AMERICA'S ESSENTIAL HOSPITALS

January 29, 2020

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Steven Mnuchin
Secretary
U.S. Department of the Treasury
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Alex Azar II
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Seema Verma, MPH
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Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
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Ref: CMS-9915-P: Transparency in Coverage

Dear Secretaries Scalia, Azar, and Mnuchin and Administrator Verma:

America's Essential Hospitals appreciates the opportunity to respond to the above captioned proposed rule from the departments of Labor, Treasury, and Health and Human Services. In particular, we provide comments in response to the departments' request for information (RFI) about quality measurement and reporting related to price transparency.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to providing high-quality care to all. While our members represent just 6 percent of hospitals nationally, they provide 23 percent of all charity care nationwide, or about $5.5 billion, and 17.4 percent of all uncompensated care, or about $6.7 billion.[1] The high cost of providing care to low-income and uninsured patients leaves essential hospitals with limited financial resources. Even with their limited means, our member

[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2017 Annual Member Characteristics Survey*. America's Essential Hospitals. April 2019. www.essentialdata.info/. Accessed December 19, 2019.

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hospitals demonstrate an ongoing commitment to serving vulnerable patients. Essential hospitals provide specialized services their communities otherwise would lack (e.g., trauma centers, emergency psychiatric facilities, burn care); expand access with extensive networks of on-campus and community-based clinics; furnish culturally and linguistically appropriate care; train health care professionals; supplement social support services; and offer public health programs.

Essential hospitals are continually called on to meet the complex clinical and social needs of the patients that come through their doors. Our members provide comprehensive ambulatory care through networks of hospital-based clinics that include onsite features—radiology, laboratory, and pharmacy services, for example—not typically offered by freestanding physician offices. Their ambulatory networks also offer behavioral health services, interpreters, and patient advocates who can access support programs for patients with complex needs.

America's Essential Hospitals supports the departments' efforts to improve transparency and ensure patient access to vital information to make informed decisions about their care. However, we urge the departments to achieve greater alignment of measures across payers, address disparities, and reduce reporting burden for essential hospitals.

1. **The departments should promote the sharing of individualized cost information with patients, including information generally received in an explanation of benefits (EOB), before they receive covered items and services.**

The departments propose to require group health plans and health insurance issuers disclose to beneficiaries cost-sharing information in a manner most familiar to them—i.e., existing notices that plans and issuers generally provide to beneficiaries after health care items and services have been furnished, such as an EOB. As proposed, disclosure of such information would be required before the delivery of items and services to allow beneficiaries the opportunity to understand their cost-sharing liability before receiving care. Sharing patient-specific information on their own out-of-pocket costs is a more accurate and potentially less burdensome use of hospital resources and will lead to less confusion among patients, especially essential hospitals' patients, who often have low health literacy or limited English proficiency (LEP).

We agree sharing of information, which generally is received in an EOB, before services are rendered does not pose an increased risk to plan or issuer and would benefit the beneficiary. Further, we urge the departments to require health plans to make this information available to providers. Doing so will ensure the best possible care that meets patients' needs by allowing providers, plans and issuers, health organizations, and patients to more freely share and receive information about health care costs and related financial constraints.

Our members are pioneering work to promote individualized communication about health care costs with all patients, including vulnerable patients facing social, linguistic,

and economic obstacles. An essential hospital in Indiana has been at the forefront of providing price information to their patients in a timely manner. This essential hospital invested time and resources to offer a cost estimation tool with which patients can fill out a web-based form that asks about insurance coverage and their specific procedure. A dedicated team of hospital staff then uses the information to create a personalized estimate of the patient's out-of-pocket costs. When appropriate, the team produces multiple estimates based on various foreseeable circumstances. Accuracy of estimates is a critical component of transparency, and this essential hospital uses internal audits to ensure credibility in their tool.

