

Hospital Price Transparency Frequently Asked Questions (FAQs)

This document is designed as a resource for Hospital Price Transparency frequently asked questions (FAQs).

All FAQs presented in this document are current as of June 27, 2023.

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General Provisions

Where can I find the regulations that govern hospital price transparency and the final rules that implemented those regulations?

The regulations are found at 45 C.F.R. Part 180. CMS finalized hospital price transparency requirements under section 2718(e) of the Public Health Service Act, as well as a regulatory scheme under section 2718(b)(3) that enables CMS to enforce those requirements, in the Calendar Year 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 Final Rule (CMS-1717-F2) (Hospital Price Transparency Final Rule). The Hospital Price Transparency Final Rule was published in the Federal Register on November 27, 2019 (84 FR 65524) and is available at <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>

CMS amended some of the hospital price transparency requirements in the Calendar Year 2022 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model Final Rule with comment period (CMS-1753-FC) (2022 Updates to Requirements for Hospitals to Make Public a List of Their Standard Charges), which was published in the Federal Register on November 16, 2021 (86 FR 63458, 63941) and is available at <https://www.federalregister.gov/documents/2021/11/16/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment#h-628>

What are hospitals required to do under the hospital price transparency regulations? When do hospitals have to comply with these requirements?

As of January 1, 2021, each hospital operating in the United States was required to provide clear, accessible pricing information about the items and services they provide in two ways:

1. Comprehensive machine-readable file with all items and services.
2. Display of shoppable services in a consumer-friendly format.

What amendments did CMS finalize for the hospital price transparency regulations in the CY 2022 OP/ASC final rule?

CMS finalized the following amendments to the hospital price transparency regulation, which are effective January 1, 2022.

- Increase in Civil Monetary Penalties (CMP): CMS set a maximum CMP of \$300/day that

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applies to smaller hospitals with a bed count of 30 or fewer, a maximum CMP of \$10/bed/day for hospitals with a bed count of 31 up to and including 550 beds, and a maximum CMP of \$5,500/day for hospitals with greater than 550 beds. Under this approach, for a full calendar year of noncompliance, the minimum total penalty amount would be \$109,500 per hospital, and the maximum total penalty amount would be \$2,007,500 per hospital. This approach to scaling the CMP amount retains the current penalty amount for small hospitals, increases the penalty amount for larger hospitals, and affirms the Administration's commitment to enforcement and public access to pricing information.

- **Deeming State Forensic Hospitals as Having Met Requirements:** CMS amended the regulations to deem state forensic hospitals that provide treatment exclusively to individuals who are in the custody of penal authorities as being in compliance with the requirements.
- **Prohibiting Additional Specific Barriers to Access to the Machine-Readable File:** CMS updated the regulation's prohibition of certain activities that present barriers to access to the machine-readable file, specifically requiring that the machine-readable file be accessible to automated searches and direct downloads.

Refer to [86 FR 63941](#).

What is the purpose of the Hospital Price Transparency regulation?

The Hospital Price Transparency Final Rule sets forth the requirements for complying with the law (PHS Act section 2718(e)) that requires hospitals to make public their standard charges. The public release of hospital standard charge information is important to ensuring transparency in health care prices for consumers, while working to address some of the barriers that limit price transparency. We note that while the rules we finalized are a required floor, they do not preclude hospitals from undertaking additional transparency efforts beyond making public their standard charges.

How does Hospital Price Transparency support value-based care?

We believe hospital standard charge information will be useful to the public, including consumers who need to obtain items and services from a hospital, consumers who wish to view hospital prices prior to selecting a hospital, clinicians who use the data at the point of care when making referrals, and other members of the public who may develop consumer-friendly price transparency tools or perform analyses and make policy to drive value-based care. Because the drive towards value depends on access to both quality and cost information, we believe that disclosure of hospital standard charges fully aligns with and supports our drive toward value care as one half of the value proposition. Disclosure of hospital standard charge information will therefore complement quality information so that consumers can make high value decisions about their care (84 FR 65538-65539).

Will CMS ensure alignment between the Hospital Price Transparency final rule, the Transparency in Coverage (TIC) Final Rules, and the No Surprises Act?

As the federal government undertakes to implement these new laws and regulations over the

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next several years, we will continue to monitor and align the Hospital Price Transparency regulations, as necessary (86 FR 63942).

Will hospitals be able to apply for a hardship waiver or exception to meeting the Hospital Price Transparency requirements?

No. The Hospital Price Transparency Final Rule contains no provisions that address waivers or hardship exemptions.

Definitions

How is hospital defined under the Hospital Price Transparency Final Rule? Does the rule apply to Critical Access Hospitals (CAHs), other small or rural hospitals, state owned/operated institutions, Rural Emergency Hospitals (REHs), and non-acute hospitals such as inpatient psychiatric hospitals and inpatient rehabilitation facilities (IRFs)?

Under 45 CFR [§ 180.20](#), hospital means an institution, in any State in which State or applicable local law provides for the licensing of hospitals, which 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. All hospital location(s) operating under the same hospital license (or approval), such as a hospital's outpatient department located at an off-campus location (from the main hospital location) operating under the hospital's license, are subject to the requirements in this rule. This definition includes all Medicare-enrolled institutions that are licensed as hospitals (or approved as meeting licensing requirements) as well as any non-Medicare enrolled institutions that are licensed as a hospital (or approved as meeting licensing requirements). Given this definition, this rule applies to every institution that meets the definition of 'hospital' established by the Hospital Price Transparency Final Rule including institutions such as critical access hospitals, specialty hospitals, and state owned or operated facilities other than those deemed compliant.

Federally owned or operated hospitals (for example, hospitals operated by an Indian Health Program, the U.S. Department of Veterans Affairs, or the U.S. Department of Defense) that do not treat the general public, except for emergency services, and whose rates are not subject to negotiation, are deemed to be in compliance with the requirements for making public standard charges because their charges for hospital provided services are publicized to their patients in advance (for example, through the *Federal Register*). In addition, beginning January 1, 2022, state forensic hospitals that provide treatment exclusively to individuals who are in the custody of penal authorities are deemed to be in compliance with 45 CFR Part 180 because such hospitals are wholly funded through state general funds and treat patients who are not

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responsible for the cost of their care in such hospitals (86 FR 63941).

Does the Hospital Price Transparency Final Rule apply to hospitals in the State of Maryland that are subject to global payments set by the Maryland Health Services Cost Review Commission?

Yes. If your institution meets the definition of ‘hospital’ as defined by the Hospital Price Transparency Final Rule, then your institution must comply. However, some required data elements for display may not be applicable to your hospital. For example, under the Hospital Price Transparency Rule, your hospital is obligated to make public the payer-specific negotiated charges as applicable for each item and service your hospital provides. The term “payer-specific negotiated charge” is defined as the charge that the hospital has negotiated with a third-party payer for an item or service. The term “third party payer” means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service. If your hospital has not negotiated a charge with a third-party payer for an item or service your hospital provides, then your hospital would not have a “payer-specific negotiated charge” to display for that item or service.

