CONSUMERS F1RST
The Alliance to Make the Health Care System Work for Everyone

September 11, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **1786-P**
P.O. Box 8010
Baltimore, MD 21244-1810

RE: CMS-1786-P - Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction

Submitted electronically via Regulations.gov

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 our 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 2024.

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 to 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 in this letter represent the views of the *Consumers First* steering committee and 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:

- **XVIII. Proposed Updates to Reimbursements for Hospitals to Make Public a List of Their Standard Charges**
- **VIII. Payment for Partial Hospitalization and Intensive Outpatient Service**
- **As a collection:**
    - **XIV. Hospital Outpatient Quality Reporting Program Requirements, Proposals, and Requests for Comment**
    - **XV. Requirements for the Ambulatory Surgical Center Quality Reporting Program**
    - **XVI. Proposed Requirements for the Rural Emergency Hospital Quality Reporting Program**

XVIII. Proposed Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges

Consumers First strongly supports CMS's efforts to increase hospital price transparency to help make health care more affordable. Every person should have the right to know what a health care procedure costs at different hospitals or health care facilities, whether it is an X-ray, an MRI, or a surgery, yet that is not how it works in the U.S. health care system. 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 that service has been delivered and they receive a bill.[1] And hospital care represents the largest share of the nation's health care expenditure.[2] For the two-thirds of Americans who receive health care through private insurance, health care prices are established in closed-door negotiations between large hospital corporations and health plans, and based on which organization has more market power.[3] These health care prices — often referred to as negotiated rates — are buried in proprietary contracts without insight into or oversight over the price of health care services by the public and policymakers.[4] This lack of transparency is particularly alarming given that high and rising health care prices are the primary driver of our nation's health care affordability crisis.[5]

The pricing information that is most critical to achieving 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,

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[1] Danielle Scheurer, "Lack of Transparency Plagues U.S. Health Care System," *The Hospitalist*, May 1, 2013, https://www.the-hospitalist.org/hospitalist/article/125866/health-policy/lack-transparency-plagues-us-health-care-system; Ann Boynton and James C. Robinson, "Appropriate Use of Reference Pricing Can Increase Value," *Health Affairs Forefront*, July 7, 2015, https://www.healthaffairs.org/do/10.1377/forefront.20150707.049155/full/; Sarah Kliff and Josh Katz, "Hospitals and Insurers Didn't Want You to See These Prices. Here's Why," *New York Times*, August 22, 2021, https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html.

[2] "National Health Expenditures 2021 Highlights," *CMS,* https://www.cms.gov/files/document/highlights.pdf

[3] Katherine Keisler-Starkey and Lisa N. Bunch, "U.S. Census Bureau Current Population Reports, P60-274, Health Insurance Coverage in the United States: 2020," *Washington, DC: U.S. Government Publishing Office*, September 2021, https://www.census.gov/library/publications/2021/demo/p60-274.html; Kliff and Katz, "Hospitals and Insurers."

[4] "RAND Health Care Price Transparency," *Rand Corporation*, https://www.rand.org/health-care/projects/price-transparency.html.

[5] Noam N. Levey, "100 Million People in America Are Saddled With Health Care Debt," *Kaiser Health News*, June 16, 2022, https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/; Mark Smit, et al, "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America," *Institute of Medicine, Washington, DC: National Academies Press,* 2013, ; Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, "It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt," *Health Affairs* 38, no. 1 (January 2019): 87–95, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144.https://www.nap.edu/catalog/13444/best-care-at-lower-cost-the-path-to-continuously-learning; Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, "It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, and a Tribute to Uwe Reinhardt," *Health Affairs,* January 2019, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144.

including 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.

Since going into effect in January 2021, the Hospital Price Transparency Rule has required hospitals to disclose standard charges for all items and services, specifically negotiated rates, by insurer and the particular insurance plan, gross charges, discounted cash prices, and a deidentified maximum and minimum negotiated rate for each service.[6] However, far too many hospitals are still not complying with the rule; recent estimates put compliance at only 36%.[7] The rule requires hospitals to make public, in a machine-readable and consumer friendly format, standard charges for the care they provide.[8] Despite the detailed data requirements in the regulation, many hospitals have posted no information on negotiated rates at all or posted it with vast swaths of N/As, or data in the unhelpful form of a percentage of Medicare or an algorithm representing negotiated rates.[9] In the time since enactment, CMS issued seven civil monetary penalty (CMP) notices and imposed only four CMPs, even with the above-mentioned reports of high to moderate noncompliance.[10] However, in early 2023, CMS updated its enforcement process, requiring corrective action plan (CAP) completion deadlines, imposing CMPs automatically after hospitals fail to submit a CAP after 45 days of the notice of noncompliance, and streamlining the compliance process by no longer issuing warning notices before requesting a CAP – We appreciate these efforts by CMS to strengthen compliance with the rule.[11] In order for the Hospital Price Transparency rule to be fully realized, monitoring and enforcement by CMS must be *strong* and *consistent*.

In that vein, *Consumers First* supports CMS in its proposal to:

- **Add monitoring and assessment capabilities for CMS in overseeing compliance,**
- **Add the ability of CMS to contact the health system of a non-compliant hospital to address systematic noncompliance in larger health care systems,**
- **Publish additional compliance actions and outcomes, outside of just posting CMP notices, as it will raise public awareness and encourage swift remediation of hospital violations.**

We note that in some places throughout the regulation, CMS used the terms "assessment," "monitoring," and "enforcement" when discussing hospital compliance.[12] We strongly encourage CMS use consistent and strong language throughout the regulation and recommend that CMS use the word "enforcement" wherever appropriate to send a strong message to hospitals about the seriousness of enforcement activities. Even with these improved enforcement efforts, far too many hospitals across the country remain out of compliance with the federal rule. Moreover, the fact that thousands of U.S.

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[6] 84 Fed. Reg. 65,524 (November 19, 2019) (codified at 45 C.F.R. §§ 180.10-.110).
[7] "Fifth Semi-Annual Hospital Price Transparency Compliance Report," *Patient Rights Advocate,* July 20, 2023, https://www.patientrightsadvocate.org/july-semi-annual-compliance-report-2023
[8] 84 Fed. Reg. 65,524 (November 19, 2019) (codified at 45 C.F.R. §§ 180.10-.110).
[9] Fifth Semi-Annual Hospital Price Transparency Compliance Report," *Patient Rights Advocate,* July 20, 2023, https://www.patientrightsadvocate.org/july-semi-annual-compliance-report-2023; Sophia Tripoli and Adam Axler, "The Power of Price Transparency: Unveiling Health Care Prices to Promote Accountability and Lower Costs," *Families USA,* April 2023, https://familiesusa.org/wp-content/uploads/2023/04/Power-of-Price-Transparency-final-4.19.23.pdf
[10] "Enforcement Actions," *CMS,* August 2023, https://www.cms.gov/hospital-price-transparency/enforcement-actions
[11] "Hospital Price Transparency Enforcement Updates," *CMS,* April 26, 2023, https://www.cms.gov/newsroom/fact-sheets/hospital-price-transparency-enforcement-updates
[12] 88 FR 49860, https://www.federalregister.gov/d/2023-14768/page-49860

hospitals would rather risk paying a $2 million per year fine than comply with federal regulations to disclose prices serves as evidence that hospitals are both making undue profits by keeping health care prices hidden and that they have a powerful financial interest not to disclose how monopolistic prices have become. *Consumers First* applauds CMS in its proposal to establish a standardized template for hospital data submissions and offers recommendations for the administration to 1) narrow the standardized template form to one, unified form; 2) standardize a code format to report on services (that is, CPT or HCPCS codes, not facility-specific codes) and; 3) require hospitals to submit all negotiated rates in dollars and cents, not in algorithms or percentages.

