



CLEAR CHOICES

A MOVEMENT FOR INFORMED HEALTH CARE

January 26, 2016

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Johnny Isakson
Senator
Committee on Finance
United States Senate

The Honorable Mark Warner
Senator
Committee on Finance
United States Senate

Submitted electronically

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The Clear Choices Campaign is pleased to offer our input to the Senate Finance Committee Chronic Care Working Group on policy options to help improve outcomes for Medicare patients requiring chronic care.

Clear Choices is a multi-stakeholder advocacy association dedicated to making health markets more transparent, accountable, and consumer-friendly. We are committed to ensuring that patients have access to relevant, meaningful, and actionable information so they can make informed decisions about their health care and health coverage. We believe doing so will not only empower consumers, but also improve quality and health outcomes while lowering health costs. Realizing this potential will require the broader availability and use of data to generate meaningful and accurate comparative information on health plan and provider choices. More information is available at www.ClearChoicesCampaign.org.

Our recommendations to help better manage chronic conditions through transparency and quality metrics are outlined below, and include:

- Providing beneficiaries with accurate, practicable quality information;
- Providing beneficiaries information on the total and out-of-pocket costs for procedures across sites-of-service;

- Requiring greater transparency and opportunities for public input from federal agencies; and
- Empowering beneficiaries to make better, more informed decisions about their current and future treatment options.

These comments reflect the positions of the Clear Choices Campaign, but may not necessarily reflect the individual views of our members.

Background on Chronic Illness, Transparency, and Consumer Engagement

Care for chronic diseases imposes a staggering cost burden on Medicare. According to the Medicare Payment Advisory Commission’s (MedPAC) March 2015 report,¹ Medicare beneficiaries with six or more chronic conditions accounted for 46 percent of all program spending in 2010—at an average \$32,658 per such beneficiary, compared with an average of \$9,738 across all other fee-for-service (FFS) beneficiaries. A factor driving this increased spending is the different prices in Medicare for the same or similar medical services across sites-of-service and the difficulties beneficiaries face in attempting to comparison shop based on little or no available evidence on either cost or quality. Given the substantial costs associated with chronic care, we believe improving both price and quality transparency for differing sites-of-service would be a crucial step to empower chronic care beneficiaries to better manage their health while positively impacting provider and plan behavior to contain costs and improve quality.

To best support a functioning, competitive marketplace, consumers need more actionable information on the upfront costs and quality of their potential choices to better stimulate innovation by directing their business to more efficient providers.² Hospitals have 20,000-30,000 items in their “charge masters,” which generally consist of list prices charged only to those patients with the least market power—mainly the uninsured.³ The complexity and unreliability of this price information, and its lack of integration with quality measures, has reduced the effectiveness of early attempts at price transparency. Consumers need highly reliable information, reflecting the actual costs of bundled services, in order to better make rational choices.

Clear Choices is enthused that the Committee is looking at enhancing these aspects for Medicare beneficiaries in certain instances, but we stress that more can be done to increase transparency in a meaningful way for consumers.

¹ “Context for Medicare Payment Policy.” Medicare Payment Advisory Commission, Mar. 2015. [http://www.medpac.gov/documents/reports/chapter-1-context-for-medicare-payment-policy-\(march-2015\).pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/chapter-1-context-for-medicare-payment-policy-(march-2015).pdf?sfvrsn=0)

² “Improving Health While Reducing Cost Growth: What is Possible?” Brookings Institution, Engelberg Center for Health Care Reform, Apr. 2014. http://www.brookings.edu/~media/events/2014/04/11%20health%20care%20spending/improving_health_reducing_cost_growth_mcclellan_rivlin.pdf

³ “Hospital Costs Go Public: What Changes in Health Care?” NPR, 8 May 2013. <http://www.npr.org/2013/05/08/182295999/dramatically-different-health-care-cost-go-public>

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), Title XVIII requires the Secretary of the Department of Health and Human Services (HHS) to establish a plan for the development of quality measures. Clear Choices believes this will be profoundly important for beneficiaries in making appropriate and informed care decisions. These quality metrics should be structured in a manner that minimizes burdens on providers for reporting data and increases reliability, accuracy, and meaningfulness to consumers.

Finally, Clear Choices is also encouraged by the call for more transparency and opportunities for public engagement on behalf of federal agencies, particularly on policies that could have enormous impact on patients, providers, payers, and the overall health care system.