Another essential hospital, in the Boston area, created a price quote telephone line within its financial assistance department. The line is promoted externally, on a website, and internally as a resource for patients to request a price quote for services at the hospital. The hospital's customer service staff manage the request internally, utilizing a standardized price quote request form to expedite the process. Coding staff then perform the necessary research and evaluation and convey this information back to the customer service staff. The patient is called with the information and sent a confirmation letter (by mail or email, based on patient preference) once the request is completed. The standard letter format includes both the pricing for the requested services and a link to the website of the payer for the patient to access information related to the required allowed amount by their insurance company. **We support policies that encourage the sharing of individualized cost information at the patient level to assist in shared decision making, and we note that such policies thrive when they are created organically, based on user needs, rather than prescribed by federal policies.**

2. **The departments should not finalize proposals on the public disclosure of negotiated rates and historical out-of-network allowed amounts that exceed the administration's legal authority and would only confuse consumers.**

America's Essential Hospitals supports efforts to improve transparency and ensure patients have access to vital information to make informed decisions about their care. However, **we have concerns about mandating the public posting of payer-specific negotiated rates.** The proposal would require plans and issuers to publicly disclose negotiated rates with in-network providers and historical out-of-network allowed amounts. The departments' approach to price transparency would confuse—not help—patients in understanding their potential out-of-pocket cost obligations; severely disrupt contract negotiations between providers and health plans; and exceed the administration's legal authority. **We urge the departments to consider the unintended consequences that could come from disclosure of negotiated rates, abandon this proposal, and seek alternatives that better serve the needs of the consumer.**

a. The departments lack the legal authority to compel the public disclosure of highly sensitive and confidential pricing information.

The departments' proposal to require health plans to broadly and publicly disclose negotiated rates violates the Affordable Care Act (ACA). Further, the proposal to mandate disclosure of highly confidential and commercially sensitive negotiated rate information is in violation of the First Amendment.

The departments rely on section 1311(e)(3) of the ACA as their purported authority to compel broad and public disclosure of negotiated rates. Section 1311(e)(3), titled "Transparency in coverage," states each health insurance exchange must "require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, [and] the State insurance commissioner, and make available to the public" eight statutorily enumerated types of information related to coverage (e.g., claims payment policies and practices, periodic financial disclosures, data on enrollment).[2] Section 1311(e)(3) also includes a catchall provision that requires disclosure of "[o]ther information as determined appropriate by the Secretary."[3] The departments assert that negotiated rates are "other information" that is a proper subject of disclosure under the catchall provision.[4]

However, all of the information subject to disclosure under section 1311(e)(3) must be related to "[t]ransparency in coverage."[5] In other words, where the health and human services secretary designates "other information" for disclosure under section 1311(e)(3)'s catchall provision, that other information must further transparency in coverage, just as the statutorily enumerated types of information do. The departments cannot lawfully require disclosure of negotiated rates under section 1311(e)(3) because it relates to price, not coverage.

Further, the departments' proposal to mandate the disclosure of highly confidential and commercially sensitive negotiated rate information constitutes compelled speech in violation of the First Amendment to the United States Constitution. Government regulation of nonmisleading commercial speech is unlawful unless it "directly advances" a "substantial" governmental interest and is no "more extensive than is necessary to serve that interest."[6] The departments' proposal to mandate public disclosure of negotiated rates does not advance a substantial governmental interest, much less in a narrowly tailored way.

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[2] Section 1311(e) of the ACA is codified at 42 U.S.C. § 18031(e)(3).
[3] 42 U.S.C. § 18031(e)(3)(ix).
[4] 84 Fed. Reg. 65,464, 65,477 (Nov. 27, 2019).
[5] 42 U.S.C. § 18031(e)(3) (emphasis added); *see generally Almendarez-Torres v. United States*, 523 U.S. 224, 234 (1998) ("'[T]he title of a statute and the heading of a section' are 'tools available for the resolution of a doubt' about the meaning of a statute.") (citing *Trainmen v. Baltimore & Ohio R. Co.*, 331 U. S. 519, 528–29 (1947)).
[6] *Central Hudson Gas & Electric Corp. v. Public Service Commission of New York*, 447 U.S. 557, 566 (1980). Certain uncontroversial commercial disclosures may be required consistent with *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626 (1985). But the departments have failed to identify a sufficient predicate to justify the application of *Zauderer* to the facts presented here. In any event, the proposed rule here would fail under either test. Even under *Zauderer,* a disclosure requirement cannot be "unjustified or unduly burdensome." *Id.* at 651.

b. Price transparency efforts should be limited to the types of information important and useful to consumers.

