STATEMENT OF

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ON

"LOWERING UNAFFORDABLE COSTS: LEGISLATIVE SOLUTIONS TO INCREASE TRANSPARENCY AND COMPETITION IN HEALTH CARE"

BEFORE THE

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"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."
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Chairs McMorris Rodgers and Guthrie, Ranking Members Pallone and Eshoo, and Members of the Subcommittee, thank you for the opportunity to discuss the Centers for Medicare & Medicaid Services' (CMS's) work to lower health care costs and increase price transparency across the health care system.

As the nation's largest payer for health care, CMS plays a key role in incentivizing high-quality care and smarter spending across the industry. CMS programs cover over 170 million people across the United States, including more than 92 million people enrolled in Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program, over 64 million people enrolled in Medicare, and over 16 million Americans who selected or were automatically re-enrolled in health insurance coverage through HealthCare.gov Marketplaces and State-based Marketplaces (SBMs) during the 2023 open enrollment.[1,2] Efforts across the Agency are based on a foundation of goals that aim to advance health equity, eliminate avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and provide the care and support that our enrollees need to thrive.

We greatly appreciate the additional tools and resources provided by Congress through historic legislation such as the Patient Protection and Affordable Care Act (P.L. 111-148), and more recently, the American Rescue Plan Act (P.L. 117-2), the Inflation Reduction Act (P.L. 117-169), the Bipartisan Safer Communities Act (P.L. 117-159) and the Consolidated Appropriations Acts, 2021 (P.L. 116-260), 2022 (P.L. 117-103), and 2023 (P.L. 117-328). Thanks to provisions in these important laws, the Administration has made tremendous progress toward increasing

[1] CMS FY 2022 Financial Report: https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2022.pdf
[2] CMS Press Release, "Biden-Harris Administration Celebrates the Affordable Care Act's 13th Anniversary and Highlights Record-Breaking Coverage" https://www.cms.gov/newsroom/press-releases/biden-harris-administration-celebrates-affordable-care-acts-13th-anniversary-and-highlights-record

access to affordable treatments, strengthening the Medicare program, lowering prescription drug costs, and expanding access to health coverage in Medicaid and through the Marketplace.

CMS is committed to building on the work we have done to date, and is continuing to find ways to address rising health care costs—including both costs to the health care system overall and out-of-pocket costs borne by patients—in a way that allows us to advance health equity, expand access, improve health outcomes, and increase transparency.

Implementing the Inflation Reduction Act and Lowering Drug Costs

Drug costs account for a growing portion of overall health care costs, and Americans are often forced to make difficult decisions between paying for their prescriptions or other basic needs, like paying their rent or putting food on the table. On average, one in four Americans who take prescription drugs struggle to afford their medications. Nearly 3 in 10 American adults who take prescription drugs say that they have skipped doses, cut pills in half, or not filled prescriptions due to cost.[3] In 2021, prescription drug spending increased by 7.8% to $378 billion, compared to 3.7% in 2020.[4] CMS is responding to this growing problem by taking proactive steps to reduce what Americans pay at the pharmacy counter and to reduce overall drug spending within our programs.

Among other efforts, CMS is hard at work implementing provisions of the Inflation Reduction Act (IRA), which lowers prescription drug spending for millions of people with Medicare, redesigns the Part D program, keeps prescription drug premiums stable, and strengthens the Medicare program both now and in the long run. Thanks to this work, people with Medicare prescription drug coverage are already beginning to see lower out-of-pocket costs. For example, beginning in January of this year, people with Medicare prescription drug coverage now have coverage of vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), such as the shingles vaccine, at no cost. Starting October 1, 2023, most adults enrolled in Medicaid or CHIP will also have access to ACIP-recommended adult vaccines with no cost-

[3] Executive Order on Lowering Prescription Drug Costs for Americans, https://www.whitehouse.gov/briefing-room/presidential-actions/2022/10/14/executive-order-on-lowering-prescription-drug-costs-for-americans/
[4] National Health Expenditure Data Fact Sheet, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet

sharing. And, as of January this year, people with Medicare prescription drug coverage who use insulin now pay no more than $35 per one-month supply of covered insulin. The President's Fiscal Year (FY) 2024 Budget builds on this progress by proposing to extend this $35 cap on insulin products for a monthly prescription to group and individual market plans.

