SOUNDING BOARD

Phasing Out Fee-for-Service Payment

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for the National Commission on Physician Payment Reform

In March 2012, the Society of General Internal Medicine convened the National Commission on Physician Payment Reform to recommend forms of payment that would maximize good clinical outcomes, enhance patient and physician satisfaction and autonomy, and provide cost-effective care. The formation of the commission was spurred by the recognition that the level of spending on health care in the United States is unsustainable, that the return on investment is poor, and that the way physicians are paid drives high medical expenditures.

The commission began by examining factors driving the high level of expenditures in the U.S. health care system. It found that reliance on technology and expensive care, higher payments for medical services performed in hospital-owned facilities than in outpatient facilities, and a high proportion of specialist physicians as compared with generalists were all important cost drivers. But fee-for-service reimbursement stood out as the most important cause of high health care expenditures.

The commission then set out 12 recommendations for changing current methods of physician payment. The aggressive approaches that are recommended below provide a blueprint for containing costs, improving patient care, and reducing expenditures on unnecessary care. (The commission's report is available at http://physicianpaymentcommission.org/report/ and in the Supplementary Appendix, available with the full text of this article at NEJM.org.)

BLUEPRINT FOR A NEW PHYSICIAN PAYMENT SYSTEM

Recommendation 1: Over time, payers should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives.

The fee-for-service mechanism of paying physicians is the major driver of higher health care costs in the United States.[1] It contains incentives for increasing the volume and cost of services (whether appropriate or not), encourages duplication, discourages care coordination, and promotes inefficiency in the delivery of medical services.

Recommendation 2: The transition to an approach based on quality and value should start with testing new models of care over a 5-year period and incorporating them into increasing numbers of practices, with the goal of broad adoption by the end of the decade.

The long-range solution is a system that provides appropriate and high-quality care, emphasizes disease prevention and the management of chronic conditions rather than treatment of illness, and values examination and diagnosis as much as medical procedures. This implies a shift from a payment system based on a fee-for-service model to one based on value through mechanisms such as bundled payment, capitation, and increased financial risk sharing. But changing from the current model of care to one that is value-based cannot be accomplished overnight. It will require a transition period, with the likely end point being a blended system with some payment based on the fee-for-service model and other payment based on capitation or salary.

Recommendation 3: Because the fee-for-service model will remain important into the future, even as the nation shifts to fixed-payment models, it will be necessary to continue recalibrating fee-for-service payments.

Whatever system reforms (accountable care organizations, bundled payments, patient-centered medical homes, or capitation) are ultimately adopted, fee-for-service payment will remain an integral part of physician payment for a long time.[2] Although paying a fixed payment through bundling or capitation is reasonable, appropriate, and desirable for acute episodes of care requir-

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ing hospitalization, many issues remain as the concept is expanded outside of hospitals. Some services are not appropriate for bundling. And the best ways to allocate bundled payments to individual physicians remain to be clarified.

Recommendation 4: For both Medicare and private insurers, fees should be increased for evaluation-and-management codes, which are currently undervalued. Fees for procedural diagnosis codes, which are generally overvalued and thus create incentives for overuse, should be frozen for 3 years. During this period, efforts should continue to improve the accuracy of relative values, which may result in some increases as well as some decreases in payments for specific services.

The time that physicians spend on services that fall under codes for evaluation and management is reimbursed at lower rates than time that is spent providing services under procedural codes. The undervalued evaluation-and-management services at issue are often those that provide preventive health and wellness care, address new or undiagnosed problems, and manage chronic illnesses.

The current skewed physician-payment system creates disincentives to spending time with patients with complex chronic conditions. It leads physicians to offer care for highly reimbursed procedures rather than lower-reimbursed care. It neglects illness prevention and disease management. Lastly, it induces medical students to choose procedural specialties over evaluative ones. Although the relative undercompensation of primary care physicians has commanded much attention, the real issue is not one of relative payment for primary care physicians versus specialists but rather of payment for evaluation-and-management services as compared with procedural services. These evaluation-and-management services include those that are provided by neurologists, psychiatrists, pediatricians, obstetrician–gynecologists, and internal medicine subspecialists.

Recommendation 5: Increased payment for facility-based services that can be performed in a lower-cost setting should be eliminated. In addition, the payment mechanism for physicians should be transparent and provide physicians with roughly equal reimbursement for equivalent services, regardless of specialty or setting.

Over the past years, there has been a trend toward reimbursing medical services that are performed in facilities owned by hospitals at a higher rate than that for the same services provided in office settings. This disparity has a negative effect on the way health care services are delivered. Cardiology presents a telling example. Medicare pays $450 for an echocardiogram performed in a hospital and only $180 for the same procedure performed in a physician's office.[3]

Furthermore, spurred in part by the inducements of enhanced income from procedures, large hospital systems are buying up independent practices, threatening the viability of independent physicians and raising the cost of health care. In 2010, the *New York Times* reported that practices around the country were selling to health systems or hospitals; the CEO of the American College of Cardiology was quoted as saying, "The share of cardiologists working in private practice had dropped by half in a year."[4]

Moreover, private payers negotiate payment for services with individual health-care-delivery groups, often resulting in different payment levels for the same physician services, depending on the market power of the physician group. Payments by private payers for medical services should be transparent to the public. These payment differentials are difficult to justify in concept or in practice.

Recommendation 6: Fee-for-service contracts should always include a component of quality or outcome-based performance reimbursement at a level sufficient to motivate a substantial change in behavior.

The incentive inherent in fee-for-service payment arrangements to increase volume can be mitigated by incorporating quality metrics into the negotiated reimbursement rates. This is already being done in programs conducted by the federal government and private insurers. On a budget-neutral basis, the modifier will increase or decrease payment rates to physicians on the measures of quality and cost.[2] Although to date the overall evidence on the effectiveness of pay-for-performance programs based on quality measures is mixed, some programs are showing positive results.

Recommendation 7: For practices with fewer than five providers, changes in fee-for-service reimbursement should encourage methods for the

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practices to form virtual relationships and thereby share resources to increase the quality of care.

Large, integrated networks of providers dominate the provision of health care services in some areas of the country, but small, independent practitioners provide care for 9 out of 10 Americans, including millions living in rural and underserved areas.[5] Fee-for-service payment should reimburse small practices for care that is not delivered in person (e.g., by telephone or e-mail) and for coordination among providers, as well as allow for sharing of ancillary providers, such as nutritionists, social workers, and psychiatric providers, who are critical to the integrated "whole person" model envisioned in the medical home.

Telemedicine and other forms of remote communication have improved outcomes for many types of patients, including those in remote intensive care units,[6] the frail elderly,[7] and those being treated for depression in clinics not served by a psychiatrist.[8] These interventions have shown reduced costs in some populations and should be reimbursed appropriately.

Recommendation 8: As the nation moves from a fee-for-service system toward one that pays physicians through fixed payments, initial payment reforms should focus on areas in which there is substantial potential for cost savings and better quality of care.

The sickest 5% of patients consume half the nation's health care resources. Many of these patients have multiple chronic conditions, including behavioral health disorders. Improving their care offers substantial potential for cost savings and improved quality. A logical place to start is by changing how physicians are paid to deliver care to these high-cost patients.

Another logical place to begin implementing payment reforms is with in-hospital procedures and their follow-up. Treatments for many conditions, such as heart attack and joint replacement, lend themselves to fixed payments.

Recommendation 9: Measures should be put in place to safeguard access to high-quality care, assess the adequacy of risk-adjustment indicators, and promote strong physician commitment to patients.

Any prospective payment system should be accompanied by adequate protections for patients and recognition of the centrality of patient care. Quality measures are necessary to ensure that evidence-based care is not denied as a cost-saving mechanism. A body of evidence now shows that prevention, care coordination, and the prudent practice of medicine not only will save money but also will lead to better outcomes. Risk adjustment is important for any type of fixed payment to discourage physicians and other providers from cherry-picking the healthiest patients and avoiding the sickest ones.

Recommendation 10: Medicare's sustainable growth rate (SGR) adjustment should be eliminated.

The SGR has not worked in practice and shows no prospect of ever working. The practice of setting expenditure targets for 1 year and ignoring the consequences of exceeding them the next year makes no sense. Moreover, setting a spending cap without addressing the underlying issues of the volume and price of services and health outcomes is a short-term answer to a problem that requires a long-term solution. And since the SGR is based on the aggregate payment for physicians' services by Medicare, there is no incentive for individual physicians to try to hold down costs, and those who do so are, in effect, penalized.

Recommendation 11: Cost-saving measures to offset the elimination of the SGR should come not only from reduced physician payment but also from the Medicare program as a whole. Medicare should also look for savings from reductions in inappropriate utilization of Medicare services.

The commission believes that the $138 billion that the Congressional Budget Office estimates will be needed to offset the elimination of the SGR can be found entirely by reducing overutilization of medical services within Medicare. We believe that enacting the recommendations in this report can go a long way toward recouping those dollars.

Recommendation 12: The Relative Value Scale Update Committee (RUC) should continue to make changes to become more representative of the medical profession as a whole and to make its decision making more transparent. The Centers for Medicare and Medicaid Services (CMS) has a statutory responsibility to ensure that the relative

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values it adopts are accurate. Therefore, it should develop additional open, evidence-based, and expert processes beyond the recommendations of the RUC to validate the data and methods it uses to establish and update relative values.

The RUC, which is managed by the American Medical Association and composed of members named by national medical-specialty societies, makes recommendations to the CMS regarding updates to the relative value scale on which fee-for-service physician payment is based for Medicare as well as private payers. Both its composition and its operations are flawed.

The RUC has come under scrutiny for its composition, which is skewed toward the procedural and highly technological specialties[9] and its operating procedures: meetings are largely closed to the public; RUC members sign confidentiality agreements; individual voting records are not made public; and transcripts of meetings are not published. Moreover, critics contend that since nearly 90% of the RUC's recommendations have historically been adopted by the CMS,[10] it should be considered as a federal advisory committee and be subject to the sunshine requirements and oversight mandated by the Federal Advisory Committee Act.

As of 2012, improvements in the RUC include the addition of new primary care and geriatrics seats and the requirement that vote totals for all recommendations be published. The commission urges continued improvement of the RUC and encourages the CMS to look more widely at alternative sources of relative value and other payment recommendations.

CONCLUSIONS

Controlling rising expenditures for health care will not occur without changing the way that physicians are paid. This will require the aggressive pursuit of new physician-payment models with no delusions that the fee-for-service model will be swiftly or entirely eliminated. As we transition to various forms of blended physician payment, fixing current payment inequities under fee-for-service models will be of the utmost importance. Those fixes include reducing gaps in payments between different sites of care, rewarding caring for complex and underserved patients, and ensuring that evaluative and management services are valued as highly as technological care.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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APPENDIX

Members of the National Commission on Physician Payment Reform are as follows: William Frist, M.D., honorary chair; Steven A. Schroeder, M.D., chair; Judy Ann Bigby, M.D., secretary of the Executive Office of Health and Human Services, Commonwealth of Massachusetts (at the time the commission was formed); Troyen A. Brennan, M.D., CVS Caremark; Suzanne Delbanco, Ph.D., Catalyst for Payment Reform; Thomas Gallagher, M.D., University of Washington School of Medicine; Jerry Kennett, M.D., Missouri Cardiovascular Specialists and Boone Hospital Center; Richard Kravitz, M.D., M.S.P.H., University of California, Davis; Lisa Latts, M.D., M.S.P.H., M.B.A., WellPoint (at the time the commission was formed); Kavita Patel, M.D., Brookings Institution; Meredith Rosenthal, Ph.D., Harvard School of Public Health; Amy Whitcomb Slemmer, Health Care for All; Michael Wagner, M.D., Tufts Medical Center; and Steven Weinberger, M.D., American College of Physicians.

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