Cleverley + Associates

A RESPONSE TO THE CY22 OPPS PROPOSED RULE (CMS-1753-P) FOR PROPOSED CHANGES TO REQUIREMENTS FOR HOSPITALS TO MAKE PUBLIC A LIST OF THEIR STANDARD CHARGES

Provided by: Cleverley + Associates

1) BACKGROUND

The CY22 OPPS Proposed Rule contains additional information and requirements regarding hospital price transparency. The proposed changes relate to current requirements found in CY 2020 OPPS Final Rule on Transparency (CMS-1717-F2).

CURRENT DISCLOSURE REQUIREMENTS SUMMARY:

As a continuation of the FY19 IPPS Final Rule, the CY20 OPPS Final Rule on Transparency introduced additional clarification and requirements for hospitals. These requirements became effective on January 1, 2021 and include the following key elements:

1) A definition of "hospital" that requires nearly all hospitals to comply with the rule,
2) Definitions for five types of "standard charges" to be disclosed by hospitals (gross charge, discounted cash price, payer specific negotiated charge, and the deidentified minimum and maximum negotiated charge)
3) A definition of hospital "items and services" that would include all items and services (including individual items, services, service packages, and employed professional fees) provided by the hospital to a patient in connection with an inpatient admission or an outpatient department visit;
4) Requirements for making public a machine-readable file that contains all definitions of standard charges for all items and services and service packages provided by the hospital;
5) Requirements for making certain standard charges public for select hospital-provided items and services that are "shoppable" and that are displayed in a consumer-friendly manner – either through a file or a web-based patient estimation tool;
6) Non-compliance monitoring, actions, civil monetary penalties, and appeal process.

2) CY22 OPPS PROPOSED RULE UPDATES TO TRANSPARENCY REQUIREMENTS

The proposed rule contains four primary sections:

1) **Proposal to Increase the Civil Monetary Penalty Using a Scaling Factor**
   Increase the amount of the penalties for noncompliance through the use of a proposed scaling factor based on hospital bed count
2) **Proposal to Deem Certain State Forensic Hospitals as Having Met Requirements**
   Deem state forensic hospitals that meet certain requirements to be in compliance with the requirements of 45 CFR part 180
3) **Proposals Prohibiting Additional Barriers to Accessing the Machine-Readable File**
   Requirements to prohibit certain conduct that have been concluded to create barriers to accessing the standard charge information
4) **Clarifications and Requests for Comment**
   Expected output of hospital online price estimator tools, and comment requests on a variety of issues being considered to improve standardization of the data disclosed by hospitals.

We now summarize the key areas above with feedback to be considered by hospitals in their comments to the CMS.

3) INCREASING CIVIL MONETARY PENALTIES FOR NONCOMPLIANCE

Summary: The CY20 OPPS Final Rule specified a penalty of up to $300 per day for noncompliance. This amounts to $109,500 for a noncomliant hospital for an entire year. Under the CY22 OPPS Proposed Rule, the minimum penalty remains $300 per day but would apply to small hospitals (bed count of 30 or fewer). For hospitals with more than 30 beds this would include a penalty of $10 per bed per day, maxing out at a daily penalty of $5,500 for hospitals with greater than 550 beds. This means, for a year of noncompliance, hospitals would be subject to a total penalty amount of $109,500 for a small hospital and a maximum penalty of $2,007,500 per hospital with greater than 550 beds.

Proposed Application of CMP Daily Amounts for Hospital Noncompliance for CMPs Assessed in CY 2022 and Subsequent Years

Number of Beds	Penalty Applied Per Day	Total Penalty Amount for full Calendar Year of Noncompliance
30 or less	$300 per hospital	$109,500
31 up to 550	$310 - $5,500 per hospital (number of beds times $10)	$113,500 - $2,007,500 per hospital
>550	$5,500 per hospital	$2,007,500 per hospital

Clearly CMS is doubling down on its enforcement of the letter of the rule. However, this may change, as CMS is seeking comments on alternative or additional criteria that could be used to scale the penalty. Other options include:

- Hospital Revenue
- The nature, scope, severity, and duration of noncompliance
- The hospital's reason for noncompliance

