CMS Pricing Transparency – Final Rule Requirements, Compliance Challenges, Legal Outlook

August 21, 2020

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Introductions

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Thank you

CMS Price Transparency: 2019

PYA

- Requirement of the Affordable Care Act
- Effective January 1, 2019
- Requirement: hospitals must post standard charges for all items and services on a public-facing website in a machine-readable format
  - Applies to all hospitals, including critical access, inpatient rehab, and inpatient psych
  - Revenue codes and charge codes not required
  - Concern regarding use of CPT/HCPCS codes (AMA copyright)
- Subsection (d) hospitals (those paid under IPPS) also required to publish charges by DRG

Executive Order: June 24, 2019

PYA

- Provided 60 days to develop requirements and propose regulations
  - Hospital publication of standard charge information including charges and information based on negotiated rates
  - Also post bundled charge information for common or shoppable services
- Provided 90 days for issuance of advance NPRM requiring providers and insurers to facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive them

Actions Following Executive Order

PYA

- Hospital pricing transparency proposed in outpatient prospective payment system rule for CY2020
  - Not addressed in final OPPS rule however
  - Separate final rule issued November 15, 2019
  - Effective January 1, 2021
    - Potential for delay in effective date
- Transparency in coverage proposed rule also issued November 15, 2019
  - Comments originally due January 14; extended to January 29
  - Over 20,250 comments received
  - To date, no final rule issued

Pricing Transparency Final Rule 11/15/19

PYA

- Defines various terms
  - Standard charge
    - Includes both amounts contained in the chargemaster and payer-specific negotiated charges
      - Conflicts with Medicare reimbursement manual requirement for “like charges”
        - *Charges should be related consistently to the cost of the service and uniformly applied to all patients whether inpatient or outpatient*
  - Items and services
    - Includes both hospital services ***and*** physician/professional fees, if employed by the hospital
    - Includes both individual items and service packages provided to either an inpatient or an outpatient

Requirements of the Final Rule: Part 1

- Requires charge data to be posted in a single machine-readable file
  - No barriers to access
    - Free of charge, no account or password required
    - No PHI required to access
  - Individual charge level – both actual charge and payer-negotiated charge
    - Five types of "standard charges"
  - Updated at least annually and show date of last update on file
  - Required of each hospital location if there is a different set of standard charges
  - Information not expected to be used by consumers, but rather by employers, other providers, and tool developers

Five Types of Standard Charges

- Post in a machine-readable file on the website
  - Gross charges – chargemaster rate
  - Payer-specific negotiated rates – applies to ***all*** third-party payers where rates are negotiated
  - De-identified minimum rates
  - De-identified maximum rates
  - Discounted cash price – for those who pay cash for services
- Other required information
  - Description of each item or service
  - Any code used by hospital for accounting or billing purposes (HCPCS code, DRG, APC, etc.)

Required Data Elements

- Item/service description
  - Consumer-friendly language
  - All standard charges
    - Could vary between inpatient and outpatient
  - Any applicable codes for the item/service
    - HCPCS code
    - DRG code
    - Revenue code
    - National drug code
    - Others
- Formats include .XML, .JSON, .CSV
    - .PDF format is not machine readable

Example of Machine-Readable File

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.

Requirements of the Final Rule: Part 2

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- Displaying shoppable services
  - Standard charges for at least 300 shoppable services or bundles
    - Includes the five types of standard charges
  - Defined as a service that can be scheduled by a health care consumer in advance
  - Services selected for display should be those commonly provided to that hospital's patients
  - 70 bundles identified by CMS – provider must have total of at least 300 even if not all 70 are offered at facility
    - Easily searchable and consumer-friendly
- No barriers to access
- Information updated at least annually

Information to be Displayed

- Plain language description of the service
- Any primary codes used for accounting or billing
- Ancillary services provided with the “shoppable service”
- Location of where the service is provided (inpatient, outpatient, or both)
- Includes physician charge / payment information for employed physicians

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

Shoppable Service	Primary Service and Ancillary Services	CPT/ HCPCS Code	[Standard Charge for Plan X]
Office Visit	New Patient Outpatient Visit, 30 Min	99203	$54

Shoppable Service	Primary Service and Ancillary Services	CPT/ HCPCS Code	[Standard Charge for Plan X]
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)]	[$]
	Monitoring After Delivery	[Code(s)]	[$]

Alternative to Shoppable Services

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- Providers deemed to meet this requirement if it maintains an Internet-based price estimator tool
  - Must include estimates for any of the identified 70 services that are provided by the hospital plus additional services to total at least 300 shoppable services
  - Estimator would allow consumer to determine what **they will be expected to pay for the service**
  - Prominently displayed on hospital website
    - Without barriers to access such as a fee, registration or establishing user account
- Providers still required to post machine-readable file tied to chargemaster detailing “standard charges”

Compliance Concerns

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- Considerable administrative burden to comply
  - Requires a team approach
- Inclusion of employed physician services confusing for the consumer and hospital
  - Not all hospitals employ the same types of physicians
    - Service packages would not be consistent when viewed by the consumer
    - Need clear explanation of which physician services are included

Compliance Concerns

- Potential per day penalty for non-compliance - $300
  - Likely to first receive initial written warning
  - Request for corrective action plan
- Non-compliance noted on CMS website
- Potential CoP tied to interoperability
- Media concerns

Legal Developments

PYA

- ***Am. Hosp. Ass'n, et al. v. Azar*, No. 1:19-CV-03619 (D.D.C. June 23, 2020)**
  - Hospitals made four arguments
    - The rule exceeds the statutory requirement to publish "a list of standard charges"
    - CMS lacks enforcement authority
    - The rule is arbitrary
    - The rule violates the First Amendment

Legal Developments

PYA

- ***Am. Hosp. Ass'n, et al. v. Azar*, No. 1:19-CV-03619 (D.D.C. June 23, 2020)**
  - On June 23, the district court upheld the rule.
  - The court rejected the plaintiffs' arguments that CMS had acted without statutory authority in adopting the rule.

Legal Developments

PYA

- ***Am. Hosp. Ass'n, et al. v. Azar*, No. 1:19-CV-03619 (D.D.C. June 23, 2020)**
  - Rejected argument that "standard charges" necessarily means "chargemaster" rates
    - Congress could have used "chargemaster" in statute
    - Statute requires DRG rates – which are not regularly maintained as line items in hospitals' chargemasters
  - Deferred to CMS's decision to require multiple "charges"
  - The rule did not violate the First Amendment because commercial speech may be compelled in "public interest"
  - Statute authorizes CMPs

Legal Developments

PYA

- ***Am. Hosp. Ass'n, et al. v. Azar*, No. 1:19-CV-03619 (D.D.C. June 23, 2020)**
  - Rule continues to be scheduled to go into force as of January 1, 2021
  - An appeal was filed on June 30, 2020 with briefs

Proposals in FY2021 IPPS NPRM

PYA

- Hospitals would report median payer-specific negotiated **charge** by MS-DRG in their cost reports
  - Effective for cost reporting periods ending on or after January 1, 2021
  - Applies to all third-party payers, including Medicare Advantage
  - Hospitals would be required to report:
    - Median payer-specific negotiated charge for all Medicare Advantage plans by MS-DRG
    - Median payer-specific negotiated charge for all third-party payers, including Medicare Advantage, by MS-DRG
  - CMS considering using this information to calculate future MS-DRG relative weights beginning in FY2024

Questions

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