catalyst FOR PAYMENT REFORM

Action Brief
Improving Fee-for-Service Payment

WHAT IS FEE-FOR-SERVICE PAYMENT?

In a fee-for-service system, an insurer pays the provider for each covered medical service or procedure after the patient receives the service. A fee-for-service system pays retrospectively for one-time services.

WHAT PROBLEMS DOES FEE-FOR-SERVICE PAYMENT TRY TO SOLVE?

Before the 1960s, providers were paid in various ways. When Medicare and Medicaid were established in 1965, the federal government used the Usual, Customary, and Reasonable (UCR) fee method to standardize provider payment. However, this approach was criticized as it was based on physicians' billed charges, which incentivized providers to continually increase their charges. Eventually, in 1992, payers came to view predetermined payment maximums as determined by resource-based relative value scale (RBRVS) as a preferred approach.

A fee-for-service system creates a standardized payment schedule across all insurers and providers. This approach is useful for making payments predictable, countering inflation, and compensating for variety in clinician and practice experiences, among other reasons.

Our current fee-for-service payment system dates back to the 20th century. Over 100 years later, the vast majority[1] of health care providers are still paid per service they provide even if there are various incentives layered on top.

HOW DOES FEE-FOR-SERVICE PAYMENT WORK?

In a fee-for-service system, the system under which a significant portion of the health care system operates today, payers follow a standard fee schedule, which is a list of the maximum rates a payer will allow per service. Most payers' fee schedules are based on the Medicare Physician Fee Schedule (PFS), which was introduced in 1992, along with the resource-based relative value scale (RBRVS) formula and the American Medical Association/Specialty Society RVS Update Committee (RUC). The Medicare PFS is based on relative value units, or estimates of

covered services' relative resource costs, the value of physicians' work as measured by time and intensity, and professional liability costs. In operation, providers are paid by volume and quantity of services, without regard for outcomes or the quality of care delivered.

WHAT ARE THE ADVANTAGES OF FEE-FOR-SERVICE PAYMENT?

Fee-for-service (FFS) payment has significant strengths. This type of payment promotes access to services since it pays providers for every service they deliver and, therefore, also offers patients some protection against being under-treated. FFS payment also provides incentives for provider productivity—a fee schedule gives payers control over payment. Other advantages include:

- FFS payment does not require provider integration—a FFS system implicitly adjusts for different case mixes, different clinicians, and different practice experiences.
- It is the traditional form of payment in all other types of insurance, and FFS billing systems are mature and accepted across the industry.
- FFS payment rewards provider activity and promotes patients' access to and utilization of care.

WHAT PROBLEMS DOES FEE-FOR-SERVICE PAYMENT PRODUCE?

FFS payment also has significant weaknesses that make it an ideal target for reform in order to improve quality of care and reign in health care costs. These disadvantages include:

- FFS is inherently inflationary. It creates a strong financial incentive to deliver more care and more costly care, even if care is of no or marginal benefit to the patient.
- FFS does not create incentives for, or reward, superior care delivery or outcomes, nor does it reward efficiency or care coordination across providers or settings, which contributes to care fragmentation.
- FFS has produced shortages of certain services, including primary care, by offering much greater financial reward for specialty interventional services (e.g., surgery, testing) than for non-interventional (cognitive) services.
- FFS and fee schedules only pay for codified services, leaving providers unreimbursed for certain services, like care coordination.
- FFS payment systems generate a large volume of billable transactions, which leads to high administrative costs for health professionals.
- Payers must dedicate significant effort to keeping

Despite the United States health care system spending far more than any other comparable countries, the U.S. ranked last on performance and near last on access, administrative efficiency, equity, and health outcomes. According to a Commonwealth Fund analysis, the U.S. health care system is an outlier based on its high spending and low performance.[2]

recognized services and fee schedules up to date. This includes considering technological changes and work process improvements.

- The fee schedule and relative values are subject to bias—clinicians and providers have influence in the process of setting relative values, undervaluing some services and overvaluing others.

HOW COULD WE IMPROVE FEE-FOR-SERVICE PAYMENT?

