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 6, 2024.

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Hospital Price Transparency Frequently Asked Questions (FAQs)

General Provisions

What is the legal basis for the Hospital Price Transparency requirements?

Section 1001 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by Section 10101 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), amended Title XXVII of the Public Health Service Act (the PHS Act), in part, by adding a new section 2718(e). Section 2718 of the PHS Act, titled "Bringing Down the Cost of Health Care Coverage," requires each hospital operating within the United States (U.S.) for each year to establish and update and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups (DRGs) established under section 1886(d)(4) of the Social Security Act (the Act). Section 2718(b)(3) of the PHS Act requires the Secretary of the Department of Health and Human Services (Secretary) to promulgate regulations to enforce the provisions of section 2718 of the PHS Act, and, in so doing, the Secretary may provide for appropriate penalties. Please refer the discussion starting at 84 FR 65525.

How does the Secretary require hospitals to make public their standard charges? What is the intent of this disclosure?

Hospitals are required to make public their standard charges in two ways: (1) as a comprehensive machine-readable file (MRF); and (2) in a consumer-friendly format. We codified these requirements at 45 CFR part 180. We believe these two different methods of making hospital standard charges public are necessary to ensure that such data are available to consumers of healthcare where and when they are needed, including through data aggregation methods (for example, via integration into price transparency tools, electronic health records (EHRs), and consumer apps), and direct availability to healthcare consumers searching for hospital-specific charge information. Additionally, data can be used specifically by employers, researchers, and policy officials, and other members of the public to drive competition and help bring more value to healthcare. Please refer to the discussion starting at 84 FR 65527.

Updated- What changes did CMS make to the Hospital Price Transparency (HPT) requirements in the CY 2024 OPPS/ASC Final Rule?

In the CY2024 OPPS/ASC final rule with comment period, we finalized proposals to revise several HPT requirements to advance the agency's commitment to increasing price transparency and enforcing compliance. These policies strengthen and streamline our monitoring and enforcement capabilities; improve access to, and the usability of, hospital standard charge information; standardize the way hospital's standard charges are presented; reducing the compliance burden on hospitals by providing technical guidance for display of hospital standard charge information; align, where feasible, certain HPT requirements and processes with requirements and processes we have implemented in the Transparency in

Coverage initiative; and make other modifications to our monitoring and enforcement capabilities that will, among other things, increase the transparency to the public. Please refer to 88 FR 81545. Details can be found in the CY 2024 OPPS/ASC HPT Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/hospital-price-transparency-fact-sheet

Updated- Did CMS make any changes to the shoppable services display requirements in the CY 2024 OPPS/ASC Final Rule?

No. CMS did not make any changes to the shoppable services display requirements in the CY 2024 OPPS/ASC Final Rule.

Updated- What is the implementation timeline for the new Hospital Price Transparency requirements in the CY 2024 OPPS/ASC Final Rule?

CMS established a phased implementation timeline with respect to the hospital price transparency requirements finalized in the CY 2024 OPPS/ASC Final Rule. The effective date for hospitals to comply with all the changes to the hospital price transparency regulations at 45 CFR Part 180 is January 1, 2024. However, we specified a phased approach by which hospitals must be in compliance with these new requirements. Please refer to the discussion at 88 FR 82109-82111. Implementation dates for each requirement are detailed in the tables below:

Implementation Timeline for CMS Template Adoption and Encoding Data Elements

Requirement	Regulation cite	Implementation (Compliance) Date
MACHINE-READBLE FILE INFORMATION		
Machine-Readable File Date	45 CFR § 180.50 (b)(2)(i)(B)	July 1, 2024
CMS Template Version	45 CFR § 180.50 (b)(2)(i)(B)	July 1, 2024
HOSPITAL INFORMATION		
Hospital Name	45 CFR § 180.50 (b)(2)(i)(A)	July 1, 2024
Hospital Location(s)	45 CFR § 180.50 (b)(2)(i)(A)	July 1, 2024
Hospital Address(es)	45 CFR § 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Licensure Information	45 CFR § 180.50 (b)(2)(i)(A)	July 1, 2024
STANDARD CHARGES		
Gross Charge	45 CFR § 180.50 (b)(2)(ii)	July 1, 2024
Discounted Cash	45 CFR § 180.50 (b)(2)(ii)	July 1, 2024
Payer Name	45 CFR § 180.50 (b)(2)(ii)(A)	July 1, 2024
Plan Name	45 CFR § 180.50 (b)(2)(ii)(A)	July 1, 2024
Standard Charge Method	45 CFR § 180.50 (b)(2)(ii)(B)	July 1, 2024
Payer-Specific Negotiated Charge –Dollar Amount	45 CFR § 180.50 (b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge –Percentage	45 CFR § 180.50 (b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge –Algorithm	45 CFR § 180.50 (b)(2)(ii)(C)	July 1, 2024
Estimated Allowed Amount	45 CFR § 180.50 (b)(2)(ii)(C)	January 1, 2025

