



healthcare financial management association

May 23, 2019

Don Rucker, M.D.  
National Coordinator for Health Information Technology  
Department of Health and Human Services  
Office of the National Coordinator for Health Information Technology  
Attention: 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program Proposed Rule  
Mary E. Switzer Building  
Mail Stop: 7033A  
330 C Street, S.W., Washington, D.C. 20201

Re: RIN 0955-AA01

Dear Dr. Rucker:

On behalf of the Healthcare Financial Management Association's (HFMA's) 40,000 members, I would like to commend you and your team for the thoughtful questions related to price transparency put forward in the proposed "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" rule. HFMA is the nation's leading membership organization for healthcare financial management professionals. As an organization, we are committed to helping our members improve the management of and compliance with the numerous rules and regulations that govern the industry. 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's members are strong supporters of price transparency. We believe that increased price transparency will support informed patient choice, improve the patient financial experience of care and reduce the total cost of care. To advance the cause of price transparency we have convened multiple cross-industry taskforces (consisting of consumers/patients, health plans, hospitals and physicians) which have resulted in the following whitepapers and industry best practices:

- Price Transparency Task Force report<sup>1,2</sup>
- Understanding Healthcare Prices: A Consumer Guide<sup>3</sup>
- Patient Financial Communications Best Practices<sup>4</sup>
- Avoiding Surprises in Your Medical Bills: A Guide<sup>5</sup> for Consumers.

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<sup>1</sup> "Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force," HFMA, 2014.

<sup>2</sup> Includes industry consensus principles for price transparency (Appendix I) and best practices for health plans, hospitals, and physicians

<sup>3</sup> "Understanding Healthcare Prices: A Consumer Guide," HFMA, 2015.

<sup>4</sup> "Patient Financial Communications Best Practices," HFMA, 2016.

<sup>5</sup> "Avoiding Surprises in Your Medical Bills: A Guide for Consumers," HFMA, 2018.

We have encouraged the adoption of these best practices through a variety of programs including our Patient Financial Communications Adopter recognition program and making compliance with certain best practices a prerequisite to apply for HFMA's revenue cycle high performance award (MAP Award).

We believe this work, coupled with our members' roles in the healthcare financing system, provides us with unique perspective that is crucial for furthering price transparency in a way that improves patient/consumer choice and results in higher value care. It is this perspective we share with you in comments related to providing price estimates for insured and uninsured patients, giving price estimates in a timely manner, disclosing privately negotiated rates publicly and empowering clinicians with price information.

**Price Estimates for Insured Patients:** For insured patients receiving in-network services, the patient's health plan is the most appropriate source of price information related to the service(s). Health plans will, in most instances, have the most up-to-date data related to the patient's annual deductible and other cost sharing requirements. This allows for the most accurate estimate of the patient's out-of-pocket responsibility. The plan can either provide the information directly to the patient, through a patient portal for example, or the provider can partner with the plan to provide the information described below. UC Health in Denver, Colorado<sup>6</sup> is one example of a health system that has partnered with multiple health plans to provide its patients with real-time price estimates.

Any price estimate provided should include the following four items to allow a patient to make a value-based decision about where to receive care.

- 1) **Total estimated price of the service:** This is the dollar amount for which the patient is responsible (deductible, coinsurance, co-payment) plus the amount that will be paid by the health plan or, for self-funded plans, the employer. This should be provided at the unit level for which payment will be calculated for the specific, anticipated service. For example, if the patient is seeking an estimate from their health plan for a joint replacement surgery paid on a fee-for-service basis, then the amount paid by the employer/health plan and patient cost sharing should be detailed for each typical component of the service (e.g., the hospital (surgery), orthopedic surgeon, physical therapist, etc. Alternatively, if the plan/employer is paying for the service on the basis of a bundle, then the estimate should detail the payment from the plan and the patient's related cost sharing at the level of the bundle. In both scenarios, anything that is typically required for the episode of care, but not included in the estimate, should be called out so that the member is aware of this additional anticipated expense. The amount will necessarily be an estimate for several reasons. First, the patient may require additional services not included in the estimate. Second, the physician may code and bill for a service different from the service for which the patient sought an estimate. To address these issues, best practice typically involves displaying the total cost of care for the episode as a range with the median cost identified, as opposed to providing the patient with a singular estimate.
- 2) **Network status:** The information provided should give a clear indication of whether a particular provider is in network. It should also offer details on where the patient can try to locate an in-network provider, such as a list of in-network providers that offer the service. Finally, information on the benefit structure for out-of-network services should be included to help the patient/member determine their cost sharing responsibility if they elect to receive care from an out-of-network provider. If an estimate for an insured patient is provided by the hospital, the hospital should clearly indicate if anyone involved in the care is an out of network provider.

