OPPS and ASC Proposed Rule Listening Session

Moderated by Leah Nguyen
August 14, 2019 2:30 pm ET

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen only mode until the feedback session. This call is being recorded and transcribed. If anyone has any objections you may disconnect.

I will now turn the call over to Leah Nguyen, thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd like to welcome you to this Medicare Learning Network Listening Session on the Outpatient Prospective Payment System and Ambulatory Surgical Center proposed rule. During today's session, CMS experts briefly cover provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission. Topics include Price Transparency, requirements for all United States hospitals to make their standard charges public, and increasing choices and encouraging Site Neutrality, including payments for clinic visits.

Before we get started, you've received a link to the representation in your confirmation email. The presentation is available at the following URL go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

At this time, it is my great pleasure to introduce our CMS Administrator Seema Verma, who will provide opening remarks. Administrator Verma.

Opening Remarks

Seema Verma: Thank you and good afternoon everyone and thank you for joining the call today. So, we are eager to share with you our proposals that we released a couple weeks ago under the calendar year 2020 Outpatient Prospective Payment System and The Ambulatory Surgical Center Payment System notice of proposed rulemaking. I'll note that we also announced important proposals that impact physicians, that reward the time that physicians spend with patients, as well as the End Stage Renal Disease and Durable Medical Equipment Proposed Rule, and all of these builds on President Trump's recent Executive Order to advance kidney health, and advances our strategic initiatives to strengthen Medicare and unleash innovation.

I want to thank you all for your work as it helps to inform our policies and advance our goals to strengthen Medicare and empower patients. One of our main goals has been to reduce provider burden, which we've done through eliminating unnecessary documentation requirements, streamlining measurement reporting, and increasing flexibilities around scope of practice. And that's all a part of our Patients Over Paperwork Initiative. I will note that we are not done, this is an ongoing effort and we've actually set up an office within CMS that's going to focus exclusively on reducing provider burden.

So there will be more to come with the reform of the physician self-referral regulations, or Stark, that will help hospitals and physicians by modernizing and clarifying the regulations as we know them today, and we're also looking at ways to clear a path for innovative arrangements that will allow parties to provide high-quality coordinated care, as well as allow other business arrangements that don't pose a risk to the Medicare program and its beneficiaries. We've heard your pleas for clarity and bright line rules, and are considering ways to provide some relief there, too, so stay tuned.

Today, however, I want to spend some time focusing on a couple of key proposals and the hospital outpatient rule, Price Transparency and Site Neutral Payments. As you may know in June, President Trump issued a historic Executive Order on health care transparency, which directs us to eliminate unnecessary barriers to price and quality transparency, and to increase the availability of meaningful price and quality information for patients. So, we're responding to the executive order through this proposed rule and building on the initiatives we started a year ago.

Last year for the first time, we required hospitals to post their charge information online and we asked for your input on how hospital price transparency should work. We received feedback from many of you as well as hospital CEOs across the country, and we've also seen many hospitals who have gone above and beyond our regulations to develop innovative and consumer-friendly price transparency tools, so thank you for those efforts.

Those efforts helped inform our recent proposals by giving us examples of how price transparency tools can work. We've also heard that while most hospitals posted their charge information to be compliant, the way many hospitals display the information was not user-friendly and didn't allow for comparisons across hospitals. We also heard that not all hospitals are complying, and we're taking steps to address that.

Our proposals to take action to implement President Trump's Executive Order to ensure we're empowering patients with the information that they need to make health care -- informed health care decisions. So, if finalized, this would go into effect on January 1st of 2020. We are proposing that all hospitals will have to publish all of their payers' specific negotiated rates for all of their services, organized in a standardized way so that patients will be able to do an apple-to-apple comparison on the price of a procedure across hospitals. By posting negotiated rates, patients will be able to see prices that are meaningful and useful to them.

We are also proposing that hospitals post on a website their negotiated rate for 300 common shoppable services, in an easy to understand format. Again, this will allow consumers to look up the price of services that are not urgent and can be scheduled in advance, so they can shop around and make decisions on what's best for them. These proposals will apply to any hospital licensed by a State to be a hospital, and includes hospitals beyond those enrolled in just Medicare. We expect this to impact over 6,000 hospitals across the country.

And as you read our proposals that you will see, we are asking for your input on what other type of pricing information is helpful to consumers, and the number and type of common shoppable services that hospitals should show pricing information for. We also heard last year that hospitals should be held accountable for complying with our regulations and we agree, and which is why we're proposing new enforcement tools like monitoring, auditing, and imposing civil monetary penalties of over a $100,000 per year for hospital non-compliance.

Patients should be able to shop for services not only on cost, but the quality is also an important part of a patient's decision-making process. And so we want to hear from you on how we should do that, right now patients can get information on quality of care on our hospital compare website, but we understand that it's easier for patients to be able to see price and quality together when they're making decisions about their care. So, with these proposals, the Trump administration is ensuring that we're putting patients first and back in control of their health care.

So, switching gears, I want to talk about our efforts to strengthen Medicare and to give seniors more choices and to lower their out-of-pocket costs. As you know, Medicare pays substantially more for visits at hospital outpatient departments then it does for the same types of visits when they happen in a doctor's office. Last year, we announced a change to pay comparably for clinic visits, essentially a checkup with the doctor, in either physician offices or an off-campus hospital outpatient department, that we would phase in over two years. This year we're continuing those efforts to reduce out-of-pocket costs for beneficiaries, and we're completing the phase-in.

This will save beneficiaries an estimated a $160 million in lower copayments, and save the Medicare program an estimated $650 million dollars in 2020, after already saving $380 million for patients in Medicare in 2019. Second, we are expanding the services that can be provided in hospital outpatient departments and ambulatory surgery centers, which offer patients a lower cost alternative to going to the hospital for many same-day procedures, for example, like, colonoscopy. Today's proposals increase patient choice even more, allowing patients to get total knee replacements and certain coronary procedures at ambulatory surgery centers.

With these proposals, we're ending just allowing these services to just be offered in the hospital. With all of these proposals, the Trump administration is taking significant steps to secure and protect Medicare, to lower costs, and empower patients with the information they deserve. I look forward to an ongoing dialogue with you on these proposals and reading your comments. And with that, I'll turn it over to the team to discuss the proposals in more detail, thank you.

