

PRESIDENT'S COLUMN

SGIM Convenes the National Commission on Physician Payment Reform: Determined to Get it Right this Time!

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In this column a year ago, citing both the current increasing interest in accountable care organizations (ACOs) and the seeming acceptance of capitated payment by general internists in the 1990s, I called for us to contribute more completely now than we did then to the examination of benefits and hazards of such strategies. All SGIM members address, in some way, the need to improve the coordination and efficiency of care, to reduce costs for care, and to strengthen the central role of general internists. But at a national level, how could we best contribute to a revision of a central driver of health care costs—physician payment? Could we contribute to getting payment reform right this time? It seemed a propitious time for SGIM to call for a National Commission on Physician Payment Reform. I am pleased now to be able to announce the composition and initiation of the Commission's work.

The National Commission on Physician Payment Reform will assess how physicians are paid as potential impacts of proposed health care payment models, such as ACOs, patient-centered medical homes, and value-based purchasing. We are grateful beyond words that Steve Schroeder, MD, our former president and the former president of the Robert Wood Johnson Foundation, has agreed to chair the group, working alongside Bill Frist, MD, the former Senate majority leader and distinguished physician. The Com-

mission is comprised of 11 other members (see below) and will complete its work within a year—culminating in a report that we hope will receive serious attention from those who will ultimately influence the policy process.

Health care expenditures are growing at unsustainable rates, and key drivers of this escalation are the payment for physicians and for services and goods controlled or influenced by physicians. There have been decades of micro- and macro-level adjustments of physician payment and systemic approaches to rein in costs in ways that are intended to also improve the delivery of care. Improved coordination and efficiency of care to reduce costs drove interest in capitated managed care in the 1990s and in ACOs more recently. Similarly, patient-centered medical homes (PCMHs) have been proposed to promote better and coordinated care as part of global payment arrangements with incentives for improved efficiency.

In these and other models in which health care providers (physicians, hospitals, and other care organizations) take on overall financial responsibility for the medical care of groups of people—thereby assuming part or most of the health insurance functions—there are concerns about balancing the needs of individual patients with the need to limit overall costs. Yet the need for constraining costs cannot be dodged. The nation needs a thoughtful and focused discussion of this topic, as

costs of health care are not solely the purview of patients, providers, and payers—they reverberate throughout the health care system and beyond. Health care expenditures divert funds that otherwise would be available for nursing homes, jails, teaching hospitals, schools, transportation infrastructure, and many other public services. This situation simply must be addressed.

To do this, the Commission will address the opportunities and risks of the coming health care payment configurations and come to consensus on the following and related tough questions:

- What are the ideal forms of physician payment that will maximize good clinical outcomes, enhance patient and physician satisfaction and autonomy, and provide incentives for cost-effective care?
- Given the enormous size of the American health care system and the central role of physicians in generating costs, what are the optimal incentives and safeguards surrounding the three principal forms of physician payment: fee-for-service, capitation, and salary?
- Given the increasing commercialization of medical care, with issues of physician ownership of equipment, payment from industry, and

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public disclosure of performance, what are the best mechanisms to provide transparency of conflicts of interest?

- How can general internists and other physicians attain a payment system that maximizes the important goals of access, quality, and efficiency?

At this juncture, for patients, the public, and the success of practitioners, what is needed is an authentic conversation that leads to practical and attractive guidance for alternate models of care. That will be the expectation of the Commission.

The Commission will be charged with writing a balanced, nuanced, and constructive report that, in clear language, reflects the insights of major interested stakeholders' dual responsibilities to individual patients and to society. The report is expected to incorporate ideas and input from crucial non-physician players at the core of the health care system (e.g. payers, administrators, regulators, and business leaders). The report is intended to be authoritative, to make specific recommendations, and to be sufficiently compelling to be recognized as providing a very important explication of key issues with practical ways to address them and thereby serve as a useful roadmap for all charged with navigating a future American health care system that both constrains costs and optimizes care.