De-identified Minimum Negotiated Charge	45 CFR § 180.50(b)(2)(ii)	July 1, 2024
De-identified Maximum Negotiated Charge	45 CFR § 180.50(b)(2)(ii)	July 1, 2024
ITEM & SERVICE INFORMATION		
General Description	45 CFR § 180.50 (b)(2)(iii)(A)	July 1, 2024
Setting	45 CFR § 180.50 (b)(2)(iii)(B)	July 1, 2024
Drug Unit of Measurement	45 CFR § 180.50 (b)(2)(iii)(C)	January 1, 2025
Drug Type of Measurement	45 CFR § 180.50 (b)(2)(iii)(C)	January 1, 2025
CODING INFORMATION		
Billing/Accounting Code	45 CFR § 180.50 (b)(2)(iv)(A)	July 1, 2024
Code Type	45 CFR § 180.50 (b)(2)(iv)(B)	July 1, 2024
Modifiers	45 CFR § 180.50 (b)(2)(iv)(C)	January 1, 2025

Implementation Timeline for Other New Hospital Price Transparency Requirements

Requirement	Regulation cite	Implementation (Compliance) Date
Good faith effort	45 CFR § 180.50 (a)(3)(i)	January 1, 2024
Affirmation in the machine-readable file	45 CFR § 180.50 (a)(3)(ii)	July 1, 2024
Txt file	45 CFR § 180.50 (d)(6)(i)	January 1, 2024
Footer link	45 CFR § 180.50 (d)(6)(ii)	January 1, 2024

Updated - How does the hospital price transparency initiative support consumers of healthcare services?

We believe the policies requiring public release of hospital standard charge information are a necessary and important first step in ensuring transparency in prices of healthcare services for consumers, however, we recognize that the release of hospital standard charge information is not itself sufficient to achieve our ultimate price transparency goals. The regulations are designed to begin to address some of the barriers that limit price transparency, with a goal of increasing competition among healthcare providers to bring down costs. Competition in the healthcare industry benefits consumers because it helps contain costs, improve quality, expand choice, and encourage innovation. Please refer to the discussion at 88 FR 82080 for more information.

Updated- Where can I find information about other federal price transparency initiatives?

The hospital price transparency regulations are one tool to address barriers that limit price transparency. In addition to the hospital price transparency regulations, CMS is also providing consumers with the tools to access pricing information through their health insurance plans through the Transparency in Coverage Final Rules (TiC Final Rules). Under the TiC Final Rules, plans and issuers must make price comparison information available through an internet-based self-service tool and in paper form, upon request. Under the TiC Final Rules, plans and issuers

must also post pricing information for covered items and services. This pricing information can be used by third parties, such as researchers and app developers to help consumers better understand the costs associated with their health care. More information about the Transparency in Coverage Final Rules can be found at https://www.cms.gov/priorities/key-initiatives/healthplan-price-transparency.

In addition, the No Surprises Act (NSA) includes additional requirements that relate to price transparency and protect uninsured and self-pay individuals from unexpectedly large medical bills. The NSA requires providers and facilities, upon an individual's scheduling of items or services, or upon request, to provide a good faith estimate of the expected charges for furnishing the scheduled item or service and any items or services reasonably expected to be provided in conjunction with those items and services. Should that estimate be off by more than $400, patients may be able to dispute the charge through the patient-provider dispute resolution process. Once implemented, upon receiving a good faith estimate plans and issuers will be required to send an Advanced Explanation of Benefits to the participant, beneficiary, or enrollee.

To help consumers understand their rights and protections under the NSA, CMS updated information and resources on CMS.gov. These updates give consumers who receive unexpected or high medical bills information on the protections they have and may not be aware of. New sections help consumers identify what actions are appropriate to their billing situation and provide tools for them to take next steps. The consumer content can be found at https://www.cms.gov/medical-bill-rights.

