CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

How Should Congress Pay for the Cost of Repealing the Sustainable Growth Rate?

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EXECUTIVE SUMMARY

- There is an urgent need to repeal the federal Sustainable Growth Rate (SGR). The draconian 21% cut in Medicare payments to physicians that it requires would make it difficult for physician practices to survive, make it difficult for Medicare beneficiaries to get care, and shift Medicare costs to workers and businesses, while only reducing Medicare spending by 3%.
- Medicare spending could be reduced by far more than 3% without harming patients by giving physicians the tools they need to keep patients healthy, avoid unnecessary tests and procedures, reduce avoidable hospitalizations, and prevent infections and complications. Savings from better care could be used to pay for repealing the SGR and for making reasonable annual updates to physician payments. Physicians would need to slow the growth in Medicare spending by only one-half percentage point per year over the next decade to achieve the necessary savings for SGR repeal, and slowing growth by an additional one-half percentage point would keep Medicare spending growth in line with GDP.
- The major barrier to redesigning care delivery to achieve these savings is the current fee-for-service payment system, which penalizes physicians for reducing spending and fails to pay for many services that would be better for patients and reduce spending for Medicare. Most of the "payment reforms" currently being implemented by the Centers for Medicare and Medicaid Services (CMS) don't remove these barriers, and in some cases they make the problems with the current payment system even worse.
- Accountable Payment Models – bundled payments, warrantied payments, and condition-based payments – are needed in every specialty to give physicians the *flexibility* to redesign care along with *accountability* for both the costs and quality of the services and outcomes they can influence. CMS has not implemented these kinds of payment models quickly enough, particularly for ambulatory care, even though it has the statutory authority to do so.
- Instead of waiting to "test" Accountable Payment Models in demonstration projects, CMS should make them immediately available on a voluntary basis to all physicians who wish to participate, and then the Accountable Payment Models can be evolved and improved over time, the same as has been done with all of the existing Medicare payment systems for physicians and hospitals.
- Many physicians, medical societies, and local multi-stakeholder collaboratives are developing Accountable Payment Models that could improve care and reduce spending for conditions ranging from cancer to heart disease, but there is currently no way for them to get participation by their largest payer – Medicare. Congress should require that CMS have at least one Accountable Payment Model available for voluntary use in each of the largest medical specialties within one year, and that it have at least one Accountable Payment Model available in every medical specialty within two years. To achieve these goals, Congress should create a faster pathway for reviewing and implementing the Accountable Payment Models that are already being developed by physician organizations and local multi-stakeholder collaboratives across the country.

Bad Federal Policy Needs Permanent Repeal

In April 2015, unless Congress takes action to prevent it, the federal "Sustainable Growth Rate" law will require a 21.2% cut in the payments Medicare makes to every physician for every service they deliver, ranging from an office visit to major surgery. There is no other industry in America that tells its key professionals that their compensation will be cut by over 20% regardless of whether they are doing a good job or not, but that's what federal law tells physicians in the Medicare program under the Sustainable Growth Rate (SGR) policy.

No business in America could tells its key professionals every year that their compensation will be cut by over 20% regardless of whether they're doing a good job or not, but that's what federal law tells physicians in the Medicare program.

For over a decade, the members of Congress have understood that implementing this kind of across-the-board payment cut would make it difficult for many physician practices to survive and would make it more difficult for many Medicare beneficiaries to obtain the care they need. Moreover, when Medicare pays physicians less than it costs them to deliver good care, physicians are forced to charge other patients more, causing healthcare premiums for workers and businesses to increase.

So every year for the past 12 years, Congress has prevented the cuts from going into effect. However, because Congress has *stopped each year's cut without repealing the law*, it has caused the scheduled cuts in many subsequent years to be even bigger than they would have been otherwise, and it has left physicians in a continuing limbo as to whether they will be able to afford to continue providing healthcare services to Medicare beneficiaries.

Agreement on the Need for Repeal But Not On How to Pay For It

In 2014, Congressional leaders in both parties agreed that the SGR needed to be repealed instead of continuing the annual ritual of delaying the scheduled cuts, and the members of the House Energy and Commerce Committee, House Ways and Means Committee, and Senate Finance Committee reached bipartisan, bicameral agreement on legislation to repeal the Sustainable Growth Rate. Unfortunately, the legislation failed to pass because Congressional leaders couldn't agree on how to pay for the cost of repeal. So once again, the SGR-mandated cuts were merely delayed, and once again in 2015, physicians are facing large cuts in their Medicare payments.

