CATALYST FOR PAYMENT REFORM

Improving Fee-for-Service Payment

Action Brief

WHAT IS FEE-FOR-SERVICE PAYMENT?

A payment system in which an insurer pays the provider directly (or reimburses the health plan member) for each covered medical service or procedure after the expense has been incurred.

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

Fee-for-service (FFS) payments have significant strengths. This type of payment promotes access to services since it reimburses providers for every service they provide and, therefore, also offers some protection against under-treatment as well as incentives for productivity. FFS payment requires no provider integration. It is also the traditional form of payment in all other types of insurance and FFS billing systems are mature and accepted across the industry.

WHAT PROBLEMS DOES FEE-FOR-SERVICE CREATE?

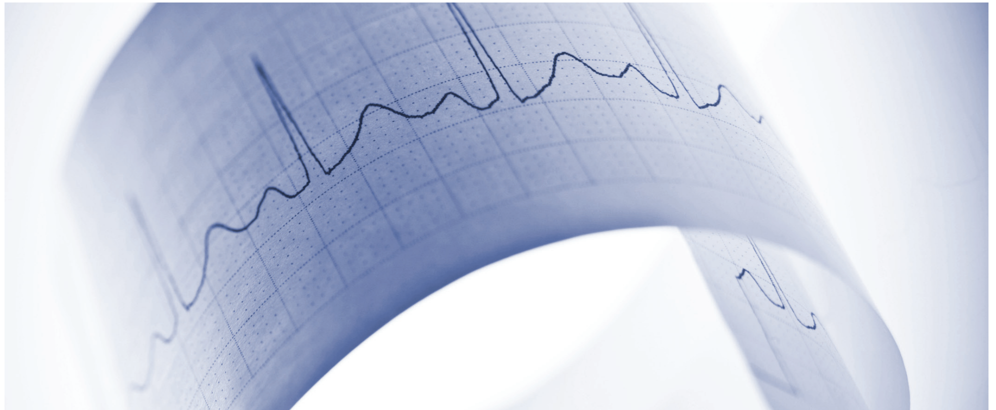
FFS also has significant weaknesses that make it an ideal target for reform in order to promote the quality and control the cost of health care:

- 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.
- 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.

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 since they will face less resistance from stakeholders (including providers, members, employers and health plans). 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.

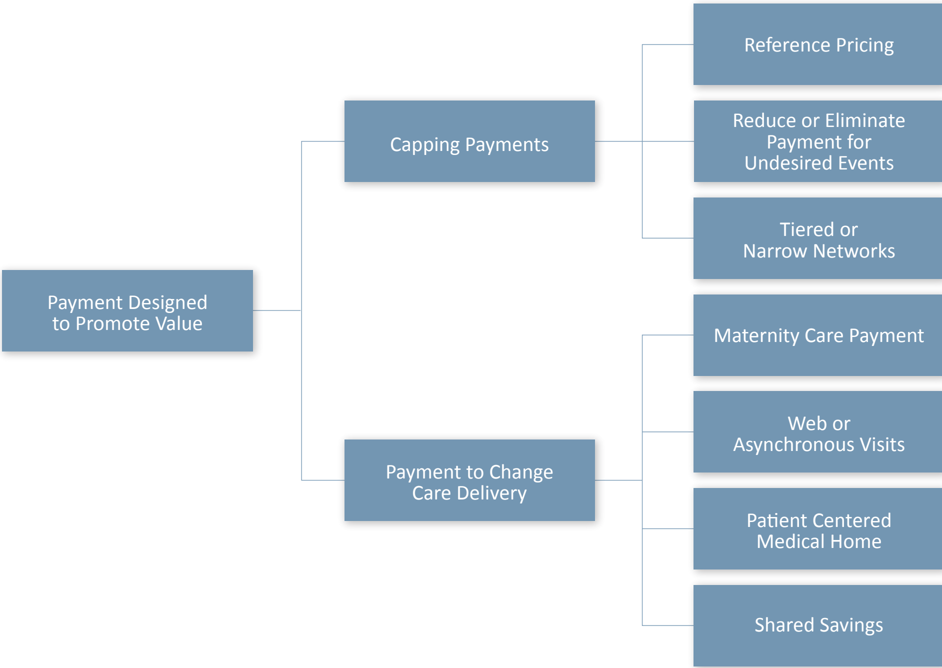
The California HealthCare Foundation provided funding for CPR to work with Towers Watson to develop a series of "potential quick wins in payment reform" centering largely on changes to fee-for service. Jeff Levin-Scherz, MD and Thi Montalvo at Towers Watson reviewed the published literature, performed interviews of experts, and analyzed a large employer claims database. Building on this work, input from health care



The criteria used for selecting the short-term reforms included (in order of importance):

- Lowers cost
- Positive impact on quality
- Health plan can administer (operations)
- Provider acceptance
- Public acceptance
- Health plan acceptance
- CPR promotion will make a difference

purchasers participating in Catalyst for Payment Reform, and a set of criteria designed to identify the most promising options, we identified to seven options for reforms that could take place in our predominantly fee-for-service payment system in the relatively short-term. The evidence regarding the impact of these options varies and in some cases is quite limited, so implementation must be followed by close monitoring and evaluation.



