

# CURBING COSTS IMPROVING CARE

THE PATH TO AN  
AFFORDABLE  
HEALTH CARE  
FUTURE



### **Acknowledgements**

The National Coalition on Health Care (NCHC) would like to offer special thanks to John Rother, President and CEO, for guiding the development of our Plan, and Larry McNeely, Manager for Policy Communications and Advocacy, for serving as the primary writer and editor. The Coalition would also like to thank its Board of Directors, member organizations, and the many other consumer, provider, health plan and business groups and health policy experts for their thoughtful input.

The National Coalition on Health Care, the oldest and most diverse group working to achieve comprehensive health system reform, is a 501(c)(3) organization representing more than 80 participating organizations, including medical societies, businesses, unions, health care providers, faith-based associations, pension and health funds, insurers and groups representing consumers, patients, women, minorities and persons with disabilities. Member organizations collectively represent—as employees, members, or congregants—over 100 million Americans.

Some members of the National Coalition Health Care do not, or cannot, take positions either on specific legislation, strategies or on any policies outside their respective mission areas. However, all that can, do endorse broad policy positions in support of comprehensive health system change.

CURBING COSTS,  
IMPROVING CARE:  
**The Path to an  
Affordable Health Care Future**





Dear Fellow Citizens,

Since its founding in 1991, the National Coalition on Health Care has brought together a diverse array of stakeholders and advocates around the goal of building a high-quality, affordable health system. By 2011, the consumer groups, religious communities, disability advocates, providers, employers, labor organizations, and health plans that make up the Coalition collectively recognized that the policy choices confronting the country in late 2012 and 2013 could be decisive for the attainment of the Coalition's mission.

Over the past year, NCHC held intensive discussions with its member groups and health care experts in order to craft a path forward on national health and fiscal policy. It was quickly apparent from our discussions that simply shifting costs among stakeholders in our health system, whether they are providers, payers, consumers, or taxpayers, is not acceptable. Instead, the United States must dramatically accelerate and expand efforts to reduce costs by promoting well-coordinated, high-quality care and improved health.

In support of that effort, we are proud to present *Curbing Costs, Improving Care: The Path to an Affordable Health Care Future*. NCHC's plan, set forth in this document, offers an alternative to cutting provider reimbursement or reducing the benefits on which the most vulnerable citizens depend. To help meet America's fiscal challenges, our plan identifies nearly \$500 billion in real budgetary savings, achieved through both lower spending and enhanced revenue. More importantly, it couples those budget recommendations with game-changing proposals that will transform the incentives for all actors in our health system.

We hope that you find this plan informative. We invite you to join with the National Coalition on Health Care as we continue to work toward an American health system we all can afford.

Sincerely,

A handwritten signature in black ink that reads "George Diehr".

George Diehr  
Vice President, CalPERS Board of Administration  
Chair, NCHC Board

A handwritten signature in black ink that reads "John Rother".

John Rother  
President and CEO

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# INTRODUCTION

Over the next several months, Congress and the President will face two major fiscal and health policy challenges: closing the immediate gap between federal spending and revenues and addressing the longer-term challenge of rising health costs.

The budget proposals advanced to date by leaders in both political parties have relied heavily on blunt, across-the-board cuts to beneficiaries, providers, and states. Taking this path simply shifts the costs now borne by the federal government onto the private sector and the states. It does not seriously address the challenge of reducing health care costs over the long term and ultimately makes the task of sustaining federal health programs more difficult and expensive.

America needs a new path forward. To ensure the affordability of health care in Medicare, Medicaid, and the private sector, we must pursue a comprehensive set of policies that together improve performance, reduce waste, and increase value.

This document presents a seven-point strategy, accompanied by 50 specific, actionable policy recommendations. The elements of that strategy are as follows:

1. Change provider incentives to reward value, not volume;
2. Encourage patient and consumer engagement;
3. Use market competition to increase value;
4. Ensure that the highest-cost patients receive high-value, coordinated care;
5. Bolster the primary care workforce;
6. Reduce errors, fraud, and administrative overhead; and
7. Invest in prevention and population health.

This strategy and the accompanying recommendations are designed to achieve two related, but distinct objectives: (1) reduce the impact of health care costs on the federal government's short-term (ten-year) fiscal balance and (2) simultaneously build a health system that is sustainable and affordable over the long term. This document includes two categories of policy recommendations: health system game-changers and supporting recommendations.

The four health system game-changers have tremendous potential to reduce both federal and private sector health spending. They may not all produce significant scoreable spending reductions in the short term, but each of these game-changers could have a transformative impact on our health system over the long term.

The remaining supporting recommendations discussed in this report lack the transformative impact of the game-changers, but can contribute to better functioning health care markets or federal programs in the short and long term. Some will curb federal spending by changing incentives to produce higher value care. A few of these recommendations will require modest federal investments in areas like workforce, health care information technology, quality measurement or prevention, but will amplify the impact of other cost-saving measures. Still others will generate increased health related revenues.

## Health System Game-changers

- Permanent repeal of the Sustainable Growth Rate formula and a transition from Medicare's fee-for-service payment system toward pay-for-value approaches;
- Value-based insurance design and quality-based tiering of providers;
- Investment in training the full range of health professionals needed for team-based primary care; and
- Innovative medical liability reforms, such as disclose and offer, evidence-based safe harbors, and health courts, that improve patient safety, more effectively compensate injured patients, and reduce defensive medicine.

## Summary of Identified Savings (Spending):<sup>1</sup>

Implement Centers of Excellence Program for select surgical services	\$0.45 billion
Equalize payment for outpatient and physician office services in Medicare	\$19 billion
Reform Medicare post-acute and home health payment	\$37 billion
Strengthen penalties for potentially avoidable acute care complications	\$23 billion
Strengthen penalties for potentially avoidable acute care readmissions	\$29 billion
Create trigger imposing a value-based withhold on Medicare providers if savings are not realized from specified delivery and payment reforms	\$64 billion
Use competitive bidding to lower Medicare and Medicaid DME costs	\$9.8 billion
Remove barriers to competition for affordable generic drugs	\$24.3 billion
Double proposed increase for Health Care Fraud and Abuse Control funding	\$3.7 billion
Miscellaneous budgetary savings	\$10.72 billion
Total	\$220.97 billion

## Summary of Identified Savings (Revenue):

Equalize and increase federal taxation of tobacco	\$88 billion
Impose penny-per-ounce federal excise tax on sweetened beverages	\$130 billion
Equalize federal alcohol taxes and update for inflation	\$58 billion
Total	\$276 billion

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<sup>1</sup> This list summarizes the budgetary impact of the specific policy options identified in this document as producing credible budgetary savings. Whenever possible, we have relied on existing estimates produced by the Congressional Budget Office or MedPAC. In other instances, we have relied on credible estimates from other sources or extrapolated our own savings estimates from existing CBO estimates of similar policy options. Please note that this list does not reflect the impact of those recommendations in this document that lack a specific estimate of savings.



## STRATEGY ONE: Change Provider Incentives to Reward Value, Not Volume

**E**xperts and advocates across the political spectrum have long argued that America's health care payment system must be transformed into one that incentivizes value and effectiveness, rather than ever-greater volume and complexity of medical services.

Unfortunately, Medicare's current fee-for-service (FFS) provider payment approach represents a major barrier to achieving that transformation. The Medicare Payment Advisory Commission (MedPAC), an independent, nonpartisan panel of experts charged with advising Congress on Medicare policy, explains the problem as follows:

First, [tools for increasing efficiency and improving quality] may not be able to overcome the strong incentives inherent in any FFS system to increase volume. Second, paying for each individual service and staying within current payment systems (e.g., the physician fee schedule or the inpatient [prospective payment system]) inhibit changes in the delivery system that might result in better coordination across services and lead to efficiencies or better quality across these systems.<sup>2</sup>

The National Coalition on Health Care strongly supports ongoing reform initiatives such as the Medicare Value-Based Purchasing Program, the Medicare Shared Savings Program, the Bundled Payments Initiative, and the range of pilots and demonstrations now underway. The Secretary of Health and Human Services should utilize her authority under current law to expand successful delivery reform initiatives to the greatest extent possible, without sacrificing quality or access. If this occurs, more health systems and communities will benefit from higher quality care at a lower cost.

However, given the scope of America's problem with health costs, a few more pockets of efficiency embedded in a health system that remains dominated by a broken fee-for-service payment system will not suffice. Failure to transition away from FFS payment in Medicare could negatively impact the potential of existing delivery and payment reforms and undermine the other reforms proposed in this document. Tackling this problem is the indispensable first step toward a more affordable health system.

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<sup>2</sup> Medicare Payment Advisory Commission. (2008, June). *Report to Congress*. Retrieved from [http://www.medpac.gov/documents/Jun08\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun08_EntireReport.pdf)



### **POLICY RECOMMENDATION 1.1:**

**Eliminate the Sustainable Growth Rate formula (SGR) and move from fee-for-service payment toward pay-for-value.**



#### **Budget Impact: Budget neutral**

#### **Relevant Legislative Proposal: The Medicare Physicians Payment Innovation Act of 2012, introduced as H.R. 5707 by Rep. Allyson Schwartz (D-PA) and Rep. Joe Heck (R-NV) in the House**

Medicare's provider payment policies demand a thorough overhaul. Any such reform should satisfy several criteria:

1. The Sustainable Growth Rate formula (SGR) must be eliminated, removing the periodic threat of across-the-board provider payment cuts;
2. Following SGR repeal, there should be a period of stability in Medicare provider payment, accompanied by accelerated testing and identification of new models of provider payment that support better care at lower cost;
3. This period of payment stability should conclude with an established date whereupon strong payment signals should be implemented to encourage Medicare providers to move toward any one of a number of proven payment models;
4. The overall proposal must encourage and reward primary care while enabling primary care providers to work effectively with specialists; and
5. To make both enactment and successful implementation possible, any reform proposal must have a significant level of support from providers themselves.

To date, only one concrete legislative proposal fits these criteria and has earned the support of the National Coalition on Health Care—the Medicare Provider Payment Innovation Act of 2012 (MPPIA).

This legislation, sponsored by Rep. Allyson Schwartz (D-PA) and Rep. Joe Heck (R-NV), would repeal the Sustainable Growth Rate (SGR) formula and provide five years of modest increases in fee-for-service payments for primary care providers and stable payment for specialists. Throughout this period, the Centers for Medicare and Medicaid Services (CMS) would be charged with aggressively testing value-based models of provider payment. The legislation would then require CMS to identify at least four separate payment models. Beginning in 2018, traditional fee-for-service payment levels would gradually be reduced to create a strong economic incentive for providers to switch to those payment models. Providers would also have an option to receive fee-for-service payments, adjusted for their participation in and performance on quality measurement, patient registry, and health information technology initiatives.

This structure establishes a date whereupon providers would be subject to strong incentives to move toward pay-for-value models of care and payment. Fee-for-service would not be completely eliminated, but the overall balance would shift from today's predominantly fee-for-service system with pockets of value-based payment to a predominantly pay-for-value system with pockets of fee-for-service. The American College of Physicians and the American Academy of Family Physicians have expressed support for the legislation.<sup>3</sup>

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<sup>3</sup> Office of Representative Joe Heck. (2012, May 9). *Heck and Schwartz Introduce Legislation to Repeal the SGR and Reform Medicare Physician Payment System*. Press Release. Retrieved from <http://heck.house.gov/press-release/heck-and-schwartz-introduce-legislation-repeal-sgr-and-reform-medicare-physician>

CBO is required to compare legislation to existing law, and would normally score repeal of the SGR as increasing the deficit. However, this legislation is designed to achieve budget neutrality through the use of unspent monies from the Overseas Contingency Operations (OCO) Fund.

## Interim Reforms to Medicare Provider Payment

The transition to new payment models will take several years. There are additional steps that should be taken to enhance value in Medicare provider payment during the interim.

### **POLICY RECOMMENDATION 1.2:**

**Expand participation in CMS demonstrations and pilots by allowing rolling application from providers.**

#### **Budget Impact: Not yet scored**

As currently structured, CMS allows limited time for interested participants to apply or opt in to most ongoing pilots and demonstrations. This reduces the number of providers who can participate and slows the broader advance of payment and delivery reforms. Policymakers should provide for rolling application to pilots and demonstrations such as the Pioneer Accountable Care Organization (ACO) program, the Independence at Home demonstration, the Comprehensive Primary Care Initiative, the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, and the Multi-payer Advanced Primary Care Initiative. This policy change should significantly increase participation in the pilots and demonstrations over time. The American Medical Association has recently proposed a similar approach.<sup>4</sup> For the purposes of evaluation of the demonstrations' results, CMS also should continue to track the original cohort of participants in these demonstrations.

### **POLICY RECOMMENDATION 1.3:**

**Apply immediate payment incentives for participation in quality and value initiatives to the existing fee-for-service pay schedule.**

#### **Budget Impact: Budget neutral**

The American College of Physicians has proposed that any period of payment stability be accompanied by enhanced payment updates for participation in quality improvement and value-based initiatives.<sup>5</sup> Those physicians participating in approved models such as registries, pay-for-performance models, medical homes, and ACOs would receive higher payment increases than those who do not. NCHC supports the implementation of this proposal. Such a proposal could be designed to be budget neutral.

### **POLICY RECOMMENDATION 1.4:**

**Sustain CMS funding for developing and implementing quality measures.**

#### **Budget Impact: Limited increase in federal spending**

The development of quality measures is vital to the successful implementation of most value-based payment models including ACOs, medical homes, and value-based purchasing. In the

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<sup>4</sup> Hoven, A.D. (2012, July 11). *Statement by the American Medical Association before the Senate Committee on Finance*. Retrieved from <http://www.ama-assn.org/resources/doc/washington/medicare-physician-payment-policy-testimony-11july2012.pdf>

<sup>5</sup> Bronson, D.L. (2012, July 24). *Statement for the Record before the House Ways and Means Health Subcommittee on Physician Organization Efforts to Promote High Quality Care*. Retrieved from [http://www.acponline.org/advocacy/where\\_we\\_stand/medicare/statement7-24-12.pdf](http://www.acponline.org/advocacy/where_we_stand/medicare/statement7-24-12.pdf)

short term, the funding needed to support CMS' continued engagement in the development, review, and endorsement of these measures must be sustained. Over the longer term, dedicating a set portion of mandatory Medicare funds to support these efforts should be considered.

#### **POLICY RECOMMENDATION 1.5:**

**Encourage episodic bundled payments either by expanding the Acute Care Episode (ACE) Bundled Payments Demonstration nationally or by implementing a Centers for Excellence for Selected Surgical Procedures program in Medicare.**

#### **Budget Impact: \$0.45 billion in savings over ten years**

The Center for Medicare and Medicaid Innovation is currently implementing a promising Bundled Payments for Care Improvement Initiative, which is open to providers nationwide that opt to pursue one of four forms of episodic bundled payments from Medicare.

