

Answered: Your 7 Biggest Questions About the Federal Price Transparency Rule

On June 23, 2020, a federal D.C. District Court judge upheld the Trump Administration's 2020 Price Transparency Rule. The final rule requires hospitals to disclose their charges and payer-specific negotiated rates for all services they provide.

Following are the highlights that Guidehouse's Managed Care and Pricing Strategy team believe to be critical to hospital finance executives as this rule and court challenges evolve.

1. Is this law settled? Will there be an appeal?

- The American Hospital Association (AHA) is appealing the ruling but in the meantime, the rule is scheduled to take effect on January 1, 2021.
- It is also possible the administration could seek to provide administrative relief given the current COVID-19 pandemic. However, given President Trump's tweet championing the ruling, this appears less likely than before the ruling.

2. What does compliance with the federal price transparency rule look like?

Unlike the 1/1/2019 price transparency rule, hospitals are required to show their prices in two ways under the new rule:

1. **A comprehensive machine-readable file.** This is a single machine-readable file that contains **five types** of standard charges for all the items and services provided by the hospital.
2. **Consumer-friendly file** of shoppable services: hospitals would be required to make public a consumer-friendly set of at least 300 shoppable services, which would include 70 CMS-specified shoppable services and 230 hospital-selected shoppable services that are provided by the hospital. Hospitals may opt to use their existing patient estimator tool to fulfill this requirement.

For both of these files, the following types of prices or rates will be communicated:

1. Gross Charge - "the charge . . . that is reflected on a hospital's chargemaster, absent any discounts."
2. Discounted Cash Price (Uninsured Rate) - "charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service."
3. Payer-specific Negotiated Charges (Payer A - Payer C) - "the charge[s] that a hospital has negotiated with a third-party payer for an item or service." Payers will have to be specifically identified by name.
4. De-identified Minimum Contracted Rate
5. De-identified Maximum Contracted Rate
 - a. (Min and Max Rates) - "which are the highest and lowest charges that a hospital has negotiated with all third-party payers for an item or service but are not linked to the particular third-party payer."

Example of the "standard charges:"

Service Code	Charges	Payer A Rate	Payer B Rate	Payer C Rate	Uninsured Rate	Min Rate	Max Rate
DRG 470	\$75,000	\$35,000	\$32,000	\$29,000	\$50,000	\$29,000	\$35,000

3. What is excluded from the current rule?

- Patient Out-of-Pocket Spend: The listed charges show what is the contractual obligation between the hospital and third-party payer for each service, but it does not include the patient out-of-pocket payment. Each patient's out-of-pocket payment

could vary significantly depending on individual's plan type, how much of their deductible has been spent in the year, provider's network affiliation, or any additional services are rendered at the same time.

- Exact rate information: In some cases, the rates would be an approximation - e.g., in cases where services are paid as a percent of charges, the final rate will be based on the total charges after all the services has been rendered.
- Hospital comparison: It is not a central database of all hospitals. In its current state, a consumer must manually look up each hospital's rates individually to determine the best rate in each market. There would also be additional burden if the service is not part of the consumer-friendly list which is easily accessible by patients.

4. What are the consequences for non-compliance?

- According to the rule, compliance will be audited and enforced by CMS, with a fine of \$300 a day [\$109,000 per year] per hospital that does not comply.

5. How does COVID-19-related utilization changes impact price transparency?

- As volumes fluctuate amid the pandemic, the careful balance of cross-subsidization of services, payers, and locations needed to preserve margins has been disrupted.
- Increase in uninsured, unemployed and price-conscious consumers so payers and providers should expect heightened sensitivity to prices/costs of healthcare.
- What is “shoppable” may be redefined and/or further expanded as volumes shift. Transparency around services like telehealth, lab testing, and office visits may see increased demand.

6. How might this affect my hospital, pricing strategy, and overall market dynamics?

- Additional Scrutiny on High Prices/Rates from Media, Competitors: To date, the most significant outcome of any price transparency regulation has been to increase the attention paid by media and competitors to individual prices. In the short term, price is unlikely to be a major factor in patient decision-making, as provider relationships, brand, and perceived quality tend to be drivers. A defensible charge master and set of contracted rates and a clear quality story will help hospitals prepare to defend against accusations of high rates.
- Price Competition on Shoppable Services & Ambulatory Competition: On certain commodity services, where there is a limited perceived quality gap, more price information could mean greater competition. Specifically, the most significant competitor will be ambulatory settings that can offer lab, imaging, and urgent care services for significantly less than a hospital setting. Organizations should review their own price parity and ambulatory and free-standing strategies to ensure it can compete in this new dynamic.
- Pricing Strategy Shift—from Optimization to Rebalancing: Payers and providers may have access to a new wealth of information, which will create a new set of parameters in rate negotiations. Providers may use comparisons to demand higher rates, payers may use the same data to request lower rates. Ultimately, negotiations will need to be framed around pay me right vs pay me more. Payers and providers may need to agree to a rebalancing strategy, shifting higher rates to higher value services, and lower rates to more commodity, shoppable, and price sensitive services.


7. What should hospital executives do next to prepare?

With many unanswered questions from CMS, hospital/health system executives should proactively prepare for continued consumerism in the healthcare space. Following are our prioritized actions.

1. **Identify services impacted by the mandate** – Evaluate current services offered that are part of the 300 common shoppable services codes and evaluate what settings these services are currently provided.
2. **Strategize around your market and potential magnitude of impacts** – Determine current pricing levels relative to market and site of service, evaluate how much of the current revenue portfolio is comprised of these services, and magnitude or risk from both volume shifts and changes in pricing (both chargemaster and negotiated rates).
3. **Evaluate your own pricing and rate strategies by site of service** – Strategize logical pricing and rate relationships by site of service and location across a system; ensure that prices/rates are defensible, while maintaining positive margins and market positions.
4. **Assess your payer relationships and strategize potential risks and opportunities** – Where will payers put the most pressure on you to decrease? Will you have an opportunity to leverage this data to enhance any contracts? When are your upcoming contracts coming due? Are any payers at risk of termination prematurely?
5. **Determine current capabilities** – From becoming compliant with the rule to answering daily patient calls around price comparisons—this rule may enhance the need for analytical and consumer-facing services that could be underdeveloped at your organization. What gaps do you have, and how will you fill them?
6. **Proactively create consumer-focused sustainable margin** – Evaluate margins across services/service lines and sites of care and ensure margins can be sustainable as price/rate pressure increases for commodity, highly shoppable services. Consider a rebalancing strategy in upcoming payer negotiations and price adjustments.
7. **Become the market leader** – Drive toward full transparency on consumer commodity services, beyond CMS requirement. Establish real-time patient liability estimator portal/technology and/or targeted direct to consumer pricing strategies (demand/bundle-based pricing).

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