

September 27, 2019

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1717-P  
P.O. Box 8013  
Baltimore, MD 21244-1850

File Code: CMS-1717-P

Re: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals -Within-Hospitals

Dear Administrator 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; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals -Within-Hospitals* (hereafter referred to as the Proposed Rule) published in the Federal Register on August 9, 2019.

HFMA is a professional organization of more than 42,000 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 commend CMS for its thorough analysis and discussion of the many Medicare payment decisions addressed in the 2020 Proposed Rule. Our members would like to comment on the proposals related to:

- Proposed changes to the Inpatient Only List (IPO)
- Separately Payable Drugs Provided by 340B Hospitals
- Proposed Method to Control Unnecessary Increases in the Volume of Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)
- Proposed Ambulatory Surgery Center (ASC) Payment and Comment Indicators

- Proposed Requirements for Hospitals to Make a List of Their Standard Charges Available
- Proposed Prior Authorization Process Requirements for Certain Outpatient Hospital Department Services
- Comment Solicitation on Cost Reporting, Maintenance of Hospital Chargemasters, and Related Medicare Payment Issues

Below, please find specific comments on the items above.

### **Proposed Changes to the Inpatient Only (IPO) List**

CMS is proposing to remove Total Hip Arthroplasty (THA), CPT Code 27130, from the Medicare IPO list for CY20. This would allow the procedure to be performed as an outpatient surgery paid under the OPSS for patients who are healthy enough to not require an inpatient stay. And, like Total Knee Arthroplasty (TKA),<sup>1</sup> we anticipate that within the next two to three years, THA would be covered by Medicare when the procedure is performed in an ASC. **HFMA’s members conditionally support CMS’s proposal. This support is directly predicated on adequately adjusting the MS-DRG payment and target prices for Lower Extremity Joint Replacement (LEJR) episodes for this significant policy shift.**

THA is a high-volume inpatient procedure. Using publicly available CMS data, HFMA estimates that in FY17, there were over 220,000 THAs performed. The total allowed amount for these procedures was \$3.2 billion for MS-DRG 470, Major Joint Replacement or Reattachment of Lower Extremity w/o MCC (the most likely MS-DRG impacted by this policy shift). If this MS-DRG is mis-priced, given the volume of these procedures, it will have a significant negative financial impact on the hospitals where these procedures are performed.

Our members are concerned that THA procedures for healthier patients will be shifted into an outpatient setting, leaving sicker, more costly patients to have their procedures performed in the inpatient setting. The “weight” for MS-DRG 470, like all MS-DRGs, is a blended historical average of all Medicare patients who have this procedure. Under the scenario described above, it will be approximately two years before MS-DRG weights are based on claims experience that incorporates this policy. In the interim, hospitals will be under-reimbursed for providing a medically necessary service to Medicare beneficiaries unless CMS proactively adjusts the weight for MS-DRG 470 to reflect this policy shift.

In addition to repricing the MS-DRG itself, CMS will need to account for this policy shift in LEJR episode target prices by adjusting for projected changes in the number of “outlier” cases, increased use of post-acute care sites of service, and a potential increase in readmissions rates for the patients who continue to have THA procedures performed in the inpatient setting. HFMA’s members believe cases fitting the following criteria could be removed from the existing data set to determine the correct MS-DRG weight and episode pricing if CMS decides to implement this policy:

- Cases with no listed co-morbidities listed on the claim or that have a low-risk HCC score
- Short length of stay (two days)
- No institutional post-acute care utilization
- No readmissions

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<sup>1</sup> Assuming CMS finalizes its CY20 proposal to cover TKA when performed in an ASC.

Finally, if CMS moves forward with this policy, we believe CMS will need to monitor and possibly adjust readmissions rates used in the Hospital Readmissions Reduction Program and posted on the Hospital Compare website. We are concerned that differential rates of adoption of performing LEJR procedures across and within regions could potentially skew readmission rates.

