

ACHIEVING REAL SAVINGS THROUGH BETTER CARE

*Policy Options for Improving Care
and Slowing Cost Growth through
Bipartisan Delivery System and
Payment Reform*

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EXECUTIVE SUMMARY

The current volume-based reimbursement that pervades America's health care system encourages more, not better, care and is driving up spending at an unsustainable rate. National health expenditures continue to outpace the growth of the overall economy and are projected to grow from \$2.9 trillion in 2013 to \$4.72 trillion by 2021. Federal health spending will grow from 4.9 percent of Gross Domestic Product (GDP) in 2013 to 6.3 percent by 2023.

As a result, there is a strong need for delivery system and payment reforms in Medicare and across the health system overall. These reforms must look beyond one-time reductions in spending and cost-shifts to a fundamental realignment of incentives aimed at better care and lower cost growth.

What Sort of Reforms Have Been Proposed?

Health care stakeholders, thought leaders, and policymakers on both sides of the aisle have united around the notion that more can be done to place put health care spending on a sustainable path. This new, emerging consensus embraces three key principal strategies: 1) reward value of health care services over volume; 2) promote care coordination; and 3) inject more competition into our health care system.

Rewarding Value, Not Volume

- **Physician Payment Reform:** *Replacing Medicare's Sustainable Growth Rate (SGR) formula with payment reforms that move providers away from volume-based fee-for-service reimbursement to payment models that encourage care coordination and enhanced quality*
- **Value-Based Purchasing (VBP):** *Basing a portion of a provider's payment on measures of care quality or value*
- **Value-Based Insurance Design:** *Implementing value-based insurance design (VBID), an approach which adjusts cost-sharing to incentivize beneficiaries to seek higher value, more coordinated providers and treatments*
- **Shared Savings:** *Allowing providers to share in savings if certain budget and quality targets are achieved, through expansion of existing programs like the Medicare Shared Savings Programs or new value-based payment withhold proposals, and enabling state governments to share in savings if they lower health care spending rates without compromising quality or access*
- **Reducing Rates of Preventable Readmissions:** *Expanding current penalties for avoidable hospital readmissions, while adding reforms to protect safety net providers*
- **Reducing Healthcare-Acquired Conditions:** *Increasing penalties for high-rates of avoidable complications and expanding the penalties to a broader set of providers*
- **Reforming the Medical Malpractice System:** *Reforming the medical malpractice system to reduce the cost of defensive medicine and promote safe, evidence based medicine*

Improving Care Coordination

- ***Episodic Bundled Payments:*** Expanding bundled payment arrangements whereby providers are paid with a fixed amount for a bundle of services, including some combination of acute, post-acute and physician care
- ***Improve Care Coordination for Dually Eligible Beneficiaries:*** Improving care coordination for beneficiaries enrolled in Medicare and Medicaid, especially those with high costs and complex care needs
- ***Implementing Alternative Benefit Packages:*** Creating an alternative benefit package that moves away from fee-for-service Medicare and encourages care coordination

Encouraging Competition

- ***Competitive Bidding:*** Expanding competitive bidding for durable medical equipment and other services
- ***Prescription Drug Policy:*** Remove barriers to generic competition in Medicare's Low-Income Subsidy program

While the options described here focus on Medicare policy, they are intended to spark changes in health care delivery and payment that will produce lower costs and better outcomes across the health system. Because Medicare has such a large role in paying for health care services, successful implementation of delivery system reforms in the Medicare program would not only reduce federal health spending, but would lead to structural improvements in the health care system overall, which would substantially slow the growth of health spending in the public and private sector beyond the direct savings to Medicare

Achieving Budgetary Savings from Delivery System Reform

Improved quality and better value for Americans' health care dollars are worthy goals in and of themselves, but finding budgetary savings remains a vitally important consideration.

The Congressional Budget Office has found that reforms such as policies to prevent avoidable readmissions, expand competitive bidding and encourage generic drug utilization can produce "scoreable" budgetary savings.

Other reforms such as care coordination, improved integration of care for dually eligible beneficiaries and value-based purchasing may not produce "scoreable savings" today but are worth pursuing and testing because of the potential for savings in the future.

Policymakers could consider coupling delivery system reforms with well-designed enforcement mechanisms that can both spur the transformation of health care delivery and provide some assurance of budgetary savings. One such mechanism is to build targeted, scoreable payment reductions into a delivery or payment reform proposal, thereby sharpening the incentives for providers to deliver higher-value, more coordinated care. A "value-based withhold" could also serve to guarantee savings from delivery system reforms.

Conclusion

While other proposed reforms to federal health care programs have proven politically challenging, a broad, bipartisan consensus is building around delivery and payment reforms, and that consensus could make them viable, realistic solutions in coming months. For policymakers who want to place our health system on a sustainable path while promoting the best care for patients, these policies are a great place to start.

Achieving Real Savings through Better Care: Policy Options for Improving Care and Slowing Cost Growth through Bipartisan Delivery System and Payment Reform

Introduction

The current health care delivery system is driving up spending on an unsustainable path. The Centers for Medicare and Medicaid Services (CMS) projects that total national health expenditures will grow from \$2.9 trillion in 2013 to \$4.72 trillion by 2021 an annual growth rate of 6.1 percent over the course of the intervening years—far outpacing projected GDP growth over the same period.¹

This health care inflation has impacts across the economy, straining family budgets and driving up employers' costs. But for federal policymakers, it is of particular concern. Under current policy, federal health spending will grow from \$779 billion, or 4.9 percent of GDP, in 2013 to over \$1.6 trillion or 6.3 percent of the economy by 2023. Federal health spending will reach 8.3 percent of GDP by 2035, and 11 percent by the late 2050s.

The latest biannual report from the Medicare Payment Advisory Commission (MedPAC) noted that in the next ten years, Medicare, Medicaid, other health insurance programs, Social Security and the net interest expenses stemming from them will account for more than 16 percent of GDP, while total federal revenues have averaged 17.4 percent of GDP in the past 40 years.²

This growth is rooted in the incentive structure across Medicare and the rest of our health care system. Currently, physicians and other providers are generally rewarded for quantity rather than quality and value, and lack strong financial incentives to improve clinical quality or to coordinate care with other providers. At the same time, beneficiaries lack the incentives and the information they need to seek out higher-value providers and treatments. While traditional fee-for-service (FFS) Medicare is more often faulted for these problems, they remain a significant issue among Medicare Advantage plans, private commercial plans and employer-provided insurance as well. Despite efforts to reorient payment toward value in the private sector, one recent survey of private payers found that 90 percent of private commercial payment was not performance-based.³

Clearly, there is a strong need for delivery system and payment reforms that "bend" the health care cost-curve. To place federal health spending and our broader health care system on a more sustainable path, these reforms should look beyond one-time reductions in spending and cost-shifts toward a fundamental realignment of incentives to slow overall

¹ "National Health Expenditure Projections, 2011-2021," Centers for Medicare and Medicaid Services. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf>

² "Report to Congress: Medicare Payment Policy," MedPAC, March 2013. http://www.medpac.gov/documents/Mar13_EntireReport.pdf

³ "National Scorecard on Payment Reform," Catalyst for Payment Reform, March 26, 2013. <http://www.catalyzepaymentreform.org/images/documents/NationalScorecard.pdf>

health care cost growth. Delivery system reforms are needed to not only slow spending, but also to improve outcomes and preserve beneficiaries' access to top-quality care,

Delivery System Reform Today

Even as the debate has raged around the Affordable Care Act's (ACA) controversial coverage and insurance market provisions, delivery system reforms initiated under that law and previous legislative efforts in 2003, 2005 and 2007 have begun to lay the groundwork needed to constrain rising spending and encourage better care. Reforms such as "never events" policies, Accountable Care Organizations (ACOs), value-based purchasing, and the Hospital Readmissions Reduction Program (HRRP) have already been implemented and are beginning to impact the delivery of care. More than 250 Medicare ACOs have been established. Average 30-day hospital readmission rates have begun to fall below historic averages. Medicare and state Medicaid programs are testing a number of innovative payment reforms and delivery models focused on improving quality and reducing cost through more coordinated care delivery.⁴

Box 1: Examples of Current Medicare Delivery System Reforms

Acute Care Episode (ACE) Demonstration

The ACE demonstration is testing the use of a bundled payment for both hospital and physician services for a select set of inpatient episodes of care for orthopedic and cardiovascular procedures. Under the ACE demo, Medicare provides an opportunity for beneficiaries who choose participating providers to share in 50 percent of the savings those providers achieve, up to the amount of the Part B premium. Currently, five health care systems are participating in the ACE demo.

Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

Enacted under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), DMEPOS replaces previously utilized existing fee schedule payments for some medical equipment with prices based on suppliers' bids in selected areas. Earlier this year, the CMS Office of the Actuary estimated that the program will save the Medicare Part B Trust Fund \$25.7 billion and beneficiaries \$17.1 billion between 2013 and 2022.

Medicare Shared Savings Program (MSSP)

The MSSP is a shared-savings program that seeks to improve care coordination by enabling participating ACOs to share in savings if they meet quality performance benchmarks while reducing costs. As of January 2013, over 250 ACOs have been selected to participate.⁵

⁴ "Innovation Models," Web page, Centers for Medicare and Medicaid Services. Retrieved on July 22, 2013 at <http://innovation.cms.gov/initiatives/index.html>.

⁵ "More doctors, Hospitals Partner to Coordinate Care for People with Medicare," Press release, Centers for Medicare and Medicaid Services, January 10, 2013. <http://www.cms.gov/apps/media/press/release.asp?Counter=4501&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

State Option to Provide Health Homes for Enrollees with Chronic Conditions

This option allows states to offer health home services such as care management, care coordination, and transitional care to Medicaid enrollees with certain chronic conditions. To date, CMS has approved proposals to create health homes from 11 states, including Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island and Wisconsin.⁶

Hospital Readmissions Reduction Program (HRRP)

Under the HRRP, all hospitals that report excessive readmission rates for Medicare patients with Acute Myocardial Infarction, Pneumonia, and Heart Failure will have their Medicare payments reduced by a maximum of 1 percent. This penalty will rise to 2 percent in FY 2014 and 3 percent in FY 2015.

Healthcare Acquired Conditions

Consistent with the Deficit Reduction Act of 2005, Medicare no longer reimburses hospitals for costs related to treating a set of avoidable adverse care events, known as “never events,” such as operating on the wrong limb or leaving medical equipment in a surgical patient. Under a related provision of the ACA, the 25 percent of hospitals with the highest rates of all hospital-acquired medical conditions are subject to a 1 percent payment penalty.

Value-based Purchasing Programs

CMS is currently implementing provisions in the ACA that institute value-based purchasing for hospitals, Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs) and establish a value-based payment modifier for physicians and physician groups that will adjust Medicare payments to these providers based on specific quality measures.