How Much Does It Cost to Repeal the Sustainable Growth Rate?

The Congressional Budget Office estimates that the cost of repealing the Sustainable Growth Rate will total $118.9 million over the next ten years if physician payment rates are frozen at their current levels.[1] Although freezing physician payments would be better than cutting them by 21%, if payments don't increase to keep up with inflation, physicians would still receive the equivalent of a 10% cut over the next decade, and once again, Medicare would be shifting its costs to the private sector and forcing workers and businesses with commercial health insurance to pay more for healthcare services. A better approach is to both repeal the SGR and increase physician payment rates based on the Medicare Economic Index; the Congressional Budget Office estimates this would cost $204 billion over the next 10 years.[2]

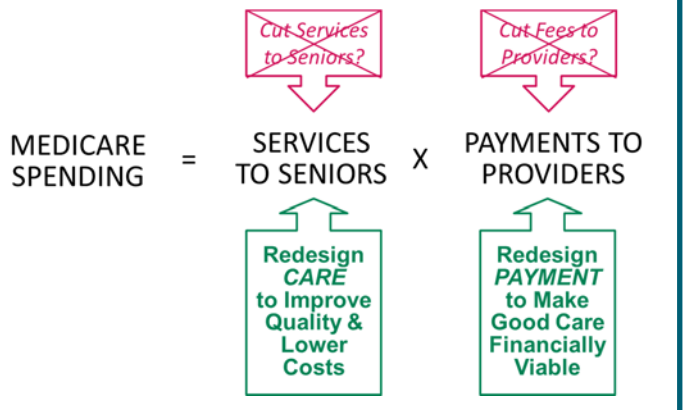
Looking for Offsets in the Wrong Places

It's not surprising that Congress will have trouble paying for SGR repeal if it tries to do it by cutting payments to other healthcare providers, cutting services to Medicare beneficiaries, or making cuts in non-healthcare programs. Repealing the SGR solves one problem but creates others if repeal is paid for by cutting physician payments in a different way, by making cuts to other providers instead of physicians, or by refusing to pay for services that patients need.

The real solution lies in *changing the way healthcare services are delivered* so that patients can get the same or better care with less total spending. Numerous studies have shown that 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 that are performed; and by preventing serious health conditions and providing treatment at earlier and lower-cost stages of disease.

Congress can't change the way health care is delivered, only physicians can. So instead of cutting payment rates

Good Ways and Bad Ways to Control Medicare Spending



for providers or refusing to pay for care that patients need, the right way to achieve savings in the Medicare program is to give physicians and other healthcare providers the ability to *redesign* care delivery so that patients will receive better care, Medicare spending will be lower, and physicians and other providers will be paid adequately for what they do.

The Payment *System* is a Problem, Not Just Payment *Rates*

The biggest barrier to achieving savings is the *way* Medicare pays for healthcare. The current fee-for-service payment system creates major barriers for physicians who want to redesign care in ways that benefit patients and save money for Medicare[3]:

- **Financial penalties for delivering higher-value care.** 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.
- **Failure to pay for high-value services.** In the Medicare program, some high-value services aren't paid for adequately or at all. For example, Medicare doesn't pay physicians to respond to a patient phone call about a symptom or problem, even though the phone calls could avoid a far more expensive visit 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.

Physicians all over the country have proven that they can both improve care for patients and save money for Medicare if they can get the resources they need to deliver services that Medicare doesn't pay for. For example, primary care physicians, cardiologists, oncologists, and others have used grant funding in demonstration projects to pay for nurses to help patients manage their health problems. These projects have dramatically reduced the rate at which their patients have had to go to an emergency room or be hospitalized for complications, saving Medicare far more than the cost of the services supported by the grants. But in most cases, the improvements in care and the savings achieved in the demonstration projects have to end when the demonstration ends because there is no way to sustain the projects under the current payment system.

Creating Accountable Payment Models, Not "Incentives"

Unfortunately, most of the "payment reforms" in Medicare today don't fix these problems, and in some cases they make them worse. The Value-Based Payment Modifier (VBM) penalizes physicians for spending on services over which they have no control, while doing nothing to remove the barriers to better care in the underlying fee for service system.[4] The Medicare Shared Savings Program also does not change the underlying payment structure, and although it does not penalize physicians the way the VBM does, it merely creates the possibility of small bonuses if total spending can be reduced, including spending the physicians have no ability to control. Tying payments to quality or spending measures will have little impact if physicians are forced to lose money in order to implement better care.