What standard charges must hospitals make public?

A standard charge means the regular rate established by the hospital for an item or service provided to a specific group of paying patients. For purposes of complying with the Hospital Price Transparency Final Rule, this includes five types of standard charges:

1. The gross charge (the charge for an individual item or service that is reflected on a hospital’s chargemaster, absent any discounts).
2. The discounted cash price (the charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service).
3. The payer-specific negotiated charge (the charge that a hospital has negotiated with a third-party payer for an item or service).
4. The de-identified minimum negotiated charge (the lowest charge that a hospital has negotiated with all third-party payers for an item or service).
5. The de-identified maximum negotiated charge (the highest charge that a hospital has negotiated with all third-party payers for an item or service).

Please refer to 45 CFR [§180.20](#).

What hospital “items and services” are included by the Hospital Price Transparency Final Rule? What is a “service package”?

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For purposes of complying with the hospital price transparency requirements, items and services 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 a hospital has established a standard charge. Examples 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. Please refer to 45 CFR [§180.20](#).

A service package is an aggregation of individual items and services into a single service for which the hospital has a single standard charge. “Service packages” may have charges established on, for example, the basis of a common procedure or patient characteristic, or may have an established per diem rate that includes all individual items and services furnished during an inpatient stay. Please refer to 45 CFR [§180.20](#).

The definition of “items and services” includes services of employed physicians and non-physician practitioners. How does CMS define “employment”?

Given the variation and complexity in employment models and possible contracting relationships that may exist between hospitals and physicians, we believe it is important to preserve flexibility for hospitals to identify employed physicians or non-physician practitioners under their organizational structure, and, for this reason, we declined to codify a definition of “employment” in the Hospital Price Transparency Final Rule. Refer to 84 FR [65535](#). One resource that hospitals could consider reviewing for purposes of determining whether or not a physician or non-physician practitioner is employed by the hospital is: <https://www.irs.gov/newsroom/understanding-employee-vs-contractor-designation>.

Do these requirements apply to non-employed physicians and other practitioners who provide and bill for the same services at the hospital?

No. Services provided by physicians and non-physician practitioners who are not employed by the hospital are practitioners that are practicing independently, establish their own charges for services, and receive the payment for their services. Such services, therefore, are not services “provided by the hospital.”

Do these requirements apply to the services of employed practitioners whose charges are not found in the hospital chargemaster?

Yes. The Hospital Price Transparency Final Rule does not limit the requirements to only hospital standard charges that are found within the hospital chargemaster, including standard charges for items and services provided by practitioners employed by the hospital. The requirements apply to such charges that may be located elsewhere within the hospital accounting and billing

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system, or, in the case of payer-specific negotiated charges, in contracts and rate sheets that are specific to a particular third-party payer. Please refer to 84 FR [65535](#).

Do the standard charges for services performed by physicians and/or non-physician practitioners outside the scope of their employment by the hospital need to be included in the hospital's display of standard charges?

No, the Hospital Price Transparency Final Rule requires hospitals to post their standard charges for the items and services they provide. Items and services include, but are not limited to, the services of employed physicians and non-physician practitioners (generally reflected as professional charges). They do not include the services that physicians and non-physician practitioners perform outside the scope of their employment by the hospital.

Public Disclosure Requirements

Can hospitals choose between displaying standard charges in a machine-readable format and displaying standard charges for shoppable services in a consumer-friendly format?

No. Hospitals must make public both of the following: (1) A machine-readable file containing a list of all standard charges for all items and services as provided in 45 CFR §180.50 and (2) a consumer-friendly list of standard charges for a limited set of shoppable services as provided in 45 CFR §180.60. Please note that CMS will deem a hospital as having met the second of these two requirements if the hospital maintains an internet-based price estimator tool that meets the requirements provided in 45 CFR [§180.60\(a\)\(2\)](#).

Our hospital does not provide a discounted cash price for items and services. How should we reflect this in the display of standard charge information in our machine-readable file?

Some hospitals may not have determined a discounted cash price for self-pay consumers for the items and services it provides. In this case, the hospital may post the gross charge as reflected in the hospital chargemaster. Please refer to 84 FR [65553](#).

Some of the hospital items or services we offer do not have an associated HCPCS or CPT code. Are we required to list such services? If so, what should be indicated next to the item or service?

Yes. The Hospital Price Transparency Final Rule requires hospitals to disclose the standard charges for each item or service it provides, therefore, all hospital items and services for which the hospital has established a standard charge must be listed regardless of whether all the required corresponding data elements are available. Corresponding common billing and

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accounting codes must be included, as applicable. Please refer to [Table 1](#) (84 FR [65558](#)) for an example of a display of gross charges which includes this scenario. When an item or service does not have a corresponding standard charge or diagnosis code associated with an item or service, we strongly recommend your hospital use a single indicator to communicate to the public that there is no corresponding code. When using a CMS template, follow the instructions provided in the data dictionary. Please refer to [Table 1](#) (84 FR [65558](#)) for an example of a display of gross charges which includes this scenario.

Is there a limitation on the number of third-party payers for which we have to make negotiated charges public? For example, does this requirement apply to contracts with our top payers only?

No. Hospitals are required to list their standard charges, as applicable, including all payer-specific standard charges, for all items and services with respect to all third-party payers. Please refer to 84 FR [65567](#).

What is a “base rate” for a service package?

The base rate is the payer-specific charge the hospital has negotiated for a service package. Base rates for service packages are typically not found in the hospital chargemaster but can be found in other parts of the hospital’s billing and accounting systems, or in what are known as ‘rate sheets’ found in hospital in-network contracts with their third-party payers. The base rate is **not** the final payment or reimbursement rate for the service package received by the hospital for individual patients.

My hospital has established a gross charge for an individual item or service (as found in our chargemaster) but it has not established a payer-specific negotiated charge for that same item or service. In this case, does the hospital price transparency rule require our hospital to establish a payer-specific negotiated charge for that item or service?

The Hospital Price Transparency regulations require hospitals to make public a list of the standard charges the hospital has established for the items and services it provides and to make these data elements available in a single machine-readable file *as applicable*. We recognize that a hospital may have established one type of standard charge (for example a gross charge) for a particular item or service without having established other types of standard charges (for example, a payer-specific negotiated charge with a particular payer/plan) for the same item or service. When an item or service does not have a corresponding standard charge associated with an item or service, we strongly recommend your hospital use a single indicator to communicate to the public that there is no corresponding standard charge. When using a CMS template, follow the instructions provided in the data dictionary.

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How should my hospital display a payer-specific negotiated charge when no standardized dollar amount applies to all the members of a payer/plan, for example, when the contract with the payer/plan specifies that the reimbursement for members covered under the plan will be determined as a standardized algorithm?

It is possible that a hospital may have established a payer-specific negotiated charge that cannot be displayed as a standardized dollar amount. In these situations, the hospital may indicate the standardized algorithm as its payer-specific negotiated charge in the machine-readable file. Note that estimates and averages do not meet the definition of a ‘payer-specific negotiated charge,’ and, therefore, cannot be displayed by themselves as payer-specific negotiated charges, however, the hospital may choose to include such information (for example, an average reimbursement amount for a procedure that is derived from historical claims data) in addition to the payer-specific negotiated charge for the procedure. Examples can be found in Appendix 1.

