AMGA
Advancing High Performance Health

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June 5, 2019

The Honorable Lamar Alexander
Chairman
United States Senate
Committee on Health, Education, Labor, and Pensions
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
United States Senate
Committee on Health, Education, Labor, and Pensions
Washington, DC 20510

Re: *Lower Health Care Costs Act* discussion draft

Dear Chairman Alexander and Ranking Member Murray:

On behalf of AMGA and our members, I thank you for the opportunity to respond to the *Lower Health Care Costs Act* discussion draft. We appreciate the work of the Senate Committee on Health, Education, Labor, and Pensions (HELP) and your efforts to address America's rising healthcare costs.

Founded in 1950, AMGA represents almost 450 multispecialty medical groups and integrated delivery systems, representing approximately 177,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide innovative, high-quality, affordable, patient-centered medical care, and they remain a resource to identify the best ways to solve the problem of rising healthcare costs.

AMGA stands ready to work with members of the Senate HELP committee to continue to develop impactful and meaningful legislation that adequately addresses the high cost of health care for our patients and gives providers the necessary tools to help patients navigate America's complex health system. We believe that in order to address Americans' rising healthcare costs, Congress must continue to create pathways to steer providers and delivery care systems towards value-based care. To that end, we offer the following comments and recommendations:

Key Recommendations

Section 501: Requirement to Provide Health Claims, Network, and Cost Information
We are encouraged by the committee's inclusion of Section 2715B within the discussion draft, which requires a group health plan or health insurance issuer offering group or individual health insurance coverage to make commercial claims data available for both patients and providers through application programming interfaces (APIs). Access to claims data from all payers has been a longstanding priority for AMGA and its members. For the past four years, AMGA has

conducted annual risk-readiness surveys of our membership to obtain a snapshot of the progress and challenges providers face during the value-based transformation of the U.S. healthcare system. In the surveys, AMGA members expressed concern with the lack of access to timely commercial payer administrative claims data as the most significant barrier to assuming risk and transitioning to value-based care. Members report that while some payers share this data with providers, the majority do not. Successfully managing a patient population requires that providers have access to data to ensure the most effective course of action in improving health outcomes. Without this data, it is challenging to manage the cost and quality of a population of patients, which is a goal of moving to value-based care.

The committee's inclusion of Section 501 within the discussion draft and its recent hearing highlighting efforts by both the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare and Medicaid Services (CMS) to adopt new standards-based measures for APIs indicates the committee's commitment to promote greater data-sharing throughout the healthcare system.[i] [ii] AMGA completely supports the committee's commitment to allow patient and provider access to commercial claims data, and we seek further clarification by the committee regarding whether providers will need prior authorization from patients to gain access to the claims data. We note that on page 155, line 22, of Section 2715B, the draft bill language states that the claims would be available "*to the enrollee, and any providers or third-party applications or services authorized by the enrollee.*" However, on page 158, line 19, the draft bill language states that, "*facilities and practitioners who are under contract with the plan or coverage could get the claims data through an API*…." We recommend the following change to the draft language in order to clarify the committee's intent:

Section 2715B; Page 55, line 22, insert: "*to the enrollee, the enrollee's providers, or third-party applications or services authorized by the enrollee, for 5 years after the date of the enrollee's enrollment in the plan or in any coverage offered by the health insurance issuer.*"

We believe that this clarification in the draft language ensures that providers and delivery systems will have the tools they need to better care for patients. We believe that providers and delivery systems are in a unique position to help steer patients through the nation's complex healthcare landscape and reduce costs because they can actually use the data to improve the care and lives of the patients. Allowing providers to have access to claims data would reduce cost in several ways including:

Population Health
Having access to commercial claims data would allow our members to get a broader perspective of what items the insurer has paid for, such as preventative screening exams and tests, even if those tests were not performed by the providers directly and are not recorded in their electronic medical records. Incorporating this additional data would give a more real-time look at the patient's individual progress, allowing providers to shift from getting tests done to getting the correct care for their patients because it would reduce test redundancies and unnecessary procedures, thus reducing the cost of care.

Transparency/Accountability
Access to commercial claims data would also lead to more accountability. If all parties are required to share their information and are held accountable for that sharing, there is more willingness to collaborate and to share resources, leading to less propensity to

"cherry-pick" patients. When the sharing is voluntary or when there are no enforcement or sharing regulations, healthcare organizations may not share their data out of fear of predatory business practices.

