Improving the Quality and Lowering the Cost of Health Care: Medicare Reforms from the National Commission on Physician Payment Reform

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The final 3 of the 12 policy recommendations by the National Commission on Physician Payment Reform (NCPPR) dealt specifically with how Medicare should reimburse, finance, and determine the value of healthcare services provided by physicians.

With the US health care system facing dual crises of waning quality and exorbitant costs, policy-makers must take action to improve the outlook of US health care. Expenditures in the US health care system total almost \$3 trillion per year and account for 18 % of the gross domestic product (GDP) or about \$8,000 per person annually.

Even with immense funding allocated to health care, health outcomes in the US are poorer than in most other developed nations. According to the World Health Organization, the US ranks 37th in overall health status, behind such countries as Oman and Morocco. The Institute of Medicine (IOM) concluded that Americans are in poorer health and live shorter lives compared to the citizens of other high-income countries.

The physician payment system contributes substantially to the high cost of US health care. Although physician salary and related expenses constitute just 20 % of overall health care spending, physician decisions drive an additional 60 % of health care costs.¹ These factors prompted The Society of General Internal Medicine to convene The National Commission on Physician Payment Reform (NCPPR) to propose new forms of physician payment that will improve health outcomes while lowering the cost of care.

First, the NCPPR recommended that Medicare's Sustainable Growth Rate (SGR) be eliminated. The SGR was enacted by the Balanced Budget Act of 1997 and intends to manage the total cost of Medicare by adjusting payments to clinicians based on expenditures from the previous year and target expenditures for the following year. However, the system has long been dysfunctional.

Recently, calls for repeal of the SGR have been multilateral and bipartisan. Several of the fundamental flaws in the SGR legislation include the SGR's failure to control volume growth in Medicare and that setting spending caps on the program without addressing the roots of the issue—volume and price of services and health outcomes—is an insufficient answer to a problem requiring a long-term solution; there is little incentive for individual physicians to attempt to hold down costs since the SGR affects physician payment in aggregate.

In looking at an immediate SGR replacement, the Centers for Medicare and Medicaid Services (CMS) should harmonize the myriad of payment adjustments and quality improvement efforts—meaningful use of electronic medical records (EMR), e-prescribing, patient quality reporting system, and others—and apply those funds to a care coordination payment, which would give physicians more support for moving to more bundled payments based on episodes of care.

Amidst widespread support for SGR repeal, questions remain on how to fund it. The second NCPPR Medicare recommendation was that repeal of the SGR should be paid for with cost-savings from the Medicare program as a whole. This year, due to a sustained period of constrained finances and innovative efforts at Medicare reform, the cost to repeal the SGR is \$139.1 billion, down from the November 2012 estimate of \$243.7 billion.²

In 2011, the IOM reported that annual excess spending in Medicare amounted to more than three-quarters of a trillion dollars, a savings that far exceeds the cost of SGR repeal.³ The excessive costs are 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

With substantial room for waste reduction in Medicare, mobilizing efforts to reduce these excess costs and inefficiencies would provide enough savings to cover the cost of the sorely needed legislative action without substantially burdening providers themselves.

A properly aligned payment system, one that reimburses the provision of high-quality, evidence-based care, has the potential to encourage savings in these areas. Enhancing relevant clinical and financial data exchange between payers and providers, and doing so quickly—ideally in real time—would provide the necessary utilization and efficiency data to payers and outcomes data to providers. Furthermore, as previously described, paying providers for various quality and efficiency elements with a care coordination payment would help to increase preventive care and patient education efforts, reduce administrative costs, and encourage the efficient delivery of the proper services at the right time.

The final NCPHR Medicare recommendation was that 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. Medicare reimburses physicians for services using a fee schedule informed by relative value units (RVUs). The RUC is the principal advisory body providing RVU update recommendations to CMS.

The composition and operating procedures of the RUC have been widely criticized. The RUC is composed of 31 members, theoretically representing the entirety of the medical profession. But currently, only nine seats represent specialties that consist of evaluation and patient management services such as general internal medicine, family medicine, neurology, and pediatrics.⁴ Since the RUC is structurally skewed toward procedure-based specialties, there is concern that it undervalues cognitive-intensive specialties, overvalues technology-intensive specialties, and thus reimburses less for the evaluation and management services that are shown to improve health and lower costs. Furthermore, RUC meetings are closed to the public, individual voting records are not released, and transcripts of the meetings are never published. A body such as the RUC should make an effort to be transparent since CMS has historically adopted more than 90 % of its recommendations.⁵

Notwithstanding, the RUC has made positive strides in recent years. In 2012, the AMA added new primary care

and geriatrics seats to the RUC and now requires that all vote totals be made publically available. Increasing the representation of cognitive-oriented specialty seats should continue. Furthermore, opening RUC meetings to the public and publishing meeting transcripts, to increase accountability, would be a positive step.

With rapidly rising costs and care of disproportionately lower quality, reform of the US health care system is pressing. While reforms to Medicare and the US health care system cannot be implemented overnight, the transition to new models of physician payment has already begun and shows promise. From payment reforms such as bundled payments and capitation to systems-based reforms such as Accountable Care Organizations and Patient-Centered Medical Homes, innovation in health care payment and delivery has the potential to curb the growth of health care spending and better align payments with quality care efforts.

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