



healthcare financial management association

March 23, 2018

The Honorable Bill Cassidy
The Honorable Michael F. Bennet
The Honorable Chuck Grassley
The Honorable Tom Carper
The Honorable Todd Young
The Honorable Claire McCaskill
United States Senate
Washington, D.C.

Dear Senators:

The Healthcare Financial Management Association (HFMA) would like to thank you for the opportunity to provide comments to inform the bipartisan initiative to increase healthcare price and quality transparency, as described in your letter of February 28, 2018.

HFMA is a professional organization of more than 38,000 individuals involved in various aspects of healthcare financial management. In 2014, HFMA convened a [multi-stakeholder task force](#) charged with reaching consensus on how consumers can obtain clear and easy-to-understand healthcare price and quality information in a timely fashion. The recommendations that emerged from this task force were published in [Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force](#). The comments submitted here are grounded in the industry-consensus recommendations found in that report, along with the [Patient Financial Communications Best Practices](#), which were developed with the guidance of a [multi-stakeholder steering committee](#) convened by HFMA.

The questions posed in your letter of February 28 are reprinted below, followed by HFMA's responses.

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

Some form of price and quality information is generally available to consumers today, but it is not always information that best serves their needs. In states that mandate publication of charge data (i.e., hospital chargemaster prices), that information is typically available online via state-supported websites. However, information on charges or on average charges is of limited value to consumers, as it will likely be significantly different from the amount they will be expected to pay. Chargemaster prices serve only as a starting point; adjustments to these prices are routinely made for contractual discounts that are negotiated with or set by third-party payers. Few patients actually pay

the chargemaster price. Information on the average amount *paid* for services is somewhat more useful to consumers but it still falls short. The price information that is most useful to consumers is an estimate of their individualized out-of-pocket responsibility for the specific service(s) they seek. For insured patients, this amount is contingent on their health plan benefit design, including coinsurance and copayments, and the amount of deductible remaining to be met. (For uninsured patients, see question 3.)

Insured patients may obtain an individualized price estimate from their health plan. Estimates are based on CPT codes, which must be obtained from a patient's physician or other care provider. Resources on the estimate-request process are available to consumers, including HFMA's [*Understanding Healthcare Prices: A Consumer Guide*](#), which is available at no charge to any healthcare organization for posting online in the patient financial services section of their websites.

In addition, many hospitals and health systems post price information for common procedures online, and/or make this information available by phone.

Some quality information is also available to consumers online. Information on quality—comprising a range of factors from patient satisfaction and experience to adherence to clinical standards and evidence-based medicine to patient safety and clinical outcomes—is necessary for patients and other care purchasers to make an informed choice of providers.

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

First, it may be helpful to specify, in some detail, the information that will help accomplish the goals stated in your question. The HFMA Price Transparency Task Force (hereinafter “the Task Force”) recommends that transparency tools and price estimates for insured patients should include three essential elements of price information: (a) *the total estimated price of the service*, i.e., the amount for which the patient is responsible plus the amount that will be paid by the health plan; (b) a clear statement of the patient's *estimated out-of-pocket responsibility*; and (c) *other relevant information* related to the provider or the specific service sought, e.g., clinical outcomes, patient safety, or satisfaction scores.

The estimated out-of-pocket responsibility should be tied to the specifics of the patient's benefit plan design, including coinsurance, copayments, and the amount of deductible remaining to be met (as close to real time as possible.)

Other relevant information should be included where it is available and applicable. This information should clearly communicate what has been measured and to whom the measurement pertains (e.g., to the facility, the physician, etc.)

Additionally, the Task Force recommends that insured patients should be alerted to the need to seek price information from out-of-network providers. The issue of “surprise bills” arising from inadvertent out-of-network utilization is an ongoing challenge. A typical example is a patient who chooses an in-network hospital for a procedure but receives services from an out-of-network provider, such as a pathologist, radiologist, or anesthesiologist. HFMA has convened a task force to develop an educational resource for consumers designed to reduce the risk of receiving surprise bills.