My hospital has not established or negotiated a standard charge for an item or service. How should I display the lack of standard charge in the machine-readable file? Should I leave it blank?

The rule at 45 CFR. 180.50 requires that hospitals make public several data elements, including all five types of standard charges, as applicable, in the machine-readable file. We believe the “as applicable” reference is reasonable and necessary, given differences across hospitals that are subject to the regulations. We encourage hospitals to consider taking steps beyond the display requirements of the Hospital Price Transparency regulations to improve the public’s understanding of the data the hospital has posted in its machine-readable file, and, in particular, to clarify why there may appear to be data missing from the machine-readable file. For example, using a single indicator throughout the file could clarify the displayed information for some formats, avoid consumer confusion and complaints, and could help avoid raising compliance concerns during a CMS comprehensive review.

How should my hospital display charges for service packages that vary based on severity of illness?

Base rates for service packages are sometimes adjusted by a multiplier to address severity of illness (SOI) or adjustments for other factors. For example, a joint replacement may have a payer-specific negotiated base rate at \$2,000 with multipliers for various SOIs: intermediate complexity at \$3,000 ($\$2,000 \times 1.5$); high complexity at \$4,000 ($\$2,000 \times 2$); or very high complexity at \$5,000 ($\$2,000 \times 2.5$). The Hospital Price Transparency Final Rule does not limit hospitals from displaying additional clarifying information for patients, for example, providing a base rate for each severity level within a DRG or other clarifying information to patients related to how a service package base rate may change depending on severity of illness (SOI). Please

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refer to 84 FR [65547](#) and [65551](#).

In the machine-readable file, can my hospital post an average charge based on historical claims as the payer-specific negotiated charge for an item or service?

No. As we explained in the CY 2020 Hospital Price Transparency final rule, average charges based on prior years are not acceptable because an ‘average charge’ is not one of the types of standard charges finalized in the rule (84 FR 65571)

If a hospital has not provided a service in the previous 12 months, is it required to post the standard charge for that service?

Yes. CMS finalized the proposal to define hospital “items and services” to mean 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. In other words, hospitals must post the standard charge (as applicable) for each item/service for which the hospital has established a standard charge. Refer to 45 CFR [§180.20](#).

Should Medicaid plan rates be considered part of the de-identified minimum charge and payer-specific charge if a state is a fully managed care Medicaid state?

Hospitals are required to make public the payer-specific negotiated charges that they have negotiated with third party payers, including charges negotiated by third party payer managed care plans such as Medicare Advantage plans, Medicaid MCOs, and other Medicaid managed care plans. Therefore, a state’s Medicaid managed care contracts may fall within this description, if such managed care contracts include rates negotiated with the hospital. Please refer to 84 FR [65551](#) where we finalized our definition of “third party payer” as an entity that, by statute, contract, or agreement, is legally responsible for payment of a claim for a healthcare item or service.

In cases where the hospital has negotiated a payer-specific negotiated charge based on the Medicare or Medicaid FFS rate, can the hospital simply indicate that the price of the hospital item/service is set to the Medicare or Medicaid rate instead of reporting a specific dollar value?

No. The payer-specific negotiated charge is defined for purposes of the Hospital Price Transparency Final Rule as the charge that a hospital has negotiated with a third-party payer for an item or service, including a service package, and the hospital should list that standard charge. For example, if your hospital has negotiated a payer-specific negotiated charge for a service package that equals 200% of the Medicare FFS reimbursement rate for MS-DRG 123, then your hospital should determine the Medicare reimbursement rate for DRG 123, multiply it

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by 2, and indicate the resulting amount as its payer-specific negotiated charge for that service package.

We believe displaying payer-specific negotiated rates publicly would violate the confidentiality clause of the hospital’s contract with our third-party payers. Has CMS addressed this issue?

Even if a contract between a hospital and a payer contained a provision prohibiting the public disclosure of its terms, it is our understanding that such contracts typically include exceptions where a particular disclosure is required by Federal law. Refer to 84 FR [65544](#).

Can you give examples of how to determine the de-identified minimum and maximum negotiated charges for an item or service?

Once your hospital has listed each item and service it provides, along with the corresponding payer-specific negotiated charges the hospital has established for each one, you must identify the minimum and maximum amount. The following illustrations provide simple examples of how a hospital can determine the de-identified minimum and maximum negotiated charges for each item or service across all their payers. Each example assumes one plan per payer.

Example 1: A hospital negotiates the following payer-specific charges with three payers for an individual item or service, for example, an imaging test identified by billing code ‘12345’.

Item/service description	Billing Code	Payer 1 negotiated charge	Payer 2 negotiated charge	Payer 3 negotiated charge	De-identified minimum negotiated charge	De-identified maximum negotiated Charge
Imaging test	12345	\$125	\$300	\$550	\$125	\$550

Example 2: A hospital negotiates the following payer-specific charges with three payers for two different service packages. The hospital has negotiated a payer-specific charge with Payer 1 for a procedure based on an APR-DRG. With Payers 2 and 3, the hospital has negotiated a payer-specific charge based on the number of days the patient spends in the hospital, that is, a *per diem* charge.

Item/service description	Billing Code	Payer 1 negotiated charge	Payer 2 negotiated charge	Payer 3 negotiated charge	De-identified minimum negotiated charge	De-identified maximum negotiated charge
Procedure	999	\$1250	N/A	N/A	\$1250	\$1250
Per diem	xxx	N/A	\$500	\$450	\$450	\$500

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What are the similarities and differences of the requirements for the two ways that each hospital must make public a list of the hospital's standard charges for items and services it provides?¹

	Comprehensive Machine-readable File	Consumer-friendly display of Shoppable Services²
General requirement	Single comprehensive machine-readable file containing a list of standard charges, as applicable, for all items and services.	Some standard charge information, as applicable, for at least 300 shoppable services including 70 CMS-specified services presented in a consumer-friendly manner. ³ The primary shoppable service must be grouped with any ancillary services the hospital customarily provides as part of or in conjunction with the primary service.
Standard Charges	<ul style="list-style-type: none"> •Gross charge •Discounted cash price •Payer-specific negotiated charges •De-identified minimum negotiated charge •De-identified maximum negotiated charge 	<ul style="list-style-type: none"> •Discounted cash price (or gross charge, where the hospital has not established a discounted cash price) •Payer-specific negotiated charges •De-identified minimum negotiated charge •De-identified maximum negotiated charge
Description of item or service and billing codes	A description of each item or service along with, as applicable, any code used by the hospital for purposes of accounting or billing for the item or service.	A <u>plain-language</u> description of each shoppable service along with, as applicable, any primary code used by the hospital for purposes of accounting or billing for the shoppable service.