REFERENCE AND VALUE PRICING

Reference pricing establishes a standard price for a drug or other good, procedure, service or bundle of services, and generally requires that health plan members pay any contractually allowed charges beyond this amount. Reference pricing can also be designed to account for the quality of the provider, service, or procedure in which case it may more aptly be called "value pricing."

WHAT OPPORTUNITIES DOES IT OFFER?	WHAT PROBLEMS IT COULD PRODUCE?	WHAT STEPS SHOULD A PURCHASER TAKE?
• Encourages providers to offer lower prices • Encourages more member engagement while preserving choice • Decreases the substantial cost variation per unit • Can increase health care value	• Potentially increases employee cost-sharing • Patients may feel at odds with their physicians' suggestions for referrals • High-cost providers may protest and low cost providers may raise prices to the reference price • Administrative challenges to extend beyond elective procedures • Challenging to bundle professional and technical services • Limited ability to get accurate price information to patients before their decision	• Determine if contracted plans are offering reference pricing • Identify services with both large price variation and available comparative quality information (or for which quality can be assumed not to vary) • Push for strong price and quality transparency tools • Begin planning well in advance of implementation since this strategy requires both benefit design and insurer/Third Party Administrator (TPA) system changes • Consider issuing quality- and efficiency-based RFPs for specific services (e.g., hips and knee replacement)

EXAMPLE: Reference Pricing

The most basic reference pricing is deployed in prescription drug benefits,[1] where a reference price is set for a class of substitutable medications, and members pay any incremental costs for medications priced higher than the reference price. Research has shown that reference pricing can reduce the growth of pharmacy costs.[2] For example, British Columbia's Pharmacare program on angiotensin-converting enzyme (ACE)

KEY COMPONENTS FOR SUCCESS:

- Requires excellent price and transparency tools
- Strong communication between health plan and members

PROVIDER-FOCUSED CHANGES

- Maternity Care Payment
- Web or Asynchronous Visits
- Patient Centered Medical Home
- Shared Savings

CONSUMER-FOCUSED CHANGES

- Reference pricing
- Tier or Narrow Networks

inhibitors (to treat hypertension) among more than 120,000 elderly patients found a 29 percent decrease in the use of higher-price agents.[3]

Reference pricing can be used in other settings, too. RAND estimated a reduction of total state health care spending of 0.1 to 1.3% if reference pricing were implemented for academic medical centers in a state with heavy use of these facilities.[4] In another example, Safeway has instituted reference pricing for screening colonoscopy for employees covered under certain Safeway-sponsored health plans. In the San Francisco Bay area where, for example, screening colonoscopy was costing from $900 to $7200, it pegged the facility price for colonoscopies at $1,250. If the facility charges exceed that amount, the employee pays the difference.[5] A third example is CalPERS' PPO plan requirement that plan reimbursement for hip and knee joint replacement surgery be limited to a maximum benefit of $30,000 with the member paying 100% of any fee in excess of the reference price.[6]

Transparency of cost and quality data is critical to the success of reference pricing to ensure that patients are receiving cost-effective care with good outcomes, not merely the lowest cost care available. Comprehensive and intuitive support tools that not only educate consumers on the price and quality of providers, but also help consumers anticipate out-of-pocket costs, are needed to ensure a successful transition into a reference pricing program. For more detail, see CPR Action Brief entitled "From Reference to Value Pricing.

MATERNITY CARE PAYMENT REFORM

Create disincentives for unnecessary and potentially harmful interventions in childbirth and labor and delivery, such as pre-term elective inductions orcesarean deliveries, by removing any financial incentive to intervene unnecessarily.

WHAT OPPORTUNITIES DOES IT BRING?	WHAT PROBLEMS IT COULD PRODUCE?	WHAT STEPS SHOULD A PURCHASER TAKE?
• Aligns payment practices with evidence-based maternity care • Builds on existing bundled payments • Rewards providers who offer less-invasive care • Experience with reforming maternity payment could be used to address other overused services	• Could be perceived as de-creasing consumer choice • Runs counter to demands of some women for elec-tive interventions • Difficult to find a payment level that adequately ad-dresses the increased op-portunity cost of a vaginal delivery or a VBAC for an obstetrician	• Determine your insurer's or TPA's current approach to payment for maternity care • Determine current rates of pre-term elective births, elective inductions and cesarean deliveries • Educate workforce on hazards of intervention in labor and delivery, includ-ing elective pre-term and cesarean deliveries • Insist on transparency on key metrics • Push for health plan hospi-tal credentialing • Experiment with new forms of payment including bundled payments or a single blended hospital payment for birth

