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The National Commission on Physician Payment Reform and Health Policy Implications: Perspectives from a Hospital CEO

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SGIM has endorsed the recommendations of the National Commission on Physician Payment Reform. For the recommendations from the report to be refined and executed, input from all key stakeholders will need to be elicited. In the spirit of administrative advocacy, I requested a meeting with Mimi Roberson, the chief executive officer of Presbyterian/St Luke's (P/SL) Medical Center in Denver, CO, and asked her to review and provide insights regarding the report's recommendations from the viewpoint of a hospital executive. For background, P/SL is a for-profit HCA hospital that assists in supporting a general internal medicine primary care training program and hospitalist program for the University of Colorado in collaboration with the Colorado Health Foundation. Prior to my request, she had not heard of the report but did quickly note that having Bill Frist as a co-chair of the Commission added extra value and credibility.

In regard to the specific recommendations, Ms. Roberson had a favorable reaction to the report's effort to focus payment reform on the current disproportionate value proposition created by fee for service and to improve parity of payment for clinical services offered by primary care providers. Recommendations from the report to strengthen the outpatient management of patients with the intent to reduce unnecessary hospitalizations align well with the strategic goals of the hospital and thus are talking points to emphasize when advocating with hospital administrators.

Key recommendations of the report focus on converting from fee-for-service to value-based payment for clinical services. The complexities of multiple variables in play with chronic care management are not lost on hospital administrators. However, to make the recommendations more valuable and deliverable, it is critical to discuss with policy makers the importance of standardization of data definitions and the need to have uniform platforms to optimize sharing of clinical information across health systems to help make this recommendation a reality.

I was surprised to hear that recommendation #7, which discusses reimbursement for telemedicine services, was the one that caught her attention the most. Ms. Roberson's viewpoint is that a robust method to enhance and encourage communication between internal and external referring providers is critical to reduce unnecessary hospital admissions and transfers. For this to happen, Ms. Roberson's opinion is that credentialing will need to move from the current state-specific method to a process of national credentialing; thus, this could be an actionable advocacy point to discuss with policy makers.

The recommendations of the National Commission on Physician Payment Reform have the intent to fundamentally change how physicians are paid—and hospital executives interpret this statement to mean all physicians, not just primary care. For example, the report lacked commentary on income generated by physicians-owners of outpatient surgery centers. A possible unintended consequence could be that declining reimbursement for specialty services could result in cost shifting, with specialists looking to hospitals to buffer their financial losses. One mechanism to do this would be for specialists to leverage federal EMTLA rules that require hospitals to have full scope specialty call coverage. Specialists could begin asking the hospital to pay more for these professional relationships; therefore, it is reasonable to review these federal requirements with policy makers in this changing landscape of payment reform. Also not receiving comment in the report were work-life balance issues of today's physicians and the consequences associated with income and benefits relevant to part-time providers.

So how can general internists be most effective for advocating at the hospital administrative level regarding the recommendations of the National Commission on Physician Payment Reform? In Ms. Roberson's opinion, physicians are seen by hospital administrators as clinical partners, and it is important that hospitalists and outpatient physicians become united in patient management with hospitals and health care systems. The National Commission for Physician Payment Reform provides a vehicle to spur conversations between general internists and hospital administrators. The need for partnership and ongoing dialogue has never been stronger or more critical during this time of significant change in the systems of health care delivery.

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