

Physician Network on Health Care Costs Consensus Themes and Recommendations

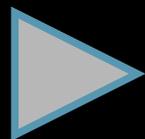
Eighteen diverse physicians provided frank feedback on ways to curb the cost of health care in the United States. *Their solutions might surprise you.*

Nearly all health care stakeholders, from doctors to patients to hospital executives, agree that U.S. health care costs are rising at an unsustainable rate, and may be unsustainable even at current levels of growth. In 2011, the Centers for Medicare & Medicaid Services (CMS) estimated that national spending reached \$2.7 trillion, or 17.9 percent of the U.S. Gross Domestic Product (GDP). CMS projects that number to rise to nearly \$4.8 trillion, and 19.6 percent of GDP, by 2021. And while many health care stakeholders have different perspectives on the best strategies for restraining the growth of health care costs, all agree that the time for action has come.

Physicians, who serve as both advocates and chief clinical decision-makers for their patients, hold an integral perspective on where and how the care of individuals and overall costs intersect. They will also personally experience changes to the health care payment system—whether that entails a move away from fee-for-service to bundled payment structures, shifts in their overall compensation, or new bonus incentives tied to quality performance. Given these realities, physicians are deeply concerned about the design of new payment systems, and believe their clinical expertise can and must be included in these efforts.

The Robert Wood Johnson Foundation recently gathered 18 physicians with a diverse range of experiences, including anesthesiologists, internists, primary care physicians, oncologists, and surgeons. The physicians practice in a variety of settings, from academic medical centers to primary care practices, and range in their roles from medical directors to residents. Over conversations spanning several months, the physicians frankly discussed existing proposals to curb runaway U.S. health care costs and brought forth their own ideas. Some might be surprised by their solutions.





Why should payment models be evidence-based, physician-endorsed, and thoroughly tested? Hear from:

Christine A. Sinsky, MD, FACP
Dubuque, IA

Jeffrey L. Carson, MD
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Payment models must be evidence-based, physician-endorsed, and thoroughly tested.

A common element in most policy proposals aimed at reducing health care spending is paying physicians for value and quality instead of volume of services. Physicians convened by RWJF recognize that new value-based, bundled payment systems that realign incentives are a critical and inevitable component of ongoing health care delivery transformation in both the public and private sectors.

Physician panelists believe they have a key role to play in giving new payment systems a strong clinical grounding, “leading the way” in providing content expertise to complement the economic and administrative expertise offered by other stakeholders.

Panelists also argue that CMS, as the largest payer in the U.S. health care delivery system, should take the lead in rigorously piloting new payment systems. However, there is significant concern among the panelists that efforts by CMS to date have been too onerous, requiring providers to comply with too many performance measures. As an alternative, some panelists would like to see new models focus on a smaller, core set of measures. Others recommend a leading role for states to experiment more actively with the reengineering of delivery systems through their Medicaid programs.

While physician panelists are broadly accepting of value-based payment, some argue that some elements of the current fee-for-service system should remain that way. These panelists argue that some health care services—especially those that are essential to patients—may not be adequately compensated for in a value-based model. These services include:

- Preventive care, including immunizations and wellness examinations
- Trauma care
- Patient follow-up visits in select instances

As new payment systems evolve, participants have varying opinions about the best methods for reimbursing care for “super-utilizer” patients, or the small subset of patients that consume a disproportionate share of health care resources. While some propose keeping these patients in the fee-for-service system, others believe that including this cohort in a more value-based system is essential to controlling health care costs. Some group members suggest the creation of stop-loss coverage to protect providers after a super-utilizer patient cohort reaches a set amount of resource consumption.

Physician members would also like to see the social determinants of health factored into risk adjustments for new payment models. Some believe these adjustments would be particularly appropriate for patients with chronic disease, some of whom suffer from a paucity of social ties and support. In some instances, these patients suffer from untreated or undiagnosed mental illness.

The gathered physicians strongly believe that hospital payments must become more transparent to all parties. Some panelists believe, however, that the higher payments associated with some hospital service lines support other critical areas of operation that may not be self-sustaining financially. These areas, panelists say, include medical education, the hiring of nurses to reduce readmissions, and some physician fees. In addition, other members would like to see greater incentives for delivering care in the most appropriate setting—which could potentially mean incenting some procedures to transition from the acute care setting to outpatient providers.



Protecting and creating financial incentives is critical to broad physician buy-in.

While physician members agreed with policy analysts who point to the current fee-for-service system as a key contributor to rising health care costs and accept the challenge of containing the growth of health care costs, there is widespread concern among physician members of all specialties and practices that these efforts could ultimately reduce their income by as much as 20 percent to 30 percent.

