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Issue Brief

Paying for Value: Replacing Medicare's Sustainable Growth Rate Formula with Incentives to Improve Care

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ABSTRACT: This brief sets forth a set of policy options to improve the way health care providers are paid by Medicare. The authors suggest repealing Medicare's sustainable growth rate (SGR) formula for physician fees and replacing it with a pay-for-value approach that would: 1) increase payments over time only for physicians and other providers who participate in innovative care arrangements; 2) strengthen primary care and care teams; and 3) implement bundled payments for hospital-related care. These reforms would be adopted by Medicare, Medicaid, and private plans in the new insurance marketplaces, with the goal of accelerating innovation in care delivery throughout the health system. Together, these policies could more than offset the cost of repealing the SGR formula, saving $788 billion for the federal government over 10 years and $1.3 trillion nationwide. Savings also would accrue to state and local governments ($163 billion), private employers ($91 billion), and households ($291 billion).

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OVERVIEW

Since its formation in 1965, Medicare, following private insurance practices at the time, has had different payment rules for different providers in different settings. It has little flexibility to recalibrate prices to reflect value and offers little support or reward for health care providers who deliver more appropriate, coordinated, or efficient care. Although Medicare began to "bundle" payments for inpatient hospital care with the introduction of diagnosis-related groups (DRGs) in 1983, for the most part payments tend to be tied to the volume and intensity of services provided, with little to hold care systems accountable for patients' outcomes or care experiences, much less the total cost of care. With the exception of some well-integrated systems and experiments with innovative delivery models, this has also largely been the case for private insurers.

This has begun to change over the past few years. In both the public and private sectors, there have been efforts to achieve greater transparency in terms

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of health care quality and outcomes and to develop value-based purchasing approaches. The Affordable Care Act has helped support this process by mandating value-based purchasing for Medicare, establishing a Medicare Shared Savings Program for accountable care organizations (ACOs), and creating a Center for Medicare and Medicaid Innovation to develop models of payment and delivery for both Medicare and Medicaid aimed at improving health system performance.

In this issue brief, we propose a set of policies to replace Medicare's sustainable growth rate (SGR) formula—a substantial impediment in the move toward value-based purchasing—with a reformed payment system that would cultivate innovation and care coordination. The SGR formula was intended to control providers' incentive to increase the volume and intensity of services under the current fee-for-service system, but over the past decade it has triggered a series of sharp reductions in physician fees that have been routinely, but temporarily, overridden by Congress. This has only made it more difficult to deal with the broader issue of physician payment reform.

According to the SGR formula, payment rates were due to be cut by 27 percent on January 1, 2013.[1] Although this across-the board cut was averted (and physician fees held at their 2012 levels) by the American Taxpayer Relief Act of 2012, the threat of future cuts under the formula remains.

The policy options we describe below elaborate on recommendations made by The Commonwealth Fund's Commission on a High Performance Health System in the report *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System*.[2] They focus on improving provider payment by strengthening primary care, providing incentives for physicians to participate in innovative delivery systems, requiring accountability for population outcomes and total costs of care, and rewarding the adoption of best practices. These policies would:

- Repeal the Medicare SGR immediately and direct all future increases in physician payments to those participating in innovative delivery reforms such as accountable care organizations, patient-centered medical homes, or similar approaches. Medicare also would recalibrate payment rates for overvalued, or undervalued, services.
- Establish a new way of paying for primary care and care teams that are able to provide high-value, patient-centered care for high-cost beneficiaries across care systems.
- Institute a new bundled payment approach for hospital episodes that includes both hospital and physician services during the initial hospital stay; any related hospital readmissions for 30 days after discharge; and, for selected conditions and procedures, postacute care as well.

