

DRIVE HEALTH INITIATIVE

Deliver Results, Innovation and Value for *Everyone*

DRIVE Health Initiative Response to Senate Transparency Stakeholder Inquiry

March 23rd, 2018

Dear Senators Cassidy, Bennett, Grassley, Carper, Young, and McCaskill,

Thank you for the opportunity to participate in this timely, bipartisan effort to improve transparency in the health care system. As representatives of payers who fund and manage the health benefits of tens of millions of Americans, we appreciate the need to move forward into a system that drives value by empowering patients and purchasers with the information they need to get the best treatment, at the best costs, armed with the right data and information.

We submit these comments to you pursuant to our partnership in the *DRIVE Health Initiative* (<http://www.drivehealth.org/>), a joint project of The ERISA Industry Committee (ERIC) and the Pacific Business Group on Health (PBGH), in cooperation with the active members of our Advisory Council, including the Leapfrog Group. The *DRIVE Health Initiative – Deliver Results, Innovation and Value for Everyone* – is a campaign to decrease costs, improve quality and strengthen the economy by urging the federal government to implement policies that promote value-based care.

About our respective groups:

- ERIC is the only national association that advocates exclusively for large employers on employee benefit public policies at the federal, state, and local levels.
- PBGH is a not-for-profit business coalition focused on improving the quality and affordability of health care. PBGH supports some of the largest companies in the country in implementing innovative solutions to improve health care outcomes and value.
- The Leapfrog Group is a national nonprofit organization driving a movement for giant leaps forward in the quality and safety of American health care.

Collectively, our organizations (and the *DRIVE Health Initiative*) are dedicated to improving the health care system, helping patients make informed decision, driving quality and value, and reducing health care costs. We believe that improved transparency is critical to these goals, and are eager to participate in efforts to further this cause.

As you know, more than 178 million Americans currently obtain health insurance through an employer-sponsored plan. On average, employers pay about 75 percent of health care costs on behalf of plan beneficiaries – including employees, their families, and retirees. Employers offer this coverage on a voluntary basis, and are on the forefront of innovation in the health care system. Employer-sponsored plans were innovators and early adopters of health information technology (HIT), care coordination models and accountable care organizations (ACOs), centers of excellence programs, reference pricing, and numerous strategies aimed at leveraging cost and quality data to help patients seek out the best care at the best prices.

Employers will continue to fight to inject more transparency and value into the health care system; however, action by Congress, leading the way with Medicare and the 100 million Americans enrolled in

government-sponsored health programs, and leveraging these programs to implement change in the private sector, could dramatically accelerate system improvement. Below, we will respond to selected questions laid out in your February 28, 2018, request for comments.

I. Why transparency is needed now more than ever

Before responding to specific questions, we feel that it is important to lay out why this project is extremely timely. As you are no doubt aware, a great deal of change has taken place in health care markets over the last several decades. Whereas “the norm” in the past may have been a PPO or HMO plan, wherein beneficiaries had relatively fixed costs, whether for a primary care visit, a specialist, or filling a prescription, and costs were more directly managed by the plans, that norm has evolved.

Increasingly, Americans are enrolling in consumer-directed health plans, which put patients in the driver’s seat. This year, more than 20 million Americans are enrolled specifically in plans paired with Health Savings Accounts (HSA)s, many because they choose to do so, as well as many because their employers have moved to full replacement, eliminating other plan options in order to focus on the consumer-directed plans. These plans are growing at a rapid rate, and show no sign of abatement – but at the same time, there are both challenges and rewards in this development.

The challenges are surmountable but stark. For instance, many of the rules governing these plans were crafted in the early 2000s, when the health care markets looked very different, and our understanding of the solutions to the cost and quality conundrums were less evolved. Much of this might be fixed with passage of legislation such as the *Bipartisan HSA Improvement Act* (H.R. 5138), but more improvements would still be needed. Perhaps the most pressing issue that would still need to be addressed would be transparency – after all, without the ability of patients to make informed decisions, consumer-directed health plans simply don’t work.