Moving forward, CMS will continue our efforts to lower drug costs for the American people. In 2024, CMS will implement provisions of the IRA to remove burdensome coinsurance costs for people with Medicare prescription drug coverage whose out-of-pocket spending places them in the catastrophic coverage phase, and extend full cost-sharing assistance to all enrollees in the Low-Income Subsidy (LIS) program, lowering premiums and cost-sharing for an estimated 300,000 beneficiaries. And in 2025, for the first time, a cap on out-of-pocket drug costs for people with Medicare prescription drug coverage means millions of Americans won't pay more than $2,000 a year for their prescriptions, and they will have the option to pay their prescription costs in monthly amounts spread over the year rather than all at once.

Medicare Drug Price Negotiation Program

CMS is also focused on taking steps to lower drug costs leveraging new authority under the IRA for Medicare to negotiate directly with drug manufacturers for the price of certain high-expenditure brand-name drugs that don't have competition. Medicare's new ability to negotiate drug prices will mean lower drug costs for people with Medicare and the Medicare program, improving access to innovative, life-saving treatments for people that need them. Earlier this year, CMS took our first steps toward implementing the Medicare Drug Price Negotiation Program. The initial program guidance,[5] published on March 15, 2023, specifies the requirements and procedures for implementing the Negotiation Program for the first round of negotiations, which will occur during 2023 and 2024 and result in prices effective in 2026. Among other things, the initial guidance details how CMS intends to identify selected drugs, consider factors in negotiation, conduct the negotiation process, and establish the requirements for manufacturers of selected drugs. CMS sought public comment on key elements of the initial

[5] Medicare Drug Price Negotiation Program: Initial Memorandum, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026, and Solicitation of Comments, https://www.cms.gov/files/document/medicare-drug-price-negotiation-program-initial-guidance.pdf

guidance, and we will continue to provide multiple comment opportunities for members of the public, people with Medicare and their families, beneficiary and consumer advocates, pharmaceutical manufacturers, health care providers, and other stakeholders to provide input as we move forward with implementing the law.

Medicare Prescription Drug Inflation Rebate Program

CMS is also implementing the provisions of the IRA that discourage drug companies from increasing their prices faster than the rate of inflation. The Medicare Prescription Drug Inflation Rebate Program will require manufacturers to pay rebates to the Medicare Trust Fund in cases of price increases for certain drugs that exceed inflation, particularly brand name drugs, which make up 80 percent of all prescription drug spending. Since one of the primary drivers of increased prescription drug spending has been increases in spending per prescription, requiring rebates for price increases above inflation for drugs already on the market may help reduce future growth in Medicare prescription drug spending. Thanks to these policies, CMS is already reducing coinsurance for some people with Medicare Part B coverage.

Ensuring Sustainability Across CMS Programs

We are committed to fulfilling our obligation under the law to be a good steward of CMS programs, ensuring that taxpayer dollars are spent appropriately and improving the long-term sustainability of these programs.

Strengthening Medicare

The Administration is working to strengthen the Medicare program for current and future generations, and our efforts are getting results. This year's Medicare Board of Trustees Report estimates that the solvency of the Medicare Hospital Insurance Trust Fund has been extended by three years since last year's report.[6] Adopting the proposals in the President's FY 2024 Budget would further extend the solvency of the Medicare Hospital Insurance Trust Fund by at least 25 years by making the wealthy pay their fair share in taxes and by furthering efforts to lower prescription drug costs. Proposals in the budget would build on efforts in the Inflation Reduction

[6] 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, https://www.cms.gov/oact/tr/2023

Act (IRA) to lower prescription drug costs and would invest $8 billion to enhance Medicare benefits, such as expanding access to diabetes prevention services, behavioral health services including addiction services, nutrition and obesity counseling, and community health workers. Additionally, the budget proposes to align income and asset determination processes for people with Medicare, easing administrative burdens for states and removing enrollment barriers for individuals who seek help affording premiums and cost-sharing.