Physicians don't need "incentives" to deliver higher-value care, they need *Accountable Payment Models* that remove the *barriers* in the current fee-for-service system. Three types of Accountable Payment Models are needed:[5]

- **Bundled Payments** that give physicians and hospitals the flexibility to redesign care in ways that reduce costs without rationing.
- **Warrantied Payments** that pay physicians and hospitals adequately for preventing complications instead of paying more for treating them.
- **Condition-Based Payments** that pay physicians for what patients really want – to have their health problem addressed both successfully and affordably. Under a condition-based payment, physicians and hospitals aren't financially penalized for using equally effective but less expensive treatment methods or fewer invasive procedures to treat patients' health problems.

ACCOUNTABLE PAYMENT MODEL	HOW THE PAYMENT MODEL WORKS	HOW PHYSICIANS AND HOSPITALS CAN BENEFIT	HOW MEDICARE AND PRIVATE PAYERS CAN BENEFIT
Bundled Payment	Single payment to two or more providers who are now paid separately (e.g., a hospital and a physician)	Higher payment for physicians and lower costs for hospitals if physicians improve the efficiency of care	Providers can offer a lower total price to Medicare and health plans than today
Warrantied Payment	Higher payment for quality care, but no extra payment for correcting preventable errors and complications	Higher payment for physicians and hospitals with low rates of infections and complications	Medicare and health plans no longer pay more for high rates of infections or complications
Condition-Based Payment	Payment based on the patient's condition, rather than on the procedure used	No loss of payment for physicians and hospitals using fewer or lower-cost tests and procedures	Medicare and health plans no longer pay more for unnecessary or avoidable procedures

Not every *alternative* payment model has the elements needed for success. There are four key elements needed to create an effective Accountable Payment Model:

- **Flexibility** for the physician to deliver the combination of services patients need in order to achieve the best outcomes in the most efficient way;
- **Accountability** by the physician for controlling spending and improving quality, but with accountability limited to the aspects of care delivery that that physician can control;[6]
- **Adequacy** of payment to cover the costs of high-quality care; and
- **Protection against inappropriate risk**, e.g., ensuring that physicians are not penalized for taking care of sicker patients or unusually complex patients.[7]

Accountable Payment Models: A Win-Win-Win for Physicians, Medicare, and Patients

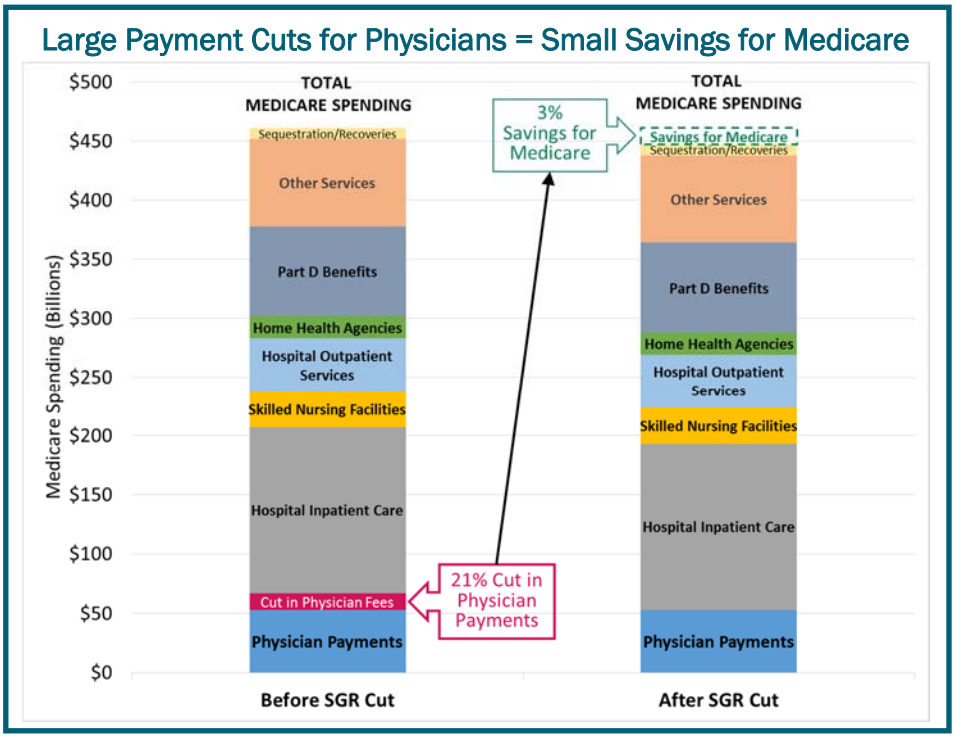
Accountable Payment Models can create a win-win for both Medicare and physicians for a very simple reason: most Medicare spending doesn't go to physicians. Medicare physician fee schedule payments currently represent only 16% of total spending in Medicare Parts A, B, and D. Over the next decade, the Congressional Budget Office projects that physician fee schedule payments will represent only 13% of total Medicare spending.[8] That means that while the draconian cuts under the SGR formula would be devastating for many physician practices, they wouldn't actually do very much to reduce *total* Medicare spending. The 21% reduction in payments to physicians that is scheduled for 2015 would reduce total Medicare spending by only 3%.

