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March 23, 2018

U.S. Senate
Washington, D.C. 20510

RE: Solicitation for Stakeholder Input related to a bipartisan effort to increase health care price and information transparency dated March 1, 2018

Submitted electronically via *transparency@cassidy.senate.gov*

Dear Senators Cassidy, Bennet, Grassley, Carper, Young, and McCaskill:

UnityPoint Health ("UPH") applauds this bipartisan effort to solicit stakeholder input in its examination of health care price and information transparency. We agree that consumers should have access to health care information that is accurate, standardized, meaningful, and easily understandable. UPH is one of the nation's most integrated healthcare systems – the 13th largest non-profit healthcare system and the fourth largest nondenominational healthcare system. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 32 hospitals in metropolitan and rural communities and home care services throughout our 9 regions, UPH provides care throughout Iowa, western Illinois and southern Wisconsin. On an annual basis, UPH hospitals, clinics and home health provides a full range of coordinated care to patients and families through more than 6.2 million patient visits.

We respectfully offer the following comments.

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

Consumers can contact UnityPoint Health hospitals directly to obtain estimated pricing information from our billing offices for specific procedures or services. In addition, UPH participates in state hospital association efforts in our various jurisdictions to make pricing information available to consumers. We have links on each UPH hospital website to these resources. The pricing information that is available from the hospital associations varies among the states, and some allow information to be compared among facilities within that state. The major limitations with these tools are that data are confined to a specific state, limited to hospital stays and procedures, and based on charges.

Out-of-pocket costs are the costs that are most meaningful to consumers, as it is the amount for which they are responsible. Out-of-pocket costs are most readily available from a consumer's insurer or

health plan and may be obtained by contacting the health plan directly or through a consumer's employer. As opposed to a health care provider, the third-party insurer will have access to the consumer's contract rates and specific benefits, such as deductibles, co-pays, or co-insurances.

Quality information is available from a multitude of sources, including providers, payors, third-party quality organizations, and consumer advocacy groups. In some instances, quality information is included within hospital association pricing websites and provided by insurers when out-of-pocket estimates are requested. Medicare has several "Compare" tools to assist consumers with comparing quality by sites of service – hospitals, physicians, home health, nursing homes, dialysis facilities, long-term care hospitals (LTCH), inpatient rehabilitation facilities, and hospice. At UPH, our website links consumers to CMS measure results for Heart Failure; Heart Attack; Pneumonia; 30-Day Readmission and Mortality; Surgical Care; Healthcare Associated Infections; Preventive Care; Emergency Department Care; and Use of Medical Imaging. Results for these measures are consistently provided for each UPH hospital regardless of our achievement/scores, so that consumers have an easy method to compare UPH care to the care of other providers. We do not believe that it is helpful to restrict public reporting to only measures where our performance exceeds state and/or national trends.

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

We are not aware of a reliable, comprehensive pricing and quality resource, meaning a single resource that shows both hospital and physician measures for quality, cost, and patient satisfaction. Such a resource would be powerful. Typically, the cost information available on the Internet targets the hospital component and is based on charges (not contracted negotiated rates). The physician component adds another pricing and quality layer, which quickly becomes more complex for services or procedures that have multiple physicians – surgeon, radiologist, pathologist, anesthesiologist, hospitalist, and/or primary care.

While we support the efforts of the state hospital associations aimed at price transparency, their reports and consumer tools for dissecting the data vary greatly. We believe this presents an opportunity for improvement and is a forum that CMS should review for pricing tool best practices. Consumers would benefit from being able to navigate standardized measures and reports. A minimum reporting standard, which health care providers could choose to supplement, would promote an apples-to-apples comparison nationally. For UnityPoint Health, our footprint extends across multiple states and we have four regional integrated systems located in border communities. Under the current system, it is difficult for consumers in border communities to readily compare services across state lines.

The CMS Compare websites are a good start for quality information; however, there is much room for improvement. First, the time lag for data publication to the Compare websites is too long, especially if we are steering consumers there to make health care decisions. Second, Compare websites do not include meaningful cost or pricing measures. Third, Compare websites can be difficult to navigate and their composite measures are not necessarily intuitive or consumer friendly.

While the above recommends tools for consumers to access information, the crux of the issue is the current pricing structure and quality measurement. Ideally, consumers should have the ability to easily access, through a centralized website or smartphone app, the price of procedures, tests, and visits from all providers that participate in the Medicare program. We do not believe that information on charges empower consumers in their health care decisions. The ideal state is not supported by reality, and the healthcare industry should reexamine the way prices are set. Currently, providers set prices at very high levels (i.e. charges) that allow for huge write-offs. Prices do not reflect costs. This is an opportunity for CMS to lead because they have this data for Medicare. At first, it would just highlight the differences between places of service. But, as commercial price inclusion is required, the market will begin to drive toward price normalization, just like every other major industry (gas, grocery, etc.). This will bring into view the reality that some markets, with a higher percentage of Medicare lives to all covered lives, generally have higher prices with commercial payors to shift costs to make the total revenue stream sustainable for providers.

