



WSC Policy Brief: Hospital Price Transparency Rule

OVERVIEW

On November 27, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized its Outpatient Prospective Payment System (OPPS) [rule for CY 2020](#). Included in the rule was new price transparency regulations for hospitals, including a requirement that hospitals make standard charges public.

Since its publication last year, the rule has been at the center of a legal battle brought on by the several industry groups and hospitals that argue the disclosure of private payer rates would violate their First Amendment rights and potentially lead to more provider consolidation. Recently, however, a federal judge dismissed the case, paving the way for the rule's implementation at the start of the new year. The case is currently under appeal.

PRICE TRANSPARENCY RULE

Public Display

Beginning January 1, 2021, most institutions in the U.S. that are licensed as hospitals or otherwise approved as meeting applicable licensing requirements must, establish, update, and post a list of their standard charges prominently on a publicly available website. Standard charges must be posted two ways:

1. **Machine Readable File:** Single machine-readable digital file containing the standard charges (listed and defined below) for all items and services provided by the hospital.
2. **Consumer-friendly Display of Shoppable Services:** Display of at least 300 "shoppable services" (or as many as the hospital provides if less than 300) that a health care consumer can schedule in advance. Must contain plain language descriptions of the services and group them with ancillary services.

Required Charges for Display

- **Gross Charges*:** The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.
- **Discounted Cash Price:** The charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service.
- **Payer-specific Negotiated Charge:** The charge that a hospital has negotiated with a third party payer for an item or service in either the inpatient or outpatient department setting. Each payer-specific negotiated charge must be clearly associated with the name of the third party payer and plan.



- **De-identified Minimum Negotiated Charge:** The lowest charge that a hospital has negotiated with all third party payers for an item or service.
- **De-identified Maximum Negotiated Charge:** The highest charge that a hospital has negotiated with all third party payers for an item or service.

* *Gross charges are only required to be displayed in the machine readable file (i.e., they do not have to be displayed on the “consumer-friendly” display of shoppable services.*

Multiple-hospital systems: Each hospital location operating under a single hospital license that has a different set of standard charges than the other location(s) operating under the same hospital license must separately make public the standard charges applicable to that location.

Frequency of updates: Hospitals must update the standard charge information described above at least once annually. Hospitals must clearly indicate the date that the standard charge data was most recently updated, either within the file itself or otherwise clearly associated with the file.

Requirements for Machine-Readable Files

Required data elements: In addition to the charges listed above, each hospital must also include the following data elements:

1. Description of each item or service provided by the hospital.
2. Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other common payer identifier.

Accessibility: The hospital must ensure that the standard charge information is easily accessible, without barriers, including but not limited to ensuring the information is accessible a) free of charge; b) without having to establish a user account or password; and c) without having to submit personal identifying information (PII).

Format: The digital file and standard charge information contained in that file must be digitally searchable. The file must use the following naming convention specified by CMS, specifically:

`<ein>_<hospital-name>_standardcharges.[json|xml|csv].`

Requirements for Consumer-friendly Display

Required charges: A hospital must make public the standard charges (except gross charges) for as many of the 70 CMS-specified shoppable services that are provided by



the hospital, and as many additional hospital-selected shoppable services as in necessary for a combined total of at least 300 shoppable services. In selecting a shoppable service for purposes of this section, a hospital must consider the rate at which it provides and bills for that shoppable service. If a hospital does not provide 300 shoppable services, the hospital must make post the standard charges for as many shoppable services as it provides.

Price-estimator tools: A hospital is deemed by CMS to meet the requirements if the hospital maintains an internet-based price estimator tool which meets the following requirements:

1. Provides estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.
2. Allows healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.
3. Is prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password.

Discounted cash price alternative: If the hospital does not offer a discounted cash price for one or more shoppable services (or corresponding ancillary services), the hospital must list its undiscounted gross charge for the shoppable service (and corresponding ancillary services, as applicable).

Required data elements: In addition to the charges listed above, each hospital must also include the following data elements:

1. A plain-language description of each shoppable service.
2. An indicator when one or more of the CMS-specified shoppable services are not offered by the hospital.
3. The location at which the shoppable service is provided, including whether the standard charges for the shoppable service apply at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both.
4. Any primary code used by the hospital for purposes of accounting or billing for the shoppable service, including, as applicable, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), or other common service billing code.

