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Consumers First 2021 Administrative Agenda: Policy Solutions to Strengthen the Infrastructure of U.S. Health Care Payment and Delivery

The Biden administration has an important opportunity to enact bold administrative policy to address the inefficiencies, inequities, and market failures ingrained in the infrastructure of the U.S. health care system that drive high-cost and low-quality care. Some critical policy changes require congressional action as laid out in [Consumers First's legislative agenda for the 117th Congress](#). But there are many solutions that fall within the authority of the executive branch.

Consumers First, an alliance that brings together diverse organizations representing the interests of families and children, working people, employers, and primary care providers to improve the fundamental economic incentives and design of our health care system, urges the Biden administration to enact health care payment and delivery infrastructure policy reforms that improve health care affordability, equity, and quality in five key areas:

- 1. Make health care more affordable by preventing further consolidation of health care markets and lowering health care prices.**
- 2. Increase price and quality transparency to create a more efficient, fair, and equitable health care system.**
- 3. Improve health outcomes by shifting payment incentives to deliver health, reduce inequity, and emphasize service value over volume.**
- 4. Strengthen our system of primary care by investing in services that keep people healthy and prevent them from needing to access more expensive care settings.**
- 5. Establish national data-sharing and interoperability standards to reduce waste and enable real-time coordination of services across health sectors.**

THE PROBLEM:

The U.S. Health Care System Was Challenged by Market Failures before COVID-19; Now the Cost and Quality Crisis Is Undeniable.

The COVID-19 pandemic created enormous new challenges for our health care system and exacerbated long-standing inequities and inefficiencies that threaten the security of our health, the financial sustainability of certain sectors in the health care system, and the economic livelihood of our nation's families, workers, and employers. Even before the pandemic struck, the U.S. health care system was facing serious challenges, with national expenditures on health care rising at a staggering rate and health care costs increasing faster than workers' wages and inflation, making it more difficult for families to access and afford health care.^{1,2} At the same time, our health care system is responsible for the highest infant mortality and maternal mortality rates and the lowest life expectancy compared with other industrialized nations.³ And there continue to be millions of people who live with the burden of poor health, who cannot access the right care at the right time, who receive low-quality care,⁴ and who disproportionately face systemic inequities, including communities of color, people with low incomes, people with disabilities, and people living in distressed neighborhoods.⁵

Data confirms this growing health care cost and quality crisis in the U.S.:

- » Sixty percent of the U.S. population has at least one chronic condition,⁶ which results in lower quality of life, health complications and increased health care spending.⁷
- » From 2019 to 2020, average family health insurance premiums increased 4%, but workers' wages only increased 3.4%, and inflation increased 2.1%.⁸
- » The total cost of an employer-sponsored health insurance plan for one family grew from \$5,791 in 1999⁹ to \$21,342 in 2020.¹⁰
- » Fully 44% of people in the U.S. report that they did not see a doctor when they needed to because of high health care costs, and one-third of people report that the cost of medical care interferes with their ability to secure basic needs like food and stable housing.¹¹

Our nation simply cannot afford to continue at this rate.

THE SOLUTION:

To address the U.S. health care cost and quality crisis, and to safeguard our health care system from any future public health crisis, Consumers First urges the Biden administration to consider reforms in five key policy areas focused on driving value into health care payment and delivery.

1. Make Health Care More Affordable by Preventing Further Consolidation of Health Care Markets and Lowering Health Care Prices

High and increasing health care prices are making health care unaffordable for many American families, workers, and employers. Health care prices and costs vary significantly between providers, and the differences are unrelated to the quality of care or health outcomes.¹² Paying more does not mean consumers are getting better care. For example, list prices for COVID-19 diagnostic tests — the price charged to uninsured individuals and employer plans for out-of-network treatment — ranged from \$20 to \$850 per test at major hospitals across the U.S.¹³ This large variation in prices does not account for the quality of the test. In fact, the quality of the test is unrelated to the prices charged. This is not a new phenomenon. It is well established that hospital prices for private plans range from 150% to more than 400% of Medicare rates.¹⁴

These high and variable health care prices are often the result of growing consolidation across and within health care markets among hospitals, insurers, and other health care organizations that battle for relative market power and control to set prices or prevent health care data from being shared.¹⁵ Consolidation undermines the competitiveness of health care markets, allowing providers, insurers, and other members of the health care industry that amass a disproportionate share of market power to set prices.

