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June 25, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Price Transparency Request for Information (RFI); CMS–1694–P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services (CMS) on how to better assist patients in accessing pricing information for health care services. These comments supplement a separate letter the AHA has submitted responding to the other elements of the proposed rule for the inpatient prospective payment system (PPS) for fiscal year (FY) 2019.

In the proposed rule, CMS announced updated guidelines for hospital compliance with existing transparency requirements. Specifically, effective January 1, 2019, hospitals must post a list of their current standard charges on the internet in a machine-readable format. The agency also solicited input on ways to make more useful pricing information available to consumers. The agency seeks input on how to define “standard charges;” how hospitals can best enable patients to use charge and cost information; whether providers should be required to disclose out-of-pocket costs before a service is furnished; and how the agency can best enforce these requirements, among other issues.

The AHA is committed to improving patients' access to information on the price of their care. CMS's updated guidelines may help some patients obtain pricing information; yet, numerous challenges must be overcome to provide accurate price estimates broadly. The provision of care is complex, and often the exact course of care is not knowable in advance. Moreover, individuals are more interested in knowing how much they will need to pay for their care or, more specifically, their out-of-pocket costs. Yet hospitals, health systems and other providers do not have access to detailed data on health plan benefit and beneficiary cost-sharing amounts; rather, insurers hold this information. **We recommend that the agency convene a multi-stakeholder process to discuss how we can work together to improve price transparency, the sharing of information on health plan benefit structure and cost-sharing amounts, and overall health care literacy.**

Below are our detailed comments on how patients access out-of-pocket cost information today, the challenges associated with providing upfront out-of-pocket estimates for health care services, and ways in which we can better provide this information to patients.

Standard Charges. CMS seeks input on how to define "standard charges" for purposes of price transparency requirements, including what the agency should require hospitals to publically post in machine-readable format. As noted above, charge information may not help the vast majority of individuals. Instead, the most relevant information is their potential out-of-pocket costs for a given service or course of treatment. More than 90 percent of individuals in the U.S. have health coverage, and their payer – whether Medicare, Medicaid or a private insurance plan – establishes their cost-sharing obligations, which takes into account whether the plan covers the service, whether the provider is in the plan's network, the plan's cost-sharing requirements and, if applicable, where the individual is under their deductible. Hospitals contract with more than 1,300 payers nationally, and the vast majority offer multiple (sometimes dozens or more) health plans with different benefit structures. Payers are the best source of information on what a covered individual's out-of-pocket costs may be for a given service.

Despite this, patients do ask providers for cost estimates and will continue to do so. Hospitals and health systems help patients obtain answers to these questions by working with insurers. Once a provider has identified the patient's need for a specific diagnostic service or care protocol, hospital financial counselors help patients work with their insurer to establish what the patient's cost-sharing obligation may be. Financial counselors may need to repeat this process multiple times, as the course of care may change for any number of reasons. This is largely a hands-on process today with hospital staff connecting with insurers via their websites and call centers to obtain patient-specific information. Many hospitals and health systems, however, are working on ways to leverage web-based technology to streamline these processes for patients.

For the 10 percent of the population that is uninsured, availability of standard pricing information can be helpful and is already available consistent with federal law. Providers can and do respond to inquiries from uninsured individuals with information on their standard charges. Many of these patients are of limited means and also will not pay the standard charge, as hospitals and health systems provide billions of dollars of charity care each year. Part of the

discussion between providers and uninsured patients on price estimates includes information on any financial assistance policies the hospital may offer.

Patient Information on Charges and Cost. CMS poses a number of questions related to the types of information that would be most beneficial to patients, how hospitals can best enable patients to use charge information, and how CMS and providers can help third parties create patient-friendly interfaces with these data. The agency also seeks information on whether and how health care providers should be required to inform patients what their out-of-pocket costs for a service will be before those patients are furnished that service, among other related questions.

As noted above, the AHA believes that out-of-pocket cost information is the most relevant pricing information for patients. A number of tools already exist to provide this information, including web-based tools developed by hospitals and health systems, commercial payers and third-party vendors. Our own examination of a number of these tools suggest that patients may encounter a number of challenges that are not the fault of the tools, but rather reflect the nature of health care. Specifically, there is a lot of uncertainty in health care. The path to diagnosis and treatment can vary significantly based on the underlying health issue and the appropriate care pathway for a given individual. Research suggests that few health care services are "shoppable." In fact, some researchers estimate that as little as 7 percent of health care services would meet the criteria.[1] While these tools can generally provide accurate price estimates for a small set of discrete services, the estimates vary widely for more complicated or variable sets of services.

