# CMS FINALIZES HOSPITAL PRICE TRANSPARENCY RULE AND PROPOSES NEW TRANSPARENCY REQUIREMENTS FOR HEALTH PLANS

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**U.S. Health Care Alert**

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On November 15, 2019, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule [1] that will require hospitals to make public a list of their standard charges for items and services furnished to patients starting January 1, 2021 (the "Final Rule"). Concurrent with the release of the Final Rule, CMS also released a new proposed rule [2] that proposes to require health plans and third-party payers to make available to consumers personalized out-of-pocket cost information for all covered health care items and services, as well as publish the in-network negotiated rates with their network providers (the "Proposed Rule"). These rules come on the heels of the release of the Calendar Year ("CY") 2020 Outpatient Prospective Payment System ("OPPS") final rule, [3] in which CMS stated it received over 1,400 comments on its hospital standard charges proposals. [4] Taken together, these rules could impose new reporting requirements on providers and payers and reflect CMS's desire to bring greater price transparency across the health care industry. [5] A full summary of the Final Rule and Proposed Rule is set forth below.

## FINAL RULE: NEW HOSPITAL PRICE PUBLICATION REQUIREMENTS

Since January 1, 2019, CMS has required hospitals to report publicly a listing of standard charges via the internet. [6] In the CY 2020 OPPS proposed rule, [7] CMS proposed to expand that requirement to require hospitals to disclose, among other things, the prices for "shoppable services" and all payer-specific negotiated charges. Under the Final Rule, hospitals must comply with the following requirements starting January 1, 2021:

- Make public all their standard changes (including gross charges, payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices) for all items and services online in a single digital file in a machine-readable format and make such information easily accessible, digitally searchable, and free of charge. This information must include a description of each item or service (including both individual items and services and service packages) and any code (for example, HCPCS codes) used by the hospital for purposes of accounting or billing.
- Display in a consumer-friendly format, payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices for at least 300 "shoppable services," defined as a service that can be scheduled by a health care consumer in advance. Of the 300 shoppable services, CMS will specify 70 services and the hospital will select 230 hospital services. If a hospital does not provide one or more of the 70 CMS-specified shoppable services, the hospital must select additional

shoppable services such that the total number of shoppable services is at least 300. If a hospital does not provide 300 shoppable services, the hospital must list as many shoppable services as they provide. [8]

The price transparency requirements apply to every facility licensed as a hospital, or that is approved by the state or local agency responsible for licensing hospitals, even if the facility is not enrolled in the Medicare program. [9] This definition likely excludes ambulatory care facilities, physician offices, or community health centers from the definition of "hospital" under the rule but is expected to include most inpatient rehabilitation facilities, critical access hospitals, and rural hospitals to the extent those entities are licensed as hospitals by the applicable state or local agency. While acknowledging the Final Rule imposes burdens on resource-limited facilities, CMS declined to offer any exemptions or deeming provisions.

Facilities subject to the price transparency requirements that fail to publish such information by the deadline are subject to a civil monetary penalty of up to $300 per day, and CMS may publicize such penalties on its website.

## PROPOSED RULE: NEW PAYER PAYMENT PUBLICATION REQUIREMENTS

In conjunction with the price transparency requirements the Final Rule imposes on hospitals, CMS also proposed payment transparency policies that are likely to significantly impact health plans and third-party payers. Under the Proposed Rule, CMS is proposing to require most group health plans, including self-insured plans, and health insurance issuers to disclose price and cost-sharing information to participants. The proposals would require plan participants to be able to access real-time, personalized cost-sharing information, including an estimate of their cost-sharing liability for all covered health care items and services through an online tool or paper format. In sum, the Proposed Rule proposes a two-pronged approach to making this information available to consumers:

