Turquoise Health

Public Comment

CMS-1786-P

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

Introduction

Turquoise Health thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on Proposed Rule CMS-1786-P, which, in part, updates the requirements for Hospital Price Transparency (HPT).

Turquoise Health is in full support of CMS' commitment to continued improvement and iteration of HPT requirements. The proposed requirements would increase efficacy in the overall effort to facilitate healthcare price transparency in the United States.

While Turquoise Health has observed a major uptick in the number of MRF disclosures from 2021 to 2023, the MRFs themselves are still plagued by schema inconsistencies and missing contents that are hard to police with automation. These shortcomings also limit the utility of existing macroeconomic (B2B competition) and microeconomic (consumer) applications.

The proposed requirement to mandate a standardized schema for hospital MRFs is critical and urgent to address the issues with data utility. We are in full support of this update.

Our comment below can be summarized by the following:

- **We iterate our strong support as a leading third party innovator in the industry for all of the newly proposed disclosure requirements**
- **We ask for clarification around two finer details of the newly required hospital MRF schema**
- **We close with thematic suggestions for continued regulatory iteration on behalf of consumers, either through the Final Rule or in subsequent rulemaking**

New Machine-Readable File Requirements Increase Usability of the Data

We support the standard schema definition proposed by CMS. In addition to new field-level requirements, we appreciate the file-level requirements that make it easier to locate files, determine the last updated date and version, as well as attribute rates to the correct provider by license number.

At the field level, we request minor modifications and clarifications. We recommend Billing Class ("professional" or "facility") remain a required data element in the schema. The initial Hospital Final Rule, CMS–1717–F2, requires that hospitals who directly employ physicians must disclose professional rates. Without Billing Class, hospitals will be unable to differentiate professional rates from facility rates in a standard manner. Within the schema, Billing Class is assigned at the Standard Charge level alongside Setting ("inpatient," "outpatient," or "both") such that the appropriate negotiated rate can be identified for a given Billing Code or set of Billing Codes. Without Billing Class, users will find conflicting charges and rates in the MRF that cannot be differentiated based on the information provided in the schema. Hospitals may then choose to include the Billing Class in a non-standard manner (e.g., Charge Codes, Description, or Additional Notes fields). An example of such rates is included as an .xlsx file in the required schema format as an appendix at the end of this comment.

Additionally, we request clarification regarding the source data used to compile the consumer-friendly expected allowed amount field. In the current Hospital Final Rule, the use of claims data as the source of payer-specific negotiated charges for items or services is forbidden. However, since the consumer-friendly expected allowed amount is an average dollar amount, claims data, or more specifically, 835 remittance files, would be the simplest and most accurate source of the allowed amount. We recommend the use of claims data as the source of truth for the consumer-friendly expected allowed amount.

We affirm that physician-administered drug pricing should be included in hospital MRFs. The addition of drug prices in HPT is crucial to give patients a comprehensive understanding of their cost of care. Drug reporting poses a number of unique challenges compared to other types of charges (e.g. room and board, operating room time), given dosage and quantity factor heavily into pricing. The establishment of uniform reporting of Drug Unit and Type of Measurement, as defined with the Proposed Rule, is transformational for drug price comprehension.

Despite its initial challenges, the creation of uniform drug pricing is possible for hospitals to disclose by 3/1/2024. Logic from open source software packages can extract pertinent unit and quantity amounts from the varying charge descriptions. Each drug has a foundational ASP unit and quantity that can be incorporated into a hospital's chargemaster description. The inclusion of drug data in MRFs allows other stakeholders within the drug ecosystem to review the posted information and, if incorrect, to help fill in gaps and pricing.

Finally, the Proposed Rule focuses primarily on fee-for-service revenue. Data elements related to the value-based care (VBC) framework are on the considered but excluded list within the Proposed Rule, given the additional burden and complexity that comes with VBC reporting. We foresee the potential for risk that hospitals may use this as an incentive to hide VBC costs and revenue, since it's harder to represent in a machine-readable file (MRF). Layering in Transparency in Coverage requirements about VBC does add some accountability to counteract that. The broader conversation related to VBC and fee for service reporting should be ongoing as price transparency legislation continues to evolve.

Importance of Permitting Standard Charge Disclosure by Dollar Amount, Percent, or Algorithm

We focus on the additional requirement that details displaying a set dollar amount for a service in an algorithm. By requiring disclosure of a formula for payment, consumers can more readily look into which hospitals have fixed prices for services and which hospitals have algorithmic prices for services. Consumers should be able to choose their care based on both competitive prices and price certainty. The inclusion of algorithmic pricing within the MRF affords consumers the opportunity to make a choice regarding whether they want to go to a hospital with a certain dollar amount, even if the price might be higher, or a hospital with an uncertain algorithmic estimate, even if the price estimate might be lower. Critically, the proposal also still permits comparisons at the dollar amount level across the board, even when an algorithm ultimately drives pricing. This proposal allows third parties to provide better context for the math behind an estimate, leading to more accurate estimates.

This price certainty pressure pushes the industry even further towards simplification, standardization, and overall predictability among business and consumer healthcare transactions. We anticipate market forces will come to bear more heavily atop the newly-structured MRF data. Patients will be unimpressed and dissuaded by complex algorithms that render costs unknown in advance. In years to come, cost certainty will win out over ambiguous algorithms.

Broadly, data standardization facilitates consumer education. It forces hospitals to create a better consumer experience by permitting physicians, care navigators, nurses, employers, and other stakeholders that consumers interact with during the care journey to have easier access to the price of healthcare.

