Comparing Health Care Cost Containment Proposals Matrix
By Katie Horton, J.D., M.P.H., R.N., Mary-Beth Malcarney, J.D., M.P.H., and Naomi Seiler J.D., George Washington University Department of Health Policy

APPENDIX A: Subcategory-by-Subcategory Analysis

The following analysis provides further detail on the six major categories featured in the matrix: (1) Payment Improvements & Realigned Incentives; (2) Implementing & Enhancing Delivery System Reforms; (3) Improving Quality & Engaging Patients; (4) Promoting Market Competition; (5) Other System Reforms; and (6) Revenue, Spending Targets & Other Reforms. Within each of these larger categories, we devised, with The Commonwealth Fund’s input, multiple subcategories. In the analysis presented here, we provide a separate examination of areas of consensus within each subcategory.

It should be noted that, in many instances, one type of recommendation might be grouped in three or more subcategories, leading to some repetition across our analysis. Where appropriate, we have referred the reader to specific analysis in another subcategory rather than repeating the same analysis.

We also note that “areas of consensus” as highlighted here indicate that several of the organizations have asserted the need for action on a specific issue, but not necessarily that they have proposed identical approaches. For example, under subcategory 3.3, several proposals supported standardizing quality measures, but each had a somewhat different idea for how this should be done. Some preferred using the National Quality Forum framework, others supported quality measures used for the Federal Employees Health Benefits (FEHB) Program, and still others recommended that health plans participating in health insurance exchanges develop a common, standard set of quality measures. We determined that where there was consensus on the notion that something ought to be done and where the various proposals seemed to point in similar directions there was potential for agreement on the specific policies that was worth noting, even where the specifics might differ.

While we have attempted to include and discuss as many specific recommendations as possible from these proposals, we have not described every recommendation from every proposal. Often, one proposal will contain policy options that are not examined by any of the other six proposals. In such cases, we may have left these recommendations out of the analysis because they were not ultimately helpful in evaluating areas of consensus.

In addition, we have included only the recommendations that were explicitly described in the reference documents listed above. Several of the organizations on the list may have taken positions (or offered more detailed recommendations) on some of these issues in separate documents. Those positions are not described here, but they may indicate even more consensus than we describe based on this analysis.

SECTION 1: PAYMENT IMPROVEMENTS & REALIGNED INCENTIVES
All seven proposals include a number of reforms that would improve and refine payments, as well as realign incentives for providers and consumers to promote the use of effective health services, improve quality of care, and discourage the use of marginally effective or inappropriate services.

1.1 Repeal or Reform the Sustainable Growth Rate Formula [Medicare]
Each of the seven proposals strongly recommends moving away from the current sustainable growth rate (SGR) formula to determine Medicare physician payment. Six of them call for complete repeal, while the Partnership for Sustainable Health Care (PSHC) calls for “transitioning away” from the SGR toward a value-based system of health care delivery and provider payment.
Some proposals would replace the SGR with a system that rewards physicians who participate in a new type of delivery system. For example:

- The Bipartisan Policy Center (BPC) proposes repealing the SGR starting in 2017, providing full payment updates and other incentives to providers who participate in Medicare Networks, an improved, enrollment-based version of an accountable care organization (ACO). Under this approach, physicians would receive updates based on the Medicare Economic Index.
- The Brookings Institution (BI) proposes eliminating the SGR and transitioning from a fee-for-service–based system to Medicare Comprehensive Care (MCC), a new delivery system model. The MCC model would include various collaborations of providers. Organizations could include integrated systems or networks of providers working together. Each system would receive a globally capitated, comprehensive payment for their attributed beneficiaries.
- The Commonwealth Fund (CMWF) proposes repealing the SGR starting in 2014 and holding fees constant at their current levels except for providers who participate in payment or delivery system innovations that help make providers accountable for the populations they serve.

All of the proposals envision a new system of payment that would promote value and care coordination and improve quality by providing incentives to improve health outcomes.

1.2 Refine Medicare Payment Rates [Medicare]

Each of the proposals outlines a number of ways to refine Medicare payment rates. Specific elements of the proposals fall into five categories: delivery system reforms; reducing or equalizing payments between settings; providing beneficiary incentives; increasing competition; and other payment reforms including providing incentives for quality.

Delivery System Reforms: Most proposals encourage a wide variety of delivery system reforms such as ACOs, medical homes, bundled payment initiatives, and others. For example:

- BPC includes proposals to develop its Medicare Network concept (see above) and to expand the voluntary payment bundling demonstration.
- The National Coalition on Health Care (NCHC) suggests applying new payment incentives for providers participating in approved models of care such as medical homes and ACOs.
- NCHC would also expand the bundled payment demonstration nationally or implement a Centers of Excellence program for selected surgical procedures.
- NCHC proposes to expand payment penalties for avoidable health care–acquired infections or readmissions.
- The Center for American Progress (CAP) would also expand the bundle of inpatient hospital services, create bundled payments for at least two chronic conditions, and reduce Medicare payments to skilled nursing facilities (SNFs) with high rates of readmission.

Equalizing Payments: Several proposals include elements that would reduce or equalize payments across settings. For example:

- BPC would equalize payment rates for evaluation and management services to the rate in the lowest cost setting.
- NCHC would equalize payment rates between certain services delivered in the outpatient and physician office settings and also would compensate physician evaluation and management services delivered in hospital outpatient departments at the same rate whether those services are delivered in hospitals, physician offices, or other outpatient settings.
- CAP recommends reducing excessive Medicare payments to hospitals for graduate medical education by limiting payments to teaching hospitals to a percentage of the national average cost per resident and would also equalize Medicare payments for the same service regardless of whether it is delivered in a physician office setting or a hospital.
Beneficiary Incentives and Cost-Sharing: Several proposals offer policy changes to influence beneficiary behavior. For example:

- To lower costs for Medicare beneficiaries and encourage more appropriate utilization of care, BPC suggests that beginning in 2016 all supplemental coverage from Medigap plans and employer-provided plans (including TRICARE for Life and the FEHB Program) be required to: (1) include a deductible of at least $250; (2) include a beneficiary out-of-pocket maximum no lower than $2,500; and (3) cover no more than half of beneficiary copayments and coinsurance.
- CMWF proposes a Medicare Essential option that incorporates positive incentives for beneficiaries who choose high-value delivery systems.
- NCHC recommends implementing the Medicare Payment Advisory Commission’s (MedPAC’s) recommendation to empower the Secretary of Health and Human Services (HHS) to vary cost-sharing based on evidence of a particular treatment’s effectiveness and would lift curbs on tiered cost-sharing in Medicare Advantage (MA).
- CAP includes a number of proposals in this area and would promote shared decision-making for high-cost conditions; limit cost-sharing based on the federal poverty line; and vary cost-sharing based on evidence of clinical effectiveness and use of providers that deliver high-quality and efficient care. CAP would also increase premiums for high-income beneficiaries.

Competitive Bidding: Several proposals include expanded use of competitive bidding. For example:

- BPC would continue the implementation of the durable medical equipment (DME) competitive-bidding program for all urban markets nationwide, but for some equipment types, benchmarks would be set lower.
- NCHC would also expand competitive bidding to additional categories of DME in Medicare except for highly customized and service-oriented devices such as custom orthotics, prosthetic limbs, and others that do not lend themselves to this model.
- CAP would use competitive bidding for all health care products by: (1) expanding competitive bidding by 2014 for DME, prosthetics, orthotics, and supplies nationwide; (2) extending competitive bidding by 2015 to medical devices, lab tests, advanced imaging services, and all other health care products; and (3) extending competitively bid prices to Medicaid and all other government health programs. CAP would also use competitive bidding for MA by basing the benchmark for private plans on their average bid by 2014.

