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Matthew Eyles
President and CEO

September 27, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1717-P
P.O. Box 8013
Baltimore, MD 21244-8050

Submitted electronically via www.regulations.gov

RE: [CMS-1717-P]: 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:

On behalf of America's Health Insurance Plans (AHIP)[1], thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Outpatient Prospective Payment System (OPPS) Proposed Rule (Proposed Rule), including the price and quality transparency provisions. Below we summarize AHIP's comments and recommendations on the transparency provisions of the Proposed Rule. The attachment offers a more detailed compilation of these comments, as well as our comments on the other sections of the Proposed Rule.

Every American should be able to get the health care information they need, when they need it, in a way that's customized and personal to their own circumstances in order to make informed health care decisions for themselves and their families. AHIP and its member health insurance providers share this commitment with the Administration, and we know that consumer-focused transparency strategies and tools are essential to our ability to deliver on it.

By contrast, forced disclosure of privately and competitively-negotiated rates, as proposed in this rule, will not provide information that is actionable by, or helpful to, consumers. It will hamper competitive negotiations and push health care prices higher – not lower – for patients, consumers, and taxpayers. That is why AHIP strongly urges CMS to withdraw the proposal to

[1] AHIP is a national association representing members that provide health care coverage for millions of Americans across the country. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, quality, access, and well-being for consumers.

publicly post payer-specific negotiated rates. Such disclosure would fail to deliver on what consumers need to make informed health care decisions, distort health care markets by driving prices and premiums up for consumers and employers, exceed CMS' statutory authority, and be operationally challenging to effectively implement.

Let us be perfectly clear: Health insurance providers unequivocally want to empower patients and consumers with more easily understandable information about the cost and quality of their care. Today, the vast majority of health insurance providers offer a variety of online tools for this purpose, such as cost estimator tools, through their secure plan member portals and mobile apps. AHIP stands ready to engage collaboratively with the Administration and other health care stakeholders to find better solutions that decrease prices and costs for everyone that simultaneously protect health care quality, choice, value, and privacy for the hardworking Americans we serve.

The Administration has advanced several interlocking proposals that aim to leverage information technology platforms, systems and applications to drive systemic change in the health care system. New regulations on interoperability, transparency, and accessibility of health information to support consumers in health care decision-making have been proposed or are under development.[2] We have submitted recommendations on these proposals separately.

The Proposal Would Not Meet Consumer Needs

This Proposed Rule would not result in consumers being provided with the type of actionable, personalized information they need to make more informed decisions about their access to health care services and their specific costs. Publicly providing a long list of each hospital's standard charges and payer-specific negotiated rates will not provide meaningful insight into what a self-pay or an insured individual would ultimately need to pay out-of-pocket. Nor would it allow patients to shop across care delivery sites (e.g., outpatient department versus ambulatory surgical center) as health insurance provider apps do. At the same time, it will risk higher prices for consumers as we outline below.

We also believe that price information should always be posted in tandem with quality indicators to give consumers a complete perspective of the provider's value. Higher prices may not be correlated with higher-quality providers and vice-versa. Yet, that integral component of quality is only in the request for information stage.

Further, releasing static large-scale datasets to third-party vendors to display to consumers would lead to the communication of inaccurate and misleading information. This data would not consider the patient's coverage under their benefit plan, where they are in their deductible or how much cost sharing (e.g., co-pays or co-insurance) would be required, and other critical benefit features that would inform the patient's out-of-pocket costs.

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[2] *See* not only this Proposed Rule, but also the CMS "Interoperability and Patient Access Proposed Rule" (84 Fed. Reg. 7610); the Office of the National Coordinator "Interoperability, Information Blocking, and the ONC Health IT Certification Program Proposed Rule" (84 Fed. Reg. 7424); and the upcoming Advance Notice of Proposed Rulemaking from the Department in collaboration with the Departments of the Treasury and Labor on health plan transparency tools required by EO 13877 Section 3(b).

Moreover, we continue to have serious concerns about the potential negative consequences for consumers and patients, as sensitive information released under the proposed interoperability rules would be combined with this information (e.g., which health conditions or medical procedures you searched for online, through mobile apps and/or social media platforms) and other public data to create individually-identifiable profiles of consumers, which could be sold to unrelated third parties for health or non-health related purposes.

The Proposed Rule Could Increase Consumer Premiums

Governmental agencies like the Federal Trade Commission (FTC), Department of Justice (DOJ) and the Congressional Budget Office (CBO) have expressed concern over the public disclosure of trade secrets and competitively-sensitive, proprietary information like payer-negotiated rates that could reduce competition and raise prices for consumers.

The FTC, for example, expressed concern about a similar open data state law, suggesting it could result in unlawful collusion, chilled competition, and a lessening of selective contracting by health plans to reduce health care costs and improve the value of health care delivery in that state. The FTC concluded that the negative impact this law would have on health care markets—and the potential upward pressure such disclosure would have on prices—would place consumers at risk for higher premiums and less access to high value care.

CMS Lacks the Necessary Legal Authority

The proposed transparency provisions requiring the public display of payer-specific negotiated rates exceed CMS' statutory authority, constitute a taking of health insurance providers' trade secrets, and unconstitutionally compel speech. The statute's text, context, and purpose show that it unambiguously precludes interpreting a hospital's "standard charge" to include "payer-specific negotiated rates.[3]" Moreover, forced disclosure of payer-specific negotiated rates impairs protected health insurance providers' property interests in trade secrets under the Takings Clause and core First Amendment interests against compelled speech.

The Proposed Rule is Operationally Infeasible Within the Given Timetable

Implementation of the transparency provisions as proposed would be operationally infeasible in the given timeline and would result in consumers trying to compare apples to oranges. Hospitals services are virtually never paid for on an item or service basis, rendering a significant portion of the proposal of no utility to consumers. Instead, items and services are generally paid for based on "service packages" but those packages can vary by service and payer. For example, some payers rely on Medicare Severity Diagnosis-Related Groups (MS-DRGs) while other use All-Patient Refined DRGs (APR-DRGs) depending on the population.

[3] See Section 2718(c) of the Affordable Care Act (42 U.S.C. § 300gg-18(e)). STANDARD HOSPITAL CHARGES.—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 for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

Even if a common grouper is used, the different payment units can vary. A DRG, for example, can be paid as a flat fee, a per-diem, a percent of charges, or even a bundled episode payment that includes far more than the inpatient stay. Furthermore, the hospital information then must be matched with physician Current Procedural Terminology (CPT) codes. While CMS requires a consumer-friendly format, it is difficult to conceive of how that would be possible under this proposal.

CMS Should Consider Policy Alternatives and Industry Collaboration

In the Proposed Rule, CMS requests comments on alternative definitions for standard charges. We do not recognize these alternative policies as fitting the definition of "standard charge," and do not believe they are supported under the statutory framework governing the Proposed Rule, but we do comment on the utility of these options to consumers.

For self-pay consumers, we urge CMS to work collaboratively with the hospital community to establish a demonstration project to make the discounted cash prices more easily accessible and standardized.

For insured consumers, only health insurance providers in partnership with health care providers can provide the information that really matters to consumers—timely, accurate, and customized cost-sharing estimates. CMS should work with hospitals and health insurance providers to educate consumers and enhance the utility of tools that are already available. However, CMS could also work with hospitals to release the unweighted average negotiated rate for commercial plans as a basic benchmark for vendors posting a general composite score, including quality metrics, for providers when certain market conditions exist that would prevent the prices paid by a particular entity from being identified. Alternatively, publicly sharing the mean of the lowest quartile of commercial rates might also serve to put downward pressure on rates in the market (under the market conditions as referenced above).

Conclusion

AHIP and our member companies believe that all consumers deserve access to health care information that is customized, personalized, and empowers them with timely and accurate information about cost and quality to make informed health care decisions for themselves and their families. We are committed to working with the Administration and other stakeholders to advance greater access to price and quality transparency for consumers and providing consumers with actionable data to make reducing health care costs a reality.