The results are health care prices that are neither value-driven nor equitable. Addressing the impact of consolidation on health care prices is a fundamental step to control health care costs. *Consumers First* urges the Biden administration to making the following regulatory changes:

- » As a condition of Medicare participation for hospitals, the U.S. Department of Health and Human Services (HHS) should prohibit the use of anticompetitive contracting terms in provider and insurer contracts that limit access to higher-quality, lower-cost care. In highly consolidated markets, large providers have the upper hand in contract negotiations to build networks and set prices. As a result, many of these contracts include terms that limit access to higher-quality, lower-cost care such as:
 - › “Anti-tiering” and “anti-steering” clauses in contracts between providers and health plans that restrict the plan from directing or incentivizing patients to use other providers and facilities with higher quality and lower prices.
 - › “All-or-nothing” clauses in contracts between providers and health plans that require health insurance plans to contract with all providers in a particular system or none of them.
- » Consistent with previous demonstrations in Maryland and Pennsylvania, HHS should consider

leveraging Medicare demonstration authority to allow states to set and administer global budgets for all hospitals as a mechanism to control the rising costs of hospital services. Any hospital global budget model implemented must ensure there are no adverse impacts on access, quality, or affordability of Medicaid services or on providers for Medicaid beneficiaries, including children. Global budget payments offer providers a fixed reimbursement amount for a fixed period for a specific patient population. This enables providers to have flexibility to deliver tailored care to patients while being held accountable for the total cost of care for the population being served. Importantly, global budgets differ from block grants in that, under a global budget, state Medicaid programs continue to receive regular Federal Medical Assistance Percentage (FMAP) at states' normal matching rate. There is no federal cap on states' FMAP.

- » HHS should expand site-neutral payments through the Outpatient Prospective Payment System proposed rule by requiring Medicare to pay the same rate to all on- and off-campus hospital outpatient departments, ambulatory surgery centers, emergency departments, and off-campus physician offices. This recommendation should include exceptions for underserved urban and rural areas to prevent any unintended adverse impact on underserved communities.
- » The Federal Trade Commission (FTC) and the U.S. Department of Justice should ensure that federal antitrust laws are fully applied to horizontal integration, including hospitals, health systems, and pharmaceutical companies; vertical integration between physician practices and hospitals as well as health plans, pharmacy

benefit managers, and specialty pharmacies; and cross-sector mergers and acquisitions between health plans and pharmaceutical managers.

- » The FTC should establish stricter review and enforcement of physician practice consolidation, including physician practice mergers and hospital acquisitions of physician practices, upon completion of its study under the Merger Retrospective Program. This is in line with the goals of the study, which seeks to analyze patient-level commercial claims data for inpatient, outpatient, and physician services in 15 U.S. states to understand the impact of physician practice mergers and hospital acquisitions of physician practices — vertical integration — on health care prices. The FTC should use the results of its study to make recommendations to Congress to prevent physician practice consolidation and increase health care market competition.

2. Increase Price and Quality Transparency to Create a More Efficient, Fair and Equitable Health Care System

The collection and availability of comprehensive health, quality, and cost data would allow consumers to make informed decisions about their care, while enabling policymakers, employers, and experts to accurately assess, and ultimately improve, the quality and value of health care services. Such data should be collected and made available in a manner that protects confidentiality and privacy, as is the standard of practice in other industries. *Consumers First* urges the Biden administration to make the following changes:

- » HHS should establish a national all-payer claims database (APCD) to lower Americans' health care costs. Such a database would require both

public and private payers to report health care utilization and claims data to the national APCD according to federally established standards across the following categories: medical and clinical, prescription drug, dental, behavioral health, available social services data, as well as prices charged for health care services related to COVID-19. Data would be required to be collected and reported across all data categories stratified by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age, and disability status. HHS already has the regulatory authority and is collecting much of this data, so this would be a natural next step in being able to use sophisticated data analysis to make important improvements in the cost and quality of health care.