Center for Medicare and Medicaid Innovation (CMMI)

CMMI was created to test the effect of innovative payment and delivery models focused on improving quality and reducing cost through more coordinated care delivery. Current initiatives include:

-Bundled Payments for Care Improvement Initiative

Participating providers will receive bundled payments for acute and/or post-acute care services and may share in any gains that result from providing coordinated and better quality care.

-Medical Home Demonstrations

Four separate demonstration projects are geared toward applying the patient-centered medical home (PCMH) approach to care delivery in traditional Medicare.⁷

⁶ “Approved Health Home State Plan Amendments,” Web page, Centers for Medicare and Medicaid Services. Retrieved on 7/22/2013 at <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html>.

⁷ These demonstration projects are the Comprehensive Primary Care Initiative, the Multipayer Advanced Primary Care Practice Demonstration, the Independence at Home Demonstration, and FQHC Advanced Primary Care Demonstration.

-Financial Alignment Initiative

This initiative allows CMS to enter into three-way contracts with States and health plans whereby health plans will receive a capitated payment to provide coordinated Medicare and Medicaid services to dually eligible beneficiaries. Both CMS and participating states will share in savings. CMS has received proposals from 26 States and entered into a memorandum of understanding with 5 states.

-Community-Based Care Transitions Program

This CMMI program tests models of care that use community-based organizations to improve transitions from acute hospitals to other settings of care for high-risk Medicare beneficiaries.

-Pioneer ACO Demonstration

In this advanced accountable care model, ACOs that reduce costs will receive shared savings but are subject to a higher level of reward and risk than those ACOs participating in the Medicare Shared Savings Program (MSSP). ACOs that meet the shared savings requirements in the first two years will then transition to a population-based payment model during the third year and may continue to receive this population-based payment during optional fourth and fifth years. There are 32 ACOs currently participating in the Pioneer ACO demonstration.

Bipartisan Delivery System Reforms

For all the promise of ongoing efforts, there is broad agreement that more can be done to put health care spending on a sustainable path. Health care thought leaders continue to advance policy proposals aimed at accelerating and expanding delivery system reforms. New initiatives designed to 1) reward value over volume, 2) promote care coordination, and 3) inject more competition into our health care system have been embraced across a broad range of health care stakeholders.

Over the past year, these three themes have emerged in proposals released by the Bipartisan Policy Center, Urban Institute, Center for American Progress, National Coalition on Health Care, American Enterprise Institute, Commonwealth Fund, Galen Institute, Heritage Foundation, and Brookings Institution. These same themes were also discernible in recent recommendations from Medicare Payment Advisory Commission (MedPAC) and in several of President Obama's budget submissions. Finally, this April, the new deficit reduction plan proposed by Moment of Truth Project Co-Chairs Erskine Bowles and former Senator Alan Simpson, *A Bipartisan Path Forward to Securing America's Future*, embraced these themes as well.

The remarkable commonality among these plans suggests that consensus is forming on the next steps policymakers must take on delivery and payment reform. And while many of the proposals can appear at first glance to focus largely on Medicare policy, their proponents argue that efficiencies achieved by the largest payer in the health care market as a result of adjustments to Medicare policy can yield lower costs for other payers as well, and that

other payers will likely align their payment policies with the value-based approaches Medicare adopts (if they are not doing so already).

Box 2: Can Medicare Help Lead Delivery System Reform?

Efficiency is hardly the characteristic most associated with large public programs. In a full range of economic and social endeavors, Americans typically look to local initiatives or the private sector, not the federal government, for innovative new breakthroughs. Health care delivery is no different.

However, Medicare has played a key role in efforts to lower costs and transform care in recent decades. Because Medicare remains the largest payer for medical services and other payers frequently base their payment policies on the program, Medicare can be decisive in whether a new delivery or payment innovation reaches the scale necessary to impact national health care spending. The adoption of inpatient prospective payment for hospitals and the creation of a “never events” policy serve as illustrative examples.

Prospective Payment for Hospitals

In the early 1980s, Medicare hospital payment policies underwent a dramatic change. Previously, Medicare had reimbursed hospitals retrospectively based on the actual costs accrued during a patient’s stay. This led to long, expensive patient stays in the hospital and helped exacerbate growth in hospital costs. A new approach was developed by researchers at Yale and tested in hospitals in New Jersey. It centered on paying hospitals prospective payments, based on the average cost for groups of admissions known as Diagnosis-Related Groups, or DRGs.

Beginning in 1982, Congress took aim at the problem. The Social Security Amendments Act of 1983 directed Medicare to establish a new prospective payment for hospitals. While DRGs have had critics and some payers continue to rely on other payment approaches, recent analysis suggests prospective payment has held down costs across the health care system.⁸ Moreover, private insurers, state Medicaid programs, and other payers largely have embraced prospective payment.⁹

“Never Events”

In 2000, the Institute of Medicine’s landmark report, *Crossing the Quality Chasm*, estimated that an epidemic of medical failures was costing America 100,000 lives and billions of dollars every year. Payment systems perversely paid hospitals more if patients developed a complication during care even if those complications were National Quality Forum-designated “never events,” like transfusing the wrong blood type or operating on the wrong

⁸ White, Chapin, “Contrary to cost-shift theory, lower Medicare hospital payment rates for inpatient care lead to lower private payment rates,” *Health Affairs*, Vol. 32 No. 5, May 2013, pp. 935-43.

⁹ Mayes, Rick and Robert A. Berenson, *Prospective Payment and the Shaping of U.S. Health Care*, Johns Hopkins University Press, 2006.

limb. In 2004, HealthPartners, a Minnesota insurer, announced a new policy that refused to provide additional payment for “never events.”¹⁰ The following year, the Deficit Reduction Act of 2005 directed Medicare to implement a similar policy. Within three years of implementation, reported incidence of several “never events” was falling in Medicare, and some spillover effects were found for patients with other insurance.¹¹ By 2011, 21 states had implemented similar policies in their Medicaid programs, and in January 2012, new rules promulgated under the 2010 federal health care law extended the ban across Medicaid.¹²

Rewarding Value, Not Volume

Physician Payment Reform: *Replacing Medicare’s Sustainable Growth Rate (SGR) formula with payment reforms that move providers away from volume-based fee-for-service payment to payment models that support care coordination and enhanced quality.*

In order to increase the efficiency of Medicare, experts across the political spectrum have called for replacement of the SGR formula, which links physician fees to Medicare spending growth. Since 2002, the SGR formula has called for an annual negative update to FFS physician payments. These cuts have several design flaws: they fail to distinguish between medical specialties; they punish all providers alike; and they do not reward those providers who are cost-conscious. Additionally, the formula is based on spending levels from 1996 and 1997; therefore, it does not reflect the influx of baby boomers that have begun to enter Medicare in recent years.

For every year since 2003, Congress has temporarily overridden the SGR-mandated cuts to physician payments. At the expiration of each temporary override, the law threatens to impose cuts sufficient to bring physician payment in line with the SGR’s original payment trajectory. Despite slight decreases in negative updates due to lower overall Medicare cost growth, CMS estimates that without additional action by Congress, the SGR will immediately trim physician payments by 24 percent in January 2014.¹³

Over the previous decade, last minute “doc fixes” have frustrated providers and delayed submission and processing of claims. Not only has the SGR formula failed to restrain health care utilization effectively, but it may have exacerbated the problem because the formula does not discriminate between physicians who work to restrain volume growth and those

¹⁰ Kazel, Robert, “Minnesota insurer won’t pay hospitals for ‘never events’,” American Medical News, November 8, 2004. <http://www.amednews.com/article/20041108/business/311089988/7/>

¹¹ Healy D and Cromwell J, “Hospital-Acquired Conditions-Present on Admission: Examination of Spillover Effects and Unintended Consequences-Final Report” Prepared by RTI International for Centers for Medicare and Medicaid Services, September 2012. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/HAC-SpilloverEffects.pdf>

¹² Galewitz, Phil, “Medicaid to Stop Paying for Hospital Mistakes,” Kaiser Health News, June 1, 2011. <http://www.kaiserhealthnews.org/stories/2011/june/01/medicaid-hospital-medical-error-payment-short-take.aspx>

¹³ Letter to Glenn Hackbarth, Chair of MedPAC, from Deputy CMS Administrator Jonathan Blum, March 5 2013. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SustainableGRatesConFact/Downloads/SGR2013-Final-Signed.pdf>

who do not. And while only 12 percent of Medicare spending is devoted to services by clinicians,¹⁴ their orders, prescriptions and advice guide most of the remainder. As a result, many health care experts have called for replacing the SGR formula with payment reforms that drive providers away from Medicare FFS and towards payment models that encourages quality and coordinated care.

Until recently, legislative efforts for comprehensive payment reform have stalled in part because of the large price tag for repealing the SGR. However, the latest Congressional Budget Office (CBO) estimate projects a 10-year cost of repeal to be less than \$140 billion—over \$100 billion less than previous projections.¹⁵ This reduced estimate offers policymakers a window of opportunity for reform. At a recent Congressional hearing, Medicare Payment Advisory Commission (MedPAC) Chair Glenn Hackbarth said, “The SGR repeal is now on sale, but the sale may not last forever.”¹⁶

With legislative conditions ripe for reform, interest is growing and comprehensive reform efforts have begun to examine how to realign provider payments in a way that encourages efficiency and quality while bending the health care cost curve. The House Energy and Commerce Committee has reported out legislation that would establish a period of stable rates in the near-term and gradually create a path toward payment based on value in the medium- to long-term. The Obama administration’s FY 2014 budget and the leadership of the Senate Finance Committee have embraced similar principles.

The momentum behind SGR reform offers a chance to transform how Medicare pays physicians (and other providers) away from broad reliance on an inefficient fee-for-service model and toward payment models which encourage care coordination. The approach taken by these policymakers shares many goals with the approaches taken by recent fiscal and health policy proposals from think tanks and stakeholders. Yet more can be done to address the upward pressure that volume-driven medicine exerts on overall federal spending.¹⁷

A number of think tanks and health policy experts have advocated replacing the SGR with a payment system that rapidly transitions away from today’s inefficient fee-for-service approach and toward coordinated care. A number of proposals would both encourage provider participation in alternative payment models like ACOs or medical homes and make improvements in the existing physician fee schedule. A number of think tanks and policymakers have proposed complementing this transition in provider payment with reforms on the beneficiary side to drive them towards higher-value providers.

¹⁴ “Report to Congress: Medicare Payment Policy,” MedPAC, March 2013.