Comment: Cleverley + Associates understands that the CMS is trying to facilitate greater compliance with the transparency requirements, however, as this is only the first year for reporting we believe it's premature to increase CMPs at this time. We know that some hospitals have been delayed in getting information posted but are working toward compliance. We also believe that the CMS audit process with current CMPs may influence more hospitals to comply, as well, as we have seen hospitals that have received letters of noncompliance disclose required information thereafter. This would indicate that the current CMPs are working to encourage compliance without the need to increase. We also feel the significant increase in CMPs proposed is extreme at a time of continued financial and operational challenge with the ongoing pandemic. Should the CMS consider increasing CMPs, we believe the level of increase should be lower than proposed and should likely be phased in over time to allow hospitals to continue to understand how the audit and appeal process could work. The CMS should also specify which exact cost report field would be used for defining bed size if this continues to be considered for a scaled penalty approach. In sum, these requirements and reviews are new to both the CMS and hospitals which is why we believe more evaluation of compliance given the current requirements is necessary before changing the CMP structure is considered.

4) DEEM CERTAIN STATE FORENSIC HOSPITALS AS HAVING MET REQUIREMENTS

Summary: The CMS proposes expanding the list of exempt hospitals to include state forensic facilities. In review of impacted facilities, the CMS has found that such state forensic hospitals have specialized patient populations, are not open to the general public, and the rates for such hospital services are not negotiated. Therefore, they believe these facilities would not need to be subject to the disclosure requirements.

Comment: Cleverley + Associates agrees with the CMS assessment and fully supports this proposed action.

5) ADDRESSING BARRIERS TO ACCESSING THE MACHINE-READABLE FILE

Summary: The CMS has observed that machine-readable files are often difficult to locate on a hospital website and sometimes challenging to download once found. As a result, the CMS is proposing two actions:

1) Seeking comment on the definition of "prominently displayed" that is currently in the rule to describe the machine-readable file's location on the hospital's website. Options the CMS is considering include requiring hospitals to use a CMS-specified URL or standardizing the location of the file from a link on the hospital's homepage.
2) To address the issue of accessibility once located, the CMS is proposing to amend the regulations by specifying "that the hospital must ensure that the standard charge information is easily accessible, without barriers, including, but not limited to, ensuring the information is accessible to automated searches and direct file downloads through a link posted on a publicly available website." The CMS intends this added language to "ensure greater accessibility to the machine-readable file and its contents and would prohibit practices we have encountered in our compliance reviews, such as lack of a link for downloading a single machine readable file, using "blocking codes" or CAPTCHA, and requiring the user to agreement to terms and conditions or submit other information prior to access."

Comment: In our research into hospital compliance, we have experienced the issues the CMS has stated. We do also appreciate the flexibility the CMS has provided in where and how the information is presented on the hospital's website as hospitals design the user experience they believe is best for their community. With this, we have the following comments:

1) "Prominently displayed" feedback – we have advised hospitals to make the file transparency disclosures available within two clicks from the hospital's homepage. We believe this definition would provide clarity to expectations while still permitting the flexibility for the hospital's web communication teams.
2) Proposed accessibility language feedback – we understand the need for direct access to the machine-readable files without barrier. We also understand that some hospitals have created some protections to direct downloads to safeguard the overall web-based hosting environment. Because the size of the machine-readable files can be quite large, repeated attempts to download this file from external sources can put pressure on the hospital's network availability.

While these actions can be mitigated, it does present additional network considerations. We encourage hospital administrators to discuss this proposal with their IT teams and determine how concerns regarding this proposal should be communicated to the CMS given their specific network environment.

6) CLARIFICATIONS AND REQUESTS FOR COMMENT

The CMS has provided clarifications and requests for comment in the following areas:

1) Clarification of the Price Estimator Tool Option and Request for Comment on Considerations for Future Price Estimator Tool Policies

Summary: The CMS has provided an option for hospitals to meet the consumer-friendly display of shoppable services through an online price estimator tool. In 180.60(a)(2), the CMS requires that the tool:

- Provides estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.
- Allows healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.
- Is prominently displayed on the hospital's website and be accessible without charge and without having to register or establish a user account or password.

The CMS is seeking input in the following areas regarding the price estimator tool:

- What best practices should online price estimator tools be expected to incorporate?
- Are there common data elements that should be included in the online price estimator tool to improve functionality and consumer-friendliness?
- What technical barriers exist to providing patients with accurate real-time out-of-pocket estimates using an online price estimator tool? How could such technical barriers be addressed?

What best practices should online price estimator tools be expected to incorporate? Are there common data elements that should be included in the online price estimator tool to improve functionality and consumer-friendliness?

