Commonwealth Fund Task Force on Payment and Delivery System Reform

Health Care Delivery System Reform:
Six Policy Imperatives

The Commonwealth Fund

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Commonwealth Fund Task Force on Payment and Delivery System Reform

OVERVIEW

Despite its centers of academic excellence, world-renowned research, and leadership in innovation, the U.S. health care system is also known for other traits: high costs, fragmented coverage and care, uneven quality of services, and pervasive inequities. Overlay the ravages of the COVID-19 pandemic on these shortcomings, and the list grows longer: unprepared, disorganized, dysfunctional, and inefficient.

Attempting to overcome these deficiencies, health systems in the U.S. have long studied, tested, and adopted improvements in the delivery of care. For their part, payers and policymakers have sought to encourage these improvements through incentives and mandates. Yet health care delivery systems continue to demonstrate high levels of inefficiency, while longstanding disparities in care persist by race and ethnicity, income, gender, and geography.

The Commonwealth Fund Task Force on Payment and Delivery System Reform believes that meaningful improvements to how health care is organized, paid for, and delivered are both needed and possible, even at a time when discourse around health care is politically contentious. The Commonwealth Fund in March 2019 convened the Task Force — whose membership includes delivery system leaders, health insurance executives, patient advocates, current and former federal and state officials, and business leaders reflecting a wide array of expertise and perspectives — to look back on more than a decade of experimentation and innovation in payment and care delivery. Drawing on evidence from these initiatives, and on their own expertise, Task Force members reached consensus on a concrete policy agenda that could inform congressional and legislative attempts to put the nation on a path to health care system improvement over the next 10 years.

It should be noted that achieving meaningful improvements that benefit all Americans will require many far-reaching initiatives and reforms that this report does not address. These include: significant expansions in health care coverage; a stronger public health system; measures to address social determinants of health; and efforts to eliminate deeply embedded racism in society generally and in health care in particular. The Task Force also recognizes that in focusing on federal action, the report does not speak to the critical role states have in improving the health of their residents.

These limitations, however, do not obviate the critical role of federal leadership in addressing the flaws in our health care system and in stimulating efforts within the private sector. The Task Force chose to start at the national level and with delivery system reform, an area holding substantial opportunities for bipartisan collaboration — a particularly important consideration as the nation confronts health, social, and economic crises that are devastating already vulnerable communities and straining our health care workforce.

VISION AND GOALS

The Task Force's overarching vision is to ensure that all Americans — regardless of race and ethnicity, income, gender or geographic location — have access to high-quality, equitable, affordable health care. To achieve this vision, we outline three goals:

1. **Improve the quality** of health care services delivered to patients and communities, enabling health systems and providers to contribute to improvements in population health.

2. **Advance equity** in health care access, quality, and outcomes, particularly for people of color, individuals with low income, women, and people in rural areas.

3. **Increase the affordability** and financially sustainability of health care for patients, families, payers, employers, and government.

Because sound metrics are essential to achieving each of these goals, the Task Force selected measures to monitor progress toward meeting them (Exhibit 1).

EXHIBIT 1. SELECTED METRICS FOR MONITORING PROGRESS TOWARD TASK FORCE GOALS

Goal #1: Improve quality of care

Selected Metrics:

1. Performance and trends on patient-centered care, patient safety, healthy living, effective treatment and care coordination (AHRQ National Health Care Quality & Disparities Reports)

Goal #2: Advance health equity

Selected Metrics:

1. Disparities in measures of access, quality, and outcomes of health care by race/ethnicity, income, gender, and by urban/rural populations (AHRQ National Health Care Quality & Disparities Reports)

2. Racial disparities in maternal and infant mortality and morbidity (CDC National Pregnancy-Related Mortality Surveillance & National Center for Health Statistics data)

Goal #3: Increase affordability

Selected Metrics:

1. Growth in health care spending in relation to growth of GDP (Congressional Budget Office)

2. Rate of cost-related access barriers (Commonwealth Fund Biennial Health Insurance Survey)

PROCESS

The Task Force developed its recommendations over the course of several in-person and virtual meetings between May 2019 and October 2020. It began its work with an extensive review of the evidence on payment and delivery system innovations over the last decade (see bibiliography), which later expanded to include lessons from prior health-related disasters as well as emerging lessons from the COVID-19 pandemic. The recommendations were further informed by the knowledge and expertise of Task Force members, each of whom is a health care leader with decades of experience. The consensus recommendations were then shared with an array of other stakeholders and experts for their review and comment.

This report does not provide extensive rationales for each recommendation. Task Force members and Commonwealth Fund staff, however, are available to provide readers with further explanation.

OVERVIEW OF RECOMMENDATIONS

The Task Force has identified six policy imperatives for achieving its goals:

1. **Increase delivery system preparedness for health disasters.**

2. **Increase health system accountability for health care quality, equity, and cost.**

3. **Strengthen the nation's primary health care system.**

4. **Support empowerment and engagement of people, families, and communities.**

5. **Reduce administrative burden.**

6. **Encourage a balance of regulatory and competitive approaches to promote a high-performing health system.**

These imperatives are essential to helping the nation chart a course to a health system that enables all Americans to lead long, healthy, and productive lives. To implement the recommendations, the Task Force also identified a range of tactics and policies. Following are few examples to illustrate the depth and breadth of the ideas contained in the full report.

1. **Increase health care delivery systems' preparedness for health disasters.** The COVID-19 pandemic has exposed numerous deficiencies and inequities in the U.S. health care system and its capacity to prepare for, or respond to, any national health-related crisis — not just a novel virus. Without better policies and systems in place to ready our delivery systems against national disasters, Task Force recommendations to improve quality, advance equity, and lower costs will be ineffective.

   We identified three key areas for federal policymakers to ensure health care delivery systems are prepared to partner effectively with their public health counterparts: improved digital systems for communication and data collection; updated workforce policies that allow for flexibility in care delivery; and development of a refined national crisis response strategy. The Task Force outlines several recommendations, among them:

   • Congress should amend federal legislation to strengthen surveillance systems to better track epidemic and nonepidemic illnesses and the health impacts of public health crises, as well as to ensure the availability of vital supplies for managing surges in such conditions.

   • Congress should empower the U.S. Department of Health and Human Services (HHS) to develop and implement an interoperable and secure public health information system that enables rapid and secure exchange of standardized electronic health information. This system should include necessary data drawn from public and private organizations, such as public health departments, laboratories, providers of clinical care, and manufacturers.

2. **Increase health system accountability for health care quality, equity, and costs.** Over the past 10 years, the federal government has invested in many payment and delivery reforms. These experiments have yielded insights into what works, what shows promise, and what should be discontinued. Based on a careful review of the evidence, the Task Force offers guidance to accelerate the adoption of value-based payment approaches in Medicare and Medicaid and lays out criteria for the Center for Medicare and Medicaid Innovation (CMMI) to set priorities to maximize success over the next five years. Example recommendations include:

   • The Centers for Medicare and Medicaid Services (CMS) should require all Medicare providers to participate meaningfully in promising value-based payment arrangements. The agency should offer financial and technical assistance for providers that need it and permit limited exceptions as necessary.

   • In Medicaid and the Children's Health Insurance Program, Congress should allow a higher federal match rate for promising value-based payment approaches.

3. **Strengthen the nation's primary health care system.** Evidence shows that a strong foundation of primary care is associated with better health outcomes, greater equity, and lower per capita costs. Yet the primary care system in the U.S. often falls short, especially for people of color, women, individuals with low income, and rural residents. The Task Force envisions a team-based primary care system for the 21st century, one that is untethered to a clinician's office, tech-enabled, and fully capable of addressing behavioral health and social needs.

   Recommendations for federal policymakers focus on reforming payment for primary care services, increasing the supply and retention of primary care clinicians, and leveraging telemedicine. For example, the Task Force recommends:

   • CMS should significantly increase reliance on capitated and hybrid prepayment models in primary care.*

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* Capitated payments are prospective, fixed per patient, per month (or year) payments for a defined set of services regardless of the quantity provided. Hybrid payment models use a combination of capitated payments and fee-for-service payments for selected high-value services.

- CMS should establish a new process for determining the value of primary care services and compensation for clinicians who provide them. The new approach should ensure the financial viability and attractiveness of a career in primary care and be modified over time to support a robust clinician supply.

4. **Support the empowerment and engagement of people, families, and communities.** Partnerships between providers, patients, and their communities are essential to ensuring our health system offers high-quality care, achieves value, and reverses longstanding racial and ethnic disparities. The Task Force recommends engaging patients, family caregivers, and communities in codesigning new delivery models and policies, in confronting and combatting racism in health care, in promoting availability of digital tools and telehealth services, and strengthening policies to protect the privacy and security of patients' personal information. Here are two of the many recommendations in this area:

   - HHS and national health care accreditation organizations should require all provider organizations and insurers, in partnership with patients and communities, to develop, implement, and maintain plans and programs for eliminating health disparities and combatting structural racism in their organization and to publicly report progress in meeting goals.

   - Congress should fund, through the Federal Communications Commission, the establishment of broadband internet service in all communities currently lacking it.

5. **Reduce administrative burden.** Without addressing the complexities in our health system that contribute to financial waste, patient frustration, and clinician burnout, the U.S. will simply not achieve high performance. To reduce administrative burden and costs, the Task Force calls for changes in billing and payment; streamlined, standardized performance measures; and removal of unnecessary administrative

obstacles at the point of care. By way of example, the Task Force recommends:

- Congress should direct the Office of the National Coordinator for Health Information Technology (ONC) and CMS to create a uniform, national, standardized billing system for all private and public payers.

- Congress should direct HHS to establish a parsimonious set of core quality and equity metrics that can be used by all payers and clinicians.

6. **Encourage a balance of regulatory and competitive approaches to promote a high-performing health system.** The recommendations from the other five areas will be effective only if they are accompanied by efforts to address notable failures in health care markets. The Task Force recommends a range of regulatory and competition-promoting policies, including antitrust enforcement, to produce more efficient health care markets that deliver greater benefits to everyone. Examples include:

   - Congress should require the federal government to correct market distortions and control costs in areas where health care competition is absent and states have failed to implement remedies.

   - HHS should fully implement current authorities, and Congress should pass new legislation as necessary, to provide payers and purchasers in local markets with transparent information on price, quality, and utilization (stratified by demographic identifiers including race, ethnicity, age, gender, and zip code) for each individual service and episode of care.

Imperative 1: Increase Delivery System Preparedness for Health Disasters

The COVID-19 pandemic has exposed numerous deficiencies and inequities in the U.S. health care system and in its capacity to prepare for and respond to national health crises. The federal government and the states are struggling to coordinate and distribute resources. Health care delivery systems are rushing to respond, despite a lack of needed equipment, technology, and information systems and despite a reduction in revenues generated under their current business models and payment systems. Our health care workers, who have met the pandemic with bravery, are nonetheless striving to meet the demand for care.

Our nation's disorganized and often uncoordinated response to the pandemic has also pulled back the curtain on the structural racism present in our society and our health care system, including its devastating impact on access to care and health outcomes for people of color.

Achieving and sustaining a more equitable, higher-quality, and less costly health care delivery system will require a paradigm shift toward a culture of national preparedness. Health care delivery systems will need to prepare to team up with their public health counterparts to protect patients, communities, and workers during any kind of emergency, including a pandemic. Without emergency preparedness, the other system improvements the Task Force advocates may not hold during national crises.

In reflecting on lessons from the COVID-19 pandemic, the Task Force has identified three key areas for federal policymakers to ensure health care delivery system preparedness in the event of national emergency: improved digital information systems for communication and data collection; updated workforce policies that allow for flexibility in care delivery; and development of a national crisis response strategy. These recommendations for increasing preparedness complement other areas
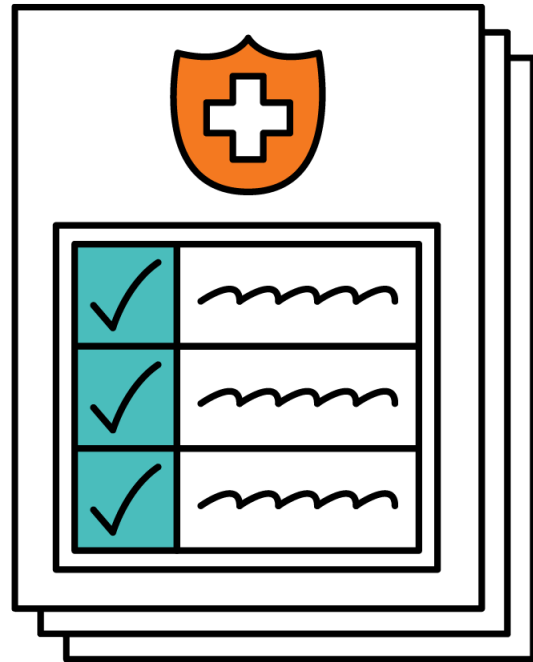
we highlight, such as creating sustainable payment mechanisms, strengthening our primary care system, and expanding the use of telehealth.

While we do not address the issue here, the Task Force recognizes that disaster preparedness must also include shoring up our public health system, whose weaknesses have been exposed so dramatically by COVID-19. Here, the Task Force focuses on the elements of disaster preparedness that concern our health care delivery system.

Leverage Digital Information Solutions, Data, and Research to Support National Disaster Response

1. Congress should amend existing legislation to create and regularly test a national preparedness information and surveillance system that tracks in real time the health effects of a public health crisis — such as presence of disease — and the supply of, and need for, vital resources for managing such crises. The amended legislation should:

a. Facilitate public–private collaborations and increase coordination among academic health centers, community hospitals, community health centers, private clinics, suppliers, manufacturers, public agencies, and other pertinent actors.

b. Require health systems, pharmacies, suppliers, and manufacturers to collect and share on a daily basis relevant data with local, state, and federal government officials during national emergencies to help the country monitor and manage the crisis. This should include information reported with demographic identifiers such as race, ethnicity, age, gender, and zip code.

c. Require that essential equipment be tagged with radio frequency identification (RFID) as appropriate.

d. Set parameters for data use agreements and ensure systems align with protections to ensure civil liberties, due process, nondiscrimination, and data and health privacy.

2. Congress should empower HHS to develop and implement an interoperable and secure public health information system, based on open-source APIs (application programming interfaces), that enables the rapid and secure exchange of standardized electronic health information necessary to meet the nation's public health needs. This system should include data drawn from public and private organizations that are critical to addressing national public health emergencies, including public health departments, laboratories, health systems, clinicians, manufacturers of medications and equipment, suppliers, and other parties.

3. Congress should legislate a national health data privacy and security framework that ensures the private, secure use of personal health data and personal digital tools in managing national health disasters. Such a framework should balance patients' right to privacy and security of information with the need for providers' access to data essential for patient care.

4. The federal government should establish a research and development fund for health system preparedness, to be managed cooperatively by the National Institutes of Health's Office of Emergency Care Research, the Assistant Secretary for Preparedness and Response, the CDC, and the Agency for Healthcare Research and Quality (AHRQ).

5. Congress and CMS should make permanent recent regulatory flexibilities in Medicare and extend appropriate flexibilities to Medicaid to enable expanded use of telehealth. These should be subject to ongoing evaluation of the safety, efficacy, equity impacts, and cost-effectiveness of alternative technologies and approaches to providing virtual care.

a. Funding should accompany any permanent expansion of telehealth flexibilities to ensure support for expanded access to broadband services, particularly in medically underserved communities (see Section 4, Recommendation 13).

Prepare the Health Care Workforce and Delivery Systems for Disasters

6. Congress should fully fund provisions in the Affordable Care Act (ACA) that require HHS to train more experts with advanced degrees in public health epidemiology and emergency preparedness and response.

7. Congress should develop and fund a national preparedness training program for community health workers and other nonclinical frontline personnel to ensure they are ready and able to respond to health-related emergencies through outreach, public education, and public health surveillance activities.

8. HHS should facilitate the development of interstate compacts enabling health professionals to practice across professional and geographic boundaries during national emergencies.

9. HHS should work with national accreditation agencies like the Joint Commission to review and update their requirements for preparedness plans on the part of health care delivery organizations.

10. Congress should give HHS the authority to provide emergency funding to primary care clinicians during national health emergencies, with priority given to practices in rural, underserved, or highly impacted areas.

11. Congress should fund the Indian Health Service to assist preparations for national emergencies and strengthen coordination among federal, tribal, state, and local health agencies.

12. CMS should allow states to make retainer payments to essential Medicaid clinicians during national emergencies through Section 1115 waivers.

13. HHS and the Federal Emergency Management Agency (FEMA) should develop an emergency response plan for assessing and meeting the physical safety and behavioral health needs of health care workers and first responders, at no additional cost to them, during national health care crises.

Develop, Implement, and Regularly Update a National Strategy for Disaster Response

14. Congress should establish a nonpartisan, independent commission of experts, including delivery system leaders and public health experts with both operational and logistical expertise, to assess the nation's response to the novel coronavirus pandemic and make recommendations to raise the nation's preparedness level and the resiliency of the care delivery system. Relevant federal agencies should implement and update annually the applicable federal recommendations of the nonpartisan commission. At a minimum, the commission's recommendations and subsequent congressional action should address:

    a. Local, state, and federal responsibilities during crises, including a governance structure for national response and coordination among federal agencies and between the federal government and the states.

    b. A transparent, real-time national inventory of necessary supplies and equipment. HHS should develop and make public an allocation strategy focused on delivery systems that ensures critical supplies are distributed on the basis of population health needs and that promotes collaboration — not competition — among states.

    c. Proper funding and mechanisms to support surge capacity within the acute care system.

    d. Systems and requirements for national, state, and local authorities to regularly collect and report data critical to managing national response to disasters in real time, including: the potential and actual impact of disasters, broken down by race, ethnicity, age, gender, zip code, disability status, pregnancy status, and facility type (whether long-term care or correctional facilities).

    e. Measures to address people's behavioral health needs, including assessment, prevention, and treatment, both during and after a national disaster.

    f. Necessary increases in funding for the Hospital Preparedness Program to enable hospitals and health systems to implement federal, state, and local recommendations.*

15. Congress should authorize an emergency response fund for the CDC that would automatically appropriate funds to the agency when a national emergency is declared, the amount of which would be predetermined by Congress. Clear guidance on CDC accountability and congressional oversight would be needed, as well as a mechanism for continuing funding after the emergency's initial phase has been addressed.

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* The Hospital Preparedness Program, operated by the Assistant Secretary for Preparedness and Response, offers federal funding to states to improve health system preparedness and response for large-scale national emergencies, with the goal of maintaining a consistent national focus on preparedness, improving patient outcomes during emergencies, and fostering recovery after disasters (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness, 2016).

Imperative 2: Increase Health System Accountability for Health Care Quality, Equity, and Cost

Payment and delivery system reforms have long been levers for improving health care quality, increasing equity, improving health outcomes, and lowering health care costs. Over the past 10 years, the federal government and states have invested in and accelerated the adoption of such reforms. These experiments have yielded insight into what works, what shows promise, and what should be retired. This period of innovation has also revealed areas of unmet need, particularly around confronting and combatting structural racism* within the health care system.

Based on our careful review of the evidence on value-based payment models from the past 10 years, the Task Force recommends that federal and state officials speed up the adoption of promising value-based payment approaches in Medicare and Medicaid that enhance accountability for health care cost, quality, and equity. The Task Force believes acceleration toward value-based payment is critical at this juncture, particularly as Medicare faces insolvency, possibly as soon as 2024, and Medicaid accounts for an increasing share of state budgets. We focus on federal policy in this area for these reasons, and also because Medicare and Medicaid have powerful direct and indirect influence on the behavior of private actors, including commercial payers.

While transferring more financial risk to elements of the health delivery system will come with its challenges, the COVID-19 pandemic has also highlighted the benefits of value-driven payment approaches to health systems and clinicians. Uncoupling compensation from the volume of services provided could increase financial security and flexibility to adapt to crises. Under fee-for-service arrangements, providers' financial survival depends

on their throughput; during disasters, however, when providers' services are most needed, their financial survival can be jeopardized by dramatic declines in revenue. An additional benefit of prospective advance payment is that it creates the aligned incentives that are critical to creating shared accountability for quality, cost, and equity among the many parties whose actions are essential to improving our health care delivery system.

While evidence indicates that payment reform is a critical tool, it alone will not transform the care delivery system. This is why the Task Force proposes several other federal actions, including creating a robust primary care system, reducing administrative burden, and engaging patients and their families in the design and delivery of care.

Improve and Accelerate Value-Based Payment in Medicare

1. Building on lessons learned from efforts to reform provider payment in Medicare, and incentivized by opportunities to reduce administrative burden (see Section 5, "Reduce Administrative Burden"), Congress

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* Structural racism refers to "the totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable systems (in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, and so on) that in turn reinforce discriminatory beliefs, values, and distribution of resources, which together affect the risk of adverse health outcomes" (Bailey et al., 2017).

should require that providers in Medicare participate in promising value-based payment (VBP) arrangements that reward them for:

a. Slowing the rate of cost increases among the patients and communities they serve.

b. Meeting requirements based on a new, parsimonious set of standardized quality goals that include indicators of patient experience (see Recommendation 3 under "Reduce Administrative Burden").

c. Reducing disparities in process and outcomes measures by race, ethnicity, age, gender, and zip code (see Recommendation 3 under "Reduce Administrative Burden").

d. Partnering with community-based entities to address the comprehensive health needs of patients, including behavioral health and social needs (such as supportive housing and access to essential nutrition) that have been demonstrated to improve health, increase equity of health services, and/or lower costs of care.

2. To promote uptake and ensure successful implementation of these payment reforms, CMS should:

a. Make start-up capital and technical support available to small, rural, and independent practices and to practices in medically underserved areas so they can succeed with VBP.

b. Permit limited exceptions for certain clinicians, health systems, or regions where alternative payment arrangements cannot be implemented effectively.

c. Increase auditing of coding practices to ensure risk adjustment is valid and appropriate, that it incorporates relevant socioeconomic variables, and that clinicians and health care organizations do not engage in risk selection, cherry-picking, or upcoding.

d. Provide stronger incentives for clinicians and health care organizations to address social determinants of health in traditional Medicare and in Medicare Advantage.

e. Where possible, align structure, payment approach, and quality metrics with state Medicaid VBP efforts.

f. Hold constant or lower fee-for-service reimbursement rates to encourage migration to VBP arrangements by nonexempt clinicians.

3. VBP arrangements should include substantial downside risk (with limited exceptions as noted in Recommendation 2b in this section) as well as approaches proven to, or highly likely to, achieve greater value and reward clinicians for delivering high-quality care, such as:

a. Accountable care organizations.

b. Physician-led models or programs.

c. Medicare Advantage plans that delegate risk and resource-allocation decisions to all or most of the clinicians in their networks.

d. Other arrangements certified by CMMI or recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) (see Recommendation 11 in this section).

4. To increase the value of prescription drugs in Medicare and address concerns about their affordability, we recommend that:

a. CMS and/or CMMI test alternative payment models specifically for prescription drugs, in which payments to stakeholders are tied to value through improved outcomes, reduction in disease complications, or increased consumer affordability (e.g., lower out-of-pocket costs).

b. CMS include Medicare Part D spending in total-cost-of-care calculations for accountable care organizations (ACOs) and other alternative or value-based payment arrangements.

c. Congress and CMS develop and implement incentives to encourage the prescribing of lower-cost drugs in Medicare, for example by:

    i. Reforming Medicare Part B reimbursement to encourage clinicians' use of lower-cost biosimilar products when they are available.

    ii. Requiring Medicare Part D plans to favor a biosimilar over a reference biologic (when the biosimilar has a lower net price) through formulary management or copay rules, and by lifting prior authorization and utilization management requirements for biosimilars.

    iii. Increasing financial risk for drug manufacturers and plan sponsors under Medicare Part D in a manner that does not increase premiums for beneficiaries.

    iv. Requiring Medicare Part D plans to add FDA-approved generic and biosimilar drugs to their formulary as soon as the generic or biosimilar comes on the U.S. market, and allowing plans to place generic or biosimilar drugs on tiers to encourage use of drugs with the lowest net price.

    v. Strengthening the FDA's clinician education campaign on the safety and efficacy of biosimilar products and interchangeability.

d. Congress pass legislation to lower the cost of prescription drugs for Medicare beneficiaries by revising the current benefit structure to require a firm cap on annual out-of-pocket spending for prescription drugs under Medicare Part D.

In Partnership with States, Improve and Accelerate Value-Based Payment Models in Medicaid and the Children's Health Insurance Program (CHIP)

5. CMS should encourage state Medicaid and CHIP programs to develop value-based payment arrangements that reward all health systems or clinicians for:

a. Slowing the rate of cost increases among the patients and communities they serve.

b. Meeting a parsimonious set of standardized quality goals that include indicators of patient experience (see Recommendation 3 under "Reduce Administrative Burden").

c. Reducing disparities in process and outcome measures by race, ethnicity, age, gender, and zip code (see Recommendation 3 under "Reduce Administrative Burden").

d. Providing and/or partnering as needed with community-based entities to offer the full complement of services needed by their patients, including integration of behavioral health services, interventions to address social determinants of health, and oral health.

6. To promote uptake and ensure successful implementation of these recommendations:

a. Congress should authorize higher federal match rates (federal medical assistance percentage, or FMAP, rates) for states implementing value-based payment programs meeting the above requirements.

b. CMS should, where possible, align structure, payment approach, and quality metrics with federal Medicare VBP efforts.

c. CMS should offer technical assistance to participating states and encourage them to:

    i. Develop an explicit "glide path" for helping Medicaid and CHIP clinicians to successfully transition from upside-only to two-sided risk within a two-year period.

    ii. Make start-up capital and technical support available to small, rural, and independent practices and practices in medically underserved areas so they can succeed with VBP.

    iii. Permit limited exceptions for certain clinicians, health systems, or regions where alternative payment arrangements cannot be implemented effectively.

    iv. Create stronger incentives for, and offer technical assistance to, clinicians and health systems to encourage provision of evidence-based nonmedical health benefits for beneficiaries.

    v. Increase auditing of coding practices to ensure that risk-adjustment is valid, that it is appropriate, and that it incorporates relevant socioeconomic variables, as well as to ensure that clinicians and health care organizations do not engage in risk selection, cherry-picking, or upcoding.

d. CMS should allow states the flexibility to align managed care rate-setting with value-based payment concepts to reward plans for long-term investments (such as allowing states to set multiyear rates and base rates on factors beyond historical claims or utilization of medical services).

Increase Adoption of Integrated Care for People Dually Eligible for Medicare and Medicaid

7. Congress should enable CMS and/or state Medicaid agencies to automatically enroll all full-benefit dually eligible beneficiaries into integrated plans (accompanied by the protections and supports listed in Recommendations 8 and 9 in this section), with the following requirements:

a. That integrated care plans include Medicare-Medicaid plans, fully integrated or highly integrated dual-eligible special needs plans (FIDE/HIDE SNPs), or the Program for All-Inclusive Care for the Elderly (PACE).

b. That beneficiaries have the option to disenroll in accordance with existing Special Enrollment Period options and be regularly notified of the option.

c. That Congress provide additional federal funds to enhance states' capacity to develop expertise in Medicare and to implement integrated care models.

8. The CMS Medicare-Medicaid Coordination Office should:

a. Closely monitor individual Medicare-Medicaid plan performance on quality and equity, with particular attention to the experience of different subpopulations of enrollees, such as those determined by race/ethnicity, age, gender, zip code, functional status, disability status, or chronic conditions.

b. Rigorously evaluate the aggregate effects of integrated products on quality of life, total health care spending, and equity of care.

c. Make upfront financial support and technical assistance available to states and plans for the implementation of integrated models.

d. Address financial and regulatory barriers that have hindered the spread and scale of models to date.

9. CMS should require and fund all state Medicaid programs to enhance their capacity to improve care integration with the Medicare program by having:

a. Well-staffed help lines to assist dually eligible beneficiaries in understanding and navigating their benefits.

b. Dedicated ombudsperson programs for people dually eligible beneficiaries.

c. A dedicated Medicare person to coordinate the dual-eligible program and collaborate with CMS.

10. Congress should provide general waiver authority to the HHS secretary to align administrative differences between the Medicare and Medicaid programs, while protecting essential program benefits and patient rights.

Identify Top Five CMMI Priorities for Strategic Investment over the Next Five Years to Promote Value-Based Payment and Delivery System Reform

11. CMMI should review existing and past initiatives to identify no more than five to prioritize for investment over the next five years.

    a. CMMI should accelerate successful models (such as ACOs, home-based primary care, multipayer models, and mandatory surgical episode bundled payments) with necessary adjustments based on evidence and/or expert opinion.

    b. Where there is compelling need and emerging evidence to suggest their efficacy, CMMI should test new initiatives in areas such as:

        i. Phased-in site-neutral payments models.*

        ii. Geographic-specific payment models.**

        iii. Population-specific payment models.***

        iv. Condition-specific payment models.****

    c. CMMI should implement rapid-cycle evaluation techniques to assess its new and existing programs.

12. CMMI should, in partnership with communities of color, patient advocates, and other stakeholders, test care models that promote health equity and dismantle structural racism in health care. It should, for example:

    a. Develop new, improved risk-adjustment, quality-rating, and equity-rating methodologies and evaluate the impact of such models on measures to improve quality and increase equity across all demonstrations and initiatives.

    b. Accelerate existing and develop new models designed specifically to address social needs (such as food and housing insecurity, transportation issues, and financial or legal needs) and promote public–private partnerships — that is, partnerships between private-sector health care organizations and public health authorities, local governments, or social service organizations — for this purpose. This could, for example, involve pilot-testing the use of Medicaid dollars to pay for housing for high-need, high-cost patients for whom lack of secure housing is adversely affecting their health and increasing their use of health care resources.

    c. Expand national value-based payment demonstrations to reduce racial disparities in maternal mortality and birth outcomes based on interventions empirically shown to improve outcomes in experimental settings (such as use of doulas, midwives, community-based maternity models, and pregnancy medical homes).

    d. Develop health care innovation awards to pilot and evaluate methods of reducing health disparities, including confronting structural racism and implicit bias and addressing mistrust between communities of color and the health care system.

13. Congress should require the HHS secretary to add a "disparities mitigation" standard (in addition to standards for mitigating impacts on cost and quality) when evaluating which models piloted by CMMI are to be widely adopted by Medicare. This standard should examine whether the model reduces disparities, particularly by race and ethnicity.

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* Payment is equal for all services, regardless of site of care.
** Clinicians in a defined region take on risk for all beneficiaries in that region.
*** Clinicians bear risk for a defined group of patients with certain shared characteristics.
**** Clinicians bear risk for a defined group of patients with specific conditions (e.g., diabetes).

Imperative 3: Strengthen the Nation's Primary Health Care System

Comprehensive, coordinated, continuous, longitudinal, and first-contact primary care is not only the foundation of a high-performing health system but a critical complement to accelerated value-based payment. In fact, decades of rigorous research show that robust primary care is associated with better health outcomes, greater equity, and lower health care costs per person. Yet the U.S. primary care system often falls short, especially for people of color, individuals with low income, rural residents, and women. The supply and availability of primary care clinicians is inadequate for the need, and too many are inadequately compensated, overworked, and deeply stressed. Moreover, primary care is frequently unavailable to Americans after working hours, resulting in unnecessary use of emergency room services. The COVID-19 pandemic has further caused massive disruptions in health care, placing greater financial pressure on already strained primary care practices.

The Task Force aims to strengthen and modernize primary care in the U.S. so that it meets the health needs of patients, from prevention and chronic disease management to behavioral health and social services. Our vision for primary care in the 21st century is not limited to the traditional clinician's office, nor is it focused exclusively on the physician. Like the rest of our health care system, the primary care sector needs to innovate — for example, by using multidisciplinary care teams and digital health tools to promote sustained relationships between clinicians and patients.

To realize a high-performing primary care system such as this, we recommend that federal policymakers focus on three key areas: 1) reforming payment in order to support primary care improvement; 2) increasing the supply and retention of primary care clinicians, particularly in medically underserved areas; and 3) promoting telemedicine use. There are two components to reforming primary care payment, which is essential to strengthening
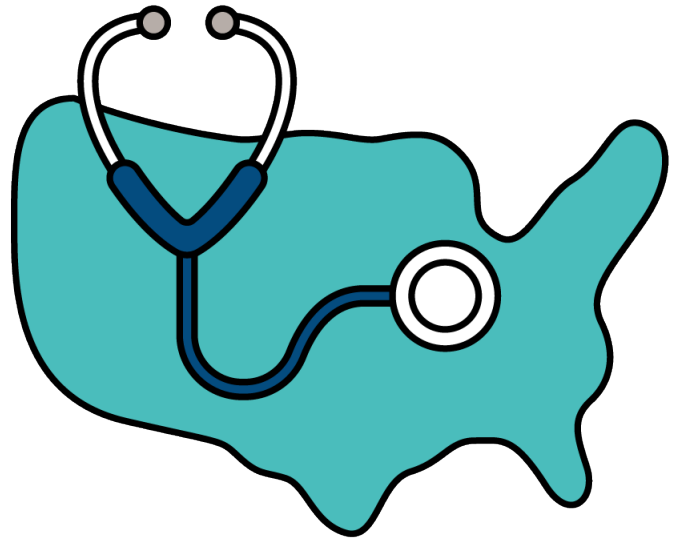
primary care: paying clinicians differently (through value-based payment) and paying them more to help compensate for decades of underinvestment.

While the recommendations advanced under other sections may apply to a range of providers and services, including primary care, additional and explicit federal action focused on primary care is needed to ensure we have a robust system at the frontlines for all Americans. Strengthening primary care in the ways outlined below would also reinforce other recommendations put forward by the Task Force, since primary care is essential to making our delivery system more prepared, effective, competitive, and beneficial for patients.

Improve Quality and Comprehensiveness of Care Through Payment Reform

1. CMS should significantly increase reliance on the following prepayment models in primary care:

   a. Capitated payment models, with appropriate risk adjustment, that subject providers to fewer administrative requirements that have been imposed to prevent overuse of services (such as prior authorization and post hoc utilization management).

b. Hybrid payment models that combine prospective approaches with modest levels of fee-for-service reimbursement to encourage the provision of highly valued services, such as chronic care, prevention, and care delivered outside of working hours. Hybrid models should be weighted toward capitation (at least 65% of compensation), risk-adjusted, and accompanied by fewer administrative requirements designed to prevent overuse of services.

2. CMS should review primary care payment approaches by Medicare Advantage plans and Medicaid managed care plans and develop incentives to encourage prepayment of primary care clinicians in the former.

3. Building on lessons from multipayer primary care models tested to date, CMMI should develop and test payment models that reward and enable primary care clinicians to:

    a. Address patients' behavioral health and social needs.

    b. Build continuous patient–clinician relationships.

    c. Tailor primary health care to the unique needs of women across the life course, such as integrating prenatal and postpartum care into primary care settings.

    d. Adopt team-based approaches to comprehensive medication management.

4. Congress should mandate that federally funded health centers transition a meaningful proportion of revenue to value-based payment arrangements in the next three years and establish technical assistance and financial support to facilitate this transition.

5. CMS should incentivize achievement of certified medical home status on the part of clinicians in or contracted with Medicaid managed care and Medicare Advantage plans.

6. CMS should develop incentives for primary care practices to achieve recognition by an accrediting

body for providing culturally and linguistically appropriate services.

7. The Health Resources and Services Administration (HRSA) and Substance Abuse and Mental Health Services Administration (SAMHSA) should expand upfront financial assistance, technical assistance, and training programs for integrating behavioral health into primary care practice settings, particularly for small, rural, and independent practices.

8. CMS and Congress should make home-based primary care (such as the Independence at Home model) a permanent option under Medicare and expand the populations that are eligible.

9. To strengthen primary care provision, Congress should provide HHS the authority to offer financial incentives to states that spend 10 percent or more of total health spending on primary care.

Expand Supply, Diversify, and Increase Retention of Primary Care Clinicians, Particularly in Underserved Communities

10. Congress and HHS should support enhanced and streamlined compensation of primary care clinicians as follows:

    a. Medicare, through its combination of payment mechanisms, should compensate primary care clinicians at a level such that, if the program were the sole payer, they would achieve an enhanced target annual income conditioned on productivity, quality, and equity metrics. This annual income should be high enough that it will increase the recruitment and retention of primary care clinicians, especially in rural and underserved areas.

    b. CMS should establish a new process for determining the value of and compensation for primary care services that is designed to ensure the financial viability and attractiveness of primary care careers and that is modified over time to ensure a robust supply of primary care clinicians.

c. Medicaid should reimburse primary care clinicians at Medicare rates, with the federal government covering 100 percent of the cost increase.

d. All federally regulated private insurance plans, including Medicare Advantage plans, should be required to compensate nurse practitioners and physician assistants for providing primary care without supervision by physicians and with appropriate accountability for quality, cost, and equity.

e. HHS should eliminate the practice of incident-to billing, whereby advanced practice registered nurses and physician assistants bill under a physicians' national provider identifier, in order to accurately assess the provision of primary care services and appropriately target resources.

11. Congress and HHS should adopt policies and supports to expand and diversify the workforce, particularly in medically underserved and high-poverty areas, by:

a. Substantially expanding the number of slots, generosity of scholarships, and loan forgiveness in the National Health Service Corps (NHSC) and Indian Health Service (IHS) scholarship and loan repayment programs.

b. Establishing goals for NHSC and IHS to recruit clinicians of color.

c. Increasing funding for programs authorized under Title VII of the Public Health Service Act that aim to diversify the health care workforce.

d. Substantially expanding the Teaching Health Center Graduate Medical Education Program and the Advanced Nursing Education Workforce program in medically underserved areas.

e. Convening a national technical expert panel tasked with identifying strategies beyond the NHSC and IHS to recruit primary care clinicians to serve in rural and frontier areas and retain them.

12. Congress should provide funding to further expand and strengthen the community health center program, for example, by:

a. Increasing the number of federally funded health centers in rural and high-poverty areas over the next 10 years.

b. Tasking the Bureau of Primary Health Care with developing and testing programs to increase clinical collaboration between clinicians at health centers and specialists in other settings (such as private practices, hospitals, and academic medical centers) to enhance access to specialty care for patients.

Promote Use of Telemedicine for Primary Care

13. Congress should legislate national rules specifying the scope of telemedicine practice and licensure for qualified primary care clinicians, including physicians and nonphysician practitioners who deliver services remotely.

14. Congress should authorize grants and loans that support the adoption of telemedicine by primary care clinicians and support clinician-to-clinician teleconsultation, particularly in rural, high-poverty, and medically underserved areas.

a. Congressional recommendations to promote telemedicine should be accompanied by expanded access to broadband services (see Section 4, Recommendation 13).

Imperative 4: Support Empowerment and Engagement of People, Families, and Communities

Engaging and empowering patients in health care has long been a goal of delivery system leaders and policymakers. Progress, however, has been slow and insufficient: reports of mistrust in the health care system are increasing; we continue to take a top-down approach to designing and delivering care; and there is ongoing racism, sexism, and other bias in the health care system.

By involving patients and communities more in the design of care delivery approaches and policies, we not only can improve patients' experiences, but we can also improve health outcomes, reduce the burden on clinicians, improve patient–clinician interactions and trust, and increase health system efficiency. Their perspectives can be powerful tools for identifying and combatting inequities, particularly structural racism, in our health system.

If the other recommendations in this report are realized, we will come closer to making health care more accessible, more patient-centered, and more appealing for people to interact with. For example, increasing the supply of primary care clinicians and reforming the way they are paid (see Imperative 3, "Strengthen the Nation's Primary Health Care System") could improve access to care and enable clinicians to spend more time with their patients — helping to build trust and continuous relationships.

However, even success in the other areas is not sufficient for achieving the level of health system performance the Task Force envisions. A separate and explicit focus on designing care delivery that is more authentically responsive to patients' needs is necessary to reverse longstanding trends in mistrust, disengagement, and disparities, as well as to improve health outcomes, equity, and affordability.

To place people at the center of care and increase patients' trust in and engagement with the health care system, we believe improvement in four policy areas is critical.

We urge: 1) greater collaboration with patients and communities to codesign improvement programs, develop policy, and serve on care teams; 2) a focus on confronting racism in health care; 3) greater and more equitable access to digital tools that enhance care, facilitate patient–clinician communication and patient self-management, and enable real-time collection of patient experience data; and 4) strengthened privacy protections that allow patients to engage more actively, and safely, in their care.

Engage Patients, Caregivers, and Local Communities in the Care Delivery and Policymaking Process

1. Congress should require the inclusion of patients, caregivers, and members of affected communities — especially people of color — in the design, development, and implementation of care models, payment and delivery system reforms, and other policy changes highlighted throughout this report.

   a. Congress should direct the HHS secretary to establish an office for community engagement at HHS to develop and oversee approaches for including patients, caregivers, advocates, and representatives of affected communities in these activities, as well as to ensure that the process is grounded in evidence and best practices.

2. Through payment policy, grants and loans, Congress and HHS should expand use of community health workers, *promotoras*, and peer navigators for specific services, such as care management, connection to social services, and engaging patients.

3. Congress and HHS should offer incentives to health systems to form, maintain, and meaningfully engage diverse patient advisory councils that reflect the communities they serve. Patient advisory councils should provide substantive input on strategy, policies, and care design. Building on evidence and best practice, HHS should provide these health systems with support on how best to recruit, train, and collaborate with community members on the councils.

4. HHS should develop and support education, information, and training programs for unpaid caregivers.

5. CMMI should test alternative approaches to providing financial protections and assistance to unpaid caregivers.

6. HHS should fast-track use of evidence-based, patient-centered care planning protocols that take into account patient goals and preferences for care throughout their lifespan, including end-of-life decisions.

7. To foster trust, CMS should require that patients have fully transparent and understandable information about provider payment and any financial incentives intended to influence provider behavior or performance in care models.

Confront and Combat Racism in Health Care

8. HHS and health care accreditation organizations, in partnership with patients and communities of color, should require health care entities — delivery systems, health plans, provider groups — to:

   a. Develop and implement plans and programs to eliminate racial and ethnic health disparities and to identify and combat structural racism in their organizations' programs, practices, and policies.

   b. Publicly collect data on, and report progress, in eliminating health disparities, such as information on activities that are underway and changes in racial and ethnic disparities in access, quality, and outcomes.

9. CMS should tie direct and indirect graduate medical education payments to training on structural racism and implicit bias and how to address it through antiracist medical practice, partnering with communities of color to develop the evidence-based curricula. HHS should similarly promote training on structural racism in all health professional training programs.

10. CMS should require health systems, plans, and provider groups to have diverse governing boards of directors reflective of the communities they serve — and including members of underrepresented minorities in particular — and make information about the demographic composition of the board publicly available.

11. CMS should develop and implement financial incentive programs that reward health care entities for:

    a. Recruiting and hiring clinicians and organizational leaders from their own community, in ways that are representative of that community.

    b. Deploying community benefit programs in which a set percentage of total operating expenses is dedicated to community programs for reducing racial health disparities, reducing mistrust in health care providers by marginalized groups, and addressing racism itself in the community.

    c. Establishing public–private partnerships that specifically address needs of communities of color.

12. CMS should coordinate with the Internal Revenue Service to require tax-exempt hospitals to report on disparities in care and outcomes by race and ethnicity in their communities as part of the mandated Community Health Needs Assessments.

Promote Digital Platforms for Patient Engagement

13. Through the Federal Communications Commission, Congress should fund the establishment of broadband internet services in all communities currently lacking them.

14. CMS should require all providers receiving Medicare and Medicaid reimbursement to offer all patients ready access to their longitudinal health information, either through downloadable versions of that information and/or through equally complete and accessible patient portals. Information available to patients should be informed by patient needs, made readily accessible and useable, and include access to all patient-related information contained in electronic health records, such as clinician notes, care plans, lab values, pathology reports, images, and reports of images.

15. Through the NIH, AHRQ, and the Patient-Centered Outcomes Research Institute (PCORI), the federal government should partner with patients and consumer organizations to conduct research and evaluations of:

    a. Ways to present clinically meaningful digital information to patients that enables them to manage their conditions better and is perceived by patients as improving their health and well-being.

    b. Ways to make clinician and health system performance data publicly available to, understandable by, and useable for patients.

    c. Ways to integrate public health and community health information with personal health data in ways that are useable and digestible for patients and not unduly burdensome for providers.

    d. The effects of making available to patients, providers, and payers real-time, patient-reported experience measures and patient-reported outcomes measures on care quality, health outcomes, and health disparities.

    e. The effects of patient-facing artificial intelligence and machine-learning-informed clinical

information on the quality, cost, and equity of health care services.

    f. Ways to document and remedy any increase in disparities (such as based on race, ethnicity, age, gender, and zip code) that result from the adoption of new information technology services.

16. With community input, Congress should direct the HHS secretary to develop protections against bias, particularly racial bias, in health care technologies, including artificial intelligence and machine learning platforms.

17. HHS should collaborate with organization to develop and implement health IT standards to collect information about patients' social needs.

Implement Patient Protections from Fraud, Abuse, and Invasions of Privacy

18. In partnership with all necessary stakeholders — including patients, providers, policymakers, payers, vendors, developers, researchers, and performance measurement organizations — HHS should develop legal and regulatory frameworks to protect patients and providers from fraud, abuse, and invasions of privacy, including by:

    a. Third parties obtaining information for patients on their behalf.

    b. Third parties acting as repositories, stewards, or processors of health information.

19. Congress should pass additional legislation to ensure federal privacy and security protections apply to all entities not covered under existing legislation and regulation, including entities that collect, store, or exchange personal health data, including patient-facing technologies and applications.

20. Through Medicare and Medicaid reimbursement, CMS should enable patients to access third-party services that gather, process, and present their information. Third-party vendors of such information services should be accredited by federal or state authorities or private groups certified by public agencies as qualified to do so.

Imperative 5: Reduce Administrative Burden

Administrative burden is hobbling our health care system. The U.S. spends as much as one-third of national health expenditures on administrative costs, far more than any other high-income country. The complex business of credentialing, contracting, obtaining prior authorization, documenting visits, billing, and more is not only costly but a major cause of clinician burnout. Administrative burden hurts patients too: as clinicians devote more time and resources to administrative tasks, they spend less time with patients, compromising access to care, quality, and patient experience. These issues loom even larger for independent practices, safety-net providers, and providers in rural communities, where there are often fewer resources to devote to administration.

As the COVID-19 pandemic continues to place greater strains on the health care workforce, the need to reduce unnecessary and costly administrative tasks has become clearer. Without taking on the administrative complexities in our system that contribute to waste and burnout, we will not be able to achieve a high-performing delivery system.

To reduce administrative burden, we outline three areas for federal action: 1) elimination of onerous administrative processes in billing and payment; 2) a streamlined and standardized performance measurement process; and 3) removal of administrative burdens at the point of care. Evidence suggests these areas represent the largest sources of burnout and administrative spending.

Develop Uniform Standards for Billing and Payment

1. Working with stakeholders, Congress should direct ONC and CMS to create a uniform, national, standardized billing system and process that establishes a clearinghouse for billing claims submission and other national claims forms and protocols:

    a. HHS should require all private payers and billing agents, including third-party administrators, that wish to enroll Medicare and Medicaid beneficiaries use these new billing processes or else pay the additional costs of using nonstandard processes. Such costs should be excluded from their medical loss ratio for regulatory purposes.

    b. The federal government should enable patients, on a voluntary basis, to self-register with a national health information system that gathers personal health and administrative data to help their providers manage their health care more effectively. These data would be available, with patients' explicit permission, for research, administrative functions, and quality improvement by health care providers, payers, and public quality regulators.

2. CMS should require all Medicare Advantage and Medicaid managed care plans to eliminate or substantially reduce prior authorization requirements for providers that take on meaningful downside risk, use federally certified decision-support tools for specific conditions or situations, and meet quality and equity performance targets.

Streamline and Standardize Performance Metrics

3. Congress should direct HHS to establish, in partnership with the Core Quality Measures Collaborative and through an open and inclusive process, a standardized, parsimonious set of core quality and equity metrics for

data collection and reporting that will be used by all public and private insurers, purchasers and providers, with limited exemptions for data collection and reporting in cases where data are not clinically relevant. These measures should:

a. Be informed by the National Academy of Medicine's *Vital Signs* report.

b. Include patient-reported outcome measures, measures of patient experience, and net promoter scores.

c. Include measures related to high-volume, high-risk, or high-cost conditions for which providers in value-based payment arrangements will be responsible.

d. Include performance measures that promote racial health equity, such as those measuring: diversity of staff at all levels of health care organizations; implementation of health-system-wide programs to foster equity; system capacity to collect and report information about patients' race and ethnicity or communities' social needs; and levels of trust in local health systems by diverse or marginalized groups.

e. Be reported in aggregate and stratified by race, ethnicity, age, gender, and zip code, where sample sizes permit.

f. Provide a comprehensive picture of populations' clinical and behavioral health and nonmedical needs.

g. Be reviewed and updated every five years in collaboration with leading quality measurement organizations and other relevant groups.

Remove Unnecessary Administrative Obstacles in Care Delivery

4. HHS should task the National Academy of Medicine with developing policy options to reduce administrative burden at the point of care. The analysis should:

a. Identify and recommend removal of existing federal regulations that are redundant, ineffective, or excessively burdensome for the gains achieved.

b. Drawing on best practices from other countries, identify and recommend removal of unnecessary or burdensome clinical documentation that exists solely for payment purposes but offers no clinical value.

c. Identify ways to increase the effectiveness of existing authorities — and identify and recommend new ones — to promote interoperability and health information exchange among electronic health records and third-party payers while protecting patient privacy and information security.

d. Suggest ways providers can engage and value patients as coproducers of care (such as coproduced documentation and care plans or increased use of patient-reported outcome measures) without adding to administrative burdens associated with care delivery.

e. Investigate ways artificial intelligence can be leveraged to increase efficient use of clinicians' time, such as providing real-time clinical decision support during practice and analyzing pathology reports or medical tests.

f. Identify improvements to the process that the Office of Management and Budget uses for analyzing the cost and burden of compliance associated with newly proposed administrative or for reporting obligations on clinicians.

Increase Portability of Clinicians' Professional Credentials and Licenses

5. In partnership with clinicians, Congress should create national standards for credentialing, licensing, certification, and privileging to improve uniformity and portability, similar to those the U.S military uses.

6. Congress should establish a national database for licensure and credentialing, incentivizing all states to participate.
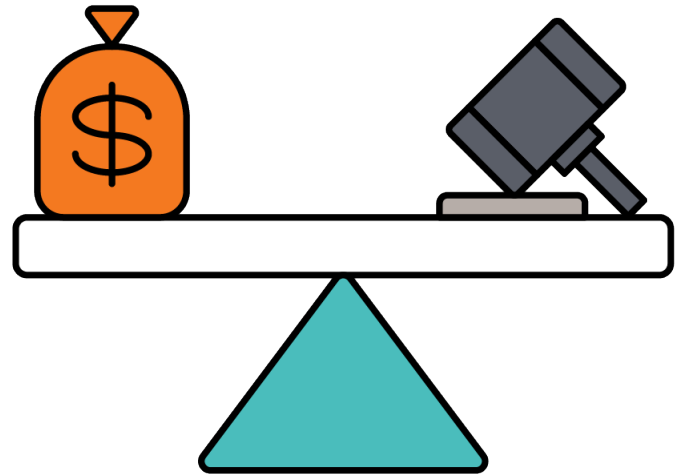
Imperative 6: Encourage a Balance of Regulatory and Competitive Approaches to Promoting a High-Performing Health System

Creating a high-performing health system requires that we address flaws in the functioning of health care markets that threaten the efficiency and quality of care. Other recommendations in this report, and the Task Force's overall goal to increase value, will be more effective if they are accompanied by efforts to remedy notable market failures.

The U.S. is unusual among high-income countries in its heavy reliance on market forces and competition to allocate health care resources. The country's widespread belief in the efficacy of competition as a way of improving the health care system suggests that any reform strategy must fully explore the possibilities of increased competition for improving the delivery of services. At the same time, leaving the distribution of health care exclusively to market forces has potential costs and drawbacks, including the favoring of individuals and communities with more resources — for both the purchase and the provision of services — which in turn aggravates inequities, particularly those related to race and ethnicity. These drawbacks have led other high-income countries to rely much more heavily on government controls and regulatory interventions.

Health care in the U.S. is characterized by high health care prices, high spending, shortages of vital and low-cost services like primary care, and underinvestment in less-profitable geographic areas, such as rural regions. Research points to problems that make it extremely difficult for markets to function as they should in theory, including distortions in payment systems, massive consolidation among providers, outdated antitrust law and enforcement policies, and lack of publicly available information about prices.

Below we outline recommendations that consider regulatory and competitive approaches to producing lower costs and meaningful benefits for patients, including better quality and greater equity. These recommendations include measures the federal government can take to enable diverse purchasers and providers to become more effective participants in a wide range of health care transactions. We also lay out recommendations to promote greater competition and transparency in the prescription drug market and suggest areas that should be the subject of intensive investigation — since whether effective competition can be established in health care, and whether it will achieve the intended objectives, remains a matter of debate.

Regulate Markets in Areas Where Competition Is Deemed Absent or Ineffective

1. HHS should develop incentives and flexibilities to encourage states to remedy market distortions caused by monopolistic and oligopolistic market structures (to be accompanied by congressional action making self-insured employer data available; see Recommendation 14 below). These include:

   a. Directly constraining prices in markets where federal or state authorities determine competition is absent or ineffective.

   b. Adopting statewide policies to control health care costs, such as developing statewide performance targets related to service cost, quality, and equity.

c. Developing and implementing all-payer global payment models in areas deemed by federal and/or state authorities to lack the requirements for competition.

2. Congress should require the federal government to remedy market distortions through the above mechanisms in cases where states do not successfully correct them, where there is a clear monopoly or ineffective competition, and where a health care entity is using its competitive advantage to obtain outsize financial gain without returning capital or benefits to the community (rent-seeking behavior).

3. For organizations found to be both vertically and horizontally integrated in markets where competition is absent, HHS should require that they collect and report publicly on total cost of care, quality of care, and patient outcomes, stratified by race, ethnicity, age, gender, and zip code where sample sizes are appropriate.

Enhance Competition Through Strengthened Antitrust Enforcement Related to Provider Systems and Payers

4. Congress should:

a. Increase budgets for antitrust enforcement in health care at both the Federal Trade Commission (FTC) and the Department of Justice (DOJ).

b. Establish processes to improve collaboration between the FTC and DOJ.

c. Establish a commission tasked with identifying improvements to modernize antitrust law that reflect current literature as it applies to health care, particularly pertaining to the effects of vertical integration within markets and the impact of cross-market consolidation (both vertical and horizontal).

d. Expand the FTC's ability to enforce antitrust laws against noncompetitive behavior in the health care industry, for example by authorizing investigations and actions against smaller mergers and anticompetitive behaviors by not-for-profit firms.

e. Require all health care entities to report merger-and-acquisition activities, regardless of amount or value, to state attorneys general, so that states are able to track and analyze them if needed or desired.

i. Participants in mergers and acquisitions should include plans to integrate value-based payment as part of the approval process.

Enhance Competition Through Payment Policy and Regulatory Flexibility

5. Federal authorities should remove payment distortions and market practices that contribute to anticompetitive consolidation in health care markets

a. Medicare and Medicaid should make site-neutral payments (paying the same amount regardless of where care is delivered) for services typically performed in physician offices. Implementation could be phased in over time to manage financial dislocations that would jeopardize community health.

b. Congress should replace the 340B Drug Pricing Program with a new program designed to realize its original intent, including provisions to:

i. Assist hospitals and other providers serving disproportionately large numbers of patients who have Medicaid, are uninsured, and have low income (e.g., federally qualified health centers, Ryan White Clinics, critical access hospitals, and family planning clinics) to purchase outpatient drugs at deep discounts both to generate revenue and provide greater financial stability in pursuit of serving patients with low income.

ii. Require health care providers or systems that receive deep discounts under a revised program to pass along a meaningful portion of that discount to patients with low income or no health insurance.

c. The FTC and DOJ should prohibit or restrict use of anticompetitive contract provisions by health care systems and private insurers, such as most-favored-nations clauses, anti-tiering and anti-steering provisions, nondisclosure agreements, and all-or-nothing provisions.

6. Congress should enable workforce flexibilities that can facilitate competition. For example, it should require that all federally regulated private insurance plans compensate advance practice registered nurses and physician assistants for providing appropriate care without supervision from physicians and with accountability for quality, cost, and equity. It should also identify telemedicine flexibilities and specify telemedicine scope of practice.

Promote Competition and Transparency in the Prescription Drug Market

7. Congress should repeal the noninterference clause of the Medicare Modernization Act, allowing the HHS secretary to directly negotiate drug prices for single-source drugs under Medicare and provide the secretary with additional authorities to control the costs of prescription drugs, such as the ability to restrict formularies.

8. Congress should reform patentability standards to make it more difficult to patent polymorphs, formulations, and additional uses of existing compounds that prevent generic alternatives from entering the market.

9. CMS should ensure that Medicare Part B does not pay higher prices for drugs than commercial payers do, by requiring calculations used for setting Part B reimbursement to include all discounts available to commercial payers.

10. Congress should authorize the HHS secretary to establish supply-chain transparency and reporting requirements for pharmacy benefit managers (PBMs), wholesalers, pharmaceutical manufacturers, and pharmacy services administrative organizations (PSAOs), including for all direct and indirect compensation, exclusive purchasing agreements, and contracts.

11. The FTC and DOJ should evaluate the effect of PBM mergers and acquisitions, retail pharmacy chains, PSAOs, and insurers on drug purchasing, distribution, and pricing.

Increase Research and Development to Understand the Implications of Policies for Promoting Competition

12. AHRQ should:

    a. Prospectively and retrospectively examine the effect of pro-competitive health policies on health care prices, spending, quality, and equity in local markets.

    b. Prospectively and retrospectively examine the effect of regulatory and quasiregulatory policies to control price and cost growth on health care price and spending levels in local markets, as well as quality and equity.

    c. Conduct head-to-head trials to compare the effectiveness of different models of regulated competition in improving the value of health services and increasing health equity in comparable markets.

    d. Evaluate the impact of "payviders" — integrated payer and provider groups — on quality, equity, and cost to understand whether this model should be encouraged through federal policy.

    e. Commission a study to explore new regulatory models for health care by examining approaches in other industries (such as the public utility model).

Promote Greater Transparency of Price, Quality, and Equity Information

13. HHS should fully implement current authorities, and as necessary Congress should pass new legislation, requiring transparency of data at the individual service and episode-of-care level for payers and purchasers in local markets. This information should include:

    a. Price data, such as negotiated commercial prices compared to a standard benchmark, like Medicare payments, for all services.

    b. Quality and utilization data stratified by race, ethnicity, age, gender, and zip code where sample sizes are appropriate.

14. Congress should enact pending legislation to prohibit surprise billing or enact surprise billing protections or limits.

15. Congress should clarify that ERISA does not permit self-insured employers to withhold data from all-payer claims databases (APCDs).

16. Congress should require that HHS create a national APCD, building off elements of, and lessons learned from, existing state APCDs. This national APCD should be used to:

    a. Identify spending drivers and outliers.

    b. Measure prices and spending growth over time.

    c. Explore the types of cost, quality, and equity information that would be useful to clinicians and patients; how to best share that information so that it is actionable; and how best to prescribe care that costs less and provides greater value.

    d. Assess the quality and validity of data on race and ethnicity data in claims to inform and set standards for improving how such data are collected and reported.

CONCLUSION

The recommendations outlined in this report establish a framework of six imperatives for the federal government to follow when shaping the future of payment and delivery system reform. The report also specifies detailed policy options to realize the promise of these imperatives. The Task Force believes that, if adopted, these changes to payment and care delivery would not only improve the experience of patients, providers, and other health care stakeholders but also help ensure more equitable, more cost-effective, and higher-quality health care for all Americans.

BIBLIOGRAPHY

Imperative #1: Increase Delivery System Preparedness for Health Disasters

1. Matthew J. Akiyama, Anne C. Spaulding, and Josiah D. Rich, "Flattening the Curve for Incarcerated Populations—COVID-19 in Jails and Prisons," *New England Journal of Medicine* 382 (May 2020): 2075–2077.

2. American Hospital Association, *Making Telehealth Flexibilities Permanent: Legislation or Regulation?* (AHA, June 2020).

3. Donald M. Berwick and Kenneth Shine, "Enhancing Private Sector Health System Preparedness for 21st-Century Health Threats: Foundational Principles from a National Academies Initiative," *JAMA* 323, no. 12 (Feb. 2020): 1133–1134.

4. Susan Birch, Maryanne Lindeblad, and Eileen Cody, *On the Front Lines of COVID-19: A Blueprint for Health and Human Services from Washington State* (Milbank Memorial Fund, April 2020).

5. Jessica Gold, "The COVID-19 Crisis Too Few Are Talking About: Health Care Workers' Mental Health," *Stat*, April 3, 2020.

6. Scott Gottlieb et al., *National Coronavirus Response: A Road Map to Reopening* (American Enterprise Institute, March 2020).

7. Government Accountability Office, *Report to the Congress: COVID-19 Opportunities to Improve Federal Response and Recovery Efforts* (GAO, June 2020).

8. Christopher F. Koller and Patrick H. Conway, "Reexamining Medicare Payment Reforms in Light of COVID-19," *NEJM Catalyst* (May 8, 2020).

9. Ateev Mehrotra et al., *The Impact of the COVID-19 Pandemic on Outpatient Visits: Practices Are Adapting to the New Normal* (Commonwealth Fund, June 2020).

10. Primary Care Collaborative, "Primary Care & COVID-19 Survey" (Primary Care Collaborative, June 2020).

11. Lee-Lee Prina, "Nicole Lurie Speech on Emergency Preparedness; Health Reform Session: 2013 GIH Meeting Tidbits," *Health Affairs Blog*, May 9, 2013.

12. Robin Rudowitz et al., *Medicaid Enrollment and Spending Growth: FY 2019 and 2020* (Kaiser Family Foundation, Oct. 2019).

13. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness* (ASPR, Jan. 2012).

14. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, *2017–2022 Health Care Preparedness and Response Capabilities* (ASPR, Nov. 2016).

15. U.S. Department of Health and Human Services, Office of Inspector General, *Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey, March 23–27, 2020* (OIG, June 2020).

16. Laurie Zephyrin et al., "COVID-19 More Prevalent, Deadlier in US Counties with Higher Black Populations," *To the Point* (blog), Commonwealth Fund, April 23, 2020.

17. Sahir Doshi et al., "The COVID-19 Response in Indian Country: A Federal Failure," *American Progress* (June 18, 2020).

Imperative #2: Increase Health System Accountability for Quality, Equity, and Cost of Care

1. Nancy Archibald et al., *Integrating Care Through Dual Eligible Special Needs Plans: Opportunities and Challenges* (Center for Health Care Strategies, April 2019).

2. Zinzi Bailey et al., "Structural Racism and Health Inequities in the USA: Evidence and Interventions," *Lancet* 8, no. 389 (April 2017): 1453–1463.

3. David Blumenthal and Melinda K. Abrams, "The Affordable Care Act at 10 Years—Payment and Delivery System Reforms," *New England Journal of Medicine* 382 (March 2020): 1057–1063.

4. Center on Budget and Policy Priorities, *Chart Book: Accomplishments of the Affordable Care Act* (CBPP, March 2019).

5. Michael E. Chernew et al., "MSSP Participation Following Recent Rule Changes: What Does It Tell Us?" *Health Affairs Blog*, Nov. 22, 2019.

6. Juliette Cubanski, Tricia Neuman, and Meredith Freed, *The Facts on Medicare Spending and Financing* (Kaiser Family Foundation, Aug. 2019).

7. Tim Doran, Kristin A. Maurer, and Andrew M. Ryan, "Impact of Provider Incentives on Quality and Value of Health Care," *Annual Review of Public Health* 38 (March 2017): 449–465.

8. Rudy Douven, Thomas G. McGuire, and J. Michael McWilliams, "Avoiding Unintended Incentives in ACO Payment Models," *Health Affairs* 34 (Jan. 2015): 143–149.

9. Laura A. Dummit et al., "Association Between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes," *JAMA* 316, no. 12 (Sept. 2016): 1267–1278.

10. John Feore and Gabriel Sullivan, *Physician-led Accountable Care Organizations Outperform Hospital-led Counterparts* (Avalere, Oct. 2019).

11. Arkadipta Ghosh, Cara Orfield, and Robert Schmitz, *Evaluating PACE: A Review of the Literature* (Mathematica Policy Research, Jan. 2014).

12. Government Accountability Office, *CMS Innovation Center: Model Implementation and Center Performance* (GAO, March 2018).

13. Mark Hadley, "CBO's Estimates of the Budgetary Effects of the Center for Medicare & Medicaid Innovation," (Invited Testimony, Committee on the Budget, U.S. House of Representatives, Sept. 7, 2016).

14. Katherine Hayes et al., *Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update and Policy Options* (Bipartisan Policy Center, April 2020).

15. Sinsi Hernández-Cancio et al., *A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems* (Families USA, June 2018).

16. Karen Joynt Maddox et al., "Evaluation of Medicare's Bundled Payments Initiative for Medical Conditions," *New England Journal of Medicine* 379 (July 2018): 260–269.

17. Karen Joynt Maddox et al., "Adjusting for Social Risk Factors Impacts Performance and Penalties in the Hospital Readmissions Reduction Program," *Health Services Research* 54, no. 2 (April 2019): 327–336.

18. Rabah Kamal, Daniel McDermott, and Cynthia Cox, *How Has U.S. Spending on Healthcare Changed Over Time?* (Peterson-KFF Health System Tracker, Dec. 2018).

19. Debra J. Lipson et al., *Accelerating the Adoption of Value-Based Payment in Medicaid by Linking Delivery System Reform to Managed Care Payment* (Centers for Medicare and Medicaid Services, Dec. 2019).

20. Marian F. MacDorman et al., "Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues," *Obstetrics & Gynecology* 128, no. 3 (Sept. 2016): 447–455.

21. Mark B. McClellan et al., *Payment Reform for Better Value and Medical Innovation: A Vital Direction for Health and Health Care* (National Academy of Medicine, March 2017).

22. J. Michael McWilliams et al., "Medicare Spending After 3 Years of the Medicare Shared Savings Program," *New England Journal of Medicine* 379 (Sept. 2018):1139–1149.

23. Medicare Payment Advisory Commission, *Site-Neutral Payments for Select Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities* (MedPAC, June 2014).

24. Medicaid and CHIP Payment and Access Commission, *Evaluations of Integrated Care Models for Dual Eligible Beneficiaries: Key Findings and Research Gaps* (MACPAC, July 2019).

25. Medicaid and CHIP Payment and Access Commission, *Integrating Care for Dually Eligible Beneficiaries: Background and Context* (MACPAC, June 2020).

26. Jeff Micklos et al., "The Center for Medicare and Medicaid Innovation Can Be A Powerful Force to Accelerate Change, But Not Without Reforms," *Health Affairs Blog,* Feb. 12, 2020.

27. Keith J. Mueller et al., *Medicaid Payment and Delivery System Reform: Challenges and Opportunities for Rural Health Systems* (Rural Policy Research Institutes, June 2016).

28. David Muhlestein et al., "Spread of ACOs and Value-Based Payment Models in 2019: Gauging the Impact of Pathways to Success," *Health Affairs Blog,* Oct. 21, 2019.

29. David Muhlestein, Robert S. Saunders, and Mark B. McClellan, "Medicare Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues," *Health Affairs Blog,* Sept. 9, 2016.

30. Emily E. Petersen et al., "Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 states, 2013–2017," *MMWR Morbidity and Mortality Weekly Report* 68 (May 2019): 423–429.

31. Hoangmai Pham and Paul B. Ginsburg, "Payment and Delivery-System Reform—The Next Phase," *New England Journal of Medicine* 379 (Oct. 2018): 1594–1596.

32. Michale E. Porter, Thomas H. Lee, and Alice C. Murray, "The Value-Based Geography Model of Care," *NEJM Catalyst* 1, no. 2 (March-April, 2020).

33. Joshua A. Rolnick et al., "Spending and Quality After Three Years of Medicare's Bundled Payments for Medical Conditions: Quasi-Experimental Difference-in-Differences Study," *BMJ* 369 (June 2020): m1780.

34. Christie Teigland, Zul Pulungan, and Bryce Sutton, *Medicare Advantage Plans Outperform Fee-for-Service Medicare in Caring for Dual-Eligible Beneficiaries with Chronic Conditions* (Avalere, May 2019).

35. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Proposal Submissions: Physician-Focused Payment Model Technical Advisory Committee* (ASPE, June 2020).

36. U.S. Department of Health and Human Services, *Report to Congress: Evaluation of the Independence at Home Demonstration* (HHS, Nov. 2018).

37. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Final Rule Creates Pathways to Success for the Medicare Shared Savings Program* (HHS, Dec. 2018).

38. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 National Healthcare Quality & Disparities Report* (AHRQ, Sept. 2019).

39. Seema Verma, "2019 Medicare Share Savings Program ACO Performance: Lower Costs and Promising Results Under 'Pathways to Success,'" *Health Affairs Blog,* Sept. 14, 2020.

40. David Muhlestein, Robert S. Saunders, and Mark B. McClellan, "Medicare Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues," *Health Affairs Blog,* Sept. 9, 2016.

Imperative #3: Strengthen the Nation's Primary Health Care System

1. David I. Auerbach, Douglas O. Staiger, and Peter I. Buerhaus, "Growing Ranks of Advanced Practice Clinicians—Implications for the Physician Workforce," *New England Journal of Medicine* 378 (June 2018): 2358–2360.

2. Jaya Aysola, DaShawn Groves, and LeRoi S. Hicks, "Health Center Professional Programs and Primary Care Workforce," *Journal of Family Medicine and Community Health* 2, no. 8 (Dec. 2015): 1063.

3. Christopher Barbey et al., "Physician Workforce Trends and Their Implications for Spending Growth," *Health Affairs Blog,* July 28, 2017.

4. Hilary Barnes et al., "Rural and Nonrural Primary Care Physician Practices Increasingly Rely on Nurse Practitioners," *Health Affairs* 37, no. 6 (June 2018): 908–914.

5. Sanjay Basu et al., "Association of Primary Care Physician Supply with Population Mortality in the United States, 2005–2015," *JAMA Internal Medicine* 179, no. 4 (Feb. 2019): 506–514.

6. Sanjay Basu et al., "High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care," *Health Affairs* 36, no. 9 (Sept. 2017): 1599–1605.

7. Andrew Bazemore et al., *The Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization* (Patient Centered Primary Care Collaborative, July 2017).

8. Joshua Breslau et al., *Primary and Behavioral Health Care Integration Program: Impacts on Health Care Utilization, Cost, and Quality* (The Assistant Secretary for Planning and Evaluation, March 2019).

9. Nadia Chait and Sherry Glied, "Promoting Prevention Under The Affordable Care Act," *Annual Review of Public Health* 39 (Jan. 2018): 507–524.

10. Chiang-Hua Chang, Julie P. Bynum, and Jon D. Lurie, "Geographic Expansion of Federally Qualified Health Centers 2007–2014," *Journal of Rural Health* 35, no. 3 (June 2019): 385–394.

11. Alice J. Chen et al., "Does Spending More Get More? Health Care Delivery and Fiscal Implications from a Medicare Fee Bump," *Journal of Policy Analysis and Management* 37, no. 4 (Aug. 2018): 706–731.

12. Martin Cohen et al., *Systematic Review of CMMI Primary Care Initiatives Final Report* (Kennell and Associates Inc, Feb. 2018).

13. Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2017 to 2032* (Association of American Medical Colleges, April 2019).

14. Sandra L. Decker. "No Association Found Between the Medicaid Primary Care Fee Bump and Physician-Reported Participation in Medicaid," *Health Affairs* 37, no. 7 (July 2018): 1092–1098.

15. Andrew L. Ellner and Russell S. Phillips, "The Coming Primary Care Revolution," *Journal of General Internal Medicine* 32, no. 4 (April 2017): 380–386.

16. Martha Gerrity, *Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness* (Milbank Memorial Fund, Dec. 2014).

17. Linda V. Green, Sergei Savin, and Yina Lu, "Primary Care Physician Shortages Could Be Eliminated Through Use of Teams, Nonphysicians, and Electronic Communication," *Health Affairs* 32, no. 1 (Jan. 2013): 11–19.

18. Xuesong Han et al., "Has Recommended Preventive Service Use Increased After Elimination of Cost-Sharing as Part of the Affordable Care Act in the United States?" *Preventive Medicine* 78 (Sept. 2015): 85–91.

19. Martijn van Hasselt et al., "Total Cost of Care Lower Among Medicare Fee-for-Service Beneficiaries Receiving Care from Patient-Centered Medical Homes," *Health Services Research* 50, no. 1 (Feb. 2015): 253–272.

20. Sinsi Hernández-Cancio et al., *A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems* (Families USA, June 2018).

21. Yalda Jabbarpour et al., *Advanced Primary Care: A Key Contributor to Successful ACOs* (Patient Centered Primary Care Collaborative, Aug. 2018).

22. Corinne Lewis et al., *Changes at Community Health Centers and How Patients Are Benefiting* (Commonwealth Fund, Aug. 2019).

23. Andrew W. Mulcahy, Tadeja Gracner, and Kenneth Finegold, "Associations Between the Patient Protection and Affordable Care Act Medicaid Primary Care Payment Increase and Physician Participation in Medicaid," *JAMA Internal Medicine* 178, no. 8 (July 2018): 1042–1048.

24. Julia Paradise et al., *Community Health Centers: Recent Growth and the Role of the ACA* (Kaiser Family Foundation, Jan. 2017).

25. Deborah Peikes et al., *Independent Evaluation of Comprehensive Primary Care Plus: First Annual Report* (Mathematica Policy Research, April 2019).

26. Deborah Peikes et al., "The Comprehensive Primary Care Initiative: Effects of Spending, Quality, Patients, and Physicians," *Health Affairs* 37, no. 6 (May 2018): 890–899.

27. Jennifer Perloff, Catherine DesRoches, and Peter Buerhaus, "Comparing the Cost of Care Provided to Medicare Beneficiaries Assigned to Primary Care Nurse Practitioners and Physicians," *Health Services Research* 51, no. 4 (Aug. 2016): 1407–1423.

28. Jennifer M. Polinkski et al., "Patients' Satisfaction with and Preference for Telehealth Visits," *Journal of General Internal Medicine* 31, no. 3 (March 2016): 269–275.

29. Stuart M. Pollack, "Pay for Relationship: A Novel Solution to the Primary Care Crisis," *NEJM Catalyst* (Oct. 30, 2019).

30. Daniel Polsky et al., "Changes in Primary Care Access Between 2012 and 2016 for New Patients with Medicaid and Private Coverage," *JAMA Internal Medicine* 177, no. 4 (April 2017): 588–590.

31. Daniel Polsky et al., "Appointment Availability After Increases in Medicaid Payments for Primary Care," *New England Journal of Medicine* 372 (Feb. 2015): 537–545.

32. Medicare Payment Advisory Council, *Per Beneficiary Payment for Primary Care: Report to the Congress—Medicare Payment Policy* (MEDPAC, June 2014).

33. Sara Rosenbaum et al., *Community Health Centers: Growing Importance in a Changing Health Care System* (Kaiser Family Foundation, March 2018).

34. Deborah M. Scharf et al., "General Medical Outcomes from the Primary and Behavioral Health Care Integration Grant Program," *Psychiatric Services* 67, no. 11 (Nov. 2016): 1226–1232.

35. Leiyu Shi, "The Impact of Primary Care: A Focused Review," *Scientifica* (Dec. 2012).

36. Erin Shigekawa et al., "The Current State of Telehealth Evidence: A Rapid Review," *Health Affairs* 37, no. 2 (Dec. 2018): 1975–1982.

37. Justin W. Timbie et al., "Implementation of Medical Homes in Federally Qualified Health Centers," *New England Journal of Medicine* 377 (July 2017): 246–256.

38. U.S. Department of Health and Human Services, Health Resources and Services Administration, *National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013–2025* (HRSA, Nov. 2016).

39. U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Equity Report 2017* (HRSA, 2018).

40. U.S. Department of Health and Human Services, the Assistant Secretary for Planning and Evaluation, *Provider Retention in High Need Areas: NHSC Enrollment and Retention* (ASPE, Dec. 2014).

41. Stephen Zuckerman, Laura Skopec, and Marni Epstein, *Medicaid Physician Fees After the ACA Primary Care Fee Bump:19 States Continue the Affordable Care Act's Temporary Policy Change* (Urban Institute, March 2017).

Imperative #4: Support Empowerment and Engagement of People, Families, and Communities

1. Kristin L. Carman et al., "Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies," *Health Affairs* 32, no. 2 (Feb. 2013): 223–231.

2. Julia Chen, Preeti Malani, and Jeffrey T. Kullgren, "Patient Portals: Improving the Health of Older Adults by Increasing Use and Access," *Health Affairs Blog,* Sept. 6, 2018.

3. Shannon Cosgrove et al., "Community Health Workers as an Integral Strategy in the REACH U.S. Program to Eliminate Health Inequities," *Health Promotion Practice* 15, no. 6 (Nov. 2014): 795–802.

4. Ronald Dendere et al., "Patient Portals Facilitating Engagement with Inpatient Electronic Medical Records: A Systematic Review," *Journal of Medical Internet Research* 21, no. 4 (April 2019).

5. Michele K. Evans et al., "Diagnosing and Treating Systemic Racism," *New England Journal of Medicine* (June 2020).

6. Laura P. Forsythe et al., "Patient Engagement in Research: Early Findings from the Patient-Centered Outcomes Research Institute," *Health Affairs* 38, no. 3 (March 2019): 359–367.

7. Gilbert C. Gee and Chandra L. Ford, "Structural Racism and Health Inequities," *Du Bois Review* 8, no. 1 (April 2011): 115–132.

8. LaShawn Marie Glasgow, "Beyond Lip Service: Taking a Genuine Approach to Tackling COVID-19 (and All) Black-White Health Disparities in the United States," *Health Affairs Blog,* June 9, 2020.

9. Hae-Ra Han et al., "Using Patient Portals to Improve Patient Outcomes: Systematic Review," *JMIR Human Factors* 6, no. 4 (Dec. 2019).

10. Sinsi Hernández-Cancio et al., *A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems* (Families USA, June 2018).

11. Benson S. Hsu and Emily Griese, "Making Better Use of Health Care Data," *Harvard Business Review* (March 12, 2018).

12. Shreya Kangovi et al., "Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial," *JAMA* 174, no. 4 (April 2014): 535–543.

13. Shreya Kangovi et al., "Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities," *JAMA* 178, no. 12 (Dec. 2018): 1635–1643.

14. Jonathan M Metzl, Aletha Maybank, and Fernando De Maio, "Responding to the COVID-19 Pandemic: The Need for a Structurally Competent Health Care System," *JAMA Editorial* (June 2020).

15. Ziad Obermeyer et al., "Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations," *Science* 366 (Oct. 2019): 447–453.

16. Patient-Centered Outcomes Research Institute, *Research Spotlight on Shared Decision Making* (PCORI, June 2020).

17. Josh Seidman, *The Promise of Shared Decision-Making in Improving Value in the U.S. Healthcare System* (Avalere, Dec. 2017).

18. Anjana E. Sharma, Lucia Angel, and Quynh Bui, "Patient Advisory Councils: Giving Patients a Seat at the Table," *Family Practice Management* 22, no. 4 (July 2015): 22–27.

19. Susan Reinhard et al., *Valuing the Invaluable: 2019 Update* (AARP Public Policy Institute, Nov. 2019).

20. National Academies of Sciences, Engineering, and Medicine, *Communities in Action: Pathways to Health Equity* (NAM, 2017).

21. David R. Williams and Lisa A. Cooper, "Reducing Racial Inequities in Health: Using What We Already Know to Take Action," *International Journal of Environmental Research and Public Health* 16, no. 4 (Feb. 2019): 606.

22. Brad Wright, "Do Patients Have a Voice? The Social Stratification of Health Center Governing Boards," *Health Expectations* 18, no. 3 (June 2015): 430–437.

23. Brad Wright, "Who Governs Federally Qualified Health Centers?" *Journal of Health Politics, Policy, and Law* 38, no. 1 (Feb. 2013): 27–55.

Imperative #5: Reduce Administrative Burden

1. Brian G. Arndt et al., "Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations," *Annals of Family Medicine* 15, no. 5 (Sept. 2017): 419–426.

2. David Cutler, *Reducing Administrative Costs in U.S. Health Care* (The Hamilton Project, March 2020).

3. David Cutler, Elizabeth Wikler, and Peter Basch, "Reducing Administrative Costs and Improving the Health Care System," *New England Journal of Medicine* 367, no. 20 (Nov. 2012): 1875–1878.

4. N. Lance Downing, David W. Bates, and Christopher A. Longhurst, "Physician Burnout in the Electronic Health Record Era: Are We Ignoring the Real Cause?" *Annals of Internal Medicine* 169, no. 1 (July 2018): 50–51.

5. Shari M. Erickson et al., "Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians," *Annals of Internal Medicine* 166, no. 9 (May 2017): 659–661.

6. Sinsi Hernández-Cancio et al., *A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems* (Families USA, June 2018).

7. David U. Himmelstein, Terry Campbell, and Steffie Woolhandler, "Health Care Administrative Costs in the United States and Canada, 2017," *Annals of Internal Medicine* 172, no. 2 (Jan. 2020): 134–142.

8. Institute of Medicine, *Vital Signs: Core Metrics for Health and Health Care Progress* (IOM, 2015).

9. Ashish K. Jha et al., *A Crisis in Health Care: A Call to Action on Physician Burnout* (Massachusetts Medical Society, 2018).

10. National Quality Forum, *Healthcare Disparities and Cultural Competency Consensus Standards* (NQF, 2012).

11. Shantanu Nundy and Michael L. Hodgkins, "The Application of AI to Augment Physicians and Reduce Burnout," *Health Affairs Blog*, Sept. 18, 2018.

12. Irene Papanicolas, Liana R. Woskie, and Ashish K. Jha, "Health Care Spending in the United States and Other High-Income Countries," *JAMA* 319, no. 10 (March 2018): 1024–1039.

13. Christine Sinsky et al., "Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties," *Annals of Internal Medicine* 165, no. 11 (Dec. 2016): 753–760.

14. Laura Tollen, Elizabeth Keating, and Alan Weil, "How Administrative Spending Contributes to Excess U.S. Health Spending," *Health Affairs Blog*, Feb. 20, 2020.

15. Puja Turakhia and Brandon Combs, "Using Principles of Co-production to Improve Care and Enhance Value," *AMA Journal of Ethics* 19, no. 1 (Nov. 2017): 1125–1131.

16. U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs* (ONC, Feb. 2020).

17. Neil W. Wagle, "Implementing Patient-Reported Outcome Measures," *NEJM Catalyst* 46, no. 6 (Oct. 2017): 273–278.

18. Colin P. West, Liselotte Dyrbye, and Tait Shanafelt, "Physician Burnout: Contributors, Consequences, and Solutions," *Journal of Internal Medicine* 283, no. 6 (June 2018): 516–529.

19. American Hospital Association, *Consensus Statement on Improving the Prior Authorization Process* (AHA 2018).

Imperative #6: Encourage a Balance of Regulatory and Competitive Approaches to Promote a High-Performing Health System

1. Stuart Altman et al., "Health Care Cost Control: Where Do We Go from Here?" *Health Affairs Blog,* July 13, 2018.

2. Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, "It's Still the Prices, Stupid: Why the U.S. Spends So Much on Health Care, and a Tribute to Uwe Reinhardt," *Health Affairs* 38, no. 1 (Jan. 2019): 87–95.

3. Robert A. Berenson et al., *Addressing Health Care Market Consolidation and High Prices* (Urban Institute, Jan. 2020).

4. Brian Blase, "Make Transparent Health Care Prices a Price of Any Future Aid to the Health Care Industry," *Health Affairs Blog,* June 16, 2020.

5. Michael E. Chernew, Leemore S. Dafny, and Maximilian J. Pany, *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health Care Market* (The Hamilton Project, March 2020).

6. Rena M. Conti et al., "Proposed Reforms to the 340B Drug Discount Program," *Health Affairs Blog,* March 7, 2018.

7. Sayeh S. Nikpay et al., "Relationship Between Initiation of 340B Participation and Hospital Safety-Net Engagement." *Health Services Research* 55, no. 2 (March 2020): 157-169.

8. Leemore S. Dafny, "Hospital Industry Consolidation—Still More to Come?" *New England Journal of Medicine* 270 (Jan. 2014): 198–199.

9. Leemore S. Dafny and Thomas H. Lee, "Health Care Needs Real Competition," *Harvard Business Review,* Dec. 1, 2016.

10. Maria de Jesus Diaz-Perez et al., "Producing Comparable Cost and Quality Results from All-Payer Claims Databases," *American Journal of Managed Care* 25, no. 5 (May 2019): e138–e144.

11. Ezekiel J. Emanuel et al., "State Options to Control Health Care Costs and Improve Quality," *Health Affairs Blog,* April 28, 2016.

12. Federal Trade Commission, *Antitrust Modernization Commission: Report and Recommendations* (FTC, April 2007).

13. Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," *Health Affairs* 36, no. 9 (Sept. 2017): 1530–1538.

14. Brent D. Fulton, Daniel R. Arnold, and Richard M. Scheffler, *Market Concentration Variation of Health Care Providers and Health Insurers in the United States* (Commonwealth Fund, July 2018).

15. Martin Gaynor, *What to Do About Healthcare Markets? Policies to Make Healthcare Markets Work* (The Hamilton Project, March 2020).

16. Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation* (The Robert Wood Johnson Foundation, June 2012).

17. Sherry A. Glied and Stuart H. Altman, "Beyond Antitrust: Healthcare and Health Insurance Market Trends and the Future of Competition," *Health Affairs* 36, no. 9 (Sept. 2017): 1572–1577.

18. Brandi Greenberg and Jessie Goldman, *4 Ways Recent Payer-Provider M&A Activity Is Reshaping Health Care* (The Advisory Board, Jan. 2018).

19. Lovisa Gustafsson and Shawn Bishop, "Hospital Price Transparency: Making It Useful for Patients," *To the Point* (blog), Commonwealth Fund, Feb. 12, 2019.

20. Jessica Heeringa et al., "Horizontal and Vertical Integration of Health Care Providers: A Framework for Understanding Various Provider Organization Structures," *International Journal of Integrated Care* 20, no. 1 (Jan. 2020): 2.

21. Carol K. Kane, *Updated Data on Physician Practice Arrangements: For the First Time Fewer Physicians Are Owners than Employees* (American Medical Association, 2019).

22. Carol K. Kane and David W. Emmons, *New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shift Toward Hospital Employment* (American Medical Association, 2013).

23. Medicaid and CHIP Payment and Access Commission, *Report to the Congress: Medicare Payment Policy* (MEDPAC, March 2017).

24. David B. Muhlestein and Nathan J. Smith, "Physician Consolidation: Rapid Movement from Small to Large Group Practices, 2013–2015," *Health Affairs* 35, no. 9 (Sept. 2016): 1638–1642.

25. Sayeh S. Nikpay, Michael R. Richards, and David Penson, "Hospital-Physician Consolidation Accelerated in the Past Decade in Cardiology, Oncology," *Health Affairs* 37, no. 7 (July 2018): 1123–1127.

26. Mary Anne Pazanowski, *Private Equity Investment in Health Care Stays Strong* (Bloomberg Law, Sept. 2018).

27. Avik Roy, Affordable Hospital Care Through Competition and Price Transparency (The Foundation for Research and Equal Opportunity, Jan. 2020).

28. Lawrence E. Singer, "Considering the ACA's Impact on Hospital and Physician Consolidation," *Journal of Law, Medicine, and Ethics* 46, no. 4 (Jan. 2019): 913–917.

29. Thomas C. Tsai and Ashish K. Jha, "Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better?" *JAMA* 312, no. 1 (July 2014): 29–30.

30. Chapin White, "Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates," *Health Affairs* 32, no. 5 (May 2013): 935–943.

31. Kate Ho and Robin Lee, "Insurer Competition in Health Care Markets," *NBER Working Paper no.* 19401 (Nov. 2016).

32. Michael F. Furukawa et al., "Consolidation of Providers into Health Systems Increased Substantially, 2016–18," *Health Affairs* 39, no. 8 (Aug. 2020).

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