Compliance Today - February 2020
CMS finalizes hospital price transparency requirements; delays start date until 2021

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Beginning January 1, 2021, hospitals throughout the country will be required to publicly disclose the prices they charge for items and services they provide, including the specific reimbursement and payment rates the hospital has with third-party payers. Both the federal government and individual states have enacted other price transparency laws over the past several years, but the new requirements represent the broadest reaching and most comprehensive mandates to date.

The new price transparency requirements were published as a final rule in the Federal Register on November 27, 2019 (final rule)[1] Despite broad opposition from the hospital industry on several aspects of the proposed price transparency rule published on July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) mostly finalized the hospital price transparency requirements as proposed, although, CMS did delay the effective date until January 1, 2021, giving hospitals just over a year to implement these requirements.

This article outlines the history of hospital price transparency efforts, the specific requirements included in the final rule, and the inevitable legal challenges brought by the hospital industry.

Price transparency background

The federal government and many states have been pushing for greater transparency surrounding the prices hospitals charge for services (and the corresponding patient cost sharing responsibility) for years. More than half of the states have legislation requiring publication of healthcare prices to some extent. And although hospitals should continue to be aware of specific state requirements, which may impose additional requirements on top of the obligations required under the final rule, the focus of this article is on the latest federal government efforts.

The Patient Protection and Affordable Care Act[2] passed in 2010 included the following requirement that hospitals make public a list of standard charges: “Each hospital operating within the United States shall for each year establish (and update) and make public…a list of the hospital’s standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act” (the price transparency law).[3] At the same time, Congress instructed the Secretary of the Department of Health and Human Services (HHS Secretary) to develop guidelines for the price transparency law.

The HHS Secretary first addressed the price transparency law in the federal fiscal year (FFY) 2015 Medicare Inpatient Prospective Payment System (IPPS) final rule[4] At that time, CMS reminded hospitals of their obligations under the price transparency law, but generally left the details up to hospitals. Hospitals could either make public “a list of the standard charges,” whether that be the charge description master (chargemaster) itself or in another form of their choice, or “their policies for allowing the public to view a list of those charges in...
response to an inquiry.”\footnote{5} Even though hospitals had broad discretion about what information to make public, without the threat of enforcement the price transparency law was largely ignored.

In August 2018, as part of the FFY 2019 IPPS final rule, CMS stated that, as of January 1, 2019, it would require hospitals to make available to the public a list of standard charges, updated annually, via the internet in a machine-readable format.\footnote{6} At that time, CMS did not further define the term “standard charges” other than to reiterate that hospitals could choose to publish either the chargemaster itself or another form of the hospital’s choice. CMS did not require hospitals to publish payer-specific data at the time but did hint that it may in the future. Concurrent with the FFY 2019 IPPS final rule, CMS published two separate FAQs related to the price transparency law.\footnote{7,8} Consistent with the rule, those FAQs did not require hospitals to disclose payer-specific payment or reimbursement rates, leaving the term “standard charges” undefined.

As a result of the flexibility under federal guidance, unless state law included a more specific requirement, most hospitals limited the price information it made publicly available to the standard charges included on the hospital’s chargemaster. Predictably, lists of hospital gross charges were largely irrelevant to what an individual patient would ultimately pay for a particular item or service and did very little to advance the underlying policy reasons behind price transparency.

The Trump administration, however, continued to analyze the issue with a focus on how price transparency laws could meaningfully contribute to efforts to lower healthcare costs. On December 3, 2018, HHS, the Department of the Treasury (DOT), and the Department of Labor (DOL) issued a report entitled, “Reforming America’s Healthcare System Through Choice and Competition” that provided a preview of the framework laid out in the final rule. Most notably, the report stated “[t]o be effective, price transparency efforts must distinguish between the charges a provider bills and the rate negotiated between payers and each provider.”\footnote{9}

Then on June 24, 2019, the Trump administration released an Executive Order on price transparency entitled “Improving Price and Quality Transparency in American Healthcare to Put Patients First,” which was aimed at giving patients access to price and quality information about their healthcare services. The Executive Order gave the HHS Secretary 60 days to propose regulations requiring hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services. Pursuant to the Executive Order, CMS included proposed hospital price transparency requirements in its calendar year (CY) 2020 Outpatient Prospective Payment System (OPPS) proposed rule, published on July 29, 2019, and issued the final rule on November 27, 2019.\footnote{10}

**Final rule hospital price transparency requirements**

The final rule established regulations promulgating many of CMS’s proposals to reinterpret and provide more detailed requirements for the price transparency law as summarized below.\footnote{11} (Note that HHS, the DOL, and the DOT issued another, related proposed transparency rule on the same day as the OPPS transparency final rule that is part of a broader healthcare transparency effort by the Trump administration. That proposed rule, “Transparency in Coverage,” would require most employer-based group health plans and health insurance issuers that offer group and individual coverage to disclose price and cost-sharing information up front to participants, beneficiaries, and enrollees. The requirements of the Transparency in Coverage proposed rule are not addressed in this article.)

**Hospitals subject to the price transparency law**

CMS defines “hospital” as any institution that is licensed or otherwise approved as a hospital by the agency of each state responsible for licensing or approving hospitals.\footnote{12} Hospitals are subject to the Price Transparency Law regardless of their Medicare enrollment status. Importantly, CMS declined requests to exclude certain hospitals such as critical access hospitals, rural hospitals, and sole community hospitals from the part or all of the requirements. However, other types of licensed facilities, such as ambulatory surgical centers, are not
required to report pricing information.

Further, Indian Health Service facilities (including tribally owned and operated facilities) and federally owned or operated facilities, such as Veterans Affairs facilities and Department of Defense military treatment facilities, will be deemed to be in compliance with the price transparency law, because they do not provide services to the general public and payment rates for services are not subject to negotiation.\[14\]

**Services subject to the price transparency law**

A hospital subject to the price transparency law must publish price information for items and services, defined as “items and services (including individual items and services and service packages) provided by the hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge.”\[15\] Several commenters questioned the feasibility and usefulness of publishing price information for “service packages,” noting that service packages are often unique to individual payers and the rates negotiated with payers are not necessarily associated with a HCPCS code, diagnosis-related group (DRG), National Drug Code (NDC), or Ambulatory Payment Classification as CMS anticipated in the proposed rule. CMS, however, declined to remove the term *service package* from the definition of items and services.

CMS also includes the services of hospital-employed physicians and non-physician practitioners (NPPs) in its definition of items and services subject to disclosure under the price transparency law.\[16\] However, the hospital does not have to post the charges of non-employed physicians and NPPs who provide services at the hospital. This would indicate that physicians and NPPs employed by another legal entity in the same health system would not be subject to the disclosure requirements under the final rule.

**Required price information**

Under the final rule, hospitals must post “standard charges” for each item and service, which is defined to include the following five types of charges (note that bullets 3–5 are additions from the proposed rule):

1. The “gross charge” is defined as the charge that is reflected on a hospital’s chargemaster without any discounts reflected.

2. The “payer-specific negotiated charges” is defined as the rates that the hospital has negotiated with each third-party payer. A third-party payer does not include self-pay patients or government payers (such as Medicare or Medicaid fee-for-service) in payer-specific negotiated charges because those rates are not negotiated, but it does include charges for Medicare and Medicaid managed care plans because those rates are negotiated.

3. The “discounted cash price” is defined as the charge that applies to an individual who pays cash or cash equivalent for a hospital item or service.

4. The “de-identified minimum negotiated charge” is defined as the lowest charge negotiated with all third-party payers.

5. The “de-identified maximum negotiated charge” is defined as the highest charge negotiated with all third-party payers.\[17\]

Once hospitals have established their standard charges for all items and services, they have to make the information publicly available in two ways: (1) a machine-readable file with all standard charges for all items and services; and (2) a consumer-friendly display for certain common “shoppable services,” defined as services that can be scheduled by a healthcare consumer in advance.\[18\] This data must be updated at least annually by the hospital. The required information to be disclosed for each is summarized in Table 1.
<table>
<thead>
<tr>
<th>Description of requirement</th>
<th>All hospital standard charges</th>
<th>Selected shoppable services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals must make available the standard charges (all five types) for all items and services, both individual items and services as well as service packages.</td>
<td>Hospitals must make available charges for as many of the 70 CMS-selected shoppable services that they provide, and as many additional hospital-selected shoppable services as is necessary for a total of at least 300 (unless the hospital does not provide 300 shoppable services).</td>
<td></td>
</tr>
</tbody>
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| Intended users | Healthcare consumers indirectly (e.g., in price transparency tools or integrated into electronic health records (EHRs)). | Directly by healthcare consumers to compare costs for common services. |

<table>
<thead>
<tr>
<th>Required data elements</th>
<th>Description of each item or service.</th>
<th>Plain-language description of each shoppable service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Corresponding gross charge, payer-specific negotiated charges (clearly associated with the name of the payer), discounted cash price, and de-identified minimum and maximum negotiated charges that apply to each in, as applicable, the hospital inpatient and outpatient settings.</td>
<td>- An indicator when a CMS-specified shoppable service is not offered by the hospital.</td>
<td></td>
</tr>
<tr>
<td>- Any code used by the hospital for accounting or billing purposes (e.g., CPT code, HCPCS code, DRG, NDC).</td>
<td>- The payer-specific negotiated charges (clearly associated with the name of the payer), discounted cash price, and de-identified minimum and maximum negotiated charges that apply to each.</td>
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<tr>
<td></td>
<td>- A list of ancillary items and services that the hospital customarily provides with the shoppable service along with the charge for each.</td>
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<td></td>
<td>- The location at which the shoppable service is provided.</td>
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</tr>
<tr>
<td></td>
<td>- Any primary code used by the hospital for accounting or billing purposes (e.g., CPT code, HCPCS code, DRG, NDC).</td>
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| Format | Single digital file that is in a machine-readable format that can be imported or read in a computer system for further processing (e.g., .XML, JSON and .CSV formats). A PDF would not be acceptable because the data could not be easily extracted without further processing or formatting. CMS also added a required naming convention for the file in the final rule. | CMS did not finalize a required format. Information may be contained in digital file(s) or an internet-based price estimator tool. Information should be displayed in a way that is understandable to patients where the shoppable service charge is displayed along with charges for ancillary services, and the consumer can search based on the service description, billing, or by payer. |

