What's Next for Hospital Price Transparency: 2024 and Beyond

December 6, 2023

Webinar FAQ Document

1. **Question:** We do not hard code modifiers in our CDM. What are the requirements regarding modifiers?

   Answer: The requirement to encode modifiers as a separate data element will take effect on January 1, 2025. In the CY 2024 OPPS Final Rule, the Centers for Medicare & Medicaid Services (CMS) clarified that a hospital will not be required to encode all combinations of modifiers, but instead will be required to encode the modifiers that have an effect on the standard charge established by the hospital when used in combination with a procedure or service.[1] Additionally, the hospital will need to provide a description of the modifier and the way the modifier impacts the standard charge.

2. **Question:** Will CMS publish a list of hospitals who have been reviewed and found to be compliant?

   Answer: There is not currently sufficient guidance to determine what actions CMS will take in the future. However, the Final Rule only outlines the steps that CMS plans to take to publish hospitals who have been found to be out of compliance.

3. **Question:** Our contracts often contain language stating that the payer may create new plans without notifying the provider of the new plan. How can we ensure that all payer and plan combinations are captured in our machine-readable file?

   Answer: It's important to remember that your machine-readable file (MRF) is a snapshot in time. CMS requires that it be updated annually and that the MRF contain the payers and plans which have negotiated rates established with the hospital at the time the MRF is published. It is not required that the MRF be updated each time that a new payer or a new plan is added. Further, CMS is allowing categories of plan names, such as "all PPO plans" or "all managed care plans" without listing specific plan names as long as the negotiated rates are the same for all plans listed.[2]

4. **Question:** Does a hospital's retail pharmacy need to participate in order to be compliant?

   Answer: The Hospital Price Transparency Rule applies to hospitals, which CMS has defined as "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.[3]" Generally speaking, a retail pharmacy is not operating under a state hospital license and therefore would likely not be included in the Rule. However, it is critical that you have your legal and/or compliance department evaluate your situation to ensure that all standard charges are included in the MRF.

5. **Question:** Does a hospital have to have all charges in the machine-readable file? Lab tests may have different components depending on panels that may not be reflected in the CDM.

   Answer: CMS requires that hospitals make public a list of the hospital's standard charges for all items and services provided by the hospital. CMS further explains that "items and services provided by the hospital are 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.[4] Based on this definition, any item or service that has at least one of the five standard charges established should be included in the MRF.

6. **Question:** Can you please reference where you found the requirements for the text file that will be required in January 2024?

   Answer: CMS has published the TXT file instructions, technical specifications, required information, and a TXT file generator on github. You can access this information at https://cmsgov.github.io/hpt-tool/txt-generator/.

7. **Question:** Does this Final Rule apply to an FQHC that doesn't offer emergency room services?

   Answer: The Hospital Price Transparency Rule applies to hospitals, which CMS has defined as "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

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[1] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, page 82105, https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf

[2] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, page 82093, https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf

[3] 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, CMS-1717-FC, page 65532, https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and#p-984

[4] 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, CMS-1717-FC, page 65533, https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and#p-984

approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing.[5]" CMS did further state in the CY 2020 OPPS Final Rule that "healthcare providers such as ambulatory surgery centers (ASC), physicians, or community health centers would not likely satisfy this definition of a hospital since these providers are not likely to be licensed by a State or locality as a hospital or to be approved by the agency of such State or locality responsible for licensing hospitals as meeting the standards established for such licensing.[6]"

8. **Question:** Do we need to list all the different off-campus locations for a given hospital?

   Answer: Per the CY 2024 Final Rule, CMS requires that hospitals encode the name(s) and addresses(es) of each hospital inpatient location and each standalone emergency department in the machine-readable file. Although CMS is encouraging hospitals to encode all outpatient locations, they are not requiring this at the current time in order to reduce burden for hospitals.[7]

9. **Question:** Is there any guidance for the timing of updating the file once a year? Does this have to be done January 1st or at the beginning of the hospital's fiscal year or does the hospital have discretion to determine the date?

   Answer: CMS requires that each hospital's MRF be updated at least once in a 12-month period. CMS allows each hospital to update its MRF at any point in time during the year, so long as the update to the charge data occurs no more than 12 months after posting.[8]

10. **Question:** Is there a 2-character abbreviation for mcg?

