CONSUMERS F1RST

The Alliance to Make the Health Care System Work for Everyone

July 10, 2020

The Honorable Seema Verma,
Administrator Centers for Medicare & Medicaid
Services Department of Health and Human Services
P.O. Box 8013 Baltimore, MD 21244–1850

RE: CMS – 1735-P Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals. (Vol. 84, No. 86), May 29, 2020

Dear Administrator Verma:

Consumers First is an alliance that brings together the interests of consumers, children, employers, labor unions, and primary care working to change the fundamental economic incentives and design of the health care system. Our work is to realign the incentives and design of health care, so the system truly delivers the health and high value care that all families across the nation deserve.

Medicare payment policy often establishes a standard that is then adopted by other payers, including commercial insurers and Medicaid. Changes made to the Medicare Inpatient Prospective Payment System (IPPS) for Calendar Year 2021 offer an important opportunity to strengthen the Medicare program and to signal to other payers the need to realign the economic incentives of health care payment and delivery to truly meet the needs of all families, children, seniors, and adults across the country. The following policy recommendations could catalyze the transformational change needed in our payment system to drive high value care into the health care system and across health care markets in the U.S.

Consumers First appreciates the opportunity to provide comments on the Hospital IPPS rule for 2021. We ask that these comments, and all supportive citations referenced herein, be incorporated into the administrative record in their entirety. These comments represent the consensus views of the *Consumers First* steering committee, as well as those of the other organizations signing this letter.

Given our focus on transforming health care payment and delivery systems to provide high value care to consumers, our comments focus on the following sections of the proposed rule:

- Hospital Value-Based Payment Program
- Hospital Inpatient Quality Reporting Program
- Market-Based MS-DRG Relative Weight Proposed Data Collection and Potential Change in Methodology for Calculating MS-DRG Relative Weight

Hospital Value-Based Payment (VBP) Program

To make the Medicare program more effective, *Consumers First* believes that Medicare should be a leader among other payers to drive equity into Medicare payment and care delivery, particularly as we strive to build a high value health care system. There continue to be millions of people, and in particular Medicare beneficiaries, who live with the burden of poor health, who systematically cannot access the right care at the right time, and who receive low-quality care.[1] Those facing systemic inequities disproportionately include communities of color, those with low incomes, those with disabilities, and people living in distressed neighborhoods.[2] The COVID-19 pandemic has further unveiled the harsh realities of existing disparities in health and health care in the United States, where Black, Latino and Native American communities have experienced significantly higher rates of infection and death.[3]

Currently, 20 percent of Medicare beneficiaries are dually eligible for Medicare and Medicaid, most of whom live below the federal poverty level.[4] Moreover 13.7 million – or 25 percent - of Medicare beneficiaries come from communities of color including the African American, Latino, and Asian communities.[5] In order to ensure the health of these Medicare beneficiaries, the Medicare program should build financial incentives designed to reduce health disparities into its hospital payment systems, including the Hospital Value-Based Payment Program.

Currently, public and private payment systems take a narrow clinical view of health and health care, rewarding quantity over quality, and have generally not been designed to target reductions in disparities specifically. In fact, new payment models could inadvertently create incentives for hospitals to avoid patients with more complex needs, or to reduce health care utilization among populations whose main challenge is the underutilization of appropriate care. In addition, new payment models could financially undermine safety net hospitals who offer a significant portion of the care to communities of color and underserved communities. Importantly, value-based payment models must account for the specific socioeconomic and clinical challenges of the patient population being served in a way that reduces health disparities and does not deter hospitals from caring for high risk patients.

Consumers First recommends the following:

- **Incorporate robust risk adjustment for social risk factors into the VBP's program payment methodology to ensure hospitals are not penalized for caring for patients with more complex health and social needs. In addition, prioritize the development and continued refinement of risk adjustment methods to account for social risk factors.**
- **Incorporate health disparity reduction measures into the VBP program's measure set.**

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[1] Institute of Medicine, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America (Washington, DC: The National Academies Press, 2013), available online at https://www.nap. edu/catalog/13444/best-care-at-lower-cost-the-path-to-continuouslylearning

[2] Kenan Fikri and John Lettieri, The 2017 Distressed Communities Index (Washington, DC: Economic Innovation Group, 2017), available online at http://eig.org/wp-content/uploads/2017/09/2017-DistressedCommunities-Index.pdf.