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	Comprehensive Machine-readable File	Consumer-friendly display of Shoppable Services²
Service not offered by hospital	No requirement. CMS recommends using an indicator when one or more of the services are not offered by the hospital (for example, N/A).	Use an indicator when one or more of the CMS-specified shoppable services are not offered by the hospital (for example, N/A).
Format	A single digital file that is machine-readable	No requirement
Naming Convention	Must adhere to the CMS naming convention: <ein>_<hospital-name>_standard charges. [json xml csv]	No requirement
Location of information	Displayed prominently on a publicly-available website and in a prominent manner that clearly identifies the hospital location with which the information is associated.	Displayed prominently on a publicly-available website and in a prominent manner that clearly identifies the hospital location with which the information is associated.
Access to information	Must be free of charge and may not require a log-in, password, and/or the submission of any personal identifying information (PII) in order to access. In addition, the information must be accessible to automated searches and direct downloads.	Must be free of charge and may not require a log-in or password, other barriers, and/or the submission of any personal identifying information (PII).
Search Capability	Digitally searchable	Searchable by service description, billing code, and payer
Updates	Annually – with date of last update clearly indicated	Annually – with date of last update clearly indicated

¹ A complete overview of requirements can be found at [Subpart B-Public Disclosure Requirements](#).

² A hospital is deemed by CMS to meet the requirements of this section if the hospital maintains an Internet-based price estimator tool which 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 healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.
- 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.

³ If a hospital does not provide 300 shoppable services, the hospital must make public its standard charges for as many shoppable services as it provides.

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Machine-Readable File

What is a ‘machine-readable’ file format?

A machine-readable file format is a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of this format include, but are not limited to, .XML, .JSON, and .CSV formats. Refer to 45 CFR [§ 180.20](#).

What updates did CMS make to the accessibility requirements of the machine-readable file in the CY 2022 OPPI/ASC final rule?

As of January 1, 2022, CMS requires that the machine-readable file must be accessible to automated searches and direct downloads through a link posted on a publicly available website (45 CFR [§180.50 \(d\)\(3\)\(iv\)](#)). Specific examples of barriers to automated searches and direct downloads that CMS identified include, but are not limited to, lack of a link for downloading a single machine-readable file, using “blocking codes” or CAPTCHA, and requiring the user to agreement to terms and conditions or submit other information prior to access. Refer to 86 FR [63952](#).

How can my hospital ensure that its machine-readable file is “prominently displayed”?

The Hospital Price Transparency final rule states “displayed prominently” means “the value and purpose of the web page and its content is clearly communicated, there is no reliance on breadcrumbs to help with navigation, and that the link to the standard charge file is visually distinguished on the web page.” Additionally, “easily accessible” means “the standard charge data are presented in a single machine-readable file that is searchable and that the standard charges file posted on a website can be accessed with the fewest number of clicks” (84 FR [65561](#)). We recommend that hospitals do the following to ensure the machine-readable file is prominently displayed:

- Review and use, as applicable, the HHS Web Standards and Usability Guidelines (available at: <https://webstandards.hhs.gov/>), which are research-based and are intended to provide best practices over a broad range of web design and digital communications issues.
- Post a link to the machine-readable file on a website where the value and purpose of the web page and its content is clearly communicated, for example, a dedicated price transparency webpage or a webpage devoted to patient billing or financing healthcare services.
- While “breadcrumbs” (e.g., secondary navigation aids) can be useful for navigating a website, they should not be relied upon in order for consumers to find the link to the machine-readable file. Instead, facilitate user navigation by including searchable terms on the webpage such as “price transparency,” “standard charges,” or “machine-readable file.”

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Ensure that the link to the machine-readable file is visually distinguished on the web page, and that its purpose is to open the single machine-readable file for a particular hospital location. Refer to [45 CFR § 180.50\(d\)\(2\)](#)

What naming convention should hospitals use when making public the machine-readable file? How can I find the EIN and associated hospital legal name?

Hospitals must use the following CMS naming convention as specified in the regulations at 45 CFR [180.50\(d\)\(5\)](#) for the machine-readable file: <ein>_<hospital-name>_standardcharges.[json|xml|csv] in which the EIN is the Employer Identification Number of the hospital, followed by the hospital name, followed by “standardcharges” followed by the hospital’s chosen file format (84 FR 65562). It is important that you follow the rule’s naming convention. Specifically, hospitals must use the following schema:

- Write out “standardcharges” as a single word, without capitalization.
- Finish by using the .json, .xml, or .csv as applicable to the file format you have chosen.
- Separate the EIN, hospital name, and “standardcharges” by using an underscore: 12345678_example-hospital-name_standardcharges.csv

In addition, hospitals may do the following:

- Exclude dashes from the EIN (use “12345678”, not “12-345678”)
- Use the legal name of the hospital without capitalization and include dashes between words (use “example-hospital-name”, not “Example Hospital Name”)

Hospital EINs and legal names can be found using lookups hosted by the IRS (<https://apps.irs.gov/app/eos/>) and SEC (<https://www.sec.gov/edgar/search/>)

We have multiple facilities and locations, each with its own list of standard charges, functioning under the same EIN and legal name. CMS regulations require that “Each hospital location operating under a single hospital license (or approval) that has a different set of standard charges than the other location(s) operating under the same hospital license (or approval) must separately make public the standard charges applicable to that location.” In this case, what naming convention should we use for these machine-readable files?

Hospitals must use the CMS naming convention as specified in the regulations at 45 CFR [180.50\(d\)\(5\)](#) but may also add “-<NPI>” following the EIN (where “#” is the National Provider Identifier that corresponds to the hospital location). NPIs and hospital names can be found using this lookup: <https://npiregistry.cms.hhs.gov/>. For example, “Example Hospital Name” with EIN of 12345678 has two locations with NPIs of “1011121314” and “1516171819”, each with its own set of standard charges. This hospital could name its two csv-formatted machine-readable files as “12345678-1011121314_example-hospital-name_standardcharges.csv” and “12345678-1516171819_example-hospital-name_standardcharges.csv”, respectively.

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In the machine-readable file, are hospitals required only to display the payer-specific negotiated charges for each item/service that is found in the hospital chargemaster, even when the hospital has negotiated rates with some payers based on ‘service packages’?

The machine-readable file posted online by the hospital should include not only the items and services listed in the chargemaster but also list any service packages for which the hospital may have established a standard charge. For example, some payer-specific negotiated rates are for ‘service packages’ (for example, per diem or based on a procedure). Such ‘service packages’ are not typically found in the hospital chargemaster which is a list of itemized items and services, but a hospital is still required to display the payer-specific negotiated charge (and all other standard charges applicable) for which the hospital has established a standard charge regardless of whether it appears in the chargemaster. Please refer to 84 CFR [65534](#) for further discussion.

Consumer-friendly Display of Shoppable Services

What is a shoppable service? Are medications considered shoppable services?

A shoppable service means a service that can be scheduled by a healthcare consumer in advance. Procedures such as joint replacements and services such as physical therapy are examples of shoppable services. Hospital administration of a medication could be considered a shoppable service if it can be scheduled in advance. Examples of administration of a medication that could be considered a shoppable service are the administration of flu shots or medication infusions for chronic conditions. The definition of ‘shoppable service’ can be found at 45 CFR [§180.20](#).

