AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

Submitted Electronically

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1786-P
P.O. Box 8010
Baltimore, MD 21244-1810

RE: Calendar Year 2024 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule (CMS-1786-P)

Dear Administrator Brooks-LaSure:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we write in response to the proposed rule for the Calendar Year (CY) 2024 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System, published in the *Federal Register* on July 31, 2023. AMRPA is the national trade association representing more than 700 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals, referred to by Medicare as inpatient rehabilitation facilities (IRFs). Our members focus on the care and functional recovery of some of the most vulnerable Medicare beneficiaries – such as traumatic brain injury, stroke, and spinal cord injury patients. Our member hospitals help patients maximize their health, functional ability, independence, and participation in their communities, so they are able to return to home, work, or an active retirement.

With respect to the CY 2024 OPPS proposed rule, our comments focus only on the proposals dealing with hospital price transparency requirements.

I. Effectiveness of Price Transparency Requirements as Applied to Inpatient Rehabilitation Hospitals

As raised in our comments on the CY 2020 and 2022 OPPS proposed rules, AMRPA continues to question whether the goals of price transparency requirements are truly applicable to services provided in inpatient rehabilitation hospitals and whether the collected information can be meaningfully used by the specific patient populations that our hospitals serve. In the agency's initial price transparency proposals, this year's proposed rule, and in public statements about price transparency, CMS continues to tout the importance of providing accessible price information so that consumers can "shop" and compare prices across hospitals before receiving care. AMRPA generally supports CMS' efforts to empower patients to make more educated decisions on the price and convenience of their health care treatment; however, most IRF

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services simply are not "shoppable." The core services provided by IRFs are those provided to inpatients, typically those who are admitted directly from an acute care hospital where they were treated for serious illness or injury. Often, patients have arrived in an ambulance; rarely are IRF services scheduled in advance. For the vast majority of IRF patients, their medical and clinical circumstances and care trajectories afford little or no opportunity to plan or anticipate what level of services they may need or where those services should be acquired, limiting the value of price transparency for inducing cost-effective health care consumerism. As discussed below, reports from the field corroborate the expectation that patients are not engaging with the posted information as applicable to IRF services.

AMRPA continues to urge CMS to closely examine the scope of the current price transparency requirements and determine whether revising their applicability to certain providers – particularly inpatient rehabilitation hospitals – would be a more effective way of improving reporting.

II. Mandatory Use of Standard Template for Hospitals

CMS proposes to mandate that all hospitals use a CMS-developed "template" layout for posting their standard charges. Previously, CMS had issued templates as optional suggestions for hospitals but did not mandate a specific format, as long as charges were posted online in a single machine-readable file (MRF). The rule also proposes a new set of required data elements, including general hospital information, descriptions of each item or service, any codes used for accounting or billing (including modifiers), and extensive information on payer-specific negotiated charges (such as contracting methods and algorithms used to determine pricing). Use of this new template would be required beginning January 1, 2024, though CMS also proposes a slightly longer "grace period" for enforcement of an additional 60 days.

While some hospitals may already be using the CMS templates, many are not, and all facilities will have to make at least some operational changes to implement the new standard data elements and other technical changes. Preparing standard charges for publication on a hospital website is already a time-consuming process, for which many hospitals directly populate data from their chargemaster files used internally to the MRF posted online. Transitioning to a new standard format presented by CMS will impose significant additional burden on hospitals and staff, as much of the data conversion and encoding process will have to be done manually, requiring hospitals to shift resources away from patient care and other critical initiatives. Even for hospitals that are already using existing CMS templates, we question whether the forthcoming templates will be meaningfully different and still require additional changes for those hospitals already using a CSV or JSON format.

We urge CMS to extend the time period for hospitals to transition to the new template format, until at least October 1, 2024. This will ensure that hospitals are able to conform to CMS requirements without threatening their ability to properly perform existing duties and reduce undue burden on facilities.

Further, AMRPA is concerned that some of the proposed new requirements relating to the standard template are overly burdensome and would decrease, not increase, the utility of posted prices for consumers. For example, requiring hospitals to post extensive details on payer-specific negotiated prices by each plan will make the files extremely unwieldy, and given the wide array of plans that individual payers offer, many consumers will likely have difficulty determining which data actually apply to their coverage. The same concerns apply with regards to disclosures of contracting algorithms negotiated between hospitals and payers. Instead of benefitting consumers, we believe that such granular information will largely benefit payers seeking to renegotiate rates based on what contracts their competitors have obtained.

Similarly, we fail to see how requiring that hospitals encode all charge information with accounting and billing modifiers will assist consumers in estimating health care costs. Modifiers and other similar billing codes are unlikely to be relevant to individual consumers, and in many cases, these are not incorporated into hospitals' standard chargemaster files, which form the basis of the information reported under the price transparency requirements. Instead, these are typically added later in the process by coding and billing staff, or through a hospital's electronic medical record system. Requiring these modifiers to be added to publicly reported charges would dramatically increase burden on hospital staff while arguably making this information less digestible for consumers.

AMRPA asks CMS to reconsider mandating the use of the CMS-developed templates due to some of the reporting difficulties (e.g., providing detailed information on payer-specific negotiated prices) as well as the time and resources that certain providers will need to expend on implementation of this provision. In the alternative, if CMS opts to finalize this proposal, AMRPA urges CMS to extend the compliance deadline until *at least* October 1, 2024.