¹⁵ “The Budget and Economic Outlook: Fiscal Years 2013 to 2023,” Congressional Budget Office, February 2013.
<http://cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf>

¹⁶ Fiegl, Charles, “Lawmakers urged to seize the moment on Medicare SGR Reform,” American Medical News, February 25, 2013.
<http://www.amednews.com/article/20130225/government/130229984/4/>

In designing a new payment system to replace the SGR, policymakers also could consider policy changes that create similar incentives encouraging coordinated care for all providers rather than just physicians and others currently reimbursed through the physician fee schedule. Doing so would not only improve efficiency and reduce cost of care in those settings but would also make it more likely that reforms intended to encourage physicians to participate in coordinated care models succeed.

Additionally, several reform proposals have included higher payment rates for primary care providers to encourage undervalued primary, preventive and coordinated care services. MedPAC, for example, has recommended freezing payment rates on primary care providers and gradually reducing payments for specialists over the first few years. MedPAC also recommended shared savings opportunities for providers who join alternative payment models such as an ACO.

A Bipartisan Path Forward proposed modestly reducing reimbursement rates below a freeze and allowing CMS to make certain budget-neutral adjustments to improve quality in the short term. In the medium term, it recommended charging CMS with developing an improved physician-payment formula that promotes participation in new models like ACOs and patient-centered medical homes, encourages care coordination across multiple providers, prioritizes primary care, and reduces Medicare costs. This requirement would be enforced by the potential reinstatement of a re-based SGR mechanism – if a new payment formula were not implemented – in order to give all parties an incentive to work together on a new payment system and impose budgetary limits on that new system.

Value-Based Purchasing (VBP): *Basing a portion of a provider's payment on measures of care quality or value.*

Value-based incentives have gained momentum among private payers, and are already beginning to be implemented at the federal level. Under the ACA, a hospital value-based purchasing (VBP) program was established in Medicare to pay hospitals based on performance on quality measures related to common and high-cost conditions. The same statute also applies a value-based modifier to physician payment and requires CMS to develop plans to implement value-based purchasing for skilled nursing facilities, home health agencies, and ambulatory surgical centers.

Policymakers have a number of options to further develop VBP. A number of commentators have argued for increasing reliance on metrics focused on outcomes and patients' experience of care (e.g., whether a patient's blood pressure is controlled) rather than processes of care (e.g., whether a patient is screened for high-blood pressure). CMS also could expedite the development and implementation of VBP for non-hospital providers. Finally, policymakers could consider increasing the percentage of Medicare payment affected by value-based purchasing; current statute caps the penalty at 3 percent of the hospital's Medicare revenue.

Value-Based Insurance Design: *Implementing value-based insurance design (VBID) – an approach which adjusts cost-sharing to incentivize beneficiaries to seek higher value, well-coordinated care.*

In addition to reforms at the provider level to reduce spending and improve outcomes, Medicare’s benefit design can also contribute to increasing value in the system. One such approach, known as value-based insurance design (VBID), would modify Medicare cost-sharing rules to encourage beneficiaries to pursue high-value services. In addition to current law provisions that ensure access to a limited set of preventive services without cost, coinsurance or copayments could be adjusted or combined in a number of ways to further drive beneficiaries toward choosing higher-value services.

Proponents argue that VBID would move away from an un-nuanced, one-size-fits-all approach to cost sharing, and help curb spending over time. On the other hand, critics point out that treatment-specific cost-sharing could further complicate an already fragmented and confusing benefit design.

Implementation of VBID is not without complications. Certain services may be of high value for most beneficiaries, while others may depend on factors such as a beneficiary’s health and socioeconomic status. For example, it might be more beneficial for a beneficiary who has had a heart attack to have lower coinsurance or copayments for proven high-value treatments to prevent future attacks than a beneficiary who has no history of cardiac problems. Other concerns include how certain services or providers would be defined as higher value and which measures would be chosen to make that determination.

Still, proposals to either test or implement VBID in certain parts of Medicare have been featured in a number of recent proposals, including those of MedPAC, the National Coalition on Health Care, and the stakeholders belonging to the Partnership for Sustainable Healthcare. *A Bipartisan Path Forward* embraces the idea of allowing value-based adjustments to coinsurance, in the context of a broader reform to Medicare’s benefit design.

Box 3: Value-Based Pricing and Coverage Policy

A leading factor in the growth of health care cost growth is the adoption of new medical technologies.¹⁸ Medicare’s reimbursement policies have contributed to this dynamic by rewarding newer, and more expensive, procedures, tests, drugs, and devices, regardless of whether they have been demonstrated to be more effective than existing treatment.

Outright denial of coverage for lower-value interventions has long been a pillar of health policy in the United Kingdom and elsewhere. However, this approach has proven entirely unacceptable to both consumers and voters in the United States, and arguably could have a chilling effect on innovation.

¹⁸ “Technological Change and the Growth of Health Care Spending,” Congressional Budget Office, January 2008. <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/89xx/doc8947/01-31-techhealth.pdf>

A dynamic, or value-based, pricing strategy offers an alternative, more nuanced approach to improving how Medicare and others pay for new treatments and technologies. First introduced by Stephen Pearson and Peter Bach, the concept was included in the Partnership for Sustainable Healthcare's March 2013 health care plan.¹⁹ Newer, more expensive technologies would have to be proven more effective than existing technology within three years of the initial decision to cover them in Medicare. Those that could not demonstrate equivalent or superior effectiveness would be reimbursed at the level of the less expensive, previously used technology.

This particular policy has yet to be introduced as legislation and has not been evaluated by the CBO. However, because it would lower reimbursement for new, unproven treatments, broad application of this approach across Medicare and other federal health care programs would likely lower federal spending over the next ten years. Additionally, over the longer term, a value-based pricing policy could substantially affect the trajectory of health spending in both the public and private sectors. Those who create new drugs, devices, treatments, and tests would have stronger incentives to invest in developing interventions that have a high probability of enhancing clinical effectiveness. Conversely, they would be less likely to invest in the creation or marketing of therapies that do not.

Shared Savings: *Allowing providers to share in savings if certain budget and quality targets are achieved, through expansion of existing programs like the Medicare Shared Savings Programs or new value-based withhold proposals. Enabling state governments to share in the savings if they lowered health care spending rates without compromising quality or access.*

Another option that has received attention in the debate on payment reform is the concept of shared savings, which is used in several existing programs. Currently, the Medicare Shared Savings Program (MSSP) demonstration facilitates coordination among providers participating in ACOs in order to improve quality for FFS beneficiaries and reduce avoidable costs. Under the MSSP model, providers can share in savings and losses relative to a benchmark of the average Part A and B expenditures for the beneficiaries in the ACO, if they meet specific quality goals. In the one-sided model, ACOs are paid a share of the savings if spending is less than the benchmark. In the two-sided model, the potential for reward is even greater but comes with a risk. Under this option, ACOs can share in a larger amount of savings but also share in losses if spending exceeds a certain target and they fail to meet specific quality goals. The Pioneer ACO Demonstration relies exclusively on a two-sided risk model.

Since the MSSP's implementation began in April 2012, the number of ACOs and providers entering shared savings arrangements has already grown rapidly. However, it may be possible to further improve and expand this program. One approach would curb FFS payments in Medicare, making traditional FFS payments less lucrative and encouraging

¹⁹ Pearson SD and Bach PB, "How Medicare could use comparative effectiveness research in deciding on new coverage and reimbursement," *Health Affairs*, Vol. 29 No. 10, October 2010, pp. 1796-804; "Strengthening Affordability and Quality in America's Health Care System," Partnership for Sustainable Healthcare, April 2013. <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405432>

more clinicians and providers to join shared-savings programs.²⁰ Another would strengthen the incentive to produce savings and improve quality by encouraging greater participation in the two-sided risk model.²¹ Other proposals have suggested encouraging beneficiaries to receive care through an ACO through shared savings in the form of lower premiums and lower cost sharing for care received through the ACO.

One variation of the shared savings approach would apply a “value-based withhold” to all Medicare providers. Under the model proposed by Jonathan Skinner, James Weinstein, and Elliot Fisher at the Dartmouth Institute for Health Policy and Clinical Practice, a certain amount of provider payments would be “withheld” and rewarded to providers if savings and quality targets are met.²² However, if the savings targets are not achieved, Medicare would keep the withheld amount. With this incentive in place, supporters of this withhold concept hope that it would spur more providers to form and participate in shared savings organizations like ACOs. This option could be structured in a number of different ways to reach desired savings depending on the providers included, the baseline of spending used to establish the target, and the percentage of payments withheld. Unlike blunter reductions in provider payment, a “withhold” has the benefit of targeting the higher-cost providers, not all providers across-the-board.

At a broader level, the federal government could apply the concept of shared savings not just to providers but also to states. The federal government has granted the state of Oregon a waiver to reduce the state’s Medicaid expenditure growth in return for a global payment with flexibility to pursue efforts that improve delivery of care. Policymakers could choose to systematize such an arrangement and make similar opportunities available to other state Medicaid programs. *A Bipartisan Path Forward*, for example, proposed allowing states to share in Medicaid savings if they lower per capita health care cost growth by both public and private payers to a certain target, such as GDP growth. It also suggested including bonus payments for states that meet various performance targets on cost, quality, and access. Just as in provider shared savings models, where clear quality standards are needed to avoid stinting on care, a state-level shared savings policy may require strong protections to ensure that savings come from better and more efficient care, not restrictions on access to care.

Even broader versions of this idea could enable states that lower total health care costs to share in the savings that accrue to the federal government from the lower trend. Versions of this idea have been advanced by the Partnership for Sustainable Health Care, Center for American Progress and the President and CEO of the top health insurance lobby, America’s Health Insurance Plans.²³

²⁰ “Moving Forward from the Sustainable Growth Rate (SGR) System,” Letter, MedPAC, October 14, 2011. http://medpac.gov/documents/10142011_medpaC_sgr_letter.pdf

²² Skinner JS, Weinstein JN, and Fisher ES, “Withholds to Slow Medicare Spending: A Better Deal Than Cuts,” *Journal of the American Medical Association*, Vol. 307 No. 1, January 4, 2012, pp.43-4.

²³ “Strengthening Affordability and Quality in America’s Health Care System,” Partnership for Sustainable Healthcare, April 2013. <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405432>

Reducing Rates of Preventable Readmissions: Expanding and increasing current penalties for avoidable hospital readmissions, while adding reforms to protect safety net providers

Since a 2007 MedPAC report found that many hospital readmissions were potentially preventable,²⁴ increasing attention has been given to reforms that would incentivize hospitals to reduce the rates of these readmissions. The ACA acted upon this recommendation by creating a Hospital Readmissions Reduction Program (HRRP) that reduced Medicare payment to hospitals with a high number of readmissions for certain conditions. Currently, this policy applies to readmissions for patients who have had acute heart attacks, heart failure, and pneumonia. This may already be helping to reduce spending on hospital readmissions. A recent CMS analysis found that all-cause, 30-day readmissions for Medicare patients dropped from a 5-year average of 19 percent to 18.4 percent in 2012, resulting in about 70,000 fewer readmissions.²⁵ However, many health care experts believe much more can be done to lower rates of avoidable readmissions in Medicare and to reduce the costs they impose on taxpayers and beneficiaries.