However, two much smaller Medicare demonstrations, the ongoing Acute Care Episode and the 1990s' Medicare Heart Bypass Bundled, have combined episodic bundling with an additional element not included in the Bundled Payments for Care Improvement Initiative. Each of these demonstrations dedicated some of the savings to reducing cost-sharing or deductibles for beneficiaries, which provided a powerful incentive for beneficiaries to seek out care from participating providers. If applied to a broader geographic area, it could substantially enhance the potential of episodic bundling to improve care and lower costs. Expanding this approach to other types of episodes, beyond those in the ACE demonstration, or to include post-acute care, could generate further savings.

While the Congressional Budget Office has not scored such an expansion, it has evaluated a similar, regional Centers of Excellence proposal that would also bundle payments for a limited number of cardiac and orthopedic services and reduce deductibles for beneficiaries who utilize participating providers. That proposal was estimated to save \$450 million in federal spending over ten years.<sup>6</sup>

Federal policymakers should either implement a regional Centers of Excellence program or instruct CMS to expand the Acute Care Episode demonstration to qualified and willing providers across the country. Policymakers should also consider expanding this program to embrace procedures not included in the original limited set of cardiac and orthopedic episodes or to include associated post-acute services.

#### **POLICY RECOMMENDATION 1.6:**

**Equalize payment rates between certain services delivered in the outpatient and physician office settings.**

#### **Budget Impact: \$19 billion in savings over ten years**

Physician evaluation and management services delivered in hospital outpatient departments should be compensated at the same rate whether those services are delivered in physician offices, hospitals, or other outpatient settings. MedPAC has concluded that this change would remove distorted incentives to provide services in the more expensive hospital setting and save \$10 billion over ten years.<sup>7</sup>

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6 Congressional Budget Office. (2008, December). *Budget Options, Volume I: Health Care*. Retrieved from <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>

7 Medicare Payment Advisory Commission. (2011, October 14). *Moving Forward from the Sustainable Growth Rate (SGR) System*. Letter to Chairmen and Ranking Members of Congressional committees of jurisdiction. Retrieved from [http://medpac.gov/documents/10142011\\_MedPAC\\_SGR\\_letter.pdf](http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf)

MedPAC is also examining broader policy changes that equalize payments across the provider office and outpatient settings for 25 procedural and diagnostic services, and reduce the differential in payments for 61 additional services. While these recommendations have not been finalized, MedPAC staff has estimated such a policy could yield \$900 million in Medicare savings and \$250 million in lower cost-sharing in one year.<sup>8</sup> Simply extrapolating that level of savings over ten years would produce \$9 billion in savings.

### **POLICY RECOMMENDATION 1.7:**

#### **Expand Medicare payment penalties for high rates of potentially avoidable health care-acquired complications and readmissions.**

##### **Budget impact: Greater than \$52 billion in savings over ten years**

Incentives for hospitals to reduce costs and improve value should be dramatically sharpened by strengthening penalties for hospitals with high rates of readmissions and complications.<sup>9 10</sup>

The first element of this proposal would require that hospitals take on increased financial accountability for reducing the rate of potentially avoidable hospital-acquired complications. Hospitals would be penalized with a reduction in all Medicare payments based on the degree to which their risk-adjusted rate of avoidable complications exceeded a national average. These penalties would be greater than those established by the Affordable Care Act (ACA) and apply to a broader range of complications.

The second element sharpens the current hospital readmissions penalty to encompass readmissions that were potentially avoidable. Hospitals with rates of potentially avoidable readmissions that exceed the national average would be subject to additional penalties. Once again, the penalties would be greater than those included in the ACA and would apply to patients with a wider range of diagnoses than called for under current law.

The effect of these expanded penalties would be to provide a competitive advantage to hospitals that provide superior care. In effect, Medicare would buy more of the high-quality care that patients need and less of the low-quality care they do not need.

This policy could achieve substantial additional budgetary savings. The consumer group, Community Catalyst, has estimated that \$52 billion could be saved over ten years by applying these payment changes to Medicare hospitals.<sup>11</sup> By applying similar pay-for-outcomes strategies to Medicare post-acute and long-term care providers, including nursing homes and home health care providers, even greater savings are possible.

However, in implementing this approach, policymakers must take care not to harm those beneficiaries whose only care option is a lower-performing hospital. A portion of the savings, therefore, should be used to fund quality improvement programs in low-performing institutions. Additionally, penalties should be adjusted to incentivize improvement in rates of complications and readmissions, as well as overall level of performance. Finally, to avoid discouraging providers from treating high-risk patients, robust risk adjustment and adjustment for the socioeconomic status of patients must be included in any such program.

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8 Zabinski, D. & Winter, A. (2012, October 4). *Addressing Medicare Payment Differences Across Settings: Ambulatory Care Services*. Staff presentation to MedPAC. Retrieved from [http://medpac.gov/transcripts/1012\\_presentation\\_amcareservices.pdf](http://medpac.gov/transcripts/1012_presentation_amcareservices.pdf)

9 Fuller R., et al. (2011, Spring). A New Approach to Reducing Payments Made to Hospitals With High Complication Rates. *Inquiry*, 48, 68-83.

10 Averill R, et al. (2009, Summer). Redesigning the Medicare Inpatient PPS to Reduce Payments to Hospitals with High Readmission Rates. *Health Care Financing Review*, 30(4), 1-15.

11 Miller, M. and Howitt, K. (2011, April). *Better Care at Lower Costs: An Approach to Reduce Federal Health Spending by Weeding Out Wasteful Spending*. Report. Community Catalyst.

## Reforming Payment for Post-Acute and Home Health Care

Efforts to improve value must not end with physicians and acute care hospitals. Medicare covers a range of other services including skilled nursing care, rehabilitative care, and home health care. As value-based forms of payment (like ACOs) and episodic bundled payment drive the delivery of medical care away from more expensive acute care settings, post-acute providers will only become more important.

However, the vast majority of these services will still be reimbursed for the next several years through Medicare's current payment system, and that system needs urgent reform.

MedPAC has concluded that the Skilled Nursing Facility (SNF) payment system disproportionately rewards the provision of therapy services while inadequately reimbursing for the non-therapy ancillary services needed by medically complex patients.<sup>12</sup>

Additionally, the overall level of Medicare reimbursement for SNFs appears to be excessive. Medicare margins currently reach 18.5 percent<sup>13</sup> for skilled nursing facilities. This has attracted a range of for-profit post-acute providers and significant private investment. These for-profit chains and private investment homes have not always added value to the program, exhibiting a pattern of aggressive Medicare billing and upcoding<sup>14</sup> and poor performance on quality metrics.<sup>15</sup>

The home health sector has its own unique set of challenges. Home health providers in Medicare have remarkably high Medicare margins—an average of 19.4 percent for freestanding providers and 14.7 percent for agencies.<sup>16</sup> Unlike SNFs, whose high margins are attributable to skewed payment incentives, a substantial portion of these lucrative home health margins are attributable to fraud and abuse.<sup>17</sup>

### POLICY RECOMMENDATION 1.8:

#### Implement short-term reforms to post-acute and home health payment.

##### Budget Impact: \$37 billion in savings over ten years

Policymakers should implement several reforms related to Medicare's post-acute and home health payment systems. The elements of this approach are listed below, accompanied by estimates of corresponding scoreable savings.

- In 2013, rebalance SNF prospective payment system's incentives to reimburse adequately for the non-therapy ancillary services needed by medically complex patients, and reduce incentives for SNFs to provide unnecessary levels of rehabilitative services (no score available).

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12 Medicare Payment Advisory Commission. (2012, March). *Report to Congress: Medicare Payment Policy*. Retrieved from [http://medpac.gov/documents/Mar12\\_EntireReport.pdf](http://medpac.gov/documents/Mar12_EntireReport.pdf)

13 Medicare Payment Advisory Commission. (2012, March). *Report to Congress: Medicare Payment Policy*. Retrieved from [http://medpac.gov/documents/Mar12\\_EntireReport.pdf](http://medpac.gov/documents/Mar12_EntireReport.pdf).

14 HHS Office of the Inspector General. (2010, December). *Questionable Billing at Skilled Nursing Facilities*. Retrieved from <http://www.oig.hhs.gov/oei/reports/oei-02-09-00202.pdf>

15 Harrington, C., Olney, B., Carillo, H., Kang, T. (2011, February). *Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains and Chains Owned by Private Equity Companies*. Health Services Research. Retrieved from <http://www.hsr.org/hsr/abstract.jsp?aid=47287011682>

16 Medicare Payment Advisory Commission. (2012, March). *Report to Congress: Medicare Payment Policy*. Retrieved from [http://medpac.gov/documents/Mar12\\_EntireReport.pdf](http://medpac.gov/documents/Mar12_EntireReport.pdf)

17 Reschovsky, J.D., et. al. (2012, May). Durable Medical Equipment And Home Health Among The Largest Contributors To Area Variations In Use of Medicare Services. *Health Affairs*, 31(5), 956-964. doi: 10.1377/hlthaff.2011.0243. Retrieved from <http://content.healthaffairs.org/content/31/5/956.full?ijkey=eg9xgCnd2ViiU&keytype=ref&siteid=healthaff>

- Rebase SNF payments to reflect costs more accurately (\$23 billion—MedPAC).<sup>18</sup>
- Rebase Home Health payments to more accurately reflect costs and freeze them for 2012 (\$10 billion—MedPAC).<sup>19</sup>
- Implement a readmissions policy that reduces SNE, IRE, Long-term Care Hospital, and home health reimbursement if the provider exhibits high rates of risk adjusted preventable readmissions. (\$4 billion—MedPAC).<sup>20</sup>

## Achieving Scoreable Savings from System Transformation

The Congressional Budget Office takes an intentionally conservative lens to its budgetary estimates. Historically, it has scored policies that raise or lower reimbursement rates or beneficiary cost-sharing, while assigning little savings to the efficiency improvements that can result from expected changes in consumer or provider behavior. Consequently, CBO's estimates of the savings from promising payment reform initiatives included in current law, such as value-based purchasing and enhanced care coordination, have been lower than those projected by other health care analysts.<sup>21 22</sup>

For similar reasons, the first five recommendations listed above (Recommendations 1.1 through 1.5) are unlikely to receive CBO scores commensurate with their actual savings potential.

However, it is possible to produce a specific amount of CBO scoreable savings for these policies. This can be achieved through a trigger, which would impose reductions in spending in the event that these five recommendations do not produce savings.

In the past, proposals to institute similar triggers have relied on across-the-board cuts like those mandated by the SGR. This is exactly the sort of blunt-force approach to spending restraint that this NCHC package of recommendations is designed to avoid.

However, NCHC would support a more nuanced form of trigger if it could guarantee scoreable savings for the specific delivery system reform policies discussed in this report.

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18 Medicare Payment Advisory Commission. (2011, October 14). *Moving Forward from the Sustainable Growth Rate (SGR) System*. Letter to Chairmen and Ranking Members of Congressional committees of jurisdiction. Retrieved from [http://medpac.gov/documents/10142011\\_MedPAC\\_SGR\\_letter.pdf](http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf)

19 Medicare Payment Advisory Commission. (2011, October 14). *Moving Forward from the Sustainable Growth Rate (SGR) System*. Letter to Chairmen and Ranking Members of Congressional committees of jurisdiction. Retrieved from [http://medpac.gov/documents/10142011\\_MedPAC\\_SGR\\_letter.pdf](http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf)

20 Medicare Payment Advisory Commission. (2011, October 14). *Moving Forward from the Sustainable Growth Rate (SGR) System*. Letter to Chairmen and Ranking Members of Congressional committees of jurisdiction. Retrieved from [http://medpac.gov/documents/10142011\\_MedPAC\\_SGR\\_letter.pdf](http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf)

21 The Commonwealth Fund Commission on a High Performance Health System. (2009, February). *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*. The Commonwealth Fund. Retrieved from [http://www.commonwealthfund.org/-/media/Files/Publications/Fund%20Report/2009/Feb/The%20Path%20to%20a%20High%20Performance%20US%20Health%20System/1237\\_Commission\\_path\\_high\\_perform\\_US\\_hlt\\_sys\\_WEB\\_rev\\_03052009.pdf](http://www.commonwealthfund.org/-/media/Files/Publications/Fund%20Report/2009/Feb/The%20Path%20to%20a%20High%20Performance%20US%20Health%20System/1237_Commission_path_high_perform_US_hlt_sys_WEB_rev_03052009.pdf)

22 Berenson, R.A., et al. (2009, July). *How We Can Pay for Health Care Reform*. Urban Institute. Retrieved from [http://www.urban.org/uploadedpdf/411932\\_howwecanpay.pdf](http://www.urban.org/uploadedpdf/411932_howwecanpay.pdf)

### **POLICY RECOMMENDATION 1.9:**

**Implement a value-based withhold in Medicare in the event that expected savings do not materialize.**

**Budget Impact: Savings from this policy can be dialed up or down based on the size of the withhold and the range of providers to which it is applied. For the purposes of this report, we recommend a goal of \$64 billion.**

Drs. Elliott Fisher, James Weinstein and Jonathan Skinner of the Dartmouth Institute of Health Policy and Clinical Practice have proposed a withhold to Medicare reimbursement as an alternative to across-the-board provider cuts.<sup>23</sup> Under their plan, a percentage is withheld from providers' reimbursement throughout the year. If a group of providers manages to reduce spending over the year by more efficiently delivering care, they will receive either the whole or a portion of the withhold amount at the end of the year.

To implement this approach, NCHC recommends specifying a reasonable amount of savings to be expected from certain specified delivery, payment and market reforms. After five years, if the CMS' Office of the Actuary finds that Medicare is not on a path to realize that level of savings from these initiatives, this policy would require that a percentage withhold be imposed on Medicare reimbursement to make up for the difference.

If triggered, the withhold would work in the following way: groups of providers would be given a savings target based on the costs their patients are expected to generate for Medicare. Providers that achieve those savings would be allowed to recover some of the withheld reimbursement if they managed to reduce spending and maintain patient quality. But when providers fail to reach that target, they would not receive the withheld reimbursement.

A key design question for any withhold proposal relates to what grouping of providers to use in applying the withhold. ACOs and managed care plans, already accustomed to being held accountable for population spending and health, could easily participate. It may also be possible to hold groups of providers participating in certain medical home and patient registry programs accountable for their patient population's spending. For those providers not currently participating in these population-based payment models, however, the Dartmouth researchers have proposed applying the withhold at the Hospital Referral Region level.

Applying a withhold by region is a somewhat blunt instrument to achieve savings. However, for providers, this approach is undeniably superior to the across-the-board cuts mandated by the sequester and the SGR for two reasons. First, these regional withholds would allow providers in a region to recover the withheld reimbursement funds provided that they were capable of improving quality and lowering costs in their area. Secondly, providers would be able to avoid the regionally based withhold entirely by joining an ACO or other population-based model. Neither of these two options would be available to providers if federal policymakers were to impose across-the-board cuts.

