September 24, 2018

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

Re: CMS-1695-P, Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model; Proposed Rule (Federal Register, Vol. 83, No. 147, July 31, 2018)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and nearly 50 health systems, the Illinois Health and Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule establishing new policies and payment rates for hospital outpatient and ambulatory surgery services for calendar year (CY) 2019. IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough analysis in the development of this rule. However, IHA has strong concerns with several provisions, and presents the following comments for your consideration:

PRICE TRANSPARENCY: In the federal fiscal year (FFY) 2019 Inpatient Prospective Payment System (IPPS) proposed rule, CMS had asked for comments regarding its proposal requiring hospitals to post their charges for services on the Internet in machine-readable format. In this proposed rule, CMS is again soliciting comments pertaining to price transparency and how pricing information can be made more meaningful to patients. IHA is repeating many of the comments it submitted as part of the IPPS comment letter here as well for your reference.

- **Requirements for Hospitals To Make Public a List of their Standard Charges via the Internet:** IHA is pleased to respond to your request for comments on healthcare price transparency and to share the progress that has been made in Illinois. IHA supports price transparency that provides relevant and meaningful healthcare price information to patients making healthcare
decisions and has developed price transparency principles which have been adopted by our members. These principles embrace the need for a collaborative approach between providers and public and private health plans to convey the value of care, as well as to insure that patients understand the many factors that influence the final price of the care provided.

What we hear most often is that patients want to know what their out-of-pocket financial obligations will be. Given that 93 percent of Illinoisans have health coverage and their health plan sets their cost-sharing financial obligations, we believe that information is best provided from their health plan. For those without healthcare coverage, healthcare providers should provide estimates of pricing, including available financial assistance, as well as assistance with additional information regarding public health coverage.

- **Response to Updated Guideline to Post Charges on the Internet:** In the IPPS final rule, CMS acknowledged that challenges continue to exist for patients related to insufficient price transparency and further stated its concern that chargemaster data is not helpful to patients for determining what they are likely to pay for a particular service or hospital stay. However, despite strong objections from IHA and others, CMS finalized its proposal requiring the posting of charges on the Internet in machine-readable format by Jan. 1, 2019.

  We agree that chargemaster data does not advance the goal of helping patients know their financial obligations for an episode of care. A catalog of services representing a master charge list that has no bearing on the actual amount a patient or third-party payer will have to pay is not particularly useful for commercially insured patients where the rates are contractually negotiated or government-covered patients where set rates are applied. As such, we do not believe posting the same information on the Internet will be a helpful step.

  The Healthcare Financial Management Association (HFMA) Price Transparency Task Force, comprised of providers, health plans, consumers and other stakeholders, developed helpful guidance and tools to advance price transparency, including definitions for charges, price and cost. We recommend these definitions be utilized in further price transparency discussions. Hospitals already have resources in place to provide patients with price estimates by either utilizing commercial software tools or their own price estimators. **Illinois already has a law requiring the provision of an estimate for any procedure the patient is contemplating.**

  The rule lists the concern that challenges exist related to surprise out-of-network bills for physicians providing services at in-network hospitals and physician fees for emergency room services. As both these concerns are related to physician fees, posting
hospital charges on the Internet will do nothing to alleviate these problems. Illinois has passed legislation to hold patients harmless when out-of-network physicians provide services at in-network hospitals and requiring the physician and insurance plan to negotiate payment, thereby removing the challenge of surprise bills.

- **Response to CMS’ Questions on Price Transparency:**
  - **Standard charges:** We believe the definition of standard charges should not mean the discounted rates across payers, as that is typically considered the allowed amount. It is also not useful to include each item on the chargemaster, but rather certain services or groups of services could be identified for which charges must be posted, similar to Illinois law. The main obstacle for making standard charges meaningful for patients is that the gross charge for services is not reflective of what the patient’s financial obligation will be. That obligation is directly related to what the patient’s health plan requirements are for their deductible, co-insurance or copay. Consequently, IHA believes that the health plan is the best source for this information.
  - **Information most beneficial:** The information most beneficial to patients is how much their out-of-pocket obligation will be and for commercially-insured patients, that amount is determined by their health plan. Therefore, again, the health plan is the best source to provide that information. Most health plans in Illinois have developed cost estimator websites so their subscribers can obtain estimates of what their care would cost at specific providers and what their out-of-pocket obligation would be.