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

Given the flawed pricing structure, this is a difficult question. If there is true price transparency, then cash price becomes irrelevant. Based on the current system, it may seem reasonable to require health care providers to publish their cash discount policy so consumers can obtain a "sticker price"; however, it is doubtful that a sticker price approach will be helpful to encourage providers to transition from volume to value. If cash price is defined as out-of-pocket costs, this effectively removes consumer responsibility from impacting total cost of care. Because of plan design, there is a disconnect between their utilization patterns and impacts on health plan rates, whether it is an employer contribution or a taxpayer contribution. From the macro perspective, the employer expense impacts the overall compensation to the employee – i.e. if employers pay more for insurance, this decreases the overall budget including funding for pay rate increases. This is equally true for Medicare or Medicaid – i.e. if the government pays more for Medicare, this decreases the overall budget for potential coverage options within Medicare or overall spending for other government priorities. While consumers are demanding greater transparency for pricing and improved data access, we would encourage a structure that pairs information access with greater accountability for costs.

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

Although we have some general observations, UPH is not located in any of the states referenced and would rely on providers within those states to better explain the nuances of these approaches. That said, we believe that the differences in state approaches signals that CMS should take the lead in identifying a standard methodology for collecting and reporting price and quality information.

Pricing information should include both hospital and physician costs and the best source for this is the consumer's health plan. Prices based on charges are not meaningful to consumers and prices based on surveys raise questions regarding the response rate and the thoroughness of those responses. None of the state approaches appear to be particularly helpful for uninsured consumers.

For quality, it is illogical that health care quality should be defined and measured differently once you cross a state border. There needs to be a consistent definition and reliable source of quality measures. There are several quality rating agencies and comparisons of these agencies have found they judge quality inconsistently. It should be prioritized that we establish one "true north" for quality. We call on CMS to develop a small common set of outcome measures around quality as well as a standard list of common procedures/services/tests/visits to start the transformation. Outcome measures could include average length of stay, quality ratings, mortality, and complication rates.

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

CMS should start a process of "right" pricing for Medicare, and CMS should develop a single standard of how to share the information, regardless of whom provides it. If an all-payer system is envisioned, we would suggest a public/private clearinghouse with governance to be determined by an advisory board appointed by Congress.

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

In addition to increasing available information on price and quality for consumers, an all-payer database supports value-based arrangements for providers in Advanced Alternative Payment Models who are responsible for total cost of care. It is our belief that by opening price transparency, prices will quickly normalize, health care operations will become more efficient, and health care competition will essentially be about quality. For pricing, the all-payer database will highlight disparities in government and commercial reimbursement across markets and force discussions about equalizing prices across broader geographies.

We support the creation of all-payer claims databases and encourage CMS to take a lead role in creating data standardization and governance rules for these databases with input and feedback from stakeholders. As a multistate health care organization, we cannot understate the importance of having a single standard across states, instead of complying with one-off solutions in each state. When designing and implementing, CMS should address potential barriers head on and weigh operational costs to providers, including vendor costs and access fees, among other technical considerations such as format, validity checks, data confidentiality, and training requirements. It also should be noted that all-claims databases by their very nature are limited in that they do not capture uninsured services or denied claims.

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

Our focus should be on engaging consumers in their care. To do that we need to be transparent about what consumers can expect from their providers. The better picture we paint, the better consumers can predict an outcome. This is aided when we have standardized quality outcome measures and technology in place that enables easy access to the information. In addition, consumers need to be able to understand the data, and payors and providers both have a role to provide knowledgeable

experts to provide context for the data. Among the important take-aways for consumers are (a) lower costs do not automatically equate to lower quality; (b) understand what the data / numbers mean (i.e. whether a high percentage is desirable or undesirable); and (c) other patient experience data, such as safety and patient satisfaction, may be available to complement price and quality information and can be factored into health care decision-making process.