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23 Fisher, E., Weinstein, J., & Skinner, J. (2012, January). Withholds to Slow Medical Spending: A Better Deal than Cuts. *JAMA*, 307(1), 43-44. doi: 10.1001/jama.2011.1946. Retrieved from <http://jama.jamanetwork.com/article.aspx?articleid=1104823>



## STRATEGY TWO: Encourage Patient and Consumer Engagement

### Cost and Quality Transparency

Consumer engagement begins with usable cost and quality information. To date, there have been some important federal efforts to display quality information on providers, including the websites Nursing Home Compare, Hospital Compare, and Physician Compare. Furthermore, a handful of states, such as Wisconsin and Texas, have passed laws designed to facilitate better price transparency.<sup>24</sup> Leading payers, including BlueCross/Blue Shield and Aetna, have produced online price estimation tools that allow consumers to estimate their out-of-pocket costs before undergoing treatment. However, most consumers do not utilize quality information when selecting physicians and continue to have little idea of what their care will cost.<sup>25</sup>

There are instances in health care where consumer choice may never be effective or even appropriate. For example, a car crash victim or heart attack victim should not have to consult quality rankings before they go to the ER. Still, whether it is choosing between treatment alternatives, selecting a primary care provider, or choosing the best value in drugs and medical devices, informed consumer choice does have the potential to help improve care and lower costs. When possible, consumers have a responsibility to be more prudent consumers of health care. Providers need this information as well, if they are to deliver higher value care.

Moving forward, providers, payers, and policymakers must work together to ensure that consumers and their providers have access to the price and quality information needed to make prudent care decisions.

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24 Lynch, W. & Smith, B. (2011). *Altarum Institute of Consumer Health Care Opinions*. Retrieved from [http://www.altarum.org/files/imce/CCCHC\\_Survey\\_Extended\\_Report\\_123011\\_rev042612.pdf](http://www.altarum.org/files/imce/CCCHC_Survey_Extended_Report_123011_rev042612.pdf)

25 Hibbard, J.H., et.al. (2012, March) An Experiment Shows That A Well-Designed Report On Costs And Quality Can Help Consumers Choose High-Value Health Care. *Health Affairs*, 31(3), 560-568. doi:10.1377/hlthaff.2011.1168. Retrieved from <http://content.healthaffairs.org/content/31/3/560.abstract>



## Targeted Consumer Incentives: Value-based Insurance Design and Tiered Networks

Transparency alone is not sufficient to foster strong consumer engagement. Consumers also need incentives to seek out the highest value care. Since at least 2001, researchers, payers, and providers have worked to advance models that use varying levels of cost-sharing to encourage high value treatments and discourage lower value ones. Originally called “benefit-based copays,” these approaches are now known as value-based insurance design (VBID).

VBID is becoming increasingly common in American health care. Most drug plans now tier prescription drug copays based on the cost of the drug and the evidentiary basis for the drug. The ACA implemented a very basic form of value-based insurance design when it mandated that Medicare and private plans cover certain proven preventive services without cost-sharing. Furthermore, private plans are applying value-based insurance design principles by establishing differential cost-sharing based on evidence of the value and effectiveness of specific treatment choices. Additionally, 16 percent of employers are now offering so-called “tiered provider networks.”<sup>26</sup> This approach provides for varied levels of cost-sharing that can be based on providers’ adherence to evidence-based guidelines, their performance on quality measures, or measures of the value or cost-effectiveness of the care they provide.

Despite all this progress, more can be done to encourage VBID and value-based tiering.

### **POLICY RECOMMENDATION 2.1:**

**Implement MedPAC’s recommendation to empower the Secretary of Health and Human Services (HHS) to vary cost-sharing based on evidence. Lift curbs on tiered cost-sharing in Medicare Advantage.**



### **Budget Impact: Not yet scored**

Under current law (with the exception of those preventive services that are provided free of cost-sharing), Medicare cost-sharing is uniform. Copays, deductibles and coinsurance rates do not change based on whether one surgery, test, or procedure has been shown to be more effective than another.

As part of a broad redesign plan for Medicare benefits, MedPAC has proposed empowering the Secretary of Health and Human Services to vary co-pays based on evidence of a particular treatment’s effectiveness.<sup>27</sup> NCHC strongly supports this specific element of MedPAC’s recommendation.

However, in designing and implementing any such policy change, it will be necessary to provide some process for exceptions in those cases where a typically low-value procedure is entirely appropriate for certain patients.

Policymakers also should lift restrictions on VBID among Medicare Advantage (MA) plans. Currently, Medicare rules prevent MA plans from adjusting co-pays based on evidence of treatment effectiveness and tiering providers based on accepted quality and patient outcome measures.

26 Sinaiko, A. (2011, June). *Tiered Provider Networks: Trends and Evidence*. Presentation for the National Health Policy Forum. Retrieved from [http://www.nhpf.org/uploads/Handouts/Sinaiko-slides\\_06-24-11.pdf](http://www.nhpf.org/uploads/Handouts/Sinaiko-slides_06-24-11.pdf)

27 Medicare Payment Advisory Commission. (2012, March). *Report to Congress: Medicare Payment Policy*. Retrieved from [http://medpac.gov/documents/Mar12\\_EntireReport.pdf](http://medpac.gov/documents/Mar12_EntireReport.pdf)

## Encouraging Personal Responsibility and Wellness in Medicare

Hypertension, arthritis, heart disease, cancer, and diabetes, the most frequently occurring conditions among seniors, are amenable to interventions that prevent the onset or progression of these diseases. Research has established the effectiveness of senior wellness programs that support increased physical activity, better nutrition, smoking cessation, and other healthy behaviors.<sup>28</sup> These programs have produced reduced inpatient admissions, lowered health care costs, and improved health-related quality of life. One particular approach, the Diabetes Prevention Program, has yielded significant success in preventing or delaying the onset of diabetes. However, despite the evidence that these initiatives work, today's Medicare program is not delivering them.

### **POLICY RECOMMENDATION 2.2:**

**Implement a Medicare Health Rewards program that provides small monetary incentives for Medicare beneficiaries to set and achieve health goals.**

**Budget Impact: Budget neutral**

**Relevant Legislative Proposal: The Medicare Better Health Rewards Program Act of 2012, introduced as S. 2243 by Senators Rob Portman (R-OH) and Ron Wyden (D-OR) in the Senate and as H.R. 6232 by Rep. Erik Paulsen (R-MN) in the House of Representatives**

Policymakers should establish a voluntary program under which Medicare beneficiaries receive incentives if they reach their health care goals. Such a program should be structured around annual wellness visits to the beneficiary's primary care provider that measure improvements in six areas of health: tobacco usage, body mass index (BMI), diabetes indicators, blood pressure, cholesterol, vaccinations, and screenings. If seniors are improving their health and achieving their targets, they earn financial incentives.

Supporters of this concept expect that this program will reduce federal Medicare costs. However, in the event that the program expenses exceed savings, the Medicare Better Health Rewards Program Act would offset those expenses using funds currently designated for the Prevention and Public Health Fund. The Prevention and Public Health Fund lies at the core of the nation's strategy to advance community prevention. Rather than risk redirecting badly needed resources from the Prevention and Public Health Fund, other measures should be used to offset the cost of the Medicare Rewards Program.

### **POLICY RECOMMENDATION 2.3:**

**Require Medicare to cover participation in the Diabetes Prevention Program (DPP) for eligible pre-diabetics.**

**Budget Impact: Not yet scored**

**Relevant Legislative Proposal: The Medicare Diabetes Prevention Act of 2012, introduced as S. 3463 by Senator Al Franken (D-MN), Senator Richard Lugar (R-IN), and Senator Jay Rockefeller (D-WV).**

Diabetes afflicts one-third of Medicare beneficiaries, and diabetes and pre-diabetes are expected to cost the federal government \$1.7 trillion between 2011 and 2020.<sup>29</sup> The National Diabetes Prevention Program (DPP) developed from a partnership between local community organizations and the Centers for Disease Control and Prevention (CDC) and is designed to help

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28 Coberley C., Rula E.Y., & Pope J.E. (2011). Effectiveness of Health and Wellness Initiatives for Seniors. *Population Health Management*, 14, S-45-S50.

29 UnitedHealth Center for Health Reform & Modernization. (2010, November). *The United States of Diabetes: Challenges and Opportunities in the Decade Ahead*. Retrieved from [http://www.unitedhealthgroup.com/HRm/UNH\\_WorkingPaper5.pdf](http://www.unitedhealthgroup.com/HRm/UNH_WorkingPaper5.pdf)

individuals make evidence-based lifestyle changes that prevent type 2 diabetes. The program, which emphasizes exercise and a healthy diet, has been shown to reduce high risk participants' odds of developing type 2 diabetes by 58 percent.<sup>30</sup>

All Medicare beneficiaries should be offered the opportunity to enroll in a certified DPP if indicated by the annual wellness visit. The Urban Institute has estimated that implementing this kind of program nationwide could save as much as \$191 billion over ten years, with about \$142.9 billion of the savings going to Medicare and Medicaid.<sup>31</sup> According to United Health Group, enrolling adults with pre-diabetes in this program could save the federal government \$61 billion over ten years.<sup>32</sup> Offering the DPP as a covered benefit under Medicare would align the program with a number of large private insurers, who have already taken advantage of the opportunity for savings.

## Increasing Medication Adherence

In the United States today, half of patients do not take their medications as prescribed, which increases the likelihood of worsening illness and increases health care spending. It is estimated that 33 to 69 percent of all medication-related hospital readmissions are linked to a patient's inability to follow a prescribed medication regimen. Poor adherence costs the United States roughly \$290 billion a year in avoidable hospitalizations, admissions to long-term care facilities, and increased medical utilization.<sup>33</sup>

As federal health policy evolves toward a more value-based system, special attention must be paid to encouraging patients to take responsibility for adhering to their medication plan.

### **POLICY RECOMMENDATION 2.4:**

**Integrate adherence measures into a variety of ongoing health care quality and value initiatives.**

#### **Budget Impact: Not yet scored; likely to be budget neutral**

Medication adherence should be a top priority within a range of quality improvement and value-based payment programs. Specific recommendations are as follows:

- Incorporate medication adherence measures into the current financial incentive structure for the Hospital Value-Based Purchasing Program. There are currently no medication adherence monitoring or quality measures in this program. The inclusion of such a measure would spur hospitals to invest further in discharge planning to conduct follow-up with patients following discharge and improve coordination with patients' primary care and post-acute providers.
- Include medication adherence as a measurable outcome in the Readmission Reduction Program and include readmissions related to non-reconciliation of medications into the risk-adjusted excess readmission ratio. The Readmission Reduction Program currently penalizes hospitals for readmissions within thirty days for heart attack, pneumonia, and chronic heart failure patients. Failure to reconcile medications when the patient is

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30 Thorpe K.E., & Yang Z. (2011, September). Enrolling People with Prediabetes Ages 60-64 in a Proven Weight Loss Program Could Save Medicare \$7 Billion or More. *Health Affairs*, 30(9),1673-679.

31 Berenson, R.A., et.al. (2009, July). *How We Can Pay for Health Care Reform*. The Urban Institute. Retrieved from [http://www.urban.org/UploadedPDF/411932\\_howwecanpay.pdf](http://www.urban.org/UploadedPDF/411932_howwecanpay.pdf)

32 UnitedHealth Center for Health Reform & Modernization. (2010, November). *The United States of Diabetes: Challenges and Opportunities in the Decade Ahead*. Retrieved from [http://www.unitedhealthgroup.com/HRm/UNH\\_WorkingPaper5.pdf](http://www.unitedhealthgroup.com/HRm/UNH_WorkingPaper5.pdf)

33 NEHI. (2009, August 12). *Thinking Outside the Pillbox: A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease*. Retrieved from [http://www.nehi.net/uploads/full\\_report/pa\\_issue\\_brief\\_final.pdf](http://www.nehi.net/uploads/full_report/pa_issue_brief_final.pdf)

admitted and at discharge decreases the probability that the patient will be adherent to their prescribed regimen. It also sends the patient into the community without a properly updated treatment plan.

- Direct National Institutes of Health grant funding toward medication adherence research projects and randomized trials of interventions that are designed to increase adherence. The reason for non-adherence varies significantly across patients and medications. This complicates the process of devising an intervention that can be applied broadly across populations. More research is needed to address medication adherence issues and their impact on the health care system.

## The Tax Exclusion for Employer-provided Health Insurance

Current law excludes contributions to employer-provided insurance premiums from income and payroll taxation. This provision has been key to building and sustaining the system of employer-provided health coverage on which 160 million Americans depend.

However, not only is a significant portion of employee compensation excluded from taxation, but employers and employees have an incentive to allocate a larger share of total compensation to health benefits than they otherwise would.

Economists have long believed that this tax subsidy for employer-provided coverage leads to unnecessary health costs. The Joint Committee on Taxation, a nonpartisan Congressional body dedicated to analyzing tax policy, has concluded that this exclusion incentivizes the purchase of more generous coverage than would otherwise be purchased, resulting in higher demand and higher prices for all health care services.<sup>34</sup> The CBO estimates that the cost of tax exclusion will equal 1.8 percent of the nation's total economic output over the next ten years,<sup>35</sup> even after accounting for the impact associated with the 40 percent excise tax on certain high cost plans, enacted in the ACA.

Proposals that would reduce the size and impact of the employer tax exclusion have emerged amidst national discussions on tax reform, ranging from complete elimination of the employer tax exclusion to reductions in the amount of income that higher-income Americans can deduct or exclude from their taxable income.

NCHC recognizes the tax exclusion will be part of the forthcoming debate, and we believe that it is possible to distinguish between better and worse approaches from a health policy perspective. However, it is unclear how the issue will be addressed, and NCHC is not offering a specific recommendation on this issue at this time.

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<sup>34</sup> Joint Committee on Taxation. (2008). *Tax Expenditures for Health Care*. Washington, DC: U.S. Government Printing Office.

<sup>35</sup> Congressional Budget Office. (2012, January 31). *Budget and Economic Outlook 2012*. Retrieved from [http://www.cbo.gov/sites/default/files/cbofiles/attachments/01-31-2012\\_Outlook.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/01-31-2012_Outlook.pdf)

## STRATEGY THREE:

# Use Market Competition to Enhance Quality and Lower Costs

### Hospital and Health System Competition

As of 2003, nearly 90 percent of hospital markets were classified as highly concentrated according to federal anti-trust standards.<sup>36</sup> More recently, continuing mergers in the hospital industry have led to further concentration. When these markets are dominated by a few systems or when one health system is particularly desirable to consumers, health systems can frustrate cost containment efforts by demanding inclusion of anti-competitive clauses in their contracts with health plans and employers.

Anti-tiering clauses are one such provision. These provisions deny plans the ability to vary reimbursement to a health system's providers based on their individual performance on quality or value measures. This prevents the use of tiered networks to rein in cost growth and encourage higher quality of care.

Another example of anti-competitive contracting is so-called "guaranteed inclusion" clauses. These provisions allow health systems anchored by hospitals or providers in high demand to force plans to include the remainder of the health system. This protects costly, poor-performing providers from exclusion from plans' coverage networks.

