WEBINAR FAQ

# Price Transparency Mandate – Making Sense of the CMS final rule

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## 1. Do physician charges need to be disclosed if services are rendered at a hospital?

If professional services are performed by individuals who are employed by the hospital, they must be disclosed. If a physician group is owned or affiliated with the hospital, but operates at a non-hospital location and the services are not performed at the hospital, then those services should not have to be disclosed, even if the physicians are employees.

## 2. How can I tell if our tax identification number (TIN) will be affected by the rule?

A TIN will be covered under this final rule if the entity is licensed as a "hospital," which is defined on a state-by-state basis. Contact your legal counsel to determine whether your entity qualifies as a hospital.

## 3. What steps does the final rule require payers to take?

While the Hospital Price Transparency Final Rule does not directly affect payers, HHS did propose a Transparency in Coverage Rule[1] which would require disclosures by payers. The proposed rule would require the following:

- All non-grandfathered individual and group health plans must make available real-time out-of-pocket cost information pertaining to covered healthcare items and services to participants, beneficiaries and enrollees (or their authorized representative)
- Disclosed information must be available in paper form and through an internet-based tool, and disclosure will be required upon participant, beneficiary or enrollee request
- Health plans must make negotiated rates with in-network providers and historical payments of allowed amounts to out-of-network providers visible to the public



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## 4. How does the rule regard and affect contracted vs. non-contracted employees?

CMS does not provide a definition regarding what it considers a contracted vs. non-contracted employee. Contact your legal counsel to confirm what particular circumstances employees fall under (e.g., typically employed physicians are given a W-2 from the hospital employer).

## 5. How will offering to show the contract rate between hospital and payer help patients?

This is one of the primary arguments from AHA, that disclosing negotiated rates does not support transparency but may lead to more patient confusion. Supporters of the bill however believe that vendors will be able to compile negotiated rate data with a patient's out-of-pocket information to develop consumer-friendly pricing tools.

## 6. Will physician practices be affected?

Physicians who are employed by a hospital and perform services in a hospital facility (e.g., an employed physician performs surgery in the emergency room) are required to disclose professional charges. Free-standing physician practices that are not owned or affiliated with a hospital or perform services at a non-hospital location should not have to disclose charges. If in doubt, contact your legal counsel to determine whether your entity will have to meet the final rule requirements.

## 7. Would a patient estimation tool satisfy the final rule requirements?

It depends if the estimation tool meets all components of the two key requirements:

1. It must offer a comprehensive machine-readable file that contains all 5 standard charges for all items and services.
2. It must offer consumer-friendly shoppable services that lists "shoppable services" for 300 items and services in consumer-friendly terms.

Please note that the patient estimation tool would only replace the 300 shoppable services disclosure, and not the requirement to post the comprehensive machine-readable file.

## 8. Should we post average payor rates or list individual plan details?

It appears the rule requires hospitals to post the negotiated rate it has with each payer and disclose the rate per network/plan.

[1] https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-proposed-rule-cms-9915-p



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## 9. Does the final rule also require out-of-network allowed amounts to be disclosed?

Hospitals are not required to disclose out-of-network amounts. However, the upcoming Transparency in Coverage Rule[1] may affect this.

## 10. How does the rule affect providers that offer prompt-payment discounts?

Detail concerning a prompt-payment discount should be included in a discounted cash price disclosure—hospitals are free to include annotations to its rates and can include any notes regarding limitations or conditions to discounted rates.

## 11. Does the final rule apply to hospice care (either in inpatient or a facility setting)?

The answer depends on who provides the service. Hospitals that perform their own hospice services (services not contracted out) will likely need to disclose the charges. We recommend consulting with legal counsel to determine if your hospice entity falls within licensure as a "hospital" in your state.

## 12. How will ambulatory surgery centers (ASCs) be affected?

The rule does not apply to entities such as ASCs or other non-hospital sites-of-care.

## 13. Will durable medical equipment (DME) suppliers be affected?

DME suppliers are not be directly affected. However, if a hospital provides DME, those will likely need to be disclosed by the hospital.

## 14. What level of compliance will be required of behavioral health organizations, especially if CMS does not pay for residential treatment care?

The rule's disclosure requirements only pertain to providers licensed as hospitals within their state. Review your state licensure to confirm your designation and whether compliance will be required.

[1] https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-proposed-rule-cms-9915-p



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