



RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

Fee Schedules for Physicians and Other Health Professionals

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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the nine payment methods discussed in the report *Payment Methods: How They Work*. All reports and chapters can be found on our project page: [Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care](#).

Fee Schedules for Physicians and Other Health Professionals

A fee schedule is a list of the maximum rate a payer will allow for services, with the definition of services based on code sets such as CPT (Current Procedural Terminology) in the United States and ICD-10 PCS (International Classification of Diseases, tenth revision, Procedure Coding System) in some other countries. Typically, the payment is the lower of the provider's actual charge or the fee schedule allowance. Most payers determine fee schedules first by establishing relative weights (also referred to as relative value units) for the list of service codes and then by using a dollar conversion factor to establish the fee schedule.

Before payers used fee schedules, they used variations what is referred to as the usual, customary, reasonable (UCR) method. This approach, modeled after the method most private payers used at the time, was enacted into law as Medicare's method for compensating physicians in 1965. Medicare's version was referred to as CPR—customary, prevailing, and reasonable—representing the lowest of (1) the physician's billed charge for the service, (2) the physician's customary charge or the physician's

median charge for the service over 12 months, or (3) the prevailing charge for that service in the geographic community. CPR was criticized as inherently inflationary, inciting physicians to continually increase their charges. Moreover, CPR perpetuated distortions in charges by providing better insurance coverage for tests and procedures than for evaluation and management services such as office visits.

Eventually, payers came to view predetermined payment maximums as a preferred approach. Initially, from the 1960s through the 1980s, payers based relative value units on prevailing charges in various markets, as with the California Relative Value Scale. Rather than rely on charges that may not reflect the underlying resource costs of providing services, Medicare's physician fee schedule, introduced in 1992, is based on estimates of covered services' relative resource costs, the value of physicians' work as measured by time and service intensity, and professional liability costs. These resource costs are adjusted for differences in input prices for goods and services in different markets, then the total is multiplied by a standard dollar amount—the conversion factor—to arrive at the payment allowance. Most U.S. payers base their own fee schedules on Medicare's, although they generally use different conversion factors; payers then sometimes modify actual fees based on price negotiations with individual practices.

Typically, fee schedules pay retrospectively for one-time services—a procedure, a test, an office visit. However, some fee schedule codes are forms of capitation (e.g., payment for a month of dialysis-related professional services) or are episode based (e.g., payment for a 90-day “global” period of postsurgery routine care, a month of complex chronic care coordination).

Key Objectives

Fee schedules for professionals, including physicians, promote professional activity in general and specific professional activities in particular by providing generous payments for services payers intended to encourage. In many national health systems and throughout the United States, fee schedules are the foundational approach on which other payment methods are based.

Strengths

- In contrast to payments based on physician charges, a fee schedule gives payers more control over payment, offers predictable payments, and counters the inevitable inflationary effect of UCR-based payment methods.

- Fee schedules reward activity and industriousness and promote patients' access to care because providers get paid more for doing more.
- The approach is consistent with how transactions are conducted in retail markets, so payers can rely on consumers' and patients' discipline with cost-sharing to affect service use and prices.
- Fee schedules are well established, with well-described impacts; specific reform proposals have been made to improve fee schedule functioning and performance.
- Theoretically, the approach can encourage desired behavior by paying more to encourage or less to discourage provision of particular services.
- A fee schedule implicitly adjusts for the different case mixes different clinicians and practices experience, thereby paying comparatively more for sicker patients that need more services.
- The approach provides payers with data about patient care, which can then be analyzed to establish performance measures or used for other purposes.
- Fee schedules can accommodate elements from other payment reform approaches that are similar to capitation or episode-based payments while also permitting targeting of particular services. The approach does not require adoption of a full, fee schedule replacement approach.

Weaknesses

- Fee schedules encourage overprovision of services, because clinicians often determine the need for services and can induce patient demand.
- The method ignores whether the service was appropriate or performed well; payment is provided for activities, not for outcomes. Indeed, even inappropriate or poorly performed services that generate need for additional services are paid.
- Fee schedules can contribute to care fragmentation, as fee schedules provide no inherent incentive for providers to coordinate care.
- Fee schedule payments generate a large number of billable transactions; this in turn generates high administrative costs for health professionals.

- Activities not codified and covered for payment in a fee schedule may be marginalized. In fact, many activities clinician practices perform are not recognized for payment because transaction costs exceed the value of the services or because the payer has difficulties assuring the services were actually performed.
- Coding complexity, with U.S. payers relying on more than 8,000 codes, makes fee schedules susceptible to “gaming” or outright fraud.
- Payers must make major effort to keep the list of recognized services and their associated fees current, reflecting technological changes and work process improvements that alter relative resource costs. Without that effort, relative fee levels distort professionals’ use of time and the mix of services they provide.
- No data are currently available from which to determine relative values for services; current fees rely on flawed estimates of work and practice expenses that somewhat reflect clinicians’ self-interest. Clinicians who help payers set relative values seem to overvalue tests and procedures, while undervaluing time spent with patients in office visits and other so-called cognitive activities.