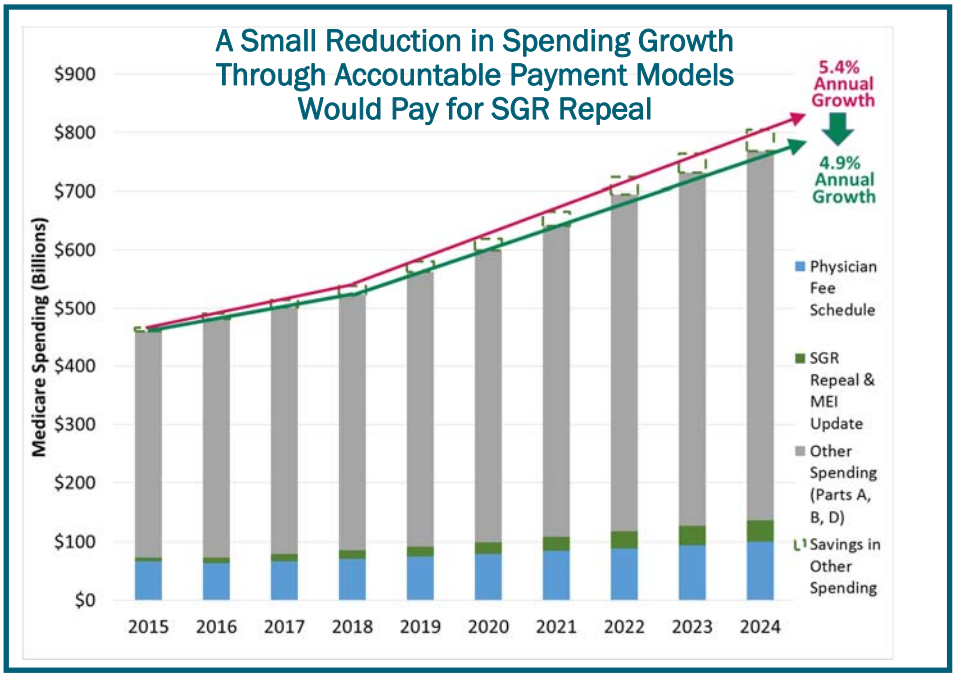
However, physicians prescribe, control, or influence most of the laboratory tests, imaging studies, drugs, hospital stays, and other services that make up the other 87% of Medicare spending. If physicians are given the ability to redesign care for patients in a way that reduces unnecessary or avoidable spending on those *other* services, the physicians could reduce *total* Medicare spending without any loss of revenue themselves. For example, if physicians can reduce Medicare spending on other services by 5% (e.g., by reducing preventable hospitalizations, using less expensive drugs or procedures, avoiding unnecessary tests and other services, etc.), payments to the physicians could increase by 3% and total Medicare spending would still decrease by nearly 4%.[9]

How Much Would Physicians Have to Reduce Medicare Spending in Order to Cover the Cost of SGR Repeal?