However, the transparency provisions of this Proposed Rule to require public posting of payer-specific negotiated rates would not advance the goals articulated above. Instead, the proposed rule would result in: consumers lacking the information they need to make informed health care decisions; higher prices and premiums for consumers and employers by distorting health care markets; the agency exceeding its statutory authority; and significant operational challenges leading to ineffective implementation. For all of these reasons, we urge CMS to withdraw the transparency provisions of the Proposed Rule and work collaboratively with health insurance providers and other stakeholders to find better solutions.

If you have any questions, please reach out to Danielle Lloyd, Senior Vice President of Private Market Innovations and Quality Initiatives at either dlloyd@ahip.org or (202) 778-3246.

Sincerely,

Matthew Eyles
President and CEO

Enclosure

Attachment

AHIP Detailed Comments on the Medicare Program: CY 2020 Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs ("Proposed Rule")

I. PUBLIC LIST OF STANDARD CHARGES

CMS proposes to require all hospitals to publicly post gross charges as well as payer-specific negotiated rates for all items and services for which there is a charge in its chargemaster as well as "service packages." All of this information must be included in an online machine-readable file, while a subset of 300 "shoppable" services must be made available in a consumer-friendly online and paper-based format.

While CMS has articulated two goals behind requiring the release of this data: assisting consumers with health care decisions by providing price quotes and reducing overall consumer prices, CMS' proposals do not achieve either of these goals. The information to be provided will not assist consumers in shopping for care and could disrupt market dynamics leading to less competition and higher prices. ***CMS should withdraw the requirement to publicly post gross hospital charges and negotiated rates because it: 1) would not meet consumer needs; 2) would distort health care markets risking higher prices for consumers; 3) exceeds statutory authority and raises Constitutional concerns and 4) is operationally unrealistic.***

A. Proposal Would Not Meet Consumer Needs (XVI. D. 1.; pgs. 39577-39580)

AHIP and its members are committed to the common goal of increasing the availability of meaningful consumer information to promote choice in health care. The vast majority of health insurance providers have developed online tools to allow enrollees to actively shop for care and bring greater value to consumers. Health insurance providers have taken significant steps toward increasing the availability of meaningful price and quality information for health care services and to promote its use in consumer decision-making.[4,5,6]

Unfortunately, this proposal will not meaningfully inform patient decision-making and allow consumers to compare prices and quality across hospitals to ascertain the full value of care. Nor would it allow patients to shop across sites (e.g. outpatient department versus Ambulatory Surgical Center) as health insurance provider apps do. A long list of each hospital's standard charges, which have little to no bearing on the ultimate expected payment by patients, whether they are insured or not, will not provide consumers actionable information. Neither will payer-specific negotiated rates

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[4] Price Transparency in Health Care Report from the HFMA Transparency Task Force, Healthcare Financial Management Association, 2014

[5] National Scorecard on Payment Reform, Catalyst for Payment Reform, 2014 reported that 97 percent of health plans offer or support a cost calculator tool https://www.catalyze.org/product/2014-national-scorecard/

[6] "Characterizing health plan price estimator tools: findings from a national survey," NCBI, 2016. Health plans use messaging on plan portals, outreach through employers, digital communications, including email, social media, and text messaging, and postal mail as the most common methods to make their enrollees aware of available price transparency tools. https://www.ncbi.nlm.nih.gov/pubmed/26885672

that do not reflect what insured patients need to know—*their* own out-of-pocket costs. In fact, CMS notes that their stakeholder engagement and research show that "consumers of health care services simply want to know where they can get a needed health service and what it will cost them out-of-pocket."[7] Even a "consumer-friendly" version of what CMS proposes will be overwhelming with scores of plans listed across one axis and scores of services listed on the other. While CMS narrows the list to 300 "shoppable" services, it retains the proposal to include each item and service, plus the service package and then the associated employed physician services. Under the proposed rule consumers would see a massive amount of information similar to what is displayed in Table 1 when the information from their health insurance provider displayed in Table 2 is much easier to understand and actionable. By providing overwhelming information that is not pertinent to consumers or even accurate for their situation, we put consumer trust at risk.

