hfma
healthcare financial management association

February 27, 2019

The Honorable Lamar Alexander
Chairman
United States Senate
Committee on Health, Education, Labor & Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
United States Senate
Committee on Health, Education, Labor & Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the Healthcare Financial Management Association's 38,000 members, I would like to commend you and the members of the Senate Committee on Health, Education, Labor & Pensions for your work to-date in exploring solutions that will reduce the total cost of care by reducing unnecessary utilization, increasing transparency, eliminating unnecessary administrative burdens (administrative simplification), and leveraging innovation.

HFMA is the nation's leading membership organization for healthcare financial management professionals. As an organization, we are committed to helping our members improve the management of and compliance with the numerous rules and regulations that govern the industry. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant. Like you, our members are deeply concerned about the unsustainable growth in the cost of healthcare goods and services.

While the federal government has aggressively led efforts to reduce the total cost of care and improve outcomes for Medicare and Medicaid beneficiaries, we believe there is more that can be done. Specifically, in addition to public programs, there is a tremendous opportunity for the federal government to drive innovation in the private sector through the Federal Employees Health Benefit Plan (FEHBP). The federal government is the largest single employer in the country. As such, the FEHBP spends $40 billion covering approximately 8.2 million federal employees, retirees, and their

dependents[1] across all fifty states and U.S. Territories. Given the scale of the FEHBP, we believe that changes implemented to it will spill over into other private market health plans (e.g. ERISA plans and those offered in the individual and small group markets). Therefore, HFMA's members recommend Congress require FEHBP participating health plans and providers use alternative payment models, price transparency tools, and innovative benefit designs. We also strongly recommend that Congress require FEHBP participating plans undertake targeted efforts to simplify administrative processes. In response to these requirements, we believe health plans and providers would make investments that they would deploy to other commercially insured populations (both employer and individual market) to amortize these costs over a larger population.

Therefore, HFMA would like to offer specific recommendations, included in Attachment I to reduce the total cost of care while improving patient outcomes. These recommendations are informed by our members' experiences as financial stewards for health plans, health systems, and physician practices, and by our extensive cross-sector research on healthcare value[2] and the impact of value-based payment on total cost of care[3] as well as our consumerism initiatives.[4]

HFMA appreciates the opportunity to submit these recommendations to the Senate HELP committee. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, the Centers for Medicare & Medicaid Services, and advisory groups. We would welcome the opportunity to meet with you or your staff to discuss these recommendations. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,

Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

[1] Blom, K.B., and Cornell, A.S., "Federal Employees Health Benefits (FEHB) Program: An Overview," Congressional Research Service, February 3, 2016.

[2] "The Healthcare Value Sourcebook," HFMA, 2015.
[3] "What is Driving Total Cost of Care? An Analysis of Factors Influencing Total Cost of Care in U.S. Healthcare Markets," HFMA, 2018.
[4] Healthcare Dollars & Sense, HFMA.

Attachment I: Specific Recommendations to Lower Costs and Improve Outcomes by Reducing Unnecessary Utilization, Increasing Price Transparency, Streamlining Administrative Requirements, and Leveraging Innovation

Reducing Unnecessary Utilization

Background: A recent study by HFMA, supported financially by the Commonwealth Fund, found that penetration of population-based value-based payment (VBP) models is not yet having an impact on curbing growth in total cost of care. The efficacy of these models in reducing growth in the total cost of care has not yet been proven, however, as even in markets where these models are more prevalent, most models do not yet incorporate sufficient financial incentives to impact care delivery significantly.[5] This result, while disappointing, is not surprising, in that alternative payment models (APMs) have not yet sufficiently aligned incentives to reward healthcare providers who deliver efficient, high quality care.

The recent Health Care Payment Learning and Action Network (HCP-LAN) progress report on adoption of APMs finds that 34 percent of payments flow through APMs which, in theory, reward providers for improving quality and reducing unnecessary utilization. However, upon closer examination, only 12.5 percent of payments are made through an APM that requires providers to take "downside risk" (e.g., repay some portion of healthcare spending in excess of a target price).[6] To the best of our knowledge, there is no definitive data identifying the amount of revenue that must be "at risk" in a downside risk APM in order to overcome the volume-based incentives inherent in the prevailing fee-for-service payment system. Anecdotal conversations with HFMA's member executives suggest that the tipping point is somewhere between 20 and 25 percent. And based on the HCP-LAN data, the U.S. healthcare system is a long way from that tipping point.

Recommendation: HFMA recommends government and commercial payers continue to experiment with models that increase incentives to make changes to care delivery models that could increase both the quality and cost-effectiveness of care. To that end, a health plan contracted to offer coverage as part of the FEHBP could be encouraged to make a certain percentage of its payment to providers through APMs that hold providers at risk for the total cost of care. Examples of such models might include, but are not limited to, episode-based payments (e.g., maternity or joint replacement bundles), shared savings/risk contracts (for a population of patients), or full or partial capitation (for a population of patients). Further, we also recommend that any provider that is part of a FEHBP carrier's network could be encouraged to participate in a risk-based APM if one is available and applicable to that specific type of provider.

This could be phased in over a period of time. The amount of a plan's revenue in a risk-based contract could be encouraged to increase annually as a percentage of the plan's expenditure on health care for

[5] "What is Driving Total Cost of Care? An Analysis of Factors Influencing Total Cost of Care in U.S. Healthcare Markets," HFMA, 2018.

[6] "Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Fee-for-Service Medicare Programs," Health Care Payment Learning & Action Network, 2018.

FEHBP participants. Similar to the recently released Medicare Shared Savings Program "Pathways to Success" final rule, HFMA also recommends encouraging the amount of risk that providers bear to increase gradually over a period of time. Flexibility should be provided so that the amount of risk can vary by the provider's capacity to bear downside risk. By the end of the phase-in period, the amount of risk participating providers bear should, at a minimum, allow the payment model to meet the criteria for the Medicare 5 percent bonus available to physicians and other providers on their physician fee schedule payments for participating in qualifying Advanced Alternative Payment Models (A-APMs).

If this policy is passed into law, it will likely have several other benefits. First, it will encourage the development of new A-APMs so that specialties that are currently excluded can participate. Second, it will likely encourage additional providers to participate in Medicare A-APMs in an effort to qualify for the A-APM bonus. Finally, more providers will likely qualify for the A-APM bonus as a result of the "all-payer" option, calculated based on the total revenue or patients covered under a qualifying A-APM.

HFMA's members report that one of the challenges to adopting alternative payment models is the administrative complexity of participating in multiple models with unwarranted variation in administrative design features (e.g., different quality metrics, attribution methodologies, reconciliation mechanisms, target prices definitions).[7] Therefore, HFMA strongly recommends that the Office of Personnel Management partner with groups like the HCP-LAN, Healthcare Transformation Taskforce, the Center for Medicare and Medicaid Innovation, and subject matter experts to design "standard" APMs that are appropriate for the working population. While we realize that some APM variation is necessary (and even desirable) to account for the sophistication (e.g., risk readiness) of participating providers and local market characteristics (e.g., rural vs. urban), unwarranted variation will increase complexity and administrative expense, ultimately undermining the potential for the FEHBP to lead the second wave of payment transformation in the American health system.