Recommendations

Clear Choices believes empowering beneficiaries and their families to make informed decisions about and remain invested in their care should be a core goal of federal health policy. Any reforms aimed at improving chronic care management and outcomes should keep this principle in mind.

To this end, we recommend that the Senate Finance Committee advance policies to:

1. **Improve Quality and Pricing Data.** Appropriate measurement and reporting of health care quality is important for informing and empowering beneficiaries and achieving better care and patient outcomes. Clear Choices supports the Committee in requiring HHS to include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease as well as process measures that aid the achievement of optimal outcomes.

In developing quality metrics, a balance should be struck between process measures and outcomes measures used in federal programs. While Clear Choices believes that outcome measures should be emphasized, process measures that are directly related to outcomes also play a vital role in ensuring that federal programs use measures relevant to both providers and patients. Included in the measures set should be metrics related to population health, improvements in patient outcomes, and those that indicate gaps in care.

In approving these measures, HHS should work with physician groups and other key stakeholders to consider ways to appropriately release quality data paired side-by-side with related cost data, which may include claims or encounter data. Measures of cost linked directly to a patient outcome measure would be more specific and actionable than the current total cost of care measures used in federal reporting programs. In addition, research shows that when cost data is presented alone, beneficiaries equate or relate higher cost providers with higher quality, when more frequently the opposite is true. While not addressed in the policy options paper, Clear Choices urges the Committee to take this opportunity to direct HHS to link cost and quality for beneficiaries and other stakeholders when approving quality measures.

Specifically, Clear Choices encourages the Committee to couple quality data with the following price transparency data:

- a. **Provide beneficiaries information on the total and out-of-pocket costs for procedures across sites-of-service.** This will help to empower beneficiaries to choose the site-of-service that best meets their needs. In its June 2013 report,⁴ MedPAC identified 66 codes related to ambulatory payment classifications that could have the same Medicare payment rate whether they are provided in a hospital outpatient department or in a physician’s office. If beneficiaries have information on lower cost options for the same or similar services, they could reduce their cost sharing. For example, chemotherapy costs are \$6,500 more in a hospital outpatient department setting compared to in a physician office.⁵

Specifically, we recommend requiring HHS to establish and update annually a searchable public website that discloses the estimated costs to the government and to beneficiaries of Medicare services provided in hospital outpatient departments compared to ambulatory surgical centers and physician offices. To the extent practicable, existing mechanisms, such as the CMS Physician Compare website, should be used to make the required information available online.

In addition, the price information disclosed for the services should ideally include:

- c. The list of providers at applicable sites-of-service;
 - d. The site-of-service with the maximum out-of-pocket cost for a beneficiary, including plan deductible and cost sharing; and
 - e. The site-of-service with the lowest out-of-pocket cost for a beneficiary.
- b. **Provide certain information with respect to providers and plans directly to the public.** This will help to facilitate Medicare beneficiary comparison-shopping. The great preponderance of health expenditures go toward care for patients with complex, individualized needs. Hospital charge masters, meanwhile, have up to 30,000 items. This complexity makes the business of medicine ill-suited to organization on a retail model. Nevertheless, some medical services, such as knee replacements, colonoscopies, and vaccinations, are relatively standard and thus amenable to retail price comparisons. Finally, health insurance itself is a retail product that beneficiaries can compare and purchase on the individual policy market. To support beneficiary choices, the Committee should:
 - c. **Require hospitals to disclose online the average amounts paid for common tests and procedures.** Most providers do not provide prices publicly, and if they do, the prices typically reflect “charges”—list prices—that often exceed actual amounts

⁴ “Medicare Payment Differences Across Ambulatory Settings.” Medicare Payment Advisory Commission, Jun. 2013. http://medpac.gov/documents/reports/jun13_ch02_appendix.pdf?sfvrsn=0

⁵ “Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy.” Milliman, 19 Oct. 2011. <http://us.milliman.com/uploadedFiles/insight/health-published/site-of-service-cost-differences.pdf>

collected by several fold. In the last Congress, Senators Tom Coburn (R-OK) and Claire McCaskill (D-MO) introduced legislation to require Medicare subsection (d) hospitals to disclose the average amounts paid from privately insured and uninsured patients for the 50 most common DRGs and APCs.⁶ We believe this approach can help better inform Medicare beneficiaries with chronic illness about their options.

