Health Affairs Blog

Breaking The Fee-For-Service Addiction: Let's Move To A Comprehensive Primary Care Payment Model

Rushika Fernandopulle

August 17, 2015

Editor's note: *This article is part of a series of blog posts by leaders in health and health care who participated in* Spotlight Health *from June 25-28, the opening segment of the* Aspen Ideas Festival*. This year's theme was* Smart Solutions to the World's Toughest Challenges. *Stayed tuned for more.*

With much fanfare earlier this year, the Obama administration announced an aggressive goal to process half of all Medicare payments by the end of 2018 through alternative payment models as opposed to traditional fee-for-service (FFS). Primary care is one of the most urgent sectors needing such payment reform. As Bob Berenson succinctly put it, "Fee-for-service, the predominant physician payment scheme, has contributed to both the continuing decline in the primary care workforce and the capability to serve patients well."

Unfortunately the alternative payment models for primary care currently offered or being proposed by Medicare involve additional payments on top of fee-for-service. Like an addict, we seem unable to go "cold turkey" and instead insist on just a little of our drug.

But this approach is bound to fail. If we truly want to move to a value-driven world and support a value-based payment model, we need to be willing to drop fee-for-service entirely.

Current Fee-For-Service

Primary care fee-for-service only pays a doctor for a certain set of discrete activities—largely confined to doctor sick visits—which are tiered by means of an arcane coding system counting very discrete micro tasks, such as how many organ systems a doctor examines, or what questions a doctor asks a patient about the quality of their symptoms.

This encourages every health care issue or question to become a doctor visit (because that is paid for), and for the doctor to do most things instead of others on the team (because that is what is paid for). It leads to reactive care (since thinking of a patient not in front of you isn't paid for), and leads to

framing the job as taking care of one patient at a time, like a never-ending series of widgets on an assembly line.

Electronic health records, not surprisingly, are thus built to optimize this fee-for-service payment, particularly the coding level of each visit, and leads to lots of useless points and clicks and incredibly long notes that, in retrospect, are extremely difficult to comprehend. And practices spend a huge percent of their time and overhead dealing with all of this, which is really just a game, and does not lead to one iota of better patient care.

Fee-for-service is simply the wrong model to pay for primary care. It is toxic to good care and to physician and team culture, so we should simply stop using it, not try to supplement it. Primary care should be about continuous healing relationships, and discretely paying for services is antithetical to this.

A Comprehensive Payment Model

For the past four years we at Iora Health have been building and operating over a dozen primary care practices across the United States that are purely based on a wholly different and simple comprehensive payment model. We start with a risk-adjusted fixed fee per patient for all of our services, and in some cases add additional payment for meeting experience, quality, or utilization targets, and/or some sort of shared savings off expected total health care costs.

What we do not do is take any sort of fee-for-service payment. Our billing for employers or union trusts are often a one-line monthly email with three numbers: the number of patients we are caring for times the rate we should be paid equals the size of the check to send us. No codes, explanation of benefits, or appeals.

Instead of perceiving their jobs as seeing one patient at a time—which can feel like an assembly line worker at times—our teams now see their job as having a defined population who are their responsibility, and their role is to improve their health, and keep them out of trouble (e.g. the hospital, emergency room, and unnecessary procedures).

Our teams can now be creative to meet our patients needs however they need to — whether by the doctor, nurse, social worker, or health coach; and whether it be in person, by email, text, video, group, home, or hospital visit. They even can spend small amounts of money on patients to address non-health care needs such as housing and transportation in order to help improve a patient's overall health.

We have implemented this model successfully with different sorts of payers (we call them sponsors) with different patient populations in different parts of the country:

Individuals

We have practices where individuals pay us a fixed fee to get primary care. For instance, we have a practice serving largely undocumented, uninsured Grameen America (a Nobel prize-winning microfinance organization) members in Jackson Heights, New York.

Self-Insured Employers And Union Trusts

Based on this payment model, we contract with purchasers of care directly to build near-site practices for their employees and families. Because they are self-insured, the sponsor benefits from the decreased downstream care, e.g. reduced hospitalizations and unnecessary procedures (and improved productivity). For example, we operate practices for participants in the Culinary Health Fund, which insures hotel and casino workers in Las Vegas, Nevada, as well as employees and families of Dartmouth College in Hanover, New Hampshire.

Health Insurance Plans

We also are paid under this comprehensive care model to operate practices for members of progressive health insurers such as Medicare Advantage patients with Humana in Seattle, Washington and Phoenix, Arizona.

