CONSUMERS F1RST
The Alliance to Make the Health Care System Work for Everyone

June 17, 2022

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1771-P
P.O. Box 8013
Baltimore, MD 21244-1850.

Submitted via regulations.gov

RE: CMS-1771-P Medicare Program: Hospital Inpatient Prospective Payment Systems; Quality Programs and Medicare Promoting Interoperability Program Requirements, etc.

Dear Administrator Brooks-LaSure:

Consumers First is an alliance that brings together the interests of consumers, employers, labor unions, and primary care providers to change the fundamental economic incentives and design of the health care system and ensure it truly delivers the health and high-value care that all families across the nation deserve. *Consumers First* appreciates the opportunity to provide comments on the Medicare Inpatient Prospective Payment System (IPPS) regulation for Calendar Year 2023. Medicare payment policy establishes a standard that is often adopted by other payers, including commercial insurers and Medicaid. Changes made through the Hospital IPPS rule offer an important opportunity to both strengthen the Medicare program and to signal to other payers the need to realign the economic incentives of health care payment and delivery.

Given our focus on transforming health care payment and delivery systems to provide high-value care to consumers, our comments focus on improving hospital price and quality transparency. *Consumers First* strongly supports the Centers for Medicare and Medicaid Services's (CMS) efforts to increase transparency in how hospital systems set prices in order to help make health care more affordable. While this proposed rule does not address hospital price or quality transparency, we believe it is critical for CMS to consider key improvements to the Hospital Transparency Regulation.

The following policy recommendations would go a long way to catalyze the transformational change needed in our payment system to drive high-value care in health care markets throughout the U.S. We ask that these comments, and all supportive citations referenced herein, be incorporated into the administrative record in their entirety.

Our comments address three areas:

- Section K. Effects of Requirements for the Hospital Inpatient Quality Reporting Program
- Section J. Hospital-Acquired Condition Reduction Program

- Additional Recommendations: Hospital Price and Quality Transparency

Section K. Effects of Requirements for the Hospital Inpatient Quality Reporting Program

Consumers First strongly supports CMS's efforts to implement health care payment and delivery policy and programmatic solutions focused on advancing health equity and closing the equity gap across CMS quality payment programs. While the comments in this section pertain to the Inpatient Quality Reporting program, Consumers First is strongly supportive of CMS's overall direction to advance health equity that is outlined within the Request for Information under Section B, Overarching Principles for Measuring Healthcare Quality Disparities Across Quality Programs.

CMS is proposing the adoption of key measures into the Inpatient Quality Reporting Program including 1) Hospital Commitment to Health Equity, 2) Screening for Social Drivers of Health, and 3) Screen Positive Rate for Social Drivers of Health.

Efforts to realign the system toward improved overall health and wellbeing are being tested through new payment and delivery models. While these new models of payment and delivery offer promise to reorient the health care system toward achieving better health at lower cost, they also risk exacerbating existing inequities if the goal of racial equity is not centered in the design and implementation of such reforms. *Consumers First* applauds CMS for efforts to identify ways to hold hospitals accountable for reducing disparities and improving health equity across the health care system. We support CMS's efforts to include the above-mentioned quality measures into the IQR program. However, we strongly urge CMS to also focus its efforts on ensuring that all hospitals are collecting and reporting on complete, disaggregated data sets. This is a critical step to reduce disparities and advance health equity across CMS quality programs and was the focus of our comments on the FY2022 IPPS proposed rule.[1]

Hospitals are not yet uniformly doing the important work of collecting disaggregated sociodemographic data or accurately stratifying quality and outcomes measures by social determinants of health or SOGI. Importantly, complete data sets are critical to be able to accurately stratify quality measures. As *Consumers First* indicated in our FY 2022 IPPS comment letter, we do not support the use of imputing data to estimate race and ethnicity data for the purpose of stratifying quality measures. While new methods for indirectly estimating race and ethnicity have emerged, there continues to be significant limitations in the reliability and accuracy of the estimated data sets. Indirect methods for estimating race typically only consider geocoded and surname data as predictors, can perform poorly among racial minorities, do not adjust for possible errors for specific datasets and are unable to provide race estimates for individuals missing some of this information.[2] The result is that there may be significant underestimates or overestimates within a data set of race and ethnicity information. The goal of stratifying quality measures by race, ethnicity and other sociodemographic factors is to enable providers, policymakers, researchers and other stakeholders to drill down to individual level quality information that illustrates where disparities are occurring in health care delivery. We urge CMS to prioritize efforts to build complete, disaggregated data sets across all hospitals.