Improving the Transparency of Price and Quality Data for Healthcare Services

In March 2018, HFMA submitted responses and recommendations to a request for feedback on issues related to price transparency from Senators Cassidy, Bennet, Grassley, Carper, Young, and McCaskill. HFMA's members believe those comments are as valid as ever and could guide the Senate HELP Committee's work. Therefore, the letter is available below in Appendix II and here. In addition to the recommendations submitted in March, HFMA's members believe there are two additional opportunities, discussed below, to improve the transparency of price and quality data that will allow consumers to make empowered decisions about where to receive their health care.

Background: HFMA's members are strongly supportive of efforts to make price and quality data available to consumers so they can make a value-informed decision about where to receive their health care. HFMA developed its Healthcare Dollars & Sense initiative to help our members transform this affirmative support into meaningful action.[8] This work includes guidelines and best practices for providers and health plans to make healthcare price and quality data transparent and improve communication with patients about their out-of-pocket responsibility. HFMA also developed consumer guides to help educate the public on receiving price estimates for healthcare services and avoiding unexpected balance ("surprise") bills[9] as part of these efforts.

[7] "The Healthcare Value Sourcebook," HFMA, 2015.
[8] Healthcare Dollars & Sense, HFMA.
[9] Understanding Healthcare Prices: A Guide for Consumers," and "Avoiding Surprises in Your Medical Bills," HFMA.

Recommendation: HFMA believes that carriers participating in the FEHBP should be required to provide their members with a transparency tool that provides access to price and quality data for common services. The data should be organized at the episode level and provide details of the cost components (e.g., types of institutions – hospital and/or providers – surgeon, anesthesiologist, physical therapy) that are typically involved in the selected episode of care. The price estimate provided by the tool should be specific to the member making the inquiry (e.g., take into account the member's benefit design and their current spending against their deductible).

Offering a transparency tool is necessary but not sufficient to transform health plan members from passive patients to engaged consumers of healthcare services. Multiple studies have found low utilization rates of price transparency tools.[10,11] HFMA's members believe the low up-take rates are driven by longstanding cultural norms. Overcoming these will require the OPM to take two steps. First, it must create a standardized benefit design all FEHBP carriers are required to use. The benefit design would rewards employees for using the transparency tool to select high value providers by sharing a percentage of the savings with the member. Priority Health, in Grand Rapids, Michigan, provides a good example of an organization that has coupled a meaningful transparency tool with incentives for its members to use it.[12] Second, given that consumers are not accustomed to shopping for healthcare services in the same manner as other goods they encounter in the broader economy, the OPM will need to work with consumer groups, health plans, and providers to develop standardized education materials and decision-making tools. These tools, along with specific training, should be made available to all federal employees. The standard tools and training should also be made available to any employer, purchaser group, or health plan that would like to leverage them to better educate their employees and members.

Background: HFMA's members would like to commend the Center for Medicare & Medicaid Services for its recently released tool that allows members to compare the setting-specific cost differential for certain outpatient surgeries.[13] However, the data is neither member- nor even geography-specific. Therefore, it is of limited utility for a Medicare beneficiary to actually determine their out-of-pocket responsibility.

Recommendation: As HFMA recommended in its Price Transparency Report,[14] CMS should make a member-specific price (e.g., their out of pocket amount for the service based on setting) and quality transparency tool available for elective services frequently provided to Medicare beneficiaries. This tool should be available to beneficiaries in both fee-for-service and Medicare Advantage.

Increase Administrative Simplification

In August 2017, HFMA submitted responses to House Ways and Means Health Sub-Committee Chairman Pat Tiberi's request for information related to the "Medicare Red Tape Relief Project." HFMA's members

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[10] Sinaiko, A.D., Joynt, K.E., Rosenthal, M.B., "Association Between Viewing Health Care Price Information and Choice of Health Care Facility," *JAMA Internal Medicine* 2016;176(12):1868-1870.

[11] Desai, S., Hatfield, L.A., Hicks, A.L., et al., "Offering a Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees," *Health Affairs*, August 2017.

[12] "Examples of Price Transparency Tools: Spectrum Health and Priority Health," HFMA.

[13] "New Online Tool Displays Cost Differences for Certain Surgical Procedures," press release, Centers for Medicare & Medicaid Services, November 27, 2018.

[14] "Price Transparency in Health Care: Highlights from the Task Force Report," HFMA.

still believe that these recommendations, if implemented, would decrease the administrative burden and related costs of participating in the Medicare program. Therefore, the letter is available below in Appendix III and here. In addition to the recommendations submitted in 2017, HFMA's members believe there are additional opportunities, discussed below, to reduce the administrative burden (and related costs) associated with providing care to participants in the FEHBP.

Background: Over half of HFMA's members report that measures of quality and cost used in health plan contracts are inconsistently defined across commercial carriers.[15] While there may be some instances where coverage of specific patient populations warrants the variation, HFMA's members report that it is largely unnecessary. This unnecessary variation drives increased administrative cost as clinical quality staff at hospitals and physician practices must ensure that quality metrics, which purport to measure the same process and outcome, are reported accurately based on the different specifications used by the various commercial carriers with whom they contract. Beyond the administrative expense, it increases organizational complexity and impedes quality improvement. Analogous to someone with multiple watches struggling to know the time, physicians and clinicians struggle to identify the right focus for their performance improvement efforts when confronted with the same quality measure defined multiple ways and yielding different values.

Recommendation: HFMA's members strongly recommend that the OPM collaborate with health plans, providers, quality improvement organizations (e.g., the Institute for Healthcare Improvement) and purchaser groups (e.g., the Leapfrog Group) to develop a standardized set of cost and quality measures for use by all carriers participating in the FEHBP and offering products on the state and federal health insurance exchanges. As part of its value research, HFMA has defined a framework for developing and using value metrics. We believe the framework is applicable to any OPM effort to develop a standardized set of value metrics for use in the FEHBP and have included it in Appendix IV.

Deploying Innovation to Empower Patients, Improve Outcomes, and Reduce Costs

Background: Changes in commercial health plan benefit design have significantly increased beneficiary cost sharing. Between 2006 and 2018, the average deductible in employer sponsored health plans has increased 345 percent (from $303 to $1,350).[16] However, the increase in deductible has been indiscriminate and has encouraged consumers to avoid all healthcare services. As a result, 43 percent of Americans with health insurance report difficulty affording their deductible and 27 percent of Americans report skipping needed care due to cost.[17] While this reduces healthcare spending in the short-term, it significantly increases the risk of an exacerbation of a condition (placing the individual's health at risk) and unnecessarily increases healthcare spending when the consumer can no longer avoid seeking care. HFMA's members believe the indiscriminate use of increased cost sharing represents a missed opportunity to proactively engage employees and retirees in the FEHBP. We believe the use of tailored benefit design, incentives, and member education presents an opportunity to engage consumers and improve patient outcomes and reduce the total cost of care. Further, given the size of the federal

[15] "The Healthcare Value Sourcebook," HFMA, 2015.

[16] "2018 Employer Health Benefits Survey Release Slides," Kaiser Family Foundation, Oct. 3, 2018.

[17] DiJulio, B., Kirzinger, A., Wu, B., et al., "Data Note: Americans' Challenges with Health Care Costs," Kaiser Family Foundation, March 2, 2017.

workforce, we believe that changes made to FEHBP health plans will be deployed by carriers in the health plans they offer to both employers and individuals.

