



American College of Radiology



American Psychiatric Association



American Society of Anesthesiologists



June 25, 2018

Re: CMS-1694-P

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8011
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

Dear Administrator Verma:

On behalf of the undersigned group of medical professionals and associations, we appreciate the opportunity to comment on the issue of price transparency and the request for information included in the "Requirements for Hospitals to Make Public a List of Their Standard Charges via the Internet" section of the fiscal year (FY) 2019 Inpatient Prospective Payment System (IPPS) proposed rule.

We recognize CMS' efforts to better understand the costs of health care and improve price transparency and accountability for patients and would like to respond directly to some of the questions posed by CMS. To better inform your request for input, our responses that follow for the most part address medical care associated with the professional services delivered to Medicare beneficiaries by our specific hospital-based specialties, rather than the entire health care delivery system.

Section 2718(e) of the Public Health Service Act requires hospitals to establish and update a list of the hospital's standard charges for items and services provided by the hospital. While CMS has issued guidance on this requirement in the past, the agency remains concerned that "challenges continue to exist for patients due to insufficient price transparency. Such challenges include patients being surprised by out-of-network bills for hospital-based physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and patients being surprised by facility fees and physician fees for emergency room visits."

Therefore, CMS is proposing to require hospitals to make available a list of their current standard charges via the Internet and update it at least annually. CMS is also considering other potential actions and requests comments on a number of issues that would help advance their "objective of having hospitals undertake

efforts to engage in consumer-friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain at the hospital, and to enable patients to compare charges for similar services across hospitals.” Specifically, CMS includes six questions in the proposed IPPS rule, which again, we are grateful for the opportunity to respond to.

- 1. Should “standard charges” be defined to mean: average or median rates for the items on the chargemaster; average or median rates for groups of services commonly billed together (such as for an MS-DRG), as determined by the hospital based on its billing patterns; or the average discount off the chargemaster amount across all payers, either for each item on the chargemaster or for groups of services commonly billed together? Should “standard charges” be defined and reported for both some measure of the average contracted rate and the chargemaster? Or is the best measure of a hospital’s standard charges its chargemaster?**

We believe that the best measure of a hospital’s charges is from its chargemaster. However, the term “standard charges” is not how these types of charges should be described. Instead, standard charges should be defined as those ‘usual and customary’ charges routinely billed by hospitals and clinicians for facility charges and professional services regardless of the payor and before any discounts are applied pursuant to governmental policies, charity or indigent discounts, or insurance carrier contracting discounts. The custom and standard trade usage of the terms is “usual and customary charges” instead of “standard charges.”

- 2. What types of information would be most beneficial to patients, how can hospitals best enable patients to use charge and cost information in their decision-making, and how can CMS and providers help third parties create patient-friendly interfaces with these data?**

We believe that it is the responsibility of payers, including CMS, to clearly provide information to consumers about the potential costs of seeking care under their particular coverage. Providers can participate by helping patients interpret or help decipher, as best they can, their patient cost-sharing responsibilities, particularly in and out-of-network out-of-pocket costs, but ultimately, the onus should be on insurers to make these costs transparent to patients. We believe that patients today truly do not understand their “high deductible” health plans and there is a dearth of information on “co-insurance,” “deductibles,” and “co-pays.”

Ultimately, while providers and hospitals may be able to provide raw pricing information upfront to patients, without accompanying information from insurers concerning the manner and methodology the insurer has utilized to adjudicate the patient’s benefits, little can actually be achieved in the form of true transparency. In fact, this information from insurers is an essential component to transparency. Further, knowing that an insurer paid a member benefit ‘at the usual and customary benefit level consistent with the member/patient’s plan benefits’ is not acceptable. Rather, the insurer must define in specific terms and in plain English the manner and methodology utilized by the insurer to adjudicate the patient’s plan benefits, notwithstanding an assertion by the insurer that the information is proprietary or confidential—which, more often than not, is an all too frequent insurer response. This often provides the patient with a cryptic response and a limited understanding on what they’re ultimately responsible for. Therefore, placing this responsibility exclusively on the shoulders of the hospital, physician or patient is unfair and of little use in satisfying the objective of CMS’s present request for true transparency.

In general, patients should be able to know if their physician is in-network, and should pay the same cost-sharing they would have paid to an in-network physician irrespective of whether they received unanticipated care from an out-of-network clinician. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. Patients should also be provided with reasonable and timely access to in-network physicians.

In terms of what type of information to provide to patients, we think that the usual and customary physician charge (“U&C charge”) procured from a not-for-profit, independently owned and operated entity is definitely optimal. This entity should offer patients access to an open and transparent database that collects physician charge data from actual claims information and makes that data commercially available to the public for consumption. The information itself must be statistically stratified, geographically adjusted, and specialty specific. The gold standard for databases is the FAIRHealth¹ database, which was found to be the best national U&C charges database to determine out of network (OON) reimbursements in two separate studies by the non-partisan and objective research organization (NORC) at the University of Chicago.²

The mission of FAIRHealth is to provide transparency to the health care and health insurance marketplaces. It was established in 2009 by then Attorney General of New York, Andrew Cuomo, in response to an investigation he had conducted against Ingenix and its parent company UnitedHealth Group. In 2008, Attorney General Cuomo found that rates of health care charges maintained by Ingenix were lower than the actual costs of certain medical services and that the Ingenix charge data had been manipulated by certain health plans, resulting in greater than necessary out-of-pocket costs to patients and consumers. Known as the “Thomas/Love” class actions brought by the AMA and five state medical societies, the major health plans settled over their use for many years of the Ingenix database for over \$1 billion including 35 BCBS plans, Aetna, CIGNA, Humana, UnitedHealth (UNH) & Anthem. Ingenix and Attorney General Cuomo reached a settlement agreement that UNH and Ingenix would help fund a non-profit entity that would develop a new healthcare pricing database. Out of this agreement came the creation of FAIRHealth.

The FAIRHealth database includes data on claims from 150 million covered lives and billions of medical procedures, and these figures are growing. The database contains claims from private insurance in all 50 states, and, through the Qualified Entity Program, has access to all Medicare Parts A, B, and D claims data. Twice a year, the database is updated with claims for the most recent 12 months available. FAIRHealth provides analytical resources and tools that serve the full spectrum of healthcare stakeholders: payers, hospitals and healthcare facilities, physicians, the Government, and consumers. Importantly for patient educational purposes, FAIRHealth has an extensive glossary of terms and definitions that would benefit patients in today’s high deductible health plan (HDHP) environment.

FAIRHealth has been designated by the state as the benchmark tool for determining out-of-network reimbursement in Alaska (since 2004 by DOI regulation), New York (DFS regulation) and Connecticut (by statute). In New York, the State Department of Financial Services, which provides oversight to insurance companies, issued guidance implementing Part H of Chapter 60 of the Laws of 2014 that

¹ More information on the FairHealth database is available at <https://www.fairhealthconsumer.org/>.

² NORC at the University of Chicago, Qualitative Assessment of Databases for Out-of-Network Physician Reimbursement, April 18, 2018.

identifies FAIRHealth as an authorized, “independent source” for health plans to determine the “usual and customary cost” for out-of-network services. If health plans in New York choose to use a source other than FAIRHealth for determining the usual and customary cost, they must seek approval from the State Department of Financial Services.

With regard to consumers and their ability to access this information in an easy and transparent manner, FAIRHealth maintains a website and mobile app that use data from its vast database to help consumers understand the costs of medical and dental services and procedures in their specific geographic area. For example, if a person wanted to know the cost of getting a stomach ulcer removed, he or she could find an estimate of the in-network and out-of-network cost in that person’s zip code.