Although individualized price and quality information are currently available, in many cases, too often it is not easy for consumers to obtain and/or understand. *Healthcare stakeholders should focus their efforts on making individualized price and quality information more accessible, convenient, clear, and easy to understand.* HFMA recognizes that the multi-step process of requesting a price estimate can be confusing, especially for consumers who are not familiar with the healthcare system, who are coping with healthcare challenges or caregiving responsibilities, or who have language or literacy barriers. HFMA encourages healthcare organizations to support consumers in their efforts to obtain price and quality information and to provide estimates in a format that is clear and easy to understand, and which specifies the limitations of the estimate. (The Task Force notes that the total estimated price will necessarily be an estimate because the patient may use—or the physician may code for and bill—additional services not included in the estimate.)

The way that price and quality information are communicated to consumers can have a significant impact on how that information is used. Individuals may equate low price with low quality. For example, in one study of 1,400 adult employees, price information that was presented through the number of dollar signs (with “\$” representing low price and “\$\$\$” representing high price) led a significant number of employees to use low price as a proxy for low quality. But when a star ranking system was used to rate providers as “being careful with my healthcare dollars,” employees in the study were significantly more likely to choose a lower-price provider.¹

Any system of price transparency will likely need to experiment with the most effective means of communicating price information to various consumer audiences.

Consumers are accustomed to having price information at their fingertips and communicated in ways that are intuitive and easy to understand. The classic example is comparison shopping for airline tickets or hotel stays on websites like Kayak or Expedia. Although choosing a healthcare provider may never be as simple or straightforward as buying an airline ticket, the comparison highlights the magnitude of the room for improvement in the presentation of healthcare price and quality information. In recent

¹ Hibbard, J.H., Greene, J., Sofaer, S., et. al., “[An Experiment Shows that a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care](#),” *Health Affairs*, March 2012, pp. 560-568.

years, some have attributed the low utilization of price transparency tools to a lack of consumer interest or willingness to factor price and quality information into their decision-making process. However, until this information becomes more consumer-friendly and convenient, HFMA believes that it is premature to draw such conclusions.

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

Patients may seek information about the cash price when (a) they are uninsured (b) they are covered by high-deductible health plans (HDHPs) or (c) they are seeking care with an out-of-network provider.

Price transparency for the uninsured is subject to a substantial and growing number of laws at both the federal and state levels. It is the first responsibility of providers to ensure that policies and practices adhere to these legal requirements.

Beyond that, HFMA's Patient Financial Communications Best Practices stipulate that providers should inform uninsured patients that they will review insurance eligibility with them to identify payment solutions or financial assistance options that may help them with their financial obligations for the care received. If appropriate, the patient should be referred to a financial counselor and/or offered information about the provider's financial counseling and assistance policies and programs. Financial assistance may take the form of free or discounted care, depending on an individual patient's circumstances along with organizational policies.

For those patients who are not eligible or choose not to apply for financial assistance, and who are able to pay cash at the time of service, some organizations offer a discount. The cash discount may be posted on the organization's website or communicated by telephone or in person, upon request.

In recent years, some hospitals offer uninsured patients or patients with HDHPs an option to pay for common tests and procedures in full at the time of service in exchange for sharply discounted prices.

If a patient seeks care from an out-of-network provider (based, for example, on that provider's reputation) and contacts the health plan for assistance, the health plan should clearly explain what percentage (if any) of out-of-network provider charges the plan will cover, and describe any other significant out-of-network benefit plan issues (e.g., a "reasonable and customary rate of reimbursement" limit on what the health plan will pay). The health plan should also inform the patient that—if the patient intentionally seeks care from an out-of-network provider—it is the patient's responsibility to independently obtain price information from that provider. Provider policies vary on whether to offer a self-pay or cash discount to these patients.

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

The question specifies Colorado, Kentucky, Virginia, and Maryland as states with approaches to price and quality information that are of interest.

Colorado collects data in an all payer claims database (APCD) that includes the full scope of providers and paid amounts, i.e., the amount actually paid for services. Information about paid amounts represents a significant improvement over charge data, as noted in the answer to question (1) above. Colorado also had the distinction of being one of only three states to receive an A grade in the [2016 Report Card on State Price Transparency Laws](#) published by Catalyst for Payment Reform (CPR), an organization that advocates for improved price transparency and publishes an annual scorecard on state price transparency laws. (The state was subsequently downgraded by CPR because it is using an interim website while improvements are made.)

