Reenvisioning Specialty Care and Payment Under Global Payment Systems

Bruce E. Landon, MD, MBA
Department of Health Care Policy, Divisions of General Medicine and Primary Care, Harvard Medical School, Boston, Massachusetts.

David H. Roberts, MD
Pulmonary, Critical Care, and Sleep Medicine, Beth Israel Deaconess Medical Center, Boston.

Under the current fee-for-service (FFS) payment system, specialists developed practice styles and business models that flourished by maximizing the delivery of highly reimbursed services. Specialists today, however, are likely to be concerned about forthcoming global payment models that are designed to reduce the inexorable increase in health care expenditures by promoting high-value services, eliminating low-value services, and improving care coordination and integration. For many specialists, this new world of global payments is slowly evolving from an amorphous concern to a potential threat to their livelihoods.

This disruption to the current norms of specialty practice, and both the concerns and opportunities presented by global payments, are evident in discussions occurring throughout the country, although likely with greater urgency in physician organizations already transitioning to global payment systems such as those participating in the Medicare accountable care organization programs. As this transition accelerates, even though much of the clinical revenue from specialists will continue to be generated from standard FFS payments, increasing numbers of patients will be covered under global budgets, even if in many cases another care system is “at risk.”

Nationwide, specialists likely are considering potential innovations to better manage patients under global risk arrangements. For instance, specialists in some areas can envision designing aggressive team-based programs aimed at reducing hospitalizations for high-risk cases of diabetes or chronic obstructive pulmonary disease with the assistance of a nurse or case manager. Others might note the opportunity for improved coordination with primary care. While currently specialists might be seeing patients with chronic medical conditions such as asthma or kidney disease 3 or 4 times per year (often with diagnostic testing that provides additional revenue, but little new information), they may recognize that many of these cases could easily be sent back to primary care physicians for the majority of their care, which would free up specialists’ schedules so that they could offer more timely access to those who truly needed their specialized knowledge and consultative services. Yet current incentives and financial models are not in place to support these innovations, which would all result in decreased FFS revenue. Additionally, and perhaps more importantly, there currently are financial disincentives to innovate, to hire practice extenders, or to offer additional consultative services, by phone or e-mail. Neither in the current FFS payment model nor in most global payment models with incentives targeted solely for primary care practitioners are there mechanisms to support such innovations in care delivery.

The current systemic constraints and contracting incentives beg the question, how should the delivery of and compensation for specialty services be structured under global payments? Specialists ideally would be motivated to not only provide optimized patient care and enhanced consultative services to their primary care colleagues but also be actively involved in redesigning practices, coordinating care, reducing unnecessary care, and improving efficiency. To achieve these goals, however, specialists must be incentivized to provide timely, thoughtful, and value-added care, even if it means changing the way that care is delivered. Such change will require overcoming years, if not decades, of deeply ingrained (and currently lucrative) behaviors that have evolved under the current FFS system.

For both patients and primary care practitioners, a key need is to obtain appropriate specialty input, but that input need not be in the form of face-to-face visits. The medium for this message may vary widely ranging from telephone consultations to e-mail or other messaging platforms, as well as asynchronous web- or video-based interactions. Traditional visits likely will remain the norm, but increasingly interactions may involve such non-visit-based encounters. Thus, under these models, job descriptions and the day-to-day activities of many specialists will change markedly, and specialist compensation methods must account for these new activities. Several likely outcomes may result, although the extent to which each of these becomes common in individual practices, organizations, and markets will vary considerably.

First, in more integrated delivery markets with prior experience with risk contracting, there is likely to be resurgence of risk-based models of specialty compensation wherein groups of specialists receive a fixed per-member-per-month fee to provide specialty care. These fees (or budgets) can be based on an entire enrolled population or can be triggered when a patient first sees a specialist. Specialist physicians may continue to receive FFS payments with intermittent reconciliation, or they might shift to mixed compensation models with salary or specific remuneration for currently uncompensated activities. Under such models, specialists will have more freedom to allocate their fixed resources to providing higher-value services and will have less incentive to see patients more frequently or perform procedures. Organizations, however, will need to put systems in place to ensure continued clinical productivity.

Second, when used, the current FFS system compensation models will need to be adapted to cover unreimbursed activities that may be valuable. Compensating physicians for services such as e-mail, telephone, and curbside consultations will need to be paired with new metrics documenting the value of these services. In addition, spe-
specialists also will need to be responsible for and incentivized to improve population-based care (eg, endocrinologists responsible for reducing an entire population's mean hemoglobin A1C) with active outreach, peer practice review, and physician education on how to determine when, whom, and why to refer to specialty care.

Third, it is likely that increasing numbers of specialists will become salaried employees of hospitals or health systems and that compensation will become less linked to actual FFS revenue generated by direct physician services. For instance, "cognitive" specialists, such as infectious disease physicians, are crucial to hospitals' functioning; yet these physicians receive lower pay than many other specialties. Thus, to ensure the availability of infectious disease consultants, hospitals may need to supplement their pay beyond the level of typical FFS payments.

Fourth, as care becomes more tightly managed, certain specialists may see substantial decreases in the demand for their services. Low-value services will diminish or be eliminated and peer education will allow for care that does not require specialty input to be provided by primary caregivers, possibly leading to less frequent initial and follow-up consultations and fewer procedures in some specialties. Practice style evolution as described above (eg, e-mail/telephone consults, enhanced disease management, incorporation of mid-level providers such as nurse practitioners or physician assistants, and care managers) will also put downward pressure on demand.

Fifth, specialists also should be prepared to see a reduction in income, particularly when compared with primary care and cognitive specialties that have been underreimbursed in the current FFS system. Current relative payment levels have been codified in the fee schedule used by Medicare that also serves as a model for FFS payment by most private health plans. Even capitated systems that do not use FFS reimbursement must pay market-level salaries to attract qualified specialists. Many health policy experts have long noted the current inequities, and current Medicare Payment Advisory Commission (MedPAC) recommendations call for a rebalancing of primary care and specialty pay to address these inequities. Combining with the likely decreased demand noted above, it is difficult to envision a future in which both payment levels and pay relative to primary care are not adjusted down for many specialties.

The coming tide of payment reform as well as continued, if not escalating, cost pressures as the Affordable Care Act is implemented and an additional 30 million individuals obtain some form of health insurance present great opportunities for innovations in how health care services are organized and delivered. For the first time in US history, more patients and physicians will operate in a system in which there are defined boundaries for costs. There may be substantial shifts in how resources are spent, whether shifting from specialists to primary care physicians or from inpatient to outpatient settings. These changes will have dramatic effects on specialist practice, with implications both for how specialists practice as well as for the forms and levels of their compensation. Although changes in specialist roles and responsibilities will better align specialists with the goals of integrated care systems, with likely benefit to the health care system overall, these changes are also likely to result in substantial changes in specialist pay and number.

ARTICLE INFORMATION

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REFERENCES