Presentation

Leah Nguyen: Thank you Administrator Verma. As I mentioned, the purpose of today's session is to address your clarifying questions to help you formulate your comments on the rule. After the presentation, we will open the lines for a feedback session. There may be questions today that we cannot answer because CMS must protect the rulemaking process and comply with the Administrative Procedure Act. We appreciate your understanding. It's also important to note that verbal comments on today's call do not take the place of submitting formal comments on the rule, as outlined on slide 4 of the presentation.

Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press you may listen in, but please refrain from asking questions during the question and answer session. If you have inquiries contact press@cms.hhs.gov.

With that, I will now turn the call over to Dr. Terri Postma from the Center for Medicare who is here to discuss price transparency and the requirements for all United States hospitals to make their standard charges public.

Price Transparency

Dr. Terri Postma: Thank you Leah. As you heard in Administrator Verma's opening comments, on June 24th the President signed an Executive Order on improving price and quality transparency in American health care to put patients first. This Executive Order expresses the policy of the federal government, should increase the availability of meaningful price and quality information for patients, and directed the Secretary of Health and

Human Services to propose a regulation consistent with applicable law to require hospitals to publicly post standard charge information.

So, as you heard from Administrator Verma, this proposal in the OPPS is a fulfillment of that executive order. These proposed rules implement section 2718(E) of the Public Health Service Act, and improves upon prior agency guidance that required hospitals to make public their standard charges upon request starting in 2015, and then subsequently online in the machine-readable format starting in January 1st of this year. Section 2718(E) requires each hospital - each hospital operating within the United States to establish and update and make public an annual list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886D4 of the Social Security Act.

I want to go through our proposals in some detail. You can find this all of course in the proposed regulation. The first thing I want to discuss is the definition - our proposed definition of hospital. In the proposed rule, we proposed to define hospital as an institution in any State in which State or applicable local law provides for the licensing of hospitals, and 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. As proposed a State would include each of the several States; the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

It includes all Medicare-enrolled institutions that are licensed as hospitals or approved as meeting licensing requirements, as well as all non-Medicare enrolled institutions that are licensed as a hospital or approved just meeting licensing requirements. We additionally proposed that federally-owned or operated institutions, for example hospitals operated by an Indian Health Program or the U.S. Department of Veterans Affairs or US Defense Department such as Military Treatment Facilities, which are not accessible to the general public except in emergency situations and already make their charges publicly available, would be deemed to have met the requirements of section 2718(E).

Second, we proposed a definition of hospital items and services. We proposed to define hospital items and services to include all items and services, including individual or itemized items and services and service packages, that are provided by hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a charge. Examples would include things like supplies, procedures, room and board, use of a facility, and other items such as facility fees, services of employed practitioners generally described as professional charges, and any other items or services for which the hospital has established a charge.

Third, we're proposing a definition of standard charges, to which we're proposing to define to mean the hospital's gross charge and the hospitals payer's specific negotiated charge for any item or service it provides. Hospitals would be required to make their standard charges public in two ways. First in a machine-readable file that posted online, the machine-readable file posted online would contain all hospital standards charge information that is both gross charges and payer-specific negotiated charges for all the items and services provided by the hospital.

The second way hospitals would be required to make their standard charges public would be on a consumer-friendly format that displays and packages payer-specific negotiated charges for a limited set of shoppable services. I'm going to go into those two ways in a little more detail now. First for the machine-readable format. This is the requirement for making public all standard charges for all items and services. We're proposing that hospitals make public both the gross charges and payer-specific negotiated charges for all items and services online in a single file that is machine-readable.

We're proposing that the hospital must include the several corresponding data elements, which as Administrator Verma mentioned are necessary to compare the services from hospital to hospital. The data elements are a description of each item or service provided by the hospital. The gross charge that applies to each individual item or service. The payer-specific negotiated charge that applies to each item or service. And each list of payer-specific charges should be clearly associated with the name of the third-party payer.

Any code that's used by the hospital for purposes of counting or billing for the service, so for example HCPCS or DRG codes and then revenue codes as applicable. We're also proposing that this file meet certain location and accessibility requirements. The hospital may select an appropriate publicly available website for making the file public, but whatever website they posted on the file must be displayed in a prominent manner and clearly identified with the hospital location. The hospital must also ensure the data are easily accessible without barriers.

All right, for that second set of requirements, these are the requirements for making public the consumer-friendly standard charges for a limited set of shoppable services. So, for this information, we're proposing to require that hospitals display payer-specific negotiated charges for at least 300 shoppable services. This would include 70 CMS-selected shoppable services and 230 hospital-selected shoppable services.

If the hospital does not provide one or more of the 70 CMS shoppable service, then the hospital would select additional shoppable services so that the total number of shoppable services made public by the hospital is at least 300. We're proposing to define shoppable service as a service that can be scheduled by a health care consumer in advance. In their display of shoppable services, the hospitals would do the following as proposed; hospitals would include charges for services that the hospital customarily provides in conjunction with the primary service that was identified by a common billing code such as HCPCS, CPT, or DRG code.

The hospital would make sure that the charge information is displayed prominently on a publicly available webpage, and clearly identifies the hospital or hospital location where the service is provided. And the information must be easily accessible without barriers, and searchable. The information would be updated at least annually. And then finally, as Administrator Verma noted through our lessons learned from the implementation earlier this year. We are proposing regulations for monitoring and enforcement of hospital compliance with these requirements.

We're proposing that CMS would have the authority to monitor hospitals for compliance with the Public Health Service Act 2718(E) by evaluating complaints made by individuals or entities to CMS, reviewing individuals or entities' analysis of noncompliance, and auditing hospital's website. Should we conclude that a hospital is noncompliant with one or more of the requirements to make public their standard charges; CMS may provide

a warning notice to the hospital for corrective action plan. If the hospital failed to respond to CMS' request to submit a corrective action plan, or failed to comply with the requirements of a corrective action plan, we propose that we may impose a civil monetary penalty on the hospital not in excess of $300 dollars per day, which amounts to over $100,000 dollars per year, and publicize these penalties on a CMS website.

We also proposed to establish an appeals process, for hospitals to request a hearing before an Administrative Law Judge of the civil monetary penalty. And finally, as Verma mentioned and as we've heard from multiple stakeholders, quality is an important piece of this. So, we're soliciting feedback on the best way to capture information on the quality of hospital inpatient care, so that information can be provided to patients in a way that's useful to them when comparing care options.