Notwithstanding the APCD-based website that enjoys an excellent reputation in industry circles, a new Colorado [price transparency law](#), which took effect in January 2018, mandates that providers and facilities tell insured patients, “You are strongly encouraged to consult with your health insurer to determine accurate information about your financial responsibility for a particular healthcare service provided at this healthcare facility/provider.” It also mandates that providers and facilities provide uninsured patients with the telephone number of the billing office that they are “strongly encouraged to contact... to discuss payment options prior to receiving a healthcare service from this healthcare facility/service provider since posted healthcare prices may not reflect the actual amount of your financial responsibility.”

This is, in effect, an acknowledgment by Colorado policymakers that the availability of a price transparency website to the general public is not a substitute for receiving individualized information about financial responsibility from a consumer’s health plan or provider. This is consistent with the HFMA task force’s recommendations for health plan and provider roles in price transparency, as detailed in the answer to question (5) below.

Kentucky’s approach to price transparency is based on median hospital charges, which is not optimal from a consumer standpoint, as previously discussed. Additionally, the [Kentucky website for price information](#) is separate from the [quality information website](#), which creates an extra step, reducing convenience and accessibility for consumers. In theory, diagnosis-specific or procedure-specific comparisons for each hospital and ambulatory facility should provide ample specificity and detail. However, that approach should be balanced against the risk of inundating consumers with information that is too technical or time-consuming to absorb.

We are told that Virginia conducts an annual survey of health plans on their reimbursement for a minimum of 25 most frequently reported healthcare services. Again, this approach does not provide the individualized information most helpful to consumers.

Maryland requires hospitals to provide and post pricing information for the most common medical treatments in all hospitals, including the number of cases, the average charge per case and the average charge per day. As previously stated, average charge information is of limited usefulness to consumers because it does not reflect the price they will be expected to pay. Beyond that, HFMA recognizes that providing transparency data for the most common healthcare services is often a good use of limited resources. (Also see the discussion of Maryland's consumer-facing website in the answer to question (6).)

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

The HFMA Price Transparency Task Force identified transparency roles for various stakeholders:

- Because health plans will, in most instances, have the most accurate data on prices for their members, they should serve as the principal source of price information for their members. Many health plans offer web-based or telephonic transparency tools for their members.
- Employers with self-funded health plans have the option of working with health plans (which often serve as third-party administrators for self-funded plans) or other vendors in developing transparency tools for insured employees and their dependents.
- The provider—i.e., the entity, organization, or individual that furnishes a healthcare service—should be the principal source of price information for uninsured patients or patients who are seeking care from the provider on an out-of-network basis.

Additionally, a number of independent vendors use data from health plans, employers, and other sources to publish price information. In many cases, this information is not tied to the specifics of an individual's benefit design and does not incorporate applicable copayment, coinsurance, or deductible requirements. Additionally, these vendors typically don't assist their customers in identifying in-network providers or quantify the impact that selecting an out-of-network provider could have on the consumer's responsibility for payment. To the extent that these limitations apply to any given vendor, the data they provide customers is not an accurate representation of the price consumers

will be expected to pay for a service. Also, an argument could be made that adding another party to a system that is already complex, as it is built around third-party payment, introduces more complexity and fragmentation to the system.

One of the guiding principles established by the Task Force is that price transparency will require the commitment and active participation of all stakeholders, due to the complexity of the healthcare payment system. There are many different sources of price and quality information, many different benefit designs for insured patients, and an increasing variety of payment models and quality indicators. Given these complexities, providers, health plans, and patients and other care purchasers should work together to define and provide the price and quality information—beyond the essential elements of price information described in the answer to question (2) above—that care purchasers need to make informed provider choices. Transparency efforts should also remain flexible to adapt to changing healthcare payment and delivery models.

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

Because all-payer claims databases (APCDs) contain data on what was actually paid for services and procedures performed by a wide range of providers, they offer more accurate price data than information based on charges or average charges.

Websites based on APCDs, like other price transparency websites, should strive to combine robust and comprehensive price data with design that is consumer-friendly and easy to navigate.

