

September 27, 2019

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-1717-P, Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children’s Hospitals-Within-Hospitals; Proposed Rule (*Federal Register*, Vol. 84, No. 154, August 9, 2019)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and nearly 50 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the proposed rule that would establish new price transparency requirements.

IHA strongly supports price transparency that provides meaningful and relevant information to patients making healthcare decisions. We appreciate the Centers for Medicare & Medicaid Services’ (CMS) desire to increase price transparency. However, **we believe this proposed rule would cause significant confusion for patients while failing to provide the information they want, which is what their out-of-pocket obligation will be. The requirements in the proposed rule would create substantial administrative burden for hospitals. Furthermore, we believe the proposed requirement for hospitals to disclose their negotiated rates exceeds the agency’s statutory authority.**

Health plans are the entities that dictate what a patient’s financial obligation will be and are therefore in the best position to provide this information on what a patient’s out-of-pocket costs will be. Most health plans have already developed price estimator tools, and we believe standardizing these tools and providing **increased patient education is the better focus for increased price transparency efforts.** For patients without health coverage,

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the hospital financial assistance policy is a key consideration in determining a patient's financial obligation, and hospitals appropriately provide assistance in these circumstances.

IHA has long championed efforts to provide patients with meaningful price transparency, including the enactment of several state laws which provide patients with useable cost information. However, we have significant concerns with the proposed rule and present the following comments for your consideration.

Illinois Price Transparency Efforts

IHA is a strong supporter of healthcare price transparency and our members [adopted price transparency principles](#) five years ago. In addition, Illinois has been a leader in passing legislation to make price estimates, billing, collection and the financial assistance process easier and more transparent for patients.

The [Illinois Health Finance Reform Act](#) 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. The Reform Act Sec. 4.2 requires hospitals to submit inpatient and outpatient claims to the Illinois Department of Public Health (IDPH), and then as per the [Hospital Report Card Act](#), IDPH posts average charges by hospital for more than 50 of the most common services on the Hospital Report Card/Consumer Guide to Health website (www.healthcarereportcard.Illinois.gov). The Hospital Report Card Act requires collection of certain hospital quality information that is also posted on the website.

The [Illinois Hospital Uninsured Patient Discount Act](#) (HUPDA) requires uninsured residents below established income thresholds to be eligible for either 100 percent discount or discounts to 135 percent of the hospital cost. The [Illinois Fair Patient Billing Act](#) (FPBA) requires a presumptive eligibility policy for financial assistance for certain categories of patients; specified information to be printed on hospital bills including availability of financial assistance; patient access to an itemized bill upon request; and responses to billing inquiries be provided within specified time frames. FPBA requires hospitals to give uninsured patients opportunity 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 may be taken.

Illinois hospitals are working to provide patients with best estimates of what their out-of-pocket obligations will be prior to provision of the service. Our members continue to explore how to better serve their patients with comprehensive information related to the services provided, including quality and price information. However, requiring hospitals to provide price estimates that can be accessed directly by patients would necessitate significant and ongoing

collaboration with the numerous health plans. And even with such collaboration, the information provided would still only be an estimate, as healthcare services are tailored to the unique medical needs of each patient and are often not knowable in advance. Additionally, there is significant complexity and variability among payment contracts, and the information related to plan design and provider networks is ever-changing.

Patient Focus

The proposed rule states that “consumers of health care services simply want to know where they can get a needed health care service and what that service will cost them out-of-pocket.” We agree this is the information that is meaningful to patients; however, we believe that what is being proposed would not in fact provide this information. Instead, the proposed requirements would result in confusing information for patients and impose significant administrative burdens on hospitals. In addition, the various complexities for payment methodologies that cannot be attributed at the chargemaster (CDM) line item level would consistently challenge the accuracy of the information provided to patients.

The proposed rule also states that providing the negotiated rate “is necessary for the consumers to be able to determine their potential out-of-pocket costs in advance...” Given 93 percent of Illinoisans are covered by a health plan that dictates what their out-of-pocket obligation will be, **we believe that health plans are best able to provide this type of information to patients.** Although hospitals can help inform a patient of their required deductible, hospitals do not know where a patient stands in regards to meeting their individual deductible. Most major health plans have already developed patient cost estimators that can provide cost information for specific procedures at specific providers; **increased consumer education on accessing and using these tools should be the agency’s first focus for increasing meaningful price transparency for patients.** Hospitals have an important role to play in advancing meaningful price transparency for patients, and routinely provide price estimates and information on the hospital’s financial assistance policy. However, patient-specific out-of-pocket information is best provided by the health plan, not the hospital. **It is important that pricing information be disseminated with related quality and financial assistance information in order to present a complete picture to the patient.**

Definition of “standard charge”

Section 1001 of the Patient Protection and Affordable Care Act requires hospitals to “make public a list of the hospital’s standard charges for items and services provided by the hospital”. Within the context of healthcare pricing and Medicare regulations, including the Medicare cost report, use of the word “standard charges” has always meant the amount charged by the hospital before any applied discounts or contractual allowances. **It is inconceivable that the agency is proposing to redefine “standard charges” to mean both the gross charge and the payment rate, which are two very different items.** It is noted that throughout the proposed rule, the terms “payer-specific negotiated charge” and “payment rate” are used interchangeably. **We urge CMS to retract the proposal to alter the common definition of**

standard charge to include a payer-specific negotiated charge, as this is not an accurate definition and will only serve to confuse hospitals.

Definition of Items and Services

There is significant variation among hospitals regarding whether they have employed physicians and non-physician professionals for which billing is done independent of the hospital chargemaster. Often physicians are employed through a separate affiliated corporation and not part of the licensed hospital, and thus would not be included in this proposed requirement. As a result, accurate comparisons among hospitals of the overall charge for a procedure that includes a physician component would not be possible. **We urge CMS to exclude employed physicians and non-physician practitioners from the definition.**

While each line item of the chargemaster has an associated gross charge, services provided linked to a payment method, such as a diagnosis related group (DRG), can vary significantly depending on the patient's age, gender, acuity, comorbidities, etc. While one patient may require one ancillary service, another patient may require different or multiple ancillary services, even though both are provided under the same DRG. One Illinois hospital provided an example of DRG 470 that showed charges over ten cases ranged from \$13,650 to \$45,970 due to the patient's needs.

Further examples of various payment methods not directly correlated to chargemaster items are outlined below.

Payer-specific negotiated charge

As indicated above, we believe the definition of standard charges should not be modified to mean negotiated payment rates and are concerned about the numerous unintended consequences this policy could have. For example, there is the potential for prices to actually increase, as hospitals with lower negotiated rates may demand higher prices in line with higher paid hospitals. Many hospital contracts also include "most favored nation" clauses which would cause the lowest reimbursement rate to be applied, significantly impacting many hospitals. Hospital and payer contracts are kept confidential which permits arms-length negotiation with other health plans. Making this information public would harm hospitals' ability to negotiate competitive contracts.

The Federal Trade Commission has warned against releasing negotiated payment rates, and in the context of price transparency, has urged such information be restricted to out-of-pocket obligations and quality information.

As the proposed rule acknowledges and our members have reported, the number of third-party negotiated contracts for a hospital can be in the hundreds, as one health plan may have numerous separate plans that each have differing contracts. These contracts will vary depending on negotiated payment and may include variation in payment models based upon a

per diem, DRG, capitation, value-based components, outliers, additional payment for implants, percent of charges, etc. Hospitals typically would not have all these various payment iterations loaded into one electronic file that could easily be produced for price comparison purposes.

Furthermore, in nearly all these cases, there is generally no direct correlation between line items contained in the chargemaster and the payment received for the total care of a patient. For example, contracts that pay on a per diem rate stay the same no matter what care was provided to the patient on a specific day. One day the patient might receive a number of diagnostic services and another day they might only receive medical services. In such a situation, there is no way to correlate the services provided with any specific payment rate designated to a charge code in a CDM. Another example is the use of bundled contract rates which also do not apply to specific charge codes in the chargemaster, but rather provide an estimate of what payment is associated with any specific procedure. Additionally, these bundled payment amounts differ between hospitals, preventing an “apples to apples” comparison for patients.

Similarly, contracts that include value-based components such as a reduction or increase in payment to the hospital if it meets certain quality targets do not allow correlation to a charge code in the chargemaster. CMS has implemented a number of such payment structures intended to reduce costs and improve value and quality. Value-based bundles set a single price for a variety of procedures that increase or decrease payment amounts depending on whether a hospital meets certain quality targets. Although these quality targets may not be associated with a specific patient, they impact the actual payment received and thus would prevent a patient from shopping across hospitals. In addition to pricing information changing as different performance metrics are met, there is also no direct line between a component of the bundle and the price of the bundle. Additionally, some payers have multi-procedure discounts, so there is one price for the first procedure, but a different price for the first procedure if there is a second procedure included.

Outpatient payments also present significant price transparency challenge as they are often reimbursed based on Enhanced Ambulatory Payment Groups (EAPGs) or Ambulatory Payment Classifications (APCs). These payment rates vary depending on the specific diagnostic services provided with the general procedure and are dependent upon the individual medical needs of each patient. The result is significant variation of payment rates for the same procedure based on what additional services could be added.

