PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

Analysis of Federal and State Actions Taken on Recommendations in Report on *Reforming America's Healthcare System Through Choice and Competition*

Updated December 2, 2020

Status	Report Recommendation	Level	Action To-Date
	Address Potential Antitrust and Provider Consolidation		
—	The Administration should continue monitoring market competition, especially in areas that may be less competitive and thus more likely to be affected by alternative payment models.	Federal	No public action to-date.
—	The Administration should ascertain the impact of horizontal and vertical integration among provider practices on competition and prices.	Federal	No public action to-date. FTC issued a report in June 2019 providing an overview of its actions to-date in health care services and products, including physician practices, but has not issued a comprehensive analysis of the impact of horizontal and vertical integration among provider practices. DOJ and FTC released new vertical merger guidelines in June 2020, though they are not specific to health care.
	Broaden Scope of Practice		
✓	States should consider changes to their scope of practice statutes to allow all healthcare providers to practice to the top of their license, utilizing their full skill set.	States	During the COVID-19 state and public health emergencies, states took a multitude of temporary actions to expand scope of practice. More than 40 states temporarily modified licensing requirements and expedited the approval processes to recruit more health care workers. Note, however, that many of the changes made were temporary, for purposes of the public health emergency.
✓	The federal government and states should consider accompanying legislative and administrative proposals to allow non-physician and non-dentist providers to be paid directly for their services where evidence supports that the provider can safely and effectively provide that care.	Both	In the wake of COVID-19, CMS provided several blanket waivers for health care providers and released several interim final rules with comment, which sought to provide greater flexibility for providers and the health system during the PHE. For example, CMS proposed to expand the types of healthcare professionals that can furnish distant site telehealth services, rolled back certain physician supervision requirements, and certain documentation requirements. In the CY 2021 Physician Fee Schedule, CMS proposed to make modifications to certain physician supervision requirements on a permanent basis.

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			CMS included an incentive for states to amend their scope of practice laws in its Healthy Opportunities Medicaid block grant guidance. In it, CMS notes that "states are encouraged to address state laws that inhibit choice and competition in their health care system…"
✓	States should consider eliminating requirements for rigid collaborative practice and supervision agreements between physicians and dentists and their care extenders (e.g., physician assistants, hygienists) that are not justified by legitimate health and safety concerns.	States	During the COVID-19 state and public health emergencies, 21 states temporarily suspended or waived practice agreement requirements for nurse practitioners. Before the public health emergency, several states relaxed physician assistant supervision and delegation laws. California SB 697 eliminated the requirement that the physician be physically available to the PA for consultation and replaced it with a provision stipulating that availability by telephone or other electronic communication is sufficient. Missouri SB 514 transitioned from a supervision-based model to a collaboration-based model, and eliminated the requirement that a supervising physician practice at the same facility as the PA for four of every 14 days and the requirement that a PA practice at a location where the physician routinely sees patients. Rhode Island HB 5572 revised state laws by eliminating all prescriptive physician supervision requirements and shifted the relationship to collaborative rather than supervisorial. The law also eliminated requirements that hospitals and health care practices have written supervision agreements with each PA on file.
✓	States should evaluate emerging healthcare occupations, such as dental therapy, and consider ways in which their licensure and scope of practice can increase access and drive down consumer costs while still ensuring safe, effective care.	States	In 2019, Connecticut, Nevada and New Mexico passed laws to allow dental therapists to practice statewide, bringing the number of states that allow dental therapy in some capacity to 12. In 2020, Florida, Massachusetts, Washington and Wisconsin considered legislation to allow dental therapy. FL SB 152 died in Committee, Massachusetts S 1215 did not pass and was placed in the Orders of the Day for the next session, Washington SB 1317 is still in Committee, and Wisconsin SB 784 died in Committee.
	Improve Workforce Mobility		
✓	States should consider adopting interstate compacts and model laws that improve license portability, either by granting practitioners licensed in one state a privilege to practice elsewhere, or by expediting the process for obtaining licensure in multiple states.	States	All 50 states and DC have waived – to varying extents- state licensure laws in order to facilitate cross-border care, but these actions are time limited. 26 states and DC are part of the Interstate Medical Licensure Compact which allows for expedited licensing in multiple states.