Strengthening the Medicare Advantage (MA) Program

All parts of Medicare should provide equitable, high-quality care that people can afford and that will be available for our children and grandchildren. This includes Medicare Advantage (MA), which now serves roughly 50% of all Medicare beneficiaries. To strengthen and improve the MA program, we released a series of regulations that take significant steps to protect beneficiaries, improve transparency and enrollee access to correct information, and protect the sustainability of MA by improving payment accuracy and recovering overpayments.

Most recently, on April 5, 2023, CMS finalized a rule focused on key consumer protections. As examples, the final rule includes changes to protect people exploring MA and Part D coverage from confusing and potentially misleading marketing practices. It also provides important protections regarding utilization management policies and coverage criteria that ensure that MA enrollees receive the same access to medically necessary care that they would receive in Traditional Medicare, while also streamlining prior authorization requirements and minimizing disruptions in access to care for enrollees.

On March 31, 2023, CMS finalized payment policies in the Calendar Year 2024 Medicare Advantage and Part D Rate Announcement[7] that improve payment accuracy, support continued substantial value and choice in MA, and continue our efforts to improve and stabilize Medicare. Payment to MA plans is projected to be 3.32% higher, on average, in 2024 than 2023 based on the final 2024 Rate Announcement.

[7] Calendar Year 2024 Medicare Advantage and Part D Rate Announcement, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents

As required by law, CMS adjusts payments to health plans offering MA to reflect the expected health care costs of enrollees based on disease factors and demographic characteristics through a process known as "risk adjustment." This ensures CMS pays more for enrollees with greater health care needs and reduces incentives for plans to favor healthier beneficiaries. CMS routinely makes updates to the MA risk adjustment model to reflect more recent utilization and cost patterns and to ensure MA payments accurately reflect the costs of care for MA enrollees. Consistent with updates made in the past, in the 2024 Rate Announcement, CMS finalized a three-year phase-in approach to make updates to the risk adjustment model.

The updated risk adjustment model will more accurately pay for greater health care needs. As a result, the final policies will help ensure MA plan payments better reflect the costs of care for people enrolled in MA, with higher payments going to plans serving people with more health care needs, such as people with diabetes, depression, and other complex conditions like substance use disorder. The updated risk adjustment model includes more than 350 depression diagnosis codes and more than 300 diabetes diagnosis codes. Additionally, CMS will continue to make higher MA payments for an enrollee who is dually-eligible compared to someone who is not, for each diagnosis. The final policies help ensure people in MA can continue to access the care they need, including people who are dually-eligible for Medicare and Medicaid and people with chronic and complex medical conditions.

In January 2023, CMS also finalized policies to improve federal oversight of improper payments in MA through the Risk Adjustment Data Validation (RADV) Program. RADV audits—our primary tool to address improper payments in the MA program—involve the review of medical records submitted by MA plans to verify that the medical diagnoses reported by MA organizations for risk adjusted payments are accurate and documented in the medical record. These changes will allow CMS to recover overpayments and support the fiscal sustainability of Medicare going forward.

These regulations work together with other efforts to improve access to care through MA, advance health equity, and strengthen Medicare's ability to serve seniors and people with disabilities today and in the future. In addition to protecting beneficiaries and the stability and

sustainability of MA, CMS is also advancing health equity and driving quality in MA health coverage by establishing a health equity index in the Star Ratings program that will reward MA and Medicare Part D plans that provide excellent care for underserved populations.

Improving Price Transparency and Consumer Experience

In addition to lowering costs and increasing access to care, CMS's ongoing efforts to increase transparency across the health care system will help to incentivize competition, improve consumer experience, and realize additional savings across the health care system, including for patients. Lack of accessible information on prices makes it challenging for consumers to shop for services and limits competition. Over the past several years, CMS has implemented—and is continuing to implement—numerous complementary policies to promote transparency across the health care system.

Hospital Price Transparency Rule

In November 2019, CMS finalized a rule[8] establishing requirements for hospitals operating in the U.S. to establish, update, and make public a list of their standard charges for the items and services they provide, effective January 2021. While federally owned or operated hospital facilities, such as facilities operated by the U.S. Department of Veterans Affairs, military treatment facilities operated by the U.S. Department of Defense, and hospitals operated by an Indian Health Program, are deemed by CMS to have already met the requirements, the remainder are required to make their standard charges public in two ways: 1) a comprehensive, machine-readable file that includes all standard charges for all items and services provided by the hospital; and 2) a consumer-friendly display comprising at least 300 shoppable services, which can be satisfied through the release of a shoppable services file or by offering an online price estimator tool.