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

The health care industry is one of the most regulated industries. While UPH would be opposed to duplicative/unnecessary reporting burdens, we understand that new/different burdens are likely when an industry transitions from an historically inefficient model. As proposals are considered and specific statutory or regulatory language developed, we encourage Congress and CMS to continue to seek stakeholder input as barriers may not always be apparent. Case in point is QualityNet, established by CMS. QualityNet houses reports to monitor performance under various CMS quality programs including the Inpatient and Outpatient Quality Reporting, Value Based Purchasing Program, HAC Reduction Program, and Hospital Readmission Reduction Program. UPH regularly uses QualityNet reports, such as (1) Overall Hospital Star Rating Hospital Specific Reports, (2) Hospital Value-Based Purchasing (VBP) Percentage Payment Summary Report (PPSR); (3) Hospital-Acquired Condition Reduction Program Hospital Specific Reports; (4) Medicare Spending per Beneficiary Hospital Specific Reports; (5) Public Reporting Preview Reports; and (6) Hospital Readmission Reduction Program Hospital Specific Reports. While each UPH hospital can access these reports through the QualityNet secure file exchange, our centralized UPH analytics personnel with QualityNet Healthcare System level access cannot receive these same reports. This requires duplicative steps by our centralized analytics team to request these reports from each hospital, which is both unnecessary and time consuming.

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?***

To be more cost-efficient, providers who are participants in two-sided risk bearing Advanced Alternative Payment Models should be able to provider steerage to high quality providers.

Since the initial enactment of the Anti-Kickback Statute (AKS) and the Stark physician self-referral law ("Stark"), the delivery of health care services and the payment for those services – among all payers, both government and private – has changed dramatically. Health care professionals face the challenge of trying to achieve system-wide clinical and financial integration to lower costs and improve health access and outcomes, while simultaneously complying with current Stark and AKS laws that create care silos. This is particularly evident in two-sided Advanced Alternative Payment Models, such as the Next Generation ACO. Unless changes are instituted, providers will be discouraged from transitioning to risk arrangements, and savings to Medicare that were intended by Congress will not be realized.

UnityPoint Health does not want to miss an opportunity to encourage a more robust system to share Medicare claims data for attributed patients. We are supportive of sharing both raw claims-level data and claims summary data. In addition, we would like to encourage HIPAA flexibility to facilitate improved service delivery:

- Access to substance abuse records by treating providers.
- Permit sharing of patient medical information between managed care plans and associated providers.
- Permit sharing of patient medical information within a clinically integrated care setting. HIPAA currently restricts the sharing of a patient's medical information for "health care operations."

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?

Foremost, CMS needs to continue to focus on population-based outcome measures, instead of a long list of process metrics. Big data should be targeted and actionable. Just because data can be collected and/or tracked, doesn't mean that the data should be collected and/or tracked. We request that CMS consolidate its data reporting programs so consumers truly know where to go to find valid information and decrease the data submission requirements for low-volume providers. We also suggest that CMS reduce the complexity of logic associated with "Stars" ratings and other complex algorithms that can be skewed towards specialists or teaching organizations.

There is a lack of awareness of current data availability by consumers. Most consumers have never heard of Hospital Compare or Physician Compare; let alone understand the individual metric data that are available and how the data relates to their care. We can do a better job of promoting the publicly reported data that are available and helping consumers to access the data, particularly when they are seeking routine or planned services, including imaging. This should be embedded into the consumer's overall healthcare experience whereby payors and providers ensure the data and educational component are integrated into the service(s) they provide.

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

Our suggestions include:

- Disseminating Health Plan Information: Under the current pricing structure, health plans possess all the contracted information on their covered lives – patient benefit information and negotiated costs. Health plans could be required to provide this information to their covered lives and to also share the same information with providers. This would enable consistent messaging from the health plan and provider.
- Engaging Consumers: Outreach is needed to provide a better consumer experience, which in turn encourages consumers to use transparency tools and make better choices.

- Format: Information should be readily available, visually appealing, easy to access, and easy to interpret to avoid consumer frustration and encourage use of these tools.
- Beyond Price to Overall Health Care Experience: Price transparency alone will not motivate consumers to choose lower cost options. Various co-pays and co-insurance impact consumer decisions, particularly for consumers whose out-of-pocket costs are the same regardless of whether they see a high-cost or low-cost provider. The goal should be for those consumers to examine quality, outcomes and satisfaction and consider their total health care experience.
- Preventative Care Focus: This is a culture shift in our society, but studies have shown that preventive medicine can help control patient cost and keep people healthy.

- Encouraging High-Value Providers: By definition, high-value providers focus on lowering costs while maintaining or improving service delivery. In a price transparent world, there is a risk that low-cost providers will be automatically associated with low-quality services, and that efficient providers will be overlooked as incentives will be targeted to improvement opportunities for inefficient providers. We urge Congress to aggressively move funds from inefficient health care providers to those early adopters of Advanced Alternative Payment Models.

We appreciate the opportunity to provide comments related to this request for information. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, UnityPoint Health Government and External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,

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