PATIENT RIGHTS ADVOCATE.ORG

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September 11, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1786–P
P.O. Box 8010
Baltimore, MD 21244–1810

Re: Comments on Proposed Rule to Revise Medicare Hospital Outpatient Prospective Payment System ("OPPS") and Medicare Ambulatory Surgical Center Payment System – Hospital Price Transparency Requirements; CMS–1786–P

Dear Administrator Brooks-LaSure:

We appreciate the opportunity to comment on the proposed rule for the Medicare Program Hospital Outpatient Prospective Payment System for 2024 ("Proposed Rule"),[1] and specifically to comment on the proposed amendments to the Hospital Price Transparency requirements in the Proposed Rule. PatientRightsAdvocate.org is a 501(c)(3) nonprofit, non-partisan organization representing the voice of American consumers, employers, unions, and workers. We advocate for systemwide price transparency in healthcare with the goal of greatly lowering the cost of care and coverage.

Every day, hospitals obfuscate their standard charge information from patients and hinder them from making critical, informed decisions about their own healthcare. Several years into their implementation, nearly two-thirds of the hospitals we surveyed continue to fail to comply with price transparency requirements.[2] These practices have dire consequences for patients, their families, employers, unions, and the healthcare system as a whole. Patients that obtain the care they need risk unexpected, catastrophic medical bills, while others avoid seeking care altogether for fear of bankruptcy and lack of trust in the health system. Employers and unions cannot steer their employees and members to the highest quality care at the lowest possible prices, resulting in runaway health plan costs that suppress workers' wages and business competitiveness. The result of this widespread noncompliance is a broken healthcare market in which hospitals' secrecy forces consumers to operate in fear of jeopardizing their health, their financial stability, or both.

We appreciate the important steps that the Centers for Medicare & Medicaid Services ("CMS") has taken to improve hospital price transparency in order to empower patients with prices and enable them to make informed decisions and lower their costs. Indeed, an efficient and fair healthcare system relies on this very information, and patients need this information to make the most personal and important healthcare decisions. Thank you for your efforts to improve disclosure of accurate and complete price information for all items and services and proposals to enhance compliance and enforcement, such as the attestation requirement. We recommend additional, important changes to ensure that patients, employers, unions, and all consumers have the information they need to make critical decisions about health care services and coverage.

Specifically, we recommend that CMS enhance these rules in the following critical ways:

- **Require the "Consumer-Friendly Expected Allowed Amount" to Be an Actual Price, and Require Hospitals to Disclose Their Pricing Formulas.** The proposed requirement that hospitals disclose the "consumer-friendly expected allowable charge" for a service does not go nearly far enough to guarantee that the patient would obtain a usable expected dollar amount to be charged. We suggest that CMS require hospitals to share accurate, upfront prices of items and services, along with the percentage or algorithm on which the price is based, and hold them accountable for these prices.

- **Prohibit the Use of "Not Applicable" or Blank Fields in Lieu of Standard Charges.** Hospitals' egregious use of "not applicable," "N/A," or blanks when required to provide standard charge information must be addressed. We recommend that hospitals only be permitted to use "not applicable" when the items or services in question are not furnished by the hospital.

- **Eliminate the Price Estimator Tool Loophole.** Internet-based price estimator tools are deceptive and are a loophole to avoid providing patients with upfront prices in a consumer-friendly manner. We recommend that price estimator tools no longer be deemed in compliance with 45 C.F.R. Part 180. To provide patients with financial certainty, estimator tools must not be permitted in lieu of actual prices.

- **Make Machine-Readable Files ("MRFs") Accessible and Readable by Both Machines and Humans.** MRFs must be accurate, complete, and usable data files that are available and easily accessible in both machine-readable *and* human-readable format. JSON files are not useful for consumers and employers and require the added cost of a third party to interpret and make meaningful. We suggest that CMS require the use of only spreadsheet formats (such as CSV files) to ensure that consumers, employers, and union plans can access this valuable information without having to pay middlemen to translate the data for their use.

- **Require Hospitals to Include All Billing Codes, Including CPT, HCPCS, DRG, and NDC.** To allow for price comparisons across hospitals, providers, and plans, hospitals must be required to provide all codes and code modifiers that are associated with the standard charges of the items and services offered. The Proposed Rule's elimination of "including but not limited to CPT, HCPCS, DRG, and NDC", as a modifier to "any code used by the hospital" is a step backwards in that it may enable hospitals to use proprietary codes that prevent standardized comparability across pricing information.

- **Require Attestations to the Accuracy and Completeness of the Content of Disclosures under the Hospital Price Transparency Rules.** Without attestation by a senior officer of the hospital as to the accuracy and completeness of price transparency disclosures, hospitals will continue to provide misleading and inaccurate information to patients, including providing inaccurate "estimates." We appreciate that attestation was included in this Proposed Rule, and encourage you to deem such attestations as material to payment from the federal government to incorporate potential liability under the False Claims Act ("FCA") for hospitals that knowingly violate the rule and falsely attest to the accuracy and completeness of their files.

- **Strengthen CMS's Enforcement.** Assessment of noncompliance is only productive when paired with effective, frequent, and timely enforcement as a consequence for noncompliance. We recommend that CMS enhance its enforcement mechanisms and penalties for noncompliance with hospital price transparency rules set forth at 45 C.F.R. Part 180. We suggest that CMS use the word "enforcement," not "assessment," throughout the regulatory text set forth in §180.70.

- **Expand the Application of Hospital Price Transparency Rules to all Items and Services Furnished by Affiliates, Subsidiaries, and other Providers Operating within the Same Health System or Enterprise.** Hospitals should not be allowed to avoid price transparency requirements through the provision of care via affiliates, subsidiaries, and other providers operating within the same system.

