September 17, 2021

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1753-P
P.O. Box 8010
Baltimore, MD 21244-1850

Submitted via regulations.gov

RE: CMS – 1753 – P Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. (Vol. 86, No. 147), September 17, 2021

Dear Administrator Brooks-LaSure:

Consumers First is an alliance that brings together the interests of consumers, children, employers, labor unions, and primary care working to realign and improve the fundamental economic incentives and design of the health care system. Our goal is to ensure the nation's health care system fulfills its obligation to the people it serves by providing affordable, high-quality, cost-effective care to everyone. *Consumers First* appreciates the opportunity to provide comments on the Medicare Hospital Outpatient Prospective Payment System proposed rule for Calendar Year 2022.

Medicare payment policy often establishes a standard that is then adopted by commercial payers and Medicaid. *Consumers First* offers these comments both to strengthen hospital outpatient payment, and because the policy changes reflected in this comment letter represent an important step toward realigning fundamental economic incentives in the health care system to truly meet the needs of all families, children, seniors and adults by lowering health care costs and improving health. These payment changes could catalyze the transformational change that is needed to ensure our payment systems drive high value care across the country.

The comments detailed in this letter represent the consensus views of the *Consumers First* steering committee and the other signers. We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

Our comments are focused on three areas of the proposed rule:

- **Section II - Proposed Updates Affecting OPPS Payments**

- **Section XV.B.7.c – Request for Comment on Potential Future Efforts to Address Health Equity in Hospital Outpatient Quality Reporting Program**
- **Section XIX – Proposed Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges**

Section II. Proposed Updates Affecting OPPS Payments

Consumers First is concerned that CMS has not proposed to continue the work of expanding site-neutral payments across additional services or sites of service through the current CY 2022 proposed Hospital Outpatient Prospective Payment System (OPPS) proposed rule. Through the CY 2021 OPPS rule, CMS finished implementation of its site-neutral payment policy for off-campus provider-based departments which applied the Medicare Physician Fee Schedule rate for clinic visit services when provided at an off-campus provider-based department and reimbursed at the OPPS rate. This payment revision was initiated through the Bipartisan Budget Act (BBA) of 2015, when Congress mandated that new off campus provider-based hospital departments be paid at the physician fee schedule rate. The BBA also included a number of exemptions for sites of care from its site-neutral payment policy including emergency departments, ambulatory surgery centers, on-campus outpatient departments, and off-campus physician offices that were built prior to November 2nd, 2015, referred to as "grandfathered" provider-based departments.

Subsequently, CMS implemented the BBA through the CY 2019, 2020 and 2021 OPPS rules with an important amendment which applies site-neutral payment – the physician fee schedule rate – to clinic visits for off-campus provider-based departments "grandfathered" under the BBA. Importantly, in July 2020 the U.S. Court of Appeals for the District of Columbia ruled that the U.S. Department of Health and Human Services can legally mandate site-neutral payments to off-campus clinics.[1] While we applaud CMS for its existing efforts to implement site-neutral payments for clinic visits when provided at an off-campus provider-based department, it is critical for site-neutral payments to be applied to a much broader set of clinic services such as those included in the 2014 MedPAC recommendations,[2] and at both off-campus and on-campus hospital outpatient departments, as well as at ambulatory surgery centers.

Under the current hospital payment system, Medicare pays higher rates for the same services performed at Hospital Outpatient Departments (HOPDs), and other provider-based outpatient facilities compared to physician offices. Yet, physician offices can deliver many of these services with the same quality and at lower cost to the Medicare program. Hospital outpatient departments typically are paid substantially more than independent physician practices for providing the same services.[3] This arbitrary distinction is distorting our health care system in unintended ways. The payment differential based on the site of service where care is provided has created a financial incentive for hospitals to acquire

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[1] United States Court of Appeals for the District of Columbia Circuit, American Hospital Association, et al Appellees v. Alex M. Azar, II, Secretary of Health and Human Services. Decided July 17, 2020. Available at: https://www.cadc.uscourts.gov/internet/opinions.nsf/E27BC5B064ED8035852585A80052C843/$file/19-5352-1852218.pdf

[2] Medicare Payment Advisory Commission March 2014 Report to Congress, "Chapter 3 – Hospital inpatient and outpatient services," MedPAC, March 2014, Available at: http://www.medpac.gov/docs/default-source/reports/mar14_ch03.pdf?sfvrsn=0

[3] 84 Fed. Reg. 39616 (August 9, 2019)

physician practices and rebrand them as HOPDs or other outpatient facilities. Importantly, the growing trend of consolidation between hospitals and physician practices is a significant driver of high and rising health care costs in the U.S. health care system.[4] Over the last decade, our nation has seen a trend of formerly independent physician practices becoming affiliated with major hospital systems.[5] This movement is part of a larger trend of consolidation among health systems and physician practices where health systems are able to use their market power to leverage higher prices for all consumers.[6] The purchasing of physician practices by hospital systems has resulted in services shifting to outpatient facilities where the costs of care are substantially higher.