Updated- Does the Hospital Price Transparency regulation require hospitals to tell me the cost of services prior to receiving care?

The Hospital Price Transparency regulation requires hospitals to make standard charge information available to the public online in two ways: a machine-readable file and a consumer-friendly list for a limited set of shoppable services. Although critical for determining an individual's out-of-pocket obligation, hospital standard charges do not represent either an individual's out-of-pocket obligation or a "guaranteed price." However, we note that individualized estimates in dollars may be obtained directly, in many circumstances, from providers and payers through other Federal price transparency efforts such as those implementing the No Surprises Act and Transparency in Coverage requirements. As such, we strongly encourage individual consumers to utilize hospital and payer price estimator and comparison tools, and to request 'good faith estimates' from hospitals and providers to provide up-front pricing that can be used to dispute final charges that are substantially in excess of the up-front amounts. Please refer to the discussion at 88 FR 82081.

Updated- I received a hospital bill that doesn't match the hospital's standard charges posted online or what the hospital billing department told me. Can the CMS Hospital Price Transparency program help me?

Hospital standard charges do not represent either an individual's out-of-pocket obligation or a guaranteed price, as they do not factor individual circumstances for each patient. As such, we strongly encourage individual consumers to utilize hospital and payer price estimator and comparison tools, and to request 'good faith estimates' from hospitals and providers which may provide up-front pricing that can be used to dispute final charges. Please refer to the discussion at 88 FR 82081. Learn more about the protections that apply to you or find an action plan for your medical bill at https://www.cms.gov/medical-bill-rights.

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 a 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 responsible for the cost of their care in such hospitals. Please refer to the discussion at 86 FR 63950.

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 standard charge information may not be applicable to your hospital. For example, under the Hospital Price Transparency Final 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.

Hospital Price Transparency Frequently Asked Questions (FAQs)

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

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. Please refer to the discussion at 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 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 the discussion at 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

Updated- Where can I look to find a hospital's standard charges? Can CMS provide me with the standard charges for a particular hospital?

Effective January 1, 2024, hospitals must ensure the public website that hosts the machine-readable file includes a link in the footer on its website, including but not limited to the homepage, that is labeled "Price Transparency" and links directly to the publicly available web page that hosts the link to the machine-readable file. Please refer to the discussion at 88 FR 82111. Hospitals' consumer-friendly displays may be located on the same web page that hosts the machine-readable file.

We did not propose, nor did we finalize, any requirement for hospitals to submit or upload a link to their standard charge information to a CMS-specified centralized website. At this time, we believe such an effort could be unnecessarily duplicative of ongoing State and private sector efforts to centralize hospital pricing information and potentially confuse consumers who may reasonably look to a hospital website directly for charge information. Please refer to the discussion at 84 FR 65561.

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).

Updated- 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 established a discounted cash price for self-pay consumers for the items and services it provides. In the machine-readable file (MRF), if the hospital has not established a discounted cash price, the hospital must include the required "standard charge | discounted cash" data element in their MRF but would not be required to encode any standard charge information for that data element. If a hospital has established other types of discounts, such as a financial aid policy for a subset of consumers, the hospital may elect to include optional data elements, for example, "hospital financial aid policy", in the CMS MRF template and encode a hyper link to the policy. For more guidance on how to display and encode an optional data element, please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

Updated- 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 element values are available. Corresponding common billing and accounting codes must be included. Please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

Is there a limitation on the number of third-party payers for which we must 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 the discussion at 84 FR 65551.

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.

Updated- 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, is my hospital required to establish a payer-specific negotiated charge for that item or service?

No. 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 this standard charge information 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. Hospitals must ensure each required data element is included in its machine-readable file and leave blanks where there is no applicable standard charge information to encode. Follow the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

Updated- My hospital has not established or negotiated a standard charge for an item or service. How should I display items and services for which there is no standard charge?

Your hospital should only include an item or service in its machine-readable file if your hospital has established one or more standard charges for it. For more guidance on how to display and encode your data in the MRF, please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

Updated- My hospital has negotiated a standard charge of $0 for a subset of items and services, how should I encode charges for the "payer-specific standard charge: dollar amount" data element in the machine-readable file?