Comment: We believe that online price estimator tools should help patients understand the different ancillary services they may utilize in conjunction with the primary service they are using to conduct their search. This information is required for the static file view that the CMS described in the final rule on transparency and can be included through patient claim analysis. Patients can see the percentage of time other patients have utilized supporting services in their course of care and how those services translated to total claim payment.

In addition, although gross charges are not required, we believe the presentation of this information is helpful to show how charges are adjusted based on contractual agreements to bring the patient a lower payment amount. Patients often see a headline that hospital prices are "high" but are only seeing the

pre-discounted gross charge in the story. A presentation of this information would educate patients and would also connect the contents of the machine-readable file to the consumer shoppable tool. Most often, these gross charges dictate payment in lesser-of, outlier, or carveout provisions which are critical in determining what a typical claim payment would be for the primary service with usual supporting service provision, as well.

What technical barriers exist to providing patients with accurate real-time out-of-pocket estimates using an online price estimator tool? How could such technical barriers be addressed?

Comment: We are concerned about one clarification on the price estimator tool that would involve these technical barriers. The clarification reads:

> To satisfy our requirement at § 180.60(a)(2)(ii), a price estimator tool "[a]llows healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service". Moreover, such a price estimator tool must be "tailored to individuals' circumstances (whether an individual is paying out of pocket or using insurance) and provide real-time individualized out of pocket estimates that combines hospital standard charge information with the individual's benefit information directly from the insurer, or provide the self-pay amount." (84 FR 65578) We emphasize this because our reviews

Our concern is that the highlighted quote doesn't appear in 84 FR 65578. There are two portions of this quote that are contained in separate sections, but this single quote combined with the "tailored" portion in the proposed rule can't be found at 65578. Our main question is that the language above would seem to indicate that this exact quote is referenced on 65578 and is an original requirement of the price estimator. However, the requirement language is, as follows:

We considered the minimum necessary functionality requirements a price estimator tool must embody to satisfy this new policy. As reflected in the comments we received on this topic, we recognize that different hospitals may maintain different types of internet based healthcare cost price estimator tools, and that the market for, and technology behind, these applications is growing. Therefore, we believe it is important to ensure there is flexibility for the data elements, format, location and accessibility of a price estimator tool that would be considered to meet the requirements of 45 CFR 180.60. We believe that the requirements we are establishing in this final rule, for certain minimum data and functionality of a price estimator tool for purposes of meeting the requirements under new 45 CFR 180.60, are a starting point. We appreciate and will consider the commenters' suggestions that we seek stakeholder input for future considerations related to the price estimator tool policies we are finalizing, including to identify best practices, common features, and solutions to overcoming common technical barriers.

Therefore, we are finalizing a modification to our proposed policy to specify in new 45 CFR 180.60(a)(2) that a hospital that maintains an internet based price estimator that meets certain criteria is deemed to have met our requirements at 45 CFR 180.60. The price estimator tool must:
• Allow healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.
• Provide estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.
• Is prominently displayed on the hospital's website and be accessible without charge and without having to register or establish a user account or password.

To be clear, we believe that a price estimator tool would be considered internet-based if it is available on an internet website or through a mobile application. We considered the additional suggestions by commenters related to ensuring that price estimator tools are consumer-friendly. In our review of available online price estimator tools offered by hospitals, we observed that their look and feel are not uniform, so, in this final rule, and so as not to be overly proscriptive or restrict innovation, we are not at this time finalizing a specific definition of a consumer-

friendly format for price estimator tools or any additional criteria. However, we encourage hospitals to take note of current estimator tool best practices and seek to ensure the price estimator tools they offer are maximally consumer-friendly. For example, we encourage, but will not require in this final rule, that hospitals provide appropriate disclaimers in their price estimator tools, including acknowledging the limitation of the estimation and advising the user to consult, as applicable, with his or her health insurer to confirm individual payment responsibilities and remaining deductible balances. Similarly, we encourage, but do not require in this final rule, that hospital pricing tools include: (1) Notification of the availability of financial aid, payment plans, and assistance in enrolling for Medicaid or a state program, (2) an indicator for the quality of care in the healthcare setting, (3) and making the estimates available in languages other than English, such as Spanish and other languages that would meet the needs of the communities and populations the hospital serves. We note that although we decline to be more prescriptive at this time, we may in the future revisit our policy to deem hospital online price estimator tools as having met requirements if we determine such tools are not meeting our goals for making hospital charge information meaningful to consumers. We further note that a hospital that meets the requirements for offering an internet-based price estimator tool would still be required to make public all standard charges for all hospital items and services online in a comprehensive machine-readable format as discussed in section II.E of this final rule and finalized under 45 CFR 180.50.