[1] Consumers First Comment Letter, FY2022 IPPS proposed rule, available at: https://familiesusa.org/wp-content/uploads/2021/06/2022-IPPS-CFComment-Letter-062821_FINAL-Copy.pdf

[2] Gabriella C. Silva, Amal Trivedi, Roee Gutman, "Developing and evaluating methods to impute race/ethnicity in an incomplete dataset," Health Services and Outcomes Research Methodology (2019) 19:175-195, Available at: https://doi.org/10.1007/s10742-019-00200-9.

As a result, Consumer *First* strongly urges CMS to:

- **Require all hospitals to collect disaggregated data by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status. The Office of the National Coordinator for Health Information Technology's (ONC) 2015 Edition Health Information Technology Certification Criteria Final Rule, the "2015 Edition" establishes HIT certification requirements that include full disaggregation of race and ethnicity, language, sexual orientation, gender identify and social and behavioral risk factors.[3] CMS should immediately adopt and endorse ONC's 2015 Edition standards for collecting disaggregated data for all hospitals and for all CMS quality programs.**
    - **As part of these efforts, CMS should require hospitals to engage in data collection methods that rely on self-reported data. Self-reported data collection of social determinant of health and SOGI data is the gold standard for collecting disaggregated data.[4,5,6] To mitigate patient concerns that race and ethnicity data may be used in a discriminatory way, providers should explain that the data will be used to improve the quality of care.[7] There are two key approaches hospitals should consider in operationalizing self-reported data methods:**
        1) **Planned Procedures: Conduct surveys with patients prior to admission as part of the pre-contact, check-in process where patients are asked to complete and verify demographic information, medical history and insurance status;**
        2) **Emergency Visits: Conduct surveys with patients when patient is stable during the time of insurance verification.**

Section J. Hospital Acquired Conditions Reduction Program Proposed Updates and Changes

Suppression of Patient Safety Information

Consumers First believes that patient safety measures are a vital tool to assessing health care quality for America's families. We are therefore **deeply disappointed in CMS' proposal to suppress the calculation and publication of the CMS Patient Safety and Adverse Events Composite (CMS PSI 90) for FY 2023.** The PSI 90 is a composite measure that includes preventable complications from surgery, such as blood leakage, kidney harm, breathing failure, sepsis, wounds that split open, and accidental cuts and tears, as well as preventable complications from medical care such as deep bed sores, lung collapse, falls that break a hip, and blood clots. The complications that make up PSI 90 are largely preventable yet kill

[3] U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology, 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule, 80 Fed. Reg. 62602-62759 (October 16, 2015)
[4] David Baker, Kenzie Cameron, Joseph Feinglass, et all, "A System for Rapidly and Accurately Collecting Patients' Race and Ethnicity," American Journal of Public Health, Vol 96, No.3, 2006, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470520/pdf/0960532.pdf
[5] Sean Cahill, Robbie Singal, Chris Grasso, et al "Do Ask, Do Tell: High Levels of Acceptiability by Patients of Routine Colleciton of Sexual Orienttation and Gender Identify Data in Four Diverse American Community Health Centers," PLoS ONE 9(9):e107104.doi:10.1371/journal.pone.0107104
[6] Haider A, Schneider E, Schuur J, et al. 2019. Comparing Ways to Ask Patients about Sexual Orientation and Gender Identity in the Emergency Room—The EQUALITY Study. Washington, DC: Patient-Centered Outcomes Research Institute (PCORI). https://doi.org/10.25302/7.2019.AD.110114IC.
[7] David Baker, Kenzie Cameron, Joseph Feinglass, et all., "Patient Attitudes Toward Health Care Providers Collecting Information About Race and Ethnicity," Division of General Internal Medicine, Department of Medicine, Feinberg School of Medicine, Northwestern Universatiy, Chicago, Ill, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1490236/pdf/jgi_195.pdf

25,000 people per year and harm another 94,000.[8] Data on the complications included in PSI-90 is available to the public from no other source. If CMS suppresses it, the American public will be in the dark on which hospitals put them most at risk. Suppressing PSI-90 would be a giant leap backward in patient safety and transparency.

In its rule, CMS proposes to suppress the PSI 90 measure *"due to the fact that the reference period (calendar year 2019) … does not include data affected by the COVID-19 Public Health Emergency and the applicable period (calendar year 2020) does include such data, this would result in risk adjustment parameters that do not account for the impact of COVID-19 on affected patients."*[9] While we recognize that the COVID-19 pandemic has put an unprecedented strain on the entire health care system, we firmly reject the implication that this provides an adequate reason to simply stop reporting on lifesaving patient safety information. Indeed, in the middle of a global pandemic, it is more important than ever the public have access to information that could literally save their lives.

