Texas Hospital Association

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Via electronic submission to: regulations.gov

PUBLIC COMMENT LETTER

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

Re: CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1717-P)

Dear Ms. Verma:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to offer comments on the Centers for Medicare & Medicaid Services' Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule. CMS proposes to require that hospitals publicly post on the internet a machine-readable file containing both gross charges and the newly defined "payer-specific negotiated charges" for all items and services. In addition, CMS proposes to require hospitals to display, in an easy-to-understand format, negotiated charges and certain other information for 300 "shoppable" items and services—information that displays a patient's expected out-of-pocket costs for nonurgent health care services that can be scheduled in advance.

THA is committed to ensuring patients have the information they need to make informed health care decisions, including timely, accurate estimates of their out-of-pocket costs. However, CMS's approach would do little to help patients understand their potential out-of-pocket cost obligations, would severely disrupt contract negotiations between providers and health plans and exceeds the Administration's legal authority. THA joins the American Hospital Association in urging CMS to abandon this proposal and instead convene providers, health plans, patients and other stakeholders on approaches that meet patient needs.

In particular, THA encourages CMS to take steps to facilitate the development and voluntary adoption of patient cost-estimator tools and resources by convening stakeholders to identify best practices, recommending standards for common features of cost-estimator tools and developing solutions to common technical barriers. Hospitals routinely work with individual patients to help them understand their out-of-pockets cost obligations for scheduled services (in fact, Texas law requires it), but this is a manual process that depends on the receipt of information from the patient's health plan. Aside from providing little or no value to most consumers, the related proposal to require disclosure of out-of-pocket costs for 300 "shoppable" services, by health plan, is challenging

because reimbursement formulas vary by plan and by service and because an accurate reflection of the consumer's cost sharing obligations wholly depends on the receipt of information from a health plan. The cost information that is valuable to an individual consumer is the amount the consumer will need to pay for an individualized service, rather than an incongruent matrix of 300 services that varies from hospital to hospital. Health plans are always in the best position to provide relevant cost information to their enrollees, and the major health plans already do so through user friendly websites and phone applications. Some Texas hospitals have taken steps—at great expense—to develop cost-estimator tools; however, the required investment and maintenance costs make uniform adoption unworkable. CMS should refocus its efforts on working with stakeholders to encourage and streamline the development and implementation of meaningful tools to help consumers understand their out-of-pocket costs.

The Proposed Disclosure of Payer-Specific Negotiated Charges is Unlawful.

CMS lacks the legal authority to require hospitals to make public payer-specific negotiated rates. In an attempt to circumvent legal barriers, CMS proposes to unlawfully redefine a payer-specific negotiated rate as a "payer-specific negotiated charge" by classifying it as a subset of a hospital's standard charges. Section 2718(e) of the Public Health Service Act requires hospitals to annually "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 . . . ." The PHSA does not provide CMS with authority to make public individually negotiated rates. CMS's proposal is contrary to the plain language of the statute because negotiated charges are not "standard charges." By definition, a "standard charge" is not privately negotiated and does not contemplate different charges for different payers. The phrase "standard charges" has long been understood to be a technical term that means a hospital's usual or customary charge description master charge.

CMS's proposed definition also violates the Administrative Procedure Act because it is unreasonable. In general usage, "standard" means "usual, common or customary."[1] Payer-specific negotiated charges (rates) are not usual, common or customary. They vary year by year, payer by payer and even health plan by health plan. Indeed, CMS has defined "charges" to mean "the regular rates established by the provider for services rendered to both [Medicare] beneficiaries and to other paying patients. Charges should be . . . *uniformly applied to all patients* . . . ."[2] CMS's rationale for seeking to require that payer-specific negotiated charges be made public undercuts the notion that those charges are standard: CMS wants payer-specific charges to be public precisely because those charges are not standard.[3]

CMS's proposal would violate the First Amendment as well, by compelling the public disclosure of individual charges privately negotiated between hospitals and health plans. Government regulation of non-misleading commercial speech is unlawful unless it "directly advances" a "substantial" governmental interest, and is no "more extensive than is necessary to serve that interest." [4]

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[1] *See, e.g.,* https://www.dictionary.com/browse/standard.
[2] Provider Reimbursement Manual, No 15-1, ch. 22, § 2202.4. (Emphasis added.)
[3] *See, e.g.,* 84 Fed. Reg. 39,175, 39,577 (Aug. 9, 2019).
[4] *Central Hudson Gas & Electric Corp. v. Public Service Comm'n of New York*, 447 U.S. 557, 566 (1980). The agency has failed to identify a sufficient predicate to justify the application of *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626 (1985) to the facts presented here. But the regulation fails under either test. Even under *Zauderer*, a disclosure requirement cannot be "unjustified or unduly burdensome." *Id.* at 651.