Table 1: Knee Replacement as Proposed

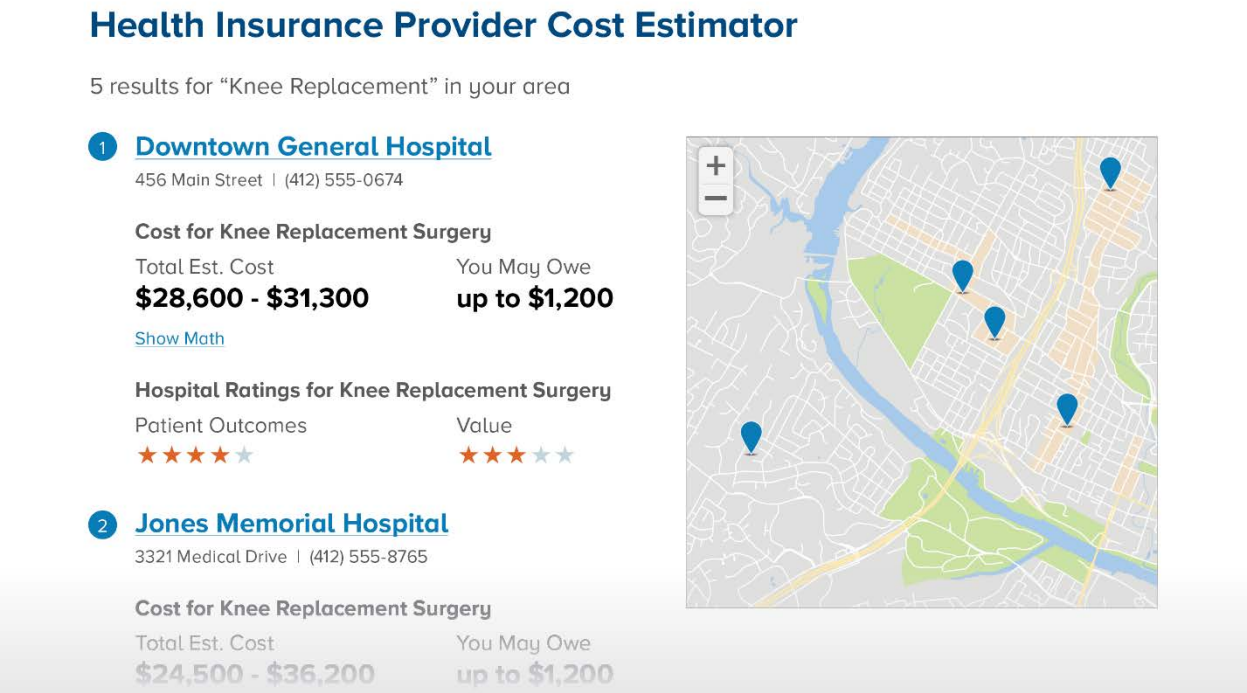
Knee Replacement

Primary Services											
Code	**Description**	**Gross charge**	**Negotiated Rate Plan A**	**Negotiated Rate Plan B**	**Negotiated Rate Plan C**	Negotiated Rate Plan D	Negotiated Rate Plan E	Negotiated Rate Plan F	Negotiated Rate Plan G	Negotiated Rate Plan H	Negotiated Rate Plan I
MS-DRG 469	Major joint replacement or reattachment of lower extremity w MCC	$60,000	$32,000	$25,000	$31,000	$36,000	$42,000	$28,000	$30,000	$32,000	$37,000
Rev	Laboratory (general)	$##,###	$##,###	$###	$#,###	$##,###	$##,###	$#,###	$##,###	$#,###	$##,###
Rev	Laboratory (chemical)	$##,###	$##,###	$###	$###	$##,###	$##,###	$###	$##,###	$###	$##,###
Rev	Laboratory (hematology) ▾	$#,###	$#,###	$###	$###	$#,###	$#,###	$###	$#,###	$###	$#,###
▸ CPT 85027	▸ Complete Blood Count (CBC) Without Differential	$43.62	$14.00	$16.00	$20.00	$#	$#	$#	$#	$#	$#
▸ CPT #####	▸ ...									$##	$##
▸ CPT #####	▸ ...									$###	$###
▸ CPT #####	▸ ...									$#,###	$#,###
▸ CPT #####	▸ ...									$###	$###
Rev	Diagn									$#,###	$#,###
Rev	EKG									$###	$###
Rev	Opera									$#,###	$#,###
Rev	Steril									$##	$##
Rev	Suppl									$##	$##
Rev	Anest									$###	$###
Rev	Room									$###	$###
Rev	Pharm									$#	$##
Rev	Drugs	$##	$#	$##	$#	$##	$#	$##	$##	$#	$##
Rev	Drugs (self adminsterable)	$###	$#	$#	$#	$#	$#	$#	$#	$#	$#
Rev	Drug	$##	$##	$##	$##	$##	$##	$##	$##	$##	$##
CPT	Physical Therapy (general)	$###	$##	$###	$##	$###	$###	$##	$###	$##	$###
CPT	Physician Therapy (evaluation)	$#,###	$###	$#,###	$###	$#,###	$#,###	$###	$#,###	$###	$#,###
CPT	Professional Service (surgon)	$###	$##	$###	$##	$###	$###	$##	$###	$##	$###
CPT	Professional Service (Anesthisiologist)	$###	$##	$###	$##	$###	$###	$##	$###	$##	$###
CPT	Professional Service (Radiologist)	$###	$##	$###	$##	$###	$###	$##	$###	$##	$###

Primary Services					
Code	**Description**	**Gross charge**	**Negotiated Rate Plan A**	**Negotiated Rate Plan B**	**Negotiated Rate Plan C**
MS-DRG 469	Major joint replacement or reattachment of lower extremity w MCC	$60,000	$32,000	$25,000	$31,000
Rev	Laboratory (general)	$##,###	$##,###	$###	$#,###
Rev	Laboratory (chemical)	$##,###	$##,###	$###	$###
Rev	Laboratory (hematology) ▾	$#,###	$#,###	$###	$###
▸ CPT 85027	▸ Complete Blood Count (CBC) Without Differential	$43.62	$14.00	$16.00	$20.00

[7] ibid

Table 2: Knee Replacement from Health Provider Site



Furthermore, the proposed rule fails to deliver that meaningful data to consumers but could also reduce market competition leading to *higher* negotiated rates and thus higher premiums. Furnishing large-scale static hospital datasets to vendors will not eliminate the need for health insurance providers to provide timely and accurate cost-sharing information based on coverage policies, co-insurance structures, deductible accounting, and other critical plan features. Finally, posting pricing information devoid of quality metrics will send an incomplete and potentially misleading signal to consumers. ***The proposed pricing transparency policies should be withdrawn as they do not provide consumers with actionable information, while at the same time putting them at risk for even higher health insurance premiums.***

B. Impact on Consumer Premiums (XVI. E. 1.; pgs. 39582-39585)
Contrary to suggestions in the proposed rule, public disclosure of negotiated rates will not put downward pressure on hospital prices and lower health care spending nationally. In fact, the proposal could have the opposite effect of reducing competition and increasing prices for consumers. CMS' proposal does not aid the legitimate concern of health care consumers who want to access information from their health plan about specific providers from whom they are seeking treatment. That information comes from their plan and will not be provided pursuant to this rulemaking.

For every premium dollar spent today in the U.S., 16 cents goes to hospital stays, 20 cents toward office and clinic visits and 22 cents towards doctor services.[8] Thus it is critical that policies help reduce health care spending not increase it. Numerous organizations including the Federal Trade Commission (FTC), Department of Justice (DOJ) and the Congressional Budget Office (CBO) have raised concerns about the unintended consequences of releasing competitively-sensitive, proprietary information, including the individual negotiated price agreed to between health insurance plans and each hospital for a wide-range of treatments, medical care and services.

The CBO, in reviewing the budgetary impacts of health care transparency proposals that are not as far-reaching as this rule, indicated that federal spending could increase "if providers became less willing to negotiate discounts once they had more information about their competitors' negotiated rates, particularly if the market is highly concentrated among a small number of providers." We are concerned that providers would use this information (as the CBO noted) to "exert their market power during negotiations" thus raising the floor on contracted pricing.[9]

Along with the CBO, both the FTC and the DOJ have expressed concerns about other similar transparency proposals, especially in more consolidated provider markets. Our members have raised the possibility that consultants aiding providers in seeking higher reimbursements from health plans will use the data included in the machine-readable files to increase their leverage (and in turn, their prices) in future price negotiations once these data are widespread and easy to manipulate.

In 2015, the FTC submitted comments to Minnesota state legislators in response for their request for comment on the possible competitive effects of a recently enacted law to have the contract terms of Minnesotan health plans subject to public disclosure. The FTC warned such release:

> "may chill competition by facilitating or increasing the likelihood of unlawful collusion and may also undermine the effectiveness of selective contracting by health plans, which serve to reduce health care costs and improve overall value in the delivery of health care services in Minnesota. This risk of such harm is especially great if this information is accessible to competing health care providers, and in highly concentrated markets where competition among providers is already limited."[10]

The FTC expressed concern about scenarios "when information exchanges or disclosures promote the sharing of sensitive information among competitors." Further noting "this may facilitate their ability to coordinate or collude to fix prices, allocate markets, or engage in other conduct that harms competition." [11] Economists at the University of Minnesota came to the same conclusion stating:

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[8] AHIP, Where Does Your Health Care Dollar Go?, May 22, 2018. https://www.ahip.org/wpcontent/uploads/2017/03/HealthCareDollar_FINAL.pdf

[9] Congressional Budget Act Cost Estimate of S. 1895 as ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on June 26, 2019. Available at: https://www.cbo.gov/system/files/2019-07/s1895_0.pdf

[10] FTC Letter to MN State Reps Hoppe and Hortman, June 29, 2015, Available at: https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702minnhealthcare.pdf. *Footnotes omitted.*

[11] ibid

"classifying plan-provider contracts as public data would offer little benefit but could pose substantial risk of reducing competition in health care markets."[12] We have the same concerns with this proposed rule.

Certain state activities have also led to hospitals seeking higher pricing during contract negotiations. In New Hampshire, Maine and Massachusetts, state organizations use claims data submitted by health insurance providers to produce health plan specific price estimates. For example, on the New Hampshire NH HealthCost™ website, consumers can search cost by hospital or medical procedure, by health insurance provider and by product type (i.e., individual market vs. group) for each service. Quality information is also available.[13] Several factors differentiate the information presented on these websites from what CMS is proposing.[14] Even with these factors that mitigate the potential impact of the rate exposure, data from these sites has been used in contract negotiations.