[3] Amber Hewitt, Eliot Fishman, Winnie Luo, Lee Taylor-Penn. "The Fierce Urgency of Now: Federal and State Policy Recommendations to Address Health Inequities in the Era of COVID-19". May 2020. Available at: https://familiesusa.org/wp-content/uploads/2020/05/HE_COVID-and-Equity_Report_Final.pdf

[4] Medicare-Medicaid Coordination Office, Medicare-Medicaid Dual Enrollment from 2006 through 2018. Available at: CMS.gov/MedicareMedicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/ MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf

[5] Distribution of Medicare Beneficiaries by Race/Ethnicity. State Health Facts. Kaiser Family Foundation. Available at: https://www.kff.org/medicare/state-indicator/medicare-beneficiaries-by-raceethnicity/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

- **Require hospitals participating in the Hospital Value-Based Payment Program to collect and report on patient social and behavioral risk data with appropriate privacy and antidiscrimination protections. This includes the accurate collection of data on race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age, and disability status. The collection of these data is a critical step in implementing equity payment incentives in health care.**

Hospital Inpatient Quality Reporting (IQR) Program

Hospitals are required to report measures and meet the administrative requirements of the IQR program to avoid having their annual market basket update reduced by one quarter. The IQR program also includes requirements to report electronic clinical quality measures (eCQMs) that align with the eCQM reporting requirements in the Promoting Interoperability Program. *Consumers First* urges CMS to integrate health equity into the hospital IQR program by **incorporating health disparity reduction measures into the IQR program.** *Consumers First* also urges CMS to **require hospitals participating in the IQR program to collect and report on patient social and behavioral risk data with appropriate privacy and antidiscrimination protections. This includes the accurate collection of data on race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age, and disability status. The collection of these data are a critical step in implementing equity payment incentives in health care.**

Market-Based MS-DRG Relative Weight Proposed Data Collection and Potential Change in Methodology for Calculating MS-DRG Relative Weight

The proposed rule would require hospitals to report through the Medicare cost report two types of charges: 1) the median payer-specific negotiated charge that the hospital has negotiated with all of its Medicare Advantage organizations payers, by MS-DRG; and 2) the median payer-specific negotiated charge the hospital has negotiated with all of its third-party payers, which would include MA organizations, by MS-DRG. In addition, CMS is seeking comment on a potential change to the methodology for calculating the IPPS MS-DRG relative weights to incorporate the collected market-based rate information.

Market-Based MS-DRG Relative Weight Proposed Data Collection

Consumers First supports the Centers for Medicare and Medicaid Services' (CMS) efforts to increase transparency in how hospital systems set prices as part of goal to make health care more affordable. While we support CMS's proposal requiring hospitals to report the payer-specific median negotiated rate through the Medicare cost report, we are concerned that reporting the median negotiated rate alone will not sufficiently unveil underlying prices.[6] The lack of price transparency in our health care system is a significant factor in increasing health care costs, and real transparency in the actual prices paid by purchasers is critical to engaging in cost containment. We also support the goal of creating more functional, and therefore competitive health care markets to improve the value of health care.

Consumers First believes that disclosing price and quality data represents a bold and critical step in providing meaningful transparency in the quality of care and the prices paid for hospital system care, and

[6] 85 FR 32791 (May 29, 2020)

ultimately the health care system more broadly.[7] Importantly, the pricing information that is most critical to achieve price transparency is the specific rate that is negotiated between payers and each specific hospital. *Consumers First* also believes that any pricing information should be paired with quality information. While additional work is needed to establish a harmonized set of quality measures, we believe that price and quality information should always be paired together to achieve meaningful transparency of cost and quality for consumers, researchers, and purchasers.

While health plans are directly negotiating prices with hospitals, it is consumers and employers that are ultimately paying for health care provided through insurance premiums, deductibles, and copays. The notion that the actual purchasers of health services are unable to find out how much they are paying for care until it has already been furnished must change. *Consumers First* strongly supports efforts to increase price and quality transparency for consumers, researchers, and purchasers. As noted above, while we support the disclosure of negotiated rates, we believe the disclosure of the median negotiated rate alone does not sufficiently unveil underlying prices. The median rate does not take into account the full range of variation in prices for a service and therefore won't provide an accurate reporting of price. To make the median negotiated rate meaningful, it should be accompanied by the full distribution of negotiated rates between hospitals and insurers.