Our concern is that the clarification section of the proposed rule implies that hospital charges MUST be connected in real-time to an individual's insurance benefit information directly from the insurer for the patient estimation tool to be compliant. However, the transparency rule does not specify this but actually encourages creating a disclaimer about the estimate and advising patients to confirm this estimate with their insurer (see highlighted language above). Creating a real-time link with the insurer adds costs to the hospital to have to query for the patient's plan and deductible position. There are fees associated for each and every query that occurs which can be quite costly considering how many different services a patient could be interested in evaluating in a web session. For this reason, some tools require the patient to enter their year-to-date plan information and then tie that to the specific payment amounts for their insurer. This allows the patient to receive an accurate estimate but does not levy per transaction fees for every web search conducted. We agree with the minimum requirements CMS has in the language but would have significant concern regarding the implications for this quote that we are not able to find in 84 FR 65578. We believe these transaction fees are an impediment to real-time out of pocket estimates for consumers.

2. Request for Comment on the Definition of 'Plain Language'

In our effort to ensure hospital compliance with the use of 'plain language,' we seek public comment on whether we should require specific plain language standards, and, if so, what those plain language standards should be.

Comment: The American Medical Association offers Consumer Friendly Descriptors that can be used, under license, by CPT®. Absent this use, the CMS could create a reference library by HCPCS for hospitals and developers to use. We believe some standard would be useful so that the language would be consistent.

3. Request for Comment on Identifying and Highlighting Hospital Exemplars

Comment: We believe the CMS could begin this process by sharing case studies of hospitals that are achieving levels of transparency desired by the CMS. This case study sharing could be delivered through a Medicare Learning Network email or webinar. Prior to those case studies, we believe two elements could be useful.

First, at these early stages of disclosure development, it could be useful to create a forum to allow practitioners the opportunity to share logistically how they are assembling the information from disparate systems. Because there is some flexibility to assemble the disclosures to meet the compliance requirements, hospital administrators could benefit from learning of different compliant approaches and how the information provided can be assembled, formatted, and shared. Some of this dialogue is

occurring through professional organizations and consulting company webinars, however, to do this collaboratively with the CMS could greatly advance the overall compliance rate among hospitals and to provide more meaningful and standardized information.

Second, we believe the CMS could develop a set of standards or transparency objectives that would allow hospitals to understand how the CMS would be reviewing hospitals for current compliance and anticipated future objectives. These standards might help hospitals understand how to determine next steps in efforts. These standards could even result from the forums outlined in the first point. We believe collaboration among government and private stakeholders could help the dissemination of relevant information to patients within a framework of current and future environmental conditions.

4. Request for Comment on Improving Standardization of the Machine-Readable File

Summary: In the CY 2020 Hospital Price Transparency final rule, the CMS expressed "concern that lack of uniformity in the way that hospitals display their standard charges leaves the public unable to meaningfully use, understand, and compare standard charge information across hospitals (84 FR 65556)." While certain data elements were required, an exact file structure is not specifically prescribed. The CMS is now revisiting this to seek comment if and how greater standardization should be considered with the following points:

- What is the best practice for formatting data such as hospital standard charge data? Is there a specific data format that should be required to be used across all hospitals? Are there any barriers to requiring a specific format to be used by all hospitals when displaying standard charge information?
- Are there additional data elements that should be required for inclusion in the future in order to ensure standard charge data is comparable across hospitals? What one(s)? Is such data readily found in hospital systems? In what ways would inclusion of such data impact hospital burden?
- Are there any specific examples of hospital disclosures that represent best practice for meeting the requirements and goals of the CY 2020 Hospital Price Transparency final rule? We invite submissions of links to machine-readable files that the public would consider to represent a best practice.
- What other policies or incentives should CMS consider to improve standardization and comparability of these disclosures?
- What other policies should CMS consider to ensure the data posted by hospitals is accurate and complete, for example, ensuring that hospitals post all payer-specific negotiated charges for all payers and plans with which the hospital has a contract, as required by the regulations?