I am now delighted to be able to announce the composition of the Commission and its initiation. The Commission was limited to a dozen members to allow for an efficient writing group and was composed to have outstanding leadership and a diverse membership—not only to

leverage the generalist perspective but also to have representation of those in insurance, policy, and a range of medical specialties who will be key to implementing the Commission's recommendations for physician payment.

The best decision I've made as president was choosing Steve Schroeder as the Commission's chair. This decision was based on a whole host of reasons—but among them, the universally acknowledged fact that he is a beloved health care community leader. And, of course, we are deeply honored that Senator Frist has agreed to lend his counsel and broad-based insight to the Commission's work.

The other Commission members, all with great expertise and commitment to the Commission's mission, include:

- Judy Ann Bigby, MD, Secretary of Health and Human Services, Commonwealth of Massachusetts, previous SGIM president, and general internist;
- Troyen A. Brennan, MD, MPH, JD, Executive Vice President and Chief Medical Officer of CVS Caremark Corporation and CVS Pharmacy, Inc., previously Chief Medical Officer and Senior Vice President of Aetna Inc., and general internist;
- Suzanne F. Delbanco, PhD, President of the Health Care Division at Arrowsight, Inc., and previously founding CEO of The Leapfrog Group;
- Thomas H. Gallagher, MD, Associate Professor at University of Washington in the Departments of Medicine and the Bioethics & Humanities and general internist;
- Jerry D. Kennett, MD, FACC,

Member of the American College of Cardiology Board of Trustees, President of the Missouri State Medical Association, and practicing cardiologist;

- Richard L. Kravitz, MD, MSPH, Co-Editor in Chief, *Journal of General Internal Medicine*, Professor and Co-vice Chair of Research, Department of Internal Medicine at University of California, Davis, and general internist;
- Lisa Latts, MD, MSPH, MBA, Vice President for Public Health Policy at WellPoint and general internist;
- Kavita Patel, MD, MS, Managing Director for Clinical Transformation and Delivery at the Engelberg Center for Health Care Reform and Fellow in Economic Studies at the Brookings Institution, formerly a member of the Obama administration and senior staff to the Senate Health Education Labor and Pensions Committee under Senator Kennedy, and general internist;
- Meredith B. Rosenthal, PhD, Professor of Health Economics and Policy in the Department of Health Policy and Management at the Harvard School of Public Health;
- Michael Wagner, MD, FACP, Chief Medical Officer at Tufts Medical Center and Chief of General Internal Medicine and Adult Primary Care, Associate Professor of Medicine, formerly CEO of EmCare Inpatient Services, and general internist;
- Steven E. Weinberger, MD, FACP, Executive Vice President and CEO of the American

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College of Physicians and internist and pulmonologist; and

- Amy Whitcomb Slemmer, Esq., Executive Director, Health Care For All.

I also need to thank key financial supporters of the Commission's activities and support, especially the Robert Wood Johnson Foundation, the California HealthCare Foundation, and the Sergei Zlinkoff Fund for Medical Education and Research. The work of the Commission will be coordinated by Leslie Dunne at the SGIM central office, and communications and advocacy will be led by

Burness Communications. I am particularly grateful to Andy Burness, who, as a veteran of many national commissions and health policy programs and efforts, has worked closely with Steve Schroeder and me in organizing the Commission and will be key to how we translate the work of the Commission into policy and practice.

As physicians and citizens, we all suffer from the failures of our current payment systems, and with our broad perspective on individual patient care and health care, and with other key members of the payment system, after decades of at-

tempts, it is crucial that our nation gets this right. It is natural that SGIM contribute to this; as general internists, we recognize our dual responsibilities both to our individual patients and to the public. With great appreciation to the Commission, including its general internists and others, I am excited and hopeful that this time we will contribute to getting it right.

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