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✓	The federal government should consider legislative and administrative proposals to encourage the formation of interstate compacts or model laws that would allow practitioners to more easily move across state lines, thereby encouraging greater mobility of health care service providers.	Federal	Through the PHE, CMS temporarily waived Medicare and Medicaid requirements that out-of-state practitioners be licensed in the state where they are providing services. In August 2020, Sens. Murphy (D-CT) and Blunt (R-MO) introduced the Temporary Reciprocity to Ensure access to Treatment (TREAT) Act, which would provide temporary licensing reciprocity for all practitioners or professionals, in all states for all types of services during the COVID-19 response and for future national emergencies. It has not yet advanced.
	Facilitate Telehealth to Improve Patient Access		
✓	States should consider adopting licensure compacts or model laws that improve license portability by allowing healthcare providers to more easily practice in multiple states, thereby creating additional opportunities for telehealth practice. Interstate licensure compacts and model laws should foster the harmonization of state licensure standards and approaches to telehealth.	States	During the PHE, all 50 states and D.C. have waived – to varying extents – state licensure laws in order to facilitate cross-border care. Idaho's Governor signed an executive order asking the state agencies to finalize permanent rule changes to the Idaho Legislature, including licensure, in January of 2021.
✓	States and the federal government should explore legislative and administrative proposals modifying reimbursement policies that prohibit or impede alternatives to in-person services, including covering telehealth services when they are an appropriate form of care delivery. In particular, Congress should consider proposals modifying geographic location and originating site requirements in Medicare fee-for-service that restrict the availability of telehealth services to Medicare beneficiaries in their homes and in most geographic areas.	Both	Through the PHE, CMS eliminated the current originating site and geographic restrictions in Medicare FFS, allowing telehealth services to be reimbursed when provided in patients' homes and in urban areas. CMS also expanded Medicare FFS payment for 80 additional telehealth services and expanded the list of practitioners able to furnish telehealth services. At the end of the PHE, current restrictions on billing for Medicare FFS telehealth services will resume; however, CMS has proposed to permanently add several codes to the list of reimbursable telehealth codes. Bipartisan legislation in the House of Representatives, the Protecting Access to Post-COVID-19 Telehealth Act of 2020 (HR 7663) would remove geographic requirements and allow Medicare beneficiaries to receive telehealth services in their homes. Telehealth reimbursement policies vary from state to state and if the state Medicaid program has managed care, telehealth reimbursement can vary from plan-to-plan. To-date, 51 state Medicaid programs (including DC) have issued specific guidance to expand coverage and access to telehealth in response to the pandemic, 43 states have temporary payment parity for at least some telehealth services compared to face to face services, and 20 states have issued guidance to waive or lower telehealth copayments.

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✓	States generally should consider allowing individual healthcare providers and payers to mutually determine whether and when it is safe and appropriate to provide telehealth services, including when there has not been a prior in-person visit.	States	16 states have waived the requirement for an existing patient-provider relationship and allowing a relationship to be established via telehealth for either the duration of the public health emergency or state emergency.
✓	Congress and other policymakers should increase opportunities for license portability through policies that maintain accountability and disciplinary mechanisms, including permitting licensed professionals to provide telehealth service to out of state patients.	Federal	Through the PHE, CMS temporarily waived Medicare and Medicaid requirements that out-of-state practitioners be licensed in the state where they are providing services. However, the 1135 waiver granted by CMS still requires states to take direct action as the waiver does not have the effect of waiving state or local licensure requirements unless waived by the state. These flexibilities expire when the PHE ends; no permanent action has been taken. In August 2020, Sens. Murphy (D-CT) and Blunt (R-MO) introduced the Temporary Reciprocity to Ensure access to Treatment (TREAT) Act, which would provide temporary licensing reciprocity for all practitioners or professionals, in all states for all types of services during the COVID-19 response and for future national emergencies. It has not yet advanced.
	Ease Restrictions on Foreign Trained Doctors		
✓	HHS, in coordination with Accreditation Council for Graduate Medical Education, should identify foreign medical residency programs comparable in quality and rigor to American programs. Graduates of such equivalent programs should be granted "residency waivers," allowing them to forgo completing an American residency and instead apply directly for state licensure.	Federal	In May 2020, the Trump Administration and US Citizenship and Immigration Services (USCIS) waived certain visa restrictions so that foreign doctors in the Conrad 30 program assigned to rural communities may practice telehealth outside their approved locations during the PHE. No permanent actions has been taken.
✓	States should create an expedited pathway for highly qualified, foreign trained doctors seeking licensure who have completed a residency program equivalent to an American GME program.	States	During the PHE: • New Jersey issued temporary, emergency licensees to foreign-licensed physicians to provide essential healthcare services during the PHE. • New York issued a temporary suspension allowing graduates of foreign medical schools having at least one year of graduate medical education to provide patient care in hospitals and obtain limited permits. Massachusetts issued an executive order requiring the Board of Registration in Medicine to allow international medical school graduates who have completed at least two