Providing tools for competitors to easily know the range of contracted rates will impede the ability of health insurance providers to contract with providers and will negatively impact health plan efforts to negotiate lower rates. This is not a hypothesis. Our member plans have seen this play out in some states that have posted health plan and specific negotiated pricing that is calculated from health plan claim submissions to state all-payer claims databases. When hospitals with less brand recognition can see what high brand hospitals are being paid, they demand higher prices. In our view, based on our member health insurance provider experience, prices will converge around the high-point, not around a low- or mid-point. Alternatively, hospitals will choose to stay out of health plan networks offered by smaller health plans in the market with fewer enrollees compared to other market players reducing the competitiveness of the insurance market. ***The pricing transparency provision of the Proposed Rule should be withdrawn as it runs contrary to the goal of lowering consumer prices.***

C. CMS Lacks the Necessary Legal Authority

The provision of the Proposed Rule requiring the publication of payer-specific negotiated rates is contrary to statute, effects a taking of health insurance providers' trade secrets, and unconstitutionally compels speech. For these reasons, ***CMS should withdraw the pricing transparency provision of the Proposed Rule.***

Statutory Basis (XVI. D. 1.; pgs. 39577-39581)

The Proposed Rule's requirement that hospitals publish confidential payer-specific negotiated rates is contrary to the authorizing statute, which calls only for publication of "hospital's standard charges."[15]

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[12] Minnesota Department of Human Services Health Care Administration, Health Care Contracting and the Minnesota Government Data Practices Act, January 30, 2015. Available at: https://mn.gov/dhs/assets/Health_Plan_Data_Report_tcm1053-166426.pdf

[13] https://nhhealthcost.nh.gov/

[14] Information posted must meet a threshold for a minimum number of claims, the information is only posted after the fact (generally several years old) and it is not physician specific (only facilities). In addition, separate prices are not presented for individual plans (e.g., plan A's HMO 1, HMO 2, PPO 1, PPO 2) but rather these numbers are averaged and combined across health insurance providers different product offerings.

[15] 42 U.S.C. § 300gg-18(e). *See Chevron, U.S.A., Inc. v Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984) ("[T]he agency[] must give effect to the unambiguously expressed intent of Congress.").

The statute's text, context, and purpose show that it unambiguously precludes interpreting "hospital's standard charges" to include "payer-specific negotiated rates."[16] Rates individualized to a particular payer, established through a negotiation process designed to depart from a hospital's normal charges, are by definition not "standard." They are also not the "hospital's … charges," but rather payment amounts that the insurance provider agrees to pay, and the hospital agrees to accept, in satisfaction of those charges. As AHIP has explained in comments on similar requirements,[17] these negotiated payment rates are insurance providers' trade secrets, and—as the agency recognized[18]—hospitals are often contractually obligated to protect them from disclosure. Therefore, unlike a "hospital's standard charges," these negotiated payment amounts are not the hospital's to disclose. Nothing in the statute authorizes CMS to require disclosures from insurance providers—yet that is precisely what the Proposed Rule does.

Statutory context confirms that the Public Health Service Act's reference to a "hospital's standard charges" does not authorize CMS to compel the disclosure of insurance providers' negotiated payments. In the context of Medicare Advantage, which is covered by the Proposed Rule,[19] Congress has protected insurance provider-hospital negotiations from interference and sensitive data from disclosure.[20] More broadly, Congress has enacted several statutes protecting trade secrets from disclosure.[21]

Given the extensive legal framework protecting this information as commercially sensitive trade secrets, and the centrality of confidentiality to insurance provider-hospital negotiations, Congress would have to speak plainly to authorize the agency to bypass these protections and require insurance providers to disclose negotiated payment rates. Statutory language requiring hospitals to disclose hospital standard charges falls far short of the authorization necessary to require the disclosure of insurance providers' negotiated payments.

Moreover, CMS' proposal not only contravenes the statute's plain meaning, it would defeat the statute's purpose, which is to bring down costs. As we note above in the Impact on Consumer Premiums section, the FTC has cautioned that disclosure of such competitively-sensitive information

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[16] *See, e.g.*, *Pharm. Research & Mfrs. of Am. v. Thompson*, 251 F.3d 219, 224 (D.C. Cir. 2001) (describing "text, structure, purpose, and legislative history" as part of the "traditional tools of statutory interpretation" to determine plain meaning).
[17] *See* Comment Letter, 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program, at 16-17 (June 3, 2019) ("Interoperability Comment").
[18] *Federal Register* / Vol. 84, No. 154 / Friday, August 9, 2019 / Proposed Rules / page 39579.
[19] *Federal Register* / Vol. 84, No. 154 / Friday, August 9, 2019 / Proposed Rules / page 39580.
[20] *See, e.g.*, 42 U.S.C. § 1395w–24(a)(6)(B)(iii) (non-interference); 42 C.F.R. § 422.310(f)(2)(iv) (implementing disclosures under risk adjustment statute with aggregation to "protect commercially sensitive data").
[21] *See, e.g.*, Defend Trade Secrets Act of 2016, 18 U.S.C. § 1836 *et seq.*; 5 U.S.C. § 552(b)(4) (Freedom of Information Act exemption for "trade secrets and commercial or financial information obtained from a person [that is] privileged or confidential").

may chill competition and could lead to higher prices.[22] These anti-competitive consequences confirm that the Proposed Rule contravenes Congress's intent.
As described above, the Proposed Rule is in irreconcilable conflict with earlier and more specific statutes, making the Proposed Rule invalid under the canons against implied repeal and dictating that more specific statutes control over general ones.[23]

Most fundamentally, forced publication of health insurance providers' trade secrets raises grave constitutional issues under the Takings Clause and the First Amendment—if not violating those provisions outright. If Congress wishes to authorize the agency to encroach upon insurance providers' property and speech rights in this manner, it must express its intent far more plainly than this statute, which on its face, provides no authority to regulate health insurance providers.[24] Nothing in the statute's plain terms can justify the Proposed Rule's upheaval of the long-established practice of maintaining confidentiality for payer-specific negotiated payments. Abrogating confidentiality will have far reaching negative consequences in health care markets with no real consumer benefit.[25]
The pricing transparency proposal should be withdrawn as it exceeds the CMS' statutory authority.

Takings Clause
The Proposed Rule exceeds the agency's power under both the Constitution and the statute. Trade secrets are private property protected by the Takings Clause, and the forced disclosure of such trade secrets under a statute, even if for private benefit, is a public use.[26] Because the Proposed Rule provides no "just compensation" to insurance providers compelled to relinquish their trade secrets for public use, it is an unconstitutional taking.

Forced disclosure of a trade secret eviscerates the "right to exclude" central to the definition of a trade secret as a property right.[27] For that reason, the Proposed Rule's disclosure requirement would effect a per se taking.[28] In addition, the Proposed Rule would represent a regulatory taking by upending health insurance providers' reasonable investment-backed expectations that payer-specific negotiated rates are trade secrets that the government is bound to protect from disclosure.

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[22] *See* Letter from FTC to The Honorable Joe Hoppe and The Honorable Melissa Hortman, Minnesota House of Representatives (2015), https://www.ftc.gov/policy/policy-actions/advocacy-filings/2015/06/ftc-staff-comment-regarding-amendments-minnesota-0; *see also* AHIP, Interoperability Comment, at 16-17.
[23] *See Nat'l Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 666 (2007) (canon against implied repeal); *Crawford Fitting Co. v. J.T. Gibbons, Inc.*, 482 U.S. 437, 445 (1987) ("Where there is no clear intention otherwise, a specific statute will not be controlled or nullified by a general one.").
[24] *Solid Waste Agency of N. Cook Cnty. v. U.S. Army Corps of Eng'rs* (*SWANCC)*, 531 U.S. 159, 172-73 (2001).
[25] *See Utility Air Regulatory Group v. EPA*, 572 U.S. 302, 324 (2014) ("We expect Congress to speak clearly if it wishes to assign to an agency decisions of vast economic and political significance.").
[26] *See Ruckelshaus v. Monsanto*, 467 U.S. 986, 1003, 1014-16 (1984).
[27] *Monsanto*, 467 U.S. at 1011 ("With respect to a trade secret, the right to exclude others is central to the very definition of the property interest.").
[28] *See Lucas v. S.C. Coastal Council*, 505 U.S. 1003, 1015 (1992); *Philip Morris, Inc. v. Reilly*, 312 F.3d 24, 35 & n.65 (1st Cir. 2002) (en banc).

