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PFC PHYSICIANS FOR FAIR COVERAGE
PHYSICIANS PARTNERING WITH PATIENTS

September 10, 2018

Re: CMS-1693-P

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-1850

Re: Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

On behalf of the undersigned group of medical professionals and associations, we appreciate the opportunity to comment on the issue of price transparency and the request for information included in the "Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information" section of the calendar year (CY) 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule.

We recognize CMS' efforts to better understand the costs of health care and improve transparency and accountability for patients and would like to respond directly to certain questions posed by CMS. To better inform your request for input, our responses that follow for the most part address medical care associated with the professional services delivered to Medicare beneficiaries by our specific specialties, rather than the entire health care delivery system.

CMS is concerned that "challenges continue to exist for patients due to insufficient price transparency. Such challenges include patients being surprised by out-of-network bills for hospital-based physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and patients

being surprised by facility fees and physician fees for emergency room visits." Therefore, the agency is considering potential actions that "would be appropriate to further our objective of having providers and suppliers undertake efforts to engage in consumer-friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain from the provider or supplier, and to enable patients to compare charges for similar services across providers and suppliers, including services that could be offered in more than one setting." Specifically, CMS includes five questions in the proposed rule, which again, we are grateful for the opportunity to respond to.

1. **How should we define "standard charges" in various provider and supplier settings? Is there one definition for those settings that maintain chargemasters, and potentially a different definition for those settings that do not maintain chargemasters? Should "standard charges" be defined to mean: average or median rates for the items on a chargemaster or other price list or charge list; average or median rates for groups of items and/or services commonly billed together, as determined by the provider or supplier based on its billing patterns; or the average discount off the chargemaster, price list or charge list amount across all payers, either for each separately enumerated item or for groups of services commonly billed together? Should "standard charges" be defined and reported for both some measure of the average contracted rate and the chargemaster, price list or charge list? Or is the best measure of a provider's or supplier's standard charges its chargemaster, price list or charge list?**

   The undersigned organizations believe that the best measure of standard charges is the usual and customary physician charge ("U&C charge") procured from a not-for-profit, independently owned and operated entity. This independence – from providers and payers – is critical. This entity should maintain an open and transparent database that collects physician charge data from actual claims information and makes that data available to all potential stakeholders, e.g. the public, regulators, clinicians, hospitals and health plans for reference. The information itself must be statistically-striated, geographically-adjusted, and specialty-specific. The "gold standard" for databases is the FAIRHealth[1] database, which was found to be the best national U&C charges database to determine out of network (OON) reimbursements in two separate studies by the non-partisan and objective research organization (NORC) at the University of Chicago. [2]

   The mission of FAIRHealth is to provide transparency to the health care and health insurance marketplaces. It was established in 2009 as the result of health plan litigation settlements facilitated by then Attorney General of New York, Andrew Cuomo, in response to an investigation he had conducted against Ingenix and its parent company UnitedHealth Group. In 2008, Attorney General Cuomo found that rates of health care charges maintained by Ingenix were lower than the actual costs of certain medical services and that the Ingenix charge data had been manipulated by certain

[1] More information on the FairHealth database is available at https://www.fairhealthconsumer.org/.

[2] NORC at the University of Chicago, Qualitative Assessment of Databases for Out-of-Network Physician Reimbursement, April 18, 2018.

health plans, resulting in greater than necessary out-of-pocket costs to patients and consumers. After the Attorney General sued, the major health plans settled the litigation over their use for many years of the Ingenix database for over $1 billion including 35 BCBS plans, Aetna, CIGNA, Humana, UnitedHealth (UNH) & Anthem. Ingenix and Attorney General Cuomo reached a settlement agreement that UNH and Ingenix would help provide initial funding of a non-profit entity that would develop a new healthcare pricing database. Out of this agreement came the creation of FAIRHealth.

The FAIRHealth database includes data on claims from 150 million covered lives and billions of medical procedures, and these figures are growing. The database contains claims from private insurance in all 50 states, and, through the Qualified Entity Program, has access to all Medicare Parts A, B, and D claims data. Twice a year, the database is updated with claims for the most recent 12 months available. FAIRHealth provides analytical resources and tools that serve the full spectrum of healthcare stakeholders: payers, hospitals and healthcare facilities, physicians, the Government, and consumers. Importantly for patient educational purposes, FAIRHealth has an extensive glossary of terms and definitions that would benefit patients in today's high deductible health plan (HDHP) environment.