What if a hospital does not provide one or more of the 70 CMS-specified shoppable services or provides less than 300 shoppable services in total? How can requirements of this regulation be met?

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. The hospital must clearly indicate any CMS-specified shoppable service that it does not provide. The hospital may use “N/A” for the corresponding charge or use another appropriate indicator to communicate to the public that the shoppable service is not provided by the hospital. Refer to 84 FR [65569](#) and [65574](#) for further discussion.

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What is an ‘ancillary item and service’?

Ancillary services, defined at 45 CFR [§180.20](#), are any item or service a hospital customarily provides as part of, or in conjunction with, a shoppable primary service and may include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including post-anesthesia and postoperative recovery rooms), therapy services (physical, speech, occupational), hospital fees, room and board charges, and charges for employed professional services. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. For example, an outpatient procedure may include many services that are provided by the hospital, for example, local and/or global anesthesia, services of employed professionals, supplies, facility and/or ancillary facility fees, imaging services, lab services and pre- and post-op follow up. To the extent that a hospital customarily provides (and bills for) such ancillary services as a part of, or in conjunction with, the primary service, the hospital should group the ancillary service charges along with the other standard charges that are displayed for the shoppable service. For further discussion of ancillary services refer to 84 FR [65564](#).

How should a hospital display charges for a shoppable service in a consumer-friendly manner when the hospital offers it as a service package or when the hospital already includes all ancillary services as part of the service package charge?

To the extent that a hospital includes in its public display a shoppable service that it commonly provides as a service package, the hospital must display the charge the hospital has established for the service package as a whole. In other words, if the hospital has established a standard charge for a service package, the hospital must display that standard charge as opposed to displaying a manufactured charge for each of the individual items and services that make up the service package. For example, when displaying the charge for a shoppable service identified by a DRG, the hospital would display the payer-specific negotiated charge (the “base rate”) negotiated with a third-party payer for the DRG. To be consumer friendly, the hospital may elect to communicate the individual items and services included in the standard charge for the service package, but this is not required under the Hospital Price Transparency Final Rule.

However, should a hospital customarily provide any items or services beyond those already included in a service package, the rule does require hospitals to list any such additional ancillary services the hospital customarily provides with the shoppable service. In other words, the hospital must provide a description of the ancillary service along with its standard charge(s) and other required data elements, as applicable.

What does CMS consider to be a plain-language description for purposes of the consumer-friendly display?

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The regulations at 45 CFR § 180.60(b)(1) require hospitals to include a plain-language description for each of the 70 CMS-specified and 230 hospital-selected shoppable services in its consumer-friendly display. We invite hospitals to review the Federal plain language guidelines that can be found here: <https://plainlanguage.gov/guidelines/>. Refer to 84 FR [65573](#).

Examples that we would consider plain-language descriptions:

- Direct Admission to the Hospital from Observation Status
- CT of the Head or Brain with Contrast
- MRI of Orbit, Face, or Neck with and without Contrast

Examples that we would *not* consider plain-language descriptions:

- OBSRV ASMT DIRECT ADMIT1
- CT HEAD/BRAIN W/CON 42
- MRI ORB/FACE/NK W/WO CON 43

Can a price estimator tool be used to meet the requirement to display shoppable services in a consumer-friendly format? If yes, what requirements must the price estimator tool meet?

Yes. In the Hospital Price Transparency Final Rule, we stated that we had been persuaded by commenters' suggestions that hospitals offering online price estimator tools that provide real-time individualized out-of-pocket cost estimates should receive consideration. For further discussion on the requirements of a price estimator tool, please see 45 CFR [§180.60\(a\)\(2\)](#).

Although we recognize that some hospital price estimator tools may not display consumer-friendly standard charge information in the precise ways we are requiring under the rule, they do appear to accomplish the goal and intent of ensuring such information is available in a consumer-friendly manner by allowing individuals to directly determine their specific out-of-pocket costs in advance of committing to a hospital service. We emphasize, however, that hospitals must still publish their standard charges for the items and services they provide in a comprehensive machine-readable file (refer to 45 CFR [§180.50](#)). In other words, offering a price estimator tool can satisfy the requirement to post shoppable service information in a consumer-friendly format but does not satisfy the requirement to display hospital standard charges in a comprehensive machine-readable file.

Further, if a hospital chooses to exercise this option, the hospital Internet-based price estimator tool must meet the following criteria to be deemed in compliance:

- Provide 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

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is necessary for a combined total of at least 300 shoppable services.

- Allow healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.
- 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.

Refer to 84 FR [65577](#) for further discussion on this topic.

If a hospital chooses to use a price estimator tool as an alternative to meeting the requirements for making public the standard charges for shoppable services in a consumer-friendly manner, may hospitals collect patient insurance information or other PII in order to generate a real-time out-of-pocket estimate for the patient?

Yes. In the Hospital Price Transparency Final Rule, we specifically did not include a requirement that no PII be collected because we recognize that insurance information may be necessary to provide patients with real-time personalized OOP price estimates. In order to ensure there is flexibility for the data elements, format, location, and accessibility of a price estimator tool that would be considered to meet the requirements of 45 CFR 180.60, we established minimum data and functionality requirements at 45 CFR §180.60(a)(2). Refer to 84 FR [65578](#) for further discussion on this topic and to 45 CFR [§180.60\(a\)\(2\)](#) for the requirements.

For the price estimator tool, would a display of an estimated range across all commercial payers for each of the 300 shoppable services meet the requirements?

No. As clarified in the CY 2022 OPPS/ASC final rule, if a hospital chooses to offer a price estimator tool in lieu of displaying standard charges in a consumer-friendly manner, the hospital must ensure (among the other requirements at 45 CFR 180.60(a)(2)) that the tool allows healthcare consumers to, at the time they use the tool, obtain an estimate of the amount that the hospital anticipates the individual would be obligated to pay. This means that the estimated amount is a personalized estimate of "the amount" the individual would be obligated to pay and is therefore represented as a single out-of-pocket dollar amount that takes into account the individual's insurance status (see 86 FR 63954). We note, however, that Hospital Price Transparency final rule is not prescriptive regarding the method by which a hospital's price estimator tool estimates the individual's single out-of-pocket dollar amount, and nothing in the rule prevents a hospital from developing an accurate and reliable cost estimate using prior claims information or from providing additional information that may be useful to the end-user, such as the range of out-of-pocket costs for the population to which the individual belongs.

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Does CMS have an example of disclaimer language that a hospital could use on its price estimator tool?

No. Each hospital is unique and serves a unique patient population. We encourage, but do not require, hospitals to provide disclaimers as applicable and appropriate in their price estimator tools, including disclaimers acknowledging the limitation of the presented standard charge information and advising the user to consult, as applicable, with his or her health insurer to confirm individual payment responsibilities and remaining deductible balances. Similarly, we encourage, but do not require, that hospital standard charge information include the following:

- Notification of the availability of financial aid, multiple procedure discounts, payment plans, and assistance in enrolling for Medicaid or a state program.
- An indicator for the quality of care in the healthcare setting.
- Making the standard charge information available in languages other than English, such as Spanish and other languages that would meet the needs of the communities and populations the hospital serves.