The network of federal statutes protecting commercially sensitive information like payer-specific negotiated rates from disclosure, including the Freedom of Information Act and the Defend Trade Secrets Act, supports health insurance providers' reasonable expectations that such rates are trade secrets not subject to involuntary disclosure. Reasonable expectations of confidentiality are also buttressed by the routine protection of negotiated rates from disclosure in litigation, given the information's demonstrated value, the measures plans take to protect rates from disclosure, and the competitive harm likely to ensure if rates are disclosed. To the extent that CMS has collected similar information in the past, it has promised to protect it, and has authorized its release only in a form that will not jeopardize a constitutionally protected property interest.[29] To break with these settled practices would disturb insurance providers' reasonable investment-backed expectations. Considering the character of the government action, which would eviscerate the value of the property interest; the lack of countervailing consumer benefit; and the severe economic impact in terms of harm to competition and health care markets, the Proposed Rule is a regulation that "goes too far" and thereby constitutes a taking.[30] At a minimum, forcing health insurance providers to disclose heretofore carefully protected payer-specific negotiated rates raises sufficient questions of constitutional infirmity that it should not be undertaken without clear congressional authorization. That authorization is lacking here. ***The proposed pricing transparency provision should be withdrawn as it takes health insurance providers' property without compensation.***

First Amendment

The Proposed Rule also implicates core First Amendment interests. The government may compel regulated entities to engage in unwanted commercial speech only when the compelled speech "directly advances" a substantial interest that cannot be "served as well by a more limited restriction on commercial speech."[31] Where a speech regulation "provides only ineffective or remote support for the government's purpose," it is invalid under the First Amendment.[32] That is precisely the case here, because—for all of the reasons we described above—the Proposed Rule is likely to increase health care costs, not lower them as it ostensibly intends. Even under the less strict standard applicable to commercial advertising, the counterproductive effect of disclosing payer-specific negotiated rates would cause the Proposed Rule to fail.[33] At a minimum, the serious constitutional questions raised by the Proposed Rule demand clear Congressional authorization. ***The proposed pricing transparency provision should be withdrawn as it unconstitutionally compels speech.***

D. The Proposed Rule is Operationally Infeasible (XV1. B. - C.; pgs. 39575 – 39577)

CMS proposes to require *all* hospitals by January 1, 2020, to make public their "standard charges" in a machine-readable file and consumer-friendly format for 300 shoppable services, including both

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[29] *See, e.g.*, 42 C.F.R. § 422.310(f)(2)(iv) (promising that release of risk adjustment data will be "subject to the aggregation of dollar amounts reported for the associated encounter to protect commercially sensitive data").
[30] *Penn. Coal Co. v. Mahon,* 260 U.S. 393, 415 (1922); *see Philip Morris, Inc.*, 312 F.3d at 33-46 (holding that forced disclosure of tobacco products' ingredient lists effected a regulatory taking).
[31] *Central Hudson Gas & Electric Corp. v. Public Service Commission*, 447 U.S. 557, 564 (1980); *see Nat'l Association of Mfrs. v. SEC*, 800 F.3d 518, 522 (D.C. Cir. 2015) (applying *Central Hudson* to disclosure requirement).
[32] *Central Hudson*, 447 U.S. at 564.
[33] *See Nat'l Association of Mfrs.*, 800 F.3d at 526 (invalidating requirement to make certain disclosures on business websites where it was "speculation or conjecture" that the disclosures would serve the asserted government interest).

gross charges and payer-specific negotiated rates. From an operational standpoint, the scope of items and services to be posted is unnecessarily broad and unduly complex. Moreover, we are concerned that the policy, as proposed, will result in data comparisons that are inaccurate and, in some cases, misleading, resulting in the equivalent of consumers attempting to compare apples to oranges.

Health care delivered in a hospital setting is rarely delivered or paid for based on a single item or service. We question the need for that level of detail and complexity given the lack of utility to consumers. The notion of "service packages" is closer to how consumers might shop but this too would be very complex and would not produce actionable consumer information because code sets and payment structures vary from payer to payer. For example, the Ambulatory Payment Classifications (APCs) developed by CMS are not universally used by private or state payers for outpatient services. Even in the case of Diagnosis-Related Groups (DRG), Medicare uses Medicare Severity DRGs (MS-DRGs) while many states use All-patient Refined DRGs (APR-DRGs). Similarly, while CMS recognizes temporary G code modifiers, many private plans do not. If hospitals were to try and capture every item and service, plus every definition of a service package (APR-DRGs, ECGs, etc.) and its associated payment structure (which we discuss below) the file would be massive, overly complex, and of very little utility to the typical consumer or vendor. ***The sheer size and scope of the file CMS proposes is unrealistic, and yet at the same time has questionable utility for consumers or vendors.***

Even when a service package is coded the same way (e.g. an MS- DRG), that does not mean that the payment rate is calculated in the same way. A DRG could be paid a flat fee, a per-diem or even a percent of charges. In addition to the variation in site-specific units of payment, there are also the broader payment methods intended to reward the overall value to a consumer across an episode of care. For example, while fee-for-service payments may be made initially under certain bundled payment arrangements and accountable care organizations, such payments may later reconcile on a per-capita basis based on performance against both cost and quality benchmarks. The ultimate payment amount will not equal the sum of the standard charges or the negotiated rate per service. In some cases, there may not even be a negotiated rate per item and/or service. For example, in fully capitated contracts based on a percent of premium. Therefore, displaying the rates of individual items and services may be infeasible in certain cases and misleading in others.

The Proposed Rule does not adequately account for the additional complexity introduced by differing payment structures, including value-based arrangements, that will impact consumer utility. Over the last decade, providers and payers have made significant efforts to move away from fee-for-service toward value-based contracts which rely on risk- and performance-based incentives. The health care industry, including CMS, have embraced this concept and participation under such contracts will likely grow. Given the structure of the proposed requirements, hospitals will not be able to appropriately account for and display current value-based payment information in a meaningful way for consumers to make direct one-to-one comparisons. ***In addition, encouraging consumers to shop on an item or service basis fundamentally runs counter to the notion of moving toward value-based arrangements and could potentially disincentivize such arrangements moving forward.***

Moreover, we do not believe that all of the 70 "shoppable" services would allow consumers to compare prices in advance and make a choice based on that information. CMS should analyze

variability in treatment (e.g. cancer treatment) and/or the level of complexity and duration of treatment (e.g. chronic condition management, behavioral health). Including services with the above factors will most likely provide consumers with cost information that is inaccurate and therefore not reliably actionable.

How the information is presented to consumers is of supreme importance, yet CMS only states that the information should be "consumer friendly," prominently displayed, easy to access, and without barriers such as fees. Thorough research is needed on how this information could be displayed in a way that is useful to consumers in a simple yet accurate and useful way. For example, consumers would need to know to pair the DRG information provided with the relevant physician Current Procedural Terminology (CPT) codes in order to shop effectively for a service. Even for a physician office visit, a consumer may need to consider depending on their benefit structure if they are a new or established patient, whether the physician is a specialist, what level of complexity the physician might bill and whether an extended visit add-on code would be used. Lastly, any figure would be only an *estimate* as anticipated services change based on factors unknown prior to the delivery of care or complications that may impact the final diagnosis, billing code and price. ***The "shoppable services" list is too broad and does not recognize the complexity of determining consumer financial obligations.***

Finally, CMS estimates that the total annual burden for hospitals to review and make public all gross and payer-specific negotiated charges for all items and services in a machine-readable format and payer-specific negotiated charges for at least 300 shoppable services in a consumer-friendly format would be 12 hours per hospital at $1,017.24 for a total burden of 72,024 hours (12 hours x 6,002 hospitals). This is a gross underestimation of the effort this would take for each hospital. The amount of time resources each hospital would have to allocate to accurately produce this amount of data within the specified timeframe is not a reasonable expectation. We do not believe such an undertaking could be executed properly in just two months from the Final Rule. ***If the transparency proposal is not withdrawn and CMS choses to move forward, we strongly recommend the Final Rule include a delay in implementation until at least CY 2021.***

E. CMS Should Consider Policy Alternatives (XVI. D. 4.; pgs. 39580-39581)
CMS requests comments on alternative definitions for standard charges. While we do not believe any of these alternative policies would fit the definition of standard charges, we comment on the relative utility of some of the options to consumers. In the Proposed Rule, CMS notes that self-pay individuals have different needs than individuals with insurance through a third-party payer with which we agree.[34] We discuss each scenario and offer scenario-specific alternatives.

