CMS Issues Final Hospital Price Transparency Rule, As Well As Proposed Insurer Cost-Sharing Disclosure Rule

Insights 11.15.19

CMS released a Final Rule today requiring hospitals to disclose their negotiated rates with third-party payers for all items, services, and service packages provided by the hospital, as well as those provided by hospital-employed physicians, effective January 1, 2021. The Final Rule was released alongside a new proposed rule that would require health insurers and group health plans to provide, upon request, an estimate of an individual's out-of-pocket expenses.

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Both the Final Rule and the new proposed rule explicitly further the Administration's goal of helping patients research the cost of medical services in advance of care and are premised on the belief that price transparency will drive down healthcare prices.

The Final Rule will likely be subject to immediate challenges in court, and much of the Rule appears to have been written with litigation in mind.

HLB continues to monitor the situation and will provide regular updates on any legal challenges to the Final Rule and the resulting impact on hospitals' and health systems' compliance obligations.

Changes in the Final Hospital Price Transparency Rule

The hospital price transparency rule was initially proposed on July 31, 2019 as part of the CY 2020 Hospital Outpatient Prospective Payment System (OPPS) proposed rule. As our previous client alert explained, the proposed rule sought to require hospitals to disclose their negotiated rates with third party payers alongside its charges in two publicly available files—a machine-readable file with charges and negotiated rates for all items and services, and a consumer friendly list that focuses on charges and negotiated rates for 300 "shoppable services."

The final rule issued today largely adopts CMS' prior proposal for hospital price transparency, with some notable changes:

Cash Prices and Minimum/Maximum Negotiated Rates. CMS has expanded its previously proposed definition of "standard charge" under section 2718(e) of the Public Health Services Act to include the amount the hospital will accept in cash for a given item or service and the de-identified minimum and maximum negotiated rates for the 300 common shoppable services. The minimum and maximum negotiated rates would not identify the specific payer, and it is possible that the Administration included this

requirement in case the payer-specific rate disclosure requirements are enjoined in future litigation. At present, however, the Final Rule defines "standard charges" to include (1) gross charges, (2) payer-specific negotiated rates, (3) the cash price, (4) the de-identified minimum negotiated rate, and (5) the de-identified maximum negotiated rate.

Price Estimator Alternative to Consumer-Friendly List for Shoppable Services. The Final Rule includes a new alternative for providing a consumer-friendly list of shoppable services, permitting hospitals to instead offer an internet-based price estimator tool that provides estimates for the 300 shoppable services (including the 70 identified by CMS). The price-estimator tool must be prominently displayed on the hospital website and accessible without charge or registration requirements. Hospitals that offer a compliant, internet-based price estimator tool, however, are still required under the Final Rule to post their payer-specific negotiated rates and other "standard charges" for all hospital items and services in a machine-readable file.

Identification of Payer and Plan. Under the Final Rule, payer-specific negotiated rates must be associated with both a payer and the specific health plan offered by that payer. This requirement will be difficult to impossible for hospitals to comply with, given that providers have incomplete information about the plans offered by the payers with whom they contract, and may not even be aware of every payer that can access a managed care agreement in a rental network situation.

Machine Readable File Requirements. CMS declined to finalize the proposal that revenue codes be included in the machine-readable file of hospital items and services. In addition, CMS has specified the technical requirements for the file format (.json, .xml, or .csv) and naming convention required for the machine-readable list.

Sample Displays of Charge Data. The Final Rule includes two tables providing examples of how a provider might display charge data for the machine-readable file and the consumer-friendly file. The first table, however, only provides an example of how gross charges might be displayed across six columns of data, with no information as to how payer-specific negotiated rates could be integrated into the file in compliance with the Final Rule. The second table shows an example of how separate tables could be created for each of the 300 shoppable services.

