September 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1717-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: [CMS-1717-P] Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals

Comments submitted electronically via www.regulations.gov

Dear Administrator Verma:

The American Society of Echocardiography (ASE) appreciates the opportunity to comment on CMS -1717-P, the CY 2020 Proposed Rule for the Hospital Outpatient Prospective Payment System. ASE is an organization of over 17,000 professionals committed to excellence in cardiovascular ultrasound and its application to patient care. ASE members include physicians, cardiac sonographers and other professionals dedicated to providing high-quality cardiovascular ultrasound services in both hospital and non-hospital settings.

The ASE is concerned about CMS' proposal to implement the Executive Order on Improving Price and Quality Transparency and further implement Section 2718(e) of the Public Health Service Act requiring that U.S. hospitals annually make public a list of standard charges for items and services. As noted in the proposed rule, the system is complex and difficult to navigate. CMS recently changed the guidelines regarding this requirement effective January 1, 2019. Despite just a few months experience with the current requirements, CMS is proposing to make numerous additional proposals which are questionable at best. There has not been sufficient time to (a) absorb and fully implement the first round of regulatory changes, and (b) determine the impact at the individual hospital level. We believe CMS should pause this initiative until more information is gathered on current implementation practices. We align with CMS' premise to put patients and their care

first, however, we believe that the Agency may have under-estimated the challenges associated making such wide-sweeping proposals in such a short period of time.

ASE is equally concerned with CMS' lack of transparency in moving forward with proposals to equalize payments. In CY2020 proposed rule CMS will complete implementation of the two-year phase-in of applying the Medicare Physician Fee Schedule (MPFS) rate for the clinic visit service (G0463 – Hospital outpatient clinic visit for assessment and management of a patient) when provided at an off-campus PBD and reimbursed under OPPS. CMS instituted the proposal based on its authority to restrict unnecessary increases in the volume of covered services. ASE does not support this assertion as there are different payment constructs in each fee schedule.

The concept of "transparency and site neutrality" has been raised by MedPAC, the Government Accountability Office, the President's Budget, and various Congressional committees. These entities have raised concerns with the payment differential between hospital inpatient and hospital outpatient services and in the context of payment differentials applicable to various post-acute care providers. However, we believe that further study is needed as there is the potential to disproportionately impact cardiovascular care. Proponents of equalizing payments for hospital outpatient services and those provided in physicians' offices often predicate their arguments on the assumption that the patient populations served in these two sites of service and that the data inputs used to create the costs are comparable. In fact, the HOPPS is designed such that some procedures within a department (regardless of whether they are provided on campus or off campus) are reimbursed based on their costs, as determined based on audited cost reports. For this reason, any site neutrality policy that reduces Medicare payment for particular outpatient procedures, by definition, reduces Medicare payment below audited hospital costs.

The Agency may recall the challenges cardiovascular services historically have faced under the Physician Fee Schedule. For example, Medicare payment for the primary cardiac ultrasound service has been reduced by almost 50% since 2007 based in part on flawed data gathered from only 55 cardiologists throughout the country. As a result of these payment reductions and a leveling off in utilization, Medicare spending for the primary cardiac ultrasound service under the Physician Fee Schedule was lower in 2016 than it was in 2001 and continues to decline. These reductions, along with payment reductions for other cardiac services, have placed many cardiology practices under substantial financial constraints and changed the independent practice of cardiology. It simply is not wise to reduce payment for critical cardiac services provided by hospitals to levels that have already been determined to be insufficient.

Moreover, as a professional association that is dedicated to the provision of high-quality cardiovascular imaging to those patients with diagnosed or suspected heart disease, ASE is concerned with any transparency proposal that has the potential to disproportionately impact hospitals' outpatient departments. Any proposal to arbitrarily post payment rates related to shoppable services to equalize payments will be cumbersome and confusing at best because of the different patient populations treated. Patients who review the inputs are not going understand differences in "ancillary services", "gross charges" or "payer-specific negotiated charges". While we applaud the intent, requiring hospitals to post incomplete and confusing information will not result in true price transparency for patients.

Finally, it is our belief that insurance companies should share the transparency burden. They have greater resources and should be held responsible for providing information to their beneficiaries related to their financial responsibility for medical services. If Medicare can provide that for their beneficiaries, why should insurance companies be exempt from this responsibility? Commercial insurance rates are not easily accessible, and they are not in the electronic systems in most hospitals as stated in the proposed rule.

In conclusion, we ask that CMS reconsider the price transparency requirements in the proposed rule. We would like a postponement of the posting of negotiated rates for hospitals until software is developed and made available to assist with this task at a reasonable price that will not burden hospitals or Medicare.

On behalf of ASE, we appreciate the opportunity to provide feedback on this important issue contained in the CY2020 HOPD. If you should have any questions or concerns with the information contained, please feel free to contact Irene Butler at ibutler@asecho.org.

Sincerely,

Madhav Swaminathan, M.D, FASE
President, American Society of Echocardiography