Implementing a standardized template for data submissions:

Consumers First applauds CMS in their proposal to implement a standardized template for hospital data submissions, a data dictionary, data specifications, and standardization of encoding of hospitals standard charge information. In past years, CMS has offered flexibility in format to hospitals as an attempt to encourage and ease compliance with the rule overall.[13] However, with the offering of a data dictionary, technical guidance on data encoding, and additional data specifications, there should no longer be an excuse for hospitals to be out of compliance with reporting requirements or for them to take advantage of loopholes that make the data non-usable for policymakers and consumers. No longer will hospitals be able to obfuscate the information using complex templates or disorganized files.[14] Requiring that hospitals submit their hospital pricing data in one standardized template is a huge win for the administration, policymakers, and the public.

In the proposed rule, CMS asks for input on offering three forms for the standard template or one, singular form. The proposed rule currently offers a JSON (plain) format and CSV "wide" and "tall" format for the standardized template; these three are the formats most often used by hospitals in their current data submission and each offer pros and cons in reducing file size, incorporating related information like payer and plan name, reducing opportunity for standardization errors.[15] ***Consumers First*** **recommends that CMS choose one standard format for hospitals to follow, specifically a CSV or XLS format, not JSON, instead of the three standardized formats that are offered in the proposed rule. This file should be both machine-readable and consumer friendly and offer policymakers and researchers the opportunity to effectively compare prices within and across hospitals. JSON files require a tech developer to convert and are therefore not human readable. This uniformity will help to ensure optimal quality and comparability of the data; clear disclosure enables the public to easily understand the pricing information, to make price comparisons across different hospital providers by service, and reduces the ability for hospitals to game the requirements under the rule.**

Establishing a standard code format

[13] 88 FR 49552 (July 31, 2023), https://www.federalregister.gov/documents/2023/07/31/2023-14768/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

[14] Dave Muoio, "CMS: Tighter Price Transparency Enforcement, Standardized Requirements for Hospitals Are on the Horizon," *Fierce Healthcare,* February 21, 2023, https://www.fiercehealthcare.com/providers/cms-tighter-price-transparency-enforcement-standardized-requirements-are-horizon; Sophia Tripoli and Adam Axler, "The Power of Price Transparency: Unveiling Health Care Prices to Promote Accountability and Lower Costs," *Families USA,* April 2023, https://familiesusa.org/wp-content/uploads/2023/04/Power-of-Price-Transparency-final-4.19.23.pdf

[15] 88 FR 49552 (July 31, 2023), https://www.federalregister.gov/documents/2023/07/31/2023-14768/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

Under the Hospital Price Transparency regulation, hospitals are allowed to use Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), or other codes when displaying services with corresponding pricing data. The rule proposes to require relevant modifiers- additions to the codes that describe the severity of the services, additional supplies that were used, or additional services- be included with those codes that the hospitals report. Modifiers are important elements of a reported code as they indicate additional resources that may be used for that service and help to clearly define the full extent of care that a patient may receive and be billed for. The proposed rule however does not establish a standardized code format or limit hospitals from using Diagnosis-Related Group (DRG), National Drug Code (NDC), common payer identified, or other codes used for billing or accounting. This flexibility in coding is problematic because without a standardized format and coding system that all hospitals are required to use, the ability to analyze prices across and within U.S. health care markets becomes nearly impossible and consumers cannot effectively shop for services. ***Consumers First*** **supports the inclusion of relevant modifiers whenever applicable and urges CMS to establish a standardized code format, that clearly requires the use of commonly used code sets like HCPCS or CPT codes, to ensuring that data related to specific services can be easily compared across hospitals and facilities.**

Requirements for pricing data submissions:

Consumers First calls upon CMS to crack down on hospitals hiding their negotiated rates through the use of algorithms, percentages (ex. Percentage of Medicare), or N/As in place of dollars and cents. Hospitals use various tactics to avoid reporting requirements and make the information they disclose hard to understand and evaluate.[16] The percentage of gross charges or percent of Medicare rates is not a meaningful piece of pricing information and is not actually a price at all. Posting prices in this way requires that anyone hoping to use the data understand Medicare base rate or gross rate charges and then make a mathematical calculation; posting algorithms puts the user in a similar predicament and renders the data files almost useless.[17] In general, performing those calculations would require a third-party to interpret and calculate, often at significant expense. Requiring that prices be posted in dollars and cents will enable consumers and employers to access pricing data free of charge.

While this rule proposes to include new data elements – hospital-specific information, data elements corresponding to standard charges, contracting methodology for payer-specific negotiated charges, data elements to enhance understanding of an item or service such as description of the item/service, billing class, hospital setting, drug-specific information, and information related to corresponding codes – and requires affirmation of the accuracy and completeness of standard charges, it continues to allow the practice of submitting algorithms or percentages of Medicare in place of the negotiated rate.[18] In situations where a hospital is posting algorithms or percentages, CMS is proposing to require hospitals to also post a "consumer-friendly expected allowed amount." While we appreciate CMS's intent to begin addressing the issue of hospitals posting algorithms or percentages, we are deeply concerned that this effort fails to address the underlying problem of hospitals posting an algorithm or percentage instead of

[16] Justin Lo et al., "Ongoing Challenges with Hospital Price Transparency," *Peterson-KFF Health System Tracker*, February 10, 2023, https://www. healthsystemtracker.org/brief/ongoing-challenges-with-hospital-price-transparency/.
[17] Sophia Tripoli and Adam Axler, "The Power of Price Transparency: Unveiling Health Care Prices to Promote Accountability and Lower Costs," *Families USA,* April 2023, https://familiesusa.org/wp-content/uploads/2023/04/Power-of-Price-Transparency-final-4.19.23.pdf
[18] 88 FR 49552 (July 31, 2023), https://www.federalregister.gov/documents/2023/07/31/2023-14768/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

providing the negotiated rate in dollars and cents. CMS itself acknowledges the limitations of this approach and clearly states that this expected allowed amount is an "estimate" and is "not the final exact amount in dollars that would actually apply to each group member."[19] Simply put, posting the negotiated rate in this way not only fails to list an actual price but also fails to uphold the intent of the price transparency rule, which is to disclose meaningful pricing information to consumers and other payers to negotiate a better deal and be more informed purchasers of health care. The most critical pricing information that must become publicly available for meaningful transparency to be achieved is the negotiated rate, which is widely recognized as the underlying price of health care services and goods.[20] **As a result, we strongly urge that CMS require all standard charges, including the negotiated rate, be displayed in dollars and cents, and specifically prohibit hospitals from posting any standard charges in the form of algorithms, percent of Medicare, or N/A's. Anything less than or different from the negotiated rate, in dollars and cents, charged by the hospital to the consumer should not be considered complete and accurate information.**

Consumers First **is strongly supportive of CMS's proposal to require affirmation by the hospitals on the accuracy and completeness of their data. Consumers First has long advocated for this policy.** This is a win for policymakers and consumers in that requiring affirmation of the accuracy of data is important in holding hospitals accountable for their compliance with the regulation. We suggest that CMS strengthen the affirmation requirement in the following ways:

(1) Clarify that a senior official (Chief Executive Officer, Chief Financial Officer, or an equivalent level) is required to attest to the accuracy and completeness of the data file,
(2) Deem that such an affirmation be material to payment from the federal government to incorporate potential liability under the False Claims Act for hospitals that knowingly violate the rule and falsely attest to the accuracy of their prices,
(3) Clarify that the affirmation covers both the machine-readable file and the consumer-friendly disclosures of the 300 shoppable services.

