College of Healthcare Information Management Executives

September 27, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Verma:

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit comments regarding the proposed rule, *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; et. al* published by the Centers for Medicare & Medicaid Services (CMS) on August 9, 2019 in the *Federal Register*.

CHIME is an executive organization dedicated to serving chief information officers (CIOs), chief medical information officers (CMIOs), chief nursing information officers (CNIOs) and other senior healthcare IT leaders. With more than 2,900 members, CHIME provides a highly interactive, trusted environment enabling senior professional and industry leaders to collaborate; exchange best practices; address professional development needs; and advocate the effective use of information management to improve the health and healthcare in the communities they serve.

CHIME appreciates the opportunity to lend our perspective and the need for patients and caregivers to have a more accurate and complete picture of the costs of healthcare services. We appreciate that the Administration is attempting to inform patients about their cost of care, which to date has been opaque and confusing. However, we have questions concerning how the agency's proposal can translate this vision into reality.

I. Recommendations

Below, we have outlined our key points and recommendations and provided more detailed feedback in the body of our letter.

1. **Health plan entities, rather than providers, are best positioned to publish the detailed and accurate information about each patient's out of pocket cost responsibilities discussed in this proposed rule.**

2. **CMS should ensure providers have more flexibility in determining the most cost-effective and accurate tool that could assist patients with understanding prices and their responsibility for costs.**
3. **We ask the agency to further consider the unintended consequences this transparency requirement could have on competition in local marketplaces, the impact on smaller and lesser resourced providers, and each patient's individual situation (i.e., deductibles met or not).**

II. Requirements for Hospitals to Make Public a List of their Standard Charges

Among the comments CMS received from stakeholders in response to requests for information (RFIs) on price transparency included in FY 2019 Medicare payment rules were suggestions that quality of care and outcome data be paired with price information in a user-friendly format to help patients make informed decisions about where to receive care. In response to stakeholders and in accordance with the President's Executive Order on "Improving Price and Quality Transparency in American Healthcare to Put Patients First", CMS is proposing an expansion of hospital charge display requirements to include charges and information based on negotiated rates and for common shoppable items and services, in a manner that is consumer-friendly. CMS is also proposing to establish a mechanism for monitoring and the application of penalties for noncompliance.

CMS proposes that hospitals make public their standard charges, which the Agency defines as including gross charges and payer-specific negotiated charges. This requirement would apply for all items and services online in a single file that is machine-readable. CMS also proposes requiring hospitals to make public in a consumer-friendly manner their payer-specific negotiated charges for a set of what CMS describes as "shoppable" services – defined as a service package that can be scheduled by a health care consumer in advance. This requirement would apply initially to 300 services, including 70 identified by CMS, and increase in the future. Hospitals also would have to identify and list payer-specific negotiated charges for all associated ancillary items and services it provides with the shoppable service, and any charge differences based on whether the service is provided in the inpatient or outpatient setting.

CMS is focusing on negotiated rates by third-party payers because many third-party payers do not reveal their negotiated rates, even to individuals on behalf of whom they pay. The Agency writes that having insight into the charges that have been negotiated on one's behalf, however, is necessary for insured health care consumers to determine their potential out-of-pocket obligations prior to receipt of a health care service. According to CMS, knowing a negotiated charge is also important because a growing number of insured health care consumers are finding that some services are more affordable if the consumer chooses to forego insurance and pay out of pocket. CMS acknowledges that the impact resulting from the release of negotiated rates is largely unknown. Some stakeholders have expressed concern with the public display of de-identified negotiated rates which may have the unintended consequence of increasing health care costs of hospital services in highly concentrated markets or as a result of anticompetitive behaviors without additional legislative or regulatory efforts.

CHIME supports patients having access to the price information that more closely resembles what they can expect to see on their healthcare bills as this will result in more engaged patients and potentially more savings to our healthcare system. In the Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term

Acute Care Hospital (LTCH) Prospective Payment System rule, CMS finalized guidelines to require hospitals to make available online a list of their current standard charges in a machine-readable format and to update this information at least annually, or more often as appropriate, beginning January 1, 2019, which is consistent with what the President called for in his Executive Order. Our members have been involved in the work to make available this data. However, they do not believe there is evidence that the availability of this data is facilitating a better understanding among patients of their costs of care.

Our members are responsible for the purchase and deployment of all healthcare related technology, and therefore have primary responsibility for ensuring compliance with the proposed reforms to CMS' transparency guidelines. While we believe these policies are well-intentioned, we have strong concerns about the feasibility of executing some of the proposed requirements. Further, while the Executive Order states, "Improving transparency in healthcare will also further protect patients from harmful practices such as surprise billing, which occurs when patients receive unexpected bills at highly inflated prices from out-of-network providers they had no opportunity to select in advance," we do not believe the policy CMS has outlined will achieve this goal. Our concerns with these new proposed policies are outlined below.

1. **Patient Impact:** We believe that the requirement for hospitals to post charges is unlikely to result in meaningful progress on CMS' goal to improve a patient's understanding of the costs he or she is likely to incur. Simply put, these prices do not reflect the price nor are they a proxy for the costs an insured patient receives and will be responsible for paying. Instead, we believe the responsibility for providing accurate, timely patient-specific information is more appropriately directed to health plan sponsors. Hospitals have numerous contractual arrangements with insurers which determine the reimbursement for services and in turn the patient obligation.

   Additionally, our engagement with patients has helped us understand that insured patients are most concerned about their co-pays and deductibles. This patient-specific information originates from the rates that are negotiated between providers and payers, and it cannot be inferred or calculated solely based on the hospital's publicly posted charges. In fact, we are concerned that posting charges could create more confusion among patients and could delay or deter them from seeking treatment in a timely manner appropriate for the nature of the patient's condition.

   Finally, as currently structured, the requirement to hospitals to post charges would require the use of third-party benefit validation software to create accurate patient out-of-pocket costs. To calculate this, it takes a combination of the following unique to the patient and insurance plan; 1) correct insurance plan validated; 2) deductible and co-payments amounts for various service; and 3) what deductibles the patient has already met. This information is not available until the bill is paid without a phone call to the payer or the use of a third-party real-time validation system, which costs money for every query made. This is further complicated by the co-pay amounts already incurred by the patient; some patients may have already been met them whereas others have not.

   Recommendations:

1. **Rather than mandating unduly complex requirements for providers on charge information which will not deliver the type of pricing information patients seek, we recommend instead that patients obtain cost information from their respective payers; and**
2. **CMS should explain how confusing or incorrect patient co-pays can be mitigated under the price transparency proposal.**

2. **Readiness:** We believe a January 1, 2020 effective data is not operationally feasible for hospitals to meet CMS' proposed policy calling for listing all charges, by contract and service line. Hospitals bill for thousands of items and services. When this information is broken down into every possible payer contract price and further broken down by different contracted rates by a single insurer (insurers can have dozens of different plans), it results in a massive spreadsheet with thousands of rows. The sheer volume of information that must be translated for individual patients makes this timeline impractical. Our concern around readiness is further informed by the following factors:
    - While we recognize there is software available that could assist patients in obtaining information about their individual cost responsibilities, this software is generally cost-prohibitive for many providers, including, but not limited to, rural hospitals.
    - Even for those hospitals that may be positioned to make these investments, the acquisition and implementation processes for such software require significant lead time that is not contemplated by a January 2020 effective date.
    - The CMS proposal will require hospitals to know the rates of each payer contract. Providers do not have this data aggregated in a single location, which makes this an operationally challenging and burdensome requirement.
    - Disclosing contractually negotiated rates will require providers review and in most instances renegotiate contracts that have a "non-compete" clause. Our members have significant concerns about the practicality of successfully completing these contractual discussions with a multitude of payers by January 2020 and their legal exposure if these contractual issues are not resolved in a timely manner.
    - Additionally, not all payer contracts list charges. Instead, some are rolled up into diagnosis-related groups (DRGs) with payers paying a discounted amount, which adds further complexity to the translating this information into patient cost-sharing obligations. And, some payer contracts specifically carve out some services, tests and or procedures.

    Recommendation: As noted above, we recommend that patients obtain cost information from their respective payers.

3. **Machine-readable format:** CMS' proposal that hospitals make public their standard charges (both gross and payer-specific negotiated charges), for all items and services online in a single file that is machine-readable, will be exceptionally challenging. We are concerned that, in developing the requirement for a "machine-readable" format, CMS has not taken into account that data is compiled dynamically. A requirement that the file be machine-readable creates a scenario by which the data is a static, snapshot in time. This could lead to confusion and inaccurate

information provided to patients. This will not achieve CMS' goal to inform patients about the price they can expect to be charged for their care.

Recommendations:

1. **We recommend instead that CMS strike the requirement that the file must be machine-readable and instead permit data to be compiled using data aggregator tools or a machine-readable format; and**
2. **Rather than focusing on standard charge, it should be on negotiated rates.**

4. **Consumer-friendly format:** CMS has called for hospitals to also make available payer-specific, negotiated charges for 300 "shoppable services" in a consumer-friendly format. Presently, not all providers have tools to accomplish this and for the ones that do it can be very costly. Big EHR vendors have subscription services that offer a cost-estimator solution; however, it is not the actual price paid by the patient. Some hospitals that can afford to do so have invested in these account receivable tools, but they are considered state-of-the-art and not every hospital has them or can afford them. Those hospitals with smaller EHR vendors will need to purchase a separate solution which also would be costly.

   Recommendation: Adequate time will be needed for all hospitals to meet these requirements, especially smaller and lesser resourced ones. We thus recommend that CMS allow a timeline up to 18 -24 months to meet the requirement to publish costs for shoppable services, if finalized.

5. **Da Vinci Project:** We understand the HL7 DaVinci project is working on patient cost transparency, and this is one of the group's use cases. However, in order to obtain a patient's cost of care you first need to establish patient eligibility. We believe the failure to incorporate eligibility information could create misinformation and confusion for patients, their families and patient advocates.

   Recommendation: CMS should determine whether use of the HIPAA Eligibility Transaction System (HETS), which provides real-time eligibility for Medicare patients and access to the Medicare Common Working File, could assist in offering pricing information.

6. **Competition:** It is unclear how the proposed policy could impact competition. It could for instance undermine the type of hospital competition that CMS has sought to promote through other policy changes. This is especially true for hospitals that are smaller or are in very competitive markets. For example, if hospital A negotiates a rate of 5% off the fee schedule and hospital B only gets 3% off, questions will be raised as to why one got a better discount than the other. Further, it will be challenging for some hospitals to obtain the best rate.

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   Recommendation: CMS should study the impact that negotiated rates have on competition prior to the proposed requirements being enforced.

III. Conclusion

We appreciate the opportunity to comment and welcome the chance to continue to help shape important policies that impact patients, providers and others in the healthcare system. We are committed to helping the state of interoperability in our nation and speed access to medical records and data for patients and providers alike. Should you have any questions about our letter, please contact Mari Savickis, Vice President of Federal Affairs, at msavickis@chimecentral.org.

Sincerely,

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CHIME

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