Price Transparency Rule Compliance, Informing the Patient, and Protecting the Hospital's Commercial Interests: Mutually Exclusive Concepts?

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Agenda

- Understanding hospital reimbursement and patient payment
- Statutory and regulatory provisions governing disclosure of “standard charges” for hospitals
- AHA court challenge to Final Rule and assessment of probability of success
- Payer proposed rule
- Antitrust considerations of the two rules
- Medicare implications of Final Rule (if implemented)
- Likely impacts (if implemented)
- Suggested actions in light of uncertainties

Hospital Reimbursement Fundamentals

- Medicare pays hospitals on a “fee for service” basis
  - Patients pay coinsurance based on statutory formulas
- Traditional Medicaid pays on the same basis, albeit at a lower rate
  - Traditional Medicaid typically has almost no coinsurance
- Commercial insurance pays on one of several models:
  - Percent of Medicare
  - Percent of charges
  - Capitation
  - Other packaged payment approach
  - Patient coinsurance is usually a percent of the total allowable, and is *not* affected by the payment model

Hospital Reimbursement Fundamentals *(cont.)*

- Hospital charges are accumulated in a listing called the charge description master, or “CDM”
- CDMs are organized in many different ways. They can be organized by individual items or services, or they can have a charge associated with each CPT code. Some are a hybrid of both.
- Medicare requires that charges bear a rational relationship to cost, which is generally interpreted as meaning that charges must be consistent across payers, which is normally not an issue.

“Standard Charges”

(e) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) 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.

"Standard Charges" *(cont).*

- CMS issued a final rule on 11/15/19 implementing the statute.
- Created a new Part 180 to title *45* of the Code of Federal Regulations
- Effective Jan. 1, 2021
- Purported goal is to reduce healthcare costs and furnish information that consumers supposedly claim that they need

“Standard Charges” *(cont).*

- Key facets of the rule
  - Definition of “hospital”
  - Definition of “items and services” provided by hospitals
  - Definition of “standard charges”
  - Public disclosure requirements
  - “Shoppable services” display requirements
  - Monitoring and enforcement
  - Appeals

“Standard Charges” *(cont).*

- Definition of “Hospital”
  - Any entity licensed as a hospital under State law
  - Not limited to Medicare-enrolled facilities
  - Exception for Federally owned hospitals

“Standard Charges” *(cont).*

- Definition of “Items and Services”
  - Includes all items and services and “service packages”
  - Includes services of “employed physicians”

“Standard Charges” *(cont).*

- Types of “Standard Charges” to be disclosed
  - Gross charge: CDM charges
  - Discounted cash price: Price to cash paying customers
  - Payer-specific negotiated charge: The rate for an item or service *for each applicable payer*
  - De-identified minimum negotiated charges: The lowest of all its charges for a particular item or service
  - De-identified maximum negotiated charges: The highest of all its charges for a particular item or service

“Standard Charges” *(cont).*

- Publicizing standard charges
  - Machine-readable file
    - A single file that contains all five types of standard charges
    - File must be displayed prominently on hospital website and be easily accessible
    - Must be updated annually

"Standard Charges" *(cont).*

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes]

Description	CPT/HCPCS Code	NDC	OP/Default Gross Charge	IP/ER Gross Charge	ERx Charge Quantity
HB IV INFUS HYDRATION 31-60 MIN	96360		$1,000.13	$1,394.45	
HB IV INFUSION HYDRATION ADDL HR	96361		$251.13	$383.97	
HB IV INFUSION THERAPY 1ST HR	96365		$1,061.85	$1,681.80	
HB ROOM CHARGE 1:5 SEMI PRIV				$2,534.00	
HB ROOM CHG 1:5 OB PRIV DELX				$2,534.00	
HB ROOM CHG 1:5 OB DELX 1 ROOM				$2,534.00	
HB ROOM CHG 1:5 OB DELX 2 ROOMS				$2,534.00	
SURG LEVEL 1 1ST HR 04	Z7506			$3,497.16	
SURG LEVEL 1 ADDL 30M 04	Z7508			$1,325.20	
SURG LEVEL 2 1ST HR 04	Z7506			$6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	00713013212	$251.13	$383.97	12 Each
PHENYLEPHRINE HCL 10 % OP DROP		17478020605	$926.40	$1,264.33	5 mL
MULTIVITAMIN PO TABS		10135011501	$0.00	$0.00	100 Each
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		$185.00		
GENETIC COUNSEL 15 MINS	S0265		$94.00		
DIALYSIS TRAINING/COMPLETE	90989		$988.00		
ANESTH, PROCEDURE ON MOUTH	170		$87.00		

[1] Note that this example shows only one type of standard charge (specifically the gross charges) that a hospital would be required to make public in the comprehensive machine-readable file. Hospitals must also make public the payer-specific negotiated charges, the de-identified minimum negotiated charges, the de-identified maximum negotiated charges, and the discounted cash prices for all items and services.