The Congressional Budget Office projects that Medicare spending under Parts A, B, and D will total $6 trillion over the next decade. The $200 billion cost of repealing the SGR and keeping physician payments current with inflation represents only 3% of that total spending and only 3.4% of the spending other than physician fee schedule payments.[10] Broad adoption of Accountable Payment Models would give physicians the tools they need to reduce Medicare spending by at least 3%, fully paying for the cost of repealing the SGR.

Moreover, Medicare spending doesn't actually have to be *reduced in absolute terms* to achieve the necessary savings; all that is needed is to slow the *growth* in spending. The $200 billion cost of SGR repeal is only 14% of the $1.4 trillion by which Medicare Parts A, B, and D spending is projected to grow over the next decade. That means that if physicians can reduce the projected average annu-





al growth in spending from 5.4 % to 4.9% – i.e., slowing growth by a mere one-half percentage point – it would generate enough savings both to pay for SGR repeal and provide annual updates for physicians. All other providers – hospitals, skilled nursing facilities, home health agencies, etc. – could still receive more revenue from Medicare every year than they do today while Medicare would spend less in total than it would otherwise. An additional one-half percentage point reduction in growth would keep Medicare spending in line with the growth in GDP.[11]

Accelerating the Implementation of Accountable Payment Models

In order to use Accountable Payment Models to save money for Medicare and pay for SGR repeal, two things have to happen:

- Accountable Payment Models need to be available in the Medicare program for every physician in every specialty who wishes to participate; 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 the Center for Medicare and Medicaid Innovation has done a lot of good work in advancing different payment models over the past several years, there are still few alternative payment models available to most physicians today, particularly specialists, and many of the payment models developed by CMS fail to overcome the barriers in the payment system or are designed in ways that make it difficult for physicians to participate. For example, as noted earlier, the Medicare Shared Savings Program is not really a true payment reform, because it leaves the current fee for service payment system completely unchanged[12], and it does not provide support for physicians in individual specialties who want to improve care just for the patients they treat, since it is only available to physicians and health systems that are willing and able to take accountability for *all* of the services Medicare beneficiaries receive. The bundled and warrantied payment models being implemented through the Bundled Payments for Care Improvement initiative are limited to patients who were hospitalized for their condition and the payments are focused on a short period of time following the hospitalization. There are no Accountable Payment Models available from CMS to support the ability of specialists to prevent hospitalizations related to the conditions they treat, to deliver treatments that do not require an inpatient hospital admission, or to provide care that occurs more than a few months after a hospitalization.

Implementing and Evolving Payment Reforms, Instead of "Testing" and Evaluating Them

One of the biggest impediments to getting more Accountable Payment Models in place faster is the myth that these models have to be "tested" in a demonstration program before they can be made available to physicians. However, demonstration projects take years to implement and evaluate, and even then, demonstrations are unlikely to show the true impacts of a significantly different payment model because physician practices are unlikely to fundamentally redesign the way in which they deliver care in response to a temporary payment change that may only last a few years.[13]

Moreover, "testing" payment reforms before implementing them has been the exception rather than the rule in Medicare. All three of the payment systems that Medicare currently uses for its largest categories of expenditures were implemented without conducting a demonstration or evaluation in advance:

- the Inpatient Prospective Payment System (i.e., hospital DRGs) was designed and implemented for most hospitals across the country in 1983 without an

evaluation demonstrating that it would work.[14] It was implemented nationwide just 14 months after Congress passed the authorizing legislation.

- 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.
- The Outpatient Prospective Payment System was implemented in 2000 to pay hospitals for outpatient procedures, with no testing or evaluation prior to implementation.

Instead of spending years trying to test these new payment systems in an artificial demonstration, all of them were implemented in a phased approach and then monitored and regularly adjusted to correct any unanticipated problems and to adapt the payment systems as changes in science, technology, and other factors occurred over time.

Similarly, new Accountable Payment Models can be implemented and then monitored and regularly adjusted to correct any unanticipated problems and to adapt them as new technologies and research results appear. Each Accountable Payment Model would have to be explicitly structured to assure CMS that Medicare spending would be lower than it would otherwise be, but it would also have to give physicians the flexibility to truly redesign care, unlike the shared savings models that CMS has been using. There would be no need to evaluate such an Accountable Payment Model in a demonstration program in order to determine whether it will save money; the physicians would be *guaranteeing* (within appropriate limits on risk) that they would redesign care in ways that would reduce the types of Medicare spending addressed by the Accountable Payment Model.[15] If at any point, CMS identifies a situation where quality is being harmed for a particular physician's patients, or where spending is not truly being reduced, that physician'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 the payment model, switch to a different Accountable Payment Model, or return to fee for service payment.