Participants argue that their field has already seen sizable reductions in payment in recent years, and are bracing for even more dramatic reductions in years to come, even as many physicians still carry high levels of training-related debt. Primary care physicians in the group are particularly concerned about an impending reduction in income, given their significantly lower incomes in comparison to specialists.

To soften the impact of potential reductions in payment, there is broad agreement that a multi-year grace period where payment is stabilized before shifting to another payment paradigm—be it value-based payment, bundled payment, capitation models, or a combination—would address physician fears and allow for a smoother transition to new systems of care provision. Some members believe that some form of medical education debt relief would help ease the ongoing transition, enabling physicians—especially new physicians—to spend time adapting to new models of care, working with their colleagues and learning new technologies and systems.

Some physician members would also like to see the development of payment protections for meeting agreed-upon thresholds of compliance for process measures or other quality metrics. This could include bonus payments for following highly indicated interventions derived from trusted sources, including medical specialty associations and other clinical groups.

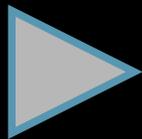
As the panelists discussed various proposals to realign financial incentives, there was considerable discussion and debate around the idea that non-financial rewards—for instance, if physicians were able to enjoy more free time when more efficient delivery systems are in place—could also serve as powerful incentives to embracing change. Some of the participants also believe that if physicians are encouraged to develop evidence-based, transparent guidelines, they will embrace the challenge as part of their professional ethos. Many believe this work could potentially emerge from individual professional societies.

Physician members are broadly in favor of developing appropriate liability protections as part of these efforts, which many believe may be more effective than further financial incentives. Many physician members believe these efforts could take the form of “safe harbors,” with independent panels assessing lawsuits for the likelihood of malpractice and determine if best practices were used appropriately, referring those cases to arbitration.

Why is protecting and creating financial incentives critical to physician buy-in? Hear from:

Jeffrey L. Carson, MD
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Jennifer Hines, MD
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Meaningful consumer engagement requires better communication and guidance from physicians, more willingness from consumers, and greater investments in prevention.

Many policy analysts argue that consumer engagement should also be a key part of changes to the health care payment system. Their belief is that involving patients in their health care will create a focus on better health without unnecessary costs. There is a broad range of opinion among physician members regarding the most appropriate role for patient engagement in shaping health care costs, specifically as it relates to physician-patient communication.

Some physician members would like to see incentives for providers to discuss the cost ramifications of different treatment options with patients. These conversations could include discussing appropriate clinical information, giving patients both clinical and cost-based information to guide their own decision-making process.

However, many of the panelists are skeptical about the ability of patients to effectively digest and utilize information about the cost and quality of varying treatment options. Some members are adamant that physicians will need to carefully guide discussions of cost as it relates to decision-making with regards to care—given the clinical expertise needed to make effective decisions. These members believe that if incentives are aligned appropriately, the appropriate information is available, and physicians have neutral financial incentives for engaging in different treatment options, their clinical expertise gives them the insight to continue to manage the provider-patient relationship.

Participants are also in broad agreement that finding ways to encourage widespread changes in patient behavior is a critical step in restraining U.S. health care costs. Some panelists support more widespread educational efforts around prevention and wellness. Following the passage of the Affordable Care Act, employers are

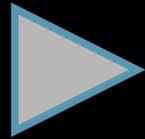
allowed to use assessments for wellness goals—for instance, blood pressure results or smoking cessation compliance—to determine between 30 percent to 50 percent of their employees' insurance premiums. Some physician members believe that Medicare should consider similar incentives for beneficiaries to improve their health. However, there is some disagreement among members of the panel about the effectiveness of these incentives in hastening significant changes in patient behavior.

Most physician members agree that patients should be better engaged in discussions about the cost of care at the end of life. Some members would like to see payment incentives structured to encourage other, less costly end-of-life treatment options, including palliative and hospice care.

Why does meaningful consumer engagement require better communication and guidance from physicians, more willingness from consumers, and greater investments in prevention? Hear from:

Christine A. Sinsky, MD, FACP
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Steven Grant, MD, FACP
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Improving quality and reducing cost requires a stronger health information technology infrastructure.

An improved health information technology (HIT) infrastructure is widely seen as a key way to increase efficiency in the health care system, and the federal government has made considerable investment in promoting meaningful use of HIT.

As physicians and other providers embark on major changes to their delivery models, there is broad agreement from members of the panel that greater investments by both payers and providers in HIT and electronic health records (EHRs) are needed to hardwire quality improvement. However, most physician members, regardless of where they practice, remain cautious about EHR implementation, given the disruption and expense associated with these projects.