FAIRHealth has been designated by the state as the benchmark tool for determining out-of-network reimbursement in Alaska (since 2004 by DOI regulation), New York (by DFS regulation) and Connecticut (by statute for emergency medicine). In New York, the State Department of Financial Services, which provides oversight to insurance companies, issued guidance implementing Part H of Chapter 60 of the Laws of 2014 that identifies FAIRHealth as an authorized, "independent source" for health plans to determine the "usual and customary cost" for out-of-network services. If health plans in New York choose to use a source other than FAIRHealth for determining the usual and customary cost, they must seek approval from the State Department of Financial Services. Furthermore, Arizona, California, Connecticut, Florida, Georgia, Kentucky, Mississippi, New Jersey, North Dakota, Pennsylvania, Texas and Wisconsin all have state licenses with FAIRHealth and utilize the data for various benchmarks and fee schedules. The U.S. Department of Health and Human Services (HHS), U.S. Government Accountability Office (GAO, the Agency for Healthcare Research and Quality (AHRQ) and CMS's Center for Consumer Information and Insurance Oversight (CCIIO) also have licenses with FAIRHealth.

With regard to consumers and their ability to access this information in an easy and transparent manner, FAIRHealth maintains a website and mobile app that use data from its vast database to help consumers understand the costs of medical and dental services and procedures in their specific geographic area. For example, if a person wanted to know the cost of getting a stomach ulcer removed, he or she could find an estimate of the in-network and out-of-network cost in that person's zip code.

Beyond the FAIRHealth database, there is little to no price data available to consumers that is provided in a clear, consistent, informative, and easily-accessible manner with data for geozips for the entire United States. While there are some attempts to rectify this product offering, including

state-sponsored all payer claims databases (APCDs) or insurers' own proprietary offerings to members such as price estimation tools, it is widely accepted that none of the currently available tools fully explain the costs of care and none of the state-based APCDs contain national data by geographical zip codes. Further, not all of these state-based tools are available to all consumers. The availability, requirements, and capabilities of APCDs, for example, vary widely from state-to-state. Determining prices, out-of-pocket costs, and quality represents a significant burden on the consumer. Currently, the FAIRHealth database represents the most consumer-friendly tools (including a mobile app) to ascertain geozip specific charges and allowable amounts for procedures and E/M services.

2. **What types of information would be most beneficial to patients, how can providers and suppliers best enable patients to use charge and cost information in their decision-making, and how can CMS and providers and suppliers help third parties create patient-friendly interfaces with these data?**

We believe that it is the responsibility of payers, including CMS, to clearly provide information to consumers about the potential costs of seeking care under their particular coverage. Clinicians can participate by helping patients interpret or help decipher, as best they can, their patient's cost-sharing responsibilities, particularly in- and out-of-network out-of-pocket costs, but ultimately, the onus should be on insurers to make these costs transparent to patients. Hospital based clinicians often are not aware of the patient's particular insurance terms and conditions, secondary or tertiary insurance, or the carriers' policy on coordination of benefits. We believe there is a serious consumer literacy problem when it comes to health insurance products. Many patients today truly do not understand their "high deductible" health plans, and there is a dearth of information on "co-insurance," "deductibles," and "co-pays." This is particularly important in light of recent studies that show that nearly 50% of working Americans have a "high deductible only" insurance plan option.

Ultimately, while clinicians and hospitals may be able to provide charge, equipment and supply pricing information upfront to patients, without accompanying information from insurers concerning the manner and methodology the insurer has utilized to adjudicate the patient's benefits, little can actually be achieved in the form of true transparency. In fact, this information from insurers is an essential component to transparency. Simply knowing that an insurer paid a member benefit 'at the usual and customary benefit level consistent with the member/patient's plan benefits' is not acceptable. Rather, the insurer must define in specific terms and in plain English the manner and methodology utilized by the insurer to adjudicate the patient's plan benefits, notwithstanding an assertion by the insurer that the information is proprietary or confidential—which, unfortunately, is an all too frequent insurer response. This is cryptic and leaves the patient with a limited understanding on what they're ultimately responsible for. Therefore, placing this responsibility exclusively on the shoulders of the hospital, physician or patient is unfair and of little use in satisfying the objective of CMS's present request for true transparency. In order to truly enhance transparency, we believe that CMS should promote and educate Medicare beneficiaries about the non-biased independent pricing data provided by FAIR Health through

www.fairhealthconsumer.org. It is free and easy for Medicare beneficiaries to access and understand. It also does not require any new systems to be set up or extra dollars spent to maintain.