#### **POLICY RECOMMENDATION 3.1:**

**Empower the FTC to combat market practices designed to frustrate competition on price and quality, and ban anti-tiering and guaranteed inclusion clauses.**

#### **Budget Impact: Not yet scored**

The Council on Affordable Health Coverage (CAHC), a national alliance of businesses, payers, providers and patient groups, has offered a solution to this growing problem. They recommend that Congress instruct the Federal Trade Commission to aggressively enforce existing anti-trust laws and expand those laws to ban the use of certain anti-competitive contracting practices in health care such as anti-tiering and guaranteed inclusion clauses.<sup>37</sup>

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<sup>36</sup> Vogt, W.B. (2009, Nov). *Hospital Market Consolidation: Trends and Consequences*. NIHCM Foundation. Retrieved from [http://nihcm.org/pdf/EV-Vogt\\_FINAL.pdf](http://nihcm.org/pdf/EV-Vogt_FINAL.pdf)

<sup>37</sup> White, J. (2011, September 9). *Statement for the Record for the U.S. House Ways & Means Hearing on Healthcare Industry Consolidation*. Retrieved from <http://www.cahc.net/2001/12/statement-for-record-by-joel-white-for.html>

## Reference Pricing

To ensure value in health care services, a number of private payers today employ an approach called reference pricing. Under this approach, the payer identifies a provider which delivers a particular procedure at an affordable price and high level of quality. It is usually applied to high-volume services such as diagnostic tests or high-cost procedures such as knee replacement surgery. The plan then sets its reimbursement for that service at the level paid to the chosen provider. Plan enrollees may continue to choose any provider to deliver that procedure, but if the enrollee chooses a higher-priced provider, they must pay the difference out of their own pocket. Reference pricing puts substantial competitive pressure on providers to redesign their care delivery and business processes to compete with the reference provider, and it has proven to be a powerful tool for reining in costs in the private sector.<sup>38 39</sup> Unfortunately, Medicare, the nation's largest payer, has little to no experience in utilizing this approach.

### **POLICY RECOMMENDATION 3.2:** **Pilot reference pricing in Medicare.**

#### **Budget Impact: Not yet scored**

To determine whether and how reference pricing could work in Medicare, Medicare should pilot reference pricing approaches for a limited number of treatments and diagnostic tests.

## Choice and Competition in Health Insurance Exchanges

By January 2014, under current law, the use of individuals' health or claims history in health insurance coverage and pricing decisions will be prohibited; the expansion of coverage to 24 million additional Americans will begin; and new health insurance exchanges are to be established in all 50 states.

These three policy changes, enacted as part of the ACA, were intended to enable health plans in the individual market to shift away from competition based on pricing or mitigating the financial risk generated by their enrollees. Instead, plans are to compete based solely on their ability to deliver the highest value coverage and care to patients. Facing this new form of competition, plans would accelerate implementation of payment and delivery innovations, and consumers would choose the plan that delivered the optimum quality of care at the best price.

There are undeniably strongly held differences of opinion about these ambitious changes and the 2010 federal health care law as a whole. Views about the law, the proper structure and governance of state health insurance exchanges, and the implementation of associated insurance reforms, vary among the NCHC's own member organizations. Nevertheless, in the event that the changes slated for January 2014 do occur, every citizen or stakeholder concerned about rising health costs shares an interest in fostering effective competition in state insurance markets. Indeed, competition could spur the adoption of innovative approaches to delivery reform and consumer engagement needed to curb national health expenditures.

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38 Appleby, J. (2011, September 22). Companies Steering Workers to Lower Priced Medical Care. *Kaiser Health News*. Retrieved from <http://www.kaiserhealthnews.org/stories/2011/september/21/companies-steering-workers-to-lower-priced-medical-care.aspx>

39 Robinson, J. (2012, September). Payers Test Reference Pricing And Centers Of Excellence To Steer Patients To Low-Price And High-Quality Providers. *Health Affairs*, 31(9), 2028-2036. doi: 10.1377/hlthaff.2011.1313.

### **POLICY RECOMMENDATION 3.3:**

**The Department of HHS and other federal agencies should accelerate efforts to promulgate the regulations and guidance needed for exchange implementation.**

To date, HHS has yet to promulgate regulations on a number of issues crucial to the operations of the exchange, including insurance market reforms and the essential health benefits requirements. In fact, the previously issued final exchange regulation and guidance on federally facilitated exchanges have left more than 100 specific regulatory issues to be resolved by future rulemaking or guidance.

If exchanges are to commence functioning in the 50 states, the District of Columbia, and federal territories by January 1, 2014, as required by law, expeditious resolution of the remaining regulatory questions is needed.

### **POLICY RECOMMENDATION 3.4:**

**Ensure that consumers in all exchanges have the price and quality information necessary for informed choice.**

#### **Budget Impact: Budget neutral**

The initial years of implementation of the health insurance exchanges are likely to focus on the basics of standing up exchanges—recruiting plans and enrolling consumers.

However, as implementation continues, the level of cost and particularly quality transparency will be crucial to delivering better value for consumers and lowering overall costs. Research shows that providing price information in health care, without concomitant quality information, can lead some consumers to choose higher-price options, believing that price is an indicator of quality.

When fully implemented, exchanges should enable consumers to easily search for and compare two or more plans on a range of criteria including price, provider network, benefits, cost-sharing, and location. Consumers should be able to prioritize these criteria and execute a customized search based on those priorities.<sup>40</sup> Additionally, every exchange should make ratings of plan quality and enrollee satisfaction easily available to consumers.<sup>41</sup>

Exchanges and policymakers at the federal and state levels should work together to ensure that consumers in all exchanges can benefit from these capabilities.

### **POLICY RECOMMENDATION 3.5:**

**Federal and state policymakers must work together to monitor for possible adverse selection and, if necessary, take additional legislative steps to combat it.**

#### **Budget impact: Not yet scored**

Current law includes numerous provisions to protect exchanges from adverse selection, including federally financed reinsurance, risk corridor, and risk adjustment programs. The ACA's tax credits are limited to insurance purchases on the exchanges, which will ensure that exchanges attract a critical mass of consumers. Its much-debated tax penalty for those who do not maintain qualifying coverage can serve to further stabilize insurance markets.

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40 U.S. Public Interest Research Group. (2011, October). *Making the Grade: As Scorecard for Health Insurance Exchanges*. Retrieved from [http://www.uspirg.org/sites/pirg/files/reports/Making-the-Grade\\_0.pdf](http://www.uspirg.org/sites/pirg/files/reports/Making-the-Grade_0.pdf)

41 Sections 1311 (c) 3 and 1311 (c) 4 of the Patient Protection and Affordable Care Act require that all Secretary of HHS develop these rating and enrollee satisfaction systems.

Also, the ACA applies insurance reform rules (including rating and essential health benefit rules) equally to coverage sold inside and outside an exchange in the individual and small group markets. Further, it requires premiums to be the same inside and outside an exchange for any product offered on an exchange.

However, no strategy can entirely eliminate the possibility of risk selection, either among plans on the exchange or between the exchange and the outside insurance market. Congress, CMS, state governments, and the exchanges themselves must fully monitor prices and enrollment patterns in every state for evidence of substantial risk selection.

In the event that adverse selection does take hold, policymakers should consider a range of tools to address it. These could include:

1. Steps to expand the risk pool such as increasing outreach and enrollment activities;
2. Additional federal or state investment in reinsurance, risk corridor, or risk adjustment strategies;
3. State regulatory action to limit practices that steer consumers toward or away from the exchange; and
4. State or Federal legislative or regulatory action requiring all plans within an exchange to compete on a level playing field.

## Competitive Bidding for Medical Devices

In the past, both Medicare and Medicaid have paid for durable medical equipment (such as wheelchairs, diabetic supplies, and oxygen equipment) through a price schedule set by administrative action. After nearly 15 years of intense legislative and legal struggle, Medicare today has implemented competitive bidding for nine categories of durable medical equipment (DME) in a total of 100 Metropolitan Statistical Areas. The categories are Oxygen Supplies and Equipment Standard Power Wheelchairs, Scooters, and Related Accessories; Complex Rehabilitative Power Wheelchairs and Related Accessories (Group 2); Mail-Order Replacement Diabetic Supplies; Enteral Nutrients, Equipment, and Supplies; Continuous Positive Airway Pressure (CPAP) and Respiratory Assist Devices (RADs), and Related Supplies and Accessories; Hospital Beds and Related Accessories; Walkers and Related Accessories; Certain Support Surfaces, and Diabetic Testing Supplies. By 2016, current law requires that competitive bidding be implemented nationally for those categories of Medicare durable medical equipment.

A 2009 test of competitive bidding has shown a 42 percent reduction in cost without negative impacts on beneficiaries, at least at this early stage of implementation.<sup>42</sup> CMS estimates that its national effort will generate savings of \$25.7 billion from 2013 to 2022 for the Medicare program and an additional \$17.1 billion for beneficiaries.<sup>43</sup> These are significant savings. While it is important that CMS monitor implementation to ensure that access, choice and quality care do not suffer, expanding competitive bidding further can achieve even more.

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42 Center for Medicare and Medicaid Services. (2012, April 17). *Competitive Bidding Update—One Year Implementation Update*. Retrieved from <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Downloads/Competitive-Bidding-Update-One-Year-Implementation.pdf>

43 Center for Medicare and Medicaid Services. (2012, April 17). *Competitive Bidding Update—One Year Implementation Update*. Retrieved from <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Downloads/Competitive-Bidding-Update-One-Year-Implementation.pdf>



### **POLICY RECOMMENDATION 3.6:**

**Expand competitive bidding to additional categories of durable medical equipment in Medicare.**

#### **Budget Impact: \$7 billion in savings over ten years**

Medicare's competitive bidding program should be expanded to the categories of durable medical equipment not included in the current program, including items such as nebulizers and ventilators. MedPAC has estimated that implementing such a policy or applying equivalent cuts to the existing payment schedule could save \$7 billion over ten years.<sup>44</sup> However, competitive bidding should not be extended to custom orthotics, prosthetic limbs, and complex rehabilitative technology (CRT) power and manual wheelchairs and related seating systems. These are highly customized and service-oriented devices that serve the needs of beneficiaries with significant disabilities and do not lend themselves well to a competitive bidding model.

### **POLICY RECOMMENDATION 3.7:**

**Adjust federal support for Medicaid durable medical equipment to reflect the lower competitively bid prices used in Medicare.**

#### **Budget Impact: \$2.8 billion in savings over ten years**

Medicaid, as well as Medicare, should benefit from lower competitively bid prices. The Obama Administration's FY 2013 budget has proposed reducing the rate at which the federal government reimburses state Medicaid programs for DME to the same level Medicare pays for that equipment.<sup>45</sup> CBO has estimated that this policy change would save \$2.8 billion over ten years.<sup>46</sup> CMS and state Medicaid programs should monitor implementation of this policy to ensure that these reductions in DME reimbursement do not compromise access and quality of care.

## **Encouraging Generic Competition in the Pharmaceutical Sector**

Since the historic Hatch-Waxman legislation in 1985 created a path for expedited Food and Drug Administration (FDA) approval of generic prescription medications, market competition from generic drugs has been a true cost containment success story. In just the past ten years, generics have generated more than a trillion dollars in savings for the health system.<sup>47</sup> Since 2003, Medicare Part D plans have had extraordinary success in encouraging generic use, helping generate program costs that are much lower than originally projected.

However, the full cost-saving potential of generics has yet to be realized because of a number of barriers that distort the market, stymie competition from generics, and keep prices high for consumers and taxpayers.

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44 Medicare Payment Advisory Commission. (2011, October 14). *Moving Forward From the Sustainable Growth Rate (SGR) System*. Letter to Chairmen and Ranking Members of Congressional committees of jurisdiction. Retrieved from [http://medpac.gov/documents/10142011\\_MedPAC\\_SGR\\_letter.pdf](http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf)

45 Office of Management and Budget. (2012, February 13). *Fiscal Year 2013 Cuts, Consolidations and Savings: Budget of the U.S. Government*. Retrieved from <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/ccs.pdf>

46 Congressional Budget Office. (2012, March 16). *Estimate of the Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year 2013–March 2012 Baseline*. Retrieved from <http://cbo.gov/sites/default/files/cbofiles/attachments/FY2013ReestimateofthePresidentsBudget-Health.pdf>

47 Generic Pharmaceutical Association. (2012, August 2). *Generic Drug Savings in the U.S.* Retrieved from <http://www.gphaonline.org/sites/default/files/IMS%20Study%20Aug%202012%20WEB.pdf>

### **POLICY RECOMMENDATION 3.8:**

**Reduce the exclusivity period for biologics from twelve to seven years.**

#### **Budget Impact: \$3.5 billion in savings over ten years**

Biologics are medicines made in living cells rather than through the admixture of chemical compounds. They represent a powerful new tool in combating serious diseases and their use can substantially increase survival rates for serious illnesses like cancer. Currently, the barrier to the wide-spread use of biologics, particularly brand-name biologics, lies in their high cost of development and manufacturing and the enormous prices that they bring on the market. For example, Genentech's cancer drug Herceptin costs as much as \$48,000 a year<sup>48</sup>, which places a huge burden on companies that cover the drug in their health plans and on consumers who face high copayments. This affordability problem is poised to become more acute in the next few years. The Congressional Research Service projects that by 2014, 50 percent of the top-grossing drugs will be biologic drugs.<sup>49</sup>

To encourage cost-saving competition in the biologics sector, the Obama administration has proposed reducing the length of time in which new biologics are guaranteed protection from generic competition from twelve to seven years. According to CBO, a seven-year exclusivity period for biologics could save an additional \$3.5 billion over ten years.<sup>50</sup>

### **POLICY RECOMMENDATION 3.9:**

**Incentivize state governments to increase generic utilization in Medicaid.**

#### **Budget Impact: Not yet scored**

**Relevant Legislative Proposal: The Affordable Medicines Utilization Act of 2011, introduced as S. 1356 by Senator Scott Brown (R-MA), Senator Ron Wyden (D-OR) and Senator John McCain (R-AZ) in the Senate and as H.R. 3342 by Rep. Charlie Bass (R-NH) in the House**

State Medicaid programs overspend more than \$300 million a year due to underuse of available generic alternatives of 20 commonly used drugs.<sup>51</sup> This underuse is related to wide variation between states in the regulations and laws that govern the dispensing of drugs. For example, some states require pharmacies to automatically provide generic versions of a prescription, unless the physician specifically indicates the brand name. Other states require pharmacists to notify or gain consent from consumers prior to generic substitution.

States should be allowed to share in the savings that the federal government would generate when generic utilization increases. Encouraging generics in this way would produce savings for state Medicaid programs and the federal government. Additionally, the changes to state prescribing laws that this legislation would encourage should enhance competition and lower drug costs for non-Medicaid consumers, employers, and plans.

However, even the smallest differences between generic and brand-name drugs can be clinically significant for certain patients. To prevent states from imprudently restricting patients' access to

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48 The Associated Press. (2005, October). *Drug Found Effective Against Early Breast Cancer*. NBC News. Retrieved from <http://www.msnbc.msn.com/id/9753394/ns/health-cancer/t/drug-found-effective-against-early-breast-cancer/#.UHXgVK4g-wdU>

49 Schacht W., & Thomas J. (2011, December). *Follow-On Biologics: The Law and Intellectual Property Issues*. Congressional Research Service. Retrieved from <http://www.ieceusa.org/policy/eyeonwashington/2012/documents/biologics.pdf>

50 Congressional Budget Office. (2012, March 16). *Estimate of the Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year 2013–March 2012 Baseline*. Retrieved from <http://cbo.gov/sites/default/files/cbofiles/attachments/FY2013ReestimateofthePresidentsBudget-Health.pdf>

51 Office of Senator Ron Wyden. (2011, July 13). *Bipartisan Bill Encourages States To Utilize Generic Drugs In Medicaid Program*. Press Release. Retrieved from <http://www.wyden.senate.gov/news/press-releases/brown-wyden-mccain-introduce-affordable-medicines-utilization-act-of-2011>

these drugs, policymakers should provide patients who have a legitimate medical need for the brand with some form of appeal mechanism.

