The National Physician Payment Commission Recommendation to Eliminate Fee-for-Service Payment: Balancing Risk, Benefit, and Efficiency in Bundling Payment for Care

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Together, the first three recommendations of the National Commission on Physician Payment Reform[1] propose eliminating the fee-for-service method of paying for care. Fee-for-service payment is a major driver in the US of high healthcare costs, and yet lacks an intrinsic focus on value and quality. Therefore, the first recommendation calls for a transition to payment systems emphasizing value and efficiency, such as bundled payment, capitation, and increased financial risk-sharing. Calls to end fee-for-service are not new. The national conversation on physician payment reform has spanned decades, and fee-for-service persists. However, the Commission's second recommendation articulates a finite time line for this transition: five years. Third, the Commission recommends that, whether based on remaining fee-for-service mechanisms, bundled payments, or some form of capitation, financial incentives should encourage high quality, coordinated, cost-effective, patient-centered care.

Although this vision would have been controversial a decade ago; now there is broad agreement among policymakers and throughout society that major changes in medical care payment are warranted. The Commission's principles and recommendations are mainstream, if distinctive for their clarity and weight. Yet, although conceptually compelling for society and for patients, how might such a change be accepted and implemented in day-to-day practice?

The background is well known. Healthcare expenditures have grown unsustainably, and the key drivers have been payments to physicians, along with the high costs for services and goods controlled or influenced by physicians. The aim of improving the coordination and efficiency of care as a way to reduce costs drove interest in capitated managed care in the 1990s, and more recently, the emergence of accountable care organizations (ACOs), patient-centered medical homes (PCMHs), and other global or bundled payment arrangements with incentives that reward high value healthcare.

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The Commission was created to examine the potential benefits and harms of various payment strategies and to include insights of major stakeholders, including the challenges posed by physicians' dual responsibilities to individual patients and to society. As was the case during the managed care era, there are concerns with new value-based payment arrangements. As healthcare providers (physicians, hospitals, and other care organizations) assume financial responsibility for the overall health and medical care of groups of people—essentially undertaking health insurance functions—the needs of individual patients could be compromised by efforts to limit overall costs.[2] Underuse of necessary care is a risk under any system that does not provide cost-plus reimbursement. However, fear of underuse does not allow us to ignore the imperative for efficiency and cost-containment in an age of increasing financial constraints. Healthcare expenditures divert funds that might otherwise be used to support other important social needs. Balance among competing priorities must be achieved in a way that accounts for individuals' and society's needs, costs, benefits, and risks.

The Commission's recommendations endorse the principles of bundling and capitation (or global payments), which transfer much of the insurance function, including financial risk and gain, to care providers. However, in advocating for increased risk-sharing by providers, the Commission insists that clinicians and their organizations be prepared—and appropriately supported—to provide more coordinated and efficient care. Doing so will likely require some reallocation of resources: from episodic care to longitudinal care; from procedural care to cognitive care; from diagnostic profligacy to "choosing wisely;" and from care focused solely on the individual to a greater concern with population health—all supported by sophisticated health information systems.

In evaluating alternatives to fee-for-service, the Commission recognized that bundled payment and capitation are not equivalent. Rather, they define a spectrum of models in which providers assume more or less risk for a larger or smaller portion of total care. Clearly, the more financial risk providers assume, the greater the incentives for efficiency, but also for stinting on care. At one end of

the spectrum, bundling of services for discrete episodes of care (e.g. ambulatory cataract surgery, including preoperative and postoperative care) does not threaten the patient-physician relationship in any broad sense, but also offers limited opportunities for savings. Total global care capitation is riskier, particularly when the risks are shared among relatively few clinicians, but offers the prospect of radically transforming care. Safeguards such as publicly reported quality metrics (and especially measures of underuse) will be crucial for all forms of risk-sharing, but especially for the more ambitious, broader, forms of capitation.

An increased focus on payment mechanisms that reward value and efficiency could inadvertently diminish the patient-centered focus that characterizes high-quality healthcare. Patients find financial incentives to control costs concerning, are partially reassured by the addition of quality metrics to these payment schemes, and strongly favor disclosure of these incentives.[3] Rather than devising new payment mechanisms in backrooms populated by policy experts, a broader dialog with the public and with our patients is warranted to reach a broader consensus about the risks and benefits of moving away from fee-for-service towards alternatives that all stakeholders, including patients, find acceptable.

Beyond the Report's scope are potential risks for the healthcare industry, such as consolidation of healthcare systems that could limit patients' options, reduce competition, and increase costs.[4] These and similar system risks, along with stinting of care for individuals, will need to be monitored. This will be a multi-stakeholder societal discussion, but primary care physicians, with responsibilities to our individual patients and to the public, and with leadership roles in healthcare, must be especially attentive to these issues and deeply involved in this conversation. And in this, special attention must be given to potential conflicts of interest that might raise concern. To take advantage of bundling of care and payment while also protecting individuals and the public, all relevant viewpoints must be incorporated.

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