

## To Pay For Medicare SGR Repeal, Build On Bipartisan Health Care Policy

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Something unexpected is happening in Washington. As most eyes track partisan battles over immigration and the Affordable Care Act, key Congressional committees have been quietly advancing truly bipartisan legislation to strengthen Medicare.

Since 2002, an outdated Medicare cost control called the Sustainable Growth Rate (SGR) has repeatedly threatened drastic Medicare provider cuts. After a decade of temporary fixes, SGR repeal appears within reach. [A bipartisan, bicameral agreement](#) by key Congressional leaders announced on February 6, 2014 goes a step further by pairing repeal with bipartisan reforms that pay physicians for the quality and value of care they deliver, not the number of tests and procedures they order.

When one of every three health care dollars is wasted on care that does not improve patients' health, transitioning away from volume-based reimbursement would be momentous. Few policy changes are more fundamental to containing health care costs and protecting the solvency of Medicare.

The challenge in Congress has shifted from getting a bipartisan agreement on new cost controls to paying for the repeal of the old one. The Congressional Budget Office (CBO) estimates the [cost of the Senate version](#) of the bipartisan repeal bill at \$149 billion over 10 years.

Offsets that can't get enacted are easy to dream up. Some Democrats want automatic rebates from prescription drugs used by Medicaid patients. They might also extend cuts to Medicare's provider payments under sequestration as they did in the unemployment bill. Some Republicans want the offsets to come from cuts to Obamacare or through medical malpractice reform.

If Congress wants to actually strengthen Medicare, not just argue about it, lawmakers must take a page from last year's Murray/Ryan budget negotiations and focus on steps both sides can agree on because they cut waste:

**Bundle payments.** Today's a la carte, fee-for-service payment structure rewards providers for the volume of tests and procedures they order rather than the overall quality of care they provide. This misalignment of incentives has led to expensive, disjointed, and often mediocre-quality service as well as wide price variation in the treatment of the same conditions. Bundling Medicare payments for all services related to certain common hospital procedures creates powerful incentives to improve care coordination while lowering costs.

**Improve medication adherence.** Patients who take their medicines as prescribed are less likely to develop serious conditions requiring hospitalization. In 2012, [CBO changed its methodology for scoring legislation related to medication adherence](#), concluding that a 5 percent increase in the number of prescriptions used by Medicare patients will lower spending on physician and hospital services by 1 percent. It makes sense. Congress should align incentives in Medicare Parts C and D to improve medication adherence, including synchronizing prescription fills, improving care coordination, and ensuring that plans who invest in strategies to lower costs also share in the savings.

**Improve patient safety while lowering costs.** In 2005, Congress stopped payments for certain hospital-acquired conditions (HAC). For example, if a patient was admitted to a hospital for the flu, but then fell and broke her hip under the hospital's care, Medicare no longer would pay for the broken hip because it was preventable. Starting this year, hospitals with high rates of HACs will face an additional penalty. Yet the top five HACs alone continue to cost Americans \$10 billion a year. Congress can help tackle this costly epidemic by learning from current initiatives, expanding over time the number of conditions to which penalties apply, and providing additional incentives to improve patient safety.

**Put smarter curbs on unnecessary readmissions.** Notwithstanding recent progress toward lowering patient readmissions to hospitals, current Medicare policies are falling short. They encourage some providers to perform extra care on patients instead of preventing patients' problems from getting worse. Worse, as currently designed, penalties against avoidable hospitalizations can pull resources away from safety net providers. Congress can increase the equity and effectiveness of these policies by broadening the conditions tracked and by ensuring providers are compared with those serving similar populations. At the same time, expanding readmissions policies to post-acute and other providers could produce billions in budgetary savings.

**Negotiate a better deal on Medicare services.** Medicare reimbursement for services like laboratory tests, certain categories of durable medical equipment, and post-hospital nursing home stays exceed prices in the private marketplace. Taxpayers should not be stuck with higher bills due to noncompetitive pricing. Aligning payment with the private sector, through some combination of competitive bidding or payment adjustments, could save billions more in health care costs.

Admittedly, policy changes this nuanced do not make for easy sound bites. But as part of bipartisan SGR reform, they could make Medicare a better deal for beneficiaries and taxpayers, and strengthen the program for generations to come.

That's something even today's divided Congress should be able to get behind.