  For those uninsured, hospitals should provide an estimated charge with information regarding its financial assistance policy and opportunities for health coverage. Illinois law already requires hospitals to furnish patients with charges estimates, upon request. Illinois law also requires hospitals to notify patients about financial assistance and provide free and discounted care depending on a patient’s income level. Additionally, payers and providers should provide corresponding quality information with pricing information to provide patients with a balanced presentation of the full value of the care they are seeking.

  - **Provide Medicare payment comparison:** We do not believe that healthcare providers should be required to provide patients with information on what Medicare pays for a particular service performed by a healthcare provider, as suggested in the rule. Such a requirement would mean providers would need to process all patient claims additionally through a Medicare pricer to determine payment, even when the patient is not covered by Medicare, thereby significantly increasing both administrative burden and cost. As Medicare
coverage is mostly applicable to older adults, it would have limited relevance for certain women and children services. It would also confuse patients as to why their charge and anticipated payment varied from the Medicare amounts, causing providers, health plans and Medicare to review and explain specific differences on millions of claims. In Illinois, Medicare payment only covers approximately 90 percent of what it costs the hospital to provide care. Medicare payment is already woefully inadequate and typically commercial health plans are paying more to cover the losses incurred from Medicare and Medicaid plans. Giving Medicare payment information to patients would necessitate explanation of why it differs from the amount of their bill.

- **Enforcement:** The rule invited comments pertaining to CMS enforcement of the price transparency requirements contained in section 2718(e) of the Public Health Service Act which requires hospitals to make public a list of standard charges, or in accordance with CMS guidelines, a policy for allowing the public to view those charges in response to an inquiry. **In Illinois, most hospitals have elected to comply through a policy to view charges rather than post the chargemaster as this provides opportunity for the important dialogue with the patient about finances.** We suggest that an attestation added to the provider agreement seems reasonable and fines should not be assessed.

It’s important that providers and patients engage in dialogue about the price for their care.

- **Illinois Price Transparency:** As introduced above, Illinois has implemented a number of laws to address various pricing concerns: the need for price estimates, a website with hospital-specific charges by procedure, free care and discounts for the uninsured, communication of financial assistance availability and patient protections from “surprise” out-of-network bills. In addition, Illinois hospitals provide nearly $800 million annually in charity care measured at cost to assist patients in need.

  - **Post charges and give estimates** - The [Illinois Health Finance Reform Act](http://www.healthca reaportcard.Illinois.gov) Sec. 4-4 (Reform Act) requires hospitals to publicly display charges for certain services, and upon request, provide prospective patients with information on the normal charge for any procedure or operation the patient may be considering.

  - **Website with hospital-specific charges by procedure** - The Reform Act Sec. 4.2 requires hospitals to submit inpatient and outpatient claims to the Illinois Department of Public Health (IDPH) then post average charges by hospital for over 50 most common services on the Hospital Report Card/Consumer Guide website, [www.healthca reaportcard.Illinois.gov](http://www.healthca reaportcard.Illinois.gov). The Illinois Hospital Report Card Act requires collection of certain hospital quality information also posted
on the website. Most health plans in Illinois have developed cost estimator websites so their subscribers can obtain estimates of what their care would cost at specific providers and what their out-of-pocket obligation would be.

- **Free care/discounts to uninsured** – The [Illinois Hospital Uninsured Patient Discount Act](https://www.illinois.gov/Healthcare/providers/Documents/General/UninsuredPatientDiscountAct.pdf) (HUPDA) requires that uninsured residents whose income is below established thresholds be eligible for either 100 percent discount (free care) or discounts up to 135 percent of the hospital’s cost. It also sets the maximum collectible amount at 25 percent of family income. The [Illinois Fair Patient Billing Act](https://www.illinois.gov/Healthcare/providers/Documents/General/FairPatientBillingAct.pdf) (FPBA) requires a presumptive eligibility policy for financial assistance for certain categories of patients.

- **Billing information** – FPBA requires specified information on hospital bills including availability of financial assistance, an itemized bill provided upon request and responses to billing inquires within specified time frames.

- **Collection action** - FPBA requires hospitals to give uninsured patients opportunities to apply for financial assistance, assess the accuracy of their bill and avail themselves of a payment plan prior to any collection action. No legal action for non-payment is allowed against uninsured patients who have clearly demonstrated lack of income or assets to meet financial obligations. It also requires the offering of a payment plan to insured patients before collection action taken.