In general, patients should be able to know if their physician is in-network, and should pay the same cost-sharing they would have paid to an in-network physician irrespective of whether they received unanticipated care from an out-of-network clinician. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties.

3. **Should providers and suppliers be required to inform patients how much their out-of-pocket costs for a service will be before those patients are furnished that service? How can information on out-of-pocket costs be provided to better support patients' choice and decision-making? What changes would be needed to support greater transparency around patient obligations for their out-of-pocket costs? How can CMS help beneficiaries to better understand how co-pays and co-insurance are applied to each service covered by Medicare? What can be done to better inform patients of their financial obligations? Should providers and suppliers of healthcare services play any role in helping to inform patients of what their out-of-pocket obligations will be?**

When determining the role of clinicians in providing this type of information, CMS must first distinguish between unanticipated care and scheduled care.

With respect to unanticipated care, informing patients upfront or in-advance about their out-of-pocket costs could be a violation of the Emergency Medical Treatment and Labor Act (EMTALA) and could cause negative consequences for patient care. The requirements of EMTALA are mandatory and are unaffected by in-network or out-of-network insurance status or payment considerations. In fact, EMTALA stipulates that a hospital may not place any signs in the emergency department regarding prepayment of fees or payment of co-pays and deductibles which can have the chilling effect of dissuading patients from "coming to the emergency department." To do so could lead patients to leave prior to receiving a medical screening examination and stabilizing treatment without regard to financial means or insurance status, which is a fundamental condition for satisfying EMTALA, and one of the most foundational principles of an important patient protection that was enacted three decades ago. Once the EMTALA obligation has been fulfilled, clinicians are willing to help their patients understand their costs.

It is also very significant to note that a large proportion of emergency care involves the acute diagnosis, treatment, and stabilization of diffuse and undifferentiated clinical conditions which may require care from on-call EMTALA clinicians, e.g. surgery, cardiology, neurology or anesthesiology. For example, two of the most common patient presentations are "chest pain" and "abdominal pain." These initial symptoms have a large range of ultimate diagnoses, and require a large variety of patient-specific lab tests, radiology exams, and other interventions. Knowing what the patient's total out-of-pocket costs will be before they are diagnosed and stabilized is nearly impossible until a proper course of medical care and progression is followed. This is very different from being able

to figure out total costs for an urgent care patient with a small, clean, superficial laceration or a sore throat.

Lastly regarding unanticipated care, we would *prefer* that our patients are not 'surprised' or caught off guard by the bills they receive and are not subject to high bills for their coinsurance balance on out-of-network care they received. Unfortunately, the current environment leaves both emergency physicians, the EMTALA on-call specialists and their patients subject to the opaque claims adjudication practices of insurance companies.

Both EMTALA and the Affordable Care Act (ACA) have created disincentives for health plans to enter into fair and reasonable contracts to provide services at reasonable, market-based in-network rates. The ACA's "essential health benefits" requirements and EMTALA mandates of care for emergency and on-call physicians have placed clinicians squarely in a regulatory paradox, where health plans do not have to provide fair coverage because they know that their insureds will receive the care regardless of the reimbursement terms the insurer chooses.

In addition, the ACA initially had very general, non-specific network adequacy standards which – as recent years' surprise billing problems demonstrate – did not improve network adequacy among ACA plans. Rather than address this, though, in June of 2017, CMS relinquished virtually all responsibility for establishing and enforcing network adequacy standards for Federally-Facilitated Exchange plans and instead deferred this activity to private organizations and the States.[3]

Our experience with network quality and network adequacy standard development and enforcement in purely state-regulated insurance markets leaves us profoundly concerned about this framework. We hope CMS is at least looking closely at network conditions under it – in terms of the quality of plans being approved; the specific time/distance and patient-to-provider ratio standards in place, particularly for specialty physicians; and the enforcement of any applied network standards – and we would be delighted to see or hear what the Agency has learned.

On a separate note, obligations on physicians providing non-emergency and anticipated (scheduled) care are different than those described above for unanticipated care. Requirements around usual and customary charge transparency for anticipated care should be narrowly tailored so not to cause unreasonable regulatory burdens on clinicians and hospitals. When appropriate, physicians who directly consult with their patients prior to scheduled care are should provide patients with clear information regarding their network participation. This communication between a physician and his/her patient allows for better informed health care decisions by the patient and eliminates confusion regarding the patient's payment responsibilities. However, it should be noted that this line of communication is not possible for physicians who do not directly engage with the patient prior to care, such as anesthesiology, pathology, radiology and other specialists.