The drive toward higher-cost, hospital-based outpatient services has had a direct negative financial impact on Medicare beneficiaries and overall Medicare expenditures. Medicare beneficiaries pay higher copays at hospital outpatient departments than they do in physician offices,[7] and HOPDs are paid more than twice as much as physicians are paid under the Medicare physician fee schedule for the same service, thereby contributing to excess Medicare expenditures.[8] These are trends that run directly counter to the interests of Medicare beneficiaries and the solvency of the Medicare Trust funds. Instead, providers should be reimbursed at a level that supports the most efficient, highest quality care irrespective of the location in which it is provided. This is a foundational principle in the efficient allocation of resources and shifting to a value-based health care system.[9,10]

Although CMS has made important steps toward correcting this long-standing distortion in hospital payment, additional regulatory reform is needed to drive high value care through the Medicare program. Not expanding site-neutral payments to additional services or additional sites of service preserves the existing perverse incentives within the hospital outpatient payment system that drive high cost and low quality care for Medicare beneficiaries. Importantly, the U.S. Court of Appeals for the District of Columbia decision that paved the way for site-neutral payments for off-campus clinics stated that site neutral payment "rests on a reasonable interpretation of HHS's statutory authority to adopt volume-control methods" that may drive up health care costs.[11] Despite recent progress on site-neutral payments, health systems continue to have significant financial incentive to add additional physicians to

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[4] Michael F. Furukawa, Laura Kimmey, David J. Jones et al, Consolidation of Providers into Health Systems Increased Substantially, 2016-18, Health Affairs, August 2020, Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00017

[5] Jeff Lagasse, "Hospitals acquired 5,000 physician practices in a single year," Healthcare Finance, March 15, 2018, https://www.healthcarefinancenews.com/news/hospitals-acquired-5000-physician-practices-single-year

[6] Physicains Advocacy Institute, Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2016, March 2018, Available at: http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf?ver=2019-02-19-162735-117

[7] 84 FR 39616 (August 9, 2019)

[8] 84 FR 39616 (August 9, 2019)

[9] Medicare Payment Advisory Committee, Report to Congress: Medicare Payment Policy, March 2021, Available at: http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf

[10] Institute of Medicine (US) Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington (DC): National Academies Press (US); 2001. 8, Aligning Payment Policies with Quality Improvement. Available from: https://www.ncbi.nlm.nih.gov/books/NBK222279/

[11] United States Court of Appeals for the District of Columbia Circuit, American Hospital Association, et al Appellees v. Alex M. Azar, II, Secretary of Health and Human Services. Decided July 17, 2020. Available at: https://www.cadc.uscourts.gov/internet/opinions.nsf/E27BC5B064ED8035852585A80052C843/$file/19-5352-1852218.pdf

on-campus clinics, including by purchasing physician practices and relocating them to the existing facilities, in order to receive the higher reimbursement rate under the OPPS payment system.[12] Additionally, the exemption for emergency departments maintains a distorted financial incentive to build more standalone emergency departments as a strategy to receive higher Medicare payment rates.[13,14] **As a result, *Consumers First* recommends that CMS:**

- **Expand site-neutral payments to all off-campus provider-based departments across a broader set of services. And, implement site-neutral payment not just for off-campus hospital-based departments but also for on-campus provider-based departments, freestanding and non-freestanding emergency departments, and off-campus provider-based entities. Specifically, we recommend:**
    - **Eliminating the "grandfathering" of higher OPPS payment rates to existing off-campus provider-based departments for all services, not just clinic visits. The Congressional Budget Office estimated $13.9 billion of savings from 2019-2028 by implementing this policy.[15]**
    - **Extending site-neutral payments for clinic visits to all on-campus provider-based departments. MedPAC's 2017 report estimated that implementing site-neutral payments for clinic visits at on-campus and off-campus provider-based departments would save Medicare $2 billion per year.[16]**
    - **Extending site-neutral payments across a broader set of clinical services delivered in on-campus provider departments starting with the 24 Ambulatory Payment Classifications identified in MedPAC's 2013 Report which found no additional benefits to performing those services in a hospital setting.[17]**