But the rewards are also significant. By making savvy purchasing decisions and engaging in their own health (via wellness programs, incentives to choose high quality providers, etc.) patients can drastically improve their outcomes and reduce their financial exposure, even turning a consumer-directed account into a powerful retiree health savings vehicle. Employers are increasingly providing patients with tools that allow them to see ratings and reviews of providers, as well as shaping plan design in such a way that rewards patients who seek out the highest quality providers and the most efficient medications.

And consumers are increasingly hungry for this information. Millennials, for instance, have grown up with instant access to pricing data across multiple platforms for every other good and service that they purchase. They devour written and video reviews, peruse pro-and-con websites, and aggregate expert advice with crowd-sourced consensus. These consumers will not accept the current state of transparency in the health care system for long, and when change comes, the system will be better for it.

II. Addressing anti-transparency arguments

Health care may be the only market in which numerous actors insist that more information could lead to worse outcomes – higher prices for goods and services, confusion over provider quality, and a diverse parade of horrors. And now that health care encompasses nearly 1/5th of the United States’ economy, there are a huge amount of resources at stake that serve as a significant incentive for many to preserve the status quo.

But the system is also currently unsustainable. Prescription drug costs, for example, are rising at a far faster rate than the economy is growing, and new treatments are being developed, but offered at prices that are far out of reach for most people. Even sophisticated purchasers may not know the actual price of the products they are buying, or have sufficient comparative effectiveness data to know which products are the best quality for the costs incurred.

Recent press has focused on the difference between the “list price” for pharmaceutical products, and the prices that patients are expected to pay – and the Administration has fixated on this as well – but it is no different when it comes to inpatient costs. Hospitals’ list prices are equally outside the limits of what any reasonable purchaser would pay, perhaps because this helps to boost the appearance of charity care, or increase the perceived discounts that negotiating partners can obtain. But it certainly obscures from patients the information they need to know in order to be smart shoppers.

As such, inpatient costs are often unpredictable for patients. Providers are often unable or unwilling to give patients a full understanding of the costs of an episode of care, and you have no doubt seen a spate of reporting of late, relating tales of patients receiving incredibly high balance bills. It may not be practical for the federal government to require a facility or provider to participate in networks, or to charge reasonable prices, but shining the light of transparency could do a great deal to alleviate a lot of suffering that patients currently face. And employers strongly support efforts to protect employees from unscrupulous practices such as improper self-dealing in referrals, drive-by doctoring, facilities that are in-network but are staffed almost entirely by out-of-network providers, and other snafus that could only make sense in health care.

When the Centers for Medicare and Medicaid Services (CMS) has attempted to help inform patients by providing quality and outcomes data, those attempts have been met with significant resistance. The fact that 50% of facilities and providers will always by definition be below average appears to cause significant consternation. As such, simple metric-driven ratings such as the CMS Hospital Compare Star Ratings come under constant fire. The new Medicare physician payment system outlined in the MACRA legislation, which takes into account quality reporting by providers, is likewise under siege, and already various stakeholders are suggesting it be thrown out. It’s no different in the private sector, where insurance companies have been sued for providing information to patients, and some providers even demand that patients sign gag-orders before obtaining care. This is a culture that must change, and your efforts should lead that charge.

III. DRIVE Health Initiative response to specific transparency questions

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

The current state of performance measurement and public reporting is dismal. Consumers and purchasers simply do not have sufficient information to choose the providers and treatments that they want. While there has been some gradual progress in the last 20 years, most consumers and patients feel “in the dark” when making critical choices. Without this information, patients are at risk and may unknowingly be receiving services they don’t need from providers who are sub-par.

The gaps in health care performance measures have been well-documented¹. From our perspective, a robust performance measurement set should include:

- Clinical outcomes (e.g., what percentage of patients died within 30 days after heart surgery?)
- Patient-reported outcomes (e.g., did your pain decrease after treatment?)
- Patient experience (e.g., did your provider listen carefully to you and treat you with respect?)

In order to fill these gaps, funding is needed for the rapid development and testing of new measures.

