WISCONSIN HOSPITAL ASSOCIATION

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September 27, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: Comments on Proposed Rule CMS–1717–P: CY 2020 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System

Dear Administrator Verma:

On behalf of our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed FY 2020 rule related to the Medicare Program Hospital Outpatient Prospective Payment Systems.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals, mid- and large-sized academic medical centers. We have hospitals in every part of the state – from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

Increasing Price Transparency of Hospital Standard Charges
In this rule, CMS proposes requiring hospitals to publicly post on the internet a machine-readable file containing both gross charges and "payer-specific negotiated charges" for all items and services. It also proposes to require hospitals to display negotiated charges and certain other information for 300 "shoppable" items and services in an easy-to-understand format. CMS would enforce compliance by auditing hospital websites and issuing Civil Monetary Penalties of $300 per day per violation.

Wisconsin Hospitals and Health Systems are Already Voluntarily Initiating Efforts to Give Consumers More Transparent Information on the Cost of their Care
WHA and our members have long supported transparency. We have been voluntarily reporting hospital price information through a website called PricePoint since 2004. PricePoint provides complete, accurate and timely inpatient and outpatient data about charges and services provided by Wisconsin hospitals and ambulatory surgery centers. Every hospital in Wisconsin voluntarily participates in PricePoint, and it is licensed for use in 10 additional states.

One of the strengths of PricePoint is how simple it is for members of the public to use. After going to www.wipricepoint.org, one simply selects the area of the body and condition, and can then directly compare service prices for up to three hospitals at a time. The site also includes an insurance checklist which directs patients to contact their health insurer to help determine their out-of-pocket cost. The checklist even includes reminders to ask about particular practitioners, such as radiologists and anesthesiologists, so as to avoid

potential surprise billing issues in the event those practitioners are not covered by their particular insurance plan.

As useful as PricePoint is, Wisconsin hospitals and health systems have shown an interest in providing even more information to consumers to better help them understand what they will pay for health care services in advance of receiving care. In response to various transparency proposals at the state and federal levels, WHA has reconvened a Transparency Task Force consisting of hospital and health system financial leaders across Wisconsin who are experts in hospital billing, insurance contract negotiation, provider networks and patient financial counseling. The aim of the task force is to document best practices that improve transparency in health care and provide feedback for policymakers on state and federal legislation being considered.

At its most recent meeting in August, members of this task force gave an overview of their organizations' efforts to help consumers get better upfront cost estimates in advance of receiving care. Some members have developed sophisticated outward-facing websites that allow consumers to go online, input certain health insurance plan information, and obtain a reliable estimate of what they will be charged – including the out-of-pocket costs they are likely to pay. Others have devoted more resources specifically to patient financial counselors, who can walk consumers through estimates using inward-facing online tools either in-person or over the phone. It appears that nearly all have made great strides at giving consumers the type of information CMS seeks to ensure is provided through this rule.

The Proposed Rule Will Add to the Already Significant Regulatory Burden

WHA strongly cautions CMS against implementing the one-size-fits-all transparency provisions in the proposed CY2020 OPPS rule. CMS's approach in the proposed rule will add to the burden that already drives up costs and creates obstacles for hospitals trying to deliver nation-leading care. An average size hospital already dedicates 59 full-time-equivalent positions to regulatory compliance, with over one-quarter of those individuals being physicians and nurses. Time spent on red tape and regulatory compliance results in less time with patients, frustration by providers and burnout. The American Hospital Association estimates the annual cost of hospital regulatory compliance to equate to $1,200 per hospital admission.

While CMS estimates this proposal will only require hospitals 12 hours, or about $1,000, to comply with, this grossly underestimates compliance costs. Most of our members have suggested it took them more than that amount of time to comply with last year's requirement to post the chargemaster alone on their websites. The new regulations would require hospitals to determine negotiated rates for hundreds of different services, with multiple different contracts. In a state like Wisconsin that has a very competitive insurance market, this is even more burdensome as hospitals would have to constantly update data covering hundreds of service items for multiple insurers. On top of that, many insurers offer slightly different products that each may have different negotiated payments to go with them.

