B, Rivlin AM. A bipartisan Rx for patient-centered care and system-wide cost containment. Bipartisan Policy Center. April 18, 2013. <http://bipartisanpolicy.org/library/report/health-care-cost-containment> Accessed October 4, 2013.
3. Brookings Institution. Bending the curve: person-centered health care reform. April 2013. <http://www.brookings.edu/research/reports/2013/04/person-centered-health-care-reform> Accessed October 4, 2013.
4. Robert Wood Johnson Foundation. Strengthening affordability and quality in America's health care system. April 2013. <http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/04/strengthening-affordability-and-quality-in-america-s-health-care.html> Accessed October 4, 2013.
5. Tilburt JC, Wynia MK, Sheeler RD, et al. Views of US physicians about controlling health care costs. JAMA. 2013;310:380-388.
6. Catalyst for Payment Reform. Only 11 percent of payment to doctors and hospitals in the commercial sector today is tied to their performance. March 26, 2013. <http://www.catalyzepaymentreform.org/images/documents/release> Accessed October 4, 2013.
7. Capretta JC. The role of Medicare fee-for-service in inefficient health care delivery. American Enterprise Institute. April 2013. [http://www.aei.org/files/2013/04/15/-the-role-of-medicare-fee-forservice-in-inefficient-health-care-delivery\\_141413376272.pdf](http://www.aei.org/files/2013/04/15/-the-role-of-medicare-fee-forservice-in-inefficient-health-care-delivery_141413376272.pdf) Accessed October 4, 2013.
8. US House of Representatives. Medicare Patient Access and Quality Improvement Act of 2013. July 24, 2013. <http://docs.house.gov/meetings/IF/IF00/20130730/101240/BILLS-113HR2810ih-HR2810.pdf> Accessed October 4, 2013.
9. Doherty B. Doctors call for an end to Medicare fee-for-service. ACP Advocate Blog. May 11, 2011. <http://advocacyblog.acponline.org/2011/05/doctors-call-for-end-to-medicare-fee.html> Accessed October 4, 2013.
10. Hoyt D. American College of Surgeons federal testimony. May 5, 2011. <http://www.facs.org/ahp/medicare/hoyt050511.html> Accessed October 4, 2013.
11. ABIM Foundation. Choosing wisely. <http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx> Accessed October 4, 2013.

12. UnitedHealthcare. Promising results. <http://accountablecareanswers.com/results/> Accessed October 4, 2013.
13. Availity. Health plan readiness to operationalize value-based payment models. April 2013. [http://www.availity.com/documents/Availity\\_Study\\_on\\_Plan\\_Readiness\\_to\\_Operationalize\\_New\\_Payt\\_Models.pdf](http://www.availity.com/documents/Availity_Study_on_Plan_Readiness_to_Operationalize_New_Payt_Models.pdf) Accessed October 14, 2013.
14. Lischko AM. Physician payment reform: a review and update of the models. Massachusetts Medical Society. [http://www.massmed.org/News-and-Publications/Research-and-Studies/Physician-Payment-Models--MMS-Review-and-Update-\(pdf\)](http://www.massmed.org/News-and-Publications/Research-and-Studies/Physician-Payment-Models--MMS-Review-and-Update-(pdf)) Accessed October 4, 2013.

Medscape Business of Medicine © 2013 WebMD, LLC

Cite this article: Will Fee-for-Service Really Disappear? *Medscape*. Oct 29, 2013.