799 9th Street NW, Suite 210
Washington, D.C. 20001

T (202) 354-2600
vizientinc.com

Summary of Price Transparency Requirements for Hospitals to Make Standard Charges Public

Vizient Office of Public Policy and Government Relations
Regulatory Update: CMS Final Rule, CY 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes

December 4, 2019

Overview

On Friday, November 15, the Centers for Medicare and Medicaid Services (CMS) issued a final rule implementing policy changes that will require hospitals to make public standard charges for items and services they provide. The stated goal of CMS is to promote transparency, increase market competition, and drive down the cost of health care services.

Key Definitions

In this final rule, CMS offers clarification and definitions of several key words and phrases:

- **Items and Services**: all individual items, services and service packages that could be provided by a hospital to a patient during an inpatient admission or an outpatient visit for which a standard charge has been established.
- **Standard Charges:**
  - Gross Charges: The charge for an individual item or service as it appears on a hospital's chargemaster, absent any discounts.
  - Payer-specific Negotiated Charge: The charge that a hospital has negotiated with a third party for an item or service.
  - Discounted Cash Price: The charge that applies to an individual who pays cash for a hospital item or service. If a hospital does not offer a self-pay discount, it should display the undiscounted gross charge from the chargemaster.
  - De-identified Minimum Negotiated Rate: The lowest charge that a hospital has negotiated with all third party payers for an item or service.
  - De-identified Maximum Negotiated Rate: The highest charge that a hospital has negotiated with all third party payers for an item or service.

Requirements

CMS finalized two primary price transparency requirements for hospitals.

First, CMS is requiring that all hospitals make public the standard charges for all items and services they produce in a machine-readable format. These charges must be compiled in a single digital file online and must adhere to CMS's guidelines regarding uniformity of the data. Specifically, the list must include a description of each item or service along with: the corresponding gross charges, corresponding payer-specific negotiated charge, the corresponding de-identified minimum and maximum negotiated charge, the corresponding discounted cash price and any additional code(s) used by the hospital for the purposes of accounting or billing. CMS defines a single digital file as "a digital representation of data or information in a file that can be imported or read into a computer system for further processing." Additionally, the information must be easily accessible, digitally searchable, not require any personal information such as an email or password, displayed on a publicly available website, and must "prominently and clearly" display the name of the hospital with which the charges are associated. CMS clarifies that a hospital "need not post separate files for each clinic operating under a consolidated state hospital license." Finally, CMS

states that the data needs to be updated at least once annually and that the file must also clearly display the date the information was last updated.

Second, CMS finalized their proposal requiring hospitals to make public standard charges for at least 300 "shoppable services" in a consumer-friendly manner. "Shoppable services" include any service that can be scheduled in advance by a healthcare consumer. If a shoppable service is accompanied by an ancillary service, the hospital must present these as a grouping of related services, whereby the charge for the primary shoppable service is displayed along with charges for any ancillary services. Of the 300 services, 70 will be specified by CMS while the other 230 will be hospital-selected. The 70 shoppable services required by CMS can be found in Table 3 of the final rule and include various evaluation and management services, laboratory and pathology services, radiology services, and medicine and surgery services. For hospitals that do not necessarily provide one of the 70 required shoppable services, CMS states that the standard charges for an additional shoppable service must be substituted. For hospitals that do not provide 300 shoppable services in total, they must list as many shoppable services as they do provide. Each shoppable service displayed must include a plain-language description, and CMS recommends that the services selected by the hospital for display should be based on those most "commonly provided" to the institution's patient population. In addition to the five standard charges (outlined above) that must be included in the online posting of the shoppable services, hospitals must also include the location at which the service is provided along with any primary code used by the hospital for billing or accounting purposes.

This data must be displayed prominently, must be easily accessible free of charge and must be updated annually. As an alternative to displaying these services on a webpage, CMS establishes that it will deem a hospital as having met the requirements if it utilizes an internet-based price estimator tool. This tool must be prominently displayed on the hospital website and accessible free of charge, allow consumers to obtain an estimate for their payment obligation beforehand, and include the specified 300 shoppable services.

Noncompliance and Appeals

The agency will monitor compliance with these new requirements in several different ways, including evaluating complaints from individuals or entities and occasionally auditing hospitals' websites.

If CMS concludes that a certain hospital does not meet one or more of the requirements, it may provide a written warning to the institution and, in certain circumstances, request a corrective action plan (CAP) from that hospital. This CAP is subject to CMS's approval and must include the timeframe in which the action will be implemented. If a hospital does not respond to CMS's request for a CAP, or if it does not comply with the specific requirements of the CAP, the rule establishes that CMS may impose a civil monetary penalty (CMP), not to exceed $300 per day, on the hospital that is noncompliant. This monetary penalty will be publicized on a CMS website. CMS acknowledges in the final rule that some hospitals may wish to assume the penalty versus comply with the new requirements but indicates they will revisit the amount of this penalty in future rulemaking.

If CMS imposes a CMP, it will provide a written notice to the hospital which includes the basis for the hospitals' noncompliance, the effective date of the violation(s), the amount of the penalty, payment instructions, a statement that the CMP will continue to be imposed for continuing violation(s), and the intent to publicize the noncompliance, among other notifications. This CMP must be paid in full within 60 days after the notice of imposition and will be adjusted annually. Hospitals may request a hearing if they would like a review of their CMP; hospitals may not appeal their penalty without such a hearing request within 30 days of the notice of their penalty.

Implementation and Conclusion

CMS elected to extend the effective date of this final rule until January 1, 2021. In doing so, CMS believes that hospitals will have sufficient time to collect and display the required information to be compliant with the policies set forth in the final rule. Several hospitals and hospital groups have filed a lawsuit against the administration, arguing that they have exceeded their legal authority in issuing this final rule.

Vizient's office of public policy and government relations will continue to advocate on behalf of our members on the impact of this final rule and will provide additional summaries and updates as appropriate.