Section XV.B.7.c – Request for Comment on Potential Future Efforts to Address Health Equity in Hospital Outpatient Quality Reporting Program

In line with Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," CMS is seeking public input on how to address health disparities through the Hospital Outpatient Quality Payment Program. CMS is seeking feedback on 1) measuring

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[12] Loren Adler, Andres de Loera-Brust, Matthew Feilder, "CMS' positive step on site-neutral payments and the case for going further", Brookings Institute, August 2018, Available at: https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/08/10/cms-positive-step-on-site-neutral-payments-and-the-case-for-going-further/

[13] Loren Adler, Andres de Loera-Brust, Matthew Feilder, "CMS' positive step on site-neutral payments and the case for going further", Brookings Institute, August 2018, Available at: https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/08/10/cms-positive-step-on-site-neutral-payments-and-the-case-for-going-further/

[14] Nancy Kane, Robert Berenson, Bonnie Blanchfield et al., "Why Policymakers Should Use Audited Financial Statements to Assess Health Systems' Financial Health," *Journal of Health Care Finance,* Vol. 48, Nov 1, Summer 2021, Available at: https://www.healthfinancejournal.com/index.php/johcf/article/view/265

[15] Proposal Affecting Medicare – Congressional Budget Office's Estimate of the President's Fiscal Year 2019 Budget, Available at: https://www.cbo.gov/system/files?file=115th-congress-2017-2018/dataandtechnicalinformation/53906-medicare.pdf

[16] The Medicare Payment Advisory Commission March 2017 Report to Congress, "Chapter 3 - Hospital inpatient and outpatient services," MedPAC, Available at: http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch3.pdf?sfvrsn=0

[17] The Medicare Payment Advisory Commission June 2013 Report to Congress, "Chapter 2 – Medicare payment differences across ambulatory settings," MedPAC, Available at: http://www.medpac.gov/docs/default-source/reports/jun13_ch02.pdf?sfvrsn=0

facility equity using indirect estimation of race and ethnicity to enhance administrative data; and 2) collection of a standard set of demographic data elements by facilities; and 3) the design of a Facility Equity Score for presenting combined results across multiple social risk factors and measures, including race/ethnicity and disability.

Consumers First strongly supports CMS's commitment to addressing health disparities and closing the health equity gap in CMS hospital quality programs, and offers important suggestions for policy change to better reach our shared goals.

Measuring Equity Using Indirect Estimation of Race and Ethnicity

Consumers First strongly supports CMS's efforts to stratify quality measures by race and ethnicity. Health care payment and delivery in the U.S. is designed to incentivize high volumes of clinically-based care for sick people rather than to improve all people's health. It does so at exceedingly high cost and at low value for consumers. Efforts to realign the system toward improved overall health and wellbeing are being tested through new payment and delivery models. While these new models of payment and delivery offer promise to reorient the health care system toward achieving better health at lower cost, they also risk exacerbating existing inequities if the goal of racial equity is not centered in the design and implementation of such reforms. Stratifying quality measure results by race and ethnicity is a critical step to ensure value-based care initiatives focus on health equity and reducing inequities. Importantly, performance measures will need to be stratified by a broader list of sociodemographic factors to drive meaningful improvements in equity. As a result, it is critical for CMS to indicate both its short-term objectives to stratify performance measures by race and ethnicity, as well as the longer-term vision to stratify measure results by additional demographic factors to reduce inequities through health care payment and delivery. ***Consumers First* recommends that CMS:**

- **Stratify all hospital quality measures by race and ethnicity initially, but to ultimately expand to a broader set of characteristics that include: primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status.**
- **Move measurement stratification efforts towards stratifying performance and outcomes measures by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status.**

Consumers First is concerned about CMS's proposal to indirectly estimate race and ethnicity to enhance administrative data until more accurate data sets with self-reported sociodemographic information become available. While we recognize that imputation is a commonly used process in statistics to replace missing data with substituted values, there is significant risk of further exacerbating existing disparities by using this approach.