Improving Quality: Each of the seven proposals includes elements that would provide incentives for improved quality. For example:

- BI’s new MCC program would require providers to sustain or improve performance on a standard set of outcome-oriented care quality and performance measures for full payment.
- Similarly, NCHC would eliminate SGR and move toward a pay-for-value system. In addition, NCHC would pilot reference pricing in Medicare for a limited number of treatments and diagnostic tests by identifying a provider that delivers a particular procedure at an affordable price and high level of quality. Payment would be set for that service at that price and enrollees would pay the difference if they choose a higher-priced provider.
- CAP would implement value-based purchasing for ambulatory surgical centers and require public reporting of related data.

1.3 Strengthen and Expand Value-Based Purchasing and Elements of Value-Based Insurance Design [Medicare, Medicaid, Private Payers]

Most of the proposals detail a variety of value-based purchasing (VBP) and value-based insurance design (VBID) initiatives that could be incorporated into Medicare, Medicaid, or the private sector. While the majority of proposal elements apply to Medicare, initiatives were also suggested in Medicaid and the private sector.
Value-Based Purchasing: While there are different ways to define VBP, at its broadest the term basically refers to any purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost. Many of these proposals suggest payment methods that reward quality of care through payment incentives and would require transparency to hold providers accountable for the quality and cost of the health care services they provide. The elements of these proposals largely fall into the following categories: (1) measuring and reporting comparative performance; (2) paying providers differentially based on performance; and (3) designing incentives to encourage individuals to select high-value services and providers and to better manage their own health and health care. Examples include:

- PSHC recommends developing robust quality metrics that are designed to gauge progress in achieving the goal of VBP models. The proposal would align quality metrics across private and public payers, update metrics on a regular basis, and retire metrics when they are no longer useful or have been universally achieved.
- PSHC would use comparative evidence to set payment rates at the time of coverage. The proposal would apply a VBP model for new services covered under Medicare so that higher payment is awarded only upon evidence of superior effectiveness. Under this new Medicare pricing system, first-time prices for new treatments would be set in conjunction with a determination of their effectiveness compared to services currently covered by Medicare.
- PSHC would simplify the measurement framework where all payers use a consistent set of measures to collect the information that is required to support value-based payment and decision-making.
- NCHC would expand Medicare payment penalties for high rates of potentially avoidable health care–acquired complications and readmissions.
- CAP would improve the FEHB Program by aligning it with Medicare’s payment reforms, metrics, and VBP.
- CAP also recommends implementing VBP for ambulatory surgical centers. Medicare should publicly report data from the Quality Reporting Program and require surgical centers to submit cost data. By 2016, Medicare should adjust payments to surgical centers based on their performance on measures of the quality of care, rewarding centers that exceed quality benchmarks or improve care and penalizing centers that have high rates of hospital transfers or admissions.

Value-Based Insurance Design: Several proposals also include elements of VBID that provide financial incentives and disincentives directed at health plan enrollees. These proposals attempt to align insurance incentives (copays, deductibles, etc.) with the goal of positively influencing consumer health behavior (adhering to wellness and prevention guidelines, following guidelines for managing chronic conditions, etc.). For example:

- NCHC would pilot reference pricing in Medicare for a limited number of treatments and diagnostic tests by identifying a provider that delivers a particular procedure at an affordable price and high level of quality. Payment would be set for that service at that price. Enrollees would pay the difference if they choose a higher-priced provider.
- PSHC would allow MA plans to use tools such as VBID incentives to induce beneficiaries to choose high-performing networks or vary their cost-sharing based on the clinical effectiveness and value of services.
- PSHC would strongly encourage the plans in the new state health insurance marketplaces (also known as exchanges) to offer a VBID option by 2019. These plans would vary cost-sharing for services based on value and for providers based on performance and quality data.
- NCHC would implement MedPAC’s recommendation to empower the Secretary of HHS to vary cost-sharing based on evidence of a particular treatment’s effectiveness. The proposal would lift curbs on tiered cost-sharing in MA.

In addition, a number of proposals incorporate plan incentives to encourage enrollees to: adopt appropriate use of high-value services, including certain prescription drugs and preventive services; adopt healthy
lifestyles, such as smoking cessation or increased physical activity; or use high-performance providers who adhere to evidence-based treatment guidelines.

1.4 Expand Bundled Payment Approaches and Other Alternatives to Fee-for-Service Payment [Medicare, Medicaid, Private Payers]

There was very strong consensus among the seven organizations that physician payment must transition from FFS to an alternative payment model. All of the organizations noted that controlling rising expenditures for health care would not occur without changing the way that physicians are paid. All agreed that the SGR formula should eventually be eliminated. (See subcategory 1.1, which describes SGR proposals in greater detail.)

Payment Approaches Based on Quality: In addition, most organizations’ proposals encourage payers to largely eliminate stand-alone FFS payment to all providers because of its inefficiencies and problematic financial incentives. All agree that payment approaches (e.g., episodic bundled payments) based on quality and value should be implemented. Examples include:

- BI would eliminate SGR and transition from an FFS-based system to MCC. Collaborations of providers (organizations could include integrated systems or networks of providers working together) would receive a globally capitated, comprehensive payment for their attributed beneficiaries and would be required to sustain or improve performance on a standard set of outcome-oriented care quality and performance measures for full payment. Providers could also choose to receive case and/or bundled payments and could participate in multiple shared savings initiatives (medical home, episode-based, ACO, etc.).

- CMWF would repeal and replace the SGR with a Medicare physician payment policy that provides incentives to improve health outcomes and would require participation in care system innovation. The CMWF would restructure the Medicare fee schedule to reduce payment rates for services meeting specified criteria as overpriced and would institute a system for future increases tied to performance. It would provide future increases in fees only for providers participating in innovative payment or delivery systems, such as patient-centered medical homes, bundled payments, and ACOs.

Episodic Bundled Payments: In addition to reforming physician payment away from FFS, all of the organizations propose some sort of episodic bundled payment for hospital, post-acute care, and other services. Several organizations note that establishing a single fee for care that involves multiple providers and provider types (often across care settings) could help address quality and efficiency problems that are rewarded by current FFS payment, which increases payment by increasing volumes of services. Pricing mechanisms that bundle and fix the price of the components of a complex episode of care could also help provide consumers with transparent price and quality information on which to make decisions. Examples include:

- BPC would expand the voluntary payment bundling demonstration into a standard Medicare payment method. Bundles—including inpatient, physician, and post-acute care, and any readmissions within 90 days—would be established nationwide no later than 2018 for certain diagnosis-related groups (DRGs).

- CMWF would accelerate bundled payment approaches for hospital and post-acute care under Medicare, Medicaid, other public programs (including the FEHB Program), and private plans participating in insurance exchanges. These bundled payments would support movement toward high performance and provide incentives for hospitals to make transitions and follow-up care a priority.

- PSHC would broadly implement Medicare pilots that use bundled payments for acute hospitalization and post-hospitalization services, including bundled payments for post-acute care, follow-up physician services, and readmissions within a defined period after discharge (for example, 30/60/90 days). PSHC would further expand these bundles through collaboration and alignment with the private sector.
• NCHC would encourage episodic bundled payments either by expanding the Acute Care Episode (ACE) Demonstration program nationally or by implementing a Centers of Excellence for Selected Surgical Procedures program in Medicare.

Finally, a number of additional delivery system reforms were categorized here. These reforms and the similarities among proposals have been described previously under subcategory 1.2.

1.5 Refine Payments Under the Medicare Advantage Program [Medicare, Medicaid, FEHBP]
Most of the proposals include reforms to the Medicare Advantage program. These include: (1) improving the benefit; (2) adjusting payment and financial incentives, including implementing better risk adjustment and competitive bidding; and (3) changing beneficiary cost-sharing based on insurance design. While six out of seven proposals support changes to MA, the proposals recommend a variety of approaches. Applying competitive bidding to MA, refining risk adjustment, and allowing MA to allow tiered network design (and tiered cost-sharing) are all ideas supported by at least two proposals. Examples include:
  • BPC would require all MA plans to include Part D prescription drug coverage by 2015.
  • Moment of Truth Project (MOT) would make MA payments based on a “competitive bidding” system rather than a fixed rate, but only if such a system could be designed to reduce costs without damaging quality.
  • NCHC would lift restrictions on value-based insurance design among MA plans to allow copays to be adjusted based on evidence and tiering of providers determined by quality and patient outcome measures. BPC would create an exceptions process if a higher-tier treatment is medically necessary.
  • CAP would improve the accuracy of risk adjustment in MA payments for beneficiary health status. Medicare would recover overpayments to private plans made in 2010, 2011, and 2012, and would require improvement in MA’s risk adjustment methodology starting in 2013.

1.6 Reformulate Payment Rates for Primary Care Services [Medicare, Medicaid, Private Payers]
Most of the proposals offer elements that would improve payment for primary care services including: revising payment for participation in delivery system reforms that prioritize primary care and prevention; replacing the SGR and creating a physician payment system that rewards primary care; change payment to reward and encourage case management, care coordination, and team-based care; and incentivize states and plans to prioritize prevention by allowing shared savings. Examples include:
  • BI would implement a person-focused Medicaid program that includes support for capitated Medicaid managed care organizations, as well as state-directed reforms that focus on particular components of care. States that reduce per capita and overall spending would receive a disproportionate share of savings (e.g., 50%). States could target initiatives to key high-risk/high-cost populations and would be encouraged to innovatively combine funding streams and prioritize prevention.
  • CMWF would change payment of primary care to reward care management, coordination, and a team-based systemic approach to caring for patients under Medicare, Medicaid, other public programs, and private plans participating in health insurance exchanges.
  • CAP would better coordinate care for beneficiaries eligible for both Medicare and Medicaid and would allow all dual eligibles to choose a primary care medical home to coordinate care.

1.7 Establish Provider Incentives to Promote High-Quality Care [Medicare, Medicaid, Private Payers, FEHBP]
Each of the seven proposals includes multiple elements for establishing provider incentives to promote high-quality care. Of the 48 elements in the various proposals analyzed, the majority fell into the following major categories:
  • Providing financial incentives to providers by allowing the providers to share in any financial savings if certain quality measures were met (including “earn-backs”);
  • Promoting tiered network design and reference pricing;
• Providing financial incentives to providers who focused on high-cost beneficiaries or dual eligibles;
• Providing additional financial incentives in delivery-system reforms like bundling or ACOs;
• Paying providers based on quality metrics achieved (and applying financial penalties for quality metrics not achieved);
• Varying beneficiary cost-sharing based on a treatment’s effectiveness or providing first-dollar coverage for primary care services;
• Improving transparency or quality and price information;
• Rewarding shared decision-making and use of patient decision-aids; and
• Rewarding use of evidence-based practice guidelines by providing physicians a safe harbor from liability.

Value-Based Purchasing and Pay-for-Performance: Of these categories, the greatest consensus was around improving strategies to expand value-based purchasing, including pay-for-performance. All of the proposals encourage pay-for-performance as an incentive-based payment system. Many proposals suggest ways to improve data collection to better identify areas for improvement and to track outcomes. Surprisingly, only two proposals addressed transparency of quality and pricing information. Examples include:

• BPC would expand the voluntary payment bundling demonstration into a standard Medicare payment method. Bundles—including inpatient, physician, and post-acute care, and any readmissions within 90 days—would be established nationwide no later than 2018 for certain DRGs. BPC would apply a withholding approach, with “earn-back” potential based on meeting spending and quality standards.
• BI would implement regulations for the insurance marketplaces that allow actuarially equivalent benefit designs combined with flexibility in plan choices to promote innovation in value, combined with quality reporting.
• CMWF would create new payment incentives and support for comprehensive primary care teams that focus on the highest-cost Medicare and Medicaid patients and would extend incentives to the FEHB Program, the military health coverage programs (TRICARE and the Civilian Health and Medical Program of the Uniformed Services), the Veterans Health Administration, and other federal programs.
• PSHC would accelerate efforts by private payers and Medicare to provide incentives to physicians and hospitals for meeting performance benchmarks compared to their peers, while accounting for case mix and socioeconomic status of their underlying populations; include benchmarks that continually drive improvement.
• MOT would expand penalties for unnecessary hospital readmissions and avoidable complications (“never events”); expand the Hospital Readmissions Reduction Program to include more medical conditions and impose higher penalties on more types of providers. MOT would calibrate penalties to adjust for patient demographics, types of condition, and timing of readmission.
• NCHC would apply immediate payment incentives for participation in quality and value incentives to the existing fee-for-service pay schedule. Physicians participating in approved models such as registries, pay-for-performance models, medical homes, and ACOs would receive higher payment increases than those who do not.
• CAP would require health insurance exchanges and state employee plans to offer tiered insurance plans that designate providers with high quality and low costs for patients (at least one tiered product at the bronze and silver levels by 2016). Quality and cost measures would be standardized from all payers and would be publicly disclosed.
• CAP would provide a “safe harbor” to physicians. Physicians would be presumed to have no liability if they: (1) documented adherence to evidence-based clinical practice guidelines; (2) used qualified health information technology (IT) systems; and (3) used clinical decision support systems that incorporate guidelines. Evidence-based clinical practice guidelines would be developed and regularly updated by physicians.
1.8 Adjust Prescription Drug Payment and Pricing [Medicare, Medicaid, FEHBP]

Several of the proposals included major elements to change prescription drug payment and pricing. These fell into the following categories: changes to Medicare Part D; changes to Medicare Part B; adjustments to Medicaid’s drug rebate system; increasing generic drug utilization; and extending drug prices to the FEHB Program. While most of the elements vary quite a bit, most organizations would make changes to the Medicare Part B payment for prescription drugs. Several proposals also include elements to encourage use of generic drugs. Two proposals (CAP and NCHC) would allow states to share in any savings that resulted. Examples include:

- **BPC** would require all MA plans to include Part D prescription drug coverage by 2015 and would adjust the Part D low-income subsidy cost-sharing and Part D plan payments to encourage the use of high-value drugs.
- **MOT** and **CAP** would require drug rebates for dual eligibles who receive drug coverage through Medicare Part D. **MOT** would require manufacturers of these drugs to be responsible for the same 23.1 percent above the average manufacturer price rebate as in Medicaid.
- **NCHC** would incentivize state governments to increase generic drug utilization in Medicaid by allowing states to share in the savings generated when generic substitution increases. An appeal process would be established for patients for whom the difference between generic and brand-name drugs is clinically significant.
- **CAP** would require the FEHB Program to reduce drug costs. The FEHB Program would have access to the same drug prices that are available to all other federal programs, and the FEHB Program would be prohibited from imposing any formulary.

1.9 Realign Graduate Medical Education Payments [Medicare, Medicaid]

Two proposals (BPC and CAP) explicitly include elements that would reform graduate medical education (GME) payments:

- **BPC** would reduce the indirect medical education (IME) percentage add-on to Medicare payments for inpatient hospital admissions from 5.5 percent to 3.5 percent. The proposal would repurpose 50 percent of the proposed reduction in IME funds for performance-based incentive payments and repurpose the remaining 50 percent to additional residency slots, one-third of which would be made available to teaching hospitals that are training above their cap. Half of the additional slots would be allocated to programs that train primary care physicians and other providers for which there are identified specialty shortages. **BPC** would also reduce per-resident amounts to 120 percent of locality-adjusted national average. **BPC** also suggests that the Centers for Medicare & Medicaid Services (CMS) should explore expanding direct GME payments to hospitals to support training for nonphysician professionals as well as physicians.
- **CAP** would separate out payments for training through its “accountable care state” and recommends a number of revisions to Medicare GME funding, including: (1) limit payments to teaching hospitals to a percentage of the national average cost per resident and reduce payments to teaching hospitals to reflect actual costs, consistent with MedPAC’s recommendations; (2) By 2014, adjust payments to teaching programs based on their performance on training that meets certain requirements; (3) require Medicare to publicly report all payments to programs on its website to increase transparency; and (4) require training and experience in nonhospital settings, especially teaching health centers, for at least one-third of residents’ time. In addition, **CAP** would require private insurers to contribute their fair share for graduate medical education ($2 per enrollee by 2014). Medicare payments for GME would be reduced by a commensurate amount.

1.10 Other Payment Reforms [Medicare, Medicaid, Private Payers]

This catchall subcategory includes several recommendations from various proposals, but no patterns or areas of consensus emerged.
SECTION 2: IMPLEMENTING & ENHANCING DELIVERY SYSTEM REFORMS

All seven proposals contained extensive recommendations to implement or expand delivery system reforms. These recommendations fall across a range of payers, with many building on existing initiatives in the Medicare program. For the most part, they fall into four main categories: promoting team-based care, such as that offered in patient-centered medical homes (PCMHs); expanding the use of ACOs; reforming delivery in the Medicare Advantage program; and encouraging state innovation in delivery system reform.

2.1 Promote Medical Homes and Team-Based Care [Medicare, Medicaid, Private Payers]

All seven proposals include recommendations for increasing the use of medical homes or other forms of team-based medical care.

Medical Homes/Team-Based Care and Medicare: All of the proposals recommend incentives for providers and beneficiaries in the Medicare program to participate in patient-centered medical homes or other types of coordinated care delivery. BPC recommends a transition toward Medicare Networks that would be responsible for providing quality care to enrolled beneficiaries. BI’s MCC proposal would include collaborations of providers. PSHC recommends a shift from the SGR to value-based systems that include PCMHs. Similarly, CAP’s and CMWF’s proposals to replace the SGR would have payment incentives for providers participating in innovative delivery or payment systems such as PCMHs. Under the CMWF proposal, Medicare beneficiaries would also have incentives, such as lower out-of-pocket costs, to seek care from high-performing systems such as PCMHs. (Under the CMWF proposal, high-cost and chronically ill Medicaid patients who choose to receive team-based care would receive enhanced services.) The MOT proposal would also direct CMS to develop a new Medicare physician-payment formula that encourages new models such as PCMHs. NCHC also recommends incentives for both PCMHs and for behavioral health homes for dual eligibles.

Medical Homes/Team-Based Care and Other Payers: Many recommendations for coordinated care, such as PCMHs, would apply across a range of payers. For example:

- CMWF recommends that all payers change payment for primary care to reward care management and team-based approaches; incentives for coordinated primary care would be expanded to the FEHB Program and military health insurance programs. CMWF also recommends that private plans offered through state-level exchanges be required to offer payment approaches that support innovations such as PCMHs and care teams and that private plans in MA and Medicaid offer beneficiaries incentives to seek coordinated care.
- PSHC recommends expanded multi-payer PCMH initiatives, as well as an increase in the proportion of medical home payments contingent on meeting quality goals.
- NCHC recommends expanded training of health professionals needed for team-based primary care.

2.2 Further Develop the Use of Accountable Care Organizations [Medicare, Medicaid, Private Payers]

In general, ACOs are a specific type of coordinated care system in which providers responsible for an enrollee’s care have the opportunity to share in any costs saved but may also bear the risk of any excess costs. All seven proposals contain provisions related to increased or enhanced use of ACOs.

ACOs and Medicare: Like the recommendations on PCMHs and coordinated care in general, many of the recommendations on ACOs focus on Medicare, where the government has already initiated many of its ACO efforts. For example:

- BPC’s recommendation for Medicare Networks formed and governed by providers would include shared savings for networks if they reach quality goals and a minimum savings rate.
- BI’s MCC Proposal would permit providers to participate in multiple shared-savings initiatives, including ACOs.
CMWF’s proposal to replace the SGR would include future increases only for providers participating in innovative payment or delivery systems, including ACOs. Its Medicare Essential plan would give Medicare beneficiaries incentives to choose high-performing care systems, including ACOs.

PSHC recommends a shift toward value-based systems of care delivery, including ACOs, in Medicare. PSHC also recommends that the existing Medicare Shared Savings Program and Pioneer Accountable Care Organization initiative be given greater flexibility to tier cost-sharing based on quality performance and clinical effectiveness.

The MOT proposal recommends that CMS develop an improved physician-payment formula that promotes participation in new models, including ACOs.

NCHC recommends a number of policy changes to promote the use of ACOs in Medicare, including allowing rolling applications from providers; applying immediate payment incentives for providers participating in quality and value initiatives such as ACOs; and launching a pilot to allow ACOs that serve dual eligibles to assume risk for Medicaid long-term services and supports.

ACOs and Other Payers: Other recommendations would implement or expand the ACO concept across a range of payers. For example, CMWF encourages aligning incentives across private and public payers to encourage more accountable care systems and recommends requiring private plans offered through state-level exchanges to incorporate payment approaches such as ACOs. CMWF also recommends that private plans participating in MA and Medicaid be encouraged to provide incentives for beneficiaries to seek care from high-quality systems, including ACOs. PSHC urges that lessons from early ACOs be applied to develop further models in both the public and private sectors and that successful ACO models be transitioned to prospective global payment systems. CAP recommends a broad reform called Accountable Care States, in which states would have global targets for all health care spending by both public and private payers and would share in risk and possible savings.

2.3 Reform Medicare Advantage Program Delivery [Medicare]

Three of the proposals make recommendations for delivery system changes specific to MA:

- BPC recommends standardizing the minimum benefit for MA plans; requiring all MA plans to include Part D prescription drug coverage by 2015; and allowing MA plans to adopt tiered network designs.
- PSHC recommends allowing MA plans to use tools that promote quality and value, including VBID incentives. PSHC would also allow MA plans to tier providers and services based on value.
- NCHC also recommends empowering the Secretary of HHS to lift curbs on tiered cost-sharing in MA.

2.4 Encourage State Innovation to Improve Quality and Reduce Costs [Medicare, Medicaid, Private Payers]

All seven proposals include recommendations for reforming delivery systems by encouraging state-level innovation to improve quality and reduce costs.

Medicaid Innovation: Some of the recommendations are specific to the Medicaid program, in which states have considerable control over programs and delivery systems. BI’s person-focused Medicaid program would support state-directed reforms, including encouraging states to innovatively combine existing funding streams. BI also encourages CMS to facilitate state reforms that coordinate the delivery of non-Medicaid support services for low-income populations. The MOT proposal recommends a new waiver program to increase flexibility for states to control Medicaid cost growth, as well as fast-tracking for waivers that offer promise in improving care and reducing costs. The proposal also suggests allowing states to accept a single “blended rate” for all Medicaid services. NCHC recommends incentivizing state governments to increase generic drug utilization in Medicaid through shared savings.
Many other recommendations regarding state innovation would span Medicaid and Medicare, and, in some cases, would apply to private payers as well. For example:

- BI recommends common performance measures and payment reforms to allow Medicare and private plans to join in state-based financing reforms.
- PSHC recommends the development of mechanisms to ensure that cost control innovations create savings across sectors rather than shifting costs.
- CAP recommends that CMS provide funding to states to create “all-payer” claims databases.

2.5 Other Delivery System Reform Proposals [Medicare, Medicaid, Private Payers]

In addition to encouraging team-based care, ACOs, and state innovation, the proposals contained a range of other recommendations for delivery system changes to reduce costs and/or improve care. For example:

- BI recommends that states and CMS facilitate the participation of Medicaid managed care plans in exchanges to mitigate enrollee shifts in and out of Medicaid eligibility.
- PSHC recommends a reduction of insurance practices—such as “all-or-nothing” contracting and refusals to participate in tiered networks—that impede VBID.
- NCHC recommends integrating medication adherence measures into a variety of ongoing health care quality and value incentives.
- CAP recommends that the FEHB Program be improved and used to help reform health care delivery.

SECTION 3. IMPROVING QUALITY & ENGAGING PATIENTS

All seven proposals contain extensive recommendations to improve health care quality and increase patient and consumer engagement.

3.1 Identify and Encourage the Use of Best Practices [Medicare, Medicaid, Private Payers]

While most of the proposals contain one or more recommendations aimed at encouraging best practices, there was a wide range of approaches in this subcategory. Proposals for encouraging the use of best practices varied greatly and included recommendations such as: (1) increasing medication adherence research and integration into health care quality and value incentives; (2) promoting shared decision-making in Medicare for high-cost conditions; (3) piloting reference pricing in Medicare; (4) disseminating best-practice information on lowering hospital readmission rates and global payment models; (5) strengthening value-based purchasing for hospital readmissions and complications; (6) coordinating the delivery of support services for Medicaid-eligible populations (e.g., mental health support services); (7) enhancing preventive services and proven secondary and tertiary preventive interventions; and (8) providing a medical liability safe harbor for physicians who adhere to evidence-based clinical practice guidelines.

Value-Based Insurance Design: One area in which there were similar proposals in this subcategory regards encouraging VBID; BI recommends supporting private employer efforts to engage employees in reducing overall health care costs through VBID, while the NCHC recommends lifting restrictions on VBID among MA plans. Both of these recommendations would allow the design of the benefit (tiered designs, copays, etc.) to be based on accepted quality and patient outcome measures.

Bundled Payments: Another issue on which there is some agreement is pushing for more bundled payments as an alternative to FFS payments under Medicare and Medicaid. NCHC recommends encouraging episodic bundled payments either by expanding the Acute Care Episode (ACE) Bundled Payments Demonstration nationally or by implementing a Centers of Excellence for Selected Surgical Procedures program in Medicare. CAP also recommends expanding the ACE demonstration, proposing that, by 2014, Medicare should expand the ACE program along with expanding the current bundle of inpatient hospital services so that within 10 years, Medicare and Medicaid should base at least 75 percent of payments in every hospital referral region on alternatives to FFS.

3.2 Improve Quality of Care for Persons Dually Eligible for Medicaid and Medicare
Most of the proposals include recommendations for improving and streamlining care for individuals eligible for both Medicare and Medicaid (dual eligibles). Recommendations for addressing dual eligibles varied but tended to fall into two categories: (1) addressing the cost of prescription drugs for this high-cost population; and (2) implementing, expanding, or making permanent programs/demonstrations/pilots that integrate care for dual eligibles.

**Prescription Drugs:** Three proposals include recommendations aimed at reducing the costs of prescription drugs among dual eligibles. NCHC and CAP mentioned the need to encourage generic drug use for dual eligibles by decreasing or eliminating cost-sharing for generic drugs and raising cost-sharing for brand-name drugs. In addition, CAP and MOT recommended extending drug rebates for duals: CAP recommends extending Medicaid rebates to all brand-name drugs purchased by duals, while MOT recommends requiring Medicaid rebates for all duals that receive drug coverage through Medicare Part D.

**Programs, Demonstrations, and Pilots:** Several proposals make recommendations about how to implement, expand, or make permanent programs or demonstrations/pilots that integrate care for dual eligibles. The details of these recommendations vary widely:

- Some call for expanding access to certain programs: for example, NCHC suggests expanding and improving the Program for All-Inclusive Care for the Elderly (PACE) and recommends streamlining state contracting with Medicare Special Needs Plans (SNPs) to enable more dually eligible beneficiaries to access SNPs.
- Other proposals recommend testing or accelerating new models at the state level: NCHC recommends implementing more demonstrations at the state level to test key protections for dual eligibles (e.g., better benefit packages, network adequacy); MOT recommends fast-tracking state Medicaid waivers that offer demonstrative promise in improving care and returning savings for dual eligibles.
- Finally, proposals recommend better coordinating care for dual eligibles through ACOs (NCHC) or through PCMHs (CAP).

### 3.3 Develop and Improve the Use of Quality Metrics [Medicare, Medicaid, Private Payers]

Most of the proposals make specific suggestions related to developing or improving the use of quality measures.

**Standard/Common Quality Measures:** Here, the largest area of general consensus is recommendations to develop common quality measures across programs (both public and private) and consistent methods for constructing measures. For example:

- BI and CAP each recommend that plans participating in health insurance exchanges provide a common, standard set of quality measures.
- BI and PSHC support developing and aligning quality metrics across private and public payers.
- CAP recommends aligning metrics used for the FEHB Program with Medicare.
- PSHC supports building a uniform national core measurement set that is used by both public and private sectors and is consistent with the National Quality Strategy.
- Both BPC and PSHC made recommendations to use the National Quality Forum (NQF) framework to convene a group to create common quality measures for all payers.

In addition, there is some consensus to increase efforts at CMS and NQF to develop additional quality measures. NCHC recommends sustaining CMS funding for developing, endorsing, and implementing quality measures, especially those related to value-based payment models. BPC’s proposal includes numerous recommendations to improve measure development at NQF (e.g., refocus efforts to convene accrediting and certifying bodies, developing pathways for physician-created and clinically relevant quality measures).
Health IT: Related to this notion of uniform measures is seeking uniformity with health IT systems as they are developed. PSHC recommends leveraging the “meaningful use” program and the health IT roadmap to provide guidance on analysis and reporting of quality measurements on high-priority health conditions.

Other: Other recommendations categorized under 3.3 vary greatly and include recommendations such as: person-focused, outcome-oriented measures as part of person-focused Medicaid (BI); improving quality metrics for procedure and episode-based bundled payment models (PSHC); integrating medication adherence measures into a variety of ongoing health care quality and value incentives (NCHC); requiring rigorous and transparent metrics of quality and access under Medicaid managed care (CAP); requiring documentation of the use of patient decision-aids under Medicare (CAP); and adjusting Medicare payments to ambulatory surgical centers based on quality performance (CAP).

3.4 Increase Patient and Consumer Engagement [Medicare, Medicaid, Private Payers, FEHBP]

Almost all of the proposals contain recommendations for increasing patient and consumer engagement in their health care.

Price Transparency: One of the strongest areas of consensus under this subcategory is recommendations among several of the proposals to increase transparency about the price of health care, on the theory that this will make it easier for patients/consumers to understand health care costs, informing their decision-making. The proposals vary in their approach:

- Both BPC and CAP recommend that private insurers should share pricing data that will help individuals to better understand out-of-pocket costs before accessing care. NCHC takes this a step further, recommending that every health benefit exchange allow customers to search plans by a range of price information necessary for informed choice. CMWF also recommends ensuring all-payer information on prices at both the state and community levels to inform consumer choice.
- NCHC recommends piloting reference pricing in Medicare for certain treatments and diagnostic tests.
- BPC recommends constructing a new Medicare open enrollment website that includes relevant pricing information on all Medicare options (FFS, MA, etc.).
- CMWF suggests increasing the use of bundled payments for hospital care and post-acute care to make it easier for patients to compare and assess the total costs of care for certain common procedures and conditions (e.g., hip replacement surgery).

Increased Information on Quality and Performance Information: Four proposals put forward ideas to increase information to consumers on quality of care and provider performance, facilitating informed decision-making based on value. They include:

- Some proposals suggest this information be available at the exchange/insurer level: for example, CAP recommends that insurers should share information about quality of care, patient satisfaction, and patient volume to facilitate informed decision-making, and NCHC recommends that every health benefit exchange should allow customers to search plans by a range of quality information necessary for informed choice.
- Other proposals recommend this information be available at the community/provider level: for example, CMWF recommends ensuring all-payer information on quality, patient experiences, and outcomes of care at both the state and community levels are available to inform consumer choice. Similarly, PSHC suggests making available to consumers aggregated information that represents all the patients of a particular provider so that consumers can assess the quality, efficiency, and appropriateness of care and performance with respect to quality metrics and customer satisfaction levels.

Value-Based Insurance Design: Most of the proposals support VBID, tiered benefit designs, and other similar mechanisms that promote value-based choices by beneficiaries. BI, CAP, and PSHC make
recommendations for VBID and tiered benefit designs in the private sector. Two other proposals, PSHC and NCHC, push for VBID within MA, while CMWF recommends VBID for all public and private payers and with a Medicare Essential plan (a new Medicare option that provides more integrated, comprehensive benefits and better protection against catastrophic costs).

Cost-Sharing: Another area of consensus under this subcategory focuses on out-of-pocket costs for Medicare beneficiaries. Three proposals suggest varying cost-sharing under Medicare based on evidence of a particular treatment’s effectiveness as a means of engaging consumers in decisions about their care.

3.5 Increase Transparency of Price and Quality Information [Medicare, Medicaid, Private Payers, FEHBP].
This subcategory shared many similarities to subcategory 3.4 (increasing patient and consumer engagement), because often the goal of increasing transparency of price and quality information is to increase consumer/patient engagement. Therefore, proposals share consensus on the areas of price transparency, increased information on quality and performance information, and VBID as described above under subcategory 3.4.

Cost-Sharing: In addition, there is even more consensus under this subcategory on modifying beneficiary cost-sharing. As under subcategory 3.4, three proposals—BPC, NCHC, and CAP—suggest varying cost-sharing under Medicare based on evidence of a particular treatment’s effectiveness, giving beneficiaries clear information on out-of-pocket costs for different treatment options. In addition, PSHC recommends requiring plans in state health insurance exchanges and under the Medicare Shared Savings Program and the Pioneer Accountable Care Organization initiative to vary cost-sharing for services based on value and performance/quality information. Finally, BI, CAP, and MOT recommend prohibiting insurer “gag clauses” that block disclosure of total and out-of-pocket price-related information.

Public Release of Claims Data: CAP and MOT each recommend requiring CMS to publicly release Medicare and Medicaid claims and payment data through a searchable database. In addition, these proposals urge CMS to put funding toward data transparency: MOT recommends directing CMS to study new ways to increase transparency of prices and quality, while CAP urges CMS to provide funding to states to create all-payer claims databases.

Other: A variety of other recommendations fit in this category, including: enhancing transparency in the CMS Financial Alignment Demonstration (BI); using savings from expanded Medicare payment penalties to fund quality improvement programs in low-performing institutions (NCHC); standardizing state investments in Medicaid information systems and access to CMS data (BI); requiring price transparency for medical devices (CAP); requiring better information on the benefits, safety, and cost of alternative high-cost medical treatment choices or technologies to inform decisions by patients and providers (CMWF); and requiring Medicare to publically report all GME payments to increase transparency in GME.

3.6 Offer New Medicare Options for Beneficiaries [Medicare]
Most of the proposals contain one or more recommendations to offer entirely new Medicare options for beneficiaries. Several themes emerge, including encouraging greater provider involvement, establishing spending targets and/or shared savings, providing positive incentives for beneficiary participation, and protecting beneficiaries against catastrophic costs. For example:

- BPC recommends establishing enrollment-based versions of ACOs, called Medicare Networks, which are formed and governed by providers. Each Medicare Network would have an individual spending target and an opportunity to share in savings if it reaches quality goals and meets a minimum savings rate. Beneficiaries would have incentives to enroll and would have access to lower premiums and copayments.
- BI recommends transitioning to an MCC system, wherein collaborations of providers (organizations could include integrated systems or networks of providers working together) receive a globally
capitated, comprehensive payment for their attributed beneficiaries and must sustain or improve performance on a standard set of outcome-oriented care quality and performance measures for full payment.

- Under CMWF’s proposal, a new Medicare Essential benefit option would be offered that provides more integrated, comprehensive benefits and better protection against catastrophic costs. The Medicare Essential plan would combine the current Part A, B, and D structure to provide beneficiaries with a benefit package that more closely corresponds to that provided by private plans in MA and those available through public and private employers. This plan would align incentives for Medicare beneficiaries with provider payment policies to encourage physician participation in high-performing health care organizations and payment innovations and would provide incentives for Medicare beneficiaries to seek care from high-performing care systems.

- MOT’s proposal is similar to CMWF in that each recommends merging Medicare Parts A, B, and D into a single benefit package, providing care coordination services, and offering lower cost-sharing to beneficiaries who use high-value providers and services.

- NCHC recommends implementing a Medicare Health Rewards program that provides small monetary incentives for Medicare beneficiaries to set and achieve health goals. This voluntary program should be structured around annual wellness visits to the beneficiary’s primary care provider that measure improvements in six areas of health: tobacco usage, body mass index, diabetes indicators, blood pressure, cholesterol, vaccinations, and screenings.

### 3.7 Reform Cost-Sharing and Premiums [Medicare, Medicaid, Private Payers]

All seven proposals contain one or more recommendations on reforming cost-sharing and premiums. Some of these proposals discussed reforms in cost-sharing related to new Medicare options for beneficiaries, as described above in section 3.6. Two additional areas of similarity related to Medicare cost-sharing emerged:

**Cost-Sharing under Medicare:** Points of consensus include:

- BI, CAP, and CMWF each recommend an out-of-pocket maximum for Medicare beneficiaries. MOT recommends an income-adjusted out-of-pocket limitation.

- CAP, BPC, and MOT favor approaches to make a distinction in cost-sharing between lower-income and higher-income Medicare beneficiaries. MOT and BPC recommend increasing cost-sharing support for low-income beneficiaries, while CAP proposes a three-tiered approach to cost-sharing for beneficiaries with varied income levels.

- BI, CAP, and MOT each recommend reforming Medigap first-dollar coverage, but these proposals take different approaches: MOT would restrict Medigap plans so that they are no longer able to provide first-dollar coverage within the Medicare deductible and can cover no more than half of the base Medicare coinsurance; CAP would prohibit Medigap coverage of the first $500 for beneficiaries with incomes above 400 percent of federal poverty level, exempting first-dollar coverage of primary care and care for chronic disease; and BI would reform Medigap coverage to eliminate first-dollar coverage unrelated to quality or value.

- BPC also recommends modifications to Medigap coverage, but this proposal does not address first-dollar coverage. Instead, BPC recommends that all Medigap plans should include a deductible of at least $250 and a beneficiary out-of-pocket maximum no lower than $2,500 and should cover no more than half of beneficiary copayments and coinsurance.

**Cost-Sharing and Medicare Advantage:** BPC, BI, and PSHC each recommend changes to cost-sharing for MA plans. BPC and BI recommend allowing MA plans to return 100 percent of the difference between their bids and the benchmark to beneficiaries in the form of lower premiums to encourage greater competition on price. BPC suggests establishing a standardized minimum benefit for all MA plans that would include slightly lower cost-sharing overall and a cost-sharing limit to protect against catastrophic expenses. PSHC recommends promoting value-based choices by beneficiaries in MA plans by allowing these plans to tier
providers and services based on value and to offer beneficiaries cost-sharing incentives to act on this information.

3.8 Other Proposals for Quality and Patient Engagement [Medicare, Medicaid, Private Payers, FEHB]

This catchall subcategory includes several recommendations from various proposals, but no patterns emerged. The type of recommendations under this subcategory vary from recommendations on provider performance incentives to mandatory Medicare funding for CMS’s continued engagement on developing and endorsing quality measures to streamlining information related to Medicare Special Needs Plans.

SECTION 4. PROMOTING MARKET COMPETITION

4.1 Encourage Generic Drug Use and Purchasing [Medicare, Medicaid, Private Payers]

Several of the proposals address generic drug use and purchasing. There were some commonalities among the proposal recommendations, including:

- **Medicare Part B Payment**: BPC, CAP, and NCHC each propose reforming Medicare Part B payment for outpatient drugs, but with varied approaches: BPC suggests changing Part B payment for provider-administered medications to reflect the average sales price plus a flat payment, on average equivalent to the current 6 percent add-on; NCHC recommends reforming Part B payment for provider-administered medications by replacing the 6 percent add-on with a set fee adjusted for the difficulty associated with storing and administering particular drugs or classes of drugs; and CAP recommends basing Part B drug payment on the lowest price of all equivalent drugs, instead of basing payment on the average price of all equivalent drugs.

- **Risk Evaluation and Mitigation Strategies (REMS) Loophole**: Two proposals—BPC and NCHC—recommend closing the REMS loophole. This refers to the use by manufacturers of brand-name drugs of the Food and Drug Administration’s authority to require strict controls on the availability of drugs with a high risk of abuse or dangerous side effects to inhibit development of generic drugs by preventing generic drug manufacturers from obtaining samples of certain brand-name drugs.

- **Reducing Exclusivity Period and Prohibiting “Pay for Delay”**: NCHC and CAP support reducing the exclusivity period for brand-name biologics to encourage generic competition. Both of these proposals recommend reducing this period to seven years. In addition, two proposals support prohibiting pay-for-delay agreements that keep generic drugs off the market.

- **Shared Savings to State Medicaid Programs for Generic Utilization**: CAP and NCHC encourage incentivizing state governments to increase generic drug utilization in Medicaid by allowing states to share in the savings generated when generic substitution increases.

4.2 Promote High-Quality, Low-Cost Health Plans in State Exchanges [Private Payers]

Most of the proposals make recommendations to promote high-quality, low-cost health plans in state exchanges. Our analysis found a few areas where proposals have consensus:

- **Encouraging Insurance Practices that Support Delivery System Innovation**: Two proposals make recommendations here, taking different approaches. CMWF supports requiring private plans participating in health insurance exchanges to incorporate alternative payment approaches to support delivery system innovation such as primary care medical homes, care teams, bundled payments for hospital episodes, and shared savings or global payment arrangements with provider systems. PSHC recommends reducing insurance practices (such as all-or-nothing contracting and refusals to participate in tiered networks) that have created impediments to the development of innovative, VBID products.

- **Value-Based Insurance Design**: PSCH and CAP recommend pushing VBID design within state health insurance marketplaces.
- **Price and Quality Transparency**: Two proposals—NCHC and CAP—recommend requiring private insurers to make price and quality information transparent so that consumers in exchanges have the information necessary to make informed choices.

- **Adverse Selection**: To combat adverse selection within exchanges, BI suggests a number of routes, including: effective broad-based outreach and default enrollment for individuals who are eligible for subsidies; limiting open enrollment periods and ability to shift to higher-value plans and applying late enrollment fees; relaxing the requirement for full community rating and the preexisting condition exclusion for consumers without continuous coverage; and temporarily extending additional financial support for the highest-risk individuals. NCHC also makes recommendations here, encouraging federal and state policymakers to work together to monitor for possible adverse selection in exchanges, taking steps to combat it. Should adverse selection occur, NCHC recommends that policymakers expand the risk pool by increasing outreach and enrollment activities or providing additional federal or state investment in reinsurance, risk corridors, or risk adjustment strategies.

### 4.3 Promote Market Competition Through Appropriate Oversight [Medicare, Medicaid, Private Payers]
Almost all of the proposals make recommendations to promote market competition through various oversight mechanisms. However, there are only a few areas of consensus:

- **Funding for Enforcement**: Two proposals support increased funding for antitrust and antifraud enforcement. PSHC recommends ensuring adequate funding for state and federal antitrust agencies, while NCHC recommends doubling the increase in funding for the Health Care Fraud and Abuse Control Program.

- **Integrated Systems of Care and Regulatory Framework**: Two proposals—BI and BPC—support updating the legal/regulatory framework to make it easier for entities to form integrated, coordinated systems of care. In addition, BI recommends that agencies clarify that enforcement review will focus on quality-based payments; BI also supports applying greater scrutiny to full clinical/financial integration mergers.

- **Strengthening FTC Infrastructure**: NCHC and PSHC recommend strengthening the infrastructure to combat anticompetitive market practices and fraud and abuse. NCHC recommends empowering the Federal Trade Commission (FTC) to aggressively enforce and expand antitrust laws, for example by improving the federal government’s provider verification system to prescreen providers. PSHC recommends that the FTC hold a series of hearings on competition issues and market-based efforts to increase efficiency and strengthen their efforts to combat violations.

### 4.4 Expand Competitive Bidding [Medicare, Medicaid, Private Payers]
Most of the proposals make recommendations to expand competitive bidding within Medicare, Medicaid, or private payers. Two major areas of consensus emerged:

- **Competitive Bidding for Medical Commodities**: Five proposals push for competitive bidding for medical commodities. CAP, CMWF, and MOT recommend competitive bidding for a large array of medical commodities—drugs, DME, laboratory tests, radiologic diagnostic services, and various other commodities. BPC and NCHC limit their recommendation for competitive bidding to DME only.

- **Medicare Advantage**: BPC, MOT, and CAP each recommend that CMS make MA payments based on a competitive bidding system rather than a fixed rate.

### 4.5 Other Proposals for Enhancing Competition [Medicare, Private Payers]
This catchall subcategory includes several recommendations from various proposals, but no patterns emerged. The types of recommendations under this subcategory vary from encouraging pro-competitive rules for insurer-provider contracting to encouraging generic competition to monitoring for adverse selection in exchanges.
SECTION 5: OTHER SYSTEM REFORMS

In addition to the payment, delivery, and other reforms described above, the proposals include a range of other system-level changes to improve efficiency and reduce health care spending.

5.1 Promote Use of Electronic Medical Records [Medicare, Medicaid, Private Payers, FEHBP]

Most of the proposals note the important opportunities presented by electronic medical records and recommend specific policies to facilitate and promote their use.

Meaningful Use: Some of these recommendations focus on the “meaningful use” program. BPC recommends that the next stage of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs prioritize sharing of information among providers, with implementation support from HHS. PSHC recommends that the “meaningful use” program and HHS’s health IT roadmap provide guidance on analysis and reporting of quality measurements. CMWF recommends that “meaningful use” be enhanced with registries that track experience with medical devices or other high-tech procedures. NCHC recommends that “meaningful use” incentive payments be available to behavioral health providers.

Common Standards: BPC recommends the development of common standards for electronic capture of data. Similarly, both PSHC and CAP recommend increased standardization of electronic information exchange among payers, providers, and vendors.

Other recommendations contemplate broader use of technology in medicine generally. PSHC recommends expanded training and resources for telemedicine, biomonitoring, and access to providers, with associated payment models. CAP recommends that GME include training in health information technology.

5.2 Bolster the Primary Care Workforce [Medicare, Medicaid]

There is significant consensus on the need to strengthen the primary care workforce, with almost all of the proposals including recommendations in this area.

Nurses: A number of proposals focus on the role of nurses: BPC suggests a financial incentive to states to enact an Advanced Practice RN Consensus Model Act; PSHC recommends refocusing registered nurse education to allow roles as case managers and population health coordinators; NCHC echoes this recommendation and also recommends increasing the number of nursing schools that can participate in the Graduate Nursing Education Demonstration, as well as implementing recommendations of the Institute of Medicine’s Future of Nursing Report.

Scope of Practice: There are a variety of recommendations related to scope of practice. BPC recommends elimination of outdated Medicare and Medicaid requirements that interfere with state scope-of-practice laws, and CAP makes a similar recommendation. BI also recommends reform of outdated licensing barriers including inappropriate scope-of-practice laws.

Provider Education: Some proposals make recommendations specific to primary care provider physician education and training. PSHC recommends modifications of scholarship and loan forgiveness programs to target the most acute workforce needs, as well as expanded training and resources on telemedicine and related models. NCHC recommends expanded federal funding for certain primary care physician workforce programs.

5.3 Invest in Prevention and Wellness [Medicare, Medicaid, Private Payers, FEHBP]

Several suggestions relate to increasing a focus on prevention and wellness within Medicare and/or Medicaid:

- In the context of a person-focused Medicaid program, BI suggests that states be encouraged to prioritize prevention.
NCHC recommends a Medicare Better Health Rewards Program that incentivizes beneficiaries to reach health goals. NCHC also recommends requiring Medicare to cover participation in the Diabetes Prevention Program, expanding Medicare coverage without cost-sharing to certain secondary and tertiary prevention services, and establishing comprehensive tobacco cessation as a mandatory benefit across Medicaid.

Other recommendations are more system-wide. For example, BPC suggests increasing collection and analysis of data from both public and private prevention programs; financial incentives for small business worksite health promotion; and increased health promotion strategies for the federal workforce.

With regard to the Prevention and Public Health Fund, BPC recommends that it be invested in demonstration programs to identify effective prevention strategies, and NCHC opposes further cuts to the fund and suggests that it be supplemented with discretionary funding.

5.4 Reduce Fraud, Waste, and Abuse [Medicare, Medicaid, Private Payers]

Several of the proposals offer a range of recommendations to address waste, fraud, and abuse in federal health care programs and in the health care system generally. For example:

- BPC suggests implementation of the Medicaid and Children’s Health Insurance Program (CHIP) Payment and Access Commission’s recommendations to strengthen Medicaid program integrity.
- NCHC recommends expanded Medicare payment penalties for high rates of avoidable complications and readmissions, as well as readmissions-related reforms for skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, and home health payment.
- NCHC also recommends increased funding for HHS’s Health Care Fraud and Abuse Control Program and a strengthening of federal antifraud authorities and infrastructure.
- MOT recommends a range of Medicare proposals to reduce waste, fraud, and abuse, including validating physician orders for high-fraud services, requiring prior authorization for advanced imaging, recouping erroneous payments and eliminating double-bonus payments to MA plans, and restricting and monitoring physician self-referrals. It also recommends adoption of the reforms in the Coburn-Carper FAST Act.
- CAP echoes the call for expanding the ban on physician self-referrals and for correcting Medicare payments for overpriced services, and argues for reduction of “excessive” Medicare payments for a range of providers and facilities. CAP also recommends that Medicare recover overpayments to private plans for risk adjustment and that the program increase efforts to root out improper payments and fraud.

5. 5 Promote Administrative Simplification [Medicare, Medicaid, Private Payers, FEHBP]

The majority of the proposals include suggestions for administrative simplification. Most are administrative reforms that would apply across payers. For example:

- BI recommends simplification and standardization of administration requirements, such as a standardized claim form and methods for plan data-sharing, as well as consistent methods for quality measures and out-of-pocket cost information.
- CMWF similarly recommends more uniform administrative policies and procedures across plans to reduce provider and plan administrative costs and complexity. CMWF also recommends integration of enrollment processes between Medicaid and insurance exchanges.
- The CAP proposal also calls for standardized electronic exchange of eligibility, claims, and other information among payers and providers.
- PSHC recommends shared health IT standards across health plans, providers, and vendors.
- NCHC suggests a single common provider credentialing system.
5.6 Reform Medical Malpractice Systems [Medicare, Medicaid, Private Payers, FEHBP]

All seven proposals reflect concerns regarding the current medical malpractice system. Several areas of consensus emerged:

Evidence-Based Guidelines and Malpractice: There was significant consensus around the need to link malpractice defense to evidence-based guidelines or quality measures. BPC recommends an Institute of Medicine panel on whether such measures could be used as a basis for provider defense, as well as consideration of a federal incentive to states to adopt evidence-based quality measures as potential defenses. BI recommends that states also consider “safe harbor” laws based on quality and safety performance. CMWF also encourages protection for providers using such standards, and PSHC suggests a process that includes consideration of whether such standards were complied with. NCHC suggests grant funding for states to develop evidence-based “safe harbors.” MOT and CAP also endorse the availability of “safe harbors” for providers meeting evidence-based guidelines.

Alternative Malpractice Models: BPC and BI recommend increased opportunities for states to develop alternative malpractice models.

Legal Procedure: Several proposals make recommendations related to legal procedure: PSHC recommends that courts be empowered to retain their own medical experts; NCHC recommends health courts for malpractice claims in the U.S. Court of Federal Claims, with claims heard by specialized tribunals or judges; and MOT recommends a statute of limitations, elimination of “joint and several liability,” and other procedural malpractice reforms.

Disclosure of Errors: MOT, NCHC, and CMWF recommend policies encouraging disclosure of errors by providers.

5.7 Increase Medicare Eligibility Age

The MOT proposal is the only one to recommend increasing the Medicare eligibility age, suggesting that the increase occur gradually until it reaches, and is then locked to, the Social Security retirement age; alternatively, the proposal recommends allowing participation in Medicare starting at age 65 but with actuarially increased premiums.

5.8 Promote Comparative Effectiveness/Patient-Centered Outcomes Research and Utilization of Such Data [Medicare, Medicaid, Private Payers]

Most of the proposals recommend increased collection and use of data to identify effective clinical and other services. For example:

- BPC recommends increased collection, analysis, and dissemination of data from public and private prevention programs, as well as investment of Prevention and Public Health Fund money in demonstration programs for prevention strategies.
- CMWF encourages the provision of better data to inform high-cost medical treatment choices and the establishment of registries to track experience with medical devices and other high-tech procedures.

Medicare and Comparative Effectiveness: Some recommendations focus specifically on comparative effectiveness information within Medicare. PSHC recommends that comparative evidence be used to set payment rates within Medicare; that the Medicare Shared Savings Program and Pioneer ACOs have additional flexibility to tier cost-sharing based on clinical effectiveness (and other factors); and that MA plans be allowed to vary cost-sharing based on clinical effectiveness and other factors. NCHC recommends implementation of MedPAC’s recommendation that the Secretary of HHS be able to vary cost-sharing based on evidence of effectiveness, along with lifting curbs on tiered cost-sharing in MA. CAP recommends the
use of shared decision-making in Medicare for high-cost conditions, as well as requiring patient decision-aids in Medicare primary care medical homes and ACOs.

SECTION 6: REVENUE, SPENDING TARGETS & OTHER REFORMS

Several proposals include recommendations related to taxes incentivizing healthier consumer behaviors, and others recommend changes to the tax treatment of health insurance. All seven proposals include some form of spending target, but they vary widely in type and scope.

6.1 Reform Federal Taxation Policies to Incentivize Consumer Behavior

NCHC recommends a set of federal tax reforms to promote healthier consumer behavior, including equalizing taxation of cigarettes and other tobacco products and increasing overall federal taxation on tobacco products. NCHC also recommends a federal excise tax on sugar-sweetened beverages and equalizing, and updating for inflation, taxes on beer, wine, and liquor. CAP similarly recommends taxing all tobacco products at the same rate and increasing the federal excise tax on cigarettes and small cigars.

6.2 Reform the Tax Treatment of Health Insurance [Private Payers]

Several proposals include reforms to the federal tax treatment of private health insurance, such as:

- BPC recommends replacing the “Cadillac tax” on high-cost employer-sponsored health benefits with a limit on the income-tax exclusion for employer-sponsored health benefits. BPC also recommends replacing the Affordable Care Act (ACA) tax on fully insured plans with a paid-claims tax.
- BI recommends that the subsidy of employer-provided health insurance be capped and that the ACA provision on taxing high-premium insurance plans be retained. CAP also recommends, contingent on ACA’s coverage expansion, limiting the tax exclusion for employer-based health insurance for high-income families.

6.3 Establish Spending Targets [Medicare, Medicaid, Private Payers, FEHBP]

All seven proposals recommend certain spending targets, some at program levels and some at global levels.

Program Level Spending Targets: At the program level, several proposals focus on Medicare. BPC’s Medicare Networks would include an individual spending target for each Medicare Network, based on historic spending for enrolled beneficiaries; these targets would eventually be regional and risk-adjusted. BPC also recommends a fallback spending limit to restrain per-beneficiary spending growth. BI’s MCC would give collaborations of providers a globally capitated, comprehensive payment for their beneficiaries. NCHC recommends a value-based withhold in Medicare with a specified amount of savings from certain reforms; if those savings don’t materialize, a percentage withhold would be applied to Medicare payment.

Global Level Spending Targets: Several proposals also recommend caps or targets at a more global federal or state level:

- CMWF proposes a target for total public and private spending to grow at a rate no greater than economic growth.
- MOT recommends a cap on the growth of per-beneficiary net federal commitment to health care.
- PSHC does not recommend federal targets, caps, or limits, but suggests a focus at the state level, including a gain-sharing program for states to innovate to control health care costs.
- CAP similarly suggests Accountable Care States, with global targets for health care spending by all payers.