September 27, 2019

To: Centers for Medicare & Medicaid Services (CMS)
From: APCD Council, on behalf of State APCDs
RE: CY 2020 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule, (CMS-1717-P)

On behalf of state health data agencies that collect and maintain statewide Hospital Discharge Data Systems (HDDS) and All-Payer Claims Databases (APCDs), the National Association of Health Data Organizations (NAHDO) and its partner the University of New Hampshire Institute for Health Policy and Practice (IHPP), working collaboratively as the All-Payer Claims Database (APCD) Council, submits these comments in response to the CY 2020 OPPS/ASC proposed rule from CMS, dated July 29, 2019. The All-Payer Claims Database (APCD) Council is a learning collaborative of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based APCDs.

We appreciate the opportunity to provide comment on this important proposed rule. States have a long history of using administrative data to better understand the costs, utilization and access to healthcare services; as well as support public health information needs. More specifically, states are custodians of statewide Hospital Discharge Data System (HDDS) and All-Payer Claims Databases (APCD). HDDS data includes patient demographic, diagnosis, clinical, and charge data for all payer types (including self-pay and uninsured) for all patients admitted to a licensed acute care hospital in a state. APCDs typically include data derived from medical, eligibility, provider, pharmacy, and/or dental files from private and public payers-beyond, including commercial carriers, Medicaid, and Medicare. Both systems require that data are submitted using a standardized format within the state. There is also similarity across states, allowing for comparable analytics/reporting.

For three decades or more, states have been advancing the policies and practices necessary to implement and advance health care transparency through standardized data collection, interoperable analytics, and public reporting of cost and quality. Because of the depth of their experience in price and quality reporting, CMS has an opportunity to leverage state data, aggregate benchmarks, and website platforms to facilitate objectives in this proposed rule.

Given where our expertise lies, we are directing our comments to the public reporting and transparency components of section **XVI. Proposed Requirements for Hospitals to Make Public a List of their Standard Charges** of this NPRM, where we believe CMS has an opportunity to

collaborate with states to promote the CMS transparency goals, and reduce reporting burden to hospitals.

As discussed in a recent blog we published with the National Academy for State Health Policy (NASHP), "…CMS took an important first step toward increasing the transparency of hospital finances when it required hospitals to post their charge information, effective January 2019. But, these charges are not prices paid — they are typically the starting point against which commercial payers negotiate discounts. States with all-payer claims databases (APCDs) have an important tool that allows them to go a step further – they can analyze the differential between "charges" and "prices paid." This is an increasingly important distinction, particularly as 90 percent of hospital marketplaces are highly concentrated. Research shows that such concentration diminishes the capacity of health plans to negotiate rates and has increased hospital costs from 20 to 40 percent without gaining improvements in efficiency or quality."[1] The proposal in this rule that individual hospital postings of negotiated charges with payers is a good start toward additional transparency. One challenge is that there is no standard approach for calculating a "negotiated charge" across hospitals. This could lead to calculations that vary greatly across hospitals, making comparison impossible.

In addition, even if calculations were standard, consumers will be challenged to acquire information hospital-by-hospital (one hospital at a time) to compare across hospitals and interpret variances in posted charges. There is an opportunity to leverage existing, centralized data systems and platforms that have been built by states and that are designed and operated as a public utility. States with APCDs and price transparency websites centralize and compare costs/prices and other attributes across providers and payers, providing a platform for disseminating standardized information.

States have a history in publishing comparative data for hospital and outpatient services. Statewide APCD data have been useful in developing benchmark and price information on a variety of conditions, focused largely on services for which consumers are most able to "shop." CMS can take advantage of that experience, invest in interoperability, and advance the work across states to support consumers. This approach would allow CMS to go beyond the hospital-based services that are the focus of the rule, by using APCD data to address outpatient services.

The development of consumer tools is only one of many uses of data at the state level. Many states also use the HDDS data to calculate hospital readmissions. Reporting at the state level eliminates 'self-reporting' by hospitals of their readmission rates and reflects system-wide utilization rates that hospitals may not be able to generate with their single-source data. More

[1] https://nashp.org/hospital-price-transparency-the-next-frontier/

recently, states are using APCD data to support efforts to address surprise medical billing, by calculating reference rates for benchmarking and negotiating.

Given the amount of work being done at the state level, the proposed rule introduces duplication of efforts and increases reporting burden on hospitals. States use legislative authority to leverage compliance to collect standardized health care data from all eligible entities, collect and validate these data, and analytically prepare the data for public consumption and publication. This system of collection and reporting may be more effective than individual hospital reporting requirements, with likely variable approaches, to publish similar data.

We appreciate this opportunity to comment on CMS's proposed transparency efforts and invite a robust collaboration between CMS and states on joint transparency objectives. States have many lessons learned from decades of public cost and outcomes reporting, and have led the way in mortality and price comparative reporting. CMS should leverage this state work to meet its transparency needs, as well.

Sincerely,

Denise Love, BSN, MBA
dlove@nahdo.org
Executive Director
National Association of Health Data Organizations
801-532-2262

Josephine Porter, MPH
Jo.Porter@unh.edu
Director
Institute of Health Policy and Practice, UNH
603-862-2964