<table>
<thead>
<tr>
<th>Location and accessibility</th>
<th>Displayed prominently on a publicly available webpage that clearly identifies the hospital location the information is associated with.</th>
<th>(underlined terms are further defined in the final rule)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data must be easily accessible, without barriers, and the data can be digitally searched.</td>
<td></td>
</tr>
</tbody>
</table>

**Table 1: Information hospitals are required to disclose**

**Monitoring and enforcement**

CMS will enforce the price transparency law through a complaint process and CMS audits of hospital websites. To address noncompliance, CMS will impose corrective action plans as well as civil monetary penalties (CMP) of
up to $300 per day, which will be adjusted for inflation annually.[22] Although an appeal process is available, any CMP ultimately imposed will be publicized on the CMS website.[23]

Effective date of final rule

One notable absence from the proposed rule was a clear indication of the intended effective date for the new disclosure requirements. Because the proposal was included in the agency’s proposed rule for the OPPS for CY 2020, many were worried that if the proposals were finalized, hospitals would have less than two months to implement the requirements. In response to stakeholder comments on the burden associated with these requirements, CMS extended the effective date to January 1, 2021, to ensure hospital compliance with the final rule.

Legal challenges

Several hospital associations, including the Federation of American Hospitals, American Hospital Association (AHA), Association of American Medical Colleges, and Children’s Hospital Association immediately issued statements of their intention to file legal challenges to the final rule. On December 4, 2019, those organizations, along with three hospitals, filed suit arguing that the final rule is illegal based on a number of arguments, including that the requirements for public disclosure of negotiated rates exceed HHS’s statutory authority and violate the First Amendment by compelling the public disclosure of individual negotiated rates.[24], [25] The complaint also pointed out that the disclosures are not “some minor administrative inconvenience,” stating that the payer-specific negotiated charges are “confidential and proprietary to both hospitals and commercial health insurers, and their public disclosure would effectively eliminate hospitals’ ability to negotiate pricing with insurers at arms’ length.”[26]

The hospital associates also signaled in the complaint their intention to file an early motion for summary judgment requesting a final decision on the merits as soon as possible so hospitals do not spend resources preparing to comply with the final rule requirements if it may eventually be invalidated. Health plans similarly are likely to object to the final rule based on concerns that it will actually force prices up rather than down. CMS, anticipating such legal challenges, stated that certain portions of the final rule are intended to be severable in the event of a suit.

Conclusion

The final rule continues the Trump administration’s goal of giving patients access to price and quality information about their healthcare services. Hospitals will need to start working quickly toward meeting the final rule requirements by the January 1, 2021, effective date. In addition, hospitals should monitor ongoing litigation challenging the final rule, which may ultimately affect the requirements for hospitals’ disclosures under the price transparency law.

Takeaways

♦ In November 2019, CMS released a final rule for hospital price transparency requirements, which will apply to any licensed hospital, regardless of type and whether or not it participates in Medicare, with limited exceptions.

♦ Starting January 1, 2021, hospitals must make available price information for all individual items and services and service packages provided by the hospital in connection with an inpatient admission or an outpatient department visit, including the services of hospital-employed physicians and non-physician practitioners.

♦ Hospitals must make available in a machine-readable format the standard charges (e.g., gross charge,
payer-specific negotiated charges, discounted cash price, and de-identified minimum and maximum negotiated charges) for all items and services provided by the hospital.

- Hospitals must make available, in a consumer-friendly format, payer-specific negotiated charges, discounted cash price, and de-identified minimum and maximum negotiated charges for as many of the 70 CMS-selected “shoppable services” and as many additional hospital-selected shoppable services as is necessary to make a combined total of at least 300 shoppable services.

- Hospitals that fail to meet the requirements in the final price transparency rule would be subject to enforcement actions, including corrective action plans and civil monetary penalties.

4812-0762-3597v4

3 42 U.S.C. § 300gg-18(e).
5 79 Fed. Reg. at 50,146.
12 45 C.F.R. § 180.
13 45 C.F.R. § 180.20.
14 45 C.F.R. § 180.30.
15 45 C.F.R. § 180.20.
16 45 C.F.R. § 180.20.
17 45 C.F.R. § 180.20.
18 45 C.F.R. § 180.40.
19 45 C.F.R. § 180.50.
20 45 C.F.R. § 180.60.
21 45 C.F.R. § 180.70.
22 45 C.F.R. §§ 180.80, 180.90.
23 45 C.F.R. §§ 180.90, 180.100.
26 AHA vs. Azar