September 13, 2022

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1772-P
P.O. Box 8010
Baltimore, MD 21244-1810

Submitted via regulations.gov

RE: CMS-1772-P - Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating

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 2023.

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, adults, and employers 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:

- II. - Proposed Updates Affecting OPPS Payments
- XIX. - Request for Information on Use of CMS Data to Drive Competition in Healthcare Marketplaces

II. - Proposed Updates Affecting OPPS Payments

Consumers First strongly supports CMS's efforts to implement site-neutral payment policy through the Medicare program building on the congressional mandate to implement site-neutral payments for off-campus provider-based departments that was originally initiated through the Bipartisan Budget Act (BBA) of 2015. We have supported and encouraged CMS to expand its site neutral payment policy as detailed in our CY 2020, 2021 and 2022 OPPS comment letters.[1] However, we are 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 2023 Hospital Outpatient Prospective Payment System (OPPS) proposed rule.

The BBA of 2015, mandated that new off campus provider-based hospital departments be paid at the physician fee schedule rate but 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 and, and now updated 2022 MedPAC recommendations,[1,2] and at both off-campus and on-campus hospital outpatient departments, as well as at ambulatory surgery centers.

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[1] Consumers First, Comment Letter on CY 2020 OPPS, https://familiesusa.org/wp-content/uploads/2019/10/Consumers-First-OPPS-Comments-9.27.19.pdf; Consumers First, Comment Letter on CY 2021 OPPS, https://familiesusa.org/wp-content/uploads/2020/10/Consumers-First-2021-OPPS-comment-letter-10.5.20.pdf; Consumers First, Comment Letter on CY 2022 OPPS, https://familiesusa.org/wp-content/uploads/2021/09/Consumers-First-Comments-on-OPPS-CY22-9.17.21.pdf.

[2] Medicare Payment Advisory Commission Report to Congress: Medicare and the Health Care Delivery System (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf.

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 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, which has resulted in the Medicare Payment Advisory Commission updating its site-neutral payment policy in its latest June 2022 Report to Congress.[7] Medicare beneficiaries pay higher copays at hospital outpatient departments than they do in physician offices, 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]

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

[4] Michael F. Furukawa, Laura Kimmey, David J. Jones et al, Consolidation of Providers into Health Systems Increased Substantially, 2016-18, *Health Affairs* 39, no. 8 (Aug. 3 2020), 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 (Mar. 15, 2018), https://www.healthcarefinancenews.com/news/hospitals-acquired-5000-physician-practices-single-year

[6] Physicians 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-Study2018-Update.pdf?ver=2019-02-19-162735-117.

[7] Medicare Payment Advisory Commission Report to Congress: Medicare and the Health Care Delivery System (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf

[8] 84 Fed. Reg. 39616 (Aug. 9, 2019).

[9] Medicare Payment Advisory Commission Report to Congress: Medicare Payment Policy, (Mar. 2021), http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf; Institute of Medicine, Committee on Quality of Health Care in America, "Crossing the Quality Chasm: A New Health System

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.[10] Despite recent progress on site-neutral payments, health systems continue to have significant financial incentive to add additional physicians to 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.[11] 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.[12] **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.[13]**
- **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.[14]**

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for the 21st Century," (Washington, DC, National Academies Press, 2001) 8, Aligning Payment Policies with Quality Improvement. Available from: https://www.ncbi.nlm.nih.gov/books/NBK222279/.

[10] 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.

[11] Loren Adler et al., "CMS' positive step on site-neutral payments and the case for going further," USC-Brookings Schaeffer Initiative for Health Policy (Aug. 2018), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-healthpolicy/2018/08/10/cms-positive-step-on-site-neutral-payments-and-the-case-for-going-further/.

[12] *Id*; 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*, 48, No. 1, (Summer 2021), https://www.healthfinancejournal.com/index.php/johcf/article/view/265.

