
Partnership

for Sustainable Health Care

*Strengthening Affordability and Quality
in America's Health Care System*

April 2013

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Introduction

Background

The U.S. health care system plays a vital role in the health of our nation's people and economy. We invest trillions of dollars in health care each year, yet miss significant opportunities to reap the value of our investment because the system was not designed to consistently reward high-quality care provided at an affordable cost. It therefore wastes limited resources without producing outcomes that support a healthy society.

We believe we can do better.

Our group of diverse health care stakeholders came together over the past year to develop a road map to transform the health care system by improving efficiency, clinical effectiveness, and value for patients. We represent stakeholders in the hospital, business, consumer, and insurance sectors: Ascension Health, the Pacific Business Group on Health, Families USA, the National Coalition on Health Care, and America's Health Insurance Plans (AHIP). The American College of Surgeons (ACS) also joined in the discussion of key principles consistent with the ACS commitment to inspiring quality, clinical registries, and reforming payment. We are committed to continuing to work collaboratively to advance these recommendations.

While representing diverse constituencies and perspectives, we strongly believe that unsustainable increases in health care spending urgently call for integrated, system-wide reforms that generate better value. We share a common vision, embrace core principles, and support key changes that are necessary to achieve the transformation we are recommending.

The importance of bringing growth in health care costs under control cannot be overstated. While the U.S. health care system has many positive attributes, the system as a whole is costly, especially when compared to other industrialized countries. Although health care spending in recent years has grown more slowly than historical rates would have predicted, forecasts suggest that the nation's health care budget will still grow at an unsustainable pace—far faster than the general economy—in the coming decades.¹ Given that the fundamental drivers of health care spending have not been altered, a return to such unprecedented levels of spending is likely in future years unless we take steps to manage costs.

Our Vision

We envision a high-performing, accountable, coordinated health care system where patient experience and population health are improved, and where per-capita health care spending is reduced.

The specific elements of our vision are as follows:

- Health care that is affordable and financially sustainable for consumers, purchasers, and taxpayers.
- Patients who are informed, empowered, and engaged in their care.
- Patient care that is evidence-based and safe.
- A delivery system that is accountable for health outcomes and resource use.
- An environment that fosters a culture of continuous improvement and learning.
- Innovations that are evaluated for effectiveness before being widely and rapidly adopted.
- Reliable information that can be used to monitor quality, cost, and population health.

Our Principles

Our vision is supported by a set of core principles. We constructed and organized our recommendations in accordance with these principles:

- The delivery and payment system must be fundamentally transformed. Incremental changes will not provide the comprehensive transformation needed to improve quality of care and control growth in health care spending.
- Health-related measures to reduce the federal budget deficit should be consistent with, and should move us toward, our goal of sustainable, system-wide improvement.
- Incentives for providers, payers, employers, and consumers must be aligned to ensure that they improve health and promote the use of effective, appropriate services.
- The best way to drive innovation and improvement is through healthy competition based on cost, patient experience, and health outcomes, with government as an important partner in this effort.
- Merely shifting costs from one party to another is not true cost control. We endorse policies that will bring total costs under control.
- Vulnerable populations should be protected as we design and implement the difficult policy reforms needed to control growth in health care spending.

Our Recommendations

The following five recommendations represent integrated, system-wide reforms that are needed to address the challenges America faces. The first three recommendations align incentives to transform the way providers deliver—and how consumers and payers demand—high-quality, well-coordinated care. The latter recommendations strengthen the infrastructure needed to achieve desired results in the form of savings and better health outcomes and provide important incentives for states to work in innovative partnerships with public and private stakeholders to truly transform the health care system.

1. Transform the Current Payment Paradigm.

We believe that transitioning away from the current fee-for-service payment system is the key to achieving high-quality, affordable care. We have been encouraged that, over the past few months, other organizations are also embracing this concept of “fundamental change.” We believe these statements of support are important indicators that the nation can increase value in health care and that the public and private sectors can work together to achieve it. Over the next five years, we encourage accelerated adoption of payment approaches that demonstrate their effectiveness in improving both quality and cost. These value-based payment approaches include a range of models that include incentives for patient safety, bundled payments, accountable care organizations, and global payments. We support the ongoing national dialogue regarding the setting of ambitious but achievable payment reform targets and recommend that valid and reliable metrics be developed to track the nation’s progress in moving payment reform forward.

2. Pay for Care that Is Proven to Work.

To the extent that we continue paying for specific health services under a fee-for-service payment structure, public programs and the private sector should reduce payments for services that prove to be less effective and to have less value than alternative therapies. The failure of the current system to make such differential payments results in the overuse of ineffective, costly services and the underuse of services that provide proven clinical benefits and high value.

3. Incentivize Consumer Engagement in Care.

When designing consumers' cost-sharing, differentiation to encourage the use of high-value services and providers should be used—without creating barriers to the appropriate utilization of services for any populations, paying special attention to the needs of low-income and other vulnerable populations. The goal of such tiered cost-sharing is to create financial incentives for consumers to make better use of their discretionary care choices, leading to savings from improved adherence to preventive measures and evidence-based care; lower utilization of unnecessary services; and the use of more efficient, higher-quality providers.

4. Improve the Infrastructure Needed for an Effective Health Care Market.

We need to strengthen and simplify the foundational infrastructure of America's health care system so that the cost- and quality-related innovations described above can work. This should include (1) accelerating research on treatment effectiveness to give patients and providers more information on which to base health care decisions; (2) prioritize the development and adoption of uniform measures and advance electronic data collection to support reporting; (3) ensuring that there is an adequate and diverse health workforce to provide coordinated care; (4) streamlining administrative processes to reduce waste; (5) reducing and resolving medical malpractice disputes by adopting innovative approaches, including those that promote patient-provider communication; (6) promoting efforts to increase the transparency of health care information, including consumers' out-of-pocket costs; and (7) encouraging competitive markets.

5. Incentivize States to Partner with Public and Private Stakeholders to Transform the Health Care System.

For states that bring stakeholders together to develop innovative reforms that lower the growth of total health care spending throughout the public and private sectors, we propose a gain-sharing system that would enable those states to receive fiscal rewards for successfully meeting cost- and quality-related goals. States could use different combinations of strategies that fit their specific cultures and political environments, ranging from working with private and public payers to collaboratively implement major payment reforms, to modifying scope of practice restrictions, to providing incentives for improvements in care coordination to promote quality and patient safety.

Our organizations are committed to working together, and with others in the private and public sectors, to achieve these objectives. The consensus recommendations set forth below are unique, but not simply because of the diversity of the organizations that developed them.

The proposals in this document present a roadmap for structural reform that will bend the overall cost curve. Our recommendations are not aimed at individual public or private programs—they are instead an integrated construct designed to promote reform. They are also designed to prevent the traditional shifting of costs from one payer to another. Our goal is to present action steps that will be undertaken in the federal, state, and private sectors to make the entire health care system safer, more affordable, and more effective, resulting in system-wide reform that will yield substantial cost savings over time.

1 Transform the Current Payment Paradigm

The Problem: Why We Need Comprehensive Payment Reform

While the United States invests billions of dollars annually to support a high-performing health care system, the system fails to consistently deliver value when it comes to cost, quality, and health outcomes. Traditional payment models exacerbate these problems, as providers are often paid based on the volume of services they perform, as opposed to whether they deliver the right care at the right time.

There are no system-wide incentives to maintain an appropriate level of spending, which results in cost shifting from one sector to another while overall costs continue to rise. Consumers lack both the information they need to make informed choices and meaningful incentives that would induce them to select higher-quality and lower-cost services, drugs, and providers. Medicare's physician payment structure fails to promote improvement in health outcomes or innovation in care delivery.

To facilitate the transformation of our delivery system into one that rewards quality and efficiency, the payment system will need to be fundamentally changed in terms of what it pays and how it pays. We believe that the government and private sector must work together to create the right incentives and ensure that the right information is in place to support efficiently, effectively delivered high-quality health care services. We support comprehensive payment and delivery reforms in both the public and private sectors, with the goal of transforming our current volume-based payment system to one that rewards health professionals and organizations when they achieve better patient outcomes, better health care, and lower costs.

Because this type of change must be system wide, it will take leadership and collaboration from a range of private- and public-sector leaders. However, since Medicare is the largest payer for care, and since other payers often use its payment approaches as a model, federal policy leadership—and a rapid transition of most Medicare payments to a value-based payment model—is essential to making these changes nationally.

The Department of Health and Human Services (HHS) and Medicare have a number of existing authorities to test and (after some time) expand certain payment innovations. However, relying solely on these authorities may ultimately prove inadequate to the task of transforming our health care system. To expedite the implementation and adoption of alternative payment models that result in improvements in both quality and efficiency in Medicare, Congress should grant HHS additional authority to make needed changes to payment policies in a timely manner.

Action 1: Promote the dissemination and implementation of alternative payment and delivery models that demonstrate success in improving quality and efficiency over the next five years.

There is broad agreement that payment reform is needed to reduce unnecessary health care expenditures and to foster practice redesign and quality improvements. We expect federal programs to use their purchasing power to accelerate the transition to value-based payment, in collaboration with private payers and purchasers. We recognize, however, that physicians and hospitals vary widely in

terms of readiness when it comes to changing how care is delivered and paid for and that the methods for changing payment systems must address this variation in capabilities. For that reason, we propose setting a clear direction for the public and private sectors but leaving the specific deployment and pacing of payment changes flexible.

A variety of models will help accelerate the shift to value-based payment and can be applied to specific patient populations and care settings. Collectively, these models have the potential to shift provider behavior toward a focus on patient health outcomes, care coordination, and the management of chronic conditions in appropriate settings.