Some academic researchers suggest that full disclosure of prices negotiated between hospital systems and insurers could result in higher prices as hospital systems use the public information to drive up negotiated prices.[8] Such researchers have cited dated studies on the impact of price transparency laws on concrete prices in Denmark and gasoline prices in Australia.[9] However, there is very little empirical evidence for researchers to analyze the impact in the United States health care market. Indeed, in the United State health care market, recent research shows that disclosing price may actually help to reduce health care costs in some markets and for some services. Researchers from the University of Michigan analyzed the impact of New Hampshire's healthcare price transparency website. The website unveils out-of-pocket costs for privately insured people across a range of medical procedures. Researchers found that the website saved individuals $7.9 million and insurers $36 million on X-rays, CT scans, and MRIs from 2007 to 2011.[10] Although *Consumers First* is broadly supportive of disclosure of negotiated prices, the possibility of higher prices in certain markets warrants consideration, and we have taken that into account in our recommendations provided below. To effectively analyze price to understand where high cost and low cost care is occurring across and within health care markets, *Consumers First* recommends that CMS:

- **Require hospitals to report in the Medicare cost report each payer-specific negotiated rate at the 10th, 25th, 75th, and 90th percentiles in addition to the median negotiated rate in order to get the full distribution of negotiated rates.**
- **Pilot full public price transparency in several health care markets and conduct longitudinal studies on the impact of the policy on negotiated prices.**
- **Make hospital- and plan-specific negotiated prices available to plan sponsors and researchers in the large group market.**

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[7] The Secret of Health Care Prices: Why Transparency is in the Public Interest. California Health Care Foundation. https://www.chcf.org/publication/secret-health-care-prices/#related-links-and-downloads

[8] Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," Health Affairs 36, no. 9 (2017): 1531, doi:10.1377/ hlthaff.2017.0556, and; David Cutler and Leemore Dafny, "Designing Transparency Systems for Medical Care Prices," New England Journal of Medicine 364 (Mar. 10, 2011): 894, doi:10.1056/NEJMp1100540.

[9] Svend Albæk, Peter Møllgaard, and Per B. Overgaard, "Government-Assisted Oligopoly Coordination? A Concrete Case," Journal of Industrial Economics 45, no. 4 (1997): 429, econpapers.repec.org., and; David P. Byrne and Nicolas de Roos, "Learning to Coordinate: A Study in Retail Gasoline," Amer. Economic Review 109, no. 2 (Feb. 2019): 591, doi:10.1257/ aer.20170116.

[10] Kelly Gooch, "New Hampshire's price transparency website helped patients save money," Becker's Hospital Review, Jan. 30, 2019, https://www.beckershospitalreview.com/finance/new-hampshire-s-price-transparencywebsite-helped-patients-save-money.html

- **Provide negotiated prices to individuals, plan sponsors, and researchers in the small group and individuals markets.**
- **Provide limited information to the public on negotiated prices. This could include providing statistical information including the range and distribution of privately negotiated rates between providers and health plans.**

We also recommend CMS pair all price data with available quality data. *Consumers First* strongly supports the development and use of meaningful quality data. However, lack of relevant quality data on certain services should not be used as an excuse to not move forward with price transparency for those services. It is also important to note that while achieving price and quality transparency among hospitals would help move transparency efforts forward, there are other critical actors in the health care system that would also need to disclose price information to achieve full price and quality transparency across the health care system.

Potential Change in Methodology for Calculating MS-DRG Relative Weight

Consumers First has significant concerns with CMS's proposal to change the methodology for calculating MS-DRG relative weights to include market-based rates. First, the proposal appropriately cites the relevant research demonstrating the close relationship between traditional Medicare inpatient payment rates and the payment rates negotiated between hospitals and MA organizations, correctly concluding that MA rates and traditional Medicare inpatient payment rates are nearly equivalent.[11] Therefore, as the proposal indicates, by definition, MA negotiated rates are not market-based prices, they are administered prices.[12] In short, using MA negotiated rates - that is, traditional Medicare administered prices - is actually contradictory to the stated goal of this proposal to move toward market-determined rates. While we support efforts to create competitive markets, it is undeniable that in many locations, current market rates are highly distorted. Using rates that are a product of a dysfunctional market will serve only to further embed the economic distortions plaguing the health care system. Until functioning markets are developed, we believe regulatory intervention is needed to address the impact of those market conditions on the health care cost crisis facing the United States health care system.