    Answer: No, there is not. The valid values for drug type are currently based on two sets of industry standards: the National Drug Code and the National Council for Prescription Drug Programs. As of January 1, 2025, each hospital's MRF will be required to include: 1) the unit value that corresponds to the established standard charge for drugs; and 2) the measurement type that corresponds to the established standard charge for drugs using a valid drug type value.[9]

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[5] 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, CMS-1717-FC, page 65532, https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and#p-984

[6] 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, CMS-1717-FC, page 65531, https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and#p-984

[7] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, page 82092, https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf

[8] 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, CMS-1717-FC, page 65563, https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and#p-984

[9] https://github.com/CMSgov/hospital-price-transparency/tree/master/documentation/JSON

The listed valid drug type values are:

GR – grams

ME – milligrams

ML – milliliters

UN – unit

F2 – international unit

EA – each

GM - gram

11. **Question:** Can you have a cosmetic policy that does not follow the typical cash discount calculation without violating the rule?

    Answer: CMS defines the cash discount standard charge to be the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service. Hospitals that do not offer self-pay discounts may display the hospital's undiscounted gross charges.[10] Cosmetic surgery services tend to be self-pay services and may therefore display the same gross charge and cash discount rate in the MRF.

12. **Question:** Do we still need to publish our CDM?

    Answer: CMS does not require that hospitals publish their CDM file, although hospitals may be subject to State specific requirements that mandate the publication of a hospital's CDM. CMS requires that hospitals make public their standard charges online in two ways:

    1. A machine-readable file containing a list of all standard charges for all items and services as provided in Code of Federal Regulations (CFR) Title 45, Subtitle A, Subchapter E, Part 180, Subpart B, §180.50; and
    2. A consumer-friendly list of standard charges for a limited set of shoppable services as provided in CFR Title 45, Subtitle A, Subchapter E, Part 180, Subpart B, § 180.60.[11]

13. **Question:** How can we display a cash discount price if our hospital does not have a set percentage but rather establishes discounts based on the financial needs of the patient?

    Answer: CMS defines the cash discount standard charge to be the charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service. Hospitals that do not offer self-pay discounts may display the hospital's undiscounted gross

[10] 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, CMS-1717-FC, page 65553, https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and#p-984

[11] https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/hospitals#key-provisions

charges.[12] Additionally, CMS has added an optional data attribute called "Hospital Financial Aid Policy". While not required, the hospital may choose to display information here related to financial aid policies including charity care or bill forgiveness. The information could be posted directly into the MRF or provided as a link to the hospital's financial aid policies on the hospital's website.

14. **Question:** We have physicians who are employed by the hospital. Do professional charges need to be included in the MRF?

    Answer: CMS requires that the MRF contain 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 a hospital has established a standard charge. CMS provides examples which include supplies and procedures, room and board, and use of the facility and other items (generally described as facility fees), services of employed physicians and non-physician practitioners (generally reflected as professional charges), and any other item or service for which a hospital has established a standard charge.[13]

15. **Question:** It was my understanding that negotiated payment amounts cannot come from claims data. However, the estimated allowed amount seems to require the use of claims data. Can you please explain?

    Answer: The current regulations require that hospitals post the payer-specific negotiated charge that is associated with each item or service provided to a specific group of paying patients. This charge is defined as the charge that a hospital has negotiated with a third-party payer for an item or service and represents the contracted rate found in the contract. The estimated allowed amount is a new requirement for January 1, 2025, and is defined as the average dollar amount that the hospital has historically received from a third-party payer for an item or service.[14] The estimated allowed amount will be a required data element when the payer-specific negotiated charge can only be expressed as a percentage or algorithm rather than a standard dollar amount. Although CMS has declined to prescribe a required data source from which to derive the estimated allowed amount, the fact that it is the amount historically received from a third-party payer seems to necessitate the use of historical claims data.

[12] 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, CMS-1717-FC, page 65553, https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and#p-984

[13] Hospital Price Transparency Frequently Asked Questions, page 6, https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf

[14] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, page 82084, https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf

