hfma

healthcare financial management association

September 21, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: 1678-P
P.O. Box 8013
Baltimore, MD 21244-1850

File Code: CMS–1695-P

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

Dear Ms. Verma:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model (hereafter referred to as the Proposed Rule) published in the *Federal Register* on July 31, 2018.

HFMA is a professional organization of more than 38,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

HFMA would like to thank CMS for the opportunity to comment on its analysis and discussion of the Medicare reimbursement decisions addressed in the 2019 Proposed Rule. Our members would like to comment on the proposals related to:

- Proposal to Apply the 340B Drug Payment Policy to Non-excepted Off-Campus Departments of a Hospital
- Comment Solicitation on Method to Control Unnecessary Increases in the Volume of Outpatient Services
- Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information

Below please find specific comments on the items listed above.

Proposal to Apply the 340B Drug Payment Policy to Non-excepted Off-Campus Departments of a Hospital

In the CY 2018 OPPS/ASC final rule with comment period, CMS finalized their proposal that separately payable, covered outpatient drugs and biologicals (other than drugs on pass-through payment status and vaccines) acquired under the 340B Program will be paid ASP minus 22.5 percent, rather than ASP plus 6 percent, when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment. CAHs are not subject to this 340B policy change because they are paid under section 1834(g) of the Act. Rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals are excepted from the alternative payment methodology for 340B-acquired drugs and biologicals. In addition, as stated in the CY 2018 OPPS/ASC final rule with comment period, this policy change does not apply to drugs with pass-through payment status, which are required to be paid based on the ASP methodology, or to vaccines, which are excluded from the 340B Program.

CMS cites various reasons for this that include:

- Medicare expenditures on Part B drugs are rising due to underlying factors such as growth of the 340B program, higher-price drugs, or price increases for drugs.
- CMS's belief that changes to its current Medicare Part B drug payment methodology for 340B hospitals would better, and more appropriately, reflect the resources and acquisition costs that these hospitals incur.
- Beneficiaries should not be liable for a copayment rate that is tied to the current methodology of ASP+6 percent when the actual cost to the hospital to purchase the drug is much lower than the ASP for the drug.

CMS is proposing to extend that policy to hospital outpatient departments subject to section 603. to reimburse separately payable Part B drugs acquired under the 340B program at Average Sales Price (ASP)-22 percent.

HFMA members strongly oppose this proposal. As discussed in our 2018 OPPS comment letter (to view the letter dated September 11, 2017, go to HFMA Comments on the CY18 OPPS/ASC Proposed Rule), we do not believe that this policy will address the underlying issues that drive both increased Part B spending for the program nor its beneficiaries. Further, we believe that if finalized, this policy will cause additional harm to safety net hospitals and the communities they serve.

Comment Solicitation on Method to Control Unnecessary Increases in the Volume of Outpatient Services

CMS is also soliciting public comments on how to maintain access to new innovations while controlling for unnecessary increases in the volume of covered hospital OPD services. In addition, it is soliciting public comments on how to expand the application of the Secretary's statutory authority under section 1833(t)(2)(F) of the Act to additional items and services paid under the OPPS that may represent unnecessary increases in OPD utilization. Therefore, it is seeking public comment on the following:

Should prior authorization be considered as a method for controlling overutilization of services?

While prior authorization is a method for controlling overutilization of services, it often leads to additional administrative burden and the overall cost of care. We support administrative simplification and with that in mind would not support additional prior authorization criteria or process that inhibit patient access and/or increase the burden for providers.

For what reasons might it ever be appropriate to pay a higher OPPS rate for services that can be performed in lower cost settings?

There are reasons that it would be appropriate to pay a higher OPPS rate for services that can be performed in lower cost settings such as patient experience, efficiency and quality that impact the care decision. Quality issues such as access, safety, outcome, and other patient factors that also warrant a higher payment The physical location and logistical aspects of an episode of care may lead to a provider to perform for a specific service (i.e. imaging, lab testing) in a higher cost setting, in an effort to improve the patient experience, expedite treatment or utilize available resources. Additionally, no purchase decisions are made solely on price/payment without the context of quality so these are other factors to consider.

Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information

CMS posed the following questions to which we have responded below:

How should we define ''standard charges'' in various provider and supplier settings? Is there one definition for those settings that maintain chargemasters, and potentially a different definition for those settings that do not maintain chargemasters?

Should ''standard charges'' be defined to mean: Average or median rates for the items on a chargemaster or other price list or charge list; average or median rates for groups of items and/or services commonly billed together, as determined by the provider or supplier based on its billing patterns; or the average discount off the chargemaster, price list or charge list amount across all payers, either for each separately enumerated item or for groups of services commonly billed together? Should ''standard charges'' be defined and reported for both some measure of the average contracted rate and the chargemaster, price list or charge list? Or is the best measure of a provider's or supplier's standard charges its chargemaster, price list or charge list?