While new methods for indirectly estimating race and ethnicity have emerged, there continue to be significant limitations in the reliability and accuracy of the estimated data sets. Indirect methods for estimating race typically only consider geocoded and surname data as predictors, can perform poorly among racial minorities, do not adjust for possible errors for specific datasets and are unable to provide

race estimates for individuals missing some of this information.[18] The result is that there may be significant underestimates or overestimates within a data set of race and ethnicity information. The goal of stratifying quality measures by race, ethnicity and other sociodemographic factors is to enable providers, policymakers, researchers and other stakeholders to drill down to individual level quality information that illustrates where disparities are occurring in health care delivery. Importantly, complete data sets are critical to be able to do this accurately. While imputing data for population health level management may be used effectively to enable an individual facility or hospital to gain insights into how it's managing disease-specific conditions within their system, *Consumers First* does not support the use of imputing data to estimate race and ethnicity data for the purpose of stratifying quality measures. Rather than relying on unreliable statistical methods to estimate race and ethnicity data, ***Consumers First*** **recommends that CMS:**

- **Commits to collecting disaggregated data by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status. The Office of the National Coordinator for Health Information Technology's (ONC) 2015 Edition Health Information Technology Certification Criteria Final Rule, the "2015 Edition" establishes HIT certification requirements that include full disaggregation of race and ethnicity, language, sexual orientation, gender identity and social and behavioral risk factors.[19] CMS should immediately adopt and endorse ONC's 2015 Edition standards for collecting disaggregated data for all hospitals and for all CMS quality programs.**
    - **As part of these efforts, CMS should require hospitals/facilities to engage in data collection methods that rely on self-reported data. Self-reported data collection of social determinants of health and SOGI data is the gold standard for collecting disaggregated data.[20,21,22] To mitigate patient concerns that race and ethnicity data may be used in a discriminatory way, providers should explain that the data will be used to improve the quality of care.[23] There are two key approaches hospitals should consider in operationalizing self-reported data methods:**
        - **1) Planned Procedures: Conduct surveys with patients prior to admission as part of the pre-contact, check-in process where patients are asked to complete and verify demographic information, medical history and insurance status;**

[18] Gabriella C. Silva, Amal Trivedi, Roee Gutman, "Developing and evaluating methods to impute race/ethnicity in an incomplete dataset," Health Services and Outcomes Research Methodology (2019) 19:175-195, Available at: https://doi.org/10.1007/s10742-019-00200-9.

[19] U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology, 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule, 80 Fed. Reg. 62602-62759 (October 16, 2015)

[20] David Baker, Kenzie Cameron, Joseph Feinglass, et all, "A System for Rapidly and Accurately Collecting Patients' Race and Ethnicity," American Journal of Public Health, Vol 96, No.3, 2006, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470520/pdf/0960532.pdf

[21] Sean Cahill, Robbie Singal, Chris Grasso, et al "Do Ask, Do Tell: High Levels of Acceptability by Patients of Routine Collection of Sexual Orientation and Gender Identity Data in Four Diverse American Community Health Centers," PLoS ONE 9(9):e107104.doi:10.1371/journal.pone.0107104

[22] Haider A, Schneider E, Schuur J, et al. 2019. Comparing Ways to Ask Patients about Sexual Orientation and Gender Identity in the Emergency Room—The EQUALITY Study. Washington, DC: Patient-Centered Outcomes Research Institute (PCORI). https://doi.org/10.25302/7.2019.AD.110114IC.

[23] David Baker, Kenzie Cameron, Joseph Feinglass, et all., "Patient Attitudes Toward Health Care Providers Collecting Information About Race and Ethnicity," Division of General Internal Medicine, Department of Medicine, Feinberg School of Medicine, Northwestern University, Chicago, Ill, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1490236/pdf/jgi_195.pdf

- **2) Emergency Visits: Conduct surveys with patients when patient is stable during the time of insurance verification.**

Collection of Standardized Demographic Data by Facility

Consumers First strongly supports CMS's efforts to collect a standardized set of demographic data elements by facilities on the day of service. As noted above, a critical first step in being able to identify underlying disparities in health care delivery – and then to reduce these disparities - is collecting and reporting on disaggregated data including race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status. For too long, collecting disaggregated data has been identified as an insurmountable barrier in being able to hold the health care system accountable for reducing disparities and improving the health of all people.