#### **Separately Payable Drugs Provided by 340B Hospitals**

CMS proposes to continue paying ASP-22.5% for separately payable drugs provided by 340B hospitals. **HFMA, as discussed in its comment [letter](#)<sup>2</sup> on the CY18 proposed rule strongly opposes this policy.**

In the proposed rule, CMS seeks comments on how to devise a remedy that ensures 340B providers receive the correct payment for the drugs they have provided Medicare beneficiaries in a budget-neutral manner, in the event that CMS loses its appeal of *American Hospital Association et. al v. Azar et al.*, the United States District Court for the District of Columbia.

**HFMA's members suggest providing 340B hospitals with a lump sum settlement that includes the amount for patient coinsurance. Our members believe retrospectively repaying individual claims to 340B hospitals is administratively too burdensome.** Further, requiring hospitals to collect an additional coinsurance amount from either Medicare beneficiaries (or their Medigap plans) would not only be administratively burdensome but also create significant confusion for Medicare beneficiaries. We do not believe they should be harmed as a result of a Medicare policy change that was subsequently found to be illegal.

**To achieve budget neutrality, HFMA's members recommend reducing payments to non-340B hospitals over a period of five years to recoup the increased payment to 340B hospitals.** We believe that a five-year recoupment period will minimize the negative financial impact to these providers.

**Moving forward, HFMA's members strongly believe that 340B hospitals should continue to pay ASP+6% for separately payable drugs acquired under the program.** The purpose of the 340B program is to assist providers that care for a high number of low-income and uninsured patients. Any reduction of payment to 340B hospitals would create financial stress to safety net hospitals that provide care to these at-risk patients. HFMA strongly believes that any reduction in payment to 340B providers (e.g., to ASP+3% as suggested in the proposed rule) without sufficient supporting data (collected in a transparent manner and calculated using a methodology all stakeholders agree is valid) would be as arbitrary and capricious as reducing payments to 340B providers by ASP-22%.

#### **Proposed ASC Payment and Comment Indicators**

CMS proposes in the 2020 OPPI rule to cover TKA, CPT Code 27447, when the procedure is provided in ASCs. **HFMA's members conditionally support CMS's proposal. This support is directly predicated on adequately adjusting the MS-DRG payment and target prices for LEJR episodes for this significant policy shift.** Please see our specific comments related to CMS's proposal to remove THA (above) from the IPO list for our detailed recommendations, as these recommendations apply to TKA procedures as well.

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<sup>2</sup> [HFMA Comment Letter to CMS](#), September 11, 2017.

### **Proposed Method to Control Unnecessary Increases in the Volume of Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)**

HFMA continues to strongly oppose CMS’s proposal to pay for clinic visits furnished in excepted off-campus PBDs at the site-neutral PFS-equivalent rate. The proposed rule continues to implement this policy, increasing the reduction from 30 percent of the OPPS rate in CY2019 to 60 percent in CY2020.

HFMA urges the agency to withdraw this proposal from consideration. As U.S. District Judge Rosemary Collyer found in her September 17<sup>th</sup> ruling in *AHA et al. v. Azar*<sup>3</sup>, CMS lacks statutory authority to reduce payments to excepted PBDs to the level of nonexcepted PBDs, particularly in a non-budget-neutral manner. Congress expressly chose not to confer on CMS authority to reimburse excepted off-campus PBDs at the reduced rates paid to nonexcepted off-campus PBDs – it clearly intended for there to be a material distinction in payment rates between excepted and nonexcepted PBDs.

In addition, the agency’s proposal is arbitrary and capricious – CMS has no basis to conclude that PBD services have increased unnecessarily, which is the predicate finding necessary to support its proposed policy. Indeed, the agency’s so-called analysis that identifies “unnecessary” shifting of services from physician offices to PBDs completely ignores substantially impactful factors outside of hospitals’ control that also result in increases in OPPS volume and expenditures.

### **Proposed Requirements for Hospitals to Make a List of Their Standard Charges Available**

In the proposed rule, CMS expands its prior interpretation of section 2718 of the Public Health Services Act (PHS Act). If finalized, the rule would require all hospitals to make a list of both gross charges and negotiated rates for all services in the hospital chargemaster, as well as a set of shoppable services, publicly available. The rule specifies the manner and format in which the lists are to be made publicly available. Hospitals that do not comply with the requirement may be subject to a civil monetary penalty (CMP) of up to \$300 per day.