We discussed the flexibility to provide disclaimers in hospital price estimator tools at 84 FR [65578-65579](#).

Can CMS provide a list of internet-based price estimator tool vendors?

No, we do not have an available list of vendors who provide price estimator tool application software.

Can hospitals provide additional consumer-friendly resources?

Yes. Hospitals are encouraged to embrace a patient-centered approach to care in all forms, including providing consumer-friendly resources related to cost of care that will empower patients with pricing information to help them make healthcare decisions that work best for them.

Do contracts with non-payer companies, i.e., local employers for drug screening, need to be included in the list of payer-specific negotiated rates?

The term “payer-specific negotiated charge” is defined as the charge that the hospital has negotiated with a third-party payer for an item or service. The term “third party payer” is defined as an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service. Therefore, if a local company meets the definition of “third party payer” and your hospital has negotiated a payer-specific negotiated charge for an item or service with that company, then you must list the payer-specific negotiated charge for the item or service, along with the other required data elements, as applicable. These definitions can be found at 45 CFR [§180.20](#).

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Monitoring and Penalties for Noncompliance

What happens if a hospital does not comply?

CMS has 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 provide a warning notice to the hospital, request a corrective action plan (CAP) from the hospital if its noncompliance constitutes a material violation of one or more requirements, and may assess on a hospital a civil monetary penalty, and publicize the penalty on a CMS website, should the hospital fail to respond to CMS' request to submit, or comply with the requirements, of a CAP. Please refer to amended 45 CFR § 180.90 for adjusted penalty amounts under [Subpart C- Monitoring and Penalties for Noncompliance](#).

Is CMS enforcing the Hospital Price Transparency rules?

Yes. CMS expects hospitals to comply with these legal requirements and is actively enforcing these rules to ensure people know what a hospital charges for items and services. The public is invited to [submit a complaint](#) to CMS if it appears that a hospital has not posted information online.

What is CMS' process for enforcing the Hospital Price Transparency rules?

The enforcement process is established in the Hospital Price Transparency regulations and occurs in a phased manner. The process typically involves a comprehensive compliance review in response to CMS audit or a complaint received through the Hospital Price Transparency website. If CMS concludes a hospital is noncompliant with one or more of the requirements to make public standard charges, CMS may take any of the following actions, which generally, but not necessarily, will occur in the following order:

- Provide a written warning notice to the hospital of the specific violation(s)
- Request a Corrective Action Plan (CAP) if noncompliance constitutes a material violation of one or more requirements
- Impose a civil monetary penalty

In accordance with 45 CFR 180.80(c), if CMS issues a request for a hospital to submit a CAP, it must be submitted by the date specified in the request and must specify the process the hospital will take to address the deficiency(ies) identified by CMS and the timeframe by which the hospital will complete the corrective action. A CAP is subject to CMS review and approval. For reference, CMS has developed a [CAP Response Sample](#) as an optional format for submitting a CAP. Should a hospital that CMS has identified as noncompliant fail to respond to CMS' request to submit a CAP or comply with CAP requirements, CMS may impose a CMP in accordance with 180.90(a). Once CMS issues a CMP, CMS will post the notice of imposition of a CMP on a CMS website (45 CFR 180.90(e)).

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How does CMS assess compliance?

During a comprehensive compliance review, CMS assesses whether the hospital's disclosure of standard charges meet the requirements specified at 45 CFR Part 180. Specifically, CMS assesses whether the hospital has displayed standard charges in a machine-readable file in accordance with the criteria established at 45 CFR §[180.50](#) and shoppable services in a consumer-friendly manner in accordance with the criteria established at 45 CFR §[180.60](#).

What is CMS doing to educate hospitals and assist them with compliance?

CMS has, to date, engaged in a number of education and outreach activities to help prepare hospitals for compliance:

- held several National Open Door Forums to review the requirements of the Hospital Price Transparency final rule;
- established a dedicated [hospital price transparency website at https://www.cms.gov/hospital-price-transparency](https://www.cms.gov/hospital-price-transparency); and
- established an inquiry email box (PriceTransparencyHospitalCharges@cms.hhs.gov) and (HPTCompliance@cms.hhs.gov).

Transcripts of National Open-Door Forums can be found here: <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts>. The hospital price transparency website includes the following resources to assist hospitals in meeting compliance:

- A link to the Hospital Price Transparency final rule in the Federal Register (<https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf>).
- A link to the CY 2022 OPPS/ASC final rule (<https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf>)
- August 11, 2021 Hospital Price Transparency Stakeholder Webinar Presentation (PDF): <https://www.cms.gov/files/document/august-11-2021-hospital-price-transparency-odf-slide-presentation.pdf>
- An extensive FAQ document that is continually updated to provide guidance and address common inquiries (<https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf>);
- Two step-by-step documents designed to assist hospitals in implementing each of the two main requirements: *8 Steps to a Machine-Readable File* (<https://www.cms.gov/files/document/steps-machine-readable-file.pdf>) and *10 Steps to a Consumer-Friendly Display* (<https://www.cms.gov/files/document/steps-making-public-standard-charges-shoppable-services.pdf>); and
- A Quick Reference Checklist to assist hospital review of the Hospital Price Transparency regulatory requirements (<https://www.cms.gov/files/document/hospital-price-transparency-final-rule-quick-reference-checklists.pdf>).

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I received a warning notice from CMS. How do I contact CMS with questions about the deficiencies outlined in the notice?

The CEO/President of the hospital or their authorized representative may contact CMS via email at: HPTCompliance@cms.hhs.gov. When contacting CMS for technical assistance regarding the Hospital Price Transparency warning letter you received, please submit detailed questions in writing. CMS cannot offer anything that could be construed as legal advice and recommend that individuals consult with hospital counsel and/or compliance officials.

How do I authorize a representative to talk to CMS about my hospital's warning notice?

As a policy matter, CMS will only discuss the hospital's compliance status with the recipient of the warning notice (specifically, the addressee of the warning notice) or the authorized representative. The CEO/President of the hospital may appoint a designee if he/she will not be the official representative communicating with CMS regarding the Hospital Price Transparency program. To appoint a representative the CEO:

- Should notify CMS by emailing HPTCompliance@cms.hhs.gov from the CEO's corporate e-mail of the intent to appoint someone other than the CEO as the official representative of the organization for Hospital Price Transparency.
- Should include in the email the designee's name, title, e-mail, and phone number to ensure any confidential information will be shared only with the hospital's official representative.
- Should send the email to HPTCompliance@cms.hhs.gov.

Do I need to notify CMS when my hospital has corrected any deficiencies identified in the warning notice?

If your hospital receives a warning notice, CMS will indicate the date by which the hospital must take action to correct the deficiency or deficiencies identified by CMS. CMS will review the hospital website after the close of the indicated period to determine if the deficiencies have been remedied or if further compliance actions are warranted.