In terms of data, since the 2016 U.S. Supreme Court ruling in [*Gobeille v. Liberty Mutual Insurance Company*](#), state laws creating APCDs cannot mandate the disclosure of ERISA (or “self-insured”/ “self-funded”) plans’ claims and other information. Because self-insured or mixed-funded (i.e., funded through a mixture of insurance and self-insurance) plans accounted for [48 percent](#) of health plans in 2014 (the most recent year for which data are available) and those plans covered 83 percent of plan participants, this poses a significant obstacle for APCDs. Additionally, published APCD data are not always as current as data furnished directly to consumers by health plans and providers; there may be a significant lag time for reporting and analysis.

With regard to consumer-friendly website design, APCD performance varies. APCD status confers no particular advantage in this arena. The annual scorecard on state price transparency laws issued by Catalyst for Payment Reform (CPR), a strong proponent of APCDs, is instructive in this regard. In its most recent report, [Price Transparency and Physician Quality Report Card 2017](#), published jointly with Altarum, CPR gave two states with APCDs (New Hampshire and Maine) an A grade while two other states (Vermont and Virginia) received C grades, even though both of the latter states collect

data in APCDs that include paid amounts and a full scope of providers. CPR writes that “the nature of [Vermont’s and Virginia’s] consumer-facing websites—decidedly not consumer friendly—prevented them from earning higher scores.”

Maryland’s [Wear the Cost](#) (which received a B grade from CPR in 2017) presents APCD-derived information in an exceptionally consumer-friendly way. Also, it breaks data down into average total costs for typical care and for potentially avoidable complications—an interesting approach to integrating service-specific quality and price information—for four common, shoppable procedures. (It should be noted that at this writing, the site is using 2014-15 data from commercial insurance providers.)

It is important to realize that APCDs are not the only avenue for collecting and publishing price and quality information. For example, the not-for-profit organization Minnesota Community Measurement hosts [Minnesota Health Scores](#), a consumer-friendly website that includes price and quality information for most providers in the state.

Finally, consumers must be able to calculate their copayment and coinsurance and know their progress toward meeting their deductible in order to apply the information provided by even the best APCD-based websites (or other web resources that don’t offer one-on-one customer support) to their specific situations. Research conducted by the Kaiser Family Foundation demonstrates that [relatively few consumers](#) are able to make these computations.

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

As stated in the question, pairing price and quality information, rather than providing them separately, is of key importance. The more closely integrated the information, the better, both to enhance ease of use and to reduce consumers’ propensity to conflate price and quality. As patient engagement expert [Judith Hibbard, Dr.PH.](#), Research Professor, Health Policy Research Group, University of Oregon, told CPR “...[P]resenting price information within quality tiers or presenting quality information within cost tiers... will show consumers that there is variation in both cost and quality and that higher quality and price are not necessarily linked.”

As a finance organization, HFMA does not have particular expertise in the presentation of quality information. However, we do have expertise in linking finance and quality metrics. An HFMA representative has served on the National Quality Forum Measure Applications Partnership, a multi-stakeholder partnership that guides the U.S. Department of Health and Human Services on the selection of performance measures for federal

health programs. HFMA stands ready to collaborate with other organizations that are seeking finance expertise in their efforts to advance greater awareness and usage of paired quality and finance information.

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

This is an important consideration. Increasing administrative costs in an effort to enhance price transparency, which could potentially raise prices for consumers, would be counterproductive.

Careful consideration should be given before adopting any measures that would create additional data collection or reporting requirements or standardize the presentation or format of price and quality information. Price and quality transparency frameworks should avoid being overly prescriptive in order to promote innovation and allow healthcare organizations to serve consumers in ways that best meet their needs. This entails taking into consideration local or community-specific health issues, socioeconomic factors, cultural contexts, and health and financial literacy levels, among other factors.

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?