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<sup>6</sup> <https://www.uchealth.org/billing-and-pricing-information/>

- 3) **Out-of-pocket responsibility:** Another essential element is a clear statement of the patient's estimated out-of-pocket payment responsibility, tied to the specifics of the patient's health plan benefit design, including coinsurance and the amount of deductible remaining to be met (as close to real time as possible).
- 4) **Quality and Other Relevant Information:** Information related to the provider or the specific service sought (e.g., clinical outcomes, patient safety or satisfaction scores) should be included where it is available and applicable. This information should clearly communicate what has been measured and to whom the measurement pertains (e.g., to the facility, the physician, etc.).

**Price Estimates for Uninsured Patients:** For patients who are uninsured or elect to seek care out of network, the provider is the most appropriate source of price information. Similar to insured patients, the estimate should be provided at the most appropriate level of service based on whether the provider is offering a service bundle (e.g., includes the hospital, hospitalist and surgeon costs for a joint replacement) or just a component of the necessary care (e.g., providing only an estimate of costs related to the hospital component of the knee replacement surgery). There are several basic considerations that should be communicated when price estimates are provided to uninsured patients or patients receiving care out of network.

- 1) **Identify the estimate's limitations:** Prices in most instances will take the form of an estimate; that is, provide a price for a standard procedure without complications. The estimate should make clear to the patient the services included in the price and how complications or other unforeseen circumstances may increase the price.
- 2) **Identify inclusions and exclusions:** Providers should clearly communicate to patients what services are and are not included in a price estimate. If any services that would have significant price implications for the patient are not included in the price estimate, the provider should try to provide information on where the patient could obtain this information. As an example, this would include providing the contact information for an anesthesiologist who will be involved in a surgical case.
- 3) **Quality and Other Relevant Information:** Providers should give patients other relevant information, where available. Some states have begun to make both price and quality data available on public websites. A number of public and private organizations also offer public access to data on patient outcomes, safety and patient satisfaction or credentialing information on providers who have met certain quality benchmarks. The price estimate that a provider gives to patients can reference and provide links to various reliable websites where the provider knows relevant information is available.

**Giving Price Estimates in a Timely Manner:** The timing of price estimates for insured and uninsured patients will vary based on the nature of the service. For elective procedures and services, HFMA's members believe that a patient should be able to access price estimates for common services (e.g., MS-DRGs and APCs with more than 100 cases) within three days of receiving a request for an estimate. For lower volume procedures that may require a more extensive review of historical data, those estimates should be available prior to delivery of the service, assuming it was scheduled at least a week in advance (or within a timeframe that complies with state law, where applicable).

For unscheduled services, an estimate will be provided too late to give the patient sufficient information to choose his or her provider. Additionally, the Emergency Medical Treatment and Active Labor Act (EMTALA) and state law (where applicable) govern the timing of any discussion related to payment for

medical care. In general, these conversations should not occur before the patient is screened and stabilized. These conversations can take place once this has occurred. However, a provider's ability to arrive at a reasonably accurate estimate (or give the patient sufficient information to get an estimate from their health plan) will vary based on the complexity of their medical condition and the frequency with which the facility or health plan provides care/coverage for that condition. Therefore, we do not believe the ONC should mandate the provision of a price estimate for services provided on an unscheduled basis. Given that it is in providers' best interest to communicate to patients what they owe to facilitate the collection of the patient's cost sharing, these estimates are frequently provided at discharge.

**Disclosing Privately Negotiated Rates Publicly:** HFMA does not believe the ONC has the authority to require the public posting of privately negotiated rates between health plans and healthcare providers. The proposed rule's definition of Electronic Health Information (EHI, included in Appendix II) focuses on the individual nature of EHI repeatedly. Specifically, the proposed rule's definition (emphasis added) states:

"We propose to define EHI to mean: (ii) any other information that – **identifies the individual**, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual;"

"We propose that EHI does not include health information that **is de-identified** consistent with the requirements of 45 CFR 164.514(b)."

As a result of this definitional focus on the individual, HFMA's members believe the ONC is barred from requiring the public disclosure of commercial health plan rates negotiated between health plans and providers for both uninsured and insured patients.

Commercially negotiated rates are not specific to uninsured patients. Therefore, they cannot be used to identify the individual. As discussed above, the price (rate) that is individually identifiable for an uninsured patient will be for the specific provider from whom they receive services. Beyond getting a specific price estimate from a hospital or physician practice, a conversation with the provider's financial counselor will help the patient/consumer understand what their actual out-of-pocket payment will be, based on their eligibility for financial assistance and other discounts. The price, post-discount, is what is most applicable and meaningful to an individual patient – not a rate from a commercial payer who is not providing them with coverage.

For privately insured individuals, the specific rate that applies to the patient will not be truly known until the service is performed and the claim is billed. However as noted above, estimates of out of pocket estimates are a reasonable expectation. Additionally, this is not the rate that is most relevant to commercially insured patients. What matters most to commercially insured individuals is their specific out-of-pocket spending, which will be predicated on multiple factors, including their health plan's benefit design and the patient/member's utilization in the plan year, as it will impact their deductible. HFMA's members believe the most appropriate source of information for commercially insured patients/members is their health plan because it will have the necessary data to provide the most accurate, relevant estimate. Also, health plans can (and in many cases do) provide the patient/member with comparative estimates based on the prices of multiple in-network providers who offer the service in a given geographic area.