CMS's stated interest in putting *consumers* "at the center of their health care" is unlikely to be served by the mandated disclosures. The agency's own research makes clear that when it comes to price, patients are interested in their *own* out-of-pocket costs—not their health plan's costs. CMS's repeated admissions that the proposed disclosures are merely a "first step" or a "step towards" the rule's stated goals make clear that the proposed rule does not "directly" and "materially" serve the stated interest.[5]

CMS's proposal also is much more extensive than necessary to serve the proffered interest. Because hospitals rely heavily on the confidentiality of health plan-negotiated charges to permit them to negotiate arm's-length charges with other health plans, disclosure of prices negotiated with individual health plans would unduly burden hospitals' ability to enter into competitive contracts; it goes well beyond the level of regulation necessary to promote the stated government interest. The charges negotiated between hospitals and health plans are confidential trade secrets[6] and contracts between health plans and hospitals almost always prohibit disclosure of negotiated reimbursement amounts. As such, requiring their public disclosure would infringe upon intellectual property rights recognized by Congress and individual states.[7]

Mandating the public disclosure of trade secrets protected under both federal and state law would result in significant harm to hospitals and health plans alike. CMS has failed to demonstrate that the proposed regulation is narrowly tailored or that its interests "cannot be protected adequately by more limited regulation of . . . commercial expression."[8]

Disclosure of Payer-Specific Negotiated Charges Would Harm Consumers and Competition.

Apart from issues with legality, the proposed disclosure threatens competition and the movement toward value-based care. The Federal Trade Commission has warned numerous times against the disclosure of competitively sensitive information, such as payer-negotiated prices. Such disclosure can "facilitate collusion, raise prices and harm . . . patients . . . ."[9] That warning extends explicitly to contract terms with health plans.[10] The FTC has urged that transparency be limited to "predicted out-of-pocket expenses, co-pays and quality and performance comparisons of plans or providers."[11]

At least one commercial health insurer warned that disclosure of payer-specific negotiated charges would "impair the movement to value-based care" and allow "[d]ominant health plans to seek and use that information to deter and punish hospitals that lower rates or enter into value-based arrangements with the dominant plan's competitors."[12]

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[5] *See id*. at 39,574, 39,585, 39611.
[6] *See West Penn Allegheny Health Sys., Inc. v. UPMC*, 2013 WL 121441532 (W.D. Pa. Sept. 16, 2013) ("[i]nformation regarding pricing and rates constitutes trade secret information").
[7] 18 U.S.C. § 1836.
[8] *Central Hudson Gas & Electric Corp. v. Public Service Comm'n of New York*, 447 U.S. 557, 570 (1980).
[9] FTC Letter to the Hon. Nellie Pou, April 17, 2001.
[10] FTC Letter to Hons Joe Hoppe and Melissa Hortman, June 29, 2015.
[11] Id.
[12] UnitedHealth Group Comments on Re: RIN 0955-AAOI, 21st Century Cures Act, Proposed Rule, June 3, 2019.

CMS Vastly Underestimated the Proposal's Operational Challenges.

In addition to THA's legal and public policy concerns, THA has significant operational concerns with this proposal. This proposal, if finalized, would pose excessive burden on hospitals and health systems—far exceeding CMS's estimate of 12 hours. One hospital system alone estimates that it has more than 3,000 contracts with health plans, multiplied by the dozens of benefit plans within those contracts. Thinking about displaying this information is nothing short of mind-boggling. Texas hospitals have already raced to comply with the Jan. 1 requirement to post their charge description masters online. A typical charge description master has anywhere between 8,000 and 20,000 lines of data. Cursory math indicates that CMS's proposed mandate would require hospitals to sort, compile and make public millions of lines of data. Moreover, the information CMS intends to make public is not neatly grouped into categories because plans reimburse hospitals based on different formulas. Hospitals may contract with one health plan on a DRG-basis while contracting with another insurer on a per diem basis. Further, quality measures often affect reimbursement for services, which means the negotiated rates are not static figures.

THA appreciates the opportunity to comment on CMS's proposed rules, and hopes that CMS will abandon its new proposals related to the disclosure of negotiated rates and convene stakeholders to work towards a solution to equip consumers with meaningful data to make informed decisions about their health care.

Respectfully submitted,

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Texas Hospital Association