- **Expand the Price Transparency Requirements to Ambulatory Surgery Centers, Imaging Centers, and Laboratories.** Ambulatory Surgical Centers ("ASC") play an increasingly important role in patient care and provide many of the same items and services as hospitals, and imaging centers and laboratories furnish services that significantly impact the overall cost of care. We suggest you hold ASCs, imaging centers, and laboratories to the same price transparency standards as hospitals to ensure that healthcare consumers can make informed decisions and lower their costs.

- **Require Hospitals to Publicly Post their Charity Care or Financial Aid Policies in a Manner Accessible to Patients.** Hospital policies regarding charity care and financial aid should be readily available to patients as a means of increasing hospital price transparency and providing patients with financial certainty.

- **Require Hospitals to Post a Discounted Cash Price and Accept Cash Regardless of Insurance Coverage.** Hospitals must be required to post accurate discounted cash prices and to accept cash payment from individuals who choose to pay the discounted cash price, regardless of whether such individuals have coverage.

- **Provide Notice to the Public.** A fully informed and aware public is the strongest defense against false and misleading healthcare price information. We encourage the Biden Administration to inform all individual consumers and employers that they have the right to real and accurate prices from hospitals where they seek care.

Below, we discuss each of these key recommendations for CMS in greater detail. We also address questions raised by CMS in the proposed rule.

1. Require the "Consumer-Friendly Expected Allowed Amount" to Be an Actual Price, and Require Hospitals to Disclose Their Pricing Formulas.

Hospitals must be required to disclose actual prices, expressed as a dollar amount, in all cases—including where a standard charge may vary. In the event of a variable price, the hospital's disclosures must include both (a) an accurate price, expressed as a dollar value, that patients can rely on, and (b) the formula upon which the actual price is based.

When afforded the opportunity to use "N/A," hospitals have used this meaningless response to hide prices from consumers when such prices are known or knowable. However, an effort to correct this fraudulent practice through the requirement that hospitals produce a "consumer-friendly expected allowed amount" if the negotiated charge cannot be expressed as a dollar amount falls short of guaranteeing that the most usable and accurate information be shared with the patient.

CMS defines the consumer-friendly expected allowed amount as the "average dollar amount that the hospital estimates it will be paid by a third-party payer for an item or service."[3] In cases where the standard charge that applies to a group (rather than to individual patients) in a particular plan can only accurately be expressed as an algorithm, the algorithm and a calculated expected charge based on that algorithm should be disclosed. However, rather than display an expected charge for the "average patient," we suggest mandating that hospitals calculate the expected dollar amount to be charged, and that the hospital be prohibited from charging a patient more than that amount.

Under the current CMS definition and requirement, if the hospital's discounted cash price for an MRI is $300 and the highest negotiated rate is $7,500, then the average is $3,900. This "consumer-friendly expected allowed amount" is deceptive and not helpful for patients—it dramatically underestimates the actual cost for patients at the $7,500 level and fails to inform patients of the price when the choose to pay cash. We encourage you to place the burden of identifying usable information on the hospital, not on the healthcare consumer.

To achieve the goals of the Proposed Rule, every ascertainable charge must be *the actual price* expressed as a dollar value—not an estimate. For example, if the negotiated rate with a payer is equivalent to a percentage of the hospital's billed charge, the hospital must apply that percentage to the charge it would bill to enter the actual dollar value of the negotiated rate. Estimates and averages, wherever allowed, enable hospitals to game their disclosures and hinder patients from ascertaining the true price of healthcare. Therefore, even in cases where price information is variable, we strongly suggest that CMS require hospitals to disclose an actual price. Moreover, we recommend prohibiting hospitals from charging the patient an amount in excess of the disclosed range.

We support CMS's proposal that hospitals disclose both a formula/algorithm and a dollar amount. In all cases where an expected allowed amount is entered, it should be an actual price (not an estimate or average) in dollars and cents, and the complete underlying formula by which actual reimbursement is determined should be disclosed in a separate formula sheet. To deliver the most usable, accurate price information to patients, we encourage CMS to go a step further and require posting of the actual contract formulas, pricing rates, and contractual terms and conditions for determining prices.

The Proposed Rule's definition at 45 C.F.R. § 180.20 of "consumer-friendly expected allowed amount," is: "the average dollar amount that the hospital estimates it will be paid by a third party payer for an item or service."[4] We recommend that CMS require that hospitals disclose a "guaranteed maximum payment amount" rather than an "expected allowed amount" in order to hold hospitals accountable to the price information that hospitals share with their consumers. We

recommend that CMS replace the "consumer-friendly expected allowed amount" with the following:

> *Regulatory Text Proposal: "Consumer-friendly guaranteed maximum payment amount* means the maximum actual dollar amount that the hospital expects to be paid for an item or service based on the hospital's historical payments, algorithms, and other calculations or inputs that are reasonably available to the hospital. The hospital shall not bill, charge, or seek reimbursement of an amount in excess of the guaranteed maximum payment amount or the range disclosed for the specified item or service."

In addition, we recommend enhancing the requirement at proposed 45 C.F.R. § 180.50(b)(2)(iii) that "[i]f the standard charge is based on a percentage or algorithm, the MRF shall also specify what percentage or algorithm determines the dollar amount for the item or service, and the consumer-friendly expected allowed amount for that item or service"[5] and should include a requirement that the formulas disclosed be consistent with contractual terms, as follows:

> *Regulatory Text Proposal: "*If the standard charge is based on a percentage or algorithm, the MRF shall also specify what percentage or algorithm determines the dollar amount for the item or service, and the guaranteed maximum payment amount for that item or service, and such algorithms shall be produced in a separate formula sheet to preserve the machine readability of the file. Hospitals shall post actual contract formulas, pricing rates, and contractual terms and conditions for determining prices referenced in the machine readable file."