The departments reason that the proposed disclosure requirements would help "expose price differences so that consumers can judge the reasonableness of provider prices and shop for care at the best price." Given the large number of plans and variation in reimbursement rates set by insurance companies, requiring public posting of negotiated charges only will add to the volume of complex, disparate information consumers might neither access nor find useful. **We urge the departments to take a more strategic approach to disclosure that focuses on the kinds of information most useful to consumers.**

Further, information made publicly available must explain how and why the cost of patient care varies among hospitals. Essential hospitals often have higher costs given their complex patient mix and the provision of services vital to the community, such as trauma or behavioral health care. Much of this care is provided to disadvantaged patients, who often are uninsured. This leaves essential hospitals to shoulder the costs of the uncompensated care provided to these patients. In addition, essential hospitals are committed to teaching and training the next generation of physicians, further increasing the cost of care. Information provided to patients should include the unique cost challenges essential hospital face in their mission of caring for vulnerable people. We urge the departments to consider the unique role essential hospitals play in serving patients who face social, linguistic, and economic obstacles, as well as the high costs associated with tackling these challenges, when discussing price transparency initiatives or policies.

3. The departments should leverage existing quality data before creating new reporting requirements in the context of price transparency.

Essential hospitals are committed to quality improvement through meaningful measures, transparency, and accountability. These hospitals understand the importance of quality improvement reporting, especially with increasing demands for accountability, movement toward value-based purchasing, and growing consumer engagement. Even before hospital quality reporting efforts became law, hospitals began voluntarily reporting quality information through the Hospital Quality Alliance in 2003. The Centers for Medicare & Medicaid Services (CMS) Hospital Inpatient Quality Reporting (IQR) Program was implemented to further promote hospital quality reporting by developing financial incentives for adherence to reporting requirements. Similarly, the Hospital Outpatient Quality Reporting (OQR) Program requires hospitals to publicly report on measures of hospital outpatient quality. Hospital IQR and OQR data, along with other reporting data, is published on CMS' Hospital Compare website, a public website for consumers that shares quality information about more than 4,000 Medicare participating hospitals across the country.

In addition to CMS' Hospital Compare website, there are several nongovernmental websites that rate hospitals on various measures and characteristics. Consumers can

easily be overwhelmed and misled by these varying, and often contradictory, rating systems. America's Essential Hospitals supports quality improvement initiatives and the display of information to help guide patient choice. But we caution that many disparate quality reporting standards serve only to increase administrative burden without necessarily meeting their goals. Additionally, there is a lack of alignment across public and private payers. When multiple payers and CMS require a hospital to report on a particular condition using different measure definitions, the result is duplication, waste, and added burden. We are encouraged by the work of the National Quality Forum and America's Health Insurance Plans to seek better alignment of provider-level measurement through the Core Measure Quality Collaborative. **We urge the departments to leverage data from existing efforts before creating any new requirements related to price transparency.**

4. **Quality measurement and reporting must account for social risk factors that impact health outcomes and are unrelated to care quality.**

No current public resources for consumers to engage in decision making—before or at the time of service—account for hospitals that perform a greater number of complex surgeries and serve patients with social risk factors, unrelated to care quality, that affect outcomes. The departments seek feedback on the use of existing care quality information from CMS programs, such as the Quality Payment Program (QPP), for in-network providers in the individual and group markets. America's Essential Hospitals previously expressed concern that measures in CMS' quality programs—including the QPP—unduly penalize hospitals that serve the nation's most vulnerable populations because of a failure to account for all external factors outside the control of the hospital and impact outcomes. Homelessness, cultural and linguistic barriers, low literacy, and other socioeconomic factors can skew results on certain quality measures, such as those for readmissions. If patients receive information on price and quality that does not accurately account for differences in patient populations and factors outside the control of the hospital, or is not comprehensible and useful, it can lead to misinformed choices. **To ensure health care consumers receive accurate, relevant information to make the best care decisions, quality measures should be adjusted for socioeconomic and sociodemographic factors that complicate care for vulnerable patients.**

5. **Quality measurement and reporting should have a clear tie to improving patient safety and advancing CMS' existing quality priorities.**

The rapid growth in measures and measure reporting requirements has jeopardized the effectiveness of efforts to make meaningful quality improvements. Although some measures provide useful information, their sheer number—as well as lack of focus, consistency, and organization—limits their overall effectiveness in improving health system performance. We applaud CMS' efforts to increase measure alignment across programs and reduce provider reporting burden through its Meaningful Measures initiative. Through this initiative, the agency has taken significant steps to identify high-priority areas for quality measurement and improvement and remove duplicative

measures. However, the proposed use of quality measurement and reporting requirements narrowly focused on bolstering a price transparency agenda could hinder the success of the Meaningful Measures initiative. **As the departments consider the role of quality information in price transparency policies, it is critical that any new requirements align with the Meaningful Measures framework.** Further, we urge the departments to examine potential gap areas in current quality measurement, such as behavioral health and equity of care.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

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President and CEO