Specifically, we're seeking comment on improving availability and access to existing quality of health care information for third parties and health care entities to use when developing price transparency tools and when communicating charges for health care services. We're also seeking comment on improving incentives and then accessing the ability of health care providers and suppliers to communicate and share charge information with patients in advance of them getting the service or making a referral.

With that, I'll turn it back over to Leah.

Site Neutrality

Leah Nguyen: Thank you Terri. Our next presenter is David Rice from the Center for Medicare discussing increasing choices and encouraging site neutrality, including payments for clinic visits.

David Rice: Thanks Leah. The proposed rule includes a number of policies that reduce payment differences between care settings, and expand patients' choice of where they seek care. As finalized in last year's rule, CMS is completing a two-year phase-in of a method to reduce unnecessary utilization in outpatient services, by addressing payments for clinic visits as furnished in the off-campus outpatient hospital setting. Clinic visits are the most common service billed under the OPPS, and currently CMS beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting.

As we explained in the 2019 OPPS ASC final rule in which we adopted this policy, we believe that payment incentives in the form of higher payment amounts under the OPPS for clinic visits services have driven volume for that service from the physician office to the off-campus provider-based department, thereby causing unnecessary increases in the volume of that service under the OPPS. As a result, we determine in the 2019 final rule to pay for the clinic visit code G0463 at the physician fee schedule equivalent rate.

This change was phased in over two years with half of the reduction between OPPS and the PFS rate made in 2019 and the full reduction applied in 2020. This proposed change would result in lower co-payments for beneficiaries, and savings for the Medicare program, estimated to be a combined total of $810 million dollars for calendar year 2020. For example, for clinic visit furnished in the accepted off-campus provider-based department average beneficiary cost sharing is currently $16 dollars in 2019 but would be $23 dollars absent this policy.

With the completion of the two-year phase-in that cost sharing would be reduced to $9 dollars, saving beneficiaries an average of $14 dollars each time they visit an off-campus department for a clinic visit in calendar year 2020. CMS is also proposing to remove total hip arthroplasty, CPT code 27130 from the Inpatient Only list, making it eligible to be paid by Medicare in both the hospital inpatient and outpatient setting. This procedure has been a topic of discussion for removal from the Inpatient Only list for a number of years, including a comment solicitation on this topic in the 2018 OPPS ASC proposed role.

After considering that public comments from past rules, stakeholder feedback, in consultation with our clinical advisors, we believe that appropriately selected patients could have this procedure on an outpatient basis. We're seeking public comment on our proposal to remove this procedure from the Inpatient Only list. Additionally, CMS is proposing to establish a one-year exemption from medical review activities for procedures removed from the Inpatient Only list beginning in 2020. Specifically, we are proposing that QIOs reviews of short stay inpatient claims for procedures that have been removed from the list within the first year will not be counted against a provider in the context of the Two-Midnight rule.

QIOs will have the opportunity to review such claims in order to provide education to providers and practitioners regarding compliance with the Two-Midnight rule. The claims identified as noncompliant would not be denied with respect to the side of service under Medicare Part A. Furthermore, these procedures would also not be eligible for a referral to the recovery audit contractor for a one-year period after the removal from the Inpatient Only list. This proposal is not an exception from the Two-Midnight benchmark, which states that generally services are considered appropriate for inpatient hospital admission and payment under Medicare Part A when the physician expects the patient to require stay that across at least Two-Midnights and admits the patient to the hospital based upon that exception.

CMS believes that a one-year postponement of QIO referral to recovery audit contractors and recovery audit contractor patient status reviews for procedures performed in the inpatient setting, is an adequate amount of time to allow providers to gain experience with application of the Two-Midnight rule for these procedures. The ASC Covered Procedures List is a list of covered surgical procedures that are eligible for payment under Medicare when furnished in Ambulatory Surgical Center. Covered surgical procedures aref those procedures that are in part would not be expected to pose a significant risk to beneficiary safety, and for which the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.

For calendar year 2020, CMS is proposing to add Total Knee Arthroplasty, knee mosaicplasty, and three additional coronary intervention procedures, to the ASC Covered Procedures List. We previously solicited comment on adding Total Knee Arthroplasty to the ASC Covered Procedures List in the 2018 OPPS ASC proposed rule. We note in this proposed rule that we agree with prior commenters that there's a subset of Medicare beneficiaries that may be suitable candidates to receive TKA procedure in the ASC setting, and that we believe physicians should continue to play an important role in exercising their clinical judgment when making side-of-service determinations.

We also know that we believe that appropriate limitations - appropriate limits are necessary to ensure that payment will only be made for TKA procedures performed in the ASC setting when that setting is clinically appropriate. CMS is soliciting comment on our proposal to add TKA to the Covered Procedures List, and

soliciting comment on whether there should be any additional limitations on the provision of Total Knee Arthroplasty or any other procedure in the ASC setting.

Additionally, CMS is soliciting comment on how the agency could redesign the role of the ASC Covered Procedures List to improve physician's ability to determine the setting of care as appropriate for a given beneficiary situation. Finally, in the 2019 OPPS ASC final rule, we finalized our proposal to apply the hospital market basket update to ASC payment rates for interim period of 5 years. CMS is not proposing any changes to this policy to use the hospital market basket update for ASC payment rates for calendar year 2020.

Using the hospital market basket, CMS proposes to update the ASC rates for calendar year 2020 by 2.7%, which is based on the projected hospital market basket increase of 3.2% minus 0.5 percentage point adjustment for multi-factor productivity. This change will also help to promote Site Neutrality between hospitals and ASCs by providing these two settings with the same rate update. Now I'll turn it back to Leah.

Question & Answer Session

Leah Nguyen: Thank you David. Before we get started on the feedback session, I would like to set a few ground rules. An effort to get to as many participants as possible today, we'll spend a maximum of three minutes on each question and answer. We are looking to take clarifying questions to help you submit your formal comments on the rule. Today's call is not the forum for specific questions about your medical practice or place of business. There may be questions today that we cannot answer because CMS must protect the rulemaking process and comply with the Administrative Procedure Act. We appreciate your understanding.

It's also important to note that verbal comments on today's call do not take the place of submitting formal comments on the rule, as outlined on side 4 of today's presentation. As a reminder today's session is being recorded and transcribed. We will now take your clarifying questions. All right Dorothy, we're ready for our first caller.

Operator: To provide feedback press star followed by the number one on your touch tone phone, to remove yourself from the queue press the pound key. Remember to pick up your handset to assure clarity. Once your line is open state your name and organization. Please note your line will remain open during the time you are providing your feedback, so anything you say, or any background noise, will be heard in the conference. Please hold while we compile the roster. Please hold while we compile the roster.