HFMA is a strong supporter of price transparency as a mechanism to empower patients to make more cost-effective decisions about where to receive care. However, we also recognize the potential for unintended consequences. Among the unique features of the U.S. healthcare marketplace is the existence of a business-to-business marketplace between providers and private health plans. For a typical hospital, this marketplace determines payments that make up approximately one-third of the hospital’s total revenue. From a consumer perspective, as a general rule, the more transparency the better. But within a business-to-business marketplace, some healthcare economists and the federal antitrust enforcement agencies have noted that public transparency of negotiated rates could actually inflate prices by discouraging private negotiations that can result in lower prices for some buyers<sup>4</sup>. Providers, for example, may have less incentive to offer lower prices to certain payers if they know other

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<sup>3</sup> [American Hospital Association et al v. Alex M. Azar, II](#), Secretary of the Department of Health and Human Services, Civil Action No. 18-2841 (RMC), U.S. District Court for the District of Columbia.

<sup>4</sup> For a summary of the federal antitrust agencies’ concerns regarding provider exchanges of price information, see the U S Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, Statement 6, Aug 1996.

payers in the market will demand similar rates. They may also have less incentive to offer lower prices if they think this will set off a price war with other providers in the market. Within the privately insured market, these considerations suggest that an approach to transparency that emphasizes out-of-pocket payments for insured patients instead of full transparency of negotiated rates may be preferable<sup>5</sup>.

To advance price transparency HFMA has convened multiple taskforces involving participants representing the perspectives of consumers, hospitals, physician practices and health plans to develop operational solutions that will facilitate greater price transparency within the healthcare industry. The resulting white papers and consumer guides<sup>6</sup> provide practical guidance that, if followed, will create an environment where patients and consumers can use data related to their specific out-of-pocket spending, the total price of the episode of care, and quality to make a value-based decision about where to receive “shoppable services.”

Despite our fundamental belief in the power of well-organized, clearly communicated financial and quality data to empower patients and consumers to make choices about where to receive care that are aligned with their values and financial interests, **HFMA’s members do not support the expanded requirements that hospitals post their payer-specific negotiated charges. The rule, as currently proposed, exceeds CMS’s statutory authority, has significant unresolved issues, imposes a material administrative burden on providers and fails to create an environment conducive to consumerism.** Each of these issues is discussed in detail below.

**Exceeds Statutory Authority:** In expanding the requirement we believe CMS has exceeded Congress’s intent in three ways.

- 1) **Definition of Standard Charges:** 42 U.S. Code § 300gg–18(e) (Section 2718(e) of the PHS Act states:

*Each [hospital](#) operating within the United [States](#) shall for each [year](#) establish (and update) and make public (in accordance with guidelines developed by the [Secretary](#)) a list of the [hospital’s standard charges](#)<sup>7</sup> or items and [services](#) provided by the [hospital](#), including for diagnosis-related groups established under [section 1395ww\(d\)\(4\) of this title](#).*

When used as an adjective, the Merriam-Webster dictionary defines **standard** as “regularly and widely used, available, or supplied.”

Further, in Part I, Chapter 22, Section 2202.4 of the Medicare Provider Reimbursement Manual, CMS defines **charges**<sup>8</sup> as:

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<sup>5</sup> For an overview of the potential adverse effects of transparency in business-to-business healthcare marketplaces, see Cutler, D , and Dafny, L , “Designing Transparency Systems for Medical Care Prices,” New England Journal of Medicine, March 10, 2011, pp 894-895

<sup>6</sup> HFMA, [Healthcare Dollars & Sense](#).

