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BENDING THE CURVE

Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth



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About Engelberg Center for Health Care Reform:

The Brookings Institution is committed to producing innovative policy solutions to our nation's most difficult challenges. The country may face no more important domestic policy challenge than the much-needed reform of our health care system. To help turn ideas for reform into action, the Brookings Institution established the Engelberg Center for Health Care Reform. The Engelberg Center's mission is to develop data-driven, practical policy solutions and recommendations that promote broad access to high-quality, affordable, and innovative care in the United States. The Center also facilitates the development of new consensus around key issues and provides technical support to implement and evaluate novel solutions in collaboration with a broad range of stakeholders with the keen focus on reform that will improve not just the health care system, but the health of individual patients.

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EXECUTIVE SUMMARY

We propose a framework for health care reform that focuses on supporting person-centered care. With continued innovation toward more personalized care, this is the best way to improve care and health while also bending the curve of health care cost growth.

Our health care system holds great promise. As a result of fundamental breakthroughs in biomedical science, improvements in data systems and network capabilities, and continuing innovation in health care delivery, care is becoming increasingly individualized and prevention-oriented. The best treatment for a patient involves not just specific services covered under traditional approaches to health insurance financing, but also includes new technologies and new kinds of care and support at home and in other settings different from traditional medical care. These advances require health care providers to work with patients and their caregivers to target increasingly sophisticated treatments and to coordinate care effectively in ways that works best for each patient.

Our report's person-focused reforms aim to support these changes in care—not as an afterthought or as an addition to our health care financing and regulation, but as the core goal. Instead of having to work around fee-for-service (FFS) payments and regulations that can complicate getting the highest-value care in each case, providers and patients will be able to receive more support for the specific approaches to care delivery that can make the most difference. The support comes from aligning reforms in provider payment, benefit design, regulation, and health plan payment and competition. To avoid short-term disruptions, our systematic framework involves a clear path that builds on existing reforms in the public and private sector, supports transitional steps to assist providers, and includes close evaluation and opportunities for adjustments along the way. While our primary goal is better health through better care, we estimate that our reforms would achieve an estimated $300 billion or more in net federal savings in the next decade, and provide a path to sustaining per capita cost growth that is much more in line with per capita growth in Gross Domestic Product (GDP). After the proposed reforms are implemented in the coming decade, long-term savings from achieving better health and sustainable spending growth will exceed $1 trillion over 20 years. Our proposals can be scaled up or down, and can also be combined with other proposed reforms to achieve additional reductions in health care costs. Our approach enables Congress to focus on overall cost, quality, and access goals that are very difficult to address under current law—so that whatever the spending level, that spending will do more for health.

These issues of health care quality and cost must be addressed. If a clear framework like ours is not implemented, the alternative is likely to be continued reliance on short-term cost controls, including across-the-board cuts in payments like sequestration, or delays and restrictions in both needed coverage updates for vulnerable populations and new types of innovative care—perpetuating large gaps in quality of care.

Our proposals represent an alternative to such care disruptions, cost-shifting, and threats to more innovative, person-focused care. We include proposals for Medicare, Medicaid, and private health insurance. We also propose a set of system-wide regulatory reforms and other initiatives, including antitrust and liability reforms. While some of these proposals are specific to particular programs and regulations, they are all grounded in our core goal of supporting quality care resulting in lower costs. This means a clear path for moving away from FFS payments and benefits and open-ended subsidies for insurance plan choices toward a direct focus on supporting better care and lower costs at the person level. Our proposals encompass significant reforms—such as modifications in Medicare payment mechanisms and

benefits, and a change in the tax exclusion for employer-provided health insurance. The proposals reflect ideas that have gathered broad support in the past, but also include new approaches for addressing some of their shortcomings. Implementing our reforms together enables them to reinforce each other and create much more momentum for improving care while bending the cost curve.

Reforms for Medicare

» Transition to *Medicare Comprehensive Care* (MCC)

- MCC organizations include collaborations of providers that receive a globally capitated, comprehensive payment for their attributed beneficiaries and must meet a set of care quality and outcome performance measures for full payment.
- Structural requirements for these contractual organizations would be flexible; the organizations could include integrated systems or networks of providers working together.
- Providers would also be able to participate in MCC by accepting a case-based or bundled payment for their services and by meeting similar care quality and outcome performance standards for full payment.
- The initial benchmark for the MCC comprehensive payment would be based on current beneficiary spending and quality of care, and the spending target will be increased over time according to a statutory limit on per capita growth (GDP plus 0 percent per capita). MCC providers would also be expected to sustain or improve quality of care over time, as reflected in increasingly sophisticated performance measures, facilitated by information systems used to support a beneficiary-level focus in care delivery.
- Providers can continue to receive traditional FFS payments, though those payments will likely continue to tighten over time and become less optimal for covering the costs of delivering effective care.
- Within 5 years, Medicare should offer beneficiaries the opportunity to choose MCC providers to receive their care. In conjunction with this choice, MCCs could offer beneficiaries incentives such as reductions in their Medicare premiums and/or co-pays.
- The MCC reforms would be phased in over 10 years with a set of milestones for measuring progress. By that time, we expect the vast majority of Medicare beneficiaries to be treated by providers who are paid using MCC methods.

» Reform Medicare benefits to support more comprehensive care and lower costs

- Medicare benefits would be updated to have an out-of-pocket (OOP) maximum and reforms in co-pays and deductibles similar to proposals by the Medicare Payment Advisory Commission (MedPAC) and other expert groups. These reforms would lower beneficiary costs on average and provide more protection. Medicare beneficiaries would also receive clear information about their OOP costs for different options for care.
- Medigap coverage would be reformed to eliminate "first dollar" coverage. This could be accomplished through a surcharge on Medigap plans that have average co-pays higher than 10 percent based on their additional costs to Medicare. Medigap plans would be able to offer lower co-pays for high-value services and providers.
- MCCs could offer lower co-pays and premiums for Medicare beneficiaries who choose to receive care from them.

» Reform Medicare Advantage to promote high value health plan competition

- Medicare Advantage payment updates would be the same as for MCC plans—that is, equal to GDP growth per capita, or less if overall Medicare spending grows more slowly.

- Medicare Advantage plans would be allowed to return the full difference between their bids and the benchmark to beneficiaries in the form of lower premiums.

» Use Medicare savings to create predictable payments in traditional Medicare and support the transition to MCC

- Specific elements of our proposed Medicare reforms would achieve over $200 billion in gross federal savings in the coming decade. Our framework calls for redirecting these savings within the Medicare program to support the transition to MCC models and provide a more predictable and sustainable long-term financing framework for Medicare. This includes reforming Medicare physician payment to replace the "sustainable growth rate" (SGR) with a payment system that increasingly includes elements of case-based payments, making similar changes in other FFS payment systems, and providing other incentives and support for the transition to MCC.

Reforms for Medicaid and Care for Vulnerable Populations

» Current state Medicaid waivers would transition to *Person-Focused Medicaid*, a standard process for states to implement Medicaid reforms

- The Centers for Medicare and Medicaid Services (CMS) would implement a long-term, system-wide strategy for *Person-Focused Medicaid* that includes extensive support, monitoring, and evaluation. This systematic approach would replace negotiating one-off waivers with states.
- This process would routinely track quality of care and per capita cost growth for Medicaid beneficiaries. States that improve quality of care and reduce per capita beneficiary cost trends would keep a disproportionate share of the savings (for example, 50 percent of the federal savings in our simulations).
- States would be encouraged to combine funding streams and to support innovative, efficient strategies for care delivery for both low-income uninsured populations and for dual-eligible beneficiaries.

» Medicaid reforms would be aligned with other initiatives and financial support for health care for lower-income individuals to facilitate care continuity and improve efficiency

- States and CMS would facilitate the participation of Medicaid managed care plans in state insurance marketplaces to help mitigate shifts in and out of Medicaid eligibility that disrupt both coverage and in how individuals receive their care.
- CMS would facilitate state reforms that coordinate funding streams and the delivery of services across programs to assist lower-income individuals (e.g., local safety-net initiatives and supports for mental health, Federally Qualified Health Centers, etc).

» CMS would make permanent and expand its "Financial Alignment Demonstration" for Medicare-Medicaid Enrollees into a reformed program for *Medicare-Medicaid Aligned Care*. This permanent, person-focused program would enable the development of strong and systematic ongoing support, performance measurement, and evaluation capacity to provide a stronger foundation for effective and efficient comprehensive care for Medicare-Medicaid beneficiaries ("dual-eligible" beneficiaries)

- This permanent program would include a substantial quality improvement and evaluation infrastructure at CMS. The infrastructure would: 1) provide timely access to readily usable Medicare data on dual-eligible beneficiaries to the states and their provider and health plan partners; 2) produce more meaningful and consistent measures of quality of care and costs for dual-eligible beneficiaries; and 3) share evidence and best practices with states on effective steps for improving care for dual-eligible beneficiaries.

- Performance measures would include increasingly meaningful measures of quality of care as well as combined per capita expenditures across Medicare and Medicaid. States that improve performance and reduce overall cost trends would receive at least a proportionate share of the total savings (Medicare and Medicaid). State reforms that do not improve quality while lowering costs would be phased out, with increasing incentives over time for states to switch to effective programs.

Reforms for Private Health Insurance Markets and Coverage

» Limit the exclusion of employer-provided health insurance benefits from taxable income by imposing a cap that would grow at the same per-capita rate as federal subsidies in Medicare and the insurance marketplaces

- A cap on the employer-provided health insurance subsidy would be phased in over time by capping the exclusion at a high level initially (e.g., at the 80th to 90th percentile plan) and then indexing the cap by GDP growth once its subsidy value aligns more closely with other subsidy programs. This subsidy level would be designed to achieve significant health care savings from choosing lower-cost plans while still providing substantial incentives for employees to remain in employer-sponsored coverage.

» Encourage and support employer leadership in driving innovative reforms in health care coverage and delivery

- Support employer efforts to engage employees in reducing overall health care costs through the Employment Retirement Income Security Act (ERISA) and other health plan regulations that promote value-based insurance designs and tiered benefit designs, narrow networks of providers that demonstrate high performance, and employees' ability to share in the savings from health care choices and changes in behavior that reduce costs.
- Promote transparency by making standard measures of provider performance available from Medicare and Medicaid that could be more easily combined with similar measures constructed by employers from their own data on health care costs and quality.
- Facilitate the adoption of payment reforms by providers in Medicare and Medicaid to match value-based payment reforms used by the private sector.

» Promote insurance market competition to support high-quality, lower-cost health plans, and that provides appropriate incentives for state regulation

- Implement regulations for the insurance marketplaces that allow flexibility in plan choices with actuarially equivalent benefit designs.
- All options would be required to meet meaningful minimum requirements for essential benefits for creditable coverage, but given the disparities in covered benefits across states, offset state-specific subsidy growth that is attributable to increases in the impact of state-required benefits over time.

» Facilitate stable non-group and small-group health insurance marketplaces by taking steps to reduce adverse selection and encourage broad participation for more affordable insurance

- Enhance participation through effective broad-based outreach and default enrollment for individuals who are eligible for subsidies.
- Limit open enrollment periods to one to two months per year.
- Impose limits on individuals' ability to shift from a plan with relatively low actuarial value to higher value (for example, allowing movement from a "bronze" to a "silver" plan in terms of actuarial value during open enrollment, but not a "bronze" to a "gold" plan).

- Relax the requirement for full community rating when consumers have not maintained continuous coverage and include late enrollment penalties (as in Medicare Part B and Part D).

Reforms for System-Wide Efficiencies

» Simplify and standardize administrative requirements to support higher-value care
  - Implement an updated standardized claim form.
  - Promote standard methods for quality reporting by providers and plans, including clinical, outcome, and patient-level.
  - Promote standard methods for timely data sharing by plans with health care providers and patients who are involved in our proposed financing reforms.
  - Provide further support for state investments to update their Medicaid information systems, including standard quality measure reporting and access to CMS data for quality improvement.

» Improve cost and quality transparency
  - Implement consistent methods across providers and payers for constructing quality measures and for plans to provide relevant out-of-pocket cost information (a core set of common measures and conditions, at minimum).
  - Require plans, as a condition of participation in insurance marketplaces, to provide a common set of cost and quality measures—at the plan- and provider-level.
  - Restrict "gag" clauses.

» Promote effective antitrust enforcement
  - Require the ongoing production of a set of timely, comparable quality and cost measures at the level of major episodes of care and at the population level prior to integration and subsequently for clinical integration activities and mergers above a reasonable market-share threshold of concern. Failure to achieve improvements in quality and cost would be a foundation for subsequent antitrust action.
  - Update the antitrust enforcement framework to place greater emphasis on favoring clinical integration activities that are accompanied by financing reforms that move away from FFS payments and place providers at financial risk for quality gaps and higher costs.

» Address outdated licensing barriers for more effective and efficient care
  - Reform scope of practice laws to allow all health professionals to practice at the top of their licenses and capabilities.
  - Remove barriers to telemedicine services caused by state-specific licensing restrictions to enable licensing reciprocity.

» Encourage states to develop more efficient medical liability systems
  - Promote "safe harbor" or "rebuttable presumption" laws that establish legal protections for providers who achieve high quality and safety performance using valid measures.
  - Promote reforms that modify the existing judicial process for resolving tort claims with lower-cost and more predictable alternatives (e.g., a "Patient Compensation System").

» Enable states to implement system wide reforms
  - Use common performance measures and the MCC payment reforms to create a more straightforward pathway for Medicare to join in state-based financing reforms that have a "critical mass" of participants in a state including private plans, state/employee retiree plans, and Medicaid plans.
  - Provide enhanced opportunities for states to share in savings in Medicaid and Medicare that are generated as a result of state-led reforms affecting beneficiaries in these programs.

INTRODUCTION

We propose a framework for health care reform that focuses on achieving better care for each person, resulting in lower health care cost growth while promoting better health. Our proposals involve reforms across our health care system—Medicare, Medicaid, private health insurance markets, and important regulations like medical liability and antitrust rules. In all of these areas, we build on approaches that are already gaining traction but include new ideas that help them fit together better and that also avoid major short-term changes or disruptions in the care that patients receive.

Our report comes as the United States continues to struggle with major gaps in the quality and efficiency of health care, and as Congress and the Administration consider further steps to reform the federal entitlements and subsidy programs that account for the bulk of projected federal spending growth in the years ahead. More importantly, our report comes at a time of important breakthroughs in genomics, systems biology, and other biomedical sciences that are not only leading to better treatments, but also the prevention of disease and further complications based increasingly on each person's characteristics. These developments have been accompanied by improvements in data systems and network capabilities that make it possible to support and deliver much more personalized care that is customized to the needs and preferences of individual patients. Moreover, improvements in wireless and other technologies make it possible to prevent complications and deliver care at home and in other settings different from traditional medical care. Our reforms focus on supporting providers and patients in taking advantage of these innovations in technology and health care.