To create consistent incentives across payers and reduce complexity for providers, these payment reforms would apply to Medicaid as well as Medicare and to private plans participating in the new health insurance marketplaces. Payment approaches could be designed to interact in mutually supporting ways to accelerate delivery system innovation. Assuming they were enacted in 2013 and implemented in 2014, these policies have the potential to reduce national health spending by $1.3 trillion over the 10-year period through 2023, compared with projected trends under current policies.[3] Potential federal savings of $788 billion would more than offset the federal costs of repealing the SGR formula. In addition, this approach could yield substantial savings for state and local governments, private employers, and households.

A NEW DIRECTION FOR PAYMENT POLICY

The policies we propose would avoid the steep across-the-board cuts in physician fees under the SGR formula and enhance system performance.

Replace the SGR with a New Payment System Focused on Value

The first reform is to repeal the SGR formula and instead direct any future increases in payments to

providers who participate in patient-centered, high-value models of health care delivery with a strong primary care focus (such as those described below).

In addition, the Secretary of Health and Human Services (HHS) would collect data on the cost and utilization of services so that the Centers for Medicare and Medicaid Services could identify and recalibrate payment rates for overpriced services. Diagnostic imaging, clinical laboratory testing, and other services that meet the criteria established in the health reform legislation would be examined to ensure that payment rates for those services are appropriate.[4] Such recalibration would occur at least once every five years to adjust to market patterns and evidence of over- or undervalued services.

To further align payment rates with value and accountability, payment levels for several other providers and services would be revised. This would both improve the accuracy of provider payment and help offset the cost of repealing the SGR. These adjustments would include:[5]

- Discontinuing the Medicare Advantage quality bonus demonstration that provides additional payments to private plans with quality ratings as low as three stars out of five. Current policies that reward Medicare Advantage plans with higher ratings would continue.
- Expanding competitive bidding for durable medical equipment.
- Setting payment for physician visits in hospital outpatient departments at the same rate as that paid in physicians' offices or other community settings.
- Increasing the minimum proportion of Medicare patients that require intensive rehabilitation for a facility to qualify for the higher Medicare inpatient rehabilitation facility payment rate.
- Rebasing the payment rates for clinical laboratory, skilled nursing facility, and home health services to better reflect the costs of efficiently providing those services.
- Requiring that ambulatory surgery centers submit cost and quality data to the HHS secretary to develop and implement value-based purchasing.
- Requiring prescription drug manufacturers to offer the same rebate on medications covered by Medicare Part D for low-income Medicare beneficiaries as they offer on medications for Medicaid-only beneficiaries.
- Modifying cost-sharing rules for the Medicare Part D low-income subsidy to encourage use of generic drugs, where appropriate.

These incremental changes would provide a more accurate foundation for value-based payment policies to be adopted in the future.[6]

New Payments for Primary Care, Health Care Teams, and Innovative Health Care Delivery

As part of a new method of setting and updating physician payment rates, Medicare would raise payments for primary care services, which are currently undervalued relative to more specialized services. Payments would also be used to support care teams (including nurses and other health care personnel) and the infrastructure needed to improve access and care, particularly for high-cost, complex patients.

Support for primary care providers. For primary care services, Medicare payment rates would be maintained at their 2012 level (including the 10 percent increase for primary care applied under a provision of the Affordable Care Act) from 2013 through 2023, but additional policies would seek to strengthen primary care and encourage the availability and use of high-cost care management teams, including:

- A modest additional payment per patient per month for primary care providers to deliver services to Medicare beneficiaries who designate those providers as their regular source of care.

- A somewhat larger additional payment per patient per month for providers who qualify as medical homes, with the potential for further bonus payments for high performance on measures of quality and efficiency.

To provide broad-based support to primary care and provider teams, the federal government would encourage states to use similar payment approaches for their Medicaid programs, or Medicare could join state initiatives to adopt innovative payment methods for their Medicaid programs. For physician practices caring for disabled or seriously mentally ill patients, both Medicare and Medicaid could enhance payments in recognition of the need for a multidisciplinary approach and community-based services. The cost of the enhanced payments would likely be offset by reductions in readmissions and the use of hospital emergency departments.