Employed Physicians and Professionals. As in the proposed rule, CMS' final price transparency rule extends to professional fees for physicians and non-physician practitioners who are "employed" by a hospital. CMS has declined, however, to provide further guidance on whether physicians in specific circumstances should be considered "employed" by the hospital – for instance, if the physician is a faculty member of a large academic medical center that is not employed directly by the hospital but instead is employed by an affiliated business entity. CMS stated that, given the "variation and complexity, we believe it is important to preserve flexibility for hospitals to identify employed physicians or non-physician practitioners under their organizational structure."

Types of Hospitals Included. The Final Rule does not alter the propose definition of "hospital," despite comments and concerns regarding its applications to inpatient rehabilitation facilities ("IRFs"), long-term care hospitals ("LTCHs"), and other facilities that may be licensed as hospitals. CMS also declined to exempt any hospital from the requirements concerning "shoppable" services despite comments indicating that IRFs and LTCHs do not offer any shoppable services. The Final Rule, however, does permit a hospital that offers fewer than 300 shoppable services to confine its consumer-friendly disclosure to those shoppable services it does offer.

Compliance Burden. In the Final Rule, CMS increased its burden estimate, determining that a total burden of 150 hours for the first year is reasonable for hospitals nationwide, and it revised certain requirements to reduce burden (e.g., eliminating the requirement to provide a paper copy of the consumer-friendly charge list within 72 hours). The Final Rule, however, repeats the assumption that managed care agreements include simple rate sheets with set dollar figures for each item and service or service bundle that can easily be imported into the files required by the Final Rule.

CMS has also sought to bolster the statutory authority upon which it relies in promulgating this rule. Originally, the price transparency rule was proposed exclusively under section 2718(e) of the Public Health Services Act (42 U.S.C. § 300gg-18(e)), which requires hospitals to disclose a list of their standard charges. In the Final Rule, CMS now takes the position that Social

Security Act section 1102(a) (42. U.S.C. § 1302(a)) provides the necessary authority for it to issue this Final Rule because transparency broadly impacts healthcare costs and the transparency requirements will "promote the efficient administration of the Medicare and Medicaid programs." The Administration relied on a similar argument to support its rule compelling drug manufacturers to disclose drug prices in direct-to-consumer advertisements, but in July of this year, a federal judge struck down the rule as lacking necessary statutory authority, saying "HHS cannot do more than what Congress has authorized." The case is currently on appeal before the Court of Appeals for the D.C. Circuit, with oral arguments scheduled for January 13, 2020.

Implications for Hospitals in the Proposed Insurer Cost-Sharing Disclosure Rule

The Proposed Rule on price transparency for payers released today does not apply directly to hospitals or health systems. At a high level, it requires health insurers and group health plans to provide cost-sharing information to patients and their authorized representatives. Like the Final Rule for hospitals, the Proposed Rule requires the disclosure of in-network negotiated rates. The Proposed Rule would also require payers to publish historical out-of-network allowed amounts online. The portion of the Proposed Rule requiring insurers and plans to disclose out-of-network allowed amounts may be helpful to providers, who frequently have no ability to estimate in advance the reimbursement they expect to receive from out-of-network payers.

Last, the Proposed Rule also seeks input on whether CMS should impose requirements for the disclosure of quality information about providers of health care items and services.

In sum, this proposed rule has the potential to affect important provider interests, though less directly than the Final Rule discussed above. Providers are encouraged to submit comments in response to this rule, and comments will be due in mid-January, 60 days after the Proposed Rule is published in the Federal Register.

Future Outlook

Expect one or more lawsuits to be filed shortly challenging the Final Rule on hospital price transparency. The plaintiffs in those suits will seek a preliminary injunction to prevent the disclosure from going into effect and will contend that such an injunction needs to be entered well in advance of 2021 in light of the extraordinary burdens associated with the Final Rule. HLB will be monitoring such efforts closely.

For questions, please contact Katrina Pagonis in the San Francisco office, Eric Chan or Bridget Gordon in the Los Angeles, Kelly Delmore in the Washington DC office, or your regular Hooper, Lundy & Bookman contact.

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