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

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

- **Extending site-neutral payments across a broader set of clinical services including the 57 ambulatory payment classifications (APCs) identified in the June 2022 MedPAC Report to Congress to align the OPPS and alternate care site payment rates with those set in the physician fee schedule; and the 11 APCs that should align the OPPS payment rates with the ASC payment rates and continue to use the physician fee schedule rate when the service is provided in a freestanding office.[15]**

XIX. - Request for Information on Use of CMS Data to Drive Competition in Healthcare Marketplaces

Consumers First strongly supports CMS's efforts to increase competition in US health care markets by releasing a request for information through CY 2023 proposed OPPS rule. It is now well established that high and increasing health care prices are making health care unaffordable for our nation's families, workers, and employers. For decades, health care costs have been rising faster than workers' wages and inflation, making it more difficult for families to access and afford health care.[16] From 2001 to 2021, premiums roughly tripled for both individual and family coverage, a far faster increase than the 68 percent rise in median weekly earnings over the same time period or the 58 percent increase in the consumer price index.[17] Moreover, since 2000, the price of medical care has risen faster than prices in the overall economy, which has resulted in more than 40% of people in the U.S. today reporting that they don't see a doctor when they need to because of the cost of care. [18,19]

Health care prices and costs vary significantly between providers, and the differences are unrelated to the quality of care or health outcomes.[20] It is well established that hospital prices for private plans range from 150 percent to more than 400 percent of Medicare rates, and that these high and variable health care prices are often the result of growing consolidation across and within health care markets among hospitals, insurers, and other health care organizations that battle for relative market power and control to set prices or prevent health care data from being

[15] Medicare Payment Advisory Commission Report to Congress: Medicare and the Health Care Delivery System (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf
[16] Kasier Family Foundation, Newsroom, November 10, 2021, https://www.kff.org/health-costs/press-release/average-family-premiums-rose-4-this-year-to-top-22000/.
[17] Nicole Rapfogel & Emily Gee, Employer- and Worker-Led Efforts To Lower Health Insurance Costs, Center for American Progress (July 28, 2022), https://www.americanprogress.org/article/employer-and-worker-led-efforts-to-lower-health-insurance-costs/; Bureau of Labor Statistics, CPI Inflation Calculator, https://www.bls.gov/data/inflation_calculator.htm.
[18] Emma Wager et al., Overall inflation has not yet flowed through to the health sector, Peterson-KFF Health System Tracker (June 3, 2022), https://www.healthsystemtracker.org/brief/overall-inflation-has-not-yet-flowed-through-to-the-health-sector/.
[19] Alex Montero et al., Americans' Challenges with Health Care Costs, Kaiser Family Foundation, July 14, 2022, https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/.
[20] Christopher M. Whaley et al., *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.

shared. [21],[22] Consolidation undermines the competitiveness of health care markets, allowing providers, insurers,[23] and other members of the health care industry that amass a disproportionate share of market power to set prices.[24] The results are health care prices that are neither value-driven nor equitable.[25] Addressing the impact of consolidation on health care prices is a fundamental step to control health care costs.

Thus, *Consumers First* strongly supports CMS's efforts to promote competition in health care marketplaces. Additional details to support the following recommendations is provided below. Specifically, ***Consumers First*** **urges CMS to:**

- **release ownership data for other types of providers including physician practices and dialysis centers;**
- **require additional data from enrolled providers on contractual relationships and involvement of private equity in acquisitions;**
- **facilitate research by releasing data that aligns across datasets and conducting research internally; and**
- **strengthen the hospital price transparency rule.**

Release ownership data for other types of providers

Consumers First **urges CMS to release ownership data for other provider types, in particular physician practices and dialysis centers.** Vertical integration is a critical component of health care consolidation, and physician practice acquisition and affiliation with hospitals has increased substantially in recent years.[26] Consolidation in physician practices can serve to increase costs for consumers, workers and employers in the form of increased prices, copayments, and insurance premiums.[27] Research has also found that hospital acquisition of

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[21] Chapin White and Christopher M. Whaley, *Prices Paid to Hospitals by Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative* (Santa Monica, CA: RAND Corporation, 2019), https://www.rand. org/pubs/research_reports/RR3033.html.