» HHS should make important improvements to the Hospital Price Transparency final rule by requiring all disclosed pricing information to be paired with quality information to achieve meaningful transparency of cost and quality for consumers, researchers, and purchasers. In addition, the HHS secretary should:

› Mandate transparency on a smaller but nationally uniform set of high-cost and high-volume services provided in both inpatient and outpatient settings, rather than focusing on 300 “shoppable” services as defined by the current Hospital Price Transparency rule (including 230 to be defined by hospitals themselves). A reasonable requirement would be the publication of 100 total services, with 25 in each of the following four categories:

- Highest price inpatient services.
 - Highest dollar value inpatient services (defined as the price per service multiplied by the number of services provided).
 - Highest price outpatient services.
 - Highest dollar value outpatient services.
- › Revise the civil monetary penalty for noncompliance by imposing a penalty of \$300 per day per licensed bed in each hospital. Enacting a stronger civil monetary penalty will increase hospital compliance with the new regulation and appropriately scale the monetary penalty based on hospital size.

» Building on the Hospital Price Transparency rule and the Transparency in Coverage rule, HHS should require the disclosure of negotiated rates by all payers, including group health plans and each specific provider, and should require that all disclosed pricing information be paired with quality information to achieve meaningful transparency of cost and quality for consumers, researchers, and purchasers. In addition, the secretary should:

- › Identify and engage select health care markets in which to pilot full public price transparency for all services and conduct associated longitudinal studies on the impact of the policy on negotiated prices.
- › Make provider- and plan-specific negotiated prices for all services available to plan sponsors and researchers in the large-group market.

- › Provide negotiated prices for all services to individuals, plan sponsors, and researchers in the small-group and individual markets.
- › Provide information to the public on negotiated prices, within reasonable limits (e.g., providing statistical information, including the range and distribution of privately negotiated rates between providers and health plans).
- » HHS should undergo a multistakeholder process to develop a core health equity measure set, and require all payers and providers to report on those measures through Medicare and Medicaid.
- » HHS should establish harmonized reporting of performance measures by health care providers across all payers, which should include the core set of disparity reduction measures described above. The secretary should lead a multistakeholder process to build consensus and then publish the harmonized set of measures by 2022.

3. Improve Health Outcomes by Shifting Payment Incentives to Deliver Health, Reduce Inequity, and Emphasize Service Value over Volume

COVID-19 has laid bare deeply rooted and pervasive systemic health inequities that have led to Black, Latinx and Indigenous communities experiencing significantly higher rates of infection and death.¹⁶ As health care payment and delivery transform to achieve the triple aim of improved health, improved quality and patient experience, and lower health care costs, the health care system has a critical role and responsibility to reduce disparities and advance health equity.

It is well-established that the financial incentives associated with fee-for-service (FFS) payment lead to an increase in the volume of services provided within the health care system, which in turn drives up health care spending without any corresponding increase in the quality of care. In fact, FFS health care is a significant driver of poor health outcomes¹⁷ and billions of dollars of health care waste in our system.¹⁸ FFS payment does not support care coordination services or services that address the social determinants of health. The result is that FFS incentivizes fragmented care delivery that fails to provide the full spectrum of services required to meet peoples' health needs and improve their health.

The shortcomings of FFS were amplified by the COVID-19 pandemic, in which providers faced significant revenue shortfalls as the volume of routine visits and procedures plummeted and patient needs rapidly changed. At a time when many people needed health care the most, FFS payments left physician practices and the patients they serve in a precarious and untenable position. Some physician practices, particularly within primary care, experienced declines of up to 50% in service volume, which threatened to collapse nearly 30% of primary care practices and forced many to turn to government relief programs for health care providers and businesses.¹⁹ To ensure that our health care system is stronger and more equitable moving forward, *Consumers First* urges the Biden administration to make the following changes:

- » The Centers for Medicare & Medicaid Services (CMS) should increase the number of mandatory alternative payment models to establish new methodologies for Medicare payment for models that have shown to improve quality without increasing Medicare spending, reduce Medicare spending without reducing quality, or both improve

quality and reduce Medicare spending. Expanding mandatory models in Medicare will increase the number of providers who shift away from volume-driven health care payment, improving quality and patient experience for Medicare recipients and generating savings to the Medicare program and for the seniors who depend on it for their care. Over time, the lessons learned from these models can be further expanded to improve quality and reduce spending for children and families throughout the system, including in Medicaid and health insurance marketplaces.

