October 5, 2020

**Price Transparency: Requirements for Hospitals and Health Plans**

Price transparency has been a key priority for the Trump Administration to empower consumers to make informed choices about the care they receive and to encourage competition. Following an [October 2017 Executive Order](https://www.hhs.gov/about/news/2017/10/02/promoting-healthcare-choice-and-competition-across-united-states.html) on “Promoting Healthcare Choice and Competition Across the United States,” the Department of Health and Human Services (HHS), Department of the Treasury, and Department of Labor issued a report in December 2018 on “Reforming America’s Healthcare System Through Choice and Competition.” Among other things, the report recommended “developing price and quality transparency initiatives to ensure that newly empowered health care consumers can make well-informed decisions about their care.”

President Trump signed an Executive Order in June 2019 entitled, “[Improving Price and Quality Transparency in American Healthcare to Put Patients First](https://www.hhs.gov/about/news/2019/06/19/improving-price-and-quality-transparency-americans-healthcare-put-patients-first.html).” The Executive Order required HHS rulemaking to require hospitals to publicly post standard charge information and HHS-Treasury-Labor rulemaking to solicit comments on requiring health plans to provide access to expected out-of-pocket costs for patients. Building upon hospital price transparency requirements established by the Affordable Care Act (ACA) and the interoperability requirements and vision under the 21st Century Cures Act, this Executive Order set in motion a number of regulatory actions over the past year to increase price transparency reporting requirements for hospitals and health plans and the availability of data to support consumer-directed third party applications. Most recently, the Inpatient Prospective Payment System (IPPS) final rule for FY2021 ("IPPS Final Rule") requires hospitals to report median payer-specific negotiated charges for Medicare Advantage (MA) organizations on cost reports beginning in January 2021. Failure to comply with this requirement could result in providers not receiving Medicare payments.

**Reporting Requirements under the Hospital Price Transparency Final Rule**


1. A comprehensive machine-readable file with standard charges of items and services provided by the hospital.

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1 The 2019 IPPS Final Rule, published in November 2018, required “hospitals to make public a list of their standard charges via the Internet in a machine readable format, and to update this information at least annually,” effective January 1, 2019.

2 Section 2718(e) of the ACA required hospitals to establish “a list of the hospital’s standard charges for items and services provided by the hospital.” In the 2015 IPPS Proposed Rule, CMS reminded hospitals of this requirement and encouraged hospitals to “undertake efforts to engage in consumer friendly communication of their charges” to help inform patients about likely charges for obtaining services at the hospital.

3 In addition to those requirements highlighted in this issue brief, the CMS [Interoperability and Patient Access final rule](https://www.cms.hhs.gov/Interoperability/) requires health plans, beginning January 1, 2021 (with enforcement beginning July 1, 2021) to implement, test, and monitor a standards-based API that allows third-party apps (with patient approval) to retrieve adjudicated data (including provider remittances and enrollee cost-sharing), encounter data from capitated providers, and clinical data that is maintained by the payer (including lab results). Plans, excluding QHPs, must also make a Provider Directory API available through a public-facing digital endpoint on the payer’s website. CMS also launched [Blue Button 2.0](https://www.bluebuttonudging.org/) in 2018, an API to give Medicare beneficiaries the ability to securely connect their Medicare Part A, Part B and Part D claims and encounter data to apps and other tools developed by innovators.
hospital. The file must contain data on the following types of charges: gross charges, payer-specific negotiated charges, cash payment amount, and the minimum/maximum negotiated charges. A hospital can meet the requirements with a file that:

a. Is available on a “publicly available website” and is “easily accessible, without barriers,” including being free of charges and without an account/password requirement, being searchable, and not requiring submission of personal identifying information;

b. Identifies the hospital location with which the information is associated; and,

c. Is updated at least once annually.