III. Additional Technical Comments on Proposed Requirements

Certification of Accuracy and Completeness

CMS proposes to require that an authorized hospital official submit to CMS a certification that the standard charge information posted in the MRF is accurate and complete "*at any stage of the monitoring, assessment, or compliance phase.*" We question whether this additional certification is necessary, as the expectation is that all information posted by a given hospital is in fact accurate. However, we have particular concerns about the completeness requirement and how exactly that will be applied to hospitals. With regards to the certification directly in the MRF (proposed at § 180.50) that information is complete, CMS clarifies that is intended to indicate to the public that any blank cells in the file are intentional, such as to reflect when a hospital has not established a discounted cash price for a given item or service or the corresponding information otherwise is not available. This clarification is not included with respect to the certification "at any stage of the monitoring, assessment, or compliance phase" (proposed at § 180.70). As a result, AMRPA members have raised questions as to whether they can in fact certify completeness at this stage if circumstances require any blanks in their posted file(s). We urge CMS to clarify the intention of this provision to avoid any confusion.

Publicizing Compliance Information

CMS currently has the authority to publicize information on non-compliant hospitals if and when a civil monetary penalty (CMP) is imposed. Now, CMS proposes to dramatically expand such public reporting to include information relating to *any* compliance activities, regardless of whether and how a given hospital is responsive to CMS' outreach. This does not appear to account for any situations where a hospital may be informed of a technical non-compliance issue and then remedies such concerns in a timely fashion. Especially given the volume of newly proposed requirements for price transparency, we are concerned that this could result in hospitals being "publicly shamed" for administrative or minor technical issues that can be easily corrected. In fact, as CMS directly reports in the proposed rule, the vast majority of hospitals that received initial warning notices from CMS addressed any deficiencies directly, and only four hospitals progressed to receiving CMPs.

CMS notes that if this proposal is finalized, any public information "would only be relevant as of the date indicated, and should not be taken to suggest any ongoing state of compliance or noncompliance." However, the agency does not suggest any process for updating such information when hospitals remedy any technical noncompliance, nor any detailed explanation for the general public to protect against confusion regarding a hospital's current compliance status. Accordingly, we urge CMS to maintain its current policy of only publicizing non-compliance status when a CMP has been imposed.

IV. Value of Price Transparency for Inpatient Rehabilitation Patients & Impact of Payer-Facing Transparency Requirements

Once again, while AMRPA supports the idea of transparency and ensuring that patients have access to critical information about health care costs, we question whether individuals in need of inpatient rehabilitation services are truly receiving value from the current price transparency efforts.

Since the effective date of the current hospital price transparency requirements, IRFs have complied by posting prices for individual services, despite our ongoing concerns that these prices have little value for patients. Reports from the field have only bolstered these concerns. Our members consistently report that few, if any, patients have contacted their hospitals seeking more information or clarifications regarding posted prices or have engaged with any staff made available to discuss price transparency. Instead, IRFs report that the only engagement they have encountered with their posted prices comes from payers, who are increasingly utilizing price transparency as a method to renegotiate contract prices based on information posted regarding competitors' agreements. Given these experiences, we urge to CMS to review whether price transparency is meeting the goals the agency identified in promulgating these regulations or whether the benefits are eluding patients and instead supporting payer interests.

The questions surrounding the utility of IRF-reported pricing information for medical rehabilitation patients have become more pronounced since insurer-focused pricing transparency initiatives took effect [such as the Transparency in Coverage (TIC) and No Surprises Act (NSA)

regulations]. In comparison to those plan-specific coverage rules, the hospital-facing rules requiring IRFs to report prices for individual services simply do not align with how patients access IRF care. When patients are admitted to an IRF, they receive a comprehensive mix of intensive rehabilitation services to meet their specific needs, including physical and occupational therapy, speech language pathology, orthotics and prosthetics care, rehabilitation nursing, and other services, as defined in the patient's individualized overall plan of care. IRF patients do not pay for these services individually; instead, they are charged a per diem rate that reflects the overall cost of care. Accordingly, being able to access information about the price for each service provided in an IRF simply does not assist individuals with estimating their cost-sharing responsibilities, nor with making price-sensitive determinations regarding their care (even if they were able to effectively able to "shop" for IRF services ahead of time).

Finally, we note that the agency has specifically sought comment on how price transparency regulations may interact with requirements for the provision of a "good faith estimate" of expected charges for uninsured or self-insured individuals, as well as requirements for insurers to provide an advance explanation of benefits (AEOB) to covered individuals. While regulations are still forthcoming, and the technical implementation of these requirements will be paramount for success, we believe that patients are more likely to receive practically useful information about expected health care costs through these requirements, which should incorporate individualized information about their specific plan(s), coverage, and expected cost-sharing. With current hospital price transparency files, even patients who do engage with posted information will have to expend significant time and effort to identify which service codes they are seeking, locate specific rates for their individual plan, and calculate their expected out-of-pocket costs. In the proposed rule, CMS asks whether there is "still benefit" to require hospitals to display standard charges and other information in a "consumer-friendly" manner given the new requirements that apply to plans under the TIC and NSA regulations, respectively. Given AMRPA's longstanding concerns about the inapplicability of the hospital price transparency requirements to IRF services, we believe that these recent payer-facing regulations require a large-scale reconsideration of whether hospital-level requirements should apply to specialized hospital providers such as IRFs.

We recommend that CMS carefully consider whether applying hospital price transparency requirements for inpatient rehabilitation services meaningfully advances the agency's goals in increasing consumer information about health care costs.

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AMRPA appreciates CMS' attention to our comments and the agency's efforts to engage with stakeholders regarding the OPPS and hospital price transparency. AMRPA and our members remain committed to working with CMS to create a more effective, efficient, and patient-centered Medicare program. If you have any questions regarding our comments, please contact Kate Beller, AMRPA Executive Vice President for Government Relations and Policy

Development, at kbeller@amrpa.org or 202-207-1132 and Joe Nahra, Director of Government Relations and Regulatory Policy, at jnahra@amrpa.org or 202-207-1123.

Sincerely,

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