Our first feedback comes from the line of Ronald Hirsch.

Dr. Ronald Hirsch: Good afternoon, Administrator Verma stressed the importance of reducing beneficiary out-of-pocket costs, yet a proposal to allow Total Knee Arthroplasty and cardiac procedures in surgery centers will result to Medicare beneficiaries having significantly higher out of pocket costs to the tune of hundreds of dollars. Since there's no limit on the coinsurance in ASCs as there is with outpatient hospital services, and the ASCs are not required to notify the patient at all, but it's going to cost the more to have it done there. Does CMS have any plans to required ASC to notify the patients of this financial obligation?

David Rice: Hi Dr. Hirsch, this is David Rice. It sounds like your comment on the co-payment for the TKA procedure in the ASC, or something you perhaps might want to add as a comment to the comments for the final rule.

Dr. Ronald Hirsch: Okay.

Leah Nguyen: Thank you.

Dr. David Rice: Thank you.

Operator: Your next feedback comes from the line of Larry Field.

Larry Field: Hey, good afternoon. Have some concern about the price transparency. I realize it's an Executive Order, letting everybody know what charges are perhaps can lead to price fixing, and in addition we all know sometimes the charges don't add up to what is the acceptable amount or allowed amount, how are you going to deal with that?

Dr. Terri Postma: Hey thank you for your comments, this is Terri. We, in the preamble to the proposed rule, we walk through in our impact statement. We walk through a number of studies that have indicated that when pricing is made public and people are given the opportunity to shop that prices for some shoppable services have shown to decrease, but we also recognize and have gotten input from folks who have the same concerns that you do, and we talk a little bit about that in the proposed rule. I would encourage you to submit your comments and any research or data or background that you have that would help us out with the final.

Leah Nguyen: Thank you.

Larry Field: Well, following that up, I mean particularly if you're talking about Medicare pricing, I mean the hospitals don't determine pretty much what they're going to get paid, that's coming from you guys since it’s an APC the price’s fixed, if it's DRG based obviously there's multiples of whatever base rate is, etcetera. Do you feel that you know having charge data out there would confuse the patients, given that charge data really doesn't have any bearing on what the price actually that they're going to pay is?

Dr. Terri Postma: You're right that Medicare sets rates and Medicare makes those rates public; what we're proposing is that third payer party rate would similarly become public so that patients can use that information to determine what their out of pocket cost maybe if they go to one hospital setting versus another. Appreciate your comments.

Leah Nguyen: Thank you.

Operator: Your next feedback comes from the line of Tim Wolters.

Tim Wolters: Yes, thank you very much. As far as the price transparency requirements for the gross charges, I understand generally what you're talking about as far as the description and any codes in the gross charge. For the negotiated rate, are you anticipating that we will - that you want us to essentially add, you know, dozens of columns out to list out every single contract we have, so we show, you know, Anthem versus Aetna

versus Coventry etcetera, etcetera, etcetera, just list them all out and show every single rate for every single line item?

Dr. Terri Postma: Yes, we did an analysis that looked at some data in the society as data, to get a sense of how many contracts there may be in different service areas, and it can amount to a lot of different contracts, not all of them of course will have different negotiator rate, but they may, and so, yes, the concept would be that in this machine-readable file that's posted online there would be a list of the hospitals items and services that the hospital provides, as well as a list of the gross charges for each of those items and services and then a list of each payer-specific negotiated rates for each item and service.

Tim Wolters: What about - we have a number of players where the contract actually prohibits us from disclosing the rates. How are we to handle that in terms of violating the contracts because of a government requirement, and what is the assumption, that we grant to essentially modifier all our contracts, or what is the proposed solution to that?

Dr. Terri Postma: And that's a legal question that I'm not equipped to answer today, but if you would submit that comment that would be great.

Leah Nguyen: Thank you.

Operator: Your next feedback comes from the line of Shane Schilling.

Shane Schilling: Yes, good morning, here in California the State owns and operates developmental centers, which are licensed and certified to keep your hospitals with distinct parts, long term as SNF and ICF serving only intellectually disabled individuals. These are closed facilities with admission only to our regional centers statewide system or through the court. The question is, is this type of State-owned facility going to be exempt, and then if not will the services be provided in the long term stepping ICF or those exempt from notice? And then lastly, if the facility is providing services in a setting only for forensics or committed individuals is that exempt?

Dr. Terri Postma: Thanks for your question. As proposed, each hospital operating in the United States would be required to make these charges public, and we're, as discussed earlier, proposing to define a hospital as one that's licensed by the State as a hospital. We recognize though that there may be hospitals that are already making their charges public and such as or have closed populations like VA hospitals and Indian Health Service hospitals; we have requested comment on whether there are other hospitals that should be deemed to be meeting requirements already by making their charges public.

Leah Nguyen: Thank you.

Shane Schilling: Okay are you are you suggesting that we shouldn't submit something to include our hospitals?

Dr. Terri Postma: Yes, if there are hospitals do you believe that should be added to that list of hospitals that are deemed to already meet requirements for making public their standard charges, we would appreciate that.

Shane Schilling: Okay, and if I may, one more question, negotiated rates that include our medical contracts and do items include drugs?

Dr. Terri Postma: Okay, so that, I hear two questions, one is, what negotiated rates should be and what payer-specific negotiated rate should be included and the answer to that is found in the definition of payer-specific negotiated rate. Essentially, if the rate has been negotiated with a third-party payer then it should be included. The second question I'm hearing is what is the scope of hospital items and services, does that include drugs, and it may, if that is something that is provided by the hospital that falls within our proposed definition of hospital items and services, then you would include it on your list of hospital-provided items and services.

Shane Schilling: Thanks for your time.

Leah Nguyen: Thank you.

Operator: Your next feedback comes from the line of Avery Scott.

Avery Scott: Hey good afternoon. Thanks for taking my question. My question is around the definition of the word customary, so I noticed you said for the list of 70 shoppable services you want to also include customary services or customary charges that go with those; have you put any thought into a numeric definition of what customary would be?

Dr. Terri Postma: No, I don't believe we addressed that, if that is something we should address we'd appreciate that comment.

Leah Nguyen: Thank you.

Avery Scott: Yes, I'm thinking of it's like, the median dollar charges that go with those services or something like if more than 50% of the services include X, Y, and Z. I think would be useful to have a common definition across hospitals for that.