Another aspect that reflects the complexity of actual charge and payment is any procedure that includes a surgical component done in an operative type setting (e.g., general OR, Interventional Laboratory). Surgical procedure codes typically do not have hardcoded charges, as operating room charges utilize a tiered charging methodology aligned with length of time in the operating room and case complexity. Charge capture for these procedures relies on coding

staff to abstract (based on documentation in the medical record) in order to assign the accurate “soft-coded” CPT code that attaches to the operating room charge.

Critical Access Hospitals (CAHs) contracts are particularly complicated as their contracts with Medicare Advantage and Medicaid managed care organization (MCO) plans often have the same payment rates as Medicare and Medicaid. As a result they are given an interim inpatient per diem payment rate which is then settled via a cost report. Medicaid MCOs may pay based on the Medicaid fee schedule and then apply a hospital-specific EAPG rate that is used when the diagnosis is for the higher-level procedures. In other words, CAHs are often paid based on estimated rates and receive a lump sum settlement at the end of the year that is not tied to a specific chargemaster or procedure.

Healthcare services are dependent on the unique needs of each patient and can vary depending on patient-specific factors such as the underlying medical condition, length of time spent in surgery or recovery, necessary specific equipment, supplies or medication, complications requiring unanticipated procedures or other treatment ordered by the physician, to name a few.

Many procedures identified in the proposed rule’s list of “shoppable services” are performed in ambulatory surgical treatment centers or other non-hospital settings. However, these non-hospital settings are not included in the proposed rule, thus preventing patients from being able to adequately compare pricing information.

For the many practical reasons discussed above, we urge CMS to not require hospitals to list payer-specific contracted payment rates.

Administrative burden

The proposed rule estimates a hospital would need only 12 hours at a cost of \$1,017.00 to comply. This grossly understates the time and expense for hospitals to attempt to produce this information and post it in the required formats. Many hospitals do not maintain payer-specific payment amounts in their electronic systems due to the complexity of contracts, limitations of electronic health records systems and the complexity of billing regulations. Even for those with contract management software, they limit the number of contracts loaded due to significant expense, and even with that information, pricing estimates would typically need to be individually run through the system.

Illinois hospitals have estimated that complying with this proposed rule could take in excess of 2,000 hours, depending on whether outsourced and the complexity of the hospital or health system. Costs that include third-party vendor support could be as much as \$250,000. The departments involved in complying would at least include patient financial services, information technology, decision support, managed care, revenue cycle, customer service, financial counselors and registration. Small and rural hospitals, which typically do not have

sophisticated computer systems, would most likely have to outsource the work, creating another unfunded government mandate that siphons scarce resources without improving care or quality – or providing patients with the information sought through this proposal.

Proposed Disclosure of Negotiated Rates is Unlawful

In addition to the practical reasons stated above, we believe CMS does not have legal authority to require hospitals to make public their payer-specific negotiated rates. Section 2718 (e) of the Public Health Service Act requires hospitals to make public their standard charges. As previously discussed, “standard charges” has long been defined as a hospital’s usual or customary chargemaster charges and not negotiated payment rates.

Additionally, the agency’s proposed modified definition would also violate the Administrative Procedure Act, because it is unreasonable. The term “standard” means usual, common or customary and payer-specific negotiated charges (payment rates) are by their very nature, not usual, common or customary as they vary from payer to payer. CMS has defined “charges” as the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be ...uniformly applied to all patients...(Provider Reimbursement Manual, No 15-1, Ch 22). Therefore, by definition, a payer-specific negotiated charge (payment rate) cannot be considered a standard charge.

Finally, by compelling hospitals to make public the privately negotiated payment rates, CMS violates the First Amendment. Government regulation of non-misleading commercial speech is unlawful unless it “directly advances” a “substantial” governmental interest and is no “more extensive” than is necessary to serve that interest. CMS has admitted that what patients want to know is what their out-of-pocket obligation will be; release of what the health plans’ agreed payment would be does not advance that interest. The payment rates negotiated between hospitals and health plans are confidential, and their disclosure would violate contracts and cause substantial harm to hospitals and health plans.

IHA urges CMS to retract its proposal to require hospitals to post their payer-specific negotiated payment rates and instead focus on increasing patient health literacy, standardizing the elements to be included in price estimators and urging health plans to provide greater information to their subscribers.

Ms. Verma, thank you again for the opportunity to comment.

Sincerely,

A.J. Wilhelmi
President and CEO
Illinois Health and Hospital Association