We strongly urge CMS to withdraw its proposal to suppress calculation and publication of the PSI 90 measure and publish those data in a timely fashion.

Recommendations for CMS Efforts towards Hospital Price and Quality Transparency

Consumers First strongly supports CMS's efforts to increase hospital price transparency to help make health care more affordable. The pricing information that is most critical to achieve price transparency is the specific rate that is negotiated between specific payers and each specific hospital. While health plans are directly negotiating prices with hospitals, it is consumers and employers that are ultimately paying for health care through insurance premiums, deductibles, and copays. The fact that the actual purchasers of health services are unable to find out how much they are paying for care until it has already been delivered must change. For nearly 20 years, researchers have known that the underlying drivers of U.S. health care costs are high and variable health care prices that often result from consolidation across and within U.S. health care markets.[10,11,12,13]

Price transparency is a critical tool for consumers, purchasers and regulators in a health care system in which business success is not tied to innovation, population health and customer service, but rather to market power. Anti-competitive practices also prevent data from being shared and undermine

[8]Armstrong Institute for Patient Safety and Quality, *Lives Lost, Lives Saved: An Updated Comparative Analysis of Avoidable Deaths at Hospitals Graded by The Leapfrog Group,* May 2019: https://www.hospitalsafetygrade.org/media/file/Lives-Saved-White-Paper-FINAL.pdf.
Agency for Healthcare Research and Quality, *Patient Safety Indicators (PSI) Benchmark Data Tables, v2021,* July 2021: https://qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2021/Version_2021_Benchmark_Tables_PSI.pdf
[9] Centers for Medicare and Medicaid Services, *RIN 0938-AU84 Medicare Program,* 2022. Page 913.
[10] Gerard Anderson, Uwe Reinhardt, Peter Hussey et al, "It's the Prices Stupid: Why the United States is So Different from Other Countries," Health Affairs June 2003, Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.22.3.89?journalCode=hlthaff
[11] Irene Papanicolas, Liana Woskie, Ashish Jha et al, "Health Care Spending in the United States and Other High-Income Countries," Journal of American Medical Association, March 2018, Available at: https://jamanetwork.com/journals/jama/article-abstract/2674671
[12] White C, Bond AM, Reschovsky JD. High and varying prices for privately insured patients underscore hospital market power. Res Brief. 2013 Sep;(27):1-10. PMID: 24073466.
[13] Whaley, Christopher M., Brian Briscombe, Rose Kerber, Brenna O'Neill, and Aaron Kofner, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation, 2020. https://www.rand.org/pubs/research_reports/RR4394.html.

affordable, high quality health care for our nation's families, workers and employers.[14] For too long, health care prices have been hidden in proprietary contracts between private insurers and providers without any insight into or oversight over the price of health care services by policymakers, the public and other health care purchasers. As detailed in our comment letters on the CY 2021 IPPS proposed rule[15], CY 2020 OPPS proposed rule,[16] and the CY 2021 OPPS proposed rule[17], recent research shows that disclosing price may actually help to reduce health care costs in some markets and for some services.[18]

Consumers First applauds CMS for its efforts to rein in anticompetitive practices between hospitals and health plans that lead to unaffordable, low quality health care for Medicare beneficiaries, consumers, working people and employers across the country. Uncovering health care prices is a critical step forward to both empower consumers, workers and employers to be more informed purchasers of health care, and to enable policymakers to make more informed decisions that support a high value health care system.

Consumers First strongly supports CMS's efforts to implement and improve the Hospital Price Transparency Rule. Health care is one of the only sectors in the U.S. economy where consumers and purchasers are blinded to the price of a service until after they have used a service and received a bill. This practice runs counter to the interests of Medicare beneficiaries and further illustrates that the business interests of the health care sector continue to undermine the interests of the people that the Medicare program is designed to serve.

