Report of

The National Commission on
PHYSICIAN PAYMENT REFORM

March 2013

> "Our nation cannot control runaway medical spending without *fundamentally changing how physicians are paid.*"

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EXECUTIVE SUMMARY

The United States spends nearly three trillion dollars a year on health care—more than any other developed country—yet provides care of uneven quality.

Recognizing that the level of spending on health care in the United States is unsustainable, the return on investment is generally poor, and the way that physicians are paid contributes substantially to the high cost of health care, The Society of General Internal Medicine (SGIM) convened The National Commission on Physician Payment Reform in March 2012 to recommend new ways to pay physicians that will ultimately improve patient outcomes but also rein in health care costs.

The commission was charged with assessing current physician payment systems, the incentives that drive physicians' care recommendations, and exploring new payment systems to yield better results for both payers and patients.

Chaired by Steven A. Schroeder, MD, with former Senator William H. Frist, MD, serving as the honorary chair, the 14-member commission comprised physicians from a variety of specialties, as well as others who are expert in health care policy, delivery, and payment.

The United States health care system is plagued by the twin ills of high cost and uneven quality. Health care spending in the U.S. represents 18 percent of gross domestic product or $8,000 per person annually. As a proportion of the federal budget, the cost of Medicare has risen from 3.5 percent in 1975 to 15.1 percent in 2010. In 2020, it is projected to consume 17 percent of the federal budget. This enormous investment has not produced a commensurate improvement in the nation's health. In fact, the health status of Americans pales in comparison to other nations, with the U.S. ranking 37th in health status.

Many factors drive the high level of expenditures in our health care system, yet several stand out:

- **Fee-for-service reimbursement.** Under this model, physicians are reimbursed for each service they provide. Pay is not necessarily linked to outcomes.
- **Reliance on technology and expensive care.** The federal government and private insurers reimburse technology-intensive procedures—such as imaging or surgery—at higher rates than services focused on evaluating patients or managing the care for chronic conditions over time, such as an appointment to discuss diabetes management.
- **Reliance on a high proportion of specialists.** The U.S. has a high ratio of specialists to primary care physicians. The higher-intensity, higher-cost practice of specialists makes their care particularly expensive. The current payment system favors high-cost procedures over time spent on evaluation or management of care.

- **Paying more for the same service or procedure when done in a hospital setting as opposed to an outpatient setting.** For example, Medicare pays $450 for an echocardiogram done in a hospital and only $180 for the same procedure in a physician's office.

HOW PHYSICIANS ARE PAID DRIVES HEALTH CARE EXPENDITURES

The commission examined the factors that contribute to high cost and uneven quality, and the consequences to society and individuals, examining the role of physician payment. While physician salary and related expenses account for 20 percent of health care spending, the decisions they make influence an additional 60 percent of spending.[1] The commission reviewed the ways in which physicians are compensated, focusing on the incentives of fee-for-service payment toward more—and more expensive—care and the potential for fixed payment mechanisms such as capitation and bundling of fees to promote more prudent, high value health care. The commission concluded that our nation cannot control runaway medical spending without fundamentally changing how physicians are paid, including the inherent incentives built into the current fee-for-service pay system.

The issues currently facing physician payment fall into two general categories:

- **Systemic issues**—specifically, the skewed incentives of fee-for-service payment.
- **Medicare issues**—in particular, the sustainable growth rate (SGR) and the operation of the Relative Value Scale Update Committee (RUC).

COMMISSION RECOMMENDATIONS

The commission's recommendations focus on the near-term, calling for drastic changes to the current fee-for-service payment system and a five-year transition to a physician-payment system that rewards quality and value-based care. The recommendations pertain to the way physicians are paid throughout the health care system—both public and private payers.

The commission adopted twelve recommendations.

Our nation cannot control runaway medical spending without fundamentally changing how physicians are paid.

The recommendations stress the importance of eliminating the current fee-for-service payment system and provide a blueprint for transitioning to new systems over a five-year-period. They also call for transparency in determining how physicians are paid and services reimbursed, and offer suggestions for how to eliminate the SGR and its associated "doc-fix."

Transitioning from fee-for-service

The first three recommendations propose a rapid transition away from fee-for-service payment, yet recognize the need to fix current fee-for-service system inequities while the system is still in place. It is likely that fee-for-service will remain relevant for some time given that many delivery and payment models being tested under the Affordable Care Act, such as accountable care organizations (ACOs) and bundled payments, still pay individual doctors on a fee-for-service basis.

1. Over time, payers should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives.

2. The transition to an approach based on quality and value should start with the testing of new models of care over a 5-year time period, incorporating them into increasing numbers of practices, with the goal of broad adoption by the end of the decade.

3. Because fee-for-service will remain an important mode of payment into the future, even as the nation shifts toward fixed-payment models, it will be necessary to continue recalibrating fee-for-service payments to encourage behavior that improves quality and cost-effectiveness and penalize behavior that misuses or overuses care.

Recalibrating fee-for-service and advancing fixed payment models

The next six recommendations provide a blueprint for transitioning to a value-based blended payment model over a five-year period, focusing on increasing reimbursement for evaluation and management services, reducing gaps in payment for the same physician services regardless of specialty or setting, and advancing bundled payment and capitation:

4. For both Medicare and private insurers, annual updates should be increased for evaluation and management codes, which are currently undervalued. Updates for procedural diagnosis codes should be frozen for a period of three years, except for those that are demonstrated to be currently undervalued.