- **Out-of-network/Surprise bills** – [Public Act 96-1523](https://www.illinois.gov/healthcare/providers/Documents/General/SurpriseBillsAct.pdf) holds insured patients harmless for any increased out-of-pocket obligations from facility-based, out-of-network provider services at an in-network hospital. A facility-based physician or other provider is defined as one who provides radiology, anesthesia, pathology, neonatology or emergency department services in a participating hospital or ambulatory surgical treatment center. FPBA requires that notice be given to insured patients that healthcare professionals affiliated with the hospital may not be participating providers within the same insurance plans and networks as the hospital.

Healthcare is unlike other industries where consumers are able to price shop for standardized commodities. Some outpatient procedures may lend themselves to greater standardization of service and price, but the underlying principle that needs to be understood is that people are unique. Their care can vary because of their medical condition, length of time necessary to provide the care, necessary specific equipment, supplies and medication, complications requiring unanticipated procedures or other treatment ordered by the physician.
Illinois hospitals are eager to engage patients in financial conversations and assistance. We believe that the progress made in Illinois through laws and regulations has advanced price transparency by providing patients with information most helpful to them.

**REDUCTION IN PAYMENT FOR DRUGS PURCHASED UNDER THE 340B DRUG PRICING PROGRAM:** Beginning in CY 2018, CMS now pays a reduced rate of Average Sales Price (ASP) minus 22.5 percent, versus the previous rate of ASP plus 6 percent for nonpass-through separately payable drugs and biosimilar biological products purchased under the 340B program. The reason for the reduction is that CMS believes that 22.5 percent below the ASP reflects the average minimum discount that 340B hospitals receive for drugs acquired under the 340B program. Rural sole-community hospitals (SCHs), children’s hospitals, and PPS-exempt cancer hospitals are exempt from the 340B adjustment, and consequently receive drug payments based on ASP plus 6 percent.

IHA strongly advocated against this change and continues to advocate against this reduction. In the OPPS rule, CMS proposes to extend the ASP minus 22.5 percent payment rate to 340B drugs (excluding vaccines and drugs on pass-through payment status) provided at non-excepted, off-campus provider-based departments. This proposed policy would not apply to rural sole community hospitals, children’s hospitals, or to PPS-exempt cancer hospitals. Consistent with our stance on the 340B reduction implemented in CY 2018, IHA strongly opposes CMS’ proposal to expand the payment reductions for drugs acquired through the 340B Drug Pricing Program in those additional circumstances. We urge the agency to withdraw its proposal for the following reasons:

- IHA believes that CMS’ proposed reduction in Medicare Part B payments for 340B drugs will put significant financial pressure on our hospitals, negatively impacting their ability to provide high-quality care to their Medicare beneficiaries and their communities at large.
- Many of the 340B-eligible hospitals in our state are rural hospitals in precarious financial situations. The further expansion of this policy will simply exacerbate that situation.
- Finally, we continue to challenge CMS’ statutory authority to implement the reductions, much less expand them.

Consequently, IHA urges CMS to withdraw the 340B drug payment proposal and redirect its efforts toward halting the unsustainable increases in the cost of drugs.

**EXPANSION OF THE SITE-NEUTRAL PAYMENT POLICY TO INCLUDE CLINIC VISITS AT OFF-CAMPUS, EXCEPTED HOSPITAL-BASED DEPARTMENTS:** In CY 2019, in order to control for what CMS believes is an unnecessary increase in OPPS service volume for basic clinic visits (which represent a large share of the services provided at off-campus, provider-based departments (PBDs), CMS proposes to expand the Medicare Physician Fee Schedule (MPFS) payment methodology to excepted off-campus PBDs (currently paid under the OPPS rates), for those Evaluation and Management visits (HCPCS code G0463). For our members, this reduction
represents an approximate 60 percent cut in payment for those services. CMS further proposes that this payment method would be implemented in a non-budget neutral manner, meaning that no corresponding, offsetting increase to the OPPS conversion factor would be added, as was the case in 2018. **IHA strongly opposes CMS’ proposed change to the payment methodology for these visits, and urges the agency to withdraw its proposal for the following reasons:**