At least one of our members has already voluntarily produced a website that allows consumers to obtain estimates of their total out-of-pocket costs by plugging in information from their insurers. Their online tool covers about 500 of their 6,000 chargemaster service items. They estimate it took them 20 FTE hours to set up the basic framework and an ongoing 2-4 FTE hours per week to continue the build of all services and test for errors. They also pay $2,400 per month in contracting costs to support this service. The next step for them is to input real-time insurance information to provide patients with estimated out-of-pocket costs, which has taken an estimated 150 FTE hours to date. So far, about 26 customers have visited this website per month in the nine months it has been available, while they have compiled estimates in person or over the phone for about 145 customers per month over the same time period.

This should give CMS some idea of just how significant a burden this new requirement could be, and it is unclear how much more this member alone would have to do to comply with one-size-fits all components of this rule. With the current appetite hospitals and providers have for improving information available to consumers, CMS would be much better served by helping facilitate and incentivizing hospitals to provide cost

estimates to consumers. This will give providers the ability to innovate and better respond to changing market demands for this information, rather than saddling them with more government regulations that may not be as helpful for consumers as CMS believes they will be.

CMS Likely Lacks the Legal Authority to Impose these Requirements

WHA also questions whether CMS has the legal authority to compel hospitals to provide this information. CMS cites authority under Section 2718(e) of the Public Health Service Act, which required that "each hospital operating within the United States, 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 for items and services provided by the hospital." For years, standard charges have been defined and understood to mean a hospital's usual or customary chargemaster charge that it charges uniformly to all patients. To define standard charges as variable negotiated payments hospitals receive from health plans would violate existing law that requires standard charges to be applied uniformly.

The Federal Trade Commission Warns that Such Information May be Counterproductive

Additionally, while WHA and our members support transparency that helps consumers have meaningful information to make informed choices about their health care, transparency for the sake of transparency can be counterproductive. For instance, the Federal Trade Commission has noted[1] that some types of information cloaked in transparency "are not particularly useful to consumers, but are of great interest to competitors." Too much transparency can harm competition and lead to price-fixing and collusion, rather than lower prices. The FTC encourages health care transparency efforts to focus on "the types of information most useful to [patients] when they compare and select health care providers and services such as actual or predicted out of pocket expenses, co-pays, and quality and performance comparisons of plans or providers."[2]

In summary, CMS's proposed rule would subject hospitals to significant additional regulatory burdens, is likely not lawful, and may be counterproductive to the goals of lowering health care costs. With the current environment in which hospitals are already responding to consumer demands for more cost information, WHA urges CMS to drop the stick and pick up the carrot. CMS should use this opportunity to bring hospitals and health insurance plans together and utilize incentives rather than penalties to increase transparency for consumers.

RFI on Quality

CMS has asked for feedback on combining quality data with pricing to facilitate shopping. It should be noted that in addition to the PricePoint website mentioned previously, WHA runs a sister website, CheckPoint, which provides consumer-focused initiatives that include reliable, valid measures of health care in Wisconsin to aid the selection of quality health care and quality improvement activities within the hospital field. PricePoint and CheckPoint are linked together to allow users to easily compare Wisconsin hospitals on both charges and quality measure scores and make determinations on the value of the care they can receive from Wisconsin hospitals.

Yet, WHA urges CMS to approach this endeavor with due caution. While it is a relatively objective exercise to list the price of every service a hospital offers, there is a limited amount of quality data that is publicly available and not representative of every service a hospital offers. Additionally, the quality data lags the pricing data considerably, so improvements in quality or reductions in price cannot be aligned appropriately and interpreted by consumers correctly. While quality data is beneficial for consumers, it must be recognized that quality data can be more subjective, like patient experience survey data. For example, a hospital may score very well on services that are measured compared to other hospitals that perform worse. This could lead consumers to determine the high scoring hospital is the better hospital. Unfortunately, such a conclusion leaves out the fact that there may be many other services not measured which could be better indicators of

[1] Koslov, Tara Isa & Jex, Elizabeth. (2015, July 2). Price transparency or TMI? [Web blog post]. Retrieved September 20, 2019, from https://www.ftc.gov/news-events/blogs/competition-matters/2015/07/price-transparency-or-tmi

[2] Koslov, Tara Isa & Jex, Elizabeth.

overall hospital quality that are not reflected in the measured quality metrics. In summary, WHA supports offering consumers more information on quality, but encourages CMS to consider the challenges of linking price to quality measurements so that consumers are not misled.