We applaud CMS for identifying the need to establish standardized data collection practices across the CMS enterprise as an essential part of this RFI, and RFIs through the CY 2022 Inpatient Prospective Payment System proposed rule and the CY 2022 Medicare Physician Fee Schedule proposed rule.

A key element in establishing standardized data collection is to ensure a robust data system and health information technology infrastructure that is able to surface accurate insights about health disparities and to make data-driven and informed decisions about reducing disparities and advancing health equity. Comprehensive demographic data must be a core element of HIT and data exchange efforts to advance equity and reduce disparities across the CMS enterprise. This will require CMS to take an "equity in all programs and policies" approach and to leverage what other HHS agencies have already developed. The RFI accurately states that, "ONC finalized a certification criterion in the 2015 Edition which supports a certified health IT products ability to collect social, psychological, and behavioral health data…however, this functionality is not yet included as part of the certified EHR technology required by the Medicare Promoting Interoperability Program."[24] Indeed, the RFI acknowledged that "the technical functionality exists to achieve the gold standard of data collection."[25] **As a result, *Consumers First* urges CMS to adopt ONC's 2015 Edition certification standards across all CMS quality programs including CMS's Promoting Interoperability program.**

Design of a Facility Equity Score

Consumers First applauds CMS for efforts to identify ways to hold facilities accountable for reducing disparities and improving health equity across the health care system. While we believe holding facilities and hospitals accountable through an equity score has significant potential impact, we do not believe CMS is ready to construct an accurate equity index. Hospitals and facilities are not yet uniformly collecting disaggregated sociodemographic data or accurately stratifying quality and outcomes measures by social determinants of health or SOGI data. Collecting disaggregated data that leads to more complete data sets and stratifying quality and outcomes measures should be the focus of CMS's efforts initially, rather than jumping directly to a hospital or facility equity score. *Consumers First* recognizes the utility of CMS developing an equity score, over time, and supports efforts to develop one as more accurate data become available.

[24] 86 FR 42255 (August 4, 2021)
[25] 86 FR 42255 (August 4, 2021)

In the immediate-term, CMS should consider holding hospitals and facilities accountable through equity standards that are already developed. For example, the Office of Minority Health at the US Department of Health and Human Services has already developed the National Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS Standards are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for health and health care organizations. There are 15 standards across governance, leadership and workforce; communication and language assistance; and engagement, continuous improvement and accountability. The National CLAS standards were revised in 2013 to account for the increasing diversity of the U.S. population, the growth in cultural and linguistic competency fields, and the changing policy and legislative landscape, including the Affordable Care Act.

HHS's Office of Minority Health contracted with RAND Corporation to develop a long-term evaluation framework and toolkit for implementing the CLAS standards across four settings: ambulatory care, hospitals, behavioral health and public health.[26] The evaluation framework provides a systematic approach to gather data to evaluate the effectiveness of the National CLAS Standards including a conceptual framework, setting-specific logic models, and process and impact measures that can be used to assess hospital performance on implementing the CLAS Standards across. The National CLAS Standards are a ready-to-use, validated framework and set of standards that CMS can move to implement and hold hospitals accountable for immediately, rather than building something new. ***Consumers* First urges CMS to require all hospitals and facilities to demonstrate how they are implementing the National CLAS Standards and report publicly on their CLAS implementation score.**

Section XIX – Proposed Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges

Consumers First strongly supports CMS efforts to increase hospital price transparency to help make health care more affordable. The pricing information that is most critical to achieve price transparency is the specific rate that is negotiated between specific payers and each specific hospital.

While health plans are directly negotiating prices with hospitals, it is consumers and employers that are ultimately paying for health care through insurance premiums, deductibles, and copays. The fact that the actual purchasers of health services are unable to find out how much they are paying for care until it has already been delivered must change. For nearly 20 years, researchers have known that the

[26] Malcome V. Williams, Laurie T Martin, Lous M. Davis et al, Evaluation of the National CLAS Standards, US Department of Behavioral Health, Office of Minority Health, Available at: https://minorityhealth.hhs.gov/assets/PDF/Evaluation_of_the_Natn_CLAS_Standards_Toolkit_PR3599_final.508Compliant.pdf

underlying drivers of high U.S. health care costs are high and variable health care prices resulting from consolidation across and within U.S. health care markets.[27,28,29,30]