Recommendation: HFMA members believe carriers participating in the FEHBP should be required to adopt clinically nuanced cost-sharing (also known as value-based benefit design) in all of the products they offer to federal employees. Value-based insurance design (VBID) is the explicit use of plan incentives to encourage enrollee adoption of one or more of the following: appropriate use of high value services, including certain prescription drugs and preventive services, adoption of healthy lifestyles, such as smoking cessation or increased physical activity, and use of high-performance providers who adhere to evidence-based treatment guidelines. Enrollee incentives can include rewards, reduced premium share, adjustments to deductible and co-pay levels, and contributions to fund-based plans, such as health savings accounts.[18] VBID encourages payers and providers to create payment models with out-of-pocket costs that vary by service, patient, and provider. Examples of dynamic benefit designs would include lower out-of-pocket costs for high-cost drugs after other therapeutics have been tried and failed; or initially high out-of-pocket costs for an MRI for lower back pain before the patient has attempted physical therapy.[19] Evidence has shown that VBID can increase adherence to pharmaceutical regimens used in the treatment of chronic disease, resulting in cost savings from a reduction in unnecessary utilization,[20,21] as well as reduce unnecessary utilization of outpatient procedures and specialty care.[22]

Recommendation: OPM should develop, in collaboration with providers, clinical decision-making aids for high-volume elective services that will engage patients in their care. The initial focus should be on services that clinicians believe are of questionable value. Patient decision aids target care that is not aligned with patients' wishes by helping them choose between courses of treatment for a given condition. They are particularly helpful for conditions such as lower back pain, where the value of an invasive procedure is uncertain, or the procedure has not been shown to consistently produce a measurably better outcome over time than can be achieved with conservative treatment.

A 2012 study published in *Health Affairs* reports that patients who use decision aids report feeling more engaged in their care process, experience reduced uncertainty about the decision, and have more realistic expectations for outcomes. The study found that, beyond improvements in patient experience of care, 25 percent of patients who use the tools elect not to have surgery. A study of the use of patient decision aids at Seattle-based health system Group Health Cooperative (subsequently acquired by Kaiser Permanente), provides an example of their potential: 95 percent of Group Health's members who responded to a survey said the aids helped them better understand their treatment options. As a result, hip and knee replacement surgeries decreased by 26 and 38 percent respectively, after the decision aids

[18] "Value-Based Benefit Design: A Purchaser's Guide," National Business Coalition on Health, 2009.
[19] "The Future of Patient Engagement: A Report from HFMA's Ninth Annual Thought Leadership Retreat," HFMA, 2016.

[20] Chernew, M.E., Juster, I.A., Shah, M. "Evidence That Value-Based Insurance Can Be Effective," *Health Affairs*, March 2010.

[21] Fuhrmans, V., "A Radical Prescription," *The Wall Street Journal*, May 10, 2004.

[22] Shah, N.D., Naessens, J.M., Wood, D.L., "Mayo Clinic Employees Responded to New Requirements for Cost Sharing by Reducing Possibly Unneeded Health Services Use

were deployed, reducing costs for patients with osteoarthritis between 12 and 21 percent over a six-month period.[23]

Physicians are generally supportive of using patient decision aids, with 67 percent of physicians responding to a 2012 survey reporting they believe these aids would promote better conversations with their patients. However, time and administrative constraints are common barriers to broader deployment.[24]

For elective procedures for which a shared decision-making aid exists, FEHBP members should be required to complete the aid as a condition of coverage for the service or procedure. As administering the shared decision-making aid will require physician staff time and resources, FEHBP plans should be required to pay physicians for this service. This payment is conceptually similar to the Medicare payment for end-of-life planning for Medicare beneficiaries. Finally, the shared decision-making guides developed by the OPM should be made publicly available so that other employers, health care purchasers, and providers can use them.

Recommendation: OPM should launch an advance directive program as a required training module for its employees and retirees. Programs such as Respecting Choices® help educate individuals as to the importance of advance directives and help them develop advance directives that are aligned with their values. Respecting Choices also provides the structure and a framework for facilitating the completion of an advance directive.

Almost one-third of Americans 55 and older lack an advance directive. And as an individual's level of educational attainment decreases, so does the likelihood that they have an advance directive.[25] Closing the gap for older individuals—particularly those with chronic conditions—could reduce overtreatment at the end of life, leading to significant improvements in quality. Having a documented advance directive has been shown to improve the quality of care for both decedents and their survivors across a range of factors. The quality of death, as reported by next-of-kin, is higher for decedents who die at home or in hospice care. It also reduces the detrimental impact on physical and mental health that caregivers experience following deaths characterized by use of aggressive end-of-life care, and it reduces the likelihood that surviving spouses will die shortly thereafter.[26,27] Beyond the positive impact on quality, increasing the use of advance directives presents an opportunity to reduce unnecessary spending. A recent study found that, in the highest-spending hospital-referral regions (HRRs), end-of-life spending

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[23] Arterburn, D., Wellman, R., Westbrook, E., Rutter, C., Ross, T., McCulloch, D. Handley, M., and Jung, C., "Introducing Decision Aids at Group Health Was Linked to Sharply Lower Hip and Knee Surgery Rates and Costs," *Health Affairs*, September 2012

[24] Tilburt, J.C., Wynia, M.K., Montori, V.M., Thorsteinsdottir, B., Egginton, J.S., Sheeler, R.D., Liebow, M. Humeniuk, K.M., Goold, S.D., "Shared Decision-Making as a Cost-Containment Strategy: US Physician Reactions From a Cross-Sectional Survey," BMJ Open, 2014.

[25] Rao, J.K., Anderson, L.A., Lin, F-C., and Laux, J.P., "Completion of Advance Directives Among U.S. Consumers," *American Journal of Preventive Medicine*, January 2014.

[26] Curtis, J.R., Patrick, D.L., Engelberg, R.A., Norris, K., Asp, C., Byock, I., "A Measure of the Quality of Dying and Death: Initial Validation Using After-Death Interviews with Family Members," *Journal of Pain Symptom Management*, July 2002.

[27] Wright, A.A., Zhang, B., Ray, A., Mack, J., Trice, E., Balboni, T., et al., "Associations Between End-of-Life Discussions Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment," JAMA, Oct. 8, 2008; and Christakis NA, Iwashyna TJ. "The Health Impact of Health Care on Families: A Matched Cohort Study of Hospice Use by Decedents and Mortality Outcomes in Surviving, Widowed Spouses," *Social Science Medicine*, August 2003.

for individuals with documented advance directives was $5,585 lower than those without.[28] Not surprisingly, the savings stemmed from lower inpatient hospital use, which was partially offset by increased hospice use and outpatient spending.

[28] Nicholas, L.H., Langa, K.M., Iwashyna, T.J., and Weir, D.R., "Regional Variation in the Association Between Advance Directives and End-of-Life Medicare Expenditures," *JAMA*, Oct. 5, 2011.

Appendix II: HFMA Response to Senate Price Transparency Initiative

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March 23, 2018

The Honorable Bill Cassidy
The Honorable Michael F. Bennet
The Honorable Chuck Grassley
The Honorable Tom Carper
The Honorable Todd Young
The Honorable Claire McCaskill
United States Senate
Washington, D.C.

Dear Senators:

The Healthcare Financial Management Association (HFMA) would like to thank you for the opportunity to provide comments to inform the bipartisan initiative to increase healthcare price and quality transparency, as described in your letter of February 28, 2018.

HFMA is a professional organization of more than 38,000 individuals involved in various aspects of healthcare financial management. In 2014, HFMA convened a multi-stakeholder task force charged with reaching consensus on how consumers can obtain clear and easy-to-understand healthcare price and quality information in a timely fashion. The recommendations that emerged from this task force were published in *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*. The comments submitted here are grounded in the industry-consensus recommendations found in that report, along with the *Patient Financial Communications Best Practices*, which were developed with the guidance of a multi-stakeholder steering committee convened by HFMA.

