HEALTHCARE BUSINESS TODAY

Price Transparency Will Challenge Hospital Reporting Systems In 2024

By Michele Madison | November 9, 2023

Recently, the Centers for Medicare and Medicaid Services ("CMS") proposed changes to the hospital price transparency rules. (1) If finalized, the proposed changes will go into effect on January 1, 2024. Hospitals that have not yet carefully reviewed the proposed changes could be in for a rude awakening, as significant preparation is required involving multiple operational parties to be in compliance.

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Current Requirements:

In an effort to provide price transparency to patients, a licensed hospital is currently required to establish and publish a list of standard charges for the items and services it provides. The publication must be in a comprehensive "Machine-readable file" in a consumer-friendly format. The publication requirements include the standard charges, discounted cash price, payer-specific negotiated charges and the minimum and maximum negotiated charges. (2) Failure to publish these charges for larger hospitals can result in penalties of over $2 million.

Proposed Changes:

CMS's goal of ensuring transparency in healthcare prices for consumers was not accomplished by its prior proposed rule. Therefore, to increase both price transparency and competition among healthcare providers with the ultimate goal of reducing costs, CMS is proposing several changes to the price transparency rules to improve access and usability of the information. The four key areas of focus relate to defining specific terms; revising the data elements that must be published; making the data readily available and improving the enforcement process to support compliance.

First, CMS is proposing to provide a "CMS Template" to standardize how the pricing information is displayed. CMS proposes the formatting of the standard charge data to conform to the CMS template display and to be in a comma-separated values ("CSV") format and a JSON schema. The format must be in a Machine-readable file" which means a single digital file that is in a Machine-readable format. The changes to the CMS Template in a Machine-readable file would likely support individuals or entities being able to search for the files using internet search engines without having to search extensively for the files on each hospital's website.

The data in the file must contain the "consumer-friendly expected allowed amount" which means the average dollar amount that the hospital estimates will be paid by a third-party payer for an item or service.

This data must be "Encoded" into the CMS template so the form of the data will be standardized for all hospitals in the CMS Template form that will be Machine-readable.

In order to avoid "confusion" for patients, CMS is proposing to require hospitals to add into the form a statement affirming that, to the best of its knowledge and belief, the hospital has included all applicable standard charge information in the Machine-readable format. If a Hospital is required to give an affirmative representation that its

CMS template is complete and accurate, there is a risk that the government would claim during the enforcement process that if the template misses a specific element, then the affirmative representation was false. False certifications may be used by the government in litigation or to prosecute entities when evaluating compliance with applicable laws. Because of the extensive amount of data required by the CMS Template, it would be difficult for the hospital representative to ensure that all charge information is included in all of the different formats required by CMS.

Therefore, this certification statement may increase the risk of additional claims through the enforcement process.

Second, the data elements required to be reported in the proposed format will expand. The reporting would require the hospital name, license number and the location and address where the items and services are provided. In addition to providing the negotiated rates with payers, the proposed rule also requires including a description of the type of contracting with the payer, such as a fee schedule, case rate, per diem, percentage-based negotiated rate or an algorithm negotiated fee schedule. The payer-specific negotiated rates by each specific payer and each associated plan must be identified. If the Hospital has negotiated a rate based upon an algorithm that may differ for patients who are receiving the same 'type of service' depending upon the supplies and circumstances specific to that patient, the 'consumer friendly expected amount' must be included in the publication. Hospital decision support teams will need to evaluate each managed care contract to determine the rate calculation and contracting methods with each payer to ensure that each time a contract is updated there is an update to the publication to reflect the changes. The hospital decision support team would also need to calculate an estimated amount that it believes it will receive for an average patient based upon the algorithm negotiated with specific payers. Although CMS believes that hospitals already engage in this activity as part of the revenue cycle management back-end check on reimbursement integrity, this is not always the case. In fact, this may be a resource-intensive project, as many hospitals will need to manually evaluate and update this information based on the current revenue cycle management information technology systems in use. Moreover, many hospitals lack the staffing and information technology tools to engage in back-end checks or lack the capacity to calculate a rate for each procedure considering the different contracting algorithms.