My hospital is part of a larger hospital system. If one of the hospitals in the system received a warning notice from CMS outlining deficiencies, does this mean that all other hospitals in my system are compliant?

No. A warning notice or request for corrective action sets forth CMS's determination of non-compliance with respect to the specific hospital receiving the letter. Nothing in the warning letter sent to a hospital in a system of hospitals implies a determination of non-compliance for other hospitals in the system. The warning notice, however, may serve as a helpful compliance indicator for other hospitals within a hospital system that have followed similar (or identical) reporting methods. Refer to [Subpart C- Monitoring and Penalties for Noncompliance](#).

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How will CMS calculate the Civil Monetary Penalty (CMP), beginning January 1, 2022, and with respect to that timeframe forward? What is the CMP calculation?

The maximum daily CMP amount for hospitals with 30 or fewer beds is \$300, even if the hospital is in violation of multiple discrete requirements. The maximum daily CMP amount for hospitals with at least 31 and up to 550 beds is the number of beds times \$10. For hospitals with greater than 550 beds, the maximum daily CMP amount is \$5,500, even if the hospital is in violation of multiple discrete requirements. Refer CFR 180.90(c)(2).

Ex. A noncompliant hospital with a bed count of 200 would be assessed a maximum daily CMP of \$2,000/day ($\$10 \times 200/\text{day}$) or \$730,000/year.

Number of Beds	Maximum Penalty Applied Per Day	Total Maximum Penalty Amount for full Calendar Year of Noncompliance
30 or fewer	\$300 per hospital	\$109,500 per hospital
31 up to 550	\$310 - \$5,500 per hospital (number of beds times \$10)	\$113,150 - \$2,007,500 per hospital
>550	\$5,500 per hospital	\$2,007,500 per hospital

Note: In subsequent years, amounts will be adjusted according to 45 CFR 180.90(c)(3).

Why is a scaling factor being used?

A scaling factor is being used to address a trend towards a high rate of hospital noncompliance identified by CMS through sampling and reviews to date, and the reported initial high rate of hospital noncompliance with 45 CFR part 180. Several factors informed our decision to use a scaling factor to determine the CMP, including: the ability to penalize based on a sliding scale method that relates to the hospital's characteristics, such as using the hospital's number of beds as a proxy for the size of the patient population;; the use of scaling factors in other Federal programs to determine CMP amounts; and the availability of a reliable source of data that can be used to establish a CMP amount across most hospitals. We believe a scaling factor approach strikes an appropriate balance and provides for the assessment of a CMP that is commensurate with the level of severity of the potential violation. Refer to 86 FR [63948](#).

What is the source of data used to determine bed count for scaling the CMP and where is that information located?

The scaling factor for the CMP amount uses hospital cost report data. This data is routinely submitted by Medicare-enrolled hospitals, is certified by a hospital official, and is reviewed by a Medicare Administrative Contractor (MAC) to determine acceptability and is submitted annually. The cost report contains provider information such as facility characteristics and financial statement

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data. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS). Further, the chief financial officer or administrator of the provider certifies the content of the submitted cost report is true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions.¹ The website is available here: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports>. Refer to 86 FR [63944](#)

How will CMS determine the bed count for a hospital that is not a Medicare-enrolled hospital?

If the bed count information cannot be determined using Medicare hospital cost report data, CMS will specify the conditions for CMS' receipt of documentation from the hospital to determine its number of beds, and if the hospital does not provide CMS with such documentation (in the prescribed form and manner, and by the specified deadline), CMS will impose a CMP on the hospital at the highest, maximum daily dollar amount (\$5,500 per day). Refer to 45 CFR [§180.90\(c\)\(2\)\(ii\)\(D\)\(2\)](#).

Where will the public list of non-compliant hospitals that are assessed a CMP be located?

The public list of non-compliant hospitals that are assessed a CMP will be located on the CMS Price Transparency website: <https://www.cms.gov/hospital-price-transparency>.

Appeals of Civil Monetary Penalties

Can a hospital appeal a civil monetary penalty related to hospital price transparency?

Yes. A hospital upon which CMS has imposed a penalty may request a hearing before an Administrative Law Judge (ALJ) in accordance with [45 CFR part 180, subpart D](#). In deciding whether the amount of a civil monetary penalty is reasonable, the ALJ may only consider evidence of record related to the following: hospital's posting(s) of standard charges, if available; material the hospital timely previously submitted to CMS (including with respect to corrective actions and corrective action plans), and material CMS used to monitor and assess the hospital's compliance.

How long does a hospital have to request a hearing?

A hospital must request a hearing within 30 calendar days after the date of issuance of the notice of imposition of a civil monetary penalty. The "date of issuance" is no more than five (5)

¹ 42 CFR 413.24(f)(4)(iv). See also, Form CMS-2552-10. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935>, Chapter 40-(T16)-- Hospital & Hospital Health Care (Form CMS-2552-10) (ZIP), file "R16P240f.pdf", Part II – Certification.

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days after the filing date postmarked by the U.S. Postal Service, or deposited with a carrier for commercial delivery, unless there is a showing that the document was received earlier. Please refer to 45 CFR §[150.401](#), [150.405\(a\)](#).

Can a hospital request an extension of time for filing a request for a hearing?

A request for an extension of time must be made promptly by written motion. The ALJ may extend the time for filing a request for hearing only if the ALJ finds that the hospital was prevented by events or circumstances beyond its control from filing its request within 30 calendar days after the date of issuance of the notice of imposition of a civil monetary penalty. Please refer to 45 CFR [§ 150.405\(b\)](#).

What happens if a hospital does not request a hearing within the required timeframe?

If a hospital does not request a hearing within 30 calendar days of the issuance of the notice of imposition of a CMP, CMS may impose the CMP indicated in such notice and may impose additional penalties pursuant to continuing violations according to 45 CFR 180.90(f) without right of appeal. 45 CFR §[180.110\(b\)](#) provides that the hospital has no right to appeal a penalty for which it has not requested a hearing in accordance with 45 CFR §150.405, unless the hospital can show good cause, as determined at §150.405(b), for failing to timely exercise its right to a hearing.

In the CY 2022 OPPS/ASC final rule, CMS indicated a belief that it was necessary to increase the penalty amount as a result of an internal analysis in early 2021. What were the findings from the CMS analysis?

Beginning January 1, 2021, CMS initiated audits of the websites of hospitals subject to the hospital price transparency rule and determined that the noncompliance rate with one or more of the requirements was approximately 75%. As a result, we proposed and finalized an increase to the penalty for noncompliance, beginning January 1, 2022.

What were the most frequent “deficiencies” seen by CMS during a comprehensive compliance review in 2021?