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			years of postgraduate medical trainings (residencies) in an accredited U.S. program to apply for a license and to expedite the approval process for them until the end of the state of emergency. • Colorado issued an executive order creating pathways for internationally trained nurses and doctors to provide healthcare services in response to the pandemic. • Nevada issued an executive order authorizing the waiver of licensing requirements for a wide range of medical services providers with training from another country. Note – these are temporary changes, and will likely sunset at the end of the PHE.
	Streamline Federal Funding of Medical Education		
—	As proposed in the FY 2019 President's Budget, the federal government should streamline federal HHS spending on GME into a single GME grant program. The budget proposal also provides the Secretary with the authority to modify amounts distributed to hospitals based on the proportion of residents training in priority specialties or programs and based on other criteria identified by the Secretary, including addressing healthcare professional shortages and educational priorities.	Federal	CMS Administrator Verma noted that enacting this proposal would require legislative action; no action to-date.
—	The Administration should continue the work done by the HRSA's National Center for Health Workforce Analysis, which studies U.S. physician supply needs across specialties and geographic areas. HRSA should launch a study that will also assess: • The Administration's workforce development programs. • Gaps between existing programs and future workforce needs and identifying actions needed to address them.	Federal	No public action to date.
	Repeal or Scale Back CON and COPA Requirements		

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✓	States should consider repeal of Certificate of Need (CON) statutes or, at a minimum, significantly scale back the scope of their CON regimes, for example by ensuring that competitors of CON applicants cannot weigh in on these applications.	States	Recently several states have enacted new laws or policies related to CON in the wake of COVID-19. - Alabama Governor temporarily suspended the state's CON program after issuing an executive order in late April related to the COVID-19 pandemic. - Connecticut temporarily suspended its CON laws in March, but has taken no permanent action to repeal CON laws. - New Jersey waived its CON laws temporarily in March, but has taken no permanent actions to repeal the laws. - New York Governor Andrew Cuomo suspended CON laws for projects deemed necessary for a COVID-19 response in March, but has taken no long-term actions to repeal the laws. - Oklahoma suspended its CON program temporarily for hospital beds in April, but has taken no long-term actions to repeal the laws. - Rhode Island suspended its CON program temporarily in April, but has taken no long-term actions to repeal the laws. - Tennessee has suspended its CON program temporarily to aid in COVID-19 response. - Virginia suspended its CON program temporarily to combat COVID-19. - Florida's legislature repealed a portion of its CON law in June 2019. This article provides a state by state overview of actions to repeal or modify CON laws between 2018 and 2020.
✓	The FTC and its staff should make appropriate policy recommendations after completing ongoing research on the benefits and disadvantages of CON and COPA statutes and regimes.	Federal	In June 2019, FTC held a meeting to assess the impact of COPAs in healthcare markets. While no recommendations were issued, information presented during the meeting found that during the COPA period, COPA was effective in constraining prices. In October 2019, the FTC announced it had issued orders to 5 health insurance companies and 2 health systems to provide information to study the effects of COPAs on price, quality, access and innovation.
—	States should discontinue the use of COPAs to shield anti-competitive provider collaborations and mergers from antitrust scrutiny in the absence of any clear evidence that these regulatory schemes produce better results than market-based competition.	States	No action to date.
	Amend Federal Trade Commission (FTC) Jurisdiction Over Nonprofits		
—	Congress should amend the FTC Act to extend FTC's jurisdiction to nonprofit	Federal	No public action to-date.

