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# MANDATED HOSPITAL DISCLOSURE OF NEGOTIATED RATES AND ITS POTENTIAL IMPACT ON FAIR MARKET VALUE (FMV) ANALYSES

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Healthcare spending in the United States has been consistently touted as disproportionately high when juxtaposed with certain healthcare outcome measures, including life expectancy and infant mortality.[1] The most recent reporting from the Centers for Medicare and Medicaid Services (CMS) estimated total U.S. healthcare spending in 2019 at $3.8 trillion, accounting for nearly 18% of Gross Domestic Product; in particular, Medicare spending in 2019 increased to nearly $800 billion, from $750 billion just two years prior.[2] One solution proffered to address this concern is to increase price transparency at the hospital level, with the ultimate goal of cost savings to the consumer, as well as an overall increase in patient satisfaction.[3]

The concept of hospitals publishing standard charges for items and services for the general public's use is not a novel reform, but is a statutory requirement originally set forth under §2718(e) of the Public Health Service Act, which was enacted as part of the Patient Protection and Affordable Care Act in 2010. Within the United States' fee-for-service payment model, hospital charges (commonly referred to as a "chargemaster"[4]) do not necessarily equate to the dollar amount *reimbursement* that will be received; instead, the ultimate payment is a result of negotiated reimbursement between the particular hospital and the particular payor. Acting as an impetus for transforming these statutory directives into action and providing actionable information to the public, on June 24, 2019, then-President Trump issued an Executive Order seeking improved transparency in healthcare spending.[5] Directly answering this call to action, CMS, in its finalized outpatient prospective payment system rule for calendar year 2020, imposed a mandate requiring hospitals to publicly disclose "standard charges," which include negotiated reimbursement rates with third party payors for certain "items and services," such as "services furnished by physicians and non-physician practitioners who are employed by the hospital." Additionally, CMS also mandated that hospitals disclose a list of payor-specific negotiated reimbursement for "shoppable services."[6] Failure to comply with these new rules may result in civil monetary penalties in the amount of $300 per day.[7] These mandates officially took effect on January 1, 2021.[8]

[1] *U.S. Health Spending Twice Other Countries' with Worse Results* (March 13, 2018), https://www.reuters.com/article/us-health-spending/u-s-health-spending-twice-other-countries-with-worse-results-idUSKCN1GP2YN.
[2] *NHE Fact Sheet* as published by CMS, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet (last assessed Jan 24. 2020, with historical 2017 data as assessed September 20, 2019).
[3] *Is the Price Right? Solving Healthcare's Transparency Problem* (September 2, 2017), https://www.modernhealthcare.com/reports/achieving-transparency-in-healthcare/#!/.
[4] *Understanding Healthcare Reimbursement* (February 27, 2020), https://www.verywellhealth.com/reimbursement-2615205.
[5] Exec. Order No. 13877, 84 Fed. Reg. 124 (June 24, 2019).
[6] Defined therein as "a service package that can be scheduled by a healthcare consumer in advance." The finalized list of services includes X-Rays, mammograms, blood tests, and routine electrocardiograms.
[7] *Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public.* 45 C.F.R. Part 180.
[8] In issuing the mandate, CMS writes that "[w]e believe there is a direct connection between transparency in hospital standard charge information and having more affordable health care and lower health care coverage costs." *Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public.*, 45 C.F.R. Part 180.

In promulgating its rule, CMS highlights the advantages of the public sharing of standard charge and reimbursement information, in that patients may be encouraged by price transparency measures to shop around for medical services and select service providers who offer lower rates for services of similar or better quality.[9] However, some industry experts are not optimistic that this proposal will have its intended effect, contending that the mandatory disclosure of negotiated rates is the "wrong approach to price transparency, and that the administration should reverse course on this provision."[10] Many of these concerns revolve around the notion that the new rule will undermine a hospital's ability to negotiate competitive private-payor rates, and would incite anti-competitive behavior in which a race to establish a "floor for hospital prices" would ensue.[11]

In addition to the posited negative consequence to a hospital's bottom line, the publishing of the negotiated rates for "shoppable services," including physician services, may eventually impact the fair market value[12] for those services, as one indication of FMV looks to the allowable fees reimbursed by commercial payors as compared to Medicare. The correlation between Medicare and commercial payor rates has been a longstanding concern to the U.S. Congress, and, in 2002, the non-partisan Medicare Payment Advisory Commission (MedPAC) sponsored a study comparing average rates of commercial reimbursement to Medicare.[13] This regulatory concern has continued with the annual publication of a report to Congress, which, inter alia, examines allowable Medicare physician reimbursement to private payor allowed fees.[14] Given the current proposal concerning the publication of private payor rates, we would expect this regulatory concern to diminish somewhat, as market conditions may pressure reimbursement rates for both government and private payors to become more standardized, gradually closing the gap between private payor allowable rates and those set forth by Medicare.

Although the long-term impact of the new price transparency rule remains yet to be determined, some predict the short-term consequences to revolve around an increased effort to set competitive prices for "discretionary" services (such as imaging, laboratory services, and certain non-emergent or elective medical and surgical procedures)[15], while insulating any financial loss through the raising of prices for emergent services (including trauma and emergency department visits).[16] Healthcare Appraisers, as an expert in valuation and healthcare strategy, is well suited to help our healthcare clients navigate any needed revisions to compensation arrangements in an effort to get ahead of the impact of the price transparency rule.

[9] In the final rule, 45 C.F.R. Part 180, CMS specifically notes that "[k]nowing a negotiated charge is also important because a growing number of insured health care consumers are finding that some services are more affordable if the consumer chooses to forego insurance and pay out-of-pocket [. . .] However, consumers cannot make such determinations without knowing the rate their third party payer has negotiated." (39579).

[10] *Joint Statement from National Hospital Associations on Proposed CY 2020 OPPS Rule* (July 20, 2019), https://news.aamc.org/press-releases/article/opps-joint-statement-20190729/.

[11] *CMS Wants to Force Hospitals to Reveal Negotiated Rates. Can it do that?* (August 5, 2019), https://www.healthcaredive.com/news/cms-wants-to-force-hospitals-to-reveal-negotiated-rates-can-it-do-that/560149/.

[12] *See, e.g.*, 42 CFR §411.351 (as set forth by the Centers for Medicare and Medicaid Services (CMS) with respect to physicians' referrals to health care entities with which they have financial relationships).

[13] As its principal objective, the study contends that "[a]s major purchasers, there is significant interdependence between Medicare and private health plans, with each likely influencing and being impacted by the other." Dyckman & Associates for the Medicare Payment Advisory Commission, *Survey of Health Plans Concerning Physician Fees and Payment Methodology*; August 2003.

[14] MedPAC, Report to the Congress: Medicare Payment Policy; March 2020. This updated annual publication found that in 2018, commercial payment rates for preferred provider organizations were 135% of Medicare payment rates for provider services.

[15] 10 *Things to Expect from the New Hospital Price Transparency Rule* (March 6, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200304.157067/full/.

[16] *See Id*.