Comment: We agree with the CMS that there is not currently a way to meaningfully connect hospital machine-readable files as the file structure and specific data contents are not specifically prescribed. In our research, we have found four primary obstacles to creating a national database for hospital information that can be utilized for creating tools and resources for interested stakeholders to utilize. The four challenges and suggested solutions are, as follows:

1) **CHALLENGE: Presence/Updates of information:** the first challenge is locating and downloading files as some have forgotten to utilize the CMS required naming convention.
   SOLUTION: we believe file access should improve once hospitals utilize the required CMS naming convention for the machine-readable file. We have also advised that the definition of "prominently displayed" should be considered within two clicks from the

hospital or health system home page.

2) **CHALLENGE: File Type & Layout Differences:** standardizing the input files, once obtained, presents challenges as the file types (txt, xml, JSON, xlsx, etc.) and layouts (worksheets, columns, rows, etc.) vary significantly.

   SOLUTION: we believe requiring the same file type and standardizing the file structure and defining the data elements will permit the creation of a national database. We propose a structure after challenge #4 below.

3) **Relational Differences:** hospitals have decided to report payer specific negotiated charges in a variety of ways: HCPCS, MSDRG, APC, per diems, case rates, charge codes. These different displays reflect the vastly different ways hospitals have structured their contracted rates and terms with payers. Beyond this, there are differences in what these elements represent (MSDRG base rate versus all charges, as example).

   SOLUTION: we believe creating a standardized display for payer-specific negotiated charges is the only way to determine payment differences. We describe a method that is supported from the current transparency rule after challenge #4 below.

4) **Payer Naming Differences:** categorizing payers into appropriate comparison buckets presents challenges as there are no standard naming conventions.

   SOLUTION: we believe items 2-4 above can be addressed by creating a uniform structure for reporting the required data in the following ways:

PROPOSED STANDARDIZED SINGLE MACHINE READABLE FILE

In a December 2019 CMS MLN call, it was stated that the single machine-readable file could have different sections (worksheets, tabs, etc.) but needed to contain all required elements. We propose having each section of required information separately defined to allow for uniform reporting and file consistency. We describe the sections below:

SECTION ONE: GROSS CHARGE INFORMATION – there is little confusion with how to extract and display the "GROSS CHARGE" information among hospitals. We propose six fields, as illustrated below in the "Gross Charge Display Example." The primary comparison link for gross charges is CPT®/HCPCS, however, revenue codes can also be compared on a more manual basis through item descriptions, as well (useful for room rates and operating room associated codes, as primary examples).

SECTION ONE: GROSS CHARGE DISPLAY EXAMPLE

Item Code	Description	Revenue Code	CPT®/ HCPCS	Modifier	Default Gross Charge	Additional Gross Charge Columns for Patient Type or Site of Service Differentials
1234567	LEVEL 1 EMERGENCY CARE	450	99281		350.00	N/A
1234568	LEVEL 2 EMERGENCY CARE	450	99282		550.00	N/A
1234569	LEVEL 3 EMERGENCY CARE	450	99283		950.00	N/A
1234570	LEVEL 4 EMERGENCY CARE	450	99284		1,250.00	N/A
1234571	LEVEL 5 EMERGENCY CARE	450	99285		2,500.00	N/A

SECTION TWO: DISCOUNT CASH PRICE INFORMATION – not all hospitals have established their cash pay policies and prices in the same way. Some do not have these rates established at all, some have plans established to assist certain patients in varying financial classes or under certain circumstances, and others have established prices by code for any patient. In order to account for this variation while still permitting standardized reporting, we believe the "Discount cash price" section should have two options. These two options would capture text fields for those that have more "policy" driven structures and alpha-numeric fields for those that have established price lists. The two options are, as follows:

- **Option One: POLICY** – this would be a text field for an explanation of the hospital's discount cash price policy, how it is applied, and contact information for financial assistance. This approach would allow hospitals without a single price list to still be able to communicate important information and resources for prospective cash pay patients.
- **Option Two: PRICE LIST** – for those hospitals with an established price list, information could be displayed in the same format as the Gross Charge display.

SECTION TWO: DISCOUNT CASH PRICE DISPLAY EXAMPLE – POLICY

Discount Cash Price Policy
Self-pay cash price discount is 30% of charge for all patients regardless of income level. The hospital also provides 100% charge reduction for patients between 0-200% federal poverty level and 50% discounting for patients between 201-400% of federal poverty level. To understand discount cash pricing or to speak with a financial counselor, please contact 555-555-5555.