2. **Prohibit the Use of "Not Applicable" or Blank Fields in Lieu of Standard Charges.**

The regulation must make clear that all prices must be posted in the form of a true dollars-and-cents price. We encourage you to not allow hospitals to continue the deceptive practice of posting "N/A" instead of standard charges where hospitals know or can know the expected charge. We recommend that CMS clarify that the use of "N/A" in lieu of a standard charge may only be permitted for items and services that are not in fact furnished by the hospital, consistent with statements made publicly by the CMS Administrator and published by CMS in its guidance.[6] This change would greatly reduce the burden and confusion on consumers who view the "N/A" response when they are attempting to ascertain price information.

> *Regulatory Text Proposal:* Clarify at 45 C.F.R. § 180.50(b) that "Hospitals shall use 'N/A' or 'Not Applicable' only to fill a cell in the MRF in the event that the item or service corresponding to the cell are not furnished by the hospital."

3. **Eliminate the Price Estimator Tool Loophole**

The Proposed Rule seeks comments on the value of price estimator tools. Price estimator tools are worse than worthless—hospitals use them to hide true prices while bypassing meaningful regulatory requirements. We strongly urge CMS to eliminate the provision for "deemed" compliance based on hospitals' use of internet-based price estimator tools at 45 C.F.R. § 180.60.

For too long, hospitals have used price estimator tools as a means of avoiding providing healthcare consumers with accurate, upfront prices for shoppable services – prices for which they are fully capable of furnishing. As such, these price estimator tools actually further obfuscate true price information and perpetuate hospitals' practices of hiding prices from consumers. As we see from the many patients that reach out to us with surprise bills significantly beyond the amount of their estimates, too often, the "estimates" provided are meaningless and false, and are accompanied by disclaimers of any hospital accountability. Patients who do utilize the price estimator tools are still charged wildly divergent prices, which are financially devastating. Such deceit makes price estimator tools not merely unhelpful (which would be sufficiently problematic for the goals of hospital price transparency rules), but seriously *harmful*.

If CMS continues to allow price estimator tools, we suggest that it (a) prohibit collection of personal information, and (b) require the tool to provide a binding price for which the hospitals are held accountable:

Many hospitals' price estimator tools impose gatekeeper questions that require patients to provide insurance information in order to generate price estimates. If CMS continues to allow the use of internet-based price estimator tools to comply with consumer-friendly disclosure rules, we suggest it mandate that price estimator tools not require patients to submit personal information of any kind, including coverage information. Tools that do require submission of such information violate patient privacy and may prevent consumers from utilizing price estimator tools altogether.

Hospitals have the means today to provide actual, upfront prices to allow patients to make informed decisions about their healthcare. Therefore, hospitals that provide inaccurate estimates through price estimator tools are knowingly providing false information to their patients and should, at the very least, be held accountable to the prices they provide. If hospitals are permitted to rely on price estimator tools, they should be required to attest to the accuracy of the information presented in these tools and held responsible for any variation between the price estimate offered to patients and the ultimate dollar amount charged.

Finally, we note for CMS's consideration that a bill that would codify the hospital price transparency requirements and phase out the use of price estimator tools by 2025 recently received unanimous support in the House Energy & Commerce Committee earlier this year.[7] It is time for CMS to eliminate the use of the price estimator tool which has allowed hospitals to continue to mislead healthcare consumers in the name of transparency.

> *Regulatory Text Proposal:* Remove 45 C.F.R. § 180.60(a)(2), the regulatory language providing deemed compliance use of price estimator tools.
>
> In the alternative, at a bare minimum, add language to 45 C.F.R. § 180.60(a)(2) that would prohibit requiring submission of consumers' personal information within the price estimator tool's requirements. For example, revise paragraph (iii) to read: "Is prominently displayed on the hospital's website and accessible to the public without charge, without having to register or establish a user account or password, and without having to enter coverage-related or other personal information."

In addition, add language that would hold hospitals accountable to the outcomes of price estimator tools. For example, a new paragraph (a)(2)(iv) as follows: "(iv) Holds patients harmless to the extent that a charge exceeds the amount provided to a patient as an estimate for shoppable items and services."

4. **Make Machine-Readable Files ("MRFs") Accessible and Readable by Both Machines and Humans.**

We recognize the importance of standardizing formatting and data elements set forth in the Proposed Rule, and we applaud CMS's standardization efforts. However, we note that to fully achieve CMS's purpose of enhancing price transparency for consumers, MRFs must not only be formatted in a manner that allows for coding solutions and IT specialists to process content, but also to enable consumers to open, view, and comprehend the content of such files. MRFs need to be in a spreadsheet format that can be read by both machines and humans.

Under the Proposed Rule, CMS would supply hospitals with template CSV spreadsheet format as well as a JSON file format to standardize the display of standard charge information. The flexibility that CMS proposes to continue offering in this approach is both unnecessary and harmful. Hospitals are more than capable of following standardized spreadsheet templates, and should be required to do so to advance CMS's goal of consumer-friendly information exchange. CSV files, or other spreadsheet formats, are significantly more accessible to consumers than JSON files, because JSON formats require programming expertise to either convert the file or use the file. These barriers can be costly, and inconsistent disclosures can make prices inaccessible to most individuals and employers seeking knowledge of comparatives prices, to ensure medical bills and claims are not overcharged, and to lower cost by choice. In addition, the use of JSON files allows for inconsistent disclosures and inaccessible files, hindering any hope of comparability for individuals and employers seeking to compare prices across different facilities.