Voluntary Programs, Not Mandates or Demonstrations

A growing number of physicians want to participate in properly designed Accountable Payment Models in order to overcome the barriers they face in delivering high-quality care under the current fee-for-service system. There would be no need to *mandate* participation by physicians in Accountable Payment Models if they are designed by the physicians who would be using them or with

EXAMPLES OF ACCOUNTABLE PAYMENT MODELS CURRENTLY UNDER DEVELOPMENT*

HEALTH PROBLEM	OPPORTUNITIES FOR SAVINGS	ACCOUNTABLE PAYMENT MODELS NEEDED	GROUPS DEVELOPING PAYMENT MODELS
Stable Angina	• Reduce unnecessary use of stress tests and cardiac imaging • Reduce unnecessary invasive cardiac imaging and interventions	• Condition-Based Payment	America College of Cardiology and Wisconsin Partnership for Healthcare Payment Reform
Breast, Colon, Lung, and Other Cancers	• Reduce avoidable emergency department visits and hospitalizations • Reduce unnecessary use of expensive tests and drugs	• Condition-Based Payment	American Society of Clinical Oncology
Heart Failure	• Reduce avoidable emergency department visits and preventable hospitalizations	• Condition-Based Payment	Oregon Chapter of the American College of Cardiology
Knee Osteoarthritis	• Increase use of non-surgical alternatives for treating knee pain and mobility problems • Reduce the cost of knee surgery • Reduce infections and complications of surgery	• Bundled Payment for Non-Surgical Care • Bundled/Warrantied Payment for Surgery • Condition-Based Payment	Central Oregon IPA and Oregon Health Care Quality Corporation
Ovarian and Endometrial Cancer	• Reduce costs of testing and treatment • Reduce complications of surgery	• Bundled/Warrantied Payment for Surgery • Condition-Based Payment	Society for Gynecologic Oncology
Other Health Conditions	• Use lower-cost treatments and treatment settings • Reduce avoidable hospitalizations • Reduce misdiagnosis and unnecessary tests and treatments • Identify and treat conditions at earlier stages	• Condition-Based Payment	American Medical Association and multiple medical specialty societies

** Additional details on these and other efforts are available from the Center for Healthcare Quality and Payment Reform*

their input to ensure the payment models provide the necessary flexibility to improve care and that they focus accountability on the costs and quality the physicians can control or influence. Conversely, not all physicians will have the ability to successfully participate in Accountable Payment Models that guarantee savings for Medicare, particularly during the early years of implementation. Consequently, the current RBRVS fee-for-service payment system should remain in place, while giving those physicians and other providers who wish to participate n Accountable Payment Models the ability to do so voluntarily.[16]