Dr. Terri Postma: Yes, we recognize that not all hospitals provide the same ancillary services. Each hospital may have different items and services that are provided customarily with the primary shoppable service, and so we'd appreciate any thoughts or comments or specific things that we should be considering when we're talking about how the hospital should make the charges for their primary service, and any ancillary services you know make that available in a way that's consumer-friendly.

Leah Nguyen: Thank you.

Avery Scott: Okay great, and then the other thing is I noticed there was some reference to specific MS-DRGs within the list of shoppable services if a given hospital impaired don't use MS-DRGs they use a different DRG system, would you consider them exempt from that specific item within the list of 70.

Dr. Terri Postma: So remember, with the list of at least 300 shoppable services, what we're talking about is the hospital, or what we proposed is that the hospital make public their payer-specific negotiated rate for that shoppable service, along with the payer's specific negotiated rate for any ancillary services at the hospital

customarily provides along with that primary shoppable service. So, you know MS-DRG's are specific to Medicare, Fee-For-Service, Medicare Fee-For-Service, typically it would not be included in the definition of payer-specific negotiated rate because Medicare does not negotiate rates.

So DRGs for the shoppable services would be related to any payer-specific negotiated charges that the hospital has that are actually negotiated charges with third-party payers.

Leah Nguyen: Thank you, we'll take our next question.

Operator: Our next question - our next feedback comes from the line of Darryl Drevna.

Darryl Drevna: Hi, this is Darryl Drevna at AMGA, just looking to clarify the difference between the two ways that you're requiring the hospitals to publicize these charges, the machine-readable format and it's shoppable chart; is the shoppable just a subset, that's more consumer-friendly, of all the other charges that you have to post, is that correct interpretation?

Dr. Terri Postma: Yes, that's right, it's packaged in a little bit more consumer-friendly way, and whereas the single file machine-readable that is posted online of all items and services, and all gross and payer-specific negotiated rate in the proposed rule in the preamble. We talk about that probably be most useful for third-party payer – third-party price transparency tool developers and the like, whereas that second file, or the second set of information is really derived from that, but just packaged in a more consumer-friendly way.

Leah Nguyen: Thank you.

Darryl Drevna: Great, and well there's a line about without barriers, did you define barriers at all in the regulation?

Dr. Terri Postma: Yes, sorry, I'm looking it off-hand up for a minute, we did talk about that, if you look in the preamble - sorry I don't have the page off-hand, but we did talk about what we mean by…

[Cross Talk]

Dr. Terri Postma:… it's there.

Darryl Drevna: Great, I can find it in there, I appreciate it. Thank you.

Leah Nguyen: You're welcome, thank you.

Dr. Terri Postma: Oh I'm sorry, I found it, sorry, I just found it, what we proposed is that the hospital must ensure the standard charge data is easily accessible without barriers, including but not limited to ensuring the data is accessible free of charge without having to establish a user account or password, and without having to submit personal identifying information.

Leah Nguyen: Great, thank you.

Operator: Your next feedback comes from the line of Rachel Shirer.

Rachel Shirer: Yes, most of my questions have already been answered, it was in regard to the transparency, but I was wanting to confirm that you'll are expecting this to go into action for 2020.

Dr. Terri Postma: Yes, as the Administrator noted, these proposed rules, if finalized, would become active as of January 1st, 2020.

Leah Nguyen: Thank you.

Rachel Shirer: Thank you so much.

Operator: Your next feedback comes from the line of Simita Vaughn.

Simita Vaughn: Hi. When will we know if the proposed rule is finalized and this information will be required by January 1, and then also where do I find the list of the shoppable services?

Dr. Terri Postma: So, if you follow the Federal Register, the final rule needs to be finalized, I think, by November 1st. So, you know, the process is that we're collecting all your public comments, your formal comments, and they're due by September 27th. We take all those comments, review them all, and then that helps us create our final policies, which are then published in the Federal Register, and the final rule, which statutorily cannot be later than November 1st. So, you should look for it in the Federal Register around that date.

And your second question about where to find the shoppable services, so currently as proposed the shoppable services, we've proposed that CMS select 70 of them and then the hospital select, hospital-specific 230 additional services for at least 300 services. The 70 CMS selected services are proposed in the preamble of this proposed rule. So if you look in the Federal Register you can see what 70 services CMS proposed, and the others 230 would be 230 that the hospital would select based on, you know, they are commonly provided shoppable services, and then if finalized as proposed the hospital would make that set of 300 services, at least 300 services, public on online on an appropriate publicly available website.

Simita Vaughn: Okay, thank you.

Leah Nguyen: Thank you.

Operator: Your next feedback comes from the line of Karen Robinson.

Karen Robinson: Yes, regarding the Site Neutrality is the payment reductions still only applicable to the G0463, and not other procedures performed in the off-campus provider-based department?

David Rice: Yes, this is David Rice, yes, that's correct, that provision that was implemented in last year's rule and with a two-year phase and that we're finalizing this year only applies to the G0463 code.

Karen Robinson: Okay, thank you.

Leah Nguyen: Thank you.

Operator: Your next feedback comes from the line of Sandy Sage.

Sandy Sage: Hi, I understand that you're seeking to reduce the burden on hospitals, however most of the hospitals do not have their commercial contracts necessarily loaded into their electronic systems since they are so complex and there are multiple contracts, even finding contract management software is difficult because of that reason, so you estimate the burden on hospitals to be slightly over a thousand dollars. I think that's really low. If they use a company for price transparency tool that can run into the tens of thousands of dollars. So, attempting to conform to all the payer-specific pricing guidelines that you're wanting us to put out there. It's going to be extreme burden on hospitals much greater than a thousand dollars, so is there going to be any assistance or exceptions for small hospitals?

Dr. Terri Postma: Thank you for that comment and I would encourage you to submit that for our consideration as well as any research background or analysis that you know of or has been done that would support what you consider to be a more reasonable estimate of burden.

Leah Nguyen: Thank you.

Sandy Sage: Okay and if they don't if they don't even do 300 schedule services is there an exception to that as well, some of the very, very small rural hospitals, don't do 300 services that can be scheduled in advance, what do we do in that case?

Dr. Terri Postma: We seek comment on that issue, so if there are situations that we should be aware of or if we should be considering in the final a number that's lower than 300, we encourage you to submit that comment too.

Sandy Sage: Okay, thank you so much.

Leah Nguyen: Thank you.