<sup>7</sup> Emphasis added

<sup>8</sup> CMS, [The Provider Reimbursement Manual, Part 1](#)

*“Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and **uniformly applied to all patients whether inpatient or outpatient**<sup>9</sup> [emphasis added]. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.”*

The industry has defined price, charge, and cost as follows<sup>10</sup>:

- **Charge:** *The dollar amount a provider sets for services rendered before negotiating any discounts. The charge can be different from the amount paid.*
- **Price:** *The total amount a provider expects to be paid by payers and patients for healthcare services.*
- **Cost:** *The definition of cost varies by the party incurring the expense:*
  - *To the patient, cost is the amount payable out of pocket for healthcare services.*
  - *To the provider, cost is the expense (direct and indirect) incurred to deliver healthcare services to patients.*
  - *To the insurer, cost is the amount payable to the provider (or reimbursable to the patient) for services rendered.*
  - *To the employer, cost is the expense related to providing health benefits (premiums or claims paid).*

We note that the industry's definition of charges is similar to CMS's definition of charges in the Provider Reimbursement Manual.

CMS's definition of charge in the Provider Reimbursement Manual is longstanding and relatively unchanged since the inception of the Medicare program over 50 years ago. Further, the word “standard,” as it is used in Section 2718(e) of the PHS Act has a common meaning that is well understood. Therefore, we believe the congressional staff who drafted the Patient Protection and Affordable Care Act (ACA) chose these specific words intentionally and the congresspersons and senators who voted on it intended for them to be interpreted within the context of a common, well understood meaning.

Despite the well understood meaning of the words “standard charges,” in the proposed rule, CMS reinterpreted the definition to have two different meanings:

- 1) **Gross charges:** The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts
- 2) **Payer-specific negotiated charges:** The charge that the hospital has negotiated with a third-party payer for an item or service

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<sup>9</sup> Emphasis added

<sup>10</sup> HFMA, [Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force](#), 2014.

HFMA's members believe the definition of gross charges is within Congress's intended meaning of "standard charge." It is clearly aligned with the longstanding CMS definition of charges as found in the Provider Reimbursement Manual.

However, HFMA believes that CMS's recent invention of the phrase "payer-specific negotiated charge" redefines the phrase "standard charge" to mean something wholly different from what Congress intended when it specifically included the words "standard charge" in an amendment to the PHS Act as part of the ACA. It more resembles the industry definition of price than either the industry's or CMS's definition of charge. **CMS is expanding the definition of standard charge to include "charges" that vary by third party payer and are therefore not uniform across all patients. As such, HFMA's members do not believe the agency has the statutory authority to finalize this definition and strongly encourage the agency not to do so.**

HFMA's opposition to this proposal is rooted solely in the fact that CMS, in this specific instance, is attempting to expand its authority beyond what Congress intended when it specifically choose the words "standard charges." However, there are other instances where it is appropriate for CMS to reinterpret the Medicare statute based on Congress's clear intent. Inpatient and outpatient outliers are a specific example of where this applies. Sections 1833(t)(5)(A) and 1886(d)(5)(A)(ii) of the Social Security Act both require the use of charges as a proxy for cost for an inpatient discharge or outpatient service so that CMS can make an outlier payment to hospitals based on the cost of the discharge or service provided. In the future, if hospitals can provide CMS with the actual allowable cost of an inpatient discharge or outpatient service, we believe it is appropriate for CMS to no longer base outlier payments on charges as Congress clearly intends for outlier payments to be based on cost, not a proxy for cost (e.g. charges).

- 2) *Including Services Provided by Employed Physicians and Non-Physicians in the Definition of Items and Services.* In the rule, CMS proposes including services provided by employed physicians and non-physicians in its definition of "Items and Services" provided by the hospital. Section 2718(e) of the PHS Act (provided above) makes no reference to services provided by employed physicians or non-physicians. Therefore, Congress did not intend for CMS to include the charges of employed physicians and non-employed physicians in the definition of "items and services" under Section 2718(e) of the PHS Act. **Because CMS lacks the statutory authority to include the services of physicians and non-employed physicians, HFMA's members strongly encourage CMS not to include the services of employed physicians and non-physicians in its final definition of "items and services."**

Beyond lacking the legal authority to compel hospitals that employ physicians and non-physicians to include the payer specific negotiated charge and gross charge for services provided by employed physicians and non-physicians in the data made publicly available, there is also an issue of comparability.