Accessibility: The hospital must ensure that the standard charge information is easily accessible, without barriers, including but not limited to ensuring the information is: a) free of charge; b) accessible without having to register or establish a user account or password; c) accessible without having to submit personal identifying information (PII); and d) searchable by service description, billing code, and payer.



Format: Hospitals have discretion to choose a format for making standard charges publicly available online.

Monitoring and Penalties for Noncompliance

Monitoring: CMS is responsible for evaluating whether a hospital has complied with the requirements above. The agency may use methods to monitor and assess hospital compliance including, but not limited to: evaluation of complaints made by individuals or entities to CMS; review of individuals' or entities' analysis of noncompliance; and an audit of hospitals' websites.

Penalties for noncompliance: If CMS concludes that the hospital is noncompliant with one or more of the requirements, the agency may take any of the following actions, which generally, but not necessarily, will occur in the following order:

1. Provide a written warning notice to the hospital of the specific violation(s).
2. Request a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements.
3. Impose a civil monetary penalty on the hospital and publicize the penalty on a CMS website if the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan.
 - a. The maximum daily dollar amount for a civil monetary penalty to which a hospital may be subject is \$300.
 - b. Even if the hospital is in violation of multiple discrete requirements of this part, the maximum total sum that a single hospital may be assessed per day is \$300
 - c. The amount of the civil monetary penalty will be adjusted annually using the multiplier determined by OMB for annually adjusting civil monetary penalty amounts.
 - d. **Timing of CMP payment:**
 - i. A hospital must pay the civil monetary penalty in full within 60 calendar days after the date of the notice of imposition of a civil monetary penalty from CMS.
 - ii. In the event a hospital requests a hearing, the hospital must pay the amount in full within 60 calendar days after the date of a final and binding decision to uphold, in whole or in part, the civil monetary penalty.

COURT CASE

On October 15, a federal appeals court in Washington, D.C., heard oral argument in an appeal from the American Hospital Association AHA and other hospital groups to overturn the price transparency final rule. Hospitals claimed that the regulation was beyond HHS' authority, that it was a violation of commercial speech, and that disclosing price information would actually lead to higher costs. Insurers also pushed back against the regulation, though none joined the lawsuit.



The lower court previously upheld the rule, despite saying it was a “close call” in the case, as a reasonable statutory interpretation by the agency under a legal theory announced in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.* (1984), which instructs a court to defer to such reasonable agency interpretation.

“Plaintiffs are essentially attacking transparency measures generally, which are intended to enable consumers to make informed decisions; naturally, once consumers have certain information, their purchasing habits may change, and suppliers of items and services may have to adapt accordingly,” U.S. District Judge Carl Nichols wrote in his decision.

During the appeals hearing, counsel for AHA and the hospital groups faced tough questions on the reasonableness of HHS’ statutory interpretation of Section 2718(e) of the 2010 Affordable Care Act on which it relied for authority to finalize the rule. Meanwhile, the government focused its responsive arguments on benefits to patients that it contends the rule would bring by requiring specific disclosures. However, the government offered little legal support for its statutory authority to compel these disclosures.

For their part, the three appellate judges – all of whom were appointed by Democratic presidents, were skeptical of the AHA’s argument that HHS doesn’t have the authority to implement the rule. HHS leaned on a part of the Affordable Care Act (ACA) that requires hospitals to post their chargemaster rates, which is the maximum cost for each service and item a hospital provides. Hospitals were required to post their chargemaster rates last year.

“What makes you think that the purpose of this statute was not to communicate information to consumers?” said Judge Merrick Garland, a Clinton appointee. “I would have thought when I saw this, this was an effort for transparency to patients.”

The judges also showed signs that they were skeptical of the burden arguments. “Many new regulations require substantial initial investment by regulated parties,” said Judge David Tatel, a Clinton appointee. “Here the government seems to be aware of that. It did increase dramatically the amount it thought compliance would cost and extended it for a year.”

Counsel for AHA and the hospital concluded by urging the court to decide the appeal quickly because of the looming January 1 compliance deadline that the rule “established and the unreasonable burden it places on the hospital field.”



POLICY BRIEF



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MORE INFORMATION

- [CY 2020 Hospital OPPS Final Rule](#)
- [CMS Hospital Price Transparency Landing Page](#)
- [CMS Hospital Price Transparency FAQ](#)
- [Lower Court Decision in *AHA v. Azar*](#)