Issue Brief

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CMS Releases Final Hospital Charge Rule & Proposed Health Plan Transparency Regulation

The Centers for Medicare & Medicaid Services released two rules aimed at "Price Transparency Requirements to Increase Competition and Lower Healthcare Costs for All Americans." The first is a final rule that establishes requirements for hospitals operating in the U.S. to establish, update and make public a list of their standard charges for the items and services that they provide.

The second is a proposed rule setting forth requirements for group health plans, and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request, to a participant, beneficiary or enrollee (or his or her authorized representative), including an estimate of such individual's cost-sharing liability for covered items or services.

Both documents are listed in the Nov. 15 ***Federal Register*** display pages. A copy of the hospital rule currently is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24931.pdf. The transparency in coverage proposal is at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-25011.pdf. Both rules are scheduled to be published in the ***Federal Register*** on Wednesday, Nov. 27.

The material that follows pertains to the hospital rule, which would be effective Jan. 1, 2021.

CMS is adding a new Part 180 – Hospital Price Transparency to Title 45 of the Code of Federal Regulations that will codify these regulations on price transparency that implement section 2718(e) of the Public Health Service Act.

COMMENT

While this rule is responding to comments made on July 29 as part of CMS' proposed CY 2020 hospital Outpatient Prospective Payment System, it now stands as a separate rule. Further, while this rule responds to those comments, its regulatory text section is complete and may be much easier for a reader to comprehend changes being made.

This rule is intended to include all hospitals except governmental facilities.

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CMS estimates the total burden for hospitals to review and post their standard charges for the first year to be 150 hours and $11,898.60 per hospital, for a total burden of 900,300 hours (150 hours X 6,002 hospitals) and total cost of $71,415,397 ($11,898.60 X 6,002 hospitals).

INCREASING PRICE TRANSPARENCY OF HOSPITAL STANDARD CHARGES

CMS is finalizing the following: (1) definitions of "hospital," "standard charges," and "items and services;" (2) requirements for making public a machine-readable file online that includes all standard charges (including gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges) for all hospital items and services; (3) requirements for making public discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges for at least 300 'shoppable' services (70 CMS-specified and 230 hospital-selected) that are displayed and packaged in a consumer-friendly manner; and (4) monitoring for hospital noncompliance and actions to address hospital noncompliance (including issuing a warning notice, requesting a corrective action plan and imposing civil monetary penalties), and a process for hospitals to appeal these penalties.

Definition of a Hospital

CMS is finalizing its proposal to define "hospital" to "mean an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law, or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. For purposes of this definition, a State includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa and the Northern Mariana Islands."

Definition of "Items and Services" Provided by Hospitals

CMS says items and services means "all items and services, including individual items and 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 include, but are not limited to the following.

- supplies and procedures
- room and board
- use of the facility and other items (generally described as facility fees)
- services of employed physicians and nonphysician practitioners (generally reflected as professional charges)
- any other items or services for which a hospital has established a standard charge

Definition of "Standard Charges"

CMS is finalizing the definition of "standard charges" to include the following.

- the gross charge (the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts)
- the discounted cash price (the charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service)
- the payer-specific negotiated charge (the charge that a hospital has

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negotiated with a third- party payer for an item or service)

- the de-identified minimum negotiated charges (the lowest charge that a hospital has negotiated with all third-party payers for an item or service)
- the de-identified maximum negotiated charges (the highest charge that a hospital has negotiated with all third-party payers for an item or service)

Requirements for Making Public All Standard Charges for All Items and Services in a Machine-Readable Format

For each hospital location, hospitals must make public all their standard changes (including gross charges, payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices) for all items and services online in a single digital file in a machine-readable format. Examples of machine-readable formats include but are not limited to .XML, .JSON and .CSV formats. A PDF would not meet this definition because the data contained within the PDF file cannot be easily extracted without further processing or formatting.

Specifically, CMS is finalizing a requirement that the machine-readable list of hospital items and services include the following corresponding information, as applicable, for each item and service.

- A description of each item or service (including both individual items and services and service packages).
- The corresponding gross charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- The corresponding payer-specific negotiated charge that applies to each item or service (including charges for both individual items and services, as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Each payer-specific negotiated charge must clearly be associated with the name of the third-party payer and plan.
- The corresponding de-identified minimum negotiated charge that applies to each item or service (including charges for both individual items and services, as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- The corresponding de-identified maximum negotiated charge that applies to each item or service (including charges for both individual items and services, as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- The corresponding discounted cash price that applies to each item or service (including charges for both individual items and services, as well as service packages) when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- Any code used by the hospital for purposes of accounting or billing for the item or service, including but not limited to the CPT code, HCPCS code, DRG, NDC or other common payer identifier.