SECTION TWO: DISCOUNT CASH PRICE DISPLAY EXAMPLE – PRICE LIST

Item Code	Description	Revenue Code	CPT®/ HCPCS	Modifier	Discount Cash Price	Note
1234567	LEVEL 1 EMERGENCY CARE	450	99281		245.00	N/A
1234568	LEVEL 2 EMERGENCY CARE	450	99282		385.00	N/A
1234569	LEVEL 3 EMERGENCY CARE	450	99283		665.00	N/A
1234570	LEVEL 4 EMERGENCY CARE	450	99284		875.00	N/A
1234571	LEVEL 5 EMERGENCY CARE	450	99285		1,750.00	N/A

SECTION THREE: PAYER-SPECIFIC NEGOTIATED CHARGE – this is clearly the area that contributes to the lack of consistency and comparability within the files. The central reason for this is that there is an incredible amount of variability in how hospitals structure their contracted rates and terms with payers. Beyond this, there is a huge issue in mapping payers and plans from one hospital to those at another. Until there is standardization with these two areas there cannot be utility with this information. We believe there are three primary ways to address these issues:

1) STANDARDIZED PAYMENT – quite simply, unless all payers utilized the exact same payment methodologies there cannot be a way to evaluate payment differences. We cannot know how a per diem rate at one hospital compares with a MSDRG-based or percent-of-charge structure at another. Further, these contracts are typically much more complex and involve payment carveouts for certain areas, conditional hierarchies, outlier provisions, and charge lesser-of language, to name several key elements. In all cases, patient utilization is also essential to understanding payment. Higher resource intensity at one hospital with lower payment rates can lead to higher overall payment per patient encounter than a hospital with higher payment rates but lower resource intensity. Standardized payment rates and utilization must be considered in order to understand payment differences.

A standardized payer specific negotiated charge can be determined based on current resources and supported by current language from CY 2020 OPPS Final Rule on Transparency (CMS-1717-F2). The CMS has established payment systems for inpatient and outpatient claims that are utilized by all hospitals subject to the transparency reporting requirements. The solution to standardizing disparate payment systems is for hospitals to determine how the claim would be paid using the specific payer negotiated contractual language and then reported under Medicare-based grouping logic by MS-DRG (inpatient) or primary APC (outpatient). The steps to do this, are:

i. Derive expected claim payment for all items and services based by consulting the negotiated rates and terms with the specific payers. This would be done for all claims – not using historical reimbursement – but a calculation of payment using current payment terms and rates.
ii. Determine the MS-DRG (inpatient) or primary APC (outpatient) assignment for the particular patient claim. Grouper logic is quite common for hospitals and many already run every claim through Medicare logic to determine a MS-DRG assignment. Each claim would be labeled with a MS-DRG or primary APC designation (more on outpatient grouping later).
iii. Report the standardized payer specific negotiated charge by MS-DRG or APC for all required payers in a simple format illustrated below. This display would encompass all items and services and service packages and would also be representative of service utilization – the critical element needed to understand payment differences.

Support from CMS-1717-F2 – 65569

In this method, the hospital would "consult their rate sheets or rate tables within which the payer-specific negotiated charges are often found" – and – "display the individualized items and services and service packages for a specific payer's plan based on the rate sheet derived from the hospital's contract with the payer."

In practice, the hospital would derive the payer specific negotiated charge by consulting their contracted rate sheets and terms and applying those to actual patient claims for the specific third-party payer. The display of this data would be in a unified inpatient and outpatient format and would allow "all items and services and service packages" to be displayed. Other potential formats would not be able to do this as patient utilization is essential in understanding payment. Without patient claim detail the hospital cannot satisfy the requirements of the rule because the number of combinations of items, services, and service packages is nearly limitless on a per patient basis. An expected derivation of service utilization is critical. This methodology provides the following benefits to fulfill the "payer specific negotiated charge" display requirement:

- Better understanding of total encounter payment as payment is most often related to actual service utilization – even in fixed fee arrangements
- All hospital items and services to be covered – including drugs and supplies
- Permits meaningful payment comparisons across payers and hospitals
- Custom contract definitions, payment hierarchies, and outlier/lesser-of status to be factored into payment calculations – these terms, conditions, and rates

involve criteria conditioning unique to individual payment encounters that must be "derived" to present relevant information
- In keeping with the rule's language, as well as the intent to provide meaningful information to patients

Alternative Views

We believe this methodology solves issues that other alternative formats present. We briefly summarize other "standardized" formats for payer specific negotiated charges and inherent challenges in those views:

Detailed Rate/Term View: the CMS could request that each term and rate be provided for each payer in a consistent way (a field for percent of charge discount, per diem amount, base rate, etc.) – however – each of these fields (for which there would be an incredible amount – typical contracts have pages of terms, definitions, and rates) would then need to be further defined (does the discount of charges apply to all charges or only for certain codes, is the per diem medical, surgical, etc., what DRG version is being used and what are the weights). This information – even provided perfectly across all hospitals (again, not feasible given the vast variation) would then need to be applied to patient claim detail to create a payment comparison. As an example, payment would need to be calculated using patient claim detail in order to understand if hospital A (with percent of charge) had higher or lower payment than hospital B (with per diem rates). The methodology we propose does the very thing that would be necessary to understand these differences and does not overly burden the hospital to extract an immense amount of contract detail and benefits researchers and tool developers as the math for expected payment has already been calculated and presented consistently.

Other Derived Views: the CMS could utilize the methodology we've described but try to attribute payment to individual lines on patient claims and have reporting occur in a view similar to the Gross Charge Display. The primary challenge to this – and we recognize that some are promoting this – is that payment is not at a line level – it occurs at a claim level. So, these derived amounts would need to be applied to patient claim detail to determine relative payment positions. Again, the utilization of services on a patient claim is critical and these "line-level derivations" do not address that. Payment is made at the claim level by payers and should be presented that way.

A NOTE ABOUT THE OUTPATIENT GROUPING

The MS-DRG grouping is one that is very intuitive for most in our industry and an MS-DRG assignment is common for claims processing/grouping. The primary APC assignment is straight-forward but less utilized. Essentially, the primary APC would be the highest weighted CPT®/HCPCS code on the patient claim using the APC payment methodology. So, in the example above, if the 99283 code was highest weighted on the patient claim then that claim would be grouped/assigned to APC 5023 "Level 3 Type A ED Visits." All other services on the claim (lab, imaging, etc.) would be considered secondary to the primary reason why the patient was at the hospital – for a level three ED visit. While MS-DRG groupers are quite common for hospitals, this type of outpatient assignment should be intuitive and accessible given

Medicare payment methodologies.

If the CMS is hoping to create a way to evaluate payment differences, then two things are essential: 1) disparate payment methodologies must be presented in a standardized way and 2) utilization differences must be taken into account. Our proposed methodology does both and is supported by language from CMS-1717-F2.

2) STANDARDIZED PAYER MAPPING

Once payment has been standardized using the methodology described above, payers must be able to be compared through a common mapping. We believe the CMS could create a list of common national/regional payers that the hospital would link to in the disclosure file. This "National Payer Map" could be for the top twenty or thirty payers that would allow some mechanism to create comparisons and would likely cover a significant number of US hospital payment. Beyond this, the CMS could have a "plan map" that would list common types of plan structures (PPO, HMO, ALL, OTHER, etc.) to provide for the appropriate payer/plan linkages.

Examples of the "CMS National Payer Map" and "CMS National Plan Map" can be seen below in the Section Three example.

3) STANDARDIZED REPORTING STRUCTURE

Finally, this information could be presented in a simple, standardized format as illustrated below:

SECTION THREE: PAYER SPECIFIC NEGOTIATED CHARGE DISPLAY EXAMPLE – INPATIENT

MS-DRG	Description	Hospital Payer Name	CMS National Payer Map	CMS National Plan Map	Payer Specific Negotiated Charge
807	Vaginal Delivery Without Sterilization Or D&C Without Cc/Mcc	Blue Cross PPO	Blue Cross	PPO	9,530
807	Vaginal Delivery Without Sterilization Or D&C Without Cc/Mcc	Cigna PPO	Cigna	PPO	9,880
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity Without Mcc	Blue Cross PPO	Blue Cross	PPO	30,200
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity Without Mcc	Cigna PPO	Cigna	PPO	33,135

SECTION THREE: PAYER SPECIFIC NEGOTIATED CHARGE DISPLAY EXAMPLE – OUTPATIENT

APC	Description	Hospital Payer Name	CMS National Payer Map	CMS National Plan Map	Payer Specific Negotiated Charge
5023	Level 3 Type A ED Visits	Blue Cross PPO	Blue Cross	PPO	934
5023	Level 3 Type A ED Visits	Cigna PPO	Cigna	PPO	1,120
5102	Level 2 Strapping and Cast Application	Blue Cross PPO	Blue Cross	PPO	947
5102	Level 2 Strapping and Cast Application	Cigna PPO	Cigna	PPO	864