The HRRP could be expanded in a number of ways. Policymakers could apply penalties to a broader set of conditions, expand the program to include other types of providers, or increase the amount of the penalties. CMS has proposed to exercise its existing statutory authorities to expand the program to admissions for chronic pulmonary obstructive disorder and hip or knee replacement. In his last two budget proposals, President Obama has proposed reducing payments to Skilled Nursing Facilities (SNFs) by up to three percent for high rates of preventable readmissions. One of the more aggressive options would statutorily lift the cap on the amount of hospital payments at risk and broaden the benchmarks by which readmissions are measured.

At the same time, even advocates of expanding the current policy concede that improvements are needed to adjust for socioeconomic factors and timing of readmission. One consumer group, Community Catalyst, has suggested the option of reinvesting some additional savings into quality improvement efforts for low-performers. MedPAC has proposed that hospitals' readmissions be evaluated relative to performance of other Medicare hospitals that serve socioeconomically similar Medicare beneficiary populations, rather than the performance of all acute care hospitals participating in Medicare.

A Bipartisan Path Forward recommends calibrating penalties to adjust for patient demographics, types of condition, and timing of readmission. It also suggests decreasing

The Senior Protection Plan," Center for American Progress, November 2012. <http://www.americanprogress.org/wp-content/uploads/2012/11/SeniorProtectionPlan.pdf>; Ignani K, "Health Plan Innovations in Delivery System Reforms," American Journal of Managed Care, Vol. 19 No. 4, April 2013.

<http://www.ajmc.com/publications/issue/2013/2013-1-vol19-n4/Health-Plan-Innovations-in-Delivery-System-Reforms>

²⁴"Report to Congress: Promoting Greater Efficiency in Medicare." MedPAC, June 2007,

http://www.medpac.gov/chapters/jun07_ch05.pdf

²⁵Gerhardt G, Yemane A, Hickman P, Oelschlaeger A, Rollins E and Brennan N, "Medicare Readmissions Rates Showed Meaningful Decline in 2012," Medicare & Medicaid Research Review, Vol. 3 No. 2, 2013, pp. e1-e12.

http://www.cms.gov/mmrr/Downloads/MMRR2013_003_02_b01.pdf

penalties for providers who are able to reduce their readmissions or complications over time or those who demonstrate that readmissions are leading to lower mortality rates, acknowledging the competing risks at play in the readmissions metric.

Another policy challenge is that some providers may be putting Medicare patients on “observational outpatient status,” instead of admitting them.²⁶ Even though the treatment received might not differ, if these patients come back within 30 days, it does not count as a readmission for purposes of calculating Medicare payment penalties. Policy changes could be made to discourage this practice, which may be increased by the current readmissions policy. For example, one recent journal article suggests adjusting penalties currently targeted at readmissions to focus on a broader range of unplanned care including readmissions, observation stays, and visits to the emergency room.²⁷

Reducing on Healthcare-Acquired Conditions: *Increasing penalties for high-rates of avoidable complications and expanding the penalties to a broader set of providers.*

The Institute of Medicine’s landmark report, *Crossing the Quality Chasm*, estimated that as many as 100,000 Americans died from medical mistakes every year, adding billions to America’s health care bill. Additionally, preventable infections have driven up health care costs and mortality rates. Despite increasing focus by providers on these problems and new payment penalties set to take effect in 2015 for hospitals with high rates of healthcare-acquired conditions, this problem continues to cost American lives and money. Broadening the “never events” policy or a healthcare-acquired condition penalty to additional providers, such as post-acute facilities, home health providers, and ambulatory surgical centers, offers one opportunity to address this challenge and lower costs to Medicare. Additionally, increasing the penalty for Medicare hospitals with high rates of such complications beyond the current ceiling of 1 percent could further sharpen incentives to reduce their incidence and decrease program spending. One particularly aggressive proposal would expand the applicable complications for which hospitals could be penalized from 27 to 64, levy penalties on all hospitals below the national average, and set the size of the penalties proportionate to the costs those complications generate for Medicare.²⁸

Medical Malpractice Reform: *Reforming medical malpractice to reduce the cost of defensive medicine and promote safe, evidence-based medicine.*

²⁶ Feng, Z, Wright B, and Mor V, “Sharp Rise in Medicare Enrollees Being Held in Hospitals For Observation Raises Concerns About Causes and Consequences,” *Health Affairs*, Vol. 31 No. 6, June 2012, pp. 1251-1259.

²⁷ Baier RR, Gardner RL, Coleman EA, Jencks SF, Mor V, and Gravenstein S, “Shifting the Dialogue From Hospital Readmissions to Unplanned Care,” *American Journal of Managed Care*, Vol. 19 No. 6, June 19, 2013.

<http://www.ajmc.com/publications/issue/2013/2013-1-vol19-n6/Shifting-the-Dialogue-From-Hospital-Readmissions-to-Unplanned-Care>

²⁸ This particular proposal was first advanced by Community Catalyst, and has more recently been embraced by the National Coalition on Health Care, See Miller M and Howitt K, “Better Care at Lower Costs: An Approach to Reducing Health Spending by Paying for Outcomes,” *Community Catalyst*, January 2013.

http://www.communitycatalyst.org/doc_store/publications/Better_Care_Lower_Costs.pdf; and “Curbing Costs, Improving Care: The Path to an Affordable Health Care Future,” National Coalition on Health Care, November 8, 2012.

<http://nchc.org/plan-for-health-and-fiscal-policy/>

Provider and physician organizations have identified the practice of “defensive medicine” as a driver of clinically unnecessary tests and procedures. Substantial evidence confirms that the cost of malpractice lawsuits to providers has an effect on the utilization of health services.²⁹ Additionally, from a quality standpoint, fear of lawsuits may be harmful to the robust provider-patient communication needed for high-quality, efficient care.

Certain changes to medical malpractice procedures can make providers less likely to practice defensive medicine and thereby reduce overall health care costs. The CBO has concluded that a package of reforms, including caps on non-economic damages and punitive damages, would reduce spending in Medicare Parts A and B by 0.5 percent.³⁰

A number of alternative approaches could also play a role in reducing spending on defensive medicine and improving patient safety. These include creating safe harbors for providers using evidence-based clinical guidelines, supporting disclose and offer programs, and implementing health courts for malpractice claims. *A Bipartisan Path Forward* recommended the adoption of many of these reforms together. While there are many ways to reform the malpractice system and the topic remains the subject of vigorous debate, many health care experts across the spectrum agree reform is a necessary and important part of improving delivery of care.

Improving Care Coordination

Episodic Bundled Payments: *Increasing payment bundling where providers are paid with a fixed amount for a bundle of services, including some combination of acute, post-acute, and physician care.*

As discussed above, the current FFS payment structure encourages high volume of treatment, drives up spending, and jeopardizes quality of care. To realign incentives toward quality and efficient care, reforms have been offered to bundle certain provider payments. Under a bundled payment system, providers are paid a set amount for the treatment of a particular condition or for a particular “episode of care.” Bundled payments are already being used to cover payments across multiple providers during an episode of care for certain services. For example, Medicare has been bundling payments for dialysis treatments since 2011.

Another area where bundled payments have been piloted in Medicare is the Acute-Care Episode (ACE) Demonstration. This program seeks to establish greater accountability for providers to lower Medicare spending, improve quality, discourage volume, and encourage greater care coordination.

²⁹ Letter to Senator Orrin Hatch, Congressional Budget Office, October 9, 2009.

http://cbo.gov/sites/default/files/cbofiles/ftpdocs/106xx/doc10641/10-09-tort_reform.pdf

³⁰ “Cost Estimate: H.R. 5, Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, as ordered reported by the House Committee on the Energy and Commerce on May 11, 2011,” Congressional Budget Office, May 23, 2011.

<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/122xx/doc12209/hr5.pdf>

Bundled payment reforms can be integrated with incentives on the beneficiary side as well. The ACE demo has also included payments which offset cost sharing for beneficiaries who choose to receive care from participating providers.

Many proposals, including *A Bipartisan Path Forward*, have recommended expanding the ACE demo nationally or expanding bundled payments to other services such as post-acute care. In designing bundled payment policies, policymakers will need to decide whether the bundled payment should be made to a single entity such as an ACO or hospital which apportions the payment among all providers involved in care or adjust payments to individual providers in order to ensure that the total payments to all of the providers for all of the defined services do not exceed the total bundled payment amount.

While exact savings from bundled payments would depend on the extent and design of any program, they can be expected to not only lower costs but also more efficiently use existing resources to improve outcomes. Proposals to expand bundled payments have been estimated by CBO to reduce federal spending in the past.³¹

Improve Care Coordination for Dually Eligible Beneficiaries: Improving care coordination for beneficiaries enrolled in Medicare and Medicaid, especially those with high costs and complex care needs.

Approximately 9 million low-income seniors and disabled individuals are dually eligible for enrollment in both Medicaid and Medicare. While this population is very diverse, they tend to generate higher costs to each program than other beneficiaries. Full dually eligible beneficiaries comprise 13 percent of Medicare enrollees but account for 34 percent of its spending. In Medicaid, they make up 15 percent of beneficiaries but draw 39 percent of its spending. Divided coverage across the two programs makes coordinating care more difficult, resulting in higher costs to both federal and state governments.

Although CBO has been reluctant to attribute substantial savings to these policy proposals, many health economists believe substantial savings could be achieved because of the costliness of this population to both Medicare and Medicaid. In fact, analysis of CMS' Physician Group Practice Demonstration, an early prototype version of the ACO, found that while overall per-beneficiary savings were limited across the beneficiaries involved, real savings were achieved among the dually eligible population.³²

Recently, CMS began a three-year demonstration program, the Financial Alignment Demonstration, to integrate Medicare and Medicaid financing for beneficiaries entitled to full benefits under both Medicare and Medicaid. Still, restrictions in the current programs

³¹ "Budget Options Volume 1 Health Care," Congressional Budget Office, December 2008.

<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>

³² Colla CH, Wennberg DE, Meara E, Skinner JS, Gottlieb D, Lewis VA, Snyder CM, and Fisher ES, "Spending differences associated with the Medicare Physician Group Practice Demonstration," *Journal of the American Medical Association*, Vol. 308 No. 10, September 12, 2012, pp. 1015-23.

often limit the ability to advance other reforms that could help lower costs and improve care coordination.³³ This presents an opportunity to reshape policy to promote greater flexibility to improve coordination of care and potentially lower costs in the long term.