As a condition for participation in the new health insurance marketplaces, private plans also would adopt these types of approaches to paying for primary care. This would facilitate consistency in payment and reporting practices across public and private payers, thus reducing administrative costs and promoting coordination of care.

Incentives to innovate. For other physician services, Medicare payment rates would be maintained at their 2012 level from 2013 through 2023, with eligibility for additional payment if practices participate in a high-value accountable care organization, bundled payment arrangement, or other innovative model of health care delivery that shows promise of encouraging high-value care. As with the primary care policies described above, this policy would be coordinated across Medicare, Medicaid, and private plans participating in the health insurance marketplaces.

Bundled Payment for Hospital Episodes

Under a bundled payment approach, a single payment is made for an episode of care—a defined set of services delivered by designated providers in specified health care settings, usually within a certain timeframe. The services included in the bundled payment are those related to treating a certain medical condition or performing a major surgical procedure. The goal is to encourage hospitals, physicians, and other providers to work together to coordinate care during a hospital stay, improve the transition to new care settings, reduce the need for rehospitalizations, and ensure the delivery of appropriate care following hospital discharge by holding them accountable for patient outcomes and total costs.

The following policies would accelerate the application of bundled payment approaches, building on initiatives under way in Medicare and the private sector:[7]

- Bundling all physician services performed at the hospital during the inpatient stay with the hospital DRG payment. This would be a first step to a more comprehensive bundling policy, building on current Medicare demonstrations.[8]
- Including related readmissions in the bundle, building on initiatives already taking place to reduce preventable readmissions.[9]
- For select orthopedic and cardiovascular episodes (similar to those that are included in the current Medicare Acute Care Episode demonstration), including in the bundle related postacute care delivered within 60 days of the inpatient discharge.[10]
- Applying this bundled payment approach for hospital episodes to Medicare, Medicaid, and private plans participating in the health insurance marketplaces.

The payment rate for each type of bundle could be set based on the historical distribution of total costs for the related diagnoses, to account for variation in the cost of treating individual patients in each category. Payment would be designed to reduce the variation in costs across similar episodes and to provide incentives for providers to adopt best practices and take responsibility for the effectiveness and efficiency of resources used during the episode of care.

COORDINATION ACROSS PUBLIC AND PRIVATE SECTORS

High and rising health spending puts pressure not only on the federal budget but on the entire health system.[11] To confront high health care costs most effectively, the policies described here would apply not only to Medicare and Medicaid but also to private health plans participating in the health insurance marketplaces.

Realizing the full potential of these policies will require public and key private payers to adopt consistent approaches so that their goals can be effectively communicated to providers and the incentives and desired responses are clear. There are several mechanisms available to the federal government to encourage spread, including requiring all plans participating in the Federal Employees Health Benefits Program to adopt consistent payment approaches and mandating payment innovation and coordination among plans offered in the insurance marketplaces.

The policies described here envision Medicare developing, and Medicaid and the private sector then adopting, new payment methods that encourage and support high-value care. This evolution would be similar to the way Medicare's DRG payment system for inpatient hospital services spread to Medicaid and private payers in the 1980s, or the more rapid proliferation of Medicare's resource-based relative value scale for physician payment in the early 1990s.[12] However, given the many payment and delivery reform initiatives currently being developed throughout the public and private sectors, the federal government could also play a more active role in brokering, facilitating, and partnering in these reforms at the state and local levels and enhancing their spread.

Among the health reform initiatives that have been adopted in both the public and private sectors are: the growing number of ACOs involving Medicare, Medicaid, and private payers; initiatives that involve coordination across Medicare and Medicaid to promote patient-centered medical homes and other comprehensive primary care models; and the State Innovation Models Initiative being conducted in several states to promote multipayer (public and private) payment and delivery models.[13] There also are examples of collaboration across the public and private sectors in Arkansas, Colorado, Michigan, North Carolina, Oklahoma, Pennsylvania, Vermont, and other states.[14]

States, in fact, have some advantages in promoting health system change. They are able to convene all health sector participants, without the threat of antitrust action—a powerful tool in achieving coordination across public and private stakeholders. A unified approach to health system reform, with all payers pulling together, is key to making rapid progress over time. As a bonus, such an approach would reduce administrative complexity for practices and care systems.