### **POLICY RECOMMENDATION 3.10:**

#### **Implement MedPAC's proposal to encourage generic use in the low-income subsidy population.**

##### **Budget Impact: \$17 billion in savings over ten years**

Although Medicare Part D plans have used lower copays to increase utilization of lower-cost generic alternatives overall, flaws in the program design of Medicare's low-income subsidy (LIS) have produced much lower rates of generic utilization for this population.<sup>52</sup>

LIS beneficiaries (dually eligible beneficiaries, beneficiaries who receive Supplemental Security Income or low-wealth beneficiaries who earn less than 150 percent of poverty) are eligible for a subsidy to defray the cost of premiums, deductibles, and copays for Medicare prescription drug coverage. Currently, the copay differential between generics and brands is much smaller than that encountered by non-LIS Part D beneficiaries.

MedPAC's March 2012 Report to Congress recommends a copay structure that eliminates copays for generic drugs and increases those for brand-name drugs. MedPAC has estimated that this policy would save \$17 billion in federal spending over ten years.<sup>53</sup> The National Coalition on Health Care supports this recommendation, provided that special appeal mechanisms are made available to patients who have a legitimate medical need for the brand version.

### **POLICY RECOMMENDATION 3.11:**

#### **Reform Medicare Part B reimbursement for provider-administered medications.**

##### **Budget Impact: \$3.2 billion in savings over ten years**

Physician-administered drugs represent a growing portion of Medicare's overall expenses. Medicare Part B currently reimburses doctors at a rate equal to the average sales price of the drug plus a fee equal to six percent of the drug's cost (ASP +6). This payment formula creates a powerful economic incentive for providers to administer the highest-price, brand-name drug, eschewing less expensive generic or brand alternatives. This arrangement may be lucrative for some providers, but it distorts competition among provider-administered drugs, resulting in higher Medicare program costs and increased financial drain on the beneficiary.

A proposal to set reimbursement at ASP plus three percent was an option under consideration by Vice President Joe Biden and Congressional leaders in 2011 budget negotiations. This approach was estimated to save \$3.2 billion over ten years. However, this plan does not eliminate the distorted incentives to choose higher-cost drugs that are created by a percentage-based administration fee.

The current six percent fee should be replaced with a set fee, adjusted for the difficulty associated with storing and administering particular drugs or classes of drugs. The aggregate level of those fees should be set to yield \$3.2 billion in savings over ten years. This approach would eliminate the inflationary incentives inherent in a percentage-based fee, produce budgetary savings, and still provide adequate reimbursement for the costs that providers incur in administering these drugs.

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52 Medicare Payment Advisory Commission. (2012, March). *Report to Congress: Medicare Payment Policy*. Retrieved from [http://medpac.gov/documents/Mar12\\_EntireReport.pdf](http://medpac.gov/documents/Mar12_EntireReport.pdf)

53 Medicare Payment Advisory Commission. (2011, October 14). *Moving Forward from the Sustainable Growth Rate (SGR) System*. Letter to Chairmen and Ranking Members of Congressional committees of jurisdiction. Retrieved from [http://medpac.gov/documents/10142011\\_MedPAC\\_SGR\\_letter.pdf](http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf)

### **POLICY RECOMMENDATION 3.12:**

**Close the REMS loophole in drug safety regulations that allows brand-name manufacturers to deny generic competitors access to samples of certain high risk drugs.**

#### **Budget Impact: \$753 million in savings over ten years**

Current law empowers the FDA to require special restrictions on the sale of brand name drugs that are prone to abuse or pose serious health risks under a program known as Risk Evaluation Management Strategies (REMS). This program is an entirely appropriate strategy to improve patient safety.

However, brand-name manufacturers are using these restrictions to refuse sale of samples to potential generic competitors. Access to the originating brand drugs is crucial to the development of any generic drug.

Policymakers should close this loophole, and create a process for manufacturers to provide samples to generic competitors. The CBO has estimated that legislation closing the REMS loophole would reduce the average drug cost for consumers and cut federal spending by \$753 million over nine years, if applied to chemical drugs.<sup>54</sup> Additional savings are likely to accrue from explicitly applying this policy to generic biologics as well.

## **Promoting Cost-Effective Innovations**

Current rules for approving new devices and products in health care focus on safety and efficacy; the FDA does not consider the price of a new device or product. The health care industry lacks some of the natural price pressures that encourage development of less-costly alternatives as a result of comparison shopping by consumers. Thus, there are few incentives for manufacturers to develop or promote less-expensive alternatives that achieve similar outcomes. Indeed, a review of medical innovation from 2002 to 2007 showed that a majority (72 percent) of new treatments increase cost and improve health.<sup>55</sup> Only 16 percent described innovations that improved outcomes while reducing cost. Even fewer (1.6 percent) described innovations that were much less costly while producing slightly-worse outcomes (with examples that saved tens of thousands of dollars while decreasing life expectancy by days or hours). Facing the escalating burden of health care costs, the need for innovative, lower-cost alternatives has never been greater.

### **POLICY RECOMMENDATION 3.13:**

**Provide research grants to accelerate innovative, lower-cost medical alternatives and establish an FDA division for the rapid review and approval of innovations.**

#### **Budget Impact: Not yet scored**

Fast-track research grants should be established for the specific purpose of supporting development and clinical trials for innovations that produce equivalent or similar outcomes at significantly lower costs. A small division within the FDA should be created to serve as an incubator for establishing the approval process for and encouraging rapid review of innovations that meet those established criteria.

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54 Congressional Budget Office. (2012, May 16). *Congressional Budget Office Cost Estimate: S 2516 Food and Drug Administration and Safety Act of 2012, as reported by the Senate Health, Education, Labor and Pensions Committee*. Retrieved from <http://cbo.gov/sites/default/files/cbofiles/attachments/S2516.pdf>

55 Nelson, A., Cohen, J., Greenberg, D., & Kent, D. (2009). Much Cheaper, Almost as Good: Detrimently Cost-Effective Medical Innovation. *Annals of Internal Medicine*, 151(9), 662-667.

## STRATEGY FOUR: Ensure that the Highest-Cost Patients Receive High-Value, Coordinated Care

### Specialized Care and Supports for High-Need, High-Cost Beneficiaries

Today's health care payment and delivery system too often fails to care properly for the patients who account for the greatest proportion of costs: those with the most complex medical needs.

Interventions such as delivering complex care management services,<sup>56</sup> using nurse care coordinators to reduce hospital admissions among frail nursing home residents,<sup>57</sup> offering palliative care to patients with advanced illness, or providing integrated behavioral health and primary care services<sup>58</sup> have been shown to improve quality and outcomes while reducing cost. Unfortunately, the bulk of beneficiaries enrolled in traditional Medicare are unlikely to receive these services.

As more providers transition to new population-based payment models such as the Accountable Care Organization (ACO) and as ongoing pilot and demonstration programs expand, the availability of these cost-saving services should increase in traditional Medicare. However, even with the aggressive implementation of current law and the enactment of provider payment reform proposals such as those recommended under Strategy One in this document, the adoption of these new models will take several years. Immediate steps should be taken to ensure patients with the greatest needs and the highest costs have access to these important services in the interim.

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56 Nelson, L. (2012, January). *Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination*. Congressional Budget Office. Working Paper. Retrieved from [http://www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012-01\\_Nelson\\_Medicare\\_DMCC\\_Demonstrations.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012-01_Nelson_Medicare_DMCC_Demonstrations.pdf).

57 Ouslander, J.G., et al. (2011, April). Interventions to Reduce Hospitalizations from Nursing Homes: Evaluation of the INTER-ACT II Collaborative Quality Improvement Project. *Journal of the American Geriatrics Society*, 59(4), 745-53.

58 The Commonwealth Fund. (2010, January). *States in Action Archive Missouri: Pioneering Integrated Mental and Medical Health Care in Community Mental Health Centers*. Newsletter. Retrieved from <http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Jan/December-2010-January-2011/Snapshots/Missouri.aspx>.

## Palliative Care

Palliative care is a form of medical care that is focused on relieving suffering and improving quality of life for patients with serious illness at any stage of life, rather than solely focusing on curing a patient's disease. It is delivered by multidisciplinary teams of professionals including physicians, pharmacists, nurses, psychologists, chaplains, and others.

Significant evidence exists that palliative care can improve outcomes and increase patient satisfaction for patients with serious illness.<sup>59</sup> Unfortunately, more than one out of every three hospitals lack palliative care teams, and even when available their services are dramatically underused by patients with serious illness because they often are not offered the choice.<sup>60</sup> Medicare does not reimburse for palliative care consultations, and the field is further challenged by a lack of well-trained palliative care professionals.

Population-based payment models like the ACO have the potential to encourage the provision of palliative services, but patients who need palliative care should not have to wait for ACOs to spread nationwide.

### **POLICY RECOMMENDATION 4.1:**

**Include provision of palliative care consultations in the Medicare's Value-Based Purchasing Program's quality metrics.**

#### **Budget Impact: Budget neutral**

A palliative care participation metric should be included in the hospital Value-Based Purchasing (VBP) program, based on the percentage of appropriate patients who received a palliative care consultation.

### **POLICY RECOMMENDATION 4.2:**

**Support education of palliative care professionals**

#### **Budget Impact: Not yet scored**

**Relevant Legislative Proposal: The Palliative Care and Hospice Education and Training Act introduced as S.3407 by Senator Ron Wyden (D-OR) in the Senate and as H.R. 6155 Rep. Elliot Engel (D-NY) in the House.**

The authors of the Palliative Care and Hospice Education and Training Act have proposed an innovative approach designed to train experienced health care providers in palliative care. The legislation would:

- Create incentives to improve the training and retraining of interdisciplinary health professionals in palliative care;
- Establish 24 Palliative Care Education Centers at medical schools and fund fellowships enabling faculty to upgrade their knowledge and clinical skills for the care of individuals with serious and chronic illnesses; and
- Provide grants or contracts for health care professionals to teach or practice in the field of palliative care for at least five years.

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<sup>59</sup> Meier, D. (2011). Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. *Milbank Quarterly*, 89(3), 343-380.

<sup>60</sup> Center to Advance Palliative Care. (2012). *Growth of Palliative Care in US Hospitals: 2012 Snapshot*. Fact Sheet. Retrieved from <http://www.capc.org/capc-growth-analysis-snapshot-2011.pdf>

## Improving Quality and Coordination of Care for Dually Eligible Beneficiaries

Medicare and Medicaid often fail to provide beneficiaries eligible for both Medicare and Medicaid with the well-coordinated care and benefits that they need. If federal health care programs are to lower costs and improve quality, delivering higher-quality, integrated care for these beneficiaries is critical. If federal programs serving dually eligible enrollees fail to change, these often vulnerable individuals will continue to navigate two complex, uncoordinated federal programs on their own. The result will be failures in care and greater costs to the programs.

NCHC supports the goal of ensuring that all dually eligible beneficiaries have access to a coordinated model of care and services. In supporting that goal, NCHC does not advocate for the imposition of a one-size-fits-all solution on the diverse individuals in this population, such as shifting every dually eligible beneficiary to managed care, primary care case management, or Medicare ACOs. Instead, we urge policymakers to ensure that these beneficiaries have access to any number of coordinated care models and are encouraged to participate in them.

### Ongoing Financial Alignment Demonstrations

Under the direction of the CMS Office of Medicare/Medicaid Coordination's Financial Alignment Demonstrations, 26 states have already proposed various combinations of capitated and primary care case management strategies to coordinate care for current dually eligible beneficiaries.

Some critics have warned that the capitated option available in these demonstrations could result in moving too many enrollees to private plans unequipped to deal with them.<sup>61</sup> Indeed, this outcome is possible if the demonstrations are improperly conducted.

### **POLICY RECOMMENDATION 4.3:**

**CMS should insist on key beneficiary protections throughout the implementation of state demonstrations.**

#### **Budget Impact: Not yet scored**

In executing the ongoing Financial Alignment demonstrations, states and CMS must work together to ensure careful implementation and oversight. CMS should take three specific steps to ensure better care for beneficiaries in these demonstrations.

1. Any test of the capitated model in these demonstrations, at a minimum, should satisfy Medicare Advantage standards for benefit package, network adequacy, drug benefit, and administrative processes.
2. Passive enrollment of beneficiaries into plans should be undertaken only if a process is established whereby beneficiaries can opt out of a plan that is not meeting their medical needs.
3. Furthermore, because the goal of the demonstrations should be to improve value for dually eligible beneficiaries, passive enrollment should be limited to high-quality plans, as reflected in CMS' quality rankings or other accepted measures of plan and care quality.

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61 Letter from consumer groups to Melanie Bella. (2012, July 18). Retrieved from <http://www.ncpssm.org/Portals/O/pdf/dual-eligible-demonstrations.pdf>.

#### **POLICY RECOMMENDATION 4.4:**

**Launch a pilot enabling ACOs to assume risk for Medicaid long-term services and supports and behavioral health benefits as well as Medicare-covered care.**

##### **Budget Impact: Not yet scored**

Accountable Care Organizations represent a promising model of care and payment. By making these organizations financially accountable for the Medicare spending of an entire population, this model creates powerful incentives for improved coordination and quality of care. However, this model, as currently constructed, leaves out the crucial behavioral health services and long-term services and supports that dually eligible beneficiaries receive under Medicaid.

Medicare should work with state Medicaid programs to pilot a model whereby ACOs currently participating in the existing Medicare Shared Savings and Pioneer ACO programs can also assume risk for Medicaid-covered services and supports, as well as behavioral services utilized by those enrollees attributed to that ACO. Participation in this pilot could be made available to states or areas of states that were not engaged in the broader state Financial Alignment Demonstrations discussed above.