Patients Should Receive the Same Estimate, Regardless of the Source or Relevant Legal Mandate

We support and affirm consolidation of price transparency initiatives that would result in increased simplification, standardization, and overall certainty of transparent pricing across Transparency in Coverage and the No Surprises Act. It’s important that the estimate a patient receives from any channel contains the same data - whether from the hospital (by MRF or estimate tool), their plan, a third party, or through a Good Faith Estimate per the No Surprises Act.

We recognize that CMS likely cannot achieve estimate consistency through HPT rulemaking alone. However, attention should be placed on the following areas:

- Consistency in the data contained in the MRF vs. the shoppable services requirement / patient estimate tool. We’ve seen draft legislation requiring the 300 shoppable services to be made machine readable. While this is one option, the main problem to address is the patient receiving a different estimate from the hospital’s estimate tool compared to the same service on a third party website (where the data is sourced from the MRF).
- Standardization of shoppable service packages. The above issue could be addressed through a standard library of shoppable services packages that can be used for code-level disclosure in the MRF, patient estimate tool, and even in template Good Faith Estimates. We speak to this in more depth in our suggestion below.

Our Response to Questions About Consumer Applications of Transparency Data

Turquoise Health has been providing pricing information to consumers since January of 2021. While our website has helped increase awareness of public hospital prices (over 50,000 users engage with the site each month), there is still a long way to go to create a true consumer experience in healthcare. Increased trustworthiness in the data, which lawmaking and rulemaking can facilitate, will yield third party investment in a true consumer healthcare experience.

- **How, if at all, and consistent with its underlying legal authority, could the HPT consumer-friendly requirements at § 180.60 be revised to align with other price transparency initiatives?**
    - Similarly to the TEP panel convened to discuss a hospital MRF standard, CMS should convene an expert panel to discuss a standard, open source shoppable service package that can be shared by all estimates across HPT, TiC and the No Surprises Act. Industry consensus on this issue up front will yield consistent consumer experiences to evolve across platforms. Without investing here, the government risks creating a fragmented estimates ecosystem that lacks cross-platform compatibility.

- **We solicit recommendations on raising consumer awareness.**
    - When it is possible to facilitate a guaranteed upfront price for an insured patient, millions of dollars of investment will naturally pour into consumer healthcare. Until then, utility (and possibility for consumer awareness) is limited. Estimates and data disclosures lack accountability. The government can facilitate consumer awareness by getting the ball in motion: create standardization of estimates across mandates, and require estimates for insured patients to be binding within a certain dollar amount.

- **What elements of health pricing information do you think consumers find most valuable in advance of receiving care? How do consumers currently access this pricing information? What are consumers' preferences for accessing this price information?**
    - Consumers value price, accessibility and quality. Price must be conveyed with a level of certainty. Access encompasses whether a provider is in-network, whether a service requires authorization, the ease of scheduling the service, how far away the provider is, and more of that ilk. Quality is less discretely solvable than the former two. While consumers value quality information in performing research, there is no industry standard scale for quality across all providers and service types. We expect that consumer-grade quality scores will continue to evolve alongside the evolution of consumer price transparency applications.

- **Given the new requirements and authorities through TIC final rules and the NSA, respectively, is there still benefit to requiring hospitals to display their standard charges in a "consumer-friendly" manner under the HPT regulations?**
    - There is great benefit as hospitals know the protocol for the services they provide. While insurers can only rely on claims data to anticipate the packaging of services from a hospital, hospitals control their chargemasters and service offerings. Thus, hospitals are best equipped to control and communicate their shoppable service packages in real time.

- **Within the contours of the statutory authority conferred by section 2718(e) of the PHS Act, should information in the hospital consumer-friendly display (including the information displayed in online price estimator tools) be revised to enhance alignment with price information provided under the TIC final rules and NSA regulations? If so, which data should be revised and how?**
  - The data powering the consumer friendly shoppable services requirement should align 1:1 with Good Faith Estimates required from the hospital by the No Surprises Act. In no circumstance should a consumer receive a different estimate from the patient estimate tool than they would requesting a Good Faith Estimate from the hospital. We've observed many cases where the cash rates in a hospital's MRF, patient estimate tool, and Good Faith Estimate service are all in disagreement. This creates a fragmented consumer experience that erodes trust.

- **How effective are hospital price estimator tools in providing consumers with actionable and personalized information? What is the minimum amount of personalized information that a consumer must provide for a price estimator tool to produce a personalized out-of-pocket estimate?**
  - A consumer should have the right to receive the most accurate, personalized estimate possible. At a minimum, the consumer should provide in plain language information about the service they're looking to receive and their insurance plan without requiring submission of insurance ID. However, other factors may determine the complexity of the care a consumer will receive. The hospital may need to request additional, non-identifying demographic information, such as age or medical conditions, in order to furnish the most accurate estimate possible, and guarantee an upfront payment.

- **How are third parties using MRF data to develop consumer-friendly pricing tools? What additional information is added by third parties to make standard charges consumer-friendly?**
  - Third parties combine pricing data with provider directory information, quality information from various sources, service code descriptions, consumer-friendly plain language descriptions, and real-time benefits connections in order to create a more user-friendly browsing experience.

- **Should we consider additional consumer-friendly requirements for future rulemaking, and to the extent our authorities permit? For example, what types of pricing information might give consumers the ability to compare the cost of healthcare services across healthcare providers? Is there an industry standard set of healthcare services or service packages that healthcare providers could use as a benchmark when establishing prices for consumers?**
  - Cash prices for non-hospital providers are the main missing data element from consumer price transparency today.
  - CMS should convene an expert panel to discuss various paths forward for open source shoppable service packages that can be shared as templates by payers, providers and third parties.

Conclusion

We look forward to a collaborative hospital, third party innovator, and government effort on the transition from Proposed to Final Rule.

Sincerely,
Chris Severn - CEO, Turquoise Health