Illinois Health and Hospital Association

November 21, 2019

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

SUBJECT: CMS Final Hospital Price Transparency Requirements (CMS-1717-F2)

On Nov. 15, the Centers for Medicare & Medicaid Services (CMS) issued final price transparency requirements for hospitals, requiring all hospitals operating in the United States to make public their negotiated rates by including this information under the agency's revised definition of "standard charges." IHA strongly opposed these requirements, citing this is not the information patients want, significant operational challenges and flawed definitions, Illinois' current price transparency requirements and commitment to consumer protections, the belief that CMS exceeded legal authority to require release of negotiated rates, and the burden these requirements will place on hospitals. However, CMS finalized its proposed requirements with only minor adjustments, and barring judicial interference the provisions of the final rule are effective Jan. 1, 2021.

Under this final rule, hospitals are required to:

- Make standard charges (defined as gross charges, payer-specific negotiated charges, de-identified minimum and maximum negotiated charges and discounted cash prices) publicly available for all items, services, and service packages provided to patients;
- Make standard charges for 300 shoppable services publicly available in a consumer-friendly format (**hospitals may fulfill this requirement by displaying a price estimator on their website**); and
- Update publicly available standard charge data at least annually.

CMS acknowledged that hospital standard charges do not provide a comprehensive out-of-pocket estimate for insured patients. However, CMS maintains that standard charges are useful in helping consumers make healthcare decisions prior to obtaining services when combined with additional information available from payers.

To that end, CMS also released a proposed price transparency rule, Transparency in Coverage (CMS-9915-P), which would require most health plans to make negotiated rates, historic payments and out-of-network allowed amounts publicly available. Both the hospital final rule and the health plan proposed rule are scheduled for publication in the *Federal Register* on Nov. 27. National hospital groups, including the American Hospital Association, along with several hospital plaintiffs, will take legal action in an attempt to prevent the hospital final rule from going into effect. Additional details of this final rule, including definitions and appeal rights, follow.

Hospital Charges for Items, Services, and Service Packages

All hospitals operating in the United States are required to publicly display charge information for all items, services, and service packages provided to patients. This rule applies to all licensed hospitals. Only federally owned or operated hospitals, such as Veterans Affairs or Indian Health Program hospitals, are already considered compliant with these requirements and are thus exempt from this final rule.

Hospitals must make public, via the Internet, charge information for all individual items, services, and service packages that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge. Examples of items and services include, but are not limited to: supplies and procedures; room and board; facility fees; and professional charges.

CMS defined five specific standard charge amounts that must be made public for each item and service provided by a hospital. These include:

- Gross Charge: The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts.
- Payer-Specific Negotiated Charge: The charge a hospital has negotiated with a third-party payer for an item or service. Third-party payers are entities that, by statute, contract, or agreement, are legally responsible for payment of a claim for a healthcare item or service. Each payer-specific negotiated charge must be clearly associated with the name of the third-party payer and plan.
- Discounted Cash Price: The charge that applies to an individual who pays cash for a hospital item or service. Hospitals that do not offer self-pay discounts may display the hospital's undiscounted gross charge as found in the hospital chargemaster.
- De-identified Minimum Negotiated Charge: The lowest charge a hospital has negotiated across all third-party payers for an item or service.
- De-identified Maximum Negotiated Charge: The highest charge a hospital has negotiated across all third-party payers for an item or service.

For service packages, hospitals are not required to list separately each individual item or service within the package. Additionally, hospitals are not required to post fee-for-service Medicare or Medicaid charges as these rates are already publicly available. Finally, CMS clarified that the code numbers listed for DRG procedures are MS-DRG codes, not APR-DRGs or other third party payer service package codes. Table 1 in the desk copy of this final rule provides a sample display of gross charges (PDF p. 134).

In summary, hospitals are required to provide the following common data elements for all items, services and service packages provided by the hospital, indicating the appropriate setting (inpatient vs. outpatient, as applicable):

- A description of each item, service, and service package;

- The corresponding gross charge;
- The corresponding payer-specific negotiated charge;
- The corresponding discounted cash price;
- The corresponding de-identified minimum negotiated charge;
- The corresponding de-identified maximum negotiated charge; and
- Any code used by the hospital for purposes of accounting or billing including, but not limited to, the CPT code, HCPCS code, DRG, NDC, or other common payer identifier.

CMS did not finalize the inclusion of the revenue center code as a required data element, but it encourages hospitals to include this data element where appropriate.