5. Higher payment for facility-based services that can be performed in a lower-cost setting should be eliminated.

6. Fee-for-service contracts should always incorporate quality metrics into the negotiated reimbursement rates.

7. Fee-for-service reimbursement should encourage small practices (those having fewer than five providers) to form virtual relationships and thereby share resources to achieve higher quality care.

8. Fixed payments should initially focus on areas where significant potential exists for cost savings and higher quality, such as care for people with multiple chronic conditions, and in-hospital procedures and their follow-up.

9. Measures to safeguard access to high quality care, assess the adequacy of risk-adjustment indicators, and promote strong physician commitment to patients should be put into place for fixed payment models.

Medicare payment

The final three recommendations focus on ways to improve physician payment within the Medicare program:

10. The Sustainable Growth Rate (SGR) should be eliminated.

11. Repeal of the SGR should be paid for with cost-savings from the Medicare program as a whole, including both cuts to physician payments and reductions in inappropriate utilization of Medicare services.

12. The Relative Value Scale Update Committee (RUC) should make decision-making more transparent and diversify its membership so that it is more representative of the medical profession as a whole. At the same time, CMS should develop alternative open, evidence-based, and expert processes to validate the data and methods it uses to establish and update relative values.

There is no question that we need to reform our physician payment system. Both private and public payers must take steps now to move the U.S. toward a physician payment system that drives higher quality and more cost-effective care, and helps improve not only individual health but that of the nation.

The Commission is funded in part by the Robert Wood Johnson Foundation and the California HealthCare Foundation.

THE COMMISSION'S RECOMMENDATIONS WERE BASED ON THESE PRINCIPLES:

- Payment reform should result in a decreased rate of growth in total per capita expenditures and improve the efficiency, effectiveness, and quality of health care delivery systems.
- Payment reform should encourage the routine delivery of evidence-based care and discourage inappropriate care or care that adds minimal value.
- Payment reform should encourage caring for and managing those with complex medical problems, multiple social support needs, and those who are traditionally medically disadvantaged.
- Recalibrating physician reimbursement should be done by considering total medical expenses not just as a zero-sum game of current physician-related expenses. Supplementation of incomes of specialists with high proportions of evaluation and management services can come from reducing marginal, ineffective and harmful services.
- Payment reform should be transparent to patients and the public. Interested patients should have access to easily understood summary-level information about how physicians are paid.
- Payment reform should reward patient-centered comprehensive care that manages transitions between sites of care and among providers of care.

BACKGROUND

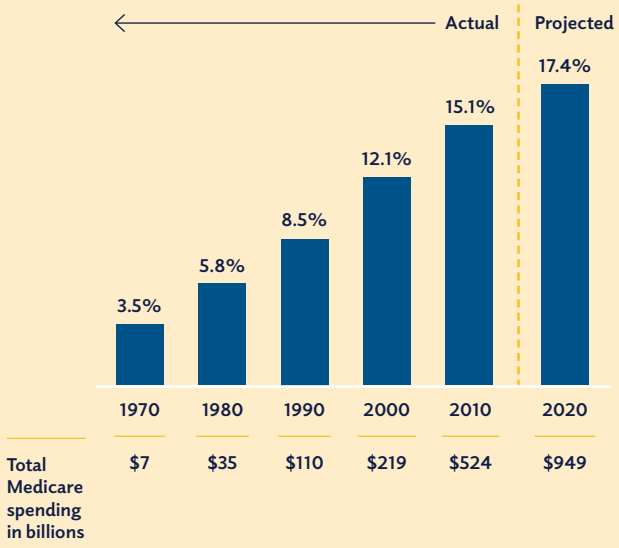
The United States health care system is plagued by the twin ills of high cost and uneven quality.

At the national level, high spending on health care—especially within the Medicare program—threatens to crowd out other social expenditures and contributes significantly to the national deficit. Expenditures for Medicaid are squeezing the budget of nearly every state.[2] For businesses—especially small ones—and individuals, high premiums make health insurance virtually unaffordable. Although the Affordable Care Act promises some relief, more action is needed to address the high and rising cost of care.

At nearly three trillion dollars a year—18 percent of gross domestic product or $8,000 per person annually—expenditures on health care in the U.S. exceed those of any other developed country.[3] As a proportion of the federal budget, the cost of Medicare has risen from 3.5 percent in 1975 to 15.1 percent in 2010 ($524 billion in 2010). In 2020, it is projected to consume 17 percent of the federal budget (4 percent of GDP).[4]

This enormous investment of resources has not produced a commensurate improvement in the nation's health. At its best, American health care is unsurpassed anywhere in the world. However, the health status of Americans pales in comparison to other nations. The World Health Organization ranked the U.S. 37th in health status—behind, among others, Oman, Morocco, and Paraguay.[5] A recent Institute of Medicine study concluded, "Americans… are, on average, in worse health than people in other high-income countries."[6]