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	healthcare entities to prevent unfair methods of competition.		
	Scrutinize Non-Compete Clauses and Other Restrictive Covenants		
✓	States should scrutinize restrictive covenants such as non-compete clauses, particularly their impact on patient access to care and on the supply of providers.	States	During the 2019-2020 legislative session, at least six state legislatures considered outright prohibitions on non-compete clauses for health care providers or limits on their enforceability. In most states, lawmakers sought to limit the applicability of restrictive covenants, and most nullify any agreement that would impose a restriction based on distance or geographic area. • Indiana SB 0423 (enrolled) would make physician noncompete agreements to only be enforceable by meeting certain provisions. • Rhode Island H7530 (introduced) expands the rights of physician assistants and prohibits non-compete clauses that exceed five years with regard to the purchase and sale of a practice. • Kentucky HB 86 (introduced) would create a new statute to make non-complete provisions in physician and osteopath employment contracts void and unenforceable, except in limited circumstances. • New Jersey A4003 (introduced) restricts the use of restrictive employment covenants for physicians and nurses. • Connecticut SB 0143 (introduced) would prohibit non-compete covenants for physicians. • Pennsylvania HB 601 (introduced) would limit restrictive covenants in health care practitioner employment agreements.
	Scrutinize Any-Willing-Provider Laws		
—	Federal and state policymakers should carefully scrutinize the impact on competition and consumers of AWP laws, rules, and proposals, along with other restraints on network formation and selective contracting.	Both	No federal action to date. Since 2018, Arkansas enacted legislation that would require a health insurer to contract with a licensed health care provider if the provider is permitted to participate in Medicare, Medicaid, or any other federal health benefit plan. Meanwhile, Oregon revised its regulations to provide more flexibility.
	Loosen Network Adequacy Requirements		
✓	The Administration should continue to provide flexible network adequacy standards for Medicare Advantage and other federally sponsored programs and avoid stringent requirements that are not conducive to innovation and modern	Federal	The Calendar Year 2021 MA and Part D final rule codifies policy previously modified through guidance establishing standards for network adequacy. The final rule also made modifications to network adequacy policy, including by providing certain flexibilities for plans that offer telehealth or in states with Certificate of Needs laws or "other state-imposed anti-competitive restrictions." The HHS Rural Action Plan, released in September 2020, calls for HHS to develop new flexibility for MA plans to improve access to managed care options in rural areas through changes in network

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	medicine and that do not allow states flexibility to meet their specific needs.		adequacy assessments for MA plans and to take into account the impact of telehealth providers in contracted networks. CMS proposed changes to network adequacy requirements in the November 2018 Medicaid Managed Care rule, removing the requirement that states use time and distance standards to ensure provider network adequacy and instead letting states choose any quantitative standard. This proposed rule has not yet been finalized. CMS' final 2019 Notice of Benefit and Payment Parameters includes standards for issuers and exchanges providing clear authority to the states to determine network adequacy in their QHP certification reviews.
✓	States should consider loosening network adequacy standards and avoid stringent requirements.	States	CMS proposed the 2018 Medicaid Managed Care rule to reduce state administrative burden and enhance the ability of states to manage their Medicaid and CHIP programs, including providing states more flexibility to set meaningful network adequacy standards using quantitative standards that can take into account new service delivery models like telehealth. The proposed rule would remove the requirement that states use time and distance standards to ensure provider network adequacy and instead let states choose any quantitative standard. The proposed rule has not been finalized. In 2018, California Department of Health Care Services (DHCS) submitted four network adequacy certification documents to CMS to allow Medi-Cal Managed Care Plans that were unable to meet one or more standards for network certification to be deemed conditionally compliant and have a DCGS-approved temporary standard in place. According to a September 2018 MACPAC report, few states have standalone network standards. 14 states have a draft or final contract strategy, while some provide a model contract or copies of an actual MCO contract.
	Loosen Insurance Rules and Mandates		
✓	The Administration should continue to work with Congress to enact legislation that remedies key problems resulting from the ACA, that promotes greater choice and competition in healthcare markets, and that produces a sustainable government healthcare financing structure.	Federal	Congress effectively eliminated the ACA's individual mandate in December 2017, but otherwise has not made substantive changes to the ACA's individual and small group market requirements. The Administration has made changes to Marketplace policies, including by cutting payments to issuers for Cost-Sharing Reductions they are required to make, finalized regulations allowing for expanded use of Association Health Plans (part of which were later vacated by federal courts),