Reforms to FFS payment seek to modify or counter the perverse incentives rooted in the fee-for-service model. While reforms to FFS are less far-reaching than payment reforms like bundled or global payment, they may help reduce cost and increase value in a shorter timeframe. Today's fee-for-service payment rates also set the baseline for the bundled and global payments of the future; increasing value now will help contain future costs.[3]

- One approach is to modify individual fees to account more accurately for underlying resource costs. Historically, private payers have relied on Medicare's relative value scale to set fees, though Medicare's relative fees are generally thought to be distorted—undervaluing primary care activities and overvaluing tests and procedures. To make fee schedules more accurate, additional payers could actively participate in the fee-making process or can modify their own relative values.

- To incorporate elements of value-based payment in fee-for-service systems, fee schedules can reduce coding granularity, establish clear coding rules, and better codify high-value services like care coordination.

- Similarly, instead of creating relative value units and fees solely on resource costs, fees can reflect policy judgement. In other words, fees could be modified so that health professionals would change the mix of services they provide with the goals of producing a high-value mix of services and altering how clinicians spend their time.

There are various initiatives in place across the United States to test alternative payment models, as fee-for-service payment systems are criticized for incentivizing high quantities of care, with no focus on quality or value.

These ongoing efforts to innovate with alternative payment models and delivery reforms include:

- Accountable Care Organizations (ACOs)
- Bundled Payments
- Global Budgets
- Patient-Centered Medical Homes

Check out CPR's Action Briefs on these topics to dive deeper into payment reform options and efforts.

- Another option for improvement is combining fee schedules with capitation and pay-for-performance, or other hybrid approaches. Models like these have been adopted in countries such as Denmark and the Netherlands.[4] These hybrids between fee schedules and capitation systems seek to balance over- and under-utilization.
    - For example, a hybrid payment system could pay primary care physicians 70% of a revalued, more accurate fee schedule and 30% capitation—with some element of public reporting of quality metrics to support pay-for-performance reimbursements. This payment strategy could be structured within a patient-centered medical home approach, where providers would have incentives to coordinate care and support patients in meaningful ways, like office visits and email and telephonic communications. Implementing such a program could require significant investments of time and resources to successfully reform how care is delivered, like the addition of registered nurses, physician assistants, behavioral health providers to help the provider efficiently manage and interact with patients.

WHAT STEPS CAN PURCHASERS TAKE TOWARD IMPROVING FEE-FOR-SERVICE PAYMENT?

LONGER TERM STRATEGY

There is a broad need to realign and revalue payments to health care providers, increasing payments to primary care providers and for preventive services, and decreasing payments for procedures and interventions, as well as much of specialty care services. This would require federal advocacy to continue to recalibrate Medicare rates, which most private health plans follow, and local efforts to implement market-level changes in commercial rates. Some private health plans are beginning efforts to diverge from the Medicare PFS.

Realigning and revaluing payments to health care providers will require teamwork and innovation across all stakeholders.

FEDERAL EFFORTS

The federal process used to set Medicare payment rates is based on the resource cost of providing a service and has led to a great chasm between payment rates for primary care services and specialty care services. Historically, rates have been set based on physician self-reporting of resource cost rather than use of objective data.[5] This process has been heavily influenced by specialists, who thus receive higher payment rates.

Medicare also allows for "component billing" which appears to result in higher payments than if Medicare (and private insurers) required consolidated coding for all services delivered by a given provider to a patient during an episode of care.[6]

Purchasers and payers have a stake in how Medicare values services and should actively participate in opportunities to comment on and influence this process to discourage counterproductive Medicare payment policies.

LOCAL EFFORTS

Federal legislative and rulemaking processes are slow, but purchasers may seek more immediate changes in local markets by influencing private insurer payment systems. Purchasers can build on any existing payer-supported efforts, including primary care capacity development, state and insurer efforts to redistribute funds to primary care, and/or Medical Home initiatives as a platform.

ABOUT US

Catalyst for Payment Reform (CPR) is an employer-led, national nonprofit on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace

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