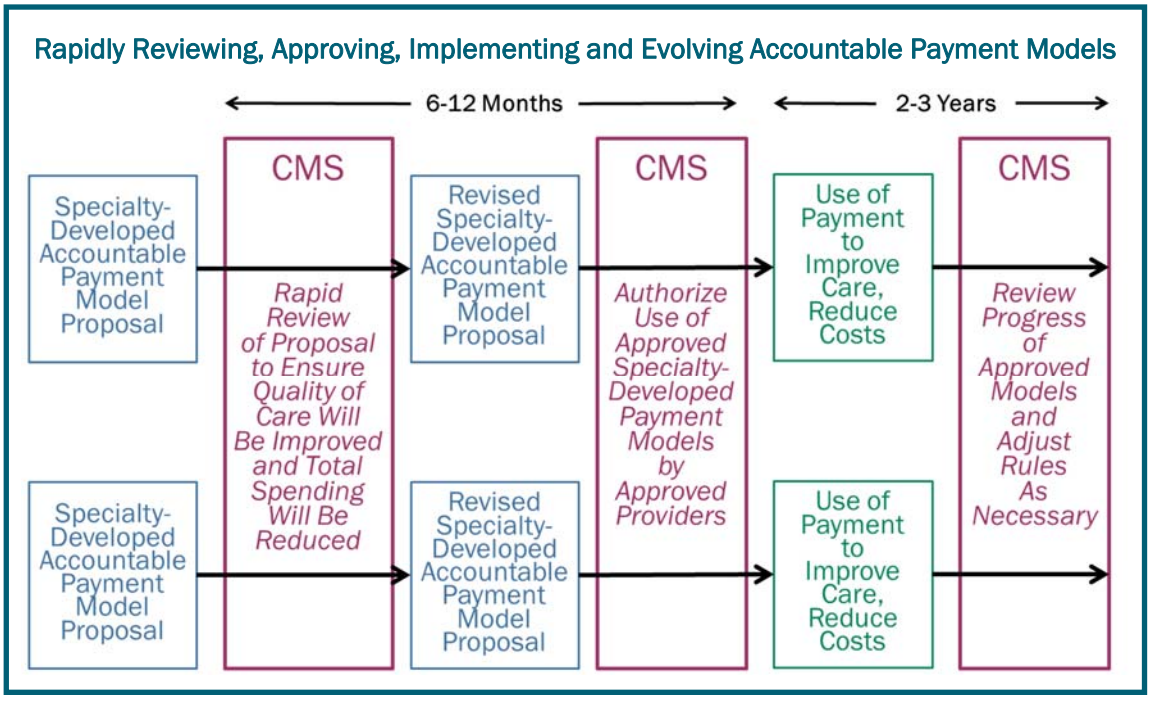
Not every physician would have to participate in an Accountable Payment Model in order for the Medicare program to achieve significant savings. Because of the differences in the types of procedures they perform and the types of drugs and tests they use, some physician specialties influence much larger portions of total Medicare spending than others, so it is particularly important to ensure there are Accountable Payment Models available for physicians in those specialties so they can redesign care in ways that will save larger-than-average amounts of spending. However, the biggest overall savings for Medicare and the greatest benefits for the largest number of Medicare beneficiaries will be achieved if physicians from all specialties can participate in appropriately-designed Accountable Payment Models.

Rapid CMS Response Needed to Physician-Developed Accountable Payment Models

Many physicians, medical societies, and multi-stakeholder Regional Health Improvement Collaboratives have been working to develop Accountable Payment Models that are specifically designed to improve care for particular health conditions and groups of patients in ways that will save Medicare and private payers money. There are both individual specialty and multi-specialty efforts to redesign care and payment underway for many different types of patient health problems. These efforts would improve care for millions of Medicare beneficiaries and save billions of dollars for the Medicare program. However, there is currently no way for the physicians and other organizations who are developing these payment models to get CMS to use them, and without Medicare participation, it may not be possible for the physicians and other providers to implement the care changes, even with private payer support.

In order to ensure rapid progress in implementing Accountable Payment Models and to achieve the savings needed in the Medicare program, Congress should require that CMS have at least one Accountable Payment Model available for voluntary use in each of the largest medical specialties within one year, and that it have at least one Accountable Payment Model available in every medical specialty within two years. These models must be designed by physicians or with the input of physicians in order to ensure they will be successful.[17]

The work that is already underway around the country to develop Accountable Payment Models can enable these milestones to be achieved if Congress also creates a mechanism so that physician organizations, medical societies, and local multi-stakeholder collaboratives can bring a proposal for an Accountable Payment Model to CMS, have the agency rapidly review the proposal so it can be refined, and then have CMS implement the payment model quickly if it includes appropriate mechanisms to ensure accountability for costs and quality. This rapid review and implementation process will not only create more savings for the Medicare program in a shorter period of time, it will enable the largest number of Medicare beneficiaries to benefit from higher quality care.