SECTION FOUR: DEIDENTIFIED MINIMUM/MAXIMUM PAYER-SPECIFIC NEGOTIATED CHARGE – The benefit of using the structure identified in Section Three is that minimum/maximum values are very easy to present – and – to some extent become irrelevant given the standardized

MSDRG and primary APC reporting. A researcher could easily calculate minimum, maximum, and other statistical measures based on the standardized data format presented. Still, this information could be compiled, as follows:

SECTION FOUR: DEIDENTIFIED MINIMUM/MAXIMUM CHARGE DISPLAY EXAMPLE

MS-DRG/ APC	Description	Deidentified Minimum Charge	Deidentified Maximum Charge
807	Vaginal Delivery Without Sterilization Or D&C Without Cc/Mcc	8,200	12,775
5023	Level 3 Type A ED Visits	575	1,345

We believe that if the CMS seeks to standardize the Machine Readable File it should do so in a way that will meet current requirements while providing meaningful information. The structure we have proposed addresses these requirements and solves for the challenges that stakeholders are experiencing with current disclosed data.

7) FINAL THOUGHTS

We certainly support reasonable efforts to continue to help patients understand the financial implications of their care. However, we continue to be concerned that much of this additional disclosure information will go unutilized by patients. The CMS has held that this information will lead to reduced costs. However, it is interesting to note that one of the referenced sources in their rulemaking (Desai S, Hatfield LA, Hicks AL, et al. Association Between Availability of a Price Transparency Tool and Outpatient Spending. JAMA. 2016;315(17):1874-1881. Available at: https://jamanetwork.com/journals/jama/fullarticle/2518264) concludes the opposite, finding:

In this analysis, offering a health care services price transparency tool to employees was not associated with lower outpatient spending. This was also true in subanalyses focused on employees with higher health plan deductibles and those with comorbidities at baseline. Furthermore, those offered the price transparency tool did not shift their care from higher-priced HOPD settings to lower-priced ambulatory settings.

The same article also runs counter to other "benefits" the CMS believes will occur with increased reporting of the requirements:

A series of factors may underlie the lack of a negative association between offering the price transparency tool and outpatient spending. First, despite selecting 2 employers with the highest uptake and substantial marketing from the employers, use of the tool was relatively low, with only 10% of employees logging on in the first year of its introduction. Such low use rates have been reported for other price transparency tools. Moreover, low utilization is the most commonly reported challenge to price transparency initiatives by insurers who offer tools. Patients may not find the information compelling or may simply forget about the tool if they seek health care infrequently.

Second, there may be limited opportunities for patients to save money via the tool. Price shopping is most useful for care that is nonemergent and of lower cost, and there may be a limited set of services that meet those criteria. A recent report found that only 40% of spending is attributable to shoppable services. In this study, a substantial fraction of searches were for services whose prices exceeded the employee's deductible, so that out-of-pocket amounts would be the same regardless of which clinician or hospital was chosen. Also, approximately half of employees met their deductible within the year.

After reaching their deductible, patients may have little incentive to price shop. Third, a common service through which patients could benefit from price shopping is clinician office visits. However, many patients have established relationships with their clinicians that they may wish to maintain regardless of price.

We hope that this information has been useful to summarize the proposed changes to the transparency requirements and comments for future requirements. Given these concerns, we highly encourage hospitals to submit feedback to the CMS within the comment window which ends on September 17, 2021 at 5pm EDT.

RESPONDING TO THE CMS

The following information provides direction from the OPPS proposed rule for commenting:

DATES: Comment Period: To be assured consideration, comments on this proposed rule must be received at one of the addresses provided in the ADDRESSES section **no later than 5 p.m. EST on September 17, 2021.**

ADDRESSES: In commenting, please refer to file code CMS-1753-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1) Electronically. You may (and we encourage you to) submit electronic comments on this regulation to http://www.regulations.gov. Follow the instructions under the "Submit a comment" tab.

   ***Search for CMS-1753-P and select "Comment" from search results*

2) By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1753-P, P.O. Box 8010, Baltimore, MD 21244-1850.

   Please allow sufficient time for mailed comments to be received before the close of the comment period.

3) By express or overnight mail. You may send written comments via express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1753-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

   b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.