Policymakers could consider assigning one of the two programs full responsibility for the care of this population in order to reduce costs and administrative complexity. In one such approach, the state Medicaid programs would assume full responsibility and dual eligible beneficiaries would be required to be enrolled in Medicaid managed care, while the federal government would continue to pay its share of the costs or take on more responsibility in another area of Medicaid. In another scenario, the federal government would take full responsibility for this population in Medicare. This option would increase federal spending unless there was a corresponding reduction in Medicaid-matching payments or other federal payments to states (a so-called “swap” of responsibilities).

Alternative Benefit Packages: Creating an alternative benefit package that moves away from traditional Medicare and encourages care coordination.

Several prominent health care proposals have included the creation of a new alternative benefit package in Medicare that would simultaneously drive beneficiaries and providers toward higher-value health care. As part of that benefit alternative, benefits provided through Medicare Part A, B, and D could be merged into a single benefit package and include coverage above the standard package in order to minimize the need for supplemental plans. Such an alternative plan could be financed with an additional monthly premium, with assistance for lower-income beneficiaries and lower cost-sharing for beneficiaries who use high-value providers and services. To further support improved care and lower costs, these alternative plans could choose to pay providers through bundled payments, ACOs, medical homes, or other VBP arrangements.

Policymakers could allow CMS to offer such an alternative plan alongside traditional Medicare and Medicare Advantage, give CMS the ability to contract with third parties to administer such plans, or create a demonstration where the plan is available for certain high-cost populations. *A Bipartisan Path Forward* recommended Congress and the administration consider establishing one or more alternative packages, either as a demonstration project or alternative option(s) for beneficiaries to choose.

While the exact name and plan specifics vary among recent proposals, alternative benefit packages could play an important role in aligning the incentives for both providers and consumers with the goals of lower cost and better care.

³³ Specifically, the current split nature of the system has discouraged states from pursuing reforms which could result in savings and efficiency improvements because those savings would flow to the federal government through the Medicare program,

Encouraging Competition

Competitive Bidding: Expanding competitive bidding for durable medical equipment and other services.

Historically, Medicare durable medical equipment (DME) payments largely have been determined by a fee schedule with amounts updated each year by a measure of price inflation. However, multiple reports by the Government Accountability Office (GAO) and Department of Health and Human Services (HHS) have shown that because this fee schedule does not reflect market changes and variations in prices, Medicare pays above-market prices for certain DME items.³⁴ To address these overpayments, policymakers have enacted a demonstration program for Medicare to use a process known as competitive bidding, where prices are determined by suppliers' bids for certain medical equipment and devices. The ACA requires Medicare to expand this demonstration for equipment, prosthetics, orthotics, and supplies in all regions by 2016. In 2011, under round one of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, Medicare spending on medical equipment declined by almost 42 percent. Earlier this year, the CMS Office of the Actuary estimated DMEPOS will save the Medicare Part B Trust Fund \$25.7 billion and beneficiaries \$17.1 billion between 2013 and 2022.³⁵

Due to this early success, many experts have recommended accelerating implementation of Medicare's competitive bidding program and/or extending the same principle to other Medicare services. For example, competitive bidding could be expanded to additional categories of medical devices, laboratory tests, radiologic diagnostic services, and other commodities. *A Bipartisan Path Forward* recommended expanding competitive bidding to all of these services and medical goods.

Another option proposes to utilize competitive bidding to set payment rates for health plans participating in the Medicare Advantage program. Current law sets Medicare Advantage plan payments based on benchmarks tied to local per capita costs for traditional Medicare in each county. Instead, benchmarks could be tied to the average plan bid in each county and weighted by the previous year's enrollment. This approach was discussed during the ACA debate but not ultimately included in statute.

Some variations on this policy have suggested allowing Medicare Advantage plans to return the difference between their plans' costs and the benchmark in the form of a reduced premium to enrolled beneficiaries. However, such a competitive bidding program could result in significantly higher benchmarks in rural counties than current law and higher

³⁴ "Summary: Issues for Manufacturer Level Competitive Bidding for Durable Medical Equipment," Web page, Government Accountability Office, May 31, 2011. <http://gao.gov/products/GAO-11-337R>

³⁵ "Medicare Announces Substantial Savings for Medical Equipment Included in the Next Round of Competitive Bidding Program," Press Release, Centers for Medicare and Medicaid Services, January 13, 2013. <https://www.cms.gov/apps/media/press/release.asp?Counter=4512&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

program spending. To avoid this problem, one recent proposal advanced by the Bipartisan Policy Center would allow the benchmarks set by current law to serve as the ceiling for benchmarks established under the competitive bidding process.³⁶

Prescription Drug Policy: *Remove barriers to generic competition in Medicare’s Low-Income Subsidy program.*

For years, private insurers have used lower cost-sharing to encourage consumers to choose lower-cost generic drugs as substitutes for more expensive brand-name drugs when clinically appropriate. However, Medicare beneficiaries in the Low Income Subsidy (LIS) program who receive subsidies to help pay for drugs currently do not have the same incentives. MedPAC and several other experts have recommended using changes to cost-sharing for LIS beneficiaries to encourage the use of generics and low-cost drugs in certain therapeutic classes, with appropriate safeguards to ensure access is not negatively affected.³⁷ Various reforms to achieve this goal range from lowering the copayments for generics and increasing copayments for non-preferred brand-name drugs to eliminating cost-sharing for generics altogether.

By driving beneficiaries toward higher-value, low-cost generics where clinically appropriate, this policy can help slow growing spending overall and, in many cases, lower out-of-pocket spending for low-income beneficiaries. Notably, a version of this policy was included in President Obama’s FY 2014 budget.³⁸

Achieving Budgetary Savings from Delivery System Reform

Improved quality and better value for Americans’ health care dollars are worthy goals in and of themselves, but as policymakers confront the fiscal challenges facing both federal health programs and the broader economy, finding budgetary savings remains a vitally important consideration.

The first and perhaps easiest way to address the need for savings over the ten year budget period is to identify delivery reform options that are “scoreable.” The Congressional Budget Office has previously concluded that certain policy changes related to readmissions penalties, health care-acquired conditions policies, competitive bidding, and generic drug utilization in the LIS population can actually reduce federal spending. Related policy options identified in this paper are likely to yield scoreable savings as well if properly designed.

³⁶ “A Bipartisan Rx for Patient-Center Care and System-wide Cost Containment,” Bipartisan Policy Center, April 2013.

<http://bipartisanpolicy.org/sites/default/files/BPC%20Cost%20Containment%20Report.pdf>

³⁷ “Report to Congress: Medicare Provider Payment Policy,” MedPAC, March 2013.

http://www.medpac.gov/chapters/Mar12_Ch13.pdf

³⁸ “Fiscal Year 2014 Budget-in-Brief,” U.S. Department of Health and Human Services, April 2013.

<http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>

A second approach is to insist on persistent, aggressive testing of other, less-proven models of delivery reform. Some reforms (for example, in the areas of care coordination,³⁹ improved integration of care for dually eligible beneficiaries,⁴⁰ and value-based purchasing⁴¹) may lack the evidentiary support which CBO requires in order to attribute scoreable savings to them. But even when CBO cannot attribute scoreable savings to these reforms, there are sound fiscal reasons to pursue them. Some of these less-tested approaches will fail to yield actual budgetary savings, but others could prove quite successful at reducing federal spending without sacrificing quality. This process of testing models of health care delivery and payment will reveal which reforms do in fact achieve savings. Furthermore, the lessons learned from this process should produce information that could open the door to other models and enable providers to revamp their approach to yield cost savings.⁴²

In pursuing this strategy, CMS will likely require significant flexibility to modify demonstration projects based on results and expand demonstrations which are successful in reducing costs without harming the quality of care. The Bipartisan Path Forward assumed relatively modest savings from delivery system reforms and included several policies for which it did not assume any savings, but noted that the reforms in the plan have the potential to reduce the rate of growth of health care spending by a significantly greater amount.

Finally, policymakers may also establish enforcement mechanisms that, if properly designed, can both spur the transformation of health care delivery and provide some assurance of budgetary savings.

One such enforcement mechanism is simply to build targeted, scoreable payment reductions into a delivery or payment reform proposal. For example, President Obama's FY2014 budget proposal to apply bundled payment in post-acute care achieves scoreable savings, in part by stating that the total bundled payment will be set at levels sufficient to achieve a cumulative reduction of 2.85 percent by 2020.

³⁹ "Budget Options Volume 1 Health Care," Congressional Budget Office, December 2008.

<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>

⁴⁰ Dual Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies,"

Congressional Budget Office, June 2013. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308_DualEligibles.pdf

⁴¹ "Budget Options Volume 1 Health Care," Congressional Budget Office, December 2008.

<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>

⁴² Skeptics of delivery and payment reform point to CBO January 2012 analyses documenting lessons learned from recent Medicare demonstrations of value-based payment, disease management and care coordination. In that report, CBO found limited savings across most of these demonstrations.

Still, a more careful reading of CBO's analysis indicates that under the right circumstances, savings can be achieved from delivery system reform. CBO specifically notes that certain participating providers in these demonstrations were able to produce savings, particularly among higher cost beneficiaries including dual eligibles. This is illustrative of the result which aggressive persistent testing of delivery reform models can and should produce. The demonstrations analyzed by CBO identified the most promising models for reform, and yielded information (i.e. that savings were concentrated in high-cost populations) that could allow other models to be modified to produce savings.

Under another enforcement approach, a “value-based withhold” could serve to guarantee savings. This policy was discussed above as an example of a variation on shared savings. Providers that reach a particular savings target would receive some or all of the withheld monies as a bonus, while costs to the Medicare program would be reduced due to lower overall spending on those providers’ patients. In the case of providers that fail to meet the savings target, Medicare achieves savings by keeping the withheld monies. In addition to providing a mechanism to enforce limits on health spending growth, a value-based withhold also has the potential to enhance the chances of success for delivery system reforms that rely on changes in provider behavior, as there would be adverse consequences if those providers fail to control costs.

Conclusion

Overall, enacting any of the delivery system and payment reforms discussed in this paper has the potential to improve efficiency and encourage higher value in our health care system. The exact amount of savings, both from federal health programs and overall national health expenditures, can be more difficult to ascertain for some particular reforms. But overall, the potential for savings is substantial. That potential is even greater if policymakers pursue these reforms in a comprehensive approach that includes enforcement mechanisms to ensure savings and policy outcomes.

With growing support, many of these reforms will likely be on the table in future discussions surrounding entitlement reform. While policymakers can expect to face political challenges with other policies, these delivery and payment reforms have garnered broad, bipartisan support and would not only help slow health care spending growth but also improve the quality of care for patients. Lawmakers in Washington would be wise to pursue such reforms to put our budget and health care system on a more sustainable path.