2) A “consumer-friendly,” online searchable list of payer-specific rates for 300 common “shoppable” services (i.e., those that can be scheduled by a healthcare consumer in advance). Hospitals must display payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices for each service. CMS specifies 70 services that must be included if the hospital provides them, while allowing hospitals to select 230 additional services. A hospital “is deemed by CMS to meet the requirements” if the hospital maintains an internet-based price estimator tool that:

a. Is available on ”an appropriate publicly available internet location” and 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;”

b. Identifies the hospital location with which the information is associated;

c. Allows a consumer to “obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service;” and,

d. Is updated at least once annually.

The Price Transparency Final Rule, a dedicated CMS website, and other supporting CMS documents include detailed requirements on how charges must be displayed, location and accessibility, updating data, and sample displays of reports. In addition, the Price Transparency Final Rule indicated that CMS would use enforcement tools for non-compliance, including monitoring, auditing, corrective action plans, and civil monetary penalties of $300 per hospital per day for noncompliance. Additionally, the Executive Order entitled, “An America-First Healthcare Plan,” which was signed on September 24, 2020, directs the HHS Secretary to update the Medicare.gov Hospital Compare website within 180 days to inform beneficiaries whether each hospital is complying with the Price Transparency Final Rule, effective January 1, 2021.

Although CMS estimated that compliance with requirements in the Price Transparency Final Rule would cost hospitals $11,900 initially and $3,000 per year thereafter, the AHA estimated that the rule would cost hospitals between $400,000 and $500,000.

**Legal Challenges to Price Transparency Final Rule Requirements**

Hospital groups, led by the American Hospital Association (AHA), sued to block the Price Transparency Final Rule in December 2019, arguing that CMS exceeded its statutory authority; the requirements violated their First Amendment free speech rights by compelling disclosure of confidential and proprietary negotiated rates; and that the rule was arbitrary and capricious under the Administrative Procedure Act. However the US District Court for the District of Columbia upheld the rule in June 2020. The hospital groups then appealed this decision to the US Court of Appeals for the District of Columbia Circuit, which is expected to hear arguments on October 15th, with a decision expected before January 1, 2021.

If the Price Transparency Final Rule is upheld on appeal, some hospitals, including critical access hospitals in rural areas are reportedly considering not complying and simply paying the associated fine for noncompliance. However, anecdotal evidence suggests that many hospitals may be electing to comply with the consumer-friendly shoppable service internet-based price estimator tools.

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4 A Health Care Cost Institute analysis found that the 70 CMS-specified shoppable services totaled 11.8% of total 2017 medical spending and 15.6% of out-of-pocket spending among individuals with employer-sponsored insurance.
New Data Reporting Requirements for Hospitals in IPPS Final Rule

On September 2, 2020, CMS released the FY 2021 IPPS Final Rule, which imposed additional price reporting requirements on hospitals. Specifically, CMS finalized a market-based MS-DRG relative weight methodology beginning in FY 2024 using market-based data collected on hospital cost reports due on or after January 1, 2021. CMS indicates that most Medicare certified hospitals have cost reporting periods that end between July and September of each year, and that hospitals have a 5-month period after their cost reporting periods end to submit. Thus, most hospitals will not submit the first affected cost report any earlier than November 2021. Failure to comply with these new reporting requirements could potentially result in possible loss of Medicare payments for hospitals.

In order to implement the market-based MS-DRG relative weight methodology, CMS will require hospitals to report median payer-specific negotiated charges for Medicare Advantage (MA) organizations on cost reports for periods ending on or after January 1, 2021; CMS chose not to finalize its proposal to require hospitals to report median payer-specific negotiated charges for all of its third-party payers primarily on the basis that MA rates were more closely related to FFS rates, and thus less disruptive to the market (although CMS does not discuss the potential effects of this change on MA payments). This data will be used to establish the MS-DRG relative weights used in determining payment rates for inpatient hospital stays beginning in 2024.

These changes help satisfy the directive of the October 2019 Protecting and Improving Medicare for Our Nation’s Seniors Executive Order for HHS to identify “approaches to modify Medicare FFS payments to more closely reflect the prices paid for services in MA and the commercial insurance market, to encourage more robust price competition, and otherwise to inject market pricing into Medicare FFS reimbursement.”