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			short-term limited duration insurance, and health reimbursement arrangements, among other policies.
✓	The Administration should provide states with the maximum ability to expand healthcare choice and competition and create a sustainable financing structure.	Federal	CMS issued new 1332 guidance to states providing greater flexibility to reform their insurance markets.
✓	States should allow maximum consumer choice and competition in their healthcare markets, including through Association Health Plans and short-term limited duration insurance.	States	Several states have passed legislation allowing for expanded use of Association Health Plans, including Arizona, Florida, North Carolina, and Virginia.
—	Congress should repeal the ACA's employer mandate consistent with the FY 2019 President's Budget.	Federal	No federal action to date.
	Replace Restrictions on Physician-Owned Hospitals		
✓	Congress should consider repealing the ACA changes to physician self-referral law that limited physician-owned hospitals.	Federal	No direct action to lift the ACA's restrictions on physician-owned hospitals, however CMS and HHS OIG have released proposed rules that would loosen restrictions related to physician self-referral and the Anti-Kickback Statute, respectively.
	Reconsider Section 1557 of the ACA		
✓	The Administration should reconsider regulations authored under Section 1557 of the ACA to ensure they do not create undue administrative burdens and serve as unnecessary barriers to entry that inhibit competition.	Federal	A federal judge has temporarily blocked a rule that would rescind ACA nondiscrimination protections for transgender patients.
	Realign Incentives		
✓	Congress should expand consumers' abilities to benefit from Health Savings Accounts (HSAs), including by allowing a greater number of plans (e.g., any plan with an actuarial value below 70 percent) to be HSA-qualified non-group premiums, allowing Medicare beneficiaries in enrolled high-deductible health plans to contribute to an	Federal	Congress has introduced 15 bills expanding use and benefits from HSAs, but no legislation has been passed in the 116th Congress.

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	HSA, and enabling consumers with HSAs to enter into provider-consumer fixed-fee arrangements, including direct primary care arrangements.		
✓	The Administration should explore ways to administratively expand consumers' abilities to benefit from HSAs, including by interpreting preventive services to allow HSA-qualified plans greater ability to cover preventive low-cost treatments for chronic conditions.	Federal	President Trump issued an executive order in July 2019 urging the U.S. Department of the Treasury to expand HSAs to improve access to low-cost healthcare, like preventative medical services or devices such as insulin, inhalers, and statins, that will prevent patients' conditions from worsening. The Treasury Department has also released guidance documents on high deductible plans and expenses related to COVID-19 and changes to health care spending available under the CARES Act, along with proposed regulations relating to section 213 of the Internal Revenue code regarding the treatment of amounts paid for certain medical care arrangements, including direct primary care, health sharing ministries and other government sponsored health care programs.
✓	Consistent with Executive Order 13813, the Administration should work through the regulatory process to increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with non-group coverage.	Federal	In October 2018, HHS, Treasury and Labor proposed a rule that would provide employers with significant new flexibility in how they fund health coverage. The rule is effective as of August 19, 2019.
	Delivery System Reform		
—	The Administration should focus on identifying alternative payment models that allow free markets and patients to define value, rather than rely on technical and burdensome definitions invented in Washington.	Federal	Although CMMI developed the Direct Contracting Model with the intent of allowing providers to participate in a Medicare APM that "draws upon private sector approaches to risk-sharing arrangements and payment with reduced administrative burden commensurate with the level of downside risk," CMMI models writ large continue to be prescriptive in nature, thus limiting the extent to which free markets and patients define value.
✓	The Administration should evaluate the best metrics for measuring value and quality in the healthcare sector, eliminating unnecessary and potentially counterproductive measures and reducing the burden on providers.	Federal	HHS announced a quality summit in July 2019, bringing together industry stakeholders and government leaders to discuss how current quality programs can be further evaluated, adapted, and ultimately streamlined to deliver a value-based care model focused on improving outcomes. This lead to the National Health Quality Roadmap In its proposed Calendar Year 2021 Medicare Physician Fee Schedule, CMS proposed to streamline and align quality measurement for MIPS APMs and practices participating in MSSP. The new