Moreover, it is critical, especially in light of the flexibility afforded to hospitals, that CMS follow through with its proposal that a hospital's failure to abide by the standardization requirements in the Proposed Rule would be met with corrective and enforcement actions. As CMS notes, though some hospitals are abiding by requirements to present information in an MRF, many are formatting and presenting this information in a manner that deliberately hinders both machine and human readability.

Therefore, in response to CMS's request for comments to improve accessibility and standardization of MRF files, we urge CMS to consider requirements that not only improve the digital searchability and machine readability of the file, but also the accessibility and consumer-readability of the file, requiring hospitals to use CSV files or other spreadsheet formats. We also note again that the regulation must clarify that all prices must be posted in the form of a true dollars-and-cents price. These requirements will better achieve CMS's goal of making hospital price data available and accessible for consumers.

Regulatory Text Proposal: Modify the Proposed Rule to eliminate the phrase "or JSON schema" from the definition of MRF at 45 C.F.R. § 180.20 and removing "json|" from 45 C.F.R. § 180.50(d)(5).

5. **Require Hospitals to Include All Billing Codes, Including CPT, HCPCS, DRG, and NDC**

In the Proposed Rule, CMS rightly expands the data elements for which hospitals must display complete standard charge information. CMS's overall proposal to be more prescriptive in how such data must be encoded is appropriate, and will aid in the consumer-usability of the data. To further CMS's goal of ensuring standardized information exchange that allows for readability and comparability, CMS should require hospitals to include all codes used to designate the particular items or services associated with standard charges, especially any code of a nationally recognized code type, such as CPT, HCPCS, DRG, or NDC.

Allowing hospitals to present "any code used by the hospital" without specifying that it must use nationally recognized code types and deleting this language could be interpreted by hospitals that they can simply disclose their own, non-standard, proprietary billing or revenue codes. Because different hospitals often have different or non-standardized billing and revenue codes, such a practice would preclude comparability and usability of this data, and provide hospitals yet another way to obfuscate the true price of its items and services.

As CMS recognizes in its Proposed Rule, hospital-established standard charges are intricately connected to the billing of any given item or service. Requiring publication of all associated code types ensures that the information provided is as comprehensive and usable as possible. As we have noted previously CMS, CMS must require that explicit billing codes, such as CPT or DRGs, be identified for each item or service (and group of items and services), and require separate files or tabs for each billing code type, including CPT, DRG, HCPCS and NDC. In addition, we support CMS's proposal to mandate the inclusion of modifiers for codes under which the modifier changes the standard charge for the item or service.

> *Regulatory Text Proposal:* Do not use proposed language and replace the current requirement at 45 C.F.R. § 180.50(b)(7) that a MRF include, as a data element, "[a]ny code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the CPT code, HCPCS code, DRG, NDC, or other common payer identifier" with a requirement to include "all codes used to designate the particular item or service associated with standard charges, including, but not limited to, any code of a nationally recognized code type, such as CPT, HCPCS, DRG, or NDC."

6. **Require Attestations to the Accuracy and Completeness of the Content of Disclosures under the Hospital Price Transparency Rules**

We appreciate CMS holding hospital executives accountable for their price disclosures by adding attestation to the Proposed Rule. Patients and consumers relying on hospitals' price information understand how truly meaningless such information is without affirmation of the data's accuracy and completeness. It is no surprise that CMS has received numerous questions about the accuracy of information provided pursuant to the Hospital Price Transparency rules, as CMS notes in the Proposed Rule.[8]

Therefore, as is the case for many entities that report information to CMS, we recommend requiring hospitals to attest to the accuracy and completeness of their disclosures (including

website postings) submitted in accordance with hospital price transparency rules. More specifically, we suggest that CMS require senior officers from the hospital to make such attestations so that hospital leadership understands the weight of their obligation to consumers, the public, and to the federal government.

To ensure the greatest compliance with hospital price transparency requirements, we suggest that the regulation deem such attestations as material to payment from the federal government to incorporate potential liability under the False Claims Act ("FCA") for hospitals that knowingly violate the rule and falsely attest to the accuracy of their files. Incorporation of the FCA as a potential enforcement mechanism would increase the compliance efforts by hospitals while relieving enforcement pressure on CMS due to the broader enforcement mechanisms of the FCA.

We applaud the Proposed Rule's requirement that hospitals affirm the accuracy of information presented in MRFs. We encourage CMS to promulgate a similar requirement for the consumer-friendly disclosures to ensure that the information provided in each disclosure pursuant to the hospital price transparency rules is accurate, complete, and reliable.

> *Regulatory Text Proposal:* Include a requirement in 45 C.F.R. § 180.40 that "(b) A senior official from each hospital (the Chief Executive Officer, Chief Financial Officer, or an official of equivalent authority) shall attest to the accuracy and completeness of the disclosures made in accordance with the hospital price transparency requirements set forth in this regulation. Such attestation shall be deemed to be material to payment from the federal government."

7. **Strengthen CMS's Enforcement**

We applaud CMS's efforts to enhance assessment of noncompliance in the Proposed Rule as adding to the assessment and enforcement mechanisms already established in 45 C.F.R. Part 180. Namely, CMS proposes to publicize compliance assessments, actions, and outcomes, add methods for monitoring and assessing compliance with the hospital price transparency rules, require acknowledgment of receipt of a hospital warning notice of noncompliance, and notify hospital leadership of noncompliance enforcement action. We support this change and recommend additional measures to push more hospitals into compliance with this rule.

We encourage CMS to clarify that the proposed assessment and enforcement measures would not replace the enforcement mechanisms in place under 45 C.F.R. Part 180, but would supplement them by strengthening CMS's capacity to assess compliance and respond to verified cases of noncompliance with enforcement actions. Without such clarification, the Proposed Rule may be interpreted as a weakening or dilution of CMS's willingness to respond to noncompliance. This need for clarification arises from the addition of "assessment" in §180.70(a) and failure to use the word "enforcement" throughout this section in the Proposed Rule.