Alternative for Self-Pay Individuals

[34] See 84 Fed. Reg. 39574. For example, a self-pay individual may simply want to know the amount a health care provider will accept in cash (or cash equivalent) as payment in full, while an individual with health insurance may want to know the charge negotiated between the health care provider and payer, along with additional individual benefit specific information such as the amount of cost-sharing, the network status of the health care provider, how much of a deductible has been paid to date, and other information.

For these purposes, we consider "self-pay" individuals as the uninsured, those with health reimbursement accounts through their employers that are not associated with a high-deductible health plan, and insured patients who are receiving non-covered or out-of-network services. For self-pay patients, gross charges will not reflect what the patient would expect to pay. In these cases, hospitals may initially bill the patient actual charges or a derivative thereof; however, hospitals rarely expect to receive remunerations of charges in full. Hospital charges are an artifact of the contracting system and do not, on their own, have any meaning.[35]

Payer-specific negotiated rates are specific to the benefit plan of a particular product. Thus, the negotiated rates will vary by payer and the particular provider's payment structure. Any singular rate published for a particular service would not directly relate to what a hospital may expect a self-pay individual to ultimately pay. Moreover, as we established above, the release of negotiated rates could have the unintended and serious consequence of raising consumer prices. ***As neither the standard charge nor the payer-specific negotiated rate provides useful or even pertinent information for self-pay individuals, and yet could put consumers at risk for higher prices, CMS should withdraw its proposal.***

CMS offers an alternative: requiring facilities to post a discounted cash price, often described as a prompt-pay discount, that can take many forms depending on the facility. For example, it could be a percent reduction off charges, an average across many payers or other methodologies. While standard charges would not be informative for the self-pay populations, some estimate from the hospital of expected payment (or a "walk-in" rate) that is easily accessible, simplistic, and provided alongside a description of charity care policies could be helpful to guiding decision-making. CMS notes that such a discounted cash price would be informative for self-pay individuals.[36] Prospective patients need to understand that these postings would only serve as a reference and not reflect the exact final payment expected after the items and/or service(s) are rendered. However, we believe such a walk-in rate or other statement of discount for self-pay patients would be of far greater assistance to patients than chargemaster data or even charges grouped in MS-DRGs or other service packages.

However, this would not fit the commonly held definition of "standard charge" under the ACA provision, thus CMS would need to work collaboratively with the hospital community to determine an appropriate path to make such information more widely available than it is today. ***CMS should work with the hospital community to establish a demonstration project to make "walk-in" rates more easily accessible for self-pay patients.***

Alternatives for Individuals with Third-Party Coverage (XVI. D. 4. b.; pgs. 39581 – 39582)
CMS notes that the ultimate cost-sharing is what is pertinent to an insured individual. For an insured patient with third-party coverage, neither gross charges nor payer-specific negotiated rates would reflect patient-specific cost-sharing. Patient specific cost sharing requires the application of co-pays, co-insurance, deductibles, coverage rules, medical management policies and other plan-specific considerations. The information CMS would require be made available would not enable third-party

[35] Bai, Ge. US Hospitals Are Still Using Chargemaster Markups To Maximize Revenues. *Health Affairs.* September 2016. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0093
[36] See 84 Fed. Reg. 39574.

application developers to create customized price quotes for insured individuals. A static hospital dataset could not support cost-sharing estimates for consumers based on their specific health insurance product, where they are in their deductible accumulation, etc. ***Only health care and health insurance providers can provide accurate, timely and customized cost-sharing estimates to individuals with third-party coverage.***
The negotiated rate, in and of itself, does not provide actionable cost-sharing information, could be misleading to consumers, and could result in other unintended negative consequences. For example, a consumer may delay care for a service because they have relied on a negotiated rate posted on a hospital website (or more likely a vendor website accessing hospital files) not realizing that co-insurance is waived for the service because it is preventive or because a maximum out-of-pocket policy apply. The health care cost estimation website Guroo has a warning on its page, "Do not avoid getting health care based on the information on this site."[37] Moreover, as we established earlier, the release of negotiated rates could have the unintended consequence of raising consumer prices. ***As neither the standard charge nor payer-specific negotiated rate provides useful information for insured individuals, and yet could put consumers at risk for higher prices and dissuade consumers from obtaining necessary care, CMS should withdraw its proposal.***

The Proposed Rule also offers a series of alternative policies such as a mode, mean, or median across plan negotiated rates. We do not believe such alternatives are supported under the statutory framework governing this Proposed Rule but comment on their merit compared to the stated goals. One feature of alternative aggregation options is in providing less granular payer information, that will reduce the risk of exposing trade secrets thereby disrupting market competition and raising consumer prices.[38] Like CMS' payer-specific negotiated rates proposal, making this information public would not further the Administration's goal of providing consumers with the individually customized, actionable information. However, providing appropriately structured aggregated data under a suitable framework could aid the additional stated goal of lowering consumer prices and furnishing data to vendors to develop consumer tools.

Guidance from the DOJ and FTC indicates that it is important to prevent the prices paid by a particular entity from being identified. Two alternate benchmarks to consider that would be the mean and the mean of the lowest quartile of rates across products and plan types—in appropriate markets for appropriate services. An unweighted average could provide a broad-based indicator of value, without raising the significant risk of consumer harm associated with the release of all rates paid by all payers. For example, a consumer or a purchaser shopping for insurance could benefit from a value-composite reflecting the overarching cost and quality of in-network facilities. Such a benchmark, however, should exclude Medicare and Medicaid rates paid in both the fee-for-service program and Medicare Advantage plans. As CMS notes, administered pricing is not indicative of market rates, including plan rates, and could artificially lower the benchmark. The mean of the lowest quartile of rates across products and plans would not individually identify negotiated rates and could actually serve to put downward pressure on the market. ***The maximum rate, on the other hand, should be immediately rejected, as the release of such information poses a grave risk of***

[37] https://www.guroo.com/#!care-bundles/HY007/47900-washington-district-of-columbia
[38] 42 C.F.R. § 422.310(f)(2)(iv) (implementing disclosures under risk adjustment statute with aggregation to "protect commercially sensitive data")."

leading to higher prices as discounting is reduced and prices coalesce around that maximum. Moreover, the median will inherently identify the true rate for a particular payer and thus should not be included.

Focusing on aggregated data alternatives prevents the direct public release of the individual plan rates. The FTC/DOJ Guidance goes further, however, and suggests that data releases should also protect against such anonymity being superficial and subject to reverse engineering. Thus, the Guidance counsels against releasing data that is based on underlying data from fewer than five entities. Put another way, to prevent harm from competition from the release of an unweighted average, such rates should only be released when there are five or more negotiated rates (i.e. insurance plans) in the market at issue.[39] Depending on what metric CMS chooses, it may also be necessary to avoid reverse engineering by ensuring that no entity's data constitutes more than 25 percent of the result. And, consider the concentration of the providers in that market. For example, a Sole Community Hospital contracting with 5 payers in the area, but one represents 50 percent of the market share will inherently drive a weight average and be fairly transparent.

The release—in appropriate markets—of either an unweighted average or the mean of the lowest quartile across products and plan types, excluding all Medicare and Medicaid, for a subset of high-volume service packages would provide a general benchmark on which to establish indicators of high-value providers for insured consumers to integrate into consumer-facing tools.