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			Alternative Payment Model Performance Pathway (APP) evaluates practice performance based on six measures. This is a first step to broader alignment across programs.
✓	The Administration should ensure that smaller physician and provider practices are not unduly harmed by delivery system reform and corresponding requirements.	Federal	CMMI has sought to develop models, such as the CHART model, which intends to encourage smaller or rural physician practices to take part in the MSSP program through an ACO Transformation Track, or Primary Care First, that are geared towards smaller practices who provide primary care services. CMMI has also requested input on models that would not be an opportunity for smaller practices and that could result in consolidation in certain markets. One example is the Direct Contracting Geographic Model option, for which an RFI was released in April 2017.
✓	The Administration should ensure that these delivery system reform models, which aim to hold providers accountable to a set of population-based metrics and total spending, foster collaboration across systems within a geographic area and do not produce harmful consolidation, particularly horizontal consolidation.	Federal	The CHART model is a delivery system reform model which holds both providers in ACOs and health systems accountable based on a set of population-based metrics and fosters collaboration across systems within a geographic area. The Pennsylvania Rural Hospital Model and the Vermont All Payer ACO model are also delivery system reform models.
✓	The Administration should pursue policies and programs that encourage value, competition, and choice, such as Medicare Advantage, and move away from a fee-for-service model.	Federal	CMS continues to develop new models like Direct Primary Care and CHART, which seek to accelerate the shift towards value-based care for Medicare FFS clinicians. Additionally, CMS has taken steps to promote the value of MA, such as by expanding the types of supplemental benefits that plans can offer to beneficiaries as well as expanding supplemental benefits in MA-VBID and Special Supplemental Benefits for the Chronically Ill
	Positively Realigning Incentives Through Payment Reform		
✓	Congress should establish site neutral payment policies based on the anticipated clinical needs and risk factors of the patient, rather than the site of service. In delivering these reforms, Congress should account for differing levels of patient acuity.	Federal	In the CY2019 and CY2020 Medicare OPPS rules, CMS finalized site neutral payment policies certain hospital outpatient departments. Specifically, CMS plans to pay for services provided in non-excepted, off-campus departments under the Medicare Physician, rather than the OPPS. Hospital organizations have sued CMS, but lost an appeal in July 2020. Additionally, in the proposed CY2021 OPPS, CMS proposes to phase-out the so-called "Inpatient Only List," a list of services that require inpatient care, allowing such services to be provided in outpatient settings. Congress to-date has not passed legislation codifying the Administration's actions.

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—	State Medicaid programs should embrace site neutrality as a goal and reform their payment systems to pay for the value delivered where value is defined according to a relatively limited, straightforward, and non-gameable set of metrics. Additionally, metrics should not be designed and proposed solely by the entities to which they will ultimately apply.	States	No public action to date.
	Quality Improvement and the Measurement and Reporting of Quality		
✓	As proposed by CMS' Patients Over Paperwork initiative, the Administration should streamline and standardize quality measures across programs to avoid duplicative reporting requirements and limit the number of measures where the expected cost of collecting the measure exceeds the expected benefit. In addition, the Administration should collaborate with state Medicaid programs, private payers, and other government payers to align and streamline quality measures and reporting structures to reduce physician burden.	Federal	CMS announced the Patients Over Paperwork initiative in 2017 with the goal of reducing regulations and reporting requirements that place burden on providers and the health care system. As part of this effort, CMS has reduced billing documentation requirements, reforming E&M coding, simplifying office visit documentation, streamlined hospital reporting, and other activities. As of August 2019, CMS estimated that the initiative has saved the healthcare system at least $6.6 billion through 2021, and eliminated 42 million hours of burden. In its proposed Calendar Year 2021 Physician Fee Schedule, CMS proposed to streamline and align quality measurement for MIPS APMs and practices participating in MSSP. The new Alternative Payment Model Performance Pathway (APP) evaluates practice performance based on six measures.
✓	The Administration should seek to develop measures that are meaningful to providers and patients, and help them assess quality and value.	Federal	CMS launched the Meaningful Measures framework as part of the Patients Over Paperwork initiative, with the goal of identifying high priority areas for quality measurement and improvement that would apply across CMS programs. As an example of CMS' efforts, the recently proposed CY2021 Physician Fee Schedule proposes to streamline and sync quality measures and reporting for MSSP ACOs and other providers participating in Alternative Payment Models, so that there is one single APM Performance Pathway measurement standard.
✓	The Administration should focus on providing a framework for quality reporting in plain language that is more accessible and appealing to consumers.	Federal	The Meaningful Measures framework is also intended to identify measures that are patient-centered and meaningful to patients.