The questions posed in your letter of February 28 are reprinted below, followed by HFMA's responses.

1. **What information is currently available to consumers on prices, out-of-pocket costs, and quality?**

   Some form of price and quality information is generally available to consumers today, but it is not always information that best serves their needs. In states that mandate publication of charge data (i.e., hospital chargemaster prices), that information is typically available online via state-supported websites. However, information on charges or on average charges is of limited value to consumers, as it will likely be significantly different from the amount they will be expected to pay. Chargemaster prices serve only as a starting point; adjustments to these prices are routinely made for contractual discounts that are negotiated with or set by third-party payers. Few patients actually pay the chargemaster price. Information on the average amount *paid* for services is somewhat more useful to consumers but it still falls short. The price information that is most useful to consumers is an estimate of their individualized out-of-pocket responsibility for the specific service(s) they seek. For insured patients, this amount is contingent on their health plan benefit design, including

coinsurance and copayments, and the amount of deductible remaining to be met. (For uninsured patients, see question 3.)

Insured patients may obtain an individualized price estimate from their health plan. Estimates are based on CPT codes, which must be obtained from a patient's physician or other care provider. Resources on the estimate-request process are available to consumers, including HFMA's *Understanding Healthcare Prices: A Consumer Guide*, which is available at no charge to any healthcare organization for posting online in the patient financial services section of their websites.

In addition, many hospitals and health systems post price information for common procedures online, and/or make this information available by phone.

Some quality information is also available to consumers online. Information on quality—comprising a range of factors from patient satisfaction and experience to adherence to clinical standards and evidence-based medicine to patient safety and clinical outcomes—is necessary for patients and other care purchasers to make an informed choice of providers.

2. What information is not currently available, but should be made available to empower consumers, reduce costs, increase quality, and improve the system?

First, it may be helpful to specify, in some detail, the information that will help accomplish the goals stated in your question. The HFMA Price Transparency Task Force (hereinafter "the Task Force") recommends that transparency tools and price estimates for insured patients should include three essential elements of price information: (a) *the total estimated price of the service*, i.e., the amount for which the patient is responsible plus the amount that will be paid by the health plan; (b) a clear statement of the patient's *estimated out-of-pocket responsibility*; and (c) *other relevant information* related to the provider or the specific service sought, e.g., clinical outcomes, patient safety, or satisfaction scores.

The estimated out-of-pocket responsibility should be tied to the specifics of the patient's benefit plan design, including coinsurance, copayments, and the amount of deductible remaining to be met (as close to real time as possible.)

Other relevant information should be included where it is available and applicable. This information should clearly communicate what has been measured and to whom the measurement pertains (e.g., to the facility, the physician, etc.)

Additionally, the Task Force recommends that insured patients should be alerted to the need to seek price information from out-of-network providers. The issue of "surprise bills" arising from inadvertent out-of-network utilization is an ongoing challenge. A typical example is a patient who chooses an in-network hospital for a procedure but receives services from an out-of-network provider, such as a pathologist, radiologist, or anesthesiologist. HFMA has convened a task force to develop an educational resource for consumers designed to reduce the risk of receiving surprise bills.

Although individualized price and quality information are currently available, in many cases, too often it is not easy for consumers to obtain and/or understand. *Healthcare stakeholders should*

focus their efforts on making individualized price and quality information more accessible, convenient, clear, and easy to understand. HFMA recognizes that the multi-step process of requesting a price estimate can be confusing, especially for consumers who are not familiar with the healthcare system, who are coping with healthcare challenges or caregiving responsibilities, or who have language or literacy barriers. HFMA encourages healthcare organizations to support consumers in their efforts to obtain price and quality information and to provide estimates in a format that is clear and easy to understand, and which specifies the limitations of the estimate. (The Task Force notes that the total estimated price will necessarily be an estimate because the patient may use—or the physician may code for and bill—additional services not included in the estimate.)

The way that price and quality information are communicated to consumers can have a significant impact on how that information is used. Individuals may equate low price with low quality. For example, in one study of 1,400 adult employees, price information that was presented through the number of dollar signs (with "$" representing low price and "$$$" representing high price) led a significant number of employees to use low price as a proxy for low quality. But when a star ranking system was used to rate providers as "being careful with my healthcare dollars," employees in the study were significantly more likely to choose a lower-price provider.[29]

Any system of price transparency will likely need to experiment with the most effective means of communicating price information to various consumer audiences.

Consumers are accustomed to having price information at their fingertips and communicated in ways that are intuitive and easy to understand. The classic example is comparison shopping for airline tickets or hotel stays on websites like Kayak or Expedia. Although choosing a healthcare provider may never be as simple or straightforward as buying an airline ticket, the comparison highlights the magnitude of the room for improvement in the presentation of healthcare price and quality information. In recent years, some have attributed the low utilization of price transparency tools to a lack of consumer interest or willingness to factor price and quality information into their decision-making process. However, until this information becomes more consumer-friendly and convenient, HFMA believes that it is premature to draw such conclusions.

3. What role should the cash price play in greater price transparency? How should this be defined?

Patients may seek information about the cash price when (a) they are uninsured (b) they are covered by high-deductible health plans (HDHPs) or (c) they are seeking care with an out-of-network provider.

Price transparency for the uninsured is subject to a substantial and growing number of laws at both the federal and state levels. It is the first responsibility of providers to ensure that policies and practices adhere to these legal requirements.

[29] Hibbard, J.H., Greene, J., Sofaer, S., et. al., "An Experiment Shows that a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs*, March 2012, pp. 560-568.

Beyond that, HFMA's Patient Financial Communications Best Practices stipulate that providers should inform uninsured patients that they will review insurance eligibility with them to identify payment solutions or financial assistance options that may help them with their financial obligations for the care received. If appropriate, the patient should be referred to a financial counselor and/or offered information about the provider's financial counseling and assistance policies and programs. Financial assistance may take the form of free or discounted care, depending on an individual patient's circumstances along with organizational policies.

For those patients who are not eligible or choose not to apply for financial assistance, and who are able to pay cash at the time of service, some organizations offer a discount. The cash discount may be posted on the organization's website or communicated by telephone or in person, upon request. In recent years, some hospitals offer uninsured patients or patients with HDHPs an option to pay for common tests and procedures in full at the time of service in exchange for sharply discounted prices.

If a patient seeks care from an out-of-network provider (based, for example, on that provider's reputation) and contacts the health plan for assistance, the health plan should clearly explain what percentage (if any) of out-of-network provider charges the plan will cover, and describe any other significant out-of-network benefit plan issues (e.g., a "reasonable and customary rate of reimbursement" limit on what the health plan will pay). The health plan should also inform the patient that—if the patient intentionally seeks care from an out-of-network provider—it is the patient's responsibility to independently obtain price information from that provider. Provider policies vary on whether to offer a self-pay or cash discount to these patients.

4. What are the pros and cons of different state approaches to price transparency? What is the best quality and price information to collect for consumers and businesses?

The question specifies Colorado, Kentucky, Virginia, and Maryland as states with approaches to price and quality information that are of interest.

Colorado collects data in an all payer claims database (APCD) that includes the full scope of providers and paid amounts, i.e., the amount actually paid for services. Information about paid amounts represents a significant improvement over charge data, as noted in the answer to question (1) above. Colorado also had the distinction of being one of only three states to receive an A grade in the *2016 Report Card on State Price Transparency Laws* published by Catalyst for Payment Reform (CPR), an organization that advocates for improved price transparency and publishes an annual scorecard on state price transparency laws. (The state was subsequently downgraded by CPR because it is using an interim website while improvements are made.)