- Of hospitals that received warning notices in CY 2021, approximately 70% had deficiencies associated with the machine-readable file, while just under 30% were cited for deficiencies in both the machine-readable file and the consumer-friendly display. Very few hospitals were cited for deficiencies related only to the consumer-friendly display. Of hospitals found to be noncompliant with the machine-readable file display, the most common deficiencies included:
- Failure to make public a single machine-readable file.
- Missing one or more of the five types of standard charges.
- Including all five types of standard charges but failing to clearly associate the payer-specific

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negotiated charges with the name of the third-party payer and plan.

Of hospitals found to be noncompliant with the consumer-friendly display, the most common deficiencies included:

- Failure to make available a consumer-friendly list of standard charges for shoppable services or to offer a price estimator tool
- Failure to include all corresponding data elements (such as the required types of standard charges, ancillary services, and relevant billing codes).

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Appendix 1: Machine-Readable File Display Recommendations

Example 1: For Payer A/Plan 1, the hospital has established a payer-specific negotiated charge for a procedure that is based on a percent discount off the total gross charges generated during a patient’s stay, and the total gross charges generated during a patient’s stay will vary from patient to patient.

Display recommendation: In this case, for Payer A/Plan 1, the hospital could provide a description of the procedure and indicate a payer-specific negotiated charge of “50% off total gross charges”.

Example 2: For Payer A/Plan 1, the hospital has established a payer-specific negotiated charge for a procedure that includes both a standardized dollar amount (such as a base rate of \$5,000) and an amount that is variable (such as a 50% percent discount off the gross charge for the implanted device chosen by the surgeon).

Display recommendation: The preferred approach is to display each standard charge as a standardized dollar amount. For example:

Description	Code	Gross Charge	Payer A/Plan 1
[procedure]	[code]	N/A	\$5,000
[implantable device 1]	[code]	\$1,500	\$750
[implantable device 2]	[code]	\$2,000	\$1,000

In some cases, the standardized dollar amount for an implantable device may not be available, for example, when the device is purchased on an as-needed basis and the cost of the device is dependent on the prevailing market rate at the time of purchase. In this example, for Payer A/Plan 1, the hospital could provide a description of the procedure and indicate a payer-specific negotiated charge of the base rate (\$5,000) and a separate charge of “50% off the gross charge” for the implantable device.

Description	Code	Gross Charge	Payer A, Plan 1
[procedure]	[code]	N/A	\$5,000
[implantable device 1]	[code]	Market price	50% off gross charge

In other cases, the same implantable device may be used in different procedures, and the payer-specific negotiated charge for the device varies for each procedure. For example, the payer-specific negotiated charge for the implantable device is 50% of the gross charge when used for procedure X and the payer-specific negotiated charge for the same implantable device is 60% of the gross charge when used for procedure Y. The preferred approach would be to describe the procedure and provide the standardized dollar amount as the base rate (\$5,000) and ensure that the description of each implantable device reflects its use in each procedure along with their associated standardized dollar amount (discounted rate) as

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follows:

Description	Code	Gross Charge	Payer A, Plan 1
[procedure X]	[code]	N/A	\$5,000
[procedure Y]	[code]	N/A	\$5,000
[implantable device 1 when used for procedure X]	[code]	\$1,500	\$750
[implantable device 1 when used for procedure Y]	[code]	\$1,500	\$600

As an alternative, for Payer A/Plan 1, the hospital could provide a description of procedure X and indicate a payer-specific negotiated charge as the base rate (\$5000) + the established percent discount off the gross charge for the implantable device as follows:

Description	Code	Gross Charge	Payer A, Plan 1
[procedure X]	[code]	N/A	\$5,000 + 50% off the gross charge of the implantable device
[procedure Y]	[code]	N/A	\$5,000 + 60% off the gross charge of the implantable device
[implantable device 1]	[code]	\$1,500	

Example 3: For Payer A/Plan 1, the hospital has established a payer-specific negotiated charge for all medications of 50% off the gross charge when administered in one setting (such as the emergency department identified by revenue center code 0450) and 60% of the gross charge when administered in another setting (such as the general medical inpatient ward, identified by revenue center code 0150).

Display recommendation: As noted above, we recommend that hospitals display the payer-specific negotiated charge for each medication in each setting as a standardized dollar amount by listing each one separately.

The preferred approach is for hospitals to display the payer-specific negotiated charges for each medication as a standardized dollar amount like this:

Description	Quantity	Code 1	Code 2	Gross Charge	Payer A, Plan 1
[medication 1]	[X]	[NDC 1]		\$3.00	N/A
[medication 1]	[X]	[NDC 1]	Rev code 0450	\$3.00	\$1.50
[medication 1]	[X]	[NDC 1]	Rev code 0150	\$3.00	\$1.20
[medication 2]	[X]	[NDC 2]		\$4.00	N/A
[medication 2]	[X]	[NDC 2]	Rev code 0450	\$4.00	\$2.00
[medication 2]	[X]	[NDC 2]	Rev code 0150	\$4.00	\$1.60
[medication 3]	[X]	[NDC 2]		\$5.00	N/A

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[medication 3]	[X]	[NDC 2]	Rev code 0450	\$5.00	\$2.50
[medication 3]	[X]	[NDC 2]	Rev code 0150	\$5.00	\$2.00

However, we recognize that doing so could exponentially increase the data in the file which may present a challenge for some hospitals and a barrier to consumer access. Therefore, the hospital could also display payer-specific negotiated charge established by the hospital as a standardized algorithm if the standardized algorithm (e.g., 50% off gross charges) and the description of the item/service (e.g. all medications provided in the emergency department) is sufficient for the public to determine what the payer-specific negotiated charge would be and under what conditions:

Description	Quantity	Code 1	Code 2	Gross Charge	Payer A, Plan 1
[medication 1]	[X]	[NDC]		\$3.00	N/A
[medication 2]	[X]	[NDC]		\$4.00	N/A
[medication 3]	[X]	[NDC]		\$5.00	N/A
All medications provided in the emergency department	[X]	[NDC]	Rev code 0450	N/A	50% of gross charges
All medications provided in the general medical ward	[X]	[NDC]	Rev code 0150	N/A	60% of gross charges

Example 5: In this example, the hospital has established gross charges for all itemized items/services. With Payer A/Plan 1, the hospital has established a payer-specific negotiated charge for Procedure X of “60% off the total gross charges” and for Procedure Y of “75% off the total gross charges.” The hospital has also established a gross charge of “50% of gross charges” when the same items and services are not provided in the context of any procedure that is otherwise specified in the contract. In this case, the display recommendation is as follows:

Item/service	Code	Gross Charge	Payer A/Plan 1
Room & board (each day)		\$500	\$250
OR time (each 15 min)		\$100	\$50
Procedure X	[code]	N/A	60% of total gross charges
Procedure Y	[code]	N/A	75% of total gross charges

Example 6: The hospital has established a payer-specific negotiated charge for a procedure as an algorithm that includes two standardized dollar amounts, specifically, the base rate (\$5000) multiplied by an adjustment factor (for example, the hospital’s case mix of 3.4).

Display recommendation: In this case, the hospital could display a standardized dollar amount as the payer-specific negotiated charge by multiplying the procedure’s base rate by the case mix adjustment factor and display the resulting payer-specific negotiated charge.