However, CMS should consider hospitals not in compliance with the federal rule if hospitals fail to publish negotiate rates in dollars in cents, even if hospitals affirm the completeness of data. Importantly, ***Consumers First*** **strongly recommends that CMS not use requirements for hospitals to affirm the completeness and accuracy of data to streamline CMS's enforcement and oversight protocol. Requiring hospitals to affirm the accuracy and completeness of the data should be considered an additional layer of enforcement and oversight by CMS.** While hospital affirmation is critical, it should not preclude CMS from conducting a full compliance review of any hospitals that are flouting the rules, regardless of whether they attested to completeness of their data file or not. Full transparency of health care price and quality data is a critical step toward driving value into the U.S. health care system and ensuring our nation's families receive the affordable, high quality health care and improved health they deserve. While we strongly support regulatory efforts to increase hospital transparency, we also strongly support federal legislation that codifies and strengthens these requirements, including increasing penalties, as the most lasting and effective means of improving compliance and enforcement.

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[19] Ibid.

[20] Jaime King, "Examining State Efforts to Improve Transparency in Healthcare Costs for Consumers," *Subcommittee on Oversight and Investigation, Committee on Energy and Commerce,* July 17, 2018, https://www.congress.gov/115/meeting/house/108550/witnesses/HHRG-115-IF02-Wstate-KingJ-20180717.pdf

VIII. Payment for Partial Hospitalization and Intensive Outpatient Service

Consumers First is a strong proponent of comprehensive site neutral payment policy to end the longstanding distortion in Medicare reimbursement that incentivizes vertical integration and contributes to the country's health care affordability crisis. 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.[21] While CMS made mention of "site neutral" changes in this year's proposed rule, **we are deeply concerned that CMS did not propose to continue the work of expanding comprehensive site-neutral payment policy across additional services or sites of service.**

Congress and CMS have taken steps to address this issue in the past. The Bipartisan Budget Act (BBA) of 2015 mandated that new off campus provider-based hospital departments be paid at the physician fee schedule (MPFS) 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 2, 2015, referred to as "grandfathered" provider-based departments.[22] Subsequently, CMS implemented the BBA through the CY 2019, 2020 and 2021 OPPS rules with an important amendment which extended the application of site-neutral payment – the MPFS rate – to clinic visits delivered by off-campus provider-based departments "grandfathered" under the BBA.[23] 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.[24] 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 that site-neutral payments be applied to a much broader set of clinic services, such as those included in the 2014 Medicare Payment Advisory Commission (MedPAC) recommendations to Congress, and updated list in 2023 MedPAC recommendations, and at both off-campus and on-campus hospital outpatient departments, as well as at ambulatory surgery centers.[25]

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

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[21] Consumers First, "Comment Letter on CY 2020 OPPS," *Families USA,* September 2019, https://familiesusa.org/wpcontent/uploads/2019/10/Consumers-First-OPPS-Comments-9.27.19.pdf; Consumers First, "Comment Letter on CY 2021 OPPS," *Families USA,* September October 2020, https://familiesusa.org/wp-content/uploads/2020/10/Consumers-First-2021-OPPS-comment-letter10.5.20.pdf; Consumers First, "Comment Letter on CY 2022 OPPS," *Families USA,* September 2021, https://familiesusa.org/wpcontent/uploads/2021/09/Consumers-First-Comments-on-OPPS-CY22-9.17.21.pdf.

[22] "H.R. 1314- Bipartisan Budget Act of 2015," *House Ways and Means,* November 2015, https://www.congress.gov/bill/114th-congress/house-bill/1314/text

[23] 83 FR 58818 (42 CFR Parts 416 and 419), November 2018, https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24243.pdf; 84 FR 61142, November 2019, https://www.federalregister.gov/documents/2019/11/12/2019-24138/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center; 83 FR 58818 (42 CFR Parts 416 and 419), November 2018, https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24243.pdf

[24] "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.