Operator: Your next feedback comes from the line of Julie Hall.

Julie Hall: Hello, I'm wondering with regards to the pricing transparency, why the ASC services surgical locations or provider types were not required to post their charges, is there a reason behind that?

Dr. Terri Postma: Yes, thanks for your question. As I mentioned, we are, the statutory authority that we're using is under the Public Health Service Act section 2718(E) and that language refers simply to hospitals and not to ASCs or any other entities. So, you know we propose a definition of hospital; if you think the definition of a hospital should be modified in the final and can legally support expanding that definition to something other than hospitals, and that comment would be great.

Leah Nguyen: Thank you.

Julie Hall: Okay, thank you.

Operator: Your next feedback comes from the line of Melea Rimaco.

Melea Rimaco: Hi, I was wondering if you could clarify on the price transparency the items, so as you know, especially in larger city hospitals, there are a lot of medical equipment, DMEs, are you are suggesting that every single item be listed and the price.

Dr. Terri Postma: Yes, thanks for the question. So, we know that as a result of the January 1st, 2019 guidance that required hospitals to make public their chargemasters online, that hospital items and services is listed in the chargemaster can exceed sometimes 50,000 different line items. We've proposed a definition in this proposed rule of items and services to include all items and services, individual items and services that are found in the chargemaster, as well as any service packages that are provided by the hospital to a patient in connection with the inpatient admission or outpatient department a visit for which the hospital has established a charge. So essentially, if the hospital provides that item or service and has established a charge for it, then as proposed the hospital would make that public along with those charges online.

Leah Nguyen: Thank you.

Melea Rimaco: So then my follow up question to that would then be, you know, certain items have a better quality that help us prevent, for example, health care associated infections, how are we going to ensure that we still have access to perhaps an item that's a little more expensive, but has a better efficacy and outcome for the patient?

Dr. Terri Postma: So, as proposed this is simply a process of making the prices transparent, it's not limiting services that the hospital can provide or that a patient may get, it's just simply listing what the price is for that item or service. If you want, by the way, examples of how hospitals are currently making public chargemasters, you know you can look in online and find that as a result of the January 1st, 2019 guidance, then that might help you see what's already out there.

Leah Nguyen: Thank you.

Melea Rimaco: But if it’s.

Operator: Your next feedback comes from the line of Jory Hatton.

Jory Hatton: Hi everyone, thank you. By utilizing the science space DRG system price estimates achieved much greater accuracy and detail due to their intrinsic reliance on patient condition, which allows for pricing to be established before, during, or after hospitalization. What is the best way to make it clear to hospitals they must utilize the DRG system when they are posting their prices?

Dr. Terri Postma: As proposed, our proposed definition of items and service would include individual items and services, or itemized items and services, as well service packages. For example, DRGs would be a service package. Does that answer your question?

Jory Hatton: Okay, thank you.

Leah Nguyen: Thank you.

Operator: Your next feedback comes from the line of Andrew Leibfried.

Andrew Leibfried: Hi, good afternoon, my question is related to the price transparency portion of the proposed rule, kind of a two part. Did CMS purposefully excluded terms estimate or estimated when defining payer-specific negotiated charges, and does CMS use the terms charge and rate interchangeably in the proposed rule? I noticed that Administrative Verma in her introduction used the term payer-specific rights when describing price transparency, we are just looking for a little clarification.

Dr. Terri Postma: Sure, I'm going to take the second one first, if you look in at the very last few pages of the proposed rule, that's what's called the regulations text, kind of the reader's digest condensed version of the preamble that goes into more detail, but you'll see a list of proposed definitions there, one of which is a proposed definition for standard charges which tracks back to the law, to the statute, and you'll also see proposed definition for gross charges and payer-specific negotiated charges. So those are the three charges that where the two with specific charges, the gross charges and the payer-specific negotiated charges that we're talking about and proposing that hospitals make public. Often times, people will use the term charge and rate interchangeably, but for purposes of this proposed rule, we're making very specific proposals for definitions for payer-specific negotiated charge and standard charge, and please repeat your question for - about the estimate.

Andrew Leibfried: Sure, my question was what the terms estimate or estimated purposely excluded when defining payer-specific negotiated charges. I noticed that many States will insert the term estimate or estimated as a qualifier for these types of requirements and we just wanting some insight into that.

Dr. Terri Postma: Yes, thanks for that comment. If you think that that's the distinction that should be made, we would appreciate you submitting a comment on that and the reason, you know, give some reason why you think that's a necessary qualifier that would be helpful.

Leah Nguyen: Thank you.

Andrew Leibfried: Thank you so much.

Operator: Your next feedback comes from the line of Eena Vender.

Eena Vender: Hello, regarding the price transparency, I just wanted to get some clarification whether CMS took into consideration that will provide some clarification about rate, many payers may have a published rate for a particular service but the actual payment of that service varies — can vary from patient to patient depending on whether the services was packaged with other services, whether the service was provided in emergency room versus operating well versus clinic.

So they're going to be any clarifications what exactly the hospital should be publishing in those kinds of circumstances, that's kind of part one, and the second question I had is the payments were actual services, for

example, for drug a driven off how many units of a drug were actually provided to the patient. So, we expected to publish the base rate for the billable unit of the drug, but the actual payments would charge for the drug could vary significantly from patient to patient?

Dr. Terri Postma: Yes, thanks for that question. So, I think the answer to both of them is that, as proposed, payer-specific negotiated rate would be the rate that the hospital has negotiated with the third-party payer prospectively so whatever that rate is. I recognize -- we recognize that when hospitals provide services and submit the bill to the insurance company the published rate may be different than the payment that the hospital ultimately received, but as proposed what we're talking about is payer-specific negotiated rate that the hospital has negotiating with the third-party payer in advance.

Leah Nguyen: Thank you.

Eena Vender: Thank you, and as a follow-up in terms of the actual rate, you know many contracts across the country have provisions about possibly percentage of charges, and it's just a number, you know, 10% charge 50 whatever that number is, so is their expectation that we need to publish that percentage or is their expectation that providers actually calculate that number, so it's not a number like a set number of you know $50 dollars, but it's just the percentage of something? I think would be helpful to get those clarifications.

Dr. Terri Postma: Yes, as proposed, and let's talk about the machine-readable file; as proposed, the hospital would list all of their items and services along with the gross rate that applies for each of those items and services along with a charge that would apply for each payer-specific that each payer by name, so if you know the hospital has negotiated 10% off each or 50% off each item services off their gross rate then that charge reflected under the payer-specific column would be paid 50% of the gross charge for example.