“Standard Charges” *(cont).*

- Publicizing standard charges *(cont.)*
  - Consumer-friendly display of shoppable services
    - “Shoppable” refers to a service that can be scheduled in advance
    - CMS has chosen 70 such services
    - Hospitals must choose another 230
    - Must also include all “ancillary” services, including employed physician services
  - Price estimator alternative
    - The shoppable service requirement can be met through providing an online tool that estimates of their payment obligation for the 300 services at issue
    - Must be easily accessible

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“Standard Charges” *(cont).*

Sample Display of Shoppable Services

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes or disclaimers]

Shoppable Service	Primary Service and Ancillary Services	CPT/ HCPCS Code	[Standard Charge for Plan X]
Colonoscopy	Primary Diagnostic Procedure	45378	$750
	Anesthesia (Medication Only)	[Code(s)]	$122
	Physician Services	Not provided by hospital (may be billed separately)	
	Pathology/Interpretation of Results	Not provided by hospital (may be billed separately)	
	Facility Fee	[Code(s)]	$500
Office Visit	New Patient Outpatient Visit, 30 Min	99203	$54
Vaginal Delivery	Primary Procedure	59400	[$]
	Hospital Services	[Code(s)]	[$]
	Physician Services	Not provided by hospital (may be billed separately)	
	General Anesthesia	Not provided by hospital (may be billed separately)	
	Pain Control	Not provided by hospital (may be billed separately)	
	Two Day Hospital Stay	[Code(s)]	[$]
	Monitoring After Delivery	[Code(s)]	[$]

“Standard Charges” *(cont).*

- Monitoring and Enforcement
  - CMS has claimed that it has the authority to impose penalties on hospitals that are non-compliant
  - Will rely mostly on complaints for determining what entities should be auditing priorities
  - First CMS will impose a CAP, and then if the noncompliance is not addressed, it will impose a penalty of up to $300 per day
  - Appeals can be heard in front of an ALJ

“Standard Charges”

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AHA Litigation

- Case filed in DDC on Dec. 4, 2019
- Claims
  - Exceeds statutory authority because “standard” rate cannot be the same as the “negotiated” rate
  - Violates the First Amendment, as it is compelled speech
  - Is otherwise arbitrary and capricious because it will more likely confuse, rather than illuminate, hospital pricing for consumers
- Seeks for the regulation to be overturned
- Briefing to be completed by March 20
- Presumably the decision will be issued Q3/20, but will be subject to appeal

Payer (Tri-Agency) Proposed Rule

- Proposed rule issued November 2019, comment period closed Jan. 29, AHIP and AHA are aligned in opposition
  - Asserted legal authority: ACA provision on exchange certification requirements related to coverage
  - If the rule is finalized it may be challenged
- Goals of the transparency rule(s)
  - Informed consumer choice, clarify opaque pricing structures
- Focus on “shoppable” services, only 12% of 2017 spending
- Disclose cost-sharing estimates
- **Public release of payer-specific negotiated rates for in-network providers**

Issuers Support the Goal of Informing Consumers, but …

- Forced disclosure of negotiated rate information is not actionable information for consumers
- Exceeds statutory authority
- Likely to cause health care prices to go up not down
- Health plans already provide apps and tools to provide actionable information but widely underutilized
- Privacy concerns – transparency proposals appear targeted to providing app developers access to third party data but without HIPAA protections

Antitrust and Competition Policy Considerations

- **Antitrust is about consequences** ("competitive effects")
  - Transparency is not a competition value for its own sake
  - Does it make markets function better or worse for consumers?
- Antitrust agencies recognize that information sharing among competitors can be procompetitive (*See* Competitor Collaboration Guidelines (2000), FTC blog post, (July 2015))
- Competitive analysis on information exchanges is fact and industry specific
- Need to factor in quality, not just price

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FTC Staff Comments on MN proposal

- Would have required public disclosure of information relating to price and cost
- FTC's (and DOJ's) competition advocacy program, state officials can request a competitive analysis of proposed legislation or regulation.
- FTC provided comments to the MN state legislature (June 29, 2015) comments to state legislators highly critical of disclosure requirements

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FTC Comments (continued)

- Likely competitive effects:
  - Anticompetitive coordination among competitors
  - Harms selective contracting by health plans, a significant source of hospital and provider competition
    - Hospital merger enforcement is predicated on selective contracting theory
  - Decreased incentives to negotiate discounts
  - Hospitals without strong brand names will demand higher reimbursement
  - Gives hospitals increased leverage in negotiations

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Medicare Implications

- OIG could investigate hospitals for violations of the “substantially in excess” rule (Social Security Act, § 1128(b)(6)
- Publicizing a cash discount could trigger concerns as to whether uncompensated costs have been properly reflected in the disproportionate share hospital (“DSH”) calculation
- If there are differences in the lab test charges reported for purposes of this rule and those reported for PAMA, that could result in penalties under PAMA
- If a hospital reports different charge structures for different locations, there is at least a possibility that the provider-based rule has been violated

Likely Impacts *(if implemented)*

- Hospitals will likely end up with a flat rate structure, as it would not be rational to offer a discount to one payer, which would allow another payer to negotiate for the same one
- Rates will also undergo some level of equalization across a geographic area, probably raising some rates and lowering others
- Patients will not likely get any benefit, other than where hospitals have a functional pricing calculator
- Depending upon what the data shows, CMS may seek authority to create a PAMA-type authority to lower pricing to market rates

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Likely Impacts *(cont.)*

- Disclosure of negotiated rates not actionable by consumers – little competitive benefit and potential for anticompetitive effects
- Out of pocket cost and in-network status more immediately relevant

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Actions to Consider Now

- Begin the process of rationalizing all payer agreements, and making sure that rates are in a narrower bandwidth than they might otherwise be. Develop a policy for when the organization will consider giving an outlier discount, and determine how to communicate to other payers why that price was offered.
  - Comment: raises significant competition concerns, could impede value based payment models
- Consider developing a pricing tool that will truly advance the goal of informing the patient about their costs of care
  - Consider building into that tool the way in which the organization's financial assistance policy might reduce the patient's cost
- Become active in addressing the issue with AHA and/or the State hospital association, including advocating for:
  - Pre-emption of State law
  - Limitations on the information to be disclosed to just what a patient truly needs

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