Notwithstanding the APCD-based website that enjoys an excellent reputation in industry circles, a new Colorado price transparency law, which took effect in January 2018, mandates that providers and facilities tell insured patients, "You are strongly encouraged to consult with your health insurer to determine accurate information about your financial responsibility for a particular healthcare service provided at this healthcare facility/provider." It also mandates that providers and facilities provide uninsured patients with the telephone number of the billing office that they are "strongly encouraged to contact… to discuss payment options prior to receiving a healthcare service from this healthcare facility/service provider since posted

healthcare prices may not reflect the actual amount of your financial responsibility."

This is, in effect, an acknowledgment by Colorado policymakers that the availability of a price transparency website to the general public is not a substitute for receiving individualized information about financial responsibility from a consumer's health plan or provider. This is consistent with the HFMA task force's recommendations for health plan and provider roles in price transparency, as detailed in the answer to question (5) below.

Kentucky's approach to price transparency is based on median hospital charges, which is not optimal from a consumer standpoint, as previously discussed. Additionally, the Kentucky website for price information is separate from the quality information website, which creates an extra step, reducing convenience and accessibility for consumers. In theory, diagnosis-specific or procedure-specific comparisons for each hospital and ambulatory facility should provide ample specificity and detail. However, that approach should be balanced against the risk of inundating consumers with information that is too technical or time-consuming to absorb.

We are told that Virginia conducts an annual survey of health plans on their reimbursement for a minimum of 25 most frequently reported healthcare services. Again, this approach does not provide the individualized information most helpful to consumers.

Maryland requires hospitals to provide and post pricing information for the most common medical treatments in all hospitals, including the number of cases, the average charge per case and the average charge per day. As previously stated, average charge information is of limited usefulness to consumers because it does not reflect the price they will be expected to pay. Beyond that, HFMA recognizes that providing transparency data for the most common healthcare services is often a good use of limited resources. (Also see the discussion of Maryland's consumer-facing website in the answer to question (6).)

5. Who should be responsible for providing pricing information and who should share the information with consumers?

The HFMA Price Transparency Task Force identified transparency roles for various stakeholders:

- Because health plans will, in most instances, have the most accurate data on prices for their members, they should serve as the principal source of price information for their members. Many health plans offer web-based or telephonic transparency tools for their members.

- Employers with self-funded health plans have the option of working with health plans (which often serve as third-party administrators for self-funded plans) or other vendors in developing transparency tools for insured employees and their dependents.

- The provider—i.e., the entity, organization, or individual that furnishes a healthcare service—should be the principal source of price information for uninsured patients or patients who are seeking care from the provider on an out-of-network basis.

Additionally, a number of independent vendors use data from health plans, employers, and other sources to publish price information. In many cases, this information is not tied to the specifics of an individual's benefit design and does not incorporate applicable copayment, coinsurance, or deductible requirements. Additionally, these vendors typically don't assist their customers in identifying in-network providers or quantify the impact that selecting an out-of-network provider could have on the consumer's responsibility for payment. To the extent that these limitations apply to any given vendor, the data they provide customers is not an accurate representation of the price consumers will be expected to pay for a service. Also, an argument could be made that adding another party to a system that is already complex, as it is built around third-party payment, introduces more complexity and fragmentation to the system.

One of the guiding principles established by the Task Force is that price transparency will require the commitment and active participation of all stakeholders, due to the complexity of the healthcare payment system. There are many different sources of price and quality information, many different benefit designs for insured patients, and an increasing variety of payment models and quality indicators. Given these complexities, providers, health plans, and patients and other care purchasers should work together to define and provide the price and quality information—beyond the essential elements of price information described in the answer to question (2) above—that care purchasers need to make informed provider choices. Transparency efforts should also remain flexible to adapt to changing healthcare payment and delivery models.

6. What role should all-payer claims databases play in increasing price and quality transparency? What barriers currently exist to utilizing these tools?

Because all-payer claims databases (APCDs) contain data on what was actually paid for services and procedures performed by a wide range of providers, they offer more accurate price data than information based on charges or average charges.

Websites based on APCDs, like other price transparency websites, should strive to combine robust and comprehensive price data with design that is consumer-friendly and easy to navigate.

In terms of data, since the 2016 U.S. Supreme Court ruling in *Gobeille v. Liberty Mutual Insurance Company*, state laws creating APCDs cannot mandate the disclosure of ERISA (or "self-insured"/ "self-funded") plans' claims and other information. Because self-insured or mixed-funded (i.e., funded through a mixture of insurance and self-insurance) plans accounted for 48 percent of health plans in 2014 (the most recent year for which data are available) and those plans covered 83 percent of plan participants, this poses a significant obstacle for APCDs. Additionally, published APCD data are not always as current as data furnished directly to consumers by health plans and providers; there may be a significant lag time for reporting and analysis.

With regard to consumer-friendly website design, APCD performance varies. APCD status confers no particular advantage in this arena. The annual scorecard on state price transparency laws issued by Catalyst for Payment Reform (CPR), a strong proponent of APCDs, is instructive in this regard. In its most recent report, *Price Transparency and Physician Quality Report Card 2017*, published jointly with Altarum, CPR gave two states with APCDs (New Hampshire and

Maine) an A grade while two other states (Vermont and Virginia) received C grades, even though both of the latter states collect data in APCDs that include paid amounts and a full scope of providers. CPR writes that "the nature of [Vermont's and Virginia's] consumer-facing websites—decidedly not consumer friendly—prevented them from earning higher scores."

Maryland's Wear the Cost (which received a B grade from CPR in 2017) presents APCD-derived information in an exceptionally consumer-friendly way. Also, it breaks data down into average total costs for typical care and for potentially avoidable complications—an interesting approach to integrating service-specific quality and price information—for four common, shoppable procedures. (It should be noted that at this writing, the site is using 2014-15 data from commercial insurance providers.)

It is important to realize that APCDs are not the only avenue for collecting and publishing price and quality information. For example, the not-for-profit organization Minnesota Community Measurement hosts Minnesota Health Scores, a consumer-friendly website that includes price and quality information for most providers in the state.

Finally, consumers must be able to calculate their copayment and coinsurance and know their progress toward meeting their deductible in order to apply the information provided by even the best APCD-based websites (or other web resources that don't offer one-on-one customer support) to their specific situations. Research conducted by the Kaiser Family Foundation demonstrates that relatively few consumers are able to make these computations.

7. How do we advance greater awareness and usage of quality information paired with appropriate pricing information?

As stated in the question, pairing price and quality information, rather than providing them separately, is of key importance. The more closely integrated the information, the better, both to enhance ease of use and to reduce consumers' propensity to conflate price and quality. As patient engagement expert Judith Hibbard, Dr.PH., Research Professor, Health Policy Research Group, University of Oregon, told CPR "…[P]resenting price information within quality tiers or presenting quality information within cost tiers…will show consumers that there is variation in both cost and quality and that higher quality and price are not necessarily linked."

As a finance organization, HFMA does not have particular expertise in the presentation of quality information. However, we do have expertise in linking finance and quality metrics. An HFMA representative has served on the National Quality Forum Measure Applications Partnership, a multi-stakeholder partnership that guides the U.S. Department of Health and Human Services on the selection of performance measures for federal health programs. HFMA stands ready to collaborate with other organizations that are seeking finance expertise in their efforts to advance greater awareness and usage of paired quality and finance information.