F. Potential Industry Collaboration

According to a study last month by the Kaiser Family Foundation, 20 percent of respondents said they use the internet or a smartphone to research the price of services at least a few times a year.[40] This is in contrast to 70 percent of respondents saying they use the internet to research symptoms or learn more about health conditions. Posting more data will not overcome the challenge of better engaging consumers. ***We recommend CMS partner with health care and health insurance providers as well as purchasers to build on the immense efforts already being undertaken to advance price and quality transparency and to educate consumers about existing tools to enhance engagement.***

We also recommend working together to explore ways in which existing tools can be improved. This could be through additional consumer research or facilitating the development of standards across tools to ensure comparability of experience as members change plans. CMS already partners with AHIP, as well the Veteran's Administration and Defense Health Services, on the Core Quality Measure Collaborative (CQMC) that seeks to align provider quality measures across private and public payers. However, this work could be expanded as it currently covers eight clinical conditions and ambulatory measures. CMS could also partner with private plans to develop definitions of shoppable services that could be included across consumer tools. We note that working within the

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[39] U.S. Department of Justice/Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, at 50 (1996). While the statement specifically relates to provider exchanges of price and cost information, the principles expressed in the statement can apply, and have been applied, in various contexts.

[40] Altman, Drew, "Separating hype from reality in health tech", *Axios*, September 10, 2019. https://www.axios.com/authors/Drew_Altman

health care and health insurance provider portals and apps provides additional protections to consumers and ensures that the information contained within the search (e.g. diagnosis) stays within the bounds of the Health Insurance Portability and Accountability (HIPAA) Act.
CMS should work collaboratively with health insurance providers to explore ways in which existing tools could be improved to enhance consumer utility.

G. Effective Date of Proposed Rule

We urge CMS to withdraw the requirement to publicly post gross charges and negotiated rates because it: 1) would not meet consumer needs; 2) would distort health care markets risking higher prices for consumers; 3) exceeds statutory authority and raises Constitutional concerns and 4) is operationally unrealistic. ***However, if the agency does not withdraw the transparency proposal, and CMS chooses to move forward despite these fatal flaws, we strongly recommend a Final Rule include a delay in implementation until at least CY 2021.***

The compelled disclosure of payer-specific negotiated rates will cause immediate, irreparable harm when the rule goes into effect. Once health insurance providers' trade secrets are disclosed, their value is greatly diminished. Because disclosure vitiates the value of a trade secret, courts routinely find that disclosure of such commercially sensitive information would cause irreparable harm.[41,42] Moreover, once the rule goes into effect, the anti-competitive effects are likely to be far-reaching and not susceptible to correction. An extended period of time prior to implementation is thus essential for health insurance providers and other stakeholders to prepare for these disruptive market effects and to determine how, if at all, they can mitigate these harms. Furthermore, as established in the Operational Challenges section, this complex undertaking cannot be executed properly in just two months from the Final Rule to implementation.

II. QUALITY MEASUREMENT RFI (XVII.; pgs. 39594 – 39596)

CMS seeks comment on improving the availability of and access to existing quality of health care information for third parties and health care entities to use when developing price transparency tools and when communicating charges for health care services. Specifically, CMS seeks comment on the types of existing quality information that would be of most benefit to patients, how CMS can help providers, suppliers, and third parties create patient-friendly interfaces with this information, and whether providers should integrate this information when informing patients about their out-of-pocket costs.

AHIP appreciates CMS' continuing efforts to advance quality measurement and reporting programs that contribute to the availability of consistent and reliable performance information. We strongly support the pairing of quality and cost information, where feasible. Health insurance providers already offer transparency tools that give consumers estimates of anticipated costs and allow them to compare services based on aspects of care such as quality, experience and accessibility of care. We remain committed to offering consumers actionable information about provider performance to help them make decisions about where to receive their care, and we feel this is best achieved through

[41] *NACM-New England, Inc. v. Nat'l Ass'n of Credit Mgmt., Inc.*, 927 F.3d 1, 5–6 (1st Cir. 2019) (affirming preliminary injunction enjoining disclosure of trade secrets).
[42] *Bimbo Bakeries USA, Inc. v. Botticella*, 613 F.3d 102, 118 (3d Cir. 2010) (same).

reducing provider measure reporting burden and aligning measures across public and private payers. We have been deeply involved in the American Hospital Association's Measures That Matter Collaboration, which brings together the major national associations representing hospitals and insurance providers to provide strategic recommendations for improving hospital performance measurement in public and private reporting and pay-for-performance initiatives. AHIP also leads the Core Quality Measures Collaborative (CQMC) in partnership with CMS and other insurance providers, medical providers, consumers and purchasers, promoting alignment of quality measures across public programs and the private sector. ***We strongly urge the Department to continue its efforts as part of public-private partnerships to align quality measures across payers rather than dictating what health care and health insurance providers must provide.***

Just as any price transparency proposals should focus on information that is most valuable to the consumer, so too should complementary quality measurement proposals prioritize information that would be most helpful to consumers choosing a provider. The existing landscape of quality information is vast, and many stakeholders are actively engaged in reducing the burden of measure reporting. Despite the industry's efforts, little information exists on what quality information consumers find most useful. CMS should lead efforts to solicit input from consumers about what quality information would be most useful to them, what quality measures they would want access to in conjunction with cost information, what measures would be most likely to influence their choice of provider, and what measures should be developed in the future. CMS should also lead efforts to educate consumers about the utility of quality metrics more broadly.

After gathering this information, CMS should work with the CQMC to develop a recommended process for pairing quality measure results and cost information on websites and mobile applications, including suggested formats for display of quality information and recommended measures or measure sets to be used for this purpose. CMS should leverage existing quality measures, such as those found in CQMC Core Measure Sets, and reporting mechanisms such as *Hospital Compare*. When considering quality measures for its own purposes as a payer, CMS should explore how to represent results when measure data is unavailable and how to communicate the differences between measure data collection periods and the time periods associated with cost information. At this time, we recommend CMS focus on displaying results using national benchmarks to compare quality performance rather than star ratings. We also recommend CMS engage an independent third party to collect, audit and analyze measure data used for this purpose. A process similar to the NCQA HEDIS auditing process would be useful to ensure data accuracy and to ensure that measures are appropriately used. During all of these steps, CMS should share learnings with the private sector to hasten advancement nationally.

Lastly, we strongly recommend that CMS discourage third-party application developers from creating their own proprietary quality measures for use in cost estimation tools. It is vital that quality information used for this purpose be aligned, evidence-based, and scientifically sound. Creating new, untested measures will create dissonance in the signal provided to consumers inhibiting their ability to accurately compare provider cost and quality and providers by impairing their ability to alter their practice to achieve the intended outcome. Adding to the current fragmentation of the quality measurement enterprise will run counter to the Administration's and

health insurance providers efforts to alignment measurement to reduce provider burden, inform consumers and fairly compensate for value.

CMS also seeks comment on improving incentives and assessing the ability of health care providers and suppliers to communicate and share charge information with patients. CMS is exploring developing Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) questions to assess how well hospitals and other providers and suppliers communicate and discuss the cost of care with their patients or leveraging existing measures/measure concepts for this purpose. We feel it is vital to encourage providers to communicate with patients about their out-of-pocket costs. We recognize that an individual provider may not have access to general or patient-specific cost information during the visit, but they could direct the patient to the billing department or a web portal to obtain this information either before or after the visit. ***We urge CMS to proceed cautiously in this area and seek multi-stakeholder feedback to ensure robust measures of patient engagement around the cost of care, not the accuracy of cost estimates, are developed and adopted as a starting point.***

III. PRIOR AUTHORIZATION PROCESS FOR CERTAIN OUTPATIENT DEPARTMENT SERVICES (XX.; pgs. 39606 -39608)

Based on an analysis of claims showing higher than expected increases in the utilization of some services that are likely to be cosmetic surgical procedures and/or are directly related to cosmetic surgical procedures that are not covered by Medicare, CMS is proposing to require prior authorization for certain covered OPD services as a condition of Medicare payment. These services cover 40 CPT codes and fall within the following five categories: blepharoplasty; botulinum toxin injections; panniculectomy; rhinoplasty; and vein ablation.