Reconfiguring the types of services subject to transparency:

While we support CMS's efforts to drive price transparency into the health care system, we encourage CMS to implement a price transparency vision that establishes more national uniformity across services. This would allow consumer, employers, providers, policymakers, and researchers to gain greater insight into health care markets with high value or low value care that can inform policymaking, and would help providers to deliver higher value care to consumers. The current Hospital Price Transparency rule requires hospitals to post the payer-specific negotiated charges for 300 "shoppable" services. Under current rulemaking, CMS would mandate 70 services and each hospital system would choose 230. Evidence suggests that health care price transparency alone has little impact on consumer behavior.[19] There are several reasons for this, including difficulty in understanding even well-intended transparency

[14] Michael F. Furukawa et al., "Consolidation of Providers into Health Systems Increased Substantially, 2016-18," Health Affairs 39, no. 8 (August 2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00017.
[15] Consumers First Comment Letter on CY2021 Inpatient Prospective Payment System proposed rule, July 10, 2020, Available at: https://familiesusa.org/wp-content/uploads/2020/07/Consumers-First-IPPS-Comment.pdf
[16] Consumers First Comment Letter on CY 2020 Hospital Outpatient Prospective Payment System proposed rule, September 27, 2019, Available at: https://familiesusa.org/wp-content/uploads/2019/10/Consumers-First-OPPS-Comments-9.27.19.pdf
[17] Consumers First Comment Letter on CY 2021 Hospital Outpatient Prospective Payment System proposed rule, September 17, 2021, Available at: https://familiesusa.org/wp-content/uploads/2021/09/Consumers-First-Comments-on-OPPS-CY22-9.17.21.pdf
[18] 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-transparency-website-helped-patients-save-money.html
[19] Mehrotra, Ateev, et al., "Promise and Reality of Price Transparency," New England Journal of Medicine, Vol. 378, No. 14 (April 5, 2018); and Whaley, Christopher, et al., "Association Between Availability of Health Service Prices and Payments for These Services," Journal of the American Medical Association, Vol. 312, No. 16 (May 3, 2018).

information and a lack of quality data against which to compare price.[20] CMS should change the scope of its transparency framework in recognition that consumers -- specifically Medicare beneficiaries -- have an important interest in price transparency that is broader than shopping for services. Price transparency will help to change the behavior of providers and payers and inform policymakers and regulators. Individual providers can effectively use price and quality information to encourage patients to access lower-cost, higher-value referred providers.[21] The same holds true for employers and other payers who can use price and quality transparency information to drive care toward higher-value providers.[22] There also is evidence to suggest that high-cost providers may change their pricing behavior due to public scrutiny.[23] As a result, ***Consumers First*** **recommends that CMS:**

- **Mandate transparency on a smaller, but nationally uniform set of high-cost and high-volume services provided in inpatient and outpatient settings. A reasonable requirement would be the publication of 100 total services to include a broadly representative sample of services (i.e. imaging, evaluation and management, core surgical specialties, radiation oncology etc.) from the following categories:**
    - **a. 50 highest dollar volume (price x volume) inpatient services**
    - b. **50 highest dollar volume (price x volume) outpatient services**

As health care price transparency efforts evolve, *Consumers First* also supports the need to disclose quality data alongside existing price data as a critical step in providing meaningful transparency in the quality of care and the prices paid for hospital system care, and ultimately the health care system more broadly.[24] While we understand that additional work is needed to arrive at and report on a harmonized set of quality measures, we believe it is important for CMS to build quality data into price transparency data over time. It is critical to establish a standard where publicly disclosed price and quality information are paired together in order to achieve meaningful transparency of cost and quality for consumers, researchers, and purchasers. Importantly, we do not support the notion of slowing down price transparency efforts until quality data is more readily available. In fact, we view calls urging CMS to wait for quality data to move forward with price transparency efforts as a delaying tactic that undermines CMS's current work to implement price transparency regulations. Instead, we recognize and support CMS's efforts to move forward with current price transparency efforts as swiftly as possible, and also encourage CMS to work simultaneously on disclosing quality information to be paired with existing price transparency data in the near future. As a near-term goal, *Consumers First* recommends that CMS:

- **Move towards requiring all disclosed pricing information to be paired with quality information to achieve meaningful transparency of cost and quality for consumers, researchers and policymakers.**

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[20] Austin, D. Andrew and Jane G. Gravelle, Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector, Congressional Research Service, Washington, D.C. (July 2007).
[21] Carman, Kristen, et al., "Understanding an Informed Public's Views on the Role of Evidence in Making Health Care Decisions, "Health Affairs, Vol. 35, No. 4 (April 2016); and Levinson, et al., "Not All Patients Want to Participate in Decision Making-A National Study of Public Preferences, "Journal of General Internal Medicine (June 2005).
[22] Robinson, James, and Timothy Brown, Evaluation of Reference Pricing: Final Report, letter to David Cowling of CalPERS (May 15, 2013). Available at: https://kaiserhealthnews.files.wordpress.com/2014/05/reference-pricing-california-berkeley.pdf.
[23] Wu, Sze-jung, et al., "Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition," Health Affairs, Vol. 33, No. 8 (August 2014).
[24] 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.