Additional Resources

American Enterprise Institute: “Medicare Makeover: Five Responsible Reforms to Make Medicare Healthy”

<http://www.aei.org/issue/health/entitlements/medicare/medicare-makeover-five-responsible-reforms-to-make-medicare-healthy/>

Antos, Joseph R., Mark V. Pauly, and Gail R. Wilensky. "Bending the Cost Curve through Market-Based Incentives." *The New England Journal of Medicine*, 12 Sept. 2012.

<http://www.nejm.org/doi/full/10.1056/NEJMs1207996>

Bipartisan Policy Center: “A Bipartisan Rx for Patient-Centered Care and System-wide Cost Containment”

<http://bipartisanpolicy.org/sites/default/files/BPC%20Cost%20Containment%20Report.PDF>

The Brookings Institution: “Bending the Curve: Person-Centered Health Care Reform”

<http://www.brookings.edu/research/reports/2013/04/person-centered-health-care-reform>

Center for American Progress: “The Senior Protection Plan”

<http://www.americanprogress.org/wp-content/uploads/2012/11/SeniorProtectionPlan.pdf>

The Commonwealth Fund: “Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System”

<http://www.commonwealthfund.org/Publications/Fund-Reports/2013/Jan/Confronting-Costs.aspx>

The Moment of Truth Project: “A Bipartisan Path Forward to Securing America’s Future”

<http://www.momentoftruthproject.org/publications/bipartisan-path-forward-securing-america-future-0>

National Coalition on Health Care: “Curbing Costs, Improving Care: The Path to an Affordable Health Care Future”

<http://www.nchcbeta.org/wp-content/uploads/2012/05/NCHC-Plan-for-Health-and-Fiscal-Policy.pdf>

President Obama’s FY2014 HHS Budget Proposal

<http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>

Urban Institute: “Can Medicare Be Preserved While Reducing the Deficit?”

<http://www.urban.org/publications/412759.html>

Appendix I: Comparison of Health Proposals and their Delivery System Reforms

	A Bipartisan Path Forward	Bipartisan Policy Center	Urban Institute	Center for American Progress	National Coalition on Health Care	Common-wealth Fund	Brookings Institution	AEI
Rewarding Performance, Not Volume								
Physician Payment/SGR Reform	-Direct CMS to create a more effective SGR formula that encourages a move away from FFS.	-Repeal and replace SGR with a new method that freezes FFS payments from 2017-23 for the full spectrum of providers, reserving payment updates for those providers in or contracting with a Medicare Network (an enhanced version of current ACOs).	-Replace the SGR, reduce rates for overpriced services and increase rates for primary care providers; 2% per-year reduction in non-primary care for 3 years, and then flat payment for another 7 years for all services with a budget-neutral redistribution of fees that would reduce non-primary care fees by 6%.	-Starting in 2017 Medicare would reduce FFS payments to all specialists and any primary care physicians not participating in a certified primary care medical home by 3%. -Permanently extend the 10% increase for primary care physicians under the ACA.	-Supports the approach embodied in Medicare Provider Payment Innovation Act (MPPIA); repeal SGR for 5 years with modest increases for primary care providers; task CMS with identifying at least four value-based payment models; by 2018, FFS payment would begin growing slower than those available through value-based payment models. -Revalue payment codes equal to at least 1% of Medicare spending each year. Dedicate any savings from reducing fees for overvalued services to increasing payment for undervalued services.	-Repeal SGR; Assumes a 1% update for 2013 and constant Medicare payment rates thereafter, while adjusting relative payment rates for services that meet specified criteria as "overpriced." -Provide increases in future payments only for providers that participate in payment and delivery system innovations that are accountable for the populations they serve.	-Replace the SGR with a payment system that increasingly includes elements of case-based payments and incentives for providers to transition Medicare Comprehensive Care.	-Replace the current system with a stable payment system that spreads cuts among all parties: physicians, other providers, and beneficiaries. -Institute a new physician payment methodology that rewards quality and prudent medical practice. -Develop alternative payment models such as competitive bidding, bundled payment, performance-based payment, etc.

<p style="text-align: center;">Shared Savings</p>	<p>-Fast-track state Medicaid waivers and enable states to share in Medicaid savings if they lower per capita health care cost growth by both public and private payers to a certain target, such as GDP growth; savings to the federal government would depend on the amount shared with the state, but could be enhanced by state efforts to constrain health care cost growth in the private market; bonus payments could be included for states that meet various performance targets on cost, quality, and access.</p> <p>-Establish presumptive eligibility criteria for up to 10 states over the next decade for a new waiver program for states to control costs.</p>	<p>-In their proposed “Medicare Networks,” providers would share in savings from greater quality and efficiency of care, but also in losses; also provide disincentives for staying in the less efficient FFS system.</p> <p>-Allow states shared-savings opportunities for dually eligible beneficiaries.</p>	<p>-Provider payment reductions could be accompanied by a payment reform that would add a shared savings component to prospectively set rates.</p>	<p>-Form “accountable care states,” which would give states greater flexibility and the opportunity to share in savings if they implement a global spending target; states would agree to pay back Medicare/Medicaid if they exceed target; states could be eligible for bonus payments if they meet certain quality and cost measures.</p>	<p>-ACO’s currently participating in the existing the Medicare Shared Savings and Pioneer ACO programs can also assume risk for Medicaid-covered services and supports and behavioral services utilized by those dually eligible beneficiaries attributed to that ACO.</p> <p>-Allow states to share in the savings that the federal government would generate when generic utilization increases.</p>	<p>-Recalibrate payments to MA plans based on the cost of the new Medicare Essential option with shared-savings for lower-cost, high-quality plans and their enrollees.</p> <p>-Encourage adoption of shared-savings or global payment arrangements with networks of providers.</p>	<p>-Build on Medicare Shared Savings program, have CMS implement a pathway for MCC organizations to transition in the coming years to partial and full capitation for their assigned beneficiaries.</p> <p>-Enable physicians to share in the savings for care decisions they make that improve quality and reduce overall Medicare costs.</p> <p>-In implementing a spending target, states that are able to reduce per capita and overall Medicaid spending growth significantly below the expected benchmark trends would be able to keep a disproportionate share of the savings (and would also be accountable for a disproportionate share of cost overruns).</p>	
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<p style="text-align: center;">Reducing Rates of Readmissions and Hospital-Acquired Conditions</p>	<p>-Realign incentives to discourage unnecessary hospital readmissions and avoidable complications known as “never events”; calibrate penalties to adjust for patient demographics, types of condition, and timing of readmission; penalties could also be decreased for providers who are able to reduce their readmissions or complications over time or those who demonstrate that readmissions are leading to lower mortality rates.</p>	<p>-Bundle provider payments for readmissions within 90 days through a withhold approach.</p>	<p>-Expand penalties to SNFs and HHAs.</p>	<p>-Reduce Medicare payments to skilled nursing facilities with high rates of re-hospitalization.</p> <p>-Strengthen VBP for hospital readmissions and complications.</p>	<p>-Expand penalties for hospital readmissions and complications.</p>	<p>-Expand episode of care to include readmissions for the same condition within 30 days, and any diagnostic tests within 3 days of the admission and 30 days after discharge.</p>	<p>-Implement new care coordination procedures for chronically ill patients to avoid readmissions.</p>	
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<p style="text-align: center;">Value-Based Insurance Design and Purchasing</p>	<p>-Replace Medicare’s current cost-sharing structure with a payment model that rewards outcomes, and gives patients more control over their health care.</p>	<p>-Beneficiaries enrolled in a Medicare Network would receive a \$60 annual discount on their Medicare premium for the first 3 years, along with lower cost-sharing for in-network providers; if a network meets quality and savings targets, beneficiaries could receive 25% of the savings in the form of reduced monthly premiums.</p> <p>-Allow Medicare Advantage plans to adopt tiered network designs.</p>	<p>-Reduce payments for hospital outpatient services to be roughly equal with those for physicians performing the same services outside a hospital setting.</p>	<p>-Implement value-based purchasing for ambulatory surgical centers.</p>	<p>-Task CMS with identifying at least four value-based payment models, and by 2018, FFS payments would be gradually reduced to shift towards new payment models.</p>	<p>-Establish a new integrated plan called Medicare Essential which varies copays and coinsurance with incentives to seek high-value providers and systems.</p> <p>-Reward beneficiaries in a patient-centered medical home with lower cost-sharing.</p> <p>-Modify ACA MA changes to give beneficiaries an incentive to choose high-value health systems for both traditional Medicare and MA plans in two phases: (1) replace current benchmarks with new set of local reference prices; and (2) after 2019, shift from local reference prices to average bids associated with the new Medicare Essential benefit plan.</p>	<p>-Transition Medicare FFS to Medicare Comprehensive Care with aligned value-based payment systems for Medicare ACOs, medical home, episode-based treatments, and globally capitated, comprehensive payment.</p> <p>-Facilitate the adoption of payment reforms by providers in Medicare and Medicaid to match value-based payment reforms used by the private sector.</p> <p>-On the beneficiary side, the MCC would offer beneficiaries the option to reduce their premiums and/or copays in exchange for choosing higher-value MCC providers.</p>	<p>-Establish a plan option that offers a network of high-quality providers who will accept lower Medicare payments in exchange for recognition of their superior service, and allow Medicare authorities greater latitude to adopt innovative payment schedules and management practices that reward improved health care delivery.</p>
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Medical Malpractice	<p>1) Institute a statute of limitations for malpractice claims; 2) Replace “joint and several liability” with a “fair-share rule;” 3) Place sliding-scale limits on lawyer contingency fees; 4) Create provider safe harbor for certain FDA-approved products; 5) Allow consideration of collateral source income to be considered in deciding damages; 6) Institute evidence-based clinical practice guidelines and a safe harbor for physicians who follow them; 7) Expand federal support for disclose-and-offer programs; 8) Apply a health court model to malpractice claims in the Federal Claims Court.</p>	<p>-Create Institute of Medicine (IOM) panel on evidence-based quality measures as a provider defense in medical liability cases, and advise appropriating existing state grants for medical liability reform to current tort litigation.</p>		<p>-Institute evidence-based clinical practice guidelines and a safe harbor for physicians who follow them.</p>	<p>-Apply a health court model to malpractice claims in the Federal Claims Court.</p> <p>-Expand federal support for disclose-and-offer and evidence-based safe harbor programs.</p>	<p>-Implement malpractice reform that institutes a process for addressing malpractice claims and that rewards adoption of best practices.</p>	<p>-Encourage states to develop more efficient medical liability systems.</p> <p>-Promote “safe harbor” or “rebuttable presumption” laws that establish legal protections for providers who achieve high quality and safety performance using valid measures.</p> <p>-Promote reforms that modify the existing judicial process for resolving tort claims with lower-cost and more predictable alternatives (e.g., a “patient compensation system”).</p>	
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Improving Care Coordination

Episodic Bundled Payments	-Expand Medicare's Acute Care Episode (ACE) Demonstration Program in support of bundled payments.	-Extend bundled payments into the standard Medicare payment; establish bundle method for post-acute care, physician, and inpatient services, as well as readmissions within 90 days by 2018 for certain DRGs.		-Expand the current bundle of inpatient hospital services from three days to seven; expand the ACE Program to include more services, especially post-acute; make bundled payments for at least two chronic conditions.	-Encourage bundled payments either by expanding the Acute Care Episode (ACE) Bundled Payment Demo, or by implementing a Center for Excellence for Selected Surgical Procedures program in Medicare.	-Expand bundled payments to post-acute care, SNFs, home health, and DME; set a "cutpoint" equal to the 65 th percentile of the wage-adjusted cost of bundles grouped by payment code, and if the episode cost exceeds the cutpoint, the payment is reduced by 40% of the excess.	-Implement a progressively expanding set of bundled payments with performance measures that are focused on common beneficiary health problems and common combinations of problems, along with primary-care case payments. -Providers would be able to participate in their proposed Medicare Comprehensive Care by accepting a case-based or bundled payment for their services and by meeting similar care quality and outcome performance standards for full payment.	-Develop other payment models and include bundled payment as an option.

