



healthcare financial management association

January 28, 2020

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS- 9915 -P  
P.O. Box 8010  
Baltimore, MD 21244-1810

File Code: CMS- 9915 -P

Re: Proposed Rule – Transparency in Coverage

Dear Administrator Verma:

On behalf of the Healthcare Financial Management Association's (HFMA's) 50,000 members, I would like to thank the Departments of Health and Human Services, Labor and Treasury (hereafter the "tri-agencies") for the opportunity to comment on the Transparency in Coverage proposed rule (hereafter the "proposed 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 surgical centers, 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 can 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 reports, industry best practices and consumer resources:

- 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 out-of-pocket estimates for insured patients.

**Price Estimates for Insured Patients:** For insured patients receiving in-network services, we agree with the proposed rule that 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. However, we believe the plan should have the flexibility to either provide the information directly to the patient, through a patient portal for example, or to partner with providers 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 amount for which the patient is responsible (deductible, coinsurance, copayment) 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-

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

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.

- 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.).

We commend the tri-agencies for issuing a proposed rule that largely adheres to these principles and best practices in the proposed rule. To improve the proposal further, HFMA's members encourage the tri-agencies to include the following recommendations in the final rule.

- 1) *Include Quality Measures in the Information Provided to Members Seeking Estimates*: Price alone is not sufficient to enable patients and other care purchasers to make an informed choice of providers. As noted in the Price Transparency Task Force report's definition of value, information on quality—comprising a range of factors, including patient satisfaction and experience, adherence to clinical standards and evidence-based medicine, and patient safety and clinical outcomes—is needed to ensure that a provider offers the desired level of value.

Furthermore, given that many consumers associate higher cost with higher quality in healthcare services HFMA's members are deeply concerned that in the absence of quality data, transparent prices may actually increase spending.<sup>7,8</sup> Therefore, HFMA's members strongly recommend the tri-agencies delay the effective date of implementation of the final rule until they have worked with health plans and providers to develop a consensus methodology for displaying quality data related to the most common elective conditions and procedures for which health plan members could shop.

- 2) *Allow Flexibility in How the Total Cost of Care Is Displayed*: The manner in which price information is communicated to stakeholders can have a significant impact on how that information is used. Individual patients, for example, may equate low price with low quality. In one study of 1,400 adult employees, price information that was presented through the number of dollar signs (with "\$" representing low price and "\$\$\$" representing high price) led a significant number of employees to use low price as a proxy for low quality. But when a star ranking system was used to rate providers as "being careful with my healthcare dollars," employees in the study were significantly more likely to choose a lower-price provider. Any

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<sup>7</sup> <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.1168>

<sup>8</sup> <https://www.nejm.org/action/showPdf?downloadfile=showPdf&doi=10.1056/NEJMp1100041&loaded=true>

system of price transparency will likely need to experiment with the most effective means of communicating price information to various audiences.

Instead of requiring the negotiated rate to be provided as a dollar amount, HFMA's members believe the final rule should provide the flexibility for health plans to display price information either as dollars or using some proxy that either conveys the price relative to other providers or the cost effectiveness of the providers for a given service relative to their peers. We believe granting this flexibility will allow health plans and other transparency tool vendors to innovate with different transparency frameworks to see which are the most effective in communicating with patients. Not only will this flexibility allow the tri-agencies to update these requirements based on real-world evidence, but it will also allow plans to tailor their communications to their members who, in many instances, are not a homogenous block. Therefore, it is likely that different segments of the commercially insured population will find different presentations of price data more beneficial than others for making a value-based healthcare purchasing decision.

- 3) *Allow for Price Estimates to be Provided as a Range*: Price information will likely take the form of an estimate or price range, given that unexpected complications may increase the price of care. Providers should make clear that they are providing estimated prices for a standard procedure or service, describe what is included in the estimate, and indicate who will pay for any services related to unexpected complications.

HFMA's members believe the final rule should allow both for ranges for out-of-pocket cost sharing and the total price of the service (for health plans that elect to display this data as a dollar amount). We believe this, along with the plain language notifications (described in the proposed rule) that the estimate is subject to change and the actual cost will vary (depending on the actual clinical service delivered) will help ensure that health plan members have a positive financial experience.