The valid values for the "payer-specific standard charge: dollar amount" data element must be

indicated as a numeric value. the Data Dictionary indicates that all "Numeric" data elements must be positive numbers. Entering a negative number or "0" will generate a deficiency. If your hospital has negotiated a $0 dollar amount for a hospital item or service, you should not encode data in the “payer-specific standard charge: dollar amount” data element and provide additional context in either the “additional payer notes” or “additional notes” data element, depending on which CMS Template layout you choose to adopt. For more guidance on how to display and encode your data in the MRF, please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

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 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. Please refer to the discussion at 84 FR 65544.

Machine-Readable File

Updated- What is a 'machine-readable' file? What formats are hospitals allowed to post their machine-readable files in? Are hospitals allowed to post their machine-readable files in a format other than the ones made available through the CMS template layout, such as Microsoft Excel, .XML, PDF?

A machine-readable file is a single digital file that is in a machine-readable format. Beginning on July 1, 2024, the hospital's machine-readable file must conform to a CMS template layout, data specifications, and data dictionary. CMS has made the CMS template available in three non-proprietary formats: CSV "tall", CSV "wide", and JSON. Hospitals must make their file available in one of these templates. Files in Microsoft Excel, .XML, or PDF are not compliant. CMS strongly recommends hospitals start with one of the template layouts to create your machine-readable files as opposed to trying to convert an existing machine-readable file to one of the templates. Refer to 45 CFR § 180.20, 45 CFR § 180.50(c), and the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at GitHub - CMSgov/hospital-price-transparency.

Updated-Where can I find the required CMS templates or more information on how to encode my hospital's standard charge information and each of the required data elements?

CMS has created a GitHub repository to house the required CMS templates, in a CSV "tall", CSV "wide" and JSON format, and provides the data dictionary, or technical instruction, on how hospitals must encode standard charge information into machine-readable files for each required data element. The CMS Hospital Price Transparency - Data Dictionary GitHub repository is available at https://github.com/CMSgov/hospital-price-transparency.

Updated- Will changing the order of the CSV headers or JSON attributes in the CMS templates result in a deficiency or cause my MRF to be considered noncompliant with the form and manner prescribed by CMS for encoding standard charge information?

Changing the order of the CSV headers or JSON attributes in the CMS template layouts will not generate a deficiency. Please refer to the documentation and examples on the CMS Hospital Price Transparency - Data Dictionary GitHub repository for more information at https://github.com/CMSgov/hospital-price-transparency.

Updated- My hospital's machine-readable file update occurs between publication of the CY 2024 OPPS/ASC Final Rule and July 1, 2024, when use of the new CMS template is required. Am I required to update my hospital's machine-readable file now and again in the new CMS template as of July 1, 2024?

As finalized in the CY2024 OPPS/ASC final rule, beginning July 1, 2024, all hospitals must adopt a CMS template and encode in it the hospital's standard charge information in the form and manner finalized in the CMS Hospital Price Transparency - Data Dictionary GitHub repository available here https://github.com/CMSgov/hospital-price-transparency. CMS will enforce these requirements beginning on July 1, 2024.

What updates did CMS make to the accessibility requirements of the machine-readable file in the CY 2022 OPPS/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 agree to terms and conditions or submit other information prior to access. Refer to the discussion at 86 FR 63951.

Updated- How can my hospital ensure that its machine-readable file is "prominently displayed"? What requirements must hospitals adopt to improve automated access to machine-readable files because of the CY 2024 amendments to the Hospital Price Transparency Final Rule?

In the CY 2024 OPPS/ASC Final Rule, CMS finalized the following accessibility requirements, effective January 1, 2024, the hospital must ensure that the public website it selects to host its

machine-readable file establishes and maintains, in the form and manner specified by CMS:

- A .txt file in the root folder that includes a standardized set of fields including the hospital location name that corresponds to the machine-readable file, the source page URL that hosts the machine-readable file, a direct link to the machine-readable file (the machine-readable file URL), and hospital point of contact information. For more information, access the Hospital Price Transparency TXT File Frequently Asked Questions (FAQs).
- A link in the footer on its website, including but not limited to the homepage, that is labeled "Price Transparency" and links directly to the publicly available web page that hosts the link to the machine-readable file.

In addition, we recommend that hospitals 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.

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| |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. json or .csv as applicable to the CMS Template you have selected.
- 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.