We encourage software developers and other technical experts to work with providers and insurers on tools that they can use to help respond to patient pricing inquiries. For example, software developers could help develop a web-based portal that connects providers to multiple insurers' information. We again note that only insurers, including CMS for the Medicare population, have complete information about what their enrollees may pay for the same service at different in-network providers

Additionally, we urge CMS to be mindful of unintended consequences. We do not want patients to forgo needed care, especially if the quoted price is for the total cost of the service and not what the patient will be expected to pay out-of-pocket. Exposure to upfront prices may result in patients delaying or altogether foregoing care, including necessary care. The Department of Health and Human Services (HHS) and the White House acknowledged this challenge in the recent *Blueprint to Lower Drug Prices*. Specifically, the *Blueprint* noted that cost burden is "not only a financial challenge, but a health issue as well: One study found that consumers asked to pay $50 or more at the pharmacy counter are four times more likely to abandon the prescription than a consumer charged $10."[2]

[1] Health Care Cost Institute, "Spending on Shoppable Services in Health Care," March 2016. Accessed at: http://www.healthcostinstitute.org/files/Shoppable%20Services%20IB%203.2.16_0.pdf
[2] U.S. Department of Health & Human Services, "American Patients First: The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs," May 2018. Accessed at: https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf

Moreover, we urge the agency to explore how best to inform patients about other considerations in addition to cost. Importantly, patients should be able to evaluate the quality of different providers, as well as better understand the importance of following through with the prescribed course of care. We encourage HHS to assist the field in improving health care literacy and expanding the knowledge base about the impact of pricing information on patient decision-making.

Transparency in Medicare Payment. The agency seeks information on whether health care providers should provide patients with information on what Medicare pays for a particular service and, if so, the steps that would be needed to operationalize this. Given that fee-for-service (FFS) Medicare uses a standard cost-sharing amount for inpatient services, we do not believe that any new information or tools need to be developed for FFS Medicare beneficiaries seeking inpatient care. With respect to outpatient care, we note that the copay structure, as well as high enrollment in supplemental coverage, precludes providers' abilities to automatically provide an accurate initial out-of-pocket cost estimate to every Medicare beneficiary for a discrete Part B service. Instead, hospitals and health systems should continue to work with the patient and any supplemental payers to determine the specific individual's cost-sharing obligation for a service.

Enforcement of Price Transparency. CMS solicits input on how it can best enforce any requirements related to price transparency. Given the challenges associated with making price information more easily accessible, we discourage CMS from taking a punitive approach against providers who cannot meet all patient expectations for price transparency. First, as previously mentioned, providing exact cost estimates for most services is not possible given the inherent uncertainty of health care and the fact that providers do not have access to every health plan's cost-sharing requirements. Second, the challenge of providing appropriate pricing information may relate to a patient's level of understanding of their health coverage. Hospitals and health systems report that an increasing number of patients, particularly those in high-deductible health plans, are surprised by their out-of-pocket cost because they do not understand how their coverage works. We encourage CMS to convene providers, insurers, patients, and employers to explore ways to increase patients' health care literacy, especially around their health plan benefit design.

Supplemental Coverage (Medigap). The agency seeks input on how price transparency proposals should work in the scenario where a beneficiary has supplemental coverage. The Medigap scenario provides just another example of why providers must work with payers to determine accurate patient-level cost information. We reiterate that this is often a manual process that relies on hospital financial counselors working directly with patients and the payers to develop out-of-pocket cost estimates.

CONCLUSION

As articulated above, price transparency is an extremely complex topic that involves the engagement of numerous stakeholders. Hospitals and health systems do our part to help patients understand the cost of their care. We agree that improvements can and should be made. Thus, over the past two months we have met with almost 550 health care leaders to explore potential policy options for moving forward. We would like to sit down with CMS and other stakeholders to work to develop solutions that will help move the field forward on price transparency. The engagement of health care insurers will be critical.

We believe enhanced price transparency can be achieved. Consequently, the AHA appreciates the opportunity to provide input on how the health care field can better support patients in accessing information on their out-of-pocket costs for care. Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, vice president of policy, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President