- » CMS should nationally scale alternative payment models that use prospective, ongoing payments not tied to FFS in order to shift economic incentives toward improving patients' health rather than volume-driven care. Examples of alternative payment models that should be scaled nationally include Comprehensive Primary Care Plus, Track 2, and Primary Care First.
- » CMS should integrate telehealth into existing alternative payment models (APMs) that utilize prospective, capitated payments rather than relying on a FFS reimbursement structure for telehealth services through the Medicare Physician Fee Schedule. Examples of alternative payment models that could immediately integrate telehealth include Comprehensive Primary Care Plus, Track 2, and Primary Care First.
 - › Efforts to adopt and further proliferate APMs throughout the health care system will continue over the long term, but there is an immediate need to build an effective telehealth reimbursement system to support providers' ability to deliver and be paid for telehealth services and to improve

consumer access to care during the public health emergency. As longer-term efforts to advance APMs continue, in the immediate term, CMS should:

- Develop a telehealth provider reimbursement rate structure that supports telehealth service delivery and reimbursement as a care modality among other care modalities to improve patient health and access to care. CMS should ensure the reimbursement structure augments in-person care, supports community-based care delivery, and does not undermine the importance or role of in-person health care delivery.
 - Promulgate a regulation to ensure all telehealth visits meet quality standards and serve the needs of Medicare and Medicaid beneficiaries.
- » CMS should incorporate health equity into quality measurements and performance-based payments, including paying providers for reducing disparities in health outcomes: "pay for equity." As part of these efforts, CMS should:
- › Require Medicare and Medicaid value-based payment programs and payment reform models to stratify performance and quality measures by race, ethnicity, and primary language, at minimum, and move to incentivize the adoption of evidence-based quality improvement activities that reduce of disparities across these measures.
 - › Require and incentivize all providers in Medicare and Medicaid value-based payment programs, including hospitals and other health care facilities, to collect patient social

and behavioral risk data disaggregated by key demographic factors, with appropriate privacy and anti-discrimination protections. Accurate collection of data on race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age, and ability status is a difficult but critical step in implementing equity payment incentives in health care.

4. Strengthen Our System of Primary Care by Investing in Services That Keep People Healthy and Prevent Them from Needing to Access More Expensive Care Settings

Central to improving the health and health care of our nation’s families is ensuring that primary care providers are valued and empowered in our health care delivery system.²⁰ Historically low reimbursement for primary care has resulted in an inadequate supply of primary care providers in our nation and reduced access to primary care for many families.²¹ Moreover, much of the waste in our health care system is anchored in high-cost specialty care.²² Office/outpatient evaluation and management (E/M) services — a category of Current Procedural Terminology (CPT) codes most commonly used by family physicians and other primary care providers — encompass activities that require significant investments of the clinician’s time, such as taking a patient’s history, examining the patient, and engaging in medical decision-making — services that cannot be easily replaced or optimized by advances in technique or technology.

Recognizing the need to reevaluate office/outpatient E/M codes, CMS increased the relative value units (RVU) for E/M services. In the 2021 Medicare Physician Fee Schedule final rule, CMS also finalized an add-on code (G2211, formerly GPC1X) that physicians can bill for complex office visits, including primary

care visits. However, Congress acted to supersede CMS by delaying implementation of G2211 for three years in order to help offset budget neutrality cuts to certain procedural specialists. This decision by Congress preserved the historical imbalances in payment between primary care and specialists that CMS had attempted to correct, further exacerbating access to primary care during the pandemic for America’s families. While the E/M value increases are an important step to addressing the historical imbalance in payment rates between primary care and specialty care, the new values do not fully correct for the long-standing lower reimbursement rate, nor do they account for the inherent complexity and additional resources required to furnish comprehensive primary care services. CMS emphasized this point in explaining its rationale for adopting this new add-on code, stating, “[W]e continue to believe that the typical visit described by the revised and revalued office/outpatient E/M visit code set still does not adequately describe or reflect the resources associated with primary care and certain types of specialty visits.”²³ The G2211 add-on code is designed to account for the time and cost related to care coordination and planning, ongoing monitoring, and patient engagement that is integral to high-value primary care that meets peoples’ health needs.

To address this profound concern, it is critical that CMS continues to implement policies to correct the historical payment distortion. *Consumers First* urges the Biden administration to:

- » Implement an add-on code in the CY2024 Medicare Physician Fee Schedule to account for the unique complexity of continuous primary care services.
- » Incorporate office/outpatient RVU increases into primary care payments included in alternative payment models.