[25] "Report to Congress: Medicare Payment Policy," *MedPAC,* 2014, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar14_entirereport.pdf.; "Report to Congress: Medicare Payment Policy," *MedPAC,* 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf.

physician offices. Yet, physician offices can deliver many of these services with the same quality and at lower cost to the Medicare program – HOPDs typically are paid substantially more than independent physician practices for providing the same services.[26] This arbitrary distinction is distorting prices in 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.[27] Over the last decade, our nation has seen a trend of formerly independent physician practices becoming affiliated with major hospital systems.[28] 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.[29] 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, resulting in MedPAC updating its site-neutral payment policy in its latest March 2023 Report to Congress.[30] Medicare beneficiaries pay higher copays at HOPDs 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.[31] These are trends that run directly counter to the interests of Medicare beneficiaries and the solvency of the Medicare Trust fund. 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 and accounting for differences in collectively negotiated employee compensation. This is a foundational principle in the efficient allocation of resources and shifting to a value-based health care system.[32]

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 drives high cost and low-

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[26] 84 Fed. Reg. 39616 (Aug. 9, 2019).
[27] Michael F. Furukawa, Laura Kimmey, and 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.
[28] 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
[29]Physicians Advocacy Institute, "Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018," *February 2019*, http://www.physiciansadvocacy; Physicians Advocacy Institute, "COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021," April 2022, http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d
[30] "Report to Congress: Medicare Payment Policy," *MedPAC,* 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf.
[31] 84 Fed. Reg. 39616 (Aug. 9, 2019).
[32] "Medicare Payment Advisory Commission Report to Congress: Medicare Payment Policy," *MedPAC,* 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 for the 21st Century," *Washington, DC, National Academies Press, 2001 8, Aligning Payment Policies with Quality Improvement,* https://www.ncbi.nlm.nih.gov/books/NBK222279/.

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.[33] 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.[34] 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.[35] 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 for existing off-campus provider-based departments for all services, not just clinic visits,
- 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.[36]

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 MPFS, and the nine APCs that should align the OPPS payment rates with the Ambulatory Service Center (ASC) payment rates and continue to use the MPFS rate when the service is provided in a freestanding office,[37]

<u>Eliminating the "grandfathering" clause:</u>

***Consumers First* recommends that CMS extend site neutral payment policies to currently "grandfathered" sites for all applicable services, not just clinic visits. The Congressional Budget Office estimates $13.9 billion in savings between 2019 and 2028 by implementing this policy change.[38]**

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[33] "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, https://www.cadc.uscourts.gov/internet/opinions.nsf/E27BC5B064ED8035852585A80052C843/$file/19-5352- 1852218.pdf.
[34] 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-onhealthpolicy/2018/08/10/cms-positive-step-on-site-neutral-payments-and-the-case-for-going-further/.
[35] Nancy Kane, Robert Berenson, and 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.
[36] "Medicare Payment Advisory Commission March 2017 Report to Congress, Chapter 3 - Hospital inpatient and outpatient services," *MedPAC,* Mar. 2017, http://www.medpac.gov/docs/defaultsource/reports/mar17_medpac_ch3.pdf?sfvrsn=0
[37] "Report ot the Congress: Medicare and Health Care Delivery System," *MedPAC,* 2022, https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf ; "Report to Congress: Medicare Payment Policy," *MedPAC,* 2023, https://www.medpac.gov/wp-content/ uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf.
[38] "Proposal Affecting Medicare – Congressional Budget Office's Estimate of the President's Fiscal Year 2019 Budget," *Congressional Budget Office, 2019,* https://www.cbo.gov/system/files?file=115th-congress-2017-2018/dataandtechnicalinformation/53906-medicare.pdf.