NOTES

1. Congressional Budget Office. Medicare's payment to physicians: the budgetary effects of alternative policies. November 14, 2014.
2. The legislation to repeal the SGR that was developed in 2014 by the House and Senate Committees (H.R. 4015 and S. 2000) included smaller annual updates for physicians and other provisions affecting payment; the cost of that legislation is estimated to be $144.0 billion over ten years.
3. Miller HD. Ten barriers to payment reform and how to overcome them. Center for Healthcare Quality and Payment Reform; 2013. Available from: http://www.chqpr.org/reports.html.
4. Miller HD. Measuring and assigning accountability for healthcare spending. Center for Healthcare Quality and Payment Reform, August 2014. Available at http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf.
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. Many of the alternative payment models that have been developed by CMS are problematic because they require that individual physicians take responsibility for the costs of *all* services that their patients receive, including services unrelated to the conditions the physicians are treating or aspects of spending that the physicians cannot control.
7. Mechanisms such as risk adjustment, outlier payments, risk corridors, and risk exclusions can protect physicians against inappropriate risk while giving them accountability for costs they can control. See Miller HD. Transitioning to accountable care: Incremental payment reforms to support higher quality, more affordable healthcare. Center for Healthcare Quality and Payment Reform; 2012. Available from: http://www.chqpr.org/reports.html
8. Congressional Budget Office. April 2014 Medicare baseline. April 14, 2014.
9. For examples of how spending can be reduced without harming physicians or other providers financially, see Miller HD. Making the business case for payment and delivery reform. Robert Wood Johnson Foundation and Network for Regional Healthcare Improvement. February 2014. Available from http://www.nrhi.org/reports.html.
10. Spending on other services would need to be reduced by only 2.8% to generate the savings needed to pay for the $144 billion cost of the SGR repeal bills (H.R. 4015 and S. 2000) that were considered by Congress in 2014.
11. An example of achieving significant savings over time by slowing the growth in healthcare costs can be found in the multi-year Alternative Quality Contract (AQC) implemented by Blue Cross Blue Shield of Massachusetts beginning in 2009. Physician organizations and health systems that entered into the AQC received a global payment budget equivalent to the per-patient spending on their patients before the AQC program began. Each subsequent year's budget was then increased by a percentage selected to achieve savings for the health plan compared to what it would have expected to spend in the absence of the AQC. An evaluation has shown that the first four cohorts of AQC participants achieved average savings ranging from 5.8% - 9.1% by the end of 2012, and the savings in 2012 exceeded the bonuses provided for improved quality. Song Z et al. Changes in health care spending and quality 4 years into global payment. N Engl J Med 2014; 371:1704-14. Similar approaches could be developed for specific types of patients in Condition-Based Payment models.
12. 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.
13. Even though it is not a demonstration program, the same problem exists with the Medicare Shared Savings Program, because the shared savings payments are explicitly temporary payments to the Accountable Care Organizations (ACOs), and there is no change to the underlying fee-for-service payment structure to sustain new or different services after the shared savings payments end.
14. Although the Health Care Financing Administration (the predecessor to the Centers for Medicare and Medicaid Services) sponsored a demonstration project in New Jersey to pay hospitals under a DRG system, the demonstration was not completed or evaluated before the Inpatient Prospective Payment System was implemented nationally, and the DRG system used in New Jersey was significantly different from the system Medicare implemented nationally. See Smith DG. Paying for Medicare: the politics of reform. New York: Aldine de Gruyter 1992, pp 65-66.
15. This is similar to the approach that the Center for Medicare and Medicaid Innovation is using in its Bundled Payments for Care Improvement demonstration project, where a budget for a bundle of services is defined in advance. The size of the budget is set at a level that is lower than what CMS would have expected to pay for the services in the absence of the program, and then the physicians, hospitals, and other providers are responsible for keeping the costs of the services within the pre-defined budget. http://www.innovations.cms.gov/initiatives/Bundled-Payments/index.html
16. This voluntary approach is the way that the Medicare Shared Savings Program is structured today for ACOs.
17. The legislation to repeal the SGR that was developed in 2014 by the House and Senate Committees (H.R. 4015 and S. 2000) included a process for review of physician-developed alternative payment models, but the legislation did not require that alternative payment models be implemented by CMS and it allowed problematic payment models such as shared savings models to be considered as alternative payment models, rather than requiring CMS to use specialty-specific accountable payment models that provide flexibility to redesign care and focus accountability on the services, costs, and quality that physicians can control or influence.

About the Author

Harold D. Miller is the President and CEO of the Center for Healthcare Quality and Payment Reform, a national policy center that facilitates improvements in healthcare payment and delivery systems. He is a recognized expert on healthcare payment and delivery reform, and has worked in more than 30 states and metropolitan regions to help physicians, hospitals, employers, health plans, and government agencies design and implement payment and delivery system reforms. He assisted the Centers for Medicare and Medicaid Services with the implementation of its Comprehensive Primary Care Initiative in 2012. He has authored a number of widely used papers and reports on health care payment and delivery reform.

Miller also serves as Adjunct Professor of Public Policy and Management at Carnegie Mellon University. In previous positions, he served as President and CEO of the Network for Regional Healthcare Improvement and Director of the Pennsylvania Governor's Office of Policy Development.