COLLEGE of AMERICAN PATHOLOGISTS

January 29, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9915-P
P.O. Box 8010
Baltimore, MD 21244-8010

Submitted electronically to: http://www.regulations.gov

Re: Transparency in Coverage

Dear Administrator Verma:

The College of American Pathologists (CAP) appreciates the opportunity to provide comments on the agency's proposed rule regarding requirements for group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information (CMS-9915-P). As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) emphasizes the agency's goal "to support a market-driven health care system by giving consumers the information they need to make informed decisions about their health care and health care purchases." According to the CMS, "if consumers have better pricing information and can shop for health care items and services more efficiently, they can increase competition and demand for lower prices." The CAP agrees that patients must be able to make informed decisions about their health care, and we understand how access to price information prior to services may be useful for patients, but we wish to express continued concerns about risk for patient harm from any delays and difficulty in determining the cost of pathology services in advance of services conducted by the pathologist. Further, we provide comments on the agency's request for information (RFI) related to provider quality measurement and reporting.

<u>Proposed Rules Regarding Transparency and Issuer Use of Premium Revenue Under the Medical Loss Ratio Program</u>

The CAP believes that, when feasible, patients should have access to appropriate price information prior to services, and specifically, that providers should be transparent about

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their own anticipated charges when scheduling services for patients. Further, insurers should be transparent about the amount of those charges they will cover. We agree that "increases in health care costs and out-of-pocket liability" pose serious challenges to patients and are committed to protecting patients and ensuring access to high-quality health care.[1] However, the CAP continues to have serious concerns about any changes that would require pathologists to inform patients about out-of-pocket costs for a service before patients are furnished that service. In addition to risk for patient harm from any delays, there is significant – and particular – difficulty in determining the cost of pathology services in advance of services conducted by the pathologist. For instance, a surgical or invasive diagnostic procedure performed by a dermatologist, surgeon, gastroenterologist, urologist, or other clinician may result in no specimens obtained or it may result in multiple specimens requiring anatomic evaluation. Additionally, anatomic pathology services typically involve a pathologist performing microscopic analysis of tissue or body fluids to determine whether cancer or other disease is present and, if so, its characteristics. The type of specimen or complexity of the analysis is often not known in advance of the initial microscopic analysis conducted by the pathologist, making it impossible to provide a reliable estimate of charges or costs. In fact, this reality is reflected by the CMS in Medicare's Benefit Policy Manual with a surgical/cytopathology exception that notes there are additional tests a pathologist may need to perform after an examination or interpretation, "even though they have not been specifically requested by the treating physician/practitioner."[2]

For this reason, the CAP supports the requirement in this proposed rule to convey that actual charges for the participant's, beneficiary's, or enrollee's covered items and services may be different from those described in a cost-sharing liability estimate, depending on the actual items and services received at the point of care. We would also support additional patient education efforts around cost and other price information to ensure patients understand the data/estimates provided, including the fact that that price alone does not determine the value of care or services (see further comments on quality RFI below). Without adequate understanding of all pricing information and individual benefit design details, patients looking to make cost-conscious decisions may be overwhelmed by unhelpful or irrelevant information, confused by different data points and their meaning, and/or make decisions that could lead to decreased quality of care.

Finally, the CAP supports the agency's focus on group health plans and health insurance issuers and disclosure of cost-sharing liability, as we believe out-of-pocket costs to the patient are the most relevant and meaningful price information, and the only accurate information on these patient-specific calculations is held by the enrollee's

[1] https://www.cap.org/news/2019/providers-to-congress-protect-patients-from-surprise-bills-without-compromising-access-to-care
[2] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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health plan. However, we stress our opposition to additional administrative requirements on physicians that interfere with or impair the patient's medical diagnosis and care. Relatedly, we also have concerns about benefit design or financial incentive programs/provisions that encourage consumers to shop for lower-cost health care, where those programs could jeopardize patient health and/or coordination/quality of patient care. The CAP agrees that patients should be empowered to make cost-effective health care choices, but is concerned with any program, provision, or protocol that impinges on the practice of medicine and could improperly encumber and curtail medically necessary clinical laboratory and pathology services in serving the financial interest of the payer. As explained above and in our comments on the RFI below, unless patients have a full understanding of all pricing information and consequences of shopping for care, there is a risk of patients making care decisions that disrupt coordination, add burdens, or lead to lower quality. This is a particular concern for the most vulnerable patient populations, including those with low income and/or chronic conditions. Further, in selecting an immediate lower-cost service that presents coordination/quality issues, there could be additional utilization and/or costs downstream. Thus, while we understand the agency's interest in increasing "consumer engagement in health care purchasing decisions," we are hesitant to support the CMS's efforts to encourage issuers to pursue these kinds of insurer programs/provisions.

<u>Request for Information: Provider Quality Measurement and Reporting in the Private Health Insurance Market</u>

The CAP comments to the specific questions in the RFI are included below. While overall we believe that including quality information with cost information is important, we caution restraint as it is not yet well-understood what quality information is important to consumers around non-patient facing diagnostic providers. Pathologist services should be included in quality information only when it is well-understood what information would be necessary or useful to consumers. Specifically, pathologists have special circumstances as non-patient facing clinicians, which the CMS has recognized by allowing for certain exceptions for pathologists in quality reporting. There is currently insufficient understanding of how price or quality data could help patients understand their choice of pathologists. Therefore, even though pathologists are critical members of the care team and can ultimately influence total costs of care, pathologists should be phased in when these issues are resolved.