Standard Charge Information Publication Requirements
Hospitals must post standard charge information in a single, digital, machine-readable file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, .XML, .JSON and .CSV formats. PDF files do not meet this definition.

If using an .XML format, the file may include several tabs. CMS provided an example of this format, suggesting that the first tab display gross charges from the hospital's chargemaster, and subsequent tabs display negotiated charges from specific payer-plan combinations. Hospitals must name the file using the following convention: <ein>_<hospital-name>_standardcharges.[json|xml|csv]. The EIN is the hospital's employer identification number, and [json|xml|csv] reflects the file format.

Hospitals must post this file prominently on a publicly-available website that clearly identifies the hospital location with which the standard charge information is associated. The file must be easily accessible, free of charge and free of barriers such as the need to establish a user account, password, or provide any personally identifiable information. Hospitals must update this file at least annually, and clearly indicate the date of the last update.

Hospitals do not need to post separate files for each clinic operating under a consolidated state hospital license, so long as the file includes charges for all items, services and service packages offered by the clinics under that license. In cases where off-campus and affiliated sites operate under the same license as a main location but have different standard charges or offer different items and services, separate standard charge files must be made publicly available.

Shoppable Services
In addition to the exhaustive standard charge file described above, hospitals must publicly display, in a consumer-friendly format, another file of standard charges for 300 shoppable services, 70 of which are identified by CMS in Table 3 of the final rule desk copy (PDF p. 186; see also Appendix A). If a hospital does not provide 300 shoppable services, the hospital must list as many shoppable services as it provides.

CMS defines shoppable services as services that can be scheduled by a healthcare consumer in advance. CMS clarifies that when a shoppable service is customarily accompanied by ancillary services, both the primary and ancillary services should be presented as a group so that the consumer may view all applicable charges at once. Table 2 of the desk copy of this final rule provides a sample display of shoppable services (PDF p. 169). Hospitals are not required to make public the professional fees for non-employed clinicians practicing in hospital-based clinics.

In summary, hospitals must include, as applicable, all of the following data elements in its list of shoppable services for each service and ancillary service:

- A plain-language description;
- An indicator when one or more of the 70 CMS-specified services are not offered;
- The payer-specific negotiated charge, clearly associated with the name of the third-party payer and plan;
- The discounted cash price, or undiscounted gross charge if the hospital does not offer a discounted cash price;
- The de-identified minimum negotiated charge;
- The de-identified maximum negotiated charge;
- The location at which the service is provided (inpatient, outpatient, or both) and whether the standard charges apply at that location; and
- Any primary code used by the hospital for purposes of accounting or billing, including, as applicable, the CPT code, the HCPCS code, the DRG, or other common service billing code.

Hospitals must update this information at least annually, and clearly indicate the date of the last update.

Similar to the exhaustive standard charge file, hospitals are required to prominently display shoppable service information in a consumer-friendly format on a publicly-available website that clearly identifies the hospital location with which the standard charge information is associated. The file must be easily accessible, free of charge and free of barriers such as the need to establish a user account, password, or provide any personally identifiable information. The file must also be searchable by service description, billing code and payer. Information must be in a format that is accessible to people with disabilities, in accordance with any applicable federal or state laws.

At this time, hospitals are not required to make paper copies of these data available. However, CMS stated that if it determines the lack of a paper copy of hospital standard charges prevents consumers from accessing hospital charge information, it may revisit this decision in future rulemaking.

Hospitals that display a price estimator tool on their website will be considered as in compliance with this requirement.

Monitoring and Enforcement

CMS will primarily evaluate hospital compliance with this final rule by evaluating complaints made by individuals or entities to CMS, reviewing individuals' or entities' analysis of noncompliance and auditing hospitals' websites. If CMS determines a hospital is not in compliance, it will:

- Provide a written warning to the hospital regarding specific violation(s);
- Request a corrective action plan (CAP) from the hospital if its noncompliance constitutes a material violation of one or more requirements;
- Impose a civil monetary penalty (CMP) on the hospital of up to $300 per day if the hospital fails to respond to CMS' request to submit a CAP, or fails to comply with the requirements of a CAP.

Hospitals that wish to appeal a CMP must do so within 30 calendar days of receiving the CMP notice. Otherwise, hospitals must pay the CMP in full within 60 calendar days of the CMS notice.

If you have any questions or comments, contact Sandy Kraiss, vice president, Health Policy and Finance, at 630-276-5522 or skraiss@team-iha.org, or Cassie Yarbrough, director, Medicare Policy, at 630-276-5516 or cyarbrough@team-iha.org.