ESTIMATED IMPACTS ON HEALTH SPENDING

Estimates of the cumulative potential impact of the policies described above are based on modeling by the Actuarial Research Corporation (ARC).[15] The estimates were part of a larger effort to gauge the potential impacts of the comprehensive set of policies proposed by the Commission on a High Performance Health System.[16]

For purposes of this analysis, a "current policy" baseline was computed by ARC that assumed Congress would continue to override the payment rate cuts mandated by the SGR formula. Instead of these cuts, ARC assumed that Medicare physician fees would be increased by 1 percent in 2013 and then held constant through 2023.[17]

Policy Impacts

The potential impacts of the policies we have set forth were first estimated separately and then combined, accounting for potential overlaps. The estimates examine the potential cumulative savings for state and local governments, businesses, and families in addition to federal government savings over the decade from 2013 through 2023.

Repealing the SGR and recalibrating Medicare payments for physicians and other providers. The potential impact on national health expenditures of the repeal of the SGR mechanism,

implemented together with refinements in Medicare payments for other providers described above, would be $228 billion in savings (Exhibit 1).[18] Of this total, $155 billion would accrue to the federal government, $12 billion to state and local governments, $11 billion to private employers, and $51 billion to households.

Providing new payments to strengthen primary care, health care teams, and innovative health care delivery. Policies designed to strengthen primary care and provide incentives for physicians to participate in innovative models of health care delivery would apply to Medicare and Medicaid as well as to private plans participating in the health insurance marketplaces. If these policies were implemented quickly and effectively, and spread rapidly across the public and private sectors, they have the potential to yield $496 billion in savings from 2013 through 2023, with $345 billion accruing to the federal government, $88 billion to state and local governments, $14 billion to private employers, and $49 billion to households (Exhibit 1).

Bundled payment for hospital episodes. Instituting the bundled payment policy described above for Medicare, Medicaid, and private plans could generate a cumulative $620 billion in savings in national health spending, with the federal government saving $296 billion, state and local governments $64 billion, private employers $66 billion, and households $194 billion (Exhibit 1).

Potential combined net impact of payment reform policies. The potential combined effect on national health expenditures of the entire package of provider payment reforms described here compared with projected trends would be $1.3 trillion in savings, of which $788 billion would accrue to the federal government, $163 billion to state and local governments, $91 billion to private employers, and $291 billion to households (Exhibit 1).

The potential savings to the federal government from this set of provider payment reforms would be more than enough to completely offset the estimated cost of forgoing the across-the-board cuts required under the SGR formula. These policies not only would reduce Medicare spending but also would address the most important needs of beneficiaries, as well as improve health care and reduce cost growth throughout the health care system.

It is important to note that households—including workers and their families as well as Medicare and Medicaid beneficiaries—would benefit greatly from the resulting lower out-of-pocket costs for care and lower premiums, compared with projected trends. Moreover, they would benefit from having greater access to patient-centered and effective care as the health system moves toward high performance.

Although substantial, these net savings reflect relatively modest changes in the projected growth in revenues for hospitals and physicians. Even with a $1.3 trillion reduction in national health expenditures over 10 years, provider revenues would continue to grow (Exhibit 2). Spending on hospital care would increase by 72 percent—an annual rate of 5.6 percent—between 2013 and 2023, totaling $12.2 trillion over the decade. Similarly, spending on physician and clinical services would grow by 81 percent over the same period—an

Exhibit 1. Cumulative Net Impacts of Combining Policies to Improve Provider Payment: 2013–2023 (in billions)

	National health expenditures	Federal government	State and local governments	Private employers	Households
Repealing the SGR and recalibrating Medicare payments*	–$228	–$155	–$12	–$11	–$51
New payments for primary care, health care teams, and innovative health care delivery	–$496	–$345	–$88	–$14	–$49
Bundled payment for hospital episodes	–$620	–$296	–$64	–$66	–$194
Cumulative impact	**–$1,333**	**–$788**	**–$163**	**–$91**	**–$291**

* Impacts include malpractice reform.