We urge you to require all Medicare alternative payment models to include meaningful and useful publicly reported measures of patient-reported outcomes (PROs) as well as clinical outcomes and patient experience. Furthermore, steps should be taken to ensure health plan enrollees (including those in the Federal Exchanges and Federal Employee Health Benefits Program) have meaningful and useful quality information and price calculators that include plan- and provider-specific total costs and expected out-of-pocket costs for common inpatient and outpatient procedures and conditions.

Patient-reported Outcomes

Patient-reported outcome tools, patient-reported outcomes measures (PRO measures or PROMs), are essential components of a patient-centered health care system. PROMs enable value-based payment based on a co-definition of 'value' between the clinician and the patient by providing both a systematic channel for soliciting patient feedback and reliable data on the impact of care from the perspective of patients.

In the current landscape, PROMs are not widely available for many important areas of care quality. We urge CMS to invest resources and support the further development of PROMs by promoting adoption of PRO tools and meaningfully incorporating these tools into all aspects of care transformation and performance assessment throughout the Quality Payment Program (QPP).

Patient Experience

Patient experience measures are critical for quality improvement, consumer choice, and value-based purchasing. The Merit-based Incentive Payment System (MIPS) program presents an opportunity for CMS to reinforce the message to providers that patient experience is a key tenet of a person-centered health care system. We urge CMS to require a standardized patient experience measure for all MIPS clinician groups of 2 or more and to allow multiple standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) tools to fulfill the patient experience reporting requirement. The Consumer-Purchaser Alliance has previously recommended the use of specialty-specific CAHPS tools where available, such as the Surgical Care CAHPS instrument. CMS should not delay consumers' access to this information or delay requiring the robust collection and reporting of patient experience data using currently available tools.

¹ CMS Quality Measure Development Plan: 2017 Annual Report, Appendix C: Finding of the CMS MDP Environmental Scan and Gap Analysis Report. Accessed online 3/22/18 at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/2017-CMS-MDP-Annual-Report.pdf>

Patient Safety

Patient safety must be a critical component of the quality measurement equation. Particularly in high risk health care environments like hospitals, system-wide breakdowns in patient safety are frequent, harmful to patient outcomes, and lead to additional services and a higher total cost of care. A recent analysis published in the medical journal BMJ suggested that avoidable safety problems in hospitals may be the third leading cause of death in the United States, and analysis by The Leapfrog Group and others suggests that one in four patients experiences some form of harm when admitted to a hospital. The problems are ubiquitous enough that safety must be incorporated alongside quality and pricing analytics to get a full picture of the total cost and value of care. A complication that disables or kills the patient nullifies the value of the service.

National data on hospital safety is already available. Some of it is collected and publicly reported by federal entities including CMS and the Centers for Disease Control and Prevention (CDC). But there is a wide variety of hospital safety and quality data that is collected at the federal level, but not made available to the public. This includes hospital accreditation reports, registry data, and some of the CDC's National Healthcare Safety Network data. If this information was transparent and available to all consumers, employers, and payers, they would be able to make more informed decisions about where to receive care.

We recommend reinstating the hospital-acquired condition measures removed from the Inpatient Quality Reporting Program in 2013. These are measures of events purchasers call “never events,” such as objects left in after surgery, which CMS no longer reports on its public-facing website. Moreover, there is virtually no information reported at all on the safety of ambulatory surgical centers (ASCs) or outpatient surgical units, despite the fact the majority of surgeries are now done there. With only about five safety measures reported for ambulatory surgical centers, CMS recently removed one of them without explanation--use of a surgical safety checklist in the OR.

Ambulatory Surgery Centers

Employers are encouraging movement of employees to ASCs and less-invasive outpatient options for appropriate surgical procedures, but there is very little public information about the quality and safety of these options. In addition to increasing the amount of information publicly reported (which is minimal compared with other programs), HHS must make this data consistent and comparable across care settings; namely, between hospital outpatient departments and ambulatory surgical centers. People do not care who owns the operating room, a hospital or an ASC, they care whether the procedure will be performed in a safe, high-quality environment. Currently, CMS segregates reporting for hospital outpatient departments from ASCs—and then offers only a handful of measures for each. As a result, consumers have no data to compare among these two types of facilities, even when they offer the same service.

Limitations of the Quality Measure Menu Approach under MIPS

We remain very concerned about the limitations of the MIPS menu approach to selecting quality measures. A menu approach may lead providers to report only those measures for which they are high performers, obscuring results of poor care. A menu approach also prevents an “apples to apples” comparison among providers, leaving consumers and purchasers to make choices without critical

information about provider performance. As a recent MedPac report stated, MIPS scores are not comparable among clinicians because each clinician’s composite MIPS score will reflect a mix of different, self-chosen, measures.”²

Already, the pick-your-measures approach has created problems in MIPS program implementation, hindering CMS’s ability to both identify topped out measures that should be removed from the pay-for-performance segment of the program and evaluate meaningful quality improvement by clinicians. We support CMS’s intent to reward clinicians who make meaningful improvements in the quality of care delivered. However, without year-over-year reporting on the same quality measures, CMS cannot know whether or by how much quality has improved. The menu approach also undermines virtually any methodology used for identifying topped-out measure benchmarks. Calculating a measure’s benchmark using data only from those clinicians who choose to report on the measure provides an incomplete picture of performance on that measure.

CMS should move as quickly as possible to establish core sets of high-value measures by specialty or subspecialty. This is consistent with MedPac’s recommendation for an alternative to MIPS, in which clinicians would report on a “*Uniform set of measures in three categories: outcomes, patient experience, and value (cost/value); measures would be patient centered, comparable with measures used to assess A-APM performance and to assess quality across time and the delivery system.*”³ A core set approach using high-value measures would enable direct comparison among similar clinicians, with assurance that they are being assessed against a consistent and standardized set of important quality indicators that are closely linked to their clinical practice. Meaningful and actionable performance information is critical for consumers to make informed health care decisions, enabling them to take control of their health and health care.

In the near term, CMS should consider awarding bonus points to those clinicians who report on a complete Core Quality Measures Collaborative (CQMC) core measure set to promote alignment within the program as well as with other payers. The measures that compose the CQMC core measure sets have already been adopted into MIPS, and clinicians who report on a full set should be rewarded for their additional effort.

- *What is the best quality and price information to collect for consumers and businesses?*

Price information must be coupled with quality information. The real value of health care can only be measured by the combination of price, safety and quality. Price information alone is meaningless. Quality can widely differ among health care providers and facilities even within the same city. Consumers, payers, and employers deserve to have this data available to them so they can choose the best care at the best price. Moreover, price alone can be misleading about the actual cost. For instance, a procedure performed at an institution with a high complication rate will not necessarily lower costs even if the procedure is priced low. Maternity care at a hospital with a high C-section rate will often result in much higher costs, no matter what the price assigned to a vaginal delivery. The variation in

² Medicare Payment Advisory Commission, “Report to Congress: Medicare Payment Policy”, Chapter 15: “Moving Beyond the Merit-Based Incentive Payment System”. March 2018. Accessed online 3/22/18 at http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch15_sec.pdf?sfvrsn=0

³ Ibid.

health care performance is so significant these differences must be considered in order to address the cost problem.

One simple change that CMS could make would vastly improve the information available to the public on the performance of individual hospitals and physician practices: change the rules on assignment of Medicare Provider Numbers (MPNs). Currently, health systems can choose to assign one MPN to all of their hospitals and practices, even if they have a dozen or more. Consumers do not care about the infection rate at a health care system of ten hospitals, they care about the infection rate at the brick-and-mortar facility in their neighborhood. Medicare should require reporting by facility.

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

A national all-payer claims database (APCD), housed within the federal Department of Labor (DOL), could be a powerful tool for lawmakers, federal agencies, insurers, plan sponsors, and researchers to use in perceiving trends, designing benefits, early detection of problems among specific regions or populations, success or failure of various interventions, quality ratings and consumer empowerment, detecting and prevent patient safety incidents, comparative effectiveness research, accurate setting of reimbursement rates, and many more positive activities that will improve the health system.

First, though, one thing must be made clear: there is currently no such thing as an APCD. The reason for this is that those efforts currently underway, are unable to access the full scope of government claims data, as well as data protected under the Employee Retirement Income Security Act (ERISA). They could generously be referred to as “partial claims databases.” Often times they are drawn along arbitrary lines – for instance, a claims database bound within a state might make little sense, due to the intermingling of patients, plans, and providers in nearby states. Or a state with a significant population that participates in various government programs that do not share data, might end up with lopsided and misleading data.

It is imperative that the solution not be to drastically increase the administrative and compliance costs thrust upon plan sponsors (and government programs) by requiring that they comply with 50+ different state data collection practices, protocols, data formats, and the like. Instead, collection and aggregation should take place on the national level, by an agency such as DOL that understand self-insured plans, has experience working in collaboration with the Department of Health and Human Services (HHS), CMS, and other agencies, and is already a trusted partner to large plan sponsors. States also have experience reporting to and working with DOL, and the responsibility given to state entities to fulfill state-level obligations to the APCD will not be unprecedented or foreign.

While we empathize with the argument that different states may want to experiment with different models, we feel that this problem is abrogated by giving states the same access to the data that other stakeholders would have. A state would merely need to report in, and then have access to draw out data, either just about their state, or a broader data set. The problems associated with siloing data state-by-state are too great to justify such an approach – not to mention the unacceptable burden on multi-state plans and plan sponsors.

Also critical will be balancing protection of patient privacy, with openness and usefulness of the data. Regardless of how simple and straightforward data submission can be, there will be a cost associated with that process borne by plan sponsors (through their carriers and third-party administrators, PBMs,

etc.). However, that cost is an acceptable tradeoff in exchange for (1) avoiding the nightmare patchwork of 50 different state efforts and reporting requirements, and (2) access to the database in a meaningful fashion that allows plan sponsors to make informed decisions about benefits, networks, formularies, and the like.

Patient data must be de-identified in order to protect privacy and minimize damage associated with any security breaches. However, quality information will require the ability to track patient information for the same patient over time – this will be critical in understanding things like readmission rates, patient safety failures, and the effectiveness of various treatments. There are already generally accepted practices in this space that fulfill both the needs for privacy and for data completeness. Patients must maintain their full protections afforded under HIPAA, GINA, and other associated laws.

The potential for a national APCD is vast; consider the power of using supercomputers and advanced data algorithms to analyze the collected data, which could include: insurance claims, pharmacy benefit manager claims, dental and vision plan claims, workers compensation claims, claims from Medicare, Medicaid, or any other public health insurance program, including contracted and subcontracted managed care entities, information from the National Institutes of Health and the Food and Drug Administration, long-term care insurance claims, and much more.

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

It is important to educate consumers that price does not correlate with quality for health care services. Unlike the provision of goods and services in many other sectors of the economy, there is [little to no correlation](#) between price and quality when it comes to health care services. Consumers provided with price information alone will assume that a higher priced service equates with higher quality when, in fact, the opposite might be true. Because this is so counter-intuitive to how consumers think about and evaluate other goods and services, price information presented in isolation misleads consumers, often with unintended consequences. For instance, consumers may choose the highest priced provider under the assumption that is automatically the highest-quality provider.

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

Administrative costs in our health care system are too high, and the efforts to capture and report performance data contributes to those costs. In addition, these administrative costs reduce the time that clinicians can spend with patients, and they contribute to the problem of physician burnout. But there is another side of the equation: the costs of collecting and reporting performance data should be weighed against their benefits. The goal should not be to simply minimize the administrative costs for clinicians and health systems; the goal should be to *maximize the net value (benefits/costs) of gathering and reporting performance information*. As a recent position paper by American College of Physician stated, *“Perhaps the value added to patient care is high enough that activities that typically are viewed as burdensome—and that increase administrative work—are instead viewed as worthwhile.”*⁴

⁴ Shari M. Erickson, et al., “Putting Patient First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians”, *Ann Intern Med.* 2017;166:659-661. doi:10.7326/M16-2697

Every effort should be made to improve the efficiency of the processes of collecting and reporting performance data. Two primary ways to improve efficiency are to:

- Integrate data capture and reporting into normal clinical processes, ideally using electronic health record systems; and
- Align and standardize the performance measures requested by all payers, including Medicare, Medicaid and private health plans. Initial steps to align performance measures have been taken by the [Core Quality Measures Collaborative](#), currently led by CMS and AHIP.