WHA Supports CMS's Proposed Change to Level of Supervision Required for Outpatient Therapeutic Services
WHA applauds CMS for finally proposing to clarify the level of supervision needed for outpatient therapeutic services. For years, WHA has advocated for CMS to change this policy (which was made without providing any rationale) and participated in efforts to get Congress to put a moratorium on CMS enforcing it. WHA is very pleased to see CMS come to the conclusion that direct supervision is not necessary for initiating outpatient therapeutic services in all hospitals, including critical access hospitals. WHA and our members sincerely appreciate efforts by CMS to reduce the unnecessary regulatory burden on hospitals, and this is a great example of CMS listening to these concerns.

Comment on Potential 340B Remedies
CMS requests comment on potential remedies for the nearly 30% reduction in reimbursement for certain 340B hospitals that a district court judge ruled were unlawful in calendar years 2018, 2019, and that CMS proposes again in 2020. WHA supports HHS making every impacted hospital whole by refunding payments made and calculated using the JG modifier, which identifies claims for 340B drugs reduced in the 2018 and 2019 rules. While CMS has argued this must be made in a budget-neutral manner, HHS has previously corrected errors for future and past underpayments without doing so in a budget-neutral manner, and we believe the same should be done in this instance so that those who were not impacted by the 340B reductions are not negatively impacted by the remedy. Going forward, HHS should resume 340B payments at the statutory rate of ASP plus 6%, which is the rate intended by Congress. We also believe patients who have already paid their copays for 340B drugs obtained in 2018 or 2019 should be held harmless and not subjected to further copays by HHS.

Site-Neutral Payments
Like the 340B cuts previously mentioned, site-neutral payment reductions to hospital outpatient departments (HOPDs) are another example of CMS acting unlawfully by going around Congress's clear statutes in attempting to implement a policy at the expense of hospitals. For CY 2020, CMS proposes to complete the phase-in from the 2019 OPPS rule that will reduce payments for clinic visit services in grandfathered off-campus HOPDs at the physician fee schedule rate of 40% of the OPPS rate. WHA expressed its displeasure in the 2019 OPPS rule and was joined by Members of Wisconsin's Congressional Delegation in asking CMS to abandon this proposal that goes against the clear wishes of Congress. While CMS has cited unnecessary utilization, this contradicts past statements from CMS that recognized hospitals face a higher regulatory burden, serve sicker, more complex patients, must run 24/7 Emergency Departments, and thus face higher costs for which they are not adequately reimbursed.

WHA was relieved to see U.S. District Judge Rosemary M. Collyer recently rule in hospitals' favor, agreeing that CMS acted unlawfully in issuing these cuts. Unfortunately, appeals by CMS could lead to considerable challenges for hospitals impacted by this policy that are trying to plan their budgets. WHA urges CMS to use the 2020 rule as an opportunity to restore certainty for hospitals by respecting Congress's and the Court's wishes and dropping this ill-conceived proposal.

Wage Index
The proposed rule would implement new wage index provisions finalized in the 2020 IPPS rule. As we commented in the 2020 IPPS rule, WHA applauds CMS for exploring ways to restore fairness to the wage index in this and other rules. In that rule, CMS proposed to begin excluding reclassified hospital wage index data when calculating each state's rural floor, and also bringing up hospitals with a wage index in the bottom 25th percentile by adjusting downward the wage index for hospitals in the top 25th percentile.

WHA has long decried the inherent unfairness that has resulted in states gaming the system, with the Bay State Boondoggle being the most egregious example of coastal states benefiting by artificially tilting the wage

index in their favor at the expense of states like Wisconsin. In the 2020 IPPS rule, WHA urged CMS to ensure its adjustments did not unfairly penalize hospitals in naturally-occurring high labor markets that had not gamed the system. Unfortunately, in the final rule, CMS went in a different direction and instead applied the budget neutrality provision not only to hospitals in the top 25th percentile, but to all hospitals above the bottom 25th percentile. While this may have sounded good in theory, it resulted in even more money being redistributed away from Wisconsin hospitals through no fault of their own. While WHA supports bringing up hospitals that have unfairly lost under the current system, CMS should find a way to do this by downwardly adjusting those hospitals that have unfairly benefited, rather than bluntly applying it to all hospitals in a way that only exacerbates the unfair system for some.

WHA appreciates the opportunity to provide comment on this proposed rule.

Sincerely,

Eric Borgerding
President & CEO