We strongly urge CMS to consistently use the word "enforcement," not just "assessment" and "actions to address noncompliance" to convey that CMS intends to fully, and timely enforce these rules, including through civil money penalties. CMS must emphasize its pursuit of robust enforcement of its Hospital Price Transparency rules. Moreover, any enhanced assessment

capability must be paired with corresponding enforcement authority to engender compliance, particularly from hospitals which have thus far refused to comply with the Hospital Price Transparency rules set forth in 45 C.F.R. Part 180.

We remind CMS that a significant majority of hospitals remain out of compliance with the regulations,[9] and many more are deemed to comply due to implementation of inadequate price estimators that do not actually achieve CMS's stated purpose of enhancing systemwide price transparency. In spite of this rampant noncompliance, only fourteen hospitals have received civil monetary penalty notices for violations of the Hospital Price Transparency rules.

We disagree with CMS's theory that noncompliant hospitals would attempt compliance but for the compliance burdens on hospitals. In fact, CMS's own calculations found that the total cost for hospitals to review and post their standard charges for the first year to be 150 hours per hospital at $11,898.60 per hospital, and $3,610.88 per hospital for subsequent years.[10]

Rather, hospitals choose to ignore or circumvent the hospital price transparency requirements in order to continue to overcharge patients and hinder awareness of the true cost of healthcare services. The thousands of hospitals that remain brazenly noncompliant are not only violating federal regulation but also harming healthcare consumers with false or inaccessible price information. This widespread noncompliance merits enhanced focus on enforcement by CMS to create sufficient incentives for all hospitals, including large health systems and corporate hospital chains, to comply with hospital price transparency requirements.

Importantly, enforcement has proven effective in the few cases where CMS has actually penalized hospitals. Now is the time for CMS to double down on its enforcement efforts to bring more hospitals into compliance.

Regulatory Text Proposal: Modify Section 45 C.F.R. § 180.70 as follows:

> **"§ 180.70 Monitoring and enforcement.**
> ***
> (a) Monitoring and assessment.
> ***
> (b) **Enforcement** actions to address hospital noncompliance.
> ***
> (c) **Enforcement** actions to address noncompliance of hospitals in health systems.
> ***
> (d) Publicizing assessments, compliance actions, and **enforcement**."

In addition, we suggest adding clarifying text to the preamble, including a statement by CMS that the Proposed Rule would not limit the agency's enforcement authority, range of enforcement actions as set forth in 45 C.F.R. Part 180, or willingness to impose penalties on noncompliant hospitals, but that the Proposed Rule includes additional assessment capabilities to identify cases of noncompliance which may continue to result in enforcement action if so required by the terms of 45 C.F.R. Part 180.

Preamble Text Proposal: For the avoidance of doubt, CMS is modifying 45 C.F.R. Part 180 to expand the assessment capabilities to identify cases of noncompliance. CMS shall continue to pursue enforcement actions within its authority to address cases of verified noncompliance.

8. **Expand the Application of Hospital Price Transparency Rules to All Items and Services Furnished by Affiliates, Subsidiaries, and other Providers Operating within the Same Health System or Enterprise**

Limiting the hospital price transparency requirements to "items and services provided by the hospital,"[11] enables hospitals to continue to hide price information from patients by providing services through entities other than the hospital itself. Therefore, we recommend that CMS expand the requirements' application to all items and services furnished by affiliates, subsidiaries, and other providers operating within the same health system or enterprise as the hospital. Such a rule would prevent hospitals from gaming the system and would provide patients with more complete information to shop for care.

Regulatory Text Proposal: Expand the definition of "items and services" as follows:

> *"Items and services* means all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge. Items and services also include items and services provided by a subsidiary, parent, or affiliate of the hospital, such as an ambulatory surgery center within the same health system."

Corresponding to this more inclusive definition, expand the requirement at 45 C.F.R. § 180.40 to provide as follows:

> "(a) A hospital must make public the following, with respect to items and services furnished directly by the hospital and separately for items and services furnished by a subsidiary, parent, or affiliate of the hospital:
>
> (1) A machine-readable file containing a list of all standard charges for all items and services as provided in § 180.50.
>
> (2) A consumer-friendly list of standard charges for a limited set of shoppable services as provided in § 180.60."[12]

9. **Apply Price Transparency Requirements to Ambulatory Surgery Centers, Imaging Centers, and Laboratories**

Given the increasingly important role that ASCs, imaging centers, and laboratories play in patient care, CMS must require that these additional provider types are held to the same standards and abide by the same requirements as hospitals. In particular, failure to include ASCs in the hospital price transparency requirements set forth in 45 C.F.R. Part 180 would create a significant gap in the guaranteed access to price information and leave patients with a

fragmented picture of the price of care. ASCs provide items and services that overlap significantly with those provided by hospitals; thus such items and services may be properly interpreted as "hospital services" that should be captured within the statutory directive to disclose the standard charges for hospital items and services.[13] Along similar lines, imaging centers and laboratories provide ancillary services that often accompany hospital services and that significantly impact the overall cost of patient care for hospital-based services. Furthermore, ASC's, imaging centers, and labs that are independently owned are often significantly less expensive than hospitals and provide a substantial opportunity for savings for consumers and employers alike, once all actual, upfront prices are revealed.

> *Regulatory Text Proposal:* Regulatory language should include ASCs, imaging centers, and laboratories within the definition of hospitals under Part 180.20. Alternatively, a new section could provide that "each ambulatory surgical center, imaging center, or laboratory that receives payment under this title for the furnishing of items and services shall comply with the price transparency requirements set forth in 45 C.F.R. Part 180."