Physician members are broadly supportive of efforts to promote the interoperability of EHR systems, though there is considerable skepticism that the HIT industry will lead the way in promoting interoperability. The ability for systems to exchange data, though, is seen as having a major influence on care coordination, the reduction of duplication, and ultimately an impact on reducing cost.

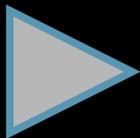
In order to achieve the cost savings made possible through using these systems, some of the panelists believe they need access to better data analytics and quality measures. There is also the desire for more comprehensive data about models for reducing health care costs and transparent platforms for information sharing between providers.

As it pertains to the design of a future, more coordinated health care system that could ultimately reduce costs through greater efficiency, participants recommend the widespread development of protected, web-based platforms where they could access full patient information from a multitude of providers.

Why will improving quality and reducing cost require a stronger health information technology infrastructure? Hear from:

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Major changes in education and practice are needed to help reduce costs.

While the role of the physician is often discussed in concert with health reform, the role of how we train physicians is often ignored. Physician members are deeply concerned about the paucity of medical education related to health care costs, and encourage broad efforts to better educate both practicing and training physicians on the relative costs of their clinical decision-making.

There is some difference of opinion about the best way to reach that goal—whether physicians will be more motivated by their professional ethos and competitiveness or via specific training and education around health care costs.

Many panelists argue that having access to comparative, provider-level cost data that would enable physicians to compare their performance against their peers would be a meaningful first step in bending the cost curve. In addition to private data sources, some would like to see greater public data that details the average cost of treating a specific diagnosis group. Group members would also like to see the development of more clinical informatics that would allow them to assess the cost of particular treatment options at the point of care.

Others argue that improving physician literacy around health care costs, partially by incorporating themes of cost transparency and unintended consequences in medical training, is equally important. Suggestions for achieving this goal include working with teaching hospitals on cost issues, subsidizing related physician training and mentorships, and enforcing recertification among those “training

the trainees.” A panelist mentioned his work with the *Teaching Value and Choosing Wisely* competition, which invites medical students, residents, fellows, and faculty to identify cost-saving innovations.

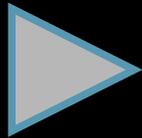
While there is no consensus around loosening scope of practice barriers, many panelists believe that by enabling other clinicians—for instance, nurses and community health workers—to practice at the top of their licenses, physicians would be better enabled to concentrate on their top clinical priorities. However, member physicians acknowledge that achieving these goals will require consensus among different clinical professions and physician specialty groups.

There is also consensus that efforts to simplify the administrative and regulatory burdens faced by physicians would also free physicians to focus more on clinical care. Some panelists interpret this to mean they would spend less time engaged in billing processes; others would like to see the pre-operative paperwork process potentially streamlined.

Why are major changes in education and practice needed to help reduce costs? Hear from:

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Conclusion

As policy-makers and health care stakeholders move forward in developing new payment systems, the insights from RWJF's Physician Network on Health Care Costs are instructive. No two physicians brought the same perspective to every issue, and there was plenty of debate about the role of physicians in curbing health care costs, as well as differences of opinion about the details of what a new payment system might look like and the policies and infrastructure that would support those systems. However, all physician panelists agreed that any new payment systems must be shaped in large part by physicians' own unique perspectives and clinical expertise. This is vital, the participants said, in order for physicians to advocate for and ultimately embrace any changes. Not to include the perspectives of practicing physicians in the design of any payment reform proposals, in their view, is both shortsighted and perilous.

Physicians participating in RWJF's Physician Network on Health Care Costs include **Drs. John Lumpkin** – Princeton, NJ (Moderator); **Valerie Arkoosh** – Philadelphia, PA; **David Asch** – Philadelphia, PA; **Karen Borman** – Abington, PA; **Kevin Bozic** – San Francisco, CA; **Jeffrey Carson** – New Brunswick, NJ; **Shrearest Crenshaw** – Memphis, TN; **Steven Grant** – Farmington Hills, MI; **Jennifer Hines** – Saint Paul, MN; **Diane Meier** – New York, NY; **David Meltzer** – Chicago, IL; **Rita Redberg** – San Francisco, CA; **Alan Schroeder** – San Jose, CA; **Neel Shah** – Boston, MA; **Manoj Singh** – Cincinnati, OH; **Christine Sinsky** – Dubuque, IA; **Thomas Smith** – Baltimore, MD; **Chris Thomson** – Lynchburg, VA; **Clyde Yancy** – Chicago, IL.

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