[22] 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.

[23] Leemore Dafney, Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience, Commonwealth Fund Issue Brief (Nov. 20, 2015), https://www.commonwealthfund.org/publications/issue-briefs/2015/nov/evaluating-impact-health-insurance-industry-consolidation.

[24] Chapin White et al., "High and varying prices for privately insured patients underscore hospital market power," Res Brief. (Sept. 2013), https://pubmed.ncbi.nlm.nih.gov/24073466/; Leemore Dafny et al., "The Price Effects of Cross-Market Mergers: Theory and Evidence From the Hospital Industry," RAND Journal of Economics 50, no. 2 (Summer 2019), https://doi.org/10.1111/ 1756-2171.12270.

[25] Karyn Schwartz et al., "What We Know About Provider Consolidation," Kaiser Family Foundation (Sept. 2, 2020), https://www.kff.org/report-section/what-we-know-about-provider-consolidation-issue-brief/.

[26] Richard Scheffler, Arnold, Daniel and Whaley, Christopher. "Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices," *Health Affairs* 37, no. 9 (Sept. 1, 2018), https://doi.org/10.1377/hlthaff.2018.0472.

[27] Cory Capps, David Dranove, and Christopher Ody. "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending." *Journal of Health Economics* 59 (May 1, 2018), https://doi.org/10.1016/j.jhealeco.2018.04.001.

physician practices increases spending on imaging and laboratory services.[28] Similarly, consolidation among dialysis providers has been widely documented[29] and research suggests this consolidation is associated with increased Medicare spending.[30] Disclosing change in ownership data for additional types of providers would help to unveil key market trends around mergers and acquisitions, including highlighting anticompetitive behavior, and facilitate investigation and enforcement action by state and federal regulators. Additionally, disclosing change in ownership data across other types of providers will also help to increase the transparency around mergers and acquisitions that often skirt federal and state oversight. Many experts indicate that merger and acquisition activity is prolific among these types of organizations, particularly among joint venture capitalists. For these reasons, ***Consumers First*** **also supports releasing ownership data prior to 2016** to equip researchers and policymakers with critical longitudinal data that helps to understand longer-term trends around the impact of mergers and acquisitions on health care cost and quality.

Require additional data from enrolled providers on involvement of private equity and other contractual relationships

Consumers First **urges CMS to require additional disclosure from enrolled providers, in particular on the involvement of private equity in provider ownership and describing contractual relationships between providers.**

CMS should secure better data about the role private equity firms play in health care provider ownership. Private equity firms are acquiring health care providers with increasing frequency.[31] Recent research has confirmed what many consumer advocates have long believed: when private equity firms acquire health care providers, provider prices and profits often increase.[32] Additionally, private equity firms often look to resell acquisitions after holding them for a relatively short period of time, exacerbating the existing opaqueness about the role of private