Health care consolidation occurs among hospitals, insurers and other health care organizations that battle for relative market power and control to set prices. Anti-competitive practices also prevent data from being shared and undermine affordable, high quality health care for our nation's families, workers and employers.[31] For too long, health care prices have been hidden in proprietary contracts between private insurers and providers without any insight into or oversight over the price of health care services by policymakers, the public and other health care purchasers. As detailed in our comment letters on the CY 2020 OPPS proposed rule,[32] and CY 2021 IPPS proposed rule[33], recent research shows that disclosing price may actually help to reduce health care costs in some markets and for some services. Researchers from the University of Michigan analyzed the impact of New Hampshire's healthcare price transparency website. The website unveils out-of-pocket costs for privately insured people across a range of medical procedures. Researchers found that the website saved individuals $7.9 million and insurers $36 million on X-rays, CT scans, and MRIs from 2007 to 2011.[34]

Consumers First applauds CMS for its efforts to rein in anticompetitive practices between hospitals and health plans that lead to unaffordable, low quality health care for Medicare beneficiaries, consumers, working people and employers across the country. Uncovering health care prices is a critical step forward to both empower consumers, workers and employers to be more informed purchasers of health care, and to enable policymakers to make more informed decisions that support a high value health care system.

Consumers First strongly supports CMS's efforts to implement and improve the Hospital Price Transparency regulation through the CY 2022 OPPS proposed rule. CMS is proposing to: 1) Increase the civil monetary penalty for noncompliant hospitals using a scaling factor; 2) Prohibit certain hospital conduct acting as a barrier to accessing standard charge information; 3) Seek feedback on ways to improve the standardization of the data disclosed by hospitals.

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[27] Gerard Anderson, Uwe Reinhardt, Peter Hussey et al, "It's the Prices Stupid: Why the United States is So Different from Other Countries," Health Affairs June 2003, Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.22.3.89?journalCode=hlthaff

[28] Irene Papanicolas, Liana Woskie, Ashish Jha et al, "Health Care Spending in the United States and Other High-Income Countries," Journal of American Medical Association, March 2018, Available at: https://jamanetwork.com/journals/jama/article-abstract/2674671

[29] White C, Bond AM, Reschovsky JD. High and varying prices for privately insured patients underscore hospital market power. Res Brief. 2013 Sep;(27):1-10. PMID: 24073466.

[30] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2020. https://www.rand.org/pubs/research_reports/RR4394.html.

[31] Michael F. Furukawa et al., "Consolidation of Providers into Health Systems Increased Substantially, 2016-18," Health Affairs 39, no. 8 (August 2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00017.

[32] Consumers First Comment Letter on CY 2020 Hospital Outpatient Prospective Payment System proposed rule, September 27, 2019, Available at: https://familiesusa.org/wp-content/uploads/2019/10/Consumers-First-OPPS-Comments-9.27.19.pdf

[33] Consumers First Comment Letter on CY2021 Inpatient Prospective Payment System proposed rule, July 10, 2020, Available at: https://familiesusa.org/wp-content/uploads/2020/07/Consumers-First-IPPS-Comment.pdf

[34] Kelly Gooch, "New Hampshire's price transparency website helped patients save money," *Becker's Hospital Review*, Jan. 30, 2019, https://www.beckershospitalreview.com/finance/new-hampshire-s-price-transparency-website-helped-patients-save-money.html

Proposal to Increase Civil Monetary Penalty Using Scaling Factor

We support CMS's commitment to achieving price transparency and efforts to increase the civil monetary penalty based on a scaling factor for hospitals who fail to comply with the current regulations to disclose health care prices under the Hospital Price Transparency regulation. Specifically, CMS is proposing to revise the civil monetary structure as follows:

- For hospitals with 30 beds or less: Fine noncompliant hospitals $300 per day for a maximum annual penalty of $109,500.
- For hospitals with 31 to 550 beds: Fine noncompliant hospitals $10 per bed, per day, for a maximum annual penalty of $2,007,500.
- For hospitals with greater than 550 beds: Fine noncompliant hospitals $5,500 per day, for a maximum annual penalty of $2,007, 500.

While we applaud CMS for increasing the civil monetary penalty for hospitals who fail to comply with current regulations to disclose their health care pricing information, we are deeply concerned that the revised penalty remains too low to truly incentivize hospitals to comply with current regulations.