<p style="text-align: center;">Care Coordination of Dually Eligible Beneficiaries</p>	<p>-Fast-track Medicaid waivers with demonstrable promise, extend to reforms that seek to advance care coordination between states and the federal government for dually eligible beneficiaries, such as placing them into managed care plans.</p>	<p>-Give states shared-savings opportunities with duals.</p> <p>-Explore alternative models such for delivery of care to duals, such as the financial integration of prescription drugs.</p> <p>-Have CMS test a model where states contract with CMS to provide the full range of Medicare and Medicaid services through the Medicare program.</p>		<p>-Encourage state Medicaid programs to coordinate care by allowing states to keep up to 60% (first three years, and 75% by 4th year) of the savings to Medicare if minimum quality standards are met.</p>	<p>-Insist on beneficiary protections in the Financial Alignment Demonstration, wherein states are testing primary care case management strategies to coordinate care for current dual-eligible beneficiaries.</p> <p>-Expand the Program for All-inclusive Care for the Elderly, a model Medicare and Medicaid benefits for frail beneficiaries.</p> <p>-Pilot test the inclusion of Medicaid services in a Medicare ACO.</p> <p>-Establish a template state Medicaid plan amendment that would make it easier to contract for Medicaid services with high-quality Medicare Special Needs Plans.</p>	<p>-Support multidisciplinary teams to coordinate care for high-cost patients with chronic conditions or disabilities.</p> <p>-More broadly, implement a number of policy changes to improve coordination and standardization (i.e. standard benefit design, smart insurance cards, core set of quality and cost metrics, review of regulatory requirements, etc.).</p>	<p>-Implement new Part B payments for care coordination for primary care physicians.</p> <p>-Make the "Financial alignment demonstration" for dual eligible beneficiaries into a permanent, person-focused program that: 1) provides timely access to readily usable Medicare data on dually eligible beneficiaries to the states and their provider and health plan partners; 2) produces more meaningful and consistent measures of quality of care and costs for dual eligible beneficiaries; and 3) shares evidence and best practices with states on effective steps for improving care for dually eligible beneficiaries.</p>	

Encouraging Competition

Prescription Drug Policies	-Apply Medicaid drug discounts to dually eligible beneficiaries in Part D.	-Eliminate copayments for Low-Income Subsidy (LIS) beneficiaries using generic and low-cost drugs, and increase the price of brand-name drugs slightly.	-Expand drug rebates that drug manufacturers currently provide to Medicaid to dual-eligible beneficiaries in Medicare as well. -Encourage substitution of generic drugs for brand-name drugs for low-income Part D beneficiaries.	-Extend Medicaid drug rebates to low-income Medicare beneficiaries. -Increase cost-sharing for brand-name drugs and eliminate for generics for low-income beneficiaries; maximize use of generic drugs in Medicare and Medicaid using the lowest price of equivalent drugs as the reference price, apply to drugs with 2+ therapeutically and chemically equivalent drugs; and reduce the upper limit to more accurately reflect costs.	-Direct HHS to establish a copay structure that eliminates copays for generic drugs and increases copays for brand-name drugs.	-Adopt MedPAC proposals to use Medicaid level drug rebates for dual-eligible beneficiaries and encouraging use of generics for LIS Part D beneficiaries. -Under their “Medicare Essential” plan, the drug benefit would be provided by a nationwide pharmacy benefit manager, and the plan would encourage the use of generic drugs through lower cost-sharing.	-Enable Medicare Prescription Drug Plans to share in overall savings.	

Competitive Bidding	<ul style="list-style-type: none"> -Expand competitive bidding to lower the cost of medical devices, laboratory tests, radiologic diagnostic services, and various other commodities. 	<ul style="list-style-type: none"> -Expand competitive bidding for other DME, but with benchmarks set lower for some equipment types. -Implement a competitive bidding system for MA plans. 		<ul style="list-style-type: none"> -Expand competitive bidding to health care products; competitively bid prices to Medicaid and other federal programs. -Apply competitive bidding for Medicare Advantage. -Require Medicaid managed care programs to use competitive bidding and pay-for-performance. 	<ul style="list-style-type: none"> -Expand competitive bidding to additional categories of durable medical equipment, excepting certain customized products. -Apply competitively bid prices to Medicaid. 	<ul style="list-style-type: none"> -Adopt the MedPAC recommendation to expand competitive bidding to all durable medical equipment categories. 		<ul style="list-style-type: none"> -Expand use of competitive bidding for medical products. -Replace the current Medicare Advantage bidding system with fully competitive bidding that allows for variations in prices among local markets.

Appendix II: Alternative Benefit Packages

Bipartisan Policy Center's "Medicare Networks"

- Providers and beneficiaries would have three options under Medicare: Traditional Medicare fee-for-service (FFS), a new version of ACOs called "Medicare Networks," and Medicare Advantage.
- The new Medicare Networks would be comprised of a group of providers working together to deliver care and sharing in any savings or losses. A network would contract with CMS and have a unique spending target.
- Providers in this model would be paid through a mix of a fixed per beneficiary payment and a fee schedule. Providers would share in savings from improved efficiency and could benefit from other incentives such as payment for services not previously reimbursed by Medicare.
- On the beneficiary side, those who enroll in a Medicare Network would receive a \$60 annual discount on their Medicare premium for the first three years along with lower cost-sharing for in-network providers. If a network meets quality and savings targets, then beneficiaries in that network would receive 25 percent of the savings in the form of reduced monthly premiums.

Commonwealth Fund's "Medicare Essential"

- New comprehensive insurance plan for Medicare beneficiaries to choose so they no longer need supplemental coverage.
- A premium would be charged to offset the cost of the more comprehensive benefit package and improved protection against catastrophic out-of-pocket costs, but this additional premium would be offset by the reduced costs of wrap-around coverage (i.e. Medigap, employer, Medicaid).
- Integrates Medicare Part A, B, and D with a single deductible and an out-of-pocket maximum, covers preventive care in full, and varies copayments and coinsurance with incentives to seek high-value providers and systems (i.e. tiering).
- Drug benefit would be provided by a nationwide pharmacy benefit manager (selected by competitive bid) authorized to negotiate prices on behalf of Medicare.
- Beneficiary incentives to register with a primary care doctor/medical home and for using high-value networks like ACOs.
- Traditional Medicare would still be available to all current beneficiaries. Future newly-eligible Medicare beneficiaries would be automatically enrolled in this new option, but could opt to enroll in a Medicare Advantage plan or traditional Medicare.
- Limits Medigap plans to have minimum cost-sharing limits, including a \$250 deductible and copays for physician and emergency room visits (\$20 and \$50, respectively).

Brookings Institution's "Medicare Comprehensive Care"

- The Brookings Institution's proposal Medicare Comprehensive Care (MCC) would be an alternative payment system and benefit package to align incentives with higher value care.
- On the provider side, MCC would build on current payment reforms such as bundled payments, ACOs, and medical homes to replace FFS payments so that by the end of the decade the majority of Medicare services are reimbursed by these alternative arrangements.
- All Medicare payments (FFS, MCC, and Medicare Advantage) would be based on current per beneficiary spending and limited to the per capita growth rate of GDP.
- On the beneficiary side, the MCC would offer beneficiaries the option to reduce their premiums and/or copays in exchange for choosing higher-value MCC providers. The report also proposes incorporating an out-of-pocket maximum and requiring Medigap plans to have an actuarially equivalent copay of at least 10 percent.

Appendix III: Illustrative Legislative Specifications of Novel Proposals

Strengthen Policies to Deter Avoidable Readmissions and Healthcare-Acquired Conditions

As noted in the text of this report, several recent budget and health care plans, including the *Bipartisan Path Forward*, have recommended strengthening federal policy regarding readmissions and healthcare-acquired conditions. Building on proposals previously advanced by the consumer group Community Catalyst, we offer an example of how an overhaul of these programs could be designed.

As outlined by Community Catalyst, a revised Healthcare-Acquired Condition (HAC) policy would differ from current law in several ways. The current penalty, capped at 1 percent of a hospital's revenue, would be changed to a penalty proportionate to the actual cost to the Medicare program. The set of complications on which hospitals are measured would expand from 27 to the 64 Potentially Preventable Complications utilized by 3M Health Information Systems.⁴³ Penalties would apply to all hospitals below the national average, not simply the bottom quartile, as provided for under current law. Finally, this revised HAC policy would apply not only to hospitals but also to ambulatory surgical centers and post-acute providers.

Community Catalyst has proposed a similarly aggressive overhaul of Medicare's controversial Hospital Readmissions Reduction Program. Whereas current law applies penalties to hospitals with high readmissions rates for three conditions (i.e. pneumonia, heart attack and chronic heart failure) and then instructs the Secretary of Health and Human Services (HHS) to expand that list to seven for FY 2015, this proposal would base penalties on all readmissions clinically related to the initial admission within 30 days that were potentially preventable. In this case, potentially preventable is defined as readmissions that could have been prevented by one or more of the following: (1) the provision of quality care in the prior hospitalization, (2) adequate discharge planning, (3) adequate post-discharge follow-up, or (4) improved coordination between the inpatient and outpatient health care teams. This approach would also eliminate the statutory cap that limits the size of a hospital's readmissions penalty to no more than 2 percent of a hospital's Medicare payments in FY 2014 and no more than 3 percent in FY 2015 and subsequent years. Instead, penalties would be based on the cost of the hospital's readmissions to the Medicare program, with no upper limit.