[28] Christopher M. Whaley et al., "Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration," *Health Affairs* 40, no. 5 (May 3, 2021), https://doi.org/10.1377/hlthaff.2020.01006.
[29] Kevin F. Erickson et al., "Consolidation in the Dialysis Industry, Patient Choice, and Local Market Competition," *Clinical Journal of the American Society of Nephrology* 12 no. 3 (Mar. 2017), https://cjasn.asnjournals.org/content/12/3/536.
[30] Eugene Lin, Bich Ly, Erin Duffy, and Erin Trish, "Medicare Advantage Plans Pay Large Markups To Consolidated Dialysis Organizations," *Health Affairs* 41, no. 8 (Aug. 1, 2022), https://doi.org/10.1377/hlthaff.2021.02009.
[31] Jane M. Zhu et al., "Private Equity Acquisitions of Physician Medical Groups Across Specialties, 2013–2016," *JAMA*, vol. 323, no. 7 (Feb. 18, 2020), https://doi.org/10.1001/jama.2019.21844; Anaeze C. Offodile II et al., "Private Equity Investments in Health Care: An Overview of Hospital and Health System Leveraged Buyouts, 2003–17," *Health Affairs* 40, no. 5 (May 3, 2021), https://doi.org/10.1377/hlthaff.2020.01535.
[32] Joseph D. Bruch et al., "Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition," *JAMA Internal Medicine* 180, no. 11 (Aug. 24, 2020), https://doi.org/10.1001/jamainternmed.2020.3552; Robert Tyler Braun et al., "Private Equity in Dermatology: Effect on Price, Utilization, and Spending," Health Affairs 40, no. 5 (May 3, 2021), https://doi.org/10.1377/hlthaff.2020.02062; Loren Adler et al., "High Air Ambulance Charges Concentrated in Private Equity-Owned Carriers," USC-Brookings Schaeffer Initiative for Health Policy (Oct. 13, 2020), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/10/13/high-air-ambulance-charges-concentrated-in-private-equity-owned-carriers/.

equity in consolidation.[33] CMS should require providers submitting change of ownership forms to disclose whether the acquiring entity is substantially owned by a private equity fund. This disclosure would assist CMS and interested third parties in more quickly identifying areas of potential abuse.

CMS should also require disclosure of contractual relationships between providers. Vertical integration plays a key role in provider consolidation that stifles competition and drives up costs for families and businesses, and much vertical integration is accomplished via contractual relationships.[34] CMS should be doing more to track vertical integration via contractual relationships. **To that end, *Consumers First* encourages CMS to follow the model of states like Massachusetts, which require provider organizations to register with the Commonwealth and report their organizational and operational structure and governance.**[35] This information has informed the work of the Massachusetts Health Policy Commission as it implements policies to constrain health care cost growth and reviews health care organization transactions for potentially problematic provider consolidation. Similar data at the federal level would facilitate improved analysis of this type of consolidation.

Facilitate research by releasing data that aligns across datasets and conducting research internally

***Consumers First* urges CMS to release data in a way that facilitates further research, in particular by aligning data across datasets and by conducting research internally.** As discussed below, *Consumers First* has noted that linking transparency data on pricing with quality data is crucial to meaningfully understanding the relevance of that data. This is also true for ownership information. The precise impacts of changes of ownership on pricing and quality of care, in particular differentiated by the type of organization acquiring the provider, remain important research questions and require further data to be disclosed for researchers to conduct additional research on the impact of mergers and acquisitions among various types of providers in order to have a more comprehensive understanding of the impact in the market. Ensuring that any data CMS releases as part of these efforts is aligned across datasets will help facilitate this analysis.

CMS should also support and conduct its own analysis of data on hospital consolidation it possesses. CMS conducting this analysis internally would allow CMS to leverage its analytical strength and may allow for the use of data CMS may not be able to disclose publicly. In particular, ***Consumers First* encourages CMS to review the impact of cross-state health care provider mergers, which individual states are uniquely ill-suited to review.**

[33] Karyn Schwartz et al., "What We Know About Provider Consolidation," Kaiser Family Foundation (Sept. 2, 2020), https://www.kff.org/report-section/what-we-know-about-provider-consolidation-issue-brief/.
[34] Susan Ridgely et al., "Consolidation by any other name? The emergence of clinically integrated networks." Health Services Research 55 (Aug. 2, 2020), https://doi.org/10.1111/1475-6773.1349; Vilsa Curto et al., "Price Effects Of Vertical Integration And Joint Contracting Between Physicians And Hospitals In Massachusetts," Health Affairs 41, no. 5 (May 2, 2022), https://doi.org/10.1377/hlthaff.2021.00727.
[35] Massachusetts Health Policy Commission, Registration of Provider Organizations: Program Overview, https://www.mass.gov/service-details/registration-of-provider-organizations (last accessed Aug. 4, 2022).