Although some stakeholders argue that these new requirements will increase burden on hospitals, CMS believes that “additional calculation and reporting of the median payer-specific negotiated charge will be less burdensome for hospitals” because hospitals are already required to publicly report payer-specific negotiated charges, in accordance with the November 2019 Price Transparency Final Rule. Thus, the logic is that median MA rates will be relatively easy to calculate since hospitals are presumably complying with the underlying calculation of the MA rates for specific items and services for disclosure in January 2021. In total, CMS estimates that the additional median payer-specific negotiated charge reporting requirements in the IPPS Final Rule will cost each hospital $1,353.40 annually.

In public comments, the AHA said it was “disappointed that CMS continues to require hospitals and health systems to disclose privately negotiated contract terms with payers” rather than focusing on patient’s out-of-pocket costs.

Increased Stakes for Failing to Comply with IPPS Final Rule Requirements

Although some hospitals are reportedly considering not complying with the Price Transparency Final Rule at a penalty cost of $300 per day, CMS made clear in the IPPS Final Rule that if a Medicare provider does not furnish the median MA negotiated rates on Medicare cost reports, then “potentially no Medicare payments will be provided.” While CMS does not explicitly state that non-compliance will automatically result in loss of Medicare payments, the agency cites Section 1815(a) of the Social Security Act authority: “no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider.” In addition, “Failure to disclose required information, supply requested information on subcontractors and suppliers; or supply payment information” is a statutory basis for OIG permissive exclusion authority.

The data submissions required under the Price Transparency Rule and the 2021 IPPS Final Rule are promulgated under different statutory authorities with different compliance penalties. Importantly, the IPPS Final Rule requirement is not implicated in the Price Transparency Rule litigation. However, the one technical connection between the two rules is that in practice, to calculate the IPPS Final Rule’s MA median rates, a hospital would have to have first calculated the Transparency Rule’s MA rates for service packages. Absent additional litigation, hospitals that do not comply with the MA-median-rate cost reporting requirements...
established in the IPPS Final Rule could put Medicare payments at risk. Whether this will have any effect on hospital considerations regarding compliance with the Price Transparency Rule reporting is less clear.

**Forthcoming Health Plan Transparency Final Rule**

Just as hospitals are addressing compliance with payer-negotiated rate transparency requirements taking effect January 1, 2021, certain commercial health plans are awaiting a final rule that would impose additional requirements for sharing provider-negotiated rates. The White House Office of Management and Budget is currently reviewing its Transparency in Coverage final rule. The proposed rule, published in November 2019 by HHS, Department of Labor (EBSA), and Department of Treasury (IRS), proposed requiring group health plans and health insurers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary, or enrollee. Specifically, the rule proposed requiring plans to do the following:

1) Give consumers real-time, personalized access to cost-sharing information, including estimated cost-sharing liability for all covered healthcare items/services; and,
2) Disclose on a public website their negotiated rates for in-network providers and allowed amounts paid for out-of-network providers.

CMS sought comment on: (1) whether group health plans and health insurance issuers should also be required to make cost-sharing information available through a standards-based application programming interface (API); and, (2) how health care quality information can be incorporated into the price transparency proposals included in these proposed rules.

Requirements of the proposed rule would become applicable for plan or policy years beginning on or after 1 year after the finalization of the rule.

**Next Steps**

While hospitals await a final decision on whether the original Price Transparency Final Rule will be enjoined or struck down before January 1, 2021, they must continue taking steps to ensure that they can appropriately comply with reporting requirements of both the Price Transparency Final Rule and IPPS Final Rule or face the respective consequences discussed above. CMS appears ready to use enforcement tools at their disposal, including civil monetary penalties—and in the case of failure to report median negotiated MA charges, potential suspension of Medicare payments. Price transparency has been a key priority for the current Administration, and it is expected to remain an area of great focus regardless of who wins the next Presidential election.
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