d. **Direct and provide resources for CMS to streamline and enhance the Medicare Plan Finder and five Medicare Compare websites to improve beneficiaries' access to relevant and understandable information on the cost and quality of health care services.**⁷ We note that this process should be completed in concert with implementation of MACRA, which requires CMS to make quality measures more meaningful, useful, and transparent to beneficiaries. Specifically, we recommend requiring CMS to:

- A. Provide beneficiaries with comparative quality information side-by-side with price data across various plan options;^{8,9}
- B. Provide in-depth information on the estimated out-of-pocket costs for Medicare beneficiaries for common in-network services, customized to the beneficiary's personal information as feasible;
- C. Allow beneficiaries to customize the provider information presented to highlight the data most relevant to them; and
- D. Expand the provider information made available to include more topics relevant for beneficiaries, such as patient-reported outcome measures.
- E. Provide online decision support tools and assistive and cognitive technology tools, such as virtual assistants, to help consumers better understand the information provided and help them arrive at the best plan decision and best doctor.

2. **Increase Transparency and Opportunities for Public Engagement in Federal Agencies.**

Clear Choices supports the Committee's efforts to increase transparency about federal agency actions, especially the Center for Medicare and Medicaid Innovation (CMMI). Clear Choices is concerned that CMMI has been opaque in its development of models that will

⁶ S. 2005, the CLEAR Cost Information Act, available here: <http://www.gpo.gov/fdsys/pkg/BILLS-113s2005is/pdf/BILLS-113s2005is.pdf>

⁷ "HEALTH CARE TRANSPARENCY: Actions Needed to Improve Cost and Quality Information for Consumers." Government Accountability Office, Oct. 2014. <http://www.gao.gov/assets/670/666572.pdf>.

⁸ "Report Card on State Price Transparency Laws." Catalyst for Payment Reform, 25 Mar. 2014. <http://www.catalyzepaymentreform.org/images/documents/2014Report.pdf>.

⁹ "Recommendations to Achieve a More Transparent Health Care System for Consumers." Engelberg Center for Health Care Reform, Brookings Institution, Feb. 2015. <http://www.brookings.edu/~media/research/files/papers/2015/02/03-medicare-physician-payment-data/health-policy-brief--recs-for-transparent-health-system.pdf>.

have a major impact on patient care and in reporting the outcomes of its research. This is particularly troubling in cases where model participation is mandatory.

Clear Choices recommends that all demonstrations coming from CMMI should be required to go through public notice and rulemaking if they are estimated to have a significant impact on Medicare spending, provider effort, beneficiary access or cost, or if model participation is mandatory.

We appreciate that the rulemaking process may slow the implementation of models, but this does not discount the need for adequate notice or opportunities for feedback from stakeholders, particularly beneficiaries and those charged with their care. In cases where demonstrations will have a smaller impact or existing demonstrations will be modified or expanded in a manner that is predictable, the Committee should require adequate notification of all planned models to Congress and further require the consideration of feedback from the body.

Too many important policy decisions are being made and effectuated at the sub-regulatory level, with little or no public input. This should change so that all may participate in the input process.

- 3. Empower beneficiaries to make better, more informed decisions about their current and future treatment options.** Clear choices is broadly supportive of any policies aimed at improving the treatment and management of chronic conditions through better patient engagement. Accurately and adequately educating beneficiaries on their treatment options is one key way to do this.

While not addressed in the policy options document, Clear Choices feels that including policies that will spur greater education and empowerment of beneficiaries should be a key component to any reform package. For example, policies contained in both the *Care Planning Act of 2015* (S. 1549) and the *Medicare Choices and Empowerment Act of 2015* (S. 2297) seek to incentivize both patients and their providers in taking critical steps to engage on treatment options and decisions that must be made at the end of life. Discussing, planning, and creating an advanced directive is critical to the empowerment for all Medicare beneficiaries, but particularly those facing multiple chronic conditions.

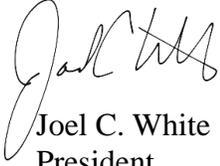
We urge the Committee to consider these particular policies and others that seek to educate and empower consumers as it finalizes its reform package.

Conclusion

We appreciate the Committee's leadership on this crucial issue and are pleased that the Chronic Care Working Group intends to take steps to improve Medicare beneficiaries' role in managing their health care.

We look forward to continuing to work with you to ensure that all beneficiaries and stakeholders have access to the information they need to make better health care choices.

Sincerely,

A handwritten signature in black ink, appearing to read "Joel White", written in a cursive style.

Joel C. White
President
Clear Choices Campaign