In addition to establishing the conditions of payment for OPD services that require prior authorization, CMS' proposal would also establish the submission requirements for prior authorization requests, including provision of relevant documentation, establish methods for expedited review of prior authorization requests, and provide for exemption of the prior authorization process based on performance with periodic reassessment. CMS is proposing to pattern some of these provisions after the prior authorization program already established for certain durable medical equipment, prosthetics, and supplies (DMEPOS). This requirement would begin for dates of service on or after July 1, 2020.

AHIP supports this proposal and shares CMS' goal of ensuring the continued appropriateness of payment for services furnished in the hospital outpatient department to Medicare beneficiaries. Evidence-based medical management is essential to a well-functioning health care system and value-drive approaches like prior authorization work. AHIP and our members have worked consistently to convey information and provide education on the benefits of medical management and prior authorization to providers, patients, policymakers, and other stakeholders. And, as CMS notes in the proposed rule, its value has been recognized not just in the private sector but by public programs as well. The Medicare fee-for-service program has used prior authorization since 2017 for certain DMEPOS that are frequently subject to unnecessary utilization. Medicare has also begun implementation of an evidence-based guideline and prior authorization program for advanced diagnostic imaging. Additionally, Medicare has implemented a

number of prior authorization demonstration programs for specific services, including repetitive, scheduled non-emergent ambulance transports, non-emergent hyperbaric oxygen therapy, home health services, and power mobility devices.
A recent GAO report recommended that Medicare continue these prior authorization efforts, estimating that savings from prior authorization demonstrations through March 2017 could be as high as $1.1 to 1.9 billion.[43]

Some of the ways our member plans are using medical management tools like prior authorization in the commercial market include:

- Encouraging providers to follow nationally recognized care recommendations (e.g., opioid prescribing consistent with federal guidelines);
- Protecting patients from unnecessary and potentially harmful care (e.g., unnecessary exposure to potentially harmful radiation from inappropriate diagnostic imaging);
- Ensuring that medications are safe, effective, and provide value for specific populations or subpopulations who may be affected differently by a medication (e.g., antipsychotic medications for children and adolescents);
- Making sure that the clinician providing the care has the appropriate training to deliver the care being requested (e.g., limiting prescribing of chemotherapy medications to oncologists); and
- Ensuring that when patients are prescribed a medication such as buprenorphine to treat opioid use disorder, the patient also receives services such as counseling, peer support, or community-based support which are critical to the success of the treatment.

And, consistent with CMS' proposal, health insurance providers in the commercial market put similar emphasis on the importance of providing all necessary supporting information and documentation at the time of a request for prior authorization. Our member plans report that incomplete information from providers is a leading cause of delay in prior authorization request determinations. Also consistent with CMS' proposal, health insurance providers in the private market have expedited processes in place for making prior authorization determinations for urgently needed care and many have begun exploring opportunities to waive prior authorization requirements based on provider performance and/or participation in risk-based contracts.

AHIP is undertaking a number of initiatives related to maximizing the value of prior authorization, while at the same time minimizing the burden and improving the process for providers and patients. For example, we are in the process of coordinating a demonstration project with health information technology companies, plans, and providers, to evaluate the impact of automating various components of the prior authorization process. The project will test prior authorization automation solutions that are as integrated as possible with practice workflow and have the potential for widespread adoption.

[43] CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending. Government Accountability Office (GAO). April 2018.

We encourage CMS to finalize its prior authorization proposal and continue to explore additional ways to use medical management tools to make care more efficient, effective, and affordable.

IV. INPATIENT ONLY PROCEDURES (IX. B. 2.; 39523 – 39525)

CMS routinely identifies procedures that are typically provided only in an inpatient setting and thus Medicare will not pay for under the OPPS. CMS reviews each procedure against five criteria to determine if they should be placed on or removed from the Inpatient Only (IPO) list each year: (1) Most outpatient departments are equipped to provide the services to the Medicare population. (2) The simplest procedures described by the code may be performed in most outpatient departments. (3) The procedure is related to codes that we have already removed from the IPO list. (4) A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis. (5) A determination is made that the procedure can be appropriately and safely performed in an ASC and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC list. Procedures do not need to meet all established criteria to be removed from the IPO list.

CMS identified one procedure using the above criteria to be removed from the IPO list for CY 2020: CPT code 27130 (Arthroplasty, acetabular and proximal femoral prosthetic placement (total hip arthroplasty (THA) with or without autograft or allograft). CMS also proposes to remove the below CPT codes from the IPO list:

1. 22633 - Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/ or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar;
2. 22634 - Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/ or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar;| each additional interspace and segment
3. 63265 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
4. 63266 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic
5. 63267 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
6. 63268 - Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral

We agree with CMS that total hip arthroplasty (CPT code 27130) meets criterion two (the simplest procedure described by the code may be performed in most outpatient departments) and criterion three (the procedure is related to codes that CMS has already removed from the IPO list). AHIP members believe that with appropriate preoperative screening by experienced medical teams to ensure the inclusion of only patients with low anesthesia risk, who are without significant comorbidities, and for whom family members can assist at home are good candidates for outpatient THA procedures. As previous commenters expressed, there has been success in achieving preoperative goals with same day discharge patients who have been previously screened if the

procedure was performed early enough in the day to allow for home discharge by the end of the day. With careful patient selection and strict protocols, which include at-home preoperative and postoperative environmental assessment and pain management and rehabilitation, patients may experience rapid recovery and perform activities of daily living.
More use of this method could lead to improved efficiency, cost savings to the Medicare program, and shorter hospital stays from fewer medical complications, improved results for patients, and better patient satisfaction. ***AHIP supports CMS' proposal to remove total hip arthroplasty from the IPO list and the assignment of the procedure to C-APC 5115 with status indicator "J1."***

V. AMBULATORY SURGICAL CENTERS COVERED PROCEDURES (XIII. C. 1. d.; pgs. 39542 – 39545)

CMS reviews all covered surgical procedures under the Ambulatory Surgical Center (ASC) Covered Procedures List (CPL) annually to identify appropriate additions or removals from the ASC CPL. As part of this, CMS reviews HCPCS codes currently paid under the OPPS but that are not paid under the ASC CPL to determine if the procedure meets CMS' proposed definition of a surgery and if technology and/or medical practice affect the clinical appropriateness of these procedures being performed in the ASC setting.

Based on the above review, CMS proposes to add 8 procedures to the ASC CPL. These additions include a total knee arthroplasty procedure, a mosaicplasty procedure, and six coronary intervention procedures:

CY 2020 CPT Code	CY 2020 Long Descriptor	Proposed CY 2020 ASC Payment Indicator
27447	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)	J8
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)	J8
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	G2
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J8
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	N1

We agree with CMS' assessment that these procedures that are paid separately under the OPPS would not pose a significant risk to beneficiary safety if performed in an ASC. In addition, we agree that the procedures do not require active medical monitoring and care of the beneficiary at midnight following the procedure. Furthermore, we agree that these procedures do not meet the general exclusions criteria. **AHIP supports CMS adding the above procedures to the ASC Covered Procedures List**.

VI. OUTPATIENT QUALITY REPORTING PROGRAM (XIV. B. 3. b.; pgs. 39554 – 39557)
CMS proposes to remove one measure from the Hospital Outpatient Quality Reporting (OQR) Program for the CY 2022 payment determination: OP-33: External Beam Radiotherapy for Bone Metastases (NQF#1822). This measure assesses the "percentage of patients (all-payer) with painful bone metastases and no history of previous radiation who receive EBRT with an acceptable dosing schedule." We agree with CMS that the costs associated with the measure outweigh the benefit of its continued use in the program. We further note that this measure was already removed from the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program for the fiscal year 2022 payment determination. **AHIP supports the removal of OP-33: External Beam Radiotherapy for Bone Metastases.**