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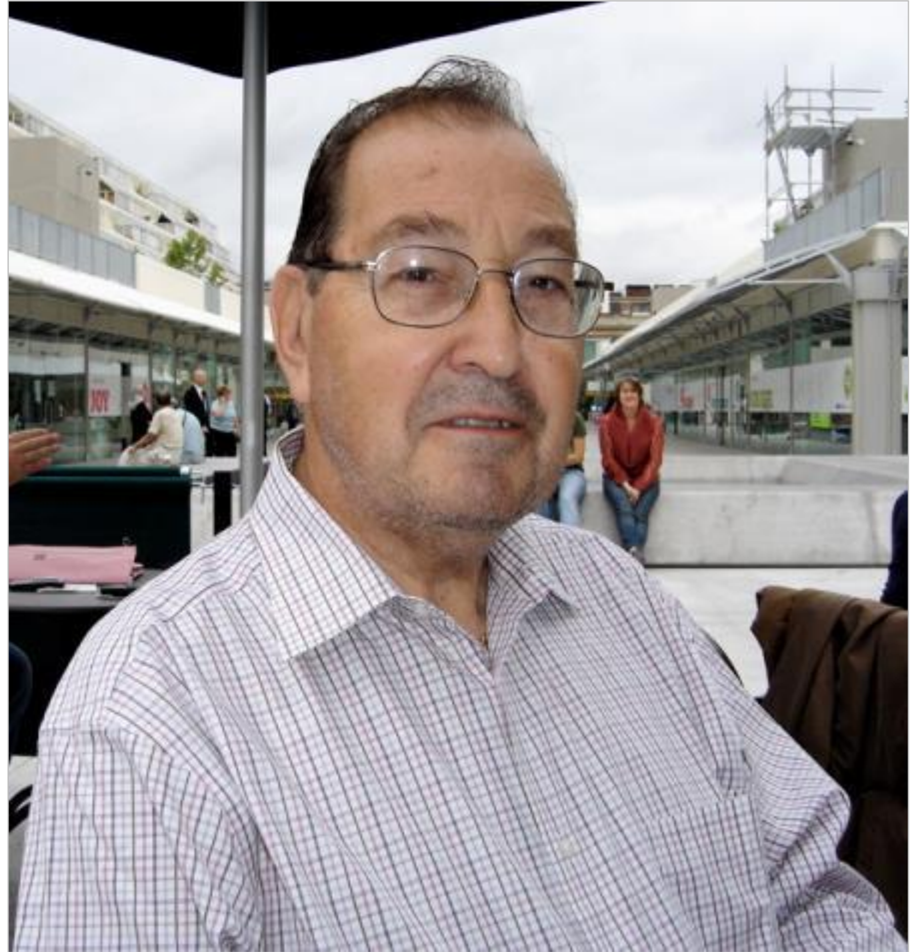

Report of

The National Commission on

PHYSICIAN PAYMENT REFORM

March 2013

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

Headlines: Announcement

- *POLITICO* New commission aims to improve physician payment system
- CQ Internists Launch Physician Payment Reform Commission
- *Modern Healthcare* Medical Society launches panel on doc-payment reform
- *HealthLeaders Media* Physician Payment Reform Gets Serious
- *Boston Globe (White Coat Notes blog)* Secretary JudyAnn Bigby and others from Mass. Join national panel on physician payment
- *California Healthline* New Panel Formed To Study Physician Payment Reform

Headlines: Report Release

- *The Washington Times* Study adds fuel to fire in push for entitlement reform
- *Fox News* New call for 'drastic changes' in how medicare pays doctors
- *British Medical Journal* Physician Pay is Changing
- *The Hill* Panel recommends overhauling US doc payments
- *Politico Pro* Commission advocates ending fee-for-service system
- *CQ Healthbeat* Panel Urges Rapid Move Away from Fee for Service Medicine
- *Kaiser Health News* Panel Calls for 'Drastic Changes' In Medicare Doctor Pay
- *Medpage Today* Report: Kill Fee-For-Service by Decade's End
- *Modern Healthcare* Commission on doc pay urges shift from fee-for-service, end to SGR
- *HealthLeaders Media* SGIM Calls for End to Fee-For-Service

Commentary

The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD

Phasing Out Fee-for-Service Payment

Steven A. Schroeder, M.D., and William Frist, M.D.,
for the National Commission on Physician Payment Reform

In March 2012, the Society of General Internal Medicine convened the National Commission on Physician Payment Reform to recommend forms of payment that would maximize good clinical outcomes, enhance patient and physician satisfaction and autonomy, and provide cost-effective care. The formation of the commission was spurred by the recognition that the level of spending on health care in the United States is unsustainable, that the return on investment is poor, and that the way physicians are paid drives high medical expenditures.

The commission began by examining factors driving the high level of expenditures in the U.S. health care system. It found that reliance on technology and expensive care, higher payments for medical services performed in hospital-owned facilities than in outpatient facilities, and a high proportion of specialist physicians as compared with generalists were all important cost drivers. But fee-for-service reimbursement stood out as the most important cause of high health care expenditures.

The commission then set out 12 recommendations for changing current methods of physician payment. The aggressive approaches that are recommended below provide a blueprint for containing costs, improving patient care, and reducing expenditures on unnecessary care. (The commission's report is available at http://physicianpaymentcommission.org/report/ and in the Supplementary Appendix, available with the full text of this article at NEJM.org.)