8. How do we ensure that in making information available we do not place unnecessary or additional burdens on health care stakeholders?

This is an important consideration. Increasing administrative costs in an effort to enhance price transparency, which could potentially raise prices for consumers, would be counterproductive.

Careful consideration should be given before adopting any measures that would create additional data collection or reporting requirements or standardize the presentation or format of price and quality information. Price and quality transparency frameworks should avoid being overly prescriptive in order to promote innovation and allow healthcare organizations to serve consumers in ways that best meet their needs. This entails taking into consideration local or community-specific health issues, socioeconomic factors, cultural contexts, and health and financial literacy levels, among other factors.

9. What current regulatory barriers exist within the health care system that should be eliminated in order to make it less burdensome and more cost-efficient for stakeholders to provide high-quality care to patients?

The following were largely submitted to the House Committee on Ways and Means, Subcommittee on Health in conjunction with the Medicare Red Tape Relief Project in July 2017:

A. *Make Medicare Price-Sharing Amounts Explicitly Available with Charge and Payment Data*. Congress should expand on Section 4011 of the 21st Century Cures Act (Pub. L. 114–255), and pass legislation instructing the Centers for Medicare & Medicaid Services (CMS) and its administrative contractors to make price sharing information for specific services available to Medicare beneficiaries for services provided in settings other than hospital outpatient departments and ambulatory surgical centers. For CMS, this information should be available on the Hospital Compare website so a beneficiary can evaluate both cost and quality to make a truly informed decision. Also, CMS may consider developing an easy-to-use consumer format--such as a mobile app--in addition to the Compare websites.

B. *Reform the Medicare Recovery Audit Contractor Program to Hold Contractors Accountable.* Medicare Recovery Audit Contractors (RACs) are paid a contingency fee that financially rewards them for denying payments to hospitals, even when their denials are found to be in error. There is a substantial backlog in resolution of disputes related to inappropriately denied claims. Congress should amend the statutes relating to the RAC program to incorporate a financial penalty for poor performance by RACs, as measured by Administrative Law Judge appeal overturn rates.

C. *Provide More Regulatory Flexibility for Participants in Alternative Payment Models.* CMS's continued application of fee-for-service (FFS) regulatory barriers within payment reform models often hinders providers' ability to identify and place beneficiaries in the most clinically appropriate setting. It also inhibits their ability to test new, more patient-centered and streamlined clinical pathways. Testing new approaches in an environment free from artificial barriers to care coordination, such as the IRF 60 Percent Rule and the home health homebound rule, will more effectively advance solutions that improve clinical outcomes and reduce overall costs and variation. HFMA encourages Congress to modify existing Medicare fraud and abuse statutes to create safe harbors from laws such as "Stark," "Anti-Kickback"

and
"Civil Monetary Penalty" for physicians, hospitals, post-acute care providers, and other entities caring for Medicare beneficiaries that participate in alternative payment models such as the Medicare Shared Savings Program or Comprehensive Care for Joint Replacement program.

D. *Create Stark Exemptions for Clinical Integration Arrangements.* Hospitals cannot succeed in their efforts to coordinate care and participate in new payment models because of outdated statues, such as the Anti-Kickback and the "Stark" laws. A new exception should be created that protects any arrangement that meets the terms of the newly created Anti-Kickback safe harbor for clinical integration arrangements.

E. *Create Safe Harbor in Anti-Kickback Statute for Assistance to Patients.* This type of safe harbor is necessary so hospitals can help patients realize the benefits of their discharge plan and maintain themselves in the community. Arrangements protected under the safe harbor also would be protected from financial penalties under the Civil Monetary Penalties for providing an inducement to a patient. The safe harbor should do all of the following:

- Protect encouraging, supporting, or helping patients to access care or make access more convenient
- Permit support that is financial (such as transportation vouchers) or in-kind (such as scales or meal preparation)
- Recognize that access to care goes beyond medical or clinical care, and include the range of support important to maintaining health such as social services, counseling, or meal preparation
- Remove the regulatory prohibition on a hospital offering advice to a patient on the selection of a provider for post-hospital care or suggesting a specific facility

F. *Remove HIPAA Barriers to Integrated Care.* HIPAA regulations currently restrict sharing a patient's medical information for "health care operations" like quality assessment and improvement, including outcomes evaluation, or activities that relate to the evaluation of provider qualifications, competence, or performance, to information about those patients with whom both the disclosing and receiving providers have – or have had – a patient relationship. The challenge this poses in the integrated care setting is that frequently patients do not have a relationship with all of the providers among whom information should be coordinated. A clinically integrated setting and each of its participating providers must focus on and be accountable for all patients. Moreover, achieving the meaningful quality and efficiency improvements that a clinically integrated setting promises requires that all participating providers be able to share and conduct population-based data analyses. Therefore, the HIPAA medical privacy regulation enforced by the Office for Civil Rights should permit a patient's medical information to be used by and shared with all

participating
providers in an integrated care setting without requiring that individual patients have a direct relationship with all of the organizations and providers that technically "use" and have access to the data.

G. *Allow Treating Providers Access to Their Patient's Substance Use Disorder Records*. Requiring individual patient consent for access to addiction records from federally funded substance use treatment programs, as current requirements do, is an obstacle to an integrated approach to patient care. It also may unknowingly endanger a person's recovery and his or her life. Congress should fully align requirements for sharing patients' substance use records with the requirements in the HIPAA statue that allow the use and disclosure of patient information for treatment, payment, and healthcare operations. Doing so would improve patient care by ensuring that providers and organizations who have a direct treatment relationship with a patient have access to his or her complete medical record.

H. *Expand Coverage for Telehealth.* Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech monitoring without requiring patients to leave their homes, and less expensive and more convenient care options for patients. However, coverage and payment for telehealth services remain major obstacles. Medicare lags far behind other payers due to its restrictive statutes and regulations. For example, CMS approves new telehealth services on a case-by-case basis; as a result, Medicare pays for only a small percentage of services when they are delivered via telehealth. HFMA urges Congress to expand Medicare coverage, such as by a presumption that Medicare-covered services also are covered when delivered via telehealth unless CMS determines on a case-by-case basis that such coverage is inappropriate.

I. *Cancel "Stage 3" of Meaningful Use*. Hospitals and physicians face extensive, burdensome, and unnecessary "meaningful use" regulations from CMS that require significant reporting on the use of electronic health records (EHRs) with no clear benefit to patient care. These excessive requirements are set to become even more onerous when Stage 3 begins in 2018. They also will raise costs by forcing hospitals and physicians to spend large sums upgrading their EHRs solely for the purpose of meeting regulatory requirements. Congress should pass legislation canceling Stage 3 of meaningful use by removing the 2018 start date from the current regulations. The Administration also should institute a 90-day reporting period in every future year of the program and gather input from stakeholders on ways to further reduce the burden of the meaningful use program from current requirements.

10. How can our health care system better utilize big data, including information from the Medicare, Medicaid, and other public health programs, to drive better quality outcomes at lower costs?

