



**American Hospital
Association®**

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January 7, 2021

The Honorable Alex M. Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans, and our clinician 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, **we urge you to exercise enforcement discretion with respect to the hospital price transparency rule.**

Hospitals ability to comply with the rule at this time is particularly challenged by an increase in the volume of COVID-19 patients and the need to distribute multiple vaccines. Both of these events are straining hospital and health system resources at a critical time in the course of the pandemic sweeping the nation. These strains are further compounded by the considerable gaps in federal guidance creating compliance uncertainty and recent legislation placing new price transparency requirements on hospitals. In light of these exigencies, we urge you to exercise enforcement discretion until the end of the public health emergency.

COVID-19 and Hospital and Health System Resources to Comply

COVID-19 has strained hospital and health system resources since March 2020. However, the recent upsurge in infections has exacerbated that strain to record levels. Moreover, hospitals are now in the position of being able to distribute life-saving vaccines. Meeting both of these challenges requires many of the same personnel who are needed to comply with the rule. This includes finance, billing and information technology (IT) staff. For example:

- The same revenue and IT departments needed to implement this rule are critical when it comes to building out hospital surge capacity.
- The same IT staff who are responsible for updating the hospital websites with the machine-readable files and creating new, consumer-friendly websites with



shoppable service information also are responsible for building a tracking system for COVID-19 vaccine administration in order to comply with state and federal reporting requirements.

- The same revenue and billing staff integral in coordinating the development of the machine-readable files also are needed to establish a new system for the administration of COVID-19 vaccines and managing the cancellation and rescheduling of hundreds to thousands of procedures.

The time and resources these employees devote to implementing this rule are time and resources diverted from responding to the COVID-19 pandemic. These competing resource constraints do not diminish simply because we have passed the Jan. 1, 2021 implementation date.

Gaps in Federal Guidance

The Department of Health and Human Services has not provided sufficient guidance to hospitals in several key areas of the rule. Among the most significant gaps is guidance for which rate hospitals should use when no rate exists in the contract. Specifically, the Centers for Medicare & Medicaid Services requires hospitals to post a list of their standard charges – including the gross charges, negotiated rates, de-identified minimum and maximum negotiated rates, and discounted cash price – for all items and services in a machine-readable format on their websites. However, there are a number of instances where a single negotiated rate simply does not exist. Rather, multiple contracted rates for a single service may exist, based on certain conditions, some of which are only determined at the time of service or as a result of the outcome of the service. For example:

- The final rate of a service, i.e., the rate that is ultimately included on the patient's explanation of benefits, depends on whether the service is considered the primary or secondary service.
- The final rate of the service also may vary based on inputs such as the length of time spent in the operating room or the type of implant used.

In short: the number seen on a patient's bill or explanation of benefits may not exist until patient-specific factors are known. While we have repeatedly presented this conundrum for resolution, we still do not have clear guidance on whether or how to generate a rate in these situations.

New Statutory Price Transparency Requirements

The difficulties in implementation are newly compounded by legislation passed at the end of the year that included additional transparency requirements for providers. While the legislation and the hospital price transparency rule overlap in their respective focus on assisting consumers in understanding what they will pay for their health care, they differ significantly in how they achieve that objective. The new law requires providers to develop "good faith estimates" of the total expected charges for scheduled items and services, with new requirements for exactly how and what information needs to be

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shared. Though regulations are needed to define precisely how providers can meet these requirements, it is clear that the current requirements related to machine-readable files will not be useful to meet these goals. A great deal of coordination will be required to mesh the current and new requirements and the focus should remain on those that best assist patients in understanding what they will pay and thus enable them to be more prudent purchasers of health care.

We again ask that the agency exercise enforcement discretion at least until the end of the public health emergency and use that time to effectively mesh the new and existing requirements. We stand ready to work with you to align these requirements to benefit patients. We thank you for your consideration.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

Cc: Seema Verma, Administrator, Centers for Medicare & Medicaid Services