Not all hospitals employ the same types of physicians and non-physicians. For example, hospital A employs its anesthesiologists. Hospital B's anesthesiology coverage is provided by a free-

standing practice that has privileges at the hospital. The free-standing practice has negotiated its own contracts with managed care plans for the services it provides and bills its patients separately from the hospital for services provided by freestanding practice anesthesiologists in hospital B (and other hospitals it partners with). The gross and payer specific negotiated charges made public by hospital A (who employs their anesthesiologists) for major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (MCC) (MS-DRG 470) will, everything else held constant, be greater than at hospital B (does not employ anesthesiologists) because these two “service packages” do not include the same services and are therefore not comparable. As a result, if the proposed rule is finalized, it is likely to cause consumers to mistakenly choose higher cost providers who look less expensive because a key component of the service was not included.

HFMA does not believe this can be remedied by compelling hospitals to include the gross and payer specific negotiated charges for non-employed physicians and non-physicians in the amounts posted. First, this would foist an incredible administrative burden on both hospitals and their physician partners. Second, it would make hospitals responsible for the accuracy of data provided to them (or not provided to them at all) by a third party that they could not verify. And finally, the payer specific negotiated charge is the result of a private negotiation between health plans and physician practices. We do not believe it is appropriate that hospitals should be able to see the amounts that health plans pay community physicians who may practice at the hospital, but also in many circumstances compete with hospital employed physicians by providing similar services.

However, if CMS chooses to ignore Congress’s intent under Section 2718(e) of the PHS Act and the comparability issues described above by including the services of employed physicians and non-physicians the final rule, the agency needs to provide several key clarifications so that hospitals can meet the new requirements in a timely manner.

First, in many instances, the charges for employed physicians and non-physicians are not included in the hospital’s chargemaster. If a hospital does not include charges for employed physicians and non-employed physicians in its chargemaster, is it required to make those charges publicly available?

Second, many hospitals own off-campus provider-based clinics and freestanding physician practices. Are hospitals required to include the charges for services provided by employed physicians and non-employed physicians in these settings in its public charge posting? The proposed rule clearly states “that the proposed definition of ‘hospital’ would not include entities such as ambulatory surgery centers (ASCs) or other non-hospital sites-of-care from which consumers may seek health care items and services. For example, nonhospital sites may offer ambulatory surgical services, laboratory or imaging services, or other services that are similar or identical to the services offered by hospital outpatient departments.”

While we believe that CMS does not intend for hospitals to include charges for services provided in off-campus provider-based clinics and hospital-owned freestanding practices in the requirement, we ask CMS to confirm that is correct in the final rule.

Third, what gross and payer specific negotiated charge should hospitals make publicly available in instances where, for the same service, the physician component of the service is sometimes provided by an employed physicians, sometimes provided by a physician employed by a freestanding practice who has privileges at the hospital?

- 3) ***Ability to Assess Civil Monetary Penalties to Noncompliant Hospitals:*** The proposed rule cites 2718(b)(3) of the PHS Act for its authority to assess noncompliant hospitals with a CMP of up to \$300 per day. This provision only applies to section 2718(b) – entitled, “Ensuring that Consumers Receive Value for Their Premium Payments” – which pertains to the medical loss ratio rebate provisions.

Beyond the specific statutory construction of section 2718, that 2718(b)(3) of the PHS Act only applies to the provisions in section 2718(b) is evidenced by an exchange between a CMS staffer and a caller on the November 13, 2018, Hospital Open Door Forum. When a caller asked CMS staff about what penalties would be assessed if hospitals did not comply with the standard charge posting requirement, the staffer responded that the hospital would be out of compliance with the law. When the caller clarified her question to what specifically the penalty was for non-compliance, the CMS staffer repeated his response—and did so without asserting that CMS has *any ability to assess CMPs* on noncompliant hospitals.

**Therefore, HFMA’s members do not believe that CMS has the statutory authority to assess CMPs for noncompliance and strongly recommend it not finalize this provision.** Section 2718(b)(3) of the PHS Act existed for almost 10 years when the Open Door Forum call referenced above transpired. At that time, CMS did not claim any enforcement authority related to 2718(e). HFMA knows of no congressional action that revised that specific section that occurred subsequent to the November 2018 Open Door Forum. If CMS persists in finalizing this change, we believe it needs to detail the specific documents that it believes illustrates Congress’s intent to apply 2718(b)(3) to 2718(e).