Empowered Patient
Most importantly, allowing providers and delivery systems access to data will ultimately lead to a more empowered patient. As we shift to patients accessing more of their healthcare data, it is pertinent that both the patient and provider are equal partners in their physician/patient relationship. The only way to accomplish that is to ensure that the provider has a full account of the patient's medical history. Allowing providers access to commercial claims data that is both transparent and streamlined is a step toward shifting that narrative. Transparency of data allows the patient to track their own numbers and results, leading to better conversations with their providers, which leads to better health outcomes.

A recent report from the United States Government Accountability Office (GAO) to the Senate Finance Committee, entitled *Medicare: Voluntary and Mandatory Episode-Based Payment Models and Their Participants*, shares AMGA's belief in the importance of providers having access to commercial claims data to create better care management for their patients. The GAO report reviews several value-based payment models within CMS' Center for Medicare & Medicaid Innovation (CMMI), where providers are allowed to access timely patient claims data within their care models. The report highlights that:

> Officials from one provider group told us that many physician group practices that signed up for the [Oncology Care Model] (OCM) did so to gain access to robust claims data from CMS. During OCM implementation, CMS is providing participating providers with claims information on their beneficiaries, as well as feedback on their performance. The officials explained that these data were often the most comprehensive and real-time data oncology practices had ever received, because the data included claims for all services received by their patients in all care settings (e.g., end of life care and emergency room visits), not just those for cancer-related visits. **According to CMS, access to comprehensive claims data allows participating providers to understand what services their patients utilize outside of their oncology practices, which helps the providers better manage care for their patients**.[iii] (Emphasis added.)

AMGA believes that the transparent reporting of healthcare data has the potential to improve the healthcare delivery system and create an educated patient/consumer. By allowing providers to access all forms of data and by standardizing the data submission process, we believe that Congress has the opportunity to dramatically improve the quality of care for patients, which will ultimately reduce costs within the healthcare system.

We also are pleased with the committee's decision to require that a group health plan or health insurance issuer offering group or individual health insurance coverage share claims data in a single, longitudinal format that is easy to understand and secure and that may update

automatically. AMGA members state that when providers have access to data, they frequently spend an unnecessary amount of time and resources translating data sets from different types of payers. According to an AMGA Consulting survey, for every 100 physicians AMGA member groups employ, they require 17 IT professionals to support them. Providing access to data in a standard format would greatly reduce provider regulatory burdens throughout the healthcare system, potentially saving money and reducing provider burnout.

Relatedly, we are pleased with the committee's requirement that a group health plan or health insurance issuer offering group or individual health insurance coverage share claims that were adjudicated by the group health plan or health insurance issuer during the previous five years or the enrollee's entire period of enrollment in the applicable plan or coverage if such period is less than five years. Access to long-term data allows providers to have a more accurate look at the patient's progress throughout the entire course of care.

We further encourage the committee to work with both CMS and ONC to develop a certification program for APIs to reduce potential burden and liability on providers. Third-party developers will face significant technical challenges in developing an application that tracks patient data and is consumer-friendly. As it stands, providers face difficulties in accessing data on their patients as they move throughout the healthcare system. The creation of an API certification program would ensure that third-party applications and developers were successfully meeting the interoperability standards proposed by ONC. AMGA believes that as these APIs are developed and implemented, providers also will benefit from the ability to more seamlessly transmit and share data on shared patients.[iv]

Section 101: Protecting Patients Against Out of Network Deductibles in Emergencies

We support the Senate HELP Committee's commitment to reducing patient surprise billing in emergency care settings. AMGA members have strong concerns regarding the current lack of patient consumer protections regarding surprise billing within the healthcare system. Too often, patients face significant medical debt due to lack of information from health insurance companies about which providers are in their health insurance network. A recent poll by the Kaiser Family Foundation found that "39 percent of insured adults under age 65 said they had received a medical bill within the previous 12 months that they'd figured would be covered or that was higher than they anticipated."[v] AMGA believes that Congress must take action.

We are particularly supportive of Section 2729A of the discussion draft, which creates an independent dispute resolution process for resolving payment disputes between group health plans or health insurance issuers offering group or individual health insurance coverage and facilities or practitioners furnishing services. AMGA believes that the creation of an independent dispute resolution process to resolve payment issues balances the interest of both the provider and the health insurer while leaving patients out of the process. We are committed to working with Congress to address this critical issue.