CMS is not finalizing the proposed revenue center code as a required data element.

CMS is finalizing that a hospital would have discretion to choose the Internet location it uses to post its file containing the list of standard charges so long as the comprehensive machine-readable file is displayed on a publicly available website, it is displayed prominently and clearly identifies the hospital location with which the standard charges information is associated (§ 180.50(d)(1) and (2)).

CMS is finalizing, as proposed, that the hospital must ensure the standard charge data are easily accessible and without barriers, including but not limited to that the data can be accessed free of charge; without having to establish a user account, password or submit personal identifying information; and is digitally searchable.

CMS also is finalizing a modification to require that the hospital must use a CMS-specified naming convention for the file (§ 180.50(d)(5)). The naming convention for the file must be: <ein>_<hospital-name>_standardcharges.[json|xml|csv]

Finally, CMS is requiring the data be updated at least annually and clearly indicate the date of the last update (either within the file or otherwise clearly associated with the file).

Requirements for Displaying Shoppable Services in a Consumer-Friendly Manner

CMS says that hospitals must make public standard charges for at least 300 "shoppable services" (including 70 CMS-specified and 230 hospital-selected) the hospital provides in a consumerfriendly manner. CMS defines "shoppable service" to mean a service that can be scheduled by a health care consumer in advance.

The 70 CMS-specified shoppable services are found in the table below and are divided into four broad categories: E&M Services, Laboratory and Pathology Services, Radiology Services, Medicine and Surgery 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 of other outpatient visit, typically 45 min	99204
New patient office of 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 (40-64 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 than 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 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 nonmalignancy 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

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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 heart for diagnosis	93452
Sleep study	95810
Physical therapy, therapeutic exercise	97110

CMS says hospitals must do the following.

- Display payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices for at least 300 shoppable services. If a hospital does not provide one or more of the 70 CMS-specified shoppable services, the hospital must select additional shoppable services such that the total number of shoppable services is at least 300. If a hospital does not provide 300 shoppable services, the hospital must list as many shoppable services as they provide.
- Include a plain-language description of each shoppable service, an indicator when one or more of the CMS-specified shoppable services are not offered by the hospital, and the location at which the shoppable service is provided, including whether the standard charges for the shoppable service applies at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both.
- Select such services based on the utilization or billing rate of the services. In other words, the shoppable services selected for display by the hospital should commonly be provided to the hospital's patient population.
- Include charges for services that the hospital customarily provides in conjunction with the primary service that is identified by a common billing code (e.g. Healthcare Common Procedure Coding System codes).

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- Make sure that the charge information is displayed prominently on a publicly available web page, and clearly identifies the hospital location with which the standard charge information is associated.
- Ensure the data is easily accessible, without barriers, including ensuring the data is accessible free of charge; does not require a user to register; establish an account or password or submit PII; and is searchable by service description, billing code and payer.
- Update the information at least annually and clearly indicate the date of the last update.

Additionally, CMS will deem a hospital as having met the requirements for making public standard charges for 300 shoppable services in a consumer-friendly manner if the hospital maintains an internet-based price estimator tool that meets the following requirements.

- Provides estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.
- Allows health care consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay for the shoppable service by the hospital.
- Is prominently displayed on the hospital's website and accessible to the public without charge, and without having to register or establish a user account or password.

Monitoring and Enforcement

claims to have the authority to monitor hospital compliance with Section 2718(e) of the Public Health Service Act, by evaluating complaints made by individuals or entities to CMS, reviewing individuals' or entities' analysis of noncompliance, and auditing hospitals' websites. Should CMS conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, CMS may assess a monetary penalty after providing a warning notice to the hospital or after requesting a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements. If the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan, CMS may impose a civil monetary penalty on the hospital not in excess of $300 per day, and publicize the penalty on a CMS website. The rule also establishes an appeals process for hospitals to request a hearing before an Administrative Law Judge of the civil monetary penalty. Under this process, the administrator of CMS, at his or her discretion, may review in whole or in part the ALJ's decision.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

FINAL THOUGHTS

CMS' estimate of the cost burden for hospitals to comply with this rule appears too low.

As noted earlier, this rule creates a new regulatory section. Therefore, the regulation text is a complete description of the requirements being set forth. As such, it may be easier for the reader to simply refer to this text and not be consumed by the rule's preamble reflecting comments and responses.

The rule has clear "final action" sections.

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