##### **The Program for All Inclusive Care for the Elderly (PACE)**

In the Program for All Inclusive Care for the Elderly (PACE), Medicare and Medicaid jointly contract on a capitated basis with non-profit organizations that provide the full range of benefits to frail and elderly enrollees through an interdisciplinary team of providers. The program is typically structured around an adult day care center, which provides an alternative to full-time institutionalization in nursing homes. Serving a patient population with an average of 7.9 health conditions and 3.6 limitations on activities of daily living,<sup>62</sup> PACE has demonstrated significant reductions in hospital admissions, mortality, and nursing home utilization.<sup>63</sup>

However, PACE enrollment is currently confined to beneficiaries aged 55 years and over and those who are certified as eligible for nursing home care. Programs are not available in all locales. Twenty states have no PACE program at all. PACE programs served only 22,000 beneficiaries in 2010.<sup>64</sup>

#### **POLICY RECOMMENDATION 4.5:**

**Implement MedPAC's recommendations for expansion of the PACE program.**

##### **Budget Impact: Not yet scored**

The Medicare Payment Advisory Commission (MedPAC) recently examined the PACE program and has offered several recommendations to expand the program that should be implemented. The content of those recommendations are as follows:

1. Remove the age limit for eligibility for PACE, allowing the program to serve disabled Medicare recipients below age 55;
2. Develop appropriate risk-adjusted quality measures to enable PACE providers to participate in the Medicare Advantage quality bonus program by 2015;

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62 Mukamel, D.B., Peterson, D.R., Temkin-Greener, H., Delavan, R., Gross, D., Kunitz, S.J., Williams, T.F. (2007, September). Program Characteristics and Enrollees' Outcomes in the Program of All-Inclusive Care for the Elderly (PACE). *Milbank Quarterly*, 85(3), 499-531. Retrieved from <http://www.npaonline.org/website/download.asp?id=2109>.

63 Aguiar, C. (2011, November 3). *Coordinating care for dual-eligible beneficiaries through the PACE program*. Presentation to MedPAC. Retrieved from [http://www.medpac.gov/transcripts/November%20PACE%20slides\\_Public.pdf](http://www.medpac.gov/transcripts/November%20PACE%20slides_Public.pdf).

64 Bloom, S. (2011, June 21). *Dual Eligibles: Understanding This Vulnerable Population and How to Improve Their Care*. Testimony before the U.S. House Energy and Commerce Subcommittee on Health. Retrieved from [http://democrats.energycommerce.house.gov/sites/default/files/image\\_uploads/Testimony\\_06.21.11\\_HE\\_Bloom.pdf](http://democrats.energycommerce.house.gov/sites/default/files/image_uploads/Testimony_06.21.11_HE_Bloom.pdf).



3. Improve the Medicare Advantage (MA) risk adjustment system, pay PACE providers based on improved MA benchmarks, and permit PACE providers to participate in quality bonus programs available to MA plans that are rated highly for plan quality. These bonuses should encourage both market entry and program expansion among high quality PACE providers;
4. Prorate Medicare capitation payments to allow payment for enrollees receiving services for only part of a month; and
5. Create a temporary outlier protection for all new PACE sites for their first 3 years of operation, in order to ensure that new PACE programs are not overwhelmed by costs attributable to a few extraordinarily high cost enrollees.<sup>65</sup>

In addition to these MedPAC recommendations, the PACE program should be expanded to include PACE-without-Walls programs that rely on a tight network of providers, rather than a single adult day center as the focal point of their program. Policymakers may also consider adapting the PACE model to address the needs of Medicaid-only disabled enrollees. Taken together, these recommendations have the potential to expand the number of individuals receiving integrated care and services through PACE.

### Behavioral Health Homes

Medicaid beneficiaries facing chronic physical conditions and serious mental illness generate program costs up to 75 percent greater than beneficiaries with physical chronic conditions alone. Co-occurring mental illness and substance abuse conditions can increase Medicaid costs per beneficiary by 200 to 300 percent.<sup>66</sup> These dynamics are just as readily apparent among the 38 percent of dually eligible beneficiaries who face both mental illness and physical health challenges.

Current law offers state Medicaid programs the option of enrolling Medicaid patients with chronic conditions in health homes and offers enhanced federal matching funds for states that do so. If used properly, this option can be used to implement a powerful model of care for those dually eligible beneficiaries facing serious mental health and substance abuse conditions. Known as the behavioral health home, this approach can be realized either through full integration of services by one provider, co-location of behavioral and primary care providers, or a closely-coordinated referral system.<sup>67</sup>

The SAMHSA/HRSA Center for Integrated Health Solutions outlines five key features of a behavioral health home as follows:

- Self-management support;
- Delivery system design involving patient-centered, multidisciplinary teams and care management;
- Decision support to encourage the use of evidence-based guidelines by providers;
- Community linkages that allow patients to access other services in the community; and
- Clinical information systems that include patient registry, decision support, and consumer level electronic data.

65 Medicare Payment Advisory Commission. (2012, March). *Report to Congress: Medicare Payment Policy*. Retrieved from [http://medpac.gov/documents/Mar12\\_EntireReport.pdf](http://medpac.gov/documents/Mar12_EntireReport.pdf).

66 Boyd, C. et al. (2010, December). *Clarifying Multimorbidity to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*. Center for Health Care Strategies. Retrieved from [http://www.chcs.org/usr\\_doc/Clarifying\\_Multimorbidity\\_for\\_Medicaid\\_report-FINAL.pdf](http://www.chcs.org/usr_doc/Clarifying_Multimorbidity_for_Medicaid_report-FINAL.pdf)

67 SAMHSA-HRSA Center for Integrated Health Solutions. (2012, May). *Behavioral Health Homes for People with Mental Health and Substance Abuse Conditions: The Core Clinical Features*. Retrieved from [http://www.integration.samhsa.gov/clinical-practice/CIHS\\_Health\\_Homes\\_Core\\_Clinical\\_Features.pdf](http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf).

Missouri's Medicaid program, MO HealthNet, is now implementing the behavioral health home model for 18,000 of its Medicaid beneficiaries in partnership with that state's community mental health centers. While the program-wide implementation of this model began only in January 2012, preliminary results from a smaller pilot revealed both improved outcomes and an average monthly savings of \$300 per participating beneficiary.<sup>68</sup>

Missouri's success has depended on an integrated electronic medical record system, inclusive of both medical and behavioral care. Unfortunately, many states lack integrated clinical information systems. Successful scaling up of the behavioral health home will depend on building the robust health information technology infrastructure needed to support this model.

#### **POLICY RECOMMENDATION 4.6:**

**Support behavioral health homes by providing behavioral health providers access to Meaningful Use incentive payments.**

**Budget Impact: Limited increase in federal spending; offset by savings from 340B expansion to behavioral health providers**

Meaningful Use payments should be made available to community mental health centers and, to the extent possible, other behavioral health providers who adopt qualifying health information technology systems.

Current law denies behavioral health providers the Meaningful Use incentive payments that other medical providers are already using to implement electronic medical record systems. Consequently, even as medical providers are building up their health information technology infrastructure, behavioral health providers, particularly the community mental health centers on which many of those with serious mental illness depend, are left out. For the behavioral health home model to work on a broad scale, this gap in health IT adoption between medical and behavioral health providers must be remedied.

Expanding these incentives to community mental health centers will require a modest federal investment of \$611 million over ten years, according to Avalere Health.<sup>69</sup> To offset these costs, NCHC recommends that behavioral health providers, including but not limited to community mental health centers, be allowed to participate in the 340B program, which provides discounted drugs to low-income patients.

#### **Medicare Special Needs Plans**

Medicare Special Needs Plans (SNPs) are a special form of Medicare Advantage plan, established to provide services to three specific populations of Medicare enrollees: beneficiaries with certain specified chronic conditions (chronic condition Special Needs Plans or C-SNPs), beneficiaries receiving institutional-level care services (institutional Special Needs Plans or I-SNPs), and

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68 The Commonwealth Fund. (2010, January). States in Action Archive Missouri: Pioneering Integrated Mental and Medical Health Care in Community Mental Health Centers. Newsletter. Retrieved from <http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Jan/December-2010-January-2011/Snapshots/Missouri.aspx>. Miller, J. (2012, Aug). Taking Integration to the Next Level: The Role of New Service Delivery Models in Behavioral Health. National Association of State Mental Health Program Directors. Retrieved from <http://www.nasmhpd.org/docs/publications/docs/2012/TakingIntegrationtotheNextLevel.pdf>.

69 Avalere Health. (2010, November 7). *Estimated Costs of a Modified Proposal of the Health Information Technology Extension for Behavioral Health Services Act of 2010 - Community Mental Health Centers*. Memo to the National Council for Community Behavioral Health.

dually eligible beneficiaries (dual eligible Special Needs Plans or D-SNPs). Some SNP plans have demonstrated significant improvements in quality or cost savings.<sup>70 71 72 73</sup>

Despite its potential to improve value, however, the SNP program is not a panacea. SNPs serve only a fraction of those eligible for both Medicare and Medicaid.<sup>74</sup> Additionally, MedPAC's June 2012 Report to Congress notes that not all SNP plans provide integrated Medicare and Medicaid benefits and that the quality data that would allow comparison between SNPs and Medicare FFS is not available.

Policymakers need to take steps to monitor and encourage quality in the program, while enabling more dually eligible beneficiaries to access those SNPs that can provide both Medicare and Medicaid services at a high level of quality.

#### **POLICY RECOMMENDATION 4.7:**

##### **Streamline state contracting with SNPs.**

###### **Budget Impact: Not yet scored**

State Medicaid programs that wish to contract with SNPs to deliver Medicaid services must seek approval from CMS, through an amendment to the states' Medicaid plan or through demonstration programs. The uncertainty associated with this process can discourage states from pursuing contracts with SNPs or other managed care entities.<sup>75</sup> Currently, only nine states contract with SNPs to deliver Medicaid services,<sup>76</sup> yet current law requires D-SNPs to contract with state Medicaid programs by 2013. This policy eliminates the ability of existing SNPs to deliver integrated care to duals in most of the country. This outcome would effectively deny dually eligible beneficiaries in most parts of the country access to high-quality, integrated SNPs.

While SNPs may not be appropriate for every state or beneficiary, the program has shown too much promise to exclude it entirely as a means for providing integrated benefits for duals. CMS should establish a template state Medicaid plan amendment to help those states interested in contracting with SNPs. In order to ensure that such a template does not lead states to contract with low-performing SNPs, any such template should provide guidelines for selecting high-quality SNPs.

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70 Cohen R, Lemieux J, Schoenborn J, Mulligan T. (2012). Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients. *Health Affairs*, 31(1), 110-9.

71 Wenger NS, Roth CP, Martin D, Nickels L, Beckman R, Kamberg C, Mach J, Ganz DA. (2011). Quality of care provided in a special needs plan using a nurse care manager model. *Journal of the American Geriatrics Society*, 59(10), 1810-22.


72 Avalere Health. (2010, March 15). *Specialized Medicare Advantage Plan Saves Money Compared to Traditional Medicare Fee-For-Service*. Retrieved from <http://www.avalerehealth.net/wm/show.php?c=&id=848>

73 Hoops A. (2011, January 27). *CareMore: A model for caring for those at greatest risk*. PowerPoint slides presented at the Capitol Visitors Center, Washington, DC. Retrieved from <http://www.ahip.org/AHIPResearch/AHIPBriefingJan2012/>.

74 The Lewin Group. (2011, February). *2010 SNP Alliance Profile and Advanced Practice Report*. Retrieved from <http://www.nhpg.org/media/12019/2011lewinprofilefinal.pdf>

75 Democratic Governors Association. (2011, October 11). *Achieving \$164 Billion in Savings from Dual Eligibles*. Unreleased policy paper obtained by IWP news. Retrieved from <http://healthpolicynewsstand.com/Inside-CMS/Inside-CMS-04/12/2012/menu-id-316.html>.

76 Verdier J. (2011, Jun 28). Defining the Role of SNPs in 2011 and 2012. Powerpoint presentation. Retrieved from [http://www.mathematica-mpr.com/publications/PDFs/health/macongress\\_verdier\\_62811\\_rev.pdf](http://www.mathematica-mpr.com/publications/PDFs/health/macongress_verdier_62811_rev.pdf)



## STRATEGY FIVE: Bolster the Primary Care Workforce

**T**he first step to strengthening America's primary care workforce is an overall reform of provider payment. As discussed under Strategy One in this document, payment reforms are needed to transition the bulk of providers from today's fee-for-service payment system to new value-based payment approaches.

These policy changes will provide a new level of support for team-based primary care.

However, primary care faces some unique challenges that also must be addressed. America's medical workforce must shift from an increasingly specialty-centric one to one that supports more primary care. To that end, an existing imbalance in FFS payments levels that disadvantage primary care providers must be corrected, and more medical school graduates need to undertake residencies in primary care specialties. However, merely training more physicians, while important, will not be sufficient to meet the workforce needs of America's health system. Existing federal workforce programs must be refocused to train nurses, physician assistants and other health professionals for the key roles they must play in value-based models of care. Additionally, state and federal policymakers must reexamine the scope-of-practice barriers that prevent nurses, physician assistants, and other professionals from practicing to the full extent of their education and training.

### **POLICY RECOMMENDATION 5.1:** Implement MedPAC's proposal for re-evaluation of payment codes in Medicare FFS.

#### **Budget Impact: Budget neutral**

MedPAC has recommended that Congress direct CMS to establish an independent process for evaluating payment levels for specific services (known as codes). MedPAC also recommends re-evaluation of misvalued codes equal to at least one percent of fee schedule spending each year. This re-evaluation would be revenue neutral as it would redirect any savings from reducing payment rates for overvalued services to bolstering the payment for other, undervalued services. NCHC supports implementation of MedPAC's recommendations.

## **POLICY RECOMMENDATION 5.2:**

### **Expand funding for primary care physician workforce programs.**

#### **Budget Impact: Limited increase in federal spending**

NCHC supports the recommendations of the American Academy of Family Physicians, which call for increased federal funding for programs that train and place physicians in the primary care setting. More specifically, they have endorsed FY 2013 funding at the following levels:

- Health Professions Program, Primary Care Training and Enhancement Program: \$71 million
- Teaching Health Centers Title VII, Section 749A: \$10 million
- Rural Physician Training Grants Title VII, Section 749B: \$4 million
- National Health Service Corps: at least \$300 million

## **POLICY RECOMMENDATION 5.3:**

### **Invest in training the full range of health professionals needed for team-based primary care.**



#### **Budget Impact: Limited increase in federal spending**

New value-based models of care will require a workforce built for team-based primary care. These models will require greater numbers of registered nurses, physician assistants, and other professionals. Furthermore, physicians must be trained to play leadership roles in diverse teams of health professionals. Federal agencies and institutions of higher education are beginning to adjust their approach to education and training to reflect this new reality, but far more must be done.

Both physician and non-physician professionals must be prepared for this new reality of team-based patient care. In keeping with this new paradigm, NCHC recommends the following policy changes:

- Refocus existing Title VIII nursing education grant funding on programs that equip registered nurses to assume case management and population health coordinator roles in new models of care. Horizon Blue Cross/Blue Shield (a New Jersey health plan), Rutgers College School of Nursing, and Duke University School of Nursing have established a program to train RNs to serve as population health coordinators as part of Horizon's medical home efforts. Similar programs are needed nationwide to meet the need for nurses with the optimal skill set essential to case management and other roles in value-based models of care.
- Fully fund the comprehensive Primary Care Training Program, established by Section 5301 of the Affordable Care Act. This program was designed to provide grants for the training of primary care physicians and physician assistants in skills relevant to team-based management of chronic disease and models of primary care such as the patient-centered medical home. Congress has yet to appropriate the funds needed for its implementation.
- Double the cap on the number of nursing schools that can participate in the Graduate Nursing Education Demonstration from five to ten, and double the funding for the demonstration. This program is designed to train advanced practice nurses in community-based primary care settings, and it is currently funded at the level of \$200 million over the four-year life of the demonstration.

#### **POLICY RECOMMENDATION 5.4:**

**Implement the recommendations of the Institute of Medicine's *Future of Nursing* report.**

#### **Budget Impact: Not yet scored**

Nurses will play a critical part in the delivery system reform efforts currently underway as well as the full range of cost-saving, quality-enhancing reforms recommended in this document. A 2010 Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health* has put forward recommendations to expand practice opportunities, improve education and training, and support a broader, inter-professional workforce data infrastructure.<sup>77</sup> Policymakers should work with providers to craft policy that can put these recommendations into action.

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<sup>77</sup> Institute of Medicine. (2010). *The Future of Nursing: Leading Change, Advancing Health*. Retrieved from [http://thefutureofnursing.org/sites/default/files/Future%20of%20Nursing%20Report\\_O.pdf](http://thefutureofnursing.org/sites/default/files/Future%20of%20Nursing%20Report_O.pdf).

## STRATEGY SIX: Reduce Fraud, Errors, and Administrative Overhead

### Taming Fraud and Abuse

The Government Accountability Office (GAO) has estimated that improper payments cost Medicare and Medicaid \$70 billion in 2011.<sup>78</sup> In recent years, the Department of Health and Human Services has intensified fraud control efforts utilizing both existing programs and new authorities provided in the Affordable Care Act.<sup>79</sup> In August 2012, CMS launched a joint effort with private insurance companies to curb fraud across the public and private sectors. However, even more aggressive action is needed.

#### POLICY RECOMMENDATION 6.1:

**Double the increase in funding for the Health Care Fraud Abuse and Control program.**

**Budget Impact: \$3.69 billion in savings (off-budget) over ten years**

Investment in fraud prevention and enforcement programs should be increased. One approach would be to double the spending cap increase for the Health Care Fraud and Abuse Control (HCFAC) program proposed in President Obama's FY 2013 budget.

The net ten-year savings from the Obama administration's proposed spending cap increase of \$3.66 billion is estimated to be \$1.84 billion.<sup>80</sup> NCHC would support doubling the increase proposed by the Obama administration. If that cap increase is doubled to \$7.32 billion, the net savings should double as well to \$3.69 billion over the next 10 years.

#### POLICY RECOMMENDATION 6.2:

**Strengthen federal anti-fraud authorities and infrastructure.**

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78 King, K, Dir. Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments. (2011, Mar 9). Testimony Before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate. Retrieved from <http://www.gao.gov/new.items/d11409t.pdf>.

79 Sebelius, K, U.S. Secy, HHS. (2012, May 13). Health care law enhances ability to cut fraud, strengthen Medicare. *Long Beach Press-Telegram*. Retrieved from [http://www.hhs.gov/secretary/about/opeds/health\\_care\\_law\\_enhances\\_ability.html](http://www.hhs.gov/secretary/about/opeds/health_care_law_enhances_ability.html)

80 Congressional Budget Office. (2012, Mar 16). Estimate of the Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year 2013—March 2012 Baseline. Retrieved from <http://cbo.gov/sites/default/files/cbofiles/attachments/FY2013ReestimateofthePresidentsBudget-Health.pdf>.

### **Budget Impact: Not yet scored**

**Relevant Legislative Proposal: The Medicare and Medicaid FAST Act, introduced as S. 1251 by Senator Tom Carper (D-DE) and Senator Tom Coburn (R-OK) in the Senate and H.R. 3399 by Rep. Peter Roskam (R-IL) and Rep. Tim Carney (D-DE) in the House.**

Curbing fraud in public programs will require more than simply increasing funding. To increase the effectiveness of this enhanced funding, NCHC recommends several enhancements to strengthen anti-fraud authorities and infrastructure.

**Pre-screening of providers:** The federal government's provider verification system should be improved to ensure that the providers who are prescribing services are legitimate. Pre-screening of providers will make it more difficult for criminals to become registered as Medicare and Medicaid providers and will prevent fraudulent activity before it begins.

**Consistent provider identification:** Each claim under Medicaid and CHIP should be required to have a valid beneficiary ID number. Prescriber identifiers should be required to be validated for pharmacy claims. Updating the Drug Enforcement Administration (DEA) database on a daily basis to purge individuals who have died will further eliminate opportunities for individuals seeking to steal identities in order to engage in fraudulent activities.

**Pre-payment review:** Fraud control should move away from the current "pay and chase" approach to a more proactive stance, by requiring cross-checks on services before issuing a reimbursement. CMS should take a risk-based approach focusing pre-payment review on those services and goods most susceptible to fraud. For instance, reimbursement for durable medical equipment is a high risk claims category. Thus, claims for durable medical equipment, such as wheelchairs, and home health services could be examined much more closely than other claims that are less frequently the targets of fraud.

**Cross-claims data:** The claims data maintained by CMS is essential to ensuring program integrity; without accurate data, it is impossible to combat fraud effectively. Currently, the databases that manage this data are antiquated. Data sharing should be improved between Medicare and Medicaid, allowing officials to target fraud affecting beneficiaries eligible for both programs.

**Penalties:** Penalties should be increased for individuals who have sold or distributed identification numbers for Medicare, Medicaid, or CHIP beneficiaries. This will deter others from engaging in fraudulent activities.<sup>81</sup>

## **Patient Safety and Medical Liability Reform**

The Institute of Medicine has estimated that in 2009, approximately one tenth of America's health spending was wasted on unnecessary overuse.<sup>82</sup> This unnecessary care can range from duplicative tests and procedures to over-prescribing of drugs and surgical procedures that can actually cause harm to patients. The IOM identifies a number of sources of this unnecessary care including lack of care coordination and misaligned incentives for providers. However, IOM also identifies another cause as a significant contributor to unnecessary care: providers' fear of medical malpractice lawsuits.

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81 The Office of Senator Tom Coburn. (2010, Sep 29). The Medicare FAST Act: Section by Section. Web page. Retrieved from [http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File\\_id=39e53ead-afaf-4516-a902-a9cdd24248c9](http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=39e53ead-afaf-4516-a902-a9cdd24248c9).

82 Institute of Medicine. (2011, Feb 24). The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Retrieved from <http://www.iom.edu/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx>.



This fear can have a negative effect on the patient-provider communication that is critical to good medical care. It also leads to provider behavior known as defensive medicine, whereby providers order additional tests and treatments to insulate themselves from legal liability.

Proposals for limiting the number and financial impact of medical liability lawsuits have been debated for decades. However, consumer groups and the National Council of State Legislatures have raised significant substantive concerns about the impact of caps and other traditional medical malpractice reforms on injured patients and states' traditional prerogative of regulating torts.<sup>83</sup> Given strong opposition from the plaintiff's bar, the possibility of enacting such proposals is slim.

Over the past decade, however, interest has grown in three innovative alternatives that seek to achieve both reduction in defensive medicine and improvements in patient safety: disclose and offer programs, evidence-based safe harbors, and health courts.

### Disclose and Offer Programs

Under disclose and offer programs, providers are required to report any unexpected adverse event to their institution's risk management arm. The provider then quickly offers an expression of regret or responsibility to the patient or family. The hospital or medical group mounts an expedited investigation into the event, sharing information throughout the process with the patient or family. If appropriate, the institution may offer compensation to the harmed party. While patients and their family retain the right to proceed with litigation, the process is designed to provide quick compensation while avoiding unnecessary litigation costs. A key pioneer of the disclose and offer approach, the University of Michigan's health system, has been able to reduce the number of claims by half during the first five years of its programs.<sup>84</sup>

#### **POLICY RECOMMENDATION 6.3:**

**Expand federal support for disclose and offer programs.**



### Budget Impact: Limited increase in federal spending

The U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality currently supports disclose and offer programs at four major health systems as part of its Medical Liability Reform and Patient Safety Initiative.

Additional funds should be allocated in order to significantly expand the number of programs that this initiative can support. This approach has the advantage of building on an existing program. Because the current size of the initiative is so small (\$23.2 million), the budgetary impact of even a large funding increase would be limited.

### Safe Harbors

Evidence-based safe harbors offer varying degrees of protection from litigation to providers who follow certain guidelines for care. This protection is intended to reduce defensive medicine and increase provider adherence to the best practices needed to improve quality and lower costs.

83 Letter to U.S. House of Representatives Judiciary Committee Chairman Lamar Smith from Consumer and Patient Groups, February 1, 2011, retrieved from <http://www.citizen.org/documents/Letter-opposing-HR5-20110131.pdf>.

84 Mello, M.M. and Kachalia, A. (April 2010). Evaluation of Options for Medical Malpractice System Reform: A study conducted by staff from the Harvard School of Public Health and the Harvard Medical School for the Medicare Payment Advisory Commission. Retrieved from [http://www.medpac.gov/documents/Apr10\\_MedicalMalpractice\\_CONTRACTOR.pdf](http://www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf)

The American Medical Association has expressed interest in evidence-based safe harbors,<sup>85</sup> and safe harbors have been endorsed by a recent roundtable of health experts, sponsored by the Center for American Progress.<sup>86</sup> However, empirical evidence of their effectiveness is limited.

**POLICY RECOMMENDATION 6.4:**

**Provide dedicated grant funding for states to develop and implement evidence-based safe harbors.**



**Budget Impact: Limited increase in federal spending**

As noted above, AHRQ's Medical Liability Reform and Patient Safety Initiative has awarded a series of grants to states and health systems to test innovative patient safety and malpractice reforms. Safe harbor policies were eligible for this funding, but only Oregon received resources to develop such an approach. Additionally, dedicated funding should be made available to states for the sole purpose of designing and implementing safe harbor policies.

**Health Courts**

Finally, a broad array of voices, including provider groups and AARP, as well as policymakers, like Senator Max Baucus (D-MT) and Senator Mike Enzi (R-WY), have advanced proposals to establish special health courts to address these problems. Under a health court approach, malpractice claims are heard not by a jury, but by special administrative tribunals or trial judges who specialize in medical liability claims, usually paired with systems to enhance the reporting of medical errors.

**POLICY RECOMMENDATION 6.5:**

**Implement Health Courts in Federal Claims Court.**



**Budget Impact: Not yet scored**

Policymakers should implement the health court model for malpractice claims in the Federal Claims Court, the court that hears suits against federal medical facilities.<sup>87</sup>

This effort would provide an opportunity for federal policymakers to fully test the health court approach in the United States, without interfering with states' individual tort systems. The National Coalition on Health Care would support establishing a health court system within the Federal Claims Court. Such an initiative should be paired with aggressive systems to monitor patient safety events at federal health care facilities and to facilitate more effective proactive efforts to avoid errors in the first place.

85 Lazarus, J. (2012, Aug 14). Looking Forward to an Improved Health Care System. Health Affairs Blog. Retrieved from <http://healthaffairs.org/blog/2012/08/14/looking-forward-to-an-improved-health-care-system/>.

86 Emanuel, E., et.al. (2012, Aug 1). A Systemic Approach to Containing Health System Spending. *New England Journal of Medicine*. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMsb1205901>.

87 This proposal was shared with NCHC in a personal communication from David Kendall, Senior Fellow with the centrist think tank, Third Way.

## **Administrative Costs**

America's health system spends far more on administrative overhead than necessary and the Affordable Care Act initiated a process whereby payers and providers must move toward electronic transmission of administrative information.

However, the current administrative simplification regime does nothing to standardize the credentialing processes required of all providers before they can be reimbursed for care. The Medical Group Management Association estimates that the \$2.15 billion a year the U.S. health system spends on credentialing could be slashed by 90 percent if all payers used a single system.<sup>88</sup>

### **POLICY RECOMMENDATION 6.6:**


**Establish a multipayer, common provider credentialing system.**

#### **Budget Impact: Not yet scored**

NCHC supports the creation of a panel of stakeholders and experts that will develop a process for a common, multipayer approach to credentialing. The panel should be designed to foster the greatest possible level of input and consensus from providers, plans, consumers and other stakeholders. This panel's report should be submitted to the Secretary of Health and Human Services, who should be authorized to promulgate the regulations necessary for implementation, following receipt of the panel's report.

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<sup>88</sup> Medical Group Management Association. (2004, September). Analyzing the Cost of Administrative Complexity in Group Practice. Web page. Retrieved from <http://www.mgma.com/about/default.aspx?id=280>.



## STRATEGY SEVEN: Invest in Prevention and Population Health

### Federal Investments in Community Prevention

The Prevention and Public Health Fund provides a system in which community prevention programs that encourage improved nutrition or physical activity can be resourced. This dedicated funding stream, however, has evoked significant controversy. The House of Representatives has passed legislation specifically repealing this provision of law,<sup>89</sup> and a February 2012 bipartisan agreement to extend the payroll tax cut and unemployment benefits reduced the fund's allocation by \$3.5 billion over the next ten years.

#### **POLICY RECOMMENDATION 7.1:**

**Oppose further cuts to the Prevention and Public Health Fund and supplement the Fund's efforts with additional discretionary funding.**

**Budget Impact: Not yet scored**

**Relevant Legislative Proposal: S. 3295, as passed by the Senate Appropriations Committee**

To ensure America has the resources for needed investments in community prevention, further cuts to the current level of mandatory funding for the Prevention and Public Health Fund should be rejected.

Additionally, whenever possible, additional discretionary funds can and should be provided to scale up Fund-supported programs such as Community Transformation Grants, immunizations, smoking prevention, the Diabetes Prevention program, and programs to prevent falls among the elderly.

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<sup>89</sup> White House Office of Management and Budget. (2011, September). *Living Within Our Means, Investing in Our Future: The President's Plan for Economic Growth and Deficit Reduction*. Retrieved from [www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf](http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf).

## Clinical Prevention

### **POLICY RECOMMENDATION 7.2:**

**Cover comprehensive tobacco cessation services in all Medicaid programs.**

#### **Budget Impact: Not yet scored**

Research from the American Legacy Foundation has shown that reducing smoking in the Medicaid population could offer real savings: \$970 million over five years if smoking rates were reduced by 10 percent and \$4.856 billion if reduced by 50 percent.<sup>90</sup> A 2011 George Washington University study found that the return on investment of a Medicaid tobacco cessation program was \$3.12 in savings for every \$1 expended.<sup>91</sup>

Existing law provides increased matching funds to state Medicaid programs for the coverage of certain cessation services. However, not all states have chosen to cover these vital services and in some states, the services covered are limited. Comprehensive tobacco cessation services should be a mandatory benefit in all state Medicaid programs.

### **POLICY RECOMMENDATION 7.3:**

**Expand Medicare coverage without cost-sharing to proven secondary and tertiary preventive interventions.**

#### **Budget Impact: Not yet scored**

Under Sections 4104-4105 of the ACA, Medicare is required to cover, without cost-sharing, a set of preventive services rated A or B by the US Preventive Services Task Force (USPSTF) or approved by certain other federal evaluators.

However, these services are generally “primary” preventive services designed to prevent the onset of disease (such as immunizations) or certain “secondary” preventive services designed to determine whether a person has a disease (such as colorectal cancer screenings).

Dr. Mark Fendrick of the University of Michigan’s Center for Value Based Insurance Design has proposed expanding the USPSTF’s purview to encompass those preventive services that are designed to slow, halt, or reverse the progression of a disease that a patient already has and is aware of—usually called tertiary prevention.<sup>92</sup> NCHC supports this proposal, allowing it to evaluate tertiary preventive services. Medicare should be authorized to adjust its cost-sharing accordingly.

## Federal Taxation of Tobacco, Alcohol and Sweetened Beverages

Tobacco, alcohol, and sweetened beverages like soda each generate serious problems for America’s health system. Recent scholarship has highlighted the central role that diet and obesity play in health care costs by increasing the prevalence of chronic conditions like diabetes

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90 The American Legacy Foundation. (2007, November). *Saving Lives, Saving Money II: Tobacco-Free States Spend Less on Medicaid*. Retrieved from [http://www.legacyforhealth.org/PDFPublications/saving\\_lives\\_saving\\_money.pdf](http://www.legacyforhealth.org/PDFPublications/saving_lives_saving_money.pdf).

91 Richard, P., et. al. (2011, January 6). The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts. Retrieved from <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0029665>.

92 Fendrick, M. (2012, November 10). The Role of Value-Based Insurance Design in Health Care Delivery Innovation. Testimony before the Senate HELP Committee. Retrieved from <http://www.help.senate.gov/imo/media/doc/Fendrick.pdf>. Please note that Dr. Fendrick in his testimony mislabels tertiary preventive interventions as secondary prevention.

and heart disease.<sup>93</sup> Tobacco use cost Americans \$101 billion in increased medical costs and \$96 billion in lost productivity yearly.<sup>94</sup> Alcohol-related health care costs contribute \$45.6 billion to national health spending each year.<sup>95</sup>

Increased taxation of these products can yield dual benefits. First, a higher level of taxation can deter consumption, reducing the impact of these products on America's rising health care costs. Secondly, the revenue these taxes generate can offset some of the costs that Americans using these products impose on federal health care programs.

#### **POLICY RECOMMENDATION 7.4:**

**Equalize taxation of cigarettes and other tobacco products.**

**Budget Impact: \$4 billion in increased revenue over ten years<sup>96</sup>**

**Relevant Legislative Proposal: The Tobacco Tax Equity Act of 2012, introduced as S. 3081 by Senator Richard Durbin (D-IL)**

With the Children's Health Insurance Program Reauthorization Act of 2009, Congress increased the level of taxation for cigarettes to \$1 a pack. However, taxation of other tobacco products was not increased at the same time. The result has been lower tax rates for cigars, smokeless tobacco, roll-your-own, and pipe tobacco. Predictably, with lower tax rates, the tobacco market has shifted toward greater use of these products.

Roll-your-own tobacco, pipe tobacco, smokeless tobacco, and large cigars should be taxed at the same rate as cigarettes.

#### **POLICY RECOMMENDATION 7.5:**

**Increase overall federal excise taxation on tobacco by \$1 a pack.**

**Budget Impact: Not yet scored; A 50 cent increase, however, has been estimated to produce \$42 billion in total deficit reduction. Doubling that amount could yield approximately \$84 billion**

The Congressional Budget Office has estimated that a 50 cent increase in taxation on cigarettes will produce \$38 billion in revenue over ten years, reduce tobacco use, generate a \$3 billion in budgetary savings related to productivity improvements, and yield a modest \$1 billion reduction in federal health costs over the next ten years.<sup>97</sup> The federal excise tax on cigarettes should be increased by \$1 a pack, and taxation of other tobacco products should be adjusted to achieve an equivalent increase.

NCHC makes this recommendation in order to lower rates of tobacco use, to lower the costs associated with that use over the long-term, and to generate revenue needed to cover the costs to federal health programs that chronic disease is generating today.

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93 Howard D.H., Thorpe K.E., & Busch, S.H. (2010, October 5). Understanding Recent Increases in Chronic Disease Treatment Rates: More Disease or More Detection? *Health Economics, Policy, and Law*, 5(4), 411-435.

94 Tobacco Free Kids. (2012). Toll of Tobacco in the United States of America. Retrieved from <http://www.tobaccofreekids.org/research/factsheets/pdf/0072.pdf>.

95 Kavilanz, P. (2009, November 3). These 5 Health Care Culprits Cost \$1 Trillion. Retrieved from [http://money.cnn.com/2009/11/03/news/economy/healthcare\\_hidden\\_hazards\\_costs/index.htm](http://money.cnn.com/2009/11/03/news/economy/healthcare_hidden_hazards_costs/index.htm).

96 Office of Senator Richard Durbin. (2012, May 10). Durbin, Lautenberg, Blumenthal Introduce Legislation To Close Tobacco Tax Loopholes. Press Release. Retrieved from <http://durbin.senate.gov/public/index.cfm/pressreleases?ID=8e09e0c0-43cd-4e88-869b-320f3866cb7b>.

97 Congressional Budget Office. (2012, June). Raising the Excise Tax on Cigarettes: Effects on Health and the Federal Budget. Retrieved from [http://cbo.gov/sites/default/files/cbofiles/attachments/Smoking\\_One-Col.pdf](http://cbo.gov/sites/default/files/cbofiles/attachments/Smoking_One-Col.pdf).

NCHC acknowledges that tobacco revenues have historically played a key role in financing the highly successful Children's Health Insurance Program (CHIP), which provides block grants to states for the purpose of financing children's coverage. This program ensures that America's children have high-quality, cost-effective coverage, and has enjoyed bipartisan support since its inception. NCHC remains committed to working with policy makers and children's advocates to achieve the policy changes necessary to sustain high-quality children's coverage.

#### **POLICY RECOMMENDATION 7.6:**

**Impose a penny per ounce federal excise tax on sweetened beverages.**

##### **Budget Impact: \$130-156 billion in increased revenue over ten years**

NCHC supports levying an excise tax of one cent per ounce on sweetened beverages like soda and other beverages sweetened by the addition of sugar, high-fructose corn syrup or other sugary sweeteners. This approach has been estimated to yield between \$130 billion and \$156 billion over ten years.<sup>98</sup> These estimates are based solely on the increased revenue which these taxes would generate, but this policy may also reduce federal health costs by reducing obesity-related disease costs in federal health programs and the broader health system.

#### **POLICY RECOMMENDATION 7.7:**

**Equalize taxation of beer, wine, and liquor products and update for inflation.**

##### **Budget Impact: Greater than \$58 billion in increased revenue over ten years**

The federal government currently imposes separate excise taxes on liquor, beer and wine. The tax rates on these products are not indexed for inflation, so their impact on federal revenues and consumption has decreased over time. The tax on liquor has been raised just twice since 1950, and only once on beer and wine. The last increase for any of these products was in 1991.<sup>99</sup> Additionally, the tax rates per ounce of alcohol are actually lower on beer and wine than on liquor. The combined effect of the lack of adjustment for inflation and the disparate rates on the three types of alcohol has been an effective tax subsidization of alcohol use over the past sixty years, particularly of beer and wine.

Federal alcohol taxes should be equalized across wine, beer, and liquor and updated to partially account for inflation. CBO has estimated that raising the liquor tax from the current rate of \$13.50 per proof gallon to \$16, in addition to applying that rate equally across beer, wine and liquor, would raise \$58 billion in revenue.<sup>100</sup> The impact of such an increase, however, would be modest, raising the federal tax on a six-pack of beer from 35 cents today to 81 cents.<sup>101</sup> To further reduce the health costs associated with alcohol consumption, NCHC would support increasing these taxes even further to restore taxation to the same real monetary level achieved in 1991 and further indexing those rates for inflation.

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98 Wang, et.al. (2012, Jan). A Penny-Per-Ounce Tax On Sugar-Sweetened Beverages Would Cut Health And Cost Burdens Of Diabetes. *Health Affairs*, 31(1), 199-207. doi: 10.1377/hlthaff.2011; Bipartisan Policy Center. (2010, November). Restoring America's Future: Reviving the Economy, Cutting Spending and Debt, and Creating a Simple, Pro-Growth Tax System. Retrieved from <http://bipartisanpolicy.org/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf>.

99 The Center for Science in the Public Interest. (2007, April). *The Case for Alcohol Excise Tax Increases*. Fact Sheet. Retrieved from <http://www.cspinet.org/booze/taxguide/AlcoholTaxIncreases.pdf>.

100 Congressional Budget Office. (2011, March). *Reducing the Deficit: Spending and Revenue Options*. Retrieved from <http://cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf>.

101 Congressional Budget Office. (2011, March). *Reducing the Deficit: Spending and Revenue Options*. Retrieved from <http://cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf>.



## APPENDIX A: Miscellaneous Budget Savings

In addition to the specific policy recommendations in this report, NCHC has identified a number of other miscellaneous policy options that together could generate \$10.72 billion in scoreable health care savings. We identify those options below, provide a brief description of each and indicate the basis for our savings estimate in each case.

**Dedicate “Meaningful Use” penalties to deficit reduction:** President Obama’s FY 2013 budget would rededicate the Meaningful Use penalties to deficit reduction. Current law imposes these penalties on Medicare and Medicaid providers that fail to meet standards for the use of health information. CBO estimates that this provision will reduce the deficit by \$1.4 billion.<sup>102</sup>

**Update payment rates to account for utilization of advanced imaging:** President Obama’s FY 2013 budget proposed instituting a payment adjustment to account for increasing use of advanced imaging equipment. CBO estimates that this provision will reduce the deficit by \$0.9 billion over ten years.<sup>103</sup>

**Reduce payment for PCPs who miss flu shot benchmarks:** This proposal would reduce Medicare payment for those primary care providers who failed to meet flu shot benchmarks for their patient population. CBO estimates that this change will reduce the deficit by \$0.62 billion over ten years.<sup>104</sup>

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102 Congressional Budget Office. (2012, March 16). *Estimate of the Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President’s Budget Request for Fiscal Year 2013–March 2012 Baseline*. Retrieved from <http://cbo.gov/sites/default/files/cbofiles/attachments/FY2013ReestimateofthePresidentsBudget-Health.pdf>.

103 Congressional Budget Office. (2012, March 16). *Estimate of the Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President’s Budget Request for Fiscal Year 2013–March 2012 Baseline*. Retrieved from <http://cbo.gov/sites/default/files/cbofiles/attachments/FY2013ReestimateofthePresidentsBudget-Health.pdf>.

104 Congressional Budget Office. (2008, Dec). *Budget Options, Volume I: Health Care*. Retrieved from <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>.



**Strengthen Medicaid third party liability:** President Obama's FY 2013 budget would remove exceptions to the requirement that State Medicaid agencies reject medical claims when another entity is legally liable to pay the claim and allow Medicaid to recover costs from beneficiary liability settlements. CBO estimates that this proposal would reduce the deficit by \$1.8 billion over ten years.<sup>105</sup>

**Restore HHS authority to apply the “least costly alternative”:** MedPAC has estimated that allowing HHS to apply a least costly alternative policy in its purchasing would save at least \$1 billion over ten years.<sup>106</sup>

**Recoup overpayments from inpatient hospital documentation and coding improvements:** This policy would force inpatient hospitals to repay a set of overpayments, made because of increases in billing that are unrelated to change in patient case mix. The House Committee on Ways and Means minority staff estimates that this policy could save up to \$5 billion over ten years.<sup>107</sup>

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105 Congressional Budget Office. (2012, March 16). Estimate of the Effects of Medicare, Medicaid, and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year 2013–March 2012 Baseline. Retrieved from <http://cbo.gov/sites/default/files/cbofiles/attachments/FY2013ReestimateofthePresidentsBudget-Health.pdf>.

106 Medicare Payment Advisory Commission. (2011, October 14). Moving Forward from the Sustainable Growth Rate (SGR) System. Letter to Chairmen and Ranking Members of Congressional committees of jurisdiction. Retrieved from [http://medpac.gov/documents/10142011\\_MedPAC\\_SGR\\_letter.pdf](http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf).

107 House Ways and Means Committee Minority Staff. (2011, June). Unnamed Document Listing Savings Options. Retrieved from [http://www.haponline.org/downloads/House\\_Ways\\_and\\_Means\\_Committee\\_Potential\\_Health\\_Offsets\\_Paper\\_Sept2011.pdf](http://www.haponline.org/downloads/House_Ways_and_Means_Committee_Potential_Health_Offsets_Paper_Sept2011.pdf).



**APPENDIX B:**  
**Complete List of Identified  
Savings and Sources of  
Savings Estimates**

## List of Identified Savings—Curbing Costs, Improving Care

Policy Change	Est. Savings— Low End (in billions)
Equalize outpatient E and M payment rates <sup>1</sup>	10.00
Adjust payment rates for other service to increase consistency between office and outpatient settings <sup>2</sup>	9.00
Trigger with value-based withhold <sup>3</sup>	64.00
Enhanced penalties for hospitals with a high risk adjusted rate of avoidable complications for a broader set of complications <sup>4</sup>	29.00
Enhanced penalties for hospitals with a high risk adjusted rate of avoidable readmissions; applied to a broader set of readmissions <sup>5</sup>	23.00
Establish Regional Centers of Excellence for selected surgical procedures <sup>6</sup>	0.45
Implement a readmissions policy applicable to SNFs, IRFs, LTCHs, and Home Health providers <sup>7</sup>	4.00
Rebase SNF payments <sup>8</sup>	23.00
Rebase home health and freeze for 2012 <sup>9</sup>	10.00
Expand Medicare competitive bidding to certain DME categories not currently included in a competitive bidding program or apply an equivalent savings offset <sup>10</sup>	7.00
Apply Medicare's competitive bidding prices to Medicaid DME <sup>11</sup>	2.80
7 year exclusivity period for generic biologics <sup>12</sup>	3.40
Prevent brand-name drug manufacturers from using Risk Evaluation Management Strategies to deny generics access to sample drugs <sup>13</sup>	0.70
Medicare LIS cost sharing for brand name drugs <sup>14</sup>	17.00
Change Medicare reimbursement for Medicare Part B drugs from ASP + 6 to ASP plus a flat rate administration fee equal, in aggregate, to the cost of ASP +3 <sup>15</sup>	3.20
Dedicate Meaningful Use penalties to deficit reduction <sup>16</sup>	1.40
Update payment rates to account for utilization of advanced imaging <sup>17</sup>	0.90
Reduce payment for PCPs who miss flu shot benchmarks <sup>18</sup>	0.62
Strengthen Medicaid third party liability <sup>19</sup>	1.80
Recoup overpayments from inpatient documentation and coding <sup>20</sup>	5.00
Restore HHS authority to apply "least costly alternative" <sup>21</sup>	1.00
Double increase in HCFAC funding (off-budget savings) <sup>22</sup>	3.70
<b>Total Savings (spending recommendations)</b>	<b>220.97</b>
Tobacco Tax Equity Act <sup>23</sup>	4.00
Increase Tobacco Tax by \$1 (assuming reauthorization of SCHIP for 2016-2022): <sup>24</sup>	84.00
Implement 1 cent per ounce federal excise tax on sweetened beverages <sup>25</sup>	130.00
Equalize taxation of alcohol and update for inflation <sup>26</sup>	58.00
<b>Total Savings (revenue recommendations)</b>	<b>276.00</b>

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National Association for the Advancement  
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