**Empowering Clinicians with Price Information:** HFMA's members believe clinicians who refer patients for diagnostic testing, specialist or acute care, or other healthcare services can play a significant role in

communicating price information to patients. There are indications that clinicians are increasingly willing to take on this role. The results of a Bain & Company survey from 2011 indicated that more than 80 percent of physicians “agree” or “strongly agree” that bringing healthcare costs under control is part of their responsibility.<sup>7</sup> Other studies<sup>8</sup> suggest that presenting physicians with price information leads them toward more careful consideration of the need for tests, although, as appropriate, information on the quality of patient care is the main driver of clinician decisions.

When a treatment plan has been decided upon, clinicians should have access to price information to help their patients find providers that best meet the patient’s clinical and financial needs. To address the needs of both insured and uninsured patients, clinicians should request that providers to whom they refer patients make price information available to help in referral decisions. In non-emergent situations, the clinician should provide the patient with a list of providers so that the patient can obtain and compare price information from them before the referral decision is made. However, the types of price information described above are not readily available in clinician workflows today. Therefore, HFMA’s members support efforts in future rulemaking to require health information technology developers to include in their platforms a mechanism for patients to see price information, and for healthcare providers to have access to price information. This information should be tailored to an individual patient and integrated into the practice or clinical workflow through application programming interfaces. Referring clinicians should help patients make informed decisions about treatment plans that best fit the patient’s individual situation. They should also recognize the needs of price-sensitive patients, seeking to identify providers that offer the best price at the patient’s desired level of quality. If a patient cannot afford a recommended course of treatment or would not have chosen it if they had known the financial implications at the outset, then it is not the best course of treatment for that patient, regardless of the clinical merits of the recommendation.

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<sup>7</sup> Farkas, C., and van Biesen, T., *The New Cost-Conscious Doctor: Changing America’s Healthcare Landscape*. Bain & Co., 2011.

<sup>8</sup> In a controlled study at The Johns Hopkins Hospital, clinicians (physicians and nonphysicians) who ordered lab tests through a computerized physician order entry system (CPOE) showed a decrease in the number of tests per patient day ordered when fee data for the test was presented in the CPOE. See Feldman, L.S., Shihab, H.M., Thiemann, D., et al., “Impact of Providing Fee Data on Laboratory Test Ordering: A Controlled Clinical Trial,” *JAMA Internal Medicine*, May 27, 2013, pp. 903-908.

HFMA appreciates the opportunity to submit these recommendations to the Office of the National Coordinator. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, the Centers for Medicare & Medicaid Services and advisory groups. We would welcome the opportunity to meet with you or your staff to discuss these recommendations. 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

Cc:

Michael Lipinski  
Office of Policy  
Office of the National Coordinator for Health Information Technology

#### **Appendix I: HFMA Price Transparency Taskforce Industry Consensus Principles**

The Price Transparency Taskforce, convened by HFMA, agreed that to be effective, price transparency must offer clear information that is readily accessible to patients and enables them to make meaningful comparisons among providers. The following statements represent the task force's consensus on basic principles that should guide efforts to achieve these goals.

- Price transparency should empower patients and other care purchasers to make meaningful price comparisons prior to receiving care.
- Any form of price transparency should be easy to use and easy to communicate to stakeholders.
- Price transparency information should be paired with other information that defines the value of services for the care purchaser.
- Price transparency should ultimately provide patients with the information they need to understand the total price of their care and what is included in that price.
- Price transparency will require the commitment and active participation of all stakeholders.

#### **Appendix II: ONC Definition of Electronic Health Information (EHI)**

We propose to define EHI to mean:

- (i) electronic protected health information; and
- (ii) any other information that –
  - a. is transmitted by or maintained in electronic media, as defined in 45 CFR § 160.103;
  - b. **identifies the individual**, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and

- c. relates to the past, present, or future health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

This definition of EHI includes, but is not limited to, electronic protected health information and health information that is created or received by a health care provider and those operating on their behalf; health plan; health care clearinghouse; public health authority; employer; life insurer; school; or university. In addition, we clarify that under our proposed definition, EHI includes, but is not limited to, electronic protected health information (ePHI) as defined in 45 CFR 160.103. In particular, unlike ePHI and health information, EHI is not limited to information that is created or received by a health care provider, health plan, health care clearinghouse, public health authority, employer, life insurer, school, or university. EHI may be provided, directly from an individual, or from technology that the individual has elected to use, to an actor covered by the information blocking provisions. ***We propose that EHI does not include health information that is de-identified consistent with the requirements of 45 CFR 164.514(b).***