We strongly support efforts to achieve both of these objectives.

- *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?*

Consumer-directed health plans

It was mentioned earlier that as greater numbers of individuals have enrolled in consumer-directed health plans, it has become apparent that some of the rules associated with those plans are holding back progress. Perhaps the most egregious of these rules is the current policy ban on allowing IRS-approved “high-deductible health plans” (HDHPs) from covering chronic condition management prior to a beneficiary meeting their annual deductible. As a result, an employer with a HDHP+HSA may not offer discounted or free insulin to a diabetic, or inhalers to an asthmatic, until that individual has met their (sometimes significant) deductible. This of course leads to decreased medication adherence, increased expensive in-patient interventions, and higher premiums for all plan beneficiaries. The same problem pertains to telehealth services, second-opinion services, onsite and retail medical clinics, and capitated primary care arrangements. Some of this could be addressed simply by changing IRS rules, but others would be better addressed legislatively, as laid out in the *Bipartisan HSA Improvement Act* (H.R. 5138) and the *Primary Care Enhancement Act* (S. 1358).

These barriers to value-based insurance design permeate the Medicare program as well. Rules should be changed to allow chronically-ill Medicare beneficiaries to have lower cost-sharing for high value chronic care management, especially in cases where providers have agreed to take on financial risk. Medicare Advantage plans could also benefit from increased flexibility to implement value-based design. The *CHRONIC Act* was a step in the right direction on this issue, but more action is needed.

Disclosure and notification requirements

One additional problem worth noting is that patients currently get “unnecessary information overload” throughout the health care system. Consider some of the incomprehensible information that makes its way to patients, as opposed to information that patients could actually use and learn from:

- “Summary of Benefits and Coverage” disclosures that are different from the more useful Summary Plan Documents provided by plans and plan sponsors
- “Explanations of Benefits” that can cause confusion

- Hordes of taglines required to be furnished with every “significant communication” from a plan under the HHS 1557 “nondiscrimination” rule
- Provider bills that are unclear on what the patient’s actual out-of-pocket cost will be
- A flood of plan beneficiary notices that under current policy cannot be delivered in an electronic, linked, organized fashion

This is just the tip of the iceberg, but the problem is that the more unnecessary and non-useful information patients receive, the less likely they are to read, comprehend, and act upon critical information that they truly need.

Access to out-of-pocket cost projections

And unfortunately, much of the information patients **do** need is lacking; for instance, patients (even those enrolled in exchange plans or the Federal Employee Health Benefits Program) are often unable to access provider-specific total costs and expected out-of-pocket costs for the most common inpatient and outpatient procedures and conditions. Many of the largest health systems in the country post almost no cost information online, especially information that would be useful to patients.

Health IT interoperability

Additionally, the lack of interoperable Health IT systems is hampering coordination of care, patient safety, and cost containment (through, for instance, elimination of unnecessary and duplicative tests). Electronic medical records (EMRs) must be universal, universally interoperable, accessible by the entire spectrum of a patient’s medical provider team, and include patient-generated data. This will never happen as long as the current “meaningful use” requirements remain weak, and provider reimbursement in public programs is not stricter on demanding integration of EMRs and other HIT components.

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

Reporting and incentives

Provider payment in the private sector is often based at least in part upon payment levels set by public programs. As such, the effectiveness (and value-centered nature) of those public program payments is critical to improving quality and controlling costs in the private sector. As MACRA implementation continues, it is critical that there are strong incentives for provider quality, that alternative payment models move forward with meaningful financial incentives, that alternative payment models move forward promptly and comprehensively, and that public reporting of meaningful performance measures is mandatory and wide-spread. It is imperative that provider participation in a system that is moving toward value over volume is mandatory, not voluntary.