Information on charges or on average or "standard charges" is of limited value to consumers, as it will likely be significantly different from the amount they will be expected to pay. Chargemaster prices serve only as a starting point; adjustments to these prices are routinely made for contractual discounts that are negotiated with or set by third-party payers. Few patients pay the chargemaster price. Information on the average amount *paid* for services is somewhat more useful to consumers, but it still falls short. The price information that is most useful to consumers is an estimate of their individualized out-of-pocket responsibility for the specific service(s) they seek as noted above.

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

HFMA believes that charges are not sufficiently helpful for the patient. The price information that is most beneficial and useful to consumers is an estimate of their individualized out-of-pocket responsibility for the specific service(s) they seek. For insured patients, this amount is contingent on their health plan benefit design, including coinsurance and copayments, and the amount of deductible remaining to be met. Uninsured patients may seek information about the cash price when (a) they are uninsured (b) they are covered by high-deductible health plans (HDHPs), or (c) they are seeking care with an out-of-network provider.

Price transparency for the uninsured is subject to a substantial and growing number of laws at both the federal and state levels. It is the first responsibility of providers to ensure that policies and practices adhere to these legal requirements.

Insured patients may obtain an individualized price estimate from their health plan. Estimates are based on CPT codes, which must be obtained from a patient's physician or other care provider. Resources on the estimate-request process are available to consumers, including HFMA's *Understanding Healthcare Prices: A Consumer Guide*, which is available at no charge to any healthcare organization for posting online in the patient financial services section of their websites.
In addition, many hospitals and health systems post price information for common procedures online, and/or make this information available by phone.

Beyond that, HFMA's *Patient Financial Communications Best Practices* stipulate that providers should inform uninsured patients that they will review insurance eligibility with them to identify payment solutions or financial assistance options that may help them with their financial obligations for the care received. If appropriate, the patient should be referred to a financial counselor and/or offered information about the provider's financial counseling and assistance policies and programs. Financial assistance may take the form of free or discounted care, depending on an individual patient's circumstances, along with organizational policies.

For those patients who are not eligible or choose not to apply for financial assistance, and who are able to pay cash at the time of service, many organizations offer a discount. The cash discount may be posted on the organization's website or communicated by telephone or in person, upon request. In recent years, some hospitals offer uninsured patients or patients with high-deductible health plans (HDHP), an option to pay for common tests and procedures in full at the time of service in exchange for sharply discounted prices.

If a patient seeks care from an out-of-network provider (based, for example, on that provider's reputation) and contacts the health plan for assistance, the health plan should clearly explain what percentage (if any) of out-of-network provider charges the plan will cover, and describe any other significant out-of-network benefit plan issues (e.g., a "reasonable and customary rate of reimbursement" limit on what the health plan will pay). The health plan should also inform the patient that—if the patient intentionally seeks care from an out-of-network provider—it is the patient's responsibility to independently obtain price information from that provider. Provider policies vary on whether to offer a self-pay or cash discount to these patients.

Should health care providers be required to inform patients how much their out-of- pocket costs for a service will be before those patients are furnished that service? How can information on out-of-pocket costs be provided to better support patients' choice and decision-making? What changes would be needed to support greater transparency around patient obligations for their out-of-pocket costs? How can CMS help beneficiaries to better understand how co-pays and coinsurance are applied to each service? What can be done to better inform patients of their financial obligations? Should providers and suppliers of healthcare services play any role in helping to inform patients of what their out-of-pocket obligations will be?

HFMA believes that patients should receive information about their out-of-pocket costs for a service before the service is furnished, though as stated previously, we believe for insured patients, the health plan is best positioned to provide that information. For uninsured patients, the provider—i.e., the entity, organization, or individual that furnishes a healthcare service—should be the principal source of price information for uninsured patients or patients who are seeking care from the provider on an out-of-network basis.

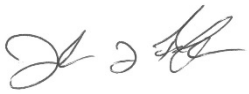
Can we require providers and suppliers to provide patients with information on what Medicare pays for a particular service performed by that provider or supplier? If so, what changes would need to be made by providers and suppliers? What burden would be added as a result of such a requirement?

Similar to "standard charges" the Medicare payment information for a particular purpose would not be useful for patients as Medicare payments vary from provider to provider depending on a multitude of factors. Additionally, those non-Medicare beneficiaries would not see this information as relevant for their purposes. So, providing this information would likely be more confusing than useful.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the 2019 OPPS. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, and advisory groups.

We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 38,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.