Fee for Service Payments: Affect on Patient Care, Operating Room Procedures and Anesthesia Services

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• Medicare • Payment reform • Care fragmentation
• Bundling • Medical home

Medicare's traditional method of paying for units of service, be they hospital admissions, office visits, outpatient surgeries, or laboratory tests, evolved gradually from a payment system that originated in the 1930s, when private insurance for hospitalizations and physician services first emerged in this country. At that time, hospitals were just beginning to cure patients, emerging from their centuries-long primary function as almshouses that provided housing and minimal comforts to the sick poor. Desperate for capital resources, hospitals founded the first hospitalization insurance plans and designed their largely cost-based, open-ended payment systems to favor their own expansive growth. Physicians in the 1930s reluctantly joined private, largely physician-controlled insurance schemes to stave off compulsory public insurance. Fee-for-service was the payment system of choice for keeping insurers, with more restrictive or prescriptive forms of payment, out of the practice of medicine. Hospitalization and physician payment systems were designed to entice providers into accepting them, not to ensure that the right care was delivered at the right place and at the right time.

TOO MANY PAYMENT SILOS

The delivery system has come a long way since the 1930s, when the hospital was the physician's private workplace. As capital costs and technological advances have accelerated, hospitals, physicians, and other health care providers, willingly or not,

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have become increasingly interdependent, but current payment systems and medical culture do not reflect these changed relationships. Medicare's 18 separate payment systems for 16 different provider/supplier types, plus two types of private insurance plan (medical and drug) represent an elaborate scheme of "silos" that frequently pits the interest of one set of providers (eg, physicians) against the interests of another (eg, hospitals), leaving the patient in a daze, looking for an ombudsman.

PROLIFERATION AND FRAGMENTATION IN THE SITES OF TREATMENT

Changes in the sites of treatment have exacerbated fragmentation. Medicare expenditures for inpatient care have fallen from 50% of total traditional (non–managed care) spending in 1996 to only 34.5% in 2006.[1] In the same decade, Medicare spending for outpatient care rose from 4.5% to 8.3% of total traditional spending, and spending for "other fee-for-service settings" including hospice, outpatient laboratory, ambulatory surgical centers, and health clinics, grew from 11.2% to 15.5% of total traditional spending. For surgical procedures, the shift from hospital-based to free-standing ambulatory surgical centers (ASCs) has been dramatic: Medicare payments to ASCs doubled between 2000 and 2006, and the number of ASCs increased by more than 50% to 4707. Surgical care runs the risk of increased fragmentation with the proliferation of hospitals specializing in cardiac, orthopedic, and general surgeries. The number of such specialty hospitals grew from 46 to 89 between 2002 and 2004 and reached 130 in 2006 after the 2004–2005 moratorium on new specialty hospitals expired.[2] Even within hospitals, new "noninvasive, nonsurgical" approaches to disease via radiology and medical specialty clinics increase the likelihood of fragmentation by adding a whole new cadre of providers with whom the patient and the primary care-giver must interact, often without an infrastructure for doing so.

INCREASE IN THE NUMBER AND TYPES OF PHYSICIANS INVOLVED IN PROVIDING SERVICES

Even within the same payment silo (eg, physician services), the scope and number of providers involved in specialty treatment has increased the need for better care coordination. Within imaging services, for example, where growth in units of service per beneficiary has exploded in the last decade, radiologists now receive 43% of Medicare payments; the rest go to cardiologists (25%), surgical specialties (9%), independent diagnostic testing facilities (8%), internal medicine (6%), and other specialists (10%).

The average Medicare beneficiary sees five physicians a year. Nearly two thirds of Medicare beneficiaries with three or more common chronic conditions (eg, coronary artery disease, congestive heart failure, and diabetes) see 10 or more physicians in a year.[3] Yet fewer providers than ever are willing to spend the time, much of it unreimbursed, to coordinate care or communicate with the patient or other providers regarding the implications of the various tests and procedures provided.

Because of fragmentation, lack of coordination, and the fee-for-service incentives of Medicare payment, there is enormous variation in resource use and adherence to recognized quality standards and outcomes within severity-adjusted episodes. For instance, for similar severity-adjusted hypertensive patients, a high-cost cardiologist in Boston spends 1.74 times more on evaluation and management, 1.56 times more on imaging, and 1.39 times more on tests than the average Boston cardiologist. Similar variation occurs across metropolitan areas: in 2002, physicians in Boston treating Medicare patients for hypertension used 96% of the national average resource use per episode, whereas physicians in Houston and Miami used 120%,