Numerous reports have shown that less than 20% of hospitals across the country are in compliance with the existing regulation.[35] The fact that hospitals are choosing to pay the current $300 per day fine rather than comply with federal regulations to disclose prices should serve as evidence that hospitals are making undue profits from keeping health care prices hidden and that they have a powerful financial interest against adhering to a law that enables consumers and other health care purchasers to be informed purchasers of health care. The proposed maximum fine of $2 million remains negligible, particularly given that large hospital systems own billions of dollars of cash and investments.[36]Importantly, health care is one of the only sectors in the U.S. economy where consumers and purchasers are blinded to the price of a service until after they've used a service and receive a bill. This practice runs counter to the interests of Medicare beneficiaries and further illustrates that the business interests of the health care sector continue to undermine the interests of the very people that the Medicare program is designed to serve.

Hospitals have spent years fighting price transparency regulations including through judicial action[37] in an effort to avoid regulatory oversight of their anticompetitive health care prices. Given that CMS will issue a written warning and utilize a corrective action plan for noncompliant hospitals prior to issuing the civil monetary penalty under current regulation, we urge CMS to send a stronger message to hospitals by further increasing the civil monetary penalty. ***Consumers First*** **recommends that CMS:**

[35] Caitlin Owens, "Most hospitals aren't complying with price transparency rule," Axios, June 15, 2021, Available at: https://www.axios.com/hospitals-price-transparency-costs-regulations-noncompliance-ebf6bd21-5709-4298-b67a-74c8a90a1ec1.html

[36] Nancy Kane, Robert Berenson, Bonnie Blanchfield et al., "Why Policymakers Should Use Audited Financial Statements to Assess Health Systems' Financial Health," Journal of Health Care Finance, Vol. 48, Nov 1, Summer 2021, Available at: https://www.healthfinancejournal.com/index.php/johcf/article/view/265

[37] Morgan Haefner, "Hospitals lose appeal in price transparency case," Becker's Hospital Review, December 2020, Available at: https://www.beckershospitalreview.com/legal-regulatory-issues/hospitals-lose-appeal-in-price-transparency-case.html

- **Increase the civil monetary penalty for hospitals with 31 beds or more to $300 per bed per day. A recent survey found that 75% of U.S. adults across the political spectrum support increasing the penalty for hospitals who do not comply with current regulation to $300 per hospital bed per day.[38]**
- **Monitor compliance on an ongoing basis to determine whether the civil monetary penalty is sufficiently high to increase hospital compliance.**

Prohibit Hospital Conduct Acting as Barrier to Accessing Standard Charge Information

Consumers First strongly supports CMS's proposal to amend the existing regulation by requiring hospitals to ensure the standard charge information is easily accessible, without barriers, including but not limited to, ensuring the information is accessible to automated searches and direct file downloads through a link posted on a publicly available website. We agree that these additional requirements will help to ensure greater accessibility of the required machine readable file and its content, and may help to reduce hospital practices that make it difficult or impossible for consumers to access the pricing information including using "blocking codes" or CAPTCHA, requiring consumers to agree to terms and conditions prior to gaining access, or failure to provide a link for downloading the machine-readable file. The proposed rule accurately details a long list of hospital practices designed to make it difficult or nearly impossible for consumers to access the required standard charge information.[39] These examples should serve as further evidence of the lengths hospitals will go to in order to prevent public disclosure of health care prices. To hold hospitals accountable for engaging in practices that restrict consumers' access to the required standard charge information, ***Consumers First*** **recommends that CMS explicitly state in regulation that any intentional practices found to prevent consumers from accessing the required standard charges information during CMS's compliance review process will immediately result in the forfeiting of the corrective action plan process and will be subject to the maximum civil monetary penalty**.

Feedback on Ways to Improve the Standardization of the Data Disclosed by Hospitals

We support CMS's efforts to standardize the data disclosed by hospitals by requiring hospitals to post machine-readable files using a CMS-specified URL in addition to the CMS-specified naming convention. We also support CMS's approach to require a standardized location for hospitals to post a link to the machine-readable file from the hospital's homepage in order to limit the public's search for the files. While *Consumers First* supports these approaches to standardize data disclosed by hospitals, we also encourage CMS to require hospitals to disclose data on a standardized set of services with corresponding quality information.

The Hospital Price Transparency rule requires hospitals to post the payer-specific negotiated charges for 300 "shoppable" services. CMS would mandate 70 services and each hospital system would choose 230.