In addition to the payer-specified data elements, the proposed rule also requires hospitals to list if the service is an inpatient or outpatient service, among other factors. In practice, it is incredibly difficult to determine inpatient versus outpatient status for patients, so hospitals may need to identify some items and services that fall within each status designation and list them all. The drug unit and type of measurement is also a required element. The template would include the name of the drug and each measurement that is charged, even though a prescription is normally subject to the practitioner's medical judgment and the drug measurement determination is made at the time the practitioner is treating the patient. It is unlikely that a patient would know the specific drug measurement that a practitioner may order when treating the patient until after it is administered.

The proposal for additional data elements also includes identifying the modifiers and code types used in billing. Oftentimes, the use of a modifier is determined after the service has been rendered and is dependent upon billing rules and guidance. This will likely be a difficult task to capture in advance and publish for each item or service. Third, in seeking to ensure accessibility to the standard charge data, CMS is now proposing requiring hospitals to place a "footer" on their home pages to link to the website page that includes the data. The hospital's public website would have a .txt file that includes the hospital name and location with a direct link to the URL page that hosts the new standardized Machine-readable form. Previously, hospitals were required to provide the information on their website, and searching hospital websites to locate this information may have been difficult because there was no prescribed location where it must be available.

This change will eliminate the need for individuals to search through the website for the data and will immediately link the user to the data file with one potential click.

CMS believes that requiring price transparency will enhance clinical decision-making. (3) However, CMS is also seeking to enhance a patient's understanding of the charge information and proposed enhancements to the price transparency rule. Comments on the proposed rule were due by September 11, 2023, and CMS intends for the

final rule, when published, to be effective on January 1, 2024. If the proposed rule provisions remain intact in the final rule, hospitals will have a lot of work to do to be in compliance.

Effect On Hospitals

Because of the expanded data elements and the proposed requirements for format and location on the homepage, it is recommended that hospitals focus on the following five (5) operational initiatives while awaiting the final rule:

1. Locate and review all third-party payer managed care contracts and identify the Payer, the Plan and the method of how the rate was calculated. The hospital should prepare a comprehensive list as each of these elements may be required in the final rule.

2. Review the hospital's chargemaster files to determine if each drug is identified by drug and measurement. Likewise, evaluate whether the chargemaster files differentiate between inpatient or outpatient services as well as professional services versus technical/facility services. If the chargemaster lacks this information, it is recommended to coordinate teams to identify these data points for each healthcare service.

3. Identify if the hospital has multiple locations under one license and determine whether the services differ at each location. If there are differing services at each location, a separate file for each hospital location and its specific services will need to be developed for each payer, to include the gross charges, payer-specific negotiated charges by payer and plan, discounted cash price and the minimum and maximum de-identified negotiated rates.

4. The Information Technology Department should determine if it has the original source data for each service that includes all of the required elements and whether it can be populated in JSON or CSV formatting. The hospital should determine if this will require manual data entry into the CMS Template or if there is an interface or computer programming tool that can assist with populating each element into the CMS Template form.

5. Determine the proper hospital representative who will be authorized to sign and execute the certification that the hospital has included all applicable standard charge information in the Machine-readable format. This certification may give rise to liabilities if it is falsely presented. Therefore, the hospital should develop a quality assurance process to confirm that all of the elements of the standard charge information have been collected and encoded into the CMS Template properly to ensure it is Machine-readable. The file should be linked to the hospital's public website in the footer, and it is recommended to test the link to ensure the file is accessible and in the proper format required by CMS.

Developing a comprehensive team or Price Transparency Committee to review the data elements, the hospital's current information technology infrastructure, the website development, the managed care agreements and the proper billing and coding elements will be essential to support compliance with this rule in a timely manner. If this rule is finalized for an effective date of January 1, 2024, it is anticipated that the enforcement actions on the new requirements will commence on March 1, 2024. There is no time to wait for the final rule and hospitals should have their Price Transparency Committee working on these initiatives today.

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1) Centers for Medicare and Medicaid Servs., CY 2024 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes: Hospital Price Transparency Proposals (CMS-1786-P) (July 13, 2023), https://www.cms.gov/newsroom/fact-sheets/cy-2024-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price

2) 45 C.F.R. Part 180.

3) See Centers for Medicare and Medicaid Servs., *supra*.