EXAMPLE: Maternity Care Payment

Labor and delivery account for nearly a quarter of all hospitalizations for many employers,[7] and costs associated with pregnancy and its complications are a driving factor in the rising costs of health care. Cesarean deliveries, elective labor inductions and elective pre-term deliveries are also the rise. The growing use of medically unnecessary interventions is increasing costs and the incidence of complications among mothers and babies, with no evidence of improved outcomes. The World Health Organization's guideline for cesarean delivery suggests that the appropriate rate falls between 5-10%, with rates above 15% potentially cause harm to mothers and babies.[8] Healthy People 2020 identified 23.5% as the United States' goal for uncomplicated,

KEY COMPONENTS FOR SUCCESS:

- Push for hospital policy to adopt evidence-based, clinical guidelines
- Elimination of financial incentives to go against evidence-based practices
- Should be paired with benefit design, patient education and provider education and credentialing

medically necessary cesarean deliveries.[9] Despite both sets of guidelines, the rate of cesarean deliveries in the US is 32%.[10]

To date, there has been little effort to use payment as a lever to improve maternity care. While many health plans pay a level global professional fee to obstetricians for vaginal and cesarean deliveries, hospitals are almost universally paid substantially more for deliveries with surgical interventions. Overall costs of deliveries by cesarean are more than 50% higher than for vaginal delivery, and remain substantially higher even after risk adjustment.[11] Early inductions for non-medical reasons can lead to higher rates of cesarean delivery and the higher costs associated with premature deliveries.

One potential payment alternative is to create a single, blended payment for an uncomplicated delivery. Under this payment structure a vaginal birth and cesarean delivery are reimbursed at the same rate, eliminating the financial incentive to have a cesarean delivery. Other options include creating more comprehensive payment bundles for maternity care, including prenatal and post delivery care, or some other combination of services and providers paid in one lump sum. By bundling more maternity services together, hospitals face more outcome-based incentives, rather than the current volume-based incentives. For more detail, see CPR Action Brief entitled "Maternity Care Payment.

KEY COMPONENTS FOR SUCCESS:

- Requires robust risk adjustment (including present on admission indicators)
- Detailed administrative claims data
- Be aware it may be hard to distinguish between conditions for which readmissions may be appropriate and those for which it is typically not

REDUCTION OR ELIMINATION OF PAYMENT FOR UNDESIRED EVENTS OR SERVICES

Lower or no payment for readmissions and/or healthcare-acquired conditions (HACs).

WHAT OPPORTUNITIES DOES IT BRING?	WHAT PROBLEMS IT COULD PRODUCE?	WHAT STEPS SHOULD A PURCHASER TAKE?
• Aligns with Medicare policy, strengthening incentives for providers and reduces opportunity for cost-shifting to private payers • Decreases incentives in today's payment system that allow providers to earn more from mistakes • Encourages safety • Encourages appropriate measurement and transparency • Some plans can implement without renegotiating with providers • Could reduce health care expenditures	• Creates additional costs associated with identifying undesired or preventable events at the hospital level • Increases payment disputes with hospitals • Administratively burdensome because it requires retrospective review since claims data may be inadequate • HACs, "never events" and readmissions are less common in the employed population, and savings could be offset by assuring care is appropriate in the first place	• Confirm that your insurer or TPA is implementing reduced or no payment policies where appropriate • Require that your insurer or TPA updates its target list as Medicare and other payers make changes • Track The Leapfrog Group and other safety organizations for recommendations • Ask your insurer or TPA to assess the financial impact of the policy • Educate employees about the policy

TIERED OR NARROW NETWORKS

Offer members limited networks, or make them pay substantially higher rates for non-preferred providers.

WHAT OPPORTUNITIES DOES IT BRING?	WHAT PROBLEMS IT COULD PRODUCE?	WHAT STEPS SHOULD A PURCHASER TAKE?
• Encourages providers to offer lower prices and gives health plans leverage to obtain lower rates • Encourages providers to meet quality criteria that can be incorporated into tiering • Provides employees with an incentive to use the higher-value (and sometimes lower-cost) provider [12] • Makes cost and efficiency differences transparent through plan design and sharing comparative quality information	• Consumer dissatisfaction with restricted access • Delivery systems may vary in value for different services, but it is complex to tier at a service or episode level • Provider resistance • Member disruption, which employers typically try to avoid • Provider quality data sometimes changes from year to year	• Identify parties in the employer, provider and payer communities interested in advancing this concept • Lend support through a) presence at meetings and legislative hearings and b) written support • Encourage health plans to make provider pricing and or payments transparent to purchasers and consumers • Consider implementation of a tiered network benefit option with cost sharing reflective of differences in provider cost • Consider implementation of a narrow network to contain costs and assure a certain level of quality

KEY COMPONENTS FOR SUCCESS:

- Premium differential must be significant compared to non-tiered plan
- Robust risk adjustment needed to ascertain true differences in quality and cost-effectiveness
- Ensure network accessibility

PAY FOR WEB OR OTHER ASYNCHRONOUS DOCTOR VISITS

Broaden payment to physicians for asynchronous care management. Specifically, enhance access to physicians via web visits which may reduce avoidable emergency department and face-to-face office visits that otherwise could be handled effectively through a virtual medium.

WHAT OPPORTUNITIES DOES IT BRING?	WHAT PROBLEMS IT COULD PRODUCE?	WHAT STEPS SHOULD A PURCHASER TAKE?
• Increases access and patient convenience • Decreases employee productivity loss associated with unnecessary office visits • Enables more efficient use of physician time • May prevent avoidable emergency department visits	• May encourage high volume of low-value web visits due to convenience • Increases number of fee for service transactions	• Determine whether contracted plans offer any payment for asynchronous visits • Ask plans to conduct pilot to assess any cost savings and impact on patient satisfaction

KEY COMPONENTS FOR SUCCESS:

- Requires investment in IT infrastructure
- Requires physician cultural change
- Requires patient awareness

KEY COMPONENTS FOR SUCCESS:

- Support for physician practices to transform
- Payment that supports infrastructure but also creates incentives to save money and improve quality
- Rapid evaluation and adjustment

PATIENT-CENTERED MEDICAL HOME (PCMH)

Provide incremental payment for primary care practices that deliver better integrated care.

WHAT OPPORTUNITIES DOES IT BRING?	WHAT PROBLEMS IT COULD PRODUCE?	WHAT STEPS SHOULD A PURCHASER TAKE?
• Reportable quality and efficiency results • Addresses need for team care for chronic disease • Enables recalibration of primary and specialty care payment • May make primary care more attractive for medical school graduates • May improve member satisfaction • Greater payments can allow primary care providers to invest in information technologies and human resources • May reduce costs for the costliest patients – those with chronic illness [13]	• Physician participation may be more strongly linked to increased revenue than a commitment to achieving better quality or lower net cost • Employees could view employer support for medical homes as implicitly supporting a limitation of access and choice • Patient centered medical homes might not produce the hoped-for cost savings • Medical practices may take longer to transform into medical homes than employers expect	• Determine if your insurer or TPA is participating in a PCMH pilot that will be evaluated, and encourage multi-payer approaches since they will likely have broader impact on physician practices • Require that practices demonstrate improved quality and reduced costs to receive added payments. NCQA recognition as a medical home may not be enough. • Ask your insurer or TPA to combine reforming payment with supporting physician practices in their use of embedded care managers by supplying helpful data

KEY COMPONENTS FOR SUCCESS:

- Physicians need infrastructure to monitor both quality and cost
- Requires robust risk adjustment

SHARED SAVINGS

Offer providers a portion of the savings they produce through better care management.

WHAT OPPORTUNITIES DOES IT BRING?	WHAT PROBLEMS IT COULD PRODUCE?	WHAT STEPS SHOULD A PURCHASER TAKE?
• Savings paid out only if costs go down • Rewards are more acceptable to providers than penalties or "risk" • Adds cost element to pay-for-performance (P4P) concept • Transition to performance-based contracting strategies that increase risk-sharing (downside risk in addition to upside risk)	• Less potent incentive for physicians than symmetrical (upside and downside) risk • Substantial lag prior to reconciliation diminishes effectiveness of provider incentive • Costs may increase since some groups may demonstrate improvement due to randomness • Savings thresholds may make this unattractive to providers	• Determine if contracted plans are offering shared savings arrangements to contracted providers • Assure plans set cost benchmarks to secure cost savings and quality thresholds to guard against withheld care • Mirror Medicare shared-savings program and/or contract with ACOs participating in Medicare shared savings program • Pursue shared risk as second phase to shared savings

Recalibrating Primary Care Payment – A Longer-term Strategy

Beyond PMCH and paying for web visits, there is a broader 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 specialty care. 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.

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-report of resource cost rather than use of objective data. 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.

Purchasers and payers have a stake in how Medicare values services, and should actively participate in opportunities to comment on and influence the 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 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,[14] and/or Medical Home initiatives as a platform. CPR will be releasing a Market Assessment Tool in 2012 that will help to elucidate the dynamics of a specific market and provide insights regarding how these characteristics could impact the success of different reforms to FFS.

ABOUT US

Catalyst for Payment Reform is an independent, non-profit corporation working on behalf of large employers to catalyze improvements in how we pay for health services and to promote better and higher-value care in the U.S.

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