- Based on our understanding of the current legislation regarding the expansion of the 340B program reductions discussed above, we do not believe that CMS has the legal authority to implement this payment change as well.
- Many of our hospital members operate hospital-based, off-campus clinics, and a reduction of this magnitude would be extremely harmful to them. We have estimated that the impact of this change on Illinois hospitals would be a payment reduction of over $29 million in CY 2019. This reduction would compound an already estimated 2016 negative Medicare hospital outpatient margin of 16.4 percent for Illinois hospitals.
- Evaluation and Management (clinic) visits are essential services in many communities, particularly, rural communities. We are concerned that cuts of this magnitude could result in a reduction, or worse, a discontinuance of these services in these communities, resulting in decreased access for Medicare beneficiaries.
- We would like CMS to reference the data it is using to conclude that the volumes of these services have unnecessarily increased. A patient who presents at one of these clinics to be examined cannot be assumed to be utilizing the service unnecessarily.
- Finally, Section 603 of the Bipartisan Budget Act of 2015 legislated the hospital outpatient site-neutral policy, clearly establishing that payments for excepted and non-excepted facility services be different. In this proposed rule, CMS is effectively attempting to equalize the two.

**EXPANSION OF THE SITE-NEUTRAL PAYMENT POLICY TO INCLUDE NEW “CLINICAL FAMILIES OF SERVICES PROVIDED IN “EXCEPTED” OFF-CAMPUS, HOSPITAL DEPARTMENTS:** For CY 2019 and subsequent years, CMS proposes that if an excepted off-campus PBD provides services from any clinical family of services that it did not provide under OPPS during the baseline period of Nov. 1, 2014 through Nov. 1, 2015, then those items and services would be paid under the MPFS. In addition to the reasons stated above, IHA strongly disagrees with this proposal, because hospitals should be encouraged to provide new or additional services that it had not previously provided. Implementing payment reductions of this magnitude discourages hospitals from adding to their available services, and at the same time, denies the availability of these services within their communities.

**SERVICES Furnished in OFF-CAMPUS, PROVIDER-BASED EMERGENCY DEPARTMENTS:** MedPAC’s June 2017 Report to Congress states that there has been significant growth recently in the number of healthcare facilities located apart from hospitals that are devoted primarily to emergency department services. The Congressional advisory body, Medicare Payment Advisory
Commission (MedPAC), has reported that it is concerned that increased payments for these hospital-based services may be the driver of this growth.

In order to track this, CMS is proposing that effective Jan. 1, 2019, a modifier (items and services furnished by a provider-based off-campus emergency department) be reported with every claim for outpatient hospital services furnished in an off-campus provider-based emergency department. Critical access hospitals would be exempt from reporting this modifier. **IHA is concerned that adding an additional billing requirement would simply increase the already high administrative burdens placed on hospitals, without necessarily yielding conclusive data.** It may be that the increase in volume (assuming that it can be substantiated) is simply due to the complexity of the patients seeking care and that hospital-based facilities are in the best position to provide that care.

**PROPOSED INCREASE IN THE FIXED LOSS OUTLIER THRESHOLD:** CMS proposes to increase the fixed loss threshold for Medicare outlier payments from $4,150 in CY 2018 to $4,600 in CY 2019, a 10.8 percent increase. CMS defends this increase as necessary in order to ensure that outlier payments remain at the statutorily mandated 1 percent of total OPPS payments. **IHA is concerned that such a drastic reduction in outlier payments will have an adverse effect on access to services by Medicare beneficiaries and recommends that CMS implement this comparatively large increase over a three-year transition period.**

**PARTIAL HOSPITALIZATION PROGRAM (PHP) PAYMENTS:** In CY 2017, CMS consolidated the two previous current ambulatory payment classification (APC) categories for hospital-based, partial hospitalization services into one category; previously, there were two APC per-diem payments based on the number of daily services—one for three services and the other for four or more services. CMS is proposes to continue the one APC per-diem payment for three or more daily services in CY 2019.

Maintaining beneficiary access to partial hospitalization services is one of several important objectives of IHA’s focus on the provision of behavioral health services in Illinois. Behavioral health services are a key component of recently-passed legislation in Illinois focusing on the provision and transformation of health care services in the state. It is very important that fair reimbursement for those services be made to those providers to allow for access to those services to be maintained in Illinois communities. **Therefore, IHA recommends that CMS rescind its current policy and revert back to the use of two current ambulatory payment classification (APC) categories, along with two separate per-diem payments.**

Ms. Verma, thank you again for the opportunity to comment. If you or your staff has any questions on the comments, they should be addressed to Thomas Jendro at 630-276-5516 or tjendro@team-iha.org.
Sincerely,

A.J. Wilhelmi
President & CEO