

AMRPA Opposes Recently Finalized Hospital Pricing Regulations

New Regulations Will Significantly Increase Burdens Across the Hospital Sector While Potentially Jeopardizing Patient Access to Inpatient Rehabilitation

The American Medical Rehabilitation Providers Association (AMRPA) strongly opposes the hospital price reporting requirements imposed by the Centers for Medicare and Medicaid Services (CMS) in its November 15, 2019 [final rule](#). Specifically, CMS adopted policies that require hospitals to: (1) post a list of their standard charges – both gross charges and all negotiated rates – for all items and services in a machine-readable format on their websites; and (2) post the negotiated rates for specific types and numbers of “shoppable” services in a consumer-friendly way. AMRPA conveyed significant concern with these policies in our comments on the proposed rule, noting the considerable burdens posed to the entire hospital industry under this rule as well as the potential adverse impact that such policies will have on inpatient rehabilitation access. AMRPA is continuing to review the rule and will weigh other response strategies leading up to the rule’s January 1, 2021 effective date.

As an overarching matter, AMRPA very much supports this Administration’s efforts to empower consumers and improve price transparency across the healthcare marketplace. We believe that there are commonsense measures that can be taken that achieve these goals while reducing provider burdens and meaningfully educate Medicare beneficiaries. The price transparency requirements finalized in this rule, however, will accomplish few of these important policy objectives, particularly in their application to inpatient rehabilitation hospitals and units (IRH/Us). AMRPA’s primary grounds for opposition to these specific price transparency requirements follow:

The New Requirements Will Not Meaningfully Educate Patients and Are Likely to Misinform their Treatment Decisions

The new policy requires hospitals to post a plethora of pricing information, including gross charges and payer-specific negotiated rates. With respect to the former, Medicare beneficiaries rarely (if ever) pay a percent of gross charges for Part A services, as they instead face standard copayment amounts based on their total hospitalization days. As such, information about gross charges will be incredibly difficult for patients to understand and may not accurately reflect the cost they will ultimately bear. If patients are deterred from certain services due to their misunderstanding of gross charge data, these requirements will adversely affect patient treatment decisions – particularly in the post-acute care space. Furthermore, with respect to payer-negotiated rates, IRH/Us often negotiate patient-specific rates with third-party payers, including Medicare Advantage plans. If the new requirements effectively force IRH/Us to post all *patient-specific*, payer-negotiated rates, IRH/Us would face potentially unfeasible administrative and financial burdens to comply with such requirement, diverting critical resources from patient care.

Moreover, this policy may have the effect of driving patients to select their services or providers based on faulty assumptions surrounding cost, rather than clinical or quality considerations. In all, AMRPA is gravely concerned that this policy lacks any clear benefit to consumers, while adding considerable burden to IRH/Us – already among the most heavily regulated entities in the Medicare program.

CMS Must Apply a More Tailored Approach in Subjecting Hospitals to These Requirements

As AMRPA argued in our comment letter on the proposed rule, the pricing requirements finalized by CMS are particularly ill-suited to IRH/Us. As providers to some of the most medically complex patients – such as traumatic brain injury and stroke patients – the specific services that will be provided (and costs of such services) are often not determined until after the patient is fully assessed post-admission. Furthermore, the services provided by IRH/Us are a wide-ranging mix of rehabilitation and medical services provided by an interdisciplinary team, rather than a single or simple set of services that can be “shopped” in advance. These are just a few of the reasons why IRH/U services are distinct from CMS’

examples of shoppable services, and AMRPA continues to urge CMS to exempt IRH/Us from the rule's requirements.

The Finalized Policy May Adversely Affect Market Competition

While CMS asserts that these new requirements will empower patients and create a more competitive healthcare marketplace, AMRPA believes that these new requirements may actually produce the opposite of the intended effects. As we noted in our comment letter, the Federal Trade Commission (FTC) has stated that: (1) transparency efforts should be focused on items such as copayments and quality/performance measures; and (2) requiring more sensitive terms (such as payer-negotiated rates) to be posted can result in collusion and price hikes. AMRPA strongly supports such findings, particularly as provider consolidation has emerged as a major policy issue across the health sector. Furthermore, these new requirements fail to require hospitals to provide the type of meaningful information that should appropriately factor into patient treatment decisions, such as quality measures. AMRPA therefore stands ready to partner with CMS to help identify those items that would be far more effective in achieving CMS' intended goals – such as educating patients, making the healthcare marketplace more competitive, and guiding patient-centered, quality-driven treatment decisions.

In all, AMRPA strongly supports efforts to improve pricing transparency and engage patients in their treatment decisions. Unfortunately, the policy adopted by CMS would not give patients the information needed to make informed and clinically appropriate healthcare decisions and would at the same time introduce significant administrative and financial burdens across the hospital industry – particularly for IRH/Us. AMRPA will engage in outreach to both our member hospitals and CMS as we determine our next steps with respect to this harmful policy.