***Updated*- My hospital establishes the same set of standard charges across all our 30 locations. Must I list each location in the machine-readable file when using the CMS Template (effective July 1, 2024)?**

Beginning July 1, 2024, hospitals are required to encode the name(s) and address(es) of each hospital inpatient location and each standalone emergency department in the machine-readable file. While strongly encouraged, it is not required to encode all outpatient locations. We note, however, that even though we are making this practical accommodation, hospitals must still include all standard charge information in the machine-readable file, including standard charge information for outpatient locations not encoded for this data element. In other words, this accommodation should not be interpreted to mean that hospitals need not include the standard charges that apply to outpatient locations that operate under the single hospital license but whose location names and addresses are not required to be encoded. Please refer to the discussion at 88 FR 82092.

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.

Updated- If my hospital contracted for the same payer-specific standard charges across all a payer's plans, does my hospital need to list each individual plan in the machine-readable file?

As a result of a better understanding of hospital and commercial payer contracting, we finalized in the CY 2024 OPPS/ASC final rule that hospitals may indicate plan(s) as categories (such as "all PPO plans") for a particular payer when the established payer-specific negotiated charges are applicable to each plan in the indicated category. We believe this exception is necessary to ensure that hospitals are not penalized for displaying information that is consistent with their contracting practices. Moreover, we believe that this practice could improve access to machine-readable file data by avoiding repetition of standard charge information that would unnecessarily increase file size. Please refer to the discussion at 88 FR 82093.

Updated- What should I do if my hospital contracts using algorithms that are too complex and lengthy to encode in the machine-readable file?

Although we believe that a detailed algorithm provides a better understanding of the hospital's payer-specific negotiated charge, at this time, in the interest of reducing burden and complexity of files, we will allow hospitals to provide a description of the algorithm that includes any conditions that may alter the total reimbursement, rather than attempting to insert the detailed algorithm itself in the machine-readable file. For example, if a payer-specific negotiated charge is negotiated using a common "hybrid" algorithm, such as the MS-DRG, then a hospital would indicate the adjusted base rate (in dollars) for an individual rather than inserting the algorithm formula itself (88 FR 82097). Please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

Updated- Should the de-identified minimum negotiated charge and the de-identified maximum negotiated charge be based on the "Payer-specific Negotiated Charge: Dollar Amount", "Payer-Specific Negotiated Charge Algorithm", or the "Payer-specific Negotiated Charge Percentage"?

At 45 CFR § 180.20 we defined the "de-identified minimum negotiated charge" to mean the lowest charge that a hospital has negotiated with all third-party payers for an item or service and the ''de-identified maximum negotiated charge'' to mean the highest charge that a hospital has negotiated with all third-party payers for an item or service. In the CMS Template(s) the

values for these data elements should be derived from the "Payer-specific Negotiated Charge: Dollar Amount" data element. Please see the examples provided on the CMS Hospital Price Transparency – Data Dictionary GitHub Repository at https://github.com/CMSgov/hospital-price-transparency for how to encode your data in one of the three required CMS Templates.

Updated- What is an "estimated allowed amount" and when is it required in the machine-readable file?

At 45 CFR § 180.20 we defined "estimated allowed amount" as the average dollar amount that the hospital has historically received from a third-party payer for an item or service. Beginning on January 1, 2025, hospitals are required to encode a dollar value for the "estimated allowed amount" data element, when a payer-specific negotiated charge can only be expressed as an algorithm or percentage. This includes: hybrid scenarios where the standard charge dollar is a base rate and there is an algorithm that accounts for additional individualized charges; where the standard charge is a percent that cannot be calculated as a dollar figure; and where the standard charge is an algorithm (88 FR 82100). Please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

Updated- How do I calculate the "estimated allowed amount"?

In the CY 2024 OPPS/ASC Final Rule we stated that we believed hospitals should retain flexibility, in the interest of reducing burden, to determine the best data source for calculating the estimated allowed amount. We declined at the time to be prescriptive, but indicated that using information from the EDI 835 electronic remittance advice (ERA) transaction, the electronic transaction that provides claim payment information, including any adjustments made to the claim, such as denials, reductions, or increases in payment, would appear to meet this requirement as the data in the 835 form is used by hospitals to track and analyze their claims and reimbursement patterns (88 FR 82101). We will continue to work with hospitals and other interested parties to better understand how hospitals are developing the estimated allowed amount and we may provide additional guidance through future notice and comment rulemaking.

Updated- My hospital just negotiated contracts based on the percentage of billed charges with several new payers and does not have enough historical claims to derive the estimated allowed amount for specific services. What should we do?

