



BIPARTISAN POLICY CENTER

May 31, 2013

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Chairman Baucus and Ranking Member Hatch:

We appreciate the opportunity to provide input to the Finance Committee as it considers the replacement of the Medicare Sustainable Growth Rate (SGR) physician payment formula and broader reforms to Medicare fee-for-service payment.

The Bipartisan Policy Center (BPC) recently released *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, which included a multitude of recommendations to spur improvement in system-wide health care quality and efficiency. This effort, led by former senators Tom Daschle, Bill Frist, Pete Domenici, and former OMB and CBO Director Dr. Alice Rivlin, focused extensively on reforms to Medicare that would result in higher quality care and reduce cost growth for beneficiaries and taxpayers. A central aim of our recommendations, which incorporate an SGR fix, is to create strong incentives for the full range of providers to transition from the volume-based payment methods that predominate in Medicare today to advanced payment and delivery models that promote accountability for quality outcomes, patient satisfaction and value.

Reforming the SGR presents a critical opportunity for Congress to enact comprehensive Medicare reimbursement reforms that prioritize quality and value. A fix to the SGR formula should be contingent upon additional incentives to improve quality and value.

There is an emerging consensus among providers and policymakers regarding the need to move away from fee-for-service payment, which we have identified as a major driver of health care cost growth, as well as a contributor to the lack of coordination of care that many patients experience. Proposals to replace SGR from members of both parties are based on the idea that future payment updates for physicians should be tied to participation in advanced payment models with the goal of increasing quality and value of care. BPC's proposed approach to SGR is similar. First, we propose that, beginning in 2017, future updates for all providers participating in traditional Medicare, not only physicians, be contingent on participation in a payment model that includes accountability for cost, quality, and payment satisfaction. Second, we specify a potential new payment and delivery

model for traditional Medicare, a significantly enhanced version of Accountable Care Organizations (ACOs) that we call “Medicare Networks.” Medicare Networks, like ACOs, would be formed and led by providers who want to work together to deliver high quality, high value care. A critical difference, however, is that Medicare Networks would have more tools to achieve these goals. Beneficiaries and providers would also have strong incentives to participate, but the existing fee-for-service system would remain an option.

Medicare Networks

In our proposal, beginning in 2017, beneficiaries would have the opportunity to select a Medicare Network through an enrollment process. The existing Medicare ACOs automatically assign patients based on claims data, and many beneficiaries are not even aware that they are part of an ACO. This is a missed opportunity for patient engagement, and it denies ACOs key tools that would help maximize quality and value. Each Medicare Network would have a spending target, and networks that meet quality and patient satisfaction goals could share in any savings under the target. Additionally, unlike current ACOs, enrolled beneficiaries would also share in savings through Part B premium rebates. Enrollees would pay lower cost-sharing to see Medicare Network providers, but would retain the option to see any participating Medicare provider, albeit at a higher out-of-network cost-sharing amount. Finally, all Medicare Networks would be required to take two-sided risk, meaning that, in addition to potentially sharing in any savings, providers would be responsible for absorbing a portion of excess spending over the target. In this manner, Medicare Network providers would be accountable for their own outcomes and volume of services, but would have flexibility to adopt their own internal care and financial processes to best achieve these goals. Like today’s ACOs, Medicare Networks would be provider-led, but could always contract with other organizations, including health plans, for various services, such as analytics and management support.

Strong Incentives for All Providers to Participate, Plus an SGR Fix

We propose elimination of the SGR. Physicians who form or join current ACOs or future Medicare Networks would receive updates based on the Medicare Economic Index, minus a productivity adjustment. Beginning in 2017, we propose that updates for all traditional Medicare providers be reserved for those participating in Medicare Networks; providers could choose not to participate, but their payment rates would be frozen for several years. Medicare policies should encourage all providers to form organized systems of care and transition to payment models that emphasize quality and value; therefore, incentives to participate should extend to all providers, not only physicians.

Additional Considerations

Given the growth of Medicare and private-sector ACOs thus far (with [estimates](#) of over 400 operating in 49 states), we believe that 2017 is a reasonable date by which most providers will be able to organize under this model. But we also recognize that the adoption of advanced payment models will take longer in some regions. The Secretary of Health and Human Services should have authority to continue to provide normal updates to fee-for-service providers when necessary to ensure beneficiary access to care, particularly in rural areas or areas where Medicare Networks have not yet formed. Additionally, any transition to advanced payment models, such as our

proposed Medicare Networks, could require additional federal support for implementation. Better risk adjustment and improved, streamlined quality measures are essential to the success of new models. In particular, the Centers for Medicare and Medicaid Services must ensure that timely, actionable Medicare data is available to providers in order to facilitate care coordination and quality improvement. Access to capital may be an issue for some providers seeking to form Medicare Networks, and we propose that a federal loan guarantee program be established for physician-led Medicare Networks, and that rural providers, in particular, should have access to low-interest loans.

SGR and Comprehensive Medicare Reform

The reforms we propose to fix the flawed SGR formula and improve the traditional Medicare payment system can – and should – be done in concert with broader efforts to improve Medicare. A modernized traditional Medicare should include rational cost-sharing, such as simplification of deductibles and replacement of coinsurance with reasonable copayments, new protection for beneficiaries from catastrophic health costs, limitations on first-dollar supplemental coverage to encourage appropriate utilization of health care services, expanded financial assistance for low-income Medicare beneficiaries, and reduced subsidies for higher-income beneficiaries.

A comprehensive reform approach would also include improvements to Medicare Advantage, including a transition from the current, administrative payment system based on traditional Medicare spending to a competitive pricing system. Improved risk adjustment and the addition of reinsurance for Medicare Advantage would also be important improvements, as would a redesigned, consumer-friendly Medicare Open Enrollment website that would allow beneficiaries to compare all Medicare options easily and quickly. Comprehensive reform should also include other changes to Medicare payment policies in order to encourage high value care, such as rationalizing payment across sites of service and reforming the Part D Low-Income Subsidy to create stronger incentives for plans to offer, and enrollees to select, high quality, low cost drugs.

Over the next decade (FY2014-2023), our combined Medicare proposals would generate about \$300 billion in federal budget savings, notably net of the additional cost of an SGR fix and improved assistance for low-income Medicare beneficiaries. Over the second ten years (FY2024-2033), savings would approach \$1 trillion. These estimates were modeled by Acumen, LLC, which produces independent economic analyses for the Congressional Budget Office, the Institute of Medicine, and the Medicare Payment Advisory Commission.

Additional information about our proposals for comprehensive reform to improve care and lower costs for Medicare beneficiaries and taxpayers, as well as system-wide for states and the private sector, are available in our report, *A Bipartisan Rx for Patient-Centered Care and System-wide Cost Containment*.

Conclusion

Thank you for the opportunity to share our recommendations regarding reform of Medicare's physician payment formula and how to approach the challenge of a broader transition to improved payment models in Medicare. We believe that such change will lead to better outcomes and a better

care experience for patients, and that savings for the federal budget and beneficiaries would be an outgrowth of those improvements. The work necessary to achieve this vision will take many years, and it is imperative that policymakers act now to begin the transformation to a higher quality, more sustainable health care system. Fixing the SGR payment formula provides an excellent opportunity to begin this process.

Sincerely,



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