- 4) *Ensure "Apples-to-Apples" Comparison Estimates*: To ensure valid comparisons of provider price information, health plans and other suppliers of such information should make transparent the specific services that are included in the price estimate. Suppliers of price information should make sure that price estimates are accompanied by explanations of what services are included in such estimates, as well as the impact of differences in network status on such estimates, to help patients make valid comparisons among providers. For example, when comparing prices associated with receiving an imaging service, the patient should be informed whether the estimate includes both the facility costs and the radiologist's fee.

HFMA's members support the proposed rule's inclusion of an items-and-services list for bundled payment arrangements. Furthermore, our members agree with the proposed rule's broad definition of bundled services to include both relatively narrow bundles (e.g., payments based on DRG) and expansive bundles (30-day episodes of care).

- 5) *Provider Network Status*: The final rule should clearly include a requirement for health plan price transparency tools to clearly indicate which providers within a geographic area are in network vs. out of network. As the proposed rule notes, the price of healthcare services for an insured patient can vary significantly depending on whether the services are provided by an in-network

or an out-of-network provider. If a provider is out-of-network, the patient may face a higher coinsurance payment or be responsible for the out-of-network provider's entire bill, depending on the patient's benefit design.

To further protect members/patients from surprise bills, HFMA's members believe the final rule should require health plans to maintain up-to-date provider directories in online formats and information provided via phone, email or other written request. We believe the final rule should include language that limits members'/patients' cost sharing to the in-network amount if the member/patient provides documentation that they received incorrect information from an insurer regarding a provider's network status prior to a visit.

- 6) *Include Public Payers in the Out-of-Pocket Cost Sharing Estimate*: HFMA's members are deeply disappointed the proposed rule's requirements to provide out-of-pocket estimates do not extend to both Medicare and Medicaid beneficiaries. Therefore, we strongly recommend the final rule require CMS and state administrators of Medicaid programs to develop user-friendly price transparency tools for traditional Medicare and Medicaid beneficiaries. Traditional Medicare beneficiaries pay a percentage of Medicare-approved amounts for many healthcare services and also are responsible for certain deductibles (e.g., the Part B deductible) and payments for certain prescription drugs and medical devices and supplies.

While CMS has taken steps toward greater quality transparency through its [Hospital Compare](#) website and [Procedure Price Lookup](#), Medicare's price tool is based on national data. As you well know, Medicare payment for outpatient procedures can vary significantly due to regional wage differences and the setting where outpatient services are provided. So the information provided is not specific to individual beneficiaries. It also requires beneficiaries to visit multiple sites to collect both price and quality data. Therefore, CMS's current websites are inadequate in helping them make a value-based care decision.

HFMA's members believe transparency tools for beneficiaries in Medicare health plans or Medicaid managed care programs should follow the Price Transparency Taskforce report's<sup>9</sup> recommendations for patients with private or employer-sponsored insurance coverage. Beneficiaries of federal and state healthcare programs, including Medicare and Medicaid, will have different sources for price information depending, for example, on the Medicare option they have chosen (e.g., traditional Medicare or Medicare Advantage) or the structure of Medicaid within their state (e.g., whether the state has a Medicaid managed care plan). For Medicare beneficiaries enrolled in Medicare Advantage or another Medicare health plan, and for Medicaid beneficiaries in a Medicaid managed care program, the health plan or company administering the program will be the best source of price information. Medicare health plans and companies administering Medicaid managed care programs should provide beneficiaries with transparency information and tools similar to those described for patients with private or employer-sponsored insurance coverage (see page 13 of the report).

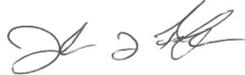
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<sup>9</sup> ["Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force,"](#) HFMA, 2014.

HFMA looks forward to any opportunity to provide assistance or comments to support the tri-agencies' efforts to provide health plan beneficiaries with out-of-pocket estimates. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, federal agencies and advisory groups.

We are at your service to help the tri-agencies 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

**cc:**

Alexander Azar, Secretary of Health and Human Services  
Steven Mnuchin, Secretary of the Treasury  
Eugene Scalia, Secretary of Labor

#### **About HFMA**

HFMA is the nation's leading membership organization for more than 50,000 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.