The health care cost crisis facing our health care system is now compounded with the COVID-19 generated economic downturn that has drastically increased the number of uninsured and the unemployment rate. *Consumers First* has significant concerns that this proposed rule does not address the underlying economic distortions in our health care system that are responsible for driving high costs and low quality care for families and children, workers and employers. We strongly oppose shifting to a market-based methodology to calculate MS-DRG relative weights.

The magnitude of market consolidation across and within health care markets in the US is a significant health care cost problem. It is well established that increased market consolidation leads to high health care prices.[13,14] With 90% of metropolitan statistical areas (MSA) having highly concentrated hospital

[11] 85 FR 32792 (May 29,2020)

[12] 85 FR 32792 (May 29,2020)

[13] Office of Attorney General Martha Coakley, Examination of Health Care Cost Trends and Cost Drivers, Boston, MA: Office of Attorney General, March 16, 2010, https://www.mass.gov/files/ documents/2016/08/vn/2010-hcctd-full.pdf

[14] Bela Gorman, Don Gorman, Jennifer Smagula, John D. Freedman, Gabriella Lockhart, Rik Ganguly, Alyssa Ursillo, Paul Crespi, and David Kadish, Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement, New York: New York State Health Foundation, December 2016, https://nyshealthfoundation. org/wp-content/uploads/2017/11/an-examination-of-new-yorkhospital-reimbursement-dec-2016.pdf.

markets, 65% of MSAs having highly concentrated specialty physician markets, and 57% of MSAs having highly concentrated insurer markets, there are few truly competitive health care markets left.[15] Importantly, negotiated rates between hospitals and insurers are not the result of competitive market negotiations. Instead, they are the result of rates negotiated based on relative market power between hospitals and insurers. Therefore, these rates are not competitive market-determined weights as the proposal assumes.[16] As the proposal appropriately notes, hospitals charge "much higher prices than commercial plans paid for profitable service lines."[17] In other words, hospitals are able to leverage their market power over insurers in negotiations to demand and get higher prices on services in which the payment would far exceed underlying costs.

Embedded in most Medicare payment systems is the concept that Medicare pays administrative rates based on the underlying cost of production. The IPPS pays per-discharge rates using two national base payment rates – covering operating and capital expenses – and then are adjusted to account for two factors that affect hospitals' costs of providing care: patient condition and related treatment, and market conditions in the facility's location. Each Medicare severity diagnosis related group has a relative weight that reflects the expected relative cost of inpatient treatment for patients assigned to that group. The proposal fails to provide a justification for moving away from a cost-based approach.[18] Further, the proposal fails to provide evidence demonstrating that market-based rates produce a better estimate of relative costs across DRGs than the current method[19], particularly given that markets are consolidated and produce distorted rates. *Consumers First* agrees that relative weights determined in competitive markets may produce more accurate relative weights than cost-based weights. However, relative weights determined in highly consolidated markets will only reward those who hold significant market power and would further entrench the economic distortions in our health care system that drive low value care.

As a result, ***Consumers First* recommends that CMS abandon efforts to use market-based negotiated rates to calculate relative weights of MS-DRGs. Instead, CMS should consider regulatory approaches to address market consolidation in an effort to restore competitive health care markets in the U.S.**

Thank you for considering the above recommendations. Please contact Sophia Tripoli, Director of Health Care Innovation at stripoli@familiesusa.org for further information.

Sincerely,

Consumers First Steering Committee

American Academy of Family Physicians
American Benefits Council
American Federation of State, County and Municipal Employees
American Federation of Teachers
Families USA
First Focus on Children
Pacific Business Group on Health

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[15] Brent D. Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," Health Affairs 36, no. 9 (September 2017): 1530–38, https://www.healthaffairs.org/ doi/10.1377/hlthaff.2017.0556
[16] 85 FR 32790 (May 29, 2020)
[17] 85 FR 32792 (May 29, 2020)
[18] 85 FR 32792 (May 29, 2020)
[19] 85 FR 32792 (May 29, 2020)

Partner Organizations

American Muslim Health Professionals
California Pan-Ethnic Health Network
Central Penn Business Group on Health
Children's Defense Fund - Texas
Consumers for Quality Care
Health Action New Mexico
International Association of Fire Fighters
Justice in Aging
Maine Consumers for Affordable Health Care
Medicare Rights Center
Missouri Health Care For All
MomsRising
National Education Association
National Partnership for Women & Families
Northwest Health Law Advocates
Right Care Alliance
Shriver Center on Poverty Law
Virginia Organizing