How Should Congress Pay for Repealing the Sustainable Growth Rate?

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A bipartisan, bicameral bill was announced earlier this month as the result of a joint effort by the U.S. House Energy and Commerce Committee, House Ways and Means Committee, and Senate Finance Committee to repeal and replace the Sustainable Growth Rate formula in Medicare. There is no other industry in America that tells its key professionals that their compensation will be cut by 25% at the end of each year regardless of whether they are doing a good job or not, but that's what the Sustainable Growth Rate formula requires in the Medicare program. Repeal is long overdue and the members and staff of the Committees should be commended for advancing a solution in a collaborative way.

The key challenge now is how to pay for the bill. Unless Congress can find over a hundred billion dollars to cover the projected cost of the legislation at a time when the federal deficit is one of the biggest challenges facing the country, the superb work of the three committees will go to waste.

Although Congress is looking at ways to cut fees to other healthcare providers, cut services to Medicare beneficiaries, or make cuts in non-healthcare programs in order to generate enough savings to pay for the bill, a better solution is actually contained within the bill itself in a little-discussed section that encourages the development and use of "Alternative Payment Models."

Alternative payment models for physicians can save a lot of money for Medicare while actually paying physicians better because the vast majority of healthcare spending doesn't go to physicians. In Medicare, physician fee schedule payments represent only 16% of total spending in Medicare Parts A, B, and D. Over the next decade, the Congressional Budget Office projects that physician fee schedule payments will represent only 12% of total Medicare spending. However, physicians prescribe, control, or influence most of the lab tests, images, drugs, hospital stays, and other services that make up the other 88%.

Study after study has shown that if healthcare services are *redesigned* to improve quality and efficiency, tens of billions of dollars in healthcare spending could be saved every year by avoiding unnecessary tests, procedures, emergency room visits, and hospitalizations; by reducing infections, complications, and errors in the tests and procedures which are performed; and by preventing serious conditions and providing treatment at earlier and lower-cost stages of disease. If physicians are given the ability to redesign care for patients in a way that reduces unnecessary spending on all of the *other* services, the *physicians* could be paid more and still reduce *total* Medicare spending.

How much would physicians have to save Medicare in order to pay for the SGR repeal?

The Congressional Budget Office projects that Medicare Part A, B, and D spending over the next decade will total more than $6 trillion[1]. The cost of repealing the SGR is currently estimated to be about $115 billion[2]. However, that figure is unrealistically low, because it assumes that physicians would receive no payment increases over the next decade, even though they haven't received any payment increases over the past decade. The very modest 0.5% increase in physician fees contained in the compromise bill would add another $20-$30 billion to Medicare spending, bringing the total cost of the repeal and updates to about $140 billion.[3]

$140 billion represents only 2.3% of total Medicare spending, and only 2.6% of the non-physician fee schedule spending. If physicians can reduce enough of the unnecessary and problematic spending in

Medicare so that non-physician spending decreases by a mere 3%, they will have more than paid for the SGR repeal.

Alternative payment models are the key to this approach for a very simple reason. The current fee-for-service payment system poses major barriers to physicians who want to redesign care in ways that benefit patients and save money for Medicare:

- Today, physicians are financially penalized for reducing unnecessary services and improving quality. Under the current Medicare payment system, physicians lose revenue if they perform fewer procedures or lower cost procedures, even if their patients are better off. Most fundamentally, under Medicare, physicians don't get paid at all when their patients stay well.
- Some high-value services aren't paid for adequately or at all. Medicare doesn't pay physicians to respond to a patient phone call about a symptom or problem, even though those phone calls can avoid far more expensive visits to the emergency room. Medicare won't pay primary care physicians and specialists to coordinate care by telephone or email, yet it will pay for duplicate tests and the problems caused by conflicting medications.