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[38] SocialSphere, "National Survey June 2021," Patient Rights Advocate, July 6, 2021, Available at: https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/60f1c21c49c4f65d0f57d5ae/1626456605014/SocialSphere+Patient+Rights+Advocate+June+2021+Survey+Results.pdf

[39] 86 Fed. Reg. 42318 (August 4, 2021)

Evidence suggests that health care price transparency, alone, has little impact on consumer behavior.[40] There are several reasons for this, including difficulty in understanding even well-intended transparency information and a lack of quality data against which to compare price.[41] In addition to focusing on changing consumer behavior, we recommend HHS broaden its focus of price transparency efforts to also change the behavior of providers and payers, and to inform policymakers and regulators. Individual providers who direct most health care spending can effectively use price and quality information to encourage patients to access lower-cost, higher-value referred providers.[42] The same holds true for employers and other payers who can use price and quality transparency information to drive care toward higher-value providers.[43] There also is evidence to suggest that high-cost providers may change their pricing behavior due to public scrutiny.[44] As a result, ***Consumers First*** **recommends that CMS:**

- **Mandate transparency on a smaller, but nationally uniform set of high-cost and high-volume services provided in inpatient and outpatient settings. A reasonable requirement would be the publication of 100 total services to include a broadly representative sample of services (i.e. imaging, evaluation and management, core surgical specialties, radiation oncology etc.) from the following categories:**

  i. **50 highest dollar volume (price x volume) inpatient services**
  ii. **50 highest dollar volume (price x volume) outpatient services**

As health care price transparency efforts evolve, *Consumers First* also supports the need to disclose quality data alongside existing price data as a critical step in providing meaningful transparency in the quality of care and the prices paid for hospital system care, and ultimately the health care system more broadly.[45] While we understand that additional work is needed to arrive at and report on a harmonized set of quality measures, we believe it's important for CMS to build quality data into price transparency data over time. It is critical to establish a standard where publicly disclosed price and quality information are paired together in order to achieve meaningful transparency of cost and quality for consumers, researchers, and purchasers. Importantly, we do not support the notion of slowing down price transparency efforts until quality data is more readily available. In fact, we view calls urging CMS to wait for quality data to move forward with price transparency efforts as a delay tactic that undermines CMS's current work to implement price transparency regulations. Instead we recognize and support CMS's efforts to move forward with current price transparency efforts as swiftly as possible, and also encourage CMS to work simultaneously on disclosing quality information to be paired with existing price transparency data in the near future. As a near-term goal, ***Consumers First*** **recommends that CMS:**

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[40] Mehrotra, Ateev, et al., "Promise and Reality of Price Transparency," New England Journal of Medicine, Vol. 378, No. 14 (April 5, 2018); and Whaley, Christopher, et al., "Association Between Availability of Health Service Prices and Payments for These Services," Journal of the American Medical Association, Vol. 312, No. 16 (May 3, 2018).
[41] Austin, D. Andrew and Jane G. Gravelle, Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector, Congressional Research Service, Washington, D.C. (July 2007).
[42] Carman, Kristen, et al., "Understanding an Informed Public's Views on the Role of Evidence in Making Health Care Decisions, "Health Affairs, Vol. 35, No. 4 (April 2016); and Levinson, et al., "Not All Patients Want to Participate in Decision Making-A National Study of Public Preferences, "Journal of General Internal Medicine (June 2005).
[43] Robinson, James, and Timothy Brown, Evaluation of Reference Pricing: Final Report, letter to David Cowling of CalPERS (May 15, 2013). Available at: https://kaiserhealthnews.files.wordpress.com/2014/05/reference-pricing-california-berkeley.pdf.
[44] Wu, Sze-jung, et al., "Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition," Health Affairs, Vol. 33, No. 8 (August 2014).
[45] The Secret of Health Care Prices: Why Transparency is in the Public Interest. California Health Care Foundation. https://www.chcf.org/publication/secret-health-care-prices/#related-links-and-downloads.

- **Move towards requiring all disclosed pricing information to be paired with quality information to achieve meaningful transparency of cost and quality for consumers, researchers and policymakers.**

Thank you for considering the above recommendations. Please contact Sophia Tripoli, Director of Health Care Innovation at Families USA, at stripoli@familiesusa.org for further information.

Sincerely,

Consumers First Steering Committee

American Academy of Family Physicians
American Benefits Council
American Federation of State, County, and Municipal Employees
Families USA
First Focus on Children
Purchaser Business Group on Health

Supporting Organizations

ACA Consumer Advocacy
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Colorado Consumer Health Initiative
Consumers for Quality Care
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