[8] "Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public" https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf

In 2021, CMS undertook rulemaking[9] to increase the penalty for noncompliance with the requirements. As a result, the maximum potential penalty amount was increased beginning in 2022 to $10 per bed per day, for hospitals with a bed count over 30, up to a maximum daily civil monetary penalty amount of $5,500. Therefore, the annual penalty amount increased from just over $100,000 annually per hospital to over $2 million annually per hospital in 2022. Between January and February 2021, and again between September and November 2022, CMS proactively conducted assessments of the websites of hundreds of randomly sampled hospitals to evaluate their compliance with the new requirements. A comparison of the results[10] shows progress in hospitals' implementation efforts since the Hospital Price Transparency regulation first went into effect, with 82 percent of hospitals in the sample meeting consumer-friendly display criteria, up from 66 percent; 82 percent posting a machine-readable file that met the website assessment criteria, up from 30 percent; and 70 percent doing both, up from 27 percent. While these results are encouraging, CMS takes seriously the concerns it has heard from consumers and stakeholders that hospitals are not making their standard charge information available online.

When a hospital is identified as potentially noncompliant (for example, through complaints made by individuals or entities to CMS, analyses related to compliance, or an audit), CMS begins a comprehensive review and works to bring hospitals into compliance. When deficiencies are found, a warning notice is sent to the hospital; if those deficiencies are not remedied, CMS requests a corrective action plan. If a hospital fails to respond to CMS's request for corrective action or comply with the requirements of the corrective action, CMS then issues a notice of imposition of a civil monetary penalty.

As of April 2023, CMS has issued over 730 warning notices and 269 requests for corrective action plans. CMS has issued civil monetary penalties to four hospitals for noncompliance

[9] "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model" https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf

[10] HealthAffairs "Hospital Price Transparency: Progress And Commitment To Achieving Its Potential" https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential

(posted on the CMS website);[11] every other hospital that was reviewed through a comprehensive compliance review has corrected its deficiencies or is in the process of doing so, and CMS helps hospitals come into compliance by conducting extensive technical assistance with hospitals throughout the compliance process.

CMS continues to collaborate and work with hospitals and stakeholders to increase and improve compliance with the hospital price transparency requirements. Importantly, we have been engaging interested parties, including consumer groups, hospitals, researchers, and other industry experts, to obtain their feedback on the most useful and meaningful ways to display hospital standard charge information. For example, in response to stakeholder feedback that the price transparency machine-readable files can be difficult to use and understand, in November 2022, CMS released several sample formats with a standardized set of data elements for machine-readable files that hospitals could elect to adopt. When developing the data elements and sample formats, CMS sought public input on best practices through a Request for Information[12] as well as a technical experts panel comprised of industry experts from hospitals, technology, and academia. Further increasing standardization could help hospitals better comply with the regulations, aid CMS enforcement, and facilitate third parties' abilities to develop innovative products that make prices more accessible and meaningful for consumers.

CMS is also taking action to streamline its enforcement efforts, including by expediting the timeframes by which hospitals must come into full compliance upon submitting a corrective action plan. Moving forward, CMS plans to take additional aggressive steps to identify and prioritize action against hospitals that have failed entirely to post files. By taking these additional steps, we believe that, together with stakeholders and members of the public, we can further unlock the potential of hospital price transparency and achieve greater competition in the health care system and lower costs for patients.

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[11] https://www.cms.gov/hospital-price-transparency/enforcement-actions

[12] Included as part of the proposed rule "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating" https://www.federalregister.gov/documents/2022/07/26/2022-15372/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

Price Transparency in Private Health Coverage

In addition to improving the transparency of prices for services provided by hospitals, CMS now requires additional price transparency from private health coverage. Health plan price transparency helps consumers know the cost of a covered item or service before receiving care, allowing them to make more informed decisions.