Both public and private payers have already introduced payment models that promote better quality and care coordination and lower costs. Private payers are using medical homes that involve payments for care coordination, bundled payments for selected inpatient procedures, and the development of accountable care organizations (ACOs).² Public programs are also testing promising alternative payment methodologies through demonstrations under the Center for Medicare and Medicaid Innovation (CMMI), the Medicare Shared Savings Program,³ the Pioneer ACO Model,⁴ the Medicare hospital value-based purchasing model,⁵ and value-based modifier physician payment⁶ programs.

While system-wide change is essential, we believe that a one-size-fits-all approach should not be the objective, given the complexity of practice settings, varying levels of provider readiness, and the different needs of patient populations. Rather, having multiple approaches allows providers and health systems to build on the model that works best for them and their populations. To the extent that these models demonstrate improved quality and efficiency, they should be expanded as quickly as possible. Collaborations among Medicare and private payers on similar payment model constructs will enable more rapid adoption, since there needs to be a critical mass of patients and revenue that are affected by new payment arrangements to drive change at the provider level. Additionally, as these new models begin to take root, competitive pressure in the market can help accelerate adoption of new payment models

and, ultimately, move the health care system closer to achieving the three-part aim (improved patient experience of care, improved population health, and reduced per-capita health care spending).

Finally, we must develop robust metrics that are designed to gauge progress in achieving the goal of transitioning public and private health care payments to value-based models over the next five years. Though still in the early stages, one such example that is currently emerging in the market is a set of metrics being developed by Catalyst for Payment Reform to assess progress in payment reform across markets.⁷

Payment model approaches and opportunities for expansion (contingent upon demonstrated improvements in quality and efficiency) include the following:

Incentives for Providers that Improve Patient Safety

Providing incentives to physicians and hospitals for meeting performance benchmarks compared to their peers, while accounting for case mix and socioeconomic status of their underlying populations, and not paying for hospitals' avoidable readmissions and preventable adverse events (such as wrong site surgery and hospital-acquired pneumonia).

- While private payers and Medicare are currently using these approaches, they must be accelerated to include other areas of preventable adverse events and must include benchmarks that continually drive improvement. Quality metrics should be aligned across both private and public payers, updated on a regular basis, and retired when they are no longer useful or when they have been universally achieved.
- Disseminating information on best practices in both the public and private sectors results in lower hospital readmission rates. These best practices include using financial incentives to reduce readmissions, promote case management, and establish Centers of Excellence.

Incentives for Providers that Improve Patient Safety

Efforts are currently underway in both the public and private sectors to provide support and incentives that are designed to improve patient safety. In the private sector, health plans have been collaborating with their network hospitals and state patient safety boards in the area of patient safety.⁸ Plans use a variety of approaches, including promoting evidence-based care, toolkits that incorporate standardized processes to prevent infections, training hospitals on error-reduction strategies, changing payment models, tracking and reporting hospital and physician infection rates, and reporting those infection rates internally and publicly. Health plans use nationally recognized patient safety indicators for “never events,” serious reportable events, surgical safety indicators, and preventable medical errors, specifically those from the Centers for Medicare and Medicaid (CMS), the National Quality Forum, Leapfrog, and the Joint Commission, among others. Health plan network hospitals that are participating in such improvement programs or activities have reduced their rates of infections and other safety events. For example:

- Blue Cross Blue Shield of Michigan’s efforts to improve patient safety and reduce health care-acquired infections resulted in a 70 percent reduction in the rate of ventilator-associated pneumonia from 2008 to 2010, as well as a reduction from 19 percent to 14 percent in the rate of catheter use from 2007 to 2010 (among hospitals using evidence-based procedures to reduce catheter-associated urinary tract infections).⁹
- Kaiser Permanente’s use of evidence-based care and toolkits to prevent infections has yielded the following results: In eight of Kaiser hospitals’ adult intensive care units (ICUs), there has not been a single bloodstream infection in more than a year, and there have been no bloodstream infections in more than two years in two of Kaiser hospitals’ adult ICUs.¹⁰

In 2011, the Centers for Medicare and Medicaid Services (CMS) began a public-private initiative called the Partnership for Patients. CMS awarded federal funding to 26 Hospital Engagement Networks (HENs) to engage and educate hospitals nationwide to improve patient safety. The partnership is focused on making hospital care safer by reducing preventable hospital-acquired conditions by 40 percent and reducing hospital readmissions by 20 percent by the end of 2013.¹¹ Individual HENs can select which of the following nine quality measures they will focus on: adverse drug events, catheter-associated urinary tract infections, central line-associated bloodstream infections, injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-assisted pneumonia.

Ascension Health was one of only five health care systems that were awarded a HEN contract. Ascension Health chose to focus on all nine of the quality measures listed above, in addition to reducing hospital readmissions. In its role as a HEN contractor, Ascension Health devised a system-wide Early Elective Delivery (EED) protocol and began implementation on March 1, 2012. An early elective delivery is an early birth that is scheduled without a medical reason, and these deliveries are associated with an increased risk of maternal and neonatal morbidity and longer hospital stays for mothers and their newborns.¹²

Because of past work in this area, Ascension Health already had an EED rate of 3.60 percent, well below the nationwide average of 10-15 percent. Over the past 12 months, Ascension Health further reduced its system-wide EED rate by 79 percent. This EED reduction is projected to decrease EED NICU admissions by 82 percent, generating a savings of more than \$3.2 million in hospital and physician costs. Thirty-five hospitals achieved an EED rate of 0 percent.¹³

Patient-Centered Medical Homes

Expanding the use of payment models, such as those that are currently used in patient-centered medical home (PCMH) pilots, to include more patients and providers.

- To date, all 50 states have some form of a PCMH model or contract in place. Health plans and health systems in the private sector are implementing models of varying sizes, and programs are also being promoted within public health insurance programs such as Medicare and Medicaid. While individual models may vary with regard to contracted payment levels, most contain similar components: a base pay, a per-member per-month (PMPM) fee for care coordination/transition, and incentives to reach or exceed agreed-upon quality benchmarks.¹⁴
- Multi-payer medical home initiatives similar to the successful multi-payer PCMH pilot in Colorado¹⁵ and other initiatives launched by the CMS Innovation Center, such as the Comprehensive Primary Care Initiative¹⁶ and the Advanced Multi-payer Primary Care Demonstration,¹⁷ should be expanded to other locations across the country as soon and as widely as practicable.
- Over time, the proportion of medical home payments that are contingent on achieving quality and cost goals should increase. Some practices may ultimately move to a model that provides a single capitated payment for a patient's primary care.

What the Evidence Shows

Patient-Centered Medical Homes

Numerous studies have found evidence of cost savings and quality improvements resulting from the implementation of medical home programs. While the magnitude of savings varies depending on a range of factors, including program design, enrollment, payer, target population, and implementation phase, substantial savings have been demonstrated across a wide range of medical home programs. Examples include the following:

- Geisinger's Proven-Health Navigator Model, which serves Medicare patients in rural northeastern and central Pennsylvania, found 7.1 percent savings over expected costs.¹⁸
- Evidence from the Genesee Health Plan in Flint, Michigan, indicates that increasing access to primary care services and using health navigators to help patients adopt healthy behaviors and manage chronic diseases reduced enrollee use of emergency department services by 51 percent between 2004 and 2007 and reduced hospital admissions by 15 percent between 2006 and 2007.¹⁹
- Community Care of North Carolina's Medicaid managed care medical home program found an average of \$25.40 in savings per member, per month (PMPM) (5.8 percent savings over expected costs). The program saw substantially higher savings within the non-aged, blind, or disabled child and adult Medicaid populations (\$32.94 and \$77.56 PMPM, respectively).²⁰
- One study found that that WellPoint's medical home model in New York yielded risk-adjusted total PMPM costs that were 14.5 percent lower for adults and 8.6 percent lower for children enrolled in a medical home.²¹
- Preliminary results from CareFirst Blue Cross Blue Shield's medical home program showed an estimated 1.5 percent savings in its first year of operation, before accounting for provider bonuses. While formal evaluations are ongoing, CareFirst anticipates that savings levels may reach 3 to 5 percent in future years.²²
- Similar levels of savings have been found in medical home models that include a mix of public and private payers. For example, UPMC's multi-state medical home pilot, which includes a mix of commercial, Medicaid, Medicare, and dually eligible patients, showed a net savings of \$9.75 PMPM for individuals enrolled in the medical home pilot.²³

Bundled Payments

Adopting bundled payments for select conditions and procedures that encompass a set of well-defined services and have a relatively clear beginning and end point.