The following were largely submitted to the House Committee on Ways and Means, Subcommittee on Health in conjunction with the Medicare Red Tape Relief Project in July 2017:

A. Make Medicare Price-Sharing Amounts Explicitly Available with Charge and Payment Data.

Congress should expand on Section 4011 of the 21st Century Cures Act (Pub. L. 114–255), and pass legislation instructing the Centers for Medicare & Medicaid Services (CMS) and its administrative contractors to make price sharing information for specific services available to Medicare beneficiaries for services provided in settings other than hospital outpatient departments and ambulatory surgical centers. For CMS, this information should be available on the Hospital Compare website so a beneficiary can evaluate both cost and quality to make a truly informed decision. Also, CMS may consider developing an easy-to-use consumer format--such as a mobile app--in addition to the Compare websites.

B. Reform the Medicare Recovery Audit Contractor Program to Hold Contractors Accountable. Medicare Recovery Audit Contractors (RACs) are paid a contingency fee that financially rewards them for denying payments to hospitals, even when their denials are found to be in error. There is a substantial backlog in resolution of

disputes related to inappropriately denied claims. Congress should amend the statutes relating to the RAC program to incorporate a financial penalty for poor performance by RACs, as measured by Administrative Law Judge appeal overturn rates.

- C. Provide More Regulatory Flexibility for Participants in Alternative Payment Models.* CMS's continued application of fee-for-service (FFS) regulatory barriers within payment reform models often hinders providers' ability to identify and place beneficiaries in the most clinically appropriate setting. It also inhibits their ability to test new, more patient-centered and streamlined clinical pathways. Testing new approaches in an environment free from artificial barriers to care coordination, such as the IRF 60 Percent Rule and the home health homebound rule, will more effectively advance solutions that improve clinical outcomes and reduce overall costs and variation. HFMA encourages Congress to modify existing Medicare fraud and abuse statutes to create safe harbors from laws such as "Stark," "Anti-Kickback" and "Civil Monetary Penalty" for physicians, hospitals, post-acute care providers, and other entities caring for Medicare beneficiaries that participate in alternative payment models such as the Medicare Shared Savings Program or Comprehensive Care for Joint Replacement program.
- D. Create Stark Exemptions for Clinical Integration Arrangements.* Hospitals cannot succeed in their efforts to coordinate care and participate in new payment models because of outdated statutes, such as the Anti-Kickback and the "Stark" laws. A new exception should be created that protects any arrangement that meets the terms of the newly created Anti-Kickback safe harbor for clinical integration arrangements.
- E. Create Safe Harbor in Anti-Kickback Statute for Assistance to Patients.* This type of safe harbor is necessary so hospitals can help patients realize the benefits of their discharge plan and maintain themselves in the community. Arrangements protected under the safe harbor also would be protected from financial penalties under the Civil Monetary Penalties for providing an inducement to a patient. The safe harbor should do all of the following:
- Protect encouraging, supporting, or helping patients to access care or make access more convenient
 - Permit support that is financial (such as transportation vouchers) or in-kind (such as scales or meal preparation)
 - Recognize that access to care goes beyond medical or clinical care, and include the range of support important to maintaining health such as social services, counseling, or meal preparation
 - Remove the regulatory prohibition on a hospital offering advice to a patient on the selection of a provider for post-hospital care or suggesting a specific facility

- F. Remove HIPAA Barriers to Integrated Care.* HIPAA regulations currently restrict sharing a patient’s medical information for “health care operations” like quality assessment and improvement, including outcomes evaluation, or activities that relate to the evaluation of provider qualifications, competence, or performance, to information about those patients with whom both the disclosing and receiving providers have – or have had – a patient relationship. The challenge this poses in the integrated care setting is that frequently patients do not have a relationship with all of the providers among whom information should be coordinated. A clinically integrated setting and each of its participating providers must focus on and be accountable for all patients. Moreover, achieving the meaningful quality and efficiency improvements that a clinically integrated setting promises requires that all participating providers be able to share and conduct population-based data analyses. Therefore, the HIPAA medical privacy regulation enforced by the Office for Civil Rights should permit a patient’s medical information to be used by and shared with all participating providers in an integrated care setting without requiring that individual patients have a direct relationship with all of the organizations and providers that technically “use” and have access to the data.
- G. Allow Treating Providers Access to Their Patient’s Substance Use Disorder Records.* Requiring individual patient consent for access to addiction records from federally funded substance use treatment programs, as current requirements do, is an obstacle to an integrated approach to patient care. It also may unknowingly endanger a person’s recovery and his or her life. Congress should fully align requirements for sharing patients’ substance use records with the requirements in the HIPAA statute that allow the use and disclosure of patient information for treatment, payment, and healthcare operations. Doing so would improve patient care by ensuring that providers and organizations who have a direct treatment relationship with a patient have access to his or her complete medical record.
- H. Expand Coverage for Telehealth.* Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech monitoring without requiring patients to leave their homes, and less expensive and more convenient care options for patients. However, coverage and payment for telehealth services remain major obstacles. Medicare lags far behind other payers due to its restrictive statutes and regulations. For example, CMS approves new telehealth services on a case-by-case basis; as a result, Medicare pays for only a small percentage of services when they are delivered via telehealth. HFMA urges Congress to expand Medicare coverage, such as by a presumption that Medicare-covered services also are covered when delivered via telehealth unless CMS determines on a case-by-case basis that such coverage is inappropriate.