In November 2019, CMS, along with the Departments of Labor and the Treasury (the Departments), finalized the Transparency in Coverage Final Rules[13] implementing requirements in the ACA for most group health plans and issuers of group or individual health insurance to publicly post pricing information for covered items and services. These rules have several components. First, as of July 1, 2022, most group health plans and issuers of group or individual health insurance coverage are required to publicly post pricing information for certain covered items and services. This pricing information can be used by third parties, such as researchers and app developers to help consumers better understand the costs associated with their health care.

The Departments envision that third-party developers and other entities will download, process, and compile this data, creating more advanced price transparency tools that will help consumers shop among plans and providers, as well as giving the broader public information on patterns in health care costs and generate opportunities for innovation. For example, with pricing information, researchers can better assess the cost-effectiveness of various treatments; state regulators can better review issuers' proposed rate increases; patient advocates can better help guide patients through care plans; employers can adopt incentives for consumers to choose more cost-effective care; and entrepreneurs can develop tools that help doctors better engage with patients.

Next, by plan or policy years beginning on or after January 1, 2023, most group health plans and issuers of group or individual health insurance coverage are required to establish an internet-

[13] "Transparency in Coverage" https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage#h-11

based price comparison tool that discloses personalized pricing information for 500 covered items and services[14] to their participants, beneficiaries, and enrollees through an online consumer tool, or in paper form, upon request. Cost estimates must be provided in real-time based on cost-sharing information that is accurate at the time of the request. By plan or policy years beginning on or after January 1, 2024, the internet-based comparison tool must include this information for all items and services.

Surprise Billing

In addition to implementing transparency provisions under the ACA, in September 2021, CMS implemented critical rights and protections for consumers under the No Surprises Act (NSA).[15] The NSA was enacted in December 2020 as part of the Consolidated Appropriations Act, 2021 (CAA), and CMS, together with our colleagues at the Departments of Labor and the Treasury, and the Office of Personnel Management, has been working to implement the law and ensure that consumers receive the benefits of the protections they are entitled to. In addition to expanding and improving the quality of information about costs available to consumers before they receive services, the NSA protects consumers enrolled in private coverage from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. On September 16, 2022, the Departments issued a Request for Information (RFI) on implementing NSA requirements that plans and issuers provide enrollees an Advanced Explanation of Benefits. The RFI seeks information and recommendations on transferring data from providers and facilities to plans, issuers, and carriers; other policy approaches; and the economic impacts of implementing these requirements. Implementing the Advanced Explanation of Benefits requirement is a key priority for CMS. We want to ensure that, when consumers receive these documents, it provides meaningful, actionable information for them.

[14] "Transparency in Coverage," 85 Fed. Reg. 72158, 72182-72190 (November 12, 2020).
[15] "Requirements Related to Surprise Billing; Part II" https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii

The NSA also requires all providers to provide 'good faith estimates' of expected charges to uninsured and self-pay consumers prior to receiving a healthcare service. Starting January 1, 2022, uninsured and self-pay consumers can access the patient-provider dispute resolution process if they are billed an amount substantially in excess of the good faith estimate they received before the item or service was furnished. Uninsured or self-pay consumers who receive a final bill that exceeds the initial estimate by $400 or more can dispute the final charges using this newly-established process.

In order to ensure that consumers, group health plans, health insurance issuers, providers, facilities, and providers of air ambulance services have the tools and information necessary to understand and comply with these new requirements, in January 2022, the Departments launched the No Surprises Help Desk, which allows consumers, providers, and payers to ask questions concerning the NSA and submit complaints about potential violations of the law. The Help Desk refers complaints to the appropriate federal agency for follow up action. In some cases, states are the appropriate enforcement agencies. To assist stakeholders with the resolution of payment disputes and ensure fair payment, the Departments also set up an online portal for disputing parties and certified independent dispute resolution entities to resolve these disputes through the Federal Independent Dispute Resolution (IDR) process.

Between April 15, 2022, the date the Departments launched the Federal IDR portal, and December 5, 2022, disputing parties initiated over 164,000 cases through the Federal IDR portal—almost ten times the number initially estimated by the Departments for the full calendar year.