10. **Require Hospitals to Publicly Post their Charity Care or Financial Aid Policies in a Manner Accessible to Patients**

We encourage CMS to require hospitals to post their charity care or financial aid policies in a manner accessible to patients on their website in an easy to find location. Such information may be invaluable to patients, and yet, it is often hidden or only available at the patient's request. We suggest that CMS require hospitals to display policies related to financial support prominently in physical locations and on websites. Although CMS need not establish the substance of such policies given the differences in mission and operations among different types of hospitals, patients should not be cheated into thinking that there is no such support available, particularly based on care furnished by hospitals that nominally maintain generous financial aid programs.

> *Regulatory Text Proposal:* Add a requirement either as a new paragraph under 45 C.F.R. § 180.40, a new section in Subpart B of Part 180, or both, as follows:
>
> > "A hospital shall establish, maintain, and disclose a policy, in plain language, regarding charity or indigent care or financial aid available to patients to relieve the financial burden associated with the cost of items and services furnished by the hospital. Such policy shall be prominently displayed on the hospital's website and in facility locations, and be easily accessible to the public, without subscription, fee, or having to submit personal identifying information."

11. **Require Hospitals to Post a Discounted Cash Price and Accept Cash Regardless of Insurance Coverage**

Hospitals negotiate reimbursement with payers without any input from the patients/members who receive hospital items and services. This process results in greater costs to employers—especially small employers—and greater costs to patients, many of whom are enrolled in high-deductible health plans, and thus must bear the full cost of negotiated reimbursement that they did not themselves negotiate. Hospitals often charge lower prices to patients who are not

covered by insurance,[14] and they should be required to disclose the cash price and to accept payment of that amount in cash from patients regardless of their coverage status.

We understand that patient transparency and choice are of the utmost importance to CMS; prohibiting hospitals' restrictions on patients' methods of payment would make that transparency immediately more impactful. Patients should ultimately be able to choose whether to use their insurance (if they have such coverage) or to pay cash, so those with coverage would not be trapped into paying higher negotiated rates than the actual cash price of the service.

> *Regulatory Text Proposal:* Add a requirement under Subpart A of Part 180 to provide that "a hospital shall accept cash payment, in the amount set forth as the discounted cash price for an item or service, from a patient that may elect to pay for items and services in cash, regardless of such patients' coverage status."

12. **Provide Notice to the Public**

Hospital price transparency requirements are only as strong as patients' ability to demand compliance with such requirements. Notwithstanding the efforts of community and advocacy organizations to publicize patients' rights, Americans have grown accustomed to an opaque and burdensome healthcare pricing system. Without an informed public, hospitals can easily continue to hide accurate price information from its consumers without being held accountable. Therefore, we encourage CMS and the Biden Administration to implement strategies to inform all consumers that they have the right to real and accurate prices from hospitals and ASCs where they seek care. This may be accomplished through a wide variety of communications strategies including Medicare communications, direct communications with beneficiaries and patients, Public Service Announcements (PSAs), and even social media campaigns to ensure that all Americans know they have a right to demand more and better information about the price of their care.

The regulations also should require hospitals to notify patients and consumers seeking cost information upfront that they have the right to access accurate and comparative pricing information, and that they may choose to pay cash for items or services regardless of insurance status.

In addition to making all consumers aware of their rights through such notice, the Biden Administration has the opportunity through the Department of Labor to inform, through Summary Guidance, all employers that they have the right to thorough and accurate data through the Consolidated Appropriations Act (CAA), Transparency in Coverage, and the Hospital Price Transparency Rule (OPPS). Together, these laws establish employers' rights to obtain access to all of their claims data, coverage data, and hospital pricing data. Employers now have the right access to this information as well as indirect and direct compensation fees for services. Yet most employers, at this time, are not yet aware of their rights to this pricing and billing data. CMS and the Biden Administration must act to ensure that all individual consumers and employers are armed with their rights to transparent and accurate information from hospitals.

> *Regulatory Text Proposal:* Add a new section under Subpart B of Part 180 that sets forth the following requirement:

> "A hospital shall establish and maintain a publicly available notice to all patients and consumers regarding their right to access accurate and comparative pricing information, and that patients may elect to pay cash for items or services regardless of insurance status. Such notice shall be prominently displayed on the hospital's website and in facility locations, and be easily accessible to the public, without subscription, fee, or having to submit coverage or other personal information."

Finally, we address the specific questions in the Proposed Rule regarding how the hospital price transparency requirements can best support the consumer-friendly requirements found in other price transparency initiatives. Our comments are outlined below:

How, if at all, and consistent with its underlying legal authority, could the HPT consumer-friendly requirements at § 180.60 be revised to align with other price transparency initiatives?

First, as mentioned earlier, we suggest that CMS eliminate price estimates. Price transparency rules that require merely estimates, regardless of whether those rules apply to hospitals, payers, or other health care entities, are meaningless. To ensure both accuracy of price disclosures and alignment between requirements, the hospital price transparency rules must require disclosure of *actual prices*, not estimates, in all consumer-friendly disclosures. Without actual prices, different players in the health care industry will be "estimating" different prices for the same items and services—with no accountability for those estimates, and no reason to expect consistency between and among them.

In addition to making prices more transparent for patients, alignment between transparency rules can support enforcement and compliance with those rules. CMS, together with the other agencies that oversee compliance with health care price transparency requirements, can use the alignment between different transparency rules to compare among different entities' disclosures. In some cases, a component of one entity's disclosure may overlap with a component of another entity's disclosure. For example, a hospital's consumer-friendly disclosure of the price of a shoppable service at a provider or facility that is in-network with a particular payer should match the same information from that payer's disclosure under Transparency in Coverage requirements. If the prices do not match, CMS and the other agencies would have an opportunity to investigate or audit transparency compliance on a targeted basis, which can assist with enforcement efforts.