1. Whether, in addition to the price transparency requirements the Departments propose in these rules, the Departments should also impose requirements for the disclosure of quality information for providers of health care items and services.

   The CAP agrees that disclosure of quality information for health care providers could

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lead to an increased value in health care, and any information related to cost should be displayed in conjunction with quality information to ensure providers continue to provide quality care and it does not lead to stinting on care. In addition, quality metrics need additional detail in order to be fairly understood: the CAP also asks that factors such as clinical complexity and setting of care be used to adjust quality metrics. This ensures that beneficiaries are getting a complete picture of a physician's cost and quality metrics including information on why physicians who take care of higher risk, complex patients especially in certain care settings may have higher costs and lower quality if risk adjustment or other factors are not taken into account.

2. Whether health care provider quality reporting and disclosure should be standardized across plans and issuers or if plans and issuers should have the flexibility to include provider quality information that is based on metrics of their choosing, or state-mandated measures.

   The CAP believes that quality reporting and disclosure should be standardized across plans and issuers to reduce the burden of collection and reporting. Standardization would also reduce confusion among patients so that they are able to compare standardized metrics and able to form value-based purchasing decisions based on information that is consistent across payers. Moreover, physicians should have the opportunity to review the format and accuracy of the quality information prior to its publication. This would ensure that the information is in an understandable and clear interface for patients to make well-informed decisions.

3. What type of existing quality of health care information would be most beneficial to beneficiaries, participants, and enrollees in the individual and group markets? How can plans and issuers best enable individuals to use health care quality information in conjunction with cost-sharing information in their decision making before or at the time a service is sought?

   Efforts to increase availability of price information for patients must be accompanied with education efforts to ensure patients understand the information provided, including the fact that that price alone does not determine the value of care or services. The CAP also encourages the CMS to work with private health insurers to develop educational tools for patients viewing cost and quality information. The CAP believes it will be important to note when a physician could not participate in a specific measure or activity listed due to circumstances beyond his/her control. For example, not all quality measures are applicable to pathologists, most of whom practice as non-patient facing physicians. Thus, the absence of this explanatory information is potentially misleading and could imply a lack of interest in quality

when the issue is actually lack of applicability of the program to that physician.

4. Would it be feasible to use health care quality information from existing CMS quality reporting programs, such as the Medicare Quality Payment Program (QPP) or the Quality Measures Inventory (QMI) for in-network providers in the individual and group markets?

   The CMS has acknowledged the special circumstances under which pathologists and other non-patient facing physicians practice by allowing certain needed flexibilities for these clinicians in the QPP. For these reasons, the CMS should ensure that if information from existing CMS quality reporting programs is used, it is done in a manner that takes into account the unique circumstances of pathologists' practice and that not all measures and activities that might be applicable to patient-facing physicians are applicable to pathologists. In addition, the CAP believes that all providers should have an opportunity to review their quality information that will be disclosed prior to posting. Prior review by physicians will give them the opportunity to ask for corrections to any information that might be inaccurate.

5. Could quality of health care information from state-mandated quality reporting initiatives or quality reporting initiatives by nationally recognized accrediting entities, such as NCQA, URAC, The Joint Commission, and NQF, be used to help participants, beneficiaries and enrollees meaningfully assess health care provider options?

   The CAP encourages the CMS to standardize and harmonize information from different quality reporting initiatives as much as possible while maintaining the integrity of the data. This will allow patients to assess comparative information while making their health care decisions instead of trying to compare different metrics from different sources.

6. What gaps are there in current measures and reporting as it relates to health care services and items in the individual and group markets?

   The CAP believes that there are some gaps in measures and reporting for pathologists. There is a lack of clarity regarding which pathology-related services are actually "shoppable" and should be assessed and have information shared on cost and quality, and what information consumers want or need related to these different types of services. For example, there may need to be considerations for attribution of price and quality for Anatomic Pathology (i.e. pathologist specific) and Clinical Pathology (i.e. laboratory specific services that are not paid directly to pathologists on the physician fee schedule).

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7. The Departments are also interested in understanding any limitations plans and issuers might have in reporting on in-network provider quality in the individual and group markets.

   N/A

8. The Departments seek more information about how and if quality data is currently used within plans' and issuers' provider directories and cost-estimator tools. The Departments also seek information on the data sources for quality information, and whether plans and issuers are using internal claims data or publicly-available data.

   The CAP believes that one of the current gaps is that claims-based data alone does not provide a full picture of quality for physicians, and often additional Electronic Health Record (EHR) and Laboratory Information System (LIS) data is needed. Because gathering information from different sources could increase burden, and since it is essential in order to reflect physicians' cost and quality information in an accurate manner, the availability of this additional data should be considered.

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The College of American Pathologists appreciates your consideration of these comments. Please direct questions on the Transparency in Coverage proposed rule to Elizabeth Fassbender, JD, Assistant Director, Economic and Regulatory Affairs, at (202) 354-7125 / efassbe@cap.org. For questions on the provider quality RFI, contact Loveleen Singh, Assistant Director, Quality, at (202) 354-7133 or lsingh@cap.org.