In 2015, Congress enacted a site-neutral payment policy through the BBA which mandated that new off-campus provider-based hospital departments be paid at the lower MPFS rate. However, sites built before November 2, 2015, were exempt from the policy; these "grandfathered" locations include but are not limited to on and off campus outpatient departments, APCs, and emergency departments.[39] In the CY 2020 OPPS rule, CMS applied site-neutral policies to these facilities for clinic visits only, which was a start but far from a comprehensive fix for this loophole. Ultimately, the BBA of 2015 applied only to a small number of health care facilities and more work is needed to fully address this payment distortion driving unaffordable health care for American families.[40]

For decades, hospitals have leveraged site of service payment differentials to push the delivery of routine care to higher cost care settings and drive-up health care spending with no meaningful improvement in care quality or safety. Hospitals benefit from this "grandfathering" loophole and continue to charge inappropriate fee schedules and rack up profits at these locations on the backs of consumers receiving unaffordable bills. It is long past time for CMS to close this loophole for all applicable services, not just clinic visits.

Implementing a more complete set of APCs:

***Consumers First* recommends that CMS update the services which site neutral payment policy applies to include the total 66 APCs identified by MedPAC; the recommendation includes 57 APCs to align to the MPFS rate and 9 APCS to align with the ASC rate.** Currently, consumers are paying unnecessarily high prices for these services and the system is paying for them at that rate that is irrationally running up the bill for Medicare, eroding Medicare solvency.[41] Since 2014, MedPAC has issued clear recommendations to Congress on comprehensive site-neutral payment policy that would address underlying payment distortions and lower health care costs for our nation's families.[42] The 57 APCs that MedPAC identified to be aligned with the MPFS rate represent more than 70% of total Medicare volume, accounting for $11.4 billion in annual Medicare spending.[43]

It is clear that enacting comprehensive site neutral payment policies would result in significant savings for consumers and Medicare, savings that are currently wasted in paying for a location change instead of quality improvement. Specifically, enacting MedPAC's recommendations would reduce the total cost of health care spending across the nation and lower out-of-pocket costs for consumers; MedPAC estimates that in 2019, Medicare would have seen $6.6 billion in savings and $1.7 billion in reductions to patient

[39] "H.R. 1314 — Bipartisan Budget Act of 2015," *114th Congress,* 2015, https://www.congress.gov/bill/114th-congress/ house-bill/1314/text.
[40] Palmisano, Loren Adler, et al., "CMS' Positive Step on Site-Neutral Payments and the Case for Going Further," *Brookings,* August 10, 2018, 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/.
[41] Emily Gee, "The High Price of Hospital Care," *Center for American Progress*, June 26, 2019, https://www.americanprogress.org/article/high-price-hospital-care/.; 84 Fed. Reg. 39616. 2019. https://www.govinfo.gov/content/pkg/FR-2019-08-09/pdf/2019-16107.pdf.
[42] "Report to Congress: Medicare Payment Policy," *MedPAC,* 2014, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar14_entirereport.pdf.; Medicare and the Health Care Delivery System," *MedPAC,* 2022 https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v2_SEC.pdf.; "Report to Congress: Medicare Payment Policy," *MedPAC,* 2023, https://www.medpac.gov/wp-content/ uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf.
[43] "MedPAC Continues to Recommend Ambulatory Site-Neutral Payment to Reduce Spending," *Trilliant Health,* https://www.trillianthealth.com/insights/the-compass/medpac-continues-to-recommend-ambulatory-site-neutralpayment-to-reduce-spending.

cost sharing had comprehensive site-neutral payment policy been enacted.[44] In early 2020, the Congressional Budget Office estimated that a site- neutral policy would save Medicare approximately $140 Billion over the next decade.[45] In early 2023, the Committee for a Responsible Budget estimated that implementing a comprehensive site neutral payment policy for Medicare would reduce cost-sharing for Medicare beneficiaries by $94 billion.[46]

Site neutral payment policy is a common-sense solution to a problem that is currently only benefitting large hospital corporations' bottom lines at the expense of the pocketbooks of families and individuals; *Consumers First* encourages CMS to address this issue in their final OPPS rule.