***Significant Unresolved Technical Issues.*** If CMS persists in finalizing this proposal despite its lack of statutory authority to do so, there are multiple technical issues where CMS will need to provide hospitals with specific guidance. These include:

- 1) ***Creating “Service Packages” for Outpatient Services:*** The rule requires hospitals to create “service packages” that include both the primary service and any ancillary services. For some service packages, this will be relatively straightforward. For others, the ancillary services required by one patient will be different from the ancillary services required by another.

This is the same challenge CMS faces when it rebases ambulatory payment classification (APC) weights for outpatient services. In any given year, CMS typically only uses approximately

half (91 million out of 175 million for the CY19 final rule) of outpatient claims processed by fiscal intermediaries to develop the relative weights.<sup>11</sup> The specific issue is that for claims with multiple APCs (i.e., multiple “service packages”) it is often impossible to determine what ancillary services are related to the multiple primary services that trigger APC (and the related payment). And CMS has advantages over individual hospitals as it attempts to create “Service Packages” for APC weight setting. It is able to analyze over 175 million individual claims using sophisticated software to identify common utilization patterns to attribute ancillary services to primary services. Individual hospitals will have neither sufficient claims volume nor access to sophisticated software to replicate CMS’s methodology and create service packages.

In reality, very little is standard from one patient to another for more complex shoppable services. Therefore, if CMS elects to finalize the proposed rule it needs to provide guidance or frameworks to help hospitals define outpatient service packages and attribute ancillary services to specific primary services.

- 2) *Determining the Actual Payer-Specific Negotiated Rate*: While hospitals have a specific negotiated rate with their third-party payers, there are multiple scenarios where the negotiated rate may differ from the actual rate the hospitals receive. Examples of these scenarios include, but are not limited to, instances where the hospital has entered into a shared savings/shared loss contract with the third-party payer, the contract with the third-party payer includes a quality bonus, the contract includes a volume discount if the number of members of a specific health plan (or contract within the health plan) exceeds a pre-defined threshold, or the contract has an outlier provision for extraordinarily high cost cases.

**HFMA recommends that these types of discounts not be included in the negotiated rate that is posted, if CMS finalizes its proposal.** We believe including these types of discounts will significantly increase administrative complexity and the cost to comply with the rule. However, if CMS persists in requiring these discounts be incorporated into the negotiated rate, it needs to provide specific guidance as to the timing and manner in which this should occur.

**Imposes Material Administrative Burden.** In the proposed rule, CMS estimates that complying with its reinterpretation of standard charge posting requirement under 2718(e) of the PHS Act will only require 12 hours per hospital, costing each hospital approximately \$1,000 or \$6 million nationally.

**HFMA’s members strongly dispute this estimate of administrative burden. Based on estimates by HFMA’s members – who will ultimately be responsible for helping their hospitals comply with this requirement –the average time required to comply is 150 hours.** Using CMS’s estimate of labor costs from the proposed rule, the actual cost of complying with the reinterpreted requirement is \$12,716 per hospital per year or \$76 million nationally, annually.

While we did not adjust CMS’s weighted average hourly wage estimate, we believe the most glaring omission from the estimate of administrative burden is clinical staff time. Our members believe it will be

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<sup>11</sup> Medicare CY 2019 Outpatient Prospective Payment System (OPPS) Final Rule Claims Accounting

necessary to involve physicians and other clinicians in determining the mix of specific HCPCS/CPT codes that accurately represent an average “service package” for a given service. Because HFMA has not adjusted the weighted average hourly rate to reflect the addition of physicians/clinicians to the team that is responsible for implementing the negotiated charge requirement, it is likely that even this estimate does not fully capture the administrative burden of this new requirement.

The proposed standard charge posting requirement involves multiple commercial payers for each hospital. And each payer could have a different payment methodology for the same service. For instance, some payers negotiate by payment by revenue code, some by CPT, and some by ASC groupers. Further, many commercial payers will have multiple contracts with different prices for the same services based on the what’s been negotiated with an employer (or group of employers).

