AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

September 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1694-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Delivered Electronically

Re: **Proposed Requirements for Hospitals To Make Public a List of Their Standard Charges & Request for Information (RFI): Quality Measurement Relating to Price Transparency for Improving Beneficiary Access to Provider and Supplier Charge Information** [CMS-1717-P], 84 FR 39398 (August 9, 2019)

Dear Administrator Verma:

This letter is submitted on behalf of the American Medical Rehabilitation Providers Association (AMRPA) related to the Centers for Medicare and Medicaid Services' (CMS) proposed price reporting requirements included in the Calendar Year 2020 Hospital Outpatient Prospective Payment System (PPS) and Ambulatory Surgical Center (ASC) Policy Changes and Payment Rates Proposed Rules. Our comments focus specifically on CMS' proposal to require hospitals to (1) post a list of all of their standard charges – both gross charges and all negotiated rates – for all items and services in a machine-readable format on their websites, and (2) post the negotiated rates for specific types/numbers of "shoppable" services in a consumer-friendly way. As an overarching issue, AMRPA believes that the standard and shoppable price posting requirements, as proposed, would result in significant administrative and financial burdens across the entire hospital industry. At the same time, due to the nature of the pricing information that CMS proposes to be made public, consumers would see limited benefit from this data, and may in fact make inappropriate treatment decisions as they attempt to base care decisions off such complex information.

Furthermore, in the event that CMS proceeds to finalize the policy in whole or in part, AMRPA respectfully requests that inpatient rehabilitation hospitals and units (referred to by CMS as inpatient rehabilitation facilities, or IRFs) be exempt from these proposals. AMRPA believes an exemption is appropriate due to: (1) the unique, patient-specific negotiation with payers that IRFs often engage in, (2) the fact that inpatient rehabilitation services – designed to treat some of the most medically complex patients in the Medicare program – contrast sharply with the other "shoppable" services (such as laboratory services) included in the proposed rule, and (3) given that IRFs are arguably the most regulated hospital entity in the Medicare program, these

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additional regulatory burdens pose a substantial threat to patient access to inpatient rehabilitation services. While AMRPA strongly supports the Administration's longstanding interest in improving price transparency throughout the healthcare ecosystem, we believe that this proposal will not achieve its intended goal – improved consumer awareness and decision-making – and may unintentionally result in inappropriate or less clinically effective post-acute care placements.

AMRPA is the national voluntary trade association representing more than 650 freestanding rehabilitation hospitals and rehabilitation units of general hospitals (collectively referred to by CMS as inpatient rehabilitation facilities (IRFs)), outpatient rehabilitation service providers and several other types of rehabilitation providers. In 2017, IRFs served 340,000 Medicare beneficiaries with more than 380,000 IRF stays.[1] On average, Medicare Part A payments represent approximately 60 percent of IRF revenues.[2] AMRPA members help patients maximize their health, functional ability, independence, and participation in society so they are able to return to home, work, or an active retirement. Medicare beneficiaries admitted to IRFs for their immediate post-acute care have significantly better outcomes across a range of quality indicators compared to clinically matched beneficiaries who received their immediate post-acute care in another setting.[3]

The services provided by IRFs are based directly on patient need/conditions, due in part to the extensive pre- and post-admission evaluations and documents that apply specifically to IRFs. The interdisciplinary nature of inpatient rehabilitation services distinguish IRFs from other sites of care, with CMS requiring physical therapists, occupational therapists, speech-language pathologists, rehabilitation nurses, rehabilitation physicians, and other clinician types to work in a highly coordinated manner in order for a patient with a serious debility to regain function and quality of life.[4] These and other requirements help demonstrate why IRF services are significantly distinct from other types of "shoppable" services that patients can easily select in isolation and/or in advance, as outlined in more detail below.

AMRPA, along with numerous other provider associations, urges CMS not to finalize this proposal. If adopted, the proposal would not only create new and often crippling burdens for the hospital industry, but would also run in direct contrast to the goals of this Administration' *Patients over Paperwork* initiative. In the first section of our comments, we detail our major concerns with this proposal across the sector, as well as highlight how these measures would result in exceptional burdens for IRF providers and their patients. The second section of our comments addresses our separate legal concerns that the proposal exceeds the agency's regulatory authority and raises Administrative Procedure Act issues.

