FROM THE EDITORS' DESK

Do We Get What We Pay For? Transitioning Physician Payments Towards Value and Efficiency

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Unless current trends are interrupted, health care will consume 34 % of the gross domestic product (GDP) by 2040.¹ Rising US health care costs have not produced measurable improvement in the overall health of the public, in comparison with other industrialized nations. Additionally, geographic regions spending more on health care have not seen commensurate improvements in quality or outcomes. While about a quarter of projected health care cost increases can be ascribed to the aging of the population, the remainder are likely due to rising health care costs from system inefficiencies and new (often important) technologies, coupled with patient and physician expectations for the “best” of Western medicine. Some estimate that we could reduce 5 % of GDP spending by reducing system inefficiencies, without significant changes in service provision.

How can rising costs be slowed? Certainly, health care systems redesign experiments are occurring within the Affordable Care Act, and the medical marketplace is expanding into new care delivery modalities with direct-to-consumer solutions, such as telemedicine and expansion of midlevel provider services. Horizontal and vertical healthcare system integration may address some inefficiencies. In addition, individual patient and physician behaviors can be influenced. For instance, providing benchmarking data about physician performance has been shown to change behavior and choices within organizations, as does leadership focus.

This month in *JGIM*, Horn et al. demonstrate that displaying comparative laboratory costs to intervention physicians at the point of care reduced test ordering in comparison with controls.³ George Lundberg's accompanying editorial “Calling All American Physician Leaders” provides insight into the larger context of health care reform.⁴ Within the Veterans Affairs (VA) hospital system, Restuccia et al. found that alignment of VA leadership and physicians around care goals lead to greater adoption of

national quality improvement initiatives.⁵ When the price or compensation differential is sufficient, consumer behavior and physicians are both affected. Consulting groups have estimated that a difference of 20 % of physician compensation is sufficient to influence the adoption of new approaches to care delivery. This month, *JGIM* authors Ho and Sandy also remind us that a comprehensive approach to health care reform is necessary for systems transformation, including upgrading performance measures, monitoring for unintended consequences of new initiatives, using an expanded systems toolbox, and remembering that care provision is local.⁶

Conceptually and practically, the current US fee-for-service (FFS) payment structure provides incentives for health systems to focus on service-intensive, extreme disease and disease complications, not on methods to prevent disease inception or progression. For instance, preventing a single patient from needing a cardiac-related hospitalization through better primary or secondary prevention would reduce system-wide costs by up to \$40,000 per myocardial infarction hospitalization. To address these issues, national think tanks have convened to innovate around designing a better US health care system, including innovating around physician payments.

In March 2013, one such group, the National Commission on Physician Payment Reform (NCPPR), released a report with twelve recommendations to reform how physicians are paid, linking incentives to quality in patient care to curtail rising health care costs.² The independent Commission was established by the Society of General Internal Medicine (SGIM) and partly funded by the Robert Wood Johnson Foundation and the California Healthcare Foundation. Its report provided a 5-year roadmap to transition the United States from the current FFS reimbursement model to a blended payment system that better aligns practice and payment policy with Berwick's triple aim of improving patients' experience of care, improving population health, and reducing health care costs. As noted by then SGIM President Harry Selker, “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.” Following a Capitol Hill briefing and a New

England Journal of Medicine article describing the report by Commission Co-Chairs Steven Schroeder and former US Senator Bill Frist [R, TN], SGIM established an ad hoc Committee to advocate for implementation of the Commission recommendations. To that end, SGIM's ad hoc Committee, co-chaired by Mark Schwartz and Robert Baron, is building a coalition of stakeholder organizations to work with Congress and Executive branch agencies to operationalize these policy strategies.

In this issue, SGIM ad hoc Committee members offer three Comments addressing the Commission's recommendations. First, Selker and colleagues review the first three recommendations, which argue for phasing out the current volume-based, fee-for service (FFS) reimbursement model over 5 years, to be replaced by a system emphasizing value and efficiency, with incentives that promote high quality, coordinated, and cost-effective, patient-centered care.⁷ Then Siddiqui et al., addressing Commission recommendations four through nine, contend that while transitioning away from FFS, the US must strengthen the primary care foundation of high performing healthcare systems, notably evaluation, management and preventive services.⁸ Finally, Patel and Nadel examine the Commission's last three recommendations, arguing that Medicare's Sustainable Growth Rate (SGR) formula be repealed and replaced with policy that rewards value rather than volume, and that is based on a valuation of physician work that rectifies the current relative value unit (RVU) bias in favor of procedural compared with cognitive-based services.⁹

As the complex process of US health care reform moves forward, *JGIM* invites its readers to engage in dialogue,

research, and action to align incentives and innovation for physician payment policy around the triple aim.

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