Beyond the FAIRHealth database, there is little to no price data available to consumers that is provided in a clear, consistent, informative, and easily-accessible manner. While there are some attempts to rectify this product offering, including state-sponsored all payer claims databases (APCDs) or insurers’ own proprietary offerings to members such as price estimation tools, it is widely accepted that none of the currently available tools fully explain the costs of care and none of the state-based APCDs contain national data by geographical zip codes. Further, not all of these tools are available to all consumers. The availability, requirements, and capabilities of APCDs, for example, vary widely from state to state. Determining prices, out-of-pocket costs, and quality represents a significant burden on the consumer. Currently, the FAIRHealth database represents the most consumer-friendly tool to ascertain regional costs for procedures, both in-network and out-of-network.

3. Should health care providers be required to inform patients how much their out-of-pocket costs for a service will be before those patients are furnished that service? What changes would be needed to support greater transparency around patient obligations for their out-of-pocket costs? What can be done to better inform patients of these obligations? Should health care providers play any role in helping to inform patients of what their out-of-pocket obligations will be?

When determining the role of providers in providing this type of information, CMS must first distinguish between unanticipated care and scheduled care.

With respect to unanticipated care, informing patients upfront or in-advance about their out-of-pocket costs could be a violation of the Emergency Medical Treatment and Labor Act (EMTALA) and could cause negative consequences for patient care. The requirements of EMTALA are mandatory and are unaffected by in-network or out-of-network insurance status or payment considerations. In fact, EMTALA stipulates that a hospital may not place any signs in the emergency department regarding prepayment of fees or payment of co-pays and deductibles which can have the chilling effect of dissuading patients from “coming to the emergency department.” To do so could lead patients to leave prior to receiving a medical screening examination and stabilizing treatment without regard to financial means or insurance status, which is a fundamental condition for satisfying EMTALA, and one of the most foundational principles of an important patient protection that was enacted three decades ago. Once the EMTALA obligation has been fulfilled, providers are willing to help their patients understand their costs.

It is also very significant to note that a large proportion of emergency care involves the acute diagnosis, treatment, and stabilization of diffuse and undifferentiated clinical conditions. For example, two of the most common patient presentations are “chest pain” and “abdominal pain.” These initial symptoms

have a large range of ultimate diagnoses, and require a large variety of patient-specific lab tests, radiology exams, and other interventions. Knowing what patients' total out-of-pocket costs will be before they are diagnosed and stabilized is nearly impossible until a proper course of medical care and progression is followed. This is very different from being able to figure out total costs for an urgent care patient with a small, clean, superficial laceration or a sore throat.

Finally, regarding unanticipated care, we would prefer that our patients are not 'surprised' or caught off guard by the bills they receive and are not subject to high out-of-network bills (i.e., balance bills). Unfortunately, the current environment leaves both emergency physicians and the EMTALA on-call specialists and their patients subject to the opaque claims adjudication practices of insurance companies. Both EMTALA and the Affordable Care Act (ACA) have created disincentives for health plans to enter into fair and reasonable contracts to provide services at reasonable, market-based in-network rates. The ACA's "essential health benefits" requirements and EMTALA mandates of care for emergency and on-call physicians have placed clinicians squarely in a regulatory paradox, where health plans do not have to provide fair coverage because they know that their insureds will receive the care regardless of the reimbursement terms the insurer chooses.

Obligations on physicians providing non-emergency and anticipated (scheduled) care are different than those described above for unanticipated care. Requirements around price transparency for anticipated care should be narrowly tailored so not to cause unreasonable regulatory burdens on clinicians and hospitals. In addition, those obligations should be accompanied by commensurate obligations on the health plans to achieve sufficient network adequacy standards and in-network contracting terms that represents fair, reasonable, and market-based reimbursement standards.

4. Should we require health care providers to provide patients with information on what Medicare pays for a particular service performed by a health care provider? If CMS were to finalize a requirement that this information be made available to beneficiaries by health care providers, what changes would need to be made by health care providers? What corresponding regulatory changes would be necessary?

As stated above, we believe that insurers, including CMS, should make coverage terms and conditions available to their consumers. With respect to Medicare, we also note that the physician fee schedule should not be used as a marker to assess market-based reimbursement standards. In fact, the HHS Office of the Inspector General (OIG) in the past has acknowledged that neither the Medicare nor the Medicaid fee schedule would be appropriate references when defining "usual charges." Specifically, OIG stated that the following should not be considered in the definition of "usual charges": charges for services to indigent patients, capitated payments and "fees set by Medicare, State health care programs and other Federal health care programs ..." ³ Furthermore, the 2018 Medicare Trustees Report, which was just released on June 5, acknowledges that annual updates for physician reimbursement do not keep pace with the increasing cost of providing physician services. The Trustees believe that, absent a change in the delivery system or future legislative update to physician rates, access to Medicare-participating physicians will become a significant issue in the long term. ⁴

³ <https://oig.hhs.gov/authorities/docs/FRSIENPRM.pdf>

⁴ The 2018 Medicare Trustees Report is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf>

5. **What is the most appropriate mechanism for CMS to enforce price transparency requirements? Should CMS require hospitals to attest to meeting requirements in the provider agreement or elsewhere? How should CMS assess hospital compliance? Should CMS publicize complaints regarding access to price information or review hospital compliance and post results? What is the most effective way for CMS to publicize information regarding hospitals that fail to comply? Should CMS impose civil money penalties on hospitals that fail to make standard charges publically available as required by section 2718(e) of the Public Health Service Act? Should CMS use a framework similar to the Federal civil penalties under 45 CFR 158.601, et.seq. that apply to issuers that fail to report information and pay rebates related to medical loss ratios, as required by sections 2718(a) and (b) of the Public Health Service Act, or would a different framework be more appropriate?**

To the extent that CMS has transparency requirements regarding non-EMTALA based anticipated or scheduled care, additional civil penalties are not appropriate given the myriad of existing fraud and abuse potential penalties hospital face today and regulatory burdens commensurate with the same. Medicare Administrative Contractor (MAC) guidance and review could serve as an appropriate and proper mechanism to address patient out of pocket cost transparency issues associated with non-EMTALA based anticipated or scheduled care.

6. **How does Medigap coverage affect patients' understanding of their out-of-pocket costs before they receive care? What challenges do providers face in providing information about out-of-pocket costs to patients with Medigap? What changes would be needed to support providers sharing out-of-pocket cost information with patients that reflects the patient's Medigap coverage? Who is best situated to provide patients with Medigap coverage clear information on their out-of-pocket costs prior to receipt of care? What State-specific requirements or programs help educate Medigap patients about their out-of-pocket costs prior to receipt of care?**

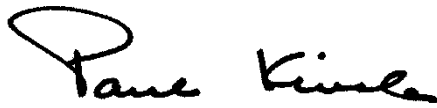
Like all health plans, Medigap plans should be required to provide the information described above to patients. How coordination of benefits may be achieved and issues of primary versus secondary or tertiary supplemental insurance policies are best described and explained by the health plans as they are the best source to turn to for adjudicating claims and providing sufficient transparent member benefit information pursuant to policies and procedures that they themselves have created, implemented and sold to consumers in the marketplace. Clinicians are often unknowing that a patient's secondary or tertiary supplemental policy is a Medigap policy nor its terms and conditions, and often do not know or have access to this information until after claims have been adjudicated by the supplemental insurer and the patient is well into the revenue cycle process. Requiring clinicians and hospitals to explain detailed terms and conditions of Medigap policies before or during patient care would be an unreasonable regulatory burden.

We appreciate the opportunity to share our comments and look forward to continuing working with you and your staff.

Sincerely,

American College of Emergency Physicians
American Academy of Emergency Medicine
American College of Osteopathic Emergency Physicians
American College of Radiology
American Psychiatric Association
American Society of Anesthesiologists

Emergency Department Management Association
Healthcare Business Management Association
Medical Group Management Association
Physicians for Fair Coverage
Radiology Business Management Association
Society for Academic Emergency Medicine



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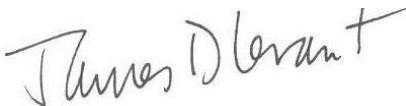


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