The potential for unintended consequences is heightened when price transparency is used in payment systems where prices are administratively set. In the context of Medicare or Medicaid, the Center for Medicare and Medicaid Innovation (CMMI) should do the following:

a. Couple price data with relevant *quality measures that are appropriately risk adjusted*. Otherwise, safety net hospitals will be unfairly penalized for the patient populations they serve, as the measures as currently reported may not accurately reflect the quality of care they provide.
b. Similar to target price or benchmark calculation in Medicare Alternative Payment Models, *CMMI should remove add-on payments* related to teaching and indigent care from prices shown to patients. Otherwise, CMMI will steer patients away from these providers and inadvertently harm them financially.
c. Provide price data comparisons for episodes of care, not discrete services. We believe Maryland's Wear the Cost website is a reasonable example of this principle in action. It includes the price of all services and provides and describes the costs associated with potentially avoidable complications.
d. Provide actual price data, not charges, as is commonly done in many states. When price data is provided, it should entail both the total price to the purchaser and any out-of-pocket expense the beneficiary is responsible for.
e. The definition of key terms—cost, charge, and price--should not be used interchangeably. Cost varies by the party incurring the expense, charge is the dollar amount set before negotiating discounts, and price is the total amount expected to be paid by payers and patents for healthcare services.
f. While there has been historical relationship between charges and prices for healthcare services, that relationship has become less relevant as new payment models have emerged. Consideration about billing systems that are not reliant on the chargemaster but based on these payment models such as episodes of care or cases should be examined. This is a complex process and require multi-stakeholder input.

11. What other common-sense policies should be considered in order to empower patients and lower health care costs?

Providing price data to Medicare beneficiaries is not enough to change behavior. CMMI should experiment with beneficiary engagement strategies, ranging from benefit design to the use of positive incentives to reward desired behaviors.

HFMA strongly supports the concept of value-based insurance design (VBID). VBID structures benefits and cost sharing to encourage consumers to use high-value clinical services (defined as those with the greatest potential, relative to cost, to positively impact health). We encourage CMMI to create a VBID model pilot in the Medicare accountable care organization (ACO) models (Medicare Shared Savings Program tracks, Next Generation) and Comprehensive Primary Care Plus (CPC+). ACO and CPC+ participants interested in participating should have the opportunity to apply.

HFMA looks forward to any opportunity to provide assistance or comments to support the Senate's transparency initiative. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, federal healthcare agencies, and advisory groups.

We are at your service to help provide a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,

Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 38,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.

Appendix III: HFMA Response to Medicare Red Tape Request for Information

Please Provide Responses to the Fields Below Electronically to be Accepted

Medicare Red Tape Relief Project
Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: August 2, 2017

Name of Submitting Organization: Healthcare Financial Management Association

Address for Submitting Organization:

1090 Vermont Avenue NW
Suite 500
Washington DC 20005

Name of Submitting Staff: Richard Gundling

Submitting Staff Phone: 202.296.2920 ext. 605

Submitting Staff E-mail: rgundling@**hfma**.org

Statutory__X**_ Regulatory_X__**

Please describe the submitting organization's interaction with the Medicare program:
HFMA is the nation's leading membership organization for more than 40,000 healthcare financial management professionals. As an organization, we are committed to helping our members improve the management of and compliance with the numerous rules and regulations that govern the industry. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant. In these roles our members interact with the disparate Medicare payment systems and related value-based payment programs. As a result, of this interaction they have experienced firsthand how many of the program's outdated or misguided regulations (or statutory requirements) increase the total cost of care and decrease patient and caregiver satisfaction without commiserate improvements in quality or patient outcomes.

Please use the below template as an example of a submission regarding statutory or regulatory concerns, and submit any further concerns past those listed below in a separate Microsoft Word document in the same format. Submissions must be in the requested format or they will not be considered.

In the case of listed Appendices, please attach as PDF files at the end of the submission, clearly marked as "Appendix [insert label]"

In the case of a multitude of submissions, it is recommended that they be submitted in order of priority for the submitting organization or individual.

1. **Short Description:** *Make Medicare Cost-Sharing Amounts Explicitly Available with Charge and Payment Data*:

   Summary: Annually, CMS makes hospital and physician charge data available to the public for common services. While cost sharing data is included in the total payment amount, the information necessary for an average Medicare beneficiary to understand their cost sharing isn't readily apparent. For example, in the outpatient hospital services file, cost sharing data is included in the average total payments. For inpatient hospital services, there are two columns – one that provides "average total payments," which includes cost sharing, and a column "average Medicare payments" that details the average amount Medicare pays a hospital. In theory a Medicare beneficiary could calculate their outpatient or inpatient cost sharing using this data. However, the information necessary to do so requires a level of sophistication far beyond what is possessed by the average Medicare beneficiary.

   Proposed Solution: HFMA believes that Congress should expand on Section 4011 of the 21st Century Cures Act (Pub. L. 114–255), and pass legislation instructing CMS (and its administrative contractors) to make costing share information for specific services available to Medicare beneficiaries for services provided in settings other than hospital outpatient departments and ambulatory surgical centers. For CMS, we believe this information should be available on the hospital compare website so that a beneficiary can evaluate both cost and quality to make a truly informed decision. This is in line with recommendations from HFMA's "Price Transparency in Health Care21" whitepaper which suggested consensus best practices for providers and purchasers. One of those purchasers was Medicare and Medicaid.

2. **Short Description:** *Reform the Medicare Recovery Audit Contractor Program to Hold Contractors Accountable*

   Summary: Medicare Recovery Audit Contractors (RACs) are paid a contingency fee that financially rewards them for denying payments to hospitals, even when their denials are found to be in error. We believe that CMS's two rounds of settlements with hospitals for cases inappropriately denied by the RAC is more than sufficient proof of the program's substantial flaws. In the 2014 settlement, over 2,000 hospitals settled approximately 350,000 disputed claims for $1.47 billion. Despite the sheer size of the settlement, it did not make a dent in the administrative backlog due to inappropriately denied claims necessitating another settlement.

   Proposed Solution: HFMA urges Congress to amend the statutes relating to the RAC program to incorporate a financial penalty for poor performance by RACs, as measured by Administrative Law Judge appeal overturn rates.

3. **Short Description:** *Provide More Regulatory Flexibility for Participants in Alternative Payment Models*

   Summary: CMS's continued application of fee-for-service (FFS) regulatory barriers within payment reform models often hinders providers' ability to identify and place beneficiaries in the most clinically appropriate setting. It also inhibits their ability to test new, more patient centered and streamlined clinical pathways. Testing new approaches in an environment free from artificial barriers to care coordination, such as the IRF 60 Percent Rule and the home health homebound rule, will more effectively advance solutions that improve clinical outcomes and reduce overall costs and variation.

   Proposed Solution: HFMA encourages Congress to modify existing Medicare fraud and abuse statutes to create safe harbors from laws such as "Stark," "Anti-Kickback" and "Civil Monetary Penalty for physicians, hospitals, post-acute care providers, and other entities caring for Medicare beneficiaries that participate in alternative payment models such as the Medicare Shared Savings Program or Comprehensive Care for Joint Replacement program.

4. **Short Description:** *Create Stark Exemptions for Clinical Integration Arrangements*

   Summary: Hospitals cannot succeed in their efforts to coordinate care and participate in new payment models because of outdated statues, such as the Anti-Kickback and the "Stark" laws.

   Proposed Solution: A new exception should be created that protects any arrangement that meets the terms of the newly created Anti-Kickback safe harbor for clinical integration arrangements.

5. **Short Description:** *Create Safe Harbor in Anti-Kickback Statute for Assistance to Patients*

   Summary: This type of safe harbor is necessary so that hospitals can help patients realize the benefits of their discharge plan and maintain themselves in the community. Arrangements protected under the safe harbor also would be protected from financial penalties under the Civil Monetary Penalties (CMPs) for providing an inducement to a patient.