Leah Nguyen: Thank you. Dorothy, we will take our next question.

Operator: Our next feedback comes from the line of Wendy Cook.

Wendy Cook: Hi, yes, two questions, when you spoke about services of the employed practitioners need to be published, does that include the provider-based RHC?

Dr. Terri Postma: As proposed, hospital items and services, the definition would include things like the services employed practitioners, and so the idea is that the hospital has employed certain practitioners for purposes of providing services on behalf of the hospital. So, the hospital is, you know, is charging for the services of the employed practitioner. There's bit of a discussion of this in the preamble of the proposed rule and I'd encourage you to read through that and if any clarifications are needed it or if you have any thoughts that we should consider as we go into the final on that point please submit them.

Leah Nguyen: Thank you.

Wendy Cook: All right and one other--

Operator: Your next feedback comes from the line of Sandeep Patel.

Sandeep Patel: Hi good afternoon, thank you for your time, I have a question specific to the calendar year 2020 proposal for payment for non-opioid alternative. The proposed rule stated that there was not compelling evidence to suggest revision to the OPPS payment policy for non-opioid alternatives, stating the majority of drug and device manufactures only offered survey reports and anecdotal evidence, which lacks adequate sample size and can contain possible conflicts of interest that may not have been fully published in peer reviewed literature. My question is what level of evidence would drug or device manufactured need to provide in order to warrant a revision to the OPPS payment, for example would randomized controlled trials demonstrating safety, computer efficacy, and opioid reduction be sufficient?

David Rice: Hi, this is David Rice. I don't have the section of the rule right in front of me, but we did discuss some level of what we're looking for, including giving an example of peer-reviewed studies that would help in that manner. I'd have to kind of pull the exact section from the rule to give you kind of more detail what's in there, but if you have kind of further information along that track it would be useful to submit that as a comment for the final rule.

Leah Nguyen: Thank you.

Operator: Your next feedback comes from the line of Rosemary Holiday.

Rosemary Holiday: Good afternoon, thanks for the session. A quick question related to the 300 common services that are shoppable. From the charge standpoint from the hospitals, is CMS expecting if there are flat rates that have been listed in that shoppable services with the package services included, does CMS expect that to be the claim amount or a single line on the hospital outpatient claim, and will that be monitored or is that a number that's the ballpark that's most common?

Dr. Terri Postma: Hi this is Terri, as proposed for the 300 or at least 300 shoppable services for each service, primary service, the proposed rule would require hospitals to list their payer-specific negotiated rate-- sorry, charge, for that shoppable service, along with the payer-specific charge or payer-specific negotiated charge for each ancillary item or service that customarily provided along with that primary shoppable service. So, they would all be listed separately, and it would be again the payer-specific negotiated rate charge that hospital has negotiated in advance with a third-party payer. So, you know it's not claims based, it's what the hospital has negotiated with each third-party payer.

Rosemary Holiday: So, my question is do hospitals - is CMS expecting hospitals to come up with a flat rate for things that they currently itemized. That's a big issue related to systems and data file maintenance.

Dr. Terri Postma: If the shoppable service is an itemized service then there would be a payer-specific negotiated rate-- charge associated with that service, and then the hospital would list any additional itemized ancillary services that hospital customarily provides along with the primary shoppable service and with each of their, you know, payer-specific negotiated charges.

Leah Nguyen: Thank you.

Rosemary Holiday: Well the final question is--

Dr. Terri Postma: I'm sorry if I'm not getting it, could you submit a formal comment along with like a detailed example, that would be helpful.

Operator: Your next feedback comes from the line of Mike Klein.

Mike Klein: Hi my question is kind of been answered already, but it's more specific to the hospital reported services and we're in a hospital employed physicians institutions versus doesn't employee physicians, say for example on the 30 that CMS establishes, if one were one were CTs for example, if not employed physicians do the read, it's my understanding that we're not expected to report the contract for both physicians, but if another organization has employed radiologists perhaps there're entitled to report those as part of the fees, how do you make that clear to the consumers that this CT's with read CT's interpretation while the other organization it's not because they don't employ the radiologist.

Dr. Terri Postma: Yes, that's a good question, and we talk a little bit in the preamble if you want to read through that section, and that's part of making that information consumer-friendly. We did leave a lot of discretion for hospital you know one of the consumer-friendly ways that we proposed was that the hospital make it clear what services, what ancillary services are included with the primary shoppable service, and potentially which ones are not, so you raised a good point, and you know, regardless of what we finalize we really encourage hospitals to make that information as consumer-friendly as possible, so consumers do understand what's included and what isn't when they're getting a hospital-provided service.

Leah Nguyen: Thank you.

Mike Klein: Thank you.

Operator: Your next feedback it comes from the line of the Meg Huston.

Jill Cutler: Hi this is Jill Cutler from Florida from the hospital side and we had a follow-up question on pricing transparency. I know many of us do charge the same price regardless of payer, so if we have a lab test that we're going to do and it's $10 dollars then the price that we're using for gross is the same price that we're using for each of the negotiated payers. However, what we may be paid for that service is very different, so like if you guys use the example earlier for Medicare, we would be paid off of lab fee schedule, but for another payer we might be paid a percentage charge.

So maybe we only get paid 50% of that $10 dollars, so we only get paid $5 dollars, so as a follow-up question, I know we've been going back and forth about charge versus rate, in that scenario would the expected data that we need to publish the $10 dollars across the board or would it be $10 dollars and then $5 dollars for that payer that I gave as an example?

Dr. Terri Postma: Yes that's a great question, if they're distinction and nuances that we should take into consideration as we go into the final I'd really encourage you to submit those with specific examples, but as proposed, we are proposing that the hospitals make public their payer-specific negotiated rate for each of their item– sorry charges, payer-specific negotiated charges for each of their items and services, and we're proposing a definition of payer-specific negotiated charge to mean the charge that a hospital has negotiated with a third-party payer for an item or service.

Meg Huston: The reimbursement has been negotiated.

Dr. Terri Postma: As proposed, it means the charge that hospital has negotiated with a third-party payer for an item or service. If we need to clarify that further in the final, again, I just really encourage you to submit comments with detailed example so that we can consider it.

Leah Nguyen: Thank you.

Meg Huston: And we can absolutely do that thank you.

Operator: Your next feedback it comes from a line of Linda Phillips.