- Health plans and payers would be required to make available to participants, beneficiaries, and enrollees personalized out-of-pocket cost information for all covered health care items and services through an internet-based self-service tool and in paper form upon request, meaning most consumers would be able to understand how costs for covered health care items and services are determined by their plan and shop and compare costs for health care before receiving care.
- Health plans and payers would be required to make available to the public, including stakeholders such as consumers, researchers, employers, and third-party developers, the in-network negotiated rates with their network providers and historical payments of allowed amounts to out-of-network providers through standardized, regularly updated, machine-readable files. This would provide opportunities for innovation to drive price comparison and consumerism in the health care market. [10]

Finally, CMS has also proposed to allow health plans that share with consumers savings that result from consumers shopping for lower-cost services to take credit for such "shared savings" payments in issuers' medical loss ratio ("MLR") calculations. [11] MLR is a financial measurement that calculates the amount a health plan spends to pay its customers' medical claims and activities that improve the quality of care. CMS estimates that this proposal would facilitate health plan savings resulting from decreased consumer medical costs (some of which would be retained by issuers, shared directly with consumers, or used by issuers to reduce future premium rates). [12]

## CONCLUSION

These two rules represent a significant change in CMS's approach to health care pricing and may signal to the industry that the agency is likely to continue to be involved in cost and payment transparency. [13] The rules are also likely to be subject to intense opposition and lobbying. Given the regulatory burdens imposed by the Final Rule, hospital entities have already indicated they intend to file a lawsuit to block the rules. [14] Likewise, there is likely to be extensive lobbying aimed at altering or further delaying the Final Rule; we similarly expect the Proposed Rule to be subject to intense lobbying as well. K&L Gates' health care practice and public policy and law practice regularly advise clients on hospital payment and compliance matters and facilitate stakeholder engagement with Congress and the administration.

Contact the authors of this article or your K&L Gates attorney with questions on changes to CMS payment policies or to receive updates on developments in hospital price transparency.

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NOTES:

[1] 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, CMS-1717-F2 (Nov. 15, 2019) (to be codified at 45 C.F.R. pt. 180), https://www.hhs.gov/sites/default/files/cms-1717-f2.pdf.
[2] Transparency in Coverage, CMS-9915-P (proposed Nov. 15, 2019), (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pts. 147, 158), https://www.hhs.gov/sites/default/files/cms-9915-p.pdf.
[3] Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to Grandfathered Children's Hospitals-Within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots, 84 Fed. Reg. 61,142 (Nov. 12, 2019).
[4] *Id.* at 61,434.
[5] Transparency in Coverage, CMS-9915-P, at 52.
[6] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2019 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims, 83 Fed. Reg. 41,144, 41,686 (Aug. 17, 2018).
[7] 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, 84 Fed. Reg. 39,398 (Aug. 9, 2019).

[8] CMS, CY 2020 Hospital OPPS Policy Changes: Hospital Price Transparency Requirements (CMS-1717-F2) Fact Sheet (Nov. 15, 2019), https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price.
[9] *See* Price Transparency Requirements for Hospitals, CMS-1717-F2, at 28, 34 (explaining that CMS declined to base the definition of "hospital" on Medicare participation; rather, the definition of "hospital" subject to the price transparency reporting requirements is intended to capture all hospitals operating within the United States that are, in fact, operating as hospitals under state or local law, even if such hospitals are not enrolled in Medicare).
[10] CMS, Transparency in Coverage Proposed Rule (CMS-9915–P) Fact Sheet (Nov. 15, 2019), https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-proposed-rule-cms-9915-p.
[11] *Id.* at 123.
[12] *Id.* at 123–24.
[13] Stephanie Armour, *Trump Administration Delays Rule Forcing Hospital-Cost Transparency*, WALL STREET J., Nov. 1, 2019, https://www.wsj.com/articles/trump-administration-delays-rule-forcing-hospital-cost-transparency-11572639300 ("The administration is super aligned [on the need for hospital price transparency]," said Administrator Verma).
[14] Susannah Luthi & Rachel Roubein, *White House rolls out sweeping transparency rules for hospitals, insurers*, POLITICO, Nov. 15, 2019, https://www.politico.com/news/2019/11/15/trump-hospital-insurers-071093.



 