In light of the potential policy and legal issues tied to these measures, AMRPA urges CMS withdraw this proposal and instead convene hospital stakeholders to identify best practices that

[1] Medicare Payment Advisory Commission (MedPAC), "Chapter 10: Inpatient Rehabilitation Facility Services," Report to the Congress: Medicare Payment Policy, March 2019
[2] Id.
[3] Dobson Davanzo & Associations, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities* (IRFs) and After Discharge (July 2014)
[4] *See* Medicare Benefit Policy Manual § 110.2.5 - Interdisciplinary Team Approach to the Delivery of Care

more meaningfully educate patients -- without creating new burdens for their providers. We have provided below a summary of CMS' proposals, which are followed by our substantive recommendations and comments.

I. AMRPA Response & Recommendations to CMS' OPPS Price Transparency Proposals

A. Proposed Definition of Hospitals Subject to Price Transparency Requirements, p. 39,575

CMS proposes to define "hospital" for the purpose of its transparency proposal as "as an institution in any State in which State or applicable local law provides for the licensing of hospitals, (1) is licensed as a hospital pursuant to such law or (2) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing." CMS specifically proposes to require that IRFs that satisfy these two criteria to comply with the price posting/transparency requirements.

CMS also notes that the agency considered whether it was appropriate to establish different requirements for hospitals located in a rural areas, or hospitals that are not federally owned or operated but that serve special populations (such as psychiatric hospitals), among others. CMS states, however, that because "such hospitals are open to the general public, and their charges are generally not made available to the public," CMS believes there "is value in such hospitals making public their standard charges."

AMRPA urges CMS to employ a more tailored approach in determining which hospitals must comply with the standard/shoppable charges posting requirements. Unlike general acute care hospitals, IRFs furnish specific services tailored to the needs of patients with specific conditions (required under CMS' 60% rule), such as traumatic brain injury (TBI) and stroke. Often, what specific services the patient needs (and consequent financial liability) will not be determined until after admission to the IRF, when the patient can be fully assessed. In fact, Medicare regulations require that IRFs complete a post-admission patient evaluation (PAPE) and develop an Individualized Plan of Care (IPOC) outlining the trajectory of services to be furnished to its patients, based on the extensive evaluations provided at and after admission.[5] It will be difficult for a patient to know which services they will need prior to assessment by the IRF and the corresponding cost. Even then, the services needed will be a wide-ranging mix of rehabilitation and medical services provided by an interdisciplinary team, rather than a single or simple set of services that can be "shopped" in advance. As such, the services provided by IRFs are distinct from those provided in other hospital settings, and for this reason among others, AMRPA urges CMS to carve-out IRFs from the proposed definition of hospitals subject to the rule's transparency requirements.

[5] 42 C.F.R. 412.622

B. Proposed Definition of the Standard Charges that Must be Posted by Hospitals, p. 35,977

CMS proposes to require hospitals to make public two types of standard charges: (1) gross charges; and (2) payer-specific negotiated rates. The rule defines a gross charge as the charge for an item or service reflected in a hospital's chargemaster without any discounts. CMS explains that making gross charges publicly available is important because hospitals use these charges as the starting point for negotiating discounted rates with insurers. According to the Agency, higher gross charges are associated with higher negotiated rates and higher premiums and out-of-pocket costs for insured individuals.

Because more than 90 percent of consumers rely on a third party to cover their health care costs, CMS further proposes to require publication of negotiated rates. The rule explains that improving transparency for negotiated rates will enable consumers to compare the charges between hospitals and determine his or her out-of-pocket costs. CMS proposes to define payer-specific negotiated rates as the charges that the hospital has negotiated with third-party payers for an item or service. This would also include charges negotiated with Medicare Advantage (MA) plans.