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			CMS updated, streamlined, and combined its provider comparison tools in September 2020. The new Care Compare combines the eight existing compare tools to provide single interface providing information on cost, quality of care, volume of services, and other information.
✓	The Administration should consider providing incentives and technical assistance to support the development of virtual provider groups (e.g., independent practice associations, alternative payment models, or regional quality collaboratives) that can increase the competitiveness of small practices through access to shared resources and help build capacity for care management.	Federal	CMS allows virtual groups in the Merit-based Incentive Payment System, defining virtual groups as a combination of two or more TINs consisting of the following: 1) solo practitioners who are MIPS eligible or 2) groups that has 10 or fewer clinicians. Clinicians in a group TIN that are part of a virtual group may also be alternative payment model participants. CMS provides technical support to small practices to help them to succeed in MIPS and in entering into VBC, including help with selecting and reporting appropriate measures, engaging in quality improvement, optimizing HIT, and evaluating options for joining APMs.
✓	HHS should explore opportunities to initiate research into machine learning techniques that can directly access data on CMS beneficiaries from the provider Electronic Medical Records (EMRs) using open application programming interfaces in order to enable quality analysis and payments based on value while reducing burden and cost and benefitting the public.	Federal	CMS launched the AI Health Outcomes Challenge in March 2019, alongside the American Academy of Family Physicians and Arnold Ventures. The challenge is intended to promote the use of AI/deep learning methodologies to predict unplanned hospital and SNF readmissions and adverse events, based on Medicare claims data, and to develop innovative strategies and methodologies to provide clinical decision support to clinicians. In February 2020, the White House released an annual report on the steps it has taken to advance AI, including within healthcare. To-date, no specific actions on using machine learning/AI to enable quality analysis and payments based on value.
	Facilitate Price Transparency		
✓	Federal agencies should eliminate any federal rules or policies that create unnecessary barriers to state, federal or private sector initiatives that provide price transparency.	Federal	CMS has proposed and finalized regulations seeking to promote price transparency for consumers. • CMS finalized price transparency requirements for hospitals through the CY2019 and again in the CY2020 Hospital Outpatient Prospective Payment System (OPPS) rules, which will require hospitals to establish, update, and make public a list of their standard charges for items and services. • In November 2019, CMS proposed the Transparency in Coverage rule, which will require plans to provide enrollees with real-time personalized access to cost-sharing information. It has not yet been finalized.

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			• Through the 2019, 2020 and 2021 MA and Part D final rules, CMS updated policies to require Part D plan sponsors to implement one or more Real Time Benefit Tools to provide patient-specific cost information in the CY 2021/22 Medicare Advantage and Part D Rule • ONC's proposed rule on information blocking and interoperability included a request for information on Price Information, and proposed to include price information in the definition of Electronic Health Information, although ONC ultimately did not finalize the policy.
—	The Administration should consider legislative proposals to empower patients as they shop for healthcare by making it easier to pay directly.	Federal	No public action to date.
✓	Congress should seek to empower patients as they shop around for healthcare by making it easier to pay for their healthcare directly. Actions might include: • Allowing all Americans, including Medicare beneficiaries, to maintain and contribute to a HSA, not only those enrolled in high deductible health plans. • Increasing flexibility for beneficiaries and providers in the Medicare program by allowing for direct negotiations between these parties so that beneficiaries can access services at a price or under a payment plan that works for them.	Federal	15 bills have been introduced in the 116th Congress relating to expanding access to HSAs and increasing flexibility for beneficiaries to access services. None of the HSA specific bills have become law. The CARES Act was enacted in March 2020, and allows individuals who have high deductible health plans for the purposes of health savings accounts to have supplemental coverage for telehealth services. CMMI's Direct Contracting Model is a voluntary payment model with options aimed at reducing expenditures and preserving or enhancing quality. The model is expected to increase beneficiaries' access to innovative, affordable care while maintaining all original Medicare benefits.
✓	Congress, federal agencies, and states should incentivize providers to compete on price, including right to shop modeled on successful state efforts as well as understandable reference pricing models.	Both	CMS issued a proposed rule in June 2020 to empower consumer plans and states to negotiate payment for innovative new therapies based on patient outcomes, The proposed rule proposes to allow manufacturers to report multiple "best prices" for a therapy under the Medicaid Drug Rebate Program if the prices are tied to a value-based payment arrangement.
	Using Choice to Bring a Longer-Term View to Healthcare		
✓	The Administration should continue to publicly release and increase access to	Federal	As part of the MyHealthEData initiative, CMS launched Blue Button 2.0 in 2018, which provides four years of Medicare Part A, B, and D data for 53 million Medicare beneficiaries.