- I. *Cancel “Stage 3” of Meaningful Use.* Hospitals and physicians face extensive, burdensome, and unnecessary “meaningful use” regulations from CMS that require significant reporting on the use of electronic health records (EHRs) with no clear benefit to patient care. These excessive requirements are set to become even more onerous when Stage 3 begins in 2018. They also will raise costs by forcing hospitals and physicians to spend large sums upgrading their EHRs solely for the purpose of meeting regulatory requirements. Congress should pass legislation canceling Stage 3 of meaningful use by removing the 2018 start date from the current regulations. The Administration also should institute a 90-day reporting period in every future year of the program and gather input from stakeholders on ways to further reduce the burden of the meaningful use program from current requirements.

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?

The potential for unintended consequences is heightened when price transparency is used in payment systems where prices are administratively set. In the context of Medicare or Medicaid, the Center for Medicare and Medicaid Innovation (CMMI) should do the following:

- a. Couple price data with relevant *quality measures that are appropriately risk adjusted*. Otherwise, safety net hospitals will be unfairly penalized for the patient populations they serve, as the measures as currently reported may not accurately reflect the quality of care they provide.
- b. Similar to target price or benchmark calculation in Medicare Alternative Payment Models, *CMMI should remove add-on payments* related to teaching and indigent care from prices shown to patients. Otherwise, CMMI will steer patients away from these providers and inadvertently harm them financially.
- c. Provide price data comparisons for episodes of care, not discrete services. We believe Maryland’s [Wear the Cost](#) website is a reasonable example of this principle in action. It includes the price of all services and provides and describes the costs associated with potentially avoidable complications.
- d. Provide actual price data, not charges, as is commonly done in many states. When price data is provided, it should entail both the total price to the purchaser and any out-of-pocket expense the beneficiary is responsible for.
- e. The definition of key terms—cost, charge, and price--should not be used interchangeably. Cost varies by the party incurring the expense, charge is the dollar amount set before negotiating discounts, and price is the total amount expected to be paid by payers and patients for healthcare services.
- f. While there has been historical relationship between charges and prices for healthcare services, that relationship has become less relevant as new payment models have emerged. Consideration about billing systems that are not reliant on

the chargemaster but based on these payment models such as episodes of care or cases should be examined. This is a complex process and require multi-stakeholder input.

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

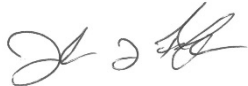
Providing price data to Medicare beneficiaries is not enough to change behavior. CMMI should experiment with beneficiary engagement strategies, ranging from benefit design to the use of positive incentives to reward desired behaviors.

HFMA strongly supports the concept of value-based insurance design (VBID). VBID structures benefits and cost sharing to encourage consumers to use high-value clinical services (defined as those with the greatest potential, relative to cost, to positively impact health). We encourage CMMI to create a VBID model pilot in the Medicare accountable care organization (ACO) models (Medicare Shared Savings Program tracks, Next Generation) and Comprehensive Primary Care Plus (CPC+). ACO and CPC+ participants interested in participating should have the opportunity to apply.

HFMA looks forward to any opportunity to provide assistance or comments to support the Senate's transparency initiative. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, federal healthcare agencies, and advisory groups.

We are at your service to help provide a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 38,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.