AMRPA strongly urges CMS to reconsider its proposal to require IRFs to publicly post their gross charges and payer-specific negotiated rates. With respect to gross charges, AMRPA notes that Medicare beneficiaries will only pay a deductible and possibly a set co-pay based on the number of days the beneficiary has been hospitalized for hospital (Part A) services for that benefit year. AMRPA is not aware of any situation in which a Medicare beneficiary would be required to pay a percentage of gross charges for Part A services, and therefore asserts that this "standard charge" information is not meaningful for Medicare beneficiaries. AMRPA also urges CMS to consider that, in the context of inpatient rehabilitation, pricing information is affected by patient's assessment (required before and after every IRF admission). This would make IRF-specific standard charges even more difficult for patients to understand and may actually convey inaccurate or misleading information about the cost of care when provided in advance of the assessment.

Furthermore, with respect to payer-negotiated rates, it is critical for CMS to keep in mind that privately insured individuals have a wide range of different cost-sharing arrangements depending on their insurer and plan. Given the specialized treatment provided by IRFs and unique nature of costs associated with IRF services, IRFs often negotiate patient-specific rates with these third-party payers, including MA plans. Requiring IRFs to post *patient-specific*, payer-negotiated rates would be an incredibly burdensome task for IRFs from an administrative standpoint. CMS notes in the proposed rule that payer-specific rates will be helpful in light of the fact that "an increasing number of consumers are discovering that sometimes the providers' cash discount can mean paying lower out-of-pocket costs than paying the out-of-pocket costs calculated after taking a third party payer's higher negotiated rate into account." Given that patients in IRFs receive an intensive mix of services from an

interdisciplinary team, CMS' rationale would be very unlikely to apply in the context of inpatient rehabilitation.

Moreover, as CMS directly acknowledges in the proposed rule, the public display of payer-specific negotiated rates may have the effect of increasing hospital prices in concentrated markets due to anticompetitive behavior. These anticompetitive behaviors would particularly impact geographic markets where there are relatively few IRFs compared to other providers.

AMRPA would also like to make CMS aware of a number of other unanticipated effects of the proposal. Through this policy, CMS will be incentivizing patients to pick their providers/sites of care based solely on price, rather than outcomes-based or quality-related measures. Given that the standard charges that IRFs would be required to post are likely to vary from the patient-specific, payer-negotiated rate that would ultimately impact patient liability, AMRPA has grave concerns that patient care decisions will be guided by misrepresentative/inaccurate pricing information. Without other critical and complementary information, patients (receiving rehabilitation services in both the inpatient and outpatient setting) may ultimately make *less* informed decisions about their care by relying on limited and potentially misleading information. Therefore, in light of the significant burden that the proposal represents for IRFs, and the lack of any clear benefit to consumers (and possible harm), we urge CMS to reconsider its proposal to require IRFs to post their standard charges, as defined by CMS.

C. Proposed Requirements for Consumer-Friendly Display of the Payer-Specific Negotiated Charges for Shoppable Services, p. 39,585

CMS is proposing to require hospitals make public their payer-specific negotiated charges for at least 300 "shoppable" services in a "consumer-friendly" format. The 300 services would be comprised of 70 CMS-selected shoppable services and 230 hospital-selected shoppable services. CMS defines a "shoppable service" as a "non-urgent" service that can be scheduled by a healthcare consumer in advance, allowing consumers to "price shop and schedule a service at a time that is convenient for them." Specific examples provided by CMS include certain imaging and laboratory services and outpatient clinic visits, among others. With respect to the hospitals' selection of shoppable services, CMS proposes that hospitals should select such services based on the utilization or billing rate of the services in the past year.