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	claims data from taxpayer-funded federal healthcare programs and encourage the private sector and states to build consumer-friendly websites capable of displaying price information for the most common transactions. The administration should work to ensure that such data are technically and financially accessible for third-party transparency advocates, vendors, developers, researchers, employers, state and local governments, and the general public		CMS also announced the Data at the Point of Care API Pilot, which makes a patient's Medicare Part A, B, or D claims data available to their clinician to support treatment decisions. The ONC and CMS information blocking, interoperability, and patient access final rules require the development of Application Programming Interfaces (APIs) that will help consumers to access a standardized set of their electronic health information at any time. ONC requested comment on whether price should be included in the standard set of information that must be made available. CMS has also required hospitals to make standard charges publicly available in a machine-readable file, and to make public payer-specific negotiated charges for a set of shoppable services. However, hospitals have filed suit against these rules. CMS has additionally proposed a rule that would require plans to give consumers real-time personalized access to cost-sharing information and to disclose on a public website their negotiated rates for in-network providers and allowed amounts paid for out-of-network providers.
✓	States should coordinate their efforts on maximizing the utility of claims data (consistent with all relevant federal and state privacy protections), including simplifying the process for reporting data and using a standard reporting format.	States	According to AHRQ, 18 states have legislation mandating the creation and use of all-payer claims databased, with 16 currently being operational. More than 30 states maintain, are developing, or have a strong interest in developing an APCD. However, measures for using this data need to be developed and refined and there is still a need to standardize data. States like New Hampshire, Maine and Massachusetts are using APCD data to launch public websites with price and cost information for consumers.
	Improve Health IT		
✓	The Administration should expeditiously implement provisions of 21st Century Cures Act to prevent information blocking, make it easier for patients anywhere to get their core health information, support "Open Application Programming Interfaces" to allow patients to get data on their smart phones, and encourage support of population-level data queries to allow payers electronic access to clinical data.	Federal	HHS Office of the National Coordinator for Health IT (ONC) issued a final rule in May 2020, which implements the Cures Act's interoperability and information blocking requirements and requires Certified Electronic Health Record Technology (CERHT) to implement APIs. CMS issued a final rule in May 2020 extending interoperability and patient access requirements for payers.

Status	Report Recommendation	Level	Action To-Date
✓	CMS and ONC should continue work on documentation burden reduction to allow EHRs to provide informative medical records rather than boilerplate text for providers and patients.	Federal	No public action to date.
✓	CMS should continue its emphasis on fostering interoperability across the healthcare sector.	Federal	CMS has maintained Promoting Interoperability requirements across the Medicare and Medicaid programs, including through the annual Medicare payment rules. CMS issued guidance in August 2020 to state Medicaid agencies on implementing the CMS Interoperability and Patient Access Rule.
✓	CMS should continue its efforts to make data available to patients through efforts such as "MyHealthEData" and Blue Button 2.0.	Federal	As part of the MyHealtthEData initiative, CMS launched Blue Button 2.0 in 2018, which provides four years of Medicare Part A, B, and D data for 53 million Medicare beneficiaries. CMS also announced the Data at the Point of Care API Pilot, which will make a patient's Medicare Part A, B, or D claims data available to their clinician to support treatment decisions.
✓	ONC should continue making standards more comprehensive and robust.	Federal	ONC continues to publish the Interoperability Standards Advisory (ISA) to recognize interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs. ONC also collaborates with organizations accelerating standards work, including HL7.