Design Choices to Mitigate Weaknesses

Most payers using fee schedules must decide how to counteract the inherent incentives for providers to continually increase service production, thereby increasing costs. Medicare has attempted to establish macro-level expenditure limits that would reduce pro rata fees when a target level is exceeded.

Medicare’s sustainable growth rate (SGR) mechanism (in place for more than 15 years) seemed to give clinicians a perverse incentive to increase volume of services, even as the collective interest would have been to restrain service production. In the face of what would have been major formula-driven fee reductions, Congress repealed the SGR in 2015.

An alternative approach would be for payers to modify individual fees to more closely approximate underlying resource costs. In the past, private payers have relied on Medicare’s relative value scale to set fees. Yet, Medicare’s relative fees are generally thought to exhibit payment distortions, overvaluing tests and some procedures and underpaying activities provided by primary care physicians and so-called cognitive specialties. Other payers can more actively participate in the rule-making process that determines Medicare fee schedule payment rates or can on their own attempt to modify relative values,

although these payers would be negotiating with practices that have a financial interest in resisting such modifications. The market area's particular practice environment would likely affect how successful such a strategy would be.

Payers, including Medicare, have recently recognized they can create new fee schedule codes to reward evaluation and management activities that had never been specifically paid, including complex chronic care management and activities related to patients' transitions from hospitals to community-based or other postacute settings. Paying for some important services (e.g., routine phone calls and e-mail communications) on a fee schedule is challenging, because the transaction costs of billing and receiving might be more costly than the service itself. However, a range of other activities might be amenable for inclusion on a fee schedule.

Some elements of value-based payment can actually be included on a fee schedule. To address problems such as "upcoding" or outright fraud, payers can consider reducing the granularity inherent in the CPT coding system, which unintentionally promotes complexity and encourages providers' gaming to achieve higher payment, by not fully recognizing current fee differentials for marginally more complex services. Payers could also reduce gaming by "packaging" some low-cost ancillary services into the other services for payment purposes, thereby reducing providers' incentives to perform overvalued tests, as is done in the Medicare outpatient hospital payment system.

In sum, fee schedules could better recognize "value" through consideration of coding changes, greater accuracy in establishing relative values, reduced coding granularity, clearer coding rules, and other improvements.

Finally, some have proposed that a more direct approach to fee schedule design would add value. Instead of basing relative value units—and fees—only on resource costs, fees could be based on policy judgment. In other words, fees would be modified so that health professionals would change the mix of services they provide, with the goals of producing high value mix of services and altering how clinicians spend their time. However, Medicare would find changing fee levels to produce higher value politically challenging, with difficulty achieving consensus. Private payers modifying fees to accomplish a higher-value service mix would still be subject to market negotiations, with physicians sometimes able to prevent changes that would alter their fees.

Compatibility with Other Payment Methods and Benefit Design Options

Fee schedules are commonly a foundation for other payment methods because they are in such broad use. For physician payment, only capitation approaches represent a rejection of fee schedules as the base payment (even though an organization receiving global capitation may itself distribute payment to its constituent members through fee-schedule-based productivity metrics).

Fee schedules could be combined with capitation and pay-for-performance or included in other hybrid approaches, as adopted in other countries such as Denmark and the Netherlands. The hybrid fee schedule/capitation approach attempts to balance overuse and underuse incentives to approach payment neutrality, while still paying physicians their rough variable costs for additional fee-schedule services. For example, a hybrid payment system could pay primary care physicians 70 percent of a revalued, more accurate fee schedule and 30 percent capitation—with some element of public reporting and possibly payment for performance.

Fee-for-service is compatible with many benefit design options that rely on greater or variable cost-sharing. These designs provide consumers the choice to forego services they think unnecessary, with all the potential strengths and weaknesses of cost-sharing as a cost-containment strategy. Indeed, benefit designs that encourage consumers to shop prudently for physician services assume fee schedule payments—patients' cost-sharing obligations are based on the prices associated with fee schedule services.

The Focus on Performance Measurement

Measures of clinical appropriateness are desirable but few are available, largely because claims data (i.e., the data payers generally rely on to construct performance measures) lack the clinical nuance needed to assess appropriateness. This is especially true for the many services for which appropriateness relies on individual patients' characteristics, including their personal preferences. Given that basic fee schedule payments are agnostic about quality—they pay regardless of how well the service was provided—quality measures could well complement fee schedules, such as with the recently enacted Merit-Based Incentive Payment System (MIPS) for physicians in traditional Medicare. The pay-for-performance (P4P) strategy for improving quality and value for physicians (and other providers)

remains controversial, with evidence of its effectiveness still unclear —although it is being adopted by many payers, fostered by Medicare’s initiative.

Potential Impact on Provider Prices and Price Increases

The existence of fee schedules does not mean that prices in commercial insurance markets are necessarily consistent across either payers or individual providers. In fact, evidence suggests fee-schedule prices vary widely both across and within markets, from as little as 70 percent of the Medicare rate in some markets to more than 500 percent for some large practices in other markets. Analysts believe the variation occurs because different physicians and insurers having different leverage in their negotiations, which in turn may be attributed to factors such as an area’s level of competition and a hospital’s or physician practice’s reputation.

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A [technical expert panel](#) advised the project team and reviewed the reports at different stages.

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