   Proposed Solution: The safe harbor should do all of the following:

   a. Protect encouraging, supporting, or helping patients to access care or make access more convenient
   b. Permit support that is financial (such as transportation vouchers) or in-kind (such as scales or meal preparation)
   c. Recognize that access to care goes beyond medical or clinical care, and include the range of support important to maintaining health such as social services, counseling, or meal preparation

d. Remove the regulatory prohibition on a hospital offering advice to a patient on the selection of a provider for post-hospital care or suggesting a specific facility

6. **Short Description:** *Remove HIPAA Barriers to Integrated Care*

   Summary: HIPAA regulations currently restricts the sharing of a patient's medical information for "health care operations" like quality assessment and improvement, including outcomes evaluation, or activities that relate to the evaluation of provider qualifications, competence, or performance, to information about those patients with whom both the disclosing and receiving providers have – or have had – a patient relationship. The challenge that strict regulatory prohibition poses in the integrated care setting is that frequently patients do not have a relationship with all of the providers among whom information should be coordinated. A clinically integrated setting and each of its participating providers must focus on and be accountable for all patients. Moreover, achieving the meaningful quality and efficiency improvements that a clinically integrated setting promises requires that all participating providers be able to share and conduct population-based data analyses.

   Proposed Solution: The HIPAA medical privacy regulation enforced by the Office for Civil Rights should permit a patient's medical information to be used by and shared with all participating providers in an integrated care setting without requiring that individual patients have a direct relationship with all of the organizations and providers that technically "use" and have access to the data.

7. **Short Description:** *Allow Treating Providers Access to Their Patient's Substance Use Disorder Records*

   Summary: Requiring individual patient consent for access to addiction records from federally funded substance use treatment programs, as current requirements do, is an obstacle to an integrated approach to patient care. It also may unknowingly endanger a person's recovery and his or her life.

   Proposed Solution: Congress should fully align requirements for sharing patients' substance use records with the requirements in the HIPAA statue that allow the use and disclosure of patient information for treatment, payment, and healthcare operations. Doing so would improve patient care by ensuring that providers and organizations who have a direct treatment relationship with a patient have access to his or her complete medical record.

8. **Short Description:** *Expand Coverage for Telehealth*

   Summary: Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech monitoring without requiring patients to leave their homes, and less expensive and more convenient care options for patients. However, coverage and payment for telehealth services remain major obstacles for providers seeking to improve patient care. Medicare, in

particular, lags far behind other payers due to its restrictive statutes and regulations. For example, CMS approves new telehealth services on a case-by-case basis, with the result that Medicare pays for only a small percentage of services when they are delivered via telehealth.

Proposed Solution: HFMA urges Congress to expand Medicare coverage, such as by a presumption that Medicare-covered services also are covered when delivered via telehealth unless CMS determines on a case-by-case basis that such coverage is inappropriate.

9. **Short Description:** *Cancel "Stage 3" of Meaningful Use*

Summary: Hospitals and physicians face extensive, burdensome, and unnecessary "meaningful use" regulations from CMS that require significant reporting on the use of electronic health records (EHRs) with no clear benefit to patient care. These excessive requirements are set to become even more onerous when Stage 3 begins in 2018. They also will raise costs by forcing hospitals and physicians to spend large sums upgrading their EHRs solely for the purpose of meeting regulatory requirements.

Proposed Solution: HFMA's members urge Congress to pass legislation canceling Stage 3 of meaningful use by removing the 2018 start date from the current regulations. The Administration also should institute a 90-day reporting period in every future year of the program, and gather input from stakeholders on ways to further reduce the burden of the meaningful use program from current requirements.

Appendix IV: Guidelines for the Development and Use of Value Metrics[30]

Interviews with purchasers, payers, and provider organizations revealed some dissatisfaction with value metrics in use today. These criticisms highlighted an over-emphasis on processes rather than outcomes, the inconsistency and proliferation of metrics, and the lack of usefulness of performance data to purchasers.

In 2008, HFMA defined five principles to guide reform of the healthcare payment system: quality, alignment, fairness/sustainability, simplification, and societal benefit[31]. Consistent with these principles, and based upon interviews with purchasers, payers, and providers, HFMA proposes to all stakeholders the following guidelines for the improvement of metrics and reporting to promote the quality and cost-effectiveness of healthcare delivery.

1) **Work to replace process metrics with patient-centered functional outcomes.** HFMA's 2008 payment reform white paper notes that, consistent with the principle of quality, "wherever possible, payments should reward positive outcomes, rather than adherence to processes." Employer organizations consistently expressed that patient-centered functional outcomes, such as return to functioning or number and kinds of complications after a certain type of surgery, are preferable to process-based measures, and conveyed frustration that the market is lagging

[30] https://www.hfma.org/ValueProject/Phase2/

[31] See *Healthcare Payment Reform: From Principles to Action,* HFMA, September 2008, available at hfma.org/reform.

in providing these types of metrics. Providers, too, expressed significant interest in functional outcomes measures, with many indicating they are superior to process indicators as measurements of healthcare quality. Organizations requiring process metrics should work to establish the connection between these metrics and quality or cost outcomes.

2) **Align value metrics with the "triple aim" of improving care for individuals, improving the health of populations, and reducing the per capita costs of health care.** HFMA's 2008 white paper on payment reform encouraged alignment of payment reform with the nation's health goals. Since that time, there has been broad coalescence around the Institute of Healthcare Improvement's "Triple Aim," including its role as foundation for the National Quality Strategy. In furtherance of these goals, value metrics should align incentives for providers to coordinate care. Hospitals and health systems note that in some cases they are incentivized to coordinate care, but other providers with whom they interact (e.g., independent physicians) do not have similar incentives available. To optimize payment as a lever to coordinate care, all providers involved in care coordination efforts should be incentivized to work together more effectively.

3) **Focus on a limited set of metrics to drive performance.** Although many things can be measured, a much fewer number of metrics should be selected to drive performance. Consistent with HFMA's payment reform principle of simplification, value metrics should be used to judiciously target high-priority areas of improvement for the healthcare system, minimizing administrative burdens and optimizing the use of limited organizational resources. This guidance applies to payers in their contractual negotiations with providers as well as to providers, which may benefit from highlighting a select number of performance metrics for strategic organizational focus.

4) **Use payment incentives and penalties selectively, emphasizing performance on metrics that have been proven or stakeholders agree are most likely to drive the most desirable quality or cost outcomes.** Payment mechanisms are a blunt way to drive provider behavior and, if used indiscriminately, can result in unintended consequences such as underuse of services in a capitated model. This issue relates to HFMA's payment reform principle of fairness/sustainability. Just as stakeholders should focus on a limited number of high-impact metrics and refine them over time, so should payers be careful in how they drive provider performance through experimentation with payment. Understanding the intended and unintended consequences that result from payment experiments will be critical to refine approaches to value-based payment over time.

5) **Report provider-specific performance to end users in a way that is understandable and actionable.** Consistent with the HFMA principle of alignment, provider specific quality and price data should be accessible to purchasers in an understandable format. For example, patients may require straightforward rating systems that distinguish among providers' performance on quality and price. Further, to be actionable, it is important that performance standards allow for distinction among providers over time. For example, if all providers are incentivized to achieve performance within an extremely narrow range, that may not allow a purchaser to distinguish provider performance. Payers should be careful to convey performance expectations in a way that not only continually focuses on high impact areas, but also at levels that allow purchasers to discern excellent from average performers.