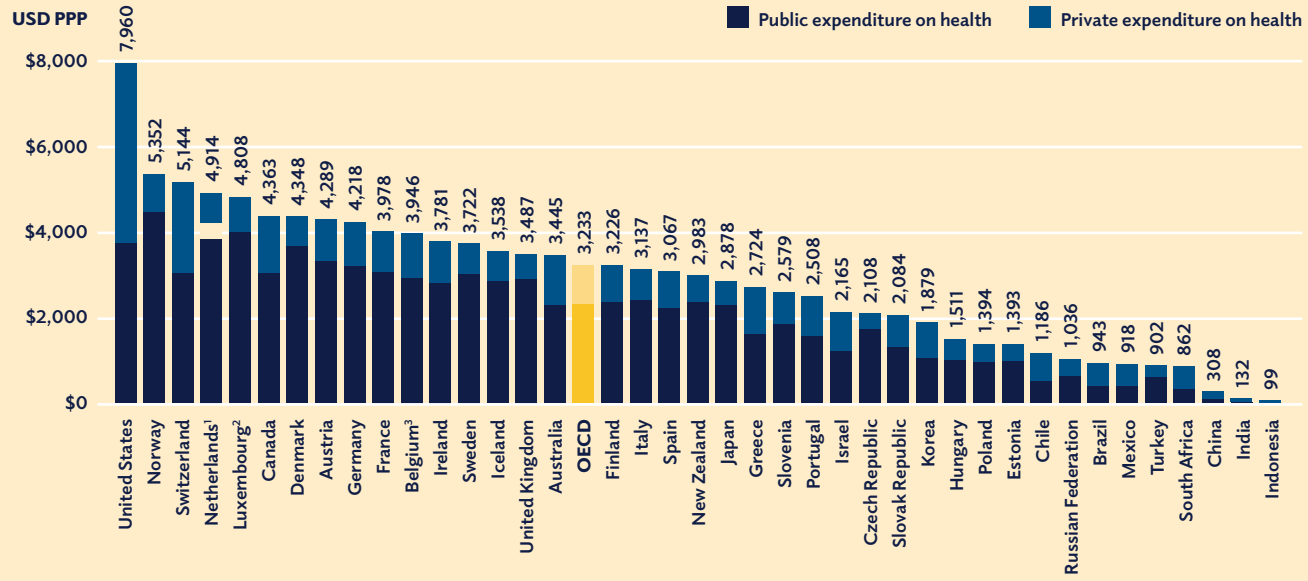
MEDICARE SPENDING AS A SHARE OF FEDERAL BUDGET OUTLAYS, 1970–2020



Source: Henry J. Kaiser Family Foundation and Congressional Budget Office, Budget and Economic Outlook, January 2010 (for 1970 data) and January 2011 (for 1980–2020 data, except 2010 which comes from CBO August 2010 Baseline: Medicare). Historical total spending for 1970–2000 from 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

* Estimates for 1970–2010 represent total Medicare outlays, estimate for 2020 represents projection of mandatory Medicare outlays. CBO (August 2010) projects discretionary Medicare outlays will be $9 billion in 2020.

TOTAL HEALTH EXPENDITURE PER CAPITA, PUBLIC AND PRIVATE, 2009 (OR NEAREST YEAR)



1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Health expenditure is for the insured population rather than the resident population.
3. Total expenditure excluding investments.

Source: OECD Health Data 2011; WHO Global Health Expenditure Database.

Recognizing that the level of spending on health care in the United States cannot be sustained indefinitely, that the return on investment is generally poor, and that the way in which physicians are paid contributes substantially to the high cost of health care, the Society of General Internal Medicine (SGIM) convened The National Commission on Physician Payment Reform in March 2012, chaired by Steven Schroeder, MD, with former Senator William Frist, MD, serving as honorary chair.

The commissioners agreed upon a set of six principles and twelve recommendations to guide physician payment reform.

WHY THE UNITED STATES SPENDS SO MUCH ON HEALTH CARE

Although no single aspect of the U.S. health care system explains why the country spends so much on health care, several features of our delivery and financing of care drive costs higher and set the U.S. apart from other developed nations.

Fee-for-service reimbursement

The basic payment model in the U.S. is fee-for-service, which reimburses physicians for each service they deliver. This creates a financial incentive to provide more—and more costly—services. Physicians determine the kind and quality of care patients receive and can be influenced by the incentives for costly care that the system offers.

Reliance on technology and expensive care

The federal government, through Medicare and Medicaid, and private insurers, which tend to follow the federal government's lead, reimburse technology-intensive procedures at higher rates than cognitive services—that is, those services requiring time for evaluation and management of patients.

A high proportion of specialists

The United States has a comparatively high ratio of specialists to primary care physicians, and most patients can self-refer directly to those specialists. The higher-intensity, higher-cost practice of specialists makes their care particularly expensive. Systems with a greater emphasis on primary care have been shown to deliver better outcomes at a lower cost.[7]

The disproportionately high number of procedural specialists and the relative lack of cognitively focused physicians is a direct result of a payment system adopted by Medicare and mimicked by private insurers that values time for services provided under procedure codes more highly than time provided under evaluation and management (E &M) codes. High reimbursement for procedures also subtly nudges specialists such as gastroenterologists and pulmonologists away from E& M services and toward doing procedures.

As a result, physicians doing diagnostic or therapeutic procedures earn considerably more than physicians who mainly evaluate and manage patients—even those with multiple chronic conditions. In 2011, a radiologist, on average, earned $315,000 a year, while a family doctor on average earned $158,000.[8] This has led medical students—many of whom leave school heavily in debt—away from the E & M specialties and toward the higher paying procedural and imaging specialties.

Consolidation in the health care industry

In recent years, the pace of hospital-system consolidation has accelerated. Because of their increased market share, large health care systems can negotiate higher reimbursement for services provided by their physicians than can physicians working independently or in smaller practices—leading the larger systems to acquire physicians' practices. For their part, physicians are banding together in larger groups to increase their own bargaining power and gain higher reimbursement.[12] This has led to a situation where private payers often pay different rates for the same service, depending on the negotiating power of the provider.