Lessons Learned

What we have learned is that patients love the sort of relationship-based care we can provide; our

physicians and teams love being able to do what they went into medicine to do — take care of patients and be creative in doing so, and not feel like code monkeys and assembly line workers. We are able to really do population management (focus on proactively managing chronic conditions) and improve the health of our patients, and we are able to help our patients dramatically reduce unnecessary downstream care.

Some other implementation lessons we have learned:

Payment Change Is Necessary But Not Sufficient

Comprehensive payment alone doesn't change anything, but it allows providers to then dramatically change the process model, implement fundamentally different information technology (IT) systems, and build a very different culture — this is what improves care.

Simply Changing The Way We Pay Isn't Enough

We also need to increase the share of health care spending going into primary care. The way to get the right comprehensive payment isn't to add up what we currently do in FFS. We currently spend only 5 percent or so of total health care on primary care, and we have found the right level is approximately double this (roughly 10 percent of total health care spending) in order to optimize a patient's health and total health care spending.

It Is Critical To Risk Adjust The Primary Care Payment

So you get paid more not for doing more, but for caring for sicker patients. This is important to prevent any disincentives to take care of sicker patients. There are a number of ways we have found to do this, for instance by using available risk adjusters such as HCC (Hierarchical Condition Categories) or MARA (Milliman Advanced Risk Adjuster) scores, or making the primary care payment 10 percent of the prior year's total health care spending. All of these are better than not doing any adjustment, but none are perfect, and more work needs to be done in this area.

You Need To Not Only Change How The Practice Is Paid, But Also Change How You Pay Your Providers And Others

Perhaps it is obvious, but having the practice get paid in a comprehensive model but continuing to pay your doctors by RVUs (relative value units or "productivity") is not a good idea. In general we have found simply paying our doctors (and teams) a simple fair salary is the easiest and best model. Our strategy is to hire people who are intrinsically motivated and want to work hard and do the right thing. We believe if we have to pay people a bonus to do the right thing, it's not clear why we are paying them a salary in the first place.

It Is Hard To Operate A Practice With Both A Comprehensive Payment For Some Patients And Fee-For-Service For Others At The Same Time

As long as you do any FFS, you still need the old coding and administrative systems, and it is very different to truly change the processes, technology, and culture. The sort of care one delivers to optimize comprehensive payment isn't a little different than the sort of care to optimize FFS — it's completely different and sometimes diametrically opposed.

For instance under FFS it is better economically to have a patient come in once a month whether they need it or not to get their blood pressure checked, while with a comprehensive payment model we have our patients regularly check their blood pressures at home and send them to us, and adjust their regimens by email or text messages, and only come in if these are not working.

Despite the general and growing agreement that the current fee-for-service payment model is toxic to primary care, we continue to find lots of resistance to change among both physicians and insurers. Even when we get paid a comprehensive fee, many of our sponsors continue to ask that we submit dummy claims (claims with the usual information but for which we don't get paid) anyway. Like an addict they cling to their old behaviors almost instinctively. When we ask why they need our claims they respond "because everyone else sends them to us, and we can compare you to them."

But we shouldn't compare practices based on how many visits they do, but rather on the results they produce. We are happy to be compared on our patient experience, clinical outcomes, and impact on downstream costs, but how we achieve this should be up to us, not the payer. Simply measuring visits or other FFS-like processes even if not tied to payment makes you create the same sort of discrete tracking systems that create the wrong culture and processes.

discrete tracking systems that create the wrong culture and processes.

If Medicare and others really want to innovate and create new value-based payment models, we believe they should have the courage to go "cold turkey," let go completely of fee-for-service, and allow the same comprehensive payment models we at Iora Health have been implementing for many years.

ASSOCIATED TOPICS: COSTS AND SPENDING, EQUITY AND DISPARITIES, HEALTH PROFESSIONALS, HOSPITALS, LONG-TERM SERVICES AND SUPPORTS, MEDICARE, ORGANIZATION AND DELIVERY, PAYMENT POLICY, POPULATION HEALTH, QUALITY
TAGS: ACOS, FEE-FOR-SERVICE, GRAMEEN AMERICA, IORA HEALTH, PRIMARY CARE PAYMENT MODEL, RUSHIKA FERNANDOPULLE, SPOTLIGHT HEALTH, VALUE BASED CARE

About *Health Affairs* Blog | Contact *Health Affairs* Blog | Terms Of Use | Project HOPE
Copyright 1995 - 2016 by Project HOPE: The People-to-People Health Foundation, Inc., eISSN 1544-5208.
Health Affairs gratefully acknowledges the support of many funders.