In the context of this specific question, we note that eliminating price estimators would make the hospital price transparency rules more consistent with the statutory authority at section 2718(e). The law requires that hospitals disclose "standard charges." Estimates are not standard charges.

Thus, revising the hospital price transparency requirements to eliminate price estimators would make it possible to align hospital price transparency rules with other transparency requirements. Alignment between these rules would ensure that a patient has "no wrong door" to access real, accurate prices while facilitating enforcement and compliance activities and bringing the rules more in line with their underlying statutory authority.

How aware are consumers about healthcare pricing information available from hospitals? We solicit recommendations on raising consumer awareness.

Most consumers remain in the dark when it comes to awareness of pricing availability from hospitals. As noted above, hospital price transparency requirements are only as strong as patients' ability to demand compliance with such requirements and having these requirements in place is ineffective if patients don't know that they exist and that they have a right to healthcare price information. Consumers have been told for decades that they should not ask for nor be concerned about the prices of health care because of insurance. Therefore, a consumer awareness campaign is necessary to see the benefits of price transparency requirements. Without an informed public, hospitals can easily continue to hide accurate price information from its consumers without being held accountable. And even when hospitals are compliant, the impact of the rules relies on patients knowing about and accessing this data.

As noted above, we recommend that CMS and the Biden administration use a wide variety of communications strategies including Medicare communications, direct communications with beneficiaries and patients, Public Service Announcements (PSAs), and social media campaigns to ensure that all Americans know they have a right to demand more and better information about the price of their care. CMS also should require hospitals to notify patients and consumers seeking cost information upfront that they have the right to access accurate and comparative pricing information. HHS has experience with these types of public campaigns, such as through the Centers for Disease Control.[15]

What elements of health pricing information do you think consumers find most valuable in advance of receiving care? How do consumers currently access this pricing information? What are consumers' preferences for accessing this price information?

Consumers with insurance would mostly need to know four things before receiving care: How much will their insurance plan be charged, how much will they will have to pay personally, how much would they pay if they didn't use their insurance or if they don't have insurance (paid cash), and how different any of these figures would be if they went to a different provider or hospital or had a different insurance plan.

Currently, consumers are generally unable to access this information, leading to inability to consider price in health care decisions and surprise bills that result in the pervasive problem of medical debt. Ineffective options that consumers use include asking their health care providers, phone calls to providers and insurers, online tools for good faith estimates provided by hospitals and plans, big data files available under both TiC and HPT rules (which are generally not known about or easy to access by consumers), and private online services with data from third parties (some based on price data and others based on past claims data). None of these sources are guaranteed, accurate or comparable for use by consumers.

Consumers' preferences are evolving. The growing use of GoodRx and similar companies has shown that consumers want to be able to compare cash prices with their insurance price and have the option to pay cash (rather than use insurance) in all provider settings. Consumers also want to know if one provider is priced lower than another (e.g., a lab test or an MRI) so they can shop for care. Over time, consumers (and their employers) would also like to know if one provider

network is priced lower than another in their community, as most consumers (and employers) make an annual choice of plan and provider network.

Given the new requirements and authorities through TIC final rules and the NSA, respectively, is there still benefit to requiring hospitals to display their standard charges in a "consumer-friendly" manner under the HPT regulations?

Yes! It is critical that hospitals display consumer-friendly prices as required by the HPT regulations. Sec 180.60 requires two important things not found elsewhere in the Rule or other rules, (a) "indicator when one or more of the CMS-specified shoppable services are not offered by the hospital" and (b) "The payer-specific negotiated charge that applies to each shoppable service (*and to each ancillary service*, as applicable)" (emphasis added). The latter especially is valuable for consumers, as most don't want to wade into the thicket of the thousands of procedure-specific codes and their individual costs. A few hospitals do it right: they provide a consumer-friendly list that shows an easy-to-understand description of a primary procedure, followed by a set of the additional (ancillary) items that the hospital typically charges when performing the primary procedure. Costs for each item are identified along with a grand total. When done properly, this type of consumer-friendly list allows consumers to determine whether another provider provides the same ancillary services in its package and allows consumers to compare individual items and services if it does not. A properly built consumer-friendly list has considerable value for consumers.

As noted above regarding alignment among different transparency initiatives, components of some disclosures overlap, including disclosures under hospital price transparency and under TiC. This overlap is necessary and useful; there should be *no wrong door* for patients to access the price of their care.

As an initial issue, regulators have struggled to ensure that TiC files can be opened on an ordinary personal computer, which seriously limits access to the content of those files. Although patients and employers would benefit from having TiC disclosures that are more available, they cannot yet count on such disclosures—so neither can CMS in its consideration of revisions to hospital price transparency rules.

Different price transparency requirements call for different data to be disclosed in different ways. Notwithstanding some overlap among different requirements, the information available from each type of disclosure differs substantially. For example, a TiC disclosure would allow a user who is enrolled in a particular plan of coverage to compare, within the universe of that plan, from which facility an item or service would be least financially difficult to bear. On the other hand, a particular hospital's disclosure *for the same item or service* may allow a patient or employer to make a better-informed decision about which plan of coverage into which to enroll based on the different payer-specific negotiated charges for the given hospital. Even though this information would overlap, their beneficial use and purpose differs.

Finally, as a practical matter, the entities subject to all of these transparency rules are failing to meet the task of complete disclosure. Whether such failure results from unwillingness by industry players to invest in compliance or from legitimate challenges with meeting the requirements, the outcome is the same: too little price information is available to patients and

employers. Until the overall state of health care price transparency is far more robust and mature, it would be foolish to even consider scaling back requirements merely because of some limited or perceived overlap.