Strengthen the hospital price transparency rule

One crucial way CMS can address provider consolidation and encourage competition between providers is through price and quality transparency. *Consumers First* strongly supports CMS's 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, consumers and employers 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. Indeed, 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 have used a service and received a bill. For nearly 20 years, researchers have known that the underlying drivers of U.S. health care costs are high and variable health care prices that often result from consolidation across and within U.S. health care markets.[36]

Price transparency is a critical tool for consumers, purchasers and regulators in a health care system in which business success is not tied to innovation, population health or customer service, but rather to market power. Anti-competitive practices also prevent data from being shared and undermine affordable, high quality health care for our nation's families, workers and employers.[37] 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 previous proposed rules,[38] research shows that disclosing price may actually help to reduce health care costs in some markets and for some services.[39]

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[36] 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), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.22.3.89?journalCode=hlthaff; Irene Papanicolas, Liana Woskie, Ashish Jha et al, "Health Care Spending in the United States and Other High-Income Countries," *JAMA*, (Mar. 2018), https://jamanetwork.com/journals/jama/article-abstract/2674671; Chapin White et al., "High and varying prices for privately insured patients underscore hospital market power," Res Brief. (Sept. 2013), https://pubmed.ncbi.nlm.nih.gov/24073466/; Christopher Whaley et al., 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.

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

[38] 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; 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; Consumers First Comment Letter on CY 2021 Hospital Outpatient Prospective Payment System proposed rule, September 17, 2021, Available at: https://familiesusa.org/wp-content/uploads/2021/09/Consumers-First-Comments-on-OPPS-CY22- 9.17.21.pdf.

[39] 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-savemoney.html.

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 Rule. The current largely opaque pricing system 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 people that the Medicare program is designed to serve.

As laid out in our comment letter on the FY 2023 Inpatient Prospective Payment System rule,[40] ***Consumers First*** **urges CMS, as it implements price transparency rules, to 1) facilitate consumer use of transparency data by requiring data on the same services from providers, 2) pair pricing data with quality data, and 3) increase enforcement to drive compliance.**

Reconfiguring the types of services subject to transparency:

We encourage CMS to implement a price transparency vision that establishes more national uniformity across services. This would allow consumer, employers, providers, policymakers, and researchers to gain greater insight into health care markets with high value or low value care that can inform policymaking, and would help providers to deliver higher value care to consumers. The current Hospital Price Transparency rule requires hospitals to post the payer-specific negotiated charges for 300 "shoppable" services; CMS mandates 70 services and each hospital system would choose 230.[41]

Evidence suggests that health care price transparency alone has limited impact on consumer behavior.[42] 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.[43] As CMS moves forward with empowering consumers with shoppable services, we urge CMS to broaden the scope of its transparency framework in recognition that consumers -- specifically Medicare beneficiaries -- have an important interest in price transparency that is broader than shopping for services. Price transparency can help to change the behavior of providers and payers and inform policymakers and regulators. Individual providers can effectively use price and quality information to encourage patients to access lower-cost, higher-value referred

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[40] Consumers First Comment Letter on FY 2023 Hospital Inpatient Prospective Payment System proposed rule, June 17, 2022, Available at: https://familiesusa.org/wp-content/uploads/2022/06/Consumers-First-Comments-on-IPPS-CY23-6.22.22-final.pdf.
[41] 45 C.F.R. § 180.60.
[42] 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).
[43] 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).