AMRPA generally supports CMS' efforts to improve patients' understanding of their healthcare costs and enable them to make more educated decisions on the price and convenience of their treatment *when such services are truly "non-urgent" and can be "shopped" across providers*. In stark contrast to the types of services CMS provides as examples of "shoppable" services, however, the services provided by IRFs are those specifically required to advance the recovery of some of the most medically complex patients, such as TBI patients. Furthermore, timely access to these services in IRFs is linked to demonstrable improvement in outcomes, whereas the time

required for price comparisons for other "shoppable" services do not have the same recovery-related implications. The importance of IRF patients receiving both *specific* inpatient rehabilitation services and *timely access* to such services is evidenced by the American Heart Association and American Stroke Association's guidelines for stroke recovery, which direct that stroke patients receive their immediate post-acute care in IRFs.[6]

AMRPA also urges CMS to take into account the fact that most IRF admissions come directly from an acute hospital where they were treated for serious illness/injury, often arriving in an ambulance for services that are rarely scheduled in advance. IRF services are therefore a continuation of this form of "non-shoppable" initial treatment. For these 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, in contrast to a reasonable interpretation of "shoppable services." As such, AMRPA urges CMS to exempt IRFs from its proposed shoppable services-related posting requirement in light of the critical differences between the patient-tailored services provided in IRFs and other "shoppable" services listed by CMS in this proposal.

D. Noncompliance and Enforcement Mechanisms for Price Transparency Requirements, p. 39,591

In the case of noncompliance, CMS proposes to first issue a warning and, if the violation continues, it proposes to require hospitals to submit and follow a corrective action plan. If a hospital does not submit or adhere to the corrective action plan, CMS proposes to impose a civil monetary penalty (CMP) of up to $300 a day.

AMRPA urges CMS to limit the use of CMPs in the context of policy and ensure both inpatient and outpatient providers have sufficient education and training required for compliance with this proposal. Based on many of the points raised earlier in this comment letter, AMRPA believes the burden of any enforcement mechanism would far outweigh the benefits to consumers. As part of its *Patients over Paperwork* initiative, CMS states that it aims to "mov[e] the needle and remov[e] regulatory obstacles that get in the way of providers spending time with patients." AMRPA believes imposing any such penalties on hospitals for price transparency requirements would accomplish just the opposite of that goal by straining hospitals' resources in order to furnish information that is minimally beneficial to consumers. In addition, given that IRFs would face special burdens in posting patient-specific payer-negotiated rates, the proposal would create serious administrative and financial burdens for IRFs if they run into logistical challenges in posting the required information.

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[6] "In-patient rehab recommended over nursing homes for stroke rehab," American Heart Association/American Stroke Association Scientific Statement, May 4, 2016, *available at* http://newsroom.heart.org/news/in-patient-rehabrecommended-over-nursing-homes-for-stroke-rehab. *See also* AHA/ASA, GUIDELINES FOR ADULT STROKE REHABILITATION AND RECOVERY: A GUIDELINE FOR HEALTHCARE PROFESSIONALS FROM THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION (2016), *available at* http://stroke.ahajournals.org/.

E. CMS Burden Estimates

With respect to its proposed price transparency measures, CMS estimates that it would take hospitals 12 hours, translating to a cost of $1,017.24, to comply with these requirements. Specifically, the agency estimates that hospitals will need four hours to compile and post charge data for all items and services and eight hours to identify the 300 shoppable services and their corresponding ancillary services, collate the charge data, create a consumer-friendly approach to displaying the data, and post it on their websites.

CMS has grossly underestimated the administrative and financial burdens associated with this proposal. As outlined in prior sections of this comment letter, IRFs in particular would likely need to post patient-specific, payer-negotiated rates, which results in a significantly higher volume of information to organize, post and update. CMS has also failed to take into account the resources – in terms of both time and staff – that would be required to build or purchase the "consumer friendly" interfaces required under this proposal. Perhaps most alarmingly, this proposal would likely require IRFs and other hospitals to shift resources away from ongoing efforts to meaningfully inform patients about their healthcare service costs and patient liability, and instead focus on compliance with new regulatory requirements that would not result in helpful price data for patients.

II. Legal and Policy Arguments Compel Withdrawal of CMS' Transparency Proposal

A. CMS Proposal Exceeds the Agency's Regulatory Authority

In addition to the aforementioned implementation-related concerns, AMRPA concurs with other hospital organizations in concluding that CMS lacks the legal authority to require hospitals to make public payer-specific negotiated charges. While AMRPA understands that CMS seeks to implement Section 2718(e) of the Public Health Service Act's (PHSA) requirement that hospitals make public a list of their "standard charges for items and services," we believe that the proposed definition is not a reasonable interpretation of this term. Instead, AMRPA finds that the term "standard charge" has been interpreted to mean a hospital's usual or customary charge – found in the hospitals' chargemaster. In the proposed rule, however, CMS seeks to require hospitals to post *payer-specific* charges, and in the case of IRFs, potentially *patient-specific* charges negotiated with various payers. AMRPA believes that this proposal is therefore an unreasonable interpretation of the authority provided to CMS under the PHSA.