- Medicare pilots that use bundled payments for acute hospitalization and post-hospitalization services should be broadly implemented across Medicare, with further expansion of these bundles through collaboration and alignment with the private sector.
 - For example, over time, Medicare and other payers should expand bundled payment initiatives beyond inpatient hospital and physician services, to include, where appropriate, post-acute care, follow-up physician services, and readmissions within a defined period following discharge (for example, 30/60/90 days).
 - Medicare and other payers should build on the experience of Medicare's Acute Care Episode (ACE) Demonstration,²⁴ which has yielded lower costs and higher quality by bundling payments for certain cardiac and orthopedic procedures at selected hospitals in five states. Following the success of the CMS Acute Care Episode Demonstration, CMMI has developed the Bundled Payments for Care Improvement (BPCI) Initiative, which aims to reimburse health care providers with a bundled payment based on the expected costs for a specific diagnosis-related group (DRG), with the expectation that high-quality care will still be delivered.²⁵ The
- ACE Demonstration and other bundling initiatives that produce cost savings and comparable- or better-quality care should be more broadly implemented across Medicare and the private sector.
- Private-sector bundled payment initiatives have addressed specific procedures as well as defined episodes of care and have shown both cost savings and quality improvements. The Prometheus Payment Project is an example of a private-sector model that bundles payments around a comprehensive episode of care that covers all patient services related to a single illness or condition, based on evidence-based care guidelines. Broader adoption of procedure and episode-based models, drawing on common elements across Medicare and private-sector bundling initiatives, should be encouraged.
- Payers should jointly develop and test episode-based payments for high-prevalence, high-cost conditions to be used across payers. This will require the use of common definitions and agreement on the services to be included in the episode-based payments. Similarly, condition-specific, episode-based payments must be explicit about which services and treatments are included and excluded from the bundled payment. In proceeding with the implementation of episodic bundling, it will be vital to continuously improve quality metrics and strengthen the link between the payment bundle and performance on those quality metrics.

Bundled Payments

Research has shown that bundled payments can align incentives for hospitals, post-acute care providers, doctors, and other practitioners to partner closely across all specialties and settings that a patient may encounter. The potential for savings under a bundled payment model is largely driven by the wide variation of costs for given episodes of care within the current fee-for-service payment system. By incentivizing providers to improve efficiency and reduce this variation in spending, bundling payments could significantly reduce overall costs. For example, a study by Miller and colleagues found that current Medicare payments for certain inpatient procedures varied by 49 to 103 percent and concluded that bundling payments could “yield sizeable savings for payers.”²⁶ Estimates of savings from bundling payments include the following:

- Recent modeling of the Medicare program estimated that reducing variations in payment for 17 specific episodes of care to the 25th percentile of payment would save \$10 billion annually. If reimbursements for the same bundles were set at the 50th percentile, annual savings of \$4.7 billion would be generated.²⁷
- A 2008 analysis conducted by the Congressional Budget Office estimated that bundling hospital and post-acute care for the Medicare population would save \$19 billion over a 10-year budget window in which bundles were implemented beginning in the fourth year and reaching full implementation in the sixth year.²⁸
- Evidence from Medicare’s Participating Heart Bypass Center demonstration project indicates that Medicare saved approximately 10 percent on coronary artery bypass graft (CABG) surgery within the demonstration population.²⁹ In addition, participating hospitals experienced a cost reduction of 2 to 23 percent by changing physician care practices and hospital processes.³⁰
- The Medicare Acute Care Episode (ACE) demonstration project bundled payment for all Medicare Part A and Part B services that were provided during acute care hospitalizations for specified cardiovascular and orthopedic procedures. Participating hospitals, physicians, beneficiaries, and Medicare itself all gained through the ACE demonstration. Not only did Medicare reduce payments within the demonstration, but, for example, Baptist Health System, one of the participating hospitals, saved \$2,000 per case. In addition, it received approximately \$280 in gain-sharing payments per episode. And each participating beneficiary saved approximately \$320 in the form of reduced Part B premiums.³¹
- Similar positive outcomes have also been demonstrated in testing in the private market. For example, Geisinger Health System’s ProvenCare model, which bundled payments for non-emergency CABG surgery, yielded not only hospital savings that averaged 5 percent, but it also reduced readmission rates, infection rates, and hospital mortality rates.³²
- Innovation in the area of bundling continues to occur, with new initiatives like UnitedHealthcare’s Cancer Care Payment Model. In 2010, UnitedHealthcare partnered with five medical oncology groups to test a new payment model for patients with breast, colon, and lung cancers. This outpatient program reimburses physicians upfront for the entire cancer treatment program of six to 12 months, with bundled payments renewed every four months thereafter as necessary.³³

Accountable Care Organizations (ACOs)

Expanding the use of accountable care organizations, which are responsible for improving the quality and lowering the cost of care in exchange for a share of savings if they meet quality and cost goals, including a shift toward shared risk model ACOs, with the collaboration of the private sector.

- Medicare's Shared Savings Program now includes 220 ACOs, an increase of 106 organizations from the initial 114 applications.³⁴ An additional 32 ACOs are participating in Medicare's Pioneer ACO program, which puts providers on a faster track toward a population-based or shared-risk payment model.³⁵
- Over time, early accountable care models (like the Medicare Shared Savings Program) that have successfully reduced costs and improved care should transition to prospective global payments.
- ACOs are also proliferating in the private market. The Brookings-Dartmouth ACO pilots, as well as countless additional collaborations among insurers and providers, continue to develop and mature. For example, one national plan currently has more than 50 collaborative accountable care initiatives in 22 states encompassing nearly 510,000 members. The plan's goal is to have 100 such initiatives reaching 1 million members by the end of 2014.³⁶
- Early lessons from private-sector experience with ACO models highlight the importance of maintaining flexibility in any arrangements designed to effectively manage population health that are tailored to provider readiness and data-sharing capability. These early lessons should inform future development of ACO models to the extent that this model continues to evolve in both the public and private sectors.

What the Evidence Shows

Accountable Care Organizations (ACOs)

Whether in the public or private sector, the goal of the accountable care organization model is to incentivize doctors, hospitals, and other health care providers to deliver the right care at the right time in the right setting, thus lowering costs while increasing quality and improving patient outcomes. While most ACOs are in the nascent stage, preliminary findings from early adopters have affirmed that cost savings and quality improvements can both be achieved. Moreover, the Centers for Medicare and Medicaid Services (CMS) has estimated that the Medicare Shared Savings Program alone will generate \$510 million in net federal savings between 2012 and 2014.³⁷ Other examples include the following:

- Findings from Aetna's Medicare Advantage partnership with the NovaHealth Physician Association in Maine (a model similar to the Medicare Shared Savings Model) demonstrate PMPM savings that have increased substantially over the course of the program, growing from \$33.77 PMPM in 2009 to \$73.91 PMPM in 2011.³⁸ Results also show lower acute admission rates, fewer acute days, fewer ED visits, and better clinical quality results.³⁹
- In the commercial market, Cigna launched a Collaborative ACO model in 2008 in Arizona, New Hampshire, and Texas. Savings were generated in each of the three test markets, ranging from \$27.04 PMPM in Arizona to \$1.78 PMPM in New Hampshire.⁴⁰
- Evidence from two additional commercial ACO programs, BlueCross BlueShield of Illinois' partnership with Advocate Health Care and Blue Shield of California's partnership with Catholic Health Care West (now Dignity Health), Hill Physicians Medical Group, and California Public Employees' Retirement System (CalPERS), demonstrate savings of 2 to 3 percentage points PMPM.⁴¹

- BlueCross BlueShield of Massachusetts' Alternative Quality Contract program, which creates a global budget for provider groups and allows them to earn bonuses of up to 10 percent of their global budget, has shown savings of 2.8 percent PMPM compared with spending observed in non-participating groups.⁴²
- Arizona's Mercy Care Plan for beneficiaries who are dually eligible for Medicare and Medicaid has had great success in improving care for this vulnerable population using a patient-centered model focused on care coordination. Evidence suggests that, when adjusted to match the health risks of those dually eligible individuals enrolled in fee-for-service plans, Mercy Care enrollees spent 43 percent fewer days in the hospital, experienced 21 percent fewer hospital readmissions, and made 9 percent fewer emergency department visits.⁴³
- Genesys HealthWorks is a model of care developed by Genesys Health System (sponsored by Ascension Health) in Flint, Michigan, to improve population health and the patient experience of care while reducing or controlling increases in the per capita cost of care. Among patients who receive care through Genesys Health System and its affiliated physicians, the model has helped lower the use and cost of care while improving physician performance on quality indicators. An analysis sponsored by General Motors (GM) and the United Auto Workers (UAW) and conducted by Thompson Reuters found the automaker spent 26 percent less on health care for enrollees who received services at Genesys versus local competitors.⁴⁴

Global Payments

Implementing global payments with full performance risk arrangements, including tested performance measurement and incentive programs, to dramatically improve quality and efficiency of care delivery. Under these arrangements, insurance risk is still retained by payers, and, in some instances, provider sponsored organizations (PSO) accept risk under these arrangements in compliance with applicable laws.

- Disseminating best practices for global payment models, including those from Medicare Advantage and Medicaid managed care, to further support movement to global payments, including alignment of quality measures across the public and private sectors.
- The Alternative Quality Contract that is used in Massachusetts has resulted in increased savings and quality over a two-year period for participating physician groups compared to their nonparticipating peers.⁴⁵

What the Evidence Shows

Global Payments

While most formal evaluations of global payment or capitation models were conducted in the late 1980s or early 1990s, a few more recent publications have evaluated such models and found that they generate cost savings. Most of these more recent analyses are focused on ACO delivery models paired with a global payment structure and do not isolate the effects of ACO savings from savings generated by the global payments. Findings include the following:

- Evidence from BlueShield of California's ACO partnership with Catholic Health Care West (now Dignity Health), Hill Physicians Medical Group, and CalPERS, which puts a global budget for expected spending in place and shares risks and savings among partners, demonstrated savings of 2 to 3 percentage points PMPM.⁴⁶
- Two separate analyses of BlueCross BlueShield of Massachusetts' Alternative Quality Contract showed savings of 2.8 percent PMPM across participating providers.⁴⁷
- HealthCare Partners, one of four ACO provider groups within the Brookings-Dartmouth ACO pilot, plans to phase in a global capitation model over the next five years with a projected potential savings of 3 to 7 percent.⁴⁸

Medicare Provider Payment Reform

Medicare is the nation's largest payer for health care services, and the reimbursement approaches of other public and private payers often draw on or build on Medicare's methodology. For these reasons, real transformation of payment and delivery across payers and settings of care will require reforming how Medicare pays physicians and other health care providers who are paid under the Medicare physician fee schedule.

These reforms should include a multi-year period focused on aggressive development and application of new payment models in Medicare. Providers should be incentivized to transition toward value-based systems of health care delivery and provider reimbursement. New value-based payment systems could involve the forms of payment discussed above (patient safety initiatives, PCMHs, ACOs, episodic bundling, and global payments), as well as value-based payment updates to Medicare's fee schedule for those providers who demonstrate high performance.

Implementing these payment reform models across the public and private sectors will provide meaningful incentives to move the system in the direction of delivering higher-quality, more efficient care. As a result, health care costs will be driven down for all of us. By allowing providers and payers across the enormous diversity of health care settings to determine the appropriate application and pacing of implementation, we built in the flexibility necessary to achieve the goal of moving toward payment via value-based models over the next five years. This strategy, coupled with an effort to align public and private implementation work, will send a coherent signal to health professionals and facilities about what society values and expects, and it will create a competitive environment among providers on cost and quality.

One Approach to Replacing the SGR

The American College of Surgeons' Value-Based Update proposal (VBU), which provides for a quality-based, varied set of payment update factors for physicians based on their performance, and which includes episode-based payment updates that are tied to specific quality measures for a range of conditions, is one example of an alternative to the current Medicare sustainable growth rate (SGR) payment update formula.⁴⁹

The SGR has historically targeted the volume of services. To be consistent with a move toward health care value, the American College of Surgeons has contemplated dissolving the SGR and moving to a new updated target system that would be tied to condition-specific, value-based targets. The update for physician payments would define the specific conditions and the targets within those conditions. Physicians would self-select their update, in accordance with their appropriate clinical practice, based on the conditions or families within which they must meet the target in order to receive next year's update. In this VBU model, target areas would be more patient-centered and include examples of targets such as improvements in chronic care, cardiac care, digestive diseases, cancer care, women's health, and children's prevention services. This value-based update replaces the SGR and is designed to incorporate all the other CMS performance measurement systems, such as PQRS and VBM, to create a top-to-bottom alignment in a value-based delivery system.

2 Pay for Care that Is Proven to Work

The Problem

Changing how we pay for health care services is only part of a multifaceted approach to bending the cost curve and improving outcomes. The quality and effectiveness of the services we pay for cannot be overlooked. Today, estimates suggest that as much as 30 percent of care in some categories is not justified by scientific evidence.⁵⁰ Sometimes, patients have diagnostic tests or treatments that may not be beneficial. At other times, patients undergo surgery or treatment regimens that are more sophisticated and expensive than other lower-cost treatments that could achieve the same result. Current payment methods provide no incentive for physicians or patients to choose the most effective, least costly alternative, or to pursue conservative treatment before undergoing high-tech, high-cost treatment that may not produce a better result.

Public and private payers should provide appropriate payment for those tests and treatments that have proven to be clinically effective and help people achieve good outcomes and less for those where evidence is insufficient. This approach will help restrain health care expenditures without limiting access to beneficial services. Under current law, and following years of precedent, Medicare generally covers any treatment that is deemed “reasonable and necessary,” regardless of the evidence on the effectiveness of that treatment or the cost in relation to other treatment options. Similarly, with only the rarest exceptions, Medicare currently assesses the strength of evidence in determining coverage policies but does not use evidence when setting reimbursement rates. Instead, it links reimbursement in one way or another to the underlying costs of providing services.

Comparative research provides evidence on the effectiveness, benefits, and detrimental effects of different treatment options.⁵¹ Without consulting this evidence, a fee-for-service (FFS) payment approach

drives costs up without demonstrating that more expensive care options are better than less costly alternatives. And too often, Medicare coverage decisions affect the coverage policies of private payers. As a result, to the extent that Medicare continues to rely on its current payment systems for services, significant inefficiency will continue throughout the health care system.

Action 2: Apply a value-based pricing model for new services covered under Medicare so that higher reimbursement is awarded only upon evidence of superior effectiveness.

Congress should change the statutory language on Medicare pricing to a system in which first-time prices for new treatments are set in conjunction with a determination of their effectiveness compared to services currently covered by Medicare. This approach is based on a simple principle: that Medicare beneficiaries (and taxpayers) should not pay more for a particular service when a similar service can treat the same condition and produce the same outcome at a lower cost.

When Medicare determines that a service will be covered, it should be required to determine the service’s level of effectiveness according to the following three categories (each of which is linked to an associated reimbursement strategy): 1) demonstrated *superior* comparative clinical effectiveness, 2) demonstrated *comparable* clinical effectiveness, or 3) *insufficient evidence* to determine comparative clinical effectiveness. Evidence would initially focus on high-cost technologies that are likely to be used in significant volume.

6. **Superior clinical effectiveness:** The first category of reimbursement should include a service for which there is adequate evidence to demonstrate that it is more effective, has fewer side effects, or both compared to the most relevant clinical standard. Payment for a service with this level of evidence would be set according to current Medicare policy at a rate sufficient to reimburse providers for the cost of providing what is, demonstrably, a superior service.
7. **Comparable clinical effectiveness:** For a service with evidence sufficient to determine that its clinical effectiveness is comparable to existing services covered by Medicare, payment should be set at a level equal to the existing service. Payment along these lines would be a form of “reference pricing” that is familiar within the pharmaceutical arena where payers reimburse brand-name drugs at the same price as equally effective generic alternatives.
8. **Insufficient evidence on clinical effectiveness:** The third category of comparative effectiveness evidence would include those services that meet Medicare’s usual standard for “reasonable and necessary” services (e.g., those services that have been demonstrated to be safe and effective but that haven’t necessarily been compared with existing treatments). Payment for these services should be set according to the current Medicare fee schedule or negotiated rates with the private sector, but only for an initial period of time. After the initial period, if additional evidence demonstrates that the new service has clinical advantages, the current payment formula would continue. If however, the evidence shows no clinical advantages or is insufficient, payment would be lowered based on current market reference price for similar covered services.⁵²

Case Study

Value-Based Pricing in Practice: A Case Study of Drug-Eluting Stents

As an example of how this approach would work, consider how Medicare coverage and reimbursement decisions were made for new drug-eluting stents (DES), a therapy that is used to treat coronary artery disease, when they were introduced into practice in the early 2000s. These stents were a promising new therapy for percutaneous coronary intervention (PCI) procedures because they delivered drugs that helped prevent inflammation and narrowing of arteries. However, at the time that these stents first gained coverage within Medicare, there had been no rigorous studies comparing the effectiveness and potential detrimental effects of DES to existing covered therapies. Nonetheless, following current Medicare payment policies, the initial reimbursement for DES was set in recognition of the increased cost and the complexity of its treatment process. Initial reimbursement for one DES, the sirolimus-eluting stent, was about \$3,200, compared to the \$600 payment for its alternative. This scenario led to a surge in use of DES around the country. For payers, the financial impact was also rapid: It was estimated that the switch to DES for all U.S. PCI patients resulted in \$600 million in

increased annual health care spending.⁵³ Evidence now shows that less use of DES among low-risk patients has significant cost-saving potential without losing clinical benefit.⁵⁴

In contrast, consider how coverage and reimbursement could have been managed for DES according to our proposed reimbursement approach. At the time of its introduction, a Medicare coverage determination would have been accompanied by a determination by Medicare that there was insufficient evidence with which to judge the superior clinical effectiveness of DES against alternative treatments. Following this determination, DES would have been slated for payment through the usual pricing policies for a limited period of time. However, instead of these prices continuing indefinitely without conditions, a decision window would have created an incentive for manufacturers and clinicians to perform the research needed to evaluate the clinical performance of DES versus other therapies. DES would still have been available to patients, but there would have been strong incentives for using DES appropriately and developing less expensive technology.

Paying for Care that Is Proven to Work

The evidence-based pricing strategies described above would build on reimbursement mechanisms such as Medicare's least costly alternative (LCA) policy as well as reference pricing strategies that are used in the private market. Reference pricing refers to a standard price that is set for a drug or health care service. If health plan members select a more expensive drug or service, they pay the allowed charges above the reference price.

Although dynamic pricing has not been applied as fully in practice as outlined above, it has the potential to reduce spending by linking evidence on the relative effectiveness of various interventions with reimbursement. Findings from relevant literature, including the following, indicate the potential that such policies have to generate savings:

Reference Pricing for Medical Procedures

- Using reference pricing for hip and knee replacements in the California Public Employees' Retirement System (CalPERS) has reduced costs per procedure by 25 percent while increasing the volume of surgeries performed by preferred providers by nearly 7 percent.⁵⁵
- By applying reference pricing to reimbursement for colonoscopy screenings, where charges have previously been found to vary considerably (ranging from \$900 to \$7,200 within one region), Safeway cut its spending on colonoscopies by 35 percent while increasing the number of employees who obtain colonoscopies by 40 percent.⁵⁶

Reference Pricing for Prescription Drugs

- Evidence from the United States and from around the world indicates the potential cost savings of reference pricing for prescription drugs. For example, the State Employee Health Plan of Arkansas applied a reference pricing strategy to proton pump inhibitors (used to treat acid reflux) by setting reimbursement at the level of the acid-reducing drug that was available over the counter. This policy yielded savings of 49.5 percent PMPM, and it reduced copayments by 6.7 percent per claim without changing utilization.⁵⁷
- Evidence from across Canada, Europe, and New Zealand indicates that reference pricing consistently results in reduced drug spending.⁵⁸
- An analysis performed by the Department of Health and Human Services' Office of Inspector General in the early 2000s found that applying Medicare's least costly alternative policy to clinically comparable luteinizing hormone-releasing hormone agonists, which are used to treat prostate cancer, would have saved Medicare \$33.3 million per year.⁵⁹

Paying equally for comparable results is a powerful principle, and a "value-pricing" model would allow it to be implemented without uprooting the entire incentive system for innovation. A limited initial time period for comparable payment would create a significant incentive for manufacturers to conduct comparative studies. For providers, this approach offers the prospect of better

evidence with which to care for individual patients, as well as the evidence necessary to make decisions about investing in new services that may be equally effective but more costly. Using comparative evidence to set reimbursement rates at the time of coverage seems to be a promising option that should be explored to help constrain unnecessary Medicare costs.

3 Incentivize Consumer Engagement in Care

The Problem

Today, many consumers and patients lack the information or incentives they need to make informed choices when they use health care services. They often do not know what the price is likely to be before they begin a course of treatment, nor do they always know whether one particular treatment is likely to be more effective than another. Consumers are limited in their ability to make decisions that reflect their interests and preferences because they don't always have access to the information that they need to make these decisions and because there often is no financial incentive for a patient to become engaged in these decisions.

Just as we recommend changing provider payment to recognize high-value performance, we should provide health care consumers with the resources necessary to identify both high-value services and high-value providers.

The goal of benefit redesign is to create financial incentives for consumers to make more informed health care choices, leading to savings from improved adherence to preventive measures and evidence-based care; lower utilization of unnecessary services; and use of more efficient, higher-quality providers.

Health plans and employers have begun to redesign benefits to encourage the utilization of higher-value providers, treatments, and services. One emerging strategy, Value-Based Insurance Design (VBID), relies on clinical research and data on provider performance as the basis for offering incentives to consumers (such as reduced cost-sharing) to use evidence-based treatments and services and to obtain care from providers with a demonstrated ability to deliver quality, efficient health care. By using solid, peer-reviewed evidence of the clinical effectiveness of services and widely recognized measures of provider performance (such as those endorsed by the National Quality Forum, or NQF), VBID modifies insurance design in ways that encourage consumers to select high-value services and providers.

States are also leveraging VBID to improve the value of care for their Medicaid populations. For example, Minnesota's Medicaid Incentives for Diabetes Prevention Program offers Medicaid patients who've been diagnosed with pre-diabetes or with a history of gestational diabetes the opportunity to participate in an evidence-based Diabetes Prevention Program. Participants can earn incentives, such as cash uploaded to a debit card or membership at the YMCA, for attending classes and meeting weight loss goals.⁶⁰ The Connecticut Medicaid program runs Incentives to Quit Smoking, a program that provides cash incentives to encourage enrollees to use tobacco cessation services and to quit smoking.⁶¹ Similarly, in Florida's Enhanced Benefits Accounts program, the state developed a list of 19 healthy behaviors (including wellness behaviors, participation in programs that change lifestyle behaviors, and appropriate use of the health care system) that allows participants who adopt these behaviors to earn rewards.

Medicare's Physician Value-Based Modifier (VBM) program is scheduled to be phased in beginning in 2015. It will include both quality and efficiency data to calculate payments to physicians. Implementation of the VBM, along with Medicare's Hospital Value-Based Purchasing (HVBP) program, are important initial steps toward aligning provider incentives with the provision of quality, efficient care within Medicare's fee-for-service (FFS) program. Yet, the current structure of Medicare's benefit design does not provide individuals or families with any corresponding incentive to make value-based decisions about their use of health care. Deductibles and cost-sharing are uniform across providers and fail to differentiate in terms of value for treatments, services, and providers. Given the wide variation in cost and quality across providers, drugs, and services, shifting demand to those that demonstrate good value would be a much better allocation of resources.

Continued adoption of Medicare's hospital and physician value-based programs will optimize these efforts by using the results of the quality and efficiency determinations to encourage beneficiaries to act on this information. To realize the full potential of these value-based programs, we recommend specific changes to the Medicare program, as well as the promotion of increased utilization of VBID in the private sector.

These suggested actions are guided by the following principles:

- VBID should apply to all payers (public and private), and incentives for consumers and providers should be aligned.
- VBID should be evidence-based.
- VBID should support both a reduction in the use of low-value services and an increase in the use of high-value services.
- VBID efforts should take into consideration the needs of vulnerable populations by including targeted support for those populations, as well as for individuals with multiple co-morbid conditions.

Action 3a: Modify traditional Medicare benefits to allow tiered cost-sharing for providers, drugs, and services, provided that the modifications do not alter the overall actuarial value of Medicare for beneficiaries.

In the short term, this could be done via authority given to the Centers for Medicare and Medicaid Services (CMS) to launch pilots that assess the impacts on cost, quality, and patient experience. As the physician and hospital value modifier programs mature, the results can be used as the basis for expanding the pilots across the Medicare program to more broadly implement differential cost-sharing based on value.

Action 3b: Allow Medicare Advantage plans to use tools that promote quality and value, such as using VBID incentives to induce beneficiaries to choose high-performing networks, or varying their cost-sharing based on the clinical effectiveness and value of services. Additional cost-sharing flexibility should also be applied to the Medicare Shared Savings Program and the Pioneer ACO Initiative to enable them to tier cost-sharing based on quality performance and the clinical effectiveness of services.

Currently, Medicare Advantage plans are not permitted to vary copayments within their provider networks, making them unable to differentiate higher-value providers from lower-value providers. In addition, such plans are not permitted to charge beneficiaries more than Medicare FFS for services of low value, again limiting their ability to align cost-sharing with value.

The provider performance data that are used to calculate hospital and physician payment modifiers, as well as data on the comparative effectiveness of treatments and services, should be used to promote value-based choices by beneficiaries in Medicare Advantage plans by allowing such plans to tier providers and services based on value and to offer beneficiaries cost-sharing incentives to act on this information.

Action 3c: Augment opportunities for value-based benefit design in Medicaid and the private sector.

While the private sector and Medicaid are already making progress in implementing value-based insurance design, there are additional opportunities for them to encourage the use of high-value services and providers. For example, the new state health insurance marketplaces (also known as exchanges) should strongly encourage all participating health plans to offer a value-based insurance design option by 2019. These plans should vary cost-sharing for services based on value and for providers based on performance and quality data.

By aligning provider incentives to deliver high-quality, more efficient, more effective care with consumer incentives to select high-quality, more efficient, more effective care, the health care system will begin to move down the path toward sustainability. Today, health care consumers and patients face substantial and growing out-of-pocket costs, but they lack the information and financial incentives necessary to make more informed health care choices. As a result, they are unable to “vote with their feet” and choose higher-performing providers, tests, and services. Changing

provider payment or coverage policies alone, as described in Actions I and II, will not stimulate the change in incentives that we believe is essential to creating real health system reform. The same evidence about clinical effectiveness, quality, and cost that underlies provider and service payment reforms must also be used to help health care consumers make smart choices. Aligning provider payment, the reimbursement of services, and consumer incentives will drive all players within the health care system to make real change.

What the Evidence Shows

Value-Based Tiered Cost-Sharing

Value-based tiering, a form of VBID, modifies cost-sharing to reflect the relative value of services. It reduces cost-sharing for services where there is a body of evidence indicating that they are high value in terms of both clinical effectiveness and cost effectiveness, and it increases cost-sharing for those services that are not indicated to be clinically effective or cost effective based on evidence. A growing body of literature shows the potential of such policies to increase adherence to treatment protocols and to reduce costs. Examples include the following:

- In the private sector, use of VBID has resulted in savings stemming from a shift to healthier behaviors and higher-value care choices. For example, Aetna’s Active Health Management program has focused its VBID efforts on high-value medications that are used to treat common chronic diseases, such as hypertension, diabetes, high cholesterol, and asthma. By lowering copayments for ACE inhibitors and angiotensin receptor blockers (ARBs, used to treat hypertension), beta blockers (used to treat hypertension), medications for glucose control (used to treat diabetes), statins (used to treat high cholesterol), and inhaled steroids (used to treat asthma), the plan was able to increase adherence to medications by 3 percentage points.⁶²
- When employer Pitney Bowes reduced copayments for two essential heart drugs, patients filled more prescriptions, ER use and hospitalizations were reduced, and overall health spending declined. Pitney Bowes also reduced copayments for diabetes and asthma drugs. As a result, the median cost for employees with these conditions fell by 12 and 15 percent, respectively, over a three-year period.⁶³
- Evidence from Novartis’s experience with reducing cost-sharing for cardiovascular medicine shows that adherence to such medication regimens went up by 9.4 percent without increasing health care costs.⁶⁴
- One study simulated the potential cost savings that could be generated by reducing copayments for cholesterol-lowering drugs for Medicare beneficiaries with diabetes. It found that if copayments were reduced to \$25, Medicare would save \$262 in Part A and B costs per beneficiary, with even greater savings (\$558) for high-risk beneficiaries.⁶⁵

Value-Based Provider Networks

Value-based provider networks tier health care providers and facilities based on performance metrics, including cost efficiency and measures of quality. Copayments are reduced for those providers and facilities that fall into a higher-performing tier and are increased for those providers and facilities that fall into a lower-performing tier. A growing body of data indicates that such networks can help drive consumers to better-performing providers and facilities while helping reduce spending. Examples include the following:

- UnitedHealthcare's UnitedHealth Premium program divides providers across 21 specialties into tiers based on quality of care and cost efficiency, with the best-performing providers receiving "Premium Two-Star" designation. The program yields estimated average savings of 14 percent, with savings ranging from 7 to 19 percent depending on physician specialty.⁶⁶
- Aetna's Aexcel tiered provider network uses clinical performance and cost efficiency criteria to divide providers in 12 specialties into tiers, and it allows employers to set the level of incentives to drive employee behavior. Aetna reports that Aexcel providers are demonstrated to be 1 to 8 percent more cost efficient relative to non-Aexcel peers within a given network.⁶⁷
- BlueCross BlueShield of North Carolina data on their tiered benefit plan indicates that savings of up to 10 percent can be generated by dividing in-network hospitals and selected specialties (general surgery, OB/GYN, cardiology, orthopedics, and gastroenterology) into two tiers based on quality, cost efficiency, and accessibility.⁶⁸
- A study of PacificCare Health System's (now UnitedHealthcare) network in California found that its use of tiers has resulted in 20 percent lower health care costs and 20 percent higher quality.⁶⁹
- Other payers and purchasers, such as CalPERS, have lowered patients' costs if they seek care from Centers of Excellence or from providers who are likely to achieve good outcomes based on historical performance. One national plan that uses provider performance as the basis for developing a tiered provider network and that offers reduced cost-sharing to consumers who seek care from high-value providers has seen a 14 percent reduction in costs per episode for care delivered by physicians who've been designated as providing higher quality and efficiency versus non-designated physicians.⁷⁰
- In addition, Lowe's, a national chain of home improvement stores, recently instituted a pilot program for major cardiac procedures that will contract with centers of excellence. Plan enrollees that use the Cleveland Clinic face no cost-sharing for their cardiac procedures and are reimbursed for related travel expenses. While savings data have not yet been made publicly available, Lowe's is expanding its contract with the Cleveland Clinic to include spinal procedures and care for back pain.⁷¹

4 Improve the Infrastructure Needed for an Effective Health Care Market

The Problem

Each of the actions described in this document involves reallocating health care resources to ensure that quality and health outcomes will be improved while the growth in health care expenditures is contained. We want to move to a system where health professionals, managers, patients and families, and public officials consult the evidence of “what works” when making program and personal decisions. Today, however, we do not have an easily accessible body of knowledge that each of these stakeholders can consult when making these decisions, and we do not have a trusted way of explaining our decisions to each other or of updating the body of knowledge on which decisions are based. In this section, we focus on the need for better data and a sufficient workforce to support a coordinated care environment. We also recommend strategies to simplify administrative processes, to reform medical malpractice policies and practices, and to ensure that markets stay competitive.

Develop a Shared Knowledge Base for Patient and Provider Decisions

Action 4a: Expand the authority to consider research on treatment effectiveness.

Consumers and providers have a right to know which treatments and technologies work and which are less effective. To expand this evidence base, Congress should provide new authorizing language for the Patient-Centered Outcomes Research Institute (PCORI), or some parallel agency, that explicitly allows it to consider research on cost effectiveness as a valid component of patient-centered outcomes research. PCORI and the Agency for Healthcare Research and Quality (AHRQ), in their funding of research on the

effectiveness of treatments and technologies and their dissemination of the results of that research, should prioritize the establishment of multi-stakeholder, deliberative processes that can use such research to provide trustworthy recommendations on high-value and low-value care options to providers, payers, and patients.

Generate Information to Support Improved Care

The infrastructure for measuring how well our health system performs is incomplete, disconnected, unnecessarily expensive, and inefficient. There is wide variation in the effectiveness of treatments, their appropriate use, and how well providers follow recommended practice guidelines or achieve desired results, but there is no single source of well-organized data that would allow for the consistent evaluation of provider performance. Many measures of provider performance exist, but they are not prioritized or consistently used across federal and private programs and systems. This limits the ability to compare performance based on value, and it increases the reporting burden.

The electronic infrastructure to support reporting is also inadequate. A recent RAND report paints a stark picture: Modern health IT (HIT) systems have not been widely adopted, and those that are in use often are not interoperable and are not used effectively.⁷² HIT systems must be interoperable if they are to improve patient care, reduce duplication of services, and assist clinicians in their decision making at the point of care. Interoperability will also allow registries and other longitudinal health records to function together so that measures of health outcomes over time (and for sub-populations) will become possible.

One of the barriers to wider adoption of HIT is the reality that, for the most part, the infrastructure and the tools that are necessary to achieve the desired level of interoperability and information sharing are not yet available in the market. Vendors should meet HIPAA and other standards to make the infrastructure and tools useful to providers and other users of the system.

Meaningful use requirements play an important role in efforts to build a national HIT system where clinicians can securely exchange information with other providers. However, these requirements currently apply only to a select group of eligible hospitals and professionals and not to the larger data ecosystem, such as mental health providers, labs, pharmacies, public health clinics, long-term care facilities, and other providers. Furthermore, current incentives for adopting meaningful use standards may be inadequate to drive adoption within the timeline needed.

Action 4b: Prioritize the development and adoption of uniform measures and advance electronic data collection to support reporting.

A critical piece of the foundation is a simplified measurement framework where all payers use a consistent set of measures to collect the information that is required to support value-based payment and decision making. To simplify data collection and prioritize measures of health system performance, we recommend that the federal government and private-sector stakeholders identify a parsimonious set of meaningful and useful performance measures, focused on high-priority health conditions where performance varies widely, building on the work begun by the National Quality Forum and expanding the scope to include all major public programs and commercial populations. By 2016, this information should be translated into a uniform national core measurement set that is used by both the public and private sectors and that is consistent with the National Quality Strategy. In building this measurement set, current measures that are not

considered helpful for clinical quality improvement or accountability programs (e.g., public reporting and provider payment incentives) should not be included. At the same time, the measurement set should address the gaps that currently exist, e.g., clinical outcomes, patient-reported outcomes, care coordination, patient experience, total cost of care, and appropriateness. Such a measurement set can help promote consistency for providers and patients and ensure comparability across the sectors, regionally, and nationally. To support local community needs, the core measurement set could be augmented with measures that best address the characteristics of the local population. To efficiently report on these core measures, a robust health information technology infrastructure is needed with health IT vendors building the capabilities to allow reporting through electronic health records (EHR) systems.

Second, CMS should make differential payments for provider adoption of and reporting of the core set of metrics on the priority conditions. These incentive payments should also be made available to health care providers besides hospitals and physicians, and these payments should be supported by Medicaid and private payers through their provider contracting. Ultimately, we need to move more quickly toward a national health IT system in which approved users can get the data they need and create competition within the vendor market to develop the needed data-sharing capabilities.⁷³

Leveraging the Meaningful Use program and a health IT roadmap developed by the National Coordinator for Health IT and CMS could provide guidance on technical requirements for extraction, analysis, and reporting of data on the priority conditions referenced above. This includes criteria for EHR technologies, data intermediaries and aggregators, clinical decision support, benchmarking and feedback systems, and public reporting. Such a roadmap should not prescribe specific decision support rules, functions, or user interfaces, but it should establish requirements and a timeline by which those capabilities are in place for all providers that do business with public health insurance programs such as Medicare and Medicaid.

Health Information Technology (HIT)

A number of studies have found that HIT reduces unnecessary utilization of services and leads to cost savings, but overall, the evidence is mixed.⁷⁴ Thus, HIT is not a magic bullet. It will take years to achieve the full potential of EHRs and decision-support tools, but over time, HIT is an investment in a “public good” that will improve care delivery and patient outcomes, reduce administrative waste, and lower total spending.

Align Workforce Policies to Support Multi-Disciplinary Care Teams

To maximize the impact of the payment reforms and quality improvement strategies described elsewhere in this document, we need a paradigm shift in how care is delivered—in private practices, hospital units, and nursing facilities across the country. The old paradigm in which a single provider heroically brings each patient back to health is increasingly inadequate for today’s challenges. The future of our health care lies instead with multi-disciplinary care teams. These teams mobilize a range of providers (specialists, nurses, primary care clinicians, home health aides, and community health workers), all practicing at the top of their license and ability. They have the capacity to manage the health of a broad patient population and collaborate on quality improvement initiatives.

Where these team-based practice and delivery approaches have been tested, they have demonstrated the capacity to improve outcomes and patient satisfaction while lowering costs. In order to apply this approach more broadly, however, our health care workforce—and workforce policies—must be redesigned.

2. Because face-to-face contact with all members of a care team is not always possible, training and resources to support telemedicine, bio-monitoring, and virtual access to providers should be expanded. The new payment models need to support these types of interactions among caregivers and patients wherever follow-up and minor health care assessments can be more conveniently conducted through these methods.
3. To help fill gaps in our health care workforce, more should also be done to facilitate the credentialing of veterans for health care jobs. Federal resources should be committed to expanding efforts to translate military health care training and experience into credit toward professional licensure in occupations in the health care field.
4. Today, as care teams become more important to the delivery of health care, states are considering adjusting their licensing regulations. Federal policymakers should remove federal-level regulatory barriers that prevent states from making optimal use of non-physician providers in care teams.⁷⁵

Action 4c: Implement a multi-pronged workforce strategy.

We recommend four strategies to enhance our health care workforce, as follows:

1. Existing scholarship and medical loan forgiveness programs should be modified to address our most acute workforce needs, including provider shortages in primary care specialties and in medically underserved geographic areas. Federal nurse education funding should be refocused to equip registered nurses to assume the roles of case manager and population health coordinator.

Reduce Administrative Overhead

Administrative processes are burdensome and are key contributors to the waste of health care resources in this country, making up a full 14 percent of total U.S. health spending.⁷⁶ Methods for routine administrative transactions among providers and health plans are often overly complex and duplicative. For example, credentialing and periodic re-credentialing of providers by health plans requires physicians and other providers to provide information on their medical education and training, medical licenses,

malpractice history, and work history.⁷⁷ Although a standardized form for doing such credentialing is available, some providers continue to use different credentialing forms for each health plan that their practice accepts.

Communication among health plans and providers regarding key transactions is another area that is ripe for administrative simplification and savings. The Affordable Care Act established new requirements aimed at reducing administrative costs for health plans and providers by increasing the use of enhanced electronic transactions. For example, HHS must adopt new standards and operating rules for how plans communicate information electronically for key transactions that take place among health plans and providers, such as eligibility determinations, claims status updates, claims payments, and electronic funds transfers to physicians and hospitals. CBO estimates that these provisions will achieve a total federal savings of \$11.6 billion.⁷⁸

Providers have made significant progress in moving toward filing claims for payment electronically. According to a recent survey, the percent of claims submitted and processed electronically has more than doubled, rising from 44 percent in 2002 to 94 percent in 2011.⁷⁹ However, for the full promise of administrative simplification to be fulfilled, health plans, providers, and the vendors they use must work toward achieving greater administrative simplification through streamlined electronic transactions that take

steps beyond just electronic claims filing. For this to occur, health plans, providers, and vendors should adopt and use the same health information technology standards to conduct electronic transactions related to eligibility determinations, claims status updates, claims payments, and electronic fund transfers.

Action 4d-i: Streamline the credentialing process by promoting the use of a single system for provider credentialing across both public and private payers.

A 2004 study conducted by the Medical Group Management Association (MGMA) committee found that physician practices submit an average of 17.86 credentialing applications per physician per year.⁸⁰ The Council for Affordable Quality Healthcare (CAQH) has created a single credentialing application and a Universal Provider Database (UPD) in which applications are stored electronically and can be accessed by health plans and public payers. The UPD is currently used by more than 1 million providers.⁸¹ However, Medicare does not use the UPD—instead it requires physicians to be credentialed through its Provider Enrollment, Chain, and Ownership System (PECOS) system. Given that duplication of credentialing processes adds cost and confusion to the health care system, we recommend that all payers, both public and private, use a single system for provider credentialing.

What the Evidence Shows

Standardized Credentialing

The Medical Group Management Association estimates that the \$2.15 billion a year that the U.S. health care system spends on credentialing could be slashed by 90 percent if all payers used a single system. CAQH estimates that the UPD saves providers nearly \$135 million per year in administrative costs.⁸²

Action 4d-ii: Build on the Affordable Care Act by requiring that providers and vendors transmit and receive documents electronically following the same electronic standards and operating rules that health plans are required to implement under the health care law.

With the evolution of the payment and delivery system reform landscape, we expect that there will be further changes to underlying businesses process

and associated transactions among payers, providers, and vendors. Already, under Medicare, providers are required to file claims electronically, receive electronic funds transfers, and receive remittance advice electronically. Conducting these functions and those specified by the Affordable Care Act with health plans in the commercial market will result in streamlined electronic data interchange among health care stakeholders. It will also have the benefit of stimulating vendors of practice management systems to design systems that facilitate these electronic transactions.

What the Evidence Shows

Electronic Billing

In a 2010 report, the Institute of Medicine calculated total administrative costs of \$361 billion (in 2009 dollars) and estimated that approximately 42 percent of this total (\$149-\$160 billion) could be saved annually if administrative complexity could be reduced.⁸³

Reform Medical Malpractice Laws and Procedures to Reduce Waste and Improve Care

The U.S. medical liability system is largely dysfunctional. It diverts scarce resources from health care while failing to promote better care or to reliably provide compensation to patients who've been harmed. The vast majority of injured patients never receive compensation. Yet fear of litigation encourages overuse of care and procedures and chills provider-patient communication. Instead of advancing pragmatic solutions to these problems, policymakers at the national level are locked in a stalemate over controversial proposals to cap damage awards and attorney fees.

Reducing medical malpractice itself, through systematically improving patient safety, patient satisfaction, and quality of care, is the most important way to reduce potentially litigious adverse events, harm to patients, and related costs. There is also growing evidence that better management of adverse events by improving communication among patients and their families is an important factor in reducing malpractice program costs. We also support the following initiatives:

- **Certificate of merit.** To avoid spending scarce justice system resources on less meritorious cases, we support evaluation of the merits of claims by independent medical experts prior to filing. Such a process should be required to consider whether the care provided was consistent with evidence-based care guidelines and best practices. Routinely evaluating quality of care data has been found in several states to help inform both plaintiff and defendant decisions regarding whether to proceed or to settle such disputes prior to court action. Although

Action 4e: Adopt innovative approaches to resolving medical disputes that promote patient-provider communication, improve quality and safety, and promote fairness.

the results of the review should not be used as evidence at trial, they can help inform decisions regarding whether to proceed or to settle the dispute by both the plaintiff and the defendant.

- **Safe harbors for evidence-based care.** We support the establishment and evaluation of safe harbors and medical malpractice protections for clinicians who effectively document and practice recognized and appropriate standards of care. A significant portion of the HHS Secretary's discretionary funding for medical malpractice pilots should be directed toward this goal.
- **Neutral medical expertise at trial.** Today, medical liability suits rely on medical "experts" who are paid for their services by either the plaintiff's or the defendant's lawyers. To ensure that courts and juries can benefit from more objective and neutral medical analysis, courts should be empowered to retain their own medical experts.

The HHS Medical Liability Reform and Patient Safety Initiative has promoted innovative pilots that focus on fostering better communication among patients and their care teams. Ascension Health has focused on improving perinatal safety since 2003, and with federal support from this HHS initiative, has trained more than 1,000 physicians and nurses on disclosure communication. The Joint Commission defines disclosure communication as when the responsible practitioner clearly explains the outcome of any treatment or procedure to the patient and family whenever outcomes differ significantly from those that were anticipated. Ascension Health has seen a 34 percent reduction in the cost of self-insured risk management programs since 2006 attributable to improvements in the case management of malpractice programs, implementation of system-wide quality and patient safety initiatives, and increased use of disclosure communication with patients when an unexpected event occurs.⁸⁴

Ensuring Competitive Markets

One of the core principles of our comprehensive proposal is that healthy competition in health care markets based on cost, patient experience, and health outcomes is the best way to drive innovation and improvement. Healthy, competitive markets rely on a solid foundation of information that is available to consumers, payers, and providers. This information is also needed to support the provider and consumer incentives that are the engines for greater efficiency and quality improvement.

Based on this principle, we propose three goals and five actions. The goals are as follows:

1. Promote competition, efficiency, and innovation in health care markets through appropriate oversight and review by the appropriate federal and state agencies.
2. Support the use of appropriate consumer incentives to enable the development of innovative, value-based insurance designs that reward consumers who choose high-quality, efficient providers and services.
3. Enhance the availability of performance information on quality and affordability to enable the development of a complete picture of a providers' performance across all patients and payers, which is needed to support the first two goals.

Action 4f-i: Continue hearings on competition.

Two ideas, which at times conflict, have gained acceptance with respect to health care markets: (1) market consolidation has led, in some markets, to anti-competitive developments that could result in the lack of consumer choice and may raise prices for consumers; and (2) the transition to a system of care that is more efficient and higher-quality requires increased levels of coordination among providers, payers, and, in many cases, employers. Further complicating the issue is the possibility that some government regulations may impede more efficient forms of provider accountability and coordination. At the federal level, the Federal Trade

Commission (FTC) is well-positioned to continue its examination of these issues and provide insights that can advance both increased competition and improved coordination in such markets.⁸⁵ The FTC has often convened public hearings on competition issues and market-based efforts to increase efficiency. Future hearings should include a focus on a range of markets and conduct with different characteristics. The hearings should explicitly address: (1) what can be learned from the history of market consolidation and the range of impacts on prices, access to care, quality, and innovation; (2) whether unnecessary or counterproductive impediments to efficient arrangements may be inadvertently created by the fraud and abuse laws and, if so, whether and how best to address them; and (3) what the state of competition is in health care markets and what are the key policy and other recommendations with respect to competition in such markets.

Action 4f-ii: Increase the transparency of market analysis and insights by the FTC and DOJ.

Given the rapid pace of consolidation and reconfiguration in many health care markets, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) should create further transparency, within statutory and other limits, in their analysis of and insights into market competition issues in health care. This can occur through many avenues, including speeches, testimony, closing statements, and reports. In addition to these approaches, the FTC and the DOJ should share information with relevant state agencies regarding reviews of potentially anti-competitive behavior in a state's health care market building on significant guidance already in the public domain.⁸⁶

Action 4f-iii: Ensure adequate funding for competition agencies.

Adequate funding should be provided for state and federal antitrust agencies to investigate, and, where appropriate, challenge anticompetitive behavior in health care markets. States are encouraged to monitor anticompetitive behavior and take appropriate regulatory or legislative action.

Action 4f-iv: Support the use of appropriate consumer incentives.

As discussed earlier, innovative, value-based benefit designs have been recognized widely as an important element of the transformation of the health care system from one characterized by silos of information and limited consumer engagement to one in which information is both shared and used to enable consumers to pursue more efficient and higher-quality care. Certain practices, however, have created impediments to the movement to such value-based designs. All-or-nothing contracting and refusals to participate in tiered networks (or refusals to be placed in less than the highest tier) have created substantial roadblocks in certain markets. These roadblocks are likely to impede the development of innovative, value-based products in the new health care market. As a general rule, and in most circumstances, these practices should be avoided.

Action 4f-v: Enhance the availability of performance information on quality and affordability.

Health plans that participate in Medicare Advantage are required to report on and make available information about quality as one way of helping beneficiaries make decisions about their health plan choices. In addition, commercial and Medicaid plans report quality performance and patient experience data to organizations such as NCQA and URAC (together with other data that are required for plans undergoing accreditation). Quality performance and accreditation data, such as HEDIS are used by NCQA to create a national ranking of health plans, and these reports are made publicly available. Oftentimes, private employers also require specific quality measures that are important to their employees to be reported and made available to employees. For health plans that will be offering coverage through a health insurance marketplaces (or exchange), accreditation and the quality data reporting that is associated with the accreditation process will be a requirement for offering a qualified health plan. As a result,

consumers have access to different types of quality and satisfaction information depending on how they get their health coverage.

Efforts have also been made to make hospital quality data available through Medicare's Hospital Compare website, which has information about the quality of care at more than 4,000 Medicare-certified hospitals. Similar efforts are underway to provide quality data on Medicare-enrolled physicians and other health care professionals.

Despite this progress, it is still often difficult to assess the quality, efficiency, and appropriateness of care because there is no source of aggregated information that represents all the patients of a particular provider. As a result, consumers and employer purchasers are often limited in their ability to identify and choose providers who offer the potential of high-quality, affordable services. In addition, health plans face limits in their ability to identify high-performing providers for the purposes of value-based benefit design to support consumer choice. Consumers and other purchasers of care should have ready access to reliable, consistent, and relevant measures of health care cost, quality, and customer satisfaction levels, as well as comparable information on health plans. The purpose of doing so would be to make available to stakeholders meaningful comparative information on consumer cost-sharing, utilization, and performance with respect to certain quality metrics while ensuring the privacy of patients. For example, the data aggregation could be used to do the following:

- Publicly report data on the quality of private health plans
- Publish doctor and hospital ratings to enable informed consumer choice
- Provide health plans with data for product and network development
- Supply doctors and medical groups with analytics and benchmarking for quality improvement
- Be a resource to advance innovative payment and performance models

Ideally, there would be mechanisms for developing such information on provider quality and prices (recognizing that the price information that is provided needs to evolve with and reflect new models of payment and delivery), as well as consumer cost-sharing. Access to these data would be provided, consistent with existing FTC/DOJ guidance on how to make data public while protecting competition. Provider performance information based on aggregating multi-payer administrative data, together with clinical data from registries or EHRs, can result in more meaningful and reliable results than analyses based solely on one payer's data (e.g., Medicare).

States should take advantage of the “qualified entities” under the Availability of Medicare Data for Performance Measurement program to link Medicare, Medicaid, and commercial claims data. The variations in and evolution of payment models, state markets, and information systems, however, create technical challenges in the creation of such aggregated databases. We recommend developing mechanisms for providing this information in a way that avoids adding unnecessary costs to the health care system, protects patient privacy, enables consistent analytic results, and allows for the data aggregation to evolve with changes in payment models and methodologies.

5 Incentivize States to Partner with Public and Private Stakeholders to Transform the Health Care System

The Problem

Historically, cost containment proposals in the United States have focused on lowering prices and decreasing utilization for a single payer or expenditure category, and they haven't had a lasting impact.⁸⁷ To compound the problem, there are fundamental uncertainties surrounding current health care spending trends. In particular, will the recent slowdown in national health care spending be sustained? Will the payment and delivery reforms underway in the private and public sectors, and the further accelerations recommended in this proposal, continue to slow growth in per-capita spending?

States play a substantial and unique role in shaping the health care delivery system within their borders. Through licensure of facilities, physicians, and other personnel, and through coordinated planning of new services and construction of facilities, states can exert significant control over the "supply side" of the health system. Moreover, states can have a significant impact in related areas that represent important opportunities to both improve health and reduce future growth in costs, including promoting public health and prevention initiatives, addressing geographic variation, and improving health care quality and safety. States' jurisdiction over insurance regulations, as well as over the Affordable Care Act's new health insurance marketplaces (which will be run by the states themselves, by states in partnership with the federal government, or solely by the federal government), give states a set of levers and opportunities to work with insurers and providers to move toward payment and delivery structures that promote evidence-based quality reforms, high-value services, and better health outcomes. For all of these reasons, states are well-positioned to take a leadership role in coordinating private and public strategies to achieve innovative health system delivery and payment reforms.

In recent years, many proposals have included national targets, caps, or spending limits on federal programs. But a national target or cap fails to create an incentive for states to think creatively to implement solutions that fit their unique coverage landscapes and provider markets or to leverage their distinct capabilities. We instead support an approach that creates a shared incentive to bend the cost curve across both the public and private sectors, rather than one that would shift costs among sectors or to consumers.

An alternative approach could focus at the state level and include mechanisms to control costs across all sectors so that costs that are compressed in one sector will not simply be shifted to another. While states have a number of levers at their disposal to address total cost containment, we suggest an approach that brings stakeholders and state governments together to achieve meaningful, system-wide reforms.

The action we discuss below serves as a lever to accomplishing the other actions proposed in this brief—it is designed to ensure that payment reforms and new benefit designs have the intended effect of lowering overall costs by giving states incentives and the necessary flexibility to promote system transformation within their borders.

Action 5: Establish a gain-sharing program for states to innovate to control health care costs.

If a state elects to participate, specific savings goals would be set, along with defined rewards for states that met them. This approach differs from an attempt to reduce direct state or federal expenditures on health programs, because it focuses on overall health care spending, not just public expenditures.

It is designed to give states the flexibility to make meaningful, system-wide reforms that address local circumstances and that lower costs by refining the incentives of the payment and delivery system, rather than by cutting coverage and services.

States that voluntarily opt into such a program and that successfully slow the growth of total health spending would be rewarded with a percentage of the amount of the savings that the federal government realizes, with recognition that states with below-average costs would have lower savings targets. Shared savings payments would be generated through lower spending on Medicare, Medicaid, Affordable Care Act subsidies (for example, for residents who obtain coverage in the new health insurance marketplaces), and through savings in tax expenditures related to the exclusion from taxable income of employer contributions to health insurance premiums.

States could choose different combinations of market-based reforms and regulations, including the development of rules and contracts for payers and providers in their new health insurance marketplaces, to advance the goals being pursued by stakeholders in the state. There are several ways that payment and delivery reforms can be accelerated that would fit the specific cultures and political environments within a state. While the specific methods would be left up to the states and their stakeholders, some examples of potential strategies include the following:

- Improved care coordination and care management for those with chronic conditions.
- Health system and delivery reforms that reward high-quality care, improve health outcomes, and reduce health care costs, such as patient-centered medical homes, disease management programs, and incentive programs for wellness and prevention.
- Alignment of public and private payment reforms that reward high-quality care over volume of care, including bundled payments for episodes of care; financial incentives for providers based on consensus-based clinical measures of quality; non-payment for adverse or “never” events; and creating financial incentives to reduce medical errors, preventable hospitalizations, and hospital re-admissions.

- Scope of practice reforms to expand access to primary care by modifying scope of practice restrictions.
- Efforts to improve quality and patient safety through promotion of health information technology and administrative simplification to improve efficiency in care.

To ensure that the cost-reducing objectives are pursued in a responsible way, there are a number of benchmarks that should be set in order for participating states to receive payment:

- A state should continue to make progress in reducing its uninsured rate, especially among its low-income, uninsured residents, and any shared savings payments should not be the result of restricting eligibility or access (as this will simply shift costs and works at cross purposes with the goal of expanding high-quality coverage).
- A state should engage in a public, multi-stakeholder process to develop, implement, and monitor its plans.
- A state should not be credited for policies that result in shifting costs to consumers, among state and federal governments, between one public program and another, and between the public and private sectors. With comprehensive tracking data, this proposal’s financial incentives will help ensure that effective cost containment is achieved across the entire health care system. HHS may also issue annual guidance to states on ways to avoid cost-shifting as a way to assure that policies effectively reduce costs overall.

States that opt to participate in the gain-sharing model would be required to define policies and mechanisms for sharing rewards with stakeholders who participated in developing and implementing cost containment strategies that resulted in measurable cost savings.

The source of funding for the program should not be discretionary and year to year. Instead, it should be a direct funding program to states.

Gain-Sharing

A state cost-containment proposal based on the shared savings approach that meets specified targets for spending reductions could result in significant savings. While there has not been a cost containment initiative to date that provides a shared savings incentive to the states in an effort to drive system-wide reform, a preliminary and conservative estimate based on an analysis of 14 years of state cost trend information illustrates the potential magnitude of savings that are possible.⁸⁸ In fact, the modeling shows that, if incentives in this type of program led half the states, on average, to successfully reduce costs by even just 0.5 percent below trend, compounded annually, roughly \$220 billion in aggregate savings could be generated over 10 years (2012-2021) to be shared among states and the federal government. Increasing a state's share of total savings would increase its motivation to implement cost-reducing measures, thereby increasing the probability of higher total savings.

Conclusion

The drafters of this report represent a diverse cross-section of health care interests: patients, providers, employers, and payers. We recognize that, on specific short-term policies, our constituents may have different positions. But because our long-term vision is unified and our commitment is strong, we believe that a series of pragmatic, incremental, and balanced policy actions can move the nation to a far more sustainable, high-quality health care system.

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