Interview with Steven Schroeder: Leading the National Commission on Physician Payment Reform

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I had the wonderful opportunity to sit down with Steven Schroeder, MD, chair of the National Commission on Physician Payment Reform. The brainchild of Harry Selker, SGIM past president, the Commission was charged with assessing current physician payment systems, incentives that drive physician’s care recommendations, and new payment systems to yield better results for both payers and patients. At the national meeting, which focused on innovation in health care, there was a lot of buzz about the Commission.

PR: How did you approach the work that was charged to the Commission?
SS: Harry (Selker) first approached me with his concern that bundled payments under ACOs (Accountable Care Organizations) created potentially perverse incentives for physicians to withhold needed care. He asked whether I would chair a commission on that topic. I responded that all forms of physician payment contained potentially perverse incentives, starting with fee for service. So Harry agreed to broaden the topic to physician payment reform, and we went from there. Initially, we were not sure whether we should address the SGR (sustainable growth rate) since it was so entwined with Washington politics. However, as we started doing our work, it became apparent that if we did not address the SGR, we would lack relevance.

PR: Atul Gawande recently tweeted, “Fee for service is dead.” How do you respond to this? Most practicing physicians do not believe this.
SS: I would say that the demise of fee for service has been predicted for some time now. Like Rasputin, it is very hard to kill. Many smart policy wonks think it will die soon; however, we will have to wait and see. I had the opportunity to meet Wilbur Cohen, the principal architect of Medicare, in the 1970s and ask him why Medicare incorporated the usual, customary, and reasonable fee schedule for paying physicians. He confessed that it was an attempt to gain the support of the American Medical Association, and in retrospect it was an unfortunate concession. But by then it was too late to change things.

PR: Is the Commission a primary care initiative? Should we not align with the other primary care organizations? So far the ACP (American College of Physicians) is the only organization that has, sort of, supported it.
SS: I believe that this is not a primary care only issue. It’s an issue that affects the neurologists, cardiologists, pediatricians, and family docs—everyone. How you pay physicians affects everyone. It is also important to note that we did have representation from other fields in the Commission—we had a cardiologist and a pulmonologist and a cardiac surgeon. Rather than posing this as primary care against everyone else, the Commission decided to make common cause with all physicians who use evaluation and management (E & M) services.

PR: With health reform, ACA, do you worry that rather than cost savings, we are only moving toward cost shifting?
SS: The ACA was really charged with expanding coverage rather than actual cost containment. It did contain some cost containment features, but they are much less robust than the coverage expansion features.

PR: Did the Commission address student debt? A couple out of medical school easily can start out with a combined debt burden of around $600K. We have seen that it does have some effect on the choice of specialties, particularly those who are more open in career choices.
SS: The Commission did spend some time talking about student debt, but addressing it fell outside the charge of the Commission. My (personal) opinion is that medical education is much too expensive and that graduating with large debt exerts unfortunate influences on subsequent career choices. However, I don’t believe that the debt burden is the only thing influencing student career choice. Lifestyle issues, including the ability to do shift work, are important for this generation—exemplified by the ROAD (radiology, ophthalmology, anesthesiology, and dermatology) specialties. Also I think primary care is not for the faint hearted—many students want to be masters of their domain, and it is harder to master the myriad conditions that present to the primary care physician.

PR: As we look at value in the context of physician payment reform, can you comment on supply? It is estimated that we will be adding about 15 to 20 million more patients to a system that is already stretched. There appears to be a looming shortage in primary care.
SS: It is time for the development of teams and leadership. States won’t pay a lot for Medicaid services, and it is likely that access may be restricted. Many doctors won’t accept Medicaid, and it is...
conceivable that federally qualified health centers and county hospitals and clinics will see the bulk of these newly insured patients. The Massachusetts experience worked relatively well but started from a high level of population insurance coverage to begin with. Each state will probably contrive a different solution, and there will be no magic bullets. NPs and PAs will surely play an important role, but in some states, like California, we are seeing that they are quite expensive and that they too have a problem with numbers choosing primary care. The emergence of concierge primary care is a fascinating new market place phenomenon. On the one hand, it clearly represents a protest against the pace and reimbursement of ordinary primary care. It seems to be flourishing in high-income areas where wealthier people are willing to pay the concierge fee in order to get the kinds of service they want. As such, concierge care is clearly in conflict with the egalitarian impulses of most SGIM members. On the other hand, to the extent that it sends a message to influencers, who find it hard to locate a primary care physician, that might generate more favorable reimbursement and other policies to help strengthen primary care.

PR: What can the primary care doctor do to support the work of the Commission?

SS: Write to your Congress representatives and senators—find influential and support candidates who will help us. Write Op-Eds for newspapers, radio. It is interesting how primary care doctors are so persuasive when it comes to their patients and are such strong advocates; yet when it comes to our field, we are not. Also, the extent to which primary care physicians have access to health insurance executives is another route to payment reform. Remember that “the moral arc of the universe is long but it bends towards justice.” I am reassured and impressed that medical students continue to go into medicine for the right reasons—nourish and nurture them. While primary care practice can be challenging, it is a rewarding field.