A significant portion of backlogged disputes are pending eligibility determinations. The process of determining whether a dispute is eligible for the Federal IDR process has been a more significant burden for certified IDR entities than either the Departments or the certified IDR entities initially expected. To address this issue, the Departments have engaged a contractor and government staff to conduct pre-eligibility reviews, which include outreach and technical assistance in support of the certified IDR entities' eligibility determinations. The Departments anticipate that continuing these efforts in 2023, in addition to pursuing other major reforms to

accelerate throughput, will allow certified IDR entities to focus on making payment determinations and expedite the resolution of initiated disputes.

To implement the NSA and the transparency provisions of Title II of Division BB of the CAA, 2021, the Departments were provided a one-time appropriation of $500 million, which expires at the end of 2024. However, most of the added statutory requirements are permanent, and the Departments will have ongoing responsibilities such as enforcement of plan, issuer, and provider compliance; complaints collection and investigation; as well as auditing comparative analyses of nonquantitative treatment limits for mental health and substance-use disorder plan benefits. That is why the President's FY 2024 Budget includes a request for $500 million to replenish and extend the No Surprises Act Implementation Fund, ensuring the Departments will have sufficient funding to enforce this law in the future.

Hospital and Nursing Home Ownership Data

Hospital and nursing facility consolidation can leave underserved areas with inadequate or more expensive health care options. Making facility ownership information transparent supports efforts to identify common owners that have had histories of poor performance, to analyze data and trends on how market consolidation increases consumer costs, without necessarily improving quality of care, and to evaluate the relationships between ownership and changes in health care costs and outcomes.[16]

In April 2022, as part of the President's efforts to increase competition and transparency, CMS publicly released for the first time data on mergers, acquisitions, consolidations, and changes of ownership from 2016-2022 for hospitals and nursing homes enrolled in Medicare. This data, now available on data.cms.gov, is a powerful new tool for researchers, state and federal enforcement agencies, and the public to better understand the impacts of consolidation on health care prices and quality of care. In September 2022, CMS released additional data publicly on the ownership of approximately 15,000 nursing homes certified as a Medicare Skilled Nursing

[16] ASPE, Ownership of Skilled Nursing Facilities: An Analysis of Newly-Released Federal Data, https://aspe.hhs.gov/sites/default/files/documents/fd593ae970848e30aa5496c00ba43d5c/aspe-data-brief-ownership-snfs.pdf

Facility, regardless of any change in ownership, including providing more information about organizational owners of nursing homes. In December 2022, CMS released detailed information on the ownership data of more than 7,000 Medicare-certified hospitals. And just last week the agency released ownership data for all Medicare-certified hospice and home health agencies. For the first time, anyone can now review detailed information on the ownership of more than 6,000 hospices and 11,000 home health agencies certified to participate in the Medicare program on the CMS website.[17]

In February 2023, CMS issued a proposed rule to require nursing homes to disclose additional ownership and management information, including information regarding individuals or entities that provide administrative services or clinical consulting services to the nursing homes. The proposed rule would also require additional information about entities that lease or sublease property to nursing homes and defines "private equity company" and "real estate investment trust ownership" for the purposes of provider enrollment and disclosure. Building on the proposals in the rule, CMS has taken steps to require Medicare skilled nursing facilities and other providers to disclose private equity company and real estate investment trust ownership interests via a revision to the Medicare enrollment application used by these providers.

In addition to fostering competition that drives high-quality care, transparent ownership data benefits the public by assisting patients, and their loved ones, in making more informed decisions about care. Analyzing this data will support CMS efforts to develop policy approaches that can improve competition in health care, a key priority for the Administration's strategy to reduce health care costs.

Moving Forward

The Administration has made expanding access to high-quality, affordable health care a top priority. We are working to not only lower prescription drug and health care costs but to make sure consumers fully understand the costs they will be expected to pay before they receive care.

[17] "For the First Time, HHS Is Making Ownership Data for All Medicare-Certified Hospice and Home Health Agencies Publicly Available" https://www.cms.gov/newsroom/press-releases/first-time-hhs-making-ownership-data-all-medicare-certified-hospice-and-home-health-agencies

CMS appreciates the work of Congress in passing groundbreaking legislation to help us achieve these goals, and we look forward to continuing to work together as we move forward with implementation and continue finding ways to advance health equity, lower health care costs, and improve transparency across our nation's health care system.