XIV. Hospital Outpatient Quality Reporting Program (OQR) Requirements, Proposals, and Requests for Comment

XV. Requirements for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program

XVI. Proposed Requirements for the Rural Emergency Hospital Quality Reporting (REHQR) Program

Consumers First is supportive of CMS's continuous efforts to improve hospital OQR, ASCQR, and REHQR measures in pursuit of reporting systems that reflect the most up to date research on health care quality and improves health outcomes within the outpatient, rural, and ASC settings. The Hospital Quality Initiative was designed to improve the quality of care delivery in hospitals, incentivize hospitals to improve care, and help consumers in making decisions about where to obtain their care.[47] These programs developed over time, with the hospital OQR program mandated by law in 2006, the ASCQR program finalized in 2012, and the REHQR program established much later in the 2021 Consolidated Appropriations Act and finalized in the CY 2023 OPPS rule.[48] This year's rule proposes technical changes to language in the OQR and ASCQR programs as well as removal, modification, or adoption of seven total measures. The rule also proposes four new quality measures to the REHQR program. Specifically, *Consumers First:*

- Encourages CMS to continue to evaluate the existing measures for gaps in quality and equity data measurement and to integrate health equity into the hospital OQR program by

[44] "Medicare Payment Advisory Commission Report to Congress: Medicare and the Health Care Delivery System Chapter 6, Aligning fee-for-service payment rates across ambulatory settings," *MedPAC,* June 2022, https://www.medpac.gov/wpcontent/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf.
[45] "An Analysis of the President's 2021 Budget," *Congressional Budget Office,* March 30, 2020. https://www.cbo.gov/publication/56301.
[46] "Moving to Site Neutrality in Commercial Insurance Payments," *Committee for a Responsible Federal Budget*, 2023, https://www.crfb.org/papers/moving-site-neutrality-commercial-insurance.
[47] "Hospital Quality Initiative," *CMS,* October 2022, https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits
[48] "Public Law 109-432: Tax Relied and Health Care Act of 2006," *109th Congress,* December 2006, https://www.congress.gov/109/plaws/publ432/PLAW-109publ432.pdf; 76 FR 74121, November 2011, https://www.federalregister.gov/documents/2011/11/30/2011-28612/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-ambulatory-surgical-center; "H.R. 133- Consolidated Appropriations Act, 2021," *House Foreign Affairs,* December 2020, https://www.congress.gov/bill/116th-congress/house-bill/133/text; 87 FR 71748, November 2022, https://www.federalregister.gov/documents/2022/11/23/2022-23918/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

incorporating health disparity reduction quality and outcome measures, including disparity-sensitive measures as well as expanding hospital data reporting requirements.
- Applauds the proposal of four new measures to the REHQR as a step towards comprehensive quality reporting for rural facilities and encourages CMS to continue to explore additions, like the adoption of a care coordination measure, to provide improved insight into how to best support and improve care for rural communities.

While measurements of clinical care are important in evaluating care delivery and the quality of health care across facilities and programs, integrating health equity into measures and overall data collection is essential in order for CMS to effectively close the equity gap across the health care system. **To achieve this goal, *Consumers First* strongly encourages CMS to:**

- **Stratify all hospital quality measures by race and ethnicity initially, and ultimately expanded 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.**
- **Commit 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 Health Information Technology (HIT) certification requirements that include full disaggregation of race and ethnicity, language, sexual orientation, gender identity and social and behavioral risk factors.[49] CMS should immediately adopt and endorse ONC's 2015 Edition standards for collecting disaggregated data for all hospitals and for all CMS quality programs.**

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 promises 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 toward ensuring that 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.

[49] 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.

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

Sincerely,

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American Benefits Council
American Federation of State, County & Municipal Employees
Families USA
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