While hospitals have this information in a contract management system for services provided in hospital outpatient departments, it’s frequently not in the same table. So, the process of creating one standardized table with all of the hospital’s negotiated rates for each individual service is far more involved than the proposed rule envisions. Staff from IT, managed care and clinical areas will need to determine how to display all of these disparate contracts in a “single digital file” for the machine-readable version.

Finally, as discussed above, the rule requires hospitals to create “service packages” that include both the primary service and any ancillary services. For some things, this will be relatively straightforward. For others, the ancillary services required by one patient will be different from the ancillary services required by another. This will require a significant time commitment from clinical staff across each of a hospital’s service lines to ensure that the definition of a “service package” is as clinically accurate and representative of an “average” case as possible. Given the complexity of this undertaking, it is unlikely that it can be completed by January 1, 2020. And it will cause the redeployment of significant clinical and analytic resources away from quality improvement and cost reduction efforts for an administrative task that will ultimately – as discussed below – not achieve the administration’s goal of creating an environment where consumers have the information necessary to shop for health care services.

***Fails to Create an Environment Conducive to Consumerism.*** Even if CMS moves forward with its ill-advised requirement that hospitals post their negotiated rates, it will not make it easier for consumers to shop for services. What CMS is proposing will be too unwieldy for consumers to use.

First, from a financial perspective, what matters most to patients as they make their decision about where to receive care is their out-of-pocket expense, or cost sharing. For insured patients, this depends on the negotiated rate, the benefit design and a patient’s progress toward meeting their deductible. Therefore, for insured patients, information about what another plan is paying for a specific service is extraneous. In the moment that they need care, it has no bearing on what their out-of-pocket costs are and will likely cause confusion when it is posted on a hospital’s website along with information for their plans.

Second, consumers will have to visit multiple hospital websites to actually shop. Even if the information is posted in a consumer-friendly manner, as envisioned in the proposed rule, it will be time consuming to wade through the extraneous data (all health plans and the individual contracts for each health plan as discussed above). Given that many health plans have multiple contracts, we believe there is a high

risk that consumers will pick price data from the same plan, but a different contract, and accidentally end up misinformed.

Third, even after successfully navigating this cumbersome data-gathering exercise, they still won't have any idea about their specific out-of-pocket costs – which is what matters most to consumers at the point of decision making – unless they understand their health plan's benefit design and know exactly what their status is relative to their cost-sharing requirements.

Finally, even if they did all of this and collected the right price data, understood their benefit design, and know their status relative to their cost-sharing requirements, they are still missing key information that will allow them to make a value-based decision. First, the proposed rule does not provide them with access to price data for potentially cheaper options in freestanding settings. Second, the proposed rule does not make service-specific quality data available to consumers where valid measures exist.

**Based on the consensus recommendations of HFMA's Price Transparency Taskforce, HFMA's members believe there is a better approach to providing actionable information to consumers that will allow them to make value-based decisions about where to receive "shoppable" healthcare services for both insured and uninsured patients.**

**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>12</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, 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

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<sup>12</sup> <https://www.uchealth.org/billing-and-pricing-information/>

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.
- 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.

**Finally, HFMA strongly recommends hospitals that provide good faith estimates to their patients should be exempt from posting payer-negotiated rates publicly.** Additionally, critical access hospitals and sole community hospitals should be exempt from this requirement, due to the resources required to maintain compliance.

### **Proposed Prior Authorization Process Requirements for Certain Outpatient Hospital Department Services**

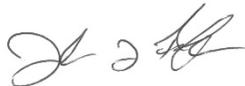
Effective January 1, 2020, CMS proposes that providers must submit a prior authorization request for any service on its list of outpatient department services requiring prior authorization. The five categories of proposed services are: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation.

HFMA's members anticipate that CMS will use a third-party authorization vendor. The resulting new process will increase the administrative burden on providers. **HFMA's members believe CMS can achieve its policy goal of eliminating accidental payment for cosmetic procedures, while minimizing the administrative burden, by developing a more robust National Coverage Determination. rather than prior authorization.**

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the 2020 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 42,000 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.