Our report also comes at a time when health care spending growth generally and Medicare spending growth in particular have slowed, and when some promising reforms are already being implemented in the private and public sector toward the goal of better, more personalized care at a lower cost. Consequently, now is a particularly good opportunity to implement reforms that are not disruptive in the short term, but can have a large impact on supporting improvements in care that can sustain slower cost growth in the longer term.

If there is not agreement soon on reforms like those we propose here, more aggressive steps will almost certainly be needed in the years ahead to achieve more urgent reductions in federal spending, like cuts in payment rates as in sequestration, or restrictions in coverage for vulnerable populations and in access to new types of innovative care.

Our proposals represent an alternative to such care disruptions, cost-shifting, and threats to more innovative, personalized care. They aim to achieve more sustainable health care cost growth through a comprehensive set of reforms in financing and regulation focused on supporting better care and better outcomes, and more value for our health care spending.

This reform proposal builds on the previous "Bending the Curve" reports that many of us authored (Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth" and "Bending the Curve through Health Reform Implementation"). Our policy reforms fell into four major categories:

- Implementing an infrastructure of electronic data exchange, timely availability of quality and cost information, and better mechanisms to improve the evidence on quality and cost—which would be promoted by our other proposed changes;
- Changes in financing and regulation to support providers—including payment reforms tied more directly to value, liability reforms, and other supporting steps;

» Changes in financing and regulation to support consumers—including "value based" changes in insurance design and other incentives for wellness, improving health, and using care efficiently, along with resources to help consumers make those decisions; and

» Insurance market reform to promote coverage choices that would encourage higher-value care—including reforms in Medicare, Medicaid, employer-provided, and individual coverage choices that both provided adequate financial support for access to quality care, but also provided much more encouragement for people to choose plans that did more to keep costs down through innovations in provider payment and benefit design.

The second report updated these recommendations in light of the passage of the Affordable Care Act (ACA). We highlighted specific changes in Medicare, Medicaid, and private insurance systems.

Our framework and previous recommendations are summarized in Appendix Table 1. Important progress has occurred for many of those recommendations. There have been improvements in developing a better electronic infrastructure to support quality measurement and improved evidence; in addition, there have been changes to provider payment in Medicare and the private sector to increase the emphasis on value. For example, while accountable care organizations (ACOs) that track quality and patient-level costs represent only a fraction of payments (less than 20 percent), they are growing rapidly in both Medicare and the private sector. A range of other value-focused provider payment reforms besides ACOs are expanding, including medical homes for primary care and steps towards episode-based payments for specialty care. Indeed, today, a much larger share of providers view the shift in provider payment to value as a key feature of the future of health care and many providers have started to invest and reorganize accordingly, perhaps even contributing to the recent slowdown in spending growth. However, there is still considerable uncertainty about how and how fast value-based reform will grow. Some provider steps toward consolidation may be in response to uncertainties about health care reform and opportunities to obtain higher prices, rather than clear incentives to achieve better care. There is some promising anecdotal evidence on the impact of these reforms, but it is too soon to tell their overall impact on bending the cost curve, and system-wide measures of quality and access to care are not yet showing major improvements.

While there has been notable progress, much more needs to be done to improve care and achieve savings as a result. Consequently, we have worked together with additional co-authors to develop a new, updated set of reform proposals. Our collaboration was guided by the following principles:

» Placing the overarching concept of achieving better health and fewer complications at the *person* level at the center of health care reform, as the pathway to lower overall health care costs;

» Supporting this goal with aligned reforms in provider payment, benefit design, and health plan payment and competition;

» Describing the steps needed to move down this path, building on promising policy reforms being implemented now; and

» Monitoring progress along the way so that adjustments can be made as necessary.

Our proposals are driven by the persistent evidence of large gaps in the quality and safety of care, which lead to preventable complications and potentially avoidable costs, and of large gaps between the quality and cost of care that providers and consumers believe should be achievable in our health care system compared to what they often experience. Numerous studies have shown significant opportunities for improvements in care for all common and serious health problems in our health care system, particularly chronic diseases. There is also extensive evidence that changes in the way that care

is provided, particularly in how providers can work together to influence health care delivery. Steps that patients take—particularly when combined with better support for those steps—can also make a big difference. But with payment systems, benefit designs, insurance choice systems, and regulations that are more closely tied to the volume and intensity of care rather than its quality and value, it is not surprising that all these gaps and variations in quality and efficiency persist. Just as medical technology is moving toward a greater focus on putting together the right treatments for each patient, our health policies also need to do much more to support getting better results for each patient.

Table 1 illustrates some of the continuing opportunities for improving quality of care. In many cases, it is a challenge to even measure quality and outcomes consistently and reliably, in part because they have not been the direct focus of our health care policies. In contrast, it is relatively straightforward to track trends in the volume of medical services—the traditional basis for most health care payments. Nevertheless, our capacity to measure quality of care and health outcomes is continuing to improve, as is the evidence on how changes in health care delivery and patient engagement can achieve improvements in performance. Further attention and progress is needed, particularly for capturing quality at the person level for particular kinds of patients—such as people who are generally healthy with risk factors that should be managed; people with particular chronic diseases like diabetes, heart disease, or cancer; people who are considering major elective procedures like joint replacements or heart surgery; and people with complex or major illnesses, such as those with multiple chronic conditions or dementia. Appendix Table 2 illustrates some of the recent progress and expected next steps toward meaningful, patient-focused measures. Our financing and regulatory proposals will accelerate the capacity to produce such measures, and increase the attention for their improvements.

Table 2 highlights the related key focus of our reforms: using better support for improvements in care to reduce per capita spending growth in *all* of the major U.S. health care coverage systems. As the table notes, current law already provides some important pressure toward lower per capita spending growth over time, particularly in Medicare and in the subsidies for the insurance marketplaces. However, without further reforms to improve the delivery of care, many experts have expressed doubt that current-law limits on payment increases can be sustained. Our proposals take advantage of the opportunity created by slower cost growth in the short term to create a much stronger foundation for assuring that sustaining this slowdown does not compromise access or quality. For example, it will be difficult to sustain lower fee-for-service (FFS) payment updates in Medicare if they diverge over time from the cost of services or private sector payments, or if Medicare does not take further steps to support providers who are trying to change health care delivery to avoid preventable costs. It will be difficult to sustain coverage subsidies in the marketplaces that are held constant as a share of the Gross Domestic Product (GDP) if health care costs in other insurance systems accounting for much more coverage grow at significantly faster rates.

Table 3 summarizes our proposals. The proposals share the common goal of achieving lower spending growth through improving health care quality. They do so by providing a comprehensive approach to move steadily away from FFS payments and benefits and away from open-ended subsidies for insurance plan choices towards a direct focus on value—better care and lower costs—at the person level. Our presentation of these proposals is organized by program: Medicare, Medicaid, and private health insurance, including insurance purchased in the new marketplaces and insurance provided through employers. Our final section describes a system-wide set of regulatory and other initiatives, including antitrust and liability reforms. Some of these proposals are specific to particular programs and regulatory issues, but they are all guided by our core goal of better care at a lower overall cost for all Americans. While they encompass significant reforms—such as modifications in Medicare payment mechanisms and benefits, and a

change in the tax exclusion for employer-provided health insurance—they all incorporate ideas that have gathered broad support in the past and that build on promising trends in our health care system.

The proposals are intended to be a comprehensive set of steps, implemented incrementally, that would add up to fundamental changes over time to support better care. A key finding from evaluations of piecemeal, individual reforms and pilots intended to improve care and lower costs is that these reforms do not always work, and that when they do, they are often too small with too little infrastructure and momentum behind them to lead to substantial system-wide effects. Of course, that does not necessarily mean that larger-scale reforms will solve health care quality and cost problems. Consequently, in moving systematically beyond a wide range of pilot programs and tests, we take a step-by-step approach to permit course corrections and adjustments as further evidence accumulates. Together, these proposals are intended to give health care providers confidence about the direction and inevitability of reform that enables better planning and investment for improving care, while making sure that the steps along the way make real progress in getting better care and lower costs for patients.

In Medicare, our previous proposals supported payment reforms that are tied more directly to the value of health care, including ACOs, primary care medical homes, and bundled payments. While we continue to support all of these reforms, we propose a new comprehensive payment reform strategy for traditional Medicare that enables these payment reforms and others to fit together to achieve measureable reductions in overall Medicare cost trends while improving health outcomes. Similarly, we propose pathways to a systematic focus on person-level quality and overall costs in Medicaid, individual and small-group private insurance in the emerging marketplaces, and employer-provided coverage. All of these proposals move away from policies that provide open-ended government support for more costly care toward policies that give providers, insurers, and patients more savings when they improve care and lower costs. Similarly, we propose a set of reforms affecting the regulatory environment of health care and the electronic infrastructure for health care delivery that match our financing reforms.

Our approach has a primary focus on supporting providers and patients in improving care for the dollars we spend, and consequently, producing savings. As a result of implementing these reforms together, we estimate that our proposals could achieve $300 billion or more in "scoreable" net federal savings over the next decade, and additionally provide substantial resources for supporting the transition to a more comprehensive, beneficiary-level focus of care in Medicare. After the proposed reforms are implemented in the coming decade, long-term savings from better care and sustainable spending growth will exceed $1 trillion over 20 years. The proposed reforms can be scaled up or down to achieve more or less savings. They can also be combined with other reforms (e.g., changes in income-related premium subsidies or changes in eligibility for Medicare or Medicaid) that could achieve additional savings. Our framework encourages Congress to focus on overall quality and goals that are very difficult to achieve with resources available under current law and that enable our health care system and our health care spending to do more for health. Our most important objective is to achieve better care that can keep improving in the years ahead.

The President's budget and the House and Senate budget resolutions include targets for spending reductions in federal health care programs. All aim to reduce costs while maintaining or improving quality of care. Respected expert groups, including the Bipartisan Policy Center and Simpson-Bowles, have also put forward plans with savings estimates that range from $560 to $585 billion. These proposals have common elements with ours—particularly an emphasis on moving away from health care financing that is based on the intensity of care rather

than its quality and its ability to improve the lives of patients. They also include other reforms that could lead to additional savings, such as changes in income-related premium subsidies for Medicare or private insurance, or changes in eligibility for Medicare or Medicaid, or new price regulations. Many of us support these or other steps to achieve additional federal savings. However, we all believe that our framework should be the foundation for any reform, and we believe that all of the reform proposals illustrate the potential for a broad agreement on a framework for reducing cost growth by improving health care.

It is time for health care reform that does much more to support the movement toward the prevention-oriented, effective, and personalized care made possible by recent and coming technological innovations—thereby slowing spending growth without compromising access or quality of care. Our report is about how to get there.

REFORMS FOR MEDICARE

We propose that traditional Medicare transition from Medicare FFS to Medicare Comprehensive Care (MCC), in which Medicare financing becomes more closely aligned with the explicit goal of better, higher-value care for each beneficiary, measured at the person level. These reforms include changes to both payments and benefits that support a comprehensive approach to care for each beneficiary, while decreasing out-of-pocket costs by reducing complications and by helping beneficiaries get the care they prefer at a lower cost. Our approach builds on current Medicare payment reforms but provides a more systematic framework for implementation while ensuring the reforms have the intended effects on quality and cost at the beneficiary level.

Current law for Medicare includes important health policy reforms from the Affordable Care Act (ACA) that are expected to reduce Medicare cost growth. These include long-term limits on payment rate increases for providers in traditional Medicare and reductions in payments for Medicare Advantage plans towards the average cost of traditional Medicare. While these steps have been critically important to achieve short-term savings and lower future Medicare cost projections, they may turn out to be difficult to sustain if Medicare payments diverge from the cost of health care services. Further, these steps do not in themselves support providers who want to invest in more significant reforms in health care delivery to reduce costs and improve quality through approaches made possible by recent health care innovations. This is especially true for health care reforms that involve new sites of care (e.g., acute care centers rather than hospitals or physician offices), new types of services (e.g., telemedicine and smartphone-based services), new ways of identifying patients who are likely to benefit from particular treatments, new ways of coordinating care, and new approaches to promoting wellness and prevention of complications. Many of these innovative health care services, which may be highly valuable in the care of certain beneficiaries, are reimbursed poorly, if at all, in traditional Medicare.

Under the ACA, Medicare must achieve per capita spending growth of no more than GDP plus one percent (GDP+1) in the years ahead. If the Medicare actuaries project that such savings will not be achieved, the Independent Payment Advisory Board (IPAB) has the authority to make recommendations for further changes in provider payments (but not reductions in benefits or increased beneficiary cost sharing) to achieve that growth rate.

The ACA also supports a wide range of reforms intended to promote improvements in health care delivery—in response to widespread evidence of gaps in quality and coordination of care for Medicare beneficiaries that lead to substantial rates of preventable complications. These reforms include a set of new programs for ACOs that are accelerating, covering around 10 percent of traditional Medicare beneficiaries today, and are projected to more than double in the next several years. The ACO programs give providers the opportunity to share in savings when they achieve lower rates of overall Medicare spending growth per capita while improving on a set of quality and outcome measures for the beneficiaries for which they are accountable. The shared savings programs are intended to transition to "shared risk" and "partial capitation" programs in which the ACO providers receive increasingly capitated, risk-adjusted payments. In particular, participating ACOs in Medicare's Pioneer program are aiming to receive more than half of their reimbursement through performance-based, non-FFS contracts within three years. CMS also intends to transition providers in the Medicare Shared Savings Program to a shared-risk program after its first three years.

At the same time, the Center for Medicare and Medicaid Innovation (CMMI) is implementing a broad range of pilot programs for other provider payment reforms that are also intended to move payments from volume and intensity toward value. These include medical home payments for primary care providers, bundled payments for certain types of care involving hospitalizations, and state- and community-led payment reform initiatives. Similar ACO, case-based, and bundled payment reforms are becoming much more prevalent in private insurance contracts, and are growing in Medicaid as well. While many are showing encouraging results, evidence remains limited on their overall impact on reforming care delivery to reduce cost growth while improving quality.

The attention to piloting payment reforms reflects both the promise of these initiatives and the history that tightening FFS payments has not previously been a long-term solution to achieving slower spending growth. While slower short-term growth in Medicare costs has eased the short-term fiscal pressures facing the federal government, sustaining such slower growth has been difficult in the past, and many experts expect that spending growth will again accelerate. In addition, FFS payments provide less support than the alternative payment systems for improvements in care coordination, and implementation of more personalized and effective approaches to care delivery. Medicare's ACO program and its other payment reform pilots are promising steps towards aligning financing and delivery reform, but they are not well supported by benefits that help engage beneficiaries in better person-level care, and they do not yet amount to a comprehensive reform strategy.

Our "Medicare Comprehensive Care" framework puts these payment reforms together into a comprehensive strategy to accomplish the following: ensures beneficiaries get higher-quality, more coordinated care that reflects their needs; provides beneficiaries new opportunities to save money when they engage with their providers to receive better care; improves competition on overall cost and quality involving Medicare Advantage plans; and aligns with similar reforms that we propose in Medicaid and private insurance competition.

Medicare Comprehensive Care

Overview

Traditional Medicare should implement a transition from primarily FFS payment to Medicare Comprehensive Care (MCC), consisting of aligned payment systems for Medicare ACOs, medical homes, and episode-based payment bundles. These value-based payments for MCC providers would substantially (though not necessarily entirely) replace FFS payments over time, so that by 10 years from now, the vast majority of Medicare services would be reimbursed under MCC arrangements. This differs fundamentally from many other proposals for "capitated" payment reform, as the core of our reform proposal involves providers working together to achieve better care at the beneficiary level.

- MCC organizations would include sets of providers that receive a globally capitated, comprehensive payment for their attributed beneficiaries and must meet a set of quality and outcome performance measures for full payment. These contractual provider organizations could develop from current ACOs, building on today's Pioneer program, as more ACOs transition to organizations that accept partially or fully capitated global payments for Medicare services. Collaborations could also include contractual relationships with Part D plans. Providers working together as an MCC would not need to be fully integrated in order to receive MCC payment: many current ACOs include groups of primary care physicians who have non-exclusive collaborations with specialty providers and hospitals.

- Providers would also be able to participate in MCC by accepting case-based or bundled payment for their services and by meeting the same kinds of quality and outcome performance standards required for full payment. As we describe below, this will require acceleration in the rate of implementing case-based and bundled payment models in Medicare that achieve the same beneficiary-level costs as the capitated MCC payments.

- The initial benchmark for the MCC comprehensive payment would be set based on current beneficiary spending and quality of care, and increased over time according to a statutory limit on per capita growth. MCC providers would also be expected to sustain or improve quality of care over time, as reflected in increasingly sophisticated performance measures that they would report from the information systems used to support their beneficiary-level focus in care delivery. Under current law, the per capita growth rate cannot exceed GDP plus 1 percent. The President and House Republicans have previously proposed spending growth limits of GDP plus 0.5 percent per capita. We support GDP plus 0 percent per capita; with our Medicare payment and benefit reforms, we believe that improvements in the value of care delivery are possible to achieve that goal while sustaining and improving access and quality of care for Medicare beneficiaries. That growth rate is also consistent with current law Medicare spending projections for the near future; adopting it as the initial MCC benchmark would thus not be a big stretch and would help ensure that it is actually achieved through improvements in care. As a result of our reforms, instead of focusing on specific payment rule adjustments, a primary Congressional policy activity in the future would be to evaluate the adequacy of the spending growth rate against a much better array of meaningful measures of beneficiary quality of care. Those deliberations should be informed by ongoing reports from MedPAC and other experts regarding quality, access, and efficiency of beneficiary care, and recommended modifications in the spending growth rate.

- So far, Medicare beneficiaries have been informed when their providers adopt payment changes like ACOs, medical homes, and bundled payments, and they "participate" through their choice of providers (i.e., to determine provider payments, beneficiaries are assigned to providers based on their actual utilization of services). Within 5 years, and especially in conjunction with the Medicare benefit reforms we describe below, Medicare should offer beneficiaries the opportunity to choose MCC providers to receive their care. In conjunction with this choice, MCCs could offer beneficiaries reductions in their Medicare premiums and/or co-pays. We describe this approach in more detail when we turn to Medicare benefit reforms.

- Medicare would continue to offer traditional payments for providers not participating in the MCC arrangements, for as long as sufficient numbers of providers participate in the existing systems. However, the traditional payment rates must not exceed the same per-beneficiary cost projections that apply in the MCC program, and they are likely to become increasingly suboptimal to cover providers' costs using effective means of delivering care. We support incremental reforms in these traditional payments to

make it easier for providers to transition to and do well in the MCC system.

We expect that, with the transitional reforms described below, the vast majority of beneficiaries would be treated by providers who are paid using MCC methods in 10 years from now. Congress should establish milestones for the expansion of MCC payment availability and benchmarks for the performance of MCCs to help achieve timely progress toward the goal of promoting widespread availability of MCCs that are improving quality while achieving lower Medicare spending growth.

Structure of MCC Organizations

The structural requirements for contractual MCC organizations should remain flexible, as in today's Medicare ACO programs, allowing for health care providers to organize in the way best suited to delivering care in their specific community circumstances. For example, some existing Pioneer ACOs are fully integrated organizations, or at least headed in that direction. However, other ACOs are predominantly made up of primary-care and possibly other physician groups, that in turn coordinate their care with specialty providers and hospitals. Still other ACOs, like Optimus Healthcare Partners in New Jersey and Fairview Health Services in Minnesota, are contractual networks among multiple physician groups and hospitals that are not fully integrated, and instead rely on contractual arrangements for risk sharing and investments in data sharing and clinical systems to support overall accountability for the cost and quality of care for a population of patients. MCC organizations could also include collaborations involving acute-care or pharmacy clinics, primary care providers who receive medical home payments, and specialists and post-acute providers reimbursed on an episode basis.

Providers could also choose to participate in MCC by receiving payments on a case and/or bundled basis. As quickly as possible, CMS should phase in the availability of case or bundled payments for most of the providers' services. This could include a medical home payment for primary care providers or episode-based bundled payments for most of the services provided by specialists. The same kinds of performance levels on quality measures would be used in the bundled-payment MCC program. CMS would determine the specific payment and performance standards for this program based on input and evidence from providers, and the program should be designed so that a broad range of providers including solo practitioners and small groups could participate.

Transition to Medicare Comprehensive Care

In this section, we provide a more detailed overview of how the transition to Medicare Comprehensive Care could occur. Medicare's payment reform initiatives, including its ACO programs, pilots of medical home and episode payments, and other payment programs that involve reporting on quality, already support the transition to MCC payments. Growing pressures from limits on updates in traditional FFS payments, which result from current law, and our goal of improving care delivery to achieve more sustainable spending growth will also make these alternative payment arrangements increasingly attractive to providers. Under our proposed reforms, providers will have more support for adopting innovative approaches to deliver better care, more predictability in overall payments, and will be able to develop more experience over time as these payment reforms are phased in.

Establishing the Foundation for Medicare Comprehensive Care

» CMS must accelerate its efforts to implement and align meaningful performance measures in Medicare. MCC will require CMS to align the quality measurement foundations as the key building blocks of this program: the Patient-Centered Medical Home initiatives, Bundled and Episode-Based Payment initiatives, and ACOs. Measures would also be aligned between MCC organizations and Medicare Advantage plans.

» In particular, Medicare along with other payers should aim for a standard set of outcome-oriented payment measures for a range of beneficiaries: beneficiaries who have no major health problems but who may

have risk factors to manage, beneficiaries with common chronic diseases, beneficiaries with serious acute illnesses and who undergo major procedures, beneficiaries with major illnesses, and beneficiaries with frailty and multiple chronic conditions. This should also include the capacity to track low-income and minority beneficiaries. Many of these measures are in the process of implementation now, and many more could be, but they have not been put together yet in a comprehensive implementation plan.

» CMS must support providers in their evaluation of whether and how to move to MCC payments by sharing more usable, timely, and standardized data on a provider's beneficiaries, and facilitate the adoption of standard ways to summarize such data across Medicare's own payment systems and those of other payers. This approach would include measures based on Medicare's claims data of how the provider(s) would perform in a "virtual" MCC, including relevant bundled payment systems based on the beneficiaries attributed to them according to their utilization of care. Thus, a primary care provider could see how his or her group is doing on both medical home measures and on population measures for their beneficiaries; and a specialist could see how his or her group is performing on relevant episode measures, as well as on their patients' overall cost and quality of care. This would also include the ability for providers to look behind their summary measures to see opportunities to improve care for particular beneficiaries.

Implementing Medicare Comprehensive Care Payment Reforms

» Building on its current Medicare Shared Savings Program, Pioneer Program, and Advanced Payment ACO option, CMS would implement a pathway for MCC organizations to transition in the coming years to partial and full capitation for their assigned beneficiaries, in conjunction with an increasingly robust set of performance measures that the organizations would report. Organizations would need to meet performance standards to receive full payment.

» CMS would also implement a progressively expanding set of bundled payments with performance measures that are focused on common beneficiary health problems and common combinations of problems, along with primary-care case payments. Drawing on their experience and the experience of other payers as well, CMS would develop a clear model of how payment reforms affecting components of health care delivery, impacted by these complementary payment reforms, contribute to overall population health and costs.

» Instead of continuing in Medicare's traditional payment system, providers could opt to participate either in MCCs that are accountable for the quality and cost of a beneficiary's overall care, or in case- or episode-based bundled payments that replace traditional Medicare payments for these groups of services. ACOs would transition to person-level MCC organizations that receive a fully capitated payment for each beneficiary attributed to the organization. Providers who choose to participate in case- and bundled-payment options would similarly receive an increasing share of their payments through these arrangements—the vast majority of payments by a decade from now.

» In conjunction with reforms in Medicare benefit design, MCC providers could offer beneficiaries co-pay reductions or (in the case of beneficiary-level MCCs) lower premiums for receiving Medicare services through their systems.

Accompanying Reforms in Medicare's Existing Payment Systems

» To facilitate providers' transition to case-based and bundled payments as alternatives to fee-for-service payments, CMS would create and then expand elements of case- and person-level payments in each of its existing provider payment systems, as part of its continuing work to update these systems and to

ensure their accuracy. These payments would be accompanied by performance measures related to patient- or case-level quality of care and efficiency as described above, and would be designed to build upon and simplify Medicare's various current quality-related payment adjustments. Medicare has implemented quality reporting systems and payment adjustments for physicians, hospitals, and other providers. But these payments are generally administered as a variety of multipliers (adjusters) to all FFS payments to the provider. In contrast, shifting some existing FFS payments into partial use of case-based payments would give providers more support in moving toward medical homes, condition-based and other bundled payments, and comprehensive (capitated) payments that allow for more of a patient-level focus in care delivery but may otherwise be too big of a leap. New Part B payments for care coordination for primary care physicians, as well as proposals by physician specialty groups to replace some of their FFS payments with case-based payments (e.g., for a component of specialty services that are currently reimbursed on a FFS basis), are examples of steps in this direction.

» Under our proposal, overall per-beneficiary payments in Medicare's traditional program should grow no faster than GDP per capita. Under current law, this is not projected to require further tightening of existing FFS payments for five or six years. If further reductions in traditional payment rates are necessary in the future, they could occur through either the IPAB as in current law, or through an across-the-board reduction in payment updates. If such payment rates are inadequate for certain providers, Congress could adjust payments while finding offsets elsewhere. If evidence suggested that overall MCC and FFS payments were creating potential quality problems, Congress could increase Medicare's per capita benchmark growth rate, as noted above.

» The savings from our Medicare reform proposals, including the savings from transitioning traditional Medicare to a slower spending growth benchmark in the years ahead, would be used to provide significant additional financial support to providers for assisting in the transition toward MCCs and improvements in care delivery. This would include stabilizing Medicare's physician payment system with an alternative to the sustainable growth rate (SGR) that promotes better and better-coordinated care. It would also include additional support for providers who switch to MCC payments to assist them with start-up investments in practice reforms.

» Any changes in traditional Medicare FFS payments should not raise overall Medicare spending, but should promote the increasing use of case- and patient-level payments and provider participation in an MCC person-level or bundled payments. For example, physician payment reform should be part of a reform package that provides a pathway for physicians to move toward case-based payments for most of their services and that begins to enable physicians to share in the savings for care decisions they make that improve quality and reduce overall Medicare costs. Physicians who opt to shift to MCC might receive larger payment increases. Similarly, any new increases in payments for other providers would be paid for by offsetting Medicare savings and would not simply be across-the-board increases in FFS rates, but would include moving an increasing share of payments into case-based or bundled payments. For example, an increase in hospital payments because of concerns about inadequate updates could be linked to a hospital shifting an increasing share of its payments into partially bundled payments with other providers for episodes of care.

Administrative Reforms and Milestones for CMS to Support Medicare Comprehensive Care

» CMS should produce usable claims-based data in a timely and consistent way to providers. For quality measures that will come from MCC providers, CMS should support standard batch data reporting, ideally through direct submission from electronic systems

including electronic medical records and registries. Since these steps will make it easier for providers to participate in quality improvement efforts, these data flow enhancements should be a high priority for Medicare program administration. While these steps would require a significant enhancement of CMS data capabilities, they build on steps that CMS is currently taking and are necessary foundations for supporting providers in improving care.

» These steps will require CMS to shift much of its current demonstration and pilot program activity—particularly on medical homes, bundled payments, and other population-based payments—into supporting the steady and effective implementation of payment reforms in the traditional Medicare program. CMS should allow providers to participate in potentially reinforcing value-based payment changes with a primary focus on how the set of payment reforms affect overall outcomes and costs for beneficiaries. In particular, collaborating providers should be able to participate simultaneously in medical home, episode-based payments, and ACO initiatives with a total shared savings calculation based on their overall results, as in many private-plan initiatives today. These payment reforms should be a coordinated and reinforcing approach for steady progress toward improvements in care and associated reductions in cost growth at the case and beneficiary level.

Legislation supporting the transition to MCC should have milestones for CMS along the path for implementing case-based payments, to assure that the vast majority of providers are able to participate as MCC organizations or contribute equivalently to achieving quality and per capita spending benchmarks by 10 years from now. For example, within two years, Medicare might be required to implement case-based elements in each of its traditional payment systems where they do not exist already, and provide options for bundled payments for care affecting at least 10 percent of Medicare spending; in four years, these payment elements might be required to address 30 percent of payments; by ten years from now, the vast majority of payments would be covered by such systems.

Reform Medicare Benefits to Support Comprehensive Beneficiary Care and Lower Costs

Medicare benefits provide critical financial support for millions of Americans, but they are not well aligned with supporting steps that beneficiaries can take to engage with their providers and to receive high-value care at a lower cost. While private health insurance benefits and Part D benefits are also imperfect, they are increasingly set up in ways that enable beneficiaries to share in the savings when they reduce overall health care costs through value-based insurance designs or higher deductibles. In contrast, Medicare beneficiaries receive limited, if any, out-of-pocket (OOP) savings when they take steps to use less costly care in Part A and Part B, especially if they have supplemental insurance such as Medigap coverage. In our previous reports, we identified benefit reforms that would reduce costs for Medicare and provide better protection against high costs for beneficiaries. MedPAC has also considered benefit and Medigap reforms similar to our proposals. These steps require care in implementation, because in cases of low to moderate expenses, beneficiaries could pay more and face somewhat less predictability of expenses. However, all of our reforms would increase overall beneficiary protection against high costs. Further, these reforms would give beneficiaries new opportunities to reduce their OOP costs when they receive care from MCC providers that deliver better care. Combining these steps in Medicare benefit reforms would give beneficiaries a much better way to meaningfully participate in choosing MCC care, reduce beneficiary costs, and significantly increase the impact of payment reforms to providers.

» Medicare benefits would incorporate OOP maximum and more rational co-payments, as in reforms considered by MedPAC and others. Beneficiaries would have better information about their OOP costs for different options when receiving care. The MCC organizations described above will help achieve this goal by providing clear information on total and OOP costs for their bundles of services (or for all of a beneficiary's care), and CMS would

provide comparative OOP cost summaries as well. In conjunction with the more complete measures of quality and cost described above, Medicare should use the same framework of virtual cost measures (e.g., estimates of the costs associated with the overall episode of care from an elective-care specialist) to implement steadily improving information about the cost consequences of choosing providers who are not part of MCCs.

» MCC organizations should be able to offer lower premiums or co-pays for their sets of services for beneficiaries who choose to use MCC providers when the MCCs demonstrate lower actuarial costs (i.e., the MCCs can use their lower overall costs relative to the MCC benchmark to buy down premiums and co-pays).

» These OOP reforms will have only limited consequences for beneficiary savings without reforms in Medigap coverage. Medigap needs to be reformed, at least for future beneficiaries, to strongly discourage "first dollar" coverage that is unrelated to quality or value and that adds substantially to costs. Medigap plans should have an actuarially-equivalent co-pay of at least 10 percent, though plans should have actuarial flexibility in adjusting co-pays to promote higher-value care. This could be accomplished through significant surcharges on Medigap plans that do not meet these standards, perhaps phased in over a transition period, and could build upon proposals from the Administration, many members of Congress, and expert groups. Implementing these Medigap reforms in parallel to the Medicare benefit reforms reflects the close link between these two reforms and demonstrates how, together, they can reduce total beneficiary payments while providing better protections against high costs and promoting better care.

» Other co-pay reforms that better reflect the value of services and effective insurance protection should also be implemented, along the lines that MedPAC is considering.

These reforms would be implemented in a manner that does not increase beneficiaries' overall cost sharing, substantially reduces Medigap premiums, and improves beneficiary protection against high costs, all while enabling greater beneficiary engagement in improving care.

Reform Medicare Advantage for Higher-Value Competition

The reforms in traditional Medicare payments and benefits described above will provide greater certainty that the current law requirement of GDP+1 percent growth or less in per capita spending can be achieved and sustained. As we have noted, we believe that a lower spending growth of GDP+0 per capita can be achieved, through better and more systematic support of needed reforms in care delivery. Because Medicare Advantage (MA) plans also provide an important means for achieving higher-value care, we propose that MA plans report the same MCC performance measures and use the same per capita growth rates for their subsidies.

» The current-law formula for updating MA payments would be modified so that the same update for MCC plans (i.e., GDP+0 percent) would apply to MA plan subsidies. That is, both programs would receive the same per capita payment increases. Along with the MCC changes, this update would allow Congress to focus much more on beneficiary quality of care and value, as well as on a single per capita payment growth rate with regard to Medicare costs in both traditional Medicare and Medicare Advantage plans.

» MA plan requirements should be modified to allow plans to return the full difference between their lower bid and the benchmark to beneficiaries in the form of lower premiums, with no requirement that plans convert lower costs into additional actuarial value of benefits. Currently, plans can receive between .67 and .73 (depending on the Medicare Star rating) of the difference between the plan's bid and the case-mix adjusted benchmark. Under this system, plans often return this difference in the form of extra benefits. To encourage greater competition on price, we

recommend that Medicare return the full amount (i.e., 1.0) of the difference if provided in lower premiums, and 0.5 if provided in the form of additional benefits. This reform would be most effective alongside the reforms in Medigap and the traditional Medicare benefit structure that we have described, so that the standard Medicare benefit package represents a more modern benefit structure.

- Implementation of these steps should be accompanied by the collection of more extensive, outcome-oriented performance measures consistent in MA plans and traditional Medicare. As we have noted, such outcome-oriented measures will be available from the MCC initiatives in traditional Medicare, and can be constructed by CMS for all beneficiaries in an area. Better measures would make it easier to detect any significant selection issues between MA and MCC plans. These measures should also address the extent to which any increasing differences between MCC and MA plans are due to health status or socioeconomic status.

- The Medicare benchmark for payments to MCC and MA plans should grow more slowly if the total costs of Medicare benefits grow more slowly. In particular, CMS would calculate the average growth of total costs per beneficiary for Medicare benefits across both traditional Medicare and Medicare Advantage plans (i.e., the average of per capita total Medicare costs in MCC organizations). If this is lower than the benchmark growth rate, and if there is no evidence of substantially worsening adverse selection between traditional Medicare and Medicare Advantage, the growth in the Medicare benchmark for both traditional Medicare and Medicare Advantage plans would equal this slower cost growth rate. Spending on premium or co-pay buydowns and other reductions in cost sharing by MCC organizations and MA plans would not count in this calculation. The lower benchmark would directly reflect the lower cost of providing all Medicare-required benefits. This proposal differs from premium support proposals. It reflects slower growth in total costs of Medicare-required benefits and thus does not shift costs to beneficiaries, it happens only in the context of reforms that enable traditional Medicare to take steps to become significantly more efficient (i.e., MCC reforms), and it occurs only with ongoing and improving measurement and evaluation of quality of care for vulnerable beneficiaries.

REFORMS FOR MEDICAID AND CARE FOR VULNERABLE POPULATIONS

Medicaid currently covers over 50 million individuals, including more than 1 in 4 children and a growing number of the lowest-income, medically complex, and frail Americans. Eligibility is slated to expand substantially, particularly for low-income adults, beginning in 2014 under the ACA. While Medicaid is an increasingly important coverage source for Americans with limited means and high health care needs, cost increases are straining state and federal budgets, and challenges exist in access, coordination, and continuity of care.

State Medicaid plans in recent years have shifted away from traditional FFS Medicaid benefits and toward more person-focused coverage and care programs. States operate on "waivers" from standard statutory Medicaid benefit requirements in providing coverage with the general requirement that beneficiaries receive

care that is as good as the Medicaid statute requires at no more than the expected cost than would have been incurred under the statutory approach. This state-by-state, waiver-by-waiver approach is now the hallmark of Medicaid, and it typically involves substantial back and forth negotiation between states and the federal government in each case.

In this waiver-based system, there is a growing evidence base for comprehensive state waivers that enable savings and better care within a global spending cap. For example, New York has included a Medicaid global spending cap in its waiver that will grow annually with the medical Consumer Price Index (CPI). The focus on global spending makes it easier for New York to implement system-wide reforms like health homes and accountable-care payments. Arkansas' 2011 waiver, the Health Care Payment Improvement Initiative, sought to move from FFS to bundled payments, to support significant improvements in care that had not been possible under FFS. California previously implemented a "Bridge to Reform" waiver for some Medi-Cal beneficiaries in which per capita payments and payment increases to Medicaid health plans are capped, and is now implementing a much broader waiver using a similar model with an emphasis on beneficiary quality of care and per capita spending growth benchmarks. Oregon's proposed Medicaid waiver renewal includes a fixed global budget for their community-based Coordinated Care Organizations (CCOs), which have both accountability for beneficiary-level results and more flexibility in using Medicaid funds to provide care.

One reason that such waivers with per capita benchmarks are important is Medicaid's joint federal-state funding that splits Medicaid costs between states and the federal government. This basic structure means that the financial benefit to states for reducing spending growth—and the costs borne by states for increased spending growth—is limited despite the fact that states have the leading role in developing and implementing reforms in Medicaid coverage to improve health care for low-income residents. For example, even if states take steps to prevent complications and to improve the coordination of care for low-income beneficiaries—leading to lower costs because of fewer hospitalizations and other complications or other inefficient services—states receive only a fraction of the Medicaid savings and little of the hospital savings. Similarly, while the new Medicaid coverage expansions will provide needed coverage for millions more low-income adults, the very high federal match rate means that states will retain an even smaller share of savings when they undertake activities to improve the efficiency of care. While there are understandable concerns that states need oversight to assure that cost savings do not come at the expense of quality, the recent waivers show that it is possible to develop models that provide stronger support to states for innovations in care delivery to improve quality and achieve greater efficiency as a result.

Similar issues and trends exist for Medicare-Medicaid "dual-eligible" beneficiaries, but the fragmentation of financing and benefits across Medicare and state programs has created even more coordination issues. As a result of the gaps in quality and coordination of care that result in preventable complications and avoidable costs, the goal of better-integrated care for dual-eligible beneficiaries has widespread support. Better coordinated services for these patients, encouraged by better-aligned Medicare and Medicaid financing, represents a critical opportunity for bending the curve of rising health care costs by improving care. Beginning this year, CMS is implementing a three-year, multi-state demonstration using new integrated payment models to support better care delivery at a lower cost for dual-eligible beneficiaries—either capitated Medicare-Medicaid managed care plans or state-managed reform initiatives with integrated financing. CMS has already approved five large-scale demonstrations, and many other states are pursuing implementation of similar demonstrations. To be sure, there are also concerns about cutting back or disruptions to care for these high-risk, vulnerable patients. However, in a three-year case-by-case demonstration, it is difficult to implement either the

state support (data systems, best practices, etc.) or the infrastructure for measuring performance to help ensure that quality and access improve.

Given this context, we are building on our previous Medicaid-related recommendations with further steps to reduce costs while providing needed care for vulnerable patients.

Create a Standard Program for Person-Focused Medicaid, Enabling States to Implement and Track Performance of Medicaid Reforms that Reduce Per-Beneficiary Cost Growth While Maintaining or Improving Quality of Care, and Enhance States' Share of Savings From These Reforms

Our proposal would move Medicaid away from operating on the basis of one-off waivers to a more standard and systematic process for states to implement Medicaid reforms that achieve reductions in per capita cost growth while maintaining or improving quality of care. This mechanism would support health care services provided by capitated Medicaid managed care plans, as well as reforms managed more directly by states that focus on particular components of care (e.g., primary care services, bundled or coordinated payments for high-risk beneficiaries or beneficiaries with particular behavioral health or chronic disease issues). Streamlining the current waiver review process, these Medicaid reforms would create an improved data infrastructure with standard processes and evaluation methods for states to implement and modify reforms that reduce per beneficiary costs while maintaining or improving quality of care. The reforms would also enable states to share in more savings given their leading role in investing in the success of these reforms.

- Rather than negotiating individualized waivers on a one-off basis with states, CMS would implement a long-term, system-wide strategy for "Person-Focused State Medicaid Plans" that would support, monitor, and evaluate the plans' impact. The Person-Focused Plans could rely on Medicaid managed care plans or on state-managed care reform approaches. States that develop such Person-Focused Plans that meet the minimum standards for participation would have an accelerated approval process, much more like the plan amendment process for the Children's Health Insurance Program (CHIP).

- The program infrastructure would start with base per capita and global spending projections. States that are able to reduce per capita and overall Medicaid spending growth significantly below expected benchmark trends would be able to keep a disproportionate share of the savings (and would also be accountable for a disproportionate share of cost overruns). For example, Oregon's current waiver anticipates a two-percentage point reduction in per capita medical costs by the end of the second year with significant financial penalties for the state if the per capita goals are not met. In our analysis, we considered models in which states would receive 50 percent of the federal savings.

- CMS would develop and support standard measures for Person-Focused State Medicaid Plans that could be applied consistently across states and that would complement performance measures used in Medicare and private insurance when appropriate. With data and evaluation support from this core CMS program, states would have to implement an ongoing evaluation capability to track the impact of the reforms on access to and quality of care in Medicaid. The measures should be person-focused and outcome-oriented, including access to care (e.g., standard source of primary care), use of preventive services and wellness, use of evidence-based care, outcomes for common chronic diseases, coordination of care measures for complex patients (e.g., readmission rates and medication reconciliation), and measures of patient and caregiver experience with care. Measures would also include overall rates of insurance coverage (Medicaid or private) in the state among lower-income populations.

- States could target initiatives to key patient populations that are priorities for achieving improvements in care and reductions in costs. This should include complex patients with high expected costs. CMS would develop specific benchmarks and evaluation support for high-risk/high-cost populations, and would prioritize efforts to help states adopt successful models and best practices. It should also include improving use of preventive services and reducing health risk factors for otherwise healthy populations, particularly children.

- While this reform structure is intended to bring a much more person-level and innovative approach to care in Medicaid, it could be implemented progressively over time based on state experiences and supporting infrastructure. States would have progressively greater authority to reform provider payments in Medicaid and benefit designs, potentially starting with regional pilots and "optional" Medicaid populations. Unlike current waivers, however, states would have a clearer set of long-term reform goals and more systematic support for achieving improvements in care and health. States that are able to implement more comprehensive evaluation mechanisms, and demonstrate improvements in key performance measures, would have greater opportunities to share in savings and risk in addition to more flexibility in designing and implementing Medicaid reforms. Over time, as experience and support accumulates, states would be expected to achieve greater savings in comparison to current Medicaid per capita cost trends.

- States would be encouraged to combine funding streams and support innovative, efficient strategies for care delivery for low-income uninsured populations, and for dual-eligible beneficiaries, as described below. States could also use these reforms to support statewide, multi-payer efforts that lead to measurable improvements in access to and quality of care.

Align Medicaid Reforms with Other Initiatives and Financial Support for Health Care for Lower-Income Individuals to Facilitate Care Continuity and Improve Efficiency

- States and CMS should facilitate the participation of Medicaid managed care plans in state insurance marketplaces to prevent shifts in and out of Medicaid eligibility that disrupt both coverage and how individuals receive their care. States and CMS should establish preferences for Medicaid plans for "optional" patient populations that offer similar or identical benefits to plans offered to low-income individuals on the marketplaces.

- Many lower-income individuals, including some particularly high-cost patients with physical and behavioral health needs, currently receive support services outside of Medicaid. These include both the health care safety net (such as local safety-net initiatives and programs for mental health and Federally Qualified Health Centers) and key non-health care services such as housing and social work assistance. These sources of care are likely to remain important after 2013. To help improve outcomes, CMS should facilitate state reforms that coordinate the delivery of services in these programs. This could be done by combining funding streams for the safety-net providers with greater accountability for care improvements for the populations they serve. Examples of local initiatives that are already taking steps like these include: Camden Coalition of Health Care Providers (a city-wide comprehensive care management program that includes social work, residential, and behavioral support, with integrated funding streams); Denver Health (an integrated system that provides safety-net care and broader population care in the Denver area, including services and funding streams for emergency care, mental health services, school clinics, and prison services); and the New York Institute for Family Health (which includes federally-supported community health centers coordinated with specialist/hospital care as well as social services support).

Expand and Make Permanent the CMS Capitated Financial Alignment Demonstration for Medicare-Medicaid Beneficiaries with a Strong and Systematic Ongoing Evaluation and Support Capacity

This proposal would implement a more systematic, long-term infrastructure to support coordinated care for dual-eligible beneficiaries. Such an infrastructure is not feasible in the short-term, case-by-case approach of the current demonstration program and is needed to be able to develop, assess, and expand the dual-eligible reform programs that work.

- CMS would transition the capitated model in the "Financial Alignment" initiative to a permanent Dual-Eligible Aligned Care Initiative, which would provide more certainty for state planning purposes and encourage states to invest with the federal government in the needed long-term operations and evaluation infrastructure for the program.
- A permanent program would be accompanied by a substantial evaluation and quality improvement infrastructure at CMS for the Aligned Care Initiative that: 1) provides timely access to Medicare data on dual-eligible beneficiaries to the states and their provider and plan partners; 2) produces much more meaningful measures of quality of care and costs for dual-eligible beneficiaries; and 3) shares evidence and best practices with states on effective steps for improving care for dual-eligible beneficiaries. Such an infrastructure is difficult to establish in a temporary demonstration but is an essential step to provide more support for better-coordinated care than exists today and to ensure that the state reforms are truly improving care.
- Combined shared savings would be calculated across both Medicare and Medicaid, and should be shared with states at least in proportion to state shares of overall dual-eligible costs. Calculating Medicare and Medicaid savings separately undermines incentives to coordinate care to achieve maximum system-wide savings, and are not necessary to achieve significant federal savings relative to current dual-eligible policies.
- The evaluation measures to be used in an ongoing basis in this initiative would be tailored to the dual-eligible population and should include measures of patient experience and care coordination, as well as increasingly comprehensive measures of other aspects of quality of care.
- State reforms that do not show both improvements in performance measures and overall cost trends would be phased out, with increasing incentives over time for states to switch to effective plans, as the experience and capacity of the initiative increases.

REFORMS FOR PRIVATE HEALTH INSURANCE MARKETS AND COVERAGE

Reforms in private insurance coverage and marketplaces for businesses and individuals are critical to lower costs and improved care. In addition to providing coverage for most Americans, these plans are implementing innovations such as wellness and care management programs and other steps toward more consumer engagement in health care and health improvement. As we have highlighted in previous reports, key reforms should include steps that promote such a person-level focus on better health without unnecessary costs. These

reforms include: reliable comparative cost and quality information to inform health plan choices; subsidies for coverage based on income and health need that are not open-ended, to share more savings from high-value choices; flexibility in the design of benefits and provider payments in the insurance plans to enable insurance plans to support high-value care; and steps to ensure that insurance markets are stable and work well for high-risk and vulnerable individuals.

The implementation of the ACA's insurance marketplaces beginning in 2014 provides an opportunity to help achieve these goals by improving access to coverage in non-group health insurance markets, promoting competition and efficiency in those markets, and thereby, driving improvements in health care delivery. The marketplaces will be supported by subsidies for health insurance coverage that are income-related, that enable beneficiaries to get the full savings of choosing a lower-cost plan, and that, after 2018, increase essentially with the growth of the economy. These key features of subsidy design are ones that our other proposals seek to bring to the rest of the health care system. However, the promise of effective reform in the individual and small-group market may only be realized if further critical further steps are taken during implementation. These include steps to assure flexibility for insurers to provide cost-effective benefits such as value-based insurance designs and network plans, additional steps to address adverse selection while promoting strong competition, and other measures that will hold down costs—all while demonstrating access to quality care.

Along with these reforms in insurance marketplaces for individuals and small businesses, analogous financing reforms are needed for employer-provided coverage. We have previously proposed reforms in the currently open-ended tax exclusion for employer-provided health insurance to achieve this goal. That tax expenditure has a cost of around $250 billion annually to federal and state governments. Moreover, it is not well targeted to those who need the most help with health care costs and it encourages less efficient care. We renew this proposal here, and also describe several other steps that would enable employers and private insurance plans to do more to lead efforts to improve quality in ways that lead to lower costs.

Limit the Exclusion of Employer-Provided Health Insurance Benefits from Income by Imposing a Cap that would Grow at the same Per Capita Rate as Federal Subsidies in Medicare and/or the Marketplaces

- In conjunction with providing better information on the quality of care in employer plans, the employer-provided health insurance subsidy should be capped. This could be accomplished over time by capping the exclusion at a high level initially, similar to the intent of the ACA provision in current law, and not index the cap until the subsidy value is closer to alignment with the subsidy in the insurance marketplaces. After that, the subsidy could increase at the rate of GDP growth, as the marketplace and Medicare subsidies would do under our other reform proposals. A somewhat higher average subsidy for employer coverage could help discourage shifts to the non-group marketplace (exchange), but concerns about such shifts can be addressed while still capping the exclusion. If this step is linked to broader tax reform that also reduces marginal tax rates, any additional costs in employee tax liability could be offset by the combination of lower tax rates and lower health care costs.

- At a minimum, retain the ACA provision on taxing high-premium insurance plans beginning in 2018. The current-law excise tax equals 40 percent of the total premium of a plan in excess of a threshold, which is set at the high level of $10,200 for individuals and $27,500 for families, and is indexed to the CPI after 2019. The additional cost of insurance premiums above the tax threshold encourages the selection of plans with premiums below the threshold.

Encourage and Support Employer Leadership in Driving Innovative Reforms in Health Care Coverage and Delivery

» Assure that Employment Retirement Income Security Act (ERISA) and other health plan regulations do not inhibit the use of value-based insurance designs, tiered benefit designs, and employees' ability to share in the savings from health care choices and changes in their behavior that reduce costs. This would facilitate employer efforts to engage employees in reducing overall health care costs.

» To promote transparency, make available standard measures of provider performance from Medicare and Medicaid that could be more easily combined with similar measures constructed by employers from their own data on health care costs and quality, as we describe below.

» To promote effective financing reform, facilitate adoption of payment reforms in Medicare and Medicaid that match value-based payment reforms adopted by private-sector payers.

Promote Competition that Lowers Costs while Providing Access to Valuable Services and that Creates Appropriate Incentives for States

» Implement regulations for insurance marketplaces that allow for actuarial equivalence in benefit design to promote innovation in value, such as tiered benefits with lower co-pays for less costly care choices, and networks of high-value providers and cost-effective treatment options, in conjunction with reporting on quality measures.

» Allow for value-based standards for coverage of medical treatments in meeting the minimum requirements for essential benefits for creditable coverage.

» Given the disparities in covered benefits across states, and the cost of enhancements in state-mandated benefits being borne by the federal government and not the states, offset state-specific subsidy growth that is attributable to increases in the impact of state-required benefits over time. For example, state regulations that expand required coverage of treatments from alternative medical providers, specialty services and products, etc., should not cause an increase in the value of federal subsidies in the state over time. One way to accomplish this goal would be to track the actuarial value of state-required benefits over time. These actuarial values are likely to vary considerably, and state-specific increases in these values should not cause an increase in the value of federal subsidies in the state.

Facilitate Stable Non-Group and Small-Group Health Insurance Markets in the Absence of a Strong Mandate by Minimizing the Risk of Adverse Selection and Shoring up the Safety Net

Reforms that encourage choices of less costly plans in insurance marketplaces require effective policies to assure that health plans compete on quality and value and are not rewarded for designing benefits to select healthy, low-cost enrollees. While we believe that the reforms we have proposed will achieve a needed emphasis on and balance between encouraging efficiency and providing access to quality care, further steps will help assure that adverse selection problems can be addressed or avoided.

» The current penalty for individuals who do not have "creditable" insurance coverage will encourage participation in insurance markets. However, the penalty is small relative to the cost of insurance, especially in the early years and especially if Congress or the Administration limit enforcement or slow its implementation. Consequently, other steps to reduce adverse selection will be important to encourage broad participation and keep insurance premiums affordable:

- Enhancing participation through effective broad-based outreach and enrollment support, particularly for those from lower socioeconomic groups and in low-income areas, and those facing language or other barriers to enrolling in an optimal plan. Default enroll individuals who are eligible for subsidies.
- Limiting open enrollment periods to one to two months per year.
- Imposing limits on individuals' ability to shift from a plan with relatively low actuarial value to a higher value plan (for example, allowing movement from a "bronze" to a "silver" plan in terms of actuarial value during open enrollment, but not a "bronze" to a "gold" plan).
- Relaxing the requirement for full community rating when consumers have not maintained continuous coverage, and including late enrollment penalties (as in Medicare Part B and Part D).
- Allowing temporary limits on coverage for pre-existing conditions for consumers who have not maintained continuous coverage.
    - Considering at least temporary extension of additional financial support for highest-risk individuals, for example through enhanced reinsurance payments.

» Monitoring for potential adverse selection problems will require consistent data and analytic capacity but does not require exhaustive data requirements on health plans.

- Data on enrollment and health status reported by health plans for calculating risk adjustment models can also be used to monitor trends in market participation and adverse selection. Aggregate data produced by insurers using standardized methods should be sufficient for this purpose, at least initially and in conjunction with audits. This information should be reported publicly and tracked at the market level to assess market sizes, stability, and risk status.
- The Department of Health and Human Services (HHS) should lead the development of a strategy and plan for reviewing and improving risk adjustment models across all of its major health care financing programs, including Medicare and Medicaid.

REFORMS FOR SYSTEM-WIDE EFFICIENCY

These proposals are designed to create a better environment for supporting quality, efficient health care delivery and high-value innovations in care. Because they support improvements in quality and efficiency in all of the major health care financing programs, they can enhance the system-wide impacts of our reform proposals for Medicare, Medicaid, and private insurance. The proposals build on our previous proposals to create a better infrastructure for health care delivery.

Simplify and Standardize Administrative Requirements

The time cost to clinicians of interacting with health plans has been estimated to be as high as $23 to 31 billion annually. Further, clinicians, health plans, and other participants in health care reform are currently subject to a wide range of diverse reporting requirements that add to costs and reduce the availability of actionable

information. Some steps have been taken recently to reduce these administrative costs through standardization. Further administrative simplification steps should include the following, all of which can be accomplished through existing standard-setting entities and public-private implementation initiatives:

- Implementation of an updated standardized claim form.
- Standard methods for quality reporting by providers and plans, including clinical, outcome, and patient-level measures—this would be an administrative benefit for providers that adopt value-based payment reforms across all of their payment systems and would lead to reduced reliance on cumbersome coding for specific types of providers.
- Standard methods for timely data sharing by plans with health care providers and patients who are involved in the financing reforms described in this report. Data sharing accomplished according to consistent standards would reduce the burden on providers and patients, and the IT vendors who serve them, for implementing the analytic tools needed to achieve greater improvements in care.
- Support for state investments to update their Medicaid information systems including standard quality measure reporting and access to CMS data for quality improvement.

Improve Cost and Quality Transparency

To support patients in making better decisions about their care—and driving the value-based insurance reforms that we have endorsed—patients need much better comparative information about the quality of their care and what they pay for it. This information should be provided where feasible at the point where patients are making decisions about care (e.g., quality and payment consequences of choosing different providers for an elective procedure or management of a non-emergent condition) and when they are making decisions about plan choice (e.g., which plan is the best value for patients with different characteristics and preferences). Of particular value to patients is personalized information on the out-of-pocket costs of their choices. Payers and purchasers also need information on total payments and quality for designing payment contracts more focused on value. Some important progress is occurring to make such information available, and the reforms we have described would significantly reinforce it (e.g., comparable information on bundled or patient-level payments for services, and relevant person-level performance measures, will facilitate the production of total and out-of-pocket payment information in conjunction with these reforms). The following steps would further promote useful transparency:

- Promoting the development and adoption of consistent methods across providers and payers for constructing quality measures and for plans to provide relevant out-of-pocket cost information, at least for a core set of important measures and conditions.
- Requiring plans, as a condition of participation in insurance marketplaces, to provide a common set of quality and utilization measures—not just at the plan level, but for the providers included in the plan. The provider-level measures could then be aggregated across private and public plans to achieve more comprehensive and reliable evidence on provider performance.
- Restricting gag clauses that prevent providers and plans from disclosing total and out-of-pocket payment information, where such price-related information is used for patient and purchaser decision tools.

While disclosure of price information might be expected to promote more effective price competition, there is some evidence that requiring more disclosures may undermine discounts offered by providers and plans that have substantial market power. Focusing on total payments for bundles of services and out-of-pocket payments actually incurred by patients—information

that determines the final flow of funds for health care spending—can help limit disruptions in service-specific rebates or other discounts that help hold down overall payments. However, as we note below, further steps are likely to be necessary to support effective price competition in markets where providers or insurers have substantial market power. Greater transparency about quality and practically meaningful prices is essential for improving decisions and will also enable more effective antitrust enforcement.

Promote Effective Antitrust Enforcement

Given the increasing complexity and diversity of individual patient needs, better support for care coordination can have important benefits for improving the efficiency and quality of care. To achieve better coordination, steps toward greater clinical integration are required, as is the financial support for such steps. This can be accomplished either through contracts and other business arrangements among health care providers, or through consolidation of providers. For example, some ACOs have been formed via contracts among physician groups and insurers; others have been formed via vertically- and horizontally-integrated health care delivery systems. While clinical integration may have important benefits, provider combination arrangements and consolidation can also increase provider market power. There is evidence that some of the recent consolidation in health care markets leads to higher prices that can offset the benefits of better integration of care.

In the context of recent payment and delivery reforms, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) have reaffirmed their commitment to effective antitrust enforcement, which in practice generally occurs under a "rule of reason" standard. These entities have longstanding policies for analyzing the clinical and financial integration of providers, as well as mergers, reflected in guidelines that were recently updated in the context of ACOs. Appropriately, these analyses focus on the credibility of the clinical integration steps relative to the risk of market power. Merger analysis involves a higher level of antitrust scrutiny, as such contractual arrangements are more difficult to undo.

However, it is not clear that current policies are optimal as financing reforms and the availability of measures reflecting health care market performance continue to evolve. "Rule of reason" review should clearly reflect these recent developments. Consequently, we support further updates in the antitrust enforcement guidelines to place a substantially greater emphasis on the extent to which clinical integration is accompanied by financing reforms that move away from FFS payments and place providers at financial risk for higher costs. In addition, we support the production and improvement of increasingly robust performance measures that reflect both the quality of care and service- and patient-level cost outcomes. We have described these measures and payment reforms above. The complementary reforms in antitrust policy include the following steps, which also have implications for the enforcement of Stark and anti-kickback laws:

- For clinical integration activities above a reasonable market-share threshold of concern (and merger activities above a somewhat lower threshold), clarify that baseline and have an ongoing production of a timely, comparable set of quality and cost measures at the patient and population level as an important consideration for enforcement. In particular, a sufficient baseline of measures including patient-level cost and quality of care (e.g., one to two years for common conditions and procedures, and for overall per capita measures) should be produced using summary data from Medicare beneficiaries and a meaningful share of privately-insured individuals in the area that would be affected by the integration agreement. Such measures should also be expected in all existing high-concentration markets that are dominated by a small number of large, integrated systems.
- Clarify that enforcement review places weight on the extent to which payment contracts for providers move away from traditional financing based on

volume and price of particular services, and toward payments that increase when quality is higher and costs are lower, as a major factor in antitrust review. In these cases, provider revenues are more directly tied to efficiency and cost reduction, not higher prices or greater intensity. These types of contractual reforms should be considered indicators of reduced risk of anticompetitive behavior in provider combinations that involve joint contracting. For example, we support restricting the ability of hospitals and physician groups to negotiate physician reimbursement in their private insurance contracts unless the physicians and hospitals are engaged in contracts with significant risk-sharing for the overall costs of patient care.

» Update "safe harbor" guidelines to include ongoing performance measurement, to provide more direct evidence of anticompetitive behavior. Many clinical coordination arrangements or even mergers among high market-share organizations could be considered safer if the merged organizations commit to producing meaningful quality and cost measures over time, if the organizations implement contracts with payers that place substantial emphasis on reducing overall costs while improving quality, and if subsequent performance on these measures improves significantly. We view this as more meaningful evidence on the value of care than analysis that focuses on prices for specific services.

» Enhance the current antitrust enforcement practice of imposing higher standards and greater scrutiny for mergers relative to clinical/financial integration contracts. Financing and delivery reforms that do not require full integration of providers are easier to modify or undo than provider mergers if they do not work. They may also permit more flexibility in health care organization as further innovations occur in health care delivery.

» As part of this strategy for better evidence to guide antitrust scrutiny and policies, support the development and evaluation of standard and compelling quality and cost measures and a better understanding of developments in bundled and risk-based financing arrangements for guiding further antitrust policies. These alternative contracts and measures of quality and cost are increasingly common in payment reforms such as ACOs and bundled payments. Indeed, as we have noted, Medicare should produce these quality and cost measures as a routine matter, and private payers would also benefit from contributing aggregate data to such standard measures to describe and better understand the competitive dynamics of health care markets. Regional and state databases also have the potential to produce comparable longitudinal measures. Analyses of these improved data on market performance and the associated clinical, financial, and consolidation arrangements should be used to refine antitrust criteria regarding whether combinations of providers are likely to present anticompetitive effects that outweigh the clinical benefits and thus should be challenged. Indeed, such standards might even be used as a basis for conditional approval of certain mergers, so that there is a greater expectation that they might be modified or undone if quality and cost improvements do not occur.

» Stark and anti-kickback laws should include safe harbors for providers that demonstrate they are combining clinical integration with meaningful financing reforms to improve care, and that demonstrate progress on improving care and lowering costs. Full integration should not be a substantial requirement for exceptions to such rules if the providers are engaged in financing reform with joint risk-bearing accompanied by meaningful performance measures. Other barriers to clinical coordination for non-merging providers should also be addressed.

Address Outdated Licensing Barriers for More Effective and Efficient Care

Providers often face barriers when transitioning to more efficient models of care delivery because of outdated

regulations that no longer provide sufficient benefit to patients. Prime examples of such regulations are state scope of practice laws that prevent nurses, pharmacists, and other non-physician health professionals from delivering clinical services for which they are trained and capable. The results of such laws are higher prices and more limited access to care without improvements in quality. States should reform scope of practice laws to allow all health professionals to practice at the top of their licenses and capabilities. Another set of examples involves barriers to telemedicine services caused by state-specific licensing restrictions. Given the similarity of physician licensing requirements across states, such barriers could be removed by enabling licensed providers of telemedicine services to have licensing reciprocity. These regulatory reforms would be accompanied by increased regulatory attention to the quality of care actually provided using the performance measures that are becoming more widely available and that would be accelerated under our proposed reforms, rather than relying just on "structural" regulation that is not closely related to quality of care.

Encourage States to Develop More Efficient Medical Liability Systems

Although estimates differ regarding the magnitude of impact of medical liability reform on health care cost growth and quality, liability reform remains a critical issue to many health care stakeholders and could reinforce reforms in care delivery that increase value. Since most tort law and related regulations are under state jurisdiction, reforms to foster a more effective medical liability system will likely require state action. To encourage state liability reform, we recommend that the federal government provide states with technical assistance and grant funding to test innovative reform models, and to include such liability reforms in state-based reform initiatives. These state-level reforms should focus on well-supported models such as:

- "Safe harbor" or "rebuttable presumption" laws that establish legal protections for providers who achieve high quality and safety performance using valid measures.
- Reforms that modify the existing judicial process for resolving tort claims with lower-cost and more predictable alternatives. These include a "Patient Compensation System" that enables most claims to be settled through a standardized administrative process with predictable awards based on the adverse outcome involved, and Health Courts in which independent experts with clinical expertise would adjudicate liability claims.

Enable States to Implement Other System-Wide Reforms

Many states are taking steps to support broad-based, multi-payer initiatives to improve care and lower costs. These include supporting health information exchanges, providing "multi-payer" system-wide quality and cost information to the public, and leading broad-based efforts to improve care such as medical homes and prevention/ wellness initiatives. With the Supreme Court decision leading to more state flexibility in Medicaid coverage expansions and with the central role of states in implementing and guiding insurance marketplaces, states need more support in using their unique opportunities to lead broad-based health care reform efforts. At the same time, comparable performance measures are needed across states to provide better evidence on which system-wide reforms are most effective and to help states identify best practices and make improvements as they implement reforms.

Many of the reforms we have proposed above will support this goal. They include:

- A facilitated pathway for Medicare to join in state-based payment reforms intended to improve the value of care if the reform has a "critical mass" of participants in a state or region, including state employee/retiree plans, Medicaid plans, and private plans.

» Enhanced opportunities for states to share in savings in Medicaid and Medicare that are generated as a result of state-led reforms affecting beneficiaries in these programs.

» Enhanced infrastructure to support state-led reforms and demonstrate their impact on quality and cost trends, such as the greater availability of consistent performance measures on quality and cost from Medicare and the private sector.

IMPLICATIONS FOR SAVINGS

Our health care reform proposals create an increasingly direct and systematic focus on supporting better care for patients. The resulting changes in care permit lowering per capita expenditure growth without compromising quality and while supporting continued innovation. Critical to this effort is the implementation of a reform framework now that enables Congress and the Administration to shift their attention to overall quality of care and cost growth, without imposing major short-term changes in particular programs. Implemented as we describe it here, our framework will also lead to significant scored savings, especially in the longer term. The proposed reforms in federal subsidies, tax expenditures, and provider payment programs can also be "dialed up" or "dialed down" before or during implementation. Because we have focused on this framework for effectively bending the curve through improvements in care, we have not included a range of other proposals—for example, income-related premiums, eligibility changes, or provider payment reductions in Medicare or Medicaid—that can also achieve cost savings. Many of us also support different versions of these proposals for savings.

Table 4 provides a summary of estimated cost savings by program from our proposals. Our summary notes no net cost reductions in Medicare over the next ten years. Under current law, Medicare per capita costs are projected to grow less quickly than GDP per capita during this decade, in particular as a result of relatively slow cost growth continuing in the coming years (Medicare cost growth per capita is projected to accelerate past GDP growth in the second half of the decade). As noted above, we believe that sustaining this slower rate of growth is much less likely to be feasible without our proposed reforms to support better ways to deliver care. To facilitate the adoption of Medicare Comprehensive Care and a more effective system for beneficiary choice and engagement in care, we believe it is necessary to direct savings from our proposed reforms in Medicare benefit design, dual-eligible care, Medicare Advantage competition, and Medicare's traditional payment systems to shore up gaps in Medicare's current law policies. This includes implementing a replacement for the Medicare physician payment system that fits with our overall payment reform strategy and other transitional incentives and support for providers.

The estimated net savings in our reform plan come from its other elements. The effective implementation of Medicaid reforms like those in Oregon and California, due to both a clearer infrastructure to support better reforms and new opportunities for state savings, suggests that we can expect federal savings of around $100 to 120 billion over ten years. State savings would be larger. Under our reforms, Medicaid spending per beneficiary would still be expected to grow faster than GDP, and performance improvements would have to be met. The savings from transitioning to a cap on the tax exclusion for employer-subsidized insurance are a modest fraction of the current tax expenditure on the exclusion and could be achieved with transitioning to a

cap at a somewhat lower level than used in the current law excise tax starting in 2018, but not much lower. That is, the vast majority of employer plans would have many years to adapt to the cap, but would still have a clear indication of the need to transition to a greater emphasis on efficient person-level care. This tax reform could be implemented as part of a tax reform package that includes offsetting savings for affected workers elsewhere, for example by modest reductions in income tax rates. Our proposal to tie exchange subsidies to GDP growth on a per capita basis also represents incremental additional savings beyond current-law projections on per capita subsidies over the next decade.

Altogether, these proposals amount to close to $300 billion in net savings over the next decade. The ten-year savings could be scaled up for additional savings (e.g., tighter limits than GDP growth in any or all four of the major health care entitlement programs) or by accompanying these reforms with other savings proposals. The ten-year savings could also be scaled down through higher per capita cost growth benchmarks. In addition, we believe our system-wide reforms—administrative efficiencies, antitrust policy, updating regulations affecting medical practice, reforming medical liability, and giving states new incentives to adopt these and other system-wide reforms—should produce significant additional savings.

NEXT STEPS

Our proposals can and should be considered as part of any policy reform debate about health care. Whether or not a "grand bargain" on deficit reduction and entitlement reform comes together in the near term, the general principles behind our proposals are likely to remain relevant in the future. Therefore, we think the time to act on these proposals is now. Health care is moving in a more personalized direction, where integration of more diverse science, health care providers, treatments, and opportunities to prevent diseases and complications will be a theme in achieving better care for patients for many years to come. Our proposals will support this needed innovation in medical technology and its use to benefit individual patients on the one hand, while bending the curve of rising health care costs on the other. This is the best path to achieve improvements in health as well as affordable costs: it is time to put a sharp and direct focus on achieving both better health and cost savings. Enacting such legislation now will create more certainty and support for providers and plans to make needed investments in higher-value care for the future and will permit the maximum opportunities for health improvements and savings.

In the meantime, in the absence of legislation on federal health care entitlement reform, it is possible to use this framework to make progress. All of our proposals build on important trends and pilots already taking place throughout our health care system. For example, CMS could develop a consistent set of outcome-oriented performance measures and resource use measures, create better data systems for providers to access the claims data they need to improve care, and implement a clear, timely, and comprehensive strategy across programs. CMS can also do more to develop an infrastructure to support state waivers that enable meaningful shared savings for steps that achieve better care and lower costs in Medicaid. In addition, legislation in more specific areas of health care, such as Medicare physician payment reform, can and should reflect our framework. Any Medicare physician payment reform or other incremental steps in Medicare should include a

systematic path for supporting measurably better health care and lower costs. However, while helpful, these steps are no substitute for more comprehensive reform legislation.

We have also outlined many ways in which states can build on state reform progress. Private employers can also do more to support multi-payer financing reforms including contributing consistent data to more comprehensive and effective ways to measure quality and continuing to innovate in reforms in benefit design to promote higher-value care.

Along with other organizations, we expect to monitor and encourage progress toward these reform goals in the future. With so much at stake, both for our health and our nation's fiscal and economic outlook, reforming health care to improve value and to bend the curve needs to happen now.

TABLE 1: OPPORTUNITIES FOR IMPROVING CARE AND HEALTH—ILLUSTRATIONS FROM THE NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEATH CARE

National Quality Strategy Priority[1]	Measure	Current Rate
Making Care Safer by Reducing the Harm Caused in the Delivery of Care	**Incidence of measurable hospital-acquired conditions**	**145 Hospital Acquired Condition (HAC) per 1,000 admissions**
Ensuring that each person and family is engaged in their care	Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted	**14.1%**
	People with a usual source of care whose health care providers sometimes or never discuss decisions with them	**15.9%**
Promoting Effective Communication and Coordination of Care	All-payer 30-day readmission rate	**14.4%** based on 32.9 million admissions
Promoting the most effective prevention & treatment practices for the leading causes of mortality, starting with cardiovascular disease	People who have hypertension who have adequately controlled blood pressure	**46%**
	People with high cholesterol who have adequately managed hyperlipidemia	**33%**
	People trying to quit smoking who get help	**23%**
Working in Communities to Promote Best Practices for Healthy Living	Percentage of adults who reported symptoms of a major depressive episode (MDE) in the last 12 months who received treatment for depression in the last 12 months	**68.3%**
	Proportion of adults who are obese	**35.7%**
Making Quality of Care More Affordable by Developing and Spreading New Health Care Delivery Models	Percentage of people under 65 with out-of-pocket medical and premium expenses greater than 10% of income	**18.5%**
	Annual all payer health care spending per person	**$8,402**

[1] U.S. Department of Health and Human Services. *2012 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care*. Revised. Washington: Agency for Health Care Research and Quality, August 2012. http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf

TABLE 2: HEALTH SPENDING PROJECTIONS UNDER CURRENT LAW

		Projected Spending		Projected Annual Growth Rates	
		Total (in billions)	Per Capita	Per Capita	Per Capita
Program	**Policy Description**	**Real Spending**	**Real Spending**	**Real Spending**	**Cost Growth in Excess of GDP**
Medicare	Beginning in 2015, IPAB is required to make recommendations to reduce Medicare spending if per capita Medicare spending exceeds the specified target growth rate. From 2015 to 2017, the target growth rate is based on CPI. Beginning in 2018, the target growth rate is the increase in per capita GDP+1%.	**2014:** $585 **2023:** $854 **Total, 2014-2023:** $6,982	**2014:** $11,037 **2023:** $12,552	**2014-2018:** 0.01% **2019-2023:** 1.9% **2014-2023:** 1.0%	**2014-2018:** -2.2% **2019-2023:** 0.8% **2014-2023:** -0.7%
Medicaid	No spending growth target under current law.	**2014:** $287 **2023:** $453 **Total, 2013-2022:** $3,783	**2014:** $5,038 **2023:** $6,766	**2014-2023:** 3.4%	**2014-2023:** 1.6%
Employer-Provided Insurance Tax Subsidy	Open-ended tax exclusion under current law. In 2018, 40% excise tax on plans with premiums over $10,200 for individuals and $27,500 for families, indexed by CPI+1% in 2019 and CPI beginning in 2020.	**2012:** $280 **2017:** $330 **Total, 2012-2017:** $1,815	**2013-2022:** $2,328	**2014-2017:** 3.6%	**2014-2017:** 1.2%
Exchange Subsidies	After 2018, the required percentage of income paid toward premiums will be adjusted if the growth in premium and cost-sharing subsidies exceeds 0.504% of GDP.	**2014:** $27 **2023:** $134 **Total, 2014-2023:** $1,402	**2014:** $5,326 **2023:** $6,564	**2015-2023:** 2.4%	**2015-2023:** 0.9%

Note: Estimates based on analysis of Congressional Budget Office and Treasury data.

TABLE 3: SUMMARY OF PROPOSALS

Reforms in Medicare:

- Transition to "Medicare Comprehensive Care"
- Reform Medicare benefits to support more comprehensive beneficiary care and lower costs
- Reform Medicare Advantage to promote high value health plan competition

Reforms in Medicaid and Care for Vulnerable Populations:

- Create a standard program for person-focused Medicaid, enabling states to implement and track performance of Medicaid reforms that reduce per capita beneficiary cost growth while maintaining or improving quality of care, and enhance states' share of the savings of these reforms
- Align Medicaid reforms with other initiatives and financial support for health care for lower-income individuals to facilitate care continuity and improve efficiency
- Expand and make permanent the CMS Capitated Financial Alignment
- Demonstration for Medicare-Medicaid Enrollees with a strong and systematic ongoing evaluation and support capacity

Reforms in Private Health Insurance Markets and Coverage:

- Limit the exclusion of employer-provided health insurance benefits from income by imposing a cap that would grow at the same per capita rate as federal subsidies in Medicare and/or the Marketplaces
- Encourage and support employer leadership in driving innovative reforms in health care coverage and delivery
- Promote competition that lowers costs while providing access to valuable services that creates appropriate incentives for states
- Facilitate stable non-group and small-group health insurance markets in the absence of a strong mandate by minimizing the risk of adverse selection and shoring up the safety net
- Address outdated licensing barriers for more effective and efficient care

Reforms for System-Wide Efficiency:

- Simplify and standardize administrative requirements
- Improve cost and quality transparency
- Promote effective antitrust enforcement
- Encourage states to develop more efficient medical liability systems
- Enable states to implement system wide reforms

TABLE 4: COST SAVINGS FROM BENDING THE CURVE III PROPOSALS

Program	10-Year Savings (in billions)	Notes
Medicare		
Transition to Medicare Comprehensive Care with Per-Capita Growth of GDP+0	$0 (2014-2018) $120 billion (2019-2023)*	Over the next decade, Medicare spending growth is projected to average below GDP+0 per capita. To ensure that this growth rate is sustained throughout the decade while improving quality, the savings from our Medicare reform proposals (including physician payment reform and other reforms in traditional Medicare payments) would be directed back into Medicare to support the transition to Medicare Comprehensive Care. Limiting per capita spending growth to GDP+0 in MCC programs and in Medicare's traditional fee-for-service payment systems in the second half of the 10-year period (e.g., through IPAB or across-the-board reductions in payment updates) provides an additional estimated $120 billion in savings that would be used for this purpose, in addition to savings from the Medicare reforms listed below.
Medicare Benefit and Medigap Reforms	$60 billion*	Reform Medicare benefits with a limit on out-of-pocket payments, a single deductible, and more rational co-pays, as in MedPAC proposals. Eliminate "first dollar" Medigap coverage; Medigap plans will have actuarially-equivalent co-pays of at least 10%. MCC providers could offer lower co-pays and premiums to beneficiaries. These reforms would reduce average beneficiary out-of-pocket payments, provide better protection against high costs, and lead to additional beneficiary savings when beneficiaries use high-value providers.
Medicare Savings from Dual-Eligible Aligned Care Reforms	$20 billion*	Medicare savings associated with the Dual-Eligible Aligned Care Program.
High-Value Health Plan Competition in Medicare Advantage	$20 billion*	Limit MA plan subsidy growth to GDP+0 per capita. Plans should receive the entire difference between their bid and the benchmark if they return the difference to beneficiaries in the form of lower premiums and half of the difference if the difference is instead returned in the form of additional benefits.

* Savings are from the specific proposals and are directed to implementing MCC and other reforms that improve quality and sustain GDP+0 per capita spending growth over the coming decade. This includes reforming physician payment to replace the SGR with our proposed reforms.

Medicaid		
Person-Focused Medicaid Reforms, with Standard Process and Infrastructure for Medicaid Reforms that Reduce Per Beneficiary Cost Growth While Maintaining or Improving Quality of Care	$100 billion	Reforms expected to reduce federal spending growth over the next decade by an average of 0.75% of GDP per capita relative to current law. This would involve achieving greater total Medicaid savings compared to current law (e.g., 1.5% per capita slower growth) with a larger share of the overall savings passed on to the states.
Dual-Eligible Aligned Care Program	$20 billion	Expand the CMS Capitated Financial Alignment Demonstration to a permanent Dual-Eligible Aligned Care Initiative with supporting infrastructure and faster/clearer implementation pathway. A model for a payment structure that ensures savings would be specified and states would share in the savings.

TABLE 4: COST SAVINGS FROM BENDING THE CURVE III PROPOSALS

Program	10-Year Savings (in billions)	Notes
Insurance Markets		
Cap the Employer-Sponsored Insurance Tax Exclusion and Limit Growth to Spending Target	$120 billion	Phase in a cap on the tax exclusion somewhat below the level of the current excise tax (but significantly above marketplace subsidy caps), and constrain spending growth to GDP+0 per capita once a meaningful cap is established.
Encourage and Support Employer Leadership in Implementing Innovative Reforms in Health Care Coverage and Delivery, and Encourage Flexibility in Benefit Design		
Limit Marketplace Subsidy Growth to GDP+0 per capita Plus Further Reforms Affecting Benefit Design, Adverse Selection, and Other Insurance Market Issues	$50 billion	Limited impact because current law constrains subsidies if total marketplace subsidy spending exceeds 0.504% of GDP after 2018. Specific mechanisms will be specified once the marketplaces and product offerings are known.
System-wide Reforms		
Simplify and Standardize Administrative Requirements	$20-$50 billion	
Improve Cost and Quality Transparency		
Promote Effective Antitrust Enforcement		
Address outdated licensing barriers		
Encourage States to Develop More Efficient Medical Liability Systems	$20 billion	
Enable States to Implement System-wide Reforms	$20 billion	Opportunity for states to share in Federal savings from system-wide reforms provides incentives for states to implement these reforms.

APPENDIX

APPENDIX TABLE 1: PREVIOUS "BENDING THE CURVE" REPORTS AND PROGRESS TOWARD BTC GOALS

BTC I (2009)	BTC II (2010)	BTC III (2013)
Building Necessary Foundation for Cost-Containment and Value-Based Care		
• Ensure investments in health IT are effective (link "meaningful use" bonuses to better results, create interoperability and provider communication standards, fund technical support program) **(Beacon Communities through the HHS Office of the National Coordinator for Health IT. CMS Medicare and Medicaid EHR Incentive Programs to measure meaningful use- must meet 20 of 25 meaningful use objectives)** • Make best use of Comparative Effectiveness Research (create entity to allocate CER funding, emphasize areas of medical uncertainty, protect providers and insurers from liability) **(AHRQ's Effective Health Care Program funds research efforts to produce effectiveness and comparative effectiveness research. ARRA created the Federal Coordinating Council for Comparative Effectiveness)** • Improve Health Care Workforce (amend state scope of practice laws, align Medicare payments to support allied health professionals, reform graduate medical education payments to promote teaching of high-value care practices) **(NCSL reports that as of October 2012, 349 bills have been adopted or enacted into law in various state legislatures related to changing scopes of practice. ONC Workforce Development Program to train workforce of skilled health IT professionals. The Graduate Medical Education Reform Act was introduced in May 2012 and would link graduate medical education funding to performance goals)**	• Build comparable data collection, aggregation, analytics, and reporting capabilities to more rapidly develop consistent evidence of the impact of reforms on cost and quality (build timely and consistent data feeds, adopt standardized performance measure) **(some common performance measures through ACO programs and other demos)**	• Accelerate comparable data collection, aggregation, analytics, and reporting capabilities and the use of consistent outcomes-based performance measures • Simplify administrative requirements (implementation of an updated standardized claim form, support for state investments to update Medicaid information systems, standards for quality reporting and timely data sharing) • Address outdated licensing barriers for more effective and efficient care • Encourage states to develop more efficient medical liability systems • Improve cost and quality transparency • Promote effective antitrust enforcement • Enable states to implement system-wide reforms

Key: Blue text indicates progress since the publication of BTC I and BTC II.

APPENDIX TABLE 1: PREVIOUS "BENDING THE CURVE" REPORTS AND PROGRESS TOWARD BTC GOALS

BTC I (2009)	BTC II (2010)	BTC III (2013)
Reforming Provider Payment Systems to Create Accountability for Lower-Cost, High Quality Cost		
• Adjust Medicare & Medicaid FFS (broaden bundled payments, expand the use of P4P, increase payment rates for primary care, provider additional payments during transition to PCMH, ensure Medicare payments support use of allied health professionals, reduce payments for care of low value relative to cost, increase spending on programs to reduce waste, fraud, and abuse, enable Medicare Prescription Drug Plans to share in overall savings, establish regulatory pathway for follow-on biologics) **(ACA established CMMI to test new payment approaches. Nursing Home VBP Demo, Hospital VBP Program, Medicare Home Health P4P Demo, the Biologics Price Competition and Innovation Act, part of the ACA, created an FDA approval pathway for "biosimilars")** • Build new payment systems for provider accountability (pilot ACOs, pilot "enhanced episode-based payment" systems and other promising payment systems, incorporate other bonuses into transition to accountable payment systems) **(CMS currently funds 153 ACOs through the PGP Transition Demo, Pioneer, and MSSP programs)** • Apply pressure to "Non-Accountable" Medicare payments (establish "virtual ACO" incentives, freeze market based payment updates for two years) • Improve payment/Coverage Flexibility and Rapid Learning to Achieve Lower Costs and Better Quality (expand and streamline CMS's piloting authority and resources, support public-private regional collaborative, empower an entity to improve the value and ensure the long-term sustainability of Medicare and Medicaid, reform medical liability, reform anti-trust laws and create processes for expedited waivers from anti-gainsharing and Stark laws)	• Speed payment reforms away from traditional volume based payment systems to align with quality and efficiency (design Medicare payment reform pilots—ACOs, bundled payments, coordinate CMMI and other pilot initiatives to promote collaboration between private and state payers as well as across federal initiatives) **(Implementation of Medicare Shared Savings Program and ACO Pioneer Pilot and a range of other CMMI payment reform pilots. Pioneer and Advanced Primary Care Medical Home pilots reinforce outcomes-based contracts with private payers)** • Strengthen & clarify authority of the Independent Payment Advisory Board (IPAB) **(effectiveness remains TBD)**	• Transition Medicare FFS to Medicare Comprehensive Care (aligned value-based payment systems for Medicare ACOs, medical home, episode-based treatments; globally capitated, comprehensive payment) • Increase states' ability to share in savings from Medicaid reforms • Medicaid reforms should be aligned with other options and financial support for lower-income individuals, to facilitate care continuity and improve efficiency • Expand and make permanent the CMS Capitated Financial Alignment Demonstration for Medicare-Medicaid Enrollees with a stronger and systematic ongoing evaluation capacity

Key: Blue text indicates progress since the publication of BTC I and BTC II.

APPENDIX TABLE 1: PREVIOUS "BENDING THE CURVE" REPORTS AND PROGRESS TOWARD BTC GOALS

BTC I (2009)	BTC II (2010)	BTC III (2013)
Improving Health Insurance Markets		
• Restructure non-group and small-group markets around exchange model that promotes competition on cost reduction and quality improvement (focus insurer competition on cost and quality, establish health insurance exchanges) **(ACA provision for establishing state or federal based exchanges)** • Reduce inefficient subsidies for employer-provided health insurance (cap existing income tax exclusion and adjust cap based on plan demographics and location) **(ACA provision to tax high cost plans starting in 2018)** • Promote competitive bidding in Medicare Advantage (set local benchmarks, establish significant quality bonus, consider transition to include Medicare FFS)	• Implement health insurance exchanges and other insurance reforms that rewards consumers with substantial savings when they choose plans that offer higher quality care at lower premiums • Set clear process for promoting vigorous competition among plans in the exchange **(preliminary regulations related to exchange, but much remain TBD)** • Develop viable alternatives to avoid adverse selection • Provide comparative monitoring and evaluation of insurance exchanges across states based on performance related to minimum functions required under ACA • Provide clarifications or loosen restrictions around ACA reforms which may impede health plans from adopting value-based designs **(Further VBID adoption among employers, private plans)** • Maintain, at minimum, current provision on taxing high-premium insurance plans (enact legislation to implement tax earlier—phasing in 2014 instead of 2018) **(ACA provision to tax high cost plans starting in 2018)**	• Reform Medicare Advantage for high value health plan competition in Medicare • Encourage flexibility in benefit design to promote competition that lowers costs while providing access to valuable services • Facilitate effective health insurance markets in the absence of a strong mandate with a particular emphasis on minimizing the risk of adverse selection and shoring up the health care safety net • Limit the exclusion of employer-provided health insurance benefits from income by imposing a cap on the exclusion. After a meaningful cap is established, it would grow at the same per capita rate as federal subsidies in Medicare and/or the exchange
Supporting Better Individual Choices		
• Reform Medicare benefit design to promote value & beneficiary savings (restructure Medicare Part A & B, establish tiered co-pays, reform Medicare supplemental plans, enhance and publicize provider quality & cost information, increase flexibility to alter benefits, assure that these steps lower beneficiary spending on health care) • Promote prevention and wellness to reduce costs (target obesity reduction, allow premium rebates for measureable health and risk factor improvements, establish public health outcome-based accountability) **(some adoption by employers, private plans)** • Support patient preferences for palliative care (provide opportunity for Medicare beneficiaries to file & update advanced directives, create liability safe harbor for providers)	• Reform coverage so that most Americans can save $ and obtain other meaningful benefits when they make decisions that improve health and reduce costs • Reform Medicare FFS benefit design and implement a competitive plan choice that is consistent with recommendations on plan choice to promote beneficiary savings from choosing higher-value care • Develop & expand demand-side wellness incentives including premium rebate to encourage all beneficiaries to undertake measurable health & risk-factor improvements	• Reform Medicare benefits to support more comprehensive care and lower costs • Recommend an out of pocket (OOP) maximum for Medicare beneficiaries accompanied by better mechanisms for incoming Medicare beneficiaries about their OOP costs (not counting Medigap) for different options for receiving care

Key: Blue text indicates progress since the publication of BTC I and BTC II.

APPENDIX TABLE 2: ILLUSTRATION OF PERFORMANCE MEASUREMENT PROGRESSION

Performance Measure Categories	Examples in Widespread Use	Examples in Limited Use*	Examples—in Development—Feasible through Supporting Outcome-Based Reforms
Preventative Health			
Colorectal Cancer Prevention	Colorectal Cancer Screening (Claims)	Quality of colonoscopy	
Cardiac Disease Prevention	BMI-Screening and Follow-Up (Clinically-Enriched)	10-Year Cardiac Disease Risk Factor Screening (Clinically-Enriched)	Use of Personalized Risk Score and Improvements in Risk Score (Clinically-Enriched plus Patient-Reported data)
Chronic Disease Care			
Diabetes Care	Preventable Hospitalization Rates (Claims); Hemoglobin A1c Control, LDL Control, Blood Pressure Control (Clinically-Enriched)	Major Clinical Complication Rates (Clinically-Enriched)	More comprehensive outcome measures including functional status
Ischemic Vascular Disease Care	Preventable Hospitalization Rates (Claims); LDL Control (Clinically-Enriched)	Functional Capability (Patient-Reported)	Coordination of Care between Primary Care, Cardiology, and Surgeons; Patient Experience with Treatment Process; More Comprehensive Functional Outcome Measures
Heart Failure Care	Preventable Hospitalization Rates; LDL Control (Clinically-Enriched)	Functional Capability (Patient-Reported)	Coordination of Care between Primary Care, Cardiology, and Surgeons; Patient Experience with Treatment Process; More Comprehensive Functional Outcome Measures
Cancer Care	Pain Intensity Quantified; Plan of Care for Pain; Radiation Dose Limits to Normal Tissues; Cancer Stage Documented	Patient Functional Status (e.g., pain, nutrition status) (Clinically-Enriched plus Patient-Reported data)	Measures of Cancer Progression using Biomarkers (Clinically-Enriched); Enhanced Patient Functional Status Measures (Patient-Reported)
Major Procedures and Treatments			
Joint Replacement for Osteoarthritis of Hip or Knee	Utilization Rate (Claims)	Post-Operation Complication Rates (Clinically-Enriched); Functional Status After Surgery (Patient-Reported)	Patient Experience with Operative Procedure (Patient-Reported)
Complex and Major Illnesses	Preventable Admissions and Readmissions (claims); Pressure Ulcers and Other Clinical Complications (Clinically-Enriched)	Patient/Caregiver Surveys of Care Preferences, Whether Preferences are being met by Care Teams (Patient-Reported)	Patient Functional Status and Quality of Life (Patient- and Caregiver-Reported)
Care Coordination and Safety	All-cause Readmission, Inpatient Admission Rate, ED visit rate (Claims); Screening for Falls Risk (Clinically-Enriched)	Condition-specific Readmission and Preventable Admission Measures by Condition (e.g., Ischemic Vascular Disease, Cancer) (Clinically-enriched); Patient Experience of Gaps/Questions in Care (Patient-Reported)	Enhanced Patient Experience Measures (Patient-Reported)
Patient and Caregiver Experience with Care Systems	Availability of Information about Plan, Overall and Categorical Ratings of Plan (Patient-Reported); Timely Care, Appointments and Information from Providers (Patient-Reported)	Overall and Categorical Ratings of Health Care Providers and Provider Networks like ACOs (Patient-Reported from surveys)	Enhanced ratings of more aspects of Health Care Providers and Provider Networks (Routine Patient-Reported data)
Resource Use	General Measures of List Prices (private) and Regulated Prices (Medicare) for Specific Procedures and Services (Claims or Price Reports)	Out-of-Pocket and Total Payments for Types of Services and Clinical Problems (Claims plus Clinically-Enriched data)	Personalized Out-of-Pocket and Total Payments made available to Individual Patients (Claims plus Clinically-Enriched data); Total Cost/Resource Use Measures for Conditions and Procedures (Claims plus Clinically-Enriched data)

* Used in pilot programs, regional initiatives, and/or some private plan and employer reforms

GLOSSARY

Accountable Care Organization (ACO) is a health organization in which provider payment is tied to quality metrics and reduction in overall cost of an assigned population. The ACO model seeks to improve beneficiary outcomes and promote value while slowing the growth in overall costs for a population of patients. It brings together coordinated networks of providers with shared responsibility to provide high quality care to their patients.

Adverse Selection occurs when sick individuals purchase health insurance in greater proportions than healthy individuals, thus raising the cost of health insurance premiums for everyone in a risk pool.

Affordable Care Act (ACA) is the health care law passed in 2010 that sought to significantly reduce the number of uninsured and underinsured by providing access to affordable health care coverage through Medicaid and health insurance marketplaces. The ACA also implemented reforms for providers, payers, and hospitals to increase the quality of care provided to patients and reduce the cost of health care over the long-term. In National Federation of Independent Business *(NFIB) v. Sebelius*, the Supreme Court determined that the Medicaid expansion would become a state choice rather than being required by the federal government.

Anti-kickback Statute prohibits providers from accepting or soliciting an item of value for the purpose of inducing or rewarding another party for referral of services paid for by a federal health care program. The statute was established in 1972 to protect patients and federal health care programs from fraud and abuse.

Antitrust Laws are designed to regulate corporations and encourage competition so that corporations do not become too large and set prices in the marketplace.

Bundled payment is a payment system in which multiple providers receive a single shared payment for a set of services, typically an episode of care (for example, a surgical procedure or the management of a chronic condition or conditions).

Center for Medicare and Medicaid Innovation (CMMI) is a branch of the Centers for Medicare and Medicaid Services that focuses on testing payment and delivery system models that provide promise for maintaining and improving the quality of care in all of the CMS programs (e.g., Medicare, Medicaid, CHIP).

Centers for Medicare and Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works with states to administer Medicaid and the Children's Health Insurance Program (CHIP).

Capitated Payment pays a physician or group of physicians a set amount for each enrolled person assigned to them, rather than paying physicians for a service provided. Physicians are expected to assume a certain level of risk under a capitated payment system.

Children's Health Insurance Program (CHIP) is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid because their family incomes are too high. States are given flexibility in designing the administration of their CHIP programs—either through Medicaid, a separate program, or a combination of both. The federal government provides matching CHIP funding to states but federal CHIP funds are capped.

Coordinated Care Organizations (CCO) is a network of all health care providers who work together to provide services to individuals receiving health care coverage as described in the Oregon Medicaid plan and related state reform initiatives. CCOs coordinates the different types of services that patients would typically receive, such as physical, behavioral, and sometimes dental, and places the focus of the system on patient-centered care.

Congressional Budget Office (CBO) produces independent analyses of budget and economic issues related to the budget process, as well as cost estimates for Congressional legislation.

Consumer Price Index (CPI) is a measure of the price level of all goods and services paid for by households. It is widely used as a measure of inflation in the economy.

Dual Eligible Aligned Care is a CMS project that seeks to better align care for dual-eligible beneficiaries of Medicare and Medicaid through state demonstrations. CMS has proposed that states use either a fee-for-service model or a capitated model, and the state programs will be assessed on whether they improved quality and reduced costs.

Dual Eligible Beneficiaries are low-income Medicare beneficiaries who also qualify for Medicaid. Medicare typically pays for some aspects of their care, while Medicaid covers many services such as long-term care that are not covered by Medicare. Dual eligible beneficiaries typically have significant medical needs and a higher per capita cost compared to other beneficiaries.

Employment Retirement Income Security Act is a federal law that sets minimum standards for most voluntarily established pension and health plans in order to protect beneficiaries from the loss of benefits that are provided through a workplace.

Episode-Based Payment is a single payment for the services in an episode of care. The episode payment may be "bundled" for multiple providers, as described above (see Bundled Payment).

Exchange Subsidies Under the ACA, households that are below 400 percent but above 133 percent of the federal poverty line who have purchased health insurance in the exchanges are eligible to receive federal subsidies. The subsidies cover the premium amount above what these households are limited by the ACA to contribute to their health insurance premiums.

Excise Tax on High Premium Insurance Plans, also known as the Cadillac tax, is a 40 percent excise tax that will be applied to the value of health insurance benefits exceeding a certain threshold ($10,200 for individual coverage and $27,500 for family coverage). The excise tax takes effect in 2018 and is designed to discourage individuals and families from buying unusually high-cost insurance plans.

Federally Qualified Health Centers (FQHCs) are safety net health care providers that provide services regardless of the ability to pay and that are primarily funded by the federal government. FQHCs, such as community health centers and public housing centers, primarily provide primary care services in urban and rural communities.

Fee-For-Service (FFS) is a payment model where services are unbundled and paid for independently, thus making payments dependent on the quantity of care rather than the quality. FFS has been the traditional health care payment model for both federal health programs and private health insurance plans.

Gag clause is a provision in a contract between a health care provider or manufacturer and a health care payer (like a health plan) that prohibits disclosure of negotiated price information.

Health Insurance Marketplace (Exchange) provides a structured marketplace in which individuals would be able to purchase insurance from their choice of participating issuers. As part of the ACA, states can either be a state-based exchange, state partnership exchange, or federally-facilitated exchange. The responsibilities of both state and federal government differ in each scenario.

Independent Payment Advisory Board (IPAB) is a government agency established by the ACA that is tasked with achieving specified savings in Medicare without affecting coverage or quality. Beginning in 2015, IPAB is required to make recommendations to reduce Medicare spending if per capita Medicare spending exceeds the specified target growth rate as set by CMS. From 2015 to 2017, the target growth rate is based on CPI. Beginning in 2018, the target growth rate is the increase in GDP per capita plus one percentage point.

Medicaid is a joint federal-state program that provides health and long-term care coverage to low-income Americans. Each state designs its own Medicaid program within federal guidelines. States generally operate their major Medicaid coverage programs according to "Section 1115 waivers" (see below).

Medicaid Managed Care Plan is a managed care plan that provides coverage for Medicaid beneficiaries.

Medicare is a federal program that provides health insurance coverage to Americans over the age of 65 and younger individuals with permanent disabilities.

Medicare Advantage (MA) is a federal program through which private health insurance plans provide Medicare benefits to beneficiaries (Part C of Medicare).

Medicare Comprehensive Care (MCC) is a new program proposed by this "Patient-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth" report that consists of Medicare payments that are aligned with care improvements and lower costs. Providers in MCC organizations opt to receive a globally capitated, comprehensive payment for their defined population of patients and must meet a set of quality and outcome performance measures for full payment. Providers who are participating in accountable care organizations today or in the future could move into this program. Providers in MCC can also opt to receive case- or episode-based payments that also require achieving quality standards to receive full payment.

Medicare Part D is a federal program that provides subsidized prescription drug coverage for Medicare beneficiaries through competing private plans. The program was enacted as part of the Medicare Modernization Act of 2003 and went into effect in January 2006.

Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency that advises Congress on issues regarding the Medicare program, such as payment to health plans and providers, and access to and quality of care for Medicare beneficiaries.

Medicare Shared Savings Program (MSSP) is intended to facilitate coordination among health care providers in order to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce avoidable costs. Providers interested in participating in the MSSP may do so by creating or participating in an Accountable Care Organization (ACO). This Shared Savings Program aims to promote accountability for beneficiary care, coordinate care for all services provided, and encourage investment in health care infrastructure.

Medicare Star Rating is a system for Medicare Advantage plans is administered by CMS and was implemented to rate MA plans according to the quality of their care on five domains (on a scale of 1 to 5) and to make quality data more transparent. Under the ACA, CMS will provide bonus payments to plans that have received a star rating of 4 or above. CMS is looking to expand the bonus payments to plans that have received a rating of 3 or 3.5 stars.

Medigap refers to supplemental private insurance plans that pays for some of the health care costs that traditional Medicare coverage does not cover, including Part B services and the Part A hospital deductible.

Pioneer Accountable Care Organizations is a CMMI initiative designed to support organizations with experience operating as ACOs or in similar arrangements to provide coordinated care to beneficiaries at a lower cost to Medicare. The Pioneer ACO Model tests the impact of different payment arrangements over a three year period. These models involve Pioneer ACO providers transitioning to the majority of their payment based on quality and efficiency (not quantity of services) within three years.

Premium Support is a health care program where beneficiaries are guaranteed a set federal payment to help cover their health care costs.

Primary Care Medical Home (PCMH) is a health care delivery model where patient treatment is coordinated through their primary care provider. The primary care provider typically receives a case-based payment for these services and must meet quality and other performance standards.

Safe Harbor Guidelines allows for certain types of transactions that are not considered criminal under anti-kickback laws.

Scope of Practice Laws are state laws that define the clinical services that nurses, pharmacists, and other non-physician health professionals can provide.

Section 1115 Medicaid Waivers provide states with funding to test new approaches to Medicaid that differ from statutory coverage requirements, but are expected to provide equivalent or better coverage at no higher cost. States generally operate Medicaid programs under Section 1115 waivers today, which they negotiate with the federal government to enact payment and delivery reforms such as managed-care programs, special benefits, and financing for populations with special needs. Section 1115 waivers are required to be budget neutral for the federal government, compared to the usual Medicaid statutory requirements.

Stark Law limits certain physician referrals for Medicare services if the physician has a financial relationship with the entity receiving Medicare payments and prohibits the entity from presenting claims for those referred services.

Sustainable Growth Rate (SGR) is the formula currently used by CMS to control Medicare spending on physician services. CMS sets a target SGR each year and develops a conversion factor that is used if expenditures exceed the target SGR. While physician payments have regularly exceeded the target SGR, Congress has stepped in and adjusted or suspended the SGR to prevent a cut in physician payments.

Tax Exclusion for Employer Provided Health Insurance excludes employer-provided health insurance benefits from taxable income and is considered a tax expenditure because it costs the federal government approximately $250 billion in lost revenue each year.

Value-Based Purchasing features additional payments to providers when they perform well on measures of value, such as improved preventative screenings or chronic disease management, and greater efficiency in care. By tying the financial incentives with quality measures, providers are expected to improve quality and achieve better health outcomes.

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