[3] See at the changes made to 45 CFR §156.230 at https://www.regulations.gov/document?D=CMS-2017-0021-4021

That said, strides toward transparency may be achieved by including clear-language statements regarding the use of U&C charges, such as "The pricing information provided includes the usual and customary fees, not quotes or guarantees. Actual costs may be higher or lower depending on many factors, including, but not limited to treatment choices, actual services rendered, complications, your particular health care needs, and the details of your insurance coverage, if any. There is no guarantee that your insurance will provide coverage. Please reach out to them to understand and confirm your plan details. You are responsible for costs that are not covered." We highly encourage CMS to include this or similar statements when providing patients with cost estimates to ensure the patient fully understands the intention of the presented price. In addition, those obligations should be accompanied by commensurate obligations on the health plans to achieve sufficient network adequacy standards and in-network contracting terms that represents fair, reasonable, and market-based reimbursement standards.

4. **Can we require providers and suppliers to provide patients with information on what Medicare pays for a particular service performed by that provider or supplier? If so, what changes would need to be made by providers and suppliers? What burden would be added as a result of such a requirement?**

   We believe that insurers, including CMS, should make coverage terms and conditions available to their consumers. With respect to Medicare, we also note that the physician fee schedule should not be used as a marker to assess market-based reimbursement standards. In fact, the HHS Office of the Inspector General (OIG) in the past has acknowledged that neither the Medicare nor the Medicaid fee schedule would be appropriate references when defining "usual charges." Specifically, OIG stated that the following should not be considered in the definition of "usual charges": charges for services to indigent patients, capitated payments and "fees set by Medicare, State health care programs and other Federal health care programs …" [4] Furthermore, the 2018 Medicare Trustees Report, which was released on June 5, acknowledges that annual updates for physician reimbursement do not keep pace with the increasing cost of providing physician services. The Trustees believe that, absent a change in the delivery system or future legislative update to physician rates, access to Medicare-participating physicians will become a significant issue in the long term. [5]

5. **How does Medigap coverage affect patients' understanding of their out-of-pocket costs before they receive care? What challenges do providers and suppliers face in providing information about out-of-pocket costs to patients with Medigap? What changes can Medicare make to support providers and suppliers that share out-of-pocket cost information with patients that reflects the patient's Medigap coverage? Who is best situated to provide patients with clear Medigap coverage information on their out-of-pocket costs prior to receipt of care? What role can Medigap plans play in providing information to patients on their expected out-of-pocket costs for a service? What state-**

[4] https://oig.hhs.gov/authorities/docs/FRSIENPRM.pdf

[5] The 2018 Medicare Trustees Report is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

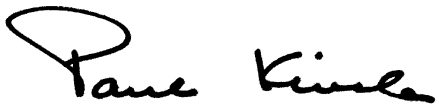
specific requirements or programs help educate Medigap patients about their out-of-pocket costs prior to receipt of care?

Like all health plans, Medigap plans should be required to provide the information described above to patients. How coordination of benefits may be achieved and issues of primary versus secondary or tertiary supplemental insurance policies are best described and explained by the health plans as they are the best source to turn to for adjudicating claims and providing sufficient transparent member benefit information pursuant to policies and procedures that they themselves have created, implemented and sold to consumers in the marketplace. Clinicians are often unknowing that a patient's secondary or tertiary supplemental policy is a Medigap policy nor its terms and conditions, and often do not know or have access to this information until after claims have been adjudicated by the supplemental insurer and the patient is well into the revenue cycle process. Requiring clinicians and hospitals to explain detailed terms and conditions of Medigap policies before or during patient care would be an unreasonable regulatory burden.

We appreciate the opportunity to share our comments and look forward to continuing working with you and your staff.

Sincerely,

American College of Emergency Physicians
American College of Osteopathic Emergency Physicians
American College of Radiology
American Society of Anesthesiologists
American Society of Plastic Surgeons
Emergency Department Practice Management Association
Medical Group Management Association
Physicians for Fair Coverage
Society for Academic Emergency Medicine



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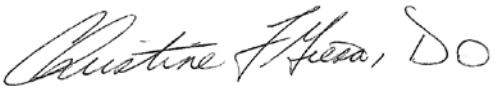

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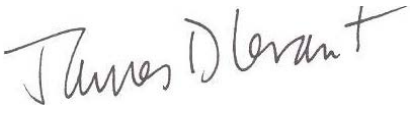

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