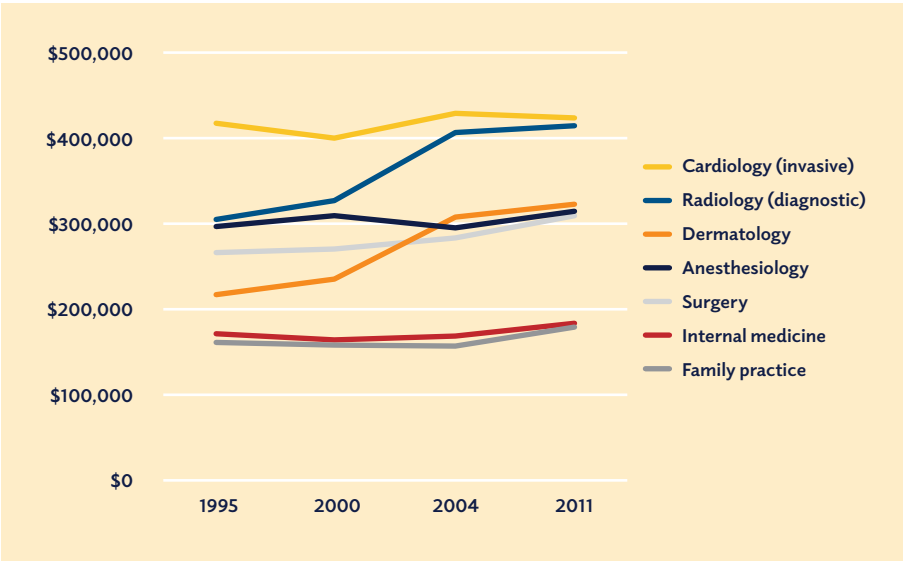
A disproportionate percentage of health care spending directed to a small number of people who are very sick and costly to treat

The distribution of spending on health care in the U.S. is skewed toward a small number of people who are extremely expensive to treat—many of them frail, elderly, and with four or five chronic illnesses. Five percent of patients account for nearly half of all health care expenditures.[13]

High administrative costs

Although Medicare's administrative costs are only 2 percent,[14] those of private insurance companies and health plans routinely reach 13 percent or more.[15] Administrative costs are expected to diminish in the future with the Affordable Care Act's requirement that at least 85 percent (80 percent for individual products) of premiums be devoted to health care.[16]

ANNUAL PHYSICIAN COMPENSATION BY SPECIALTY (IN $2004)



Source: Bodenheimer 2007[9], AMGA 2011 [10], Bureau of Labor Statistics[11].

Fear of malpractice lawsuits

Although major studies have demonstrated that malpractice is not a significant driver of health care costs,[17] the fear of lawsuits does influence physician behavior. Under the threat of lawsuits, physicians may practice defensive medicine, ordering unnecessary tests and providing unnecessary medical services.[18]

Fraud and abuse

The Institute of Medicine estimated that in 2009 health care fraud accounted for $75 billion, or 3 percent of the nation's $2.5 trillion health care budget that year.[19] Former CMS Administrator Donald Berwick and RAND Corporation analyst Andrew Hackbarth estimated that Medicare and Medicaid fraud and abuse could account for up to $98 billion and that system-wide, the cost of fraud and abuse could be $272 billion.[20] While the exact dollar amount may not be known, fraud and abuse clearly contribute to high health care costs.

THE CONSEQUENCES OF HIGH HEALTH CARE EXPENDITURES

The high and rising expenditures for health care affect society at large as well as individuals and families. Government spending on health care limits the amount available for education, transportation infrastructure, and other societal needs, and it threatens financial wellbeing at every level of government. Premiums are often so high that small businesses do not insure their employees and people choose to take their chances and go without insurance.[21] And uninsured people delay going to the doctor until they are very sick—and expensive to treat.[22]

The high and rising expenditures for health care affect society at large as well as individuals and families.

Even with the expansion of coverage under the Affordable Care Act, expenditures for health care will remain high unless action is taken to lower them.

HOW PHYSICIANS IN THE U.S. ARE COMPENSATED

Physicians in the United States are generally compensated in three ways: fee-for-service, fixed payment, and salary. In an effort to curb costs and improve quality of care—especially the care of those with multiple chronic conditions—other approaches to physician payment are being tried.

Fee-for-service

Fee-for-service is the predominant way of compensating physicians and, despite its problems, appears likely to remain so for the foreseeable future.[23] Fee-for-service arrangements have many advantages and are popular with the public. In practice, fee-for-service allows people to go to the physician of their choice and creates incentives for those physicians to be accessible. It does not restrict physicians from referring patients to specialists and for tests, which many patients desire and believe to be in their best interest. Moreover, it allows payers to know what they are buying and provides a handy way of auditing.

Fee-for-service also has many disadvantages. Most significantly, it provides an incentive to increase volume—especially for highly reimbursed care. Fee-for-service payments also disadvantage physicians who primarily deliver evaluation and management services because they can only increase volume by scheduling more and shorter appointments. Many health policy analysts consider fee-for-service to be the single most important driver of the high cost of health care.[24]

Fixed payment

Payment to physicians of a set amount can come in a variety of forms—two of the most common being capitation and bundling. A distinguishing factor of fixed payment is that physicians may bear some or all of the financial risk of patient care, that is, they may either share in the savings as compared to historical charges or market rates, or bear part or all of the increased cost.

Capitation

Under capitation, physicians are paid a specified amount, often on a monthly basis, per patient they agree to serve. The capitation model has a number of advantages. One of them is that it is agnostic about what services a patient receives and where they are delivered—a capitated provider can deliver care by phone, at home, or any way that is deemed most effective and efficient. A second advantage is its focus on primary care and prevention. A third is that since physicians may themselves bear the risk for the cost of care, it creates incentives for cost-efficient services, keeping people healthy, and reducing spending on unnecessary care.