However, it must be noted that the Hospital Readmission Reduction Program under current law has produced unintended consequences. Institutions serving low-income patients have been shown to have higher readmissions rates and are more likely to be penalized.⁴⁴ If this pattern continues, improperly designed penalties could starve key safety net institutions of the resources needed to improve. For this

⁴³ "Going Beyond Current Law: Preventing Avoidable Complications and Readmissions," Fact sheet, Community Catalyst, January 2012.

⁴⁴ "Report to Congress: Medicare and the Health Care Delivery System," MedPAC, June 2013, http://medpac.gov/documents/Jun13_EntireReport.pdf.

reason, policymakers may wish to couple expansion of HAC and readmissions policies with other measures designed to limit these unintended negative consequences for vulnerable populations and safety net providers.

A number of policy options are available for this purpose. The National Coalition on Health Care (NCHC) previously has endorsed investing a portion of the savings achieved by an enhanced readmissions policy into quality improvement and care transitions initiatives for low-performers.⁴⁵ However, this adjustment could reduce overall savings.

Another alternative, discussed in the MedPAC June 2013 Report, merits particular consideration from policymakers.⁴⁶ Under this approach, hospitals would continue to be ranked relative to all other applicable institutions—without any adjustment for socio-economic status. This ensures that underlying disparities in care delivered to various populations would remain clearly apparent. However, when computing penalties, hospitals would be divided into deciles based on the percentage of Medicare patients on Supplemental Security Income (a relatively reliable indicator of low-income status among patient populations). The benchmark determining whether penalties would be applied would be based on performance relative to other hospitals within the decile, not relative to all applicable Medicare hospitals as under current policy. So for hospitals serving lower-income patients, a readmissions rate slightly higher than the current national benchmark would be sufficient to avoid penalties. By contrast, for a hospital serving higher-income communities would have to attain a somewhat lower rate of readmissions than the current national benchmark to avoid penalties.

MedPAC's approach would actually reduce the total value of penalties applied to institutions treating low-income beneficiaries across Medicare, thereby enhancing Medicare's investment in safety net institutions relative to current policy. Yet these institutions would have strong incentives to invest those resources in avoiding readmissions, lest they fall below the benchmark for their decile and face a penalty. Furthermore, because the policy would sharpen incentives for improvement among some hospitals serving higher-income patients, it would have no detrimental effect on budgetary savings.

Community Catalyst has estimated that their enhanced HAC policy could produce \$23 billion in savings over ten years, while their enhanced readmissions policy could save \$29 billion⁴⁷. While CBO may not attribute the full \$52 billion in savings to these policies, they are likely to produce substantial savings. In each case, they would substantially increase the number of hospitals and other institutions subject to penalty and increase the magnitude of those penalties relative to current law.

⁴⁵ "Curbing Costs, Improving Care: The Path to an Affordable Health Care Future," National Coalition on Health Care, November 8, 2012. <http://nchc.org/plan-for-health-and-fiscal-policy/>

⁴⁶ "Report to Congress: Medicare and the Health Care Delivery System," MedPAC, June 2013. http://medpac.gov/documents/Jun13_EntireReport.pdf

⁴⁷ Miller M and Howitt K, "Better Care at Lower Costs: An Approach to Reducing Health Spending by Paying for Outcomes," Community Catalyst, January 2013.

Finally, as noted in the text of this paper, the use of “observation stays” has grown in recent months. Policymakers may wish to consider moving from a metric based solely on readmissions to a more comprehensive measure of unplanned care encompassing emergency room visits, observation stays, and readmissions.⁴⁸

Value-Based Withhold

Withholding is a well-established tool, used by a number of health plans. Recently, it has also been considered as a mechanism for cost containment in Medicare. We present below one possible approach to utilizing a value-based withhold as an enforcement mechanism within Medicare, as suggested in *A Bipartisan Path Forward*.

Legislation would establish a *withhold percentage*. An amount equal to that withhold percentage would be retained by the Centers for Medicare and Medicaid Services (CMS) from all Part A, B, and C payments that would otherwise be payable to those providers or plans. Prior to the beginning of the first payment year, CMS would calculate the amount that Medicare otherwise would be expected to pay the provider for a defined patient population (referred to here as the *estimated spending amount*). A *spending target* would then be assigned to each withholding entity equal to the *estimated spending amount* minus the *withhold percentage*. For those providers whose actual spending (without including effects of the withhold) is equal to or less than the *spending target*, the entire amount of the withheld payment will be returned at the end of the payment year. For those withholding entities whose actual spending is between the target and the *estimated spending amount*, a portion of the withheld monies will be returned at the end of the payment year. For those withholding entities that exceed the *estimated spending amount*, none of the withheld monies shall be returned.

To ensure that a withhold does not lead to stinting on care, providers would only be eligible for the return of withheld monies if they reported on specified quality measures and met risk-adjusted quality of care standards. Any quality metrics used for this purpose should be aligned with those utilized under other value-based purchasing and quality reporting systems in Medicare, and to the extent possible, among private payers.

The size of the withhold percentage could be adjusted to produce varying degrees of savings. And although the Congressional Budget Office (CBO) has yet to estimate the savings of a specific value-based withhold proposal, this policy relies on direct adjustments to provider payment levels to guarantee savings and is very likely to score as reducing expenditures. Researchers from the Dartmouth Institute for

⁴⁸ Baier RR, Gardner RL, Coleman EA, Jencks SF, Mor V, and Gravenstein S, “Shifting the Dialogue From Hospital Readmissions to Unplanned Care,” *American Journal of Managed Care*, Vol. 19 No. 6, June 19, 2013. <http://www.ajmc.com/publications/issue/2013/2013-1-vol19-n6/Shifting-the-Dialogue-From-Hospital-Readmissions-to-Unplanned-Care>

Health Policy and Clinical Practice estimate that a 6 percent withhold applied to all Medicare providers could save \$400 billion over ten years.⁴⁹

The key question in designing such a withhold is the nature of the provider group to which it would apply. ACOs and Medicare Advantage health plans are already equipped to take responsibility for defined populations. The challenge is how to apply the withhold for care not provided through an ACO or health plan. An article by Dr. Skinner, Fisher, and Wennberg of the Dartmouth Institute published in the *Journal of the American Medical Association (JAMA)* suggests that applying the withhold policy on the basis of Hospital Referral Region would ensure that it would be applied evenly across the full range of Medicare providers, and, according to Skinner et al., could encourage more providers to participate in ACOs and foster other forms of cooperation among providers on a regional basis. However, such a blunt approach would punish high-value providers who happen to practice within regions with high rates of spending and lower-quality performance.

An alternative would be to phase in the withhold. It could be applied initially to all providers of a certain size with the capacity to assume responsibility for defined populations—similarly to how CMS has initially restricted the implementation of the value-based modifier to physician groups of one hundred or more professionals.⁵⁰ Over time, the size of the provider organizations to which the withhold applied could be decreased. In the interim, policymakers might consider providing a modest, budget neutral payment incentive to encourage smaller provider organizations to participate on a voluntary basis. However, it must be noted that this phase-in approach would lower the budgetary savings that any particular withhold percentage could produce.

Promoting Generic Use in the Medicare Low-Income Subsidy Population

Certain Medicare beneficiaries (i.e. those who are eligible for Medicaid, receive Supplemental Security Income (SSI), or earn less than 150 percent of poverty) are eligible for a subsidy to defray the cost of premiums, deductibles, and copays for Medicare prescription drug coverage. Although Part D plans have used lower copays to increase utilization of generic alternatives among other Medicare enrollees, recipients of this low-income subsidy (LIS) continue to utilize brand-name drugs at a higher rate.⁵¹

A number of the budget plans described in this report included changes to copays for LIS to promote generic use, and President Obama's FY 2014 budget includes a particularly detailed proposal in this regard. The administration's proposal would decrease copays for generics to 90 cents for beneficiaries with income below 100 percent of the federal poverty level and \$1.80 for beneficiaries with incomes between 100 and 135 percent of the federal poverty line, while increasing copays to twice the level allowed under current law – when a lower cost generic or

⁴⁹ Skinner JS, Weinstein JN, and Fisher ES, "Withholds to Slow Medicare Spending: A Better Deal Than Cuts," *Journal of the American Medical Association*, Vol. 307 No. 1, January 4, 2012, pp.43-4.

⁵⁰ "Medicare FFS Physician Feedback Program/Value-Based Payment Modifier: Background," Web page, Centers for Medicare and Medicaid Services, April 17, 2013, Retrieved on July 23, 2013 from <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Background.html>

⁵¹ "Report to Congress: Medicare Payment Policy," MedPAC, March 2012, http://medpac.gov/documents/Mar12_EntireReport.pdf.

preferred brand alternative was available. The Administration's proposal includes several important protections for beneficiaries. Beneficiaries eligible for institutional care and who might face difficulty managing their own prescription choices would be excluded from the higher copays. The Secretary would have the authority to exclude therapeutic classes from this policy if substitution is determined to be clinically inappropriate or generic alternatives are not available. Finally, a robust exceptions or appeal process would be established to allow beneficiaries to receive the brand name at the lower copay. Even with these substantial beneficiary protections, CBO has concluded that this policy would save \$29.3 billion over ten years.

The Bipartisan Policy Center (BPC) has proposed a separate, but complementary policy. Under current law, Medicare provides payments to Part D plans to cover the cost of reducing LIS beneficiaries' deductibles and cost-sharing. When lower-cost brand and generic alternatives are available, BPC has proposed limiting these payments to what the plan would have received for the lower cost alternative.⁵² This would encourage Part D plans to manage their formularies in ways that enhance use of low-cost alternatives. Extrapolating from BPC's own cost estimates, this change alone could save Medicare \$27 billion over ten years.⁵³ In crafting any such policy, adequate protections for consumers will be important, including an exceptions policy for instances in which a particular brand is medically necessary.

⁵² "A Bipartisan Rx for Patient-Center Care and System-wide Cost Containment," Bipartisan Policy Center, April 2013.

<http://bipartisanpolicy.org/sites/default/files/BPC%20Cost%20Containment%20Report.pdf>

⁵³ BPC attributes a total of \$44 billion in savings to changes to LIS copay changes and this proposed adjustment to payments to prescription drug plans. However, at the time of release of BPC's report, the best estimate of the impact of adjusting cost-sharing was \$17 billion in savings over ten years, not CBO's subsequent estimate of \$29.3 billion. Subtracting \$17 billion from BPC's total \$44 billion estimate yields \$27 billion in estimated savings for the limits on payments to part D plans.