Within the contours of the statutory authority conferred by section 2718(e) of the PHS Act, should information in the hospital consumer-friendly display (including the information displayed in online price estimator tools) be revised to enhance alignment with price information provided under the TIC final rules and NSA regulations? If so, which data should be revised and how?

For the reasons initially discussed above regarding alignment among different transparency requirements, for both machine-readable files and information in a consumer-friendly display, alignment depends on the disclosure of *actual prices*. We reiterate that estimates are not actual prices, and they do not give consumers the information to which they are entitled; price estimator tools do not present the "standard charges" required by section 2718(e). Alignment would be best achieved by eliminating estimator tools altogether and requiring disclosure of actual prices.

How effective are hospital price estimator tools in providing consumers with actionable and personalized information? What is the minimum amount of personalized information that a consumer must provide for a price estimator tool to produce a personalized out-of-pocket estimate?

Price estimator tools are worthless, and in many cases, harmful! They are <u>not</u> an appropriate substitute for an accurate list of prices. As noted above, most have devolved into a tool of obfuscation that provides an enormous range for each estimate and no information about the components parts that are part of the estimate.

For too long, hospitals have used price estimator tools as a means of avoiding providing healthcare consumers with accurate, upfront prices for shoppable services – prices for which they are fully capable of furnishing. As such, these price estimator tools actually further obfuscate true price information and perpetuate hospitals' practices of hiding prices from consumers. Patients who do utilize the price estimator tools are still charged wildly divergent prices, which are financially devastating. Such deceit makes price estimator tools not merely unhelpful (which would be sufficiently problematic for the goals of hospital price transparency rules), but seriously *harmful*.

Even if estimators are continued to be allowed *in addition to* consumer-friendly prices for shoppable services, consumers must <u>not</u> be required to impose gatekeeper questions that require patients to provide insurance information in order to generate price estimates. We recommend that CMS <u>prohibit</u> hospitals from requiring patients to submit personal information of any kind, including coverage information. Tools that do require submission of such information violate patient privacy and may prevent consumers from utilizing price estimator tools altogether.

If hospitals are permitted to rely on price estimator tools, they should be required to attest to the accuracy of the information presented in these tools and held responsible for any variation between the price estimate offered to patients and the ultimate dollar amount charged.

Should we consider additional consumer-friendly requirements for future rulemaking, and to the extent our authorities permit? For example, what types of pricing information might give consumers the ability to compare the cost of healthcare services across healthcare providers? Is there an industry standard set of healthcare services or service packages that healthcare providers could use as a benchmark when establishing prices for consumers?

As explained in more detail above, we suggest that CMS take the following additional steps as part of this or future rulemaking:

a) Expand the application of hospital price transparency rules to all items and services furnished by hospital affiliates, subsidiaries, and other providers operating within the same health system or enterprise. Hospitals should not be allowed to avoid price transparency requirements through the provision of care via affiliates, subsidiaries, and other providers operating within the same system.

b) Expand the price transparency requirements to ambulatory surgery centers, imaging centers, and laboratories. ASCs play an increasingly important role in patient care and provide many of the same items and services as hospitals, and imaging centers and laboratories furnish services that significantly impact the overall cost of care. CMS should hold ASCs, imaging centers, and laboratories to the same price transparency standards as hospitals to ensure that healthcare consumers can make informed decisions and lower their costs.

c) Require hospitals to publicly post their charity care or financial aid policies in a manner accessible to patients. Hospital policies regarding charity care and financial aid should be readily available to patients as a means of increasing hospital price transparency and providing patients with financial certainty.

d) Require hospitals to post a discounted cash price and accept cash regardless of insurance coverage. Hospitals must be required to post accurate discounted cash prices and to accept cash payment from individuals who choose to pay the discounted cash price, regardless of whether such individuals have coverage.

Thank you for considering our comments and recommendations for the Proposed Rule. We welcome the opportunity to speak with you further about our suggestions.

Sincerely,

Cynthia A. Fisher
Founder and Chairman
PatientRightsAdvocate.org

[1] 88 Fed. Reg. 49552 (July 31, 2023).
[2] PatientRightsAdvocate.org, Fifth Semi-Annual Hospital Price Transparency Compliance Report (July 2023).
[3] 88 Fed. Reg. 49552, 49848 (July 31, 2023).
[4] *Id.*
[5] *Id.* at 49920.
[6] Centers for Medicare & Medicaid Services, *Hospital Price Transparency Frequently Asked Questions (FAQs)*, available at: https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf.
[7] H.R. 3561, available at: https://www.congress.gov/bill/118th-congress/house-bill/3561.
[8] 88 Fed. Reg. 49552, 49848 (July 31, 2023).
[9] PatientRightsAdvocate.org, Fifth Semi-Annual Hospital Price Transparency Compliance Report (July 2023).
[10] https://www.federalregister.gov/d/2019-24931/p-39
[11] 88 Fed. Reg. at 49847.
[12] Paragraph structure revised to reflect the recommendation to add an attestation requirement to the same section.
[13] Moreover, we note that the House Ways and Means Committee recently introduced a bill which would subject ASCs to the same requirements as hospitals. H.R. 4822, available at: http://waysandmeans.house.gov/wp-content/uploads/2023/07/H.R.-4822-Bill-Text.pdf.
[14] R. Lawrence Van Horn, Arthur Laffer, Robert L. Metcalf. 2019. The Transformative Potential for Price Transparency in Healthcare: Benefits for Consumers and Providers. *Health Management Policy and Innovation*, Volume 4, Issue 3.
[15] https://www.cdc.gov/healthcommunication/campaigns/index.html; https://www.cdc.gov/chronicdisease/programs-impact/campaigns/index.htm