CMS recommends that your hospital encode 999999999 (nine 9s) as the data element value to indicate that there is not sufficient historic claims history to derive the estimated allowed amount, and then update the file when sufficient history is available. Additionally, if your hospital wishes to provide further context for the lack of data, your hospital can do so in the

appropriate additional notes field. Please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

Updated- Can CMS advise me on how to encode specific standard charge information for my hospital?

As explained in the CY2024 OPPS/ASC final rule, hospitals use different methods to establish standard charges for items and services, resulting in charge/item and charge/service combinations that are often unique to that hospital. Therefore, although CMS has recently taken steps toward standardization, each hospital will continue to have some discretion related to how it chooses to encode its standard charge information (including information related to payer-specific negotiated charges) within its machine-readable file, so long as the file conforms to the CMS template layouts and data specifications as described at 45 CFR § 180.50(c)(2).

Updated- I would like to propose additional valid values for the CMS machine-readable file template, how do I do that?

You may propose additional valid values by creating a new discussion post on the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency, or by emailing the CMS Hospital Price Transparency team at PriceTransparencyHospitalCharges@cms.hhs.gov.

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 the 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 84 FR 65574 for further discussion.

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 shoppable services in a consumer-friendly manner when the hospital offers them 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?

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 (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 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.

Please 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 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 out-of-pocket price estimates. 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). Please refer to 84 FR 65577 for further discussion on this topic.

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 (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.

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.

Monitoring and Penalties for Noncompliance

What happens if a hospital does not comply with the Hospital Price Transparency Final Rule?

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.

Updated- I can't find standard charges for a hospital where I have received or will be receiving care. Should I file a complaint? What happens after I file a complaint?

The hospital price transparency team is only able to address concerns related to the specific requirements of the hospital price transparency initiative. If you are seeking a personalized price for healthcare services you received or are scheduled to receive, we recommend you contact the hospital. If you are looking for hospital standard charge information made public online in a machine-readable file format but are unable to find it, you may submit a complaint to CMS.

CMS does not respond to the original complaint. All publicly available enforcement activities and actions can be found at https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes, and https://www.cms.gov/hospital-price-transparency/enforcement-actions.

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 changes, 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 45 CFR §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)).

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 several 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 Hospital Price Transparency | CMS with extensive FAQs, guides, webinar presentations and recordings for hospitals;
- established a hospital price transparency tools website at Hospital Price Transparency - Tools (cmsgov.github.io) with tools to support hospitals in meeting some of the machine-readable file (MRF) requirements;
- established the Hospital Price Transparency- Data Dictionary GitHub repository which houses the required CMS MRF templates, provides the data dictionary (or technical instruction) on how hospitals must encode standard charge information into machine-readable files starting July 1, 2024, and provides technical support; 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.

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

An authorized official from your hospital may contact CMS via email at: HPTCompliance@cms.hhs.gov. When contacting CMS regarding the Hospital Price Transparency warning letter your hospital received, please submit detailed questions in writing. CMS cannot offer anything that could be construed as legal advice. We therefore recommend that individuals consult with hospital counsel and/or compliance officials.

Updated- Do I need to respond to a warning notice my hospital received?

Yes. As indicated in the CY 2024 OPPS/ASC Final Rule, CMS requires a hospital to submit an acknowledgement of receipt of the warning notice in the form and manner, and by the deadline, specified in the notice of violation issued by CMS to the hospital. Please refer to the discussion at 88 FR 82118.

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

No. 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.

Updated- My hospital is part of a larger hospital system. What happens if one of the hospitals in our health system received a warning notice from CMS outlining deficiencies?

As indicated in the CY 2024 OPPS/ASC Final Rule, in the event CMS takes an action to address hospital noncompliance and the hospital is determined by CMS to be part of a health system, CMS may notify health system leadership of the action and may work with health system leadership to address similar deficiencies for hospitals across the health system. Please refer to the discussion at 88 FR 82119.

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 to 45 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*200/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. Please refer to the discussion at 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 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. Please refer to the discussion at 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). Please refer to 45 CFR § 180.90(c)(2)(ii)(D)(2).

Is there a public list of non-compliant hospitals that have been assessed a civil monetary penalty (CMP)?

The public list of non-compliant hospitals that have been assessed a CMP is located on the CMS Price Transparency website: https://www.cms.gov/hospital-price-transparency/enforcement-actions.

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.

[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.

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) 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 and 45 CFR §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 45 CFR §150.405(b), for failing to timely exercise its right to a hearing.