Notes: Impacts are relative to "current baseline" projection, under which the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are assumed to be deferred and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023. Impacts on components may not add to total impact because of rounding.

Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund.

Exhibit 2. Provider Payments by Type of Service: Baseline Projection and Under Proposed Payment Policies, 2013–2023 (in billions)

		Baseline projection			Under proposed payment policies		
	2013	2023	Cumulative percent change	Annual percent change	2023	Cumulative percent change	Annual percent change
Hospital care	$902	$1,646	82%	6.2%	$1,554	72%	5.6%
Physician and clinical services	$597	$1,122	88%	6.5%	$1,080	81%	6.1%

Notes: Impacts are relative to "current baseline" projection, under which the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are assumed to be deferred and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023. Impacts include malpractice reform.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund.

annual rate of 6.1 percent—compared with 88 percent, as projected under current policy. Moreover, instead of the across-the-board cuts in payment for physicians called for by the SGR, the new payment policies would reinforce and reward innovative, effective, and efficient health care delivery.

CONCLUSIONS

Repealing the current Medicare SGR formula would remove an impediment to a pay-for-value approach and open the door to accelerated payment reform. Rather than simply cutting fee-for-service payments across the board, Medicare could realign payments and target incentives to improve care. The transition from the current system to new ways of paying for care would enable innovative health care delivery systems to develop over time, guided by the goals of better care, better outcomes, and more prudent use of resources.

In this brief, we have described a set of policies that could quickly establish new, better ways of paying for health care and accelerate the pace of delivery system reform. Although Medicare would take the lead, it would also partner with Medicaid and private payers to ensure consistency across the health system—because payment reforms will work best if they are adopted systemwide. Even more substantial cost reductions and greater improvements in health care access and quality are possible with policies that improve the functioning of health care markets. These include concerted efforts to engage consumers and furnish them with the information they need to choose high-value care systems and high-value care.[19]

NOTES

1 See Centers for Medicare and Medicaid Services, "Medicare Program, Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013; Final Rule," *Federal Register* 77(222):68892–69380, available at http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf.

2 See Commonwealth Fund Commission on a High Performance Health System, *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System* (New York: The Commonwealth Fund, Jan. 2013).

3 As described in the Estimated Impacts section, the "current policy" projection used as the baseline for this analysis assumed that the cuts in Medicare physician fees under the SGR formula would continue to be overridden by the Congress—as they have for the past decade—with a 1 percent increase in 2013 and no increase through 2023. The Congress did, subsequently, override the 27 percent SGR cut in 2013, holding Medicare physician fees at their 2012 level. Although this action resulted in somewhat lower Medicare physician fees than assumed in our baseline, it would have had very little impact on the estimates presented here.

4 See Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, D.C.: MedPAC, June 2011), "Chapter 2: Improving Payment Accuracy and Appropriate Use of Ancillary Services," available at http://www.medpac.gov/chapters/Jun11_Ch02.pdf.

5 The policies described here are similar to—but not necessarily the same as—recommendations made by the Medicare Payment Advisory Commission; see Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: MedPAC, March 2012), "Appendix B: Moving Forward from the Sustainable Growth Rate System," available at http://www.medpac.gov/chapters/Mar12_AppB.pdf.

6 The estimated impact of this set of policies also includes establishment of a prior authorization program for practitioners who order substantially more advanced diagnostic imaging services than their peers. This policy also was selected from the list of policies recommended by the Medicare Payment Advisory Commission.