Linda Phillips: Good afternoon, I was wondering if you could tell me what the 3 coronary procedures that may be added to the ASC approved list of procedures are.

David Rice: Sure, so the 3 procedures are code 92920, code 92928, and C9600.

Linda Phillips: Okay thank you very much.

David Rice: Sure.

Leah Nguyen: Thank you.

Operator: Your next feedback comes from the line of Lee Schutz.

Lee Schutz: Hi, I have a question for you as far as and when I was reading the list of the shoppable services I didn't see that you required the third-party payers, so you want that kind of blown out into 40 / 50 columns as well or is it just seeing the visual line items.

Dr. Terri Postma: Yes, it's a good question. We, as proposed, proposed some flexibility in the format that the hospital uses to make those payer-specific negotiated charges for each of their 300 shoppable services. We gave hospital flexibility to determine an appropriate consumer-friendly format for doing that. So, for that set of 300 shoppable services unlike all services, you know, all charges machine-readable file unlike that one that as proposed would be in a single file. The 300 shoppable services, we did not make a proposal that the hospital would have to have all that information in one file recognizing that likely would turn out not to be very consumer-friendly. So, as proposed, the hospitals would have discretion on the format that they use to make payer-specific negotiated charges for those 300 shoppable services the format that they would use to make it really consumer-friendly.

Lee Schutz: Okay, and then the other thing is, you know when you itemize, I mean we have thousands of supplies right, but you want to see all thousands of supplies, no payer pays for those. So that's all going to be zeros you know it's going to be our charge and a bunch of zeros, so, and then the drugs, I think someone else also commented to, you know drugs are depending on how much is given, you know, and so the drug prices are kind of meaningless if I can use the word, you know, when you tell him just a price, because it's based on,

you know ,HCPCS base quantity. So, I'm not sure how much – how much, I'm not sure how much information this whole list of thousands and thousands, nobody is going to scroll through all of that.

I can see where the actual shoppable services means something to, you know, I'm a consumer of health care as well. And I think shoppable services make more sense to me than, you know, every everything you gotten thrown out in a big pile. I'm not even going to go through that I'm going to look at something I can understand and search. But you want, you want everything out there right whether it's zero or a number?

Dr. Terri Postma: Yes, so as proposed, the first list would be all items and services, and all the standard charges for all those items and services, and that would be machine-readable file, and as discussed in the preamble we believe that that information is probably going to be most useful to, for example, third-party price transparency tool developers that's taking that information from a lot of different hospitals and creating it into a very consumer-friendly format in their price transparency tools.

Whereas, you noted the second set of at least 300 shoppable services, as proposed, the rationale behind that was because that laundry list of all items and services and all charges is probably not as useful to consumers. So that was kind of the rationale behind creating those two different things, and also, we believe that the statute requires hospitals to make public their items and services and standard charges for them and we interpreted that to mean all items and services and all standard charges.

Leah Nguyen: Thank you. Dorothy, we will take our next question.

Operator: Your next feedback comes from the line of Christie Knudsen.

Christie Knudsen: Hi, I work at a critical access hospital in Iowa and none of our contracts talk about a different charge, they all popped in terms of discounts. So, when you tell me that you want me to reveal the on my shoppable charges the true charges, I would tell you that they're all the same even though they are not necessarily related to what I'm getting paid.

Dr. Terri Postma: Yes, as proposed there would be the payer-specific negotiated charge.

Christie Knudsen: Okay my other comment is at a critical access hospital we could not have any of the contracts or that automated, so it will be a very time consuming process for us to build the shoppable, I don't know, chart or whatever you want to call it, and the $1000 dollars is not going to come close to touching what it'll cost us to do this.

Dr. Terri Postma: Thank you. As I mentioned to someone else that raised the same point, it would be great if you would submit that comment, and also, if you have any research or data to support what you believe to be more accurate estimate of burden.

Leah Nguyen: Thank you.

Christie Knudsen: Okay, thank you very much.

Operator: Your next feedback comes from the line of Caroline Znaniec.

Caroline Znaniec: Hi, good afternoon, I have a question on the pricing transparency components, when it comes down to the description of what come across the standard charge, is that our actual description that's coming across on our claims in our chargemaster, or I know there's been speak about a patient-friendly description and trying to make it more useful to the consumer?

Dr. Terri Postma: Yes, thanks for the question. So as I mentioned, we are proposing to require that hospitals make their standard charges public in two different ways, one in the machine-readable file posted online that would contain all the hospital charge standard charge information for all the items and services, and then, two, in this consumer-friendly format, just laying and packaging the payer-specific negotiated charges for a limited set of shoppable services.

For each of those ways that the hospital - we proposed a hospital we were required to make public their standard charges, for the machine-readable file we proposed that the hospital post a description of each item or service, often these descriptions are already found in the charge master and that's basically all we proposed was that just a description of each item or service to be provided. And then for the shoppable services we proposed that the hospital associate that the items and services with like more consumer-friendly description. So, I hope that helps.

Leah Nguyen: Thank you. Dorothy, we have time for one final question.

Operator: Your final feedback comes from the line of Ivy Bear.

Ivy Bear: Hi thank you. I just wanted some clarification related to the posting of a shoppable services and the ancillaries, how are the consumer supposed to use this? So, they supposed to add them together to understand the cost?

Dr. Terri Postma: Yes, thanks for the question. So the statute requires the hospital make public its list of items and services, and so we've interpreted that to mean that each item or service, so for example, with the shoppable services where there's a primary and then associated ancillary services, that each of those would have a payer-specific negotiated charge that would be listed.

Ivy Bear: Okay, so you would have to add them together somehow to get a sense of the cost as a consumer?

Dr. Terri Postma: So again, proposed, we're leaving a lot of discretion or proposing a lot of flexibility for the hospital to make this information consumer-friendly. So there's nothing that would prohibit the hospital from displaying it such that it would add them all up or something like that, but these are the basic data elements we believe need to be in place for the consumer to get a better sense of, you know, what the hospital would be providing.

Ivy Bear: Okay, thank you.

Additional Information

Leah Nguyen: Great, thank you. Unfortunately, that's all the time we have for questions today. An audio recording and transcript will be available in about two weeks at go.cms.gov/npc. Again, my name is Leah Nguyen. I would

like to thank our presenters and also thank you for participating in today's Medicare Learning Network Listening Session on the OPPS and ASC Proposed Rule. Have a great day everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect; presenters, please hold.