Appropriate funding for primary care is also critical to address our nation’s public health. An essential step in safeguarding access to vaccinations is ensuring that providers, including pediatricians, are reimbursed adequately for administering vaccinations. CMS bases the value of CPT codes for immunization administration on the Medicare Physician Fee Schedule. Immunization administration (IA) codes are commonly used, particularly by pediatricians, family physicians, and other front-line clinicians for vaccine administration and reimbursement. In 2010, CMS linked these IA codes to separate codes for therapeutic injections in adults. Then, in 2018, CMS reduced the value of those therapeutic injection codes by more than 50%, thereby significantly cutting reimbursement to primary care physicians and other health care providers who administer vaccinations to children and adults. The current rates set in the Medicare Physician Fee Schedule do not account for the cost of vaccine administration for adults or children. Medicaid and private payers rely on the Medicare Physician Fee Schedule to set their rates, and these payment cuts have significantly impacted clinicians that administer vaccines to children. In the 2021 Medicare Physician Fee Schedule proposed rule, CMS proposed to delink IA codes from therapeutic injection but did not finalize this section of the rule. *Consumers First* urges the Biden administration to make the following change:

- » HHS should delink IA codes from therapeutic injection codes used for adults through the Medicare Physician Fee Schedule to restore reimbursement rates for family physicians, pediatricians, and other front-line clinicians and ensure sustainable payments for administering vaccinations to children and adults across payers.

5. Establish National Data-Sharing and Interoperability Standards to Reduce Waste and Enable Real-Time Coordination of Services across Health Sectors

National data-sharing and interoperability standards are essential for reducing waste and inefficiencies in the health care system. They enable the real-time coordination of health care services across health care providers and organizations. This allows providers to better identify and bridge potential gaps in care and drive needed improvements in the quality and value of health care services. A national interoperable transparency system would specifically enable health care providers, including those on the front lines of the COVID-19 response, to provide better coordinated, more effective care to their patients, for example, through appropriate linkages between testing, treatment, and mental health services. *Consumers First* calls on the Biden administration to make the following changes:

- » Building on the Interoperability and Patient Access final rule²⁴ enacted in 2020, CMS should require all payers, health care providers, and public health agencies to participate in mandatory exchange of accurate, real-time data across the following categories: medical and clinical, prescription drug, dental, behavioral health, and available social services data. CMS should provide funding to states to support participation by public health agencies.
- » Building on the 21st Century Cures Act final rule enacted in 2020,²⁵ the Office of the National Coordinator for Health Information Technology (ONC) should mandate the expansion of interoperability standards to support and enable the exchange of data between health care providers, health systems, payers, public health

agencies, and social service agencies across the following categories of data: medical and clinical, prescription drug, dental, behavioral health, and available social services data. ONC should ensure that those systems have the ability to allow the information to be used in real time to provide high-quality, coordinated health care to consumers. ONC should provide funding to states to support public agencies in implementing this expansion.

It's Time to Work Together to Make Our Health Care System Work For Everyone

One key lesson from the COVID-19 pandemic is that many people in America are struggling to have their health needs met. But it doesn't have to be this way. There are tested and effective policy solutions that can be implemented immediately to transform the system, making health care more affordable and of better quality for all. By enacting these policy recommendations, the Biden administration has the opportunity to realign the economic incentives and design of health care payment and delivery to ensure the system delivers the health and high-value care that all people across the nation need and deserve. *Consumers First* stands ready to work with the administration and federal agencies to achieve that goal.

Endnotes

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²³ [85 Fed. Reg. 84472](#), 84569 (December 28, 2020).

²⁴On March 9, 2020, the Centers for Medicare & Medicaid Services finalized the Interoperability and Patient Access final rule (85 Fed. Reg. 22979), which requires payer-to-payer exchange of certain patient clinical data at the patient’s request and requires hospitals, including psychiatric hospitals, and critical access hospitals to send electronic patient event notifications of a

patient’s admission, discharge, and transfer to other health care providers or facilities.

²⁵ On March 9, 2020, the Office of the National Coordinator for Health Information Technology finalized the 21st Century Cures Act final rule, which implements new health information technology interoperability standards to enhance patients’ access to their electronic health records information. The rule also prevents data blocking by imposing civil monetary penalties of up to \$1 million per violation.

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