providers.[44] The same holds true for employers and other payers, who can use price and quality transparency information to drive care toward higher-value providers.[45] There also is evidence to suggest that high-cost providers may change their pricing behavior due to public scrutiny.[46] Specifically, as CMS implements broad price transparency rules, ***Consumers First*** **recommends that CMS mandate transparency on a smaller, 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 initially, to include a broadly representative sample of services (i.e. imaging, evaluation and management, core surgical specialties, radiation oncology etc.), including the 50 highest dollar volume (price x volume) inpatient services and the 50 highest dollar volume (price x volume) outpatient services, and growing to the 300 services CMS requires.**

Pairing Price Transparency with Quality Data

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.[47] While we understand that additional work is needed to arrive at and report on a harmonized set of quality measures, we believe it is 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 delaying 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:**

- **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.**

[44] 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).
[45] 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.
[46] 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).
[47] 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.

- **Engage in a robust non-industry multi-stakeholder process (i.e. consumers, employers, labor) to seek feedback and establish consensus on a meaningful set of quality measures to be reported alongside pricing information.**

Enhance Enforcement

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. And while we are encouraged that CMS has now begun to administer fines to hospitals who fail to comply with the regulation, we strongly urge CMS to hold hospitals that fail to comply accountable by administering more civil monetary penalties.[48] Despite warning notices and corrective action plans that CMS has administered, the vast majority of hospitals continue to withhold the required pricing information. Numerous reports have shown that less than 20 percent of hospitals across the country are in compliance with the existing regulation,[49] and some reports show compliance as low as five percent.[50] In short, most hospitals are not taking the federal law or CMS's enforcement actions seriously. Hospitals have powerful financial interests against adhering to a law that enables consumers and other health care purchasers to be informed purchasers of care. CMS must take further action by aggressively enforcing the existing civil monetary penalties and increasing the penalty until most hospitals are disclosing the required health care pricing information.

The proposed maximum fine of $2 million remains too small, particularly given that large hospital systems own billions of dollars of cash and investments.[51] Simply put, a $2 million fine remains too low to motivate most hospitals to comply.

Hospitals have spent years fighting price transparency regulations, including through litigation,[52] in an effort to avoid regulatory oversight of their anticompetitive health care prices. We urge CMS to send a stronger message to hospitals by further increasing the civil monetary penalty and administering the existing penalty to noncompliant hospitals. ***Consumers First*** **recommends that CMS:**

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[48] Marissa Plescia, "No hospitals received price transparency notices in April, CMS says," Beckers Hospital Review, (May 2, 2022), https://www.beckershospitalreview.com/finance/no-hospitals-received-price-transparency-notices-in-april-cmssays.html.
[49] Caitlin Owens, "Most hospitals aren't complying with price transparency rule," Axios, (June 15, 2021), https://www.axios.com/hospitals-price-transparency-costs-regulations-noncompliance-ebf6bd21-5709-4298-b67a74c8a90a1ec1.html.
[50] Semi-Annual Hospital Price Transparency Compliance Report July 2021, Patient Rights Advocate, https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/60f1c225e1a54c0e42272fbf/1626456614723/PatientRig.
[51] 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*, 48, No. 1, (Summer 2021), https://www.healthfinancejournal.com/index.php/johcf/article/view/265.
[52] 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.

- **Immediately begin administering the civil monetary penalty to hospitals not in compliance with the federal regulation as of January 1, 2021,**
- **Increase the civil monetary penalty for hospitals with 31 beds or more to $300 per bed per day, and remove the maximum cap of $2 million on the civil monetary penalty.**
    - **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.[53]**
- **Monitor compliance on an ongoing basis to determine whether the civil monetary penalty is sufficiently high to increase hospital compliance.**

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 Benefits Council
American Federation of State, County & Municipal Employees
Families USA
Purchaser Business Group on Health

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[53] SocialSphere, "National Survey June 2021," Patient Rights Advocate, (July 6, 2021), https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/60f1c21c49c4f65d0f57d5ae/1626456605014/SocialSph ere+Patient+Rights+Advocate+June+2021+Survey+Results.pdf.

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