September 11, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services, Department of Health and Human Services
Attention: CMS–9904–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Submitted via regulations.gov.

RE: "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction"

Dear Administrator Brooks-LaSure,

United States of Care (USofCare) is pleased to submit comments in support of the proposed rule by the Centers for Medicare & Medicaid Services (CMS) entitled "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction."

USofCare is a nonpartisan nonprofit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in states, we are able to identify unique perspectives from people on the ground to amplify on both the state and federal levels. Where possible, we uplift the voices of real people engaging with the health care system at the patient level whose perspectives have shaped our advocacy work.

Americans pay more per person for health care than any other OECD country, with health care spending typically outpacing inflation and saddling consumers and payers with unsustainable costs. An increasing growth in hospital prices leads to provider consolidation and a decreasing number of hospitals due to an influx of mergers, creating financial incentives baked into the health care market that serve to accelerate increasing prices in the industry. Provider consolidation fails to translate into high-quality care for patients and promotes health inequities. For example, Black and Indigenous people of color, immigrants, people with disabilities, the LGBTQ+ community, and additional marginalized communities are more likely to be negatively impacted by hospital closures, despite already facing systemic barriers to care and adverse health outcomes. Voters, payers, and members of Congress are desperate for legislative and regulatory solutions that apply downward pressure on hospital and provider pricing, leading to a more affordable and functional health care system for all.

In that vein, USofCare supports the proposed rule and applauds CMS for its emphasis on health equity and commitment towards hospital price transparency and affordability. We urge the agency to pursue site-neutral payment policies to ensure that all people are charged the same price for the same service, regardless of where the service is performed.

As we articulate how the rule will positively impact people's access to health care, we focus our comments on the following topics:

I. Hospital Price Transparency
II. Intensive Outpatient Program (IOP) & Partial Hospitalization Program (PHP)
III. Health Equity

Hospital Price Transparency

Our listening work has made clear that people struggle to navigate the health care system. It is important that people have easy access to information about what hospitals charge and we applaud CMS for proposing these regulations and taking steps to improve hospital price transparency and increase compliance with current requirements.

> *"I think the biggest thing that's confusing is the lack of transparency of cost. I mean, you can, you can get a bill from a doctor. So, when you get your explanation of benefits, and they've billed you like $5,000, or whatever it is. And then you look at what the insurance's negotiated rate is, and it's anywhere from 75-95% of a discount. And you're thinking, if I didn't have insurance, I'd be paying $5,000?"*
> *~ White woman, Washington*

Standardized Charges Data Accessibility & Standardization

USofCare is supportive of CMS's proposal to make hospital standard charges data more accessible and consistent. Under the rule, hospitals would be mandated to encode all standard charge information in a machine-readable file (MRF) template that includes a set of required data elements, such as each type of standard charge, a description of what product or service the charge represents, and any corresponding accounting or billing codes. To enhance consistency and minimize error, we encourage CMS to select one data format for the template (preferably CSV or XLS) instead of the three that are proposed, as well as to standardize Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes across hospitals. Hospitals should also be required to convey all standard charges in dollars and cents, as opposed to in percentages or in algorithms, for their data to be considered complete. Ensuring that all hospitals provide this data in this manner allows for a more robust, consistent data set that will foster greater analysis and understanding of how charges are promulgated.

Furthermore, CMS should take steps to ensure that hospitals publicize the availability of this data to consumers using non-digital methods so that having an internet connection is not a prerequisite for obtaining this information. People without reliable internet access otherwise may not be able to easily view this information or even be aware that it exists. In tandem with the other proposed requirements on transparency, these provisions will facilitate enhanced accountability from hospitals, preventing them from burying this critical information on their website and subjecting them to enforcement from CMS in the event of noncompliance.

Streamlined Enforcement Capabilities

USofCare has supported recent improvements made to enforcement of hospital transparency requirements and applauds CMS for continuing efforts to bring more hospitals into compliance with transparency requirements. We support the proposal for hospitals to attest to the accuracy and completeness of their data, which will provide consumers and policymakers with much-needed transparency regarding the prices of care. Requiring hospitals to publicize the location of their MRF file on their website and attest that their MRF is accurate will allow consumers to comfortably and confidently review this data without having to doubt if it is fully complete. In the final rule, we urge CMS to require that the hospital's statement of affirmation is corroborated by a senior-level hospital official and accounts for both MRF and disclosure of 300 shoppable services in a consumer-friendly manner. Hospitals should also be held accountable for conscious noncompliance or violation of their attestation by a fine levied under the False Claims Act.

Looking forward, it is critical that CMS continue to monitor and enforce compliance with this rule to ensure that people have transparency around hospital prices. This proposed rule makes it clear that CMS is taking enforcement seriously, and we applaud CMS for taking these measures.