Unfortunately, most of the "payment reforms" being pursued today don't fix these problems. Pay for performance programs and shared savings programs have had very little impact on costs for a simple reason: the barriers described earlier aren't solved by adding a small bonus or penalty on top of the existing fee-for-service system. Even tying payment to quality measures will have little impact on quality if physicians are forced to lose money in order to implement better care.[4]

Truly different payment models create "win-win-win" approaches to paying physicians that can help improve quality and reduce total healthcare spending *without* forcing physicians to take financial losses themselves. These *accountable payment models* have three key characteristics:

- They give physicians the flexibility to deliver the care patients need without worrying about whether the payment for one type of service is lower than another or whether they will lose revenue by performing fewer procedures.
- They give physicians accountability for ensuring that changes in care result in spending that is lower than it would otherwise have been, but this accountability is limited to the kinds of spending the participating physicians can actually control or influence.
- They separate insurance risk and performance risk, so physicians are not penalized financially for taking care of sicker patients or patients with unusually complex conditions.[5]

In order to use accountable payment models to pay for the SGR repeal bill, two things have to happen:

- Accountable payment models need to be available in the Medicare program for every physician in every specialty; and
- Those accountable payment models need to be designed by physicians in ways that will benefit patients and save money for Medicare, but also be feasible for physicians to implement.

Although CMS has done a lot of good work in advancing different payment models over the past several years, there are few alternative payment options available to most physicians today, particularly specialists. The only "payment reform" that exists as a formal Medicare program (rather than a demonstration project) is the Medicare Shared Savings Program, but as noted earlier, this is not really a payment reform, because it leaves the current fee for service payment system completely unchanged.[6]

The barrier to getting more alternative payment models in place faster is the belief that these models have to be "tested" in a demonstration program before they can be made available for physicians to voluntarily choose to participate in. However, demonstration projects take years to put in place and evaluate, and they

are unlikely to show the true impacts of a significantly different payment model because physician practices are unlikely to fundamentally redesign the way they deliver care in response to a payment change that may only last a few years.

Over the past 30 years, the payment systems that Medicare uses for its largest areas of expenditure have been implemented without conducting a demonstration or evaluation in advance. For example, the Inpatient Prospective Payment System (hospital DRGs) was designed and implemented for most hospitals across the country without a demonstration. The RBRVS Physician Fee Schedule was implemented for all physicians beginning in 1992 after it was mandated by Congress in 1989, with no demonstration or evaluation of the payment system before it was implemented. These payment systems were implemented in a phased approach and then monitored and regularly adjusted to correct any unanticipated problems and to adapt the payment systems to changes in science, technology, and other factors that occur over time.

Similarly, accountable payment models can be implemented and then monitored and regularly adjusted to correct any unanticipated problems. Each accountable payment model would have to be explicitly structured to assure CMS that Medicare spending would be lower than it would otherwise be. There would be no need to evaluate such an accountable payment model in order to determine whether it will save money; the physicians would be *guaranteeing* that it would reduce the types of Medicare spending covered by the model if the physicians were paid under the accountable payment model. If at any point, CMS identifies a situation where quality is being harmed for a particular provider's patients, or where spending is not truly being reduced, that provider's participation in the payment model could be terminated, similar to what CMS can do today in its standard payment systems. If physicians find they can't successfully manage under the new payment model, they could work with CMS to improve it or return to fee for service payment.

Not all physicians will have the ability to successfully participate in alternative payment models that guarantee savings to CMS, particularly during the early years of implementation. Consequently, current payment systems should not be completely replaced by any alternative payment model, but rather, physicians and other providers who wish to participate in such models should be given the ability to do so voluntarily, the same way that the Medicare Shared Savings Program is structured today for ACOs.

Many physicians, medical societies, and multi-stakeholder Regional Health Improvement Collaboratives have been working to develop payment models that are specifically designed to improve patient care and save payers money. There needs to be a mechanism for them to bring those models to CMS on an ongoing basis, have them rapidly reviewed and refined, and then put into place quickly. This will not only ensure there are enough savings to pay for the SGR repeal bill, but it will also enable the largest number of Medicare beneficiaries to benefit from higher quality care.

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[1] Congressional Budget Office. May 2013 Medicare Baseline. May 14, 2013.

[2] Congressional Budget Office. The Budget and Economic Outlook 2014 to 2024. February 2014.

[3] Projected costs or savings from other provisions have led to cost estimates above or below that amount for the individual bills reported by the Committees.

[4] Miller HD. Ten barriers to payment reform and how to overcome them. [Internet] Pittsburgh, PA: Center for Healthcare Quality and Payment Reform; 2013. Available from: http://www.chqpr.org/reports.html.

[5] Miller HD. From volume to value: Better ways to pay for health care. Health Aff (Millwood). 2009 Sept-Oct; 28(5): 1418-28.

[6] Section 1899(i) of the Social Security Act allows the Centers for Medicare and Medicaid Services to implement accountable payment models other than shared savings, but it has chosen not to do so.