Kansas Hospital Association

September 27, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1717-P
PO Box 8013
Baltimore, MD 21244-1850

RE: CMS-1717-P: Medicare Program; Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals

Dear Administrator Verma:

On behalf of our member hospitals, the Kansas Hospital Association (KHA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding CMS-1717-P, the proposed rule to update the hospital Outpatient Prospective Payment System (OPPS) for calendar year (CY) 2020. Our comments are listed below.

Price Transparency of Standard Charges
The CY 2020 OPPS proposed rule seeks to further the goal in the Public Health Act (PHA) reducing the cost of health care coverage by focusing on hospital charges and negotiated payment rates while ignoring a fundamental aspect of the cost of health care in America – the reimbursement rates provided by government programs like Medicare and Medicaid. The most recent data on hospital discharges by payer in Kansas shows that 42.8 percent of discharges were Medicare patients, while 14.2 percent were Medicaid patients. In Kansas, Medicare payments cover, on average, approximately 85 percent of the cost of care, while the Medicaid program along with the uninsured covers around 55 percent. Let us be clear that we are talking about the cost of providing care, not the charges the hospitals include in their chargemaster. The impact of 43 percent of payers subsidizing the unreimbursed cost of care for the other 57 percent cannot be ignored if the rising cost of health care coverage is to be successfully addressed in the United States.

The requirement that hospitals provide their privately negotiated rates exceeds the legal authority provided under Section 2718(e) of the Public Health Services Act. The Act requires the publication of standard charges, which have long been understood to be a technical term referring to a hospital's usual or customary chargemaster charge. All payers are charged the "standard charge." What is not standard, however, is the negotiated payment rate paid by different payers. Payer-specific negotiated charges are not usual, common or customary. They vary year by year, payer-by-payer and even health plan by health plan. Indeed, CMS has defined "charges" to mean, "The regular rates established by the provider for services rendered to both [Medicare] beneficiaries and to other paying patients. Charges should be . . . uniformly applied to all patients . . . ."[1] In addition, the Agency's rationale for seeking to require that payer-specific negotiated charges be made public undercuts the notion that those charges are standard: CMS wants payer-specific charges to be public precisely because those charges are not standard.[2]

The requirement also would eliminate hospital's and insurance companies' ability to enter into competitive contracts by eliminating the ability to negotiate rates. While the belief is that making these payment rates public will reduce the cost of coverage, it may also increase costs as payers who have been receiving less for services insist on higher payments rates.

Regardless of which way the rates shift, they will have little impact on the actual cost of care. The PHA is focused on reducing the costs of coverage, which means the cost of insurance, not the cost of actual care provided. The impact of the reduced cost of coverage will be born not by the insurance companies, but by health care providers. This would mean that hospitals in Kansas who are already struggling with an average of 57 percent of patients underpaying costs and operating on slim to negative margins, will no longer be able to keep their doors open, leaving thousands of Kansans with limited or no access to needed care.

Finally, the regulation places a significant burden on hospitals, far greater than that estimated by CMS. Many Kansas hospitals have staff who serve dual roles in attempt to lower operating costs and keep their doors open. Even if this were a simple task, it would be difficult for some hospitals. However, this is not a simple task, with multiple payers with different negotiated rates depending on their insurance products resulting in thousands of additional lines of data providing dubious benefits to patients. Hospitals already provide estimates to patients upon request, based on the patient's specific needs and information that are infinitely more actionable for the consumer.

Once again, the regulation ignores the role that insurance companies need to play in educating patients about their out of pocket costs – which is really what they care about, not the chargemaster or the negotiated rates paid to insurance companies. Hospitals are not privy to information about whether or not a patient has met their deductibles and co-pays, or how far they may be from that limit at the time services are provided. Only the insurance company can provide this information to help patients make decisions about their health care.

Decreasing the cost of healthcare is a laudable goal, but it cannot come at the cost of access to healthcare services. We would recommend that CMS convene a working group of hospitals, other healthcare providers, insurance companies and consumers to identify and address the true needs of the

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[1] Provider Reimbursement Manual, No 15-1, ch. 22, § 2202.4. (Emphasis added.)
[2] *See, e.g.*, 84 Fed. Reg. 39,175, 39,577 (Aug. 9, 2019).

patient as a healthcare consumer. Moving forward with this regulation, which provides little to no benefit to the consumer and imposes excessive burdens on hospitals, just does not make sense.

340B Drug Pricing
The Kansas Hospital Association would like to provide comments on the potential remedies for the nearly 30 percent reduction in reimbursement for certain 340B hospitals that a district court judge ruled were unlawful. There is no basis for paying hospitals less than the statutory average sales price (ASP) plus 6 percent. KHA and its members agree with the American Hospital Association that the remedy should be as follows: Refund payments should be made to each affected 340B hospital and calculated using the JG modifier, which identifies claims for 340B drugs that were reduced under the 2018 and 2019 hospital outpatient prospective payment system (OPPS) rules, and others not adversely impacted by the reductions should be held harmless. This remedy would not disrupt the Medicare program and is consistent with those for past violations of law.

Solicitation for Comment on Cost Reporting, Maintenance of Hospital Chargemaster, and Related Medicare Payment Issues
KHA appreciates CMS requesting comments regarding the relationship of the chargemaster, the cost report, and its implications on Medicare payments. The Medicare cost report was developed over 20 years ago as a mechanism to report provider information such as facility characteristics, utilization data, cost and charges by cost center as well as other financial statement data. Many of the Medicare payment methodologies rely on information contained within the cost report. Likewise, the cost report and specifically the ratio of the cost-to-charges, are used for determining not only payment rates within the Medicare program, but also the Kansas Medicaid payment system and other insurers.

Due to the variety of payers with which the hospitals interact, the use of a standardized chargemaster is necessary for hospitals to maintain. It is the primary source for cost allocation used within cost reporting systems and it contains the codes that are largely standardized and recognized by payers for reimbursement.

KHA recommends that CMS establish a task force advisory group that includes providers, Medicaid agencies, insurers and others before it begins making recommendations for changes to the cost report or the chargemaster.

Supervision of Outpatient Therapeutic Services
KHA supports CMS' proposal to change the baseline level of supervision for outpatient therapeutic services to general supervision, rather than direct supervision, for all hospitals and critical access hospitals. We also support the continuation of the Hospital Outpatient Payment Panel to review and make recommendations regarding supervision levels for particular hospital outpatient services to allow CMS to set higher levels of supervision through the regulatory process.

Thank you for the opportunity to comment on the proposed rule.

Sincerely,

Tom Bell

Tom Bell
President & CEO