Appendix A: Final List of 70 CMS-Specified Shoppable Services

Evaluation & Management Services	2020 CPT/HCPCS Primary Code
Psychotherapy, 30 min	90832
Psychotherapy, 45 min	90834
Psychotherapy, 60 min	90837
Family psychotherapy, not including patient, 50 min	90846
Family psychotherapy, including patient, 50 min	90847
Group psychotherapy	90853
New patient office or other outpatient visit, typically 30 min	99203
New patient office or other outpatient visit, typically 45 min	99204
New patient office or other outpatient visit, typically 60 min	99205
Patient office consultation, typically 40 min	99243
Patient office consultation, typically 60 min	99244
Initial new patient preventive medicine evaluation (18-39 years)	99385
Initial new patient preventive medicine evaluation (49-64 years)	99386

Laboratory & Pathology Services	2020 CPT/HCPCS Primary Code
Basic metabolic panel	80048
Blood test, comprehensive group of blood chemicals	80053
Obstetric blood test panel	80055
Blood test, lipids (cholesterol and triglycerides)	80061
Kidney function panel test	80069
Liver function blood test panel	80076
Manual urinalysis test with examination using microscope	81000 or 81001
Automated urinalysis test	81002 or 81003
PSA (prostate specific antigen)	84153-84154
Blood test, thyroid stimulating hormone (TSH)	84443
Complete blood cell count, with differential white blood cells, automated	85025
Complete blood count, automated	85027
Blood test, clotting time	85610
Coagulation assessment blood test	85730
Radiology Services	**2020 CPT/HCPCS Primary Code**
CT scan, head or brain, without contrast	70450
MRI scan of brain before and after contrast	70553
X-Ray, lower back, minimum four views	72110
MRI scan of lower spinal canal	72148
CT scan, pelvis, with contrast	72193
MRI scan of leg joint	73721
CT scan of abdomen and pelvis with contrast	74177
Ultrasound of abdomen	76700
Abdominal ultrasound of pregnant uterus (greater or equal to 14 weeks 0 days) single or first fetus	76805
Ultrasound pelvis through vagina	76830
Mammography of one breast	77065
Mammography of both breasts	77066
Mammography, screening, bilateral	77067
Medicine and Surgery Services	**2020 CPT/HCPCS/DRG Primary Code**
Cardiac valve and other major cardiothoracic procedures with cardiac catheterization with major complications or comorbidities	216
Spinal fusion except cervical without major comorbid conditions or complications (MCC)	460
Major joint replacement or reattachment of lower extremity without major comorbid conditions or complications (MCC)	470
Cervical spinal fusion without comorbid conditions (CC) or major comorbid conditions or complications (MCC)	473

Uterine and adnexa procedures for non-malignancy without comorbid conditions (CC) or major comorbid conditions or complications (MCC)	743
Removal of 1 or more breast growth, open procedure	19120
Shaving of shoulder bone using an endoscope	29826
Removal of one knee cartilage using an endoscope	29881
Removal of tonsils and adenoid glands patient younger than age 12	42820
Diagnostic examination of esophagus, stomach, and/or upper small bowel using an endoscope	43235
Biopsy of the esophagus, stomach, and/or upper small bowel using an endoscope	43239
Diagnostic examination of large bowel using an endoscope	45378
Biopsy of large bowel using an endoscope	45380
Removal of polyps or growths of large bowel using an endoscope	45385
Ultrasound examination of lower large bowel using an endoscope	45391
Removal of gallbladder using an endoscope	47562
Repair of groin hernia patient age 5 years or older	49505
Biopsy of prostate gland	55700
Surgical removal of prostate and surrounding lymph nodes using an endoscope	55866
Routine obstetric care for vaginal delivery, including pre- and post-delivery care	59400
Routine obstetric care for cesarean delivery, including pre- and post-delivery care	59510
Routine obstetric care for vaginal delivery after prior cesarean delivery including pre- and post-delivery care	59610
Injection of substance into spinal canal of lower back or sacrum using imaging guidance	62322-62323
Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance	64483
Removal of recurring cataract in lens capsule using laser	66821
Removal of cataract with insertion of lens	66984
Electrocardiogram, routine, with interpretation and report	93000
Insertion of catheter into left hear for diagnosis	93452
Sleep study	95810
Physical therapy, therapeutic exercise	97110