Section 302: Banning Anticompetitive Terms in Facility and Insurance Contracts that Limit Access to High Quality, Lower Cost Care

We are concerned with the committee's inclusion of section 302, which would "*restrict the group health plan or health insurance issuers from directing or steering enrollees to other health care providers; or offering incentives to encourage enrollees to utilize specific health care providers….*" While we understand the committee's belief that the insertion of this section

would ultimately reduce patient costs, we believe that its committee's absolute provision under section 302 which prevents "*anti-tiering" and "anti-steering" clauses*," could have unintended consequences for providers and delivery systems who adopt innovative care models. AMGA believes in the successful alignment of financing and delivery models as a way to move towards value-based, highly coordinated care. We, therefore, recommend that the committee reevaluate this proposal and work with relevant stakeholders to ensure that this section of the draft does not serve as a disincentive or obstacle to providers that have developed highly integrated delivery care models. We also urge the committee to take into account all delivery plan designs including HMO-type arrangements, ACO arrangements, tiered plan and high value networks when revising the revised draft.

Section 305: Timely Bills for Patients

AMGA understands the committee's concerns about the long-term effects of medical debt for patients. A 2016 poll by the Kaiser Family Foundation found that respondents expressed fears regarding the number of healthcare bills that accumulate over time.[vi] However, we question the committee's decision to focus on creating punitive penalties for providers who bill patients after the 30-business-day period as indicated in Sec. 399V-7 of the legislative draft. We believe the requirement that "*facilities and practitioners refund the patient for the full amount paid in response to such bill with interest, at a rate determined by the Secretary*," as indicated in page 98, line 4 of the discussion draft, to be overly prescriptive. We note that this section requires that the facility and practitioner reimburse a patient before the patient even pays the initial bill. This could lead to unintended consequences, as the patient could possibly not receive the bill due to relocation, loss of mail, or simple neglect. We seek further clarification regarding whether the committee intended for the provider to reimburse the patient before the bill payment or whether the facility or practitioner reimburse the patient if the patient pays them by mistake. We also encourage the committee to focus on defining the role of the payer when evaluating the timely processing of patient bills.

We thank you and the committee for considering our comments and recommendations, and will continue to serve as a resource as you explore ways to lower healthcare costs. Should you have questions or need more information, please do not hesitate to contact AMGA's Chief Policy Officer Chester A. Speed, J.D., LL.M., at 703.838.0033 ext. 364 or cspeed@amga.org.

Sincerely,

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer

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[i] United States. Cong. Senate. Committee on Health, Education, Labor & Pensions. Hearing on *Implementing the 21st Century Cures Act: Making Electronic Health Information Available to Patients and Providers (Part Two).* May 7, 2019. 116th Cong. 1st sess. Washington: GPO, 2019 (statement of Kate Goodrich, M.D. Director, Center for Clinical Standards and Quality, and Chief Medical Officer, Centers for Medicare and Medicaid Services).

[ii] United States. Cong. Senate. Committee on Health, Education, Labor & Pensions. Hearing on *Implementing the 21st Century Cures Act: Making Electronic Health Information Available to Patients and Providers (Part Two).* May 7, 2019. 116th Cong. 1st sess. Washington: GPO, 2019 (statement of Donald Rucker, M.D., National Coordinator for Health Information Technology, Office of National Coordinator for Health IT, Department of Health and Human Services).

[iii] U.S. Government Accountability Office. (2018, December). *Medicare: Voluntary and Mandatory Episode-Based Payment Models and Their Participants* (Report No. GAO-19-156). Retrieved from https://www.gao.gov/assets/700/696264.pdf

[iv] Penso, Jerry., et al. "'Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organizations and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in Federally-Facilitated Exchanges and Health Care Providers.'" Received by AMGA, Http://Www.amga.org/Wcm/Advocacy/20190603b.Pdf, AMGA, 3 June 2019.

[v] Rau, Jordan. "Surprise Medical Bills Are What Americans Fear Most In Paying For Health Care." *Kaiser Health News*, Henry J. Kaiser Family Foundation, 5 Sept. 2018, khn.org/news/surprise-medical-bills-are-what-americans-fear-most-in-paying-for-health-care/.

[vi] Ibid