7 Medicare's Acute Care Episode Demonstration is testing a bundled payment approach for all physician and hospital services associated with several orthopedic and cardiovascular episodes that are identified with 37 DRGs. The Center for Medicare and Medicaid Innovation is developing a bundled payment program to test additional models that would encompass postacute care and other types of conditions. Private sector initiatives, such as the Prometheus Model, also are being developed and tested.

8 For a description of the Medicare Hospital Gainsharing demonstration, see http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/DRA5007_Solicitation.pdf.

9 For example, the Hospital Readmission Reduction Rate Program. For more detail, see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduct ion-Program.html.

10 For more detail on the estimation and potential impact of this policy, see J. Mays, D. Waldo, R. Socarras et al., *Technical Report: Modeling the Impact of Health Care Payment, Financing, and System Reforms,* Prepared for the Commonwealth Fund by Actuarial Research Corporation, Jan. 2013; available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Jan/ARC_technical_report_modeling_impact_of_reforms.pdf.

11 See Commonwealth Fund Commission, *Confronting Costs,* 2013.

12 See G. M. Carter, P. D. Jacobson, G. F. Kominski et al., "Use of Diagnostic-Related Groups by Non-Medicare Payers," *Health Care Financing Review,* Winter 1994 16(2):127–58; S. L. Smith and R. Fischoff (eds.), *Medicare RBRVS: The Physician's Guide* (Chicago, Ill.: American Medical Association, March 2007).

[13] For examples on the spread of ACOs, see D. M. Berwick, "Making Good on ACOs' Promise: The Final Rule for the Medicare Shared Savings Program," *New England Journal of Medicine,* Nov. 10, 2011 365(19):1753–56; T. McGinnis and D. M. Small, *Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design* (Hamilton, N.J.: Center for Health Care Strategies, Feb. 2012); A. J. Forster, B. G. Childs, J. F. Damore et al., *Accountable Care Strategies: Lessons from the Premier Health Care Alliance's Accountable Care Collaborative* (New York: The Commonwealth Fund, Aug. 2012). For examples of primary care initiatives, see Centers for Medicare and Medicaid Services, "Multi-Payer Advanced Primary Care Practice Demonstration: Questions & Answers—Updated April 12, 2011," available at http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/map-cpdemo_QA.pdf. For more on the State Innovation Model Initiative, see Centers for Medicare and Medicaid Services, "Fact Sheet: HHS Announces State Health Care Innovation Initiative," July 19, 2012, available at http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4411&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

[14] See, for example, "*Arkansas Charts a Course for HIE and Quality Reporting*" (Hamilton, N.J.: Center for Health Care Strategies, Aug. 2010), available at http://www.chcs.org/usr_doc/Arkansas_RQI_Case_Study.pdf; M. Takach, A. Gauthier, K. Sims-Kastelstein et al., *Strengthening Primary and Chronic Care: State Innovations to Transform and Link Small Practices* (New York: The Commonwealth Fund, Dec. 2010).

[15] For more detail on the ARC micro-model and its application, see Mays, Waldo, Socarras et al., *Technical Report,* 2013.

[16] Commonwealth Fund Commission, *Confronting Costs,* 2013.

[17] The assumption that the SGR formula would continue to be overridden by Congress through 2023 added a cumulative $333 billion to national health spending, with Medicare program spending accounting for $277 billion of that amount. The Congressional Budget Office has recently sharply reduced its estimate of the cost of holding Medicare physician payments at their 2013 levels through 2023. See Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2013 to 2023* (Washington, D.C.: CBO, Feb. 2013). However, this change would have little or no effect on the potential net impacts of the policies described in this brief.

[18] This estimate also includes the potential impact of malpractice reform policies that focus on patient safety, adoption of best practices, and fair compensation for injury while reducing the burden on providers and diminishing the incentive to engage in defensive medicine. These policies are not directly related to provider payment, but would enhance the alignment of incentives to providers in support of performance improvement. See Commonwealth Fund Commission, *Confronting Costs,* 2013.

[19] Commonwealth Fund Commission, *Confronting Costs,* 2013.

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