Innovation

Employer plans are able to be nimble and innovative, but often times public payers are much slower to pick up on best practices and new innovations. One exception to this is the Center for Medicare and Medicaid Innovation (CMMI), which fast-tracks pilot programs and can make changes permanent when they show real return-on-investment for cost-savings and patient outcome improvement. It is critical that the pilots and innovations proposed by CMMI be supported, that CMMI be maintained, and that Medicare and Medicaid continue to become better “early” adopters of successful health improvement and cost-containment strategies.

Alternative payment models

Medicare's ACOs and alternative payment models (APMs) are also experiencing problems, due to barriers created in the wake of the Affordable Care Act and MACRA. For instance, larger financial incentives are needed for providers who take on two-sided financial risk, regardless of the future of MIPS. And patient engagement in health management is greatly hampered by the decision to "attribute" Medicare beneficiaries to an ACO, rather than encourage them to opt-in and participate. And in the case of providers taking on risk, this should alleviate some of the budgetary concerns surrounding the use of telehealth in Medicare – those providers should be encouraged to implement telehealth services.

Telehealth

Because medicine is regulated on the state level, states have an important role in ensuring that patients have access to the information they need, on the ground, to make informed medical decisions. It will be important for federal programs to use federal funding as a lever to ensure that states meet minimum standards of transparency. To the extent that federal policy can help to encourage states, to in turn encourage providers and others in the health system to make prices open and transparency, this activity should be pursued.

Also worth noting is that state rules for telehealth vary widely. Until recently, many states simply had no laws regulating telehealth, and as more states move to implement comprehensive telehealth legislation, this legislation is often useful to providers and devastating for patients. For instance, some states have implemented policies mandating that:

- A patient may not see a provider via telehealth unless the two have a pre-existing provider-patient relationship – one state even attempted to ban telehealth specifically and only for mental health services in this manner;
- A payer must reimburse a provider the same amount (or more) for a telehealth visit as for an in-person visit, despite the cost savings a provider can obtain by doing telehealth services;
- A patient may only access telehealth services from a designated telehealth facility; or
- A provider may only offer telehealth services if they use certain technologies or mediums.

This list is not comprehensive, but serves as a good example of the ways in which state laws are inhibiting progress in the telehealth space. Although the practice of medicine will continue to be regulated on the state level for the foreseeable future, Congress should explore options and levers to prevent these kinds of barriers, to encourage a national standard of care with telehealth services, and provide access to as many Americans as possible to potentially life-saving telehealth services.

Inappropriate 3rd-party steerage

CMS has been struggling with a similar problem that plan sponsors have on the issue of interested third parties who are steering patients to plans and facilities not for the benefit of the patient, but to maximize the reimbursement for the providers. This primarily takes two forms:

1. Kidney dialysis providers fund a charity, and use the charity funds to pay COBRA or individual market premiums on behalf of patients (steering them out of Medicaid or Medicare). These patients are not informed that the reason for this is to vastly increase provider reimbursement, and often this can increase out-of-pocket costs for patients significantly.
2. In-network providers who have an ownership interested in out-of-network facilities refer patients there to undergo treatment. This again vastly increases provider reimbursement, but

can have deleterious effects on patients' costs and quality of care – and potentially lead to significant balance bills.

Both of these kinds of steerage result in significantly inflated costs for beneficiaries of the plans in which patients are steered to, by requiring that premiums be increased to cover the increased costs experienced by the plan. This steerage is causing destructive adverse risk in the ACA individual market exchanges, as well as increasing premiums in the employer-sponsored health insurance system. As such, increased disclosure and reporting from, and regulation on, providers with ownership interests in out-of-network facilities, as well as from dialysis providers and providers in general that fund self-dealing charities, is needed.

IV. Conclusion

Thank you for the opportunity to participate in this important conversation. We hope the *DRIVE Health Initiative* and our respective organizations can be a partner and a resource in efforts going forward to improve the health care system by driving value, transparency, cost-efficiency, and quality throughout. If you have any questions or comments, or would like further information, please contact James Gelfand, Senior Vice President for Health Policy, ERIC, at (202) 789-1400, or jgelfand@eric.org, or Bill Kramer, Executive Director for Health Policy, PBGH, at (503) 679-8390, or wkramer@pbgh.org.