Intensive Outpatient Program (IOP) & Partial Hospitalization Program (PHP)
While expanding IOP and Partial Hospitalization (PHP) services at Hospital Outpatient Departments (HOPDs) under Medicare will theoretically allow greater access to critical mental health services and improve health equity, these goals will not be fully realized without instituting site-neutral payment reform in HOPDs. The current hospital payment system allows Medicare to pay HOPDs higher rates for the same services compared to physician offices without a measurable increase in quality of care, driving up costs for beneficiaries. For the same service, HOPDs are paid over twice as much as physicians under the Medicare physician fee schedule. These rules not only hurt beneficiaries through high prices, but also incentivize the increasingly prevalent trend of physician practice consolidation.

While the Bipartisan Budget Act of 2015 (BBA) subjects HOPDs established after September 2015 to engage in site-neutral payment policies, HOPDs established before that date are not required to do so, as they are "grandfathered" in. **We encourage CMS to pursue policies, including an elimination of the grandfathering clause of Section 603 of the BBA, where provider reimbursement remains the same for each service, regardless of where it is performed and accounting for nuances in collectively negotiated employee compensation.** We are also supportive of previous MedPAC recommendations to align Ambulatory Service Centers (ASCs) and Ambulatory Payment Classifications (APCs) with payment rates under the OPPS. Additionally, we urge MedPAC's recommendation to expand site-neutral payments for clinic visits to all on-campus provider-based departments, which could save Medicare $2 billion a year.

Caregiving Updates to HCPCS Codes
Caregivers play an essential role in ensuring their care recipients' health care needs are met. **USofCare is supportive of including caregiver-focused services in the list of recognized HCPCS codes for PHP and IOP programs, so long as these programs are instituted to promote site-neutral payments, to better account for the needs of caregivers.**

> *"One sleepless night, I'm on Google and there's this caregiver burnout thing . . . there's all these articles that popped up. On one hand, I thought 'It's not just me,' because you second-guess yourself, honestly. Your brain is functioning for two*

people all the time, and that is exhausting. It can be very isolating and very lonely because it's not like everyone around you is doing this."
~ Black woman, Georgia

USofCare's listening work with informal caregivers revealed that caregivers face challenges navigating the care team. The proposed caregiver training services will equip caregivers to better support their care recipient's needs and help to integrate them into the care team. We also know that caregivers endure mental health issues and burnout. Administering caregiver-focused health risk assessment instruments can identify when caregivers themselves need support, creating opportunities to improve caregivers' health and wellbeing.

Health Equity

USofCare applauds CMS for its commitment to health equity in the proposed rule through its evaluation of how telehealth and behavioral health quality measurement metrics can be better tailored to provide safer and more person-centered care for patients. We urge the agency to imbed health equity in all components of data measurement, prioritizing collecting disaggregate data on race and ethnicity and expanding to additional identities including but not limited to language, sexual orientation, gender identity, ability, age, and socioeconomic status. CMS should adopt the Office of the National Coordinator for Health Information Technology's (ONC) 2015 Health Information Technology (HIT) certification requirements as a model for doing so. Accounting for health equity in all data collection will ensure that providers and systems are better equipped to address the health needs of marginalized populations and close gaps in care.

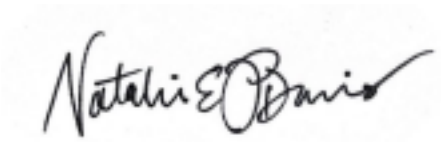
"I used to have a primary care physician, but I had to quit him. Because even though I'd gone to him for years, it wasn't until I had a very specific health question that he found out I was gay. And then, the relationship between us shifted, and it was very uncomfortable. So that's why I choose to find another primary care. It's not easy in the LGBT community to find a doctor that provides [culturally responsive care]."
~ White man, Colorado

More broadly, CMS should consider exploring and implementing culturally responsive care wherever possible. Culturally responsive care ensures that medical providers acknowledge and celebrate the identities of their patients in order to provide quality care that is tailored to their specific needs. A lack of culturally responsive providers is a systemic barrier to care for marginalized communities, especially with regards to the mental health services provided in settings like IOP and PHP programs. USofCare encourages the inclusion of peer support workers in PHP and IOP programs not only because they are effective resources for people recovering from acute mental illnesses and SUDs, but they can help provide culturally responsive care as they share lived experiences with patients.

Conclusion

If finalized, this rule will build towards our mission of ensuring that everyone can access high-quality, affordable, personalizable, and understandable health care. Please reach out to Lisa Hunter, Senior Director for Policy and Advocacy, at LHunter@usofcare.org with any questions.

Sincerely,



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