BLUEPRINT FOR A NEW PHYSICIAN PAYMENT SYSTEM

Recommendation 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.

The fee-for-service mechanism of paying physicians is the major driver of higher health care costs in the United States.[1] 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.

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

The long-range solution is a system that provides appropriate and high-quality care, emphasizes disease prevention and the management of chronic conditions rather than treatment of illness, and values examination and diagnosis as much as medical procedures. This implies a shift from a payment system based on a fee-for-service model to one based on value through mechanisms such as bundled payment, capitation, and increased financial risk sharing. But changing from the current model of care to one that is value-based cannot be accomplished overnight. It will require a transition period, with the likely end point being a blended system with some payment based on the fee-for-service model and other payment based on capitation or salary.

Recommendation 3: Because the fee-for-service model will remain important 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 (accountable care organizations, bundled payments, patient-centered medical homes, or capitation) are ultimately adopted, fee-for-service payment will remain an integral part of physician payment for a long time.[2] Although paying a fixed payment through bundling or capitation is reasonable, appropriate, and desirable for acute episodes of care requir-

The New England Journal of Medicine
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POLITICO

"We cannot control runaway medical spending without changing how physicians in this country are paid — currently the single most significant driver of health care costs."

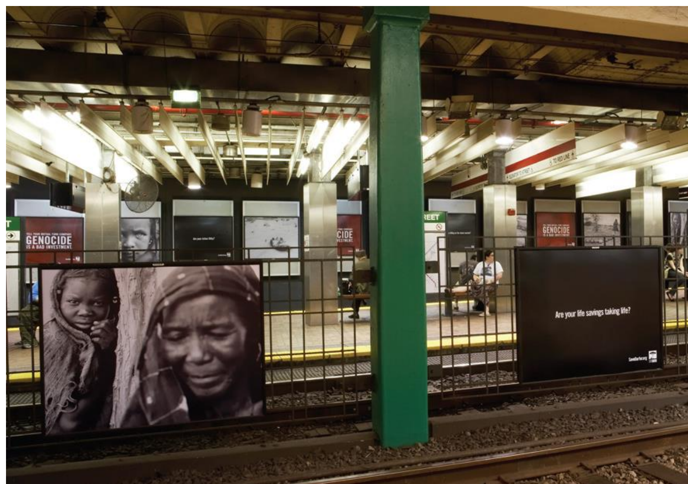
— **Senator Bill Frist and Dr. Steven Schroeder**

Health Affairs Blog

"The chorus of voices that shouted loudly and repeatedly about the need to rein in health care costs should be commended. But those same voices should now unite around a solution. From where we sit it starts with moving away from stand-alone fee-for-service payment."

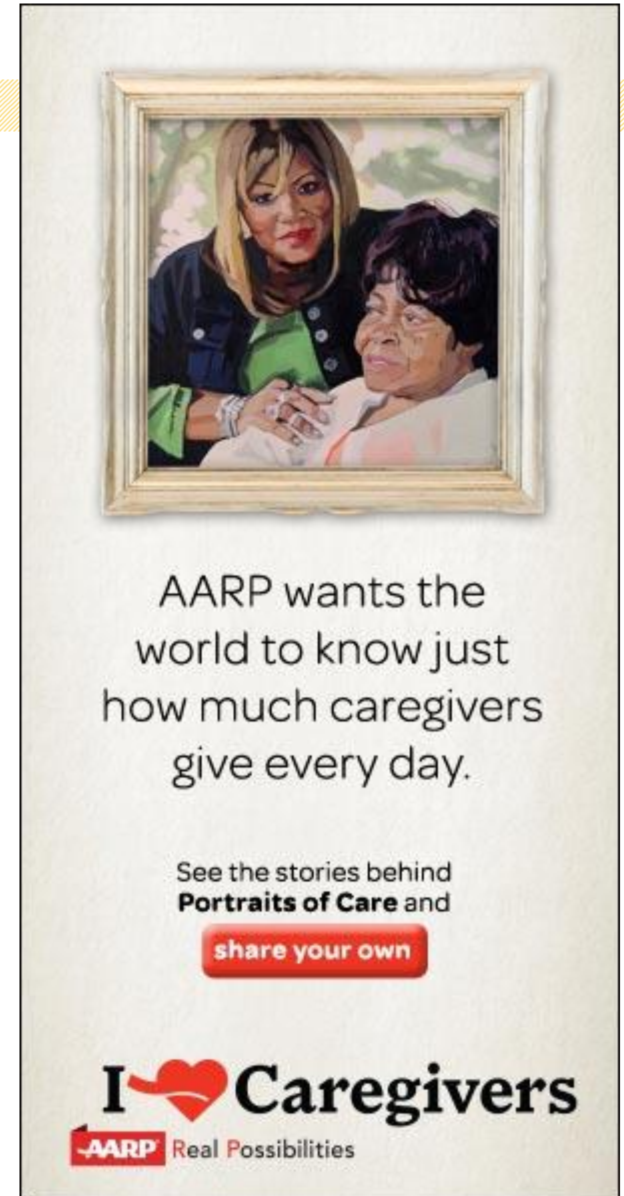
— **Senator Bill Frist and Dr. Steven Schroeder**

Metro Station Takeover



Personal Stories

AARP Real Possibilities



Awareness vs. Engagement

Metrics

2.5 Million
Ad Clicks

21 Million
Video
Completions

1.8 Million
Website Visits

74 Thousand
Conversions to
Healthcare.gov