- **Engage in a robust non-industry multi-stakeholder process (i.e. consumers, employers, labor) to seek feedback and establish consensus on a meaningful set of quality measures to be reported alongside pricing information.**

Civil Monetary Penalty and Enforcement

While we applaud CMS for increasing the civil monetary penalty for hospitals who fail to comply with current regulations to disclose their health care pricing information, we are deeply concerned that the revised penalty remains too low to truly incentivize hospitals to comply with current regulations. We are also concerned that CMS has to date only administered fines to 2 hospitals who have failed to comply. We recognize that CMS has administered 345 warning notices to non-compliant hospitals, and 136 corrective action plans to hospitals since the rule went into effect on January 1, 2021.[25] However, despite warning notices and corrective action plans, the vast majority of hospitals continue to withhold the required pricing information. Numerous reports have shown that less than 20 percent of hospitals across the country are in compliance with the existing regulation,[26] and some reports show compliance as low as five percent.[27] Despite CMS administering warning notices and correction plans, most hospitals are not taking the federal law or CMS's enforcement actions seriously. Hospitals have powerful financial interests against adhering to a law that enables consumers and other health care purchasers from being informed purchasers of care. **CMS must take further action by administering the civil monetary penalty and increasing the penalty until most hospitals are disclosing the required health care pricing information.**

The proposed maximum fine of $2 million remains too small, particularly given that large hospital systems own billions of dollars of cash and investments.[28] Simply put, a $2 million fine remains too low to motivate most hospitals to comply.

Hospitals have spent years fighting price transparency regulations including through litigation[29] in an effort to avoid regulatory oversight of their anticompetitive health care prices. We urge CMS to send a stronger message to hospitals by further increasing the civil monetary penalty and to actually begin administering the penalty to noncompliant hospitals. ***Consumers First*** **recommends that CMS:**

- **Begin administering the civil monetary penalty to hospitals not in compliance with the federal regulation as of January 1, 2022.**

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[25] Marissa Plescia, No hospitals received price transparency notices in April, CMS says, Beckers Hospital Review, May 2, 2022, Available at: https://www.beckershospitalreview.com/finance/no-hospitals-received-price-transparency-notices-in-april-cms-says.html

[26] Caitlin Owens, "Most hospitals aren't complying with price transparency rule," Axios, June 15, 2021, Available at: https://www.axios.com/hospitals-price-transparency-costs-regulations-noncompliance-ebf6bd21-5709-4298-b67a-74c8a90a1ec1.html

[27] https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/60f1c225e1a54c0e42272fbf/1626456614723/PatientRightsAdvocate.org+Semi-Annual+Hospital+Compliance+Report.pdf

[28] Nancy Kane, Robert Berenson, Bonnie Blanchfield et al., "Why Policymakers Should Use Audited Financial Statements to Assess Health Systems' Financial Health," Journal of Health Care Finance, Vol. 48, Nov 1, Summer 2021, Available at: https://www.healthfinancejournal.com/index.php/johcf/article/view/265

[29] Morgan Haefner, "Hospitals lose appeal in price transparency case," Becker's Hospital Review, December 2020, Available at: https://www.beckershospitalreview.com/legal-regulatory-issues/hospitals-lose-appeal-in-price-transparency-case.html

- **Increase the civil monetary penalty for hospitals with 31 beds or more to $300 per bed per day, and remove the maximum cap of $2million on the civil monetary penalty.**
    - **A recent survey found that 75% of U.S. adults across the political spectrum support increasing the penalty for hospitals who do not comply with current regulation to $300 per hospital bed per day.[30]**
- **Monitor compliance on an ongoing basis to determine whether the civil monetary penalty is sufficiently high to increase hospital compliance.**

Thank you for considering the above recommendations. For further information, please contact Sophia Tripoli, Families USA's Director of Health Care Innovation at stripoli@familiesusa.org.

Sincerely,

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Universal Health Care Foundation of Connecticut
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[30] SocialSphere, "National Survey June 2021," Patient Rights Advocate, July 6, 2021, Available at: https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/60f1c21c49c4f65d0f57d5ae/1626456605014/SocialSphere+Patient+Rights+Advocate+June+2021+Survey+Results.pdf