For these same reasons, the proposal also likely violates the Administrative Procedure Act (APA), as it is unreasonable for CMS to interpret "standard" charges as payer-specific charges, which by definition vary by year and across payers/plans.

B. Public Posting of Payer-Specific Negotiated Charges Would Have Unintended Consequences on Patient Access & Market Competition

Beyond the serious legal issues raised by this proposal, AMRPA also notes that this proposal could potentially result in the opposite of its intended impact on competitive pricing and value-driven care decisions. In fact, the Federal Trade Commission (FTC) has warned numerous times that the disclosure of competitively sensitive information, specifically included health plans' contractual terms,[7] can "facilitate collusion, raise prices and harm…patients…."[8] The FTC has taken a position similar to the one urged by AMRPA, calling for transparency efforts to be sensibly limited to "predicted out-of-pocket expenses, co-pays, and quality and performance comparisons of plans or providers"[9] – information that AMRPA believes will meaningfully inform patients with relevant data for their treatment decisions. In contrast, the current and overly broad proposal will actually have a negative effect on market competition, without providing patients with the type of information that can be effectively applied when making decisions on (what AMRPA views as) truly shoppable services.

III. Overall Recommendation

In all, AMRPA supports efforts to educate consumers and implement much-needed improvements to pricing transparency throughout the healthcare system. However, CMS' proposed approach would not give patients the information they need to make informed health decisions (such as their own financial liability for services, rather than the total cost), yet would introduce significant additional administrative and financial burdens for the hospital industry. AMRPA therefore urges CMS to withdraw this proposal in its entirety and instead engage in a collaborative effort with hospital stakeholders to identify ways to more effectively provide patients with meaningful information about their actual anticipated costs.

AMRPA also reiterates that this proposal is particularly misplaced when applied to the IRF sector. With IRFs often engaging in patient-specific, payer-negotiated rates, the standard posting charge would (1) result in IRFs being required to post charges that are not "standard" across their patient population, and (2) require IRFs to publish a substantially greater volume of data compared to other hospitals. Furthermore, as required by Medicare regulations, IRFs must engage in extensive pre- and post-admission evaluations to ensure that the services provided by the IRFs are specifically tailored to improve patients' recovery, outcomes and independence. In IRFs, rarely are the services provided to any two patients the same, and never would a patient be admitted to an IRF for just one service. Simply put, IRF services are not "shoppable," and stand in sharp contrast to the types of services described in the proposed rule – such as laboratory services – that are not patient-tailored and can be provided in a number of hospital settings. Given that IRFs are already arguably the most regulated entities among providers participating in the Medicare program, these additional burdens would pose a significant threat to IRF operations and to patients' continued access to critical inpatient rehabilitation services.

[7] FTC Letter to Hon. Joe Hoppe & Hon. Melissa Hortman, Jun. 29, 2015.
[8] FTC Letter to the Hon. Nellie Pou, Apr. 17, 2001.
[9] *Id.*

Lastly, AMRPA has previously provided CMS with specific recommendations to address this issue, such as focusing efforts to directly communicate cost-sharing arrangements to beneficiaries so that they fully understand their liabilities. AMRPA stands ready to work with CMS to identify and implement alternative approaches that will achieve the desired goals of improving price transparency while minimizing provider burden, in line with the goals of the Administration's other initiatives.

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AMRPA welcomes continued opportunities to collaborate with the Department of Health and Human Services (HHS) and CMS on these matters. If you have any questions about AMRPA's recommendations, please contact Kate Beller, J.D., AMRPA Executive Vice President for Government Relations and Policy Development (kbeller@amrpa.org / 202-207-1132).

Sincerely,

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