Capitation also has disadvantages, particularly its implicit restriction of patients' choice of physician and the incentive it offers physicians to limit access to expensive downstream services, such as referrals to specialists and imaging, in order to maximize financial returns. These negative aspects surfaced during the late-1990s, leading to a backlash against managed care and a subsequent retreat from its more restrictive elements.

Bundling by episode or event

Under this payment mechanism, a fixed price is paid in return for care related to a specific condition, event, or episode such as a hip replacement or a heart attack. Similar to diagnostic-related groups that Medicare uses to pay hospitals, this payment mechanism should encourage better coordination within physician teams and among physicians, hospitals, and others involved in patient care. With a fixed price for the total episode, physicians have a financial incentive to be more prudent than they would under fee-for-service.

However, bundled payment faces a number of practical difficulties: defining what is in the bundle; finding ways to divide payment among participating physicians; determining what to do when some physicians involved in the care do not share in the bundled payment; and factoring in the health status of patients (risk-adjustment).[25]

Salary

Salaried payment alone does not explicitly encourage either overuse or withholding of expensive services. A salaried physician (without bonuses or other performance incentives) might tend to over-refer complex patients, however, because there is no reward for managing such patients on one's own. In general, incentives associated with salaried payment are less "high-powered" than either fee-for-service or fixed fee arrangements. Salary is typically only found in larger employment arrangements, however, because other management mechanisms must take the place of incentives in aligning medical practice with the payer's goals.

A growing number of physicians are forgoing independent practice entirely and choosing to practice medicine as paid employees. The national physician search firm, Merritt Hawkins, found that in 2011, 56 percent of their searches assignments were for hospital-based jobs, which often are salaried employment positions—up from 23 percent five years earlier.[26]

As is the case with fee-for-service and fixed payment mechanisms, salaried physicians can receive additional compensation for meeting financial or quality targets.

With a fixed price for the total episode, physicians have a financial incentive to be more prudent than they would under fee-for-service.

For example, Geisinger Health System has developed a physician compensation plan that pays 80 percent of salary based on work effort, mainly measured by relative value units, and 20 percent on individual and group performance, as measured by a proprietary survey.

HYBRID PAYMENT MODELS

Many health policy experts believe that alternative delivery and payment systems, such as accountable care organizations with shared savings and patient-centered medical homes with care coordination fees,

represent promising approaches to reducing cost and improving quality.

Accountable Care Organizations

Spurred by the Affordable Care Act, accountable care organizations (ACOs) are viewed as a way to shift financial incentives away from fee-for-service and, through sharing of financial savings or risk, toward a system that emphasizes prevention, care coordination, quality, and value. ACOs are integrated networks of providers—often hospital systems and physician groups—that, in theory, assume financial risk for the quality and total cost of the care they provide. CMS has established several programs to test the concept—the Medicare Shared Savings Program, the Pioneer Accountable Care Program, and the Physician Group Practice Transition Demonstration Program. Additionally, private health insurers have been actively organizing ACOs in many locations around the country.[27]

Currently, most physicians in ACOs are reimbursed by fee-for-service and can share in cost savings if specified quality and financial benchmarks are met. Very few physicians have, to date, agreed to accept the downside risk of potential financial loss should expenditures exceed budget. Whether ACOs save money and improve quality is uncertain; results to date are mixed.[28]

The Patient-Centered Medical Home

The Patient-Centered Medical Home (PCMH—sometimes called Primary Care Medical Home) model has the goal of transforming care from a volume-based model to a value-based one that rewards quality and efficiency and compensates doctors for care that has not traditionally been reimbursed, such as disease management and clinical interventions outside of office visits. Believed to be particularly effective for coordinating the care of individuals with several chronic conditions, the model is built around a primary care physician who coordinates patient care and is often paid by capitation or a global budget (though care coordination fees or other bonus arrangements are sometimes included).[29] Although still unproven in large-scale demonstrations,[30] results from some early PCMH experiments have shown cost savings and improved quality of care.[31]

PAYING PHYSICIANS UNDER MEDICARE

Fee-for-service

Medicare pays physicians primarily by fee-for-service. Under the current system, a relative value unit (RVU) is assigned to every medical service that physicians carry out and that will be reimbursed by Medicare.* The RVU is then converted into a monetary value based on a conversion factor and the geographic location of the physician.**

Since the RVU system was first instituted in 1992, it has been the subject of criticism. Some of the criticism has been conceptual, for example:

- The payment system values the time for procedures that require surgery or technology (such as interpreting CT scans or inserting a stent) more highly than those requiring evaluation and management (for example, an office visit to educate a patient about a new diagnosis such as diabetes). It has skewed the field toward high-cost, high-tech medicine and away from evaluative medicine and primary care.

* The Centers for Medicare and Medicaid Services (CMS) uses Current Procedural Terminology (CPT) codes to determine services that it will reimburse for Medicare enrollees, and each CPT code has an assigned relative value unit.

** The relative value unit is based on the RVRBS, which defines the value of a service. It is based on cost and has three components. Physician work accounts for the time, skill, physical effort and mental judgment involved in providing a service and is approximately 52% of the relative value unit. Practice expense refers to direct costs incurred by the physician and includes the cost of maintaining an office, staff and supplies and accounts for 44%. Practice liability expense takes into account the malpractice insurance essential for maintaining a practice and is 4% of the calculation.

- Since the physician payment system is based on the resources physicians use, order, and prescribe rather than the outcomes their patients experience, it encourages practitioners to provide more, and more expensive, services, thus potentially rewarding overtreatment and waste. It does nothing to encourage physicians to improve either the efficiency or the quality of care.

Other criticism is leveled at the way the Medicare physician payment system works in practice. Critics charge that the AMA/Medical Specialties Societies Relative Value Scale Update Committee (RUC), which advises CMS on updating the amounts paid by Medicare for every procedure, is dominated by specialists at the expense of primary care; meets generally out of the public eye; does not disclose individual votes on recommendations; and fails to release the transcripts of meetings.

The Sustainable Growth Rate

Established by the 1997 Balanced Budget Act, the Sustainable Growth Rate (SGR) is the method that Congress established to control the growth of physician reimbursement under Medicare. It basically pegs payment for physicians' services to the growth of gross domestic product (GDP).*** If the cumulative rate of spending for physicians' services under Medicare exceeds the target SGR in a given year, payments for physicians' services the following year are supposed to be reduced, and vice-versa.

Every year, Congress is advised on a fee schedule for physicians' services for the coming year based on the estimated payments to physicians compared with the target SGR in the current year. In 2002, payments for physicians' services exceeded the SGR. This resulted in a 4.8 percent reduction in Medicare reimbursement to physicians, which caused an outcry in the physician community. Every year since then, payments for physicians' services have exceeded the SGR, and every year Congress has stepped in to prevent cuts in payments for physicians. This is the "doc-fix," and it has taken place 15 times over the past decade, most recently in January 2013. Overall, since 2002, physicians' reimbursement under Medicare has increased only 3 percent while the consumer price index rose 20 percent during the same time.

*** In reality, the SGR is somewhat more complicated. The rate is determined by four factors: (1) the estimated percentage change in fees for physicians' services; (2) the estimated percentage change in the average number of Medicare fee-for-service beneficiaries; (3) the estimated ten-year average annual percentage change in GDP per capita; (4) the estimated percentage change in expenditures for physicians' services due to changes in law or regulation.

PRINCIPLES

The issues currently facing physician payment fall into two general categories:

- **Systemic issues**—the skewed incentives of fee-for-service payment and the proposed system-wide changes that would shift to a physician-payment system that offers incentives to provide value-based care.
- **Medicare issues**—the SGR and doc-fix, RVUs as a way of determining physician payment, and the operation of the RUC.

The commission agreed upon recommendations that address both these categories. But first, however, the commission adopted six principles that should guide any system of physician payment reform. The principles are:

- Payment reform should result in a decreased rate of growth in total per capita expenditures and improve the efficiency, effectiveness, and quality of health care delivery systems.
- Payment reform should encourage the routine delivery of evidence-based care and discourage inappropriate care or care that adds minimal value.
- Payment reform should encourage caring for and managing those with complex medical problems, multiple social support needs, and those who are traditionally medically disadvantaged.
- Recalibrating physician reimbursement should be done by considering total medical expenses not just as a zero-sum game of physician-related expenses. Supplementation of incomes of physicians with high proportion of evaluation and management services can come from a reduction in the utilization of marginal, harmful, ineffective, or unnecessary medical or other services.
- Payment reform should be transparent to patients and the public. Interested patients should have access to easily understood summary-level information about how physicians are paid.
- Payment reform should reward patient-centered comprehensive care that includes management of transitions between sites of care and among providers of care.

RECOMMENDATIONS

The commission adopted twelve specific recommendations for reforming physician payment. These are listed below, along with explanations and justifications.

RECOMMENDATIONS PERTAINING TO PHYSICIAN PAYMENT THROUGHOUT THE HEALTH CARE SYSTEM

1 Over time, payers should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives.

As this report has made clear, the fee-for-service mechanism of paying physicians is a major driver of higher health care costs in the U.S.[32] It contains incentives for increasing the volume and cost of services, whether appropriate or not; encourages duplication; discourages care coordination, and promotes inefficiency in the delivery of medical services. In light of these factors, the commission believes that fee-for-service should eventually disappear as the predominant mode of compensating physicians.

The long-range solution is a system that provides appropriate, high-quality care that emphasizes disease prevention rather than treatment of illness and that values examination and diagnosis as much as medical procedures. This implies a shift from a payment system based on fee-for-service to one based on value through mechanisms such as bundled payment, capitation, and increased financial risk sharing.

2 The transition to an approach based on quality and value should start with the testing of new models of care over a 5-year time period and incorporating them into increasing numbers of practices, with the goal of broad adoption by the end of the decade.

Changing from the current model of care to one that is value-based cannot be accomplished overnight. It will require a transition period—and even then, the likely end point will be a blended system with some payment based on fee-for-service and other payment based on capitation or salary.

The commissioners judged that five years would be an appropriate length of time for a transition period. It would give physicians and health care organizations the time to make changes in their models of care—for example, to install electronic medical records and to change billing systems—and would allow time to evaluate the experiments currently underway to test ACOs, medical homes, and other delivery and payment mechanisms.

3 Because fee-for-service will remain an important mode of payment into the future, even as the nation shifts to fixed payment models, it will be necessary to continue recalibrating fee-for-service payments.

Whatever system reforms are ultimately adopted—be they ACOs, bundled payments, patient-centered medical homes, capitation—the commission recognizes that fee-for-service payment will remain an integral part of physician payment for a long time.[33] While paying a fixed payment through bundling or capitation is reasonable, appropriate, and desirable for acute episodes of care requiring hospitalization, many issues remain as the concept is expanded outside of hospitals. Some services are not appropriate for bundling. And the optimal ways that bundled payments are allocated to individual physicians remain to be clarified.

In all cases, payment—whether it be fee-for-service, fixed payment, or salary payment models—should reward behavior that improves quality, care coordination, and cost-effectiveness and/or penalize behavior that misuses or overuses care that does not add benefits to patients but simply adds to the cost.

4 For both Medicare and private insurers, annual updates should be increased for evaluation and management codes, which are currently undervalued. Updates for procedural diagnosis codes, which are generally overvalued and thus create incentives for overuse, should be frozen for a period of three years. During this time period, efforts should continue to improve the accuracy of relative values, which may result in some increases as well as some decreases in payments for specific services.

Time spent on services performed under evaluation and management (E&M) codes is reimbursed at lower rates than time spent providing services under procedure codes. The undervalued E&M services at issue are often those that provide preventive health and wellness care, address new or undiagnosed problems, and manage chronic illnesses.

The current skewed physician payment system causes a number of problems, such as creating a disincentive to spend time with patients with complex chronic conditions; leading physicians to offer care for highly reimbursed procedures rather than lower-reimbursed cognitive care;[34] neglecting illness prevention and disease management, which tend to be cognitive in nature; and inducing medical students to choose procedural specialties over evaluative ones.

While the discussion about reimbursement has generally focused on services performed by primary care physicians, the commission believes that the real issue is not one of relative payment of specialists versus primary care physicians but, rather, of payment for E&M services as contrasted with procedural services. These include E&M services provided by, among others, cardiologists, endocrinologists, hematologists, infectious disease specialists, neurologists, psychiatrists, and rheumatologists.

5 Higher payment for facility-based services that can be performed in a lower-cost setting should be eliminated. Additionally, the payment mechanism for physicians should be transparent, and it should reimburse physicians roughly equally for equivalent services, regardless of specialty or setting.

Over the past years, there has been a trend to reimburse medical services performed in outpatient facilities at a lower rate than those same services when provided in hospitals. In its March 2012 report, MedPAC noted that the previous year, Medicare paid 80 percent more for a 15-minute office visit in an outpatient department than in a freestanding physician office.[35]

The disparity is having a negative effect on the way health care services are delivered. In addition to paying extra for an in-hospital procedure that can be done more cheaply in an ambulatory facility, large hospital systems are buying up independent practices. This threatens the viability of independent physicians and raises the cost of health care. Cardiology presents a telling example. Medicare pays $450 for an echocardiogram done in a hospital and only $180 for the same procedure in a physician's office.[36] The

New York Times reported in 2010 that practices around the country were selling out to health systems or hospitals; the CEO of the American College of Cardiology was quoted as saying, "the share of cardiologists working in private practice had dropped by half in a year."[37]

Moreover, private payers negotiate payment for services with individual groups, often resulting in different payment levels for the same physician services, depending on the market power of the physician group. Payments by private payers for medical services should be transparent to the public.

These payment differentials are difficult to justify in concept or in practice.

6 Fee-for-service contracts should always include a component of quality or outcome-based performance reimbursement at a level sufficient to motivate substantial behavior change.

The inherent incentive in fee-for-service payment arrangements to increase volume can be mitigated by incorporating quality metrics into the negotiated reimbursement rates. This is already being done in many places, including programs carried out by the federal government and private insurers. For example, the Affordable Care Act created a "value-based modifier" under the Medicare physician fee schedule. It will go into effect in 2015. On a budget-neutral basis, the modifier will increase or decrease payment rates to physicians on the measures of quality and cost.[38]

Although the overall evidence of the effectiveness of pay-for-performance programs based on quality measures is mixed to date,[39] some programs are demonstrating positive results. UnitedHealthcare, for example, reports that the 250,000 physicians participating in its Premium Designation program—whose compensation depends in part on their meeting quality measures—have significantly lower complication rates for, among others, stent placement procedures and for knee arthroscopic surgery, and have 14 percent lower costs than specialists not in the program.[40] WellPoint has obtained similar results in its pilot programs.

7 In practices having fewer than five providers, changes in fee-for-service reimbursement should encourage methods for the practices to form virtual relationships and thereby share resources to achieve higher quality care.

Large, integrated networks of providers dominate health service provision in some areas of the country, but small, independent providers provide care for nine out of ten Americans, including millions living in rural and underserved areas.[41] Fee-for-service models that fail to reimburse care that is not delivered in person (for example, by telephone or email) or for coordination among providers puts patients in these areas at a continuing disadvantage.

Telemedicine and other forms of remote communication have improved outcomes for many types of patients, including those in remote, scattered intensive care units,[42] the frail elderly,[43] and those experiencing depression in clinics not served by a psychiatrist.[44] These interventions have demonstrated reduced costs in some populations and in these circumstances should be reimbursed appropriately.[45]

8 As the nation moves from a fee-for-service system toward one that pays physicians through fixed payments, initial payment reforms should focus on areas where significant potential exists for cost savings and better quality.

This recommendation refers largely to the clinical circumstances where 5 percent of the sickest patients consume half of the nation's health care resources. Many of these people have multiple chronic conditions, including behavioral health disorders. Improving care for people with these conditions offers significant potential for cost savings and improved quality of care. They are a logical place to start a transition period.

Another logical place is in-hospital procedures and their follow-up. There are many conditions whose treatment lends itself to payment by means of a fixed payment.

Treatment of heart attacks and joint replacements are two obvious examples.

Additionally, examples abound of care whose benefits are unproven or which are unnecessary that is given to (and sometimes demanded by) patients. The Affordable Care Act created a new Patient-Centered Outcomes Research Institute (PCORI) to conduct research evaluating and comparing health outcomes and assessing the clinical effectiveness, risks and benefits of medical treatments. Implementation of PCORI results should be expeditious.

9 Measures should be put into place to safeguard access to high quality care, assess the adequacy of risk-adjustment indicators, and promote strong physician commitment to patients.

This recommendation acknowledges that any prospective payment system adopted should be accompanied by adequate protections for patients and recognition of the centrality of patient care. While the main body of this report deals with ways to reduce spending on health care, the commission recognizes that:

A physician's commitment to his or her patient has traditionally been—and remains—paramount.

Quality measures are necessary to assure that evidence-based care is not denied as a cost-saving mechanism. A body of evidence now demonstrates that prevention, care coordination, and the prudent practice of medicine will not only save money but will also lead to better outcomes.

Risk adjustment is important for any type of fixed payment to avoid physicians and other providers cherry-picking the healthiest patients and avoiding the sickest ones. This recommendation is a reminder that the sickest and neediest members of our society—who are often the poorest as well—deserve the same attention as the more advantaged members of society, and that where patients with more complex illnesses need more resources, payment should be adjusted to reflect those needs.

RECOMMENDATIONS PERTAINING SPECIFICALLY TO MEDICARE

10 The SGR adjustment should be eliminated

Simply stated, the SGR has not worked in practice and shows no prospect of ever working. The practice of setting expenditure targets one year and ignoring the consequences of exceeding them the next year makes no sense. Moreover, setting a spending cap without addressing the underlying issues of the volume and price of services and health outcomes is a short-term answer to a problem that requires a long-term solution. And since the SGR is based on the aggregate payment for physicians' services by Medicare, there is no incentive for individual physicians to try to hold down costs, and those who do are, in effect, penalized. It is the Tragedy of the Commons.

Rather than tinkering with the SGR, the Commission recommends abolishing it and replacing it with a physician payment system that strengthens the doctor-patient relationship and emphasizes appropriate, cost-effective care. This recommendation is consistent with the recommendations of other bodies (for example MedPAC and the AMA) that have looked at physician-payment reform for the Medicare program and proposals by Representatives Allyson Schwartz (D-Pennsylvania) and Joe Heck (R-Nevada), that directly address the SGR.

11 **Recovering the revenues that would have been in the SGR should come not just from reduced physician payment but from the Medicare program as a whole. Medicare should not cut just physician payments, but should also look for savings from reductions in inappropriate utilization of Medicare services.**

The question of where to find the $138 billion over ten years that the Congressional Budget Office estimates it will take to eliminate the SGR is a thorny one that has generated a wide variety of responses.

The commission believes that the $138 billion needed to eliminate the SGR can be found entirely by reducing overutilization of medical services within Medicare. In a 2011 report, the Institute of Medicine found more than *three-quarters of a trillion* dollars in excess medical costs annually, as follows:

Unnecessary services	$210 billion
Inefficiently delivered services	$130 billion
Excess administrative costs	$190 billion
Prices that are too high	$105 billion
Missed prevention opportunities	$55 billion
Fraud	$75 billion [46]

12 **The Relative Value Scale Update Committee (RUC) should continue to make changes to become more representative of the medical profession as a whole and to make its decision making more transparent. CMS has a statutory responsibility to ensure that the relative values it adopts are accurate and therefore it should develop additional open, evidence-based, and expert processes beyond the recommendations of the RUC to validate the data and methods it uses to establish and update relative values.**

The RUC, which is managed by the American Medical Association (AMA) and composed of members named by national medical specialty societies, makes recommendations to CMS regarding updates to the relative value scale on which physician payment is based. Both its composition and its operations are seriously flawed.

The composition of the RUC, which is skewed toward the procedural and highly technological specialties, has led to concern that it overvalues those specialties and undervalues the cognitive specialties. Currently, six seats on the 31-member RUC are reserved for the chairman and representatives of the AMA, the American Osteopathic Association, the CPT Editorial Panel representative, the Health Care Professionals Advisory Committee representative, and the Practice Expense Review Committee representative. The remaining 25 seats are held by representatives of the various specialties. Of these, 16 are currently held by specialties whose physicians do procedures or highly technical work—such as cardiology, dermatology, plastic surgery, radiology,

and vascular surgery. Nine are held by specialties whose physicians' practices consist largely of examination and management of patients: emergency medicine, family medicine, geriatrics, internal medicine, neurology, pediatrics, primary care, psychiatry, and rheumatology.[47] Earlier versions of the RUC were even more heavily dominated by procedural-oriented specialties.

While the composition of the RUC has come under scrutiny, so too have its operating procedures. Critics observe that meetings are largely closed to the public; RUC members sign confidentiality agreements; individual voting records are not made public; and transcripts of meetings are not published. Moreover, critics contend that since nearly 90 percent of the RUC's recommendations have historically been adopted by CMS,[48] it should be considered a Federal Advisory Committee and subject to the sunshine requirements and the oversight mandated by the Federal Advisory Committee Act.

Others, while strongly agreeing that the RUC needs to be improved, note recent positive changes in both the composition and the operations of the RUC and suggest that an additional problem lies with CMS. Recent improvements in the RUC include the addition of new primary care and geriatrics seats as of 2012 and the requirement that vote totals for all recommendations be published. Moreover, supporters of improving rather than abolishing the RUC state that individuals who ask can be invited to attend RUC meetings if the RUC chair approves their request. They further note that the